State Aid and Healthcare: between competition and constitutionalism

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Abstract:

The recent state aid cases of *Dôvera* and *Casa Regina Apostolorum* demonstrate how competition and healthcare remains a contentious issue, highlighting tensions between both economic and social aspects, and EU and Member State competences. The approach taken by the EU courts typically emphasises total non-applicability of the state aid rules, although partial immunity via the Services of General Economic Interest (SGEI) mechanism is gaining greater recognition via cases such as *Brussels Hospitals* and successive Commission SGEI "packages". With the State Aid Temporary Framework – introduced in response to the COVID-19 pandemic – support for various healthcare activities was facilitated via the Article 107(3) TFEU justifications.

This chapter suggests that these three aspects – from non-applicability, via SGEI, to Article 107(3) TFEU – can offer further insight into where market forces can usefully be deployed in healthcare reform, and where these may have a detrimental effect. However, further understanding can be gained from examining constitutional aspects – not only Member State competence for healthcare under Article 168(7) TFEU, but also perceptions of "competence creep" at EU level regarding national healthcare, and implications for both levels of developing a European Health Union.

This chapter advances discussions in this area by juxtaposing "competition" and "constitutionalism" perspectives, while drawing on insights from before and during the COVID-19 pandemic.

Keywords: min. 6 keywords

Competition; COVID-19; European Health Union; EU; Member State; Service of General Interest; Service of General Economic Interest; State aid; Subsidiarity.

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1. Introduction

The relationship between competition and healthcare constitute an issue which remains topical and contentious, highlighting tensions both between economic and social aspects, and within the EU and Member State interaction. The development of competition reforms in healthcare at a national level has been accompanied by a growing literature and body of case law outlining EU competition law frameworks since the early 1990s.[1] The first decade of the 21st century offered scope for examination of this in light of the consideration that it was not possible to ignore markets in healthcare.[2]

However, recent decisions such as the Court of Justice of the European Union (CJEU)'s 2020 judgment in *Dôvera*[3] and the 2021 General Court's judgment in *Casa Regina Apostolorum*[4] perhaps suggest an ongoing reluctance by the EU courts to engage with this evolving reality of markets in healthcare. While these cases largely follow an earlier generation of cases, they unfold against a backdrop of changing attitudes towards competition reforms in healthcare[5] and expansion of private sector delivery of public healthcare services. Thus recognition of the role markets can play in healthcare system modernisation appears to become more nuanced,[6] tempered by considerations that it may be more beneficial to recognise both where active application of competition law in healthcare may be useful,[7] and where markets may not be able to deliver effectively in the public interest,[8] for example, specialist healthcare services.[9]

These new cases also unfold against the separate backdrop of possible changes in attitude regarding the interaction between the EU and Member State levels emerging from the implementation of the Lisbon Treaty. Article 168(7) Treaty on the Functioning of the European Union (TFEU) is the current formulation of the "subsidiarity clause for healthcare",[10] and deemed more extensive than its predecessor[11] in underscoring the role for Member States in determining national health policy and healthcare system organisation – both relevant for considerations of competition. The TFEU's greater recognition of SGEI – and the role of Member States in defining these – has also developed with regard to healthcare via successive Commission SGEI "packages" and notable

[1] Joined Cases C-159/91 and C-160/91 *Christian Poucet v Assurances Générales de France and Caisse Mutuelle Régionale du Languedoc-Roussillon* ECLI:EU:C:1993:63 are typically cited as among the first to engage with the interaction between EU competition policy and national healthcare systems.
[2] Szyszczak 2009.
[3] Case C-262/18 P *Commission v Dôvera zdravotná poist'ovňa*, a.s., ECLI:EU:C:2020:450, 11 June 2020.
[4] Case T-223/18 *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v Commission*, ECLI:EU:T:2021: 315, 2 June 2021.
[5] The prominent reforms in Dutch and English healthcare enshrined in legislation in 2006 and 2012 respectively have both subsequently been reframed, scaled back, and in the English context, repealed. See further, Guy 2019 and Guy 2023.
[6] Albeit reaffirming long-standing distinctions drawn between the US and Europe regarding competition in healthcare. Greaney and Odudu 2022.
[7] Nikolić 2021.
[8] Van de Gronden 2018.
[9] Van de Gronden and Guy 2021.
[10] Hancher and Sauter 2012, page 221.
[11] Article 152(5) Treaty on the European Union.

cases such as *BUPA*[12] and *Brussels Hospitals*,[13] yet the mechanism arguably remains elusive and not well understood.[14]

Both backdrops find reflection in responses to the COVID-19 pandemic, which, along with growing concerns about environmental destruction and the development of digitalisation, might be considered among the defining features of the first quarter of the twenty-first century. One of the Commission's responses to the COVID-19 pandemic was to introduce temporary frameworks relaxing the state aid rules based on the Article 107(3) TFEU exceptions which were – following several extensions – in operation between March 2020 and June 2022. While some decisions taken regarding the healthcare sector might be attributed primarily to a direct "crisis" response of, e.g., ensuring supply of items of personal protective equipment, other decisions also suggest a "continuity" response, indicating tensions to wider public healthcare delivery and access exacerbated by the pandemic which seem likely to persist.[15] This latter aspect, while addressed within the temporary framework by Article 107(3) TFEU exceptions, has features which suggest that the SGEI may provide a more robust exception over the longer term.[16] The balance between EU and national competence regarding healthcare has been given significant momentum by the further pandemic response of developing a European Health Union. While this has evolved between 2020 and 2022 to suggest that its focus may be primarily on health security threats, calls have also been made via the recent Conference on the Future of Europe for health to assume a "shared competence" status,[17]

This chapter focuses on state aid as an aspect of EU competition policy with particular relevance to healthcare both at EU and national levels.[18] It aims to advance understanding of developments in this area of the past generation[19] by juxtaposing "competition" and "constitutionalism" perspectives (respectively Sections 2 and 3) to consider key cases and policy. This discussion indicates that constitutionalism, defined here specifically with regard to differing EU-level oversight of healthcare (a national competence as noted above) may offer the more robust explanation for the approaches continued by the EU courts thus far.[20] Section 4 concludes with insights emerging both before and during the COVID-19 pandemic regarding whether the operation of the state aid rules in the healthcare context can be better understood in terms of constitutionalism rather than competition given the political sensitivities which attach to the national and EU levels.

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[12] Case T-289/03 *British United Provident Association Ltd (BUPA), BUPA Insurance Ltd, BUPA Ireland Ltd v Commission*, 12 February 2008, ECLI:EU:T:2008:29.

[13] Culminating in Commission Decision C(2016) 4051 of 5 July 2016 on State aid SA.19864 – 2014/C (ex 2009/NN54) implemented by Belgium - Public financing of Brussels public IRIS hospitals.

[14] Nikolić 2021 has suggested that Member States may prefer to try to exempt their healthcare systems totally.

[15] For an early evaluation, see Guy 2020a.

[16] Ibid.

[17] See Recommendation 49 in Conference on the Future of Europe, Report on the Final Outcome, May 2022. https://futureu.europa.eu/en/pages/reporting?format=html&locale=en This would require amendment of Article 4 TFEU, and would mark a notable development. Currently, healthcare (system organisation) is exclusively a Member State competence under Article 168(7) TFEU, while the EU can complement Member State activity in other aspects of health (notably public health) under Article 168 TFEU.

[18] Thereby complementing the chapters by Suorsa and Clark on other aspects of SGEI and healthcare in this volume.

[19] Since publication of the 2009 TMC Asser Press volume *The Changing Legal Framework for Services of General Interest in Europe – Between Competition and Solidarity*.

[20] It being noted that at the time of writing (November 2022), the CJEU appeal in *Casa Regina Apostolorum* is pending.

2. State aid and healthcare: a competition law perspective

The applicability of the state aid rules – also the antitrust rules – is determined by the "undertaking" concept – typically defined in "functional" terms as an "economic activity"[1] which consists in "offering goods and services on a market".[2] Case law interpreting these principles in the context of healthcare has generated a broad framework in which healthcare providers are typically seen as subject to competition rules (regardless of whether the healthcare system is taxation-funded or insurance-based),[3] but healthcare purchasers may not be, depending on the subsequent use of the purchased goods or services[4] This may appear to suggest a contradiction insofar as providing and purchasing may be seen as two sides of the same transaction, thus both represent the requisite "economic activities" for triggering EU competition law.[5] A further, pertinent, consideration in view of this "functional" nature of the undertaking concept is that challenges arise "…from the fact that the law is being applied to not-for-profit or bodies controlled by the state."[6] These distinctions have given rise to different interpretations by the Commission and EU courts being characterised as "abstract" and "concrete",[7] and "classic functional" and "attenuated functional",[8] according to how strictly the functional test is applied, and how much attention is paid to the national context/legal framework in reaching conclusions about applicability. The national context in particular also highlights tensions between competition and solidarity, which apply to the SGEI mechanism as well, which operates to provide "partial immunity" to the antitrust and state aid rules.[9]

Despite important conceptual differences between the antitrust and state aid rules,[10] the common starting-point of the "undertaking" concept, and the overall aims of avoiding distortions of competition in the internal market, mean that overall understanding of the EU's approach in these cases is shaped by both sets of rules. Nevertheless, the contours of the state aid regime with regard to healthcare have been considered better developed,[11] and this appears reaffirmed by the recent cases.

In locating where the state aid rules might become relevant in the healthcare context, it is useful to consider "four categories of European healthcare"[12] thus:

[1] Case C-41/90, *Klaus Höfner and Fritz Elser v Macrotron GmbH*, ECLI:EU:C:1991:161.
[2] Case C-35/96, *Commission of the European Communities v Italy*, ECLI:EU:C:1998:303.
[3] For further discussion, see van de Gronden and Guy 2021.
[4] van de Gronden and Rusu 2017.
[5] Guy 2019, page 75.
[6] Odudu 2022.
[7] van de Gronden 2004.
[8] Gallo and Mariotti 2017.
[9] See, inter alia, Belhaj and van de Gronden 2004, and Boeger 2007.
[10] For example, the consumer welfare standard underpins the antitrust rules, but arguments have been advanced for a consumer-taxpayer welfare standard to be applied regarding the state aid rules. Friederiszick et al. 2007, and for further discussion, Cseres and Reyna 2021.
[11] Hancher and Sauter 2012.
[12] This is adapted from the "four categories of English healthcare" identified in connection with the evolving interaction between the National Health Service and the private healthcare market which underpins competition reforms introduced in statute in England. See further, Guy 2019 page 40.

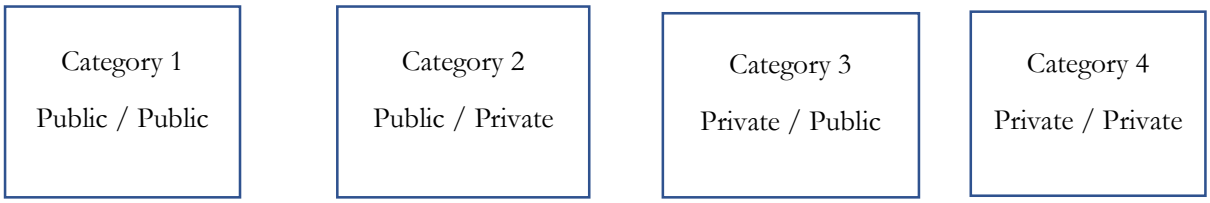

Figure 1: The "four categories" of European healthcare.

In essence categories 1 and 2 comprise the public healthcare system, in which public insurers or providers (category 1) or private insurers or providers (category 2) may operate. Conversely, categories 3 and 4 represent private healthcare markets which may coexist with public healthcare systems, with varying degrees of competition *between* the two. Thus category 3 typically comprises public provision, and category 4 private activity (insurance/provision), vis-à-vis *private* patients who fund their own treatment. While not intended to represent definitively all Member State healthcare systems, this typology nevertheless can provide a useful framing for aspects of national healthcare systems which are increasingly at issue in the EU courts' considerations, as any attempt to classify healthcare in terms of distinguishing the extremes of categories 1 and 4 becomes characterised by blurred lines. Thus in *Dôvera* we see private insurers challenging support for state insurers (category 2), while in *Casa Regina Apostolorum*, the focus has included not only private delivery of public healthcare (category 2), but also public hospitals treating private patients (category 3), with the underlying complaint coming from a private provider (with an implicit focus on category 4). In contrast, the SGEI packages, in emphasising hospital financing in particular, suggest an emphasis on category 1 activity (with some reference to category 2).[13]

Within the "mechanics" of EU competition law, three exception mechanisms can be identified: classification of a service of general interest (SGI) such that competition law does not apply; classification of an economic activity as a service of general economic interest (SGEI), which offers partial immunity from the applicability of EU competition law; and justifications for breaching the prohibitions on anticompetitive agreements (Article 101(3) TFEU) and on state aid (Article 107(3) TFEU). While the SGI blanket exception might be considered the most common in the EU courts' reasoning, the approaches taken with regard to the two other mechanisms also warrant examination. By linking these three exception mechanisms together, a more complete picture may emerge while reflecting recognition that individual cases may reference both Article 106(2) TFEU and Article 107(3)(c) TFEU in outlining a counterfactual,[14] or highlighting reference to SGEI in order to ground an assertion that the activities involved are indeed economic.[15]

2.1. SGI in healthcare

[13] The latter featuring in SA.38825 Alleged State Aid to private providers of socio-sanitary services. 02.06.2017.

[14] As happened in COMMISSION DECISION (EU) 2015/248 of 15 October 2014 on the measures SA.23008 (2013/C) (ex 2013/NN) implemented by Slovak Republic for Spoločná zdravotná poisťovňa, a. s. (SZP) and Všeobecná zdravotná poisťovňa, a. s. (VZP), paragraph 53. In contrast, the General Court in *Casa Regina Apostolorum* roundly rejected the suggested need to conduct an Article 106(2) TFEU investigation. T-223/18 *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v Commission*, ECLI:EU:T:2021: 315, 2 June 2021. See paragraphs 144-151 in particular.

[15] Which formed an aspect of the complaint to the Commission in *Casa Regina Apostolorum*. In this instance, the Commission considered that including healthcare activities in the Italian SGEI reports was not evidence of the economic nature of activities. SA.39913 (2017/NN) Alleged compensation of public hospitals in Lazio.C(2017) 7973 final. 4.12.2017, paragraph 76.

The finding of an SGI means that activities are not economic in nature – typically purchasing activities, as noted above. Indeed it has been considered in particular that the tension between the "classic" and "attenuated" functional approaches remains unresolved[16] in the context of state aid cases.

Dôvera involved a challenge by a private health insurer to state aid granted to state health insurers, against the backdrop of the coexistence of public and private bodies within the Slovak system of compulsory health insurance. The Commission's 2014 decision[17] – and indeed the CJEU's 2020 judgment[18] – might be considered to tend more towards the "concrete", or the "attenuated functional" approaches insofar as it emphasised how the health insurance scheme was operated, and the centrality of solidarity within this.[19] In contrast, the two grounds for appeal put forward by one of the private health insurers (Dôvera) tended towards the more "abstract" or "classical functional" approaches by referencing, inter alia, the scope for competition within the system, and the public and private health insurers' activities beyond this. It is, however, interesting to see how the General Court's response finding – that the state aid rules did apply – also appeared to align more with the "abstract" or "classic functional" approaches, by reference to a wider definition of 'competition' encompassing quality and price. The alignment appears encapsulated primarily by General Court's focus on the insurers' profit-making ability, and the striking consideration that

"[…] since it is common ground between the parties that the other [private] operators on the market in question are seeking to make a profit, so that SZP and VšZP [the state insurers], 'by contagion' would have to be considered to be undertakings."[20]

The CJEU's ultimate finding which focused, inter alia, on the solidarity-based nature of the Slovak health insurance scheme, indicated however a perspective which is consistent with the "concrete" or "attenuated functional" approaches.

The ongoing *Casa Regina Apostolorum* case involves a complaint by a religious congregation (which owns a private hospital) regarding alleged compensation of public hospitals in the Lazio Region in Italy. Here too the complainant's perspective might be considered to be in line with the "abstract" or "classic functional" approaches, given the emphasis it placed on perceptions of market behaviour by public hospitals and private hospitals delivering public healthcare services in light of successive competition reforms emphasising patient choice in the Italian healthcare system, as well as the treatment of private patients by the public hospitals.[21] In contrast, the Italian authorities – and subsequently the Commission – can be considered to take more of a "concrete", or "attenuated functional" approach,[22] by underscoring the underlying principle of solidarity within the Italian healthcare system which remained unchanged by either the "corporatisation" of public

[16] Gallo and Mariotti 2017.
[17] See further Van de Gronden and Guy 2021.
[18] Case C-262/18 P *Commission v Dôvera zdravotná poist'ovňa*, a.s., ECLI:EU:C:2020:450, 11 June 2020
[19] See COMMISSION DECISION (EU) 2015/248 of 15 October 2014 on the measures SA.23008 (2013/C) (ex 2013/NN) implemented by Slovak Republic for Spoločná zdravotná poisťovňa, a. s. (SZP) and Všeobecná zdravotná poisťovňa, a. s. (VZP), paras 85-99.
[20] Case T-216/15 *Dôvera zdrvotná poist'ová and Union zdrvotná poist'ová*, 5 February 2018, ECLI:EU:T:2018:64, paragraph 69.
[21] Case SA.39913 (2017/NN) – *Italy. Alleged compensation of public hospitals in Lazio.* C(2017) 7973 final. 4 December 2017. Paragraphs 12, 16, 19, 20 in particular.
[22] The latter in particular highlighted by the clear reference to the *FENIN* judgment at Case SA.39913 paragraph 57.

hospitals, or the treatment of private patients.[23] The Commission ultimately concluded that the compensation did not constitute state aid within the meaning of Article 107(1) TFEU.

On appeal, the General Court rejected the claims, including that the Commission had not paid sufficient attention to the marketisation reforms indicated by the Casa Regina Apostolorum congregation. While the General Court drew on *Dôvera* (and previous case law) to make various of its points regarding the ongoing relevance of solidarity and universality, it is interesting to note that it also drew on a logic from *CEPPB*[24] (a case concerning the Spanish education system) requiring activity-by-activity-level examination, in recognising the possibility of the coexistence of both economic and non-economic activities being performed by a public hospital.[25] This "disaggregation" logic, when coupled with the *CEPPB* "three-prong test" of public financing and public interest,[26] may come to represent an alternative approach to, or mid-way point between, the "abstract"/ "classical funcational" and "concrete" / "attenuated functional" approaches.

At the time of writing (November 2022), the Casa Regina Apostolorum congregation's appeal to the CJEU[27] is awaited. Two points of appeal are of particular interest to the present discussion. Firstly, the General Court's reliance on *Dôvera* and application of this to the facts of *Casa Regina Apostolorum* is disputed as it did not carry out a detailed analysis of certain of the competition reforms in the Italian healthcare system, nor did it compare this with the rules governing provision of healthcare services in Slovakia. Secondly, the congregation disputes the General Court's finding that the concept of activity on the basis of universality can preclude the applicability of the SGEI mechanism, given that such activities can be so regarded in other sectors, such as water. This second point in particular may offer a different dimension to the current discussion, perhaps giving more weight to a "competition" rather than a "constitutionalism" approach, or a shift towards the "abstract" or "classical functional" approaches. It is hoped that the Advocate General's Opinion and the CJEU's judgment engage with both these grounds of appeal in depth.

As a final consideration of SGIs in the healthcare context, and specifically state aid cases, it should be recalled that further scope for excluding the applicability of EU competition law resides in the finding that there is no effect of the conduct on trade between Member States. An instance of where this was found was in a 2015 Commission Decision on the granting of public financing to five public hospitals in the Czech Republic.[28] Given the national (if not regional) focus of healthcare systems, it might be considered that it would not be unusual for this intra-state trade hurdle not to be crossed, at least with regard to hospital financing.

2.2. SGEI in healthcare

From a competition perspective, various criticisms have emerged regarding development of the SGEI mechanism and how this has been applied in the healthcare context. These relate in part to the modifications made to utilising the *Altmark*[29] criteria as an exception to the state aid rules, and with an emphasis on Article 106(2) TFEU as a proxy for the fourth criterion – otherwise

[23] Case SA.39913. See in particular paragraphs 27-29, 37, 41, 59, 65, 75 and 78.
[24] C-74/16 *Congregación de Escuelas Pías Provincia Betania*, EU:C:2017:496.
[25] T-223/18 *Casa Regina Apostolorum v Commission*. See paragraphs 182-183.
[26] Van de Gronden 2018.
[27] Case C-492/21/ P *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v Commission,* application 29th October 2021.
[28] Commission Decision C(2015) 2796 final of 29.04.2015 on SA.37432 (2015/NN), *Funding to public hospitals in the Hradec Králové Region*, C(2015) 2796 final. Discussed in Gallo and Mariotti 2017 and Biondi and Ştefan 2020.
[29] C-280/00 *Altmark Trans et Regierungspräsidum Magdeburg*, ECLI:EU:C:2003:415.

conceptualised as the tension between the "state aid" and "compensation" approaches.[30] Of particular note is the General Court's readiness to find an SGEI mission in *BUPA*,[31] a case which concerned a challenge regarding the Irish risk equalisation scheme by the then largest private provider. This prompted concerns about the stricter approach taken to the Dutch risk equalisation scheme by the Commission,[32] the dynamic between government and market failures,[33] but also questions of competence.[34] The judgment was also considered to adopt a "jurisdictional approach", entailing that the application of Article 107 TFEU ultimately depends on the characterisation of the undertaking involved and the SGEI it performs, rather than on a substantive and in-depth (economic) assessment of whether the public service mission is discharged in a proportionate manner.[35] The General Court's approach in *BUPA*, which included a lower-intensity examination of national definition of SGEI, nevertheless appears to mark a point of reference in the evolution of SGEI both with regard to healthcare and in general.[36]

The General Court has also considered the assignation of SGEI in the context of hospital financing in the long-running *Brussels Hospitals* case. This evolved from a 2005 Commission finding of SGEI rendering payments to certain public hospitals in Brussels compatible with the internal market, to a 2009 appeal[37] in which the General Court established the procedure regarding when the Commission should conduct more in-depth assessments under Article 108 TFEU. The Commission's investigation was opened in 2014, and concluded in 2016,[38] finding that payments made to certain public hospitals in the Brussels region, while constituting state aid under Article 107(1) TFEU, were correctly classified as SGEI under Article 106(2) TFEU. This finding was made by virtue, inter alia, of their specific mission to ensure continuity (*pérennité*) of services in the face of financial difficulties – which did not also apply to private providers. By examining the context of the funding, it has been considered that SGEI considerations can also be characterised by the "attenuated functional" approach.[39] This might be considered to align the Commission's approach to SGEI in healthcare with that of the courts.

Certainly, the development of SGEI in healthcare has been cast as two phases – the first by the EU courts, as indicated above, and the second by the Commission in implementing its 2005 and 2012 SGEI packages to minimise legal uncertainty.[40] Within the SGEI packages, we see initially

[30] Gallo and Mariotti 2017.
[31] Case T-289/03 *British United Provident Association Ltd (BUPA), BUPA Insurance Ltd and BUPA Ireland Ltd v Commission of the European Communities*. ECLI:EU:T:2008:29.
[32] See further, de Vries 2011 and Hancher and Sauter 2012.
[33] Burke 2018.
[34] Ross 2009.
[35] Thus a third approach to be juxtaposed with the "state aid" and "compensation" approaches. de Vries, 2011.
[36] De Cecco 2013 page 145; Ølykke and Møllgaard 2016.
[37] T-137/10 *CBI v Commission*, judgment of 7 November 2012, ECLI:EU:T:2012:584.
[38] SA.19864 - 2014/C (ex 2009/NN54) implemented by Belgium Public financing of Brussels public IRIS hospitals Brussels, 5.7.2016 C(2016) 4051 final.
[39] Gallo and Mariotti 2017.
[40] Ibid.

SGEI regarding hospitals,[41] and latterly SGEI regarding "health and long-term care",[42] being exempt from notification requirements in the Commission's recognition that "[h]ealth and social services form an essential part of the welfare system of each Member State and are of crucial importance for citizens".[43] This might be considered reinforced by its attempt – via the 2012 SGEI package – to simplify compatibility criteria and reduce the administrative burden for Member States.[44] Nevertheless, concerns have emerged from a competition perspective that, by stipulating hospital financing already in the 2005 package, Member States were sheltered "from making tough decisions on access priorities and preferential funding.[45] The broadening of the 2012 package to include "health and long-term care",[46] was considered to prompt the need for further clarification of what might be included within this, given the various ways in which health and social care systems are organised across Member States.[47] Certainly a diversity of state aid allegations can be identified which might be considered to fall within in the health and long-term care context – for example, in connection with selling blood plasma below cost,[48] or regarding prescription of branded pharmaceutical manufacturers over cheaper generics[49] – but none of these were found to fall within the Article 107(1) TFEU prohibition. The broadened category of "health and long-term care" has, however, also required demonstration at a national level of how the 2012 package is being complied with. This has been seen in the elaboration of measures promoting social welfare services in Germany,[50] and, at a national level, by the classification of a Dutch government subsidy of non-invasive prenatal tests as SGEI.[51]

The 2019 review of the 2012 SGEI package regarding health and social services has recently concluded and indicated some scope for improvement, and a need, inter alia, for further clarification on the distinction between "economic" and "non-economic" activities following cases such as *Dôvera* and *Casa Regina Apostolorum*.[52]

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[41] COMMISSION DECISION of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document number C(2005) 2673) (2005/842/E), Recital 16 and Article 2(1)(b). COMMISSION DECISION of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document C(2011) 9380) (2012/21/EU), Recital 11 and Article 2(1)(b).

[42] COMMISSION DECISION of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document C(2011) 9380) (2012/21/EU), Recital 11 and Article 2(1)(c).

[43] European Commission, 'Evaluation of State aid rules for health and social services of general economic interest (SGEI) and of the SGEI de minimis Regulation'. State aid modernisation SGEI evaluation – Competition - European Commission (europa.eu)

[44] Ibid.

[45] For a critical view, see Hancher and Sauter 2013.

[46] COMMISSION DECISION of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document C(2011) 9380) (2012/21/EU), Recital 11 and Article 2(1)(c).

[47] van de Gronden and Rusu 2013.

[48] SA.37624 Alleged illegal State Aid to Imuna Pharm. 15.10.2014.

[49] SA.43092 Unlawful State Aid complaint: Nurse Prescribers Ltd vs UK Department of Health. 14.02.2017.

[50] SA.42268 State Aid for the promotion of public welfare services. 06.12.2017.

[51] *Gendia v Dutch Ministry of Health, Wellbeing and Sport*, Case No. 200.225.476/01, Gerechtshof Den Haag, 11 December 2018, ECLI:NL:GHDHA:2018:3331. The facts of the case are discussed in English in Van de Gronden and Guy 2021.

[52] European Commission, Evaluation of the State subsidy rules for health and social services of general economic interest ("SGEIs") and of the SGEI de minimis Regulation. {SWD(2022) 389 final} 01.12.2022. Page 24.

2.3. Justifications for prohibition breaches in the healthcare context

It has been considered that – in contrast to SGEI – the Article 101(3) TFEU exception is not broad enough to encompass general public interest considerations or special concerns relating to public services.[53] Whether this criticism – essentially of whether the competition rules can be flexible enough to accommodate specificities of the healthcare sector – also holds for the justifications associated with the state aid rules is moot. Certainly it is acknowledged that the Article 101(3) TFEU exception is more geared towards non-economic goals, while the state aid justifications have a different structure and focus, encompassing a range of aspects, such as aid having a social character and being granted to consumers,[54] and aid to facilitate the development of certain economic activities or areas.[55]

The most serviceable of the justifications for state aid in the healthcare context seems to be Article 107(3)(b) TFEU relating to promoting the execution of an important project of common European interest or to remedy a serious disturbance in the economy of a Member State. This has been used to support a pilot project for telemedicine infrastructure in Saxony in Germany,[56] and time-bounded financial support to three specialist clinics and two retirement homes in the Lazio region of Italy.[57]

This exception – and also Article 107(3)(c) TFEU, to facilitate development of certain economic activities or areas – formed the basis for the State Aid Temporary Framework (SATF), in operation between March 2020 and June 2022 as part of the Commission's response to the COVID-19 pandemic. While the aid approved under this scheme reached across the whole economy, concerns have emerged that the SATF did not manage to adequately contribute to a real investment in quality public health services.[58]

The SATF is also relevant to the present discussion because it has produced a range of cases upon which further contours of Commission and EU courts decisions may now emerge, particularly when it is noted that these decisions can be categorised as "crisis" and "continuity" responses.[59] Examples of "crisis" responses – typically approved under Article 107(3)(c) TFEU – include where aid was approved in connection with COVID-19 R&D, and producing COVID-19 relevant products, ranging from medicines, personal protective equipment and ventilators, to data processing tools.[60] In contrast, "continuity" responses related to healthcare provision and access not directly related to treating COVID-19, which might have implications for healthcare delivery beyond the pandemic situation. Examples of "continuity" responses include the COVID-Spas programme in the Czech Republic,[61] or support for eHealth applications to facilitate healthcare access in the Netherlands during the early stages of the pandemic.[62] These were approved under

[53] Prosser 2005, page 27. For consideration of how "non-competition goals" and public interest objectives can operate in connection with Article 101(3) TFEU in the healthcare context, see, inter alia, Hancher and Sauter 2012 and Van de Gronden 2011.
[54] Article 107(2)(a) TFEU.
[55] Article 107(3)(c) TFEU.
[56] Case SA.35679.
[57] Case SA.39426.
[58] Giosa 2023.
[59] Guy 2020a.
[60] See, for example, European Commission, 'Communication from the Commission – Temporary Framework for State Aid Measures to support the economy in the current COVID-19 outbreak' (Consolidated Version) C(2021) 564 of 28 January 2021. Sections 3.6 and 3.8.
[61] Cases SA.58018 and SA.61912.
[62] Case SA.57897 which extended an application under case SA.56915.

Article 107(3)(b) TFEU, and while not framed in these terms, the aid approved potentially gave rise to questions about the ability of markets to deliver particular services in general, thus perhaps indicating potential SGEI candidates over the longer term, which could generate further considerations of the juxtaposition of "competition" and "constitutionalism" perspectives.

3. State aid and healthcare: a constitutionalism perspective

As noted above, there are both common points governing the applicability of the antitrust and the state aid rules, and divergence insofar as conceptual differences emerge between how "competition" may be understood within these. From a constitutional perspective, state aid rules occupy a distinctive place which may be defined as between the internal market and a wider European economic constitution, and within the latter, a positioning between the free movement and antitrust rules.[63] A further distinctiveness lies in the state aid regime being exclusively EU-level, with no national equivalent. Thus, concerns which may emerge in relation to the antitrust rules, might not be expected to materialise in the same way with application of the state aid rules. Examples of such concerns might include scope for divergent interpretation resulting in "Euro-national competition rules for healthcare",[64] or concerns about national enforcement of EU law,[65] parallel application of national and EU competition frameworks,[66] or compatibility of national provisions with EU law.[67]

Insofar as economic law (thus the state aid rules) can be reconciled with constitutional law by a wider framing of the former to encompass non-market values,[68] this seems to have particular relevance to discussion of healthcare, as seen in the constitutional aspects clearly arising from the three aspects outlined above. Thus total exemption from the state aid rules via a finding of non-applicability might be considered to give effect to the Member State competence of Article 168(7)TFEU regarding healthcare system organisation. Related to this, but ultimately discrete, is the partial immunity afforded by the SGEI mechanism, with the underscoring of Member State competence in assigning SGEI. This is evident particularly given the emphasis and refocusing emerging from the Lisbon Treaty regarding SGEI.[69] While this particular focus does not engage with legal and political concerns emerging from the diverse range of instruments governing SGEI,[70] it nevertheless highlights the range of actors involved and their various understandings and the potential implications of this.[71] Finally, the Article 107(3) TFEU allowances may demonstrate how far the EU recognises differing expressions of the national competence regarding healthcare system organisation, albeit via the lenses of remedying serious economic disturbances[72] (particularly in response to the early phases of the COVID-19 pandemic), or facilitating the development of certain economic activities.[73]

Allied to constitutionalism are concerns about "competence creep", with the EU institutions apparently showing an ever-greater interest in national healthcare systems via EU competition

[63] See further, De Cecco 2012, pages 1, 17, and 31.
[64] van de Gronden and Szyszczak 2014.
[65] Hancher and Sauter 2012, pp.256-257
[66] Guy 2019 regarding the Netherlands (pp.) and England (pp.92-93).
[67] An example being "hybrid" rules for antitrust and public procurement for the English NHS – the National Health Service (Procurement, Patient Choice and Competition) Regulations (No. 2) 2013. Sánchez Graells 2015.
[68] De Cecco 2012, page 17.
[69] To include Article 14 TFEU, Protocol No. 26 and recognition within the Charter of Fundamental Rights.
[70] For an excellent discussion, see Wehlander 2016, Chapters 6 and 10 in particular.
[71] See Wehlander 2016, and also Sauter 2015, page 179.
[72] Article 107(3)(b) TFEU.
[73] Article 107(3)(c) TFEU.

policy,[74] thus perhaps breaching the "subsidiarity clause" for healthcare of Article 168(7) TFEU. However, in view of the consistent line of the EU courts in finding that either the Article 107(1) TFEU prohibition does not apply, or that the activity in question is rendered compatible with the internal market by virtue of classification as an SGEI, or via one of the Article 107 justifications, it is difficult to pinpoint exactly how this "competence creep" is manifested with regard to state aid rules. This is in contrast to the free movement rules, where arguments of "Europeanisation" might be more readily articulated in view of harmonisation underpinning the Patients' Rights Directive.[75] Certainly in contrast to other manifestations of "competence creep",[76] EU-level influence on national healthcare reforms with regard to antitrust might be considered more "responsive", with varying degrees of subtlety. A clear example would be the enactment of Article 122 Dutch Health Insurance Act 2006 (*Zorgverzekeringswet*) to ensure that private health insurers were subject to Dutch (if not EU) competition law in response to the finding of non-applicability of the antitrust rules to German sickness funds in *AOK Bundesverband*.[77] A further example would be the creation of a hybrid prohibition on "anticompetitive behaviour"[78] reflecting terminology of Articles 101 and 102 TFEU introduced as part of the competition legislation governing the English National Health Service, amid concerns prior to Brexit about the reach of *EU* (sometimes as distinct from UK) competition law in this regard.[79]

In order to gain further insight into constitutionalism in this area, it is useful to examine the division of competences between the Member States and the EUin Article 168(7) TFEU and how this interacts with applying the state aid rules in the healthcare context, before considering how responses to the COVID-19 pandemic – particularly the development of a European Health Union – may now shape approaches in this area.

3.1. The interaction between Article 168(7) TFEU and the state aid rules

Article 168(7) TFEU provides in essence:

"Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them.[…]"[80]

Relative to its predecessor, Article 152(5) EC, it has been considered, variously, that the Member State competence regarding healthcare looked "more protected" under Article 168(7) TFEU,[81] and that the shift from the requirement that "Community action shall fully respect" to Union action

[74] This has been considered both in the wider connection with the free movement rules, and exclusively with regard to EU competition policy/state aid by lawyers and political scientists. See, respectively, van de Gronden and Szyszczak 2011. Morton 2021 and Morton 2022.
[75] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare.
[76] See, for example, Garben 2020.
[77] See further, van de Gronden and Szyszczak 2014.
[78] Now repealed by the Health and Care Act 2022, but section 64(2) Health and Social Care Act 2012 provided: "'Anti-competitive behaviour' means behaviour which would (or would be like to) prevent, restrict or distort competition and a reference to preventing anti-competitive behaviour includes a reference to eliminating or reducing the effects (or potential effects) of the behaviour".
[79] For further discussion, see Guy 2023.
[80] The final sentence is not directly relevant to the present discussion, but for the sake of completeness, provides "The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood."
[81] Piris 2010, page 320.

merely respecting "the responsibilities of the Member States" left open more room for EU involvement.[82] While these different views are difficult to reconcile, the description of Article 168(7) TFEU as introducing a "delicate and sophisticated balance" between the EU and national competences in healthcare[83] nevertheless remains valid.

The link between Article 168(7) TFEU and the state aid rules appears most clear with the specification of the Member State competence including "the allocation of resources assigned to [health services]". However the reach of EU-level influence via other means – notably fiscal policy – may serve to influence this indirectly insofar as it can be considered that requirements for Member States to engage with fiscal constraints vary according to aspects such as membership of the Eurozone, and level of indebtedness. This was illustrated by the varying instruments implemented in the aftermath of the 2008-2009 economic downturn,[84] but could equally apply to the after-effects of the COVID-19 pandemic and varying implications for different Member States. Indeed it has been recognised by the Commission that the Resilience and Recovery Facility could benefit the health sector in many cases.[85]

Nevertheless, Article 168(7) TFEU has been characterised as a "subsidiarity clause for healthcare".[86] What the implications are for this with regard to the interaction with EU competition policy, and specifically the state aid rules, are evolving. In the case law, perhaps surprisingly little attention is paid to Article 168(7) TFEU, although it has been deemed a "wide discretion",[87] and raised with regard to arguments outlining Member State freedom to choose, for example, how to organise health insurance,[88] and to include private medical insurance within social and health policy.[89]

A useful starting-point was outlined in terms of the causal logic of decisions having perhaps unintended, or undesired consequences. Thus, if a Member State decides to introduce competition into the healthcare system, then competition law will apply, and "[t]his effective delegation of the applicability of competition law to national authorities is in line with both the principle of subsidiarity […] and the vesting of the primary responsibility for the organization and delivery of healthcare and medical care in Member States under [Article 152 EC]."[90] This interpretation might be further understood in terms of a wider distinguishing of subsidiarity, which frames this as concerned with promoting the efficiency of governance, rather than promoting autonomy of the Member States.[91] Certainly this might be inferred from recent case findings – notably by the CJEU in *Dôvera* and the General Court in *Casa Regina Apostolorum* – suggesting that national reforms in, respectively, Slovakia and Italy, have been insufficient to displace the solidarity basis of the healthcare systems. Whether this amounts to a streamlining of governance approaches at the EU

[82] Van de Gronden and Szyszczak 2011, page 486.
[83] Ibid.
[84] See further, Guy 2020b.
[85] European Commission, Evaluation of the State subsidy rules for health and social services of general economic interest ("SGEIs") and of the SGEI de minimis Regulation. {SWD(2022) 389 final} 01.12.2022. Page 28.
[86] Hancher and Sauter 2012, e.g., page 221.
[87] SA.39913 (2017/NN) Alleged compensation of public hospitals in Lazio.C(2017) 7973 final. 4.12.2017, paragraph 48.
[88] COMMISSION DECISION (EU) 2015/248 of 15 October 2014 on the measures SA.23008 (2013/C) (ex 2013/NN) implemented by Slovak Republic for Spoločná zdravotná poisťovňa, a. s. (SZP) and Všeobecná zdravotná poisťovňa, a. s. (VZP), paragraph 64.
[89] Case T-289/03 *British United Provident Association Ltd (BUPA), BUPA Insurance Ltd, BUPA Ireland Ltd v Commission*, 12 February 2008, ECLI:EU:T:2008:29, paragraph 164.
[90] Prosser 2010, pages 323-324.
[91] See further, Panara 2022.

level is moot. On the one hand, this would seem to offer an explanation for consistent case law findings that EU competition policy does not apply which may be easier to maintain than finding the existence of an "economic activity" but then establishing that there is no effect on trade between Member States. Indeed, scope for effects on trade between Member States may vary – while support to public hospitals may be confined to a single country (or even region),[92] support regarding insurance schemes may prove wider-ranging insofar as insurers may operate in more than one Member State. On the other hand, by effectively delegating responsibility for determining applicability of EU competition policy, and potential application of this at a national level, further governance complications may arise in light of the scope for divergent approaches.

3.2. Developing the European Health Union – what role for state aid and SGEI in healthcare?

Section 2 above considered one aspect of the Commission's response to the COVID-19 pandemic, namely, the development of the SATF and how this might further our understanding of how healthcare activities have been, and may continue to be, regarded vis-à-vis the state aid rules. A further aspect of the EU-level response has been the development of a European Health Union. This was motivated in part by perceptions that initial pandemic responses at EU level were found wanting, prompting questions about the EU's competence and whether this extended beyond the obvious source of a single Treaty provision (Article 168 TFEU). Such misconceptions were attributed in part to the political salience of Article 168(7) TFEU – that the EU-level response was necessarily constrained "because the Member States wanted it so".[93] The initial enthusiasm for "more" EU in healthcare led to suggestions that Treaty change may result,[94] and from this a suggestion that an extended public health competence would require a policy decision on how state aid rules should adapt to the new constitutional cadre.[95] The idea that the state aid rules could play an instrumental role in shaping a European Health Union was explored by parallels being drawn with healthcare exemptions modelled on the General Block Exemption Regulation in light of the Commission's experience of analysing health as an SGEI.[96] Further suggestions involved scope for EU funding of healthcare to be managed by analogy with the European Structural and Investment Funds, or via clearer links between the Member State and EU levels through the creation of networks.[97] However, the initial outlining of the construction of the European Health Union made clear that its basis would be the EU's competence to adopt incentive measures (under Article 168(5) TFEU), albeit with acknowledgement that "The European Health Union will be as strong as its Member States' commitments to it."[98]

This enthusiasm for greater EU-level competence in health became tempered over time to delegating this for discussion at the Conference on the Future of Europe,[99] and in 2021 it was played down to clarification that "[a] strong European Health Union is not about redrawing the competences of Member States".[100] However, what has emerged in 2022, is a clear call – recognised

[92] As noted in Commission Decision C(2015) 2796 final of 29.04.2015 on SA.37432 (2015/NN), *Funding to public hospitals in the Hradec Králové Region*, C(2015) 2796 final.
[93] de Ruijter and Greer 2020.
[94] Nielsen 2020.
[95] Biondi and Ştefan 2020.
[96] Ibid.
[97] Ibid.
[98] European Commission, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, "Building a European Health Union: Reinforcing the EU's resilience for cross-border health threats", Brussels, 11.11.2020 COM(2020) 724 final.
[99] von der Leyen 2020.
[100] Deutsch 2021.

by the European Parliament[101] – for a refocusing of EU and Member State competence regarding health from the Conference on the Future of Europe such that this becomes a shared competence by amending Article 4 TFEU.[102]

4. Conclusions

This chapter has sought to provide an update to considerations of how healthcare has been regarded in the context of EU competition policy in general, and the state aid rules in particular since the wider-ranging 2009 review of competition and solidarity.[103] Starting from the premise that markets in healthcare could no longer be ignored at that time,[104] it has reviewed key cases and policy developments to provide a picture of the "state of the art" in late 2022. This has generated at least three insights.

Firstly, that, by framing the interaction between healthcare and the state aid rules in terms of a continuum of SGI, SGEI and Article 107(3) TFEU, it becomes possible to consider both competition and constitutional aspects. While these are not mutually exclusive, it is nevertheless submitted that constitutional aspects offer a way to advance ongoing discussion about the extent of applicability of the state aid rules.

Secondly, that having further understanding of how the subsidiarity principle operates in healthcare may give insights into state aid decisions as well. For example, by considering Article 168(7) TFEU in the context of the wider discussion of subsidiarity as being concerned with governance rather than autonomy, it becomes possible to understand further the tensions between EU-level and Member State competence regarding healthcare. The effect of wider EU policies – notably regarding fiscal governance in light of the 2008 economic downturn and likely also the COVID-19 pandemic – can also be shown to have an effect on national competence with regard to allocating resources to healthcare services.

Thirdly, that drawing insights from different aspects and interpretations of EU law and policy becomes inevitable in light of wider circumstances. Thus it is unsurprising that the 2019 review of the 2012 SGEI package should make copious reference to the COVID-19 pandemic. The proposals for adding healthcare as a shared competence emanating from the Conference on the Future of Europe – although not expressly mentioned by the Commission's review – might also be considered in this regard.

Finally, that there is a prevalence of state aid decisions in connection with healthcare being assessed as following the "concrete" or "attenuated functional" approaches. This indicates that this might be the intuitive approach for state aid (as distinct from antitrust) cases as these deal fundamentally with questions of government financing and organisation of national healthcare systems. However, these approaches also give insights into a framework which might evolve further as approaches from *CEPPB* – a "disaggregation" logic of separating activities, if not clear recourse to the "three-prong test" – are adopted into the healthcare context in *Casa Regina Apostolorum*.

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[101] European Parliament, Resolution of 4 May 2022 on the follow-up to the conclusions of the Conference on the Future of Europe (2022/2648(RSP)).

[102] Conference on the Future of Europe, Report on the final outcome, May 2022. Recommendation 49, page 163. qtde64rjnkdaf5u2j54ocssxyn9w (prod-cofe-platform.s3.eu-central-1.amazonaws.com)

[103] Markus Krajewski, Ulla Neergaard, and Johan van de Gronden, *The Changing Legal Framework for Services of General Interest in Europe – Between Competition and Solidarity*, TMC Asser Press, 2009.

[104] Szyszczak 2009.

References

Belhaj S and Van de Gronden JW (2004) Some room for competition does not make a sickness fund an undertaking. Is EC competition law applicable to the health care sector? (Joined cases C-264/01, C-306/01, C-453/01 and C-355/01 AOK) European Competition Law Review 25(11):682.
Biondi A and Ştefan O (2020) EU Health Union and State Aid Policy: With Great(er) Power Comes Great Responsibility European Journal of Risk Regulation – Beyond COVID-19: Towards a European Health Union 11(4): 894-902.
Boeger N (2007) Solidarity and EC competition law European Law Review 32:319.
Burke JM (2018) A Critical Account of Article 106(2) TFEU – Government Failure in Public Service Provision. Hart, Oxford.
Conference on the Future of Europe, Report on the Final Outcome, May 2022. https://futureu.europa.eu/en/pages/reporting?format=html&locale=en
Cseres KJ and Reyna A (2021) EU State Aid Law and Consumer Protection: An Unsettled Relationship in Times of Crisis. Journal of European Competition Law & Practice 12(8):617-629.
De Cecco F (2012) State Aid and the European Economic Constitution. Hart, Oxford.
De Ruijter A and Greer SL (2020) EU health law and policy in and after the COVID-19 crisis. European Journal of Public Health 30(4):623-624.
Deutsch J (2021) Europe's 'health union' prepares for its first feeble steps. Politico, 1 September 2021.
De Vries SA (2011) *BUPA*: A Healthy Case, in the Light of a Changing Constitutional Setting in Europe? In: Van de Gronden JW, Szyszczak E, Neergaard U and Krajewski M (eds) Health Care and EU Law. TMC Asser Press, The Hague.

Friederiszick HW, Röller LH and Verouden V (2007) European State Aid Control: An Economic Framework. In: Buccirossi P (ed) Handbook of Antitrust Economics. MIT Press, Cambridge.
Gallo D and Mariotti C (2017) The Public Financing of Belgian Hospitals and EU Law: A Core Development in the Field of State Aid In: Mastroianni R., Arena A. (eds.) 60 Years of EU Competition Law. Editoriale Scientifica, Naples.
Garben S (2020) From sneaking to striding: Combatting competence creep and consolidating the EU legislative process. European Law Journal 26:429-447.
Giosa P (2023) Assessing the Use of the State Aid Covid Temporary Frameworks with regard to the Healthcare and Media Sector. Journal of European Competition Law and Practice, lpad030, https://doi.org/10.1093/jeclap/lpad030
Greaney T and Odudu O (2022) Introduction to Antitrust and the Provision of Healthcare in the United States and European Union In: Orentlicher D and Hervey TK (eds) The Oxford Handbook of Comparative Health Law. Oxford University Press, Oxford.
Guy M (2019) Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems. Intersentia, Cambridge.
Guy M (2020) Can COVID-19 change the EU competition law framework in health? Observatoire Social Européen Brussels Opinion Paper No. 25, September 2020. (Guy 2020a)
Guy M (2020) Towards a European Health Union: What Role for Member States? European Journal of Risk Regulation – Beyond COVID-19: Towards a European Health Union 11(4): 757-765. (Guy 2020b)
Guy M (2023) Dealing with "unworkable ideas in primary legislation": Juridifying and dejuridifying competition in the English National Health Service. Public Law.
Hancher L and Sauter W (2012) EU Competition and Internal Market Law in the Health Care Sector. Oxford University Press, Oxford.
Hancher L and Sauter W (2013) This Won't Hurt A Bit: The Commission's Approach to Services of General Economic Interest and State Aid to Hospitals In: Szyszczak E and Van de Gronden JW (eds) Financing Services of General Economic Interest – Reform and Modernization. TMC Asser Press, The Hague.

Morton AJB (2021) European Health Care Systems and the Emerging Influence of European Union Competition Policy. Journal of Health Politics, Policy and Law 46(3):468-486.
Morton AJB (2022) Re-establishing needed limits: European competition policy's role in European healthcare systems and the lessons of the *Dôvera* case. Social Policy Administration 56(3):472-484.
Nielsen N (2020) EU Commission aspires for Treaty change on health. Euractiv, 29 May 2020.
Nikolić B (2021) Applicability of European Union Competition Law to Health Care Providers: The Dividing Line between Economic and Noneconomic Activities. Journal of Health Politics, Policy and Law 46(1): 49.
Odudu O (2022) Health Care Services and EU Competition Law. In: Orentlicher D and Hervey TK (eds) The Oxford Handbook of Comparative Health Law. Oxford University Press, Oxford.
Panara C (2022) Subsidiarity v Autonomy in the EU. European Public Law 28(2):269-296.
Piris J-C (2010) The Lisbon Treaty: A Legal and Political Analysis. Cambridge University Press, Cambridge.
Prosser T (2005) The Limits of Competition Law – Markets and Public Services. Oxford University Press, Oxford.
Prosser T (2010) EU competition law and public services. In: Mossialos E, Permanand G, Baeten R and Hervey TK (eds) Health Systems Governance in Europe – The Role of European Union Law and Policy. Cambridge University Press, Cambridge.
Ross M (2009) A healthy approach to services of general economic interest? The *BUPA* judgment of the Court of First Instance. European Law Review 34(1):127-140.

Sánchez Graells A (2015) New rules for health care procurement in the UK: a critical assessment from the perspective of EU economic law. Public Procurement Law Review 1:16.
Sauter W (2015) Public Services in EU Law. Cambridge University Press, Cambridge.
Skovgaard Ølykke G and Møllgaard P (2016) What is a Service of General Economic Interest? European Journal of Law and Economics 41:205-241.
Szyszczak E (2009) Modernising Healthcare: Pilgrimage for the Holy Grail? In: Krajewski M, Neergaard U, and van de Gronden J (eds) The Changing Legal Framework for Services of General Interest in Europe – Between Competition and Solidarity. TMC Asser Press, The Hague.
Van de Gronden JW (2004) Purchasing care: economic activity economic activity of service of general (economic) interest? European Competition Law Review 25:87.
Van de Gronden JW (2011) The Treaty Provisions on Competition and Health Care'. In: Van de Gronden JW, Szyszczak E, Neergaard U and Krajewski M (eds) Health Care and EU Law. TMC Asser Press, The Hague.
Van de Gronden JW (2018) Services of General Interest and the concept of undertaking: does EU competition law apply? World Competition 41: 197-224.
Van de Gronden and Szyszczak E (2011) Conclusions: Constructing a 'Solid' Multi-Layered Health Care Edifice. In: Van de Gronden JW, Szyszczak E, Neergaard U and Krajewski M (eds) Health Care and EU Law. TMC Asser Press, The Hague.
Van de Gronden JW and Szyszczak E (2014) Introducing Competition Principles into Health Care Through EU Law and Policy: A Case Study of the Netherlands. Medical Law Review 22(2): 238-354.
Van de Gronden JW and Rusu CS (2013) The Altmark Update and Social Services: Towards a European Approach. In: Szyszczak E and Van de Gronden JW (eds) Financing Services of General Economic Interest – Reform and Modernization. TMC Asser Press, The Hague.
Van de Gronden JW and Rusu CS (2017) EU competition law and policy and health systems. In: Hervey TK, Young CA, and Bishop LE (eds) Research Handbook on EU Health Law and Policy. Edward Elgar, Cheltenham.
Van de Gronden JW and Guy M (2021) The role of EU competition law in health care and the 'undertaking' concept. Health Economics, Policy and Law 16:76-89.
Von der Leyen U (2020) State of the Union Address by President von der Leyen at the European Parliament Plenary, 16 September 2020.
Wehlander C (2016) Services of General Economic Interest as a Constitutional Concept of EU Law. TMC Asser Press, The Hague.