

**COMMISSION DECISION (EU) 2016/2327****of 5 July 2016****on State aid SA.19864 — 2014/C (ex 2009/NN54) implemented by Belgium — Public financing of Brussels public IRIS hospitals***(notified under document C(2016) 4051)***(Only the French and Dutch texts are authentic)****(Text with EEA relevance)**

THE EUROPEAN COMMISSION,

Having regard to the Treaty on the Functioning of the European Union, and in particular the first subparagraph of Article 108(2) thereof <sup>(1)</sup>,

Having regard to the Agreement on the European Economic Area, and in particular Article 62(1)(a) thereof,

Having called on interested parties to submit their comments pursuant to the provision(s) cited above <sup>(2)</sup> and having regard to their comments,

Whereas:

**1. PROCEDURE**

- (1) By letters of 7 September 2005 and 17 October 2005, registered on 12 September 2005 and 19 October 2005, the Commission received a complaint against the Belgian State as regards the alleged granting since 1995 of unlawful and incompatible aid to the five public general hospitals <sup>(3)</sup> (hereinafter 'IRIS-H') <sup>(4)</sup> belonging to the IRIS <sup>(5)</sup> network of the Brussels Capital Region (hereinafter 'IRIS'). The complaint was lodged by two associations (i.e. the *Coordination bruxelloise d'institutions sociales et de santé* (CBI) and the *Association bruxelloise des institutions de soins privées* (ABISP)) representing hospitals managed by legal persons governed under private law (hereinafter 'private hospitals') and also individually by several hospitals that are members of these associations <sup>(6)</sup>.
- (2) The complaint focused on the following groups of arguments: (i) the absence or insufficiently clear definition and entrustment of the specific public service missions that are only conferred to the IRIS-H, but not to the Brussels private hospitals (ii) the compensation of losses of the IRIS-H by public authorities, (iii) the overcompensation of the costs linked to the public service missions of the IRIS-H through the *Fonds Régional Bruxellois de Refinancement*

<sup>(1)</sup> From 1 December 2009 onwards, Articles 87 and 88 of the EC Treaty have become respectively Articles 107 and 108 of the Treaty on the Functioning of the European Union ('TFEU'). The two sets of provisions are, in substance, identical. For the purposes of this Decision, references to Articles 107 and 108 of the TFEU should be understood as references to Articles 87 and 88, respectively, of the EC Treaty where appropriate. The TFEU also introduced certain changes in terminology, such as the replacement of 'Community' by 'Union', 'common market' by 'internal market' and 'Court of First Instance' by 'General Court'. The terminology of the TFEU will be used throughout this Decision.

<sup>(2)</sup> OJ C 437, 5.12.2014, p. 10.

<sup>(3)</sup> Together, these five public hospitals operate about 2 425 of the approximately 7 260 beds that are provided by general and university hospitals (i.e. excluding psychiatric, geriatric and other specialised hospitals) in the Brussels Capital Region and employ almost 10 000 staff. Each year, they provide over 1 million medical consultations. The number of approved hospital beds was provided by the Belgian authorities (who consulted the Common Community Commission and the Federal Public Service for Public Health) and concerns the year 2015. The other information is available on the website of IRIS (see: <http://www.iris-hopitaux.be>).

<sup>(4)</sup> See Sections 2.2 and 2.4 for more detail about these public hospitals and their activities.

<sup>(5)</sup> The abbreviation IRIS stands for *Interhospitalière Régionale des Infrastructures de Soins*.

<sup>(6)</sup> The complainants had requested that their respective identities remain confidential. However, given the applications for annulment introduced by these parties and the following annulment judgment of 7 November 2012 by the General Court in Case number T-137/10, these identities are now public (see recitals 4 and 6. It also has to be noted that the ABISP and its members are no longer pursuing the complaint.

*des Trésoreries Communales*, (iv) the lack of transparency in the method of public financing of the IRIS-H, and finally (v) the presence of cross-subsidisation of the non-hospital activities of the IRIS-H through the State compensation received for the provision of their hospital missions <sup>(7)</sup>.

- (3) Following the submission of additional information by the Belgian authorities, the Commission services informed the complainants by letter of 10 January 2008 of their preliminary views on the complaint <sup>(8)</sup> and asked the complainants to submit new information allowing them to reconsider the preliminary assessment of the complaint, failing which the complaint would be considered withdrawn. Following the reply from the complainant, the Commission services confirmed their preliminary assessment in their letter of 10 April 2008.
- (4) Subsequently, the complainants informed the Commission of the fact that they had introduced an application for annulment before the Court of First Instance of the European Communities (as from 1 December 2009 the General Court of the European Union, hereinafter the 'GC') against the letter of 10 January 2008, which they saw as a Commission decision <sup>(9)</sup>. Furthermore, on 20 June 2008 the complainants lodged an application for annulment of the letter of the Commission services of 10 April 2008 <sup>(10)</sup>. Both Court procedures were suspended by the GC until 31 October 2009, based on the information submitted by the Commission that it intended to adopt a decision pursuant to the Council Regulation (EC) No 659/1999 <sup>(11)</sup>. With a view of adopting such a decision, the Commission services requested additional information from the Belgian authorities as well as from the complainant.
- (5) In its decision of 28 October 2009 <sup>(12)</sup> (hereinafter 'the Commission's 2009 decision', see also Section 4.1), the Commission decided not to raise objections to the aid for financing of the public hospitals of the IRIS network in the Brussels Capital Region as the financing at hand was deemed compatible with the common market under the conditions set out in Commission Decision 2005/842/EC <sup>(13)</sup> (hereinafter '2005 SGEI Decision') and directly with Article 86(2) EC Treaty (now Article 106(2) TFEU) with respect to entrustments pre-dating the entry into force of the 2005 SGEI Decision on 19 December 2005.
- (6) Subsequently, the complainants launched an action for annulment of this Commission decision at the General Court. The GC annulled the Commission decision by its judgment of 7 November 2012 in case T-137/10 <sup>(14)</sup> (see also Section 4.2), concluding that this decision had been adopted in violation of the procedural rights of the complainants. In particular, the GC concluded that the Commission should have had doubts concerning the compatibility of the measures at hand with the internal market considering the arguments of the complainants with respect to the compatibility. The GC therefore concluded that the Commission was required to initiate the formal investigation procedure, in order to gather any relevant information for verifying the compatibility of all the aid measures at issue with the internal market, and to allow the complainants and other interested parties to present their observations in connection with that procedure <sup>(15)</sup>.
- (7) By letter dated 1 October 2014, the Commission informed Belgium that it had decided to initiate the procedure laid down in Article 108(2) of the TFEU in respect of the public financing measures in favour of the Brussels public IRIS hospitals.
- (8) The Commission's decision to initiate the procedure (hereinafter 'the opening decision') was published in the *Official Journal of the European Union* <sup>(16)</sup>. The Commission invited interested parties to submit their comments on the measures.

<sup>(7)</sup> This latter argument was first raised by the complainants in their letter of 15 December 2008.

<sup>(8)</sup> In essence, the Commission services' preliminary assessment was that it appeared that the IRIS-H were duly entrusted with public service missions, that their compensation was clearly defined and that there was no overcompensation. Therefore, the Commission services considered that there were no problems with respect to State aid rules. In addition, they noted that the requirements concerning transparency also seemed to be fulfilled. As a result, the Commission services concluded that there were insufficient reasons to pursue the investigation unless new elements were brought forward by the complainant.

<sup>(9)</sup> Case T-128/08, not reported.

<sup>(10)</sup> Case T-241/08, not reported.

<sup>(11)</sup> Council Regulation (EC) No 659/1999 of 22 March 1999 laying down detailed rules for the application of Article 108 of the Treaty on the Functioning of the European Union (OJ L 83, 27.3.1999, p. 1).

<sup>(12)</sup> OJ C 74, 24.3.2010, p. 1.

<sup>(13)</sup> Commission Decision 2005/842/EC 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 (OJ L 312, 29.11.2005, p. 67).

<sup>(14)</sup> Case T-137/10 *CBI v Commission*, ECLI:EU:T:2012:584.

<sup>(15)</sup> *Ibid.*, paragraph 313.

<sup>(16)</sup> See footnote 2.

- (9) By letter of 22 October 2014, the Belgian authorities requested an extension of the deadline to submit their comments on the opening decision, which was accepted by the Commission by letter of 23 October 2014. A further extension of the deadline was requested by email of 1 December 2014, which was accepted by the Commission by letter of 2 December 2014. By letter of 16 December 2014, the Kingdom of Belgium submitted its observations on the opening decision.
- (10) The Commission received comments from interested parties (see Section 5) on 15 December 2014, 5 January 2015 and 9 January 2015. By letters of 13 and 20 February 2015, the Commission forwarded these comments to Belgium, which was given the opportunity to react. Belgium's comments were received by letter dated 13 March 2015, registered on 17 March 2015.
- (11) On this basis the Commission has reassessed the case and interpreted certain elements differently in comparison to the assessment in the annulled Commission's 2009 decision.

## 2. BACKGROUND

- (12) The IRIS-H operate in a complex legislative and regulatory environment which is shaped by various public authorities. A comprehensive assessment of the compliance with State aid rules of the public financing from which they benefit requires at the outset a brief description of the legislative and regulatory framework as it applies to the IRIS-H. This description encompasses an introduction to the Loi CPAS (on the basis of which the IRIS-H were created), a brief account of the creation of the IRIS-H, a survey of the legislative and other documents regulating the operations of the IRIS-H, a short overview of the main activities of the IRIS-H, as well as an enumeration of the various applicable financing mechanisms.

### 2.1. The right to social aid and the Loi CPAS

- (13) The right to social aid is a constitutional right in Belgium. In particular, Article 23 of the Belgian Constitution provides:

'Everyone has the right to lead a life in keeping with human dignity. To that end, the laws, the decree or rule referred to in Article 134 guarantee economic, social and cultural rights, taking account of the relevant obligations, and determine the conditions for their exercise. Those rights include, inter alia:

[...]

2° the right to social security, healthcare and social, medical and legal aid.'

- (14) Actual access to social aid by citizens is governed primarily by the Organic Law of 8 July 1976 <sup>(17)</sup> (hereinafter 'Loi CPAS') which created the *Centres Publics d'Action Sociale* (hereinafter 'CPAS'). The CPAS are public bodies, with legal personality, and are present in each Belgian municipality. The CPAS are governed by a board the members of which are elected by the municipal council of the respective municipality. According to Article 1 of the Loi CPAS:

'Everyone has the right to social aid. The purpose of such aid is to enable everyone to lead a life in keeping with human dignity. CPAS shall be set up to provide such aid in accordance with the conditions laid down in this Law.'

- (15) In practice, the CPAS provide social aid to persons who do not have the resources to be able to live in dignity and who are ineligible for other forms of social security (e.g. unemployment benefits). In this context, Article 57(1) of the Loi CPAS specifies that the CPAS have the mission to provide individuals and families with the aid that the community is due to provide and describes this aid as follows:

'It shall provide not only palliative and curative assistance but also preventive assistance. It shall encourage social participation by users. The assistance may be material, social, medical, medico-social or psychological.'

<sup>(17)</sup> Belgisch Staatsblad/Moniteur Belge of 5 August 1976, p. 9876.

- (16) Although each CPAS has the obligation to provide social aid to individuals and families, it does have a certain discretion as to how this aid is provided. More specifically, a CPAS may provide such aid:
- either itself, directly, or
  - ‘where necessary and if appropriate under an existing scheme’ (see also recital 19), through institutions or services which it creates (on the basis of Articles 60(6), 79, 118 Loi CPAS), in which case the CPAS setting up such an institution or service also necessarily determines its purpose; any of its social obligations, which the CPAS delegates to the institution or service, is then exercised in accordance with that purpose, or
  - through institutions or services with which it collaborates (Article 61 Loi CPAS), in which case the respective institutions or services will have been created:
    - either by the CPAS itself (see previous indent), or
    - by a third party which will also have decided the purpose of its institution.
- (17) In the latter two cases, the CPAS will delegate (part of) its social aid obligation solely in so far as this is consistent with the purpose of the collaborating institution. On the one hand, if the institution is set up by the CPAS, it will control this purpose. In the case of an entirely third-party institution, on the other hand, the collaboration will be limited by the purpose of this institution.
- (18) The legal obligation on the CPAS to provide social aid, whether material, social, medical, medico-social or psychological, is the same no matter whether it provides the aid directly or through institutions that it creates or with which it collaborates. Article 57 of the Loi CPAS imposes the obligation to provide such aid on the CPAS (alone) in all cases. Any forms of delegation are arrangements for the exercise of this obligation and do not exempt the CPAS from its responsibility to ensure that its obligation is — and continues to be — fulfilled.
- (19) The requirements that apply when a CPAS wants to create an institution or service (such as a hospital) for the performance of (part of) the CPAS mission to provide social aid are set out in Article 60(6) of the Loi CPAS:
- ‘Where necessary and if appropriate under an existing scheme, the CPAS shall set up, develop and manage social, curative and preventive establishments and services.
- The need to create or develop an establishment or service must be based on documentation including an evaluation of the needs of the municipality and/or region and of similar establishments or services already in existence, a description of their operation, an accurate assessment of the cost price and expenditure involved and, if possible, information allowing a comparison with similar establishments or services.
- The creation or development of establishments or services that will potentially receive either investment or operating subsidies can only be decided on the basis of documentation showing that the conditions laid down in the organic law or regulations on the granting of such subsidies will be satisfied.
- Notwithstanding the authorisation to be obtained from other public authorities, as soon as the decision to create or develop an establishment or service might entail a contribution from or addition to the municipal budget, it shall require the approval of the municipal council.’
- (20) The obligation in Article 57 of the Loi CPAS to provide individuals and families with aid (of social, medical, medico-social or psychological nature) is:
- General: aid is to be provided irrespective of the ideological, philosophical or religious beliefs of the beneficiary (Article 59 of the Loi CPAS) and the person’s possible lack of means. The CPAS has the specific purpose of providing aid in view of the person’s state of poverty. On this basis, each CPAS has the obligation to provide aid to all, and if it sets up an institution or service to fulfil its task the latter will necessarily have the same obligation.
  - Not subject to time limits: the aid is to be provided for as long as the social need exists. The CPAS is therefore obliged to ensure the continuity of the aid and hence of the institution or service that provides it.

- (21) On the basis of the principle of municipal autonomy, each CPAS in its respective municipality takes an autonomous decision, whilst complying with the Loi CPAS, as to the most appropriate means of fulfilling its obligation to provide social aid (including medical aid). The constitutional choice to organise social aid at the municipal level is also driven by the wish and need to establish a social aid policy that is as close as possible to the population. When a CPAS decides to set up a curative healthcare institution in order to cater for the healthcare needs of the local population, the institution thus created is regulated both by the Loi CPAS and the federal regulatory framework for hospitals (see recital 32 for this framework), which applies to all hospitals regardless of their status (public or private) and ensures a common organisational system for the whole country. Unlike private hospitals, the primary purpose of hospitals established by a CPAS, such as the IRIS-H, is however always to contribute to the provision of social aid. The exact nature of the social aid obligations that apply to the IRIS-H (see also Section 7.3.4.1) is specified in the bylaws of the IRIS-H and the IRIS strategic plans in line with the requirements of the Loi CPAS (in particular in its Articles 120 and 135 *quinquies*).
- (22) Finally, on the basis of Article 106 of the Loi CPAS, municipalities are required to cover the deficit of their CPAS when the latter does not have sufficient resources to cover the expenditures connected to the provision of its social aid obligation.

## 2.2. The creation of the IRIS hospitals

- (23) As explained above (see recital 15), the social aid provided by the CPAS includes medical and medico-social assistance, and can be both of preventive and curative nature. Such assistance may be provided either (i) directly by the CPAS, or, (ii) through a third party (such as a private hospital) in accordance with their statutory autonomy, or, (iii) particularly if the CPAS wishes to control the means of achieving those objectives, by creating an institution or service to perform part of its mission (which will then be defined in the bylaws of that institution or service and in the case of the IRIS-H also in the IRIS strategic plans (see recitals 16 and 21). To achieve their mission in the field of medical assistance, the CPAS have set up and continue to (co-)manage hospitals in several Belgian cities and municipalities.
- (24) Historically, the CPAS in the six Brussels municipalities concerned <sup>(18)</sup> have provided social assistance of medical and socio-medical nature themselves via eight public hospitals <sup>(19)</sup> spread over eight different sites. These hospitals were managed directly by the respective CPAS and did not have legal personality. Hence, it was clear that these hospitals contributed to fulfilling the social aid obligation of the respective CPAS. However, in the first half of the 1990s, the Brussels public authorities found that the structural deficits of these hospitals jeopardised their continuity. To ensure the continuity and viability (referred to as *pérennité* by the Belgian authorities) of the Brussels public hospitals, these authorities decided to restructure these hospitals.
- (25) The first step of the restructuring operation was taken on 19 May 1994 when the Belgian Federal Government, the Brussels Capital Region and the Brussels *Commission Communautaire commune* signed a cooperation agreement on hospital policy. This agreement provided for the implementation of a restructuring agreement to ensure the continuity of public and local hospital services. As stated in Article 2 of that cooperation agreement:

‘This restructuring agreement must satisfy the following conditions:

1. to provide guarantees of the **maintenance of**, on the one hand, the **specific character of public hospitals, inter alia**, by the choice of legal structures and coordination **ensuring predominance of the public sector in the management bodies** and decision-making procedures, and, on the other hand, **a local basis, through greater representation of directly elected members** in the composition of the management bodies’ <sup>(20)</sup>.
- (26) The preamble to the cooperation agreement states to that effect:

‘Whereas the financial deficit shown by the public hospitals in the territory of the Brussels Capital Region has in fact reached worrying proportions;

<sup>(18)</sup> Out of the nineteen municipalities that together form the Brussels Capital Region, these six municipalities concerned are: Anderlecht, la Ville de Bruxelles, Etterbeek, Ixelles, Schaerbeek and Saint-Gilles.

<sup>(19)</sup> More specifically: CHU Brugmann-HUDERF (until 1 January 1997 a single entity), CHU Saint-Pierre, the Institut Bordet, the Centre Hospitalier Baron Lambert, the Centre Hospitalier Bracops, the Centre Hospitalier Molière, the Centre Hospitalier Brien and the Centre Hospitalier Etterbeek-Ixelles.

<sup>(20)</sup> Emphasis added.

Despite several restructuring plans, the financial equilibrium of those institutions is extremely precarious and is accordingly burdening the municipal budgets with a structural debt;

Whereas it is necessary in those circumstances to encourage the establishment of mechanisms for coordination and cooperation between municipalities and the CPAS and associations set up in accordance with Chapter XII of the [Loi CPAS] with responsibility for public hospitals in the territory of the Brussels Capital Region;

Whereas such coordination and cooperation mechanisms **can ensure the continuity of public hospitals**, by encouraging synergies in equipment and infrastructure and their management and development resources and help to offset the deficit in municipal budgets;

Whereas this agreement in no way alters the rules for hospital financing, but is designed solely to offset the structural deficit affecting the CPAS and municipalities' <sup>(21)</sup>.

- (27) It was on that basis that the Brussels *Commission Communautaire commune* adopted the *Ordonnance* of 22 December 1995 which inserted a Chapter XII *bis* in the version of the Loi CPAS that applies in the Brussels Capital Region. The preparatory work for this *Ordonnance* <sup>(22)</sup> refers to the cooperation agreement of 19 May 1994 (see recital 25) of which the main objective was to guarantee, through the proposed restructuring, the continuity (*pérennité*) of the Brussels public hospitals <sup>(23)</sup>.

- (28) The restructuring consisted of the following key elements:

- The CPAS relinquishing the direct management of their public hospital(s) to newly created legal persons (so-called 'Chapter XII associations') which the CPAS established (jointly with the respective municipality or municipalities, the association representing the hospitals' doctors and, where relevant, the universities *Université Libre de Bruxelles* and/or the *Vrije Universiteit Brussel*).

In doing so, the CPAS departed from their original choice of managing their own hospitals themselves as they did in the past. As allowed by Articles 60(6) and 118 of the Loi CPAS (see recital 19), the CPAS chose to set up an association through which they can provide medical and medico-social assistance to the community.

As a result, the existing Brussels public hospitals were liquidated and their activities were transferred to eight local hospital associations established on the basis of Chapter XII of the Loi CPAS. In this way, the IRIS-H obtained legal and financial independence <sup>(24)</sup> on 1 January 1996. The following eight hospital associations were created: the CHU Brugmann — HUDERF, the CH Brien, the CHU Saint-Pierre (CHU-SP), the CH Etterbeek-Ixelles, the CH Baron Lambert, the CH Bracops, the CH Molière, and the Institut Bordet (IB).

These eight hospitals were then further regrouped, while retaining all hospital sites, into the current five IRIS-H as follows. The CHU Brugmann (CHU-B) and Queen Fabiola Children's University Hospital (HUDERF) were split into two separate legal entities on 1 January 1997. On 1 July 1999, the CHU Brugmann and the CH Brien became one entity named CHU Brugmann. On that same date, the CH Etterbeek-Ixelles, the CH Baron Lambert, the CH Bracops, the CH Molière merged into the Iris South Hospitals (ISH). Unless indicated otherwise, where the decision at hand refers to the 'IRIS-H' this concerns these current five local public hospital associations <sup>(25)</sup>.

<sup>(21)</sup> Emphasis added.

<sup>(22)</sup> Ordinary session 1995-1996. Documents of the Assembly of the *Commission Communautaire commune*: Draft order: B-10/1. — Report: B-10/2. Verbatim record. — Discussion and adoption: meeting of 22 December 1995.

<sup>(23)</sup> In particular, the preparatory work notes that the cooperation agreement of 19 May 1994 was concluded: 'in order to ensure the continuity of Brussels public hospitals, inter alia, by encouraging the establishment of mechanisms for coordination and cooperation between the bodies responsible for the public hospitals in the territory of the Brussels Capital Region, namely the municipalities, the [CPAS] and the associations set up in accordance with Chapter XII of the [Loi CPAS].'

<sup>(24)</sup> Article 121 of the Loi CPAS specifies that the Chapter XII associations have legal personality.

<sup>(25)</sup> Some of the IRIS-H operate on several sites. Currently, CHU-B is active at three sites (Victor Horta, Paul Brien, and Reine Astrid); CHU-SP is active at two sites (Porte de Hal and César de Paep); and ISH is active at four sites (Etterbeek-Ixelles, J. Bracops, Molière-Longchamp, and Baron Lambert).

- Creating an umbrella structure called IRIS (on the basis of Chapter XII *bis* of the Loi CPAS) to coordinate and supervise the hospital activities of each of the Chapter XII associations <sup>(26)</sup>. The main objective of the IRIS umbrella is to reach a sustainable financial equilibrium for the hospital activities performed by the IRIS-H. The main tasks of IRIS are to coordinate the activities of the IRIS-H, determining the strategic plan for the IRIS network, improving the quality of the services offered, and monitoring the budget of the network.

- (29) In line with Chapter XII of the Loi CPAS, each of the local hospital associations is established on the basis of bylaws which among others determine the purpose, the rights and obligations of the members, and the decision-making bodies of the association <sup>(27)</sup>. On this basis, each association has a General Assembly and Administrative Council in which the parties that established the association (see recital 28) are represented; but the representatives of the government (i.e. the municipality and the CPAS) always occupy a majority of the seats in these decision-making bodies <sup>(28)</sup>. As a result, it is clear that each of the IRIS-H is controlled by the public authorities. Likewise, the municipalities, the CPAS have a large majority in the General Assembly and the Administrative Council of the IRIS umbrella structure.
- (30) Chapter XII *bis* of the Loi CPAS determines, among others, the rules with respect to control and administrative oversight that apply to the local hospital associations. More specifically, the IRIS umbrella organisation is required to draw up a strategic plan which is binding on the local Chapter XII associations. On the basis of this plan, each local hospital association has to draw up management and financial plans and submit these to IRIS for approval (see Article 135 *quinquies* Loi CPAS). The local hospital associations are also required to ask the permission of IRIS before taking certain major decisions (see Article 135 *sexies*) and are monitored by IRIS on a quarterly basis (see Article 135 *octies*). IRIS also appoints a representative in each local hospital association who attends the meetings of the decision-making bodies of these associations and who can veto decisions that are not in line with those of IRIS itself (see Article 135 *novies*).
- (31) Finally, as explained in recitals 31 and 32 of the opening decision, the restructuring of the Brussels public hospitals that were supervised and managed by the CPAS also consisted of a financial part. More specifically, via the *Fonds Régional Bruxellois de Refinancement des Trésoreries Communales* (hereinafter 'FRBRTC') the Brussels Capital Region granted a loan of 4 billion Belgian francs (about 100 million EUR) over a period of 20 years to those municipalities that managed a public hospital (via their respective CPAS) <sup>(29)</sup>. In turn, the municipalities awarded these funds to their public hospitals to cover part of their financial liabilities <sup>(30)</sup>. On 6 June 1996, the Brussels Capital Region decided not to demand repayment of the loan and interests, on the condition that the hospital restructuring agreements were fully implemented and the financial plans respected.

### 2.3. The regulatory framework applying to the IRIS-H

- (32) From the previous section it is clear that the IRIS-H have been established on the basis of the Loi CPAS to enable the CPAS to fulfil their obligation to provide social aid. These hospitals are therefore governed primarily on the basis of the Loi CPAS. However, as hospitals, they are also subject to the Law of 7 August 1987 (*Loi coordonnée sur les hôpitaux*, hereinafter 'LCH') <sup>(31)</sup> Article 147 (now Article 163 of the LCH in the version of the Law of 10 July 2008) <sup>(32)</sup> of which specifies:

'In the case of hospitals managed by a CPAS and the doctors working in those hospitals, the provisions of this Coordinated Law supplement the Loi CPAS.'

<sup>(26)</sup> The supervision by IRIS is subject to the conditions specified in the *Ordonnance* (by the Brussel Capital Region) of 22 December 1995 (Belgisch Staatsblad/Moniteur Belge of 7 February 1996, p. 2737).

<sup>(27)</sup> Article 120 of the Loi CPAS specifies the minimum requirements for the bylaws of associations created by a CPAS on the basis of Chapter XII of the Loi CPAS.

<sup>(28)</sup> To this extent, Article 125 of the Loi CPAS requires that: 'Regardless of the ratio of the contribution of the various partners, public entities always have the majority of votes in the various administrative and management bodies of the association.'

<sup>(29)</sup> The FRBRTC was established by the *Ordonnance* of 8 April 1993, Belgisch Staatsblad/Moniteur Belge of 12 May 1993, p. 10889 (modified by *Ordonnance* of 2 May 2002).

<sup>(30)</sup> The amount of EUR 100 million was not sufficient to cover the hospitals' total financial liabilities as they existed at the end of 1995 as the cumulated deficit was estimated to be almost EUR 200 million.

<sup>(31)</sup> Belgisch Staatsblad/Moniteur Belge of 7 October 1987, p. 14652, replaced by the coordinated hospital Law of 10 July 2008 (Belgisch Staatsblad/Moniteur Belge of 7 November 2008, p. 58624).

<sup>(32)</sup> For the ease of reference, this decision will refer simply to Article 147 LCH, this however having to be understood as a reference to Article 163 LCH from the entry into force of the Law of 10 July 2008.

- (33) The LCH sets out, inter alia, the types of hospitals that can be formally authorised <sup>(33)</sup>, the conditions for the management of a hospital and the structure of the medical activity <sup>(34)</sup>, the hospital programming <sup>(35)</sup>, the conditions for authorisation of hospitals and hospital services <sup>(36)</sup>, the legal relationship between a hospital and the hospital doctors, the financial statute of the hospital doctors including among others the collecting and setting of the fees, what the fees cover, and the allocation of the centrally collected fees <sup>(37)</sup>.
- (34) In addition, the IRIS-H are also subject to the rules laid down in the bylaws of the local hospital associations, specifying among others the purpose of the IRIS-H as well as the rights and obligations of members of the association (see also recital 29).
- (35) Finally, the local hospital associations operate under the oversight of the IRIS umbrella organisation, restricting their ability to autonomously take certain financial and management decisions (see also recital 30). Significantly, the IRIS umbrella organisation adopts multi-annual strategic plans which are binding for the local hospital associations as determined by Article 135 *quinquies* Loi CPAS.
- (36) In conclusion, the regulatory framework in which the IRIS-H operate is made up of the Loi CPAS, the LCH, the bylaws of the local hospital associations, and the binding strategic plans adopted by the IRIS umbrella organisation.

#### 2.4. Main activities of the IRIS-H

- (37) The primary activity of the IRIS-H is the provision of hospital services to patients in the Brussels Capital Region. The IRIS-H together employ nearly 10 000 staff, provide over 1 million consultations per year, and constitute Belgium's largest emergency service. The IRIS-H offer comprehensive medical services across all major medical fields, with two of them specialising in particular disciplines (in particular Queen Fabiola Children's University Hospital specialises in paediatrics, while the Institut Bordet specialises in oncology).
- (38) In addition to medical services, the IRIS-H also engage in a series of related social activities. In particular, social workers employed by the IRIS-H assist disadvantaged patients and their families in solving and managing financial, administrative, interpersonal and social difficulties.
- (39) The five IRIS-H currently provide their medical and related social services across a network of eleven sites in Brussels. These sites are spread over six municipalities (i.e. Anderlecht, la Ville de Bruxelles, Etterbeek, Forest, Ixelles, and Schaerbeek).
- (40) The IRIS-H consider it as their mission to be '*in the service of one and all, at all moments of their existence, from cradle to grave, and irrespective of their medical problems*' <sup>(38)</sup>. Ten of the eleven IRIS-H sites are located in municipalities where the average income does not exceed the median <sup>(39)</sup> for the Brussels Capital Region. On the basis of a ranking by the Federal Public Service for Public Health (see recital 185 for the table with this ranking), the three large comprehensive IRIS-H (CHU Saint-Pierre, CHU Brugmann, ISH) are the three hospitals whose patient profile in socioeconomic terms is the weakest in Belgium. This is further illustrated by the fact that in 2012 almost 11 % of the total number of admitted patients in CHU Saint-Pierre and CHU Brugmann were not covered by the mandatory Belgian sickness insurance and could not pay for treatment, while 15 % of these hospitals' patients were (also) dependent on CPAS support.

<sup>(33)</sup> See Articles 2 to 7 of the Law of 7 August 1987.

<sup>(34)</sup> See Articles 10 to 17 of the Law of 7 August 1987.

<sup>(35)</sup> See Articles 23 to 45 of the Law of 7 August 1987. The hospital programming mechanism consists of determining the maximum number of hospital beds per Region based on the medical needs identified by the Federal Government. It follows that unless the demand for hospital beds increases, new hospital beds (or a new hospital) can only be created if existing beds are simultaneously removed elsewhere.

<sup>(36)</sup> See Articles 68 to 76 *sexies* of the Law of 7 August 1987.

<sup>(37)</sup> See Articles 130 to 142 of the Law of 7 August 1987.

<sup>(38)</sup> See <http://www.iris-hopitaux.be/en> (accessed on 19 August 2015).

<sup>(39)</sup> See footnote 246 for more detail about the median average income.



- (41) Finally, the IRIS-H also have a number of ancillary activities (e.g. ambulance transport of patients between hospitals; a nursery for the children of staff members; nursing and elderly homes; nursing schools; research; assisted living; and psychiatric care institutions; a little shop for patients and visitors; renting of TVs to patients, renting of rooms to third parties; a canteen and parking facilities). These ancillary activities represent only a very limited percentage of the IRIS-H's total activities, as reflected by their small share (i.e. on average less than 2 %) of the IRIS-H's total revenues.
- (42) The totality of these activities account for the IRIS-H costs and revenues. Their costs are, in addition to the particular activities they carry out, also influenced by their status as public hospitals which entails a number of constraints that do not apply to private hospitals. In particular, the operating costs incurred by the IRIS-H in the provision of their services of general economic interest (hereinafter 'SGEI') and ancillary activities are among others increased by factors such as:
- the requirement to pay mandatory language bonuses <sup>(40)</sup> that have to be awarded to bilingual employees with an estimated yearly cost <sup>(41)</sup> to be borne by the IRIS-H of approx. EUR [...] <sup>(42)</sup> million,
  - the pension scheme that applies to statutory employees <sup>(43)</sup> (i.e. civil servants) which is more generous than the one applying to private sector employees and for which the IRIS-H have to contribute an estimated amount of EUR [...] million per year,
  - the costs related to long-term illnesses of statutory employees <sup>(44)</sup> that have to be borne by the IRIS-H (instead of by the social security system) for an estimated yearly amount of EUR [...] million,
  - pay scale increases imposed on the IRIS-H by the Brussels Capital Region <sup>(45)</sup> which sets the pay scales for employees of the municipalities, the CPAS and the IRIS-H and which only pays for 60 % of these increases leaving an annual cost of approx. EUR [...] million for the IRIS-H, and
  - the mandatory contributions by the IRIS-H to the cost of the IRIS umbrella organisation <sup>(46)</sup> for an estimated annual cost of EUR [...] million.
- (43) These residual costs have to be borne by the IRIS-H and are not covered by other public financing sources (such as for instance the BMF, see recital 46(a)).

## 2.5. The financing and accounting mechanisms of the IRIS-H

### 2.5.1. Financing mechanisms

- (44) The fundamental principle according to which the IRIS-H are funded is enshrined in Article 46 <sup>(47)</sup> of the bylaws of each of the five local hospital associations (see recitals 28-29), which stipulate that:

'Without prejudice to Article 109 [LCH], the result of the financial year shall be allocated between partners holding at least one fifth of the votes in the General Assembly by decision of the General Assembly' <sup>(48)</sup>.

<sup>(40)</sup> This obligation is among others based on the Law of 18 July 1966, Article 42(5) of the Loi CPAS, the Law of 24 June 1988, the Decree of 25 July 1991 by the Executive of the Brussels Capital Region, and the Decree of 6 May 1999 by the Government of the Brussels Capital Region.

<sup>(41)</sup> All cost estimates in this and the following recital are for 2010 and reflect the residual costs to be borne by the IRIS-H after deduction of public financing, where applicable, by the Brussel Capital Region or the Federal Government.

<sup>(42)</sup> Information covered by professional secrecy.

<sup>(43)</sup> This obligation is in particular based on Articles 156, 161(1) and 161(2) of the Law of 24 June 1988, Article 42(5) of the Loi CPAS and Paragraph 3.4 of Trade Union Protocol 95/3 of 27 October 1995.

<sup>(44)</sup> This obligation is among others based on the Law of 14 February 1961, Article 42(5) of the Loi CPAS, the Law of 24 June 1988, the Decree of 6 May 1999 by the Government of the Brussels Capital Region.

<sup>(45)</sup> These pay scale increases are laid down in Agreements 2003/1, 2004/10, 2007/1 and 2009/1.

<sup>(46)</sup> The Brussels Capital Region imposed an umbrella structure responsible for the coordination and supervision of the hospital activities of the IRIS-H in line with Chapter XII bis of the Loi CPAS.

<sup>(47)</sup> Note that for some of the IRIS-H, this principle was initially enshrined in Article 44 or Article 47. In terms of substance however, the principle was in each case already mentioned in the original bylaws.

<sup>(48)</sup> At the moment of the creation of the IRIS-H, this principle was enshrined in Article 44 of the bylaws and was phrased as follows: 'The operating result shall be allocated between partners holding at least one fifth of the votes in the General Assembly, pro rata to their representation in the General Assembly.'

On this basis, the municipalities and the CPAS are required to fully absorb any deficit incurred by the IRIS-H as reported in their financial accounts. In addition, according to Article 106 of the Loi CPAS, the municipalities have to cover any deficit generated by their CPAS (see recital 22). In consequence, the municipalities (directly and via their funding obligation towards their respective CPAS) ultimately ensure the continuity of the IRIS-H by fully covering any deficit these hospitals may generate.

- (45) The extent to which the municipalities and the CPAS have to intervene to cover any deficit generated by the IRIS-H on the basis of Article 46 of their respective bylaws naturally depends on the degree to which the IRIS-H can cover their costs from other financing sources.
- (46) The LCH describes five financing sources that are available equally for public and private hospitals. The operating costs of Belgian hospitals are mainly covered by the first three financing sources <sup>(49)</sup> while the fourth and fifth sources are related to hospitals' investments costs.
- (a) The first financing source is the *budget des moyens financiers* (hereinafter 'BMF') <sup>(50)</sup>, which is established by the Federal Minister responsible for public health, and only takes into account healthcare activities that are covered by the social security. The BMF is determined for each hospital within the boundaries of the global Federal State budget. The available Federal budget is allocated among all hospitals and may not necessarily cover all of their eligible costs. Since 2002, the BMF for each hospital is mainly determined on the basis of the number of days of treatment provided by each hospital during the previous year. This specific amount is then paid out to each of the hospitals in two different ways. In particular, about 85 % (the fixed part) of this amount is being paid to the hospitals on a monthly basis, while the remaining 15 % (the variable part) is paid on the basis of the actual admissions and days of treatment in the hospital during the year. At the end of each year, the BMF is recalculated on the basis of the actual figures for the year and depending on the outcome the hospital either receives or has to repay an amount. The BMF is regulated in more detail by the Royal Decree of 25 April 2002 which defines the conditions and rules for setting the BMF granted to hospitals. In particular, the Royal Decree determines how the BMF is set, which type of costs are accepted for coverage by State funding and what criteria apply in this regard <sup>(51)</sup>. It is important to point out that the BMF is not set up to cover the actual costs incurred by each hospital but is instead mainly arranged as flat rate financing based on their average actual historical costs. As a result, the BMF may be insufficient in case of significant cost increases, or other evolutions in the organisation and cost structure of a hospital.
- (b) The second source of financing are the social security payments, i.e. made by the *Institut National d'Assurance Maladie-Invalidité* (hereinafter 'INAMI'), to the hospitals for the treatments they offered to their patients. This financing is based on the *Loi Assurance Maladie-Invalidité* <sup>(52)</sup>, respectively its consolidated version laid down in the Law of 14 July 1994 <sup>(53)</sup>, which sets up the Belgian social security system with regard to sickness and invalidity and specifies the medical services and medication that are eligible for compensation by the social security. The hospitals directly charge part of the doctor's fees and the cost of the patients' medication to the INAMI. These payments however do not cover the full costs that the hospitals incur when providing their healthcare activities. As a result, hospitals that have insufficient other sources of revenues risk becoming loss-making.
- (c) A third source of financing are payments made directly by the patient or by their private health insurers to the hospitals. These payments are necessary because the social security does not cover 100 % of doctors' fees nor of medication and other medical supplies (e.g. implants). In addition, if patients choose to have a single room, then supplements can be charged on top of the normal hospitalisation price and on top of the normal

<sup>(49)</sup> In September 2013, the *Mutualité Chrétienne*, one of the largest Belgian *mutuelles* (which are the private not-for-profit organisations that are responsible for the reimbursement of medical costs under the social security) published an article which shows that in 2011 Belgian hospitals' revenues were on average divided as follows between these three sources: (1) BMF: 49 %; (2) INAMI: 42 %; and (3) patients (or their private insurers): 9 %.

<sup>(50)</sup> See Articles 87 and following of the Law of 7 August 1987.

<sup>(51)</sup> See Articles 24 until 87 of the Royal Decree of 25 April 2002, Belgisch Staatsblad/Moniteur Belge of 5 July 2002, p. 30290.

<sup>(52)</sup> See Law of 9 August 1963 as amended, Belgisch Staatsblad/Moniteur Belge of 1 November 1963, p. 10555.

<sup>(53)</sup> Belgisch Staatsblad/Moniteur Belge of 27 August 1994, p. 21524.

doctor's fee (i.e. more than the standard rates that apply per treatment). Finally, patients may also be charged for the use of additional services (e.g. rent for a TV, use of the hospital parking, etc.).

All payments made by patients or third parties to compensate hospital doctors for their treatment of hospitalised patients, have to be collected centrally by the hospital <sup>(54)</sup>. The hospitals and their doctors conclude agreements that determine the percentages of the fees that the hospitals can keep to cover their collection costs and other costs that are not financed by the BMF <sup>(55)</sup>. Similarly as for the normal doctors' fees, part of the abovementioned supplements can also be retained by the hospital to cover part of its costs (again conditional on an agreement between the hospital and its doctors). Part of the doctors' fees are hence not a payment going to the doctors but instead are used to cover the operating costs of the hospitals.

- (d) The fourth source of financing is specifically meant to cover investment costs incurred by the hospitals. The investments of hospitals are mainly covered by the State (the Federal government and the Regions each pay a part) and the remaining part is paid from the hospitals' own resources combined with bank loans. The State financing is aimed at the costs of building or renovating a hospital or hospital ward and the costs of the first acquisition of equipment and medical devices <sup>(56)</sup>. Investment subsidies are capped (e.g. a fixed amount per square metre or per unit).
- (e) The fifth general source of public financing is related to investments and concerns damages payments for studies, the development of building projects, but also costs resulting from the closure or non-usage of a hospital or hospital ward <sup>(57)</sup>. In practice, this type of financing is not very commonly awarded.

- (47) Article 109 of the LCH (now Article 125 of the LCH in the version of the Law of 10 July 2008 <sup>(58)</sup>) sets out a sixth financing mechanism of which only public hospitals (such as the IRIS-H) can benefit. According to this provision, public hospitals' deficits arising from their hospital activities have to be covered by the municipalities that control them (i.e. via their CPAS or via a central structure such as IRIS). The principle of this (partial) deficit cover by the municipalities was already included in the Law of 23 December 1963 <sup>(59)</sup>, which preceded the LCH, and was confirmed by Article 34 of the Law of 28 December 1973 <sup>(60)</sup>. The criteria to calculate the deficits that the municipalities are obliged to cover are determined in a Royal Decree <sup>(61)</sup>. On this basis, the Federal Minister responsible for public health each year determines the deficit that must be covered for each public hospital. In practice, the Article 109 LCH deficit that must be covered as determined by the Minister is not exactly equal to the deficit reported in the financial accounts of the hospital, since certain cost elements (e.g., the result of the non-hospital activities which in the case of the IRIS-H are purely ancillary to the hospital activities as will be explained in recital 155) <sup>(62)</sup> contained in the deficit reported in the financial accounts are excluded from the Article 109 LCH deficit.

- (48) In conclusion, the IRIS-H thus enjoy a comprehensive financing mechanism that ensures coverage of any deficit they may generate. The five general financing measures foreseen by the LCH (see recital 46) cover the majority of the hospitals' operating and investment costs. To the extent that these sources are insufficient to cover the costs arising from the hospitals' activities, Article 46 of the bylaws of the IRIS-H obliges the municipalities to fully cover any deficit generated by the IRIS-H (see recitals 44-45). The accounting deficit addressed by Article 46 of the bylaws necessarily includes the 'Article 109 LCH deficit' <sup>(63)</sup> (see recital 47) and by fully covering the accounting deficit, the municipalities also fulfil their obligation under Article 109 LCH. The payment modalities of this deficit compensation mechanism will be described below (see Section 7.3.5).

<sup>(54)</sup> See Articles 133 until 135 of the Law of 7 August 1987.

<sup>(55)</sup> See Article 140 of the Law of 7 August 1987.

<sup>(56)</sup> See Article 46 and following of the Law of 7 August 1987.

<sup>(57)</sup> See Article 47 of the Law of 7 August 1987.

<sup>(58)</sup> For the ease of reference, this decision will refer simply to Article 109 LCH, this however having to be understood as a reference to Article 125 LCH from the entry into force of the Law of 10 July 2008.

<sup>(59)</sup> Belgisch Staatsblad/Moniteur Belge of 1 January 1964, p. 2; this Law required that 10 % of the deficit was covered by the municipality where the hospital was located and the remaining 90 % by the Belgian municipalities where the patients reside.

<sup>(60)</sup> Belgisch Staatsblad/Moniteur Belge of 29 December 1973, p. 15027.

<sup>(61)</sup> Originally this was the Royal Decree of 8 December 1986 (Belgisch Staatsblad/Moniteur Belge of 12 December 1986, p. 17023), amended by Royal Decree of 10 November 1989, and later replaced by the Royal Decree of 8 March 2006 (Belgisch Staatsblad/Moniteur Belge of 12 April 2006, p. 20232).

<sup>(62)</sup> Other elements that are excluded from the Article 109 LCH deficit are among others the estimate of the correction payments in the context of the BMF, certain provisions and certain types of depreciation.

<sup>(63)</sup> This is because the Article 109 LCH deficit is calculated by taking the accounting deficit and by then excluding certain elements.

### 2.5.2. Accounting requirements

- (49) All hospitals (i.e. public and private) are subject to accounting and transparency requirements. In particular, each hospital must keep a set of accounts that allow determining the cost of each service and that respect certain elements of the Law of 17 July 1975 <sup>(64)</sup> on accounting <sup>(65)</sup>. It is mandatory to record non-hospital activities on separate accounts. Hospitals are also obliged to appoint an auditor who certifies the hospital's accounts and financial statements <sup>(66)</sup>. Finally, hospitals are required to submit certain (financial) information to the Federal Minister responsible for public health <sup>(67)</sup> and its Federal Public Service also monitors compliance with the LCH <sup>(68)</sup>.

## 3. DESCRIPTION OF THE MEASURES TARGETED BY THE COMPLAINT

- (50) According to the complainants, the Brussels Capital Region has chosen to *de facto* take up the role of the relevant Brussels municipalities for the compensation of the deficits of the IRIS-H. In particular, the complaint mentions interventions by the *Fonds Régional Bruxellois de Refinancement des Trésoreries Communales* (or FRBRTC) which was created by the Brussels Capital Region <sup>(69)</sup>. In addition, the complaint adds that since 2003 the Brussels Capital Region itself also allegedly granted special subsidies to the municipalities <sup>(70)</sup> (i.e. up to EUR 10 million annually), which were allegedly intended to be passed on as aid for the IRIS-H.
- (51) While the complainants do not put into doubt the competence of the Brussels Capital Region towards these municipalities they consider that what they qualify as regional financing of the IRIS-H goes beyond what is envisaged by the deficit cover as specified by Article 109 of the LCH (see also recital 47). The complainants argue that the IRIS-H benefited significantly from regional financing awarded to the municipalities in which they are located and that this financing cannot be justified on the basis of the provisions of the LCH. The complainants did not refer to the deficit cover obligation in Article 46 of the bylaws of the IRIS-H.
- (52) Finally, the complainants referred to approximately EUR 100 million being awarded via the FRBRTC in the context of the restructuring of the Brussels public hospitals which led to the creation of the IRIS-H (see also Section 2.2). The complainants allege that this operation would have resulted in overcompensation of the IRIS-H.

## 4. GROUNDS FOR INITIATING THE PROCEDURE

### 4.1. The Commission's 2009 decision

- (53) As recalled above (see recital 5), on 28 October 2009, the Commission adopted a no objections decision <sup>(71)</sup>, concluding that the public financing of the IRIS-H in the Brussels Capital Region constituted State aid compatible with the internal market as compensation for the provision of services of general economic interest. The Commission based this decision on the 2005 SGEI Decision as well as directly on Article 86(2) EC Treaty (now Article 106(2) TFEU).

<sup>(64)</sup> Belgisch Staatsblad/Moniteur Belge of 4 September 1975, p. 10847.

<sup>(65)</sup> See Articles 77 and 78 of the Law of 7 August 1987.

<sup>(66)</sup> See Articles 80 until 85 of the Law of 7 August 1987.

<sup>(67)</sup> See Articles 86 until 86 *ter* of the Law of 7 August 1987.

<sup>(68)</sup> See Article 115 of the Law of 7 August 1987.

<sup>(69)</sup> See footnote 29.

<sup>(70)</sup> These special subsidies were awarded on the basis of the *Ordonnance* of 13 February 2003 (Belgisch Staatsblad/Moniteur Belge of 5 May 2003, p. 24098).

<sup>(71)</sup> Commission decision in case SA.19864 (ex NN 54/2009) (OJ C 74, 24.3.2010, p. 1).

- (54) In its decision, the Commission considered that the IRIS-H were entrusted with three hospital public service missions: first, the general hospital mission of all hospitals (public and private) under the LCH <sup>(72)</sup>; second, the obligation to treat any patient in all circumstances, including post-emergency <sup>(73)</sup>; and third the obligation to provide complete multi-site hospital care <sup>(74)</sup>. In addition, the Commission concluded that the IRIS-H were entrusted with the non-hospital public service mission of providing social assistance together with medical care <sup>(75)</sup>. Finally, reference was also made to a bilingualism obligation <sup>(76)</sup>. These missions were considered to have been entrusted to the IRIS-H via the LCH, the Loi CPAS, the IRIS strategic plans, and finally a convention signed by the IRIS-H and the CPAS. The Commission further considered that the compensation parameters were established *ex ante* <sup>(77)</sup> and that sufficient procedures for preventing and correcting overcompensation were in place <sup>(78)</sup>. Finally, the Commission was also satisfied that the IRIS-H kept separate accounts for hospital and non-hospital activities <sup>(79)</sup>, which in turn ensured the absence of cross-subsidisation of commercial non-SGEI activities of the IRIS-H <sup>(80)</sup>.
- (55) The Commission also assessed whether the IRIS-H had been overcompensated in the past (i.e. between 1996 and 2007) <sup>(81)</sup>, reaching the conclusion that this had not been the case <sup>(82)</sup>. Apart from assessing the financing measures as a whole, the Commission also examined an alleged mechanism of advances. Since the deficit compensation pursuant to Article 109 LCH was regularly only paid out with a long delay of up to 10 years, the IRIS-H allegedly received an advance on these outstanding payments through the FRBRTC. The Commission concluded that since these alleged advances would in any event have to be repaid once the deficit compensation pursuant to Article 109 LCH was paid, they could not lead to overcompensation of the IRIS-H <sup>(83)</sup>.

#### 4.2. The 2012 annulment judgment of the General Court

- (56) In response to the Commission's 2009 decision, the complainants launched an action for annulment of that decision in front of the General Court <sup>(84)</sup>. The complainants argued that the Commission violated the complainant's procedural rights by not opening the formal investigation procedure, as the Commission should have noted serious difficulties in the examination at issue <sup>(85)</sup>.
- (57) In its judgment of 7 November 2012 in case T-137/10, the General Court annulled the Commission's 2009 decision, concluding that the Commission was obliged to open the formal investigation procedure <sup>(86)</sup>.
- (58) The General Court first considered whether the IRIS-H had been entrusted with clearly-defined public service missions <sup>(87)</sup>. At the outset, the General Court noted that all parties agreed that the LCH entrusted all hospitals, public and private, with a general hospital public service mission <sup>(88)</sup>. It was thus only in doubt whether the Commission had erred in finding, in the preliminary examination, that the IRIS-H were entrusted with additional hospital and non-hospital public service missions <sup>(89)</sup>. The General Court concluded that there were doubts

<sup>(72)</sup> *Ibid.*, recitals 140-145.

<sup>(73)</sup> *Ibid.*, recitals 146-150.

<sup>(74)</sup> *Ibid.*, recitals.

<sup>(75)</sup> *Ibid.*, recitals 151-155.

<sup>(76)</sup> *Ibid.*, recital 156.

<sup>(77)</sup> *Ibid.*, recitals 175-181.

<sup>(78)</sup> *Ibid.*, recitals 182-193.

<sup>(79)</sup> *Ibid.*, recitals 204-205.

<sup>(80)</sup> *Ibid.*, recital 206.

<sup>(81)</sup> *Ibid.*, recital 198.

<sup>(82)</sup> *Ibid.*, recital 199.

<sup>(83)</sup> *Ibid.*, recital 201.

<sup>(84)</sup> See footnote 14.

<sup>(85)</sup> *Ibid.*, paragraph 70.

<sup>(86)</sup> *Ibid.*, paragraph 313.

<sup>(87)</sup> *Ibid.*, paragraphs 97-188.

<sup>(88)</sup> *Ibid.*, paragraphs 119-120.

<sup>(89)</sup> *Ibid.*, paragraph 104.

whether the provisions relied on by the Commission in its decision were sufficient to entrust the IRIS-H with the additional missions to treat all patients in all circumstances <sup>(90)</sup>, to provide multi-site hospital care <sup>(91)</sup>, and to provide additional social services <sup>(92)</sup>. In addition, with respect to the alleged mission to provide multi-site hospital care, the General Court pointed out that it was not clear how that mission differed from the general programming and operational requirements applicable to all hospitals subject to the LCH <sup>(93)</sup>.

- (59) Secondly, the General Court examined whether the Commission had demonstrated the existence of clear compensation parameters <sup>(94)</sup>. As regards the hospital missions, the General Court addressed the deficit compensation mechanism under Article 109 LCH <sup>(95)</sup> — while noting that this mechanism was explicitly not challenged by the complainant <sup>(96)</sup> — and the alleged regional financing mechanism through the FRBRTC established in order to advance temporarily the amounts needed to make up the deficits of the IRIS-H before the deficit cover under Article 109 LCH takes effect <sup>(97)</sup>. With respect to Article 109, the General Court found that the complainants had not put forward any arguments affecting the Commission's positive assessment thereof <sup>(98)</sup>. Regarding the alleged advances paid out via the FRBRTC mechanism, however, the General Court concluded that the Commission had not identified any parameters for the calculation of those advances <sup>(99)</sup>, thus evincing an incomplete examination of these advances <sup>(100)</sup>. The General Court added that the Commission contradicted its decision when it claimed, in the hearings, that the FRBRTC was only a mechanism by which the Brussels Capital Region financed the Brussels communes, but not the IRIS-H <sup>(101)</sup>.
- (60) With regards to the public financing in favour of the IRIS-H's alleged additional social mission <sup>(102)</sup>, the General Court observed that this financing apparently again originated from the FRBRTC, which had concluded an agreement with the relevant Brussels communes to grant them a special subsidy with a view to enabling the communes to finance the social missions performed by the IRIS-H <sup>(103)</sup>. The General Court concluded that this agreement did not specify the prior compensation parameters relating to the alleged additional social missions of the IRIS-H <sup>(104)</sup>.
- (61) Next, the General Court considered whether the Commission had demonstrated the existence of procedures for avoiding overcompensation and the absence of overcompensation <sup>(105)</sup>. The General Court first found that the LCH provides for sufficient safeguards to ensure that the procedure pursuant to Article 109 LCH does not lead to overcompensation <sup>(106)</sup>. It concluded further that the Commission had not established that with respect to the alleged advance payments by the municipalities that a similar mechanism existed <sup>(107)</sup>, pointing in particular to the apparent lack of a legal obligation of the IRIS-H to repay these advances once the Article 109 LCH deficit-financing was received <sup>(108)</sup>. With respect to the special subsidy referred to by the Commission as financing the additional social mission, the General Court concluded that the assessment made by the Commission of the procedure for avoiding overcompensation in connection with the funding of the social missions was inadequate <sup>(109)</sup>.
- (62) With respect to the question of whether the IRIS-H had been overcompensated in practice <sup>(110)</sup>, the General Court merely remarked that the scope of the analysis was very broad, covering all the financial results of the IRIS-H over a period of more than a decade <sup>(111)</sup>. Without concluding specifically on the Commission's finding that there

<sup>(90)</sup> *Ibid.*, paragraphs 123-151.

<sup>(91)</sup> *Ibid.*, paragraphs 152-159.

<sup>(92)</sup> *Ibid.*, paragraphs 174-188.

<sup>(93)</sup> *Ibid.*, paragraph 159.

<sup>(94)</sup> *Ibid.*, paragraphs 189-244.

<sup>(95)</sup> *Ibid.*, paragraphs 194 and 195-202.

<sup>(96)</sup> *Ibid.*, paragraph 196.

<sup>(97)</sup> *Ibid.*, paragraph 194.

<sup>(98)</sup> *Ibid.*, paragraphs 203-207.

<sup>(99)</sup> *Ibid.*, paragraphs 208-211.

<sup>(100)</sup> *Ibid.*, paragraph 215.

<sup>(101)</sup> *Ibid.*, paragraphs 216-218.

<sup>(102)</sup> *Ibid.*, paragraphs 231-244.

<sup>(103)</sup> *Ibid.*, paragraph 238.

<sup>(104)</sup> *Ibid.*, paragraphs 239-244.

<sup>(105)</sup> *Ibid.*, paragraphs 245-301.

<sup>(106)</sup> *Ibid.*, paragraphs 253-255.

<sup>(107)</sup> *Ibid.*, paragraphs 257-258 and 265.

<sup>(108)</sup> *Ibid.*, paragraphs 259-264.

<sup>(109)</sup> *Ibid.*, paragraphs 266-278.

<sup>(110)</sup> *Ibid.*, paragraphs 279-288.

<sup>(111)</sup> *Ibid.*, paragraph 286.

had been no overcompensation, the General Court considered that the breadth and complexity of the assessment made by the Commission constituted, in themselves, support for the complainant's arguments alleging the existence of serious difficulties <sup>(112)</sup>.

- (63) Finally, the complainants argued that the Commission should have taken the criterion of economic efficiency of the SGEI provider into account in its assessment <sup>(113)</sup>. The General Court however rejected that argument and concluded that:

'[T]he criterion linked to the economic efficiency of an undertaking in supplying the SGEI is unconnected with the assessment of the compatibility of State aid in the light of Article 86(2) EC [now: Article 106(2) TFEU], and the choice made by the national authorities relating to the economic efficiency of the public operator cannot therefore be criticised in that regard' <sup>(114)</sup>.

- (64) Summarizing its findings, the General Court stated that:

'The [complainant] has presented a body of consistent evidence showing the existence of serious doubts as to the compatibility of the measures under examination in the light of the criteria relating to the applicability of Article 86(2) EC [now: Article 106(2) TFEU] concerning, first, the existence of a clearly defined mandate relating to the hospital and social public service missions specific to the IRIS hospitals, second, the existence of previously established compensation parameters and, third, the existence of procedures for avoiding overcompensation in the funding of the public service missions [...]' <sup>(115)</sup>.

#### 4.3. The Commission's opening decision of 1 October 2014 <sup>(116)</sup>

- (65) In the light of the GC's conclusions <sup>(117)</sup> that the Commission should have had doubts as to the compatibility with the internal market of the disputed public financing granted to the IRIS hospitals on the basis of Article 106(2) TFEU, the Commission was required to initiate the formal investigation procedure and did so by decision of 1 October 2014. In its opening decision, the Commission noted that according to the Belgian authorities the respective Brussels municipalities and CPAS have chosen to entrust the public IRIS-H but not the private hospitals with the following additional obligations <sup>(118)</sup>, justifying the deficit compensation measures put in place in favour of the IRIS-H:

- (a) Obligation to offer medical assistance to all patients in all circumstances: the IRIS-H cannot refuse to treat patients that are not able to pay and/or are uninsured, even if they do not require urgent medical care. Private hospitals allegedly are only obliged to treat all patients that need urgent medical care, but would not have such an obligation in non-urgent situations.
- (b) Obligation to offer a full range of hospital services at multiple sites: The municipalities and the CPAS have made the deliberate choice to maintain multiple hospital sites that offer a full range of treatments in order to ensure accessibility for patients. The alternative option of regrouping the beds and accompanying services at fewer locations and hence to save costs was deliberately dismissed. This choice is especially relevant for disadvantaged patients and their families, since the IRIS hospitals are mainly located close to or in neighbourhoods with a large disadvantaged population.
- (c) Obligation to provide social services to patients and their families: social workers assist the disadvantaged patients and their families in solving and managing financial, administrative, interpersonal and social

<sup>(112)</sup> *Ibid.*, paragraph 288.

<sup>(113)</sup> *Ibid.*, paragraph 290.

<sup>(114)</sup> *Ibid.*, paragraph 300.

<sup>(115)</sup> *Ibid.*, paragraph 308.

<sup>(116)</sup> See footnote 2.

<sup>(117)</sup> See in this respect Case T-137/10, paragraphs 310 and 313.

<sup>(118)</sup> Whether these activities in fact constitute services of general economic interest in the sense of Article 106(2) TFEU and whether the hospitals have been properly entrusted will be assessed below (Section 7.3.4).

difficulties. In addition, the social workers draw up prior social reports to facilitate a financial intervention by the CPAS. While all public and private hospitals are required to employ social workers for certain hospital services (such as geriatrics and psychiatry), the Belgian authorities claim that the IRIS hospitals have a specific additional obligation which results in much larger social services and higher costs than are compensated pursuant to the LCH.

(66) On the basis of the doubts expressed by the GC <sup>(119)</sup>, the Commission invited the Belgian authorities, the complainants and any other interested parties to provide all relevant information for verifying the compatibility of the disputed public financing, in particular as regards the following points:

- the exact definition of the alleged additional missions of the IRIS-H and on what documents the entrustments of these alleged additional missions are based (see recitals 87-89 of the opening decision),
- the legal basis for the compensation of the deficits of the IRIS-H (to which the costs of each of the alleged additional missions contribute) (see recital 91) of the opening decision),
- whether there are (sufficient) measures in place to avoid overcompensation of the alleged additional missions, in particular via the deficit compensation mechanism in combination with the repayable advances (if any), and whether the IRIS-H are under a legal obligation to repay any advances they may have received in order to avoid overcompensation (see recital 95 of the opening decision),
- in the event that the payments of the special subsidies of up to EUR 10 million annually (see above recital 50) are to be considered as a transaction separate from the compensation of deficits of the IRIS-H, whether there are sufficient measures in place to ensure that the compensation does not exceed what is necessary to cover the costs occasioned by the performance of public service obligations (see recital 96 of the opening decision),
- whether no overcompensation was in fact granted to the IRIS-H since they started operating as independent legal structures (see recital 97 of the opening decision),
- any further concrete, specific and detailed argumentation and documentation whether, why and to what extent the public financing measures for the IRIS-H fall under the 2012 SGEI Decision or the 2012 SGEI Framework (see recital 98 of the opening decision) respectively the 2005 SGEI Decision (see recital 100 of the opening decision) and whether, why and to what extent all the compatibility criteria laid down therein would be fulfilled.

(67) The Commission also took the opportunity of adopting the opening decision to seek clarification on the following additional factual matters:

- whether or not any FRBRTC funds, respectively the special subsidies (see above recital 50), were directly transferred to the IRIS-H or whether the FRBRTC and the special subsidies are merely financing mechanisms between the Brussels Capital Region and the Brussels municipalities (see recital 17 of the opening decision),
- the exact nature of the requirement of Article 60(6) of the Loi CPAS (see above recital 19), the possibilities for a public hospital to close down, and the difference with the hospital programming mechanism (see recital 26 of the opening decision),
- whether or not the additional social services carried out by the IRIS-H are economic or non-economic in nature (see recital 48 of the opening decision),

<sup>(119)</sup> See in this respect Case T-137/10, paragraph 308.



- whether or not the passing on of the special subsidies (from the Brussels Capital Region to the municipalities) by the municipalities to the IRIS-H can be considered as a transaction separate from the deficit coverage mechanism (see recital 92 of the opening decision) and, if so, what is the applicable legal basis that sets out its precise modalities,
- whether or not there is a mechanism of advance payments, on what legal basis and how such payments are made (if any) and whether or not they are considered as an aid measure separate from the deficit coverage mechanism, and to clarify whether such advances (if any) were funded via the FRBRTC (see recital 93 of the opening decision),
- further clarification on the concept of *pérennité* (i.e. the continuity and viability of public hospitals, see also below recital 91), its legal basis (in particular at the level of IRIS and the IRIS-H), its implications and how *pérennité* justifies the deficit compensation mechanisms that benefit these hospitals (see recitals 102-103 of the opening decision),
- whether there are any reasons other than those explicitly mentioned in the opening decision (i.e. the existence of additional SGEI missions and the *pérennité* of the public hospitals) that may justify the additional financing for the IRIS-H (see recital 103 of the opening decision).

## 5. COMMENTS FROM INTERESTED PARTIES

- (68) The Commission received comments from four interested parties (i.e. CBI, ABISP, Zorgnet Vlaanderen and UNCPSY), as summarised below:

### 5.1. CBI

- (69) In response to the opening decision, CBI, the complainant, notes that in their view that decision does not contain any new element, arguments or explanations to establish the existence of a specific mission entrusted to the IRIS-H or concerning the compensation mechanisms for this claimed mission or the controls which would be put in place in this respect. The complainants therefore mainly refer to the arguments that were developed in their prior submissions.
- (70) The CBI confirms its position that: (1) the IRIS-H are not entrusted with specific SGEI in addition to those incumbent upon all Belgian hospitals (public and private); and (2) even if the Commission would conclude that such additional missions exist they are not defined sufficiently clearly to meet the requirements of Union law in this respect. The CBI also points out that in the proposed policy program by the new Brussels government (published in July 2014) mention is made of 'rewording the Ordonnance of 13 February 2003 to specify the missions of general interest which justify specific subsidies to municipalities'. The complainants consider this to be an indication that no such missions currently exist but would be defined in the future.
- (71) With respect to the requirements of Article 60(6) of the Loi CPAS, CBI considers that these add nothing to the LCH in terms of definition of any additional or specific SGEI that would only apply to public hospitals such as the IRIS-H. The complainants also argue that the additional social mission only appears to consist of a higher volume of social services than that provided by other hospitals and which they refer to as a 'basic social mission (common to public and private hospitals)'. CBI is of the opinion that this is insufficient to consider that the IRIS-H have an additional social mission. Furthermore, with regard to the question whether these services

are economic in nature they argue that the fact that these services are provided free of charge does not make them non-economic. Finally, CBI considers that the additional social services are inseparable from a broader healthcare service which is itself indubitably economic in nature as this has never been put into doubt.

- (72) According to CBI, the mission of universal care exists both for public hospitals and for private hospitals. In their view, there would be no difference between public hospitals and private hospitals with regard to the treatment of 'social patients', whether in an 'emergency' or 'post emergency' situation. In this context, CBI refers to a judgment of the Brussels Court of First Instance <sup>(120)</sup> concerning urgent medical aid <sup>(121)</sup> for foreigners living illegally in Belgium (hereinafter 'undocumented migrants') which would demonstrate that in this context such aid can be provided by both public and private hospitals. The CBI adds that according to a February 2004 publication <sup>(122)</sup> of the *Mutualités Chrétiennes* <sup>(123)</sup>, the private hospitals treat more than 60 % of 'social patients' in the Brussels Capital Region. The complainants also consider that no additional mission is laid down in the Loi CPAS, in the strategic IRIS plans nor in '*domicile de secours*' conventions <sup>(124)</sup>.
- (73) As regards the 'multi-site mission', CBI considers that it is still not explained what the obligation to offer complete 'multi-site' hospital care activities comprises, nor to what extent this obligation imposes additional burdens on the IRIS-H. As regards the additional social mission, CBI is of the opinion that Article 57 of the Loi CPAS does not create additional obligations with respect to the IRIS-H and, in any case, does not define them in an intelligible manner (no more than the strategic IRIS plans or the '*domicile de secours*' conventions).
- (74) With regard to the question of a clear definition of the compensation parameters CBI points out that, according to the Belgian authorities, the IRIS-H perform a specific mission distinct from that of private hospitals and that specific mission is not defined in the LCH but has another legal basis. According to CBI, it is clearly excluded that the LCH can establish the compensation parameters with respect to one or more public service mission(s) for which the LCH does not provide. In addition, CBI notes that there is no correspondence between the claimed legal bases for the specific missions in question and the compensation mechanisms. The complainants observe that it seems that no distinction is made between deficits resulting on the one hand from the costs of the claimed specific missions and on the other hand those resulting from the costs of the basic mission. Finally, CBI makes reference to a series of opinions by the Belgian Inspectorate of Finance which concluded that it was impossible to monitor the use of the special subsidies awarded on the basis of the *Ordonnance* of 13 February 2003 because that *Ordonnance* did not specify the tasks of communal interest for which these subsidies were granted.
- (75) CBI also repeats its previous assertions that there are no measures to avoid overcompensation. They add that in the absence of a precise definition of the specific missions performed by the IRIS-H, it is impossible to say what activities should be subject to compensation or not. In CBI's view, it is consequently impossible to verify the existence of a monitoring mechanism to avoid overcompensations.
- (76) Finally, CBI points out that while the *pérennité* of the public hospitals is cited in the cooperation agreement of 19 May 1994, this document does not define such a mission and does not constitute an entrustment. In particular, according to CBI this agreement would in no way indicate that a municipality or a city must have

<sup>(120)</sup> See judgment of 25 January 2013 in case RG 2010/15534/A, *ASBL La Clinique Fond'Roy v [...] and Uccle and Anderlecht CPAS*.

<sup>(121)</sup> The Royal Decree of 12 December 1996 regarding urgent medical aid specifies that the urgency is evaluated and attested by a registered medical doctor or dentist. The urgency is not defined by law but assessed by the health practitioner consulted. Therefore, urgent medical aid can encompass any curative and preventive care, delivered either in hospital or ambulatory settings, as well as drug prescription. Urgent medical aid hence differs from the case of life-threatening emergencies described in recital 97.

<sup>(122)</sup> MC-Information No 211 (February 2004), pp. 8-14.

<sup>(123)</sup> See footnote 49 for a short description of this organisation.

<sup>(124)</sup> The '*domicile de secours*' conventions were concluded between the IRIS-H and 17 of the 19 CPAS in the Brussels Capital Region (see also recitals 187-188). These conventions lay down the arrangements for the reimbursement of the treatment costs by the CPAS for patients who cannot pay for treatment and have no insurance cover provided that certain conditions are met. Among others, these conventions specify that the IRIS-H need to collect, to the extent possible, the necessary information for the so-called 'social inquiries' (see also recitals 210-211).

a public hospital on its territory and would also not lay down any rule for hospital service programming in Belgium requiring the operation of a service in a public hospital.

## 5.2. ABISP

- (77) The *Association bruxelloise des institutions de soins privées* (ABISP), one of the initial complainants (see recital 1), notes in its comments on the opening decision that all Belgian hospitals, regardless of their bylaws (*statuts*) or owners, are required by law to fulfil a mission of general interest. In this context, ABISP makes reference to Article 2 of the LCH <sup>(125)</sup>. Finally, ABISP recalls that it has withdrawn its complaint.

## 5.3. Zorgnet Vlaanderen

- (78) *Zorgnet Vlaanderen* represents over 500 Flemish care providers (such as general hospitals, psychiatric care institutions, and nursing homes). In its observations on the opening decision, *Zorgnet Vlaanderen* emphasises that all Belgian hospitals, whether they are public or private, fulfil the same public service obligations in the framework of the LCH. In addition, *Zorgnet Vlaanderen* points out that the LCH does not set out any conditions regarding the legal form (i.e. public or private) to be recognised as a hospital. Furthermore, *Zorgnet Vlaanderen* observes that the definition of the public service obligations of the hospitals does not refer to a regional specificity. Finally, *Zorgnet Vlaanderen* claims that hospitals in Flanders and in the Brussels Capital Region do not perform a different social task.

## 5.4. UNCPSY

- (79) The *Union Nationale des Cliniques Psychiatriques Privées* (UNCPSY) is the federation of private psychiatric clinics in France. In its comments on the opening decision, UNCPSY argues that for the check of whether the public funding does not exceed the net costs of the public service, this net cost cannot be without a limit and cannot ignore whether or not the service provider is well managed. In this context, UNCPSY is of the opinion that the Commission should compare public and private hospitals to determine whether or not the aid is proportionate within the meaning of Article 106(2) TFEU.
- (80) In this context, the Commission observes that UNCPSY's comments run counter to the GC's conclusion in paragraph 300 of its judgment of 7 November 2012 (T-137/10) that economic efficiency of an undertaking in supplying the SGEI is not a criterion for the assessment under Article 106(2) TFEU of the State aid compatibility of the public funding which this undertaking receives (see in this respect recital 63).

# 6. COMMENTS FROM THE KINGDOM OF BELGIUM

## 6.1. Comments from Belgium on the opening decision

- (81) In their reply to the Commission's decision of 1 October 2014 and in particular to recital 17 of that decision, the Belgian authorities note that the financial interventions by the Brussels Capital Region (i.e. the special subsidies of up to EUR 10 million per year) and by the FRBRTC were financial transfers granted to the municipalities only and not to the IRIS-H. As a result, the Belgian authorities consider these were financial transfers between public authorities which are not covered by Article 107(1) TFEU. According to the Belgian authorities, neither the Brussels Capital Region nor the FRBRTC has granted aid to the IRIS-H. Instead, they consider that

<sup>(125)</sup> Article 2 LCH reads: 'With a view to the application of this coordinated law, the following are considered as hospitals: health institutions where at any moment appropriate specialised medical examinations and/or treatments in the field of medicine, surgery and possibly obstetrics can be provided in a multidisciplinary context, within the necessary and appropriate medical, medical-technical, nursing, paramedical and logistical framework, to (patients) who are admitted and can stay there, because their health requires this care to combat the disease in the shortest possible time or to relieve, restore health or improve or stabilise lesions'.

these transfers were made as part of the Region's competence for the general financing of the municipalities, which enables the latter to fulfil their common interest missions, including the missions of the CPAS. In this context, the complainant's reference to the opinions of the Inspectorate of Finance only concerns the Brussels Capital Region and the municipalities but not the IRIS-H. Finally, the Belgian authorities argue that on the basis of the Special Law of 8 August 1980 on institutional reforms and the Opinion of the Belgian Council of State <sup>(126)</sup>, the Brussels Capital Region can only finance the municipalities and not the IRIS-H since financing specific hospital missions does not fall within the Region's competences.

- (82) With respect to the doubt expressed in recital 26 of the opening decision, the Belgian authorities clarify the difference between, on the one hand, the requirement of Article 60(6) Loi CPAS and the possibilities for a public hospital to close down with the hospital programming mechanism, on the other hand. According to them, Article 60(6) Loi CPAS <sup>(127)</sup> lays down the conditions that need to be fulfilled for a CPAS to be able to establish a hospital. In particular, a CPAS must analyse whether there is a genuine need for such a hospital taking into account the needs of the area, including the medico-social needs, and the presence of similar facilities. The Belgian authorities further point out that the hospital programming mechanism consists of determining the maximum number of hospital beds per Region by the Federal Government who bases its decision solely on the hospital needs identified without taking into account the level of social needs in each area <sup>(128)</sup>. They explain that for the Brussels Capital Region, the maximum number of hospital beds is determined for the region as a whole and not for each of the 19 municipalities separately. In contrast, each of the 19 CPAS in the Brussels Capital Region determined autonomously for their municipality whether or not to establish a hospital based on the local needs.
- (83) The Belgian authorities also explained that the closure of a public hospital or its transfer to a private sector partner are not dealt with formally or specifically in the LCH or the Loi CPAS <sup>(129)</sup>. However, according to the Belgian authorities the case law of the Belgian Council of State has clarified the arrangements and conditions for the closure and/or the transfer of institutions set up by a CPAS. In its judgment 113.428 of 9 December 2002, the Council of State ruled that the transfer of a convalescent home belonging to a CPAS to a private operator was to be annulled. In particular, the Council of State found that the need to provide medico-social services also had to be assessed before a decision was taken to close or transfer an establishment. That assessment must take due account of the assessment made when the establishment was created and hence of any changes that had occurred since the decision to create the establishment. Furthermore, the Belgian authorities note that this assessment could not be based purely on the financial situation of the establishment or on the costs incurred for its maintenance. On this basis, the Belgian authorities conclude that a CPAS cannot close its hospital unless it has first established that the medical and social needs the hospital was created to meet no longer exist.
- (84) According to the Belgian authorities, for a public hospital to be established, both the requirements of Article 60(6) Loi CPAS and of the authorities' hospital programming need to be fulfilled while for private hospitals only the latter applies. Under Article 60(6) Loi CPAS, the opening of a new public hospital has to be justified by the existence of a genuine need. Furthermore, the Belgian authorities explain that if a public hospital is opened with a capacity that equals the number of beds foreseen under the hospital programming, then there is no longer room for another (public or private) hospital in that area under that programme, in which case there is no other way of meeting the needs of the population. The Belgian authorities note that if at some point a CPAS wishes to close its public hospital it must first ensure that it is no longer needed in line with the jurisprudence by the Council of State. On the contrary, if a private operator decides to close its hospital, that operator, unlike the CPAS, is not legally required to ensure that the population continues to be provided with healthcare. According to the Belgian authorities, it is only its own choice that motivates a private hospital to remain open, a choice which can be changed at any time. The Belgian authorities refer to the abrupt closure of the private *Hôpital*

<sup>(126)</sup> Opinion of the Legislation Section of the Council of State on the preliminary draft of the *Ordonnance* of 13 February 2003 on the award of special subsidies for the municipalities of the Brussels Capital Region.

<sup>(127)</sup> See recital 19 for the exact wording of this article.

<sup>(128)</sup> The Federal Government adopts the hospital beds plan ('hospital programming') according to their indices (medical, surgical, geriatric, maternity, paediatrics, rehabilitation, psychiatry, neonatology, etc.) in the light of the total population for the Brussels, Flemish and Walloon Regions and for the Kingdom as a whole, on the basis of a proposal by the National Council for Hospital Facilities.

<sup>(129)</sup> The Belgian authorities more specifically note that at most the LCH lays down arrangements for the deficit compensation if a public hospital is transferred to a private owner while the Loi CPAS only sets out general principles for the opening and management of establishments created by the CPAS.

*Français* of Berchem-Sainte-Agathe (Brussels) in 2008 <sup>(130)</sup> as an illustration. To conclude, the Belgian authorities explain that the hospital programming mechanism equally restrains the freedom of public and private operators to establish a hospital (as this is only possible if the maximum number of hospital beds in an area has not yet been reached). In their view, the obligations arising from the Loi CPAS however put additional constraints on both the possibility for a CPAS to establish and to close a public hospital while private hospitals can close at any time.

- (85) With respect to the obligations that allegedly only apply to the IRIS-H (see recitals 87 to 89 of the opening decision), the Belgian authorities argue that these obligations are the direct consequence of the fact that the IRIS-H have been set up to contribute to the provision of social aid by the CPAS (see also Section 2.2). The Belgian authorities consider that these obligations derive from the Loi CPAS, pursuant to which the IRIS-H were created, and are entrusted by means of the bylaws of the IRIS-H and the IRIS strategic plans. The Belgian authorities also refer to these documents for the exact definition of these obligations. For reasons of brevity and in order to avoid repetition, the Commission will only cite the relevant quotations in its assessment (see Section 7.3.4.1).
- (86) In its opening decision (see recital 48), the Commission expressed doubts with respect to the economic or non-economic nature of the additional social services carried out by the IRIS-H. In their reply to the opening decision, the Belgian authorities consider that these social services are non-economic activities. In essence, they argue that the social aid in the form of material, social, medical, medico-social and psychological assistance provided by the Brussels CPAS is not part of a competitive market and that this remains the case even if part of the social aid (i.e. the additional social services) is performed by the IRIS-H on the basis of an entrustment.
- (87) With respect to the legal basis for the compensation of the deficits (see recital 91 of the opening decision), the Belgian authorities consider that the obligation for the municipalities to cover the deficit of their public hospitals is laid down in Article 46 of the IRIS-H bylaws and also in Article 109 of the LCH. They explain that Article 109 LCH lays down a general principle that applies to all Belgian public hospitals and that determines the minimum that municipalities have to do (since it only requires them to cover part of the deficit, see also recital 47). The Belgian authorities also note that Article 46 of the IRIS-H bylaws is a specific obligation that applies only to the six municipalities that established the IRIS-H and who chose to go beyond the minimum of Article 109 LCH by covering the entire accounting deficit of the IRIS-H.
- (88) In recital 92 of its opening decision, the Commission asked whether or not the passing on of the special subsidies (which the Brussels Capital Region grants to the municipalities) by the municipalities to the IRIS-H can be considered as a separate transaction from the deficit coverage mechanism. In their reply, the Belgian authorities argue that the Brussels municipalities only use the special subsidies to (partially) fulfil their obligation to cover the deficits of the IRIS-H. As will be explained in more detail below (see Section 7.3.5), the deficit compensation is paid out in several steps, among which the transfer of the special subsidies from the municipality to the IRIS-H, but all these payments are made on the same basis, namely the municipal obligation to cover the deficit.
- (89) The Commission also asked for clarification regarding an alleged mechanism of advance payments (if any), its legal basis and operation, the difference with the deficit coverage mechanism, and the role of the FRBRTC in its funding (see recital 93 of the opening decision). The Belgian authorities consider that there is no mechanism for advances in place. More specifically, they explain that the obligation to cover the deficit of the IRIS-H comes into effect as soon as the deficit occurs. Indeed, according to the Belgian authorities Article 46 of the IRIS-H bylaws refers to the accounting deficit which is laid down in the hospitals' financial statements no later than six months after the end of the financial year. In contrast, the calculation of the Article 109 LCH deficit by the Federal Public Service for Public Health takes much longer (up to 10 years). However, the Belgian authorities argue that since the Article 109 LCH deficit is merely a part of the accounting deficit which is covered immediately under Article 46 of the IRIS-H bylaws, the IRIS-H are not paid any advances that might be classified as aid distinct from

<sup>(130)</sup> The Belgian authorities note that while a buyer was being sought, the *Hôpital Français* abruptly closed its doors to admissions on 9 May 2008. They explain that this hospital had previously closed its paediatric department and its maternity department. According to the Belgian authorities, patients in these departments were moved to other hospitals in the Brussels region throughout the day.

the deficit cover mechanism. Finally, the Belgian authorities repeat that the FRBRTC has provided financing to the municipalities which helped them to fulfil their deficit cover obligation which as explained above does not constitute a mechanism of advance payments.

- (90) With regard to the measures to avoid overcompensation and the absence of overcompensation in fact (see recitals 95-97 of the opening decision), the Belgian authorities provide the following arguments. They first explain that the decisions to compensate the deficit are annual and are taken at a time when the estimated deficit for the respective year is known so that there is no risk of overcompensation. They add that the Belgian legal framework (among others the Law of 14 November 1983 and the Loi CPAS) allows the municipalities to ensure that the IRIS-H use the State aid correctly and to recover this aid in the event of non-compliance or overcompensation. In addition, to show the absence of overcompensation the Belgian authorities refer to several tables submitted to the Commission which contain the deficits and municipal interventions for each of the five IRIS-H over the period 1996-2014 (see also Section 7.3.5 for these figures).
- (91) As requested, in their reply the Belgian authorities also provide further clarification on the concept of *pérennité* (see recitals 102-103 of the opening decision). According to them, the obligation to ensure the continuity (or *pérennité*) of the IRIS-H is based directly on the Loi CPAS. As has been explained above (see Section 2.1), each CPAS can set up establishments to provide social aid, including medical and medico-social assistance, if they can demonstrate that this is necessary to fulfil a genuine need in line with Article 60(6) Loi CPAS. They explain that historically, six of the nineteen CPAS in the Brussels Capital Region established hospitals (without separate legal personality) that they managed themselves until the end of 1995 in order to provide social aid. According to them, the restructuring of these public hospitals which led to the creation of the public IRIS-H that became legally independent of the CPAS on 1 January 1996 (see also Section 2.2) did not alter the obligation on the CPAS to provide social aid whether directly themselves or via the IRIS-H. In this context, the Belgian authorities point out that the primary objective of the restructuring and the creation of the IRIS network and the IRIS-H was to ensure the continuity of public hospital services in the Brussels Capital Region (see also recital 27). Hence, they note that to ensure the continuity of the IRIS-H and hence guarantee that the social needs of the population are fulfilled, the municipalities and the CPAS are required to absorb any hospital deficit on the basis of Article 46 of the IRIS-H bylaws. Furthermore, the Belgian authorities conclude that as long as the genuine need exists, in line with the jurisprudence of the Council of State (see recital 83), the public authorities cannot close the IRIS-H nor transfer them to a private owner.
- (92) Finally, in recital 103 of the opening decision, the Commission asked whether there are other reasons that may justify the additional financing for the IRIS-H. In this respect, the Belgian authorities note that the aim of the IRIS-H is not merely to establish 'viable' hospital services, missions and programmes, as Belgian private hospitals could do. Instead, according to the Belgian authorities, the IRIS-H have to guarantee the widest possible range of healthcare, specifically in order to ensure access for everyone, including the poorest members of society, to whatever treatment their pathology requires, even if that goes well beyond the norms of hospital planning and approval applicable to all hospitals, by and under the LCH. In this context, the Belgian authorities also make reference to paragraph 162 of the General Court judgment of 7 November 2012 which states: '*compensation for public hospital deficits may be necessary for health and social reasons in order to ensure the continuity and viability of the hospital system*'. The Belgian authorities also point out that the status of a public hospital entails certain costs that are not fully compensated by the federal financing measures. They note that these costs include among others: the payment of language bonuses to bilingual staff, higher pension and sickness expenses for statutory employees (civil servants), and pay scale increases imposed (but only partially paid) by the Brussels Capital Region.

## 6.2. Comments from Belgium on third party comments

- (93) The Belgian authorities start by noting that the observations by CBI, ABISP and Zorgnet Vlaanderen to the Commission's opening decision are founded on the common assertion that in their opinion the IRIS-H are not entrusted with SGEI in addition to those incumbent on any hospital (public or private) in Belgium. In their view, this assertion is based on a single premise, namely the fact that the LCH entrusts private and public hospitals

with the same public service obligation regardless of any particular regional aspect. However, according to the Belgian authorities, the intervening parties do not explain how the Loi CPAS would not apply to the IRIS-H while according to Belgium this law is the specific legal cause for the existence of the IRIS-H. The Belgian authorities point out that Article 147 of the LCH explicitly acknowledges that for hospitals managed by a CPAS (such as the IRIS-H <sup>(131)</sup>), the LCH supplements the Loi CPAS which confirms that the LCH is not the only relevant legal basis when it comes to a hospital managed by a CPAS.

- (94) The CBI's assertion that the Brussels government's intention to reword the *Ordonnance* of 13 February 2003 to specify the missions of general interest which justify specific subsidies to municipalities (see recital 70) is an indication that no specific missions (only applying to the IRIS-H) currently exist, is deemed incorrect by the Belgian authorities. In particular, they point out that the specific subsidies foreseen by this *Ordonnance* are only awarded to the municipalities and not to the IRIS-H. Belgium furthermore confirms that the interventions by both the FRBRTC and the Brussels Capital Region itself (of up to EUR 10 million per year <sup>(132)</sup>) in support of the municipalities constitute financial transfers between public authorities outside the scope of Article 107(1) TFEU. The Belgian authorities repeat that none of these amounts have been granted by the Region or the FRBRTC to the IRIS-H. On the contrary, according to Belgium they are simply transfers between the Region and the municipalities within the Region's remit in terms of the overall funding of municipalities. This overall funding is designed to enable the municipalities to fulfil their tasks of communal interest which includes the missions of the CPAS. According to the Belgian authorities, the announced reform of the *Ordonnance* of 13 February 2003 in any event cannot amount to an admission that the IRIS-H have no additional SGEI. It is the municipalities that specify the SGEI entrusted to the hospitals they establish and the *Ordonnance* has no relevance in this context as it only concerns intra-State financing.
- (95) The Belgian authorities also refute the allegedly inaccurate portrayal of the social missions made by CBI in its observations. In particular, CBI considered that the LCH defines a 'basic social mission' common to public and private hospitals, but which only the IRIS-H would perform more intensively. From this perspective, the 'additional' social missions of the IRIS-H could not be separated from the hospital services provided and would be an integral part of these. According to the Belgian authorities, this view cannot be followed. The Belgian authorities consider that beyond the fact that CBI expressly recognises here that there is indeed an intrinsic difference between public and private hospitals (i.e. a higher volume of social services being provided by the IRIS-H), CBI does not define what it means exactly by 'basic social mission', which it considers to be a hospital SGEI, or determine the legal basis which supports it or the specific mandate which grants it. The Belgian authorities are of the opinion that only the Loi CPAS can be used to entrust 'basic social missions' to public hospitals. In their view, as far as the public hospitals alone are concerned, the LCH in fact merely supplements the Loi CPAS (see Article 147 LCH). The essential, or 'basic', mission of the IRIS-H is defined by or under the Loi CPAS and is therefore not 'common' to all hospitals. According to them, this mission is not economic in nature. Hence, the IRIS-H are established under the Loi CPAS and, once set up, expected to abide by the LCH's additional rules <sup>(133)</sup>.
- (96) With respect to CBI's observations concerning the universal care mission, the Belgian authorities observe that CBI limits the universal care mission, which it alleges to be common to all hospitals, solely to emergencies and post-emergencies. In this way, the Belgian authorities consider that CBI would implicitly recognise that private Brussels hospitals have no obligation to treat patients outside of emergency and 'post-emergency' cases, which nonetheless account for the bulk of care provided for needy people. Furthermore, the Belgian authorities argue that CBI's reference to the public interest mission described in Article 2 of the LCH does not provide a basis for any such obligation. According to them being entrusted with a basic hospital mission is not sufficient in order to be similarly entrusted with the mission of providing care to all persons in all situations and regardless of their ability to pay. The mere fact that there are specific rules governing emergencies amply demonstrates this. The Belgian authorities argue that a general interest mission cannot be implied, but is imposed. In their view, it was necessary

<sup>(131)</sup> For the purpose of the LCH, the IRIS-H are considered to be managed by a CPAS.

<sup>(132)</sup> The amount per year depends on the available resources in the budget of the Brussels Capital Region and on the applications from the relevant municipalities. In the period 2003-2014, the special subsidy amounted to 10 million in all but two years (it was only 9 million in 2010 and 9,5 million in 2011).

<sup>(133)</sup> In this context the Belgian authorities point out that private hospitals, which are established for example under the law on non-profit associations ('ASBL law'), once set up, must also comply with the LCH as far as their hospital functions are concerned. However, to the extent that the ASBL law does not entrust the institutions it governs with any specific missions, the missions of these private hospitals are only governed by the LCH.

to lay down specific requirements for emergencies because there is no mention of emergencies in the LCH definition of the basic hospital mission. Indeed, the Belgian authorities argue that the Law of 8 July 1964 <sup>(134)</sup> and its implementing decrees deal with emergency medical assistance <sup>(135)</sup> and emergency services (including ambulances). On this basis, some hospitals, both public and private, carry out certain tasks in the field of emergency medical assistance.

- (97) However, the Belgian authorities argue that the obligation to provide emergency care in both public and private hospitals is not conferred by the LCH. It is, instead, a general obligation to assist persons in danger. According to the Belgian authorities, hospitals are required to provide assistance in cases of medical emergency, according to their structure and available expertise <sup>(136)</sup>. Both public and private hospitals are subject to this obligation, as indeed is everyone else, by virtue of their duty to assist persons in danger. The Belgian authorities also explain that under Article 422 *ter* of the Belgian Criminal Code, this obligation only applies in emergency situations, and particularly in medical emergencies of a life-threatening nature. However, they point out that in all other (i.e. non-emergency) situations hospitals that have not been entrusted with a universal care mission, are not obliged to treat patients if these cannot pay for the treatment. Finally, the Belgian authorities observe that while Belgian hospitals are naturally not allowed to discriminate based on a patient's wealth (and hence on the pure fact that someone is poor), they cannot be forced to provide care for free if a patient cannot or will not pay in a non-emergency situation.
- (98) In their comments to CBI's observations, the Belgian authorities also put into context CBI's reference to a judgment of the Brussels Court of First Instance (see recital 72). According to the Belgian authorities, the judgment referred to by CBI only concerns a very specific case of urgent medical aid <sup>(137)</sup> provision for an undocumented migrant who needed psychiatric care. They point out that the IRIS-H do not provide this type of care. In their view, this judgment actually confirms that urgent medical aid for undocumented migrants is normally either provided by hospitals established by a CPAS or by hospitals with which the CPAS have concluded an agreement <sup>(138)</sup>. Finally, the Belgian authorities point out that CBI does not justify, or even attempt to justify, an alleged obligation for private hospitals to treat all patients for 'post-emergencies'. According to the Belgian authorities, no such 'post-emergency' obligation exists for private hospitals while the IRIS-H are obliged to treat all patients in all circumstances, even if there is no medical emergency.

## 7. ASSESSMENT OF THE MEASURES

### 7.1. Scope of this decision

- (99) The complaint made reference to an aid measure of approximately EUR 100 million in the context of the restructuring operation that led to the creation of the IRIS-H (see Section 2.2). However, as explained in Section 3.1 of

<sup>(134)</sup> See Law of 8 July 1964 as amended, Belgisch Staatsblad/Moniteur Belge of 25 July 1964, p. 8153.

<sup>(135)</sup> Contrary to the urgent medical aid referred to above (see recital 72) which includes planned care, emergency medical assistance concerns care that is needed immediately for life-threatening conditions.

<sup>(136)</sup> This means that even if a hospital does not carry out certain tasks in the field of emergency medical assistance as laid down in the Law of 8 July 1964, it is still obliged to provide assistance in medical emergencies to the best of its abilities (i.e. taking into account its infrastructure and personnel).

<sup>(137)</sup> Urgent medical aid is governed by Article 57(2) and the Royal Decree of 12 December 1996.

<sup>(138)</sup> In its judgment of 25 January 2013 the Brussels Court of First Instance notes: 'Within the system overall, either the CPAS itself supplies the urgent medical aid by treating a person requiring urgent care in a hospital it administers, or it pays the costs of caring for that person at a private hospital. If **this aid is typically more often provided in an establishment dependent on the relevant CPAS or with which it has concluded an agreement**, the person may be admitted to another establishment, owing to the urgency resulting from the situation of the person to be admitted to hospital. In such a case there is neither prior consultation of the CPAS, nor typically even of the person involved; instead, a rapid decision is taken unilaterally by the paramedics of the emergency service called, or, as in this case, by the Public Prosecutor. The **unusual or exceptional nature of this accelerated procedure** does not authorise the CPAS to refuse to bear the costs of a stay in a hospital other than their own' (emphasis added).



the opening decision, the Commission only took action with respect to the restructuring aid after the limitation period for the recovery of this aid had expired. Therefore, this aid measure was not included in the scope of the formal investigation carried out by the Commission and will hence not be addressed further in this decision.

- (100) Apart from the measure covered by the limitation period, the complaint formally targeted (i) the funds distributed by the FRBRTC to the municipalities in charge of the IRIS-H and (ii) the special subsidies (of up to EUR 10 million per year) granted to these municipalities by the Brussels Capital Region on the basis of the *Ordonnance* of 13 February 2003.
- (101) These two types of funds are however awarded only to the municipalities in charge of the IRIS-H and not to the IRIS-H themselves. They are in reality only financing flows between the Brussels Capital Region and the six Brussels municipalities in charge of the IRIS-H and therefore do not constitute State aid to the IRIS-H.
- (102) It is true that the Commission's 2009 annulled decision tended to confuse the FRBRTC payments and the deficit compensation mechanism of Article 109 LCH and did not separate the assessment of the compensation parameters of these two measures <sup>(139)</sup>. Furthermore, the FRBRTC funds are used by the municipalities to compensate the deficit of the IRIS-H <sup>(140)</sup> and the municipalities had the obligation to pay the FRBRTC funds to the IRIS-H within a maximum period of seven working days <sup>(141)</sup>.
- (103) Nevertheless, on the basis of the information received in reply to its opening decision and as explained below (see recital 230) the financial transfers from the FRBRTC and the Brussels Capital Region to the municipalities in charge of the IRIS-H are necessary since these municipalities have insufficient own resources to fulfil the municipal deficit compensation obligation towards the IRIS-H. It is in this context that both the FRBRTC and the Brussels Capital Region have required the Brussels municipalities to almost immediately upon receipt of these transfers make the FRBRTC funds and the special subsidies available to the IRIS-H. Regardless of this pass-on obligation, it is only the respective municipalities that have the obligation to compensate the deficits of the IRIS-H and these hospitals have no right to any compensation from the Brussels Capital Region or the FRBRTC. Likewise, the IRIS-H have been entrusted with certain obligations by the municipalities only and not by the Brussels Capital Region (see Section 7.3.4.1). Therefore, it is only the deficit compensation payments from the municipalities to the IRIS-H, whether financed on the basis of the municipalities' own resources or from funds provided to the municipalities by the Brussels Capital Region, that can be qualified as State aid within the meaning of Article 107(1) TFEU.
- (104) The Commission concludes that the intra-State financing (from the Brussels Capital Region, whether directly or indirectly via the FRBRTC, to the municipalities) is only a funding source for the municipal deficit compensation payments and does not constitute a measure of which the IRIS-H can benefit in addition to this deficit compensation. For this reason, the money flows between the Brussels Capital Region and the respective Brussels municipalities and their legal bases (e.g. the *Ordonnance* of 13 February 2003) will not be assessed as such in this decision. Instead, in this decision the Commission will assess the municipal deficit compensation payments of which the IRIS-H benefit, and for which the municipalities rely to a large extent on the intra-State financing they received from the Brussels Capital Region <sup>(142)</sup>. However, while not further pursuing the measures that are formally targeted by the complainant, the State aid assessment of the municipal deficit compensation will materially fully address the complainant's State aid concerns since it will *de facto* also cover the funds that were granted by the Brussels Capital Region directly or via the FRBRTC as the municipalities use them entirely for the deficit compensation of the IRIS-H. For this reason, the overcompensation tests that are described below (see Tables 9 to 13 in Section 7.3.5) also identify the deficit compensation payments that were financed using FRBRTC funds and special subsidies from the Brussels Capital Region. Finally, it should be underlined that the

<sup>(139)</sup> Case T-137/10, paragraphs 208-215.

<sup>(140)</sup> *Ibid.*, paragraph 217.

<sup>(141)</sup> *Ibid.*, paragraph 218.

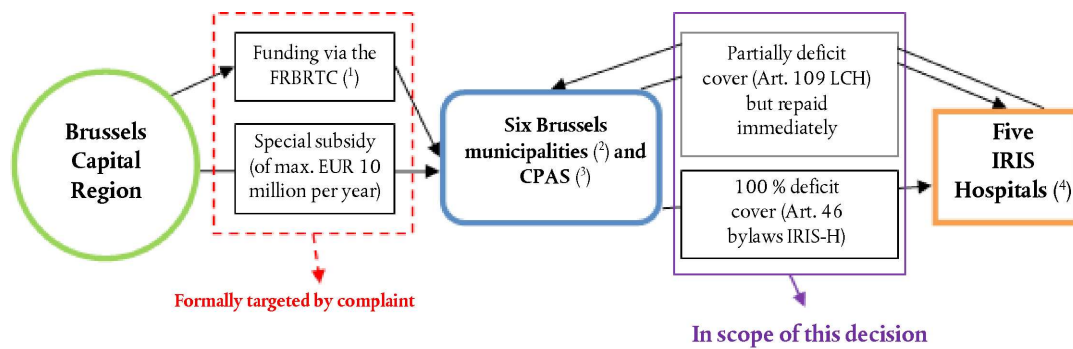
<sup>(142)</sup> In doing so, the assessment in this decision differs from the annulled Commission decision of 2009 in which the FRBRTC interventions and the special subsidies were to some extent assessed separately from the deficit compensation.

part of the municipal deficit compensation payments that was funded by the Brussels Capital Region or via the FRBRTC was insufficient <sup>(143)</sup> to cover the entire deficits incurred by the IRIS-H and these payments have at no point in time in the period 1996-2014 lead to a situation where any of the IRIS-H was actually overcompensated and would have had to repay (part of) the deficit compensation (see also recitals 234 and 238).

- (105) The Commission will therefore assess the deficit compensation awarded by the municipalities to the IRIS-H since 1996 <sup>(144)</sup>. On that basis, Figure 1 below summarises the public financing that is in scope of this decision (in the full line rectangle) and also indicates the intra-State financing measures that were targeted in the complaint (in the dashed line rectangle). More detail on these measures will be provided in Section 7.3.5 below.

Figure 1

### Financing flows and scope of this decision



<sup>(1)</sup> Fonds Régional Bruxellois de Refinancement des Trésoreries Communales.

<sup>(2)</sup> La Ville de Bruxelles, Anderlecht, Etterbeek, Ixelles, Saint-Gilles, and Schaerbeek (until the end of 2013).

<sup>(3)</sup> Centres Publics d'Action Sociale: PublicSocial Welfare Centres attached to the municipalities.

<sup>(4)</sup> CHU Saint-Pierre, CHU Brugmann, Institut Bordet, Queen Fabiola Children's University Hospital (HUDERF) and IRIS South Hospitals.

## 7.2. State aid within the meaning of Article 107(1) TFEU

- (106) Article 107(1) TFEU provides that 'aid granted by a Member State or through State resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods shall, in so far as it affects trade between Member States, be incompatible with the internal market'. Accordingly, a measure constitutes State aid if the following four cumulative conditions are met <sup>(145)</sup>:

- (a) the measure must give a selective economic advantage to an undertaking;
- (b) the measure must be financed through State resources;
- (c) the measure must distort or threaten to distort competition;
- (d) the measure must have the potential to affect trade between Member States.

<sup>(143)</sup> On average between 68 % and 90 % of the respective IRIS-H's deficits incurred over the entire period 1996-2014 has been compensated by the municipalities using FRBRTC funds or the special subsidy of the Brussels Capital Region. For the remainder, the municipalities had to use their own funds and as explained below (see recital 234) at the end of 2014 they still had to pay (again using own funds) additional deficit compensations of approximately EUR 15 million for the five IRIS-H together.

<sup>(144)</sup> Where calculations have to be done to carry out this assessment, the Commission bases itself on the available figures, i.e. the period 1996 to 2014 (for the exceptions see recital 236).

<sup>(145)</sup> Case C-222/04 *Ministero dell'Economia e delle Finanze v Cassa di Risparmio di Firenze SpA, Fondazione Cassa di Risparmio di San Miniato and Cassa di Risparmio di San Miniato SpA* ECLI:EU:C:2006:8, paragraph 129.

### 7.2.1. Selective economic advantage to an undertaking

#### 7.2.1.1. The notion of undertaking

##### General principles

- (107) Public funding granted to an entity can only qualify as State aid if that entity is an ‘undertaking’ in the sense of Article 107(1) TFEU. The Court of Justice has consistently defined undertakings as entities engaged in economic activity <sup>(146)</sup>. The qualification of an entity as an undertaking thus depends on the nature of its activity, with no regard to the entity’s legal status or the way in which it is financed <sup>(147)</sup>. An activity must generally be considered to be economic in nature where it consists in offering goods and services on a market <sup>(148)</sup>. An entity that carries out both economic and non-economic activities is to be regarded as an undertaking only with regard to the former <sup>(149)</sup>. The mere fact that an entity does not pursue a profit does not necessarily mean that its operations are not of an economic nature <sup>(150)</sup>.

##### Medical services

- (108) Where healthcare is provided by hospitals and other healthcare providers against remuneration <sup>(151)</sup>, be it directly from the patients or from other sources, it must generally be considered to constitute an economic activity <sup>(152)</sup>. The financing which the IRIS-H receive through various allowances from the federal or federated authorities (e.g., see recital 46(a), (d), (e) as regards public financing available to all hospitals and recital 44 as regards the deficit compensation for the IRIS-H), together with direct payments by patients (see recital 46(c)) and payments by the INAMI (see recital 46(b)) remunerates the IRIS-H for the medical services rendered and can therefore, in this context, be considered as constituting the economic consideration for the hospital services provided. In such a system, there is a certain degree of competition between hospitals concerning the provision of healthcare services. The fact that a hospital providing such services against remuneration is public does not render that hospital’s activities non-economic in nature <sup>(153)</sup>.
- (109) In the present case, the main activities of the IRIS-H are hospital activities consisting of the provision of healthcare services. These hospital activities carried out by the IRIS-H are also provided by other types of bodies or entities, in particular clinics, private hospitals and other specialised centres, including the private hospitals of the complainants. Therefore, these hospital activities carried out by the IRIS-H against remuneration and in a competitive environment must be regarded as economic in nature.

<sup>(146)</sup> Joined Cases C-180/98 to C-184/98 *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten* ECLI:EU:C:2000:428, paragraph 74.

<sup>(147)</sup> Case C-41/90 *Höfner & Fritz Elser v Macrotron GmbH* ECLI:EU:C:1991:161, paragraph 21 and Joined Cases C-180/98 to C-184/98 *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten* ECLI:EU:C:2000:428, paragraph 74.

<sup>(148)</sup> Case C-118/85 *Commission of the European Communities v Italian Republic* ECLI:EU:C:1987:283, paragraph 7 and Case C-35/96 *Commission of the European Communities v Italian Republic* ECLI:EU:C:1998:303, paragraph 36.

<sup>(149)</sup> Case C-82/01 *P Aéroports de Paris v Commission of the European Communities* ECLI:EU:C:2002:617, paragraph 74 and Case C-49/07 *Motosykletistiki Omospondia Ellados NPID (MOTOE) v Elliniko Dimosio* ECLI:EU:C:2008:376, paragraph 25. See also Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest (2012/C-8/02), paragraph 9.

<sup>(150)</sup> Case C-49/07 *Motosykletistiki Omospondia Ellados NPID (MOTOE) v Elliniko Dimosio* ECLI:EU:C:2008:376, paragraph 27 and Case C-244/94 *Fédération Française des Sociétés d’Assurance, Société Paternelle-Vie, Union des Assurances de Paris-Vie and Caisse d’Assurance et de Prévoyance Mutuelle des Agriculteurs v Ministère de l’Agriculture et de la Pêche* ECLI:EU:C:1995:392, paragraph 21.

<sup>(151)</sup> Case C-157/99 *B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen* ECLI:EU:C:2001:404, paragraph 58, where the ECJ ruled that the fact that a medical treatment in a hospital is financed directly by the sickness insurance funds on the basis of conventions and pre-established rates is not such as to remove that treatment from the field of economic activities within the meaning of the TFEU and that payments by the sickness insurance funds ‘albeit set at a flat rate, are indeed the consideration for the hospital services and unquestionably represent remuneration for the hospital which receives them and which is engaged in an activity of an economic character’. The ECJ also added in this context that it is not necessary that such remuneration is paid by those benefiting of the service.

<sup>(152)</sup> Case C-157/99 *B.S.M. Geraets-Smits v Stichting Ziekenfonds VGZ and H.T.M. Peerbooms v Stichting CZ Groep Zorgverzekeringen* ECLI:EU:C:2001:404, paragraph 53, Joined cases 286/82 and 26/83 *Graziana Luisi and Giuseppe Carbone v Ministero del Tesoro* ECLI:EU:C:1984:35, paragraph 16, Case C-159/90 *The Society for the Protection of Unborn Children Ireland Ltd v Stephen Grogan and others* ECLI:EU:C:1991:378, paragraph 18, Case C-368/98 *Abdon Vanbraekel and Others v Alliance nationale des mutualités chrétiennes (ANMC)* ECLI:EU:C:2001:400, paragraph 43 and T-167/04 *Asklepios Kliniken GmbH v Commission of the European Communities* ECLI:EU:T:2007:215, paragraphs 49-55.

<sup>(153)</sup> See Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest (2012/C-8/02), paragraph 24.

- (110) The solidarity aspects underpinning the Belgian national healthcare system do not call into question the economic nature of such hospital activities. Indeed, it is recalled that with regard to a national health system, which is managed by ministries and other bodies and operates 'according to the principle of solidarity in that it is funded from social security contributions and other State funding and in that it provides services free of charge to its members on the basis of universal cover', the CFI held that the management bodies in question were not acting as undertakings in their management of that national health system <sup>(154)</sup>. However, the Commission considers that there is a need to differentiate between the management of the national health system, carried out by public bodies implementing for this purpose the prerogatives of the State, and the provision of hospital care against remuneration in a competitive environment (which is at stake in the case at hand, as outlined in recitals 108-109).
- (111) Accordingly, as far as the provision of healthcare services is concerned, the IRIS-H have to be considered to constitute undertakings in the sense of Article 107(1) TFEU.

#### Social services

- (112) As explained in recital 38 above, the IRIS-H offer a series of social services to their socially disadvantaged patients and their families. These include, according to patients' needs, assistance of psycho-social, socio-administrative or socio-material character. The specific nature of these social services requires that operators eligible to exercise them have specific resources such as specially trained staff.
- (113) It is undeniable that the additional social activities that the IRIS-H are allegedly under an obligation to perform serve an exclusively social purpose. Nevertheless, as the European Court of Justice (hereinafter 'ECJ') stated in its case law, a purely social function of a system under which an organisation is allocated specific tasks, is not in itself sufficient to generally exclude the economic nature of these tasks <sup>(155)</sup>.
- (114) In the Commission's opening decision, clarification was sought on whether or not the additional social activities allegedly performed by the IRIS-H amounted to an economic activity. In their response to the Commission's opening decision, the Belgian authorities maintain that the social activities are non-economic, as they do not form part of a competitive market. The complainants however argue that the social activities cannot be separated from the hospital activities which are economic in nature. While the Commission has carefully considered the Belgian authorities' arguments, it cannot exclude that the provision of the additional social activities amounts to an economic activity. Furthermore, as will be explained below (see recital 165), the Commission considers that the additional social activities can in reality not be separated from the hospital activities which are economic in nature.
- (115) In order to proceed with the assessment, the remainder of this decision therefore assumes *ex hypothesi* that the provision of the additional social services is indeed economic in nature.

#### Ancillary activities

- (116) As outlined in recital 41 above, the IRIS-H are also engaged in a series of ancillary activities. The Commission notes that some of these activities would, when assessed in isolation from the main activities of the IRIS-H, appear to be non-economic in nature (e.g. research activities), while others appear on first sight to constitute economic activities (e.g. canteen or shop for patients and visitors). It can be argued, however, that due to their close connection to the main (economic) activities of the IRIS-H, all of the mentioned ancillary activities must be treated as constituting economic activities as well.

<sup>(154)</sup> Case T-319/99 *Federación Nacional de Empresas de Instrumentación Científica, Médica, Técnica y Dental (FENIN) v Commission of the European Communities* ECLI:EU:T:2003:50, paragraph 39. See also Case T-137/10, paragraphs 90, 91 and Communication from the Commission on the application of the European Union State aid rules to compensation granted for the provision of services of general economic interest (2012/C-8/02), paragraph 22.

<sup>(155)</sup> See to that effect Case C-355/00 *Freskot AE v Elliniko Dimosio* ECLI:EU:C:2003:298, paragraph 53. In this case, the ECJ also referred to the fact that the services and contributions on the basis of a compulsory insurance scheme at hand were established in detail by the national legislator.

- (117) In order to proceed with the assessment, the remainder of this decision therefore assumes *ex hypothesi* that the ancillary activities are indeed economic in nature.

#### 7.2.1.2. Economic advantage

##### General assessment

- (118) An advantage within the meaning of Article 107(1) TFEU is any economic benefit which an undertaking would not have obtained under normal market conditions, i.e. in the absence of State intervention <sup>(156)</sup>. Only the effect of the measure on the undertaking is relevant, neither the cause nor the objective of the State intervention <sup>(157)</sup>. Whenever the financial situation of the undertaking is improved as a result of State intervention, an advantage is present.
- (119) In the present case, it has to be noted that the various public financing systems (as described in Section 2.5.1) covering the general hospital and additional activities, among which is also the deficit compensation, allowed the IRIS-H to benefit from a package of measures designed to reduce the burdens normally borne by the providers of such activities. Therefore, subject to the examination under the principles of the *Altmark* judgment made in the following recitals, the deficit compensation mechanism that forms the subject of this decision can be considered to grant the IRIS-H an economic advantage they would not have obtained under normal market conditions, i.e. without State intervention.

##### Altmark

- (120) The Commission notes that the public financing of the IRIS-H would not grant any advantage to them in as far as it merely amounted to compensation for services provided by the IRIS-H on the basis of public service obligation(s) entrusted to them, to the extent that this complied with the conditions set out in the *Altmark* case law.
- (121) In its *Altmark* judgment, the ECJ made clear that compensation granted from State resources for costs incurred to provide a service of general economic interest does not amount to granting an advantage where four cumulative conditions are met <sup>(158)</sup>:
- (a) the recipient undertaking must actually be required to discharge public service obligations and those obligations must be clearly defined;
  - (b) the parameters on the basis of which the compensation is calculated must be established in advance in an objective and transparent manner;
  - (c) the compensation cannot exceed what is necessary to cover all or part of the costs incurred in the discharge of public service obligations, taking into account the relevant revenues and a reasonable profit for discharging those obligations;
  - (d) in case an undertaking entrusted to carry out public service obligations is not chosen pursuant to a public procurement procedure, which allows for selection of the tenderer capable of providing those services at the least cost to the community, the level of compensation needed must be determined on the basis of an analysis of the costs which a typical undertaking, well-run and adequately equipped, would have incurred in discharging those obligations.

<sup>(156)</sup> Case C-39/94 *Syndicat français de l'Express international (SFEI) and others v La Poste and others* ECLI:EU:C:1996:285, paragraph 60 and Case C-342/96 *Kingdom of Spain v Commission of the European Communities* ECLI:EU:C:1999:210, paragraph 41.

<sup>(157)</sup> Case 173/73 *Italian Republic v Commission of the European Communities* ECLI:EU:C:1974:71, paragraph 13.

<sup>(158)</sup> Case C-280/00 *Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH, and Oberbundesanwalt beim Bundesverwaltungsgericht* ECLI:EU:C:2003:415, paragraphs 87-95.

- (122) The principles and considerations laid down in the *Altmark* judgment are applicable *ex tunc*, i.e. also to those legal relations originating from times before the judgment in question <sup>(159)</sup>. Consequently, the assessment criteria set out in the *Altmark* judgment are fully applicable to the factual and legal situation of the present case, even as regards support granted to the IRIS-H before the date of the *Altmark* judgment <sup>(160)</sup>.
- (123) For the present purposes, the Commission has decided first to analyse the fourth *Altmark* criterion (i.e. whether the selection of an undertaking providing an SGEI was based on a public tender procedure or, alternatively, whether the SGEI compensation granted is based on the analysis of the costs of a typical, well-run undertaking). The Commission notes that the IRIS-H have not been selected via public procurement procedures for the public service obligation(s) with which they are entrusted according to the Belgian authorities. It can thus be concluded that the first part of the criterion in question is met in the present case.
- (124) Concerning the second part of the criterion under assessment, the Commission first notes that the Belgian authorities have not argued that the IRIS-H qualify as efficient undertakings in this sense. The Commission secondly observes that the information provided by both the Belgian authorities and the complainants is not sufficient to establish that the systems of compensation for the public service obligation(s) possibly entrusted to the IRIS-H comply with the criterion of the efficient operator within the meaning of the fourth *Altmark* condition. There is no indication that the compensation awarded is based on an analysis of the costs of a typical undertaking with the characteristics required by the relevant case law of the Union courts. There is also no sufficient evidence demonstrating that the IRIS-H can themselves be considered to constitute typical undertakings that are well-run and sufficiently equipped. In determining the compensation awarded, no considerations of sound management or the adequacy of equipment appear to have been taken into account. Finally, it must be noted that a compensation mechanism covering the IRIS-H's deficit resulting from the performance of SGEI and ancillary activities, which does not take account of the efficiency with which these hospitals are run, cannot fulfil the fourth *Altmark* criterion.
- (125) Consequently, the Commission considers that the fourth criterion of the *Altmark* judgment is not complied with in this case. As the conditions set out in the *Altmark* judgment are cumulative, failure to comply with any one of the four conditions necessarily leads to the conclusion that the deficit compensation mechanism under review in this decision grants an economic advantage in the sense of Article 107(1) TFEU.

#### 7.2.1.3. Selectivity

- (126) To fall within the scope of Article 107(1) TFEU, a State measure must favour 'certain undertakings or the production of certain goods'. Hence, only those measures favouring undertakings which grant an advantage in a selective way fall under the notion of aid.
- (127) The Commission notes that the compensation mechanism set up to cover the deficits of public hospitals in Brussels (see recital 44), but not of private ones, must be regarded as being selective in nature as it excludes private hospitals and any other healthcare providers, and operators belonging to other sectors of activity.

<sup>(159)</sup> 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, paragraph 159. The Court held that '... the interpretation which the Court of Justice gives of a provision of Community law is limited to clarifying and defining the meaning and scope of that provision as it ought to have been understood and applied from the time of its entry into force. It follows that the provision as thus interpreted may, and must, be applied even to legal relationships which arose and were established before the judgment in question and it is only exceptionally that, in application of a general principle of legal certainty which is inherent in the Community legal order, the Court may decide to restrict the right to rely upon a provision, which it has interpreted, with a view to calling in question legal relationships established in good faith.'

<sup>(160)</sup> Case C-209/03 *The Queen, on the application of Dany Bidar v London Borough of Ealing and Secretary of State for Education and Skills* ECLI:EU:C:2005:169, paragraphs 66 and 67, and Case C-292/04 *Wienand Meilicke, Heidi Christa Weyde and Marina Stöffler v Finanzamt Bonn-Innenstadt* ECLI:EU:C:2007:132, paragraphs 34 to 36.

### 7.2.2. State resources

- (128) For a measure to constitute State aid within the meaning of Article 107(1) TFEU, it must be granted by the State or through State resources. State resources include all resources of the public sector <sup>(161)</sup>, including resources of intra-State entities (decentralised, federated, regional or other) <sup>(162)</sup>.
- (129) In the present case, the deficit compensations that the IRIS-H receive from their respective municipalities for the performance of SGEI and ancillary activities, stem from public resources and are imputable to the State.

### 7.2.3. Distortion of competition and effect on trade

- (130) Public support to undertakings only amounts to State aid in the sense of Article 107(1) TFEU if it ‘distorts or threatens to distort competition’ and only insofar as it ‘affects trade between Member States’.

#### 7.2.3.1. Distortion of competition

- (131) A measure granted by a State is considered to distort or to threaten to distort competition when it is liable to improve the competitive position of the recipient compared to other undertakings with which it competes <sup>(163)</sup>. For all practical purposes, a distortion of competition is thus assumed as soon as a State grants a financial advantage to an undertaking in a liberalised sector where there is, or could be, competition.
- (132) Considering that a certain amount of competition exists between public hospitals, private hospitals, and other healthcare establishments, public financing granted to certain health establishments (including the IRIS-H) to finance the hospital activities they carry out, is liable to distort competition. The same applies to the additional social activities of the IRIS-H.

#### 7.2.3.2. Effect on trade between Member States

#### General principles

- (133) Union courts have ruled that ‘where State financial aid strengthens the position of an undertaking as compared with other undertakings competing in intra-[Union] trade, the latter must be regarded as affected by the aid’ <sup>(164)</sup>.
- (134) Public support can be considered capable of having an effect on intra-Union trade even if the recipient is not directly involved in cross-border trade. For instance, the subsidy may make it more difficult for operators in other Member States to enter the market by maintaining or increasing local supply <sup>(165)</sup>, or to exercise their right of establishment.
- (135) It is settled case-law that the Commission is not required to carry out an economic analysis of the actual situation on the relevant markets, the market share of the undertakings in receipt of the aid, the position of competing undertakings or of trade flows between Member States <sup>(166)</sup>. In the case of aid granted unlawfully, the Commission is not required to demonstrate the actual effect which that aid has had on competition and on trade.

<sup>(161)</sup> Case T-358/94 *Compagnie nationale Air France v Commission of the European Communities* ECLI:EU:T:1996:194, paragraph 56.

<sup>(162)</sup> Case 248/84 *Federal Republic of Germany v Commission of the European Communities* ECLI:EU:C:1987:437, paragraph 17 and Joined Cases T-92/00 and T-103/00 *Territorio Histórico de Álava — Diputación Foral de Álava (T-92/00), Ramondín, SA and Ramondín Cápsulas, SA (T-103/00) v Commission of the European Communities* EU:T:2002:61, paragraph 57.

<sup>(163)</sup> Case 730/79 *Philip Morris Holland BV v Commission of the European Communities* ECLI:EU:C:1980:209, paragraph 11 and Joined cases T-298/97, T-312/97, T-313/97, T-315/97, T-600/97 to 607/97, T-1/98, T-3/98 to T-6/98 and T-23/98 *Alzetta Mauro and others v Commission of the European Communities* ECLI:EU:T:2000:151, paragraph 80.

<sup>(164)</sup> Case T-288/97 *Regione autonoma Friuli-Venezia Giulia v Commission* ECLI:EU:T:1999:125, paragraph 41.

<sup>(165)</sup> See for instance Case C-280/00 *Altmark Trans and Regierungspräsidium Magdeburg* ECLI:EU:C:2003:415, paragraph 78; Joined Cases C-197/11 and C-203/11 *Libert and Others* ECLI:EU:C:2013:288, paragraph 78; and Case C-518/13 *Eventech* ECLI:EU:C:2015:9, paragraph 67.

<sup>(166)</sup> See for instance Case C-279/08 P *Commission v Netherlands* ECLI:EU:C:2011:551, paragraph 131.

- (136) Nevertheless, an effect on intra-Union trade cannot be merely hypothetical or presumed. It must be established why the measure distorts or threatens to distort competition and is liable to have an effect on trade between Member States, based on the foreseeable effects of the measure <sup>(167)</sup>.
- (137) In that respect, the Commission has in several cases <sup>(168)</sup> considered that certain activities have a purely local impact and no such effect. It seems appropriate to check, in particular, whether the beneficiary supplies goods or services to a limited area within a Member State and is unlikely to attract customers from other Member States, and whether it can be foreseen that the measure will have no more than a marginal effect on the conditions of cross-border investments or establishment.

#### Assessment

- (138) Following the principles recalled above, the Commission notes that the effect on trade can be established by reference to a variety of factors, chiefly the ‘customer’ side (relating to the area to which goods and services are supplied and the area from where customers are attracted) and the ‘provider’ side (concerning the question whether a measure creates obstacles to cross-border investment and establishment of actually or potentially competing providers). In order to find that a measure affects trade between Member States, it is enough to establish an effect on trade with respect to at least one of these factors.
- (139) As regards the measures’ effect on the ‘customer’ side, the Commission observes that the sector of healthcare in general and in-patient healthcare provided by hospitals in particular is subject to intra-EU trade. The Commission notes that the cross-border mobility of patients is increasing. It is, of course, true that healthcare remains a competence of the Member States and the mobility of patients is being governed by strict provisions regulating interventions by national social security systems. Indeed, in practice, in-patient treatment is generally provided near the place of residence of the patient in a cultural environment familiar to him and which enables him to establish relationships of trust with the treating physicians. The cross-border movement of patients occurs especially in border regions or to obtain highly specialised treatment for specific conditions.
- (140) In the present case, the Commission considers that the measures in question are liable to affect trade between Member States. In particular, the specificities of this case distinguish it from those cases where public support of hospitals was found not to affect trade between Member States <sup>(169)</sup>. In reaching this conclusion, the Commission relies in particular on the combination of the following indications:
- (a) The IRIS-H include highly-specialised hospitals with an international reputation. Queen Fabiola Children’s University Hospital and Institut Bordet, which specialise respectively in paediatrics and cancer treatment, as well as the university hospitals CHU Saint-Pierre and CHU Brugmann, offer a wide array of highly-specialised treatments and boast an international reputation. The international reputation may render these hospitals attractive for international patients, including from other Member States, regardless of the fact that the IRIS-H’s mission is to provide social healthcare to the local community in Brussels (see Section 7.3.4.1).

<sup>(167)</sup> See Joined Cases T-447/93, T-448/93 and T-449/93 *AITEC and others v Commission* ECLI:EU:T:1995:130, paragraph 141.

<sup>(168)</sup> See for instance, the Commission decisions in State aid cases N 258/2000 *Leisure Pool Dorsten* (OJ C 172, 16.6.2001, p. 16); Commission Decision 2004/114/EC of 29 October 2003 on measures in favour of non-profit harbours for recreational crafts, the Netherlands (OJ L 34, 6.2.2004, p. 63); N 458/2004 *Editorial Andaluza Holding* (OJ C 131, 28.5.2005, p. 12); SA.33243 *Jornal de Madeira* (OJ C 131, 28.5.2005, p. 12); SA.34576 *Portugal — Jean Piaget North-east Continuing Care Unit* (OJ C 73, 13.3.2013, p. 1); N 543/2001 *Ireland — Capital allowances for hospitals* (OJ C 154, 28.6.2002, p. 4); SA.37432 *Funding to public hospitals in the Hradec Králové Region* (OJ C 203, 19.6.2015, p. 1); SA.37904 *Alleged State aid to medical centre in Durmersheim* (OJ C 188, 5.6.2015, p. 1); SA.33149 *Städtische Projektgesellschaft ‘Wirtschaftsbüro Gaarden-Kiel’* (OJ C 188, 5.6.2015, p. 1); SA.38035 *Alleged aid to a specialised rehabilitation clinic for orthopaedic medicine and trauma surgery* (OJ C 188, 5.6.2015, p. 1); SA.39403 *The Netherlands — Investment aid for Lauwersoog port* (OJ C 259, 7.8.2015, p. 1); SA.37963 *United Kingdom — Glenmore Lodge* (OJ C 277, 21.8.2015, p. 1); and SA. 38208 *United Kingdom — Member-owned golf clubs* (OJ C 277, 21.8.2015, p. 1).

<sup>(169)</sup> See N 543/2001 *Ireland — Capital allowances for hospitals* (OJ C 154, 28.6.2002, p. 4); SA.37432 *Funding to public hospitals in the Hradec Králové Region* (OJ C 203, 19.6.2015, p. 1); SA.38035 *Alleged aid to a specialised rehabilitation clinic for orthopaedic medicine and trauma surgery* (OJ C 188, 5.6.2015, p. 1).



- (b) The IRIS-H in Brussels are located in relative proximity to large cities in France, the Netherlands, and Germany. For example, the cities of Aachen, Lille, Eindhoven and Rotterdam are all located less than 150 km away. In addition, Brussels is directly connected to the major European cities of Paris, London, Amsterdam and Cologne by high-speed train lines, with traveling time of two hours or less. Finally, Brussels hosts an international airport with connections to all major European and international centres. The location and connectedness of Brussels means that the IRIS-H can easily be reached by international patients attracted by these hospitals, especially those residing close to the Belgian border or in one of the towns connected by high-speed rail.
- (c) The Brussels Capital Region in general and the IRIS-H are multilingual. French and Dutch are the official languages and the IRIS-H are obliged to offer services in both, rendering them attractive in particular for French and Dutch citizens. In addition, English is widely spoken in the Brussels Capital Region, facilitating access by patients from a large variety of backgrounds.
- (d) The Brussels Capital Region is home to a large number of citizens from other Member States. In fact, of the 321 European cities included in Eurostat's 'Urban Audit', Brussels had the second-highest rate of non-citizen residents (33,8 % in 2012) and the second-highest rate of non-citizen resident from other EU Member States (20,3 % in 2012) <sup>(170)</sup>. Residents from other EU Member States regularly have a choice regarding where to obtain medical services, typically either in their home country or country of residence.
- (141) As far as the additional social activities of the IRIS hospitals are concerned, the Commission observes that to the extent that it cannot be excluded that the provision of these activities amounts to an economic activity, and taking into account how closely they are related to the general hospital activities of the IRIS-H, the reasoning developed above may hold true in this respect as well. However, in light of the considerations set out below (see Section 7.3), the Commission is satisfied that even if the public financing of the additional social services affected trade between Member States, State financing benefiting this activity would constitute State aid compatible with the internal market. For reasons of procedural economy, it is therefore not necessary to finally conclude on whether the public financing of the additional social activities affects trade between Member States.
- (142) The same considerations apply to the IRIS-H's ancillary activities (see recitals 41, 116 and 117). Assessed in isolation, the Commission considers that there would be room to argue that the public financing (if any) of most of the IRIS-H's ancillary activities (e.g., a nursery for the children of staff members, renting of rooms, a little shop for patients and visitors, the canteen and parking facilities, renting TVs to patients) would have no effect on trade between Member States. However, the close connection between the IRIS-H's ancillary and main activities may be taken to suggest that also the public financing (if any) of these ancillary activities affects trade between Member States. In any event, since State financing benefiting the ancillary activities would constitute State aid compatible with the internal market (see Section 7.3), the Commission does not consider it necessary to finally decide on this point.
- (143) In order to proceed with the assessment, the remainder of this decision therefore assumes *ex hypothesi* that the public financing of the additional social activities and the ancillary activities are liable to affect trade between Member States.
- (144) Having thus found that the measures under investigation in the present case are liable to affect trade between Member States in at least one respect (the 'customer' side), the Commission does not consider it necessary to assess whether they are also liable to affect trade between Member States as regards cross-border investments and the right to establishment (see recital 138).

#### 7.2.4. Conclusion

- (145) On the basis of the foregoing considerations, the Commission considers that with respect to the measures under investigation in this case, the cumulative State aid criteria are fulfilled and these measures thus constitute State aid within the meaning of Article 107(1) TFEU.

<sup>(170)</sup> [http://ec.europa.eu/eurostat/statistics-explained/index.php/Statistics\\_on\\_European\\_cities](http://ec.europa.eu/eurostat/statistics-explained/index.php/Statistics_on_European_cities) accessed on 8 July 2015.

### 7.3. Compatibility with the internal market

#### 7.3.1. Legal basis

##### 7.3.1.1. General principles

(146) Since the deficit compensation that applies to the IRIS-H amounts to State aid in the sense of Article 107(1) TFEU, its compatibility with the internal market needs to be assessed. The grounds on which a State aid measure can or must be declared compatible with the internal market are listed in Articles 106(2), 107(2), and 107(3) TFEU.

(147) Considering that the Belgian authorities have consistently asserted that the public financing of the IRIS-H constitutes compensation for carrying out SGEI, the compatibility of the deficit compensation with the internal market has to be assessed primarily on the basis of Article 106(2) TFEU. This Article provides that

‘undertakings entrusted with the operation of services of general economic interest or having the character of a revenue-producing monopoly shall be subject to the rules contained in the Treaties, in particular to the rules on competition, in so far as the application of such rules does not obstruct the performance, in law or in fact, of the particular tasks assigned to them. The development of trade must not be affected to such an extent as would be contrary to the interests of the Union.’

##### 7.3.1.2. Application of Article 106(2) TFEU over time: preliminary remarks

(148) The Commission has laid down the precise conditions according to which it applies Article 106(2) in a series of instruments, most recently, inter alia, the 2012 SGEI Framework<sup>(171)</sup> and the 2012 SGEI Decision<sup>(172)</sup> (hereinafter together: ‘the 2012 SGEI package’); previously, the Commission had issued and applied the 2005 SGEI Framework<sup>(173)</sup> and the 2005 SGEI Decision<sup>(174)</sup>. Any aid measure that complies with the criteria laid down in the 2012 SGEI Decision is considered compatible with the internal market and exempted from notification. Aid measures which do not fall within the scope of application of the 2012 SGEI Decision because they do not fulfil all the criteria enshrined therein are to be assessed according to the 2012 SGEI Framework upon notification.

(149) In the present case, the IRIS-H deficit compensation under investigation dates back as far as 1996, thus pre-dating the 2012 SGEI Decision and 2012 SGEI Framework. However, the 2012 SGEI package — in Article 10 of the 2012 SGEI Decision and paragraph 69 of the 2012 SGEI Framework — contains rules that provide for its application also to aid granted before the entry into force of the 2012 SGEI package on 31 January 2012. In particular, the 2012 SGEI Decision provides in its Article 10(b) that

‘any aid put into effect before the entry into force of this Decision [i.e. before 31 January 2012] that was not compatible with the internal market nor exempted from the notification requirement in accordance with Decision 2005/842/EC but fulfils the conditions laid down in this Decision shall be compatible with the internal market and exempted from the requirement of prior notification.’

As regards the 2012 SGEI Framework, paragraphs 68 and 69 of that Framework specify that the Commission will apply the principles set out in that Framework to all notified aid projects, whether the notification took place before or after the start of application of that Framework on 31 January 2012, as well as to all unlawful aid on which it takes a decision after 31 January 2012, even if that aid was granted before 31 January 2012.

(150) In consequence, the rules on the application of the 2012 SGEI Decision and the 2012 SGEI Framework as described above mean that the public financing of the IRIS-H as from 1996 onward can be assessed pursuant to the 2012 SGEI package. If the deficit compensation mechanism complies with the conditions of either the 2012 SGEI Decision or the 2012 SGEI Framework, it is compatible with the internal market for the whole period since 1996.

<sup>(171)</sup> Communication from the Commission: European Framework for State aid in the form of public service compensation (OJ C 8, 11.1.2012, p. 15).

<sup>(172)</sup> Commission Decision 2012/21/EU 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 (OJ L 7, 11.1.2012, p. 3).

<sup>(173)</sup> Community framework for State aid in the form of public service compensation (OJ C 297, 29.11.2005, p. 4).

<sup>(174)</sup> See footnote 13.

- (151) Finally, attention must be drawn to the transitional provision contained in Article 10(a) of the 2012 SGEI Decision, according to which any aid scheme put into effect before the entry into force of that Decision (i.e. before 31 January 2012) that was compatible with the internal market and exempted from the notification requirement in accordance with the 2005 SGEI Decision shall continue to be compatible with the internal market and exempted from the notification requirement for a further period of two years (i.e. until 30 January 2014 included). This means that aid which was granted under such a scheme in the period between the entry into force of the 2005 SGEI Decision on 19 December 2005 and the entry into force of the 2012 SGEI Decision on 31 January 2012 will be considered compatible with the internal market but only from the date on which it was granted until 30 January 2014 included. In any event, for aid granted in the time from 31 January 2012 onwards, the transitional provision of Article 10(a) of the 2012 SGEI Decision is not applicable and the compatibility assessment has to be made pursuant to the 2012 SGEI Decision.
- (152) In consequence, the Commission first assesses whether the public financing falling within the scope of this decision granted to the IRIS-H from 1996 onward complies with the conditions set out in the 2012 SGEI Decision. Only to the extent that this is not the case will the Commission assess that same financing pursuant to the 2005 SGEI Decision (for aid that was granted between 19 December 2005 and 31 January 2012) and the 2012 SGEI Framework.

### 7.3.2. *Applicability of Article 106(2) TFEU: genuine SGEI*

- (153) Article 106(2) TFEU and the 2012 SGEI Decision based thereon are only applicable to compensation paid to an undertaking that is entrusted with the operation of a 'genuine service of general economic interest' <sup>(175)</sup>. The Court of Justice has established that SGEI are services that exhibit special characteristics as compared with those of other economic activities <sup>(176)</sup>. It is furthermore well-established that in the absence of specific Union rules defining the scope for the existence of an SGEI, Member States have a wide margin of discretion in defining a given service as an SGEI and in granting compensation to the service provider <sup>(177)</sup>. The Commission's competence in this respect is limited to checking whether the Member State has made a manifest error when defining the service as an SGEI.
- (154) The Commission is satisfied that all economic activities of the IRIS-H that benefit from public funding (i.e. the range of hospital and social tasks performed by these hospitals) either qualify as genuine services of general economic interest, as argued by the Belgian authorities, or as activities purely ancillary thereto. In particular, all medical and social services at issue in this case exhibit special characteristics as compared with those of other economic activities, i.e. primarily their importance for the medical and social well-being of society. Accordingly, the Belgian authorities have not made a manifest error in defining these services as SGEI.
- (155) As regards the ancillary activities detailed in recital 41, the Commission notes that an activity can be considered ancillary to an SGEI where it is directly related to and necessary for the provision of that SGEI, or intrinsically linked thereto. The latter is the case where the activities in question consume the same inputs as that SGEI, e.g. material, equipment, labour, fixed capital. Ancillary activities must also remain limited in scope. The Commission considers that all of the activities outlined in recital 41 above qualify as ancillary to the IRIS-H main SGEI activity. Indeed, the activities considered ancillary are (1) all directly related to and necessary for the provision of the IRIS-H SGEI activity, as they constitute activities that a modern hospital can be expected to perform in addition to the provision of medical and social services; and/or are (2) intrinsically linked thereto as they make use of the hospitals' infrastructures (i.e. its buildings and terrains). Based on the limited share of the ancillary activities in the IRIS-H's overall revenues (on average less than 2 %), the Commission is also satisfied that all ancillary activities remain very limited in scope.

<sup>(175)</sup> Recital 8 of the 2012 SGEI Decision.

<sup>(176)</sup> Cases C-179/90 *Merci convenzionali porto di Genova* ECLI:EU:C:1991:464, paragraph 27; Case C-242/95 *GT-Link A/S* ECLI:EU:C:1997:376, paragraph 53; and Case C-266/96, *Corsica Ferries France SA* ECLI:EU:C:1997:376, ECLI:EU:C:1998:306, paragraph 45.

<sup>(177)</sup> Case T-289/03 *BUPA and Others v Commission* ECLI:EU:T:2008:29, paragraphs 166-169 and 172; Case T-17/02 *Fred Olsen* ECLI:EU:T:2005:218, paragraph 216.

### 7.3.3. Applicability of the 2012 SGEI Decision

- (156) The Commission further considers that the public SGEI financing granted to the IRIS-H falls within the material scope of the 2012 SGEI Decision, as set out in Article 2 thereof. According to Article 2(1)(b) and (c) of the 2012 SGEI Decision, this Decision applies to State aid in the form of SGEI compensation granted to hospitals providing medical care (including the pursuit of directly related ancillary activities such as, but not limited to, research) and undertakings providing SGEI meeting social needs as regards, inter alia, health and social inclusion of vulnerable groups. As the publically financed SGEI and ancillary activities carried out by the IRIS-H all can be covered by these categories of activities, the Commission finds that the deficit compensation mechanism under investigation in the case at hand falls within the material scope of the 2012 SGEI Decision. Accordingly, the costs arising from the totality of the IRIS-H's activities (SGEI and ancillary activities) are eligible to be covered by compensation granted pursuant to the 2012 SGEI Decision.

### 7.3.4. The entrustment act

- (157) The first key compatibility condition enshrined in the 2012 SGEI Decision is that the operation of the SGEI must be entrusted to the undertaking concerned by way of one or more acts, the form of which may be determined by each Member State <sup>(178)</sup>. Such act or acts should clearly specify:

- the content and duration of the public service obligations <sup>(179)</sup>,
- the undertaking entrusted with these obligations and, where applicable, the territory concerned <sup>(180)</sup>,
- the nature of any exclusive or special rights assigned to the undertaking <sup>(181)</sup>,
- a description of the compensation mechanism and the parameters for calculating, monitoring and reviewing the compensation <sup>(182)</sup>,
- arrangements in place for avoiding and recovering any overcompensation <sup>(183)</sup>.

- (158) In addition, the 2012 SGEI Decision requires the entrustment act to contain a reference to that Decision <sup>(184)</sup>.

#### 7.3.4.1. Content and burden of the public service obligations imposed on the IRIS-H

- (159) In its annulment judgment of 7 November 2012, the GC made the preliminary observation that 'where different requirements are imposed on the public and private bodies entrusted with the same public service, which presupposes a different level of costs and compensation, those differences must be clearly shown in their respective mandates, inter alia, in order that it may be verified that the subsidy is compatible with the principle of equal treatment. State aid, certain of the conditions of which contravene the general principles of EU law, such as the principle of equal treatment, cannot be declared by the Commission to be compatible with the internal market (Case C-390/06 Nuova Agricast [2008] ECR I 2577, paragraph 51)' <sup>(185)</sup>.

- (160) Paragraph 66 of the Nuova Agricast judgment <sup>(186)</sup> clarifies that 'The principle of equal treatment requires that comparable situations must not be treated differently and that different situations must not be treated in the same way unless such treatment is objectively justified (see, inter alia, Case C-248/04 Koninklijke Coöperatie Cosun [2006] ECR I-10211, paragraph 72 and the case-law cited there)'.

<sup>(178)</sup> Article 4 of the 2012 SGEI Decision.

<sup>(179)</sup> Article 4(a) of the 2012 SGEI Decision.

<sup>(180)</sup> Article 4(b) of the 2012 SGEI Decision.

<sup>(181)</sup> Article 4(c) of the 2012 SGEI Decision.

<sup>(182)</sup> Article 4(d) of the 2012 SGEI Decision.

<sup>(183)</sup> Article 4(e) of the 2012 SGEI Decision.

<sup>(184)</sup> Article 4(f) of the 2012 SGEI Decision.

<sup>(185)</sup> Case T-137/10, paragraph 95.

<sup>(186)</sup> Case C-390/06 Nuova Agricast Srl v Ministero delle Attività Produttive, ECLI:EU:C:2008:224.

- (161) However, the Commission notes that the principle of non-discrimination is not mentioned as a compatibility criterion in the 2012 SGEI Decision. Nevertheless, the Commission will assess whether or not the public IRIS-H and the private Brussels hospitals are in a legally and factually comparable or different situation. In this context, when describing the content of the public service obligations that are entrusted to the IRIS-H, the Commission will indicate whether or not a comparable obligation has been entrusted to the private Brussels hospitals.
- (162) As has been explained above (see Section 2.3), the IRIS-H are subject to a regulatory framework which consists of the Loi CPAS (on which basis the IRIS-H were created), the LCH, the bylaws of the local hospital associations, and the strategic plans adopted by the IRIS umbrella organisation. Since the public authorities (i.e. the municipalities and CPAS) have majority control on the Chapter XII Loi CPAS local associations and the IRIS umbrella organisation, both the bylaws and strategic plans are binding on the IRIS-H and hence qualify to be valid entrustment acts, the content of which will be specified below (see recitals 164, 170 et seq.). In this context, it is also worthwhile to point out that the public authorities can directly monitor the day-to-day operation of the IRIS-H and provide further instructions where necessary.
- (163) It was also noted (see recital 24) that the IRIS-H were initially managed and controlled directly by the CPAS who had created these hospitals to help fulfil their social aid obligation in line with the Loi CPAS. To ensure the continuity and viability of the Brussels public hospitals (see recital 24), a restructuring was necessary which resulted in the creation of the IRIS-H (which took the form of Chapter XII Loi CPAS local associations with financial and legal independence). However, this restructuring did not change the fundamental purpose of the Brussels public IRIS hospitals <sup>(187)</sup>, namely to provide medical and socio-medical care and as such contribute to the social aid obligation of the CPAS that created them.
- (164) The medical care provided by the IRIS-H is also shaped by the LCH which sets the relevant framework for the organisation of the Belgian hospital sector as a whole. On this basis, all Belgian hospitals, whether public or private, including the IRIS-H are entrusted by the LCH with a basic hospital mission. In particular, Article 2 LCH defines which establishments can be considered as hospitals while Articles 68 to 76 *sexies* LCH set out the conditions for authorisation of hospitals and hospital services (and which are further detailed in implementing decrees that lay down quality conditions, staff requirements, etc.). Articles 23 to 45 LCH determine the requirements concerning the hospital programming mechanism which sets limits to the number of hospital beds, hospital services and certain medical equipment (such as scanners) that can be put and kept in operation. Only authorised hospital services that meet the programming conditions are eligible for public financing. As indicated in the opening decision <sup>(188)</sup> and confirmed by the absence of third party comments in this respect, there were and are no doubts with respect to the clarity of the basic hospital mission as defined by the LCH. It is also clear that the IRIS-H fulfil these requirements as they have all the necessary authorisations and their operation is approved under the programming mechanism.
- (165) Beyond the basic hospital mission that is entrusted to all Belgian public and private hospitals the Commission's decision of 28 October 2009 (see above Section 4.1), the General Court's annulment judgment of 7 November 2012 (see above Section 4.2), and the Commission's opening decision of 1 October 2014 (see above Section 4.3), made reference to three additional (or specific) SGEI, in essence relating to (1) universal care; (2) the obligation to provide care at multiple hospital sites; and (3) additional social services, that were only and exclusively entrusted to the IRIS-H. This however does not have to mean that the basic hospital mission and the additional SGEI are necessarily to be assessed in isolation from each other. In this respect, it was mentioned in recital 23 of the opening decision that the Belgian authorities argued that the basic hospital mission is part of, or complementary to, a larger SGEI, namely the obligation to provide social aid as required by the Loi CPAS.

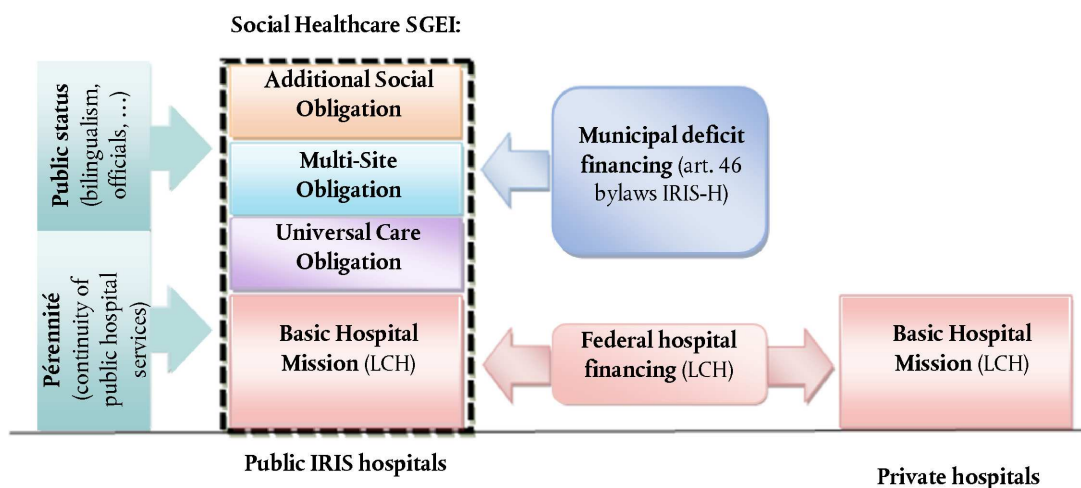
<sup>(187)</sup> See recital 25 and in particular the mentioning in the cooperation agreement of 19 May 1994 of the need to 'provide guarantees of the **maintenance of [...] the specific character of public hospitals**' (emphasis added). See also the 1996-2001 IRIS strategic plan, in particular: Section 'Structuring axes' (p. 3) 'to continue the dispensation of **medicine devoid of any market logic**' and Section 'Contributing objectives' (p. 54) 'Public hospitals (i.e. the IRIS-H) have the **basic aim of providing a social medicine**; it requires them to **meet the requirements of social missions**' (emphasis added).

<sup>(188)</sup> See recital 87 of the opening decision.

- (166) Against this backdrop, the Commission considers that the basic hospital mission entrusted to all hospitals under the LCH and the three additional SGEI obligations entrusted <sup>(189)</sup> only to the IRIS-H together de facto form one 'social healthcare SGEI' which is specific to the IRIS-H and performed only by them. Looking at the reality of all SGEI obligations entrusted to the IRIS-H and based on its analysis of the content and characteristics of all these obligations, the Commission is of the opinion that it would not be adequate to see the three additional SGEI obligations entrusted at the municipal level in isolation from the basic hospital mission entrusted under the LCH. Indeed, the additional SGEI obligations on the one hand are grounded in and build upon the IRIS-H's basic hospital mission under the LCH and on the other hand also significantly go beyond this basic obligation by obliging the IRIS-H (1) to deliver a wide range of healthcare services to everybody regardless of their ability to pay (universal care, see recitals 170-190); (2) at multiple hospital sites (ensuring proximity care, see recitals 191-204); while (3) attaching special attention to the social needs of the patients (via additional social services, see recitals 205-214). In relation to the basic hospital mission entrusted under the LCH (see recital 164), the three additional obligations cannot be considered standalone activities, as is clear from the fact that these obligations would never have been entrusted without the foundational obligation under the LCH to provide the basic hospital mission. Finally, this approach is to some extent also confirmed by the complainants when making the argument (see recital 71) that the additional social services cannot be separated from a broader healthcare service.
- (167) With regard to the approach developed in the foregoing (see recitals 162-166), the Commission would like to underline the following three points. First, the social healthcare SGEI which is performed by the IRIS-H consists of no more than the basic hospital mission entrusted to them (see recital 164) and the three additional SGEI obligations entrusted to them (see recitals 170 et seq.). Second, as will be demonstrated below, the IRIS-H and the Brussels private hospitals are not in a comparable situation in particular because only the IRIS-H are entrusted with the three additional SGEI obligations (see recitals 170 et seq.) and hence only the IRIS-H perform the social healthcare SGEI as defined above (see recitals 166-167). Third, the IRIS-H are also subject to constraints affecting the performance of the social healthcare SGEI, i.e. their public status (see recital 42), and the necessity to ensure the continuity (*pérennité*, see recitals 91 and 168) of the provision of this SGEI. Figure 2 below illustrates these two points.

Figure 2

**Obligations, constraints and public financing mechanisms applicable to the public IRIS hospitals respectively private hospitals**



<sup>(189)</sup> For details of the entrustments for these three obligations see recital 170 et seq.

(168) Since the three additional SGEI obligations go further than the minimum requirements that apply to all hospitals (public or private in Belgium) they lead to costs which are not or only partially covered by the BMF (see Section 2.5.1) and the social security system. Combined with the higher costs that follow from their public status (public servants, bilingualism, etc., see also recital 42) this explains why the IRIS-H have reported deficits for most of the years in the period 1996-2014. Combined, the accounting deficits of the IRIS-H over the period 1996-2014 amount to approximately EUR 250 million (see recital 234). The respective Brussels CPAS and municipalities want and have <sup>(190)</sup> to guarantee the continuity (*pérennité*) of their IRIS-H to ensure that the social healthcare SGEI is provided and the social aid obligation of the CPAS is fulfilled (see also Section 2.2). This is why they give a full deficit cover, which compensates the residual costs of the social healthcare SGEI (consisting of the basic hospital mission and the three additional SGEI obligations) <sup>(191)</sup>, hence ensuring the *pérennité* of the IRIS-H (see recital 91). In doing so, the deficit compensation does not distinguish between separate SGEI obligations. Against this backdrop it is appropriate to conduct the overcompensation tests that are described below (see Tables 9 to 13 in Section 7.3.5) on a global basis (i.e. for the different SGEI combined).

(169) As explained in recitals 165-167, the Commission has come to the conclusion that the additional obligations of the IRIS-H are to be considered together with their basic hospital mission as *de facto* constituting one social healthcare SGEI. While the basic hospital mission has been defined above (see recital 164) the exact content of each of the additional SGEI obligations is defined in the remainder of this section. Furthermore, it is also pointed out how these additional SGEI obligations are linked with each other and how they contribute to the social healthcare SGEI.

#### I. Obligation to treat all patients in all circumstances regardless of their ability to pay (universal care obligation)

(170) According to the Belgian authorities, the IRIS-H have the obligation to treat all patients, even if they are not able to pay and/or are uninsured, in all circumstances including situations where patients do not require urgent medical care. The complainants put into doubt that such an obligation applies to the IRIS-H and claim that the Brussels private hospitals cannot refuse patients and in fact treat a large number of 'social patients'. To support their claims, the complainants argue that the LCH entrusts all hospitals with the same hospital mission and, as stated in paragraph 150 of the annulment judgment of 7 November 2012, also refer to the general principle of non-discrimination which would prohibit them from selecting patients according to their ideological, philosophical or religious beliefs or their situation of poverty. According to them, public and private hospitals have the same obligation to treat patients in both emergency and 'post-emergency' circumstances.

(171) First and foremost, the Commission observes that the LCH does not contain any wording that can be interpreted as obliging hospitals (whether public or private) to treat patients in all circumstances and regardless of their ability to pay. However, under Belgian law there exists a general obligation to assist persons in danger. As pointed out by the Belgian authorities, under Article 422 *ter* of the Belgian Criminal Code, this obligation applies in emergency situations, and particularly in medical emergencies of a life-threatening nature. Hospitals are therefore required to provide assistance in cases of medical emergency, according to their organisation and available expertise. Both public and private hospitals are subject to this obligation, as indeed is everyone else, by virtue of their duty to assist persons in danger. There is hence no doubt that the Brussels public and private hospitals are

<sup>(190)</sup> As explained above (see recitals 83 and 91), in line with the jurisprudence of the Belgian Council of State, as long as the medical and social needs for which the IRIS-H were created to meet exist, the public authorities cannot close the IRIS-H nor transfer them to a private owner.

<sup>(191)</sup> The costs of the public status of the IRIS-H are reflected in the costs of the basic hospital mission and the additional SGEI obligations and hence may contribute to the deficits of these activities.

obliged to treat patients in emergency situations regardless of their ability to pay. In a similar vein, the deontology code that applies to doctors explicitly allows them to refuse patients with the exception of emergency situations <sup>(192)</sup>.

- (172) Second, the complainants referred to a judgment by the Brussels Court of First Instance <sup>(193)</sup>, to justify that there is no difference between public hospitals and private hospitals with regard to the treatment of 'social patients', whether in an 'emergency' or 'post emergency' situation. This judgment concerns a very specific case of urgent medical aid which the CPAS have to provide on the basis of Article 57(2) Loi CPAS. The Brussels Court of First Instance noted that the urgent medical aid is in fact never provided by the CPAS itself but by specialised medical services and that nothing can justify making a distinction whether this service is public or private. Nevertheless, the Commission notes that the obligation to provide urgent medical aid applies to the CPAS and not to the hospitals who deliver the care. In the case at hand, an undocumented migrant was urgently admitted by a Brussels private psychiatric hospital which requested the CPAS to pay for this urgent medical aid due to the migrant's manifest state of poverty. The Brussels Court concluded that if a CPAS does not provide the urgent medical aid in a hospital it manages it must pay the costs of care provided by a private hospital where the emergency services due to the urgency had decided to take the patient to a private hospital. This judgment clearly concerns an exceptional situation which derogates from the normal framework for social assistance in which the CPAS relies on its own (public) hospitals. In the case at hand, this derogation was due to the fact that the public IRIS-H do not provide psychiatric care which was needed in that case. Furthermore, the Brussels Court pointed out that 'if this aid is typically more often provided in an establishment dependent on the relevant CPAS or with which it has concluded an agreement, the person may be admitted to another establishment, owing to the urgency resulting from the situation of the person to be admitted to hospital'. The Brussels Court also noted that if the CPAS concerned (i.e. in the case at hand that of Uccle) had created its own psychiatric hospital or had concluded an agreement with such a hospital, the private hospital in question would not have had to provide care to the undocumented migrant in question but could instead have asked for his transfer to that hospital. Since this was not the case, there was no alternative available and as a result the CPAS was ordered to pay the private hospital for the care provided to the patient. As a result, all that can be concluded from the Brussels Court judgment cited by the complainants is that in some cases, owing to the urgency, private hospitals may also provide urgent medical aid to undocumented migrants and that the CPAS, where their obligation to provide urgent medical aid is discharged in this specific way, have to pay these private hospitals. Therefore, the fact that in a limited number <sup>(194)</sup> of cases urgent medical aid can be provided by the Brussels private hospitals cannot be interpreted as a general obligation for these hospitals to treat all patients regardless of their ability to pay.

- (173) Third, with regard to the principle of non-discrimination (mentioned by the complainants, see recital 170) it is clear that no hospital in Belgium is allowed to discriminate based on a patient's wealth (and hence on the pure fact that they are rich or poor) nor on any other personal criterion (e.g. religion or ethnic background). However, in a non-emergency situation, the non-discrimination principle cannot force hospitals to provide care for free if it is clearly foreseeable that a patient will not be able to pay. If these conditions are fulfilled in non-emergency situations, there is an objective justification for hospitals to differentiate by refusing these patients <sup>(195)</sup>. As indicated above (see recital 171) the deontology code that applies to Belgian doctors explicitly allows them to refuse patients in non-emergency situations. A survey of debt counsellors <sup>(196)</sup> furthermore indicates that doctors and hospitals sometimes refuse patients who had difficulties paying for treatment in the past. In this context, it is worth pointing out that hospitals do not per se bluntly refuse patients but request them to pay an advance which can be a deterrent for those who are poor. There is also anecdotal evidence suggesting that private hospitals

<sup>(192)</sup> See in particular Article 28 of the Code of the Medical Deontology prepared by the National Council of the Order of Doctors (version of 27 July 2015).

<sup>(193)</sup> See footnote 120.

<sup>(194)</sup> Indeed, the figures provided by the Belgian authorities show that in over 85 % of the cases in the Brussels Capital Region urgent medical aid is provided by the IRIS-H. This figure has to be contrasted with the fact that the IRIS-H only operate about 35 % of the number of hospital beds in the Region (see also footnote 3). The remaining cases are treated by other care providers, including general practitioners and private hospitals. Among others this may concern psychiatric care as in the case described in recital 172 as the IRIS-H do not provide this type of care.

<sup>(195)</sup> A similar justification could be invoked, e.g. by a postal operator fulfilling the universal postal service. This operator is entrusted with an SGEI but cannot be obliged to transport letters for free if the client cannot or will not pay for this service.

<sup>(196)</sup> See the study published in 2008 by Verbruikerssateljee with the title '*Is uw portemonnee ook ziek? — Een onderzoek naar medische kosten en schulden*'.



sometimes refer patients to a CPAS hospital for treatment <sup>(197)</sup>. For these reasons, in 2013 a law was proposed (but not adopted) in the Belgian Senate to exclude the refusal of healthcare provision due to the financial difficulties of patients and which would also prohibit charging advances <sup>(198)</sup>. The non-discrimination principle can hence not be invoked as entrusting all Belgian hospitals (public and private) with an obligation to treat all patients in all circumstances (i.e. outside emergency situations) even if patients cannot pay for the treatment.

- (174) From the above, the Commission concludes that it is appropriate to distinguish between emergency and non-emergency situations. In emergency situations, public and private hospitals are equally subject to the general obligation (based on the Belgian Criminal Code) to treat patients in a situation of medical emergency. However, there is no legal basis which obliges or entrusts the private hospitals to treat patients also in non-emergency situations and regardless of their ability to pay. Indeed, neither the LCH nor the Criminal Code contain such an obligation and the non-discrimination principle can also not be considered as entrusting such an obligation. Finally, the obligation to provide urgent medical aid to undocumented migrants applies to the CPAS, not to the hospitals that deliver such care.

### *The universal care obligation incumbent on the IRIS-H*

- (175) In contrast to the private hospitals, however, the IRIS-H are obliged <sup>(199)</sup> to treat all patients in all circumstances, including in non-emergency situations, regardless of patients' ability to pay and/or their insurance status on the basis of the specific rules applying only to the IRIS-H, namely their bylaws and the IRIS strategic plans as specified below. As explained above (see recital 24), the IRIS-H were established by the CPAS to allow the latter to fulfil their task to provide social aid to everyone who needs it. The CPAS are obliged to provide such aid (including medical and socio-medical care) to all individuals and families who require it <sup>(200)</sup>. The CPAS provide their services for free and were created in particular to help the poor and needy. In this context, Article 5 of the IRIS-H bylaws states:

'(1) Without prejudice to the competences of the IRIS umbrella association and the competences of IRIS-Achats [procurement branch] and of any other bodies that the umbrella association might set up pursuant to Article 135 undecies of the Organic Law of 8 July 1976 on Public Social Assistance Centres and in accordance with the laws and regulations, the association shall have the most extensive powers in the **exercise of its hospital mission**.

It shall exercise that mission with a view, firstly, to **providing quality medical care at optimum cost for everyone, irrespective of their income, insurability, origins and philosophical beliefs**, and, secondly, to establishing a sustainable financial equilibrium for the association' <sup>(201)</sup>.

- (176) Likewise, the introduction to the IRIS strategic plan 1996-2001 mentions:

'In order to fulfil its social task at any moment, the public hospitals of the IRIS network will offer a range of services **guaranteeing to everyone the best quality care at generally acceptable financial conditions for all** and will be **accessible to all patients, regardless of their income, their insurability**, their origins and their ideological convictions' <sup>(202)</sup>.

<sup>(197)</sup> *Ibid.*

<sup>(198)</sup> Belgian Senate meeting of 16 July 2013, Proposal for a law to improve the accessibility of healthcare by Mrs Leona Detiège et al. The proposal expired due to the 2014 Federal elections.

<sup>(199)</sup> In practice, the hospitals are responsible for the admission of patients (both for consultations and hospitalisations), for the invoicing and for the follow-up in case of non-payment. The majority of the doctors in the CHU Saint-Pierre, the CHU Brugmann, HUDERF, and the Institut Bordet receive a salary while the remaining doctors are paid based on the invoices for the treatment they provide independently of whether the patient pays. As a result, none of the doctors in these hospitals has any reason to refuse patients who cannot pay. The doctors working for the ISH have to respect the general rules of the hospital during at least 80 % of their time while they can choose to run a private practice for maximum 20 % of the time. During the 80 %, the doctors have to apply the INAMI tariffs and work on the basis of the principle that all patients have to be treated in line with the obligation of the IRIS-H. In this way, the ISH guarantee that all patients are treated regardless of their ability to pay.

<sup>(200)</sup> Article 57(2) Loi CPAS restricts the task of the CPAS in two specific circumstances: i.e. for foreigners residing illegally in Belgium (i.e. the undocumented migrants) and for children of such foreigners.

<sup>(201)</sup> Emphasis added.

<sup>(202)</sup> Section 'General objectives of the strategic plan' (p. 2). Emphasis added.

(177) That same introduction continues:

'The **primary objective** of the IRIS plan is to maintain a reinforced public hospital network in Brussels that is **accessible to all patients, regardless of their income, their insurability**, their origins and their ideological and philosophical convictions' <sup>(203)</sup>.

(178) In another section of this plan it is noted that the IRIS patient charter guarantees:

'**access for all patients, without distinction as to their origins, income, philosophical and ideological convictions, their situation of insurability**' <sup>(204)</sup>.

(179) Furthermore, the IRIS strategic plan 1996-2001 has a subsection 2.5.4 entitled '*Prise en charge et traitement de toute personne se présentant dans un des hôpitaux du réseau iris*' which contains the following statements:

'Public hospitals [i.e. the IRIS-H] have the basic aim of **providing a social medicine**; it requires them to meet the requirements of social missions, and this **even if this function is not recognised in the legislative and regulatory framework governing the hospital sector**.

The role of the public hospitals is **to admit and treat all patients** irrespective of their origins, circumstances, cultures, beliefs and pathologies. Hence, since they are public, our hospitals must adhere to the principles of universality, equality, continuity and change.

1. **The universality principle requires that all patients be admitted, whoever they may be. The hospital must therefore provide treatment at the highest possible level in order to be able to meet the needs of all.**

2. The equality principle, a constitutional right, requires that everyone be admitted without any discrimination. [...] <sup>(205)</sup>

(180) From the above it is clear that patients' ability to pay and their insurance status are not considered when admitting patients to the IRIS-H so that access to healthcare is guaranteed for all including in non-emergency situations. Several elements in the IRIS 1996-2001 strategic plan also demonstrate the social nature of the hospital care provided by the IRIS-H (e.g. 'to continue the dispensation of **medicine devoid of any market logic**' <sup>(206)</sup>) and the strong desire to offer quality care to all layers of the Brussels population, in particular to the poorest ones <sup>(207)</sup>.

(181) The IRIS strategic plan covering the period 2002-2014 repeats some of the key principles (access for all patients, increasing accessibility for the poor) among others by quoting Article 5 of the IRIS-H bylaws <sup>(208)</sup> (see also recital 175) and the primary objective of the IRIS strategic plan for the period 1996-2001 <sup>(209)</sup> (see recital 177), and by also referring to the IRIS patient charter <sup>(210)</sup> (see recital 178) and adds:

'The public services are to be defined on the basis of three fundamental principles, universality, equality and continuity. **On the basis of** those three principles and **their public hospital status**, hospitals in the IRIS network:

— will **accept all patients**, whoever they may be,

<sup>(203)</sup> *Ibid.*

<sup>(204)</sup> Section 'Contributing objectives' (p. 52). Emphasis added.

<sup>(205)</sup> *Ibid.*

<sup>(206)</sup> Section 'Structuring axes' (p. 3). Emphasis added.

<sup>(207)</sup> See to this extent Section 'Contributing objectives' (p. 74); to increase our accessibility to all strata of the population, and **in particular the least favoured** (emphasis added).

<sup>(208)</sup> See Section 'Introduction' (p. 7).

<sup>(209)</sup> *Ibid.* (p. 10).

<sup>(210)</sup> See Section 'The hospital project — A hospital oriented towards the patient' (p. 79).

- will **treat all patients** without discrimination,
- will **undertake to arrange cover for patients and provide any treatment they might require'** <sup>(211)</sup>.

(182) On the basis of the foregoing, the Commission concludes that the IRIS-H are obliged to treat all patients, in all circumstances (i.e. both in emergency and non-emergency situations), even if they cannot or foreseeably will not be able to pay for their treatment and/or are uninsured. This obligation is laid down and entrusted to the IRIS-H in the above cited bylaws of the IRIS-H and the IRIS strategic plans which are binding on the IRIS-H and which are founded on the obligation in the Loi CPAS to provide social aid (an obligation which is delegated by the CPAS to the IRIS-H by means of these bylaws and strategic plans).

### ***Practical impact of the universal care obligation on the IRIS-H***

- (183) The Commission also notes that the above conclusion, namely that the IRIS-H are obliged to treat all patients in all circumstances (i.e. both in emergency and non-emergency situations) and regardless of patients' ability to pay, while the private hospitals are only obliged to treat all patients in emergency situations (i.e. when care is needed immediately for a life-threatening condition), is furthermore reflected in the different profiles of the patients treated by the IRIS-H and the private hospitals in the Brussels Capital Region and their respective pricing policies.
- (184) It should first be noted that the 2002-2014 strategic plan also refers to the lower revenues <sup>(212)</sup> and higher costs <sup>(213)</sup> related to the treatment of patients who socioeconomically find themselves in a precarious situation, and who make up a significant part of patients of the IRIS-H. In this context, it is worth pointing out that the IRIS-H have agreed with their doctors that supplements (see recital 46(c) for more background) cannot be charged to CPAS patients and to patients with low incomes (i.e. who are entitled to a higher INAMI reimbursement). In addition, the percentage of admissions to single rooms (i.e. the only rooms where supplements can be charged) is well below the average for the Brussels Capital Region <sup>(214)</sup>. The available figures from one of the *mutuelles* <sup>(215)</sup> also show that when a supplement is charged by the IRIS-H, its amount is also much lower than the average for the Region (i.e. between 25 % and 67 % lower). In comparison, for the period in question some private hospitals in Brussels charged their patients on average 180 % more than the prices laid down by the social security system.
- (185) The universal care obligation has been entrusted to the IRIS-H to ensure that patients who cannot pay, have no private insurance and for whom there may not be any (or only partial) reimbursement by the social security, receive the medical care they need. One significant subgroup of these patients concern the abovementioned undocumented migrants as they are not covered by the Belgian social security and usually are not able to pay themselves for care. In 85 % of the cases in the Brussels Capital Region these migrants receive urgent medical aid from the IRIS-H (see recital 172) although these hospitals only operate 35 % of the hospital beds in that Region. Another telling indicator is the Federal Public Service of Health's ranking <sup>(216)</sup> of all Belgian hospitals on the basis of the socioeconomic profile of their patients (see Table 1 below and recital 40 above). This ranking among

<sup>(211)</sup> See Section 'The specific missions of the public hospital' (p. 85) (emphasis added).

<sup>(212)</sup> See Section 'Introduction' (p. 12) which notes that the IRIS-H treat proportionally less patients to whom the hospital can charge supplements (which are an extra source of revenue for hospitals).

<sup>(213)</sup> See Section 'Introduction' (p. 13) which refers to an estimate (from 2001) of the additional cost of accepting patients with a weak(er) socioeconomic profile. This cost would amount to approximately EUR 10,4 million per year and would be increasing.

<sup>(214)</sup> The exception being the Institut Bordet where the percentage is higher than the average which can be explained by the seriousness of the pathology (i.e. cancer) dealt with in this hospital.

<sup>(215)</sup> These are the private organisations that are responsible for the reimbursement of medical costs under the Belgian social security system (in particular the mandatory healthcare and invalidity insurance).

<sup>(216)</sup> On the basis of this ranking the Section B8 funding of the BMF is allocated (see also recital 189).

others reflects the proportion of patients who cannot pay and are not covered by the social security and for which the CPAS <sup>(217)</sup> can reimburse the costs of treatment (see also recitals 187-188) <sup>(218)</sup>. For the period 2007-2013 and for Belgium as a whole, this ranking's top three positions are occupied entirely by the IRIS-H (Institut Bordet and HUDERF being the exceptions due to their specialised nature). For the same period, the Brussels private hospitals on the other hand are not even part of the top 20 positions, which indicates that the average socioeconomic profile of their patients is significantly better than that of the IRIS-H. Even though the criteria used to draw up this ranking do not only concern patients who cannot pay or who are uninsured, it does further put into doubt the complainant's claim that the Brussels private hospitals have an obligation to treat all patients in all circumstances and is further evidence that instead only the IRIS-H have such an obligation. Indeed, if such an obligation applied to the Brussels private hospitals one could expect them to rank higher in the classification.

Table 1

**Federal Public Service of Public Health's ranking of the hospitals based on the socioeconomic profile of their patients (\*= IRIS-H, += private Brussels hospitals)**

	2007	2008	2009	2010	2011	2012	2013
CHU Saint-Pierre*	1st	1st	1st	1st	1st	1st	1st
CHU Brugmann*	2nd	2nd	2nd	2nd	2nd	2nd	2nd
Hôpitaux IRIS Sud*	5th	3rd	3rd	3rd	3rd	3rd	3rd
HUDERF*	62nd	4th	4th	6th	No figures	5th	No figures
Institut Bordet*	23rd	16th	31st	34th	No figures	18th	35th
Clin. Ste Anne St Remi <sup>+</sup>	52nd	42nd	52nd	62nd	40th	32nd	28th
Clinique Saint Jean <sup>+</sup>	25th	21st	44th	59th	39th	27th	No figures
Cliniques de l'Europe <sup>+</sup>	64th	24th	90th	93rd	61st	63rd	62nd
CHIR Edith Cavell <sup>+</sup>	110th	103rd	108th	105th	No figures	105th	103rd
Clinique Univ. Erasme <sup>+</sup>	49th	41st	48th	58th	51st	41st	36th
Clinique Univ. St Luc <sup>+</sup>	93rd	67th	95th	94th	76th	No figures	No figures
UZ Brussel <sup>+</sup>	80th	74th	91st	97th	78th	No figures	No figures

<sup>(217)</sup> The Federal Public Service for Social Integration may then reimburse the CPAS provided that certain conditions are met (see also footnote 258 for the relevant legal basis).

<sup>(218)</sup> The ranking also takes into account the proportion of patients who are covered by the social security but who have to pay a lower own contribution to the hospital because they are eligible for either the so-called (1) social maximum invoice; or (2) the maximum invoice for isolated patients with low incomes.

(186) The complainant's reference to a February 2004 publication of the *Mutualités Chrétiennes* (see recital 72), which concerns only the year 2001 and which would show that the private hospitals treat more than 60 % of 'social patients' in the Brussels Capital Region, has to be put into context. The term 'social patients' may create the impression that it concerns patients who cannot pay for treatment and who would therefore all be in scope of the universal care obligation. This is however not the case for the following reasons:

- First and foremost, the publication's definition of 'social patients' <sup>(219)</sup> only concerns persons who are insured by the Belgian social security <sup>(220)</sup> and hence does not include those patients who cannot pay and are not covered by the social security. It is however the latter group that benefits most from the universal care obligation and that represents the largest financial burden for the IRIS-H (see also recitals 187-188). Based on the broad definition used in the publication, almost 20 % (respectively about 26 %) of the admissions in private (respectively public) hospitals in Brussels would have concerned 'social patients', and private hospitals would have treated almost 66 % of the total number of these patients in 2001.
- Second, even the 'precarious patients' <sup>(221)</sup>, which the publication defines as a subgroup of the 'social patients', are covered by the social security and there is no reason to assume that they cannot pay their own contribution. However, it could be argued that such 'precarious patients' may have a higher likelihood of not being able to pay the own contribution to the hospital. The publication shows that public hospitals treat about 48 % of 'precarious patients', compared to 52 % being treated by private Brussels hospitals. However, proportionally, the public hospitals treat many more of such patients than would be expected based on their market share (in terms of beds and number of admissions). Indeed, 'precarious patients' would make up 9,5 % of the admissions in public hospitals compared to only 4,1 % in private hospitals.
- Third, in any case, the observation that in 2001 Brussels private hospitals would have treated 52 % (respectively 66 %) of 'precarious' (respectively 'social') patients cannot change the conclusion that only the IRIS-H have a universal care obligation. Indeed, in the absence of any legal obligation for private hospitals to treat all patients regardless of their ability to pay and their insurance status, any possible decision of private hospitals to provide care to 'precarious' or 'social' patients in non-emergency situations would be purely voluntary and could thus be reversed at any moment. Furthermore, the most vulnerable group of patients, i.e. those who are not covered by the social security or any other insurance, are not included in the publication's statistics. This also explains the apparent divergence between the publication's figures for 2001 and the Federal Public Service for Public Health's ranking (see recital 185) for the period 2007-2013. While this Public Service's ranking takes into account the proportion of patients who are not covered by the social security, the publication's statistics only include patients with social security cover.

For all of the above reasons, the Commission considers that the publication of the *Mutualités Chrétiennes* with statistics for the year 2001 cannot be taken as evidence that the IRIS-H would not have a universal care obligation or that the Brussels private hospitals would have a comparable obligation.

(187) The universal care obligation that is entrusted to the IRIS-H ensures that patients facing extreme financial hardship, political refugees, illegal immigrants, etc. receive treatment in all circumstances. If these patients cannot

<sup>(219)</sup> The publication of the *Mutualités Chrétiennes* defines social patients as patients who benefit from the 'social franchise' (i.e. pensioners who receive a guaranteed income, those eligible for a higher intervention or invalidity allowance, an integration allowance, higher family allowances, and the long-term unemployed). According to the Belgian authorities the notion of 'social franchise' was abolished already in 1993 and has been replaced in Belgian law by the so-called social maximum invoice.

<sup>(220)</sup> This is confirmed by the fact that the tables in this publication are based on data from the 'insuring entities' which refers to the organisations, such as the *mutuelles*, that are responsible for the reimbursement of medical costs under the Belgian social security which is governed by the INAMI.

<sup>(221)</sup> The *Mutualités Chrétiennes* publication defines these as patients who are registered with the CPAS.

pay for their treatment and have no insurance cover (neither via the social security nor through private health insurance) the CPAS will only cover these patients' costs provided that certain conditions are met. To lay down the rules that apply for such reimbursement, the IRIS-H and 17 of the 19 CPAS in the Brussels Capital Region have concluded so-called multilateral '*domicile de secours*' conventions. For non-urgent care, the CPAS refer persons to the IRIS-H and provide a written commitment (a so-called *réquisitoire*) that the CPAS will cover the cost of treatment. If patients show this document (*réquisitoire*) the IRIS-H send the invoice directly to the CPAS. For urgent care this procedure can of course not be followed. Instead, the reimbursement by the CPAS is conditional on (i) a medical certificate confirming the need for urgent admission or immediate treatment of the person; and (ii) the person's state of poverty as confirmed by the CPAS using the information collected by the hospital to complete a social inquiry. Collecting the required information is an important task for the social services departments of the IRIS-H (see also recitals 210-211) <sup>(222)</sup>.

- (188) Provided that the abovementioned conditions are met (i.e. a *réquisitoire* for non-urgent care and a medical certificate and social inquiry for urgent care), the CPAS reimburses the IRIS-H for the treatment costs of patients who cannot pay for their treatment and have no insurance cover. However, this does not relieve the IRIS-H from the entire burden of the universal care obligation. Indeed, in order to obtain reimbursement by the CPAS, the IRIS-H need to collect information for the social inquiry (which they did for 25 749 cases in 2012). This is one of the reasons why the IRIS-H employ more than twice as many social workers as e.g. university hospitals (see recital 213). The CPAS however do not reimburse the IRIS-H for the cost of collecting the information for the social inquiries <sup>(223)</sup>. Furthermore, the CPAS have longer payment delays (sometimes exceeding one year) than the *mutuelles* and insurance companies (both paying within one to two months after receipt of the invoice). As a result, the IRIS-H have to pre-finance these costs for a longer period than for 'regular' patients. On 31 December 2010, the Brussels CPAS owed the IRIS-H almost EUR 35 million (of which about 71 % concerned invoices for 2010, 12 % for 2009 and approx. 13 % for earlier years). Using a nominal annual interest rate of 2 %, the IRIS-H estimated that the cost of the longer payment delays amounted to almost EUR 700 000 at that time <sup>(224)</sup>. Finally, not all persons who may experience difficulties to pay their bill are eligible for CPAS cover <sup>(225)</sup>. On the basis of their universal care obligation, the IRIS-H nevertheless treat patients for which they do not have the commitment that the CPAS will pay the costs. In such a situation, the IRIS-H send an invoice to patients who in some cases will not be able to pay. The result is that the IRIS-H have to deal with a level of irrecoverable debt which is much higher than that of other public hospitals and of private hospitals in Belgium <sup>(226)</sup>. The IRIS-H estimated that in 2010 their amount of debt written off exceeded the average applicable for public hospitals in Belgium by approx. EUR [...] million.

- (189) Finally, it is important to put into context the funding provided under Section B8 of the BMF which is awarded to hospitals with a weak socioeconomic patient profile. This limited Federal financing is meant to compensate some of the costs related to 'social patients' (e.g. due to the fact that on average such patients stay longer in the

<sup>(222)</sup> In this context, it is worth pointing out that while the IRIS-H provide the input for the social inquiry, it is the CPAS who decide whether or not a person qualifies for reimbursement of the costs of treatment. The '*domicile de secours*' convention specifies in this respect that the IRIS-H 'shall collect, to the extent possible, the first building blocks for the social inquiry and shall send them to the CPAS'.

<sup>(223)</sup> Since the collection of information for the social inquiries is just one of the tasks of the IRIS-H's social services departments, this cost is part of the overall burden of the extensive social services obligation of the IRIS-H which will be discussed below (see recital 213).

<sup>(224)</sup> The Commission notes that the interest rate applied by the IRIS-H seems to be in line with the market interest rates at that time (i.e. beginning of 2011). Currently (in 2016), interest rates are much lower which reduces the cost for the IRIS-H. Nevertheless, the longer payment delay is in any case a burden for the IRIS-H as they still need to bridge a liquidity gap between outgoing and incoming payments.

<sup>(225)</sup> The reimbursement by the CPAS is not automatic for poor patients but the result of a case by case assessment by each CPAS on the basis of the social inquiry (for urgent care). In this context, the Belgian authorities note that in the first three quarters of 2015, 749 requests for reimbursement by the IRIS-H have been refused by the CPAS representing an unpaid amount of about EUR 3 million. In 2012, the CPAS refused the requested reimbursement by the IRIS-H of invoices for a total amount of EUR 4 174 200. Approximately 80 % of these invoices concerned care for undocumented migrants.

<sup>(226)</sup> More specifically, a report published by Belfius Bank indicates that in 2010 the net costs of short-term debts written off (i.e. invoices that will not be paid) represent on average 0,28 % of the revenue of private hospitals in Belgium and 0,40 % of the revenue of public hospitals in Belgium. In comparison, this cost amounts to 1,22 % of revenue for the IRIS-H or three times the average for public hospitals.

hospital than other patients) but is not compensation for a universal care obligation. The Section B8 financing does not compensate the actual costs incurred by hospitals for the treatment of social patients (e.g. the non-paid invoices by social patients, the need to have additional social workers). Instead, a fixed budget (i.e. approx. EUR 25 million per year for Belgium as a whole) is allocated on the basis of the ranking of the hospitals' socio-economic patient profile (see recital 185). Since the top three positions in this ranking are occupied by the IRIS-H these hospitals also receive a larger proportion of the Section B8 financing in comparison to lower-ranked hospitals (such as the Brussels private hospitals). The reason why both public and private hospitals are in principle eligible for this financing is that even in the absence of a universal care obligation like the one entrusted to the IRIS-H, hospitals can freely choose to treat social patients. They may do so because not all social patients are unable to pay or are uninsured. In fact, for social patients that are covered by the social security often lower tariffs apply and the INAMI pays a larger share which reduces the financial risk for the hospital. It is also the case that not every CPAS in Belgium has chosen to establish their own hospital. Therefore, in order to fulfil their social aid obligation, the CPAS can rely on private hospitals. In such situations, a private hospital would naturally treat a number of social patients and could also be eligible for the Section B8 financing foreseen by the BMF. However, in the Brussels Capital Region the CPAS can rely on the public IRIS-H which explains why the ranking in recital 185 shows that the average socioeconomic profile of the Brussels private hospitals' patients is significantly better than that of the IRIS-H. For all these reasons, the Section B8 BMF funding cannot be interpreted as an indication of the existence of a universal care obligation for all Belgian hospitals.

### ***Conclusion on the universal care obligation of the IRIS-H***

- (190) Based on the above, the Commission concludes that the universal care obligation only applies to the IRIS-H, is clearly entrusted and defined by the IRIS-H bylaws and the IRIS strategic plans in line with the requirements of the Loi CPAS (see recitals 29-30), and is also reflected in the ranking of the hospitals' socioeconomic patient profile (see recital 185). This obligation ensures that poor people in the Brussels Capital Region receive adequate medical treatment even if they cannot pay including in non-emergency situations. In this way, the IRIS-H provide social healthcare fulfilling the needs of the local population. As explained in the previous recital, only part of the burden of this obligation is covered directly (e.g. via reimbursement of treatment costs by the CPAS). The remaining burden is therefore covered via the deficit compensation at issue in this decision.

### **II. Obligation to offer a full range of basic hospital services at multiple sites**

- (191) The Belgian authorities consider that the IRIS-H also have the specific obligation to offer a full range of basic hospital services at multiple sites in the Brussels Capital Region. According to the complainants it is however not clear what the obligation to offer complete 'multi-site' basic hospital care activities comprises, nor to what extent this obligation imposes additional burdens on the IRIS-H. The complainants however do not claim that the Brussels private hospitals have such an obligation.
- (192) The Commission notes that the LCH does not require hospitals (public or private) to operate on multiple sites. Instead, the hospital programming mechanism determines the maximum number of hospital beds that can be offered in each Region of Belgium. For the Brussels Capital Region, the number of (general) hospital beds is limited to approximately 7 260 and each hospital in Brussels has the permission to operate a number of beds within this limit. In principle, if a hospital's capacity has been approved under the programming system, the hospital can decide freely whether and to what extent to group these beds on one site or to distribute them over multiple sites in that particular region. Likewise, it can decide whether or not to duplicate certain departments or instead to only offer distinct types of care at each of its respective sites. In this context, some of the Brussels

private hospitals have freely chosen to operate at several sites while others operate on just one site <sup>(227)</sup>. However, private hospitals can decide to regroup their beds and departments to one site at any time <sup>(228)</sup>. It is also worth noting that, within the limits set by the programming mechanism <sup>(229)</sup>, private hospitals are also free to choose the types of care they offer which gives them the possibility to specialise in the most profitable types of healthcare <sup>(230)</sup>.

### ***The multi-site obligation incumbent on the IRIS-H***

(193) With regard to the IRIS-H, the municipalities and CPAS prioritised the maintenance of local care provision over the concentration of hospital beds. They specifically chose to offer a full range of basic treatments on all sites which due to the necessary duplication of infrastructure, equipment and activities led to higher costs. It is on that basis that in the 1995 Brussels hospital restructuring the CPAS and the municipalities deliberately chose to retain the existing multi-site local hospital services offering a full range of treatments, given the needs of the population. They found that the local medico-social need prompting the initial creation of the public hospitals had not ceased to exist. In this context, it must be noted that most of the IRIS-H sites are located in the poorest municipalities of the Brussels Capital Region (see also recital 202). The public authorities hence willingly renounced efficiency gains, to the detriment of their purely financial interest, and chose to keep all existing hospital sites even though they knew that the federal hospital financing measures would not cover all the costs (e.g. due to duplication of infrastructure and operating costs, see also recital 203). This choice is reflected in the IRIS strategic plans and therefore obliges the IRIS-H to maintain all hospital sites so that patients can receive all basic treatments as close as possible to their homes.

(194) In particular, the structuring axes section of the 1996-2001 IRIS strategic plan refers to:

**'Maintaining a decentralised hospital activity** and a large outpatient coverage. **The activity will be maintained on the nine sites'** <sup>(231)</sup> <sup>(232)</sup>.

[...]

**'Maintaining the core activity on the different sites.** Patients, especially elderly patients, can hence **continue to receive hospital care at a reasonable distance from their home'** <sup>(233)</sup>.

(195) The 1996-2001 strategic plan also emphasises that the IRIS-H mainly treat patients who live in their near vicinity and are hence referred to as 'proximity hospitals' <sup>(234)</sup>. In addition, the IRIS-H want 'to increase the adequacy of [their] services to the **needs of the city's population**, [...] and **strengthen** [their] **accessibility** to all sections of the population, **in particular the less advantaged'** <sup>(235)</sup>.

(196) The 2002-2014 strategic plan adds to the above the following:

'Iris adopts the principle of a **patient-centred organisation**, enclosed in a public network of institutions working together between them in order to ensure the **provision of proximity and specialised care'** <sup>(236)</sup>.

<sup>(227)</sup> For instance: the private hospital *Cliniques de l'Europe* has a site in Uccle and one in Etterbeek while the private *Cliniques universitaires Saint-Luc* only has a site in Woluwe-Saint-Lambert.

<sup>(228)</sup> Such a choice could of course entail costs which would have to be offset by efficiency gains or which could be justified by other considerations that the private hospitals' management would deem relevant.

<sup>(229)</sup> The programming mechanism not only determines the total number of hospital beds per Region but also sets limits per type of service (e.g. maternity, geriatrics, paediatrics, psychiatrics, etc.).

<sup>(230)</sup> For example, not all private hospitals offer geriatric services which are less profitable.

<sup>(231)</sup> See Section 'Structuring axes' (p. 6). Emphasis added.

<sup>(232)</sup> The strategic plan makes reference to nine sites instead of eleven (the current number of sites) because there are two hospital campuses that each house two hospitals, i.e. HUDERF and CHU-B at the *Victor Horta* site in Laeken and IB and CHU-SP at the *Porte de Hal* site in the City of Brussels.

<sup>(233)</sup> See Section 'Structuring axes' (p. 10). Emphasis added.

<sup>(234)</sup> See Section 'Context and environment' (p. 21): '[...] the public hospitals [i.e. the IRIS-H], of which the activity is for at least 80 % a basic activity, are proximity hospitals, attracting a large part of their patients from the municipality in which they are located or from the surrounding neighbourhoods.'

<sup>(235)</sup> See Section 'Contributing objectives' (p. 74). Emphasis added.

<sup>(236)</sup> See Section 'The hospital project' (p. 36). Emphasis added.



(197) This strategic plan continues with respect to proximity care as follows:

‘Taking into account the **geographical distribution of the IRIS sites**, their impact on the general population coverage, sometimes in social destitution, the first developed objective is **to ensure at each site quality proximity medicine that is effective and accessible**.

The IRIS hospitals — apart from the Institut Bordet and the Queen Fabiola Children’s University Hospital (HUDERF) <sup>(237)</sup> which are mono-specialised reference hospitals — have as their primary vocation **to offer proximity medicine responding to a local demand by patients living in neighbouring municipalities**’ <sup>(238)</sup>.

(198) The 2002-2014 IRIS strategic plan also specifies that beyond proximity medicine relating to basic care, the IRIS-H also provide specialised care (i.e. a wider and/or more developed range of treatments) <sup>(239)</sup>. Such care is however not provided on all sites (although it is usually offered on more than one site) and is subject to planning at the level of the IRIS network <sup>(240)</sup>. The goal is always to guarantee to the Brussels population the accessibility for all at the optimal level of care provision (via proximity medicine or via specialised care) <sup>(241)</sup>. This strategic plan also contains detailed tables which specify the types of basic care and specialised care that are offered on each of the IRIS-H sites. Basic care activities are labelled as ‘level 1 — proximity level’ while the specialised care activities are marked as ‘level 2 — specialisation level’ and ‘level 3 — reference level’ <sup>(242)</sup>. It is hence very clear for the IRIS-H which types of care they have to provide at each of their sites.

(199) In order to ensure that each IRIS-H is fully aware of and managed in the light of the medico-social needs of the local population, the creation of the IRIS-H was also specifically linked to the maintenance of a ‘local basis’ for the public hospital services. This is reflected in the restructuring agreement backed by the cooperation agreement of 19 May 1994 <sup>(243)</sup> and also in the composition of the management bodies of the IRIS-H <sup>(244)</sup>. More particular, in accordance with Article 11 of the bylaws, the majority of the members of the General Assembly of the IRIS-H associations are elected by the municipal council and the Social Services Council (organised at municipal level) while the Mayor and the Chair of the CPAS are appointed as ex-officio members. Likewise, 10 of the 14 members of the Administrative Council are appointed by members of the public authorities’ delegation to the General Assembly (as required by Article 27 of the bylaws).

(200) The intention to manage the IRIS-H in the light of the medico-social needs of the local population was confirmed by the IRIS network’s Administrative Council meeting on 20 November 1996, at which an amendment to the 1996-2001 strategic plan was adopted, explicitly stating in that connection:

‘That series of constraints, necessitating restructuring, must be addressed in the wider context of our strategic objectives, which may be stated as follows:

- the IRIS public hospitals network must be a key element in the future of the Brussels healthcare system,
- our hospitals must adapt to changes in the **needs of the Brussels population**,

<sup>(237)</sup> It has to be noted that these two specialised hospitals each share a campus with another IRIS-H (see footnote 232) which ensures that all basic care services are offered at the respective sites. Footnote added.

<sup>(238)</sup> See Section ‘The hospital project’ (p. 53). Emphasis added.

<sup>(239)</sup> In this way, the Institut Bordet and HUDERF which mainly offer specialised care complement the other three IRIS-H in order to meet the healthcare needs of the local population.

<sup>(240)</sup> See Section ‘The hospital project’ (pp. 53-54).

<sup>(241)</sup> See Section ‘The hospital project’ (p. 62).

<sup>(242)</sup> See Section ‘The hospital project’ for a description of these levels (p. 37) and the tables (pp. 55-59).

<sup>(243)</sup> Article 2 of the cooperation agreement between the Federal State, the Brussels Capital Region and the *Commission Communautaire commune* states to this extent: ‘This restructuring agreement must satisfy the following conditions: 1. to provide guarantees of the **maintenance of**, on the one hand, **the specific character of public hospitals, inter alia**, by the choice of legal structures and coordination ensuring predominance of the public sector in the management bodies and decision-making procedures, and, on the other hand, **a local basis, through greater representation of directly elected members in the composition of the management bodies**’ (emphasis added).

<sup>(244)</sup> According to Article 125 of the Loi CPAS the public law entities must hold at least half the votes in the various hospital administration and management bodies and in the IRIS umbrella structure.

- the **network must be restructured for and around patients**,
- the modernisation of the network must be based on a new momentum for the hospital community generally and the medical community in particular.’

(201) This amendment goes on to state:

‘In that context, the restructuring must guarantee:

- **the continuation of medical and treatment activities at each hospital site, consistent with our mission to provide local medical services**,
- the pursuit of financial equilibrium aims,
- harmonious development of the network in order to balance the general and specific interests of each entity,
- greater coordination and collaboration between entities in the network,
- **accessibility of the network and maintenance of its public character**,
- [...].’<sup>(245)</sup>

#### ***Genuine SGEI nature of the multi-site obligation on the IRIS-H***

(202) The Commission also considered the complainant’s argument in the context of the case before the GC (see Section 4.2) that the local healthcare needs have to be seen in the context of the large number of public and private hospitals present in the Brussels Capital Region. As explained above, the hospital programming mechanism set the maximum number of general hospital beds in the Brussels Capital Region at 7 260 with the objective to avoid excess supply of medical services. This number of beds is provided jointly by public and private hospitals to meet the need for hospital care in the Brussels Capital Region. However, the programming mechanism only takes into consideration the medical needs at regional level and does not take into account the social needs of a particular population and the specific social conditions in a geographical area. Those social needs are assessed under the social aid policy of the CPAS (i.e. at municipal level). The predecessors of the IRIS-H were established to meet social needs and following the restructuring the different sites of the IRIS-H were maintained because they continue to fulfil a genuine social need (see recitals 82-84 and 91). Indeed, it is because only the IRIS-H perform the social healthcare SGEI that there is also the necessity and obligation to have multiple sites. For poor inhabitants of the Brussels Capital Region it is not only important to be able to go to a hospital close to his or her home but also to be sure that they will receive treatment even if they cannot pay and to be able to request support from the social services department. By obliging the IRIS-H to maintain their different sites, the Brussels municipalities and CPAS want to ensure that social healthcare is provided as close as possible to where there is a need. In this context, it is worth pointing out that ten of the eleven IRIS-H sites are located in municipalities where the average income does not exceed the median<sup>(246)</sup> for the Brussels Capital Region. On the contrary, five of the eleven private hospital sites are located in municipalities where the average income is higher than this median<sup>(247)</sup>. From the map below<sup>(248)</sup> (see Figure 3) there also appears to be no significant geographical overlap between the public (dashed line circles) and private general and university hospitals (full line circles) in the Brussels Capital Region. This suggests that the pure fact that there is a large number of hospitals active in the Brussels Capital Region is not sufficient to ensure accessibility to hospital care for all inhabitants.

<sup>(245)</sup> Emphasis added.

<sup>(246)</sup> The median of average incomes for the year 2012 in the 19 municipalities of the Brussels Capital Region amounted to EUR 13 746 per inhabitant. The remaining IRIS-H site is located in Ixelles where the average income is EUR 14 513 which lies between the median and third quartile (i.e. 75th percentile) of the Brussels Capital Region. Source: Centre for Information, Documentation and Research on Brussels (<http://www.briobrusssel.be/ned/webpage.asp?WebpageId=345>).

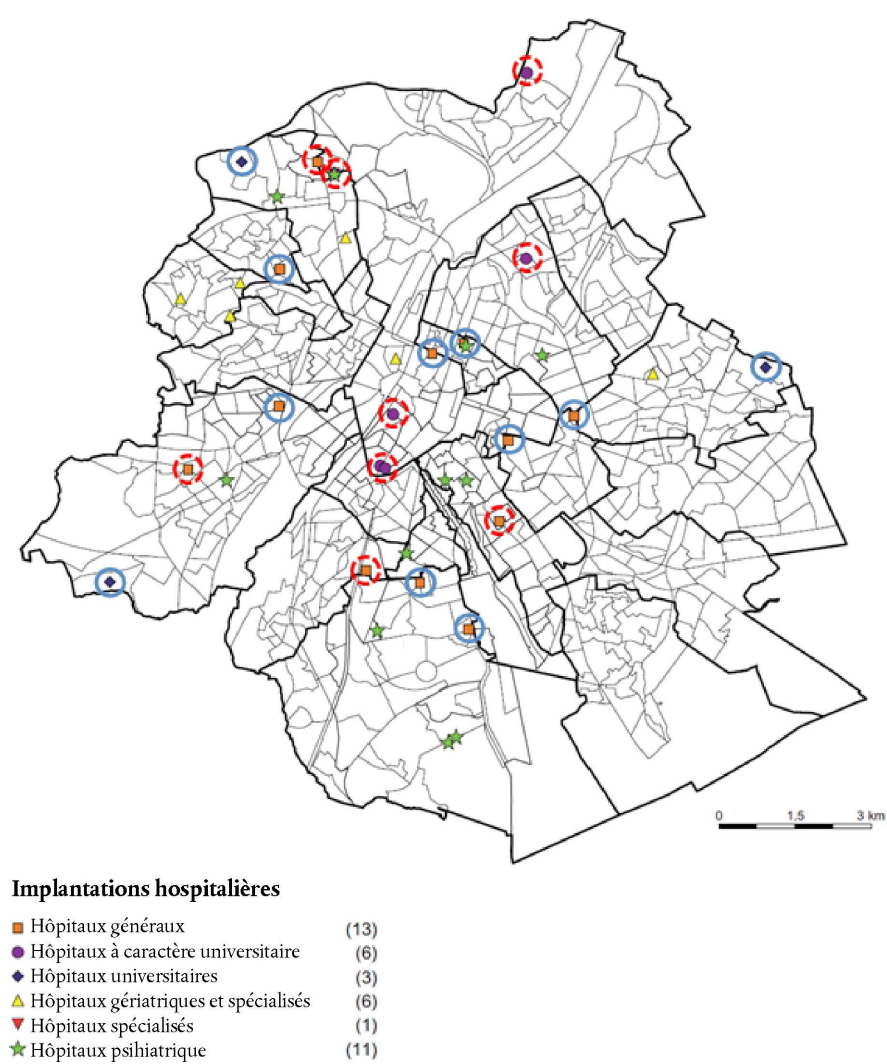
<sup>(247)</sup> Three of those five private hospital sites are located in municipalities where the average income per inhabitant exceeds the third quartile (i.e. 75th percentile) of the Brussels Capital Region.

<sup>(248)</sup> The original map was published in the *Tableau de bord de la santé en Région bruxelloise 2010* and reflects the situation on 1 July 2009. The Commission added the circles and removed one general hospital from the map (Clinique des Deux Alice which was located in Uccle) as it was closed at the end of 2011 (its activities were moved to the Sainte-Elisabeth site of the private *Cliniques de l’Europe*). One of the ISH sites (i.e. Baron Lambert in Etterbeek) is not indicated on the map since it only provides outpatient care and therefore has no hospital beds that are subject to the programming mechanism.

Furthermore, as explained above, the IRIS-H are the only hospitals in the Brussels Capital Region that provide a social healthcare SGEI and the private hospitals can hence not be seen as equivalent when it concerns catering to the social needs of the local population. On the basis of the above, the Commission concludes that the presence of several private hospitals in the Brussels Capital Region is no reason to put into doubt the genuine SGEI nature of the multiple sites obligation that applies to the IRIS-H and not to the Brussels private hospitals, especially in the light of the social healthcare SGEI.

Figure 3

Map of hospital sites in the Brussels Capital Region



*Practical impact of the multi-site obligation on the IRIS-H*

(203) The multiple sites obligation can also be considered as a burden for the IRIS-H as it requires them to duplicate certain infrastructure and brings higher operating costs. These costs relate mainly to the need to provide each site

with services such as an emergency service, a sterilisation service, a monitoring and security service and its own administration. In fact, the BMF financing (see recital 46(a)) is granted for only one such service for each hospital, irrespective of the number of its sites. The operating costs related to the various areas (maintenance, heating, cleaning, etc.) are added to those additional infrastructure and equipment costs. Based on a study made by the IRIS umbrella organisation in 2009, the costs of the multi-site obligation that were not covered by the BMF financing were estimated at EUR [...] million for 2008 and EUR [...] million for 2009 for the five IRIS-H together.

### ***Conclusion on the multi-site obligation of the IRIS-H***

- (204) The Commission concludes that on the basis of the IRIS strategic plans the IRIS-H are entrusted with the clear obligation to (1) maintain all their hospital sites in order to meet the medico-social needs of the respective local populations; and (2) to provide a full range of basic care activities on all these sites. In particular, the IRIS strategic plan lays down the types of activities that are considered as basic care respectively specialised care and indicates for each of the IRIS-H sites what types of care have to be offered. Furthermore, the provisions in the IRIS-H bylaws and the Loi CPAS ensure that the IRIS-H are fully aware of and managed in the light of the medico-social needs of the local population. In addition, the multiple sites obligation goes beyond the requirements of the LCH and the programming mechanisms as the latter does not take into account the social needs of a particular population and the specific social conditions in a geographical area. Private hospitals hence neither are obliged to operate on several sites nor are they required to provide a full range of basic care on each site (in case they choose to have multiple sites). Finally, as explained in the previous recital, the multi-site obligation generates significant costs for the IRIS-H that are not covered by the BMF and hence contribute to the deficit of the IRIS-H.

### **III. Extensive social services obligation**

- (205) Finally, the Belgian authorities consider that the IRIS-H have the obligation to provide extensive social services to patients and their families. According to the complainants the obligation only appears to consist of a higher volume of social services than that provided by other hospitals. In this context, it must be pointed out that neither the LCH nor the conditions for authorisation of hospitals (based on the Royal Decree of 23 October 1964) impose a general obligation to provide social services within a hospital. Only a few isolated rules on specific hospital services (i.e. for geriatric and psychiatric wards <sup>(249)</sup>) stipulate the need for intervention by social workers. In addition, a specific rule for university hospitals only provides that one social worker should be present for every 2 000 admissions <sup>(250)</sup>. Apart from these specific situations, private hospitals have no obligation to provide social services for all their patients. The IRIS-H on the contrary are obliged on the basis of the IRIS strategic plans, to have a social service which helps all patients who need this.

### ***The extensive social services obligation incumbent on the IRIS-H***

- (206) The 1996-2001 IRIS strategic plan lays out the general context for the global treatment of patients in the IRIS-H, including psycho-social and environmental aspects:

‘Comprehensive care of patients: The patient cannot be reduced to the medical condition for which he requires care. Certain categories of patients in particular require **comprehensive care, covering** not only purely medical aspects, but **also psychosocial and environmental aspects**: this concerns geriatric patients, paediatric patients, terminally ill patients, psychiatric patients, **socially disadvantaged patients** etc.’ <sup>(251)</sup>.

<sup>(249)</sup> For instance Annex 19 to the Royal Decree of 23 October 1964 (Belgisch Staatsblad/Moniteur Belge of 7 November 1964, p. 11709) specifies that for neuropsychiatric services treating adult patients there needs to be at least one social assistant per 120 patients.

<sup>(250)</sup> Royal Decree of 15 December 1978 fixing special requirements for university hospitals, Belgisch Staatsblad/Moniteur Belge of 4 July 1979, p. 7818.

<sup>(251)</sup> See Section ‘Structuring axes’ (p. 6). Emphasis added.

(207) The role of the social services and their main tasks are described further in this plan:

**'The [IRIS] hospitals must have social services whose main role is to contribute to the welfare of patients,** the medical quality and the optimal functioning of the institution. The social service is a colleague of the hospital's manager and partner of all the departments of the hospital. It is responsible for the humanisation of the conditions of a patient's stay in the hospital. It has to **take care of social difficulties of patients ideally before but also during the stay and when leaving the hospital.** It is the privileged link between the hospital and the patient, his family and his environment. To do this, it must:

- have the time and professional capacity to assess the needs of the patient with himself, his family and entourage and with the healthcare teams and to develop with him appropriate responses,
- have access to files regarding the admission and the patient's health which may contain social data which can contribute to the quality of care,
- be kept informed in due time of the date of transfer or exit to implement appropriate arrangements,
- give an opinion on patients with complex profiles and diseases,
- establish, with the financial services, the legal arrangements, given that the limits of its intervention are determined by the professional ethics of patient-centred relationship in all its aspects,
- **coordinate with the CPAS,**
- have knowledge of the existing health and social networks,
- propose improvements of the functioning of the hospital,
- have an infrastructure that guarantees confidentiality of exchanges and data.

The **mission of social medicine** which is the vocation of the public hospitals implies that they fulfil a coordination role among the healthcare stakeholders, that they participate in the health and social networks or even create such networks, and they are directly involved in the creation of IRIS ancillary services **necessary to meet the needs of the population** (*hotel de soins, hotel des familles, palliative care at home, care for drug addicts, homeless, domestic care services, etc.*). They will carry out the accreditation of bodies with whom they will cooperate' <sup>(252)</sup>.

(208) According to this strategic plan, the social service also plays an important role during the admission of patients:

'The reception should be considered differently according to whether the patient arrives via the emergencies, a consultation or through admissions; the reception must, in any event, ensure discretion and comfort for patients, and to help to allay the patient's concerns and those of his family. The **social services of our hospitals play a crucial role in this respect**' <sup>(253)</sup>.

(209) The 2002-2014 IRIS strategic plan adds the following to the above:

**'Social services are essential in public hospitals** to support both in- and out-patients. These involve **assisting patients and their families in resolving and managing administrative, financial, relationship and social problems related to the disease, the hospital stay and treatment,** as well as the new prognosis and circumstances.

The social service:

- accompanies patients in their autonomy and independence,

<sup>(252)</sup> See Section 'Contributing objectives' (pp. 54-55). Emphasis added.

<sup>(253)</sup> See 1996-2001 Strategic plan — Section 'Structuring axes' (p. 10). Emphasis added.

- will make sure to incorporate in the overall care the patient's norms, values, and culture, it therefore revolves around administrative assistance, psychosocial support, a role with respect to information, prevention, awareness, collaboration and coordination. The **social services will therefore act at different levels according to whether patients need socio-material psycho-social, or socio-administrative support**,
- requires the technical and interpersonal skills, at the same time conceptual and technical, and also personal and relational qualities.

[...]

In conclusion, **social services have multiple responsibilities:**

- organising the **patient's hospital admission** and making **the best possible arrangements for their discharge to an appropriate place**,
- **helping the patient to obtain social security cover enabling them to meet their medical costs**.

In this respect, the social service and social workers pursue the same objectives and interests as the hospital and their specific activity has **an impact on reducing hospital stays and on the recovery of costs incurred by the hospital'** <sup>(254)</sup>.

- (210) The role of the social services in the recovery of treatment costs from the CPAS (see also recital 187) is also reflected in the subsequent text of the 2002-2014 IRIS strategic plan. In particular, it notes that the tasks of the social services include preparing inquiries into the financial means of the patients:

'The social service establishes an electronic file which can follow the patients throughout the [IRIS] network. It **also carries out the investigation into the financial means** [of the patients], it completes the codes 'V' of the RCM <sup>(255)</sup> and other records required by the regulations. This [social] file will as soon as possible be linked to the medical file and the central IT systems. The registration of the social file must provide a scoreboard of the social missions of the public [IRIS] hospitals' <sup>(256)</sup>.

- (211) These tasks concern collecting the necessary information for the so-called 'social inquiries' which are necessary to determine whether or not the patients are eligible for CPAS coverage of their medical costs (see also recitals 187-188). More specifically, the hospital's social workers collect the relevant information <sup>(257)</sup> to allow the CPAS to verify, in line with its legal obligations <sup>(258)</sup>, the indigence of a patient and hence to be able to decide whether or not a reimbursement by the CPAS is justified.

### ***Practical impact of the extensive social services obligation on the IRIS-H***

- (212) The staff of the IRIS-H social services departments have received specific training and follow a professional code of ethics taking account of their role as liaison between different services within the hospital (including doctors, nurses, billing and admission) or outside (such as social security cover, home care and support, linguistic and cultural aspects).

<sup>(254)</sup> See Section 'The specific missions of the public hospital' (p. 82). Emphasis added.

<sup>(255)</sup> RCM stands for *résumé clinique minimum* and is a standardised and concise summary of the patient's medical record that general hospitals are required to register since 1990. It is used, among others, to determine the needs for hospital equipment, to define qualitative and quantitative standards for the accreditation of hospitals and their services and to organise hospital funding. The codes 'V' concern factors that influence the patient's health status and contact with health services. These codes can be used to mention the socioeconomic, legal and family issues that can affect the patient's stay.

<sup>(256)</sup> See Section 'The specific missions of the public hospital' (p. 83). Emphasis added.

<sup>(257)</sup> For instance, the social workers in the IRIS-H collected information for 25 749 social inquiries in 2012. This represents approx. 5,4 % of the hospitalised patients in that year.

<sup>(258)</sup> This obligation stems from Article 60(1) of the Loi CPAS, Article 9 bis of the Law of 2 April 1965 (for the possible reimbursement by the Federal Public Service for Social Integration to the CPAS provided that certain conditions are met) and the Circular of 25 March 2010 concerning the social inquiry (Belgisches Staatsblad/Moniteur Belge of 6 May 2010, p. 25432).

- (213) In order to assess the specific cost of their social service departments, the IRIS network compared the real cost of the social workers employed in the IRIS-H with a reasonable standard of one social worker for every 2 000 admissions (i.e. the obligation applying to university hospitals). This analysis shows that the five IRIS-H employed 81,1 social workers <sup>(259)</sup> while based on the reasonable standard they would only employ 36,7. The difference is hence 44,4 and indicates that the IRIS-H employ more than double the number of social workers than what would be expected based on the rule that applies to university hospitals. This illustrates that the requirements in the strategic plans oblige the IRIS-H to offer a far wider range of social services than the minimum (e.g. for geriatrics and psychiatric departments) that applies to other non-university hospitals (whether public or private). The fact that non-university private hospitals in Brussels also employ social workers can be explained on the basis of these minimum requirements rather than by a comprehensive obligation to provide social services to their patients. Likewise, as demonstrated above the IRIS-H go far beyond the basic requirement of one social worker per 2 000 admissions that applies to university hospitals in Belgium. As a result, the non-financed cost of the IRIS-H social services was approx. EUR [...] million in 2010 <sup>(260)</sup>. The extensive social services obligation therefore represents a significant burden for the IRIS-H which the private Brussels hospitals do not have to bear.

### ***Conclusion on the extensive social services obligation of the IRIS-H***

- (214) On the basis of the foregoing, the Commission concludes that unlike the Brussels private hospitals, the IRIS-H have the obligation to operate elaborate social services departments who help patients and their families in resolving and managing administrative, financial, relationship and social problems. This obligation is defined in and entrusted to the IRIS-H by the IRIS strategic plans. The existence of this extensive social services obligation is reflected by the large number of social workers employed by the IRIS-H going far beyond what is applicable to other Belgian hospitals. The tasks of the IRIS-H's social services departments include taking care of the aforementioned difficulties of patients not only during their stay but also when leaving the hospital, helping the patients to obtain social security cover enabling them to meet their medical costs, preparing social inquiries and exchanging information with the other hospital departments and also with the CPAS. This obligation and its burden are closely linked to the other obligations that constitute the social healthcare SGEI (see recital 167). Indeed, it is because the IRIS-H have the obligation to treat all patients in all circumstances and regardless of their ability to pay that there is a greater demand for social workers. It is precisely poor patients and their families who need additional social services and for whom a social inquiry has to be prepared. Furthermore, it is also because the IRIS-H have the obligation to maintain multiple sites that the number of social workers is higher than what can be reasonably expected (i.e. one social worker for every 2 000 admissions, see recital 213).

### **IV. Conclusion on the additional obligations**

- (215) The Commission concludes that the IRIS-H are performing a social healthcare SGEI which on top of their basic hospital mission in addition includes their obligation (1) to treat all patients in all circumstances (including non-emergency situations), regardless of patients' ability to pay; (2) to offer a full range of basic hospital services on multiple sites; and (3) to complement the medical care with extensive support by their elaborate social services departments. This combination of obligations ensures that the specific social needs of the Brussels population with regard to hospital services are fulfilled and guarantees the accessibility to high quality hospital care for all and in particular for the poorest. No such additional obligations apply to the Brussels private hospitals who are only entrusted with the basic hospital mission defined by the LCH. The social healthcare SGEI is therefore only provided by the IRIS-H as only they are entrusted with more stringent and far reaching obligations on top of the minimum requirements (i.e. the basic hospital mission) that apply to all hospitals in Belgium under the LCH. The performance of this social healthcare SGEI entails significant costs for the IRIS-H that are not or only partially covered by the financing sources common to both public and private hospitals, and as a result lead to the deficits

<sup>(259)</sup> The figure represents the number of full-time equivalents (or FTE).

<sup>(260)</sup> The BMF provides some funding for social workers (i.e. for those areas, such as geriatrics, where there is a minimum requirement) but this only amounted to approximately EUR 400 000 in 2010.

reported by the IRIS-H. In order to ensure the continuity of their public hospitals, the respective Brussels CPAS and municipalities therefore compensate the deficits of the IRIS-H as described in Sections 7.3.4.4 and 7.3.5.

#### 7.3.4.2. The undertaking entrusted and, where applicable, the territory concerned

- (216) Each individual IRIS-H has its own bylaws which specify their objective and the IRIS strategic plans apply to each of the five IRIS-H. In addition, like all Belgian hospitals, the IRIS-H have received an individual authorisation which they need in order to be eligible for the other types of public financing (such as the BMF). These entrustment acts do not specify a territory for the performance of their SGEI.

#### 7.3.4.3. Exclusive or special rights

- (217) The IRIS-H are not entrusted with any exclusive or special rights.

#### 7.3.4.4. The compensation mechanism

- (218) The deficit compensation mechanism is described in Article 46 of the bylaws of each of the five IRIS-H. This article currently reads as follows (see also footnote 48):

‘Without prejudice to Article 109 [LCH], the result of the financial year shall be allocated between partners holding at least one fifth of the votes in the General Assembly by decision of the General Assembly.’

- (219) It is clear from Article 46 of the IRIS-H bylaws that:

- This deficit compensation is without prejudice to the mechanism foreseen by Article 109 LCH (now Article 125 of the LCH in the version of the Law of 10 July 2008) which requires that municipalities cover the deficit of their public hospital with the exclusion of certain activities <sup>(261)</sup>. However, as will be explained below (see recital 235), the Article 109 deficit compensation has no real impact in this case since upon reception, the IRIS-H immediately fully repay these amounts to the municipality.
- The result to be covered is that which is reported in the hospital accounts (i.e. it concerns the accounting deficit of the hospital as a whole and hence also includes the result of the ancillary activities of the IRIS-H, see also recital 41). Unlike Article 109 LCH, Article 46 of the IRIS-H bylaws does not exclude certain activities from the deficit. However, it is also clear that the compensation cannot go beyond the accounting deficit as the compensation is limited to the result of the financial year.
- Only partners that have at least one fifth of the votes in the General Assembly are required to contribute to cover the deficit. In practice, this means that only the municipalities and the CPAS have to contribute <sup>(262)</sup>.

- (220) On the basis of the fact that the IRIS-H only perform SGEI and ancillary activities, Article 46 of the bylaws of each IRIS-H establishes a clear compensation mechanism by indicating that the result of the financial year (without any exceptions) has to be covered. This result is determined on the basis of a clear set of accounting principles that apply equally to both public and private Belgian hospitals. Furthermore, each hospital is required (on the basis of Articles 80-85 LCH) to appoint an independent auditor who checks their accounts and results (see recital 49).

<sup>(261)</sup> A Royal Decree (currently the Royal Decree of 8 March 2006) sets out the method to calculate the deficit which the municipalities are obliged to cover on the basis of Article 109 LCH.

<sup>(262)</sup> The association representing the respective hospital's doctors and, where relevant, the *Université Libre de Bruxelles* and/or the *Vrije Universiteit Brussel* always have less than 20 % of the votes in the IRIS-H local associations. Similarly, since 2000 the municipality and CPAS of Jette are members of the CHU Brugmann association but since they have less than 20 % of the votes in that association they do not contribute to the deficit compensation. Finally, since accounting year 2014, the municipality and CPAS of Schaerbeek also have less than 20 % of the votes in the CHU Brugmann association and hence no longer contribute to the deficit of this hospital. This means that from 2014 onwards only the Ville de Bruxelles and its CPAS are obliged to cover the deficit of CHU Brugmann.



- (221) By requiring that the entire deficit of the IRIS-H is covered, Article 46 of the bylaws goes beyond the minimum requirement foreseen by Article 109 LCH. The reason for this full deficit cover for the performance of SGEI and ancillary activities <sup>(263)</sup> is that the Brussels local authorities want to guarantee the continuity and viability of the IRIS-H (see recital 91) at all times. Article 46 is also consistent with Article 61 of the Loi CPAS which reads:

‘The CPAS can rely upon the cooperation with persons, facilities or services, which, established either by public authorities or by private initiative, will be able to use the means to achieve the various solutions that present themselves, while respecting the free choice of the person concerned.

The CPAS can bear the potential costs of this cooperation when these are not covered by the implementation of another law, regulation, agreement or a judicial decision.’

- (222) Finally, as explained above (see recitals 22 and 44) municipalities are required to cover the deficit of their CPAS. As a result, it is the municipality that has the ultimate responsibility to cover the entire deficit of its public hospital.

#### 7.3.4.5. Arrangements in place for avoiding and recovering any overcompensation

- (223) As will be explained below, the deficit compensation mechanism operates in such a way that the risk of overcompensation at all occurring is already very limited in the first place (see recital 247). In addition, the Law of 14 November 1983 (see recitals 248-250) and the Loi CPAS (see recitals 251-252) provide the municipalities with the necessary legal means to control for overcompensation and to recover overcompensation, if any.

#### 7.3.4.6. Reference to the 2012 SGEI Decision

- (224) Article 4(f) of the 2012 SGEI Decision requires that the entrustment act includes a reference to that Decision. Article 10(a) of the 2012 SGEI Decision foresees a transition period of two years for aid schemes that were put into effect before 31 January 2012 and that were compatible under the 2005 SGEI Decision. For this reason, in the case at hand, a reference to the 2012 SGEI Decision was only introduced in 2014. In particular, from 2014 onwards each decision of the respective Brussels communes to make a payment to the IRIS-H on the basis of Article 46 of the IRIS-H bylaws also refers to the 2012 SGEI Decision. In addition, it should be noted that a reference to the 2012 SGEI Decision has been added in Article 108 of the current version of the LCH by means of the Law of 10 April 2014 <sup>(264)</sup>. More specifically, this article requires that each decision letter regarding the BMF-amount that is to be awarded to a hospital, contain an explicit reference to the 2012 SGEI Decision. The Commission therefore concludes that this formal condition is fulfilled.

#### 7.3.5. Compensation

- (225) The second key compatibility condition enshrined in the 2012 SGEI Decision is that the amount of compensation paid for the provision of the SGEI shall not exceed what is necessary to cover the net cost incurred in discharging the public service obligation, including a reasonable profit <sup>(265)</sup>. The 2012 SGEI Decision furthermore sets out how the net cost is to be calculated (including by defining the costs and revenues that can be taken into account), indicates how the reasonable profit must be determined, and requires that an undertaking carrying out activities falling both inside and outside the scope of the SGEI must keep separate internal accounts for the SGEI and other activities <sup>(266)</sup>.
- (226) In the case at hand, the IRIS-H only provide SGEI and the above described (see recitals 41 and 155) limited activities ancillary to these SGEI. In performing all these activities (SGEI and limited ancillary activities), the IRIS-H incur costs which to a large extent <sup>(267)</sup> are covered by the various public and private financing sources described above (see recital 46). Nevertheless, as will be illustrated below (see Tables 3 to 7), in most years since 1996 the performance of these activities by the IRIS-H generated a deficit. The Commission considers that these

<sup>(263)</sup> All expenses incurred for the performance of SGEI and ancillary activities are public service costs including the cost of the ancillary activities.

<sup>(264)</sup> Belgisch Staatsblad/Moniteur Belge of 30 April 2014, p. 35442. Applicable from 10 May 2014 onwards.

<sup>(265)</sup> Article 5 of the 2012 SGEI Decision.

<sup>(266)</sup> Article 5(2)-(9) of the 2012 SGEI Decision.

<sup>(267)</sup> In the period 2007-2011 on average about [...] % of the IRIS-H's costs were covered by this financing.

deficits are the residual net cost (i.e. the part of the net cost that has not been covered by the financing sources described in recital 46) of the SGEI and limited ancillary activities performed by the IRIS-H. By compensating these deficits, the municipalities cover no more than the residual net cost incurred by the IRIS-H in performing the SGEI and ancillary activities and do not even award a reasonable profit. Therefore, by its very definition, the compensation of deficits incurred by the IRIS-H should not and did not lead to actual overcompensation (see also recitals 234-245).

- (227) Pursuant to Article 77 LCH all hospitals are required to keep separate accounts which show the cost of each service. The accounting principles applicable to both public and private hospitals are enacted by the Royal Decree of 19 June 2007 <sup>(268)</sup>. Under that Royal Decree, non-hospital activities (i.e. in the case at hand the ancillary activities described above in recitals 41 and 155) are to be recorded separately (more specifically they are to be listed under account codes 900 to 999, see also recital 49). The Commission received attestations by the independent auditors of each of the IRIS-H confirming that the account separation is implemented in line with the requirements of Belgian law <sup>(269)</sup>. On this basis, the Commission concludes that the requirement under Article 5(9) of the 2012 SGEI Decision to have separate accounts is fulfilled.
- (228) As explained above (see recital 44), on the basis of Article 46 of the bylaws of the IRIS-H, the Brussels municipalities and CPAS are obliged to cover the full accounting deficit of their hospitals. This obligation which exists since the creation of the IRIS-H goes beyond the partial deficit compensation mechanism foreseen by Article 109 LCH (see recital 47). Nevertheless, the compensation on the basis of Article 46 of the bylaws of the IRIS-H can never exceed the accounting deficit of the financial year. Finally, Article 46, while creating a clear obligation to compensate the deficits, however does not specify explicitly at what point in time the municipalities and CPAS actually have to transfer the money <sup>(270)</sup>.
- (229) In practice, the timing of the payments by the municipalities to the IRIS-H has always depended on the available funds in the municipal treasuries. Since there usually was insufficient money available, the municipalities tended to postpone the payment of the hospital deficit. In theory, they could keep postponing until the moment when the Federal Public Service for Public Health determined the Article 109 LCH deficit since this would then force the municipalities to pay (part) of the hospitals' deficits. However, there was a long delay (of up to 10 years) between the moment when the accounting deficit was known and when the Article 109 LCH deficit was calculated. This meant that between 1996 and 2002, the IRIS-H accumulated enormous deficits (i.e. more than EUR 50 million). To cover this gap in their financing, the IRIS-H were forced to take up bank loans, the costs of which further increased their deficits.
- (230) The municipalities realised that this situation was to their detriment, as they ended up paying for the interest on these loans via the deficit cover and hence wanted to pay the IRIS-H quicker instead of waiting for the moment when the Federal Public Service for Public Health would force them to pay the Article 109 LCH deficit. Given the lack of sufficient financial resources at the municipal level, the Brussels Capital Region had to intervene to make this possible. In particular, the Region provided financing to the respective municipalities (1) indirectly via the FRBRTC (see recital 231); and (2) from 2003 onwards also directly by granting special subsidies (see recitals 232-233). This enabled the municipalities to more quickly, albeit partially <sup>(271)</sup>, fulfil their deficit compensation obligation towards the IRIS-H. As explained above (see Section 7.1), the Brussels Capital Region only granted and continues to grant public financing to the respective Brussels municipalities and not to the IRIS-H.

<sup>(268)</sup> Belgisch Staatsblad/Moniteur Belge of 29 June 2007, p. 35929. Applicable from 9 July 2007 onwards. This Royal Decree replaced the Royal Decree of 14 December 1987 concerning the annual accounts of hospitals which laid down very similar requirements.

<sup>(269)</sup> In this context, it must be noted that some accounting flows linked to the hospital activities also have to be recorded on the account codes 900 to 999. This concerns certain flows which are not taken into account in the determination of the BMF financing (which follows a cash accounting logic rather than the accrual accounting approach that applies for the hospital accounting).

<sup>(270)</sup> In theory, the IRIS-H can ask the municipalities to pay the deficit compensation once the result of the financial year has been determined. In practice the IRIS-H did not do this because they are controlled by the municipalities and the latter did not (always) have the funds available to pay immediately.

<sup>(271)</sup> In fact, the regional financing awarded to the municipalities was insufficient to fully cover the deficits incurred by the IRIS-H during the period 1996-2014 (see also footnote 143).

- (231) The deficits incurred by the IRIS-H in the accounting years 1996 until 2002 were only compensated by the municipalities from 2002 onwards using the financing they had received from the FRBRTC. The compensation of the deficits for this period was only concluded in 2008. For the compensation of the deficits incurred since 2003, the municipalities have no longer relied on the FRBRTC financing.
- (232) From the accounting year 2003 onwards, the Brussels Capital Region started awarding on average EUR 10 million per year (for the exact amounts see Table 2) in the form of special subsidies to the municipalities. In turn, each municipality paid its share of this special subsidy usually at the start of the following year, based on the hospital's estimated deficit (e.g. at the beginning of 2015 for the 2014 financial year). The deficit is estimated on the basis of the audit of the hospital's activities and the provisional result for the first nine months of the year. Within six months after the end of the financial year (i.e. by the end of June), the General Assembly of each IRIS-H approves the hospital's financial accounts and adopts the final accounting deficit. The amount of the accounting deficit outstanding after payment of the share of the special subsidy is settled in accordance with the available funds in the municipal treasuries. The full settlement can take several more years and during the entire assessment period (1996-2014), the IRIS-H have continuously been waiting for payments by the municipalities (see the tables in recital 234 for details on the outstanding amounts).

Table 2

**Payments (financed by the special subsidy) by the municipalities to the IRIS-H**

(EUR)

Year	CHU St. Pierre	CHU Brugmann	ISH	HUDERF	Institut Bordet	Total
<b>2003</b>	1 620 000	1 770 000	3 765 000	820 000	2 025 000	<b>10 000 000</b>
<b>2004</b>	1 541 775	1 457 000	3 765 000	781 981	1 321 316	<b>8 867 072</b>
<b>2005</b>	2 132 928	3 657 000	3 765 000	778 000	800 000	<b>11 132 928</b>
<b>2006</b>	—	3 657 000	3 765 000	778 000	1 800 000	<b>10 000 000</b>
<b>2007</b>	278 330	4 125 610	3 765 000	622 529	1 208 531	<b>10 000 000</b>
<b>2008</b>	308 367	3 999 767	3 765 000	871 350	1 055 516	<b>10 000 000</b>
<b>2009</b>	490 002	3 231 504	3 765 000	1 246 998	1 266 496	<b>10 000 000</b>
<b>2010</b>	565 440	3 644 432	3 388 500	1 401 628	—	<b>9 000 000</b>
<b>2011</b>	654 580	3 206 932	3 576 750	1 220 232	841 506	<b>9 500 000</b>
<b>2012</b>	1 091 761	3 380 656	3 765 000	945 316	817 267	<b>10 000 000</b>
<b>2013</b>	1 826 753	2 500 348	3 765 000	635 966	1 271 933	<b>10 000 000</b>
<b>2014</b>	1 390 000	2 847 000	3 765 000	618 000	1 380 000	<b>10 000 000</b>
<b>Total</b>	<b>11 899 936</b>	<b>37 477 249</b>	<b>44 615 250</b>	<b>10 720 000</b>	<b>13 787 565</b>	<b>118 500 000</b>

- (233) Accounting-wise, the part of the special subsidy has in some years been directly accounted for in the hospital's result (hence lowering the remaining deficit) while in other years the amount was accounted as a compensation of the deficit (i.e. in the attribution of the result). In addition, there has been an accounting delay in 2004 for the CHU Saint-Pierre so that its part of the special subsidy was only recorded in the accounts of the next year. This explains why the total amount of special subsidy for the five IRIS-H in 2004 is only EUR 8 867 072 while in 2005 it is EUR 11 132 928, the two summing up to EUR 20 million (or EUR 10 million per year as was the intention). Despite these differences in accounting treatment, the principle behind these payments has always been to give a quick (and usually partial) compensation of the deficit without resulting in overcompensation (see the remainder of this section).

- (234) The below Tables 3 to 7 indicate for each of the five IRIS-H the accounting deficits incurred for each year (combined, these deficits amount to almost EUR 250 million over the period 1996-2014) and the payments made in each year by the municipality (these payments may relate to deficits of previous years). Tables 3 to 7 indicate when (i.e. in which years) the municipalities made payments to compensate the deficits of the respective IRIS-H but do not show for which specific year those payments compensate the deficit <sup>(272)</sup>. These tables also illustrate the accumulation of deficits during the period 1996-2002 and the delay in payments by the municipalities. Furthermore, it is clear that at any given moment in the period 1996-2014, the respective municipalities owed the IRIS-H significant amounts of unpaid deficit compensation. The open balance until the end of 2014 for the five IRIS-H together exceeds EUR 15 million. In this context, it is worth pointing out that when the IRIS-H generate a profit, these profits are retained and used to cover past or future deficits which lowers the intervention by the municipalities. Finally, it is also clear from these tables that, as argued by the Belgian authorities (see recital 89) and contrary to the complainant's allegation, there is no mechanism of advance payments (see recital 55). Indeed, the payments by the municipality are made with a significant delay after the deficit has been incurred and the obligation on the basis of Article 46 of the IRIS-H bylaws became applicable. Therefore, the timing of the payments of the deficit compensation for the performance of SGEI and ancillary activities cannot be considered as providing an advantage to the IRIS-H.

Table 3

**Timing of deficit payments and open balance for CHU Saint-Pierre**

(EUR)

CHU Saint-Pierre	Accounting deficit	Payments by municipality	Open Balance
<b>1996</b>	- 5 737 856	0	- 5 737 856
<b>1997</b>	- 6 754 920	0	- 12 492 776
<b>1998</b>	- 3 696 235	0	- 16 189 011
<b>1999</b>	- 752 234	0	- 16 941 245
<b>2000</b>	- 1 072 993	0	- 18 014 238
<b>2001</b>	- 1 416 937	0	- 19 431 174
<b>2002</b>	- 2 914 245	3 368 351	- 18 977 068
<b>2003</b>	- 2 629 012	4 925 162	- 16 680 918
<b>2004</b>	- 1 541 775	11 571 300	- 6 651 393
<b>2005</b>	- 2 248 399	1 000 000	- 7 899 792
<b>2006</b>	98 114	2 886 635	- 4 915 043
<b>2007</b>	- 774 755	2 217 900	- 3 471 897
<b>2008</b>	- 1 054 119	2 356 333	- 2 169 683
<b>2009</b>	- 1 000 933	490 002	- 2 680 614

<sup>(272)</sup> For instance, Table 3 illustrates that while CHU Saint-Pierre incurred deficits in each year since 1996, the first deficit compensation payment (of EUR 3 368 351) by the municipality was only made in 2002. What cannot be concluded from the table is which of the annual deficits since 1996 was being compensated via the payment in 2002. However, the detailed information provided to the Commission by the Belgian authorities shows that that payment was in fact made to cover part of the deficit incurred in the year 1996.

(EUR)

CHU Saint-Pierre	Accounting deficit	Payments by municipality	Open Balance
<b>2010</b>	– 1 576 429	565 440	– 3 691 602
<b>2011</b>	– 949 668	654 580	– 3 986 690
<b>2012</b>	– 1 079 200	1 091 761	– 3 974 129
<b>2013</b>	– 1 880 205	1 826 753	– 4 027 580
<b>2014</b>	– 1 441 778	1 900 931	– 3 568 427
<b>Total</b>	<b>– 38 423 575</b>	<b>34 855 148</b>	<b>– 3 568 427</b>

Table 4

Timing of deficit payments and open balance for CHU Brugmann <sup>(1)</sup>

(EUR)

CHU Brugmann	Accounting deficit	Payments by municipality	Open Balance
<b>1996</b>	N/A	N/A	N/A
<b>1997</b>	N/A	N/A	N/A
<b>1998</b>	N/A	N/A	N/A
<b>1999</b>	– 508 171	0	– 508 171
<b>2000</b>	– 3 755 229	0	– 4 263 399
<b>2001</b>	– 5 440 039	0	– 9 703 438
<b>2002</b>	– 1 976 934	0	– 11 680 371
<b>2003</b>	– 1 697 238	1 770 000	– 11 607 609
<b>2004</b>	– 1 442 292	1 457 000	– 11 592 901
<b>2005</b>	– 7 413 186	4 404 420	– 14 601 667
<b>2006</b>	– 14 180 725	10 893 584	– 17 888 808
<b>2007</b>	– 6 954 466	10 151 330	– 14 691 944
<b>2008</b>	– 6 308 290	6 699 647	– 14 300 587
<b>2009</b>	– 6 228 859	3 231 504	– 17 297 942
<b>2010</b>	– 5 011 208	3 644 432	– 18 664 719
<b>2011</b>	– 2 982 442	3 224 315	– 18 422 846
<b>2012</b>	– 2 945 806	16 219 985	– 5 148 666
<b>2013</b>	– 2 799 788	7 090 156	– 858 298
<b>2014</b>	– 2 923 714	2 847 000	– 935 012
<b>Total</b>	<b>– 72 568 385</b>	<b>71 633 373</b>	<b>– 935 012</b>

<sup>(1)</sup> See recital 236 for the explanation why the figures for the years 1996, 1997 and 1998 are missing.

Table 5

## Timing of deficit payments and open balance for HUDERF

(EUR)

HUDERF	Accounting deficit	Payments by municipality	Open Balance
<b>1996</b>	– 1 505 830	0	– 1 505 830
<b>1997</b>	– 1 026 881	0	– 2 532 711
<b>1998</b>	– 245 113	0	– 2 777 825
<b>1999</b>	1 642	0	– 2 776 183
<b>2000</b>	– 484 951	0	– 3 261 134
<b>2001</b>	– 1 218 954	0	– 4 480 088
<b>2002</b>	– 479 490	883 192	– 4 076 386
<b>2003</b>	– 1 117 778	1 583 539	– 3 610 625
<b>2004</b>	– 781 981	1 863 863	– 2 528 742
<b>2005</b>	– 1 279 230	778 000	– 3 029 973
<b>2006</b>	– 2 494 074	1 605 532	– 3 918 515
<b>2007</b>	– 2 687 621	1 688 424	– 4 917 712
<b>2008</b>	– 2 314 050	1 208 667	– 6 023 095
<b>2009</b>	– 1 868 670	1 246 998	– 6 644 767
<b>2010</b>	– 1 823 049	1 401 628	– 7 066 187
<b>2011</b>	– 1 620 663	1 220 232	– 7 466 618
<b>2012</b>	– 945 316	5 525 711	– 2 886 223
<b>2013</b>	– 528 779	635 966	– 2 779 036
<b>2014</b>	– 618 000	2 682 372	– 714 664
<b>Total</b>	<b>– 23 038 788</b>	<b>22 324 124</b>	<b>– 714 664</b>

Table 6

## Timing of deficit payments and open balance for Institut Bordet

(EUR)

Institut Bordet	Accounting deficit	Payments by municipality	Open Balance
<b>1996</b>	752 505	0	752 505
<b>1997</b>	170 241	0	922 745
<b>1998</b>	41 349	0	964 094
<b>1999</b>	44 371	0	1 008 465

(EUR)

Institut Bordet	Accounting deficit	Payments by municipality	Open Balance
<b>2000</b>	5 439	0	1 013 904
<b>2001</b>	154 518	0	1 168 423
<b>2002</b>	– 4 929 106	0	– 3 760 683
<b>2003</b>	– 4 916 506	2 025 000	– 6 652 189
<b>2004</b>	– 2 001 995	1 321 316	– 7 332 868
<b>2005</b>	– 771 467	800 000	– 7 304 335
<b>2006</b>	– 1 817 630	1 800 000	– 7 321 966
<b>2007</b>	– 1 874 162	2 673 741	– 6 522 386
<b>2008</b>	– 1 624 347	4 519 412	– 3 627 322
<b>2009</b>	– 688 005	1 266 496	– 3 048 830
<b>2010</b>	– 655 634	0	– 3 704 465
<b>2011</b>	– 838 644	841 506	– 3 701 602
<b>2012</b>	– 833 460	4 465 110	– 69 952
<b>2013</b>	– 2 551 468	1 271 933	– 1 349 487
<b>2014</b>	– 1 943 857	2 023 112	– 1 270 232
<b>Total</b>	<b>– 24 277 858</b>	<b>23 007 626</b>	<b>– 1 270 232</b>

Table 7

Timing of deficit payments and open balance (in EUR) for ISH <sup>(1)</sup>

(EUR)

ISH	Accounting deficit	Payments by municipality	Open Balance
<b>1996</b>	N/A	N/A	N/A
<b>1997</b>	N/A	N/A	N/A
<b>1998</b>	N/A	N/A	N/A
<b>1999</b>	– 1 248 404	0	– 1 248 404
<b>2000</b>	– 7 220 971	0	– 8 469 375
<b>2001</b>	– 14 782 680	0	– 23 252 055
<b>2002</b>	– 12 978 574	416 079	– 35 814 550

(EUR)

ISH	Accounting deficit	Payments by municipality	Open Balance
<b>2003</b>	– 7 990 196	6 018 822	– 37 785 924
<b>2004</b>	– 5 941 987	13 425 604	– 30 302 307
<b>2005</b>	– 4 440 896	3 765 000	– 30 978 203
<b>2006</b>	– 5 022 247	12 622 542	– 23 377 907
<b>2007</b>	– 3 882 170	10 885 280	– 16 374 797
<b>2008</b>	– 3 779 570	10 885 190	– 9 269 178
<b>2009</b>	– 3 774 545	3 765 000	– 9 278 722
<b>2010</b>	– 3 387 655	3 388 500	– 9 277 877
<b>2011</b>	– 3 572 694	3 576 750	– 9 273 821
<b>2012</b>	– 3 767 190	3 765 000	– 9 276 011
<b>2013</b>	– 3 761 761	3 765 000	– 9 272 772
<b>2014</b>	– 3 760 497	3 765 000	– 9 268 269
<b>Total</b>	<b>– 89 312 036</b>	<b>80 043 767</b>	<b>– 9 268 269</b>

(<sup>1</sup>) See recital 236 for the explanation why the figures for the years 1996, 1997 and 1998 are missing.

- (235) In practice, the deficit compensation under Article 46 of the IRIS-H bylaws takes precedence over the deficit compensation under Article 109 LCH. In fact, after the Federal Minister responsible for public health has determined the Article 109 LCH deficit (see recital 47), a letter is sent to the municipality and its bank is ordered to immediately pay this amount to the respective hospital taking into account any deficit compensation payments that have already been made by the municipality to that IRIS-H on the basis of Article 46 of its bylaws. In addition, the municipalities and the IRIS-H have agreed that the latter immediately repay the amounts paid to them under Article 109 LCH to the municipalities to avoid any double coverage of the same deficit. In this respect, the Commission has received a letter and a table from the municipalities' bank Belfius confirming that for each year and all five IRIS-H, these repayments were made immediately and hence a double deficit coverage is ruled out. Table 8 below shows a complete overview of all amounts of the 'Article 109 LCH deficit' compensations that were paid by the municipalities to the IRIS-H and were immediately repaid so that these transactions were neutralised. As a result, the IRIS-H did not derive any advantage from these payments under Article 109 LCH and hence only the deficit compensation under Article 46 of the IRIS-H bylaws is of importance for the further assessment in this decision. Table 8 only includes the payments until the accounting year 2006 since this is currently the most recent year for which the Article 109 LCH deficit has been determined by the Federal Public Service for Public Health. This illustrates the large delay that exists in practice for the payment of compensation of this deficit under the Article 109 LCH mechanism and also explains why the IRIS-H do not rely on it (and hence repay it immediately after receipt). Indeed, the compensation on the basis of Article 46 of the IRIS-H bylaws is a quicker mechanism (especially since the introduction of the special subsidies for the municipalities, see recital 232) than that on the basis of Article 109 LCH. Furthermore, the deficit cover under Article 46 of the IRIS-H bylaws goes beyond the partial deficit cover under Article 109 LCH (see recitals 47-48) as it compensates the entire accounting deficit incurred by the IRIS-H. For these reasons, the assessment in this decision only focuses on the Article 46 deficit compensation mechanism and no longer pursues an assessment of the Article 109 LCH deficit compensation mechanism unlike the annulled Commission decision of 2009 which assessed the Article 109 LCH mechanism.



Table 8

**Complete overview of the amounts of Article 109 LCH deficit <sup>(1)</sup> that were paid and immediately repaid  
(situation as of 9 November 2015)**

(EUR)

	CHU St. Pierre	CHU Brugmann	ISH	HUDERF	Institut Bordet
<b>1996</b>	560 322,61	0	2 727 844,19	0	0
<b>1997</b>	0	0	3 051 321,12	0	0
<b>1998</b>	0	0	553 331	0	0
<b>1999</b>	0	781 686,52	345 176,04	0	0
<b>2000</b>	1 019 647,97	0	0	0	2 483 585,21
<b>2001</b>	0	2 511 189,37	126 193,12	263 390,41	4 681 594,58
<b>2002</b>	0	0	0	0	0
<b>2003</b>	0	0	3 658 304,97	0	1 699 065,20
<b>2004</b>	0	0	0	0	705 798,98
<b>2005</b>	0	0	0	0	0
<b>2006</b>	0	5 727 775,67	0	384 527,59	0

<sup>(1)</sup> These are the amounts that were actually paid and repaid after taking into account any deficit compensation payments that had already been made by the municipality.

(236) The Commission has also assessed whether over the period 1996-2014 <sup>(273)</sup>, the IRIS-H were in fact overcompensated. Due to the mergers which took place on 1 July 1999 (see also recital 28) and the long time period that has expired since then, the overcompensation analysis cannot cover the years 1996-1998 for CHU Brugmann as the relevant records could no longer be retrieved. For the same reasons this analysis can only be performed for the ISH on an aggregated basis for the years 1996-1998. In this context, it has to be pointed out that the Belgian authorities provided all the relevant accounting information of the IRIS-H and the deficit payments made by the municipalities to the extent that these figures were available. Indeed, up until the entry into force of the 2005 SGEI Decision on 19 December 2005, Member States were only required to keep information available for the Commission for five years <sup>(274)</sup> (instead of 10 years under the SGEI Decisions <sup>(275)</sup>). Despite the fact that the Commission's first request for information was sent only on 22 March 2006, the Belgian authorities nevertheless managed to provide the relevant figures from 1996 onwards for the CHU St. Pierre, HUDERF and Institut Bordet and from 1999 onwards for ISH (and aggregated figures for 1996-1998) and CHU Brugmann.

(237) The Commission has examined whether the deficit compensation payments by the municipalities for a particular year (using financing from the FRBRTC, the special subsidies from the Brussels Capital Region, and their own means) exceeded the accounting deficit of that year. In this context, the Commission recalls that the IRIS-H only receive compensation for deficits incurred in the performance of SGEI and some limited ancillary activities. The below Tables 9 to 13 show the relevant figures for each IRIS-H. It is however important to keep in mind that

<sup>(273)</sup> 2014 is the most recent accounting year for which figures were available.

<sup>(274)</sup> See Article 5 of Commission Directive 80/723/EEC of 25 June 1980 on the transparency of financial relations between Member States and public undertakings (OJ L 195, 29.7.1980, p. 35).

<sup>(275)</sup> See to this extent Article 7 of the 2005 SGEI Decision and Article 8 of the 2012 SGEI Decision.

these tables do not reflect at what point in time the municipality compensated (part of) the deficit. Indeed, it is Tables 3 to 7 above (see recital 234) which show in which years the municipalities made deficit compensation payments to the IRIS-H. Tables 9 to 13 on the contrary indicate how much the municipalities paid (usually in several instalments) to the IRIS-H to compensate the deficit of a particular year without taking into account when these payments were actually made. While Tables 9 to 13 have been constructed to be able to assess whether there was any overcompensation for that year in isolation, in practice none of the IRIS-H ever benefited from actual overcompensation as explained below (see recital 238).

(238) As will be illustrated by the following tables, the comparison of the accounting deficit and the compensation paid for a particular year reveals only a few cases <sup>(276)</sup> of technical overcompensation when looking at that particular year in isolation. Tables 3 to 7 in recital 234 make clear however that in practice none of the IRIS-H ever benefited from actual overcompensation since at each moment in the period examined (1996-2014) the municipalities owed the IRIS-H large sums of unpaid deficit compensation. The technical overcompensations may have been motivated by the fact that in a particular year the municipality not only wanted to cover the accounting deficit of that year but also wanted to make up for its arrears in covering deficits relating to previous years. Even if that motivation cannot be proven, the fact remains that in each of the years in which the IRIS-H received payments that would, when looking at that year in isolation, technically amount to overcompensation for the SGEI and limited ancillary activities performed in that year, the recipient IRIS-H was in fact in aggregate terms in a state of actual undercompensation for the same SGEI and limited ancillary activities that it had performed in the previous years and the year at issue <sup>(277)</sup>.

(239) For the CHU Saint-Pierre, it can be observed in Table 9 below that when looking at each year in isolation there were limited technical overcompensations in the years 1996, 1997, and 2012. In each case, these overcompensations amounted to less than 1,5 % of the compensation awarded for that year and as a result these could have been carried over to the next year as foreseen by the SGEI Decision <sup>(278)</sup>. As demonstrated above (see Table 3 in recital 234), in practice however at each moment in the period 1996-2014 the CHU Saint-Pierre was in a state of undercompensation in aggregate terms and the municipality always owed the CHU Saint-Pierre money. Over the entire period 1996-2014, CHU Saint-Pierre was undercompensated for an amount of EUR 3 666 541. In line with their obligation under Article 46 of the IRIS-H bylaws, the relevant municipalities will still have to compensate this residual accounting deficit in the future <sup>(279)</sup>.

<sup>(276)</sup> In particular, in only 4 out of 89 years assessed for the five IRIS-H did the technical overcompensation for that year in isolation exceed 10 % of the amount of the annual compensation.

<sup>(277)</sup> In addition, it has to be kept in mind that the deficit compensation amounts only represent a small portion of the total public financing received by the IRIS-H in view of the SGEI they perform. Over the period 2007-2011, the average yearly BMF payments by the Federal government amounted to about EUR 323 million for all IRIS-H combined. Over that same period, the IRIS-H together reported average accounting deficits of EUR 13,4 million per year while the municipalities on average paid EUR 16,4 million per year in deficit compensations (which also covered deficits of prior years). The deficit compensations hence made up only about 5 % of the Federal BMF financing awarded to the IRIS-H. Therefore, if these significant amounts of public financing via the BMF would have been taken into account when calculating whether overcompensation exceeded 10 % of the compensation paid out for a specific year (and hence whether it could be carried over to the next year as allowed by Article 6(2) the 2012 SGEI Decision), the percentage of overcompensation would likely be significantly lower. This conclusion is based on the relative size of the BMF payments compared to the deficits and on the fact that the risk of overcompensation via the BMF is minimal. In particular, the BMF is mainly arranged as flat rate financing based on real hospital costs from prior years (without overcompensation). Furthermore, the Federal Public Service for Public Health performs detailed *ex post* checks on the actual costs incurred by each hospital and recalculates the BMF amount they are entitled to. Finally, it must be noted that no reasonable profit has been taken into account when comparing the compensation paid by the municipalities and the accounting deficit incurred by the IRIS-H.

<sup>(278)</sup> The relevant part of Article 6(2) of the 2012 SGEI Decision reads: 'Where the amount of overcompensation does not exceed 10 % of the amount of the average annual compensation, such overcompensation may be carried forward to the next period and deducted from the amount of compensation payable in respect of that period.' Given the absence of actual overcompensation (i.e. because on an aggregate basis the hospital was at any point in time in the period 1996-2014 undercompensated) such a carry-over never had to be executed in practice. This remark is valid for all IRIS-H (see also recitals 240-243).

<sup>(279)</sup> Alternatively, if CHU Saint-Pierre would be profitable in future years, these profits would normally be retained and used to offset the past losses. In such case, the municipalities would not or only partially have to compensate the residual accounting deficit. Such a scenario is however hypothetical since CHU Saint-Pierre has reported a limited profit in only one year (i.e. 2006) over the period 1996-2014.

Table 9

**Accounting deficit and compensation awarded for CHU Saint-Pierre**

(EUR)

CHU St. Pierre	Accounting deficit	Financed via FRBRTC or Region special subsidy <sup>(1)</sup>	Additional municipal contributions	Total compensation awarded	Over (+) or Under (–) compensation for the year	Aggregate Over (+) or Under (–) compensation
<b>1996</b>	– 5 737 856	5 738 735	0	5 738 735	879	879
<b>1997</b>	– 6 754 920	6 855 099	0	6 855 099	100 179	101 058
<b>1998</b>	– 3 696 235	3 696 092	0	3 696 092	– 143	100 915
<b>1999</b>	– 752 234	751 117	0	751 117	– 1 117	99 798
<b>2000</b>	– 1 072 993	1 072 993	0	1 072 993	0	99 798
<b>2001</b>	– 1 416 937	1 416 000	0	1 416 000	– 937	98 862
<b>2002</b>	– 2 914 245	2 914 245	0	2 914 245	0	98 862
<b>2003</b>	– 2 629 012	1 620 000	0	1 620 000	– 1 009 012	– 910 150
<b>2004</b>	– 1 541 775	1 541 775	0	1 541 775	0	– 910 150
<b>2005</b>	– 2 248 399	2 132 928	0	2 132 928	– 115 471	– 1 025 621
<b>2006</b>	98 114	0	0	0	0	– 1 025 621
<b>2007</b>	– 774 755	278 330	0	278 330	– 496 425	– 1 522 045
<b>2008</b>	– 1 054 119	308 367	0	308 367	– 745 752	– 2 267 797
<b>2009</b>	– 1 000 933	490 002	510 931	1 000 933	0	– 2 267 797
<b>2010</b>	– 1 576 429	565 440	0	565 440	– 1 010 989	– 3 278 785
<b>2011</b>	– 949 668	654 580	0	654 580	– 295 088	– 3 573 873
<b>2012</b>	– 1 079 200	1 091 761	0	1 091 761	12 561	– 3 561 312
<b>2013</b>	– 1 880 205	1 826 753	0	1 826 753	– 53 452	– 3 614 763
<b>2014</b>	– 1 441 778	1 390 000	0	1 390 000	– 51 778	– 3 666 541
	<b>– 38 423 575</b>	<b>34 344 217</b>	<b>510 931</b>	<b>34 855 148</b>	<b>– 3 666 541</b>	

<sup>(1)</sup> As explained in recital 104 the FRBRTC and the special subsidies awarded by the Brussels Capital Region to the municipalities are intra-State financing measures that are a funding source for the municipal deficit compensation mechanism. These amounts are reported in a separate column to illustrate that the municipalities use these regional funds entirely for the deficit compensation payments. This presentation cannot be interpreted as an indication that any amounts were transferred from the FRBRTC or Brussels Capital Region to the IRIS-H. These transfers were made to the municipalities who in turn used these funds to finance their deficit compensation obligation towards the IRIS-H.

- (240) As explained above (see recital 236), the overcompensation test for the ISH could not be performed individually for the years 1996-1998 due to the lack of the relevant figures. Nevertheless, the Belgian authorities could retrieve aggregate amounts for this period during which the ISH were still four independent hospitals. Over these three years some of the ISH incurred losses for a total amount of EUR 2 622 714 while other ISH reported total profits of EUR 703 624. The losses were covered entirely using FRBRTC funds that were granted to the municipality. The profits were carried over to the next year which explains why the compensation for the deficit incurred in 1999 covers only part of that deficit. The remainder of the deficit was offset by the retained profits from the period 1996-1998. Table 10 also shows that, apart from very minor technical overcompensations in the years 2000, 2010, 2011, 2013 and 2014 (in each case no more than 0,12 % of the compensation awarded for those years), the ISH have been undercompensated each year. The aggregate undercompensation over the period 1999-2014 amounts to over EUR 9 million.

Table 10

**Accounting deficit and compensation awarded for ISH**

(EUR)

ISH	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (-) compensation for the year	Aggregate Over (+) or Under (-) compensation
<b>1999</b>	- 1 248 404	446 209	0	446 209	- 802 195	- 98 571 (*)
<b>2000</b>	- 7 220 971	7 221 056	0	7 221 056	85	- 98 486
<b>2001</b>	- 14 782 680	14 782 680	0	14 782 680	0	- 98 486
<b>2002</b>	- 12 978 574	12 978 572	0	12 978 572	- 2	- 98 488
<b>2003</b>	- 7 990 196	3 765 000	0	3 765 000	- 4 225 196	- 4 323 684
<b>2004</b>	- 5 941 987	3 765 000	0	3 765 000	- 2 176 987	- 6 500 671
<b>2005</b>	- 4 440 896	3 765 000	0	3 765 000	- 675 896	- 7 176 566
<b>2006</b>	- 5 022 247	3 765 000	0	3 765 000	- 1 257 247	- 8 433 813
<b>2007</b>	- 3 882 170	3 765 000	0	3 765 000	- 117 170	- 8 550 983
<b>2008</b>	- 3 779 570	3 765 000	0	3 765 000	- 14 570	- 8 565 553
<b>2009</b>	- 3 774 545	3 765 000	0	3 765 000	- 9 545	- 8 575 098
<b>2010</b>	- 3 387 655	3 388 500	0	3 388 500	845	- 8 574 253
<b>2011</b>	- 3 572 694	3 576 750	0	3 576 750	4 056	- 8 570 197
<b>2012</b>	- 3 767 190	3 765 000	0	3 765 000	- 2 190	- 8 572 387
<b>2013</b>	- 3 761 761	3 765 000	0	3 765 000	3 239	- 8 569 148
<b>2014</b>	- 3 760 497	3 765 000	0	3 765 000	4 503	- 8 564 645
	<b>- 89 312 036</b>	<b>80 043 767</b>	<b>0</b>	<b>80 043 767</b>	<b>- 9 268 269</b>	

(\*) After adding the retained profits of EUR 703 624 from the period 1996-1998.

- (241) For the HUDERF, Table 11 below shows very minor technical overcompensations in the years 1998, 2002 and 2007 (i.e. in each case less than 0,15 % of the compensation awarded for that year). In 2013 there was a more significant technical overcompensation (almost 17 % of the compensation awarded for that year). However, combined with the significant undercompensation for the years 2010 and 2011 HUDERF was on an aggregate basis in 2013 still in a state of important undercompensation for the SGEI and limited ancillary activities it had performed up to that point. For the entire period 1996-2014, the total actual undercompensation amounts to more than EUR 700 000. In addition, as demonstrated above (see Table 5 in recital 234), in practice HUDERF has at no point in time ever been in a situation where it was actually overcompensated and would have had to repay (part of) the deficit compensation. In fact, HUDERF was always in state of undercompensation in aggregate terms and the municipality owed them money at each moment in the period 1996-2014.

Table 11

**Accounting deficit and compensation awarded for HUDERF**

(EUR)						
HUDERF	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (-) compensation for the year	Aggregate Over (+) or Under (-) compensation
<b>1996</b>	- 1 505 830	1 504 714	0	1 504 714	- 1 116	- 1 116
<b>1997</b>	- 1 026 881	1 026 279	0	1 026 279	- 602	- 1 718
<b>1998</b>	- 245 113	245 415	0	245 415	302	- 1 417
<b>1999</b>	1 642	0	0	0	0	- 1 417
<b>2000</b>	- 484 951	484 949	0	484 949	- 2	- 1 419
<b>2001</b>	- 1 218 954	1 218 000	0	1 218 000	- 954	- 2 373
<b>2002</b>	- 479 490	480 000	0	480 000	510	- 1 863
<b>2003</b>	- 1 117 778	820 000	297 778	1 117 778	0	- 1 862
<b>2004</b>	- 781 981	781 981	0	781 981	0	- 1 862
<b>2005</b>	- 1 279 230	778 000	501 230	1 279 230	0	- 1 863
<b>2006</b>	- 2 494 074	778 000	1 716 074	2 494 074	0	- 1 863
<b>2007</b>	- 2 687 621	622 529	2 065 313	2 687 842	221	- 1 642
<b>2008</b>	- 2 314 050	871 350	1 442 700	2 314 050	0	- 1 642
<b>2009</b>	- 1 868 670	1 246 998	621 672	1 868 670	0	- 1 642
<b>2010</b>	- 1 823 049	1 401 628	0	1 401 628	- 421 421	- 423 062
<b>2011</b>	- 1 620 663	1 220 232	0	1 220 232	- 400 431	- 823 493
<b>2012</b>	- 945 316	945 316	0	945 316	0	- 823 493
<b>2013</b>	- 528 779	635 966	0	635 966	107 187	- 716 306
<b>2014</b>	- 618 000	618 000	0	618 000	0	- 716 306
	<b>- 23 038 788</b>	<b>15 679 357</b>	<b>6 644 767</b>	<b>22 324 124</b>	<b>- 716 306</b>	

- (242) For the Institut Bordet, the accounting results between 1996 and 2001 were positive and there was hence no municipal intervention for those years. From 2002 onwards however the accounting result became negative and hence payments were made to compensate the deficits. Table 12 below shows limited technical overcompensations in the years 2005 and 2011 (respectively less than 4 % and 0,5 % of the compensation granted for those years). In the year 2009, there appears to be a significant technical overcompensation of approx. EUR 580 000 (amounting to almost 46 % of the compensation granted for that year). However, in the year 2008 there had been an undercompensation of approx. EUR 533 000 (almost EUR 505 000 on an aggregate basis). Taken together, this leaves an aggregate technical overcompensation of only EUR 73 702 (less than 6 % of the compensation awarded for 2009) which could have been carried over to 2010 <sup>(280)</sup> (while for 2010 until now no compensation has been awarded). Furthermore, in each year under assessment, the Institut Bordet was still awaiting compensation of incurred deficits (see Table 6 in recital 234). In the year 2009, the municipality owed the Institut Bordet approx. EUR 3 million. For the entire period 1996-2014, the total actual undercompensation amounts to more than EUR 2,4 million. As explained in recital 234, the profits of the years 1996-2001 lower the open balance of the municipalities as they deduct these profits before intervening.

Table 12

**Accounting deficit and compensation awarded for Institut Bordet**

(EUR)

Institut Bordet	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (-) compensation for the year	Aggregate Over (+) or Under (-) compensation
<b>1996</b>	752 505	0	0	0	0	0
<b>1997</b>	170 241	0	0	0	0	0
<b>1998</b>	41 349	0	0	0	0	0
<b>1999</b>	44 371	0	0	0	0	0
<b>2000</b>	5 439	0	0	0	0	0
<b>2001</b>	154 518	0	0	0	0	0
<b>2002</b>	- 4 929 105	4 929 106	0	4 929 106	1	1
<b>2003</b>	- 4 916 506	2 025 000	2 891 506	4 916 506	0	1
<b>2004</b>	- 2 001 995	1 321 316	680 679	2 001 995	0	1
<b>2005</b>	- 771 467	800 000	0	800 000	28 533	28 534
<b>2006</b>	- 1 817 630	1 800 000	17 630	1 817 630	0	28 533
<b>2007</b>	- 1 874 162	1 208 531	665 631	1 874 162	0	28 533
<b>2008</b>	- 1 624 347	1 055 516	35 509	1 091 025	- 533 322	- 504 789
<b>2009</b>	- 688 005	1 266 496	0	1 266 496	578 491	73 702
<b>2010</b>	- 655 634	0	0	0	- 655 634	- 581 932

<sup>(280)</sup> See in this regard Article 6 of the 2005 SGEI Decision and Article 6(2) of the 2012 SGEI Decision.

(EUR)

Institut Bordet	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (–) compensation for the year	Aggregate Over (+) or Under (–) compensation
<b>2011</b>	– 838 644	841 506	0	841 506	2 862	– 579 070
<b>2012</b>	– 833 460	817 267	0	817 267	– 16 193	– 595 263
<b>2013</b>	– 2 551 468	1 271 933	0	1 271 933	– 1 279 535	– 1 874 798
<b>2014</b>	– 1 943 857	1 380 000	0	1 380 000	– 563 857	– 2 438 654
	<b>– 24 277 858</b>	<b>18 716 671</b>	<b>4 290 955</b>	<b>23 007 626</b>	<b>– 2 438 654</b>	

- (243) As explained above (see recital 236), the overcompensation test cannot be performed for the CHU Brugmann for the years 1996-1998 due to the lack of the relevant figures. Table 13 below indicates limited technical overcompensation for the years 2000, 2003, 2004, 2008 and 2011 (in each case no more than 7 % of the compensation awarded for those years). In two years, namely 1999 and 2012, the technical overcompensation amounted to more than 10 % of the compensation awarded for that year (respectively 15,3 % and 12,9 %). However in the year 2012, combined with the significant undercompensation for 2009 and 2010, there was in fact undercompensation on an aggregate basis (i.e. amounting to EUR 558 858). Concerning the year 1999, there are no figures available from previous years that could be taken into account to assess the state of CHU Brugmann's compensation in aggregate terms in 1999. However, it is important to note that the first payments by the municipality (on the basis of FRBRTC financing) only started in 2003 and that, as Table 4 in recital 234 demonstrates, CHU Brugmann has at no point in time ever been in a situation where it was actually overcompensated and would have had to repay (part of) the deficit compensation to the municipality. Indeed, at each moment in the period 1996-2014, the CHU Brugmann was in a state of undercompensation in aggregate terms and the municipality owed the CHU Brugmann money to cover past deficits. In total, for that period the actual undercompensation amounts to about EUR 935 000.

Table 13

## Accounting deficit and compensation awarded for CHU Brugmann

(EUR)

CHU Brugmann	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (–) compensation for the year	Aggregate Over (+) or Under (–) compensation
<b>1999</b>	– 508 171	600 000	0	600 000	91 829	91 829
<b>2000</b>	– 3 755 229	3 755 587	0	3 755 587	358	92 188
<b>2001</b>	– 5 440 039	5 440 000	0	5 440 000	– 39	92 149
<b>2002</b>	– 1 976 934	1 976 933	0	1 976 933	– 1	92 149
<b>2003</b>	– 1 697 238	1 770 000	0	1 770 000	72 762	164 911
<b>2004</b>	– 1 442 292	1 457 000	0	1 457 000	14 708	179 619
<b>2005</b>	– 7 413 186	3 657 000	3 756 186	7 413 186	0	179 619

(EUR)

CHU Brugmann	Accounting deficit	Financed via FRBRTC or Region special subsidy	Additional municipal contributions	Total compensation awarded	Over (+) or Under (–) compensation for the year	Aggregate Over (+) or Under (–) compensation
<b>2006</b>	– 14 180 725	3 657 000	10 523 725	14 180 725	0	179 619
<b>2007</b>	– 6 954 466	4 125 610	2 828 856	6 954 466	0	179 619
<b>2008</b>	– 6 308 290	3 999 767	2 505 046	6 504 813	196 523	376 142
<b>2009</b>	– 6 228 859	3 231 504	2 600 612	5 832 116	– 396 743	– 20 601
<b>2010</b>	– 5 011 208	3 644 432	169 179	3 813 611	– 1 197 597	– 1 218 198
<b>2011</b>	– 2 982 442	3 206 932	0	3 206 932	224 490	– 993 708
<b>2012</b>	– 2 945 806	3 380 656	0	3 380 656	434 850	– 558 858
<b>2013</b>	– 2 799 788	2 500 348	0	2 500 348	– 299 440	– 858 298
<b>2014</b>	– 2 923 714	2 847 000	0	2 847 000	– 76 714	– 935 011
	<b>– 72 568 384</b>	<b>49 249 769</b>	<b>22 383 604</b>	<b>71 633 373</b>	<b>– 935 011</b>	

(244) Finally, the limited profits reported by some of the IRIS-H (i.e. by CHU Saint-Pierre in 2006, HUDERF in 1999 and Institut Bordet between 1996 and 2001) cannot be considered as an indication of overcompensation. Indeed, on the basis of the existing separation of accounts (see recital 226) in these IRIS-H, the Commission concludes that these profits, in all but one case are driven by the profits of the ancillary activities (see recitals 41, 116 and 117) performed by these IRIS-H. The SGEI activities of Institut Bordet made a limited profit in 1996 amounting to about 1 % of the hospital's total revenues for that year. The Commission considers that in any event such a limited profit would be reasonable and would hence not give rise to overcompensation. Furthermore, as explained above (see recital 234), all profits (whether stemming from SGEI or ancillary activities) are retained and used to offset future (or unpaid past) deficits hence lowering the contribution by the municipalities.

(245) On the basis of the foregoing, the Commission concludes that due to the delay in payments of the deficit compensation, the fact that at any given moment in the period 1996-2014 the respective municipalities owed each of the IRIS-H significant amounts of unpaid deficit compensation and the fact that each of the IRIS-H were overall in a state of undercompensation in aggregate terms, in practice no overcompensation of any of the IRIS-H occurred.

#### 7.3.6. Control of overcompensation

(246) The third key compatibility condition enshrined in the 2012 SGEI Decision requires Member States to take steps to ensure that undertakings entrusted with the provision of SGEI do not receive any overcompensation and obliges Member States to carry out regular checks or ensure that such checks are carried out at least every three years <sup>(281)</sup>. Moreover, where any overcompensation has in fact been received, Member States are obliged to require the undertaking concerned to repay it <sup>(282)</sup>.

<sup>(281)</sup> Article 6(1) of the 2012 SGEI Decision.

<sup>(282)</sup> Article 6(2) of the 2012 SGEI Decision.



- (247) First and foremost, it must be noted that with regard to the deficit cover at issue in this decision, the nature of this compensation mechanism as such already strongly reduces the risk of overcompensation and is hence a measure that helps to avoid overcompensation. Indeed, the municipalities can cover no more than the actual deficit incurred by the IRIS-H as a result of their provision of services of general economic interest and the limited ancillary activities. The compensation hence only covers the residual net costs (see recital 226) incurred in the provision of these SGEI and ancillary activities and does not even include a reasonable profit. All payments are made *ex post*, i.e. after the deficits have been incurred (see to this extent the tables in recital 234). The payments are made in instalments (as illustrated by the tables in recital 234) which ensures that the municipalities can withhold a payment if there is any indication of a risk of overcompensation. The municipalities also check the amount of aggregated unpaid deficits before they make a payment to the IRIS-H. As explained above (see recital 235), the municipalities and IRIS-H also agreed to immediately repay the Article 109 LCH deficit compensation thereby avoiding any double coverage of the same deficit. There is hence only a limited and theoretical residual risk of technical overcompensation when the compensation is analysed on the basis of looking at each year in isolation (see recitals 237-238). However, in practice none of the IRIS-H has in aggregate terms ever benefited from any actual overcompensation since at each moment in the period 1996-2014 the municipalities owed the IRIS-H large sums of unpaid deficit compensation (as confirmed by the tables in recital 234).
- (248) Second, the Law of 14 November 1983 <sup>(283)</sup> on control of the award and use of certain subsidies lays down the rules applicable to the control of subsidies granted, in particular by local authorities. It contains the same rules as the organic Brussels *Ordonnance* of 23 February 2006 setting out provisions applicable to the budget, accounts and audits <sup>(284)</sup>, which itself incorporates for the Brussels Capital Region the general rules set out in the Law of 16 May 2003 laying down general provisions applicable to budgets, the control of subsidies and accounts of the communities and regions and arrangements for auditing by the Belgian Court of Audit <sup>(285)</sup>. Article 1 of the Law of 14 November 1983 provides that:

‘This law shall apply to any subsidy granted by:

1° provinces, municipalities, establishments of provincial or municipal interest with legal personality, conurbations, federations of municipalities, cultural committees, associations of provinces and associations of municipalities;

2° legal or natural persons directly or indirectly subsidised by one of the providers referred to in 1°.’

Article 2 of this Law also defines its very general scope, stating:

‘Subsidy means [...] any contribution, advantage or aid, irrespective of the form or description, including advances of recoverable funds granted without interest, awarded in order to promote activities of general interest [...].’

It is clear from the above articles that the deficit compensation awarded by the Brussels municipalities to the IRIS-H for the performance of SGEI and ancillary activities is in scope of this Law.

- (249) Article 3 of the Law of 14 November 1983 establishes the principle that the subsidy must be used exclusively for the purposes for which it was granted and the beneficiary must be able to justify its use. Articles 4 and 5 lay down further rules for the grant of such subsidies and the transparency obligations imposed on the beneficiary. Articles 6 and 7 then set out the rules for checking by or on behalf of the subsidy provider on the use of the subsidies. In particular, Article 6 provides that:

‘All [subsidy] providers have the right to have on site checks carried out on the use of the subsidy provided.’

<sup>(283)</sup> Belgisch Staatsblad/Moniteur Belge of 6 December 1983, p. 15009.

<sup>(284)</sup> Belgisch Staatsblad/Moniteur Belge of 23 March 2006, p. 16710.

<sup>(285)</sup> Belgisch Staatsblad/Moniteur Belge of 25 June 2003, p. 33692.

Article 7 provides for the obligations of repayment and recovery of the subsidy. That Article reads:

‘Without prejudice to the resolute provisions to which the subsidy is subject, the beneficiary shall be required to repay it in the following circumstances:

- 1° when it does not use the subsidy for the purposes for which it was granted;
- 2° when it does not provide one of the justifications referred to in Articles 4 and 5;
- 3° when it refuses to allow the check referred to in Article 6.

However, in the case in 1°, 2°, the beneficiary shall only be required to repay the part of the subsidy that was not justified.

Legal persons under public law who have the power to impose direct taxation shall be authorised to order the recovery of repayable subsidies. The order shall be made by the accountant responsible for recovery. It shall be made enforceable by the administrative authority empowered to enforce the list of direct provisions of the relevant legal person under public law.’

(250) Hence that Law enables the municipalities to ensure that the subsidies are granted in accordance with the necessary conditions and also to check on the use and recovery of sums not required. Thus payment of the deficit compensation by the municipalities is subject to very strict rules. Through their acceptance by the hospitals concerned, these entail a right to inspection by an independent authority, which may ensure that the subsidy has actually been allocated to the use for which it was granted. Otherwise the hospital is required to repay it immediately which guarantees the recovery of any overcompensation to the IRIS-H.

(251) This is corroborated by the Loi CPAS of which Article 60(6) provides:

‘A decision may only be taken to set up or develop establishments or services eligible for investment or operating subsidies on the basis of documentation showing that the conditions laid down by the organic laws or regulations for the grant of such subsidies will be fulfilled.’

Hence if a CPAS sets up a public hospital, evidence must be provided that the rules for the award of the financing will be observed.

(252) Similarly, Article 135 *octies* Loi CPAS sets out arrangements for the monitoring of the Chapter XII local associations (in this case the IRIS-H) by their umbrella association (in this case IRIS) on a quarterly basis. In particular, this means that IRIS checks whether the decisions taken by the IRIS-H are in compliance with:

- 1° the general and specific strategic plan for hospital activity and the decisions taken pursuant to that plan;
- 2° the specific plan and the financial plan adopted by the local association on the basis of the guidelines set by the umbrella association and any amendments and updates to those plans;
- 3° the annual budget adopted by the local association on the basis of the guidelines set by the umbrella association.

In the event of non-compliance, the umbrella association shall take any measures it considers appropriate to end the non-compliance and shall notify them to the local association concerned for implementation within a period which it shall determine.

If the local association concerned fails to implement the measures within the stipulated period, the umbrella association may immediately instruct the auditor referred to in Article 135 *novies* to replace the local association body in default.’

(253) It is apparent from the above provisions that both the Loi CPAS and the Law of 14 November 1983 enable the Brussels municipalities to ensure that subsidies paid to the IRIS-H are used correctly and do not lead to overcompensation. The joint application of those provisions facilitates controlling for overcompensation and provides for the recovery of overcompensation. Furthermore, in the event of non-compliance, a power of substitution is

conferred on a third party, in order to ensure fulfilment of these obligations, particularly in regard to the budget, imposed on the IRIS-H. The municipalities, CPAS and the IRIS umbrella organisation hence have far-reaching control powers even if there is virtually no risk of overcompensation under the deficit compensation mechanism at issue in this decision.

- (254) In addition, where the operating accounts of the public hospital show a deficit, the municipal executive(s) may under Articles 111(2) and 126 Loi CPAS suspend implementation of *'any decision of the CPAS that is detrimental to the municipal interests and in particular the financial interests of the municipality.'*
- (255) Finally, it is worth emphasizing that the granting authorities (i.e. the municipalities and the CPAS) of the aid measure at hand directly control the beneficiaries. In particular, these authorities have the majority of votes in the Administrative Councils of the IRIS-H which, among others, appoints the director general of their respective hospitals. In the unlikely situation where an IRIS-H would hypothetically refuse to repay overcompensation, the public authorities could easily replace the director general to rectify this situation. Furthermore, as required by the bylaws of each IRIS-H, the Administrative Council meets at least eight times per year which allows the granting authorities to closely monitor the financial situation of the IRIS-H (among others via the quarterly reports which cover this subject as required by the bylaws).
- (256) On the basis of the above, the Commission concludes that there are sufficient arrangements to avoid, detect and recover overcompensation while the risk of actual overcompensation seems very limited given the nature of the aid measure at hand.

#### 7.3.7. Duration of entrustments

- (257) Article 2(2) of the 2012 SGEI Decision foresees that the Decision only applies to entrustments the duration of which does not exceed 10 years, unless a longer period can be justified by reference to the entrusted undertaking's need to amortise significant investments over a longer period in accordance with generally accepted accounting principles.
- (258) The duration of the bylaws of the IRIS-H, which at the municipal level are the basic entrustment acts relevant in the case at hand, is set at 30 years. The Commission considers that such long duration is justified by the need for significant investments to be made by the IRIS-H as the entrusted SGEI providers. More specifically, the most important assets of the IRIS-H are their buildings (accounting for more than 60 % of the value of their assets) which are amortised over a period of 30 years in accordance with generally accepted accounting principles <sup>(286)</sup>. Furthermore, the IRIS strategic plans which further specify the additional obligations that the IRIS-H are entrusted with are also limited in time and even have a shorter duration. The first strategic plan covered the six-year period 1996-2001. The second strategic plan initially covered the period 2002-2006 but was subsequently amended and prolonged until the end of 2014. A new strategic plan for the period 2015-2018 was adopted in January 2015.
- (259) Furthermore, the Law of 10 April 2014 <sup>(287)</sup> limited the duration of the Federal entrustment act for the basic hospital mission <sup>(288)</sup> by modifying Article 105 of the current version of the LCH <sup>(289)</sup>. In particular, Article 105 now requires that the period for which the BMF is awarded cannot exceed 10 years except for those elements of the BMF which cover the cost of significant hospital investments that need to be amortised over a longer period in accordance with generally accepted accounting principles. Finally, the individual authorisation which the hospitals need to have in order to be eligible for BMF financing also has a limited duration (depending on the region, but typically around five years and in any event not more than 10 years).
- (260) The Commission therefore considers that the requirement under Article 2(2) of the 2012 SGEI Decision to limit the duration of the entrustment act and to justify this duration is fulfilled.

<sup>(286)</sup> This amortisation period is imposed by the Royal Decree of 19 June 2007 which applies to all Belgian hospitals (see also recital 226).

<sup>(287)</sup> See footnote 264.

<sup>(288)</sup> As explained in recital 166, the Commission considers that the three additional obligations would not have been entrusted in the absence of the basic hospital mission. In this context, the Commission considers it appropriate to assess the duration of the entrustment for the basic hospital mission.

<sup>(289)</sup> I.e. the coordinated hospital Law of 10 July 2008 (Belgisch Staatsblad/Moniteur Belge of 7 November 2008, p. 58624).

#### 7.3.8. Transparency

- (261) Finally, the 2012 SGEI Decision requires Member States to publish certain information. More specifically, for compensation above EUR 15 million granted to an undertaking which also has activities outside the scope of the service of general economic interest, Article 7 of the 2012 SGEI Decision requires Member States to publish on the internet or by other appropriate means the entrustment act (or a summary which includes the elements listed in Article 4 of the 2012 SGEI Decision) and the amounts of aid granted to the entrusted undertaking on a yearly basis.
- (262) The transparency requirement of the 2012 SGEI Decision applies to 'compensation above EUR 15 million granted to an undertaking which also has activities outside the scope of the service of general economic interest'. As can be observed in Tables 9-13, the amount of municipal deficit compensation granted per individual IRIS-H does not exceed the EUR 15 million threshold in any year. Therefore, the Commission considers that the transparency requirement under Article 7 of the 2012 SGEI Decision is not applicable in this case.

#### 7.3.9. Summary conclusions on the compatibility with the internal market

- (263) On the basis of the above, the Commission concludes that the compensation of the deficits of the Brussels public IRIS hospitals by the Brussels municipalities since 1996, which forms the subject matter of this decision, complies with the requirements of the 2012 SGEI Decision and is therefore compatible with the internal market pursuant to Article 106(2) TFEU.
- (264) It follows from the foregoing conclusion and the explanations given above under recitals 148-152 that the Commission does not need to assess whether the compensation of the deficits of the Brussels public IRIS hospitals by the Brussels municipalities is also compatible with the internal market pursuant to the 2005 SGEI Decision (for aid that was granted between 19 December 2005 and 31 January 2012) or the 2012 SGEI Framework.

### 7.4. Final remarks

- (265) As explained above (see recital 159), in its annulment judgment of 7 November 2012, the GC made reference to the principle of equal treatment. In this context, the Commission recalls that the principle of non-discrimination/equal treatment is not mentioned as a compatibility criterion in the 2012 SGEI Decision. Nevertheless, for the case at hand, the Commission concludes that in any event this principle is complied with since the public IRIS-H and the private Brussels hospitals are in a legally and factually different situation due to the fact that the SGEI mission of the public IRIS-H is wider in scope than that of the private hospitals and hence is more costly to perform (as explained above, see Section 7.3.4.1). For the sake of completeness, the Commission notes that the IRIS-H are subject to a number of constraints and also additional costs (see recitals 42-43) in the performance of the SGEI entrusted to them.
- (266) Since the IRIS-H and private hospitals in Brussels are in different/not comparable situations, the compensation of the deficits of the IRIS-H cannot be regarded as a breach of the principle of equal treatment.

## 8. CONCLUSION

- (267) On the basis of the foregoing assessment, the Commission has decided that the State aid at issue in this case is compatible with the internal market based on Article 106(2) of the TFEU,

HAS ADOPTED THIS DECISION:

#### Article 1

The State aid in the form of compensation of the deficits of the Brussels public IRIS hospitals by the Brussels municipalities since 1996 is compatible with the internal market on the basis of Article 106(2) of the Treaty on the Functioning of the European Union.

*Article 2*

This Decision is addressed to the Kingdom of Belgium.

Done at Brussels, 5 July 2016.

*For the Commission*  
Margrethe VESTAGER  
*Member of the Commission*

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