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Study on Market Trends in healthcare and social housing and EU State aid implications

Final Report

Prepared by

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Study on Market Trends in healthcare and social housing and EU State aid implications

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Abstract

The 'Study on Market Trends in health and social housing and EU State aid implications' aims to provide the Commission with factual data regarding the interplay between the 2012 Service of General Economic Interest (SGEI) Package and the evolution of the healthcare and social housing sectors in 10 Member States: France, Ireland, Germany, the Czech Republic, Latvia, Portugal, Romania, Croatia, Sweden, the Netherlands. The Study provides: an overview of sector and market trends since 2012 (Task 1); an analysis of how competition on the market has evolved since 2012 (Task 2); an analysis of the extent to which Member States are aware of possible State aid implications of policy and market trends (Task 3); and an assessment of the effectiveness, efficiency, relevance and EU added value of the SGEI Package in so far as healthcare and social housing are concerned. The Study is 'backward-looking', focusing on the period following the entry into force of the 2012 SGEI Package until 2020, although the period prior to 2012 was also considered to undertake a counterfactual analysis.

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Executive Summary

Scope of the Study

EY was contracted by DG Competition to undertake a 'Study on market trends in health and social services and EU State aid implications'. The aim of the Study was to support the Commission in replying to Evaluation Questions regarding the effectiveness, efficiency, relevance and EU added value of the Commission's SGEI Package from 2012, which defines the conditions under which State aid in the form of public service compensation can be considered compatible with the EU rules. The practical aim of the Study was to provide the Commission with factual data regarding the organisation of the healthcare and social housing sectors in the 10 Member States covered by the Study.

The Study had a double coverage – the **healthcare sector** (with a focus on hospitals) and the **social housing sector**. These sectors are covered under Article 2(1)(b) and (c) of the SGEI Decision[1]. Together with the SGEI Communication[2], the SGEI Framework[3] and the SGEI de minimis Regulation[4] they form the 'SGEI Package'.

Regarding the **geographical scope of the Study**, it focused on the following Member States: France, Ireland, Germany, the Czech Republic, Latvia, Portugal, Romania, Croatia, Sweden and the Netherlands.

The Study focused on four key tasks:

1. Provide an overview of sectoral and market trends since 2012;
2. Analyse how competition on the market has evolved since 2012;
3. Examine to what extent the Member States are aware of the possible State aid implications of policy and market trends;
4. Respond to Evaluation Questions.

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[1] *Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest OJ L 7, 11.1.2012, p. 3–10, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012D0021*
Article 2 (1) (b) and (c) states : "This Decision applies to State aid in the form of public service compensation, granted to undertakings entrusted with the operation of services of general economic interest as referred to in Article 106(2) of the Treaty, which falls within one of the following categories: […] (b)compensation for the provision of services of general economic interest by hospitals providing medical care, including, where applicable, emergency services; the pursuit of ancillary activities directly related to the main activities, notably in the field of research, does not, however, prevent the application of this paragraph; (c)compensation for the provision of services of general economic interest meeting social needs as regards healthcare and long term care, childcare, access to and reintegration into the labour market, social housing and the care and social inclusion of vulnerable groups".

[2] *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 OJ C 8, 11.1.2012, p. 4–14, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A52012XC0111%2802%29*

[3] *The SGEI Framework consists of the 2012 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, the Commission Decision of 20 December 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, the Communication from the Commission European Union framework for State aid in the form of public service compensation and Commission Regulation on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid granted to undertakings providing services of general economic interest, available at https://ec.europa.eu/competition/state_aid/legislation/sgei.html*

[4] *Commission Regulation (EU) No 360/2012 of 25 April 2012 on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid granted to undertakings providing services of general economic interest, O J L 114, 26.4.2012, p. 8–13, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012R0360*

The Study was 'backward-looking', focusing on the period following the entry into force of the SGEI Decision in 2012. However, the period prior to 2012, when the 2005 SGEI Decision[5] was in force, was also considered in order to undertake a counterfactual analysis. While the Study looked at the evolutions since the 2012 Package up to the end of December 2019, the impact of COVID-19 on the sectors was raised during data collection. COVID-19 was not the focus of the Study but was considered as an 'external factor' which had an impact on the healthcare and social housing sectors.

Methodology for the Study

The Study focused on a **number of data collection tools** to gather both quantitative and qualitative data.

A core tool of the methodology was **documentary review** to gather both quantitative and qualitative data on market trends in relation to the application of the 2012 SGEI Package. It aimed at providing a strong understanding of the main changes brought by the 2012 SGEI Package, the issues at stake but also the developments in terms of market, policies or national reforms. For the Study legislative documents, documents from international institutions, reports from NGOs and think tanks, national reports and sources and written contributions sent by interviewees that answered questionnaires deployed for the Study were consulted.

In-depth statistical research was also needed to collect the necessary quantitative data for the Study. The Member States' biennial SGEI reports, which they need to submit under Article 9 of the SGEI Decision, provided an overview of the expenditure related to SGEIs in the Member States covered by the Study, with the OECD and Eurostat databases providing an overview of the Member State expenditure related to healthcare and housing as well as the European trends. The national statistical databases complement this data and provide details on certain sectoral trends.

Interviews were undertaken with stakeholders from: national/local authorities in charge of the healthcare or/and social housing sectors; national/local authorities in charge of implementing and monitoring SGEIs; providers (healthcare and social housing); national industry and consumer associations; and EU NGOs and associations (89 in total). The interviews aimed to provide qualitative data relating to the overall effectiveness, efficiency, relevance and EU added value of the 2012 SGEI Package. An **Online Survey** was sent to the above-mentioned stakeholder groups at national level. 53 stakeholders replied, covering all Member States falling under the scope of the Study. The analysis of the Online Survey was supplemented by analysis of responses to the Commission's Open Public Consultation and targeted consultation disseminated prior to the launch of the Study.

Finally, **10 Member State Fiches** were prepared for the Member States covered by the Study in order to provide an overview of: the market situation in the healthcare and social housing sectors; the reforms that have impacted the legislative landscape and the regulatory framework in the Member States; and the government expenditure for healthcare and social housing as well as the evolution in the number and type of providers and competition.

[5] *Commission Decision of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest OJ L 312/67, 29.11.2005, available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32005D0842*

Key Findings

Overview of sectoral and market trends

Healthcare and social housing are organised in ways which reflect Member States' contexts, leading to divergences in the take up of the 2012 SGEI provisions.

In relation to healthcare, the diversity of approaches regarding the manner in which healthcare services are organised in a Member State and the variety of actors involved, both public and private, can have an impact on the manner in which the SGEI Package is implemented at national level. Healthcare services in most Member States covered by the Study are financed by public funds, either directly through the State budget or through healthcare insurance schemes. Two trends were identified by the Study that have implications on the application of the SGEI Package: (i) the overall liberalisation of the healthcare sector (in relation to provision and insurance) and (ii) the presence of a risk equalisation scheme in some Member States. The divergence of approaches leads to some Member States not considering the funding of hospitals to fall under the SGEI rules.

With regard to social housing, the overall European housing market is experiencing challenges and different studies have depicted a housing "crisis" due to the **growing risk of exclusion of the population on the housing market and a growing number of households being at risk of poverty**. Currently, about 37.8% of households at risk of poverty in the EU spend over 40% of their disposable income on housing costs[6], with the housing prices constantly growing[7]. Definitions of social housing and the scope of social housing services that fall under the SGEI rules vary in the Member States covered by the Study. These variations reflect the national contexts and the fact that each Member State has its own interpretation of who should be eligible to social housing. Not all Member States falling under the scope of the Study define social housing as a SGEI. The divergences in definitions of social housing also lead to differences in comparability and scarcity of data regarding the sector.

The share of social housing dwellings within the total housing stock varies between the Member States which define social housing as a SGEI. As an example, the highest rate is in the Netherlands where social housing represented 38% of the total housing stock in 2018, as opposed to 13-14% (Ireland and France) and only 0,4% in the Czech Republic (in 2011). In Latvia and Portugal, where social housing is not defined as a SGEI, social housing represents 2% of the total housing stock in 2015..[8] In terms of social housing providers, the only Member States in which social housing providers are only public authorities are Romania and Sweden, with other Member States including other actors such as not-for-profit organisations or semi-public entities.

Evolution of competition on the market since 2012

For the healthcare sector, healthcare expenditures increased in all Member States covered by the Study between 2013 and 2018. Despite this increase, healthcare expenditure as a percentage of GDP has been stable between 2013 and 2018 with a high variation only observed in one Member States (Ireland) where the share decreased by 3.5 percentage points. Hospital expenditure specifically increased between 2013 and 2018 in all Member States covered by the Study. Nevertheless, the number of hospitals decreased in the selected Member States, since there was an average of 33 hospitals per million inhabitants in 2013 for 30 hospitals per million inhabitants in 2018 (-8%)[9]. The evolution of legislation to reduce costs and reinforce patients' rights by encouraging

[6] *Housing Europe, The state of housing in the EU 2019.*
[7] *European Commission, European Semester: Country Reports, 2020*
[8] *EY composition from Member State Fiches and OECD, Affordable housing database*
[9] *OECD Database*

private actors to enter the market could explain this trend. The Study found, however, that the presence of the public, not-for-profit and private-for-profit hospitals in a Member State does not necessarily lead to competition between these actors. This is due to the differences in services provided by these types of hospitals.

For the social housing sector, there is no presence of private providers on the market at a large scale in the majority of Member States falling under the scope of the Study. For those Member States where social housing is not considered to be a SGEI (Croatia, Latvia, Portugal and Romania), no private actors are in place, with providers mainly public authorities or organisations. For Member States considering social housing as a SGEI (Czech Republic, France and the Netherlands), the situation is similar, with no evolution occurring with regard to private providers as only public and/or not-for-profit actors are active in the social housing sector. However, for-profit providers are active in Germany and Ireland. In Germany, private actors own three fifths of the social rental housing stock. One of the main factors explaining the growing liberalisation of the social housing market is the privatisation of the *Wohnungsgemeinnützigkeit* (the public interest housing), with private actors considered as important suppliers of social housing. In Ireland, the growing importance of the private sector, which had begun in the boom years (mid-1990s to late 2000s prior to the economic crisis in 2008) through the Rental Accommodation Scheme programme (2004-2007), accelerated during the recession (2008-2012).

Awareness of Member States on possible State aid implications

The Study found that the level of awareness of the rules depends on the degree of involvement of stakeholders in the SGEI. Among the national authorities, the level of awareness depends on their working relationship with the 2012 SGEI Package. It was found that the European Affairs department or the unit in charge of State aid or an equivalent department dealing with State aid is usually and logically more aware of the SGEI rules than other parts of the public administrations. The degree of awareness also varies between central and local authorities. Municipalities for example are often less aware of the SGEI rules. Overall, the Study concluded that operators are more aware of the national rules implementing the 2012 SGEI Package rather than of the Package itself. Moreover, between operators, those in charge of SGEI are more aware of the requirements than those who are not. The level of awareness also varies between the hospital and social housing sector, with stakeholders from the social housing sector having a higher level of awareness of the SGEI rules, which could be explained by the overall size of the sector and number of actors involved (both smaller). Overall, looking at the period 2012 to 2019, the Study found that the knowledge of SGEI rules could be improved to ensure greater uptake of the SGEI.

Effectiveness of the 2012 SGEI Package

The overarching objective of the 2012 SGEI Package was to facilitate the provision of SGEI through sub-objectives relating to clarification, simplification and a proportionate approach. The comparison of the SGEI Package with other types of State aid regimes showed that it is not possible to draw meaningful conclusions as to whether the SGEI rules are more effective to provide (relevant) State aid than the other main EU State aid regimes **recorded in the EU scoreboard**[10]. Nevertheless, the Study found that the Package contributed overall to the facilitation of SGEI and to the simplification of requirements for SGEIs in healthcare and social services, though this opinion varied per type of stakeholder and sector consulted. A number of factors were identified as key for

[10] *State Aid Score Board 2019 – The State Aid Scoreboard is the European Commission's benchmarking instrument for State aid. It aims to provide transparent and publicly accessible information on the overall State aid situation in the Member States and on the Commission's State aid control activities, available at https://ec.europa.eu/competition/state_aid/scoreboard/state_aid_scoreboard_2019.pdf*

the simplification of the SGEI rules: (i) the notification exemption for healthcare and social housing and other social services; (ii) the notification exemption coupled with the SGEI de minimis ceiling; and (iii) the support provided by the Commission to implement the rules.

Despite the overall effectiveness of the SGEI Package, the Study identified that certain concepts included in the 2012 SGEI Package such as the determination of a reasonable profit and the distinction between an economic and non-economic activity were not always clear.

The factors which most impacted the implementation of the 2012 SGEI Package are linked to the interpretation of certain provisions, as further outlined under Section 3.5 and 3.6 below. Policy evolution as well as the economic situation of the Member State impacted the provision of SGEIs at different levels, depending on the market and sector. With regard to COVID-19, the Study found that its impacts were not yet visible, though it is expected that its economic impacts could lead to a higher demand for social housing. With regard to the healthcare sector, stakeholders considered that the COVID-19 crisis could have a long-term impact on the provision of State aid to ensure the sustainability of the hospital sector.

Efficiency of the 2012 SGEI Package

The 2012 SGEI Package helped to a certain extent in reducing administrative costs, especially due to the notification exemption and to the introduction of the SGEI de minimis ceiling. However, a meaningful reduction of administrative costs was not identified by the Study, particularly because stakeholders need to better understand specific rules and certain terms such as the definition of social housing and the distinction between an economic and non-economic activity. Instead of a reduction in administrative costs, national authorities generally rather observed a shift of those costs from the preparation and submission of notifications to other activities associated with SGEI (i.e. focusing on the provision of guidance to national actors, on awareness-raising sessions etc.). The Study also found that administrative costs for the Commission remained relatively stable.

With regard to the distortion of competition, the Study found that while no clear distortion of competition was identified *between* Member States, a risk of distortion could exist *at national level* for private operators in relation to social housing. Stakeholders from this group outlined during the course of the Study that by facilitating the spending of public aid towards a certain category of providers (public and/or private non-for-profit), competition with other (private) providers is distorted since the later cannot benefit from the same conditions and have to offer their services for a higher price to compensate the absence of public funding.

Relevance of the 2012 SGEI Package

The revision of the 2005 Package that led to the adoption of the 2012 SGEI Package was built upon the need to adapt to market developments. For healthcare, demand was rising while the landscape of healthcare providers was quickly evolving with a growing share of private providers competing with public ones. At the time, the approach to address these needs through clarification, simplification and a diversified approach was found to be the right approach to address the needs, since simplification was achieved to a large extent by maintaining the notification exemption and adopting the SGEI de minimis Regulation. In relation to social housing, demand was rising with housing related expenses taking a growing share of household budgets. The aftermath of the 2008 economic crisis pushed a growing share of population into poverty leading to an increasing demand for social housing. In the meantime, public expenditure towards social housing in general was decreasing due to budgetary constraints.

While the Study found the 2012 SGEI Package to be relevant to address the needs overall, evolving needs in relation to social housing were considered by a large group of stakeholders to be insufficiently addressed. The definition of social housing, as provided in recital 11 of the 2012 SGEI Decision, was perceived by a number of stakeholders as the provision which was least adapted to the evolving needs in the Member States. Due to the existing housing shortages and to the expected impacts of COVID-19 on household income, the Study identified the definition of 'social housing' to be the provision requiring greater attention to meet existing and evolving needs.

Challenges were also identified in relation to the relevance of the 2012 SGEI Package for the healthcare sector. A need was identified to agree on a clearer distinction between economic and non-economic activities in relation to the healthcare sector, particularly in relation to information and communication technologies ("ICT") or research, which are playing a greater role in the healthcare field.

The Study found that the approach adopted to facilitate the provision of SGEIs through the notification exemption for healthcare and social services and the EUR 500,000 per three years de minimis ceiling was still justified in the current market environment, even if several stakeholders argued that the de minimis ceiling was not high enough.

EU Added Value of the 2012 SGEI Package

The 2012 SGEI Package, overall, succeeded in its key objectives. Through the continuation of key elements of the 2005 Package, the 2012 SGEI Package facilitated the provision of SGEIs while maintaining State aid control, contributing to the simplification of requirements for SGEIs in healthcare and social housing. The 2012 SGEI Package also led to the clarification of rules relating to the provision of State aid in order to ensure that the path for the State aid expenditure is clearer at national level. The 2012 SGEI Package's added value lies in ensuring a continuation of State aid rules. Nevertheless, this added value varies depending on the national context and the manner in which Member States consider healthcare and/or social housing as services of general economic interest.

Résumé

Portée de l'étude

EY a été mandaté par la DG Concurrence pour réaliser une "Étude sur les tendances du marché dans les services sociaux et de santé et les implications pour les aides d'État de l'UE". L'objectif de l'étude était d'aider la Commission à répondre aux questions évaluatives concernant l'efficacité, l'efficience, la pertinence et la valeur ajoutée européenne du paquet SIEG de la Commission de 2012, qui définit les conditions dans lesquelles les aides d'État sous forme de compensation de service public peuvent être considérées comme compatibles avec les règles de l'UE. L'objectif pratique de l'étude était de fournir à la Commission des données factuelles concernant l'organisation des secteurs des soins de santé et du logement social dans les 10 États membres couverts par l'étude.

L'étude comportait deux volets - le **secteur des soins de santé** (avec un accent sur les hôpitaux) et le **secteur du logement social**. Ces secteurs sont couverts par l'article 2, paragraphe 1, points b) et c), de la décision SIEG[11]. Avec la communication SIEG[12], l'encadrement SIEG[13] et le règlement de minimis SIEG[14], ils forment le "paquet SIEG".

Concernant la **portée géographique de l'étude**, cette dernière s'est concentrée sur les États membres suivants : France, Irlande, Allemagne, République tchèque, Lettonie, Portugal, Roumanie, Croatie, Suède et Pays-Bas.

L'étude s'est focalisée sur quatre tâches principales :

1. Fournir un aperçu des tendances sectorielles et du marché depuis 2012 ;

[11] *Décision de la Commission du 20 décembre 2011 concernant l'application de l'article 106, paragraphe 2, du traité sur le fonctionnement de l'Union européenne aux aides d'État sous forme de compensations de service public octroyées à certaines entreprises chargées de la gestion de services d'intérêt économique général JO L 7 du 11.1.2012, p. 3-10, disponible à l'adresse https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012D0021.*
L'article 2 (1) (b) et (c) stipule : " La présente décision s'applique aux aides d'État sous forme de compensations de service public, accordées aux entreprises chargées de la gestion de services d'intérêt économique général visés à l'article 106, paragraphe 2, du traité, qui relèvent de l'une des catégories suivantes : [...] b)compensation pour la prestation de services d'intérêt économique général par des hôpitaux fournissant des soins médicaux, y compris, le cas échéant, des services d'urgence ; l'exercice d'activités auxiliaires directement liées aux activités principales, notamment dans le domaine de la recherche, ne fait toutefois pas obstacle à l'application du présent paragraphe ; c)compensation pour la prestation de services d'intérêt économique général répondant à des besoins sociaux en matière de soins de santé et de soins de longue durée, de garde d'enfants, d'accès et de réinsertion sur le marché du travail, de logement social et de prise en charge et d'inclusion sociale des groupes vulnérables".
[12] *Communication de la Commission sur l'application des règles de l'Union européenne en matière d'aides d'État aux compensations accordées pour la fourniture de services d'intérêt économique général JO C 8 du 11.1.2012, p. 4-14, disponible à l'adresse https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A52012XC0111%2802%29.*
[13] *L'encadrement SIEG se compose de la communication de la Commission de 2012 sur l'application des règles de l'Union européenne en matière d'aides d'État aux compensations accordées pour la fourniture de services d'intérêt économique général, de la décision de la Commission du 20 décembre sur l'application de l'article 106, paragraphe 2, du traité sur le fonctionnement de l'Union européenne aux aides d'État sous forme de compensations de service public accordées à certaines entreprises chargées de la gestion de services d'intérêt économique général, la communication de la Commission intitulée "Encadrement communautaire des aides d'État sous forme de compensations de service public et règlement de la Commission concernant l'application des articles 107 et 108 du traité sur le fonctionnement de l'Union européenne aux aides de minimis octroyées aux entreprises fournissant des services d'intérêt économique général", disponible à l'adresse suivante : https ://ec.europa.eu/competition/state_aid/legislation/sgei.html*
[14] *Règlement (UE) n° 360/2012 de la Commission du 25 avril 2012 concernant l'application des articles 107 et 108 du traité sur le fonctionnement de l'Union européenne aux aides de minimis octroyées aux entreprises fournissant des services d'intérêt économique général, JO L 114 du 26.4.2012, p. 8-13, disponible à l'adresse https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012R0360.*

2. Analyser l'évolution de la concurrence sur le marché depuis 2012 ;
3. Examiner dans quelle mesure les États membres sont conscients des implications possibles des tendances politiques et du marché en matière d'aides d'État ;
4. Répondre aux questions évaluatives.

L'étude était "rétrospective", se concentrant à ce titre sur la période suivant l'entrée en vigueur de la décision SIEG en 2012. Toutefois, la période antérieure à 2012 (lorsque la décision[15] SIEG de 2005 était en vigueur), a également été prise en compte afin d'entreprendre une analyse contrefactuelle. Si l'étude s'est principalement intéressée aux évolutions du Paquet 2012 jusqu'à fin décembre 2019, elle a aussi pris en compte l'impact de la crise liée au COVID-19 sur les secteurs (impact évoqué notamment lors de la collecte des données). Le COVID-19 n'était ainsi pas le point central de l'étude mais a été considéré comme un " facteur externe " ayant un impact sur les secteurs de la santé et du logement social.

Méthodologie de l'étude

L'étude s'est concentrée sur un **certain nombre d'outils de collecte de données** afin de recueillir des données quantitatives et qualitatives.

L'un des principaux outils de la méthodologie a été l'**examen des documents** afin de recueillir des données quantitatives et qualitatives sur les tendances du marché en relation avec l'application du paquet SIEG 2012. L'objectif était de permettre une bonne compréhension des principaux changements apportés par le paquet SIEG 2012, des enjeux mais aussi des évolutions en termes de marché, de politiques ou de réformes nationales. A ces fins ont été consultés des documents législatifs, des documents d'institutions internationales, des rapports d'ONG et de groupes de réflexion, des rapports nationaux et des contributions écrites envoyées par les personnes interrogées et ayant répondu aux questionnaires déployés dans le cadre de l'étude.

Des **recherches statistiques approfondies** ont également été nécessaires pour recueillir les données quantitatives requises pour l'étude. Les rapports biannuels des SIEG des États membres (qui doivent être soumis en vertu de l'article 9 de la décision SIEG) ont fourni une vue d'ensemble des dépenses liées aux SIEG dans les États membres couverts par l'étude tandis que les bases de données de l'OCDE et d'Eurostat ont quant à eux permis une vue d'ensemble des dépenses des États membres liées aux soins de santé et au logement ainsi que des tendances européennes. Les bases de données statistiques nationales ont complété ces données et ont fourni des détails sur certaines tendances sectorielles.

Des **entretiens** ont été menés diverses parties prenantes: autorités nationales/locales en charge des secteurs des soins de santé ou/et du logement social ; autorités nationales/locales en charge de la mise en œuvre et du suivi des SIEG ; prestataires (soins de santé et logement social) ; associations nationales d'industriels et de consommateurs ; et ONG et associations européennes (89 au total). Les entretiens visaient à fournir des données qualitatives sur l'efficacité, l'efficience, la pertinence et la valeur ajoutée européenne du paquet SIEG 2012. Une **enquête en ligne** a également été envoyée aux groupes de parties prenantes susmentionnés au niveau national. 53 parties prenantes ont répondu, couvrant l'ensemble des États membres entrant dans le champ de l'étude. L'analyse de l'enquête en ligne a été complétée par l'analyse des

[15] *Décision de la Commission du 28 novembre 2005 concernant l'application de l'article 86, paragraphe 2, du traité CE aux aides d'État sous forme de compensations de service public octroyées à certaines entreprises chargées de la gestion de services d'intérêt économique général JO L 312/67 du 29.11.2005, disponible à l'adresse https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32005D0842.*

réponses à la consultation publique ouverte de la Commission et à la consultation ciblée diffusée avant le lancement de l'étude.

Enfin, **10 Fiches des États membres** ont été préparées pour les États membres couverts par l'étude afin de fournir une vue d'ensemble de : (i) la situation du marché dans les secteurs des soins de santé et du logement social ; (ii) les réformes ayant eu un impact sur le paysage législatif et le cadre réglementaire au sein des États membres ; (iii) les dépenses publiques pour les soins de santé et le logement social ainsi que (iv) l'évolution du nombre et du type de prestataires et la concurrence.

Principales conclusions

Aperçu des tendances sectorielles et du marché

Les soins de santé et le logement social sont organisés selon des modalités qui reflètent les contextes nationaux des États membres, entraînant ainsi des divergences dans l'adoption des dispositions relatives aux SIEG 2012.

Concernant les soins de santé, la diversité des approches quant à la manière dont les services de santé sont organisés dans un État membre et la variété des acteurs impliqués(tant publics que privés) peuvent avoir un impact sur la manière dont le paquet SIEG est mis en œuvre au niveau national. Dans la plupart des États membres couverts par l'étude, les services de santé sont financés par des fonds publics, soit directement par le budget de l'État, soit par des régimes d'assurance maladie. Deux tendances ont été identifiées par l'étude et ont eu des implications sur l'application du paquet SIEG : (i) la libéralisation globale du secteur des soins de santé (en ce qui concerne la fourniture et l'assurance) et (ii) la présence d'un système d'égalisation des risques dans certains États membres. La divergence des approches conduit certains États membres à ne pas considérer le financement des hôpitaux comme relevant des règles relatives aux SIEG.

Concernant le logement social, le marché européen du logement dans son ensemble est actuellement confronté à de multiples défis et différentes études ont qualifié la situation de "crise" du logement en raison du **risque croissant d'exclusion de la population sur le marché du logement et d'un nombre grandissant de ménages menacés de pauvreté**. Actuellement, environ 37,8 % des ménages en situation de risque de pauvreté dans l'UE consacrent en effet plus de 40 % de leur revenu disponible aux frais de logement[16], les prix de ces derniers étant en constante augmentation[17]. Les définitions du logement social et l'étendue des services de logement social relevant des règles SIEG varient dans les États membres couverts par l'étude. Ces variations reflètent ainsi les contextes nationaux et sont la preuve de la libre interprétation des Etats membres quant au périmètre d'éligibilité au logement social. Tous les États membres entrant dans le champ de l'étude ne définissent pas le logement social comme un SIEG. Les divergences dans les définitions du logement social entraînent donc également des différences dans la comparabilité et renforcent la rareté des données concernant ce secteur.

La part des logements sociaux dans le parc total de logements varie au sein des États membres définissant le logement social comme un SIEG. À titre d'exemple, le logement social représentait 38 % du parc total de logements aux Pays-Bas en 2018 (constituant ainsi le taux le plus élevé parmi les Etats membres étudiés), contre 13-14 % en Irlande et en France et seulement 0,4 % en République tchèque (en 2011). En Lettonie et au Portugal où le logement social n'est pas défini comme un SIEG, ce dernier représente seulement 2% du parc total de logements en 2015. [18]Concernant les fournisseurs de

[16] *Housing Europe, La situation du logement dans l'UE 2019.*
[17] *Commission européenne, Semestre européen : Rapports par pays, 2020*
[18] *Composition de l'AE à partir des fiches des États membres et de l'OCDE, base de données sur le logement abordable.*

logements sociaux, les seuls États membres dans lesquels ces derniers sont exclusivement des autorités publiques sont la Roumanie et la Suède, les autres États membres incluant d'autres acteurs tels que des organisations à but non lucratif ou des entités semi-publiques.

Évolution de la concurrence sur le marché depuis 2012

Concernant le secteur des soins de santé, les dépenses de santé ont augmenté dans tous les États membres couverts par l'étude entre 2013 et 2018. Malgré cette augmentation, les dépenses de santé en pourcentage du PIB ont été stables entre 2013 et 2018, avec une forte variation observée uniquement dans un État membre (Irlande) où la part a diminué de 3,5 points de pourcentage. Plus spécifiquement, les dépenses hospitalières ont augmenté entre 2013 et 2018 dans tous les États membres couverts par l'étude quand bien même le nombre d'hôpitaux a diminué : il y avait en effet en moyenne 33 hôpitaux par million d'habitants en 2013 pour 30 hôpitaux par million d'habitants en 2018 (-8%)[19]. Cette tendance pourrait notamment être expliquée par l'évolution de la législation visant à réduire les coûts et à renforcer les droits des patients en encourageant les acteurs privés à entrer sur le marché. L'étude a toutefois constaté que la présence d'hôpitaux publics à but non lucratif et privés à but lucratif dans un État membre n'entraîne pas nécessairement une concurrence entre ces deux types acteurs, étant donné la différence de services fournis par ces derniers.

Concernant le secteur du logement social, l'absence de prestataires privés sur le marché dans la majorité des États membres entrant dans le champ de l'étude convient d'être notée. Pour les États membres où le logement social n'est pas considéré comme un SIEG (Croatie, Lettonie, Portugal et Roumanie), aucun acteur privé n'est en place, les prestataires étant principalement des autorités ou des organisations publiques. Pour les États membres considérant le logement social comme un SIEG (République tchèque, France et Pays-Bas), la situation est similaire et aucune évolution en faveur de l'intégration de prestataires privé ne se dessine : seuls les acteurs publics et/ou à but non lucratif sont actifs dans le secteur du logement social. Toutefois, des exceptions peuvent être notées notamment en Allemagne et en Irlande où des prestataires à but lucratif sont actifs et où les acteurs privés possèdent trois cinquièmes du parc de logements sociaux locatifs. L'un des principaux facteurs expliquant la libéralisation croissante du marché du logement social en Allemagne est la privatisation de la *Wohnungsgemeinnützigkeit* (le logement d'intérêt public), les acteurs privés étant considérés à ce titre comme des fournisseurs importants de logements sociaux. En Irlande, l'importance croissante du secteur privé, initiée pendant les années de prospérité (du milieu des années 1990 à la fin des années 2000 avant la crise économique de 2008) par le biais du programme *Rental Accommodation Scheme* (2004-2007), s'est accélérée pendant la récession (2008-2012).

Sensibilisation des États membres aux implications possibles sur les aides d'État

L'étude a révélé que le niveau de connaissance des règles dépend du degré d'implication des parties prenantes dans les SIEG. Parmi les autorités nationales, le niveau de sensibilisation dépend de leur relation de travail avec le paquet SIEG 2012. Il a été constaté que le département des affaires européennes, l'unité en charge des aides d'État ou encore un département équivalent traitant des aides d'État sont généralement et logiquement plus au courant des règles relatives aux SIEG que les autres composantes des administrations publiques. Le degré de sensibilisation varie également entre les autorités centrales et locales. Les municipalités, par exemple, sont souvent moins au courant des règles relatives aux SIEG. Dans l'ensemble, l'étude conclut que les opérateurs sont plus au courant des règles nationales mettant en œuvre le paquet SIEG

[19] *Base de données de l'OCDE*

2012 que du paquet lui-même. En outre, entre les différents opérateurs, ceux qui sont en charge des SIEG sont au fait des exigences que ceux qui n'en sont pas en charge. Le niveau de connaissance varie également entre le secteur hospitalier et le secteur du logement social, les acteurs du secteur du logement social ayant un niveau de connaissance plus élevé des règles SIEG, ce qui pourrait s'expliquer par la taille globale du secteur et le nombre d'acteurs impliqués (tous deux plus petits). Dans l'ensemble, si l'on considère la période 2012 à 2019, l'étude a révélé que la connaissance des règles SIEG pourrait être améliorée pour assurer une plus grande adoption de SIEG.

Efficacité du paquet SIEG 2012

L'objectif primordial du paquet SIEG de 2012 était de faciliter la fourniture de SIEG par le biais de sous-objectifs relatifs à la clarification, à la simplification et à une approche proportionnée. La comparaison du paquet SIEG avec d'autres types de régimes d'aides d'État a montré qu'il n'est pas possible de tirer des conclusions significatives permettant de déterminer si les règles relatives aux SIEG sont plus efficaces pour fournir des aides d'État que les autres principaux régimes d'aides d'État de l'UE **enregistrés dans le tableau de bord de l'UE** [20]. Néanmoins, l'étude a montré que le paquet a globalement contribué à faciliter les SIEG et à simplifier les exigences relatives aux SIEG dans le domaine des soins de santé et des services sociaux, bien que cette opinion varie selon le type de partie prenante et de secteur consulté. Un certain nombre de facteurs ont été identifiés comme essentiels pour la simplification des règles relatives aux SIEG : (i) l'exemption de notification pour les soins de santé, le logement social et les autres services sociaux ; (ii) l'exemption de notification associée au plafond de minimis des SIEG ; et (iii) le soutien apporté par la Commission pour la mise en œuvre des règles.

Malgré l'efficacité globale du paquet SIEG, l'étude a identifié que certains concepts inclus dans le paquet SIEG 2012, tels que la détermination d'un bénéfice raisonnable et la distinction entre une activité économique et non économique, n'étaient pas toujours clairs.

Les facteurs ayant eu le plus d'impact sur la mise en œuvre du paquet SIEG 2012 sont liés à l'interprétation de certaines dispositions, comme le soulignent les sections 3.5 et 3.6 présentées ci-après. L'évolution des contextes politiques ainsi que de la situation économique de l'État membre a eu un impact sur la fourniture de SIEG à différents niveaux, en fonction du marché et du secteur. En ce qui concerne la COVID-19, l'étude a constaté que ses effets n'étaient pas encore visibles, bien que l'on s'attende à ce que ses répercussions économiques entraînent une hausse de la demande de logements sociaux. En ce qui concerne le secteur des soins de santé, les parties prenantes ont estimé que la crise de la COVID-19 pourrait avoir un impact à long terme sur l'octroi d'aides d'État pour assurer la viabilité du secteur hospitalier.

Efficience du paquet SIEG 2012

Le paquet SIEG 2012 a contribué dans une certaine mesure à réduire les coûts administratifs, notamment grâce à l'exemption de notification et à l'introduction du plafond de minimis pour les SIEG. Toutefois, l'étude n'a pas permis d'identifier une réduction significative des coûts administratifs, notamment parce que les parties prenantes doivent mieux comprendre les règles spécifiques, certains termes (tels que la définition du logement social) ainsi que la distinction entre une activité économique et non économique. A défaut d'une réduction des coûts administratifs, les autorités nationales ont plutôt observé un transfert de ces coûts de la préparation et de la

[20] *Tableau de bord des aides d'État 2019 - Le tableau de bord des aides d'État est l'instrument d'évaluation comparative des aides d'État de la Commission européenne. Il vise à fournir des informations transparentes et accessibles au public sur la situation générale des aides d'État dans les États membres et sur les activités de contrôle des aides d'État de la Commission, disponibles à l'adresse suivante : https://ec.europa.eu/competition/state_aid/scoreboard/state_aid_scoreboard_2019.pdf.*

soumission des notifications vers d'autres activités liées aux SIEG (telles que la fourniture de conseils aux acteurs nationaux, la mise en place de sessions de sensibilisation, etc.). L'étude a également révélé que les coûts administratifs de la Commission sont restés relativement stables.

En ce qui concerne la distorsion de la concurrence, l'étude a constaté que si aucune distorsion de la concurrence n'a été clairement identifiée *entre les* États membres, un risque de distorsion pourrait exister selon les opérateurs privés *au niveau national* en ce qui concerne le logement social. Les parties prenantes de ce groupe ont souligné au cours de l'étude qu'en facilitant l'affectation des aides publiques à une certaine catégorie de prestataires (publique et/ou privé sans but lucratif), la concurrence avec d'autres prestataires (privés) est faussée puisque ces derniers ne peuvent bénéficier des mêmes conditions et doivent offrir leurs services à un prix plus élevé pour compenser l'absence de financement public.

Pertinence du paquet SIEG 2012

La révision du paquet 2005, qui a conduit à l'adoption du paquet SIEG 2012, était fondée sur la nécessité de s'adapter aux évolutions du marché. Dans le domaine des soins de santé, la demande augmentait tandis que le paysage des prestataires de soins de santé évoluait rapidement avec une part croissante de prestataires privés en concurrence avec les prestataires publics. À l'époque, l'approche consistant à répondre à ces besoins par la clarification, la simplification et par la mise en place d'une approche diversifiée a été jugée appropriée, la simplification ayant été réalisée dans une large mesure par le maintien de l'exemption de notification et l'adoption du règlement de minimis sur les SIEG. En ce qui concerne le logement social, la demande ayant augmenté, les dépenses liées au logement représentant une part croissante du budget des ménages. Les conséquences de la crise économique de 2008 ont plongé une part plus importante de la population dans la pauvreté, ce qui a entraîné une augmentation de la demande de logements sociaux. Dans le même temps, les dépenses publiques en faveur du logement social en général ont diminué en raison de contraintes budgétaires.

Bien que l'étude ait conclu que le paquet SIEG 2012 était pertinent pour répondre aux besoins dans leur ensemble, les besoins évolutifs en matière de logement social ont été considérés par un grand groupe de parties prenantes comme insuffisamment pris en compte. La définition du logement social, telle qu'elle figure au considérant 11 de la décision SIEG 2012, a été perçue par un certain nombre de parties prenantes comme la disposition la moins adaptée à l'évolution des besoins dans les États membres. En raison des pénuries de logements existantes et des impacts attendus de la COVID-19 sur le revenu des ménages, l'étude a identifié la définition du "logement social" comme la disposition nécessitant une plus grande attention pour répondre aux besoins existants et en évolution.

Des défis ont également été identifiés en ce qui concerne la pertinence du paquet SIEG 2012 pour le secteur des soins de santé. Il est nécessaire de convenir d'une distinction plus claire entre les activités économiques et non économiques dans le secteur des soins de santé, notamment en ce qui concerne les technologies de l'information et de la communication (« TIC ») ou la recherche, qui jouent un rôle plus important dans ce domaine.

L'étude a montré que l'approche adoptée pour faciliter la fourniture de SIEG par l'exemption de notification pour les services sociaux et de santé et le plafond de minimis de 500 000 euros par trois ans était toujours justifiée dans l'environnement de marché actuel, même si plusieurs parties prenantes ont fait valoir que le plafond de minimis n'était pas assez élevé.

Valeur ajoutée européenne du paquet SIEG 2012

Dans l'ensemble, le paquet SIEG 2012 a atteint ses principaux objectifs. Grâce à la poursuite des éléments clés du paquet 2005, le paquet SIEG 2012 a facilité la fourniture de SIEG tout en maintenant le contrôle des aides d'État, en contribuant à la simplification des exigences relatives aux SIEG dans le domaine des soins de santé et du logement social. Le paquet SIEG 2012 a également conduit à la clarification des règles relatives à la fourniture d'aides d'État afin de garantir que la trajectoire des dépenses liées aux aides d'État soit plus claire au niveau national. La valeur ajoutée du paquet SIEG 2012 réside dans la garantie du maintien des règles relatives aux aides d'État. Néanmoins, cette valeur ajoutée varie en fonction du contexte national et de la manière dont les États membres considèrent les soins de santé et/ou le logement social comme des services d'intérêt économique général.

Kurzfassung

Umfang der Studie

EY wurde von der DG Competition mit der Durchführung einer "Studie über Markttendenzen in den Bereichen Gesundheits- und Sozialdienstleistungen und Auswirkungen auf staatliche Beihilfen in der EU" beauftragt. Ziel der Studie war es, die Kommission bei der Beantwortung von Bewertungsfragen zur Wirksamkeit, Effizienz, Relevanz und zum EU-Mehrwert des DAWI-Pakets der Kommission aus dem Jahr 2012 zu unterstützen. Dieses Paket legt die Bedingungen fest, unter denen staatliche Beihilfen in Form von Ausgleichszahlungen für öffentliche Dienstleistungen als mit den EU-Vorschriften vereinbar angesehen werden können. Das praktische Ziel der Studie war es, der Kommission Daten und Fakten über die Organisation des Gesundheitswesens und des sozialen Wohnungsbaus in den zehn von der Studie erfassten Mitgliedstaaten zu liefern.

Die Studie hatte eine doppelte Abdeckung - den **Gesundheitssektor** (mit Schwerpunkt auf Krankenhäusern) und den **Sektor des sozialen Wohnungsbaus**. Diese Sektoren werden von Artikel 2 Absatz 1 Buchstaben b und c des DAWI-Beschlusses erfasst[21]. Zusammen mit der DAWI-Mitteilung[22], dem DAWI-Rahmen[23] und der DAWI-De-minimis-Verordnung[24] bilden sie das "DAWI-Paket".

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[21] *Beschluss der Kommission vom 20. Dezember 2011 über die Anwendung von Artikel 106 Absatz 2 des Vertrags über die Arbeitsweise der Europäischen Union auf staatliche Beihilfen in Form von Ausgleichsleistungen zugunsten bestimmter Unternehmen, die mit der Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse betraut sind (Bekanntgegeben unter Aktenzeichen K(2011) 9380) Text von Bedeutung für den EWR, ABl. L 7 vom 11.1.2012, S. 3-10, abrufbar unter https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012D0021*
In Artikel 2 Absatz 1 Buchstaben b) und c) heißt es: "Diese Entscheidung gilt für staatliche Beihilfen in Form von Ausgleichszahlungen für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse im Sinne von Artikel 106 Absatz 2 EG-Vertrag, die unter eine der folgenden Kategorien fallen: […] b) Ausgleichszahlungen für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse durch Krankenhäuser, die medizinische Versorgung, gegebenenfalls einschließlich Notdiensten, anbieten; die Ausübung von Nebentätigkeiten, die in direktem Zusammenhang mit der Haupttätigkeit stehen, insbesondere im Bereich der Forschung, steht der Anwendung dieses Absatzes jedoch nicht entgegen; c) Ausgleichszahlungen für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse, die soziale Bedürfnisse in den Bereichen Gesundheitsversorgung und Langzeitpflege, Kinderbetreuung, Zugang zum und Wiedereingliederung in den Arbeitsmarkt, sozialer Wohnungsbau sowie Betreuung und soziale Eingliederung von schutzbedürftigen Gruppen erfüllen".

[22] *Mitteilung der Kommission über die Anwendung der EU-Beihilfevorschriften auf Ausgleichsleistungen für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse, ABl. C 8 vom 11.1.2012, S. 4-14, abrufbar unter https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A52012XC0111%2802%29*

[23] *Der DAWI-Rahmen besteht aus der Mitteilung der Kommission aus dem Jahr 2012 über die Anwendung der EU-Beihilfevorschriften auf Ausgleichsleistungen für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse, dem Beschluss der Kommission vom 20. Dezember über die Anwendung von Artikel 106 Absatz 2 des Vertrags über die Arbeitsweise der Europäischen Union auf staatliche Beihilfen, die bestimmten mit der Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse betrauten Unternehmen als Ausgleich gewährt werden, der Mitteilung der Kommission - Gemeinschaftsrahmen für staatliche Beihilfen, die als Ausgleich für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse gewährt werden, und der Verordnung der Kommission über die Anwendung der Artikel 107 und 108 des Vertrags über die Arbeitsweise der Europäischen Union auf De-minimis-Beihilfen an Unternehmen, die Dienstleistungen von allgemeinem wirtschaftlichem Interesse erbringen, abrufbar unter https://ec.europa.eu/competition/state_aid/legislation/sgei.html*

[24] *Verordnung (EU) Nr. 360/2012 der Kommission vom 25. April 2012 über die Anwendung der Artikel 107 und 108 des Vertrags über die Arbeitsweise der Europäischen Union auf De-minimis-Beihilfen an Unternehmen, die Dienstleistungen von allgemeinem wirtschaftlichem Interesse erbringen, O J L 114 vom 26.4.2012, S. 8-13, abrufbar unter https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012R0360.*

Was den **geografischen Umfang der Studie** betrifft, so konzentrierte sie sich auf die folgenden Mitgliedstaaten: Frankreich, Irland, Deutschland, die Tschechische Republik, Lettland, Portugal, Rumänien, Kroatien, Schweden und die Niederlande.

Die Studie konzentrierte sich auf vier Hauptaufgaben:

1. Die Verfügungsstellung eines Überblicks über Branchen- und Markttendenzen seit 2012 ;
2. Eine Analyse, wie sich der Wettbewerb auf dem Markt seit 2012 entwickelt hat;
3. Die Untersuchung, inwieweit sich die Mitgliedstaaten der möglichen Auswirkungen von Politik- und Markttendenzen auf staatliche Beihilfen bewusst sind;
4. Die Beantwortung der Bewertungsfragen.

Die Studie war "rückwärtsgewandt" und konzentrierte sich auf den Zeitraum nach dem Inkrafttreten des DAWI-Beschlusses im Jahr 2012. Allerdings wurde auch der Zeitraum vor 2012, als der DAWI-Beschluss von 2005 [25] in Kraft war, betrachtet, um eine kontrafaktische Analyse vorzunehmen. Während die Studie die Entwicklungen seit dem Paket von 2012 bis Ende Dezember 2019 betrachtete, wurden die Auswirkungen von COVID-19 auf die Sektoren während der Datenerhebung angesprochen. COVID-19 war nicht der Schwerpunkt der Studie, wurde aber als "externer Faktor" betrachtet, der sich auf die Sektoren Gesundheitswesen und sozialer Wohnungsbau auswirkte.

Methodik der Studie

Die Studie konzentrierte sich auf eine **Reihe von Datenerfassungsinstrumenten**, um sowohl quantitative als auch qualitative Daten zu sammeln.

Ein zentrales Instrument der Methodik war die **Dokumentenprüfung**, um sowohl quantitative als auch qualitative Daten zu Markttendenzen in Bezug auf die Anwendung des DAWI-Pakets 2012 zu sammeln. Ziel war es, ein umfassendes Verständnis der wichtigsten Änderungen, die das DAWI-Paket 2012 mit sich gebracht hat, der anstehenden Fragen, aber auch der Entwicklungen in Bezug auf den Markt, die Politik oder nationale Reformen zu erhalten. Für die Studie wurden legislative Dokumente, Dokumente von internationalen Institutionen, Berichte von NGOs und Think Tanks, nationale Berichte sowie schriftliche Beiträge von Befragten, die für die Studie eingesetzte Fragebögen beantwortet haben, analysiert.

Um die erforderlichen quantitativen Daten für die Studie zu sammeln, waren auch **eingehende statistische Untersuchungen** erforderlich. Die zweijährlichen DAWI-Berichte der Mitgliedstaaten, die sie gemäß Artikel 9 des DAWI-Beschlusses vorlegen müssen, lieferten einen Überblick über die Ausgaben im Zusammenhang mit DAWI in den von der Studie erfassten Mitgliedstaaten. Die Datenbanken der OECD und von Eurostat lieferten einen Überblick über die Ausgaben der Mitgliedstaaten im Zusammenhang mit der Gesundheitsversorgung und dem Wohnungswesen sowie über die europäischen Tendenzen. Die nationalen statistischen Datenbanken ergänzen diese Daten und liefern Einzelheiten zu bestimmten sektoralen Tendenzen.

Es wurden **Interviews** mit Interessenvertretern aus folgenden Bereichen durchgeführt: nationale/lokale Behörden, die für das Gesundheitswesen oder/und den sozialen Wohnungsbau zuständig sind; nationale/lokale Behörden, die für die Umsetzung und Überwachung von DAWI verantwortlich sind; Anbieter (Gesundheitswesen und sozialer Wohnungsbau); nationale Industrie- und Verbraucherverbände; und EU-NGOs und

[25] *Entscheidung der Kommission vom 28. November 2005 über die Anwendung von Artikel 86 Absatz 2 EG-Vertrag auf staatliche Beihilfen, die bestimmten mit der Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse betrauten Unternehmen als Ausgleich gewährt werden, ABl. L 312/67 vom 29.11.2005, abrufbar unter https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32005D0842*

Verbände (insgesamt 89). Ziel der Interviews war es, qualitative Daten in Bezug auf die allgemeine Effektivität, Effizienz, Relevanz und den EU-Mehrwert des DAWI-Pakets 2012 zu erhalten. Eine **Online-Umfrage** wurde an die oben genannten Teilhaber-Gruppen auf nationaler Ebene verschickt. Es antworteten 53 Teilhaber, die alle Mitgliedsstaaten abdeckten, die in den Anwendungsbereich der Studie fallen. Die Analyse der Online-Umfrage wurde ergänzt durch die Analyse der Antworten auf die offene öffentliche Konsultation der Kommission und die gezielte Konsultation, die vor dem Start der Studie verbreitet wurde.

Schließlich wurden für die von der Studie erfassten Mitgliedstaaten **10 Member State Fiches** erstellt, um einen Überblick zu geben über: die Marktsituation in den Sektoren Gesundheitswesen und sozialer Wohnungsbau; die Reformen, die sich auf die Gesetzeslandschaft und den regulatorischen Rahmen in den Mitgliedstaaten ausgewirkt haben; und die staatlichen Ausgaben für das Gesundheitswesen und den sozialen Wohnungsbau sowie die Entwicklung der Anzahl und Art der Anbieter und des Wettbewerbs.

Wichtigste Ergebnisse

Überblick über Branchen- und Markttendenzen

Die Organisation des Gesundheitswesens und des sozialen Wohnungsbaus spiegelt den jeweiligen Kontext der Mitgliedstaaten wider, was zu Unterschieden bei der Umsetzung der Bestimmungen des DAWI-Pakets von 2012 führt.

In Bezug auf die Gesundheitsversorgung können sich die unterschiedlichen Ansätze, wie die Gesundheitsdienstleistungen in einem Mitgliedstaat organisiert sind, und die Vielfalt der beteiligten öffentlichen und privaten Akteure, auf die Art und Weise in der das DAWI-Paket auf nationaler Ebene umgesetzt wird, auswirken. In den meisten der in der Studie untersuchten Mitgliedstaaten werden Gesundheitsdienstleistungen aus öffentlichen Mitteln finanziert, entweder direkt über den Staatshaushalt oder über Krankenversicherungssysteme. In der Studie wurden zwei Tendenzen festgestellt, die Auswirkungen auf die Anwendung des DAWI-Pakets haben: (i) die allgemeine Liberalisierung des Gesundheitssektors (in Bezug auf die Bereitstellung und Versicherung) und (ii) das Vorhandensein eines Risikoausgleichssystems in einigen Mitgliedstaaten. Die unterschiedlichen Ansätze führen dazu, dass einige Mitgliedstaaten die Finanzierung von Krankenhäusern nicht als unter die DAWI-Vorschriften fallend betrachten.

In Bezug auf den sozialen Wohnungsbau sieht sich der gesamte europäische Wohnungsmarkt mit Herausforderungen konfrontiert und verschiedene Studien haben eine "Wohnungskrise" beschrieben, aufgrund des **wachsenden Risikos eines Ausschlusses der Bevölkerung aus dem Wohnungsmarkt und einer wachsenden Anzahl von Haushalten, die von Armut bedroht sind**. Derzeit geben etwa 37,8 % der armutsgefährdeten Haushalte in der EU über 40 % ihres verfügbaren Einkommens für Wohnkosten aus[26], wobei die Wohnungspreise ständig steigen[27]. Die Definitionen von Sozialwohnungen und der Umfang der Sozialwohnungsdienstleistungen, die unter die DAWI-Vorschriften fallen, variieren in den von der Studie erfassten Mitgliedsstaaten. Diese Unterschiede spiegeln die nationalen Kontexte und die Tatsache wider, dass jeder Mitgliedstaat seine eigene Interpretation darüber hat, wer Anspruch auf eine Sozialwohnung haben sollte. Nicht alle Mitgliedstaaten, die in den Geltungsbereich der Studie fallen, definieren Sozialwohnungen als DAWI. Die unterschiedlichen Definitionen des sozialen

[26] *Housing Europe, The state of housing in the EU 2019.*
[27] *Europäische Kommission, Europäisches Semester: Länderberichte, 2020*

Wohnungsbaus führen auch zu Unterschieden in der Vergleichbarkeit und Knappheit von Daten über diesen Sektor.

Der Anteil der Sozialwohnungen am Gesamtwohnungsbestand variiert zwischen den Mitgliedstaaten, die Sozialwohnungen als DAWI definieren. Am höchsten ist er beispielsweise in den Niederlanden, wo der Anteil der Sozialwohnungen am Gesamtwohnungsbestand 2018 38 % betrug, während er in Irland und Frankreich bei 13-14 % und in der Tschechischen Republik bei nur 0,4 % lag (im Jahr 2011). In Lettland und Portugal, wo der soziale Wohnungsbau nicht als Dienstleistung von allgemeinem wirtschaftlichem Interesse definiert ist, machte der soziale Wohnungsbau im Jahr 2015 2 % des gesamten Wohnungsbestands aus. Was [28]die Anbieter von Sozialwohnungen betrifft, so sind die einzigen Mitgliedstaaten, in denen die Anbieter von Sozialwohnungen nur Behörden sind, Rumänien und Schweden, während andere Mitgliedstaaten auch andere Akteure wie gemeinnützige Organisationen oder halbstaatliche Einrichtungen einbeziehen.

Entwicklung des Wettbewerbs auf dem Markt seit 2012

Für den Gesundheitssektor sind die Gesundheitsausgaben in allen von der Studie erfassten Mitgliedstaaten zwischen 2013 und 2018 gestiegen. Trotz dieses Anstiegs waren die Gesundheitsausgaben als Prozentsatz des BIP zwischen 2013 und 2018 stabil, wobei nur in einem Mitgliedstaat (Irland) eine große Abweichung zu beobachten war, da der Anteil um 3,5 Prozentpunkte sank. Die Krankenhausausgaben sind zwischen 2013 und 2018 in allen in der Studie erfassten Mitgliedstaaten spezifisch gestiegen. Dennoch ging die Anzahl der Krankenhäuser in den ausgewählten Mitgliedstaaten zurück, da es im Jahr 2013 durchschnittlich 33 Krankenhäuser pro Million Einwohner gab, während es 2018 30 Krankenhäuser pro Million Einwohner waren (-8 %) [29]. Die Entwicklung der Gesetzgebung zur Kostensenkung und Stärkung der Patientenrechte durch die Ermutigung privater Akteure zum Markteintritt könnte diese Tendenz erklären. Die Studie stellte jedoch fest, dass das Vorhandensein von öffentlichen, gemeinnützigen und privat-gewerblichen Krankenhäusern in einem Mitgliedstaat nicht unbedingt zu einem Wettbewerb zwischen diesen Akteuren führt. Dies ist auf die Unterschiede in den Dienstleistungen zurückzuführen, die von diesen Arten von Krankenhäusern angeboten werden.

Im Bereich des sozialen Wohnungsbaus gibt es in den meisten Mitgliedstaaten, die in den Geltungsbereich der Studie fallen, keine privaten Anbieter in großem Umfang auf dem Markt. In den Mitgliedstaaten, in denen der soziale Wohnungsbau nicht als Dienstleistung von allgemeinem wirtschaftlichem Interesse betrachtet wird (Kroatien, Lettland, Portugal und Rumänien), gibt es keine privaten Akteure; die Anbieter sind hauptsächlich öffentliche Behörden oder Organisationen. In den Mitgliedstaaten, in denen der soziale Wohnungsbau als Dienstleistung von allgemeinem wirtschaftlichem Interesse betrachtet wird (Tschechische Republik, Frankreich und die Niederlande), ist die Situation ähnlich: Es gibt keine Entwicklung in Bezug auf private Anbieter, da nur öffentliche und/oder gemeinnützige Akteure im sozialen Wohnungsbau tätig sind. In Deutschland und Irland sind jedoch auch gewinnorientierte Anbieter aktiv. In Deutschland besitzen private Akteure drei Fünftel des sozialen Mietwohnungsbestands. Einer der Hauptfaktoren, der die zunehmende Liberalisierung des sozialen Wohnungsmarktes erklärt, ist die Privatisierung der *Wohnungsgemeinnützigkeit*, wobei private Akteure als wichtige Anbieter von Sozialwohnungen gelten. In Irland hat sich die wachsende Bedeutung des privaten Sektors, die in den Boomjahren (Mitte der 1990er bis Ende der 2000er Jahre vor der Wirtschaftskrise 2008) durch das Rental

[28] *EY-Zusammensetzung aus Member State Fiches und OECD, Affordable housing database*
[29] *OECD-Datenbank*

Accommodation Scheme Programm (2004-2007) begonnen hatte, während der Rezession (2008-2012) beschleunigt.

Sensibilisierung der Mitgliedsstaaten für mögliche Auswirkungen von staatlichen Beihilfen

Die Studie ergab, dass der Bekanntheitsgrad der Regeln vom Grad der Beteiligung der Interessengruppen an den DAWI abhängt. Bei den nationalen Behörden hängt der Bekanntheitsgrad von ihrer Arbeitsbeziehung mit dem DAWI-Paket 2012 ab. Es wurde festgestellt, dass die Abteilung für europäische Angelegenheiten oder das für staatliche Beihilfen zuständige Referat oder eine gleichwertige Abteilung, die sich mit staatlichen Beihilfen befasst, in der Regel und logischerweise mehr über die DAWI-Regeln weiß als andere Teile der öffentlichen Verwaltungen. Der Grad des Bewusstseins variiert auch zwischen zentralen und lokalen Behörden. Gemeinden beispielsweise sind sich der DAWI-Vorschriften oft weniger bewusst. Insgesamt kam die Studie zu dem Schluss, dass die Betreiber eher die nationalen Vorschriften zur Umsetzung des DAWI-Pakets 2012 kennen als das Paket selbst. Darüber hinaus sind unter den Betreibern diejenigen, die für die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse zuständig sind, besser über die Anforderungen informiert als diejenigen, die dies nicht sind. Der Bekanntheitsgrad variiert auch zwischen dem Krankenhaus- und dem Sozialwohnungssektor, wobei die Akteure aus dem Sozialwohnungssektor einen höheren Bekanntheitsgrad der DAWI-Vorschriften haben, was durch die Gesamtgröße des Sektors und die Anzahl der beteiligten Akteure (beide kleiner) erklärt werden könnte. Insgesamt ergab die Studie mit Blick auf den Zeitraum 2012 bis 2019, dass die Kenntnis der DAWI-Regeln verbessert werden könnte, um eine größere Akzeptanz der DAWI zu gewährleisten.

Wirksamkeit des DAWI-Pakets 2012

Das übergreifende Ziel des DAWI-Pakets von 2012 war die Erleichterung der Dienstleistungserbringungen von allgemeinem wirtschaftlichem Interesse. Dieses Ziel sollte ermöglicht werden, durch eine stärkere Klarstellung, Vereinfachung und einen verhältnismäßigen Ansatz des DAWI-Pakets. Der Vergleich des DAWI-Pakets mit anderen Arten von Beihilferegelungen hat gezeigt, dass es nicht möglich ist, aussagekräftige Schlussfolgerungen darüber zu ziehen, ob die DAWI-Vorschriften für die Gewährung (relevanter) staatlicher Beihilfen wirksamer sind als die anderen [30]**im EU-Anzeiger aufgeführten** wichtigsten EU-Beihilferegelungen. Dennoch kam die Studie zu dem Ergebnis, dass das Paket insgesamt zur Erleichterung von DAWI und zur Vereinfachung der Anforderungen an DAWI im Gesundheits- und Sozialwesen beigetragen hat, auch wenn diese Meinung je nach Art der befragten Teilhaber und des Sektors variierte. Mehrere Faktoren wurden als entscheidend für die Vereinfachung der DAWI-Vorschriften identifiziert: (i) die Befreiung von der Meldepflicht für das Gesundheitswesen und den sozialen Wohnungsbau sowie für andere soziale Dienstleistungen; (ii) die Befreiung von der Meldepflicht in Verbindung mit der De-minimis-Obergrenze für DAWI; und (iii) die von der Kommission gewährte Unterstützung bei der Umsetzung der Vorschriften.

Trotz der allgemeinen Wirksamkeit des DAWI-Pakets wurde in der Studie festgestellt, dass bestimmte im DAWI-Paket 2012 enthaltene Konzepte wie die Ermittlung eines angemessenen Gewinns und die Unterscheidung zwischen einer wirtschaftlichen und einer nichtwirtschaftlichen Tätigkeit nicht immer klar waren.

[30] *Anzeiger für staatliche Beihilfen 2019 - Der Anzeiger für staatliche Beihilfen ist das Benchmarking-Instrument der Europäischen Kommission für staatliche Beihilfen. Er soll transparente und öffentlich zugängliche Informationen über die allgemeine Beihilfesituation in den Mitgliedstaaten und über die Tätigkeiten der Kommission im Bereich der Beihilfenkontrolle liefern und ist unter https://ec.europa.eu/competition/state_aid/scoreboard/state_aid_scoreboard_2019.pdf abrufbar.*

Die Faktoren, die sich am stärksten auf die Umsetzung des DAWI-Pakets 2012 auswirkten, hängen mit der Auslegung bestimmter Bestimmungen zusammen, wie in den Abschnitten 3.5 und 3.6 näher erläutert wird. Die politische Entwicklung sowie die wirtschaftliche Lage des Mitgliedstaats wirkten sich je nach Markt und Sektor auf unterschiedlichen Ebenen auf die Erbringung von DAWI aus. In Bezug auf die COVID-19 stellte die Studie fest, dass ihre Auswirkungen noch nicht sichtbar sind, obwohl erwartet wird, dass ihre wirtschaftlichen Auswirkungen zu einer höheren Nachfrage nach Sozialwohnungen führen könnten. In Bezug auf den Gesundheitssektor waren die Beteiligten der Ansicht, dass die COVID-19-Krise langfristige Auswirkungen auf die Bereitstellung staatlicher Beihilfen zur Sicherung der Nachhaltigkeit des Krankenhaussektors haben könnte.

Effizienz des DAWI-Pakets 2012

Das DAWI-Paket von 2012 hat bis zu einem gewissen Grad zur Verringerung der Verwaltungskosten beigetragen, insbesondere durch die Befreiung von der Meldepflicht und die Einführung der DAWI-De-minimis-Obergrenze. Eine nennenswerte Verringerung der Verwaltungskosten wurde in der Studie jedoch nicht festgestellt, insbesondere weil die Beteiligten bestimmte Vorschriften und bestimmte Begriffe wie die Definition des sozialen Wohnungsbaus und den Unterschied zwischen einer wirtschaftlichen und einer nichtwirtschaftlichen Tätigkeit besser verstehen müssen. Statt einer Verringerung der Verwaltungskosten beobachteten die nationalen Behörden im Allgemeinen eher eine Verlagerung dieser Kosten von der Vorbereitung und Einreichung von Anmeldungen auf andere Aktivitäten im Zusammenhang mit Dienstleistungen von allgemeinem wirtschaftlichem Interesse (d. h. Konzentration auf die Bereitstellung von Leitlinien für nationale Akteure, auf Sensibilisierungsveranstaltungen usw.). Die Studie ergab auch, dass die Verwaltungskosten für die Kommission relativ stabil blieben.

In Bezug auf die Wettbewerbsverzerrung ergab die Studie, dass zwar keine eindeutige Wettbewerbsverzerrung *zwischen den Mitgliedstaaten* festgestellt wurde, aber *auf nationaler Ebene* ein Risiko der Verzerrung für private Anbieter in Bezug auf den sozialen Wohnungsbau bestehen könnte. Interessenvertreter aus dieser Gruppe wiesen im Verlauf der Studie darauf hin, dass durch die Erleichterung der Ausgabe öffentlicher Mittel für eine bestimmte Kategorie von Anbietern (öffentliche und/oder private gemeinnützige Organisationen) der Wettbewerb mit anderen (privaten) Anbietern verzerrt wird, da letztere nicht von denselben Bedingungen profitieren können und ihre Dienstleistungen zu einem höheren Preis anbieten müssen, um das Fehlen öffentlicher Mittel auszugleichen.

Relevanz des DAWI-Pakets 2012

Die Überarbeitung des Pakets von 2005, die zur Verabschiedung des DAWI-Pakets von 2012 führte, beruhte auf der Notwendigkeit, sich an die Marktentwicklungen anzupassen. Im Bereich der Gesundheitsversorgung stieg die Nachfrage, während sich die Landschaft der Gesundheitsdienstleister mit einem wachsenden Anteil privater Anbieter, die mit den öffentlichen Anbietern konkurrieren, schnell veränderte. Der Ansatz, diesem Bedarf durch Klärung, Vereinfachung und einen diversifizierten Ansatz zu begegnen, erwies sich seinerzeit als richtig, da die Vereinfachung weitgehend durch die Beibehaltung der Freistellung von der Anmeldepflicht und die Verabschiedung der DAWI-De-minimis-Verordnung erreicht wurde. In Bezug auf den sozialen Wohnungsbau stieg die Nachfrage, da wohnungsbezogene Ausgaben einen immer größeren Anteil der Haushaltsbudgets ausmachen. Die Folgen der Wirtschaftskrise von 2008 drängten einen wachsenden Anteil der Bevölkerung in die Armut, was zu einer steigenden Nachfrage nach Sozialwohnungen führte. In der Zwischenzeit gingen die öffentlichen Ausgaben für den sozialen Wohnungsbau im Allgemeinen aufgrund von Haushaltszwängen zurück.

Während die Studie das DAWI-Paket von 2012 als relevant für die Deckung des Gesamtbedarfs erachtete, wurden die sich entwickelnden Bedürfnisse in Bezug auf den sozialen Wohnungsbau von einer großen Gruppe von Interessenvertretern als unzureichend berücksichtigt angesehen. Die in Erwägungsgrund 11 des DAWI-Beschlusses von 2012 enthaltene Definition des Begriffs "Sozialwohnungen" wurde von einer Reihe von Interessenträgern als die Bestimmung angesehen, die am wenigsten an die sich entwickelnden Bedürfnisse in den Mitgliedstaaten angepasst war. Aufgrund des bestehenden Wohnungsmangels und der zu erwartenden Auswirkungen von COVID-19 auf das Haushaltseinkommen wurde in der Studie die Definition von "Sozialwohnungen" als die Bestimmung ermittelt, die größere Aufmerksamkeit benötigt, um bestehende und sich entwickelnde Bedürfnisse zu erfüllen.

Herausforderungen wurden auch in Bezug auf die Relevanz des DAWI-Pakets 2012 für den Gesundheitssektor festgestellt. Es wurde die Notwendigkeit erkannt, sich auf eine klarere Unterscheidung zwischen wirtschaftlichen und nicht-wirtschaftlichen Aktivitäten in Bezug auf den Gesundheitssektor zu einigen, insbesondere in Bezug auf Informations- und Kommunikationstechnologie (‚IKT') oder Forschung, die im Gesundheitsbereich eine größere Rolle spielen.

Die Studie kam zu dem Ergebnis, dass der gewählte Ansatz zur Erleichterung der Dienstleistungserbringung von allgemeinem wirtschaftlichem Interesse durch die Notifizierungsfreistellung für Gesundheits- und Sozialdienstleistungen und die De-minimis-Höchstgrenze von 500.000 EUR pro drei Jahre im derzeitigen Marktumfeld nach wie vor gerechtfertigt ist, auch wenn mehrere Interessengruppen argumentierten, die De-minimis-Höchstgrenze sei nicht hoch genug.

EU-Mehrwert des DAWI-Pakets 2012

Das DAWI-Paket 2012 hat seine Hauptziele insgesamt erreicht. Durch die Fortführung zentraler Elemente des Pakets von 2005 erleichterte das DAWI-Paket 2012 die Erbringung von Dienstleistungen von allgemeinem wirtschaftlichem Interesse unter Beibehaltung der Kontrolle staatlicher Beihilfen und trug zur Vereinfachung der Anforderungen für Dienstleistungen von allgemeinem wirtschaftlichem Interesse im Gesundheitswesen und im sozialen Wohnungsbau bei. Das DAWI-Paket 2012 führte auch zu einer Klärung der Vorschriften für die Gewährung staatlicher Beihilfen, um sicherzustellen, dass der Weg für die Ausgaben für staatliche Beihilfen auf nationaler Ebene klarer ist. Der Mehrwert des DAWI-Pakets 2012 liegt darin, dass es eine Fortführung der Vorschriften für staatliche Beihilfen gewährleistet. Dennoch variiert dieser Mehrwert je nach nationalem Kontext und der Art und Weise, in der die Mitgliedstaaten die Gesundheitsversorgung und/oder den sozialen Wohnungsbau als Dienstleistungen von allgemeinem wirtschaftlichem Interesse betrachten.

1 Section 1: Introduction

1.1 Purpose and structure of the report

This Final Report is the final deliverable for the **Study on market trends in healthcare and social housing and EU State aid implications**. As outlined in the Terms of Reference for this assignment, the aim of the Final Report is to present the results of the tasks and especially:

- A description of the methodology applied
- A presentation the results of the data collection activities in each Member State
- An analysis of these data
- An answer to each of the Evaluation Questions

Taking into account the requirements of the Terms of Reference[31], this Final Report is structured in the following manner:

- **Section 1**: Introduction;
- **Section 2**: The Context relating to the SGEI Package and the overview of the Market Trends and the evolution of competition since 2012;
- **Section 3, 4, 5, 6**: Responses to the Evaluation Questions
- **Section 7**: Conclusions.
- **Annexes**: (1) List of documentation (2) Methodology (3) Member State Fiches

1.2 The objectives and scope of the study

1.2.1 Key objectives

The aim of this study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of notably the European Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union (TFEU) to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (hereafter the 'SGEI Decision')[32]. The Study focuses on healthcare and social housing in the period 31 January 2012 to 31 December 2019[33].

[31] *COMP/2019/006 Study on Market Trends in Health and Social Services and EU State Aid Implications, tender documentation available at https://etendering.ted.europa.eu/cft/cft-display.html?cftId=5308*
[32] *Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest, OJ L 7, 11.1.2012, p. 3–10, available at https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32012D0021&from=EN*
[33] *These sectors can also, under certain conditions, fall within the scope of the Communication from the Commission — European Union framework for State aid in the form of public service compensation ("the SGEI Framework").*

Other documents relevant for the scope, besides the SGEI Decision and the SGEI Framework are the 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 ("the SGEI

The Study focuses on four tasks aimed at gathering all necessary data to respond to the Evaluation Questions presented in the Terms of Reference:

Task 1: **Provide an overview of market trends since 2012** (see Section 2.2)

The following aspects have been analysed:

- How the sector/service is organised;
- How the sector/service is regulated;
- How the sector/service is financed;
- How the most important actors in these sectors / services are organised (public, private or a combination);
- How the national budgets have evolved;
- To what extent the sectors are open to cross-border activities and investments.

Task 2: **Analyse how competition on the market has evolved since 2012** (see Section 2.3)

This includes, as a minimum:

- How the pressure on (public) operators has evolved (e.g. increasing demand for their services, limited public budgets, higher efficiency needs);
- How the competition between public and/or private, non-for-profit and/or for-profit operators has evolved, in terms of both scope and (potential) overlaps.

Task 3: **Examine to what extent the Member States are aware of the possible State aid implications of policy and market trends** (the answers to this task are provided through the responses to the Evaluation Questions).

This includes, as a minimum:

- Whether and how market and policy developments and evolving competition have created/increased certain difficulties of Member States in applying the EU State aid rules;
- Whether Member States consider that the scope of the SGEI rules as regards health and social services has enabled compensation for the provision of those services to the population;
- Whether and how difficulties of Member States in applying the SGEI rules have hindered/prevented certain market developments.

The answer to the Evaluation Questions: The three Tasks set in the Terms of Reference feed the Study Team's responses to the Evaluation Questions (see Sections 3 – 6).

Communication") and Commission Regulation (EU) No 360/2012 of 25 April 2012 on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid granted to undertakings providing services of general economic interest ("the SGEI de minimis Regulation"). All four documents together are called "the 2012 SGEI Package".

The practical aim of the Study[34] is to provide the European Commission with factual data regarding the organisation of the healthcare and social housing sectors in the 10 Member States covered by the Study.

In addition to the biennial reports received by the European Commission from Member States, in accordance with Article 9 of the SGEI Decision, a need exists for the European Commission to receive a clear overview of the manner in which the sectors are organised at national level, how 'healthcare' and 'social housing' services are defined and the manner in which the SGEI rules are interpreted.

Moreover, the European Commission expects to gain knowledge, through the Study, of the costs and benefits associated with the adoption of the 2012 SGEI rules applicable to healthcare and social services for Member States and stakeholders. To provide factual knowledge relating to the application of the SGEI rules in the Member States, the European Commission wishes to receive, where possible, examples of concrete cases which have existed at national level regarding the interpretation and application of the SGEI Rules in so far as they apply to health and social services.

The Study is 'backward-looking', focusing on the period following the entry into force of the SGEI Decision in 2012. However, the period prior to 2012, when the 2005 SGEI Decision[35] was in force is also considered in order to undertake a counterfactual analysis. While the Study is looking at the evolutions since the entry into force of the 2012 Package up to the end of December 2019, the impact of COVID-19 on the sectors has been raised as an issue during data collection. COVID-19 is not the focus of the Study but has been considered as an 'external factor' which has had an impact on the health and social housing sectors.

1.2.2 Scope

The Study has a double coverage – the **healthcare sector** (with a focus on hospitals) and the **social housing sector**. These Sectors are covered under Article 2(1)(b) and (c) of the SGEI Decision[36]. Under certain conditions, these Sectors can also fall under the scope of the Communication from the European Commission – European Union

[34] *Based on discussions at the kick-off meeting and exploratory interviews.*
[35] *Commission Decision of 28 November 2015 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 with the operation of services of general economic interest OJ L 312, 29.11.2005, p. 67–73, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32005D0842*
[36] *Article 2 (1) (b) and (c) states: "This Decision applies to State aid in the form of public service compensation, granted to undertakings entrusted with the operation of services of general economic interest as referred to in Article 106(2) of the Treaty, which falls within one of the following categories: […] (b)compensation for the provision of services of general economic interest by hospitals providing medical care, including, where applicable, emergency services; the pursuit of ancillary activities directly related to the main activities, notably in the field of research, does not, however, prevent the application of this paragraph; (c)compensation for the provision of services of general economic interest meeting social needs as regards health and long term care, childcare, access to and reintegration into the labour market, social housing and the care and social inclusion of vulnerable groups".*

Framework for State aid in the form of public service compensation[37] and the SGEI *de minimis* Regulation[38] (together with the SGEI Decision hereafter the 'SGEI Package').

With regard to the **geographical scope of the Study**, the Study focuses on the following Member States: France, Ireland, Germany, Czech Republic, Latvia, Portugal, Romania, Croatia, Sweden and the Netherlands. More information on the selection of these Member States is presented in Section 1.3.5 below.

1.2.3 Evaluation Questions: how they are addressed in this Final Report

The Evaluation Questions are at the core of this Study and responding to these questions have structured the Study to a large extent. The questions focus on **four evaluation criteria** (effectiveness, efficiency, relevance and EU added value), with each question presented in Section 3 to 6 of this Report. The answers to the Evaluation Questions reflect the data available, collected and analysed.

Key challenges relating to responding to the Evaluation Questions are presented in Section 1.4 below.

1.3 Methodological tools

The Study focuses on a number of data collection tools to gather both quantitative and qualitative data. These data collection tools are presented for each task in the table below.

Table 1 Data collection tools

Task		Data collection tools
Task 1	**Step 1.1: Analysis of existing statistics and studies**	Studies relevant for the Study have been analysed and triangulated with the qualitative data gathered through primary research. A list of the documents consulted for this Study is presented in Annex 1.
	Step 1.2: Preparation of Member State Fiches	Member State Fiches have been prepared for all Member States. Elements of these Member State Fiches are reflected in the responses to the Evaluation Questions. The detailed Fiches are included in Annex 3 to this Report.

[37] *Communication from the Commission, European Union framework for State aid in the form of public service compensation (2011) (2012/C 8/03), available at https://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX%3A52012XC0111%2803%29. As outlined in paragraph 6, the principles set out in the Framework apply to public service compensation in so far as it constitutes State aid not covered by Decision 2012/21/EU. Such compensation is subject to the prior notification requirement under Article 108(3) of the Treaty.*

[38] *Commission Regulation (EU) No 360/2012 of 25 April 2012 on the application of Articles 107 and 108 of the Treaty on the Functioning of the European Union to de minimis aid granted to undertakings providing services of general economic interest, O J L 114, 26.4.2012, p. 8–13, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A32012R0360*

Task		Data collection tools
	Step 1.3: Interviews with representatives of public authorities	89 interviews were conducted for the Study. The Inception Report estimated a maximum of 10 interviews to be undertaken in each Member State with a mix of public authorities including SGEI responsible authorities, private and public providers, consumer associations and industry associations. An overview of the interviews conducted is presented in the Annex 2 to this Report. All 10 Interviews were completed for the European Associations.
	Step 1.4: In-depth statistical research	Statistical research based on the data available in EU and other databases (e.g. Eurostat and the Organisation for Economic Co-operation and Development, OECD) as well as national statistics databases (see the Member States Fiches) have been consulted. The results of the analysis are presented in this Final Report. The databases consulted are included in the bibliography in the Annexes.
Task 2	**Step 2.1: Analysis of existing statistics and studies**	As Step 1.4 above. In addition, documents (e.g. research paper, Industry associations' publication) and specialised journals (e.g. on cross-border activities in the housing sector) were consulted.
	Step 2.2: Preliminary questionnaire to be disseminated	An online Survey was disseminated to stakeholders in all Member States, covered by this Study. 53 stakeholders participated in the Survey. It is expected that a partial overlap exists between the Survey and the interviews, with some interviewees for this Study indicating that they had also responded to the online Survey.
	Step 2.3: In-depth statistical research / challenging results	The sources mentioned in Step 2.1 above were thoroughly reviewed to depict the evolution of competition on the market. However, as noted throughout this report few data is available on the matter.
Task 3	**Step 3.1: Preliminary questionnaire to be disseminated**	The online Survey disseminated for this Study included questions relating to Task 3. The responses to this Survey were triangulated with the primary and secondary data required to respond to Task 3 of this Study.
	Step 3.2: Interviews	The interviews undertaken under Step 1.3 above covered the elements which needed to be analysed for Task 3 and are presented in our analysis to the Evaluation Questions.
	Step 3.3: In-depth statistical research / challenging results	All the statistical databases and studies mentioned above have been reviewed, with the data analysed and presented throughout the responses to the Evaluation Questions.

Details for each data collection tool deployed for the Study are presented in the sub sections below.

1.3.1 The intervention logic

To consider the overall effectiveness, efficiency, relevance and added value of the 2012 SGEI Package, it was necessary to set out an intervention logic for this Study. This intervention logic, as presented in Annex 2, set out the needs existing at the time of the Package's adoption and set out the objectives of the Package as well as the expected results and impacts. The Study Team considered these elements when replying to the Evaluation Questions for the Study, as presented in Sections 3-6 of this Report.

1.3.2 Documentary review

A core tool of the methodology deployed to gather both quantitative and qualitative data on market trends in relation to the application of the SGEI Package was documentary review. It aimed at providing a strong understanding of the main changes brought by the 2012 SGEI Package, the issues at stake but also the developments in terms of market, policies or national reforms. The type of documents consulted were the following:

- Legislative documents;
- Documents from international institutions (OECD), European Institutions or bodies;
- Reports from NGOs or think tanks;
- National reports and sources consulted for the Member State Fiches;
- Written contributions sent by the interviewees that answered to our questionnaire.

The list of the documents reviewed is presented in Annex 1 to this Report.

1.3.3 In-depth statistical research

In-depth statistical research was needed in order to collect the necessary quantitative data for this Study. The Study team consulted the following sources:

- The Member States biennial reports submitted to the European Commission;
- The OECD databases related to government expenditure;
- The Eurostat database related to government expenditure;
- National statistical databases consulted for the Member State Fiches.

The Member States' biennial reports provided an overview of the expenditure related to SGEIs in the Member States covered by the Study, with the OECD and Eurostat databases providing an overview of the Member State expenditure related to healthcare and housing as well as the European trends. The national statistical databases identified complement this data and provide details on certain sectoral trends.

It should be noted that the data presented in Task 1 and 2 and those in the Member States Fiches can slightly differ. Indeed, in the Member States Fiches, national statistical databases have been preferred while for comparability purposes data from Eurostat and the OECD have been chosen in Task 1 and 2.

The data collection undertaken demonstrates that more data is available with regard to health expenditure at European level than for social housing. This is possibly due to the different understandings in Member States relating to the scope of social housing, with Member States applying their own definition at national level.[39]

1.3.4 Interviews with stakeholders

The answers to the Evaluation Questions were fed by data gathered through interviews. The following categories of stakeholders were consulted:

- National/local[40] authorities in charge of the health or/and social housing sectors;
- National/local authorities in charge of implementing and monitoring SGEIs;
- Providers (health and social housing);
- National industry and consumer associations[41];
- EU NGOs and associations.

The interviews were conducted primarily by members of the core team for the Study, with some interviews at national level undertaken by the EY local consultants in order to ensure language reach.

Two points should be noted with regard to the interviews conducted:

- **More stakeholders in the social housing sectors were consulted**. In the context of the COVID-19 pandemic during which the Study was carried out, it was challenging to consult the main stakeholders active in the field of health and hospitals. In addition, one of the hot topics in the scope of this Study is the target group for social housing included in Recital 11 of the SGEI Decision. Due to this, stakeholders active in the social housing sector were more eager to share their opinion[42].
- **The level of awareness of the SGEI rules and the detail of answers provided vary** from one category of stakeholders to another. National authorities and EU associations/NGOs were considered to have, overall, a greater level of knowledge as compared to SGEI providers (see Section3.3).

The list of stakeholders consulted is presented in Annex 2.

1.3.5 Preparation of Member State Fiches

The 10 Member States covered by the Study and for a which a fiche has been drafted have been selected on the basis of the following criteria:

[39] *Recital 11 of the 2012 SGEI Decision defines social housing as 'housing for disadvantaged citizens or socially less advantaged groups, who due to solvency constraints are unable to obtain housing at market conditions'. In a number of Member States covered by this Study, social housing is also considered to be affordable housing, with varying definitions existing, as presented in the Member State Fiches in Annex to this Report.*

[40] *For the purpose of the Study, « local » refers to a territory that is not national such as regions, counties, municipalities, Länder.*

[41] *The Study team distinguished between national industry and consumer associations and EU NGOs and associations to reflect the variety of stakeholders interviewed (associations active at the national level - industry representatives or consumers associations) and associations/NGOs active at the European level.*

[42] *In particular the EU associations and NGOs active in the social housing sector who easily shared their position paper and other lobbying materials.*

- Evolution of health and social housing policies and sectors
- Evolution in the level of expenditure for SGEIs
- Diversity in organisation of health and social housing sectors
- Participation of national level stakeholders in consultations undertaken by the European Commission

The Member State Fiches are a key element for the Study since they provide an overview of:

- The market situation in the health and social housing sectors;
- The reforms that have impacted the legislative landscape and the regulatory framework in the Member State;
- The government expenditure for health and social housing as well as the evolution of the number and type of providers and the competition.

To produce these fiches the following process was applied:

1. Pilot fiches were prepared for Ireland and France with the European Commission (Directorate General for Competition, 'DG Competition') providing comments on the fiche for France in order to provide the Study Team with an overview of key expectations for these fiches and the level of detail needed.
2. The core team undertook the drafting of the Member State Fiches for France, Ireland, Sweden, Germany and the Netherlands. For the remaining Member States, a template of the Member State Fiche and an example of the fiche for France was sent to the EY local consultants with a briefing undertaken by the Project Manager and core team members on how to complete the Member States Fiches, what data to collect and how to report the information.
3. For each Member State Fiche, documentary review, the collection of statistics and relevant data was undertaken. This first set of information aimed at providing a first overview of the situation before undertaking interviews. A grid with the indicators to collect was sent to each team member responsible for the Fiche in order to have the same level of information and data throughout the Member States.
4. The team and the local EY consultants identified the most relevant stakeholders to interview and conducted interviews with them by following the interview guide which aimed at collecting the same level of information in all Member States.
5. A first version of Member State Fiches was sent by the EY local consultants to the core team for review and for comments. When necessary, the fiches were sent back for review to the local EY consultants drafting these fiches.
6. All along the Study the core team was in constant contact with the local EY consultants to mitigate any risks and to adapt the strategy.

The Member State Fiches (presented in Annex 3) enabled the team to flag the specific issues present in certain Member States and to draw general conclusions about the market trends, issues and challenges in the Member States in order to feed the responses to the Tasks 1 and 2 and to the Evaluation Questions.

1.3.6 Online Survey

An Open Public Consultation was launched by DG Competition in 2019 on the 2012 SGEI Package[43]. Based on the information gathered in this consultation, EY aimed at completing this data with an online Survey.

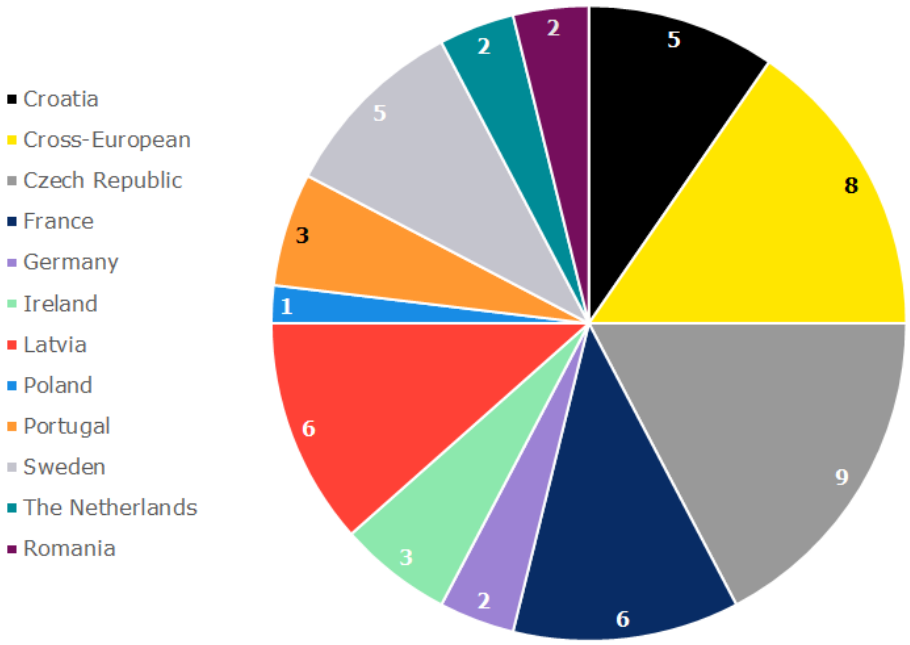
The Survey was launched in two stages: first from 13/10/20 to 07/12/20 for nine Member States, with the Survey subsequently reopened from 16/02/21 to 26/02/21 to include additional respondents from Romania. The Survey was tested with DG Competition prior to it being launched in order to ensure that all the questions were fit for purpose.

The outputs of the Survey have been included in the report to feed the answers to the Evaluation Question.

At the closing date of the Survey (26 February 2021), 53 stakeholders had replied[44] and all the Member States covered in the Study were represented.

[43] *This Open Public Consultation ran form 31/07/2019 to 04/12/2019 and is available here: (https://ec.europa.eu/info/law/better-regulation/have-your-say/initiatives/11835-Evaluation-of-State-aid-rules-for-health-and-social-services-of-general-economic-interest-and-SGEI-De-Minimis/public-consultation)*
[44] *Response rate of 15%*

Figure 1 Origin of the respondents[45]



The respondents were primarily national or local authorities (23)[46], NGOs (8), Industry associations (7)[47] and SGEI providers (6)[48]. Furthermore, the respondents operated mainly in the social housing sector (25), followed by the health sector (14) and both at the same time (13, for public authorities).

Figure 2 Profile of the respondents

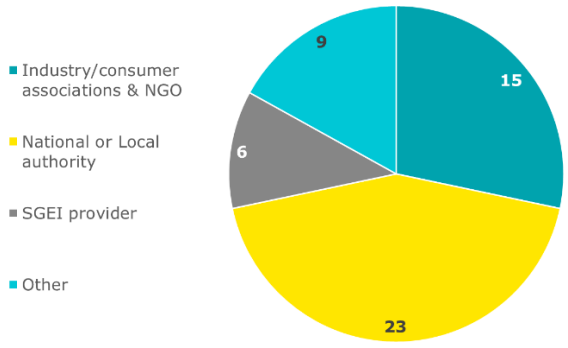
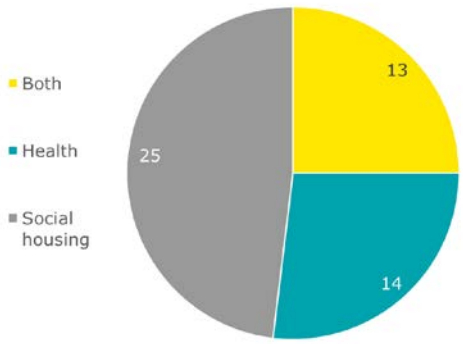


Figure 3 Sectors of the respondents



[45] *There is one Polish respondent since Poland had initially been identified as a potential Member State for the Study. Due to government reshuffles in Poland, it was difficult to continue to undertake data collection with national authorities in Poland during the timeframe of the Study. Romania was selected instead.*
[46] *Among these stakeholders, 14 were national authorities, 5 were national public bodies, 1 a local authority and three did not provide enough information to be categorised.*
[47] *Among the NGOs and Industry associations 3 were European.*
[48] *Other accounts for EU associations, national associations. Among the "other", 4 were European.*

Regarding the involvement of the respondents in the 2012 SGEI Package, 49% of the respondents indicated that they contributed to the implementation and/or control and monitoring of the good implementation of the rules in their Member State. 12% represented recipients of State aid under the 2012 SGEI Package and 15% represented consumers' interests[49].

1.4 Key challenges and mitigation strategies

A number of challenges were encountered during the Study. These are presented in turn below, along with a description of how these challenges were mitigated.

Ensuring the launch of the online Survey while avoiding delays in launching other data collection tools

Following the validation of the Inception Report in September 2020, the Study Team worked quickly to put the questionnaire, validated by DG Competition, online through the EY Survey platform. The approach proposed by the Study Team from the beginning of the assignment was to use the online Survey as an *additional* data collection tool in order to obtain the perception of stakeholders on specific issues covered by the Study, while focussing data collection on interviews in the 10 Member States and at EU level to gain practical viewpoints from key stakeholder groups.

To avoid delays in launching the requests for interviews and the preparation of Member State Fiches, the Study Team worked in parallel in order to launch interview requests with national competent authorities in all Member States as well as with EU organisations and associations to ensure that the interview schedule began as quickly as possible. While a priority was placed in piloting two Member States (France and Ireland) for the preparation of Member State Fiches, the Study team applied its approach foreseen in the Inception Report which was to identify stakeholders progressively through interviews conducted.

This approach ensured that no delays were faced in conducting interviews for the Study while also ensuring that sufficient time and resources were put in place to prepare, test and launch the online Survey and to keep the Survey open to ensure a sufficient level of response.

Ensuring a sufficient response rate to the online Survey

Following the launch of the online Survey in October 2020, the Study Team sent out several reminders to stakeholders, directly via email as well as through European associations and federations, in order to promote the Survey as much as possible. To ensure that adequate coverage was also ensured at national level, the Study Team worked with EY local consultants in order to send reminder emails in the national language, aiming to boost the response rate. Reminder emails in the national language were sent both through the central EY Survey platform and also via EY local consultants in order to add a 'personal touch' to increase the response rate.

Reaching a sufficient number of stakeholders from different stakeholder groups

[49] *Note although 1 consumer association participated in the Survey, 12% of the respondents declared representing consumers interests among each industry, NGO, SGEI provider.*

One of the main challenges for the Study was to reach out to a **sufficient number of stakeholders**. The Study Team faced challenges in conducting interviews with representatives of the health sector due to the COVID-19 crisis. However, the Study Team tried to conduct interviews with the main association representatives whom were prone to participate in interviews. The Team also relied on its internal network to identify the most relevant stakeholders at national level in order to ensure a good understanding of the national context. Between the submission of the Interim Report and Final Report, the Study Team reached out to new stakeholders and conducted additional interviews to deepen analysis on specific issues.

Availability of data

Data and statistics needed to answer the Evaluation Questions were not always available (especially for social housing). When it was not possible to rely on quantitative data, the Study complemented its analysis with the interviews and online Survey. The questions on the quantification of the administrative burden were especially challenging. In this case, interviewees fed analysis with their knowledge and experience.

The counterfactual analysis

The Terms of Reference requested a counterfactual analysis to shed light on the results brought by the 2012 SGEI Package in comparison to a situation where the Package was not applied. It was initially proposed to compare the situation from 2005 (the first Package) to the period following the implementation of the 2012 SGEI Package. Comparing the market situation before and after its implementation was the approach chosen to identify causality between the 2012 SGEI Decision and the results and impacts identified by the team during the study. However, too few data exist on the situation prior its implementation and even from 2012 onwards, the Study shows that it is challenging to collect robust data. In addition, some Member States did not report SGEIs for the healthcare and/or social housing sectors. To remedy this lack of data, the alternative approach chosen was to compare the situation in the group of Member States reporting SGEIs and in those not reporting such SGEIs[50]. When possible, the existing ('factual') situation as described in the biennial SGEI reports was compared to a counterfactual scenario under which the SGEI Package would not be used for other Member States or to other situations and sectors (e.g. sectors with other (i.e. non-SGEI) State aid regimes).

[50] *This list was drawn based on the biennial annual reports for the 10 Member States and is detailed in Section 2 below.*

2 Section 2: Context relating to the SGEI Package and overview of market trends and of the evolution of competition since 2012

2.1 The SGEI Package and key changes

While no definition of SGEIs is provided in EU legislation, the European Commission defines these services as "*economic activities that public authorities identify as being of particular importance to citizens and that would not be supplied (or would be supplied under different conditions) if there were no public intervention. Examples are transport networks, postal services and social services*[51]."

Market forces almost inevitably exclude sub-groups of citizens, especially the most vulnerable who cannot afford services that are considered as basic needs. Very often, services which target all citizens cannot be (sufficiently) profitable as they, for example, require heavy investment but imply lower return on investment. SGEIs can materialise in those cases where there is a **market failure since the provision of certain public services cannot be effectively provided through market-based solutions alone** and therefore require State intervention and compensation.

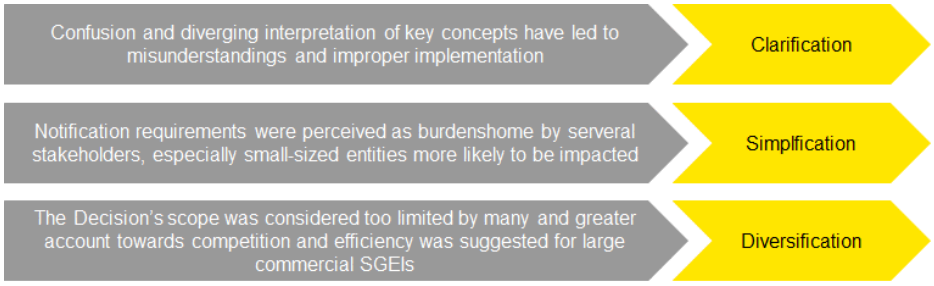
A wide variety of political systems, of cultural collective traditions, and of societal objectives have emerged across Member States. Such specificities are deemed to be respected, and Member States therefore have a margin of discretion when it comes to identifying and specifying services to be considered as SGEI[52].

Since the early 2000s, **the European Commission put some rules in place to ensure that public funding dedicated to the provision of these services does not distort competition in the Single Market**.

Following the *Altmark* Judgment of 2003[53], where it was clarified when public service compensation did not constitute State aid, a set of legal instruments known as the 'SGEI-package', 'Altmark-package' or 'Monti-Kroes-package' was established in 2005. The aim of this package was to provide Member State public authorities and market providers with legal certainty regarding measures that would qualify as State aid. The package further clarified the framework within which public service systems could be organised and financed in accordance with broader European Law and principles, set out in the TFEU (notably Articles 106 to 109)[54]. In November 2011[55], the European Commission launched an Impact Assessment on the reform of EU rules applicable to State aid in the form of public service compensation[56]. This Impact Assessment pointed out three main conclusions.

[51] *European Commission, State aid – Services of general economic interest (public services), (https://ec.europa.eu/competition/state_aid/overview/public_services_en.html)*
[52] *Koen Lenaerts, 'Defining the concept of 'services of general interest' in light of the 'checks and balances' set out in the EU treaties, Mykolo Romerio Universitetas, Jurisprudence 19(4) (2012), (100-207-1-SM.pdf (mruni.eu)*
[53] *See CJEU, Altmark Trans GmbH et Regierungspräsidium Magdeburg/Nahverkehrsgesellschaft Altmark GmbH, Case C-280/00, 24 July 2003.*
[54] *European Commission, Commission staff working paper, The Application of EU State aid rules on Services of General Economic Interest since 2005 and the Outcome of the Public Consultation, 2011.*
[55] *The 2005 Decision continued to be applied after 2011 for activities that were carried out before 2011*
[56] *European Commission, Staff Working Paper SEC 1581 on The Reform of the EU rules applicable to State aid in the form of public service compensation (Impact Assessment Report), 2011.*

Figure 4 Main conclusions from the 2005 implementation of SGEI rules



Following this Impact Assessment, **the European Commission adopted a new (revised) SGEI Package in 2011** (and the SGEI de minimis Regulation was adopted only in 2012) and reflected its main conclusions in the objectives of this new SGEI Package. The SGEI Package entered into force in 2012.

The package is composed of four instruments, that include two revised versions of previous instruments from the 2005 Package (Decision, Framework) and two new instruments (Communication, SGEI *De minimis* Regulation).

Table 2 Main changes between the 2005 Package and the 2012 Package

2005 Package	2012 Package
General ***de minimis*** **rule applied** [57] : 200,000 EUR over three years	Specific *de* ***minimis*** **Regulation for SGEIs**: 500,000 EUR over three fiscal years
SGEI Decision ▪ Hospitals and social housing ▪ Aid below 30M EUR per year for providers with turnover below 100M EUR per year ▪ Annual approach	**SGEI Decision** ▪ Health and social services: 'health and long-term care, childcare, access to and reintegration in the labour market, social housing and the care and social inclusion of vulnerable groups', without ceiling ▪ Aid below 15M EUR per year for other sectors ▪ Multi-annual approach ▪ Entrustment act less than 10 years except if a significant investment is required
Framework ▪ Compensation of all the net costs incurred by the provider ▪ Annual approach	**Framework** ▪ Compensation of the 'net avoided costs' ▪ Multi-annual approach ▪ Efficiency incentives ▪ Equal treatment

[57] *Community Framework for State aid in the form of public service compensation, OJ C 297, 29.11.2005, p. 4–7, available at https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX%3A52005XC1129%2801%29*

2005 Package	2012 Package
	▪ Control of serious competition distortions ▪ Compliance with public procurement rules when applicable ▪ Strengthened transparency
-	**Communication from the European Commission** ▪ Provides guidance on key State aid and SGEI-related concepts

Source: EY Composition from the 2005 and 2012 SGEI Package

The overall objective of the 2012 SGEI Package was to support Member states in the financing of SGEIs that are of key importance to citizens and society as a whole while preserving the key aspects of State aid control.

To that end, the 2012 Package aimed to undertake the following:

1) To **clarify** the basic concepts relevant for the application of the State aid rules to SGEIs; and
2) To **ensure a more diversified and proportionate approach** for a large variety of SGEIs, taking into account their nature and scope and the extent to which they posed a serious risk of competition distortions in the internal market.

More specifically, with regard to health and social services, the 2012 SGEI package aimed to:

1) Simplify compatibility criteria; and
2) Reduce the administrative burden for Member States which compensate undertakings entrusted to provide such services to the (vulnerable part of the) population at affordable conditions.

To achieve these objectives, the following changes were introduced in the 2012 SGEI Package (included as 'activities' in the Intervention logic for the Evaluation, in Annex 2)/ (i) extending the scope of health and social SGEIs which are exempted from notification[58]; (ii) providing guidance on the interpretation of the four criteria under the *Altmark* judgment, SGEI rules and concepts; (iii) having more transparency, in particular through the obligation for SGEI content for health and social services compensation above 15 million EUR to be published on the internet; (iv) adopting a dedicated *de minimis* Regulation for SGEIs, with a threshold of EUR 500 000 over three fiscal years.

2.2 Overview of Market Trends since 2012 (Task 1)

The aim of this Section is to answer the following questions:

- How the sector/service is organised;
- How the sector/service is regulated;

[58] *Article 2(1) of the SGEI Decision lists the SGEIs sectors exempted from notification*

- How the sector/service is financed;
- How the most important actors in these sectors / services are organised (public, private or a combination);
- How the national budgets have evolved.

Answers will be provided in sub-sections dedicated to each sector (2.2.1 for Health and 2.2.2 for Social housing). Given the scarcity of data regarding cross-border activities and investments, the answer to the below question will be provided in a separate subsection for both sectors (2.3):

- To what extent the sectors are open to cross-border activities and investments?

The approach chosen for the analysis was to present data for groups of Member States reporting hospitals activities and/or social housing as a SGEI and Member States not reporting this as a SGEI and to analyse the differences when relevant. These groups were defined based on the biennial SGEI Reports (see detailed information in section 2.2.1 for hospitals and 2.2.2 for social housing). The SGEI biennial reports for the period covered by the Study are composed of 5 sections, similar to Article 2(1) SGEI Decision:

- Compensation not exceeding an annual amount of EUR 15 million for the provision of services of general economic interest in areas other than transport and transport infrastructure
- Hospitals providing medical care, including, where applicable, emergency services;
- Social services (healthcare and long-term care, childcare, access and reintegration into the labour market, social housing, care and social inclusion of vulnerable groups, other social services);
- Air or maritime links to islands with average annual traffic not exceeding the limit set in Art. 2(1)(d)[59];
- Airports and ports with average annual traffic not exceeding the limit set in Art. 2(1)(e)[60].

Information about SGEIs in the hospital and social housing sectors were also discussed with interviewees from the Member States covered by the Study.

Table 3 Composition of the groups for the hospital sector

Group 1 – hospitals defined as SGEI	Czech Republic
	France
	Germany
	Ireland
	Latvia
	The Netherlands
Group 2 – hospitals not defined as SGEI	Croatia
	Portugal

[59] *http://data.europa.eu/eli/dec/2012/21(1)/oj*
[60] *Airports and ports with average annual traffic not exceeding the limit set in Art. 2(1)(e)*

	Romania[61]
	Sweden[62]

Table 4 Composition of the groups for the social housing sector

Group 1 – social housing defined as SGEI	Czech Republic
	France
	Germany
	Ireland
	The Netherlands
Group 2 – social housing not defined as SGEI	Croatia
	Latvia
	Portugal
	Romania
	Sweden

[61] *According to the 2018-2019 biannual Report of Romania, State Aid has been granted through the 2012 SGEI Package for the activity of supplying the medicines needed to prevent deaths and the worsening of diseases caused by a lack of human immunoglobulin. Romania was not included in Group 1 because this aid was granted only in 2018 to the National Company Unifarm S.A.*

[62] *In the biennial report for Sweden, there is one specific activity listed in the hospital section regarding a specific activity regarding the compensation to occupational healthcare providers for the purchase of medical service. However, given the specificity of this service and the fact that hospitals are considered as constituting a non-economic activity, Sweden was included in Group 2.*

2.2.1 Healthcare

According to Article 168(7)[63], "*Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them*." Substantial differences exist in the way governments ensure access to hospital services and organise their healthcare systems throughout the EU Member States. The organisation of national healthcare regimes depends on the national context of the Member States, their approaches and orientation. The healthcare sector varies from one Member State to another with regard to the financing scheme or the roles of providers.

Although almost all hospital systems in the Member States included in the Study are public services, the main difference lies in the way the purchasing of healthcare is organised. In certain Member States (e.g. the Netherlands or Czech Republic) insurers are funding healthcare while in other Member States, it is the government that purchases care[64].

Member States adopt the following types of models[65]:

- A so-called **Beveridge model** or "national health service" under which the health system is financed through public taxes, the State directly finances organisations providing healthcare and universal health coverage is provided;
- A **Bismarck system**[66] or "social insurance system" where healthcare is financed through compulsory contributions (insurance contributions and contributions funding the healthcare activities provided by public or private providers) from employers and employees and the State provides healthcare coverage to people who are not contributing through their income.
- Or a **mixed system,** where private funding from voluntary insurance schemes also plays an important role.

Table 5 Main features of Member States' healthcare systems

Member State	Healthcare system characteristics	Type of model
Croatia	The Croatian Health Insurance Fund (CHIF) -main purchaser and sole insurer- provides universal health coverage. The revenue from the	Mixed model

[63] *http://data.europa.eu/eli/treaty/tfeu_2008/art_168/oj*
[64] *European Commission, Study on the financing models for public services in the EU and their impact on competition, 2016.*
[65] *M. Gaeta, F. Campanella, L. Capasso, G.M. Schifino, L. Gentile, G. Banfi, G. Pelissero, and C. Ricci An overview of different health indicators used in the European Health Systems. Journal of Preventive Medicine and Hygiene, Jun, 58 (2), 2017.*
[66] *The two categories of healthcare systems are called these ways after the introduction of public healthcare systems in Germany by Bismarck (first Chancellor of Germany) and in the United Kingdom by Beveridge (a former British politician who was at the origin of the post WWII welfare model in the United Kingdom).*

Member State	Healthcare system characteristics	Type of model
	CHIF comes from compulsory health insurance contributions (main source of revenue) and the State budget. The State finances hospital equipment and infrastructure in coordination with regional and local authorities.	
Czech Republic	The healthcare sector is mainly financed through **public health insurance**, i.e. a **tax that is one of the pillars of the social security** scheme. It is based on the principle of compulsory redistribution payment deducted from the amount of income. It is then used in case of illness and covers the necessary healthcare that is guaranteed by law. A smaller proportion comes from public budgets, including both financial resources obtained for healthcare directly from the State budget (mainly from the Ministry of Health and the Ministry of Labour and Social Affairs) and local budgets, including resources obtained from healthcare from regional budgets.	Bismarck model
France	The healthcare system is mainly based on a social health insurance system, with a strong role of the State which relies on taxes (employers, employees, excise duties on tobacco and alcohol, …) to finance the health insurance funds.	Bismarck model
Germany	The distribution of powers is divided between the Federal State and the Länder. In Germany, public health insurance is mandatory, almost the whole population is covered, the remaining part of the population being covered by private health insurance. The health insurance system is mainly financed through a **contribution from wage income**	Bismarck model

Member State	Healthcare system characteristics	Type of model
	divided between employer and employee. Recent reforms have led to the progressive introduction of competition between healthcare providers which are now able to attract people based on different tariffs and reimbursement scheme[67].	
Ireland	The current Irish system is a multi-payer system i.e. several different organisations purchase healthcare for different segments of the population. It is primarily a tax-financed public system, financed for its major part by the Irish State's own treasury however and to a significant extent also covered by private insurances purchased by households. The healthcare system is mainly tax-based in Ireland although the share of public expenditure is below the EU average because of the important role of private health insurance (biggest duplicate insurance [68] market in Europe).[69]	Beveridge model
Latvia	Latvia has a universal healthcare coverage that is mainly funded through general taxation, out-of-pocket payments, and to a lesser extent – voluntary private insurance	Beveridge model
The Netherlands	While the healthcare system is essentially privately managed, the government plays a controlling role in order to protect the public interest, by regulating and setting a number of requirements which	Bismarck model

[67] *Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen, "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition", Lancet, 2017, (https://www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2931280-1)*

[68]

[69] *OECD, Health at a Glance, Country Health Profile: Ireland, 2019*

Member State	Healthcare system characteristics	Type of model
	guarantee the social nature of the health insurance	
Portugal	The Portuguese healthcare system draws on a mix of public and private financing. However, the national Health Service (NHS) is predominantly financed through general taxation.	Beveridge model
Romania	The Romanian healthcare system is based on social insurance and one State-owned insurance organisation (National Health Insurance House) manages the funds collected from taxpayers.	Bismarck model
Sweden	Health coverage in Sweden is universal and the enrolment is automatic. It must cover all legal residents (Health and Medical Services Act). Counties are in charge of financing and providing healthcare services; services are mainly financed through tax levy from county councils. The Social Insurance Agency administers insurances and benefits to cover illness, the old age, disability, parental supports.	Beveridge model

Source: EY composition from the Member State Fiches, literature, interviews.

The diversity of approaches existing regarding the manner in which healthcare services are organised in a Member State and the variety of actors, both public and private, involved, can have an impact on the manner in which SGEIs are implemented at national level.

The **funding of healthcare services in most of the Member States is financed by public funds** either directly by the State or through healthcare insurance schemes (more details in Section 2.2.1). The **status of healthcare providers varies from one Member State to another**.

There are two trends in particular that have implications on the application of the SGEI Package: (i) **The overall liberalisation of the healthcare sector (provision and insurance) and (ii) the presence of a Risk Equalisation Scheme in some Member**

States. A Risk Equalisation Scheme is a community rating system where the insurance premiums are defined in advance and are the same for everyone regardless of the insured age or health status. The role of the Risk Equalisation Scheme is to transfer payments from certain health insurance companies to other health insurance companies in order to neutralise the risk profile differences. However, it should be noted that Risk Equalisation Schemes concern more health insurance (companies) than the provision of healthcare. Health insurance is 'a type of insurance coverage that typically pays for medical, surgical, prescription drug and sometimes dental expenses incurred by the insured'[70]. Therefore, it is a type of funding scheme for the healthcare sector.

As stated in the introduction to this section, the funding of hospital activities falls under the SGEI rules in six out of the ten Member States falling under the scope of the study, as outlined in the Table below.

Table 6 Hospital services defined as SGEI in the Member States

Member State	Services entrusted as SGEI
Czech Republic	A high range of hospital activities are entrusted as SGEI such as out-patient care, inpatient-care (including laboratories), care in hospices, emergency services, social services provided in hospital in-patient facilities, provision of drug and alcohol addiction treatment centres.
France	Healthcare institutions that 'provide inpatient care, outpatient care or care in patients' home including care home'[71]. They are also in charge of general and/or specialised care (e.g. psychiatry), emergency services and the coordination between professionals working in office-based medical practices and "medico-social' institutions and services.
Germany	Each Land has its own definition of the hospital sector for the SGEI given their respective competencies in the area. Overall, the operations of hospitals included cover services to provide medical care to the population, medical care services, emergency services, ancillary services.
Ireland	Provision of private medical insurance through the Risk Equalisation Scheme. A stamp duty is levied against health insurers based on the number of insured lives by age (under or over 18) and the type of cover (non-advanced cover refers only to public hospitals and advanced cover include private hospitals). It is then redistributed to insurers by a way of a credit (e.g. for hospital utilisation). Hospitals are indirectly funded by this scheme.
Latvia	Provision of the following activities to 'bodies subordinate to the Ministry of Health and service providers':

[70] www.investopedia.com/terms/h/healthinsurance.asp
[71] *Article L. 6111-1 of the French Public Health Code*

Member State	Services entrusted as SGEI
	• accident and emergency medicine • primary healthcare • secondary outpatient healthcare • dentistry • laboratory testing • medical rehabilitation • healthcare at home
The Netherlands	The definition of what should be considered as SGEI has been defined by the Ministry of Health, Welfare and Sports (VWS). In the hospital sector, the provision of the following services is regarded as SGEI: • University hospitals • Post-mortem organ removal • Emergency hospital • Acute obstetrics • Mobile medical teams • Expertise and coordination Trauma Care • Accident & Emergency Department • Specialist Burns care • Trauma care education, training and practice • Specialised and tertiary psycho trauma care • Emergency ambulance transport from the Wadden Islands by helicopter • Post-mortem tissue removal

In Member States where the three types of hospital structures exist, specificities apply. For instance, in **Sweden**, all hospitals are mainly publicly funded (privately owned, regionally owned and university hospitals). In **France**, all types of hospitals can receive public funds.

In terms of the number of sites per million population, the comparison of data[72] shows that for all hospitals, the Member States in Group 1 had in 2017, on average, a number of sites per million population higher than Portugal, which belongs to Group 2 (31.6 for group 1 against 21.8 for Portugal). The number of hospital sites per 100,000 inhabitants is higher in Group 1 compared to Portugal for public hospitals (13.7 vs 10.8) and private for-profit hospitals (12.9 vs 5.4). With regard to private not-for-profit hospitals, Portugal

[72] *2017 is the latest year for which sufficient data is available to enable meaningful comparisons. Also, data regarding the number of hospital sites per million population on the OECD database is available for 7 Member States covered by the study: all the Member States for group 1 and Portugal (group 2).*

has a higher number of beds per 100,000 inhabitants than group 2 but the difference is low (5.6 vs 5).

Table 7 Number of hospital sites per million population in 2017

		All hospitals	Public hospitals	Private not-for-profit hospitals	Private for-profit hospitals
Group 1	Czech Republic	24.4	15.2 (62%)	0.3 (1%)	8.9 (36%)
	France	45.6	20.4 (45%)	10.2 (22%)	15 (33%)
	Germany	37.3	9.5 (25%)	11.7 (31%)	16.1 (43%)
	Ireland[73]	17.9	14 (78%)	N/A	4 (22%)
	Latvia	32.4	23.2 (72%)	0 (0%)	9.3 (29%)
	The Netherlands	31.9	0 (0%)	7.9 (25%)	24 (75%)
	Average group 1	*31.6*	*13.7 (43%)*	*5.0 (16%)*	*12.9 (41%)*
Group 2	Portugal	21.8	10.8 (50%)	5.6 (26%)	5.4 (25%)

EY's composition from OECD

Within Member States in Group 1, there are also differences in the number of sites per million population. The highest number of sites in 2017 was in France (45.6) with the lowest in Ireland (17.9).

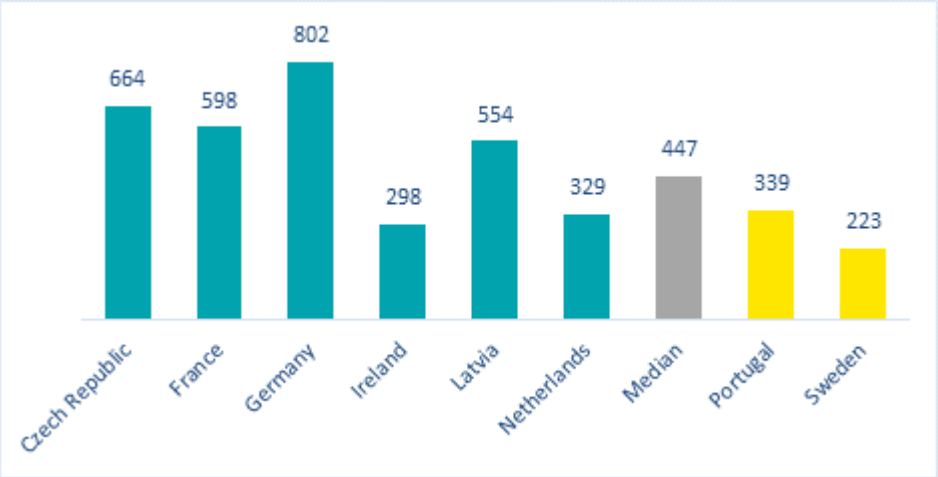
Moreover, the predominance of types of hospital sites varies between Member States. In the Czech Republic, Ireland and Latvia, public hospitals are predominant. However, with regard to **Ireland**, the data for public hospitals from the OECD database includes voluntary public hospitals. They are important players in the Irish healthcare system. These are sometimes owned by private bodies e.g. religious orders often mostly funded by the State. Other voluntary public hospitals are incorporated by charter or statute and are run by boards appointed by the Minister for Health. In **France**, public hospitals are also predominant, but they represent less than 50% of sites. In **Portugal**, 50% of sites are public and the remaining share is distributed between private actors (26% not-for-

[73] *Categories proposed i.e. publicly owned hospitals and privately owned not-for-profit hospitals do not satisfactorily represent the nature of the Irish public hospital system as public voluntary hospitals can also be sometimes privately owned.*

profit and 24% for-profit). In **Germany** and **the Netherlands** private for-profit hospitals represent the largest share, respectively 43% and 75%.

With regard to hospital beds, in 2017, the median number for the Members States covered by the Study for which the data is available on the OECD database, is 447 per 100,000 inhabitants as outlined in the figure below.

Figure 5 Total hospital beds per 100,000 inhabitants in 2017[74]



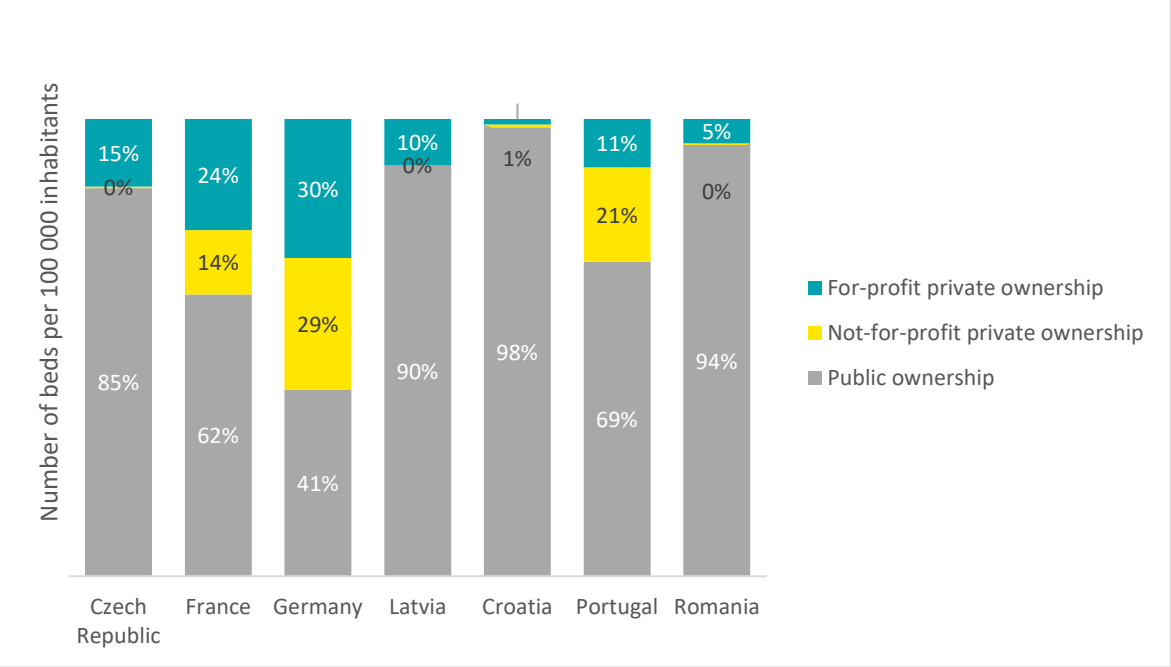
EY's composition from OECD database

In Member States falling under Group 1, four out of the six Member States are above the median: Germany (802), the Czech Republic (664), France (598) and Latvia (554). The number of beds per 100,000 inhabitants in the Member States falling under Group 2 is below the median.

The number of beds per 100,000 inhabitants and per ownership shows that public hospitals have the highest share in all the Member States covered by the Study (see the figure below).

[74] *Romania and Croatia are not OECD members; therefore, data is not available for these 2 Member States.*

Figure 6 Number of beds per 100,000 inhabitants and per ownership in each Member State[75]



EY's composition from Eurostat

In four Member States, the share of beds in the publicly owned hospitals is equal or above 85%: the Czech Republic (85%), Latvia (90%), Romania (94%) and Croatia (98%).

The comparison of the share of beds in publicly owned hospitals with the share of public hospitals[76] (Figure 6 above) shows that a higher number of beds are in public hospitals compared to private hospitals. For instance, in the **Czech Republic** 62% of hospitals are public whereas the share of public beds reaches 85%. This trend is also noticeable in France, Germany, Latvia and Portugal.

2.2.1.1 How is the sector/service regulated?

In almost all Member States of Group 1 and Group 2, the responsibilities in the healthcare sectors are shared between the national and local levels. The table below presents the actors in charge of policies in the healthcare sector including hospitals in the 10 Member States covered by the Study.

Table 8 Actors in charge of policies in the healthcare sector including hospitals

Member State	Actors in charge of healthcare and hospital policies
Group 1 – Healthcare defined as SGEI in the Member State	

[75] *Data was not available for Ireland and Sweden. With regards to the Netherlands, data was only available for not-for-profit hospitals.*
[76] *Table 6 is based on OECD which does not include data for Croatia and Romania*

Member State	Actors in charge of healthcare and hospital policies
Czech Republic	• At national level, the Ministry of Health is responsible for the national strategy (organisation, monitoring, budget). The office for the Protection of Competition is responsible of the conditions of State aid provision and monitoring of State aid providers. • At local level, regions are in charge of the organisation of the sector. They are also the hospital owners.
France	• At national level, the Ministry of Solidarity and Health is responsible for the organisation and monitoring of the healthcare system by setting the national strategy and budget. • At local level, actors in charge of organising the sector are the regional health agencies (under the control of the Health Ministry).
Germany	• At national level, the Federal Ministry of Health is responsible for the regulation of the national sickness funds and policymaking by drafting laws, guidelines. Moreover, the Federal Joint Committee which translates the legislative objectives into specific regulation. • At local level, Health Ministries of the Land are in charge of the implementation of healthcare and supervision of regional sickness funds.
Ireland	• At national level, healthcare strategy and regulation fall within the Department of Health's remit. The Health Service Executive is in charge of provision of public healthcare services.
Latvia	• At national level, the Ministry of Health is responsible for national policy, organisation and the functioning of the healthcare system. The National Health service is responsible for implementing the healthcare policies. • Local governments are responsible for ensuring geographical accessibility
The Netherlands	• At national level, the Dutch government has a role as supervisor with an oversight of market rules. Moreover, there are watchdog agencies supervising the healthcare market. • At local level, because of the distant role of the national authorities, municipalities have a more prominent role in overseeing some specific healthcare services (e.g. preventive healthcare and healthcare priorities).
Group 2 – Healthcare not defined as SGEI in the Member State	
Croatia	• At national level, the Ministry of Health is responsible for the strategy, the organisation and the monitoring of the healthcare system. This

Member State	Actors in charge of healthcare and hospital policies
	Ministry is also in charge of coordinating health expenditure in collaboration with the Ministry of Finance. • At local level, county governments are in charge of organising and managing public primary healthcare facilities. They also own general and special hospitals, health centres, polyclinics, pharmacies, institutions for emergency medical aid, home care institutions, and county institutes of public health.
Portugal	• At national level, the Ministry of health is responsible for the planning, the regulation, the coordination of the care provision and the financing. The Ministry of Finance sets the NHS Budget annually. • At local level, the regional health agencies are in charge of the organisation of the sector (planning, monitoring, allocating budget and delivering services).
Romania	• At national level, the Ministry of Health is responsible for the policies, regulatory framework and the overall management of the healthcare system. • At local level, district health insurance houses are in charge of the healthcare provision.
Sweden	• At national level, the Ministry of Health and Social Affairs is in charge of setting the national health policy and of budget allocation. • At local level, regions finance and deliver healthcare (primary care, specialists and psychiatric care).

Source: EY composition from the Member State Fiches

The only exception in relation to the distribution of actors is **Ireland** where shifts have occurred over the last 20 years regarding the presence of local actors. A single national entity responsible for the provision of public healthcare services called the Health Service Executive was established in 2004 replacing the 11 regional boards created in 1999. However, the Sláintecare Implementation Strategy (2018) foresaw the creation of regional integrated care organisations in 2020. In the Netherlands, following a reform in 2006 the role of the Dutch government has evolved in healthcare regulation from a direct supervision of volumes and prices to an oversight of market rules. Therefore, municipalities have gained a more predominant role such as overseeing some healthcare services (i.e. preventive healthcare and healthcare priorities) and controlling. Also, in Federal States, such as **Germany**, the responsibilities are divided between the Federal State and the *Bundesländer*. Hence, the organisation of hospitals will vary from one *Bundesland* to another.

The **evolution of the legal framework is dependent on the Member State's context**. However, it shows that in most of the Member States covered by the Study, the legislation evolved around the same goals of limiting the cost increases and reinforcing patients' rights and, linked to these goals, reorganising the sector (see

details below). No trend was identified regarding differences between Member States in Group 1 and in Group 2.

Table 9 Evolution of the healthcare legal framework

Member State	Evolution of the legal framework
Group 1 – Healthcare defined as SGEI in the Member State	
Czech Republic	Prior to 2012, a new healthcare system was established between 1991 and 1993 (compulsory statutory health insurance and universal coverage). The medical facilities were largely privatised and the State, through the Minister of Health, became the guarantor of the provision of healthcare. Since 1997, new laws aimed at reducing the cost through changes in the financing mechanism, decentralisation of hospital ownership, and strengthening citizen's rights by allowing them to freely choose their health insurance company and provider. In 2015, the attempts to increase the share of private expenditure in healthcare services, e.g. by user fees (initially put in place in 2008), have been gradually reversed by the later government in 2015. From 2021, the diagnosis-related groups [77] (DRG) is currently being implemented.
France	Prior to 2012, the laws established, gave and reinforced the right of the Parliament regarding the examination of the financial balance, the control of the spending growth and the expenditure monitoring on a yearly basis. Other laws created the regional health agencies in charge of defining and monitoring health policies and introduced the activity-based pricing built on the model of diagnosis-related groups. After 2012, a law established in 2016 relating to the modernisation of the healthcare system pursued the reorganisation of the sector by creating the 'territorial group of hospitals'.)[78] and reinforced patients' right.
Germany	Prior to 2012, amendments were made in the Statutory Health Insurance Act (2011) regarding healthcare financing. After 2012, laws continued to introduce changes in the healthcare financing regarding the contribution rate for sickness funds and the creation of an innovation fund. Measures were also introduced for better access to ambulatory care (i.e. outpatient care) and further financial

[77] *"DRG systems group patients according to diagnosis or procedure with the highest amount of needed resources into a single DRG" (Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J, van Ginneken E (2016). The Netherlands: health system review. Health Systems in Transition, 2016; 18(2):1–239.)*

[78] *"Territorial group of hospitals" (Groupements Hospitaliers de Territoire or "GHT"). Since the law established in 2016, public hospitals based in the same area have the obligation to form a "territorial group of hospitals" (GHT) with a shared medical project in order to mutualise their human resources and to offer graduated care services to patients.*

Member State	Evolution of the legal framework
	support for the recruitment of nurses and improvement of emergency services.
Ireland	The Health Act 1970 introduced the regionalisation of the Irish Health system by creating 8 regional boards. They were then reformed to 11 boards in 1999 and replaced by the Health Service Executive in 2004. Other measures aimed at introducing a Risk Equalisation Scheme, tax reliefs for the private hospitals and GP Visit Card[79]. In 2018, the Sláintecare Implementation Strategy, a 10-year reform programme for the healthcare and social care services, was defined following the Sláintecare report[80] The report suggested transformative reforms such as the idea to rely on community-level health structures and providers instead of public hospitals, the cooperation between public and private hospitals and the creation of regional integrated care organisations.
Latvia	Following the 2008 economic crisis, a reform led to a reduction of the number of hospitals. In 2013, the 'Procedures for organisation and funding of healthcare' were introduced after the enactment of the 2012 SGEI Decision. In 2016 and 2017 a report was published aimed at the optimisation of the hospital network. Subsequently, a law was introduced that prohibited a year-to-year decrease in healthcare funding and created a Compulsory Health Insurance System to increase the overall cashflow towards healthcare. This reform was postponed from 2019 to 2021.
The Netherlands	Before 2006, the national healthcare system was regulated under a mixed approach (national social insurance scheme and private insurance). Since 2006, the healthcare sector is characterised by competition and has reframed the role of the government. The healthcare sector is now organised as a single private insurance market. In 2012, the aim of a new law was to compensate healthcare providers for the costs related to the public service.
Group 2 – Healthcare not defined as SGEI in the Member State	
Croatia	In the early 1990s, legislation on health was mostly linked to organising, re-establishing and stabilising the healthcare system after declaring independence. The Healthcare Act was firstly introduced in 1993 and established the Croatian Health Insurance Fund (CHIF) and regulated mandatory and voluntary insurance. Other Acts were established to allow insurers other than the CHIF to offer complementary voluntary insurance, to define the scope of health

[79] *A GP Visit Card allows the entitled person to visit a participating General Practitionner for free*
[80] *Houses of the Oireachtas, Committee on the Future of Healthcare, Slaintecare Report, 2017*

Member State	Evolution of the legal framework
	insurances (mandatory and complementary) and to reform the healthcare sector (management and funding). In 2018, a new Healthcare Act was voted, dealing mostly with primary health protection system, legal status of healthcare workers that leased medical offices within public health centres and the introduction of conditions for functional merger and restructuring of the hospital system.
Portugal	The National Health System was created in 1979 establishing a centralised control but decentralised management. The 1990 Basic Law on Health, the overall framework of the healthcare system, introduced the regionalisation of the healthcare service administration, integration of healthcare (possibility of creating units with primary care and hospitals) and privatisation of (healthcare provision, management of public healthcare facilities, promotion of voluntary health insurance). In the early 2000s, the National Health Service became a mixed system based on the interaction between the public and private sectors, integrating primary, secondary and long-term care. Reforms were enacted aimed at combining the universal coverage provided by the NHS and the promotion of autonomy and efficiency in the hospital sector. After 2012, laws established have organised the palliative care facilities and created the National Health Council whose role is to issue recommendations and advice on health policies.
Romania	In the 1990s, laws aimed at decentralising, organising and structuring the healthcare system including social health insurance. The private sector in the field of healthcare was created in the 1993-1999 period. In 1999, the law on Hospital Organisation established the scope of the financing and management of hospitals. In the 2000's a law was established regarding patients' rights and the Healthcare Reform of 2006 consolidated almost all existing healthcare legislation. In 2011, the government made a proposal about the privatisation of all hospitals and public clinics which was withdrawn in 2012 as it caused controversy. In 2014, the government defined the 2014-2020 National Health Strategy to implement the Europe 2020 WHO strategy[81]. Legislation adopted in 2017, focused on the quality in the healthcare system.
Sweden	In 1982, the law regulating the healthcare system was introduced (The Health and Medical Service Act). Laws introduced from the mid 2000's reinforced the patients' care and rights. Moreover, in 2008, the Freedom of Choice in the Public Sector Act provides public and private healthcare professionals with equal conditions for establishment of their activity and public funds.

[81] *WHO (2013), Health 2020. A European policy framework and strategy for the 21st century, available at Health2020 (Long) (who.int), accessed on 16 February 2021.*

Member State	Evolution of the legal framework
	After 2012, the Patient Act from 2015 reinforced the patients' rights (shared decision making, right to get medical care in another region and obligation for healthcare professionals to inform patients about choices and risks).

Source: EY composition from the Member State Fiches

Some Member States established laws in order to liberalise the sector. For instance, **in Portugal**, in the early 1990s, the Basic Law on Health introduced the regionalisation of the healthcare system and privatisation of healthcare provision, management of healthcare facilities and voluntary health insurance. **In Ireland**, tax reliefs were introduced (starting in 2002) to encourage the financing of new private hospitals which since then led to an increase in private hospital capacity. **In Croatia**, in 2001, the amended Health Insurance Act allowed insurers other than the Croatian Health Insurance Fund to offer complementary voluntary insurance as part of a continuous process of healthcare system privatisation. **In Germany**, at the Federal level, reforms led to the progressive introduction of competition between healthcare providers which are now able to attract people based on different tariffs and reimbursement schemes. The adoption of the Freedom of Choice in the Public Sector Act in 2008 in **Sweden** provides public and private healthcare professionals with equal conditions for establishment, they have to fulfil counties' requirements to receive an accreditation and once the accreditation is received, the healthcare professional is eligible for public funds. In 2011, the **Romanian** government made an attempt at privatising all hospitals and public clinics, but they withdrew the proposal in January 2012.

Moreover, Risk Equalisation Schemes were introduced in Ireland and the Netherlands. Since 2006, the healthcare sector in the **Netherlands** is organised as a single private insurance market.

2.2.1.2 How is the sector/service financed? How have the national budgets evolved?

The total health expenditure has increased in all Member States covered by the Study between 2013 and 2018, though at different levels. The highest increases regard Romania (+52%) and Latvia (46%) while Sweden experienced the lowest increase (6%).

Table 10 Evolution of the total health expenditure between 2013 and 2018

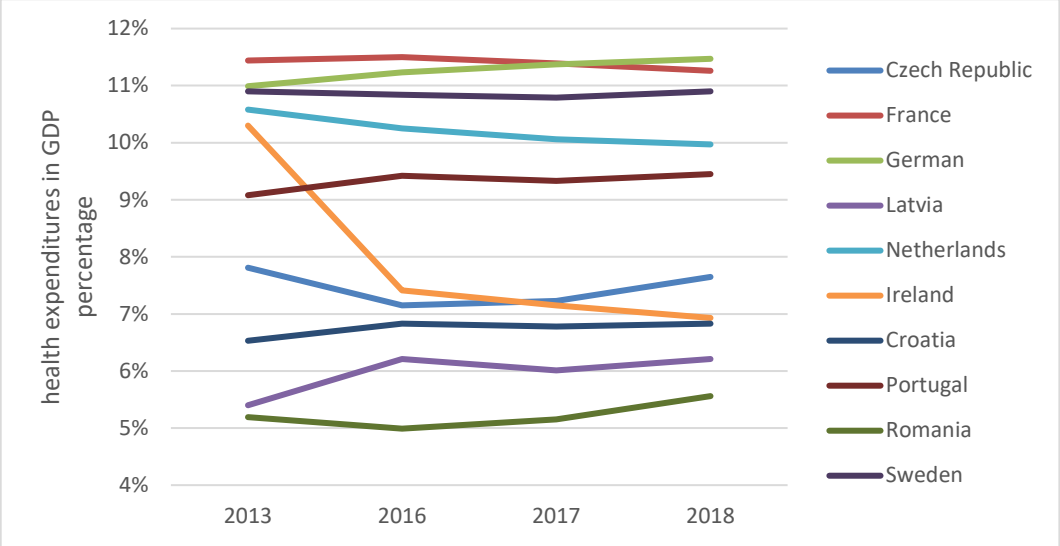
		Evolution 2013 – 2018 (in %)
Group 1	Czech Republic	29%
	France	10%
	Germany	24%

	Ireland	**21 %**
	Latvia	**46 %**
	The Netherlands	**10 %**
Group 2	**Croatia**	**23 %**
	Portugal	**25 %**
	Romania	**52 %**
	Sweden	**6 %**

EY's composition from Eurostat's data

However, the data regarding health expenditure as a % of GDP shows different trends (see the figure below).

Figure 7 Evolution of the health expenditure as a % of GDP between 2013 and 2018



EY's composition from Eurostat's data

Health expenditure as a percentage of GDP between 2013 and 2018 is stable for most of the Member States covered by the Study, with low variations not exceeding 1 percentage point. The only Member State registering a high variation is Ireland (-3.5 percentage points).

In the ten Member States, the healthcare sector is financed by the following schemes[82]:

[82] *OECD, European Union, World Health Organization. Chapter 7 'Classification of healthcare financing schemes (ICHA-HF) in A system of Health Account (2011).*

- **Government schemes and compulsory contributory healthcare financing schemes**[83]**:** The aim of these schemes is to provide access to basic healthcare for society as a whole, a large part of it or some vulnerable groups.
    - **Government schemes**: These schemes are determined by law or by the government. A separate budget is set for the programme, and a government unit has overall responsibility for it. Central government schemes and regional/local government schemes are sub-categories;
    - **Compulsory contributory health insurance schemes:** This category includes social health insurance schemes and compulsory private insurance. **Social health insurance** is a financing arrangement that ensures access to healthcare based on a payment of a non-risk-related contribution by or on behalf of the eligible person. **Compulsory private insurance** is a financing arrangement under which all residents (or a large group of the population) are obliged to purchase health insurance with a health insurance company or health insurance fund, meaning that the purchase of private coverage is mandatory;
- **Voluntary healthcare payment schemes**: This category includes all domestic pre-paid healthcare financing schemes under which access to healthcare services is at the discretion of private actors (though this "discretion" can and often is influenced by government laws and regulations). Included are voluntary health insurance, Non-profit institutions financing schemes and Enterprise financing schemes; and
- **Household out-of-pocket payment:** Its distinguishing characteristic is that it is a direct payment for healthcare goods and services from the household primary income or savings (no third-party payer is involved): The payment is made by the user at the time of the purchase of goods or use of services. Included are cost-sharing and informal payments (both in cash and in the form of goods or services).

The Table below presents an overview of the type of funders in the healthcare sector.

Table 11 Type of funders of the healthcare sector

Member State	Type of funders
Group 1 – Healthcare defined as SGEI in the Member State	
Czech Republic	• **Public or quasi-public:** State, regions and municipal authorities, the general health Insurance and seven health insurance companies. • **Private voluntary health insurance schemes**: Rare in Czech Republic, benefit for employees of international companies • **Households**

[83] *In the Eurostat dataset, **Compulsory Medical Savings Accounts** is the third category of "Government schemes and compulsory contributory healthcare financing schemes". This category is not detailed because the amount in the "Compulsory contributory health insurance schemes and compulsory medical saving accounts (CMSA)" is the sum of "Social health insurance schemes" and "Compulsory private insurance scheme" when both schemes are present in the Member States covered by the Study.*

Member State	Type of funders
France	• **Public or quasi-public:** State, Health insurance funds. • **Private compulsory or voluntary health insurance schemes** • **Households**
Germany	• **Public:** State, sickness funds, Länder, regional sickness fund • **Private health insurance schemes** • **Households**
Ireland	• **Public:** The Health Service Executive by delegation from the Department of Health • **Private health insurance schemes** • **Households**
Latvia	• **Public:** State through the National Health Service • **Private health insurance schemes** • **Households**
The Netherlands	• **Public:** State • **Private health insurance schemes** • **Households**
Group 2 – Healthcare not defined as SGEI in the Member State	
Croatia	• **Public:** State and the Croatian Health Insurance Fund • **Private health insurance schemes** • **Households**
Portugal	• **Public:** State • **Public and private health subsystems:** insurance schemes for which membership is based on professional or occupational category • **Private health insurance schemes** • **Households**
Romania	• **Public:** State through the National Health Insurance Fund • **Voluntary healthcare scheme** • **Households**
Sweden	• **Public:** State, regional and municipal authorities • **Voluntary healthcare payment schemes** • **Households**

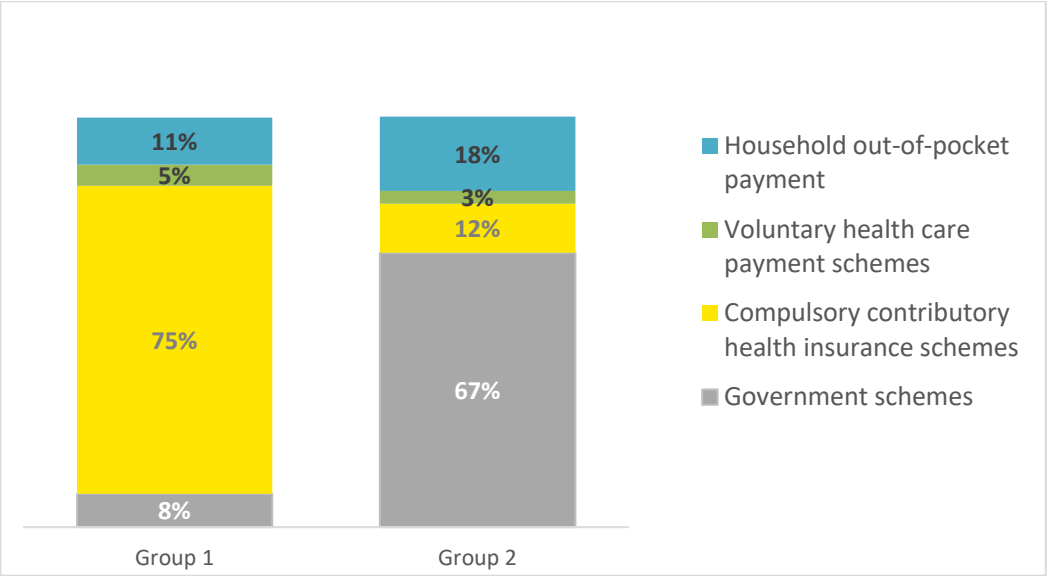
Source: EY composition from the Member State Fiches

All types of funders are present in all the Member States: (i) Public funders, (ii) health insurances and (iii) households. However, the share of funding per financing scheme varies between Member States (see figures 8 and 9 below).

Moreover, there are some specificities. For instance, **in Sweden**, the main funder is not the State but the county councils and municipalities. This decentralisation led to differences in terms of access to healthcare services which is in contradiction with

Sweden's objective of equal access to healthcare[84]. In this regard, the government has announced a primary care reform, of which an objective is to improve access to healthcare services in remote areas and to reduce disparities between regions.

Figure 8 Share of the total health expenditure per type of scheme for each group in 2018[85]



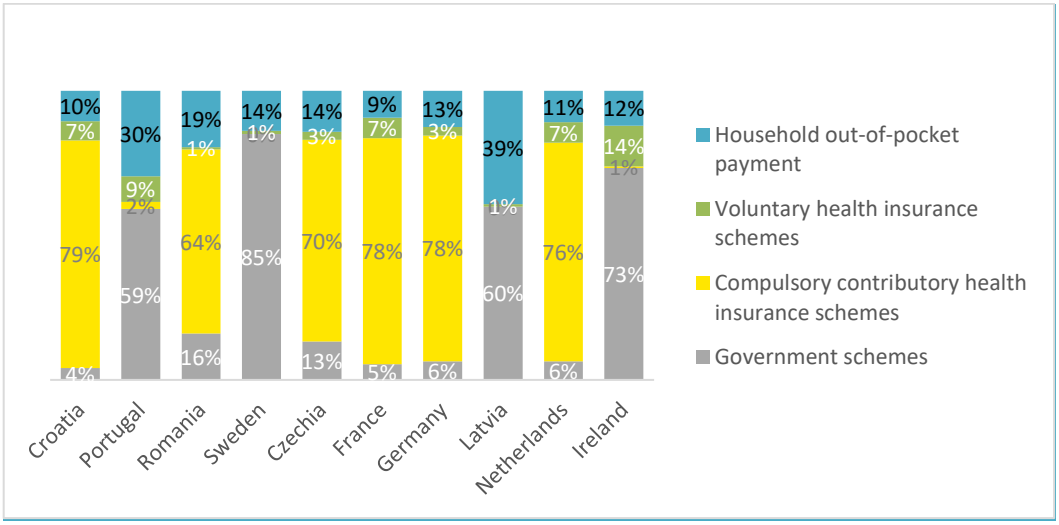
EY's composition from Eurostat's data

In 2018, health expenditure per type of funder varied between Group 1 and Group 2. The government schemes represented 67% of the health expenditure of Member States in Group 2 against 8% for Group 1. For Group 1, the predominant share of the health expenditure was the compulsory contributory health insurance schemes at 75% against 12% for Group 2. Details of the data show a high heterogeneity especially within group 2 (see below).

Figure 9 Share of the total health expenditure per type of scheme and per Member State in 2018

[84] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, (https://doi.org/10.1787/25227041)*

[85] *Percent of the health expenditure per type of scheme is based on the sum of the amount for all Member States in each group:*
For group 1: Czech Republic, Germany, Ireland, France, Latvia and the Netherlands
For group 2: Croatia, Portugal, Romania and Sweden



EY's composition from Eurostat's data

In Group 1, the schemes with the highest total health expenditure were the compulsory contributory health insurance schemes for Czech Republic, France, Germany and Netherlands (between 70 and 80%). In Latvia and Ireland, the highest share related to government schemes respectively at 60% and 73%.

Regarding Group 2, Sweden's health expenditure was mainly funded by government schemes (85%) followed by Portugal (59%). More specifically in Sweden, there were no compulsory contributory health insurance schemes while these were the main schemes in Croatia and Romania.

The Member State with the highest share of household out-of-pocket payments was Latvia (39%) followed by Portugal (30%). The Member State with the highest share of voluntary health insurance schemes was Ireland (14%).

2.2.2 Social Housing

Affordable housing v. social housing

The 2012 SGEI Decision provides a legal framework to implement housing policies targeted at "disadvantaged citizens" or "socially less advantaged groups", who due to solvency constraints are unable to obtain housing at market conditions. This type of housing constitutes "social housing". While the European Commission has not defined what it precisely means to be "disadvantaged", this concept is understood by representative groups as meaning that a social housing scheme should target at most 50% of the population[86].

While the above is not a hard criterion, this is in line with the European Commission's (limited) case practice[87]. It is for the Member State concerned to set out the conditions to define this group. This may generally be done based on income, but could be based on other criteria as well.

It is important to highlight that the current definition of social housing of the SGEI Decision is considered by some stakeholder groups as controversial, with certain

[86] *In a Guidance Paper adopted in March 2017, the EU Urban Agenda Housing Partnership, which is in favour of State aid for affordable housing, notes on the concept of social housing that "theoretically, a Member State could argue [that] 50% of the population is disadvantaged compared to the other half".*
[87] *The most extensive social housing scheme in the EU is the one in The Netherlands, where an estimated 43% of the population is eligible.*

stakeholders considering it too rigid, and others arguing that in practice it is stretched to unreasonable limits.

Social housing is however not the perfect tool to tackle affordable housing problems because those who are affected by the affordability of housing are not necessarily "disadvantaged" in the sense of the SGEI Decision. As the ratio of income-to-house-prices rises (particularly pronounced in Sweden, but also in many other Member States including France, the UK, Spain, the Netherlands and Belgium[88]), housing becomes less affordable for the population in general, and not just for disadvantaged groups. The problem is particularly pronounced in cities, where average incomes are generally higher than for the country as a whole.[89]

Where social housing clearly targets individual poverty, affordable housing targets a mix of a personal lack of resources[90] and the socio-economic phenomenon of increased housing costs. For affordable housing, the root cause of this problem is a shortage of housing, in particular of the kind that is targeted at middle-class incomes, in particular (but not exclusively) in urban centres.

This concept of affordable housing is sensitive to national and local specificities.

Recital 11 of the 2012 Decision provides that '*undertakings in charge of social services, including the provision of social housing for disadvantaged citizens or socially less advantaged groups, who due to solvency constraints are unable to obtain housing at market conditions, should also benefit from the exemption from notification provided in this Decision, even if the amount of compensation they receive exceeds the general compensation threshold laid down in this Decision*'.

Although important decisions from the European Commission and a CJEU judgment on social housing were issued against the background of the definition provided in recital 11, the EU does not hold exclusive competencies in this matter. It is up to the Member States to set their own definition of social housing. The protocol no 26 TFEU[91] underlines the discretion of national, regional and local authorities in SGEIs (this includes social housing) according to their population's needs[92]. Given the fact that Member States consider that the market fails to provide appropriate housing for everyone, social housing often falls within the scope of SGEI.

Definitions of social housing and the scope of social housing services that fall under the SGEI rules vary in the Member States covered by the Study. These variations reflect the national contexts and the fact that each Member State has its own interpretation of who should be eligible to social housing.

Not all Member States define social housing as a SGEI: Social housing falls under the SGEI rules in the Czech Republic, France, Germany, Ireland and the Netherlands (see descriptions in the table below).

[88] *Source: The Economist house-price index (which does not cover East-European Member States).*
[89] *In addition, social housing is also not the perfect tool to tackle situations of "mixité" in housing. In this respect, in the context of the Dutch social housing case, the European Commission agreed with the Dutch authorities that 10% of dwellings may be awarded to other groups (i.e. not the targeted socially less advantaged persons) on the basis of objective criteria with an element of social prioritisation, in the interest of social mix and cohesion.*
[90] *If affordability is defined with respect to household incomes, then if these incomes are sufficiently high there will not be any affordability problem.*
[91] *Consolidated version of the Treaty on European Union - PROTOCOLS - Protocol (No 26) on services of general interest OJ C 115, 9.5.2008, p. 308–308*
[92] *Issues with defining social housing. European Economic and Social Committee, 2012*

Table 12: Social housing activities entrusted as SGEI in the Member States

Member State	Social housing SGEI
Czech Republic	Renovation of an apartment block including construction of social housing and other services such as shelters, hostels, day-care centres and homes for people with disabilities and the elderly, emergency assistance.
France	All activities related to social housing - i.e. the construction, purchase, management and transfer of capped rent rental accommodations or operations of housing ownership addressed to people whose income is below a ceiling defined by the public administration – determine the SGEI[93].
Germany	Each Land has its own social housing scope for the SGEI given their competencies in the area. However, social housing activities entrusted as SGEI can be defined as the construction, renovation, provision and promotion of housing for the population unable to provide themselves with accommodation such as refugees, low-income households, single-parent families, families with children, pregnant women, elderly and disabled persons and other vulnerable persons, etc.
Ireland	Activities related to the provision of housing or with housing related purposes. Since 2019, the provision of student accommodation is included in the definition of SGEI as the development of this type of housing would make more rental stock available within the scope of social or affordable housing.
The Netherlands	Activities of construction, acquisition and management of capped-rent housing or buildings that can serve a social purpose. Provision of housing to people who have important healthcare needs and to people who encounter difficulties to access suitable housing because of their means or other circumstances. In this regard, 90% of the social housing stock is allocated to households with an income below a ceiling defined at national level. Housing associations also have a role in maintaining or improving the quality of life in the neighbourhood.

Source: Biennial SGEI reports

In the **Netherlands, France, Germany and Ireland**, all activities related to social housing are entrusted as SGEI. In **Germany**, competencies on social housing are in the Land's hands since 2006. Therefore, each Land sets its own legal framework in order to

[93] *Until 2020, dwellings aimed at middle-income people, under certain conditions defined by the law, were also defined as SGEI.*

foster social housing. Some States have no social housing programmes while others have created their own legislative framework[94]. A German specificity is the existence of a quasi-social housing as part of municipal housing stocks. They are legally outside the regulations of social housing but are often subject to similar rental and occupancy regulations due to political decisions of their public shareholders. This quasi-social housing is composed of large parts of the housing stock of the former German Democratic Republic (GDR) as well as a part of the stock which previously belonged to the social housing stock and after a few decades was transferred into the general market.

The **Czech Republic** differs from the other Member States for whom social housing is defined as a SGEI since the social housing sector is still under development, mainly due to the absence of specific legislation regarding social housing.

In **Latvia**, social housing was included under the 2012 SGEI Package for the period of 2012-2013 and State aid was granted accordingly. In **Croatia**, no clear definition exists of social housing. In **Sweden**, social housing as defined in the SGEI Decision does not exist, as public housing targets all people regardless of their means, and the municipal housing services were removed from the SGEI list in 2007 following complaints to the European Commission (see the Swedish case in Section 3.4). Municipal housing companies still exist in Sweden, though they have evolved. Since 2011, municipal housing companies must operate with "business like principles" in order to compete with private owners. However, in 2016, Sweden introduced and listed two housing SGEIs under the social housing category: the first regards the construction or renovation of housing adapted to the Elderly; the second concerns student accommodation. **Portugal** and **Romania** do not define social housing as SGEI.

Different approaches exist in the Members States covered by the Study[95]:

1. **The residual approach**: Social housing subsidised by a public authority is reserved exclusively for those who are clearly identified as disadvantaged or excluded (i.e. from the rental market). This approach does not compete with the private housing sector. Rules on the social housing allocation are strict and the rent is almost entirely covered by the social security system.
2. **The generalist approach**: This approach applies to broader categories of the population than the residual approach. It is designed to assist the disadvantaged, those that are excluded (as under the residual approach) and those with few resources, who struggle to access adequate housing due to their precarious income. For this approach, access to housing tends to be dependent on income ceilings and on the composition of the household, with rent regulated and remaining affordable. Since they are not defined based on quantitative criteria (e.g. "housing for individuals with accommodation costs amounting to above 40% of their revenue", etc.) the definition of the residual and generalist approaches overlaps.
3. **The universal approach**: This approach is intended to provide housing for anyone, regardless of their income. This includes disadvantaged or low-income individuals.

[94] *In the German biannual report, each Länder provides an overview of the State aid per SGEI categories when data is available, or expenses reported.*
[95] *Issues with defining social housing. European Economic and Social Committee, 2012*

The definitions of social housing in the Member States are presented below, with the categorisation by approach based on the definition provided as well as the results in past literature.[96]

Table 13 Definitions of social housing in the Member States[97]

Member State	Approach	Definition
Group 1 – Social housing defined as SGEI in the Member State		
Czech Republic	The residual/generalist approach	Social housing is housing provided to people who are in danger of, or facing, a financial crisis in terms of housing. This includes low-income households that spend a disproportionate amount of their income (more than 40%) on rent.
France	The residual/generalist approach	Social housing is defined as housing financed by public resources and intended to low income households.
Germany	The residual/generalist approach	Each Land has their own definition of social housing. Overall, the definition of social housing covers the provision of housing for the population unable to provide themselves with accommodation such as refugees, low-income households and single-parent families. The eligibility of target groups entitled to benefit from social housing programmes is defined on income criteria.
Ireland	The residual approach	Social housing is defined as housing provided by a local authority or a housing association to households who are unable to provide accommodation from their own resources.[98]
The Netherlands	The universal approach	Social rental housing consists of dwellings rented at set prices that are operated by private non-profit housing associations. Different target groups exist but all face challenges to find housing provided by the market. Target groups are defined by their income.
Group 2 – Social housing not defined as SGEI in the Member State		

[96] *The categorisation by approach is based on the Opinion of the EESC as well as a Report from the European Parliament on social housing in the EU, available at https://www.europarl.europa.eu/RegData/etudes/note/join/2013/492469/IPOL-EMPL_NT(2013)492469_EN.pdf*

[97] *The description of the definition of social housing in each Member State is based on the Member State Fiches, with all sources provided in the Fiches.*

[98] *OECD, PH4.3 KEY CHARACTERISTICS OF SOCIAL RENTAL HOUSING, 2019*

Member State	Approach	Definition
Croatia	Not defined as such but certain programmes / concepts are close to the residual approach	Currently, Croatia does not have a clear definition of social housing. The term is also not formally defined as such in any legal act, nor is there any strategy on (social) housing. The Constitution of the Republic of Croatia also does not explicitly mention the responsibility of the State to help its citizens in meeting their housing needs. However, certain programmes and concepts are close to social/affordable housing. Certain types of housing are offered on preferential terms or prices lower than the market to certain categories of people (people who do not own appropriate housing, residents of the territories lagging behind economically, impacted by the homeland war or people with the certain economic criteria).
Latvia	The residual approach	A social apartment is owned or rented by a local government, which is then rented to a household that is entitled to public support[99].
Portugal	The residual approach	The concept of social housing in Portugal is defined as housing built at controlled costs and intended for low-income families.
Romania	The residual approach	Social housing is defined as publicly-owned dwellings with a subsidised rent, that are allocated to households whose economic situation does not allow them to access a dwelling in the property or to rent a dwelling under market conditions.
Sweden	The universal approach	The social housing sector as defined in the SGEI Decision does not exist in Sweden, since public housing aims to provide a housing to everyone regardless of households' means.

Source: EY composition from the Member State Fiches, literature, interviews.

In Member States falling under Group 2, a mix of approaches was observed. The residual approach is found in three of the Member States of Group 2: **Latvia**, **Portugal** and **Romania**. In this approach, the population targeted by social housing is exclusively disadvantaged or excluded; hence these Member States do not consider social housing as an economic activity. In **Croatia**, some programmes are close to the residual approach. With regard to **Sweden**, the universalistic approach does not make the public housing strategy compatible with the SGEI Decision.

[99] *Ibid*

With regard to Group 1, Member States can fall under both the generalist and residual approach (**Czech Republic, France, Germany, Ireland** and the **Netherlands**). In these Member States, social housing targets a wider range of categories, but profits are marginal.

The definition of *who* should be eligible for social housing varies between Member States either in relation to the target group or to the income threshold. For instance, in **Latvia**, the government sets a minimum income threshold for households to qualify as a low-income family at a monthly income of EUR 128 per person over the past three months (equivalent to around 30% of the minimum wage in 2018). The income threshold to qualify for social housing has not been adjusted since 2009, suggesting that, given inflation trends, even fewer households today would qualify for social housing under the same income threshold compared to a decade ago. In fact, a recent OECD report points out in Latvia a "missing middle" of 44% of households who cannot afford a mortgage but are too wealthy to qualify for social housing. In the **Netherlands**, following the case presented in Section 3.4)[100], a more limited target group of households that is eligible for social housing[101], based on an income threshold, was introduced:

- Each year, 80% of social housing from housing associations need to be allocated to households with an annual income below 39,055 EUR (2020)[102];
- 10% of units may be allocated to households with an annual income between 39,055 EUR and 43,574 EUR (2020);
- 10% may be allocated to households with higher incomes.

2.2.2.1 How is the sector/service organised? How are the most important actors in these sectors / services organised (public, private or a combination)?

In addition to the differences in approaches, contexts are also different. As stated in the introduction to this section, data for the social housing sector is scarce. Therefore, data presented in the below tables are not streamlined and do not all refer to the same years.

Table 14 Social housing units in the Member States of group 1

Group 1 – Social housing defined as SGEI in the Member State					
	Czech Republic	**France**	**Germany**	**Ireland**	**The Netherlands**
	20,354 (2011)	**5,004,000 (2018)**	**1,180,000 (2018)**	**253,000 (2016)**	**3,000,000 (2018)**

[100] *In the case of Dutch social Housing, the European Commission concluded that the Dutch housing associations indeed received State aid: to be compatible, it was therefore decided that SGEI activities should focus on a particular target group of socially disadvantaged or less advantaged groups (Priemus and Gruis 2011).*
[101] *Before 2011, only 75% of the vacant social rental dwellings were allocated to the mentioned target group.*
[102] *https://www.dutchhousingpolicy.nl/topics/allocation-by-housing-associations/allocation-rules*

Social housing stock[103]					
 **Social housing share of the total housing stock**[104]	**0,4%** **(2011)**	**14%** **(2018)**	**3%** **(2018)**	**13%** **(2016)**	**38%** **(2018)**

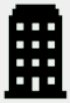
Source: EY composition from the Member State Fiches and OECD, Affordable housing database

The share of social housing dwellings within the total housing stock varies between the Member States which define social housing as a SGEI. The highest rate is in the **Netherlands**, a Member State in which the social housing dwellings represents 38% of the total housing stock. Countries with a universalistic approach are characterised by a large share of the housing stock[105]. Given that, the Netherlands had a universalistic approach until 2009, this could be an explanation of this high share.

The lowest rates concern the **Czech Republic** (0,4%) and **Germany** (3%). With regard to **Germany**, until the 1960s, social housing programmes were ambitious and aimed at erasing the post war housing shortage. Later, social housing programmes began to focus on specific target groups of people in needs. Germany was traditionally a big provider of social housing, though this changed at the end of the 1980s with the withdrawal by the German State from major social housing programmes. In 2018 compared to 2017, the number of social housing units decreased by 3.5%, representing a decrease of 53% since 2002. Moreover, the share of the private rental sector is significant as it represented 80% of the rental sector in 2017.

The table below provides an overview of the social housing units in the Member States falling under Group 2.

Table 15 Social housing units in the Member States of group 2

Group 2 – Social housing not defined as SGEI in the Member State		
	Latvia	**Portugal**
 **Social housing stock**[106]	**3,413** **(2015)**	**119,691** **(2015)**

[103] *National statistics*
[104] *OECD – Affordable Housing Database (http://www.compareyourcountry.org/housing/en/3/all/default)*
[105] *https://www.europarl.europa.eu/RegData/etudes/note/join/2013/492469/IPOL-EMPL_NT(2013)492469_EN.pdf*
[106] *National statistics*

Social housing share of the total housing stock[107]	**2%** **(2015)**	**2%** **(2015)**

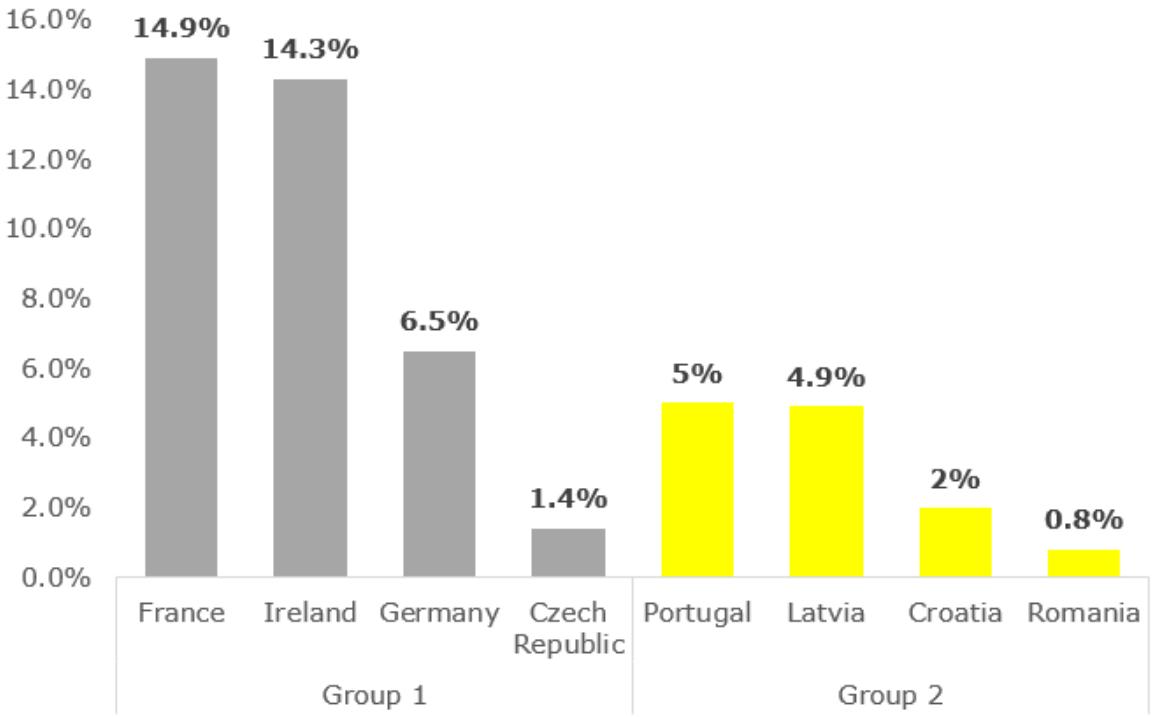
Source: EY composition from the Member State Fiches and OECD, Affordable housing database

In relation to Group 2, data regarding social housing stock is only available for **Latvia** and **Portugal**. The share of the social housing stock is very low and only represents 2% against 5%[108] for the EU average. Data is not available for **Romania** but given the fact that the owner-occupancy rate represents 98% of the total housing stock, it leaves only 2% for the rental sector in general (private and social housing). This high rate of owner-occupancy in Romania can be explained by the fact that, from 1990 to 1996, a mass housing stock privatisation occurred through the sale of units built with State funds and the completion of collective housing blocks which were in different stages of execution in 1989 and whose construction began with State funds before 1989. With regard to Sweden, there were around 1,900,000[109] rental dwellings (including special housing for elderly/disabled, student housing and other types of special housing) in 2019. Almost half of these dwellings were public housing, representing 20% of the total housing stock.

As for the share of the social housing stock, the share of households renting in the subsidised sector is variable within the Member States covered by the study.

[107] *OECD – Affordable Housing Database (http://www.compareyourcountry.org/housing/en/3/all/default)*
[108] *2020 European Semester: Country Reports*
[109] *Statistics Sweden (https://www.scb.se/)*

Figure 10 Share of households renting in the subsidised sector[110]



EY's composition from OECD – data not available for the Netherlands and Sweden

Member States in Group 1 have higher shares of households renting in the subsidised sector than Member States in Group 2, except the **Czech Republic** which has a different context from other Member States in Group 1. Indeed, in the Czech Republic, the first law regarding the supportive housing instrument was established in 2019. This rate is between 14% and 15% for **Ireland** and **France**.

In group 2, in **Portugal** and **Latvia** this rate is around 5%, while it is at 2% in **Croatia** and 0.8% in **Romania**.

In terms of social housing providers, the main providers are public authorities or organisations associated to them, as presented in the Table below.

Table 16 Social housing providers per Member State

Member State	Type of social housing providers
Group 1 – Social housing defined as SGEI in the Member State	
Czech Republic	• National authority • Local authorities • Public organisations

[110] *OECD – Affordable Housing Database (https://www.oecd.org/els/family/HM1-3-Housing-tenures.pdf)*

Member State	Type of social housing providers
France	• HLM (moderate rent housing) a sub-sector of social housing including public organisations, not-for-profit private companies and cooperatives • Semi-public organisation mainly owned by local authorities • Other social housing providers such as the State, local authorities, public organisations and other authorised providers
Germany	• Housing companies (municipal or private), which provide rental cooperative dwellings • Non-profit organisations (welfare organisations) • Social housing cooperatives (religious and non-religious organisations) • Individual builders
Ireland	• Local authorities • Approved Housing Bodies (not-for-profit organisation) • Private Landlords[111]
The Netherlands	• Housing associations
Group 2 – Social housing not defined as SGEI in the Member State	
Croatia	• National authority • Local authorities • Not-for-profit organisations
Latvia	• National authority • Municipalities and subordinate institutions, incl. social service • Authorised associations & foundations (not-for profit)
Portugal	• National authority • Regional and/or municipal authorities • Public organisations and agencies • Private Institutions of Social Solidarity (not-for profit) • Housing Cooperatives • Households

[111] *Private landlords are involved in the social housing sector through Public Private Partnerships with local authorities or contractual arrangements with Local Authorities and Approved Housing Bodies*

Member State	Type of social housing providers
Romania	• National authority • Local Authorities
Sweden	• Municipal housing companies

Source: EY composition from the Member State Fiches

The only Member States in which social housing providers are only public authorities or organisation(s) associated to public authorities are **Romania and Sweden**. In Romania, local authorities can also buy houses from the free market and use them as social houses. **In Group 1, the Netherlands is the only Member State in which public authorities are not providers**, only housing associations are responsible for the provision of social housing. This could be explained by the fact that, from 1989, the Dutch government put an emphasis on deregulation, decentralisation (from the State to local level) and self-sufficiency of housing associations. The 1990s then opened an era for private market stimulation, and municipal housing companies decreased significantly while housing associations grew stronger along with tenants' organisations.

In **France**, where a broad range of providers are in place, organisations that are part of the HLM sector (moderate rent housing) owned 84% of the social housing stock in 2018. This subsector is regulated in terms of funding, dwellings allocation and social housing stock management. It is composed of Public Offices of Housing (OPH- 41%), Social Enterprises of Housing (ESH – 41%) and Cooperative societies (COOP – 2%). Semi-public housing construction bodies (SEM) and other providers (the State, local authorities, public organisations and other authorised providers) own the remaining 16%.

Private providers are in place in most of the Member States covered by the Study (**France**, **Germany**, **Ireland**, the **Netherlands**, **Croatia**, **Latvia** and **Portugal**). These providers are mainly from the not-for-profit sector, with **Ireland** and **Germany** including actors from the for-profit sector. However, in **Ireland**, despite the presence of private actors in the sector, the 'public' social housing is predominant with local authorities owning, managing and renting more than 56%[112] of the total social housing stock. It is almost twice the share of privately-owned dwellings associated to some form of subsidy or social housing support[113] (32%). Private landlords account for an important share of total social housing stock, as compared to other European and OECD countries. The remaining 12% are owned by Approved Housing Bodies.

[112] *As of 2016. These are estimated numbers from Corrigan, E. and Watson, D., Social Housing in the Irish Housing Market, Department of Housing, Planning and Local Government, 2018. The Department does not report the housing stock i.e. the total number of social housing units on hand. It does report the number of units being rented by local authorities to tenants but this does not include the number of units being rented by the Approved Housing Bodies. The latest reported data is for 31 December 2016. Source: https://www.audit.gov.ie/en/Find-Report/Publications/2018/2017-Annual-Report-Chapter-10-Funding-and-oversight-of-approved-housing-bodies.pdf*

[113] *i.e. Rental Accommodation Scheme (RAS), Housing Assistance Payment (HAP)) and the Rent Supplement scheme operated by the Department of Employment Affairs and Social Protection.*

2.2.2.2 How is the sector/service regulated?

In terms of actors in charge of the social housing sector, there is no specific difference between Member States falling under Group 1 and Group 2, with the table below summarising the actors in charge of social housing policies in these Member States.

Table 17 Actors in charge of the policies in the social housing sector

Member State	Actors in charge of social housing policies
Group 1 – Social housing defined as SGEI in the Member State	
Czech Republic	• At National level, social housing falls within the responsibility of the Ministry of Regional Development (housing policy) and the Ministry of Labour and Social Affairs (the guarantor and supervisor of social work) • The local public authorities are responsible for establishing the local social housing permit, delivering a permit allowing the construction of social housing and building or buying premises.
France	• At national level, The Ministry of Cohesion of the French territories is responsible for facilitating access to housing by setting the national rules and organising the sector. The role of the National Social Housing Agency is to control the sector (funds and activities of the providers). • Local public authorities are in charge of establishing the local housing programme (including social housing) and delivering building permits.
Germany	• Competencies of social housing fall mainly to each Land that sets its own legal framework in order to foster social housing. • At national level, there is a social housing promotion law applicable to Länder that have not defined their own law.
Ireland	• At National level, the Irish Government sets the strategy, provides guidelines, legal certainty and full funding to all public structures providing social housing. The Housing Agency supports the delivery of housing policy as well as housing practitioners through advisory services, legal services, communication and good practices and data production. • Local authorities, the biggest landlords in Ireland, have the statutory obligation to provide housing to people who are assessed as being unable to afford housing from their own resources. They can also lease and buy properties on the private market for social housing use.
The Netherlands	• At national level, the Ministry in charge of social housing is the Ministry of the Interior and Kingdom Relations. • Municipalities issue housing permits to people, as municipalities require people to have a legitimate reason for wanting to live in their municipality (e.g. work, family or school).

Member State	Actors in charge of social housing policies
Group 2 – Social housing not defined as SGEI in the Member State	
Croatia	• At national level, the Ministry of Physical Planning, Construction and State Assets is responsible for construction regulation, State asset management, housing policy and monitors the work of the Agency for Transactions and Mediation in Immovable Properties and local agencies. Other State bodies are also in place such as the Central State Office for Reconstruction and Housing Care for housing care models and regional housing. • Local authorities implement public and social renting of dwellings.
Latvia	• At national level, the social housing services are split between three different ministries: Ministry of Economy, Ministry of Welfare and Ministry of Environmental Protection and Regional Development. • Local authorities hold the main responsibility regarding social housing provision, including financing.
Portugal	• At national level, the Portuguese Ministry of Infrastructure and Housing is responsible for the planning and regulation activities of the social housing sector. Moreover, the Institute for Housing and Urban Rehabilitation is responsible for promoting and managing access to social housing according to national rules. • Regional and municipal authorities are involved in social housing. Municipalities are responsible for establishing the local social housing regulations and programs.
Romania	• At national level, the Ministry for Development, Public Works and Administration establishes housing policy, and drafts legislation as required to establish the legislative framework for that policy. It has also the role to obtain funds to implement housing programs. Moreover, the role of the National Housing Agency is to administer financial resources for housing construction, and also to coordinate the sale, rehabilitation, consolidation and extension of the existing housing stock. • County and local councils have shared responsibilities with higher administrative units. County councils have a general oversight and intermediation role regarding housing, although they also retain important powers for prioritising investments.
Sweden	• At national level, the Ministry of Finance is responsible for housing and community planning. Its role is to set the housing policy by providing the legal and financial framework. • At local level, municipalities oversee implementing housing policies. Planning the housing provision, enabling housing construction and ensuring proper housing for elderly people are also within their remit.

Source: EY composition from the Member State Fiches

In almost all Member States covered by the study, the competence for social housing falls mainly within the Länder. The Federal State has defined a framework to be used only by Länder that have not set their social housing policy. However, the evolution of the legal framework shows that Member States are at different stages with regard to social housing.

Table 18 Evolution of the social housing legal framework

Member State	Evolution of the legal framework
Group 1 – Social housing defined as SGEI in the Member State	
Czech Republic	Before 2012, there was no specific legislation on social housing. Since 2014, several attempts have been made to undertake legislative work on this topic. In the absence of legislation, a governmental document addressing social housing was introduced in 2015 (Social Housing Concept of Czech Republic 2015–2025). In 2019, a law regarding the financial support from the State Investment Support Fund was established.
France	From 2000 to 2009, laws were introduced to reorganise the social housing sector: minimum of 20% of social housing in municipalities, merger of 2 public organisations to form the OPH (Public Offices of Housing) and increase of building in the HLM (moderate rent housing), a sub-sector of social housing. After 2012, the objectives of legislation were to pursue the reorganisation (for instance, mergers or integration into a bigger group of social housing operators) and to reduce public expenditure.
Germany	Laws introduced from 1988 to 2001 opened regional housing programmes to private investors and enabled the construction of affordable housing and the acquisition of owner-occupied housing by a broader population. In 2006, social housing competencies were transferred from the Federal State to Länder. In 2019, an amendment to the Constitution included the provision of financial assistance from the Federal Government to the Länder in order to fulfil the demand for social housing.
Ireland	From 2000 to 2011, new acts and programmes were adopted to enable local authorities to acquire lands at 'existing use value' (and not 'development value', to introduce allowances to support households in the private rented sector and the reliance on the private sector to provide social housing. The Housing Assistance Payment was introduced in 2014 to support households in the private rented sector. Later, in 2019, the Housing Bill

Member State	Evolution of the legal framework
	introduced new regulations for Approved Housing Bodies in connection with their governance and financial viability.
The Netherlands	From the 1980s onwards, the Dutch housing policy paradigm shifted towards decentralisation, independence and self-sufficiency of the housing associations. In 2009, the scope of social housing changed in order to be intended for the 'most socially disadvantaged households' (change from a universalistic to a generalist approach). Since 2013, the aim was to deepen the universal approach by measures such as incentivising households with high-income to move out from social housing and clarifying SGEI services (social rental housing for targeted groups)
Group 2 – Social housing not defined as SGEI in the Member State	
Croatia	The Acts established in the early 2000s aimed at regulating and organising the construction of subsidised housing (Programme of State-subsidised housing construction – POS) and authorising not-for-profit organisations to implement the POS on behalf of local authorities. From 2011 to end of 2012, the Subsidised House Loans and the State Guarantee Act regulated subsidised loans for people under 45 years old backed by State guarantee in case of loss of employment. After 2012, amendments to the Subsidised Residential Construction Act of 2011 were made to encourage the access to the POS such as incentivising the buying of newly built apartments and 'rent-to-buy' possibilities to lease the unsold stock. In 2017, the Subsidised House Loans Act was reintroduced.
Latvia	In 1997, laws were established regarding social apartments, social housing and group houses (for people with mental impairments). Later, to be recognised in the low-income category, a person had to comply with the provisions of the law on Assistance in Resolving Housing Issues. No new legislation was introduced after 2012.
Portugal	Before 2012, changes in the legal landscape were associated with a strategic reorientation from incentivising own housing acquisition to promoting the rental model, resulting in the end of the subsidised credit of housing loans in 2002. The laws established after 2012 had the main objective of guaranteeing access to adequate housing for all.
Romania	From 1998 to 2006, objectives of the established laws were to define and reinforce the scope of social housing (target, criteria, organisation of the sector…), including the social housing competencies attributed to

Member State	Evolution of the legal framework
	local authorities and the establishment of the National Housing Agency (1998). There have been no legislative changes in the field of social housing after 2012, but National Strategies were defined such as the National Strategy on Social Inclusion and Poverty Reduction 2015-2020 and Strategy of the Government of Romania for the Inclusion of the Romanian Citizens Belonging to Roma Minority for 2015 – 2020.
Sweden	After two complaints in 2002 & 2005 from the European Property Federation (see Section 3.4 **Error! Bookmark not defined.**) to the European Commission regarding the compliance of Sweden with EU laws regarding State aid and competition, the government created a committee to look into this topic. In order to maintain their universal approach, Sweden decided to remove the municipal housing (i.e. at the time considered as social housing) from the SGEI list. Since 2011, municipal housing companies have to operate with 'business-like principles' in order to compete with private owners.

Source: EY composition from the Member State Fiches

In some Member States, social housing or more generally affordable housing was defined in the last 25 years: in 1997 for **Latvia**, in 1998 for **Romania** and in the early 2000s for **Croatia**. With regard to the **Czech Republic**, while several attempts were made, the first legislative act regarding a supportive housing instrument was established in 2019.

In the same period, Member States such as **France**, **Germany**, **Ireland** and **Netherlands** were reorganising the sector either to reduce expenditure and/or to rely on more actors such as the private sector.

2.2.2.3 How is the sector/ is financed? How have the national budgets evolved?

The table below presents the type of funders of the social housing sectors in the Member States covered by the Study.

Table 19 Type of funders of the social housing sector

Member State	Type of funders
Group 1 – Social housing defined as SGEI in the Member State	
Czech Republic	• **Public**: State through the National fund for Housing Development. Local authorities through subsidies and their own budgets. • **Social housing providers** with their own financial resources

Member State	Type of funders
France	• **Public funders**: State (subsidies, favourable tax measures, allowance), local authorities (subsidies, delegation from the State) and the Deposits and Consignment Fund (loans for the construction or rehabilitation of social housing) • '**Action Logement'** sourced from employers' contributions to fund the construction of social dwellings. • **Social housing providers** with their own financial resources
Germany	• **Public funders**: the federal State and Länder
Ireland	• **Public funders:** State and the Housing Finance Agency (HFA) through loans
The Netherlands	• **Public funders:** State (e.g. system of guarantees) • **Housing associations** through own equity and bank loans
Group 2 – Social housing not defined as SGEI in the Member State	
Croatia	• **Public funders:** The Croatian Agency for Transactions and Mediation in Immovable Properties (APN) and decentralised local agencies.
Latvia	• **Public funders:** State and local authorities • **Other unspecified funding sources**
Portugal	• **Public funders:** State (annual budget, favourable tax measures through own institutions or banks), regional or municipal authorities (through budget transferred from the State or own financial resources), the Institute for Housing and Urban Rehabilitation (loans and grants to social housing providers, subsidies allocation)
Romania	• **Public funders**: State or local budgets • **Other sources of funding**: internal/external credits, private investors, and other legal sources
Sweden	• **Public funders**: State and municipalities

Source: EY composition from the Member State Fiches

In the **Netherlands, there is strictly speaking no public spending** directly supporting the provision of social rental housing since 1995. There is, however, a system of guarantees backed by the central government which allows housing corporations to

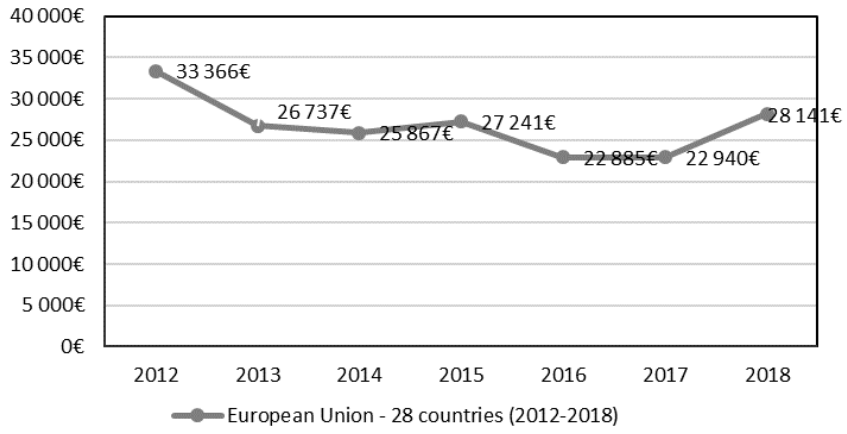
obtain credit at cheap rates, and income-tested rental subsidies to tenants[114]. Investments are financed by housing organisations. This could be explained by the fact that, in 1995, the government remitted outstanding loans to housing associations in exchange for the abolition of future subsidies ('grossing and balancing operation') which gave financial independence to housing associations. Moreover, the social housing sector is a closed system in which all revenues must be reinvested. In recent years, social housing organisations were responsible for more than 50 percent of total Dutch housing construction.

In three other Member States falling under Group 1 (**Czech Republic**, **France** and **Ireland**), social housing providers also play a role regarding the financing of the sector. In **Germany** social housing providers do not play a role as regards financing, with social housing falling under the competence of Länder since 2006. A constitutional amendment in April 2019 enabled the Federal Government to provide financial assistance to the Länder from 2020 onwards in order to fulfil the demand for social housing. Since April 2020, the federal government can provide the necessary financial assistance for social housing construction. €1 bn has been dedicated to this purpose on a yearly basis, until 2024.

In **France**, an additional funder exists through 'Action Logement', a not-for-profit organisation whose role is to manage employers' contributions in favour of housing.

According to several housing stakeholders, despite the worsening situation and the shortage of affordable housing[115] , the **available figures demonstrate a decrease in government expenditure towards housing development at EU level but also in the Member States covered by the Study**.

Figure 11 Total government expenditure towards housing development[116] in EU28, in million euro



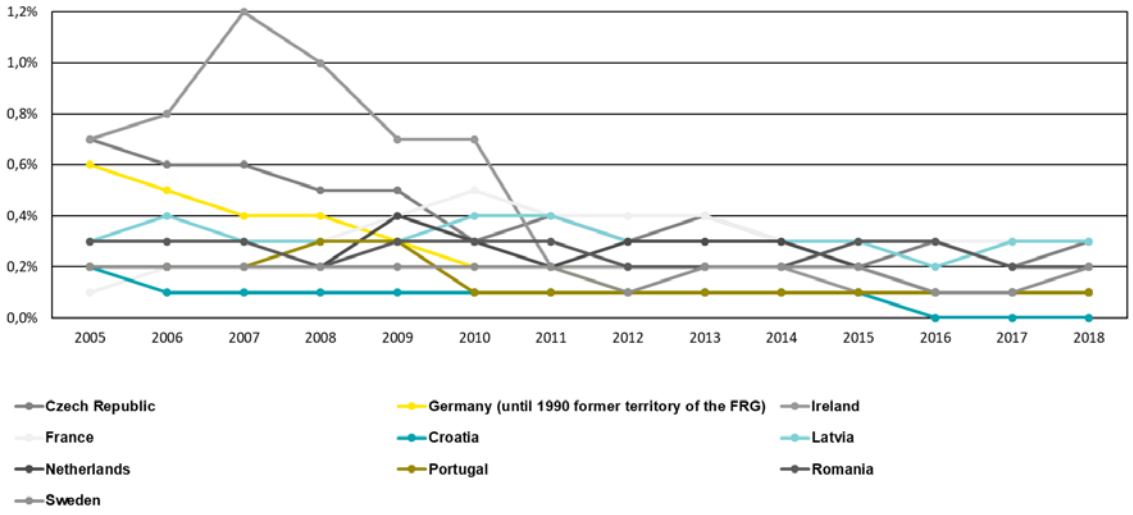
(Million euro)

[114] *Issues with defining social housing. European Economic and Social Committee, 2012*
[115] *Housing Europe, The state of housing in the EU, 2019*
[116] *Defined by Eurostat as grants, loans or subsidies to support the expansion, improvement or maintenance of the housing stock.*

Source: EY's composition from Eurostat

Between 2012 and 2018 Eurostat data records a decrease in government expenditure towards housing development at the EU28 level, from EUR 33,366 million in 2012 to EUR 28,141 million in 2018 (-16%).

Figure 12 Government's expenditure towards housing development (in percentage of the GDP)[117]



Source: EY's composition from Eurostat

Between 2005 and 2012, Government expenditure, as a percentage of GDP, towards housing, decreased for most of the Member States. It was stable for **Latvia** at 0.3% and increased in **France** (+0.3 percentage point) and in the **Netherlands** (+0.1 percentage point). From 2012 to 2018, the share was stable in the **Czech Republic**, **Germany**, **Latvia**, **Portugal** and **Romania**. It has decreased by 0.2 percentage points in the **Netherlands** and by 0,1 percentage point in **Ireland**, **France** and **Croatia**. It has increased only in **Sweden** (+0.1 percentage point).

2.3 To what extent are the sectors open to cross-border activities and investments?

Social housing and healthcare (hospitals) represent a lower risk of competition distortion [118] **than other sectors which explains their presence within the sectors exempted from State aid notifications**. Overall, stakeholders consulted in

[117] *Since 2016, the amount of expenditure has been 0% for Croatia;*
[118] *This view has been confirmed by the Survey participants. Interviewees who have expressed the same view referred to the reasons laid down in the Decision, recital (11) which underlines that "given their tasks of general economic interest", "hospitals and undertakings in charge of social services" "have specific characteristics that need to be taken into consideration. In the present economic conditions and at the current stage of development of the internal market, social services may require an amount of aid beyond the threshold in this Decision to compensate for the public service costs. A larger amount of compensation for social services does thus not necessarily produce a greater risk of distortions of competition".*

the course of this Study underlined that competition within these sectors is rather low, with the Survey launched confirming this view.

However, additional research based on stakeholder consultations and documents communicated by interviewees demonstrate that despite the scarcity of data on cross-border competition in these two sectors, recent examples underline the existence of cross-border activities and the examples of European operators active on several EU markets (see sections 2.3.1and 2.3.2below).

2.3.1 Social housing

The following examples illustrate cases of cross-border investment in the social housing sector:

- BoKlok is a low-cost home provider, jointly owned by Skanska (construction company) and IKEA. The house provider is present in the Scandinavian market and in the UK. In 2019 for instance, Boklok announced that they will deliver around 60 homes in North Somerset (UK) most of which will be for market sale while a portion will be sold to local authorities and housing associations, as part of their social housing scheme[119].
- Axa Investment Managers (Axa IM real Assets) is a French real estate manager present worldwide. In 2020, it purchased 919 units of affordable housing in Madrid which will support the provision of housing at affordable rental levels to eligible citizens that meet specific criteria[120].
- In 2020, Aberdeen Standard Investments (ASI) an international investment fund funded three French social housing providers with EUR 90 million to help achieve their social housing development plans over the coming years[121]. In their press release, ASI indicated that French social housing providers are attractive investment assets due to the "strong regulatory framework, counter-cyclical nature and predictable cash flows, with implied government support."

Although no precise figures were provided by stakeholders consulted on the evolution of cross-border competition in these two sectors, a representative of a European association active in the housing sector underlined that about a decade ago foreign residential investment started to become significant[122].

2.3.2 Healthcare

The following examples illustrate cases of cross-border investments in the healthcare sector within the EU.

[119] *See https://www.mynewsdesk.com/uk/boklok/pressreleases/boklok-uk-exchanges-contracts-on-its-fourth-development-site-3042328*
[120] *https://realassets.axa-im.com/content/-/asset_publisher/x7LvZDsY05WX/content/axa-investment-managers-real-assets-completes-forward-purchase-of-919-unit-affordable-housing-rental-portfolio-in-madrid-for-e2-82-ac150-million/24669*
[121] *https://www.aberdeenstandard.com/en/media-centre/media-centre-news-article/aberdeen-standard-investments-supports-french-social-housing--with-90m-of-investments-in-the-sector*
[122] *Interview with a representative of a European association active in the field of housing.*
The same stakeholder also stressed that despite certain complaints from private investors/landlords about the SGEI Package, the situation for cross-border investment in social housing would be much worse if there was no EU framework such as the SGEI Package.

- **Ramsay,** a French healthcare provider bought **Capio AB Group** (Sweden) in 2018 and is nowadays a leader in private hospitalisation and primary care provision in Europe, owning and managing several hospitals across France, Sweden, Norway, Denmark and Italy[123]. For instance, the Group is managing the Capio St Göran Swedish hospital which is the first and so far only privately owned emergency hospital in the country.
- **Bupa** is a health funding organisation originally from the UK, active worldwide and providing health insurance, treatment in clinics, dental centres and hospitals[124]. For instance, BUPA manages several Spanish hospitals.

2.4 How has competition on the market evolved since 2012 (Task 2)

The aim of this Section is to answer the following questions:

- How has the pressure on (public) operators evolved (e.g. increasing demand for their services, limited public budgets, higher efficiency needs);
- How has the competition between public and/or private, non-for-profit and/or for-profit operators evolved, in terms of both scope and (potential) overlaps.

2.4.1 The hospital sector

As Stated in Section 2.2.1, the amount of health expenditure increased in all Member States covered by the Study between 2013 and 2018. Despite this increase, health expenditure as a percentage of GDP has been stable between 2013 and 2018, with a high variation only observed in Ireland, where the share decreased by 3.5 percentage points.

With regard to hospital expenditure, it also increased between 2013 and 2018 in the Member States covered by the study. This increase is higher for Group 1. Based on the overall mean value of expenditure for Member States, those falling under Group 1 experienced a higher increase in their mean value in comparison to those falling under group 2.[125]

The below map shows the coefficient of variation of the hospital expenditures in order to highlight the relative importance of its evolution.

[123] *See https://ramsaygds.fr/group/history*
[124] *For instance BUPA is active in the UK, Australia, Spain, Chile, Poland, New Zealand, Hong Kong SAR, Turkey, Brazil, Mexico, the US, Middle East and Ireland. See https://www.bupa.com/corporate/bupa-where-you-are/worldwide*
[125] *The coefficient of variation (CV or relative standard deviation) is a statistical measure of the dispersion of data points in a data series around the mean value. The coefficient of variation represents the ratio of the standard deviation to the mean value, and it is a useful statistic for comparing the degree of variation from one data series to another, even if the means are drastically different from one another (https://www.investopedia.com/terms/c/coefficientofvariation.asp)*

Figure 13 Map of the coefficient of variation regarding hospital expenditure between 2013 and 2018 in the Member States covered by the Study

EY's composition from Eurostat

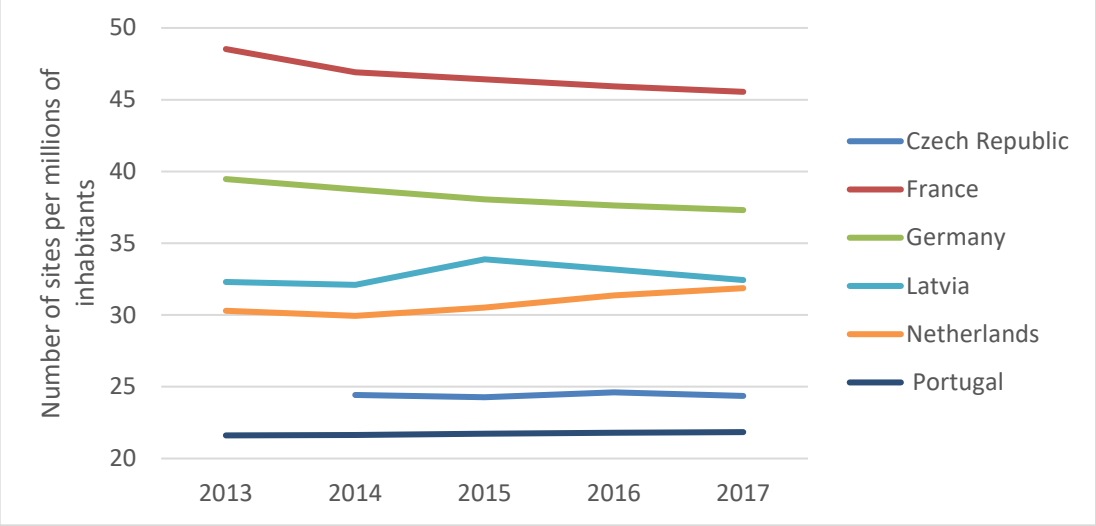
This map shows that:

- **France**, the **Netherlands** and **Sweden** represent the lowest increases;
- The **Czech Republic**, **Latvia** and **Romania** represent the highest increases.

Contrary to what was experienced with health expenditure, the number of hospitals has decreased in the Member States included in the Study, since there was an average of 33 hospitals per million inhabitants in 2013 for 30 hospitals per million inhabitants in 2018 (-8%)[126].

[126] *OECD Database*

Figure 14 Evolution 2013-2017 of the number of hospital sites per million population[127]



Source: EY's composition from OECD data

On average, in **Portugal** – the only Member State from Group 2 for which data were available – the number of sites was, on average, 65% lower than Group 1 between 2013 and 2018. During this period, variations for other Member States were low. For **Ireland**, the data was not available for 2013, 2014 and 2016. When comparing the evolution between 2012-2017, the available data show a decrease of around three sites per million population in this period (20.7 in 2012 against 17.9 in 2017). Given the low number of sites per million inhabitants in Ireland, this represents a decrease of 13%.

The data per type of ownership show that there has been a decrease in the number of hospital sites in the public sector for all Member States for which OECD data were available (see table below).

This decrease has also been confirmed with regard to the number of hospital beds in the Member States[128] included in the scope of the Study, since there were 530.4 hospital beds per 100,000 inhabitants in 2017 against 501.1 in 2012.

Table 20 Number of beds per 100,000 inhabitants in 2005, 2012 and 2017[129]

		2005	2012	2017	Evolution 2005-2012	Evolution 2012-2017
Group 1	Czech Republic	730.7	688.5	663.6	-6%	-4%
	France	680.8	620.5	598.1	-9%	-4%

[127] *This evolution regards 2013-2017 to include a maximum of Member States covered by the Study (data for Romania and Croatia is not available on the OECD – data regarding Czech Republic starts in 2014 because of break in time series)*
[128] *The average excludes Croatia, Romania (data not available on OECD) and Ireland (break in time series in 2009 and 2015)*
[129] *Data for Romania and Croatia are not available on OECD. Ireland and Sweden have not been included in the table because of break in time in series in 2009 and 2015 (Ireland) and 2015 (Sweden).*

	Germany	846.2	812.5	801.6	-4%	-1%
	Latvia	907.5	613.9	554.5	-32%	-10%
	The Netherlands	430.3	376.7	328.7	-12%	-13%
Group 2	Portugal	362.5	217.6	339	-40%	-2%

EY's composition from OECD data

The data available between 2005 and 2012 for six of the Member States covered by the Study shows a decrease in the number of beds per 100,000 inhabitants. The significance of the decrease varied between Member States. The lowest decrease was 4% in **Germany** and the highest decrease was in **Portugal** (-40%) and **Latvia** (-32%).

The evolution between 2012 and 2017 demonstrates that the number of beds per 100,000 inhabitants continued to decline during this period. In **Ireland**, the 2017 data cannot be compared to the data prior to 2015 because of a break in time series in 2009 and 2015. Data available for Ireland since 2015 reveals an upward trend (+2% between 2015 and 2018) that can be explained by the expected rapid growth and the ageing of the Irish population which is projected to increase demand for hospital care further, with a projection of a need between 4,000 and 6,300 beds in public and private hospitals combined between 2015 and 2030[130].

Several factors linked to the Member States' context and national reforms account for the decrease observed above. In **France**, the decrease of the number of beds results from the choice of reducing the surplus of hospital beds and reorganising the offer (less hospital beds and more outpatient care). In France, another explanation is the strong reduction of capacity in long-term care facilities for people over 60 (80,000 beds in 2003 against 31,000 beds in 2018),[131] that were transformed into care homes for the aging dependent people. In the **Netherlands**, the significant decrease in bed capacity can be explained with the abolition in 2008 of the central planning for hospitals. The economic crisis in **Latvia** in 2008 led to the reduction in funding and thus a reduction of hospital capacity, while primary care was prioritised.

[130] *C. Keegan, A. Brick & al., How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030, ESRI Research Bulletins, 2018*
[131] *DREES, Les établissements de santé, édition 2020*

Table 21 Evolution 2013-2018 of the number of hospital sites per type of ownerships[132]

		Public hospitals	Private not-for-profit hospitals	Private for-profit hospitals
Group 1	France	-6%	-4%	-2%
	Germany	-5%	-5%	0%
	Latvia	-2%	Does not exist	-5%
	Netherlands	Does not exist	-25%	25%
Group 2	Portugal	-7%	5%	8%

EY's composition from OECD data

In **France** and **Latvia**, the decrease in the number of sites relates to all types of ownership available. In the **Netherlands**, the number of not-for-profit hospitals decreased by 25% while an increase of 25% was observed in the for-profit sector.

With regard to the Czech Republic, there has been a decrease of 1% of publicly owned hospitals between 2014[133] and 2018. In Ireland, the number of sites decreased for both public hospitals (-6%) and private hospitals (-21%) between 2012 and 2018[134].

With regard **to hospital beds per ownership**, according to Eurostat data, the number of beds per 100,000 inhabitants **between 2005 and 2012** fell in public hospitals for all Member States covered by the Study for which the data are available (**France**, **Germany**, **Latvia**, **Portugal** and **Romania**). The number of beds in not-for-profit hospitals decreased in the Member States of Group 1 (France, Germany, Latvia and the Netherlands) and increased in Member States of Group 2 (Portugal and Romania). The number of beds in for-profit hospitals increased in all the Member State for which data is available. However, the data shows that the highest increases are in Group 2 (+35% for Portugal and +645% for Romania). With regards to Group 1, the number of beds in for-profit hospitals increased by 2% in France, 13% in Germany and 28% in Latvia.

In the **2012-2017 period**, the trends observed between 2005 and 2012 for beds in public and not-for-profit hospitals continues: decrease in the public sector (except for Romania, +2%); decrease of beds in the not-for-profit sector for Group 1 and increase for Group 2. With regard to beds in for-profit sector, there has been a decrease in Czech

[132] *Data not available for Ireland, Sweden, Romania and Croatia*
[133] *The evolution of the number of sites regards the "2014-2018" period because of the break in the time series in the OECD database. Since 2014 the statistics include convalescent homes for children.*
[134] *OECD Database – data not available for 2013*

Republic, France and Germany and an increase in other Member States (Croatia, Latvia, Portugal and Romania).

The fact that, in most of the Member States, the legislation evolved in order to reduce the costs and to reinforce the patients' rights by encouraging private actors to enter the market but also by reviewing the funding system of the healthcare sector including hospitals could explain these trends.

For instance, in **Germany**, at the Federal level, reforms have led to the progressive introduction of competition between healthcare providers which are now able to attract people based on different tariffs and reimbursement schemes[135]. In **Ireland**, tax reliefs for the private healthcare system were introduced in 2002 to encourage the financing of new private hospitals, which has led since then to an increase in private hospital capacity.

The presence of the public, private not-for-profit and private for-profit hospitals in a Member State does not necessarily lead to competition between these types of hospitals. In **France**, private and public providers are theoretically competing as they provide the same services. For instance, both these ownership types provide acute medical, surgical and obstetric care. However, public hospitals also provide a wide range of surgeries including complex surgeries whereas private for-profit hospitals specialise in predictable technical procedures that can be routinely performed, requiring only a short stay and that generate profits.

In the **Czech Republic**, despite the presence of three types of hospitals, the public hospitals are largely predominant. Within the Czech healthcare system, price competition is realistically not possible, with the reimbursement of healthcare paid from public health insurance. Competition between care providers (hospitals) takes place at the level of quality and availability of care. Reimbursement based on diagnosis related groups (DRG)[136] is currently being implemented, which should support competition between hospitals on the basis of comparable parameters.

In **Romania**, the situation is different with private hospitals having increased in popularity, especially since the 2011 proposal of privatisation came into discussion. The number of private hospitals has significantly increased, from 11 hospitals in 2005 to 109 hospitals in 2012 and 147 hospitals in 2018[137] while the number of public hospitals decreased from 422 hospitals in 2005 to 364 in 2012. The increasing number of private hospitals increases the competition for money coming from the Single National Health Insurance Fund (FUNASS), between State and private hospitals. In April 2019, the Romanian government approved an emergency decree that allowed co-payments by patients to private medical service providers. The decree states that "*Individuals with health insurance who choose to benefit from medical services provided by private*

[135] *Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen, "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition", Lancet, 2017,*

[136] *"DRG systems group patients according to diagnosis or procedure with the highest amount of needed resources into a single DRG" (Kroneman M, Boerma W, van den Berg M, Groenewegen P, de Jong J, van Ginneken E (2016). The Netherlands: health system review. Health Systems in Transition, 2016; 18(2):1–239.)*

[137] *National Institute of Statistics, Tempo Online, database SAN101A, available at TEMPO Online (insse.ro), accessed 15 February 2021.*

providers concluding contracts with health insurance companies for continuous hospitalisation, clinic specialty ambulatory and outpatient clinics can pay a personal contribution to cover the difference between the tariffs for medical services charged by private providers and the fees charged from the budget of the National Social Health Insurance Fund settled by the health insurance companies"[138].

Many private hospitals in Romania have also used the strong reputation of doctors from the State hospitals to increase their attractiveness. According to a report from the Societatea Academică din România, the work carried out by a State-employed doctor in a private hospital represents a form of unfair competition[139]. Another major change was brought by the emergency ordinance 25/2020 that allows private hospitals to provide emergency medical services and treat patients with chronic diseases and be paid by the State. The ordinance establishes the same regime of payment of medical services for private hospitals and public hospitals and eliminates the co-payment principle that was introduced by way of Ordinance 27/2019. These changes have led to a growth of the private market. It is expected that the number of hospitals in private ownership will increase even more in the coming years.

2.4.2 The social housing sector

The overall European housing market is experiencing challenges and different specialised studies have depicted a housing "crisis" (see developments below).

These challenges have been identified due to the **growing risk of exclusion of the population and a growing number of households being at risk of poverty**. Currently, about 37.8% of households at risk of poverty in the EU spend over 40% of their disposable income on housing costs[140] with the housing prices constantly growing.[141]

The OECD has stressed that, over the last two decades, housing prices have grown three-times faster than households' median income, thus housing costs are not only affecting the most disadvantaged people but a wider share of households including also those who cannot afford housing at the market price but who are not eligible to social housing either. In the meantime, public investment does not compensate for the increasing demand. Since 2018, the investment gap in affordable housing has been estimated at EUR 57 billion per year[142], while the trends in the figures above (Figure 11) tend to show that public investment in housing keeps falling. This decreasing investment was already in place prior to the economic crisis of 2008 leading to the reduction of the social housing stock in most of the EU Member States[143].

[138] *Emergency Ordinance No. 27/2019 for the completion of Article 230 of Law. No. 95/2006 on health reform, available at Ordonanța de urgență nr. 27/2019 pentru completarea art. 230 din Legea nr. 95/2006 privind reforma în domeniul sănătății actualizat 2021 - Lege5.ro, accessed on 23 February 2021.*
[139] *Societatea Academică din România, Stop concurenţei neloiale public-privat în sectorul sanitar românesc, 2013)*
[140] *Housing Europe, The state of housing in the EU 2019.*
[141] *European Commission, European Semester: Country Reports, 2020*
[142] *Ibid.*
[143] *N. Pleace, N. Teller and D. Quilgars, Social Housing Allocation and Homelessness, European Observatory on Homelessness, 2011*

Table 22 List of challenges faced by the Member States in 2020[144]

Member State	Challenges
Group 1 – Social housing defined as SGEI in the Member State	
Czech Republic	• Increase of housing prices due to high demand and low supply.
France	• Increase of demand (2,1 million of households on the waiting list for social housing in 2018) while the supply of new social housing keeps declining (105,000 new units in 2017 against 98,000 in 2018) due to budget cuts; • Unmet demand is a concern for households at risk of poverty such as single parents.
Germany	• High increase of housing rent due to the housing shortage which has an impact on housing accessibility for low and middle-income households; • Gap between the demand and housing supply, especially in the social housing sector (only one-third of the demand is met).
Ireland	• Increase of housing prices and population growth led to a housing and social housing shortage; • Increase of homelessness due to housing shortage.
The Netherlands	• Small private rental housing sector due to subsidies in favour of owner-occupancy and social housing; • Early access to owner-occupancy leads to high debt-to-income ratios.
Group 2 – Social housing not defined as SGEI in the Member State	
Croatia	• Increase of house prices (an annual average rate of 10.4% in the second quarter of 2019), including an increase of rental prices above the inflation and GDP growth (+5,9% in 2019).
Latvia	• Low stock of social housing (mostly not fit for living) lead to a waiting time of up to 25 years and an increase of the social housing need.
Portugal	• Housing precarity affects mainly households in Lisbon and Porto (26,000 families)

[144] *European Commission, European Semester: Country Reports, 2020*

Member State	Challenges
Romania	• Increase of homelessness and housing exclusion due to the small size of the social housing stock, absence of policy in this area and mass eviction; • Roma people are the category the most impacted by housing deprivation.
Sweden	• Housing shortage due to change in the evolution of the demography and insufficient new buildings, • Unmet need of affordable housing in urban areas.

Source: 2020 European Semester: Country Reports

The **low social housing supply can be partly explained by national reforms or preferences**.

In France, the finance law for 2018, published in November 2017, aimed at reducing the public expenditure on housing allowances (*Réduction du loyer de solidarité – "RLS")* and the dependence of social landlords on public aid (ex: rise of the VAT tax from 5.5% to 10% for construction and renovation), which led to a reduction of financial resources for providers. Moreover, in November 2018, the ELAN (*Evolution du logement et aménagement numérique* or "housing evolution and digital development") law encouraged mergers or integration into a bigger group of social housing operators with less than 12,000 social housing dwellings.

In Germany, the social housing stock is declining in almost all Länder except Bavaria with three factors primarily explaining this trend. Firstly, one factor explaining the decreasing importance of the social housing stock in Germany is the progressive reduction of federal support and the shorter timeframe of the subsidies. Indeed, subsidies are often granted through loans and once the loans are reimbursed the housing loses its social status (e.g. the reduced price).[145] Secondly, State-subsidised homes return to the private market in Germany after a specific period of time, approximately 30 years in most cases. They are then rented out under the same conditions as any other private apartment with much higher prices. Finally, few new social housing units have recently been built in Germany, with units therefore being lost and not replaced. Even though the Federal State subsidises the building of new social houses, this is not sufficient to keep the number of social housing constant[146].

In Ireland, the trend is different. There were 2 social dwellings per 1,000 inhabitants in 2010, which rose to more than 5.5 social dwellings per 1,000 inhabitants in 2018 (+3.5 units). In fact, between 2010 and 2018, the annual number of dwellings added to the social rental stock through construction and acquisition increased in Ireland more than in any other OECD country in the same period. However, the share of social rental

[145] *Stefan Kofner, Social Housing in Germany: an inevitably shrinking Sector?, Critical housing analysis, 2017*
[146] *https://www.thelocal.de/20190814/number-of-social-housing-units-drops-by-42000-in-germany*

dwellings of the total housing stock only slightly increased between 2010 and 2018, which indicates a general increase in stock for all types of dwellings.

However, most of the Member States in Group 1 have initiated strategies to tackle the unmet needs of social housing: "Housing First in France"[147], a target of building 375,000 new flats in Germany by 2021 and "Rebuilding Ireland[148]", a programme to build 47,000 new long-term social housing homes. However, impacts of these strategies are currently limited. In the Netherlands, the housing issue relates to the under-development of the private rental sector and the high debt-to-income ratios. In the **Czech Republic**, social housing was one of the supported activities within the Integrated Regional Operational Programme (IROP), co-financed from the European Regional Development Fund. The aim of this programme is to purchase apartments or other buildings and adapt them to the needs of eligible target groups. The parameters for social housing were specified in the programme's rules and were in line with the social housing concept of Czech Republic 2015–2025. Until 2018, IROP supported 115 projects for more than EUR 23 million. This is equivalent to 600 social housing dwellings. The aim is to create 5,000 social apartments. IROP calls will be launched until 2022.

In Group 2, **Portugal** has introduced different policy measures such as the funding of municipalities to increase the public housing stock or the use of public buildings for habitation purposes.

With regard to competition, in Group 2, in the Member States where the residual approach is used (Croatia, Latvia, Portugal and Romania), no private actors are in place. Providers are mainly public authorities or organisations. In Latvia, there are also authorised associations and foundations that are not-for-profit organisations. Therefore, no evolution has occurred through the presence of private operators. In Sweden, a Member State with a universalistic approach, municipal housing companies and private owners have the same target group. Complaints to the European Commission led Sweden to implement changes in the public housing sector (see the Swedish case in Section 3.4). In order to keep their universal system and to be compliant with EU laws, municipal housing companies have to operate on the basis of 'business like principles' when competing with private owners.

In Group 1, the situation for the Czech Republic, France and the Netherlands is similar to Group 2. For those countries, no evolution has occurred with regard to private providers as only public and/or not-for-profit actors are active in the social housing sector. However, private for-profit providers are active in Germany and in Ireland.

In Germany, private actors own three fifths of the social rental housing stock. As for the other two fifths, although they represent public actors, a significant share of their stock is privately financed. One of the main factors explaining the growing privatisation of the social housing market is the privatisation of the *Wohnungsgemeinnützigkeit* (the public interest housing). These entities, so-called "social landlords", were important suppliers of social housing. In addition, private providers are now eligible to public funding and have taken over the stock of public social housing providers. In a broader perspective, the competition between the private housing market and the social housing market has been detrimental to the social housing market. Indeed, over recent years, low rates of

[147] *https://www.gouvernement.fr/un-chez-soi-d-abord-parution-du-decret-perennisant-le-progamme*
[148] *https://rebuildingireland.ie/*

interest on capital for privately financed housing construction projects have led to worsened competition conditions for the social housing sector.

In Ireland, the growing importance of the private sector, which had begun in the boom years (mid-1990s to late 2000s prior to the economic crisis in 2008) through the Rental Accommodation Scheme[149] programme (2004-2007), accelerated during the recession (2008-2012). In fact, researchers found that '*the weak private sector supply and the reliance on the same sector [public] for the supply of social housing is likely to have contributed to the growth of homelessness*'[150] which also might explain the shift towards the private sector.

The private rental market accounted for a bigger share of total housing stock in the post-2008 crisis period. The Irish government in its 2010 budget communication announced a voluntary shift towards 'cheaper' solutions for social housing delivery, such as 'leasing' and rental supports as opposed to construction and acquisition. The private rental market rather than the traditional social housing sector filled much of the affordability gap resulting from the recession. This translated into an increase in the private share of total stock of 7.5% between 2005 and 2012 – peaking at 42% of the total housing stock during recession years (2008-2012).

Because of constrained budgets less public funding was transferred to local authorities and Approved Housing Bodies, this significantly slowed down the delivery of social housing from those operators. Consequently, the two opposite dynamics between local authorities and Approved Housing Bodies on the one hand, and the socially supported private rental market on the other hand, resulted in a decreasing share for local authorities (-8%) between 2005-2012, and a slight increased share for Approved Housing Bodies (+0.5%) in the same period. However, since 2015, the State has increased its investment in the supply of local authorities' and Approved Housing Bodies'-owned dwellings (respectively +6.5% and +0.8% of share between 2012 and 2016), while also supporting those with a long-term housing need to continue living in housing obtained from the private sector. Overall, the share of the latter category nonetheless decreased until 2016.

[149] *A long-term supplement administered by local authorities which source housing from the private rental market and enter a tenancy agreement with a private landlord and the RAS recipient.*
[150] *Corrigan, E. and Watson, D., Social Housing in the Irish Housing Market, Department of Housing, Planning and Local Government, 2018*

3 Section 3: Response to Evaluation Questions: Effectiveness

Evaluating Effectiveness

In accordance with the Better Regulation Guidelines, the effectiveness analysis considers the extent to which the SGEI 2012 Package has achieved its objectives. The aim of this Evaluation criterion is to examine the extent to which the objectives of the SGEI Decision were achieved in relation to healthcare and social housing.

This Evaluation Criterion covers the following questions:

Q1. To what extent have the updated State aid rules for SGEIs facilitated the provision of health and social SGEIs while preserving the key aspect of EU State aid control?

Q1a. To what extent have the new State aid rules brought clarification and simplification to enable Member States to pursue aid measures for health and social SGEIs?

Q1b. To what extent has the awareness of Member States of SGEI rules influenced their overall application?

Q1c. To what extent have the divergences in the Member State sectors caused differences in the application of SGEI concepts?

Q1d. Which factors and specific requirements have contributed to or stood in the way of achieving the provision of health and social SGEIs?

To be able to evaluate the effectiveness of the SGEI Decision and Framework, the Study firstly examined the overall objectives of the Package and the results which were foreseen to be achieved.

To examine the extent to which the State aid rules have facilitated the provision of health and social SGEIs adapted to the population's needs, the Study first examines the extent to which the simplification of the rules through the SGEI Decision have permitted the Member States to pursue aid measures more easily. Secondly, the extent to which the concepts have been clarified are analysed.

When considering the overall effectiveness of the SGEI rules, it is also necessary to consider the extent to which Member States are actually *aware* of the rules and consider them to apply to services relating to health and social housing in the Member States.

These aspects have been analysed through qualitative interviews with stakeholders in the 10 Member States covered for this Study as well as through the online Survey and the preparation of Member State Fiches. Documentary review has enabled us to support our findings.

Summary of findings

- Although the SGEI rules do not seem to facilitate more State aid in terms of aid amounts, a certain increase in the number of SGEI regimes has been observed (Section **Error! Reference source not found.**)
- The Package has facilitated the provision of SGEIs while maintaining State aid control (Section **Error! Reference source not found.**)
- The 2012 Package has contributed to the simplification of requirements for SGEIs in healthcare and social services, although this opinion varies per type of stakeholders and sector (Section **Error! Reference source not found.**)

- Despite an effort to clarify key terms, a certain lack of clarity continues to be observed by stakeholders (Section **Error! Reference source not found.**)
- The level of awareness of the rules depends on the degree of involvement of stakeholders in the SGEI, which subsequently influences the overall application (Section3.3)
- Social housing and healthcare are organised in ways which reflect Member States' contexts, which lead to divergences in the take up of the 2012 SGEI provisions(Section **Error! Reference source not found.**)
- The factors which have most impacted the implementation of the 2012 SGEI Package are linked to the interpretation of certain provisions (Section **Error! Reference source not found.**)
- Policy evolution at national level as well as the economic and COVID-19 crisis impacted the provision of SGEIs at different levels, depending on the market and sector (Section 3.5.2)

3.1 Q1. To what extent have the updated State aid rules for SGEIs facilitated the provision of health and social SGEIs while preserving the key aspect of EU State aid control?

3.1.1 The facilitation of State aid

Although, the reporting obligations are the same for all Member States, **the figures reported do not represent the same data from one Member State to another**. National authorities must report, through the biennial SGEI reports, on the forms of entrustment, the duration of entrustment, aid measures, the compensation mechanism, typical arrangements for avoiding overcompensation, transparency requirements, and the amount of aid granted per SGEI. However, the scope of the SGEI and what is reported varies from one Member State to another and a service may be considered as a SGEI in one Member State while it will not be in another. In addition, the degree of involvement of the authorities in the drafting of the reports varies as well (e.g. for healthcare, national authorities are responsible for reporting while for social housing different types of stakeholders are involved in the process)[151]. All these factors **hinder the comparison of data between reports and explain the differences between Member States in terms of reporting.**

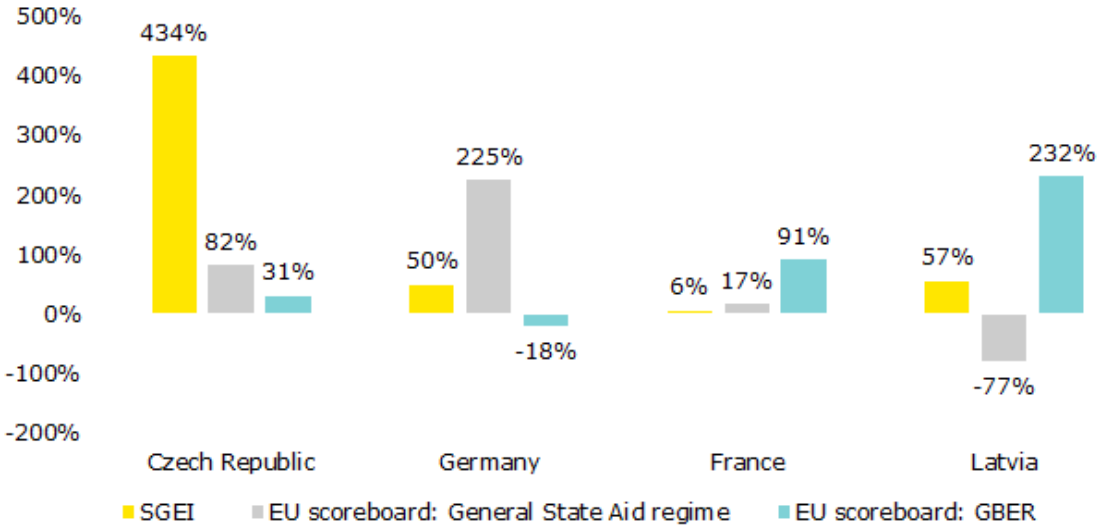
The overarching objective of the 2012 SGEI Package was to facilitate the provision of SGEI through different sub-objectives relating to clarification, simplification and a proportionate approach(see Section 2).

The comparison of the SGEI data with other types of State aid regimes shows that it is not possible to draw meaningful conclusions as to whether the SGEI rules are more effective to provide State aid than the other main EU State aid regimes recorded in the EU scoreboard[152] (i.e. in particular under the General Block Exemption Regulation[153] (GBER). This can be explained by the different methodologies

[151] *European Committee of the Regions, 2017. Implementation of the Decision and the Framework on SGEIs: involvement of LRAs in the reporting exercise and state of play as regards the assessment of social services as economic activities;*
[152] *State Aid Score Board 2019 – The State Aid Scoreboard is the European Commission's benchmarking instrument for State aid. It aims to provide transparent and publicly accessible information on the overall State aid situation in the Member States and on the Commission's State aid control activities, available at https://ec.europa.eu/competition/state_aid/scoreboard/state_aid_scoreboard_2019.pdf*
[153] *Commission Regulation (EU) No 651/2014 of 17 June 2014 declaring certain categories of aid compatible with the internal market in application of Articles 107 and 108 of the Treaty*

used to report data but also, as explained throughout this report, that the data of the SGEI biennial reports are not reported and collected in a harmonised way. Data reported for the State aid Scoreboard comprises aid expenditure from Member States that is reported on an annual basis while data reported through the biennial reports is reported by Member States on a two-yearly basis.

Figure 15 Comparison of the evolution of amounts reported under the SGEI rules and as part of regimes listed in the EU scoreboard (health, 2012-2018)[154]

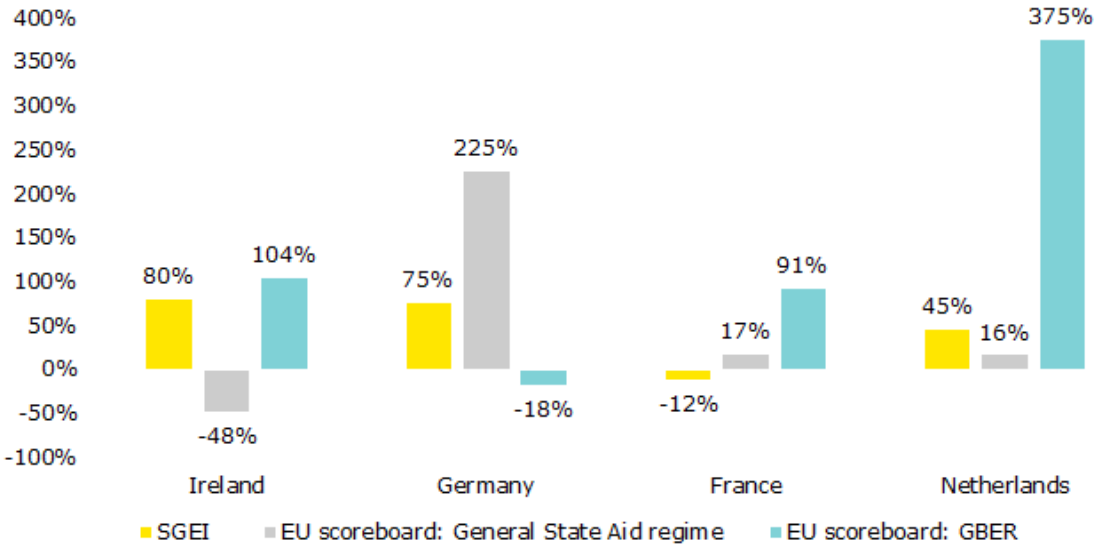


Source: EY composition from the SGEI national reports and the EU scoreboard

Note: The Member States selected for comparison cover those falling under the scope of the current Study. The amounts presented for the EU Scoreboard represent total amounts of expenditure under the General State Aid Regime (so going beyond pure health spending).

[154] *As a reminder the "The State Aid Scoreboard comprises aid expenditure made by Member States from 1.01.2009 to 31.12.2018 which falls under the scope of Article 107(1) TFEU. The data is based on the annual reporting by Member States pursuant to Article 6(1) of Commission Regulation (EC) 794/2004. Expenditure refers to all existing aid measures to industries, services (from 2014 also on Renewable Energy Schemes), agriculture, fisheries and transport for which the European Commission adopted a formal decision or received an information fiche from the Member States in relation to measures qualifying for exemption under the General Block Exemption Regulation (GBER), Agricultural Block Exemption Regulation (ABER) or the Fishery and Aquaculture Block Exemption Regulation." In the graphs, the General State Aid Regime refers to the total of aid measures reported while the GBER refers to the aid reported falling within the scope of the GBER.*

Figure 16 Comparison of the evolution of amounts reported under the SGEI rules and as part of regimes listed in the EU scoreboard (social housing, 2012-2018)

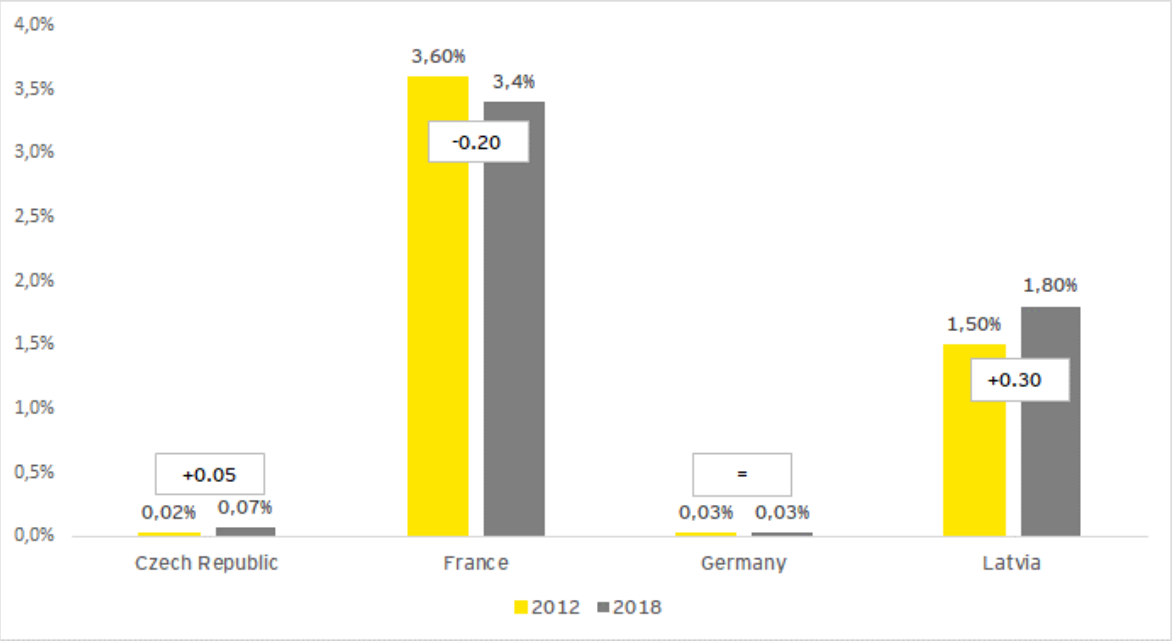


Source: EY composition from the SGEI national reports and the EU scoreboard

Note: The Member States selected for comparison cover those falling under the scope of the current Study. The amounts presented for the EU Scoreboard represent total amounts of expenditure under the General State Aid Regime (so going beyond pure social housing spending).

With regard to the evolution of SGEI spending, it is easier to draw a general trend for healthcare than for social housing. The evolution of SGEI spending for healthcare shows clearly an increase (even when the evolution of GDP is taken into account) for the **Czech Republic** and **Latvia**, with a stable expenditure in **Germany** and a slight decrease in expenditure in **France.**

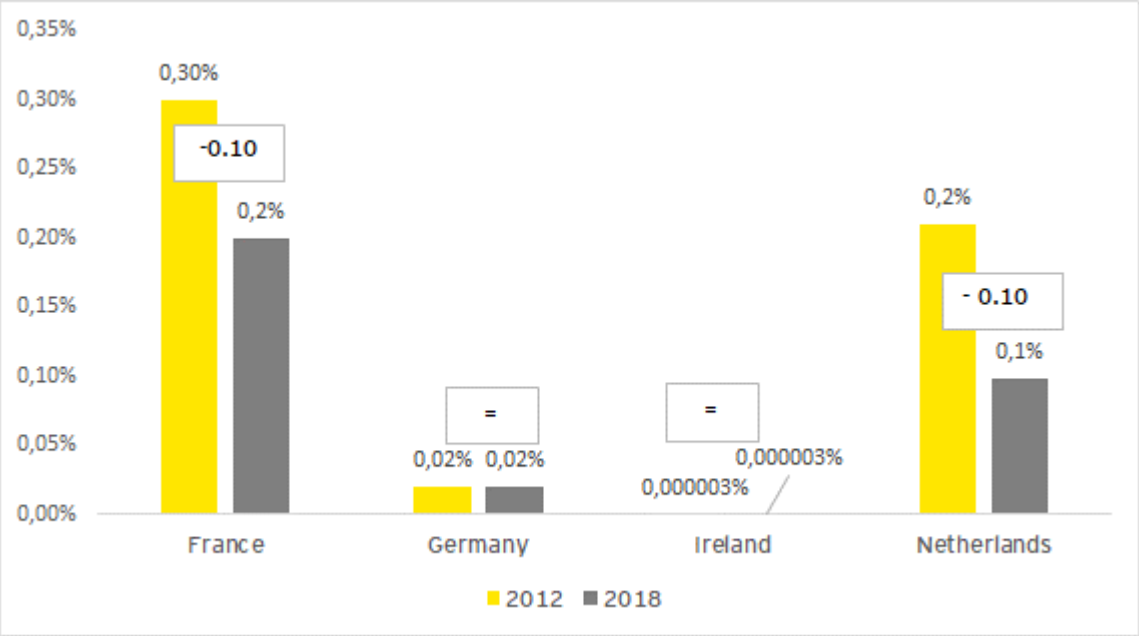
Figure 17 Health SGEI amounts granted as % of the GDP (2012-2018)



Source: EY composition from the Member States' biannual reports on SGEI

For social housing SGEIs, expenditure has remained stable for Germany and **Ireland**, while a decrease of 10 percentage points has been observed for **France** and the **Netherlands.**

Figure 18 Social housing SGEI spending as % of the GDP (2012-2018)[155]



Source: EY composition from the Member States' biannual reports on SGEI

[155] *The decrease for Ireland was of 0,00000000286%*

The context in which the social housing and health SGEIs have been provided explains certain trends in terms of government expenditure which can be analysed in light of Member States reporting SGEIs in the biennial reports.

Section 2.2 above demonstrates a certain trend when the Member States reporting SGEIs are compared to those which don't. Indeed, **despite an increase in health expenditure in all the Member States (which already existed before 2012), health expenditure is higher for the Group reporting SGEIs than for the other Member States. The same pattern is observed for health expenditures towards hospitals**.

Despite this pattern, **there are various trends within the two groups of Member States (reporting SGEI and not reporting)** since the 'newer' EU Member States of the ten selected Member States (**Czech Republic**, **Latvia**) that do not have the same level of economic development, are those experiencing the strongest increase in health expenditure related to hospitals.

Member States reporting SGEIs are also those who rely the most on compulsory contributory health insurance while Member States without SGEIs rely on government schemes.

The number of sites is also more significant for the subgroup reporting SGEI regardless of the legal structure of the hospitals in question. As for the number of beds per legal entity, this number has decreased for the public entities in all Member States. Finally, the number of sites has increased at a faster pace for private (not-for profit and for profit) hospitals in the four Member States which are not reporting SGEIs.

As for social housing, the EU trends demonstrate a general decrease in government expenditure towards housing development. No differences can be observed between the Group reporting SGEIs and the others since Section 2.2 outlines that the share of government expenditure towards housing development as a share of the GDP has only slightly increased in Sweden[156] (+0.1 percentage point from 2012 to 2018).

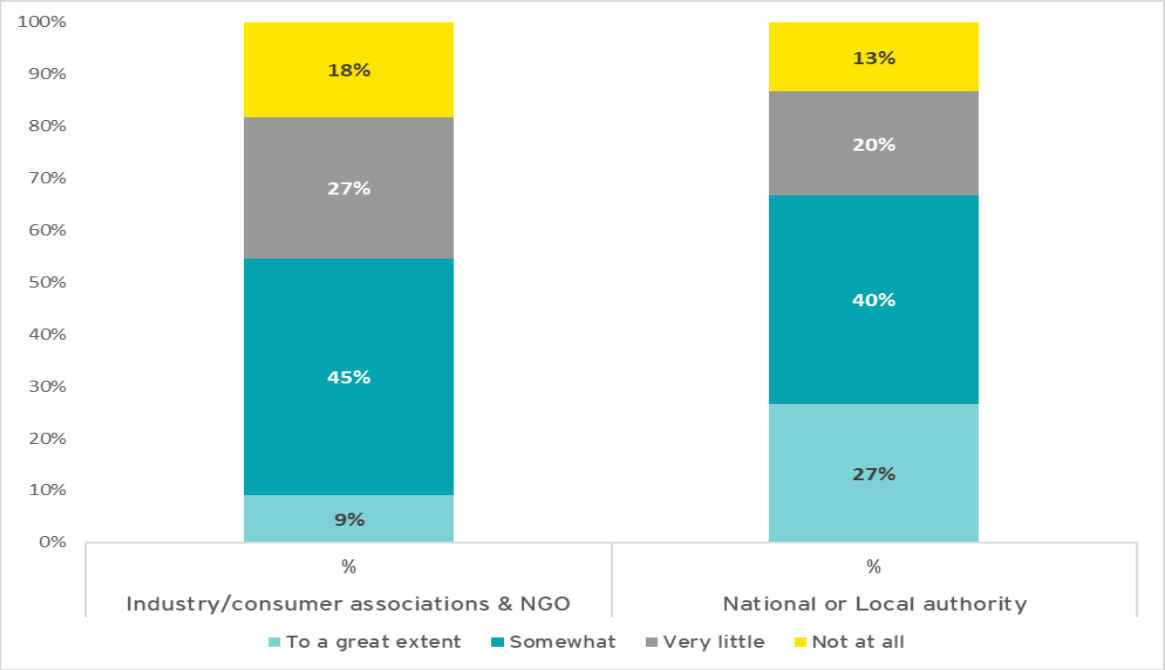
3.1.2 The preservation of State aid control

After analysing the interviews, the results of the online Survey and the targeted and Open Public Consultation launched by DG Competition, the Study found **that stakeholders perceived State aid rules as having facilitated the provision of SGEIs**. From DG Competition's Open Public Consultation, 59% of the 50 respondents considered that the Package had enabled, to a certain extent, Member States to provide SGEIs to the population at affordable conditions.[157] **This opinion is stronger among the public authorities which responded to the targeted questionnaire**, with 9 out of the 15 representatives of public authorities considering that the 2012 SGEI Package makes it possible for Member States to provide healthcare and social services to the (vulnerable part of the) population at affordable conditions.

[156] *As a reminder, Sweden is not reporting social housing as a SGEI.*
[157] *To the question "Based on your experience, have the SGEI rules applicable to health and social services achieved the objectives listed below while maintaining a competitive internal market?: To make it possible for Member States to provide health and social services to the (vulnerable part of the) population at affordable conditions.", 25.53% of respondents answered to a large extend, 34.04% to some extent*

The answers to the Survey launched by EY also shows that **stakeholders have a rather positive opinion regarding the extent to which the 2012 SGEI Package facilitated the provision of SGEIs in comparison to the situation prior to its introduction,** with 60% of respondents agreeing with this statement. 54% of industry, consumer associations and NGOs agreed to a great extent or somewhat with the statement and 67% of national or local authorities agreed to a great extent or somewhat with this statement.

Figure 19 Extent to which the 2012 SGEI Package has facilitated the provision of SGEIs in comparison to the situation prior its introduction



Source: EY Survey

Industry/consumer associations & NGO: 11 respondents

National or Local Authority: 15 respondents

Overall, stakeholders agreed on the fact that the 2012 SGEI Package has facilitated the provision of health and social SGEIs[158] although this view is not unanimously shared. Some **stakeholders underlined that the facilitation of health and social SGEIs could have been better if certain rules and concepts were clearer**. The definition of social housing as a SGEI seem particularly blurry for certain providers who questioned the fact that there is a set target group for this SGEI and not for other sectors. In addition, other actors stressed that it can be challenging to determine which services can be covered by the 2012 SGEI Package and which are excluded[159] which also comes from the fact that there are different ways of implementing the 2012 SGEI package based on the national contexts. According to these stakeholders, a greater flexibility in the definition of 'social housing' to adapt to the evolution of the housing market would

[158] *This view was stronger among the public authorities' representatives interviewed.*
[159] *Representative from a national union of tenants and several representatives of public authorities.*

be needed to unleash the full potential of the package[160] (all the challenges faced by the stakeholders will be further developed in the following paragraphs).

Stakeholders also identified several factors which facilitated the provision of SGEIs[161]:

- As with the 2005 SGEI Package, t**he 2012 Package provides legal certainty and regulatory stability**. This opinion is even stronger among providers for which this legal certainty set the ground for a predictable source of financing[162].
- As with the 2005 SGEI Package, **the notification exemption for health and social services facilitates the provision of SGEIs. Coupled with this notification exemption, the introduction of the *de minimis* ceiling of EUR 500 000 (thanks to the SGEI *de minimis* Regulation adopted in 2012) has further eased the provision of SGEIs**[163].
- **The 2012 SGEI Package brought a greater simplification of the rules.** 52% of the respondents were of the view that due to the notification exemption for certain SGEIs, the 2012 Package simplified the rules in comparison to the situation that existed before[164]. This opinion regarding the positive impact of the 2012 SGEI Package on the simplification of the rules is even greater among public authorities. Indeed, 10 out of the 15 public authority representatives who responded to DG Competition's targeted questionnaire considered that the 2012 SGEI Package helped to simplify the rules applicable[165].

S**takeholders' opinions on the impact of the 2012 SGEI Package on State aid control was also positive.** 69% of the respondents to the Survey agreed that the 2012 Package had somewhat or to a great extent helped to preserve EU State aid control. Although no specific reasons were given, this opinion was not challenged by interviewees, with none expressing a negative view on this matter.

3.2 Q1a. To what extent have the new State aid rules brought clarification and simplification to enable Member States to pursue aid measures for health and social SGEIs?

3.2.1 The simplification of requirements for SGEIs in health and social services

One of the main objectives of the 2012 SGEI Package was to achieve a simplification of the applicable rules (see Section2), linked to this was the aim of the package to clarify definitions. In relation to the simplification of requirements, the scope of the sectors subject to the notification exemption was broadened and the threshold below which public compensation is not considered as State aid was increased to EUR 500 000 per

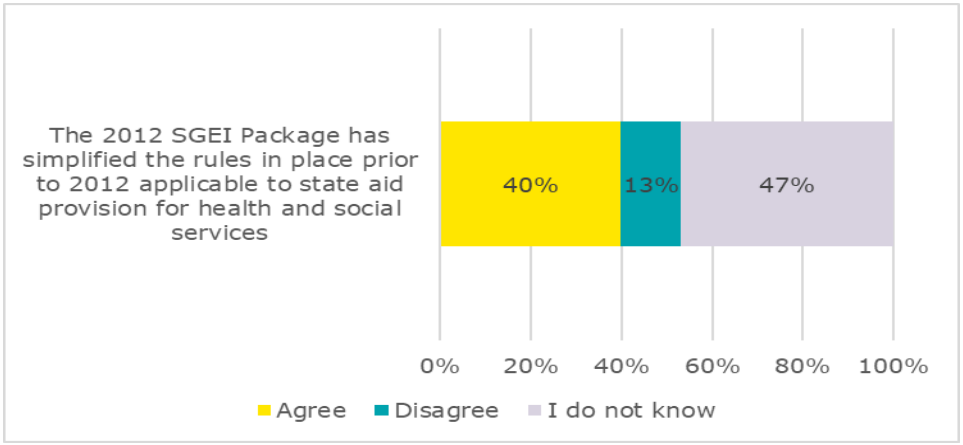
[160] *Interview with a representative of EU housing association*
[161] *These factors will be further developed in the following section especially on what concerns the simplification brought by the Package*
[162] *Interview with a representative of a national association of social housing providers and a representative of a public authority.*
[163] *Representative from EU association for housing.*
[164] *To the question: "Based on your experience, have the SGEI rules applicable to health and social services achieved the objectives listed below while maintaining a competitive internal market?: To simplify the State aid rules applicable to health and social services/SGEIs compared to the 2005 Package by exempting them from notification to the Commission?" 30% of the respondents have answered to a large extent and 42.50% to some extent.*
[165] *5 consider that it has simplified the State aid rules to a large extent and 5 to some extent.*

undertaking and per three fiscal years (compared to the general *de minimis* ceiling of EUR 200 000).

Overall, stakeholders shared a common opinion on the fact that the 2012 SGEI **Package led to a simplification of the rules applicable to SGEIs**. Of all respondents to the Open Public Consultation launched by DG Competition,[166] 72% considered that the Package had helped to simplify the State aid rules applicable and this opinion is even stronger among the public authority representatives. Although the opinion is more balanced, the Survey confirmed the results (32% agree against 30% who disagree).

However, **this positive view on simplification varies depending on the category of stakeholders**. Public authorities (national and local) were the most positive on the simplification brought by the 2012 SGEI Package since 40% agreed and 13% disagreed.

Figure 20 Survey's respondents on the simplification of the rules (public authority)



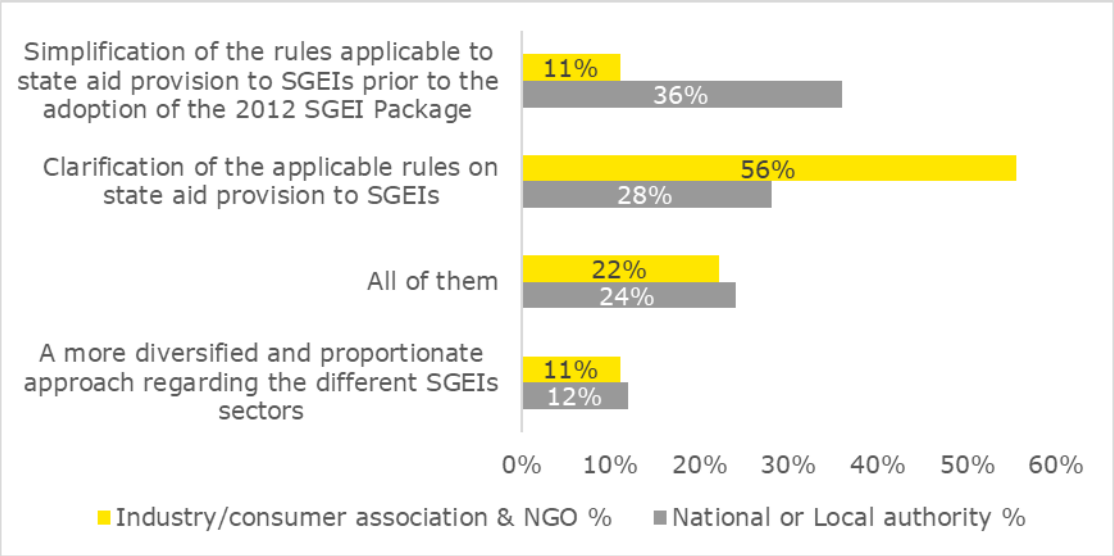
Source: EY Survey

National or Local Authority: 15 respondents

Public authorities were also the stakeholder group who considered simplification to be the main objective of the 2012 SGEI Package. This can be explained by the fact that they are the ones to interpret and implement the rules, hence the simplification of the rules had the highest impact on their workload.

[166] *European Commission, Open Public Consultation on State subsidy rules for health and social services of general economic interest (evaluation) running form 31/07/2019 to 04/12/2019.*

Figure 21: Main objective of the package per type of stakeholders



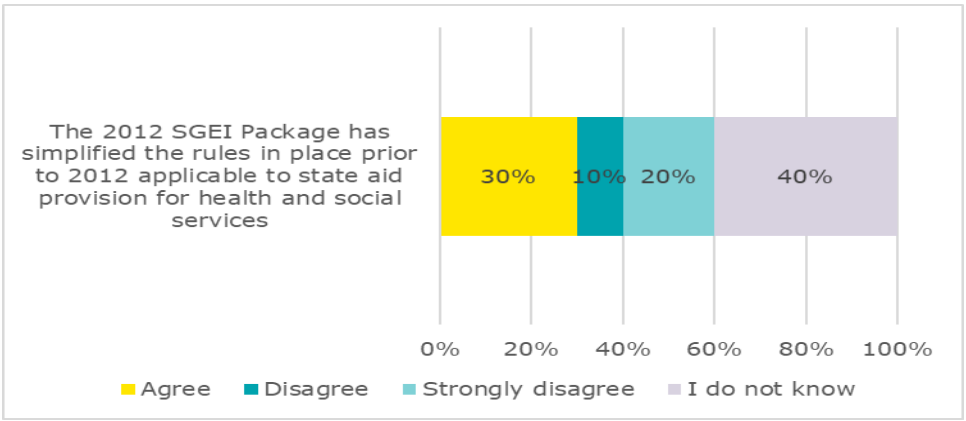
Source: EY Survey

Industry/consumer associations & NGO: 9 respondents

National or Local Authority: 25 respondents

The positive view of industry, consumer associations and NGOs on the simplification of the new rules was weaker and much more balanced. 30% of the respondents to the Survey agreed on the simplification, though 30% disagreed and 20% even strongly disagreed. This opinion is reflected by the importance attached to the clarification objective (see Figure 21). According to industry/consumer associations and NGOs, the clarification of the rules was the main objective of the 2012 Package. This is explained by the fact that their understanding of the rules is key to the business environment in which they navigate.

Figure 22 Survey's respondents on the simplification of the rules (Industry and consumer association)



Source: EY Survey

Industry/consumer associations & NGO: 11 respondents

The results of the Survey on the simplification of the rules also depends on the sector to which the respondents belong. While 38% of the respondents from the

healthcare sector agreed on the simplification brought by the package, 26% of the respondents from the healthcare sector disagreed or strongly disagreed. For the social housing sector, 46% of respondents disagreed with this statement, with 27% agreeing.

Public authorities from Member States where the definition of social housing and/or healthcare falls under the scope of the 2012 package which were interviewed concurred with the simplification brought by the 2012 SGEI Package.. These stakeholders underlined **several factors which accounted for a greater simplification of the SGEI rules:**

- **Maintaining the notification exemption for healthcare and social housing and extending it to other social services** had the strongest positive impact on the simplification of the rules[167].
- As explained above, this **notification exemption coupled with the increase of the *de minimis* ceiling**[168] significantly helped to reduce the workload of public authorities (see also Section 4: Response to Evaluation Questions: Efficiency) [169]. In other words, these two features have resulted in less notifications for the authorities in charge of implementation.
- **Several public authorities' representatives underlined that the support from the European Commission helped to simplify the implementation of the Package**. The SGEI Communication was stressed as being a good tool for helping to clarify certain terms and to provide examples on the implementation of the different terms [170]. In addition, other authorities' representatives stressed that the European Commission has provided guidance to simplify the implementation of the rules for the public authorities.[171]

The above shall be explored throughout the following sub-sections.

However, certain stakeholders also highlighted that the **lack of clarity of certain terms (see Section below) could, to a certain extent, undermine the overall efforts of simplification.**

3.2.2 The clarity of the 2012 SGEI Package

Section 2has shown that **the need for greater clarity was at the core of the revision of the 2005 Package and was clearly set as one the main objectives for the 2012 SGEI Package.**

The consultation undertaken in the course of this Study shows that a lack of clarity would undermine the implementation of the Package by resulting in heavier administrative costs [172] such as additional research for interpretation or even looking for support from externals to help to clarify certain terms (see Section 4 for further elaboration).

70% of the respondents to the Open Public Consultation **agreed with the fact that the 2012 Package clarified the rules pertaining to SGEI**., **The respondents to**

[167] *These points were underlined by several public authorities' representatives consulted in the course of this study.*
[168] *With the EUR 500 000 de minimis ceiling, there are less aid to notify hence the simplification.*
[169] *This point has been underlined by several public authority representatives.*
[170] *Interview with a public authority.*
171 Interview with a representative of a Permanent representation.
[172] *This point has been highlighted by several public authorities' representatives.*

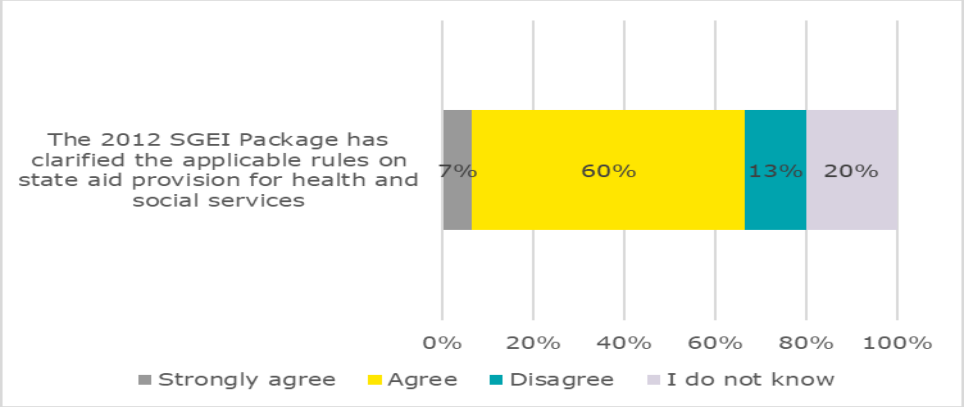
the Survey confirmed this opinion to a large extent since 39% of them had a positive view on the clarification while only 14% disagreed or strongly disagreed.

Again, **this opinion was more strongly shared by public authorities in the Survey, since 67% agreed on the clarification brought by the 2012 SGEI Package**. Officials who saw an improvement in the clarification underlined the following points as being helpful for the clarification:

- The assistance provided by the SGEI communication to understanding technical provisions (i.e. through the simplification of certain terms or the details provided);
- The guidance provided by the European Commission to support the implementation.
- The opportunity to consult the European Commission (DG Competition) to receive further explanations (see also Section4.3).

Nevertheless 13% of the public authorities disagreed with the fact that the 2012 Package clarified the SGEI rules because of certain challenges detailed in the paragraphs below.

Figure 23 Survey's participants on whether the package has clarified the rules (public authority)



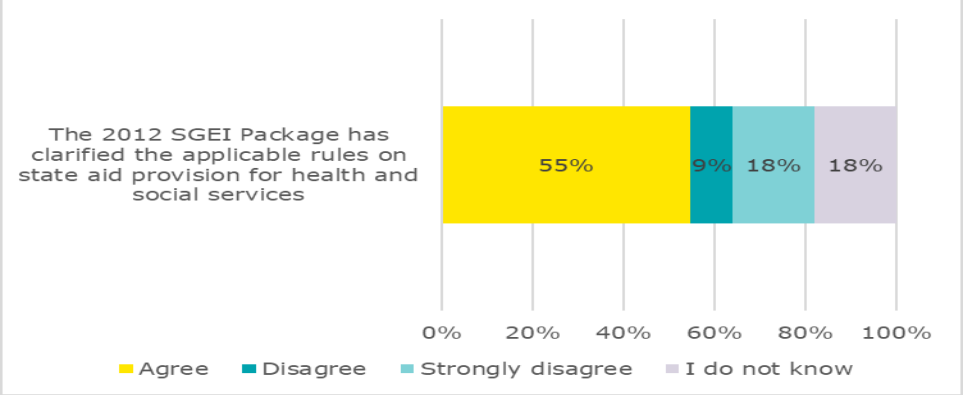
Source: EY Survey

National or Local Authority: 23 respondents

Although **industry, consumer association and NGOs considered the clarification of the rules as the main objective of the 2012 SGEI Package, they tended to be less positive on the achievement of this objective**. In comparison with the public authorities, 55% considered there to be clarification while 27% disagreed among which 18% strongly disagreed. Certain concepts remained blurry (see the paragraphs below), with some respondents stressing that while the Package clarified certain terms, its implementation in the national framework remained opaque and complex[173], with others underlining that the level of understanding mainly improved for public authorities but not for the other stakeholders[174].

[173] *Representatives of national mutuality.*
[174] *Representatives of industry associations.*

Figure 24 Survey respondents on whether the 2012 SGEI Package has clarified the rules (industry/consumer associations)



Source: EY Survey

Industry/consumer associations & NGO: 11 respondents

Respondents to the Survey from the social housing sector were less positive on the clarifications brought by the 2012 SGEI Package. 33% had a negative view on the clarification while none of the respondents from the healthcare sector shared the same view. This can be explained by the fact that the social housing definition (see below) contained in the SGEI Decision is perceived as one of the most controversial terms within the Package.

Room for improvement was identified in this regard, with certain concepts still considered to be opaque or not fit for purpose. A number of elements were identified by stakeholders which could further benefit from clarification.

The format of the reporting

Certain national authorities in the Member States covered by the Study stressed issues with the reporting process and details required. The method of presentation is not harmonised across the country reports and certain Member States pointed out that relevant examples of how to report would be helpful[175]. Streamlining the reporting process could be achieved for instance by setting up a simple electronic template with fixed compulsory elements[176].

The definition of certain concepts included in the 2012 Package

The Study **identified remaining complexities regarding the determination of reasonable profit**.[177] A 2017 Report from the European Economic and Social Committee already stressed the challenges posed by the determination of **reasonable profit** for national authorities.[178] Stakeholders confirmed that the method to calculate this reasonable profit is complex especially for periods longer than 10 years since the

[175] *Mentioned for example in the Swedish biannual report for 2016-2017 on SGEI.*
[176] *European Economic and Social Committee, Review of Member States' reports on the implementation of the European Commission Decision on the provision of State aid to the provision of services of general economic interest, 2017.*
[177] *Article 5(1) of the 2012 SGEI Decision provides that 'the amount of compensation shall not exceed what is necessary to cover the net cost incurred in discharging the public service obligations, including a reasonable profit'.*
[178] *Ibid.*

swap rates made available on the European Commission's website[179] are only applicable for 10 years[180]. In addition, acquiring information to determine a reasonable profit can be challenging especially for activities with a social character[181]. Public authorities also faced challenges to calculate the net costs and consequently Member States applied different approaches, as presented in the table below.

Table 23 Approaches applied by Member States to calculate the net cost of the SGEI

	Hospital / healthcare sector	Social housing sector
Net costs allocation	Croatia, Czech Republic, Germany, Latvia, Netherlands, Sweden	Belgium, Czech Republic, Italy, Netherlands
Net avoided costs	Not identified for the Member States covered by the Study	Germany
Other approaches	France	France

Source: European Committee of the Regions, 2017

Although they did not specify how, several stakeholders underlined that further guidance would be welcome on the method for calculation[182].

The definition of an economic or non-economic activity

As suggested by its name, the SGEI rules apply only to activities that are considered as economic (without an economic activity there is no State aid). **However, the distinction between what represents an economic activity and a non-economic activity is not always clear**. **Finding a clear-cut definition of healthcare falling within the scope for SGEI has always been rather challenging**[183]. The challenge is present at both the level of healthcare provision and healthcare financing/healthcare insurance.

Healthcare provision will usually qualify as economic if healthcare providers offer their services for remuneration and to a certain extent compete within a market environment. When a Member State decides, on the contrary, to organise its healthcare system based on the principle of solidarity, whereby the providers are directly funded from the social security contributions and other State resources and provide their services (mostly) free

[179] *Swap rate proxies for the purpose of the SGEI Decision and SGEI Framework, available at https://ec.europa.eu/competition-policy/state-aid/legislation/sgei/swap-rate-proxies_en*
[180] *Interviews with national authorities and national country reports in France and Sweden for 2016-2017.*
[181] *European Economic and Social Committee, Review of Member States' reports on the implementation of the European Commission Decision on the provision of State aid to the provision of services of general economic interest, 2017*
[182] *Interviews with representatives of national authorities.*
[183] *European Committee of the Regions, Implementation of the Decision and the Framework on SGEIs: involvement of LRAs in the reporting exercise and state of play as regards the assessment of social services as economic activities, 2017.*

of charge on the basis of universal coverage, the sector could qualify as non-economic in nature.[184]

Another challenge identified in the course of this Study pertains **to the determination of the economic nature of an activity when an undertaking performs several activities (some economic and others non-economic)**. Also, although guidelines on the definition of an undertaking are provided through the different elements of the 2012 SGEI Package and through the European Commission Notice on the notion of State aid[185], the authorities of one Member State interviewed stressed that **the notion of an undertaking, especially when it pertains to public operators, remains to a certain extent blurry**[186].

The monitoring of compensation

The method to determine the right level of compensation was described by some stakeholders[187] as challenging but the **monitoring of the compensation** *per se* can also represent a difficulty according to a national body in charge of monitoring the absence of overcompensation[188]. The general interpretation of the way the monitoring of the compensation should be done according to the Package seems to be that the monitoring should be on each single SGEI measure. However, certain national bodies in charge of control monitor the operator's whole activity to check whether they are compliant with the 2012 Package[189].

The definition of social housing

The definition of **social housing,** as laid down in recital 11 of the SGEI Decision, was seen as opaque for several stakeholders[190]. As outlined in Section 2 above, there is no common definition of social housing among Member States and each Member State has its own interpretation, creating difficulties for national authorities to know what to include in this definition[191]. In addition, **the reference to "vulnerable groups" in the definition can lead to several interpretations. Consequently, certain stakeholders advocate that the target group should be defined more precisely and/or more broadly**[192]. According to a representative of a European association, a different approach could be to define, firstly, the share of the population really in need of housing and who should receive access to social housing and, secondly, select the operators eligible to receive aid exempted from notification to the European Commission[193]. Certain stakeholders[194] stressed that the definition of social housing as

[184] *M. Anchini, Columbia Journal of European Law, The Role of The European Union in the Healthcare Market, Nov. 27, 2016.*
[185] *Commission Notice on the notion of State aid as referred to in Article 107(1) of the Treaty on the Functioning of the European Union, available at https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=uriserv:OJ.C_.2016.262.01.0001.01.ENG&toc=OJ:C:2016:262:TOC*
[186] *Interview with officials.*
[187] *European Economic and Social Committee,. Review of European Economic and Social Committee, Review of Member States' reports on the implementation of the European Commission Decision on the provision of State aid to the provision of services of general economic interest, 2017, interviews with officials, public body competent in the social housing sector, Open Public Compensation from the European Commission.*
[188] *National body in charge of checking the absence of compensation for social housing providers.*
[189] *Ibid.*
[190] *Respondents to the Open Public Consultation think that the definition of social housing in Recital 11 is the least helpful guidance to facilitate compliance.*
[191] *Information collected during several interviews.*
[192] *These stakeholders are providers of social housing and certain public authorities' representatives.*
193 *Interview with a representative of a European association in charge of construction.*
[194] *Interviews with a representative of the national authorities and national association active in the field of social housing.*

anchored in Recital 11 champions a certain conception of social housing since it echoes the residual model (i.e. where social housing targets the poorest according to income criteria). Therefore, according to these stakeholders, it excludes *de facto* the universalistic model adopted in for example Sweden.

3.3 Q1b. To what extent has the awareness of Member States of SGEI rules influenced their overall application?

The level of awareness of stakeholders of the SGEI provisions

The Study found that the level of awareness of the rules depends on the degree of involvement of stakeholders in the SGEI. **Among the national authorities, the level of awareness depends on the relation with the 2012 SGEI Package**. The European Affairs department or the unit in charge of State aid is usually and logically more aware of the SGEI rules than other parts of the public administration. The degree of awareness also varies between central and local authorities, for example municipalities are often less aware of the SGEI rules.

In some Member States, a centralised office or department responsible for providing guidelines and information on the 2012 SGEI Package has been created. This is the case, for example, in **France** with the EU Affairs Department having a coordinating role towards other Ministries and in the **Netherlands** where a knowledge centre at national level has been created which organises information meetings about State aid topics. Such activities were considered by stakeholders as beneficial to provide guidance and clarity with regard to SGEI rules, when needed. In other Member States (e.g. **Romania**) the Ministries in charge of State aid are in permanent collaboration with the competition authority which is in turn in contact with DG Competition. Stakeholders highlighted that when needed they can ask questions to DG Competition[195].

Overall, **the Study found that operators are naturally more aware of the national rules implementing the 2012 SGEI Package rather than the package itself**. Moreover, between operators, those entrusted with a SGEI are more aware of the requirements than those who are not (often private actors). **Overall, the knowledge of SGEI rules could be improved.** Certain stakeholders[196] underlined that operators are not always aware of the different State aid rules and opportunities and that the information can be challenging to find. In **Romania** for instance, certain Ministries try to organise awareness raising events with businesses and operators and provide a centralised platform on the opportunities linked to State aid grants.

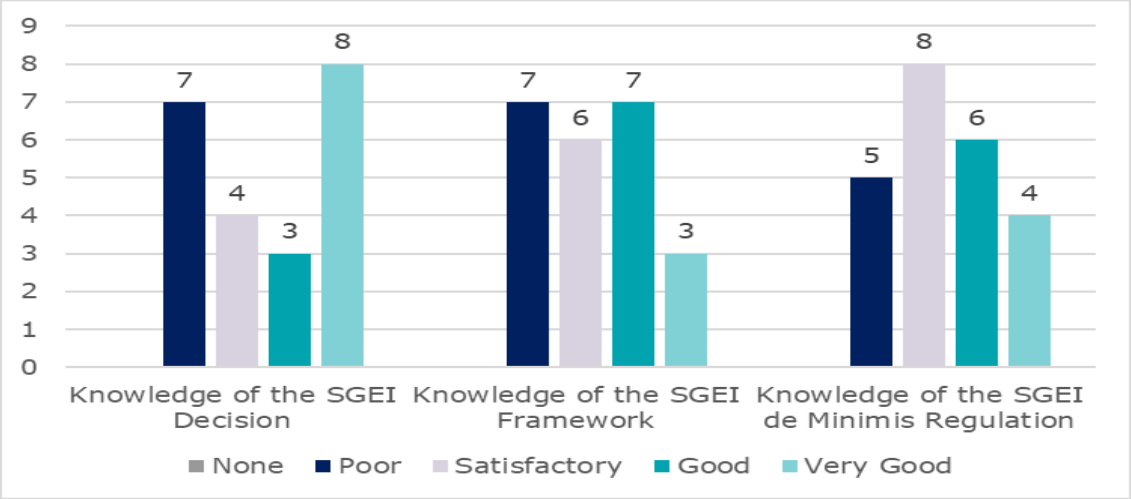
The level of awareness of the 2012 SGEI Package also varies between the hospital and social housing sectors. The Survey launched by EY shows that stakeholders from the social housing sector have a greater awareness of the 2012 SGEI Package. 52% of the stakeholders from the social housing sector have a good knowledge of the SGEI Decision (in comparison with 42% in the healthcare sector), 48% have a good knowledge of the SGEI Framework (in comparison to 28% in the healthcare sector) and 40% have a good knowledge of the SGEI de Minimis Regulation (in comparison to 28% in the healthcare sector). A reason for better knowledge could be that the definition of social housing is one of the most debated points of the 2012 SGEI Package and that the market size for social housing is smaller, leading to less

[195] *Interviews with public authorities.*
[196] *Ibid.*

actors and greater knowledge of specific rules (see Section 0 for further details), even if no stakeholder confirmed this view.

The Survey asked respondents to rate their overall knowledge of the SGEI Decision. Of the 22 respondents to the questions for national or local authorities, 50% considered their knowledge to be very good (36%) or good (14%) overall, with 18% of the view that their knowledge was satisfactory. However, 32% of national/local authorities responding to the Survey considered their knowledge to be poor. Similar results were found in relation to knowledge of the SGEI Framework and the SGEI *de minimis* regulation.

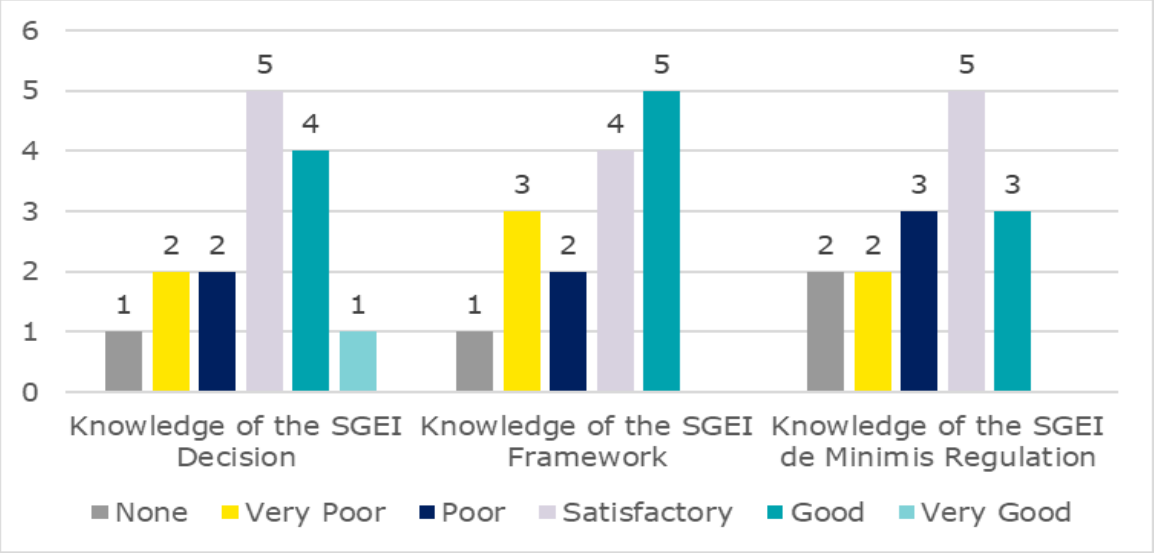
Figure 25 Stakeholder knowledge of the 2012 SGEI Package – National and local authorities



Source: EY Survey

Regarding industry/consumer associations, out of the 14 respondents to the Survey, 28% considered their knowledge to be very good (7%) or good (21%), with 36% considering it to be satisfactory. For this stakeholder group, 28% of the 14 respondents rated their knowledge however as poor or very poor. SGEI providers who also replied to the Survey (with six responses received) rated their knowledge overall to be very good (33%) or good (50%), with one respondent rating it as very poor.

Figure 26 Stakeholder knowledge of the 2012 SGEI Package – Industry/Consumer associations and NGOs



Source: EY Survey

Regardless of the category of stakeholders, the SGEI Decision is the instrument within the 2012 SGEI Package for which they have the best knowledge. This can be explained by the fact that the SGEI Decision lays down the conditions to which State aid must comply with to be exempted from notification, which is the main added value of the 2012 SGEI Package for healthcare and social services according to the stakeholders. In addition, the SGEI Decision is also the instrument which includes Recital 11 defining social housing. As shown through the Study, the target group of social housing is one of the most challenged elements of the 2012 SGEI Package, hence the better knowledge of the SGEI Decision by the stakeholders active in the social housing sector.

3.4 Q1c. To what extent have the divergences in the Member State sectors caused differences in the application of SGEI concepts?

The application of SGEI concepts in divergent Member States

As mentioned in the overview of Task 1 of this Study, **housing policy is not a competence of the EU (but State aid for the housing sector is). Thus, each Member State has the autonomy to define social housing in its own way and to reflect its national specificities.** One of the challenges of setting rules on State aid to social housing at EU level, while leaving the definition of social services to Member States, is the need to strike a balance between the freedom left to the Member States and the need to have a common ground applicable at EU level.

Consequently, in the absence of an EU-wide definition, Member States adopt different approaches when defining social housing (see Section2.2). **One Group of Member States has a generalist approach, with this Group reporting social housing as a SGEI** (**Czech Republic**, **France**, **Germany**, **Ireland** and the **Netherlands**). This is explained by the fact that this approach is the closest to that used in the SGEI Decision and it refers to specific criteria (income, household composition) to define the eligible group to social housing. As elaborated below, clearly defining the group eligible for social

housing and its defining criteria has been requested in particular in the Dutch case).[197] Therefore, it is also logical that Member States with clear target groups report social housing as a SGEI. However, even within the group of Member States reporting social housing as a SGEI, there are different approaches in defining social housing, the target group and the recipients of State aid (see Section 2.2 for further details).

On the contrary, **the group of Member States not reporting social housing as an SGEI adopts mixed approaches (the so-called generalist approaches and universalistic model) and does not use the definition provided in the SGEI Decision**. For example, while Sweden has a model where everyone has access to (social) housing it has chosen not to report social housing as a SGEI since its definition does not correspond to that provided under recital 11 of the SGEI Decision.

In these Member States and due to the manner in which they have organised their social housing sector, social housing is considered a non-economic activity. Therefore, it would not fall within the scope of the SGEI and it is not reported as such.

According to stakeholders[198] that are not eligible to State aid for social housing projects, the way that social housing is defined in certain Member States is not in line with EU law. Therefore, in certain cases, the different national contexts and the interpretations of what constitutes a SGEI have led to complaints filled to the European Commission (see box 1 below).

Box 1 Complaints relating to the implementation of the 2012 SGEI Package in the social housing sector

The Dutch Case (2009)[199]

I. Process

In 2002, the Netherlands notified to the European Commission a State aid scheme for housing corporations (*woningcorporaties*, hereafter 'wocos'). Wocos are not-for-profit bodies, whose mission is to acquire, build and rent out dwellings that are mainly aimed at underprivileged individuals and socially disadvantaged groups. The Dutch authorities subsequently withdrew their notification. In 2005, the European Commission informed the Dutch authorities that the State aid scheme for Wocos was considered existing aid[200] and expressed doubts as to the compatibility of that aid with the common market. Subsequently, the European Commission and Dutch Authorities started a cooperation procedure[201] in order to bring the aid scheme in line with Article 106(2) TFEU. Third parties (institutional property investors) also lodged

[197] *Commission Decision C(2009) 9963 final, dated 15 December 2009, relating to State aid No E 2/2005 and N 642/2009 – The Netherlands Existing and special project aid to housing corporations, as amended by Commission Decision C(2010) 5841 final, ultimately upheld by the Court of Justice of the EU, in Joined Cases T-202/10 RENVII and T-203/10 RENV II, Stichting Woonlinie e.o v Commission, dated 15 November 2018.*

[198] *See for instance the different types of stakeholders who have filled complaints in Box 1.*

[199] *Commission Decision C(2009) 9963 final, dated 15 December 2009, relating to State aid No E 2/2005 and N 642/2009 – The Netherlands Existing and special project aid to housing corporations, as amended by Commission Decision C(2010) 5841 final, ultimately upheld by the Court of Justice of the EU, in Joined Cases T-202/10 RENVII and T-203/10 RENV II, Stichting Woonlinie e.o v Commission, dated 15 November 2018.*

[200] *Council Regulation (EU) 2015/589 of 13 July 2015 laying down detailed rules for the application of Article 108 of the Treaty on the Functioning of the European Union - DEfinition of existing aid provided in Article 1(b)*

[201] *Article 21 of Council Regulation (EU) 2015/589 provides for cooperation pursuant to Article 108(1) TFEU*

complaints before the European Commission against the State aid scheme for the wocos. Appropriate commitments were proposed by the Dutch authorities, which were accepted by the European Commission. In 2009, the European Commission adopted its decision, according to which, and in light of the commitments offered by the Dutch authorities, it decided not to raise objections. Three Dutch housing corporations appealed the European Commission decision before the General Court of the EU, which led to lengthy proceedings before the Court of Justice, which, however, ultimately confirmed the European Commission decision.

II. Substance

The measures in the Dutch State aid scheme included State guarantees for loans granted by the Guarantee Fund for the Construction of Social Housing, project based aid or rationalisation aid in the form of loans at preferential rates or direct subsidies by the Central Housing Fund, sale of land by municipal authorities at below market value prices, and a right to obtain loans from the *Bank Nederlandse Gemeenten*.[202] In addition, the Dutch measures also included a special project aid for certain districts, which aimed at the regeneration of declining urban areas. The European Commission found that the wocos were undertakings in the meaning of Article 107 TFEU. In this regard, the European Commission confirmed that the wocos were providing services on a given market and that there was competition from other entities (private landlords and property developers) offering similar services that would be substitutable to the ones offered by the wocos. The European Commission then examined whether the compensation obtained by the wocos was in fact a compensation for the public service costs incurred by the wocos. In this regard, the European Commission referred to the *Altmark* criteria[203], which need to be met for public measures to be regarded as compensations for public service obligations and for them to escape being regarded as State aid under Article 107(1) TFEU: 1) the recipient undertaking must have public service obligations to discharge, 2) the parameters on the basis of which the compensation is calculated must be established in an objective and transparent matter, 3) the compensation must not exceed what is necessary to cover the costs incurred in the discharge of the public service obligation and 4) where the undertaking, which is to discharge the public service obligation is not chosen in a public procurement procedure, the level of compensation must be determined on the basis of an analysis of the costs which an undertaking, well-run and adequately provided with appropriate means would have incurred in discharging the public service obligation. In the case at hand, the European Commission found that the last Altmark criterion e was not met.

The commitments offered by the Dutch government concerned three types of activities: (i) construction and renting out of dwellings to individuals, (ii) infrastructure and (iii) construction and renting out of public purpose buildings.[204] They included the adoption of concrete thresholds for the determination of the target groups that could benefit from social housing, the maximum rent that would apply to social housing, ensuring that the dwellings in each woco are allocated to the appropriate target group, the institution of specific monitoring and audit mechanisms that would ensure that the relevant thresholds and overall commitments are observed. They also introduced conditions for public purpose buildings, namely that only establishments that serve a public purpose would qualify for aid.[205] As mentioned above, as a result the European Commission did not raise any objections to the notified measures. The Court of Justice eventually upheld the European Commission Decision on 15 November 2018.

[202] *Ibid. Commission Decision, paragraph 9.*
[203] *Judgment of the Court of 24 July 2003, in Case C-280/00, Altmark Trans GmbH and Regierungspräsidium Magdeburg v Nahverkehrsgesellschaft Altmark GmbH, and Oberbundesanwalt beim Bundesverwaltungsgericht.*
[204] *Ibid. Commission Decision, paragraph 41.*
[205] *Ibid.*

The Swedish Case (2002, 2005)

The case was brought to the European Commission by the European Property Federation('EPF') that lodged a complaint in relation to the financial support that Swedish Municipal Housing companies received from the Swedish government[206].

In 2002 and 2005, EPF along with the Swedish Property Federation filed two complaints to the European Commission. The first complaint concerned a bill from the Swedish government regarding a temporary scheme for aid to municipalities. According to the complaint, the Swedish government granted an initial EUR 300 million in subsidies to municipal housing companies (MHCs) in Sweden. Per the question raised to the European Parliament, *"[t]his included purchasing non-viable housing from MHCs for conversion to other uses and providing MHCs with equity capital and loan guarantees. The distortion of competition ensues from the fact that MHCs are not providers of social housing; they compete with private housing companies for the same tenants. The distortion is magnified by the fact that the Swedish 'utility value system' obliges local judges to set the rent of private landlords at the same rate as that of comparable MHCs. The State aid therefore enables MHCs to bankrupt genuinely private housing companies by setting rents at levels that their private competitors cannot match. The distortion is particularly relevant to the substantial and increasing European property investment in Sweden, because all of it is, by definition, private."*[207]

The second complaint concerned aid to municipal housing companies[208]. Based on a Note issued by the Policy Department of the European Parliament,[209] "*due to the 'utility value' principle in force in Sweden, two dwellings with the same characteristics should have approximately the same rent. This means that Municipal Housing Companies, receiving public subsidies, set the benchmark for all rents in the market.*" According to EPF, this practice has distorted market competition and disadvantaged real estate developers. The European Commission challenged the scheme, given that the Swedish model of social housing aims at providing housing not only for disadvantaged groups, but rather for all citizens, and consequently does not comply with the restrictive definition of social housing as a SGEI. This action led to the Swedish government updating its housing policy in 2007, removing this service from the list of SGEIs and abolishing the public service compensation for the Municipal Housing Companies. This decision was dictated by the desire to maintain the universalistic model of social housing without violating EU laws on competition. According to several analysts, operating according to a 'businesslike principle' could lead to an increase in rents, especially in urban areas with greater housing demand".[210] Following this legislative change, the complainant withdrew their complaint[211]. To date, the European Commission has not released any public statement on this matter.

The French Case (2012)

The complaint was initiated by the Union Nationale de la Propriété Immobilière **(UNPI),** an organisation of private developers in France[212]. More precisely, in July 2012, the UNPI filed a complaint to the European Commission about subsidies granted by the French State to social

[206] *Written question E-1381/03 by Gilles Chichester (PPE-DE) to the European Commission, 15 April 2003 in relation to "Swedish state aid to municipal housing companies".*
[207] *Ibid.*
[208] *Caroline Wehlander, 2016. Services of general economic interest as a constitutional concept of EU law.*
[209] *European Parliament, Directorate General for Internal Policies, Policy Department A, Social Housing in the EU (2013) available at: https://www.europarl.europa.eu/RegData/etudes/note/join/2013/492469/IPOL-EMPL_NT(2013)492469_EN.pdf*
[210] *Ibid, page 40.*
[211] *M. Elsinga and H.Lind, 2011. Working Paper, the effect of EU-legislation on rental systems in Sweden and the Netherlands, OJ C58 E/63, of 6/3/2004.*
[212] *Note that no formal decision was taken. See the European Commission website on the Urban Agenda for the EU, "Workshop on "State aid and Affordable Housing Investments" successfully concluded".*

housing providers. The main point of the UNPI was that part of the social housing stock does not set thresholds for access and therefore is not precise enough and specifically targeted to disadvantaged citizens.[213] A representative of UNPI, a French organisation for property owners, indicated that the complaint did not result in any public statement or decision from the European Commission.[214]

The healthcare sector

Section 2.2 has shown the variety in which Member States have organised their healthcare sector. Each having its own specificities in terms of funding of the healthcare system and hospitals or provisions of the healthcare services.

Consequently, the services included under the SGEI scheme vary from one Member State to another and this impacts the way that the 2012 SGEI Package is implemented. As detailed in Section 2.2, in the **Czech Republic**, **France**, **Germany**, **Latvia** and the **Netherlands**, providing financing for SGEIs in the hospital sector concerns the direct funding of healthcare while in Ireland, the SGEI are the payments made to health insurers in the form of a Risk Equalisation Scheme.[215]

This Risk Equalisation Scheme has led to a complaint and decision from the European Commission which resulted in the BUPA judgment[216] in 2008. The European Commission had already ruled (and approved) a risk equalisation system implemented in Ireland in 2003[217]. In this case, BUPA, a private health insurer, entered the Irish market which was dominated by VHI Healthcare DAC (VHI), publicly owned and the former monopolist. BUPA challenged the European Commission's approval before the General Court and appealed the relevant Irish decisions before the Irish courts on the fact that it was giving an advantage to VHI. The General Court upheld the European Commission Decision[218]. Later, the Irish Supreme Court found the risk equalisation system unconstitutional[219], with BUPA having already left the Irish Market.[220]

Another feature which has brought closer scrutiny to compliance with the SGEI rules is **the liberalisation of the healthcare sector (provision and insurance).**

Over the years, **the Netherlands experienced a progressive liberalisation of their healthcare sector** (healthcare providers and insurers) to reach a situation where the healthcare system is essentially a private system and where the government plays a controlling role. In 2005, the Dutch framework for health insurance was subject to a

[213] *European Parliament, 2013, social housing in the EU.*
[214] *Interview with a representative of a Housing Union.*
[215] *A Risk Equalisation Scheme is a community rating system where the insurance premiums are defined and are the same for everyone regardless of the insured age or health status. The role of the risk equalisation scheme is to transfer payments to health insurances in order to neutralise the risk profile differences. However, it should be noted that Risk Equalisation Schemes concern more health insurance (companies) than the provision of healthcare.*
[216] *CJEU, Case T-289/03 BUPA and Others v Commission of the European Communities, 2008.*
[217] *It should be noted that the European Commission has approved the Risk Equalization Scheme in Ireland in 2003, 2009, 2013 and 2016.See European Commission, Communication C(2020) 8730 final, 2020.*
[218] *See footnote 217.*
[219] *See Tilburg Law and Economic Center Law and Economics Discussion Paper, Taking the temperature: a Survey of the EU Law on competition and State aid in the Healthcare Sector. No. 2010-38, 2010.*
[220] *Further decisions on this matter have been subsequently taken by the European Commission, most recently SA.58851 Prolongation of the Risk Equalisation Scheme of 14 December 2020.*

European Commission decision, following a notification by the Dutch government[221]. In particular, the application of a risk equalisation system and the fact that the former public insurers, now private, were still receiving significant financing from public funds were scrutinised. The European Commission ruled that the risk equalisation system was compatible with the internal market, with the compensation also considered to be limited to the minimum necessary.[222]

The analysis undertaken has demonstrated that while the 2012 SGEI Package provides a general framework, the specificities existing in the Member States make it sometimes difficult to fit into the rules provided by the SGEI Package.

3.5 Q1d. Which factors and specific requirements have contributed to or stood in the way of achieving the provision of health and social SGEIs?

To assess the overall effectiveness of the 2012 SGEI rules, it is necessary to consider the specific factors that have contributed or stood in the way of achieving the overall objectives.

3.5.1 The interpretation of certain provisions of the 2012 SGEI Package

The survey launched for the **Study demonstrates that the main factors which have impacted the implementation of the package were mostly directly linked to the package and its provisions, not external factors**. 59% of the respondents to the Survey either strongly agreed (26%) or agreed (33%) that the SGEI rules are not fit for purpose and adapted to the market evolution. This can be examined in connection with the 43% of respondents who strongly agreed (7%) or agreed (36%) that certain provisions of the 2012 SGEI Package were unclear and have hampered implementation.

The fact that a share of stakeholders were of the view that certain SGEI provisions are not fit for purpose and adapted to the market echoes our analysis in Section 0 of this report. With regard to the lack of clarity of certain provisions, the issue has been analysed in Section3.2 of this report, with stakeholders underlining the following key issues in the open responses to the Survey:

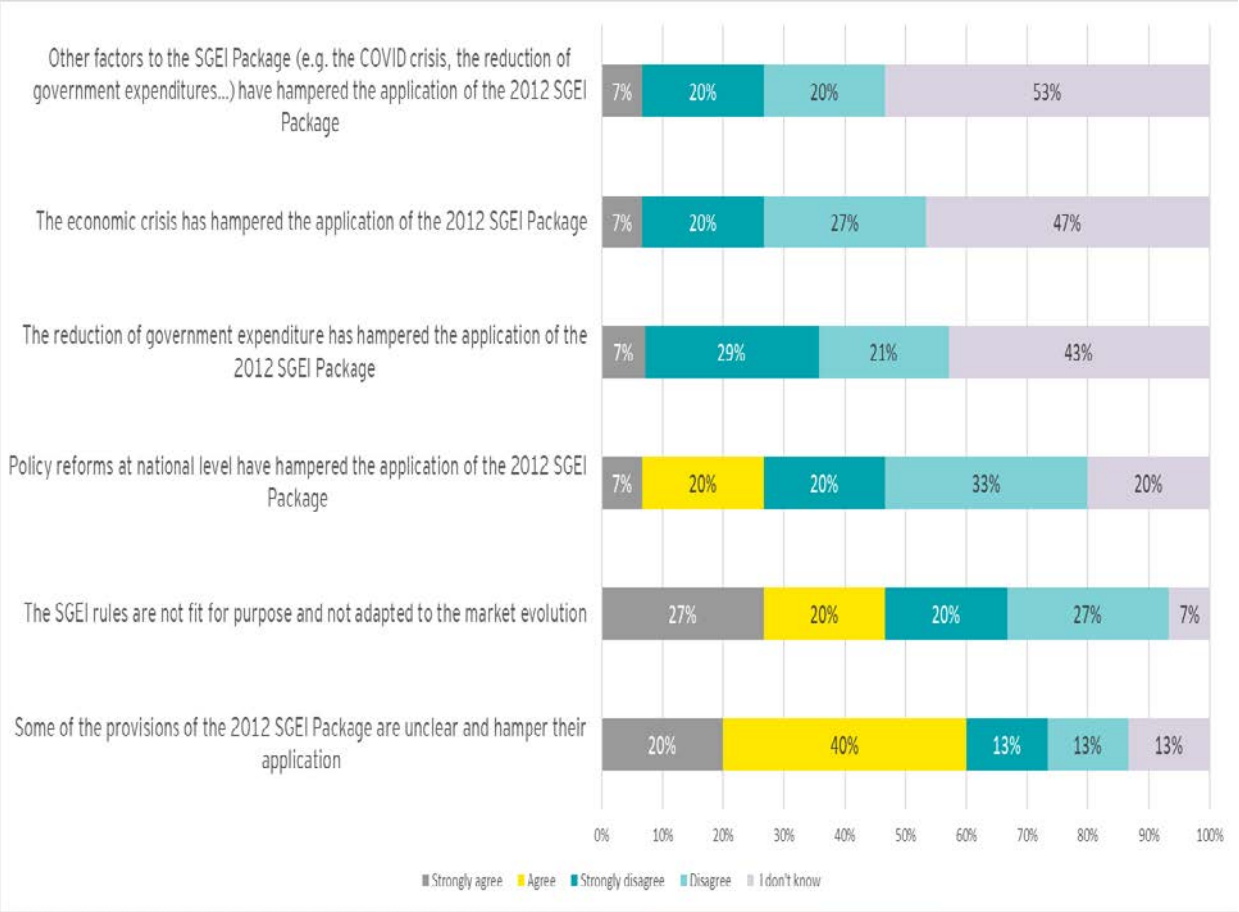
- The calculation method to check the absence of overcompensation;
- The definition of what constitutes an economic activity and a non-economic activity.

These factors, linked to the provisions of the 2012 SGEI Package itself, were identified as the two major factors hampering the implementation of the Package, regardless of the categories of stakeholders. However, industry, consumer associations and NGOs were the stakeholders with the strongest view on the fact that the lack of clarity and the lack of adaptability of the rules to the market have the heaviest impact on the Package's implementation. 69% considered that the lack of clarity of certain provisions hampered the implementation and equally 69% were of the view that the SGEI rules are not adapted to the market, with 60% and 47% of public authorities having the same review respectively. This difference can be explained by the fact that public authorities

[221] *European Commission, Decision N541/2004 and N542/2004, 2004 and Tilburg Law and Economic Center Law and Economics Discussion Paper, Taking the temperature: A Survey of the EU Law on competition and State aid in the Healthcare Sector. No. 2010-38, 2010.*
[222] *A second decision was taken on 9 July 2010 (Case No N214/2010)*

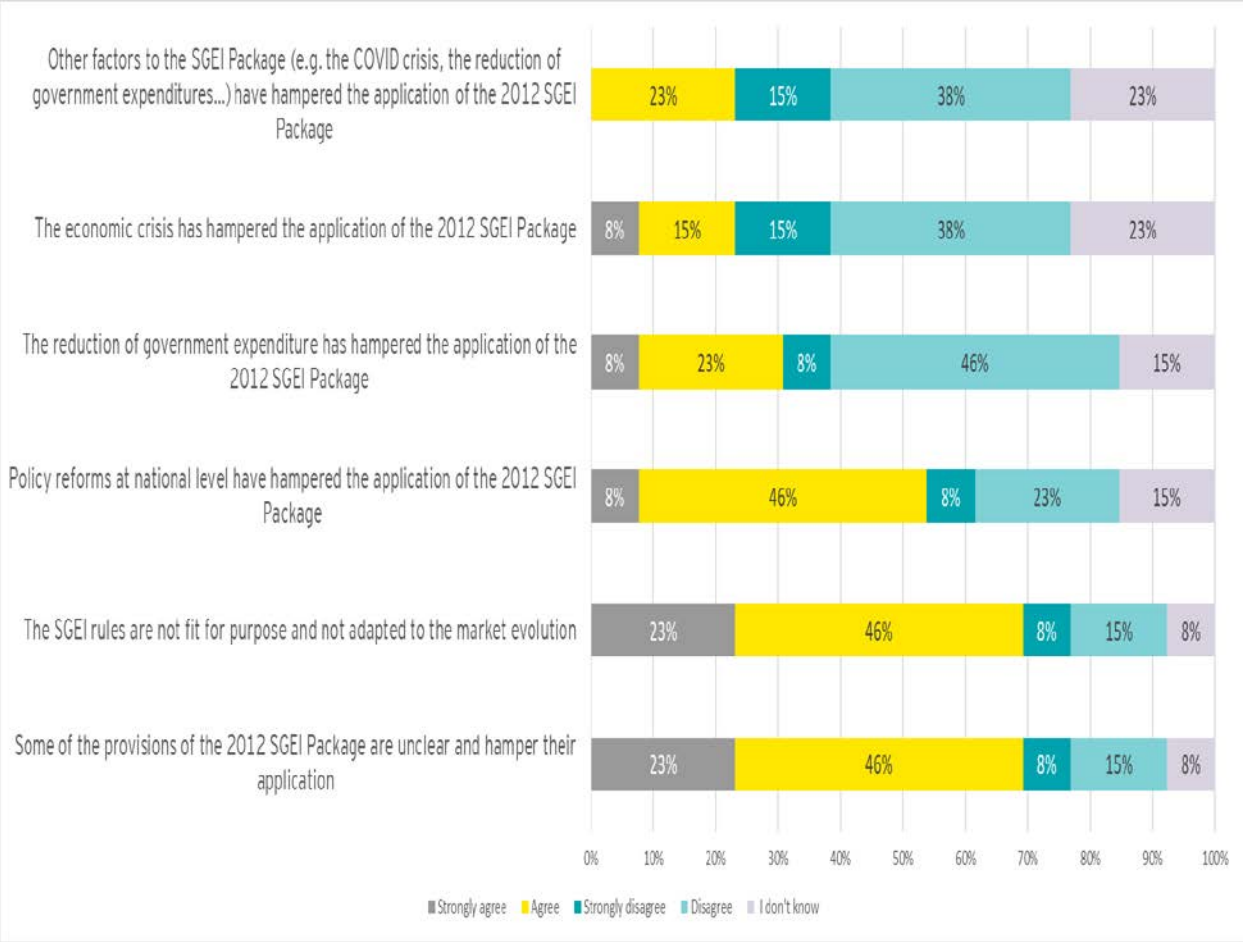
have a more positive view on the simplification and clarification brought by the Package while the gap between the SGEI provisions and the market realities has more of a direct impact on industry, consumer associations and NGOs businesses than on public authorities.

Figure 27 Public authorities on the factors which have impacted the implementation of the Package



Source: EY Survey

Figure 28 Industry and consumers associations and NGOs on the factors which have impacted the implementation of the Package



Source: EY Survey

3.5.2 Other factors impacting the provision of SGEIs

The other factors identified as potentially hampering the implementation of the Package are external since they refer to the context in which SGEIs are provided.

42% of the respondents highlighted the reform of national policies as an important factor impacting the application of the 2012 SGEI Package. This finding was supported by interviews at national level as well as research carried out for the Member State Fiches. For example, policy reforms potentially led to the exclusion of the sector from the scope of the SGEI (i.e. in Sweden). In addition, as shown in Section 2.2, the social housing definition adopted in Member States overall excludes the middle-income households from the scope of the SGEI which in the view of certain stakeholders shows that the SGEI rules are not fit for the current market situation.

Although the scarcity of financial resources as well as other factors such as the COVID-19 pandemic were mentioned as potential obstacles to the facilitation of SGEI provisions, most of the respondents to the Survey disagreed with the fact that these factors actually hampered the implementation of the 2012 SGEI Package.

This is explained, as shown in Section 2.2, by the fact that overall health expenditure increased in the Member States in which funding for hospitals falls under the 2012 SGEI Package (**Czech Republic**, **France**, **Germany**, **Ireland**, **Latvia** and the **Netherlands**) concerned by the Study. However, regarding social housing expenditure, no comparative data on social housing exists, though a 16%[223] decrease in government expenditure towards housing development from 2012 to 2018 was recorded at the EU 28 level (see figure 10 in Section 2.2.2.3). Moreover, EU associations and other stakeholders also report a decrease of government spending for social housing[224].

As for the perception of the stakeholders on the impact of the COVID-19 crisis, no common view was identified among stakeholders, given the different national contexts. Certain stakeholders underlined the fact that a greater share of the population would be in need as a consequence of the COVID-19 crisis, hence **there will be higher demand for social services including social housing**. Consequently, since more people will need social housing, some stakeholders considered that the target group falling under recital 11 of the SGEI Decision should be extended beyond vulnerable people to include a larger share of households. Other stakeholders considered[225] that at the time of the Study, the **impacts of the COVID were not yet visible** due to Member State financial support and the recovery plans (especially in Sweden and the Netherlands). So far, few tenants would have been excluded from their housing given the support measures. Instead, the **COVID crisis would have a long-term impact and the effect could be visible in the coming years**. In relation to healthcare services and especially hospitals during the crisis, stakeholders were of the view that the 2012 SGEI package could play a key role by **facilitating the provision of State aid**. However, there is a need to clarify whether certain types of activities could fall under the 2012 SGEI package (for example ICT[226]).

[223] *Eurostat data, housing development*
[224] *This point has been highlighted by several EU associations active in the field of social housing for which State aids expenditures towards social housing are too low to challenge the housing crisis.*
[225] *For instance, two representatives of national associations for social housing underlined this point.*
[226] *One representative of a national authority underlined that in the context of the COVID-19 crisis huge investment in healthcare and innovative/ICT process would be required and further guidance would be welcomed on whether ICT linked to healthcare would fall within the scope of the SGEI Package. However, no further details on what the term "ICT" covers were provided.*

4 Section 4: Response to Evaluation Questions: Efficiency

Evaluating Efficiency

In accordance with the Better Regulation Guidelines, an evaluation should always look closely at both the costs and benefits of the EU intervention as they accrue to different stakeholders.

This Evaluation Criterion considers the administrative costs and burden incurred as a result of the implementation of the SGEI rules. In addition to looking at efficiency from an administrative aspect, this criterion also examines the impact of the SGEI Decision on competition within the EU overall. However, the results should be considered in light of the research undertaken in relation to effectiveness above.

Based on the data available during the data collection phase, the Study requested stakeholders through interviews to provide estimates of costs and savings associated with the adoption of the SGEI rules in 2012.

In accordance with the Better Regulation Guidelines, efficiency considers the resources associated with the intervention, in this case with the SGEI Package and the changes generated by the Package. The Criterion examines the extent to which the desired effects of notably the SGEI Decision have been achieved at a reasonable cost. When measuring the costs and benefits associated with the SGEI Decision, the Study aimed to look at the human costs associated (in terms of time and resources) as well as the financial resources involved.

This Evaluation Criterion covers the following questions:

> **Q2. What are the costs and benefits associated with the application of the requirements set by the rules for health and social SGEIs for the different stakeholders?**
>
> Q2a. To what extent have the specific rules for health and social SGEIs enabled the provision of services without causing disproportionate administrative burden for Member State?
>
> Q2b. To what extent have the specific rules for health and social SGEIs impacted the administrative burden for service providers?
>
> Q2c: To what extent have the specific rules for health and social SGEIs had an impact on the administrative burden for the European Commission?
>
> **Q3: To what extent have the specific rules for health and social SGEIs enabled the provision of social services without distorting competition disproportionately?**

These aspects have been analysed through qualitative interviews with stakeholders in the 10 Member States covered by this Study as well as through the online Survey and the preparation of Member State Fiches. Documentary review also supported the Study's findings through the identification of examples of time and costs incurred.

Summary of findings

- The Package has to a certain extent helped to reduce costs especially due to the notification exemption and the introduction of the SGEI de minimis ceiling (Section 4.1.1).
- However, a meaningful reduction of the administrative costs has not been perceived, particularly due to the complexity of certain terms such as the definition of social housing and the distinction between an economic and non-economic activity. (Section **Error! Reference source not found.**).
- The time saved by the simplification and facilitation brought by the 2012 SGEI Package have not led to a striking reduction in the administrative costs (Section4.2).

- The administrative cost for the European Commission has remained relatively stable (Section4.3).
- The main administrative cost for providers is the obligation to hold accounting records showing the absence of overcompensation (Section4.4).
- While no distortion of competition is identified between Member States, a risk of distortion can exist at national level for private operators in relation to social housing (Section4.5).

4.1 Q2. What are the costs and benefits associated with the application of the requirements set by the rules for health and social SGEIs for the different stakeholders?

The European Commission's Impact Assessment undertaken in 2011 to assess the 2005 SGEI Package not only aimed to clarify and simplify the rules, as set out in the objectives of the 2012 SGEI Package, but also aimed to place greater emphasis on avoiding the distortion of competition and on the efficiency of the aid. The Impact Assessment outlined that '*this should avoid that the costs compensated by the State are excessively high due to the inefficiency of the provider*'.[227]

In the context of the reform of the SGEI rules in 2011, several challenges needed to be tackled. One key problem, relating to efficiency, related to the 'excessively high administrative burden for small SGEIs'[228]. The Impact Assessment from 2011 identified that both contracting authorities and undertakings may incur high costs for hiring external advice in order to clarify the rules. The problem could also be driven '*by the extent to which different sectors are affected by the current rules, in the sense that these (the rules) are too uniform*'[229]. In this case, the Impact Assessment indicated that the rules are too complex for small SGEIs. The European Commission's research showed that for certain type of activities, particularly for social services and small-scale SGEIs, a large number of stakeholders considered the SGEI Package of 2005 to be 'insufficiently flexible', with high administrative costs thus being imposed.[230]

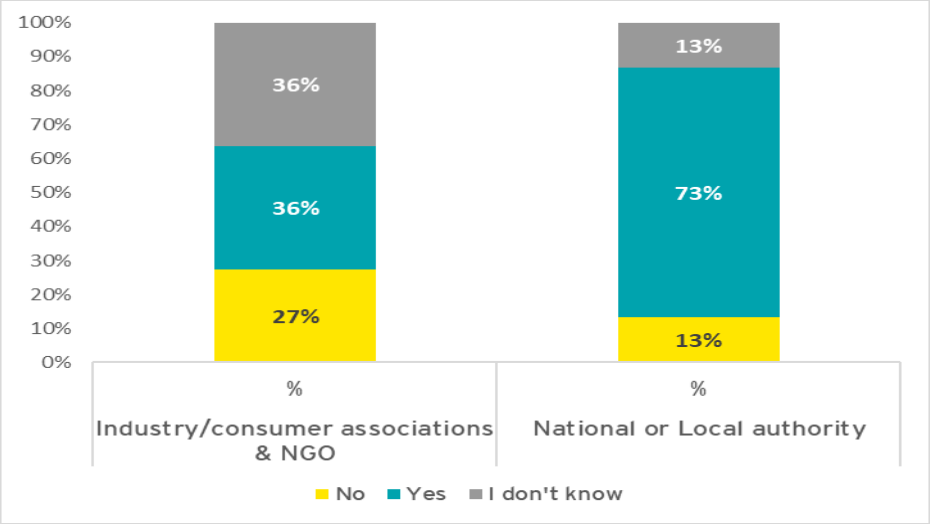
4.1.1 The reduction of costs associated with the 2012 SGEI Package

Stakeholder consultation undertaken for the Study identified several benefits associated with the 2012 SGEI Package, in comparison with the situation prior to 2012. Stakeholders consulted through **the Survey suggested that the Package brought more positive rather than negative developments** with 59% of respondents to the Survey being of this view.

National/local authorities had a more positive view on the developments brought by the 2012 SGEI Package since 73% were of the view that the Package had brought more positive rather than negative developments. This positive opinion was weaker among industry/consumer associations and NGOs with 36% of the respondents considering the developments to be more positive, with 27% not being of this view.

[227] *European Commission, SEC(2011) 1581 final Reform of the EU rules applicable to State aid in the form of public service compensation, 2011. page 10.*
[228] *Ibid page 19*
[229] *Ibid page 19*
[230] *Ibid page 20*

Figure 29. Respondents' opinions on whether the Package has brought more positive rather than negative developments



Source: EY Survey

Industry/consumer associations & NGO: 11 respondents

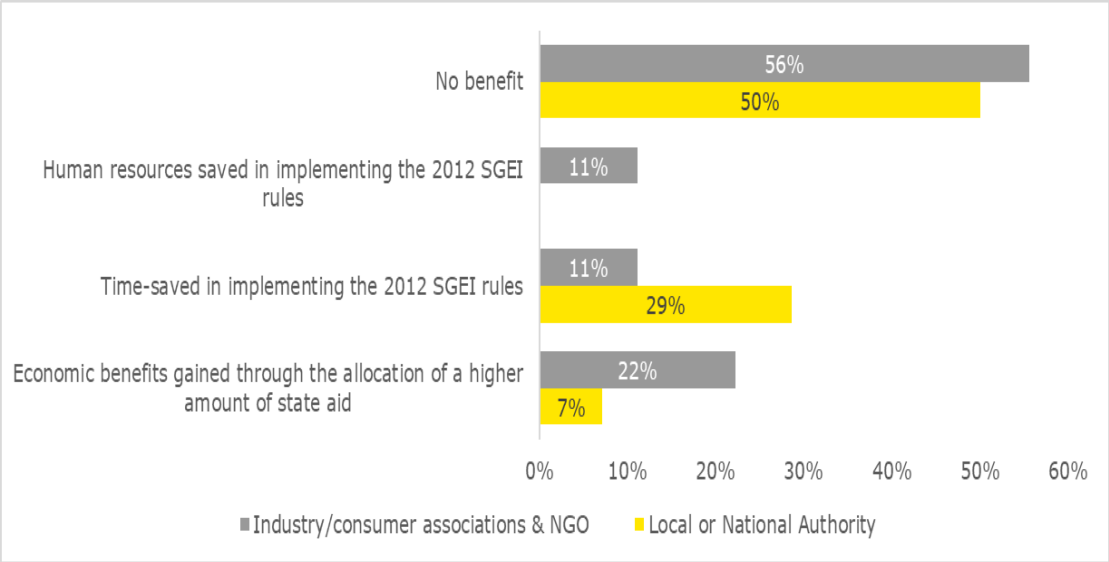
National or Local authority: 15 respondents

In addition to being asked whether the Package brought more positive rather than negative developments, stakeholders were also asked to indicate to what extent they agreed that the benefits were higher than the costs incurred.

While a large proportion of both industry/consumer associations and national or local authorities responding to the Survey were not in a position to respond to this question, **29% of national/local authorities who responded confirmed that the benefits of the 2012 SGEI Package were higher than the costs**. **66% of industry/consumer associations and NGOs responding to the Survey were equally split between those who thought that the benefits were higher and those were of the opposite view (33% for both views).**

Interviews undertaken identified that stakeholders, mostly national authorities and certain industry representatives, **confirmed that the simplification and clarification of rules provided more freedom to national authorities to provide State aid as well as more room for manoeuvre for the provision of SGEIs**. Extending the notification exemption to (other) social services (such as childcare, reintegration into the labour market etc.) and the EUR 500 000 *de minimis* ceiling has meant that a larger share of State aid does not have to be notified. Consequently, this leads to **fewer notifications** to the European Commission. This decrease of notifications has led to **time savings** for some stakeholders, as confirmed through interviews with national authorities. **Nevertheless, while national authorities from some Member States indicated that time savings were possible due to the 2012 SGEI Package, interviews undertaken with national authorities in some Member States also indicated that the Package had simply led to a change in workload** which does not necessarily represent reductions in workload (see the Section below) and thus not necessarily to a reduction in costs associated with the 2012 SGEI Package.

Figure 30 Main benefits associated with the 2012 SGEI package



Source: EY's Survey

Industry/consumer associations & NGO: 9 respondents

National or Local authority: 14 respondents

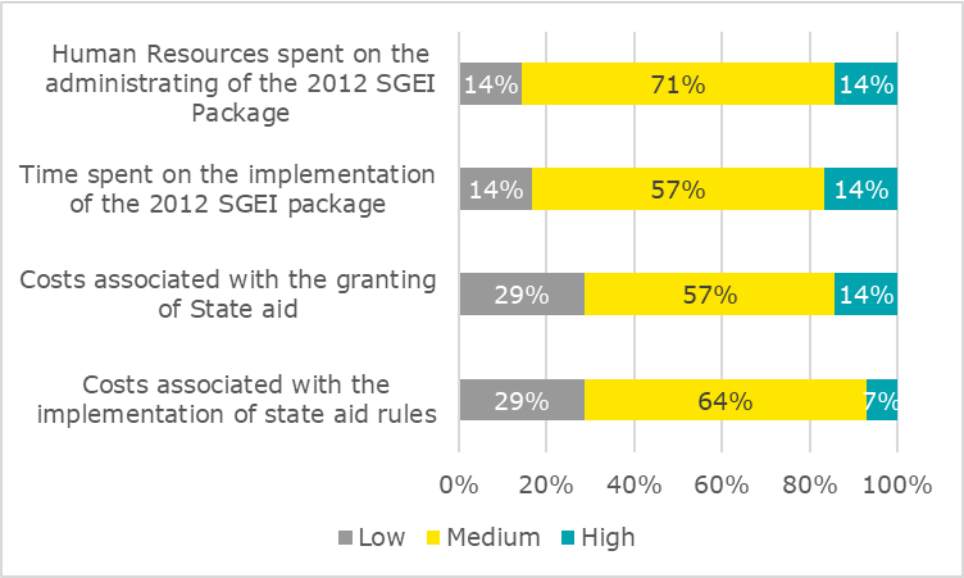
The mixed perspective of stakeholders consulted through interviews is also reflected in the results of the Survey, with the share of respondents split between those who considered that the Package led somewhat to time savings (11% of respondents from Industry/consumer associations and NGOs 29% of local/national authorities' respondents) and those who did not identify time savings associated to the 2012 Package (56% of the respondents of industry/consumer association & NGOs and 50% of respondents of local or national authority).

The type of stakeholders impacts the perception of the main benefits associated. Public authorities, who are the most positive about the effects of the Package and the benefits brought, were logically also more positive regarding the time savings due to its implementation.

4.1.2 Changes in administrative costs

Although the 2012 SGEI Package introduced new procedures and requirements which aimed to reduce the administrative burden, the gains in time savings (i.e. the removal of the notification requirement) were cancelled out by the administrative costs incurred by the new requirements. The different costs incurred as a result of the 2012 SGEI Package per type of stakeholder is elaborated on in the following section. Overall, when an estimate was possible, stakeholders considered the costs to be 'medium' (see figure 31).

Figure 31. Costs estimate associated with the implementation of the 2012 SGEI Package



Source: EY Survey

Interviews undertaken with stakeholders in the Member States covered by the Study provided further clarity regarding the types of costs incurred. The **complexity of certain provisions in the SGEI Decision**, as elaborated under the effectiveness criterion above, require technical expertise such as the distinction between an economic and a non-economic activity (especially in the healthcare sector), the interpretation of the social housing definition and the varying methods for the calculation of compensation (for further details see **Error! Reference source not found.**). **This expertise can lead to an increase in terms of time spent for interpretation and implementation as well as a need for additional staff members**. Certain structures (i.e. housing authorities)[231] have delegated these tasks to external experts (legal advisers, consultants) with at least 25% of the Survey respondents acknowledging the use of external counsel to support their work. **56% of the respondents to the Survey even declared that the administrative burden had not been reduced.** The use of external experts was a cost already identified at the time of the 2011 Impact Assessment[232] for the reform of the SGEI rules, with these costs also identified by service providers in some Member States through interviews.

In addition to the complexity of the method for cost calculation and the interpretations of legal terms, **the monitoring of the absence of compensation** itself can also be burdensome for the authorities (see the response to question 2a below).

[231] *For instance, the report from the Committee of the Regions shows that certain authorities have sought the advice of expert lawyer specialised in SGEI and State aid. See several Member States biennial reports (2018-2019) for instance Latvia and the Czech Republic.*
[232] *Ibid page 19*

4.2 Q2a. To what extent have the specific rules for health and social SGEIs enabled the provision of services without causing disproportionate administrative burden for Member States?

Time savings associated with the 2012 SGEI Package

As **shown above, public authorities were the stakeholders who had the most favourable opinion on the positive developments** brought by the Package, with most considering benefits to be higher than the costs (30% of them agreed on this point). The main benefit for public authorities (29% of these stakeholders who participated to the Survey) is **the time saved in the implementation of the rules**.

The findings outlined under the effectiveness criterion demonstrate that the novelties introduced by the 2012 SGEI Package facilitated to a certain extent the provision of SGEIs.

Even though fewer notifications helped national authorities gain some time in relation to resources, the new Package led to new administrative costs for national authorities. **43% of public authorities who participated to the Survey considered that the administrative burden had not been reduced.**

National authorities identified **time constraints** to prepare the biennial SGEI reports since the introduction of a new template for the reports for 2015/2016. It can be challenging to collect, analyse and transcript the required data especially in Member States in which many levels of governance are involved (e.g. a Federal State such as Germany)[233]. In the report from the Committee of the Regions on the difficulties experienced by the regions and cities implementing the SGEIs, the Brussels Capital Region for instance estimated that the workload needed was estimated at 7 to 10 working days per sector including the sectors relating to healthcare and social services. Based on an estimation of 15 hours per agent involved, it was estimated that this corresponded in 2014 of the mobilisation of 37 officials for a total of 567 hours including 522 hours of file analysis and 45 hours of preparation, information and coordination for the reporting per sector[234]. National authorities in the Member States covered by the Study also estimated that administrative costs had not necessarily been reduced due to the changes brought about with the 2012 SGEI Package. Instead they rather observed a shift in use of resources.

The lack of clarity of certain terms (as underlined in Section 3.2.2) required a greater effort to interpret them[235]. For instance, the methods of **calculation to prevent overcompensation** were often described as challenging by public authorities responsible for granting compensation. Moreover, the determination of the net costs or the notion of reasonable profit were also difficult especially when it comes to a social activity for which acquiring comparative data to determine the reasonable profit, or the net cost can be burdensome[236].

[233] *European Committee of the Regions,2017. Implementation of the Decision and the Framework on SGEIs: involvement of LRAs in the reporting exercise and state of play as regards the assessment of social services as economic activities.*
[234] *European Committee of the Regions, 2020. Regions and cities providing SGEIs: identifying difficulties resulting from the State aid Framework.*
[235] *Interviews with public authorities.*
[236] *Ibid. The points were also raised by several interviewees.*

Controlling the absence of compensation can also represent an additional administrative burden. Certain public authorities or bodies in charge of controlling the absence of compensation highlighted the fact that a control of the compensation every three years can be excessive and particularly burdensome for the monitoring body. Controlling the absence of overcompensation is notably burdensome because of the high number of operations implemented and financed each year[237]. As mentioned above, two approaches coexist in terms of monitoring and controlling the absence of overcompensation. First, a control per SGEI and, second, a control per SGEI provider. When the first option is chosen, the control can be highly burdensome for the authorities in charge of monitoring, since each operation must be checked to monitor whether there is a risk of overcompensation.

There is no clear answer in terms of quantification of the administrative gains represented by the notification exemption in comparison to the new administrative costs incurred. However, the majority of respondents to the targeted consultation launched by DG Competition indicated that the new level of administrative burden is rather stable in comparison to the situation existing with the previous package[238] while certain public authorities and EU associations interviewed stressed that the positive impacts of the notification exemption are larger than the new costs incurred.

4.3 Q2b. To what extent have the specific rules for health and social SGEIs had an impact on the administrative burden for the European Commission?

The administrative costs for the European Commission

Interviews undertaken with European Commission officials identified that the 2012 SGEI Package did not lead to a reduction of administrative costs for DG Competition and, at best, remained rather stable.

Healthcare and social housing were already exempt from notification under the 2005 SGEI Package. The 2012 SGEI Package did not therefore bring a radical change to DG Competition's workload in terms of assessing notifications.

However, the **notifications and the questions for clarification were considered more complex** which led to an increase in terms of administrative costs and workload. The target group that is eligible for social housing remained the same, though was questioned by more stakeholders in recent years since it is not considered fit in the reality of the market and of the housing situation (see Section 5 relating to Relevance). The lack of clarity in respect of the social housing definition, but also other concepts in the 2012 SGEI Package led to more frequent and complex internal consultation processes. It resulted in more time spent to answer questions, to explain the concepts and in a heavier workload overall. Regarding the heath sector, the concerns and questions are focused on whether the aid geared towards healthcare providers falls

[237] *Interview with a representative of a national agency for the monitoring of social housing or written contribution from local representative.*

[238] *Based on the contributions received during the Targeted Consultation, 8 respondents out of the 15 who replied to the question "To what extend did the amount of resources you spent on administrative activities with regard to health and social services change, compared to the period 2005-2012 when the 2005 SGEI package was still in force?" think that the administrative resources spent did not change after the introduction of the Package in comparison to 2005-2012.*

within the scope of the SGEI (e.g. whether healthcare services are considered economic or non-economic), also with litigation arising.

Based on the information provided by DG Competition, **the following conclusions can be drawn on the administrative costs incurred by the handling of cases** (complaints or cases coming from a Member State):

- On the basis of a sample of nine cases (of which five complaints and four coming from Member States[239]) dealt with between 2013 and 2020, **DG Competition spent 298 person days[240] on complaints and 33 on cases from a Member State** which on average represents approximately 60 person days for a complaint and approximately 8 person days for a case from a Member State.
- **Complaints require on average 7 times more person days** than cases from Member States.

4.4 Q2c. To what extent have the specific rules for health and social SGEIs impacted the administrative burden for SGEI providers?

The administrative costs for providers

The rules under the SGEI Decision exempt Member States from the notification of State aid (under certain circumstances) but in return, one of the main obligations for operators in charge of SGEI is to **hold accounting records showing that they have not received overcompensation**. Stakeholders identified the obligation to hold accounting records as the main administrative cost to bear, both in terms of time and human resources[241]. None of the SGEI providers who participated to the Survey considered that the 2012 SGEI Package helped them in the reduction of their administrative burden. The Study found through the Survey that providers were in fact the category of stakeholders requesting external support to assist them in their work.

In addition to the administrative costs incurred to generate accounting records, the following issues were also considered burdensome by several SGEI providers:

- **The entrustment act** necessary for the provision of a SGEI can be challenging to understand for the providers;
- **The control of possible overcompensation**.

Although providers are not those directly concerned by the notifications (which is done by the authorities), most of them welcome the exemption. An obligation to notify State aid would have led very likely to additional administrative requirements for the providers.

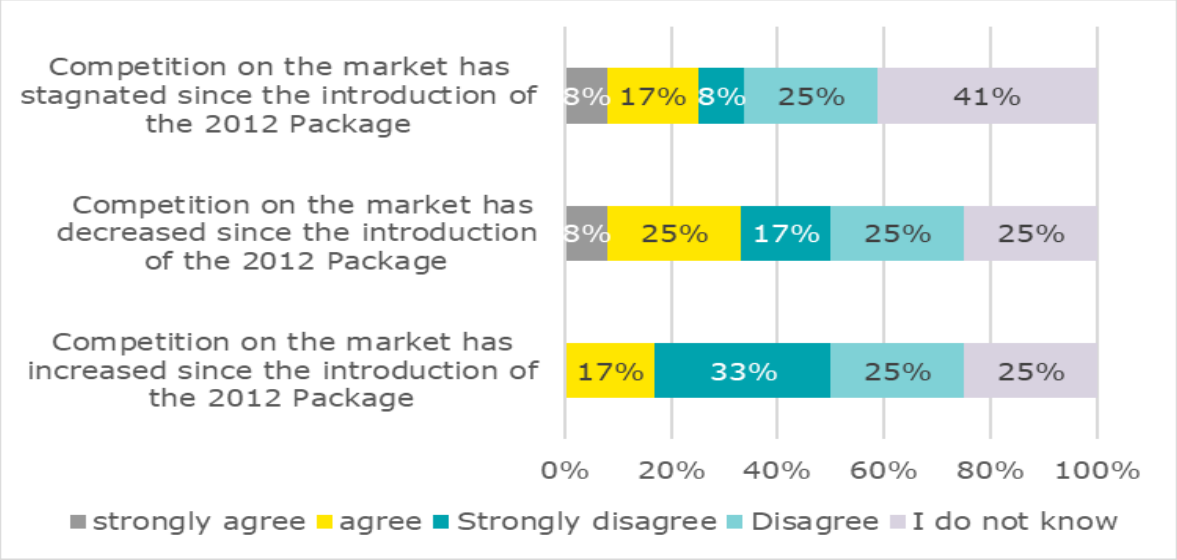
[239] *These four cases did not necessarily end in a formal Commission decision.*
[240] *One-person day is eight hours*
[241] *Again, some providers must externalise their services to legal advisors or consultants*

4.5 Q3. To what extent have the specific rules for health and social SGEIs enabled the provision of social services without distorting competition disproportionately?

4.5.1 The impact of the 2012 SGEI Package on the distortion of competition

Participants to the Survey were of the view that since the introduction of the 2012 SGEI Package, competition has not increased in the healthcare and social services sector. This conclusion is, in particular, supported by industry, consumer associations & NGOs, since 49% of them considered that competition decreased over the reference period.

Figure 32 Survey respondents' opinions on the evolution of competition since the introduction of the 2012 SGEI Package



Source: EY Survey

As outlined in Section2.2, competition is indeed rather weak, especially for social housing. In the 10 Member States covered by the Study, the type of social housing providers are to a large extent the same, since the presence of private (and for-profit) providers is well established in **Germany** and **Ireland** and to a certain extent also in the **Netherlands** and **France**. The same applies to healthcare where the competition is a bit fiercer but still rather limited.

However, based on the interviews held and the replies to the Survey, the 2012 SGEI Package is not the reason for the decrease of competition experienced. 55% of the respondents **to the Survey considered that SGEIs have been provided without disproportionately distorting competition**.

The impact of the Package on the EU cross- border competition appears even weaker since the Study has not identified, through the analysis of Member State Fiches, the existence of EU cross-border competition between SGEI providers. This was confirmed by respondents to the Survey with only 15% of the Survey respondents considering that competition at European level has been distorted.

4.5.2 Risks of distortion of competition

While 55% of the respondents to the Survey were of the view that competition has not been disproportionately distorted**, 30% considered that competition has been distorted at national level, with 15% considering this to be the case at European level.** This can be explained by the fact that, as shown in Section 2.2, cross-border activities in these two sectors is still rather marginal.

This view that competition has been disproportionately distorted is stronger among **industry/consumer associations & NGOs, who represent business interests, of which 55% considered competition at national level to be distorted disproportionately. 33% considered this not to be the case.**

This perception is also stronger among representatives of **private housing providers, landlords and property owners**[242]. Their view is rather negative in relation to the impact of social housing on competition on the **market**. The following reasons were put forward:

- By facilitating the spending of public support towards a certain category of public providers, the competition is distorted for private stakeholders since they cannot benefit from the same conditions and have to offer their goods for a higher price to compensate the absence of public support. **This situation is even truer in a "closed social housing market"**[243]. Representatives of private providers in a "closed social housing market" advocate for a notification obligation when State aid is provided to social housing. In their view, this would increase transparency.
- **The current target group for social housing should not be extended** and people eligible for social housing should be clearly defined. According to private (social) housing providers, the current target group should remain untouched since currently a large share of the population is already covered by the definition (e.g. in **France** and the **Netherlands**). Therefore, abolishing the definition of social housing in the SGEI Decision or making it broader, would mean that social housing providers compete even more with private landlords for housing targeted to middle-income households, which would lead to a greater distortion of competition. There were also private housing providers that would welcome a clearer definition of the target group for social housing which would act as a safeguard against a stronger distortion of competition.

[242] *The following developments are based on interviews conducted with members of EU associations representing private providers, construction operators, owners, landlords.*
[243] *In the so-called « open » systems, private providers contribute to the provision of social housing supply while in a "closed" system, social housing can only be provided by a number of public, semi-public or few private operators which are traditional recipients of State aid.*

5 Section 5: Response to Evaluation Questions: Relevance

Evaluating Relevance

The aim of this evaluation criterion is to examine the extent to which the SGEI rules in place for healthcare and social services are adapted to the developments of policies at national level.

To evaluate relevance, it is necessary to firstly examine and understand the needs which existed in relation to rules for healthcare and social services and the extent to which the SGEI Decision addressed these needs. Secondly, it is necessary to assess the extent to which the needs that existed when the 2012 Package was designed have evolved and whether the provisions of the SGEI Decision are still relevant to the current needs. In doing so, it is important to understand and to evaluate whether the provisions of the 2012 SGEI Package are still adapted to market developments.

Finally, it is necessary to pay specific attention to the target group of Recital 11 of the SGEI Decision which defines the people eligible to social housing in order to assess whether it is still appropriate.

This criterion aims to answer the following questions:

Q.4 To what extent were the SGEI rules for health and social housing adapted to the needs of society, markets and social policy?

Q4a. To what extent were the SGEI rules for health and social housing adapted to the needs of society, markets and social policy at the time of their adoption?

Q4b. To what extent are the SGEI rules for health and social services still adapted to the developments at national level?

Q5. To what extent is the approach for health and social SGEIs introduced in the 2012 SGEI Decision still justified?

Q5a. Is there evidence that health and social SGEIs should be treated as specific sectors due to the lower risk of distortion of competition as Stated in recital 11 of the SGEI Decision?

These aspects have been analysed through qualitative interviews with stakeholders in the 10 Member States covered for this Study as well as through the Survey and the preparation of Member State Fiches. The results of stakeholder consultation were triangulated with documentary review which enabled the Study Team to identify the needs existing at the time of adoption of the SGEI Decision and to identify changes in policy which occurred following 2012.

Summary of Findings

- The 2012 SGEI Package was adapted to the needs existing at the time of its adoption(Section5.1).
- Certain provisions of the SGEI rules could be further adapted to respond to evolving needs at national level, especially (Section5.2):
  - needs in relation to the definition of social housing as provided in recital 11 ;
  - concerns relating to the de minimis ceiling;
  - specific provisions relating to healthcare .

5.1 Q4. To what extent are the SGEI rules for health and social housing adapted to the development of society, markets and social policy?

In order to examine the extent to which the SGEI rules for health and social housing are adapted to the development of society, markets and social policy, it is necessary to not only examine the needs at the time of their adoption (Question 4a) but also the extent to which the SGEI rules are adapted to developments occurring at national level since adoption (Question 4b).

5.2 Q4a. To what extent were the SGEI rules for health and social housing adapted to the needs of society, markets and social policy at the time of their adoption?

The revision of the 2005 Package that led to the 2012 SGEI Package was built upon the need to adapt to market developments[244]:

- **Social housing**: Demand was rising with housing related expenses taking a growing share in household budgets. The aftermath of the 2008 economic crisis pushed a growing share of population into poverty leading to an increasing demand for social housing. In the meantime, public expenditure towards social housing in general was decreasing which led to budgetary constraints and the need to facilitate financing.
- **Healthcare**: Demand was rising for healthcare services while the landscape of healthcare providers was quickly evolving with a growing share of private providers competing with public ones.
- **A low risk of competition distortion for healthcare and social housing** as underlined by several interviewees[245] with a quasi-non-existent cross-border competition for these two sectors (see Section4.5).

In addition to the need to address market developments, the consultation process and the impact assessment from 2011 also identified the need for improvement:

- A greater need for **clarification** of the main concepts;
- **Simplification** of the requirements especially pertaining to notification requirements;
- A need for **diversification and a proportionate approach** adapted to the specificities of the different sectors.

As elaborated under Section 3.13.1, the approach adopted at the time of the 2012 SGEI Package turned out to be justified since the **simplification has to a large extent been achieved** due to the maintenance of the notification exemption and the introduction of the SGEI *de minimis* Regulation. Furthermore, **the 2012 SGEI Package led to an improvement in the clarification of main concepts**. One can also consider that the proportionate approach has also been successful since **the notification exemption has been extended to other sectors**.

Participants to the Survey confirmed that the approach was justified at the time of the 2012 SGEI Package's adoption with 85% of the respondents agreeing on this. This was widely shared among the respondents regardless of the sectors in

[244] *See the conclusions of the impact assessment report from the European Commission in 2011, p. 20*
[245] *Interviews with public authorities*

which they operate or the category of stakeholders they represent. However, public authority representatives were more positive (91% of them agreed with this view out of which 66% agreed to a great extent and 25% answered somewhat) than industry/consumer associations and NGOs (77% agreed).

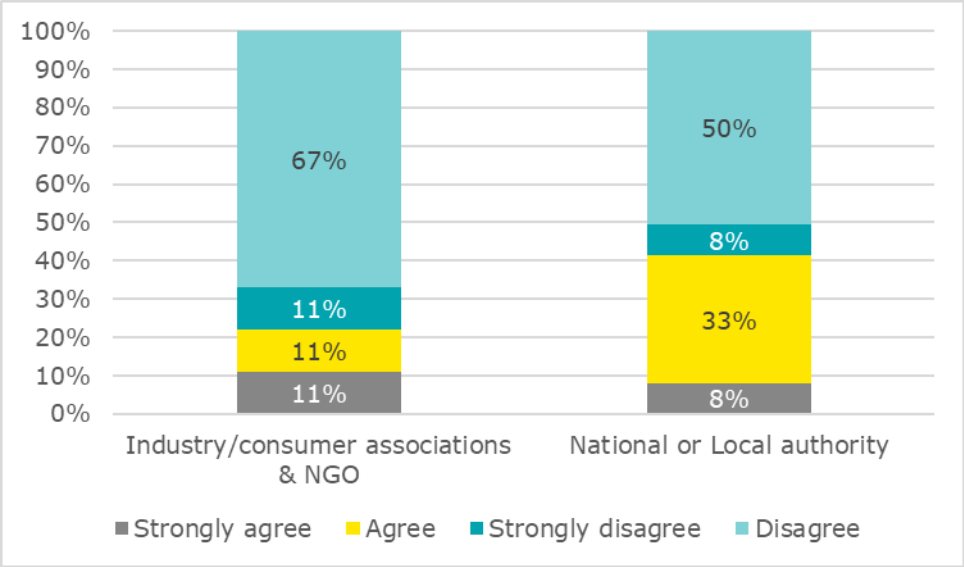
Stakeholders also agreed that the approach adopted in 2012 is still justified today. 73% of the respondents to the Open Public Consultation launched by DG Competition considered that the objectives of the 2012 SGEI Package still correspond to some extent to the current situation and 81% of the respondents to the Survey considered that it is still justified today.

5.3 Q4b. To what extent are the SGEI rules for health and social services still adapted to the developments at national level?

5.3.1 Evolving needs at national level

The Open Public Consultation from DG Competition revealed that stakeholders are rather sceptical about the extent to which the objectives are adapted to the current market environment. 38% of the 50 respondents to DG Competition's consultation considered that the objectives corresponded to a large extent to market's developments while 35% were of the view that they only corresponded to some extent and 14% indicated that they did not correspond at all. The results of the survey also show that stakeholders, regardless of the category represented, were of the view that the rules should be adapted and are no longer adapted to their needs.

Figure 33 Respondents' opinions on whether the rules are still adapted to the needs of the different stakeholders



Source: EY Survey

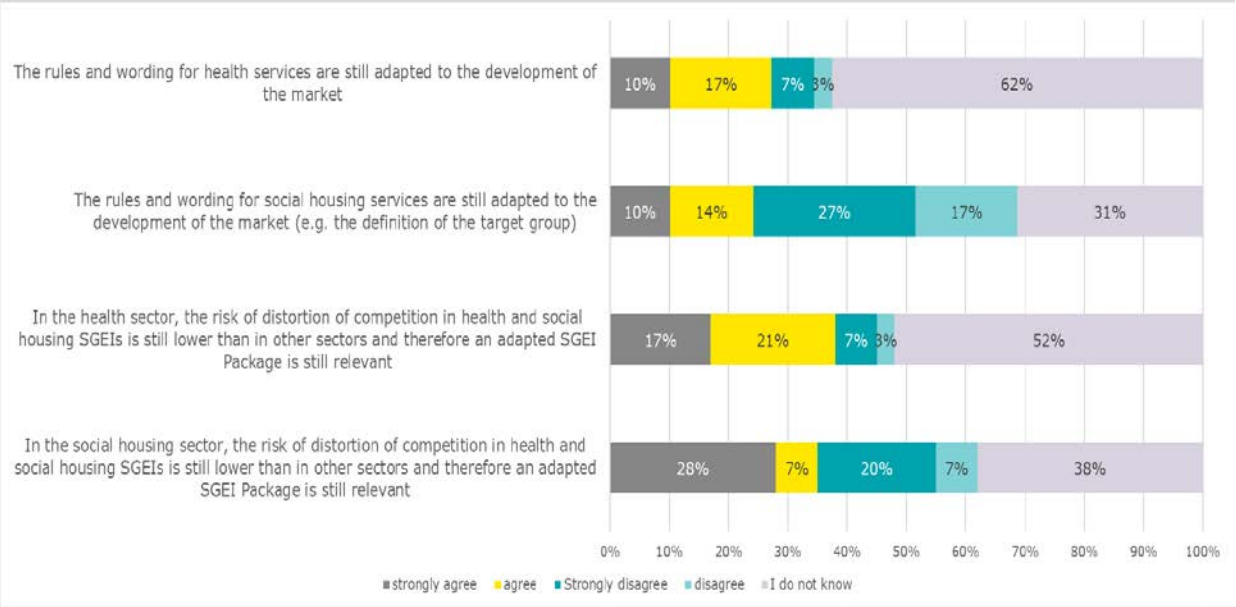
Industry/consumer associations & NGO: respondents

National or Local authority: 12 respondents

Responses to the Survey show that when tackling the lack of appropriateness of the rules, respondents did not focus on the risk of distortion of competition but more on **the need to adapt the rules and wording of the 2012 SGEI Package**. In particular,

38% of respondents considered that the rules and wording for social housing were no longer adapted to the development of the market.

Figure 34 Respondents' opinions on whether the rules are still adapted to the needs of the different stakeholders



Source: EY Survey

Industry/consumer associations & NGO: 9 respondents

National or Local authority: 12 respondents

The following sections identify areas in which the SGEI rules are not currently considered to be appropriately tailored to the recent market developments.

5.3.2 The definition of social housing

As shown above, the definition of social housing is perceived as the element in the 2012 SGEI Package that is the least adapted to market developments. Section 3.5.1 of the Study outlined that the definition of the target group contained in recital 11 of the SGEI Decision is questioned by several stakeholders of which some consider it too wide and some consider it too restrictive. The Survey showed that representatives of private housing providers were the most opposed to the extension of the target group. Indeed, 43% of the industry/consumer associations and NGOs disagreed with the fact that the definition of social housing is still adapted to the current market environment. The three SGEI providers that participated to the Survey were of the same view while only 31% of the public authorities had the same perception.

As outlined under Section 2.2.2, **housing prices in the EU have grown faster than household incomes, which has widened the supply gap for social and affordable housing**. Some stakeholders refer to this as a 'housing crisis'. In addition to factors common to most of the Member States (demand for housing rising faster than the supply and less financial resources for households), Section 2.2.2 also shows that certain national reforms may have contributed to the deterioration of the situation.

With the accessibility of the housing market deteriorating, more people are put at risk of poverty. As an example, in 2017, 85 million people were considered at risk of poverty without considering the housing costs in their expenses, this figure increased up to 156 million people when housing costs were included.[246] The situation is very likely to worsen due to the economic crisis linked to the COVID-19 crisis.

Consequently, a large share of the stakeholders consulted considered that the definition of social housing included in Recital 11 of the SGEI Decision is too restrictive and no longer corresponds to the (social) housing needs[247]. 58% of respondents to the Survey considered that the social housing definition at national level has not evolved since the adoption of the 2012 SGEI Package. The calls for change of the social housing definition from certain stakeholders focus on the scope of this definition.

According to the associations representing social housing providers and social housing tenants, social housing should **not solely target the most vulnerable people but include all the households who cannot afford decent housing under market conditions**[248]. Several European regions expressed the same view[249]:

- According to the Brandenburg Land in Germany, the definition is outdated and is no longer adapted to the evolutions of the market;
- The Hauts-De-France region underlined that housing is a universal social need and limiting social housing to the less advantaged would undermine social diversity;
- The Dutch provinces stressed that there are clear market failures for the mid-priced rental market, but this part of the rental market falls out of the scope of the social housing definition under the SGEI Decision.

Stakeholders who advocate for a change of the target group have proposed the following change:

- The responsibility to define the social housing SGEI should be the responsibility of the Member States and local authority. They are the more knowledgeable about the needs of their population and the local context. Thus, Member States and the different authorities should be the ones to define the target group[250].

However, within the group of stakeholders active in the field of housing supply for the most vulnerable, some are against the extension of the target group of Recital 11. For instance, through the Open Public Consultation launched by DG Competition, FEANTSA (the European association fighting homelessness in Europe) warned that an extension of the target group could be detrimental to the most vulnerable. In their view, the current definition is targeting the people the most in need,

[246] *Housing Europe – The State of Housing in the EU 2019, available at https://www.housingeurope.eu/resource-1323/the-state-of-housing-in-the-eu-2019*
[247] *All the social housing providers and associations of tenants who have taken part in this study share the same view.*
[248] *Again, this position is advocated by the main associations of tenants and social housing providers.*
[249] *European Committee of the Regions, 2020. Network of Regional Hubs for EU policy Implementation review-Implementation report fourth consultation on State aid SGEIs, Regional State aid Framework and Temporary Framework for State aid, available at https://cor.europa.eu/en/engage/Documents/RegHub/report-consultation-04-state-aid.pdf*
[250] *Interviews with representatives of public authority.*

while an extension of the target group would mean that a wider group of people would be eligible to social housing, hence less housing would be specifically targeted to the most vulnerable[251]. According to this association, the current definition is sufficient and the public authorities' focus should be on its implementation.

Nevertheless, **the strongest opposition to the extension of the target group comes from (social) housing providers who are not recipients of State aid, among which are private providers**. As detailed in Section2.2.2, in certain Member States, the system adopted is closed (i.e. only a limited number of public operators may provide social housing and benefit from State aid). Under such systems, associations representing private providers[252] underlined that the competition is unfair, as most operators are excluded from it, and that providers benefiting from State aid should therefore only focus on the most deprived people. According to **(social) housing providers who are not recipients of State aid**[253], an extension of the scope would further distort competition. In certain Member States, providers who are recipients of State aid are already representing a huge share of the social housing market (for instance in **France** or the Netherlands). Therefore, if their market segment is extended to cover the housing supply for the middle-class, this would lead to a greater distortion of competition. In any case, in the view of (social) housing providers who are not recipients of State aid, in a closed market the European Commission should always act as a safeguard by carefully monitoring the State aid granted.

5.3.3 The SGEI *de minimis* ceiling

The level of the ceiling was already tackled in the 2011 impact assessment which has led to the 2012 SGEI Package. At the time, the EUR 200,000 limit under the General *de minimis* Regulation was pointed out as being too low for SGEIs and an increase of this ceiling for SGEIs was underlined as an effective tool to enhance the simplification.

The ceiling for SGEIs was increased to EUR 500,000 and has been welcomed[254] as one of the greatest improvements of the 2012 SGEI Package. According to stakeholders surveyed, it has lowered the administrative burden by exempting a larger share of aid from notifications and overall control.

However, based on the Open Public Consultation, around 70% of the respondents considered that the ceiling is still too low, with stakeholders outlining that:

- The amount is too low in comparison to the amount needed for the operation of a SGEI and does not correspond to the current market situation;
- A higher ceiling would reduce the administrative burden even more.

Interviewees,[255] to a large extent, confirmed this view highlighting that the SGEI *de minimis* ceiling is easily reached, except for small scale enterprises.

[251] *FEANTSA contribution to the Open Public Consultation launched by the European Commission.*
[252] *For instance, European Housing Association and its contribution to our study.*
[253] *European representatives of building industry and housing providers and National housing associations and associations representing social housing providers*

[254] *Especially by public authority consulted.*
[255] *Especially public authority consulted.*

Consequently, several stakeholders[256] **advocate for a higher threshold**. This remark may even be more relevant in the healthcare sector since the State aid amounts are high. In addition, certain public authorities underlined that a higher threshold would consequently lead to a further reduction of the administrative burden since even less State aid would need to be notified[257].

5.3.4 The provisions related to healthcare

Less challenges were highlighted with regard to the healthcare sector, though a primary challenge related to establishing whether a healthcare system or service is economic or non-economic, as outlined in the examples below:

- **Finding a clear-cut definition of healthcare falling within the scope of SGEIs has always been rather challenging**[258]. Healthcare insurance funds are rather considered as non-economic activities (thus potentially falling outside the scope of the 2012 SGEI Package[259]) while hospitals are often considered as economic activities (thus potentially falling within the scope of the 2012 SGEI Package). However, even in the case of public hospitals, the assessment of the nature of their activity is rather complicated. For instance, in the case of a national healthcare system relying on a network of public hospitals directly funded by the social security scheme or State resources and providing free services based on universal coverage, the activity provided in principle cannot be qualified as of an economic nature[260]. In all other cases, State support for public hospitals can constitute State aid.
- This challenge to determine how, and which, healthcare provisions can be qualified as SGEI has been underlined by officials interviewed[261]. Indeed, with the **growing privatisation of healthcare in certain Member States, some officials stressed the difficulty to determine whether the provisions of healthcare should be qualified as economic (and thus could be qualified as SGEI**[262]**)**.
- A consequence of the challenge to agree on a clear definition and clear boundaries between economic and non-economic activities in the healthcare

[256] *For instance, European Committee of the Regions, 2020. Network of Regional Hubs for EU policy Implementation review-Implementation report fourth consultation on State aid SGEIs, Regional State aid Framework and Temporary Framework for State aid, available at https://cor.europa.eu/en/engage/Documents/RegHub/report-consultation-04-state-aid.pdf and national welfare associations interviewed*
[257] *Interviews with public authorities.*
[258] *European Committee of the Regions, 2017. Implementation of the Decision and the Framework on SGEIs: involvement of LRAs in the reporting exercise and state of play as regards the assessment of social services as economic activities. See also Joined Cases C-262/18 P and C-271/18 P Commission and Slovak Republic v Dôvera zdravotná poist'ovňa, a.s.examined once again the concept of 'economic activity' with the CJEU upholding the European Commission decision according to which health insurance bodies operating under Slovak State supervision do not fall within the rules of EU law on State aid*
[259] *See the report of the European Committee of the Regions mentioned above, page 51 which is based on the Smits and Peerbooms CJEU case-law.*
[260] *M. Anchini, Columbia Journal of European Law, Nov. 27, 2016. The Role of The European Union in the Healthcare Market.*
[261] *Interview with officials from a national Health Ministry.*
[262] *Interview with officials from a national Health Ministry. Although no further explanations were provided, it could be inferred that the interviewees were not sure on how to determine and under which conditions State aid granted to private providers could fall under the SGEI scope.*

sector is **the difficulty to determine whether certain activities, such as ICT or research, which are playing a growing role in the healthcare field, could qualify as a SGEI**[263].

- The **market has also evolved with regard to the types of providers**. In certain Member States there is a growing number of not-for profit organisations providing health SGEIs.[264] A suggestion from one of these non-for-profit stakeholders therefore is to modify the State aid rules to recognise the difference between for-profit providers and those that are not-for profit[265].

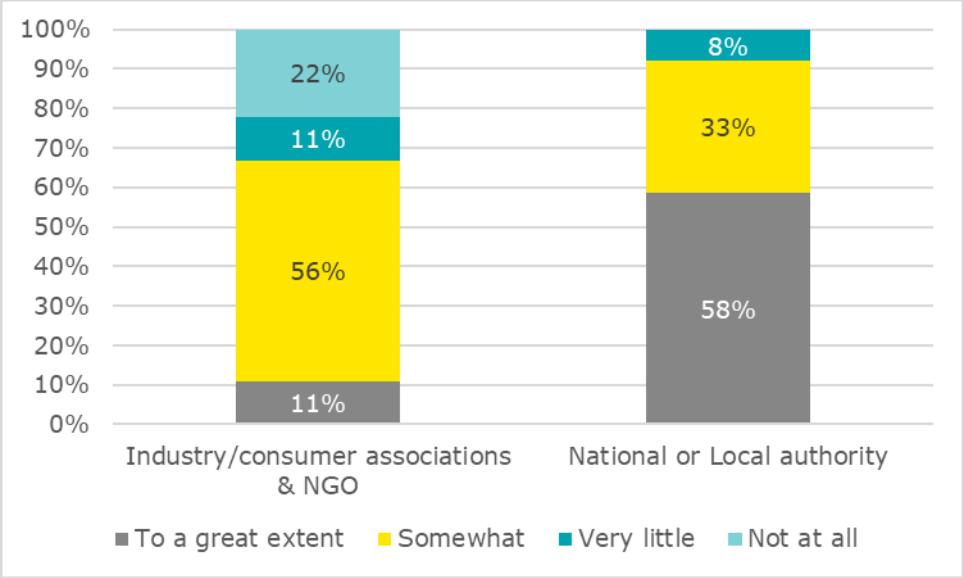
5.4 Q5. To what extent is the approach for health and social SGEIs introduced in the 2012 SGEI Decision still justified?

Justification of rules falling under the 2012 SGEI Package

Although there is room for improvement regarding certain concepts, the SGEI rules are still justified today. 81% of the respondents to the Survey considered that the SGEI rules remain justified and when asked whether the SGEI rules are still relevant considering the impact of the Covid-19 crisis, 74% of the respondents were of the view that the approach adopted is still relevant.

As with other elements highlighted through the Report, there is a clear distinction between the views of public authorities and other stakeholders, since 91% of the public authorities were of the view that the approach is still justified, against only 67% of industry, consumer associations & NGOs sharing this view.

Figure 35 Respondent's opinions on whether the approach is still justified today



Source: EY Survey

Industry/consumer associations & NGO: 8 respondents

National or Local authority: 12 respondents

263 Ibid.
264 Interview with a European mutuality group based on the cooperative model.
265 Ibid.

5.5 Q5a. Is there evidence that health and social SGEIs should be treated as specific due to the lower risk of distortion of competition as Stated in recital 11 of the SGEI Decision?

The conclusion overall is that the approach adopted to facilitate the provisions of SGEIs through the notification exemption for healthcare and social services and the EUR 500,000 SGEI *de minimis* ceiling is still justified today in the current market environment. The previous sections have shown that there is rising demand for social housing and that healthcare financing needs intensified with the current COVID-19 crisis. However, Member States struggle to have a supply matching the demand.

Two points remain to be considered by the European Commission when considering future reforms, as already outlined above:

1. The **definition of the social housing target group**: Several stakeholders[266] expressed their wish for its extension in order to adapt to the current context at national level. Stakeholders who do not receive public subsidies push for keeping the definition as it stands[267] with a stronger monitoring from the European Commission and the reintroduction of notifications for measures targeting social housing in a closed system;
2. **The ceiling of the SGEI *de minimis* Regulation** could potentially be increased.

Almost all groups of stakeholders were of the view that the risk of distortion is still lower for healthcare and social housing than in other sectors. In the Open Public Consultation, the biggest group of stakeholders that did not agree were Company and business organisations.

57% of the respondents to the Open Public Consultation at least partially agreed with the fact that the risk of distortion of competition for these two sectors is still lower than in other sectors. 34% of the respondents agreed on this view for social housing, with 37% sharing the same opinion for the healthcare sector.

In addition, many stakeholders shared a common view on the fact that the social housing and healthcare sectors are usually local and there is almost no EU-wide competition in these two markets. Stakeholders interviewed also stressed the fact that social housing and healthcare have a lower risk of competition distortion which still justifies the notification exemption for these sectors.

However, representatives of private providers and tenants flagged **the increasing risk of competition distortion in national markets if the target group were to be extended**. In their view, the European Commission should play an accrued safeguarding role by verifying compliance with State aid rules.

[266] *Especially representatives of social housing providers.*
[267] *It should be noted that the "hardliner" of this position would even welcome a more stringent definition in which social housing should only be provided to the people defined as the most vulnerable.*

6 Section 6: Response to Evaluation Questions: EU Added Value

Evaluating EU Added Value

The aim of this Evaluation Criterion is to examine the extent to which the 2012 SGEI Package has provided added value which could not have been achieved without EU intervention. Regarding healthcare and social housing, this criterion, in the context of this Study, particularly examines the extent to which the 2012 SGEI Package permitted a better task allocation between the European Commission and the Member States.

When examining the EU added value it is important to analyse the EU intervention under the angle of the subsidiarity principle, in other words whether the intervention of the EU is justified and what should be kept within the Member States responsibilities.

When examining EU Added Value, it is necessary to consider the responses to the Evaluation Questions in relation to effectiveness and efficiency. A direct link can be made between these evaluation criteria and EU added value. For example, the extent to which the objectives of the SGEI Decision have been achieved can have a direct impact on the EU added value.

Summary of Findings

- The main EU added value observed has been the continuity of the legal framework and to a certain extent the facilitation of providing SGEIs (Section6.1).
- Though the 2012 SGEI Package has led to simplification, the EU added value remains limited due to the ability for EU Member States to design the sector in such a way that it would fall or not fall under the GEI rules (Section 6.2).

6.1 Q6. What have been the benefits of adopting a new SGEI Package in 2012?

As outlined under the effectiveness criterion above, the 2012 SGEI Package had as an aim:

- The **clarification** of key concepts in the SGEI Communication,
- The **simplification** for small and local SGEIs. To this end the SGEI *de minimis* Regulation was adopted whereby public funding of less than EUR 500,000 over three fiscal years is deemed not to constitute State aid because of the lack of effect on trade between Member States and/or lack of distortion or threat of distortion of competition[268].
- The **exemption** from the obligation of prior notification to the European Commission for social services. This exemption was only applicable to hospitals and social housing in the 2005 package.

As outlined under effectiveness and efficiency above, the Package has provided additional EU added value in the following manner:

[268] *See recital 4 of the Commission Regulation EU No 360/2012, the de minimis regulation.*

- To a certain extent, the new Package **has brought a greater simplification for the implementation of the rules** (i.e. by introducing a higher *de minimis* ceiling for SGEIs and extending the scope of the notification exemption*);*
- The 2012 SGEI **Package has helped to clarify certain terms**, although certain concepts remain unclear for some stakeholders**;** and
- T**he changes brought by the Package have to a certain extent facilitated the provisions of SGEIs.**

The 2012 SGEI Package is a continuation of the 2005 Package, with certain adaptations. Stakeholders considered [269] that this continuity has improved legal certainty and has provided a stable legal environment for Member States, SGEI providers and other stakeholders. This certainty has been developed with stakeholders maturing their knowledge since the 2005 Package. Certain stakeholders from Member States that do not consider hospitals and/or social housing as an SGEI underlined that considering these sectors as a SGEI in their Member State would be welcomed since it would (i) pave the way for a clearer set of rules and (ii) facilitate the provisions of State aid[270]. Again, this point echoes the view of certain stakeholders for which the 2012 SGEI Package contributes to the establishment of legal certainty to the environment in which hospital and/or social housing providers operate[271]. This legal certainty and transparency are essential for providers to gain access to predictable sources of financing.

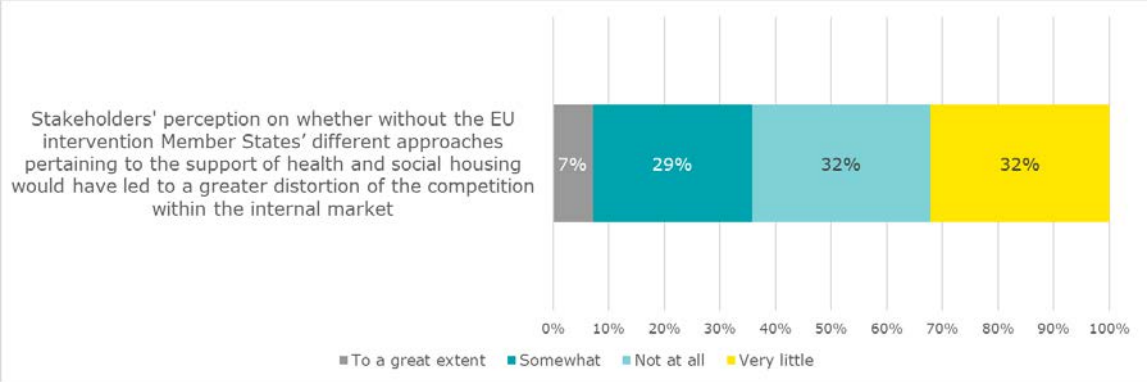
When considering the added value of the 2012 SGEI Package, it is necessary to consider the situation should the Package not be in place. Under such circumstances, the **legal framework would be general EU competition law and Member States would have to notify all State aid provided which would lead to a greater administrative and financial burden for all parties involved**. Moreover, in the absence of the 2012 SGEI Package, a lack of clarity would exist, with a lack of guidance in place on key concepts and methods such as the estimation of net cost and the avoidance of overcompensation. The guidance provided in conjunction with the 2012 SGEI Package was identified by stakeholders consulted through the Study as of considerable added value, including the European Commission's guide to the application of EU rules on State aid through frequently asked questions.[272]

When considering the positive impacts of the 2012 Package, **the primary impact has been to establish a clear framework for the provision of SGEIs**.

Nevertheless, t**he Study has not identified clear links between the 2012 SGEI Package and the safeguarding of competition in the sectors relating to healthcare and social housing**. As mentioned in Section 4.5, competition for healthcare and social housing remains predominantly national in nature, with the Survey confirming this, with 64% of respondents not considering that the distortion of competition would have been greater within the internal market without the EU intervention (i.e. the 2012 SGEI Package).

[269] *This point has been underlined by several stakeholders consulted in the course of this study in the targeted consultation.*
[270] *National stakeholders consulted for this study.*
[271] *Interviews with public authorities and industry associations.*
[272] *SWD(2013) 53 final/2 Commission Staff Working Document Guide to the application of the European Union rules on state aid, public procurement and the internal market to services of general economic interest, and in particular to social services of general interest*

Figure 36 Share of respondents who think that without the EU intervention, the distortion of competition within the internal market would have been greater



Source: EY Survey

While the Study cannot make a direct correlation between the 2012 Package and the facilitation of cross-border competition, trends have been identified by the Study in relation to the evolving cross-border EU investments in social housing. One stakeholder consulted for the Study underlined that the EU cross-border investments in the social housing sector has intensified over the past decade. They stressed that the EU added value of the Package was indeed to set a clear framework for granting State aid and that without the Package, the level of cross-border competition would have been worse[273]. This can be understood by the fact that the 2012 SGEI Package determines the conditions and criteria under which State aid can be allocated which creates a **stable, harmonised and transparent legal environment**, on which a stakeholder willing to enter the market in another Member State can rely.

When competition exists between public and private providers and when certain providers are recipients of State aid, the obligation to report accounting showing the absence of overcompensation contributes to greater transparency, to limiting the risk of cross-subsidisation of other activities (which are provided on market terms) and thus to fair competition overall.

6.2 Q6a. Has the 2012 SGEI Package allowed for a better task allocation between the European Commission and Member States?

Simplification brought by the 2012 SGEI Package

The Study has identified that the 2012 SGEI Package created simplification and clarity in relation to task allocation. Nevertheless, the discretion of Member States to set up the healthcare and/or social housing sectors falling within the scope of the 2012 SGEI Package leads to the Package being a tool in case they want to support these sectors financially, with the added value very much depending on the take-up of the 2012 SGEI Package at national level.

For the financial support to the social housing sector, Member States have the discretion to define social housing if it complies with certain criteria such as responding to a public need and falling within the scope of the target group defined in Recital 11[274]. The European Commission acts as a watchdog safeguarding the competition within the

[273] *Interview with a representative of an EU association active in housing.*
[274] *Interview with an EU association active in the area of social housing.*

internal market. The social housing definition set by the Member State can only be questioned by the European Commission if there is a manifest error.

43% of the respondents to the Open Public Consultation considered that the 2012 SGEI Package has allowed for a better task allocation between the European Commission and the Member States. 7 out of 12 respondents of the Survey who replied to this question held the same opinion.

However, some stakeholders take the view that **the competencies of who should be responsible to define social housing needs to be clarified**. Currently, the EU is not competent for social housing as such, though it is competent for controlling State aid provided to social housing companies. It is against the State aid background that the SGEI Decision provides a definition of social housing at EU level which Member States must comply with in order to benefit from the notification exemption.

Certain public authorities and EU associations[275] **questioned the perimeter of the social housing target group from a subsidiarity perspective**. According to them, the provision of social housing is a Member State competence, hence the EU, which is not competent for social housing, should not interfere with Member States' social housing policies[276]. Public authorities are obviously more aware of their national contexts. Some public authority interviews indicated that it should therefore be up to national and local authorities to determine which categories of the population should be eligible for social housing and under what circumstances. In addition, according to these stakeholders the need to safeguard competition in the social housing market is minimal since the risk of distortion of competition in the internal market is weak. Hence, according to these stakeholders there would be no need for the European Commission to intervene and define a target group for social housing.

Other stakeholders[277] **on the contrary advocate for a more detailed target group and push for a clearer delineation of the competencies between Member States and the European Commission**. In other words, they question the discretion that Member States have in framing their social housing definition and target groups without a European Commission intervention. They thus advocate for a clearer social housing definition at EU level, leaving less discretion to the Member States.

The general conclusion is that the 2012 SGEI Package's EU added value lies in ensuring a continuation of State aid rules in accordance with the principles of EU and specifically EU competition law. Nevertheless, this added value varies depending on the national context and the way Member States consider healthcare and/or social housing as services of general economic interest. The European Commission has partially met its overall aim of further clarifying and simplifying the Package, but the Study identified that certain concepts included in the 2012 SGEI Package such as the determination of reasonable profit and the distinction between an economic and non-economic activity were not always clear.

[275] *Several EU and national association active in the social housing sector and few public authorities.*
[276] *Interviews with public authorities and EU associations active in the field of housing.*
[277] *Interview with EU associations active in the field of housing.*

7 Section 7: Conclusions

The 2012 SGEI Package has, overall, succeeded in its key objectives. Through the continuation of key elements of the 2005 Package, the 2012 SGEI Package has **facilitated** the provision of SGEIs while maintaining State aid control and contributed to the **simplification** of requirements for SGEIs in healthcare and social housing. The 2012 SGEI Package has also led to the **clarification** of rules relating to the provision of State aid in order to ensure that the path for the State aid expenditure is clearer at national level.

The Study found that the 2012 SGEI Package addressed the needs existing at the time of its adoption, with the Package managing to adapt to a certain extent to the needs evolving in the healthcare and social housing sector since 2012. The simplification and clarification brought by the Package has led to reducing some costs associated with the implementation of State aid rules, especially due to the notification exemption and the introduction of the SGEI *de minimis* regulation.

Despite the overall effectiveness, efficiency, relevance and added value of the 2012 SGEI Package, specific areas were identified where the rules appeared not to have functioned fully satisfactorily. These are presented in turn below, with a reference made, where applicable, to the specific provisions of the 2012 SGEI Package.

Monitoring and Reporting (Article 9 of the 2012 SGEI Decision)

Article 9 of the 2012 SGEI Decision requires each Member State to 'submit a report on the implementation of this Decision to the European Commission every 2 years. The reports shall provide a detailed overview of the application of this Decision for the different categories of services referred to in Article 2(1), including: (a) a description of the application of this Decision to the services falling within its scope, including in-house activities (b) the total amount of aid granted in accordance with this Decision, with a breakdown by the economic sector of the beneficiaries (c) an indication of whether, for a particular type of service, the application of this Decision has given rise to difficulties or complaints by third parties and (d) any other information concerning the application of this Decision required by the European Commission and to be specified in due time before the report is to be submitted'.

The Study found that the format and the content of the biennial reports is insufficient to provide adequate data to the European Commission for the purposes of monitoring the application of the Decision. The level of information currently provided in these biennial reports varies considerably by Member State, with incomparable data provided regarding the amount of aid granted in accordance with the Decision (Article 9(b)). Moreover, the Study found that Member States' lack of clarity regarding the level of detail to be provided also led to additional time spent in the preparation of these Reports.

In addition, while the Study identified elements of simplification and clarification enabled by the SGEI Package, the lack of uniform data does not permit a clear monitoring of its impacts, for example to draw a link between the application of the SGEI Package and the greater provision of State Aid in the area of healthcare and social housing.

Calculation of compensation and reasonable profit (Article 5 of the 2012 SGEI Decision)

Article 5(1) of the 2012 SGEI Decision provides that the 'amount of compensation shall not exceed what is necessary to cover the net cost incurred in discharging the public service obligations, including a reasonable profit'. Two methods for the calculation of net costs are provided in Article 5(2): 'the net cost may be calculated as the difference between costs […] and revenues […]. Alternatively, it may be calculated as the difference between the net cost for the undertaking of operating with the public service

obligation and the net cost or profit of the same undertaking operating without the public service obligation'.

Article 5(5) defines reasonable profit as 'the rate of return on capital that would be required by a typical undertaking considering whether or not to provide the service of general economic interest for the whole period of entrustment, taking into account the level of risk'. Article 5(6) provides that 'in determining what constitutes a reasonable profit, Member States *may* introduce incentive criteria relating, in particular, to the quality of service provided and gains in productive efficiency'.

The Study identified the various approaches applied by Member States to calculate the net cost of an SGEI, with certain Member States applying the cost allocation method and others the net avoided costs one.[278] Interviews undertaken at national level with national authorities identified difficulties faced by some of them in calculating net costs.

The method to determine a reasonable profit was found by the Study to be complex, especially for periods longer than 10 years since the swap rates proxies provided by the European Commission are only applicable for 10 years. In addition, acquiring information to estimate a reasonable profit can be challenging especially for activities with a social or health character.

While the 2012 SGEI Decision, the 2012 SGEI Communication and the European Commission's guide to the application of EU rules on State aid through frequently asked questions[279] aim to provide clarity on the calculation of the net cost of the SGEI and reasonable profit, feedback given still pointed towards remaining difficulties in applying those concepts, particularly due to the complexities of specific sectors, such as those covered by this Study.

Determination of an economic activity (Paragraphs 8 to 15 of the 2012 SGEI Communication)

Paragraphs 8 to 15 of the 2012 SGEI Communication provide clarification deriving from CJEU case law regarding the concepts of 'undertaking' and 'economic activity'.

While the Study identified the benefits of the 2012 SGEI Package in providing clarification to stakeholders, the determination of what consists an 'undertaking' and an 'economic activity' is still considered by stakeholders as unclear.

The lack of clarity was particularly observed in relation to the healthcare sector, both at the level of healthcare provision and healthcare financing/insurance.

The determination of what constitutes an economic activity was considered by stakeholders as the key element constituting a barrier to the implementation of the 2012 SGEI Package.

Definition of social housing (Recital 11 of the 2012 SGEI Decision)

Recital 11 of the 2012 SGEI Decision specifies that social housing should target 'disadvantaged citizens or socially less advantaged groups, who due to solvency constraints are unable to obtain housing at market conditions'.

The Study found that the definition of social housing as laid down in recital 11 of the 2012 SGEI Decision is seen as opaque for several stakeholders. Since no common definition of social housing exists across Member States and each Member State has its own interpretation of the definition in the 2012 SGEI Decision, it is difficult for national authorities to know whether certain forms of housing can be considered social and

[278] *The research undertaken did not identify Member States applying different types of allocation method depending on the type of case/legal basis applied.*
[279] *SWD(2013) 53 final/2 Commission Staff Working Document Guide to the application of the European Union rules on state aid, public procurement and the internal market to services of general economic interest, and in particular to social services of general interest*

therefore supported under the 2012 SGEI Decision. Moreover, the Study found that the definition was considered to be 'outdated' by a large number of stakeholders considering the evolutions of the market and the needs of the population at national level for 'affordable housing'. However, on the other hand some stakeholders identified the risks associated with extending the definition too broadly, which could be detrimental to the most vulnerable or could lead to competition distortion.

The *de minimis* ceiling

The Study found that while the revised ceiling for the *de minimis* ceiling from EUR 200,000 to EUR 500,000 for SGEIs (with the new SGEI *de minimis* Regulation) was welcomed as one of the greatest improvements of the 2012 SGEI Package, questions were still raised regarding the extent to which the amount is adapted to current financing required for the operation of a SGEI. The Study found through stakeholder consultation that the *de minimis* ceiling is easily reached, with the average amount of State support increasing on average since 2012.

Awareness of the SGEI Package at national level

The Study concluded that the level of awareness of the rules depends on the degree of involvement of stakeholders in the provision of an SGEI. A higher level of awareness of the SGEI Package overall was identified in relation to the social housing sector than in the healthcare sector. The level of awareness of the SGEI Package plays an important role in the extent to which the Package is implemented and used, with the Study finding that a higher level of awareness often correlated with increased knowledge of the benefits which could be brought by the 2012 SGEI Package at national level in the sectors concerned.

Relevance of the Package in the current context

The Study identified the added value of the 2012 SGEI Package in ensuring a continuation of State aid rules in accordance with the principles of EU and specifically EU competition law. Nevertheless, this added value varies depending on the national context and the manner in which Member States consider healthcare and/or social housing as services of general *economic* interest. The Study identified partial skepticism with regard to the manner in which the SGEI Package is adapted to the current market environment.

With regard to the COVID-19 crisis, the Study found that national stakeholders expect a growing demand for particularly healthcare and housing (social and affordable).

8 Annex 1: List of documentation

The documentation listed in this Annex represents all documentation consulted for the Study. Some documentation is not directly referenced in the Final Report since it was used as background reading for the EY Team.

EU legislation relevant for services of general economic interest (SGEI)
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Portugal – National institute of statistics (https://www.ine.pt)
Romania – National Institute of Statistics (https://insse.ro/cms/)
Sweden – Statistics Sweden (https://www.scb.se/en/)

9 Annex 2: Methodology

9.1 Overview table of interviews conducted

In total, 89 interviews were conducted with national stakeholders, EU NGOs/associations and the European Commission. The Inception Report estimated a maximum of 10 interviews to be undertaken in each Member state with a mix of public authorities including SGEI responsible authorities, private and public providers, consumer associations and industry associations. The following have been undertaken:

	Public authorities			Other interested parties				Total interviews per MS
	National authority	Local Authority	Total	Industry association	Consumers' association	Provider	Total	
Croatia	4	1	5	1	1	2	4	**9**
Czech Republic	5		5		2	1	3	**8**
France	3		3	5		1	5	**9**
Germany	1	5	6	2			2	**8**
Ireland	3		3	1		7	8	**11**
Latvia	3	1	4	1	1	1	2	**7**
Netherlands	3		3	3			3	**6**
Portugal	1	1	2	2		1	2	**5**
Sweden	3		3	3	1		4	**7**
Romania	4		4		1	1		**6**
European associations & NGOS	10							

Additionally, 3 interviews were conducted with the European Commission: DG COMPETITION & DG SANTE

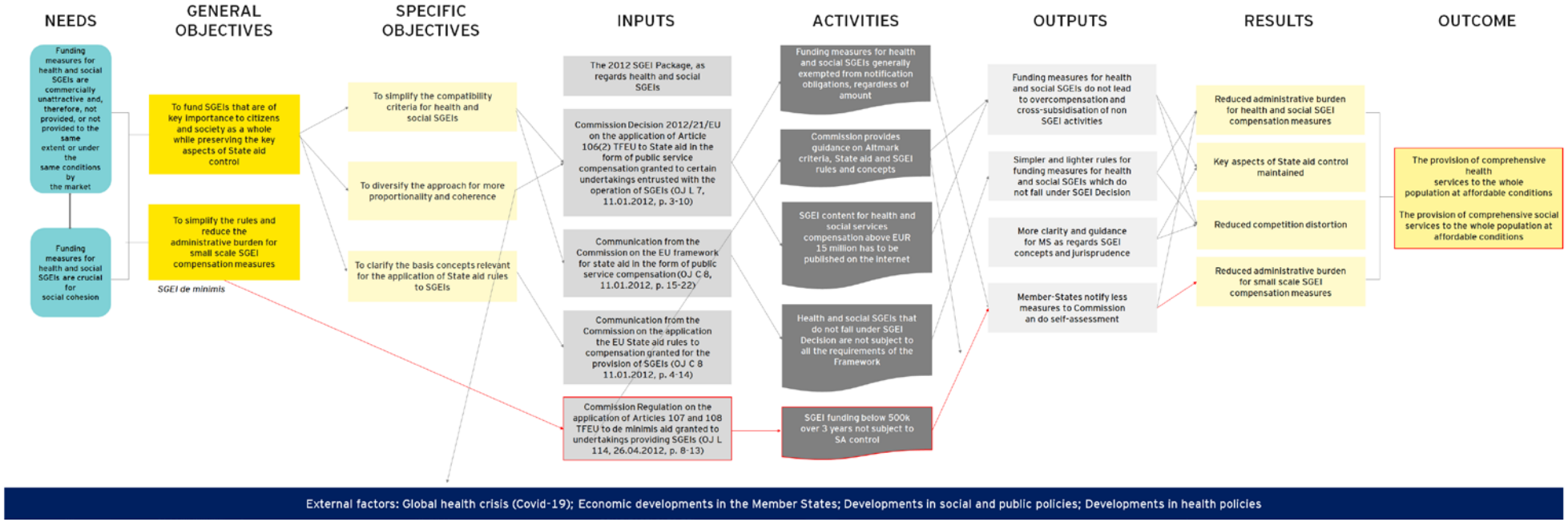
9.2 Updated Intervention Logic

The intervention logic was reconstructed at the beginning of the Study in order to map the following elements:

- The needs which existed and have led to the SGEI Package (2005 and 2012);
- The objectives (general, specific) that the Package aims to achieve;
- The inputs and activities deployed in the context of the Package implementation;
- The outputs, results and outcomes which have resulted from the implementation of the Package;
- The external factors impacting the implementation of the Package.

This intervention logic was a key tool to make sure that the Study team had a good understanding of the different elements surrounding the 2012 SGEI Package and was refined following the results of the Study.

Figure 37 Intervention Logic



9.3 Evaluation framework

Based on the work undertaken for the Inception Phase, the Evaluation Questions for the Study were reformulated. The table below provides an overview of the rationale for reformulating the Evaluation Questions.

Table 24 Overview of Reformulation of Evaluation Questions

	Questions in Terms of Reference	Reformulated Questions for the Study	Reasons for reformulation
Effectiveness	**Q. To what extent have the updated State aid rules for SGEIs facilitated the provision of health and social SGEIs adapted to the population's needs?**	**Q1. To what extent have the updated State aid rules for SGEIs facilitated the provision of health and social SGEIs while preserving the key aspects of EU State Aid control?**	Q1 has been reformulated to also take into account the preservation of key aspects of EU State Aid control, as presented in the Intervention Logic.
	a. To what extent has the simplification of the rules enabled Member States ('MS') to pursue aid measures for health and social SGEIs?	**Q1a. To what extent have the 2012 SGEI rules brought clarification and simplification to enable Member States to better pursue aid measures for health and social SGEIs?** **Q1b. To what extent has the awareness of Member States of SGEI rules influenced their overall application?**	Q1a has also been reformulated in order to include the concept of clarification as well as of simplification of State aid rules. Moreover, an additional sub-question has been added which relates to Member States' awareness of SGEI rules which can influence their overall application. This question was initially included under the relevance criterion in the Terms of Reference but should in fact be included under effectiveness since this question does not relate to the relevance of the rules but rather to the results achieved.
	b. If there are significant differences between MSs/sub-sectors what caused them? How do these differences link to the clarification of health and social SGEIs concepts?	**Q1c. To what extent have the divergences in the Member State sectors caused differences in the application of SGEI concepts?**	This question has been reformulated in order to be more evaluative in nature. The judgment criteria shall focus on the divergences existing in the Member State sectors and identifying what causes such divergences
	c. Which specific requirements have contributed to or stood in the way of achieving the provision of health and social SGEIs?	**Q1d. Which factors and specific requirements have contributed to or stood in the way of achieving the provision of health and social SGEIs?**	This question has been reformulated to include factors which have included the achievement of the SGEI provisions. It is necessary to examine the external factors which can influence such effectiveness.

	Questions in Terms of Reference	Reformulated Questions for the Study	Reasons for reformulation
Efficiency	**Q. What are the costs and benefits (both monetary and non-monetary) associated with the application of the requirements set by the rules for health and social SGEIs for the different stakeholders?**	**Q2. What are the costs and benefits associated with the application of the requirements set by the rules for health and social SGEIs for the different stakeholders?**	This question remains the same
	a. To what extent have the specific rules for health and social SGEIs enabled the provision of social services without distorting competition disproportionately?	**Q3. To what extent have the specific rules for health and social SGEIs enabled the provision of social services without distorting competition disproportionately?**	This has been made a separate evaluation question since it covers a specific aspect relating to the distortion of competition which should be examined separately to costs and benefits for stakeholders.
	b. To what extent have specific rules for health and social SGEIs enabled the provision of social services without causing disproportionate administrative burden for MS?	**Q2a. To what extent have the specific rules for health and social SGEIs enabled the provision of services without causing disproportionate administrative burden for Member States?** **Q2b. To what extent have the specific rules for health and social SGEIs had an impact on the administrative burden for the Commission?** **Q2c. To what extent have the specific rules for health and social SGEIs impacted the administrative burden for service providers?**	Additional sub-questions have been included in order to not only examine the impact of the SGEI rules on Member States but also to examine the impact on the Commission and service providers. This is necessary in order to examine all stakeholders who are impacted by the SGEI rules.
Relevance	**Q. How well adapted are the SGEI rules for health and social services to the development of society, markets and social policy?**	**Q4. To what extent are the SGEI rules for health and social housing adapted to the development of society, markets and social policy?** **Q4a. To what extent were the SGEI rules for health and social housing adapted to the needs of society, markets and social policy at the time of their adoption?** **Q4b. To what extent are the SGEI rules for health and social services still adapted to the developments at national level?**	This question was reformulated in order to add sub-questions which consider the relevance of the rules at the time of adoption as well as the relevance of the rules as evolutions have occurred

	Questions in Terms of Reference	Reformulated Questions for the Study	Reasons for reformulation
	b. To what extent is the approach for health and social SGEIs introduced in the 2012 SGEI Decision still justified?	**Q5. To what extent is the approach for health and social SGEIs introduced in the 2012 SGEI Decision still justified?**	This has been presented as a separate question since it focuses on the pertinence of health and social SGEIs specific rules with regard to the overall SGEI Decision which should be examined separately to the Evaluation Question relating to the pertinence of the SGEI Decision to the needs existing at national level.
	a. Is there evidence for the statements made in recital 11 of the SGEI Decision that the risk of distortion of competition in health and social SGEIs is still lower than in other sectors?	**Q5a. Is there evidence that health and social SGEIs should be treated as specific due to the lower risk of distortion of competition as stated in recital 11 of the SGEI Decision?**	This question has been attached to the question above relating to the pertinence of health and social SGEIS with regards to the overall SGEI decision. It has been reformulated for clarity.
	Q. To what extent are the MSs aware of the (relevance of the) rules applicable to health and social SGEIs? a. To what extent do MSs understand the applicability of (some of) the rules to each of their health and social SGEIs?	**See Question 1b above relating to effectiveness**	This question has now been included under effectiveness above since it in fact impacts the overall effectiveness of SGEI rules.
EU added value	**Has the 2012 SGEI Package allowed for a better task allocation between the Commission and MS?**	**Q6. What have been the benefits of adopting a new SGEI Package in 2012? Q6a. Has the 2012 SGEI Package allowed for a better task allocation between the Commission and Member States?**	This Question has been reformulated in order to firstly examine the overall benefits of adopting a new SGEI Package with the aspects relating to better allocation of tasks then examined.

Table 25 Evaluation Framework: Effectiveness

Evaluation Criterion	Effectiveness
Our understanding of the Evaluation Criterion	In accordance with the Better Regulation Guidelines, effectiveness analysis considers how successful the SGEI Decision has been in achieving its objectives. The aim of this Evaluation Criterion was therefore to examine the extent to which the objectives of the SGEI Decision were achieved in relation to health and social housing. In order to be able to evaluate the effectiveness of the SGEI Decision and Framework, it was necessary to consider the objectives as set out in the Intervention Logic for the Evaluation. To undertake an evaluation of effectiveness, it was necessary for the Team to first have a clear overview of the current organisation and structure of the health and social housing sectors in the 10 Member States covered by the Study. This was undertaken through Task 1 of our Study. To examine the extent to which the State aid rules facilitated the provision of health and social SGEIs adapted to the population's needs, it was necessary to examine specific points. Firstly, the Study examined how the simplification of the rules through the SGEI Decision permitted the Member States to adopt aid measures. In order to do so, it was necessary to examine the manner in which an evolution occurred since the adoption of the Decision in 2012. It was necessary to not only examine the market trends since the entry into force of the decision in 2012, but also to examine the state of play prior to 2012. This enabled a counterfactual analysis. The differences between Member States sub-sectors were also examined through the preparation of the Member State Fiches and the transversal analysis of situations in the Member States. It was necessary to examine the extent to which the health and social sectors vary in the Member States as well as within the Member States in order to ascertain whether certain sub-sectors are more developed than others and whether this development has occurred due to the simplification of the State aid rules. When considering the overall effectiveness of the SGEI rules, it was also necessary to examine the extent to which Member States were actually aware of the rules and considered them in applying services relating to health and social housing in the Member States. It was therefore necessary to specifically examine this aspect relating to awareness in order to assess the extent to which the 10 Member States covered had a clear interpretation and understanding of what is and is not covered under the SGEI rules.
Question	**EQ1: To what extent have the updated State aid rules for SGEIs facilitated the provision of health and social SGEIs while preserving the key aspect of EU State aid control?**

Evaluation Criterion	Effectiveness		
Judgment Criteria	**Indicators / Descriptors[280]**	**Primary Sources**	**Secondary Sources**
The updated State aid rules have facilitated funding for the health sector and the provision of health services for the population	▶ Type of funding available for the health sector in the 10 Member States ▶ Evolution in type and amount of funding provided in the 10 Member States since 2012 and its evolution since 2005 ▶ Aid amount provided in the 10 Member States for health SGEIs between 2005 and 2019 ▶ Perception of national authorities relating to the extent to which the new rules have facilitated funding ▶ Perception of consumer and patient organisations regarding the extent to which health services have been facilitated ▶ Perception of industry organisations about the changes brought by the new package on the number of services available to the EU population in relation to health ▶ Investments operated by SGEI providers since 2005 ▶ Evolution in investments since 2012 ▶ Evolution of contribution of SGEI to GDP since 2005	▶ EY Survey ▶ Interviews with industry organisations, public authorities, NGOs, consumers associations; Commission officials	▶ Response to Commission Public & Targeted consultations ▶ Main statistics database (OECD health statistics, industry databases e.g. Report Linker, Eurostat, State Aid Scoreboard, National statistics bodies e.g. INSEE (France), De Statis (Germany)… ▶ Review of scientific literature e.g. research papers published on Jaspers Network or ▶ Reports from European or international organisations, think-tanks and knowledge centres e.g. European Global Health Research Institutes Network, Cambridge Centre for Health Services Research (CCHSR), RAND Corporation… ▶ Reports published by Member States and national bodies e.g. the biennial reports,

[280] *Indicators are quantitative in nature (i.e. amount of funding) while descriptors are qualitative in nature (i.e. perceptions of stakeholders)*

Evaluation Criterion	Effectiveness		
			reports from Inspectorates of Finances or Directorates in charge of social health Reports published by economic and public policy consulting firms e.g. Oxera ▶ Biannual Country reports
The updated State aid rules have facilitated funding for the social housing sector and the provision of social accommodations to the population	▶ Type of funding available for social housing pre- and post-2012 in the 10 Member States ▶ Aid amount provided in the 10 Member States for social housing SGEI between 2005 and 2019 ▶ Evolution of funding (type and amount) provided to social housing sector since 2005 ▶ Investments operated by SGEI providers since 2005 ▶ Evolution in investments since 2012 ▶ Perception of national authorities relating to the extent to which the new rules have facilitated funding for social housing ▶ Perception of consumer organisations regarding the extent to which social housing services have been facilitated ▶ Perception of industry organisations about the changes brought by the new package on the number of services available to the EU population in relation to social housing	▶ EY Survey ▶ Interviews with industry organisations, public authorities, NGOs, consumers associations, Commission officials	▶ Response to Commission Public & Targeted consultations ▶ Main statistics database (OECD health statistics, industry databases from Report Linker Eurostat, State Aid Scoreboard, National statistics bodies e.g. INSEE (France), ▶ Review of scientific literature e.g. research papers published on Jaspers Network, Colombia Journal of European Law, College of Europe, Colombia Journal of European Law, European studies… ▶ Reports from European or international organisations, think-tanks and knowledge centres. Housing Europe, Build Europe, International Union of Tenants,

Evaluation Criterion	Effectiveness		
			International observatory on Social Housing … ► Reports published by Member States and national bodies e.g. the biennial reports, reports from Inspectorates of Finances or Directorates in charge of social housing ► Reports published by economic and public policy consulting firms e.g. Oxera ► Biannual Country reports
While the provision of health and social housing SGEIs has been facilitated, the updated State aid rules have helped Member States in respecting EU State aid control	► Number of cases in the Member States regarding State aid breaches since 2005 ► Number of notifications received by the Commission relating to SGEI in health and social housing since 2005 ► Number of notifications received by national authorities relating to SGEI since 2005 ► Perception of national authorities in the 10 Member States regarding the clarity of the State aid rules ► Perception of stakeholders regarding the extent to which the 2012 Decision has facilitated the application of State aid rules.	► EY Survey ► Interviews with industry organisations, public authorities, NGOs, consumers associations, Commission officials	► Response to Commission Public & Targeted consultations ► Main statistics database e.g. State Aid Scoreboard, DG COMP ► Review of scientific literature, reports from international organisations, think-tanks, national bodies ► Reports published by Member States (e.g. the biennial reports) ► Legal bases publishing EU and national case laws on State aid e.g. Concurrences, Lexxion, DG COMP

Evaluation Criterion	Effectiveness		
			▶ External reports produced for the Commission
Evaluation sub-question	**EQ1a: To what extent have the 2012 SGEI rules brought clarification and simplification to enable Member States to better pursue aid measures for health and social SGEIs?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The updated 2012 package has clarified the approach regarding the State aid rules applicable to health and social housing SGEI for public authorities	▶ Approach applied in the Member States for notification to public authorities for SGEI since 2005 ▶ Changes in approach for notification since entry into force of SGEI Decision in 2012 ▶ Stakeholders' perception about the clarification of the State aid rules applicable to health and social housing SGEI since the introduction of the 2012 SGEI package ▶ Perception of public authorities relating to the clarity brought by the SGEI Package notably the SGEI Guidance and FAQs provided by the Commission ▶ Stakeholders' perception relating to the clarity of the Commission's guidelines on the SGEI Decision	▶ EY Survey ▶ Interviews public authorities, SGEI providers, industry representatives, Commission officials	▶ Responses to Commission's open and targeted consultation ▶ Documents published on the impact of the 2012 SGEI Package e.g. papers from EARTO, College of Europe… ▶ Legal opinions published by the Commission (cooperation with national courts), specialised legal firms e.g. Lexxion and law firms ▶ Complaints addressed to DG COMP ▶ Specialised resources publishing insights from experts e.g. Global competition Review

Evaluation Criterion	Effectiveness		
	► Estimations of time and money (i.e. legal consulting, advisory) allocated to understanding State aid rules since 2005 and especially pre-and post-2012		
The updated 2012 package has simplified the approach regarding the State aid rules applicable to health and social housing SGEI for SGEI providers	► Approach applied in the Member States for notification to public authorities for SGEI since 2005 ► Changes in approach for notification since entry into force of SGEI Decision in 2012 ► Estimated time savings with regard to approach regarding State aid rules ► Stakeholders' perception about the simplification of the State aid rules applicable to health and social housing SGEI since the introduction of the 2012 SGEI (e.g checking if the SGEI package is applicable, controlling the good implementation of the rules) ► Times allocated to State aid notifications for health and social SGEIs in the Member States since 2005 (Time allocated to calculate, to define the compensation to control the compensation provided)	► EY Survey ► Interviews public authorities, SGEI providers, industry representatives, Commission officials	► Responses to Commission's open and targeted consultation ► Documents published on the impact of the 2012 SGEI Package e.g. papers from EARTO, College of Europe… ► Legal opinions published by the Commission (cooperation with national courts), specialised legal firms e.g. Lexxion and law firms ► Complaints addressed to DG COMP against alleged unlawful State aid ► Specialised resources publishing insights from experts e.g. Global competition Review

Evaluation Criterion	Effectiveness		
	This element shall also be examined with regard to efficiency		
The new block exemption and *de minimis* threshold have reduced the administrative burden in relation to State aid notifications for health and social housing SGEI for public authorities and the Commission and diversified the approach	► Number of notifications since 2005 and following adoption of SGEI Package in 2012 ► Estimation of time and money saved and administrative burden reduction with the decrease of notification to the European Commission (e.g. to check the notification, to check whether the State aid has to be notified) ► Estimation of the time and money saved and administrative burden reduction with the decrease of notification by public authorities ► Perception of stakeholders relating to the adequacy of the de minimis threshold.	► EY Survey ► Interviews public authorities, SGEI providers, Commission officials	► Responses to Commission's open and targeted consultation ► Documents published on the impact of the 2012 SGEI Package
Evaluation sub-question	**EQ1b: To what extent has the awareness of Member States of SGEI rules influenced their overall application?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
Member States are aware of the SGEI rules and consider them clear to apply	► Number of questions of clarification submitted to national authorities and to the Commission	► EY Survey ► Interviews public authorities, SGEI providers, industry	► Responses to Commission's open and targeted consultation ► Legal bases publishing EU and national case laws on

Evaluation Criterion	Effectiveness		
	▶ Issues arising with regard to the interpretation of SGEI rules in case law ▶ Perception of public authorities regarding the application of the SGEI rules and their scope ▶ Perception of public authorities as to how awareness has evolved since the adoption of the 2012 Decision ▶ Differences between public authorities' perceived awareness of SGEI rules and number of cases on the subject from the Member States ▶ Key issues raised to COM by stakeholders regarding SGEI	representatives, Commission officials	SGEI State Aid e.g. Concurrences, Lexxion, DG COMP ▶ Review of scientific literature e.g. research papers published on Jaspers Network Colombia Journal of European Law, European Papers ▶ Reports and publications from European or international organisations, think-tanks and knowledge centres e.g. Colombia Journal of European Affairs, RAND Corporation…
Member States have a clear understanding of the rules in place in relation to health and social housing SGEIs	▶ Issues arising through Case law and notifications regarding the interpretation of the SGEI rules ▶ Perception by Member State authorities regarding their understanding of the rules in place ▶ Evolution in types of frequently asked questions presented on the Commission website	▶ EY Survey ▶ Interviews with public authorities, Commission officials	▶ Biannual country reports ▶ Legal bases publishing EU and national case laws on SGEI State Aid e.g. Concurrences, Lexxion, DG COMP ▶ Case commentaries and legal opinions ▶ Complaints addressed to DG COMP against alleged unlawful State aid

Evaluation Criterion	**Effectiveness**		
	► Issues raised by Member States in biannual country reports		► Requests for opinion addressed to DG COMP ► FAQs prepared by COM on the issues
The relevant of the SGEI rules are questioned by Member State authorities	► *See Evaluation Criterion relating to relevance which shall examine this aspect.*		
Evaluation sub-question	**EQ1c: To what extent have the divergences in the Member State sectors caused differences in the application of SGEI concepts?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The definition of social housing differs in the Member States causing divergences and inconsistencies in the application of SGEI concepts	► Definition of social housing in the 10 Member States ► Comparison of definition of social housing in the 10 Member States ► Reforms put in place in relation to the provision of social housing in the 10 Member States ► Differences in application by public authorities and stakeholders of the SGEI rules due to divergences in definition ► Difficulties and challenges in applying the State aid rules applicable to social housing due to divergences in interpretation	► EY Survey ► Interviews public authorities, SGEI providers, Commission officials	► National legislative frameworks e.g. Constitutions and jurisprudence ► Responses to Commission's open and targeted consultation ► State Aid Scoreboard ► Review of scientific literature e.g. research papers published on Jaspers Network, Colombia Journal of European Law, European Papers, European Studies Associations ► Reports from European or international organisations, think-tanks and knowledge centres e.g. Housing Europe,

Evaluation Criterion	Effectiveness		
	▶ Cases and notifications relating to the SGEI rules in social housing in the Member States		Build Europe, International Union of Tenants, International observatory on Social Housing, Eurocities… ▶ Legal bases publishing EU and national case laws on SGEI State Aid e.g. Concurrences, Lexxion, DG COMP
The definition of health differs in the Member States causing divergences and inconsistences in the application of the SGEI rules	▶ Definition of health services in the 10 Member States ▶ Comparison of definition of health services in the 10 Member States ▶ Reforms put in place in relation to the provision of health services in the 10 Member States ▶ Differences in application by public authorities and stakeholders of the SGEI rules due to divergences in definition ▶ Difficulties and challenges in applying the State aid rules applicable to health services due to divergences in interpretation ▶ Cases and notifications relating to the SGEI rules in health in the Member States	▶ EY Survey ▶ Interviews public authorities, SGEI providers, Commission officials	▶ National legislative frameworks e.g. Constitutions and jurisprudence ▶ Responses to Commission's open and targeted consultation ▶ State Aid Scoreboard ▶ Review of scientific literature e.g. research papers published on Jaspers Network, Colombia Journal of European Law, European Papers, European Studies Associations ▶ Reports from European or international organisations, think-tanks and knowledge centres e.g. European Global Health Research Institutes Network, Cambridge Centre for Health Services Research

Evaluation Criterion	Effectiveness		
			(CCHSR), RAND Corporation… ▶ Legal bases publishing EU and national case laws on SGEI State Aid e.g. Concurrences, Lexxion, DG COMP
Evaluation sub-question	**Q1d. Which factors and specific requirements have contributed to or stood in the way of achieving the provision of health and social SGEIs?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The lack of clarity regarding certain provisions of the SGEI Decision have hampered the application of health and social SGEI provisions	▪ Number of questions and issues raised regarding the application of SGEI rules at national and EU level ▪ Challenges perceived by stakeholders (public authorities, SGEIs providers) in relation to understanding the SGEI rules ▪ Stakeholders' perception about the accuracy and fitness of the SGEI package provisions with regard to the evolution of the market ▪ Perceptions by stakeholders regarding difficulties in the ex ante calculations *This should also be considered with regard to the clarity brought by the SGEI rules and the level of awareness of Member States as identified above*	▶ EY Survey ▶ Interviews public authorities, SGEI providers, Commission's officials	▶ Responses to Commission's open and targeted consultation ▶ Publications from industry/consumer's associations and institutes e.g. International Union of Tenants, Housing Europe, Building Europe for the social housing sector, and The European Hospital and Healthcare Federation (HOPE) or The European Patients' Forum (EPF) for the health sector
Market and policy evolutions in the Member States have hampered the application of SGEI provisions	▪ Evolutions in health and social markets in the Member States since 2012 ▪ Evolutions in the types of services falling under the scope of the SGEI rules since 2005 and 2012	▶ EY survey ▶ Interviews public authorities, SGEI	▶ Main statistics database (OECD, Eurostat, State Aid Scoreboard, National statistics bodies)

Evaluation Criterion	Effectiveness		
	▪ Evolutions in priorities by Member States regarding the funding of services in the health and social sector since 2012 ▪ Perception by stakeholders regarding the effect of policy and market evolutions	providers, Commission officials	▶ Review of policy and legislation in the Member States ▶ Review of scientific literature ▶ Reports from international organisations, think-tanks, national bodies ▶ Reports published by Member States (e.g. the biennial reports)
Health and housing crises have impacted the application of SGEI rules in the Member States	▪ Types of health and social housing crises existing in the Member States since 2012 ▪ Extent to which the crises impacted the application of SGEI Rules ▪ Perception of stakeholders regarding the changes in application due to crises	▶ EY survey ▶ Interviews public authorities, SGEI providers, European organisations including consumer organisations	▶ ▶ Review of scientific literature e.g. research papers published on Jaspers Network, Colombia Journal of European Law, European Papers, European Studies Associations ▶ Reports from European or international organisations, think-tanks and knowledge centres ▶ Publications from industry/consumer's associations and institutes e.g. International Union of Tenants for the housing sector, or The European Hospital and Healthcare Federation (HOPE) and The

Evaluation Criterion	Effectiveness		
			European Patients' Forum (EPF) for the health sector

Table 26 Evaluation Framework: Efficiency

Evaluation Criterion	Efficiency		
Our understanding of the Evaluation Criterion	In accordance with the Better Regulation Guidelines, an evaluation should closely examine both the costs and benefits of the EU intervention for different stakeholders. This Evaluation Criterion considered the relationship between the resources associated with the application of the SGEI Decision and the changes generated by the Decision. The Criterion examined the extent to which the desired effects of the SGEI Decision were achieved as a reasonable cost. When measuring the costs and benefits associated with the SGEI Decision, it was necessary to look at the human costs associated (in terms of time and resources). Efficiency measured how the resources/inputs are converted to results and how the systems in place, including the monitoring and reporting systems and governance, assist in efficiency. During the data collection phase, the Study also requested stakeholders in interviews and surveys to provide their estimations of costs and savings associated with the adoption of the SGEI rules in 2012.		
Question	**Q2: What are the costs and benefits associated with the application of the requirements set by the rules for health and social SGEIs for the different stakeholders?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The SGEI rules have clarified and simplified rules leading to a reduction in the number of complaints,	▶ Number of complaints, Commission decisions and Court decisions per	▶ EY Survey ▶ Interviews with SGEI providers, public	▶ Reports published by Member States (e.g. the biennial reports) related to the impacts on costs and benefits

Evaluation Criterion	Efficiency		
Commission decisions and court decisions since 2012	year/sector/relevant text/MS since 2005 ▶ Stakeholders perception regarding the clarification and simplification and how it has led to greater efficiency (SGEIs providers, Commission officials and public authorities)	authorities, Commission officials	▶ Legal bases publishing EU and national case laws on SGEI State Aid e.g. Concurrences, Lexxion, DG COMP ▶ Case commentaries and legal opinions ▶ Complaints addressed to DG COMP against alleged unlawful State aid
The SGEI rules have clarified and simplified rules leading to a reduction in costs overall	▶ Number of complaints, Commission decisions and Court decisions per year/sector/relevant text/MS since 2005 ▶ Stakeholders (SGEIs providers, Commission officials and public authorities) ▶ Time, resources and administrative costs associated with the implementation and control of State aid in health and social SGEIs since 2005 (including the appeal to legal experts/consultants) ▶ Monetary/economic benefits gained through State aid since the implementation of the SGEI package	▶ EY Survey ▶ Interviews with SGEI providers, public authorities, Commission officials	▶ Response to Commission's public and targeted consultations ▶ Reports published by Member States (e.g. the biennial reports) and their regional/local bodies related to the impacts on costs and benefits
Evaluation sub-Question	**Q2a: To what extent have the specific rules for health and social SGEIs enabled the provision of services without causing disproportionate administrative burden for Member States?**		

Evaluation Criterion	**Efficiency**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The clarification and simplification brought by the SGEI rules has led to reduced administrative burden for MS authorities	▶ *See indicators relating to effectiveness on clarification and simplification* ▶ Perception by MS authorities regarding the impact clarification and simplification has had on time and costs associated with dealing with SGEI rules ▶ Resources allocated to State aid control in the Member States for health and social housing ▶ Evolution in resources allocated in the national authorities since the 2012 SGEI rules	▶ EY Survey ▶ Interviews with national authorities in the Member States	▶ Response to Commission's public and targeted consultations ▶ Internal analysis of complaints and overall case practice ▶ Data on set up costs (EY data) ▶ Reports published by Member States (e.g. the biennial reports) and their regional/local bodies related to the impacts on costs and benefits
The exemption from notification as provided for under Article 3 of the SGEI Decision reduces times and costs for MS authorities	▶ Estimation of time and costs associated with notification to the Commission pre-2012 and post 2012 ▶ Perception by MS authorities regarding the estimated time savings due to the lack of notification ▶ Number of notification cases for health and social SGEIs pre-and pos-2012	▶ EY Survey ▶ Interviews with national authorities in the Member States	▶ Response to Commission's public and targeted consultations ▶ Internal analysis of complaints and overall case practice ▶ Data on set up costs (EY data)
Evaluation sub-Question	**Q2b: To what extent have the specific rules for health and social SGEIs impacted the administrative burden for service providers?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**

Evaluation Criterion	**Efficiency**		
The SGEI rules adopted in 2012 have increased the administrative burden for service providers	▶ Resources put in place by service providers regarding accounting mechanisms for SGEI ▶ Perception of service providers regarding the changes in administration relation to SGEI rules since the entry into force of the 2012 Rules ▶ Estimation of time and costs associated with the application of the SGEI rules by service providers ▶ Costs associated with setting up a project for the provision of health and social SGEIs since 2005 ▶ Time, resources and administrative costs associated with setting up a project for the provision of health and social SGEIs since 2005	▶ EY Survey ▶ Interviews with SGEI providers	▶ Internal analysis of complaints and overall case practice ▶ Publications from industry associations and institutes e.g. International Union of Tenants for the housing sector, or The European Hospital and The European Association of Hospital Managers (EAHM) for the health sector ▶ Reports published by Member States (e.g. the biennial reports) and their regional/local bodies related to the impacts on costs and benefits
Evaluation sub-Question	**Q2c: To what extent have the specific rules for health and social SGEIs had an impact on the administrative burden for the Commission?**		
The SGEI rules adopted in 2012 have reduced the number of notifications submitted to the Commission and therefore the time spent on dealing with these notifications	▶ Number of notifications received by the Commission pre-and post-2012 ▶ Evolution in the number of notifications received pre- and post-2012 and in comparison with the evolution for other sectors (i.e. non-health and social) ▶ Perception by the Commission regarding the shift in the time spent on	▶ Interviews with European Commission	▶ Commission Impact Assessment Study on 2012 SGEI Decision and Framework

Evaluation Criterion	**Efficiency**		
	specific issues relating to SGEI rules for health and social housing ▶ Estimation of time reductions relating to notifications due to SGEI rules in 2012		
The SGEI rules have increased the time spent by the Commission in providing guidance	▶ Number of questions asked to the Commission by Member States and service providers pre-and post-2012 ▶ Time spent updating the frequently asked question on the SGEI rules ▶ Perception by the Commission regarding the evolution in time spent on such matters	▶ Interviews with European Commission	▶ Commission Impact Assessment Study on 2012 SGEI Decision and Framework
Evaluation Question	**Q3: To what extent have the specific rules for health and social SGEIs enabled the provision of social services without distorting competition disproportionately?**		
Judgment Criteria	**Indicators / Descriptors**	**Primary Sources**	**Secondary Sources**
The rules in place for health and social housing SGEIs have increased services without impacting competition at national and European level	▶ Market in the 10 Member States relating to health and social housing ▶ Evolution in the market in the 10 Member States relating to health and social housing since 2005 ▶ Evolution in actors, both public and private, in the market since 2005 ▶ Share of services provider by public providers since 2005 in health and social housing	▶ EY Survey ▶ Interviews with SGEI providers, public authorities, Commission's official, industry representatives, consumer organisations	▶ Studies and reports on the level of competition in the health and social housing sectors from European or international organisations, think-tanks, knowledge centres and consulting firms ▶ Main statistics / national databases

Evaluation Criterion	Efficiency		
	▶ Stakeholders' perception (Commission's officials, public authorities, SGEIs providers and industry representatives) about the distortion of competition at national and European levels brought by the SGEI package		

Table 27 Evaluation Framework: Relevance

Evaluation Criterion	Relevance
Our understanding of the Evaluation Criterion	In accordance with the Better Regulation Guidelines, relevance looked at the relationship between the needs and problems in society and the objectives of the SGEI Package. The aim of this evaluation criterion was therefore to examine the extent to which the SGEI rules in place for health and social services were adapted to the developments of social, markets and social policy. In order to be able to evaluate relevance, it was necessary to firstly examine and understand the needs which existed in relation to rules for health and social services and the extent to which the Package (in particular the SGEI Decision) addressed the needs existing. Moreover, it was necessary to assess the extent to which the needs which existed in 2012 evolved and whether the provisions of the SGEI decision are still relevant to the needs to this day. Future needs also need to be considered when assessing relevance. It was necessary to closely examine recital 11 where it is mentioned that 'a larger amount of compensation of social services does […] not necessarily produce a greater risk of distortions on competition'. In addition, specific attention was paid to analyse whether the SGEI package provisions were still well adapted to the development of the markets (in particular the social housing SGEI in comparison to the recent market development).

Evaluation Criterion	**Relevance**		
Question	**Q4: To what extent are the SGEI rules for health and social housing adapted to the development of society, markets and social policy?**		
Judgment Criteria	**Indicators / descriptors**	**Primary Sources**	**Secondary Sources**
The SGEI rules in place since 2012 are adapted to address the developments of society, markets and social policy with regard to health and social housing	► Policy priorities in place in the 10 Member States relating to health and social housing ► Needs existing by stakeholders relating to health and social housing in the 10 Member States ► Evolution regarding the provision of health and social housing since 2012 versus needs existing for stakeholders ► Perception by stakeholders regarding the adaptability of the SGEI rules to evolutions existing in relation to the market and policy	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Review of policy and legislation in the Member States ► Review of scientific literature, reports from international organisations, think-tanks, and knowledge centres (market trends, characteristics…) ► Reports published by national bodies and Member States (e.g. the biennial reports) on the relevance and the fitness for purpose of the SGEI rules ► Publications from industry/consumer's associations and institutes e.g. International Union of Tenants for the housing sector, or The European Hospital and Healthcare Federation (HOPE) and The European Patients' Forum (EPF) for the health sector

Evaluation Criterion	**Relevance**		
Evaluation sub-question	**Q4a. To what extent were the SGEI rules for health and social housing adapted to the needs of society, markets and social policy at the time of their adoption?**		
Judgment Criteria	**Indicators / descriptors**	**Primary Sources**	**Secondary Sources**
The SGEI rules better addressed the needs existing at the time of their adoption	► Needs existing in the Member States and at EU level at the time of adoption of SGEI rules in 2012 ► Changes in the SGEI Rules since 2005 which addressed needs in the Member States ► Perception of stakeholders regarding the relevance of the 2012 Decision in comparison to the 2005 Decision	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Commission IA Study on SGEI Rules prior to 2012 decision ► Response to Commission Public & Targeted consultations ► Reports from international organisations, think-tanks and knowledge centres (market trends, characteristics…) ► Publications from industry/consumer's associations and institutes ► Reports published by Member States or national bodies (e.g. the biennial reports) on the relevance and the fitness for purpose of the SGEI rules
Evaluation sub-question	**Q4b. To what extent are the SGEI rules for health and social services still adapted to the developments at national level?**		

Evaluation Criterion	**Relevance**		
Judgment Criteria	**Indicators / descriptors**	**Primary Sources**	**Secondary Sources**
The SGEI rules in place are still in line with the evolutions of the market in the social and health SGEIs	► Evolution regarding the provision of health and social housing since 2012 v. needs existing for stakeholders ► Evolution of market structures in the Member States ► Evolution of tendering to private providers in the Member States for health and social housing ► Evolution of actors in the Member States for the provision of health and social housing ► Perceptions by stakeholders regarding the gaps existing in the SGEI rules to better address needs existing today ► Questions and notifications provided to the Commission regarding the SGEI rules	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Commission IA Study on SGEI Rules prior to 2012 decision ► Review of scientific literature ► Reports from international organisations, think-tanks and knowledge centres (market trends, characteristics…) ► Reports published by Member States and national bodies (e.g. the biennial reports) on the relevance and the fitness for purpose of the SGEI rules
Evaluation sub-question	**Q5: To what extent is the approach for health and social SGEIs introduced in the 2012 SGEI Decision still justified?**		
Judgment Criteria	**Indicators / descriptors**	**Primary Sources**	**Secondary Sources**
The approach for health and social SGEIs (compensation and the exemption of notification) was justified when the SGEI package was introduced and is still justified today	► Evolutions in relation to market competition and cross-border activities (share of public entities and private undertakings in the sectors	► EY Survey ► Interviews with SGEI providers, public authorities,	► Commission IA Study on SGEI Rules prior to 2012 decision ► Review of scientific literature

Evaluation Criterion	Relevance		
	concerned/procedures in place for market attributions (e.g. public tenders) ► Level of competition at national and European level regarding health and social housing ► Perception by stakeholders regarding the definition of health and social housing and whether they are considered as SGEIs	industry representatives, consumer representatives	► Reports from international organisations, think-tanks and knowledge centres (market trends, characteristics…) ► Reports published by Member States and national bodies (e.g. the biennial reports) on the relevance and the fitness for purpose of the SGEI rules
Considering the COVID-19 sanitary crisis, the approach for health SGEI introduced in 2012 is still justified	► Perception by stakeholders of the impact of the COVID-19 crisis on the health SGEI sector ► Perception by stakeholders regarding the needs in the health sectors following the COVID-19 crisis ► Perception by stakeholders regarding the relevance of the rules considering the impacts brought by the COVID-19 crisis ► Perception by stakeholders regarding the impact of the COVID-19 on the social needs and on the sector/market (e.g. increase of the public aid following the crisis, possible takeover of private providers by public entities…)	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Reports from international organisations, think-tanks and knowledge centres (market trends, characteristics…) ► Reports published by Member States and national bodies (e.g. the biennial reports) on the relevance and the fitness for purpose of the SGEI rules

Evaluation Criterion	**Relevance**		
Evaluation sub-question	**Q5a. Is there evidence that health and social SGEIs should be treated as specific due to the lower risk of distortion of competition as stated in recital 11 of the SGEI Decision?**		
Judgment Criteria	**Indicators/descriptors**	**Primary Sources**	**Secondary Sources**
Health and social housing create a low risk of distortion of competition and should have specific rules assigned	► Aid amount provided in the Member States for other SGEI measures between 2005 and 2019 ► Trends with regard to provision of services in health and social housing in the Member States ► Proportion of market share to private providers v public providers since 2012	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives	► Main statistics database (OECD health statistics, industry databases e.g. Report Linker, Eurostat, State Aid Scoreboard, National statistics bodies e.g. INSEE (France), De Statis (Germany)… ► Commission IA Study on SGEI Rules prior to 2012 decision ► Review of scientific literature in law and economics ► Reports from international organisations, think-tanks and knowledge centres (market trends, characteristics…) ► Reports published by Member States (e.g. the biennial reports) ► Publications from industry/consumer's associations and institutes

Table 28 Evaluation Framework: EU added value

Evaluation Criterion	EU added value		
Our understanding of the Evaluation Criterion	The aim of this Evaluation Criterion was to examine to what extent the 2012 SGEI Package provided added value which could not have been achieved without the intervention. With regard to health and social housing, this Criterion, in the context of this Study, particularly examined to what extent the SGEI package allowed for better task allocation between the Commission and the Member States decreasing administrative burden. When examining EU Added Value, it was necessary to take into account the responses to the Evaluation Questions in relation to effectiveness and efficiency. A direct link can be made between these evaluation criteria and EU added value. For example, the extent to which the objectives of the SGEI Decision have been achieved can have a direct impact on the added value of the EU. Counterfactual analysis comparing the situation pre and post 2012 enabled the Study Team to assess the EU Added Value of the SGEI Package since it since it pinpointed the changes that could be attributed to the Package.		
Question	Q6. What have been the benefits of adopting a new SGEI Package in 2012?		
Judgment Criteria	**Indicators**	**Primary Sources**	**Secondary Sources**
The SGEI package in 2012 has benefitted the EU population with greater provision of public services in health and social housing	► Stakeholders' perception about the EU added value of the intervention compared to a baseline scenario in which the EU would have not intervened ► Stakeholders' perceptions about the EU added value about the provision of the social housing and health SGEIs	► EY Survey ► Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Reports from international organisations, think-tanks and knowledge centres ► Reports published by Member States and national bodies ► Biannual Country reports ► Publications from industry/consumer's associations and institutes

Evaluation Criterion	**EU added value**		
Evaluation sub-question	Q6a. Has the 2012 SGEI Package allowed for a better task allocation between the Commission and Member States?		
Judgment Criteria	**Indicators**	**Primary Sources**	**Secondary Sources**
Without the EU intervention the different Member State's pertaining to health and social housing SGEIs would have led to a greater distortion of competition within the internal market Without the EU intervention the provision of the social housing and health SGEIs would have been harder	► Evolution in tasks between the Commission and Member States ► Number of exemptions (i.e. notifications avoided) due to changes in rules. ► Stakeholders' perception on the better allocation of the tasks *Responses in relation to effectiveness and efficiency should be considered*	► EY Survey Interviews with SGEI providers, public authorities, industry representatives, consumer representatives	► Reports from international organisations, think-tanks and knowledge centres ► Reports published by Member States and national bodies ► Biannual Country reports Publications from industry/consumer's associations and institutes

9.4 Interview Guides

9.4.1 Interview Guide – Consumer Organisations

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.
This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package? What is your experience with regard to these rules?

Relevance

- What needs exist for the population with regard to health/social housing in your Member State?
- Are the needs existing for the provision of services addressed with regard to the facilitation of state aid rules due to the 2012 Decision and Package?
- Considering the impacts of the COVID-19 crisis, would you say that the 2012 Package addresses the needs arising from this pandemic?
- Are additional needs existing for the population with regard to health/social housing which could be better addressed by the SGEI Decision and Package?

Effectiveness

- To what extent do health/social housing SGEIs represent a low risk to the distortion of competition?
- For consumers/the population in the Member State, would it be preferable to change these rules for the provision of services? If yes, in what way?
- Have you contacted national authorities in the past to receive clarification regarding the SGEI rules? If yes, on what aspects? In your opinion, is there a clear understanding of the SGEI rules at national level?
- In your opinion, has the lowering of the block exemption threshold for aid from €30M in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the SGEI de minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?
- To what extent are the rules in place at national level regarding state aid still considered to be an obstacle to the provision of services in relation to health/social housing?
- To what extent has the COVID crisis impacted the provision of health and social housing SGEIs?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision?
- Are the SGEI rules justified for the sector?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

9.4.2 Interview Guide – European NGOs and Associations

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.
This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package? What is your experience with regard to these rules?

Relevance

- What needs exist for the European population and industry with regard to health/social housing in your Member State?
- Are the needs existing for the provision of services addressed by the 2012 SGEI Package?
- Considering the impacts of the COVID-19 crisis, would you say that the 2012 Package addresses the needs arising from this pandemic?
- Are additional needs existing with regard to health/social housing which are not currently addressed by the 2012 SGEI Package?

Effectiveness

- To what extent do health/social housing SGEIs represent a low risk to the distortion of competition?
- For your members in the Member States, would it be preferable to change the SGEI rules for the provision of health and social services?
- In your opinion, has the lowering of the block exemption threshold for aid from €30M in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 per year had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the SGEI de minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?
- To what extent are the rules in place regarding state aid still considered to be an obstacle to the provision of services in relation to health/social housing?
- To what extent has the COVID crisis impacted the provision of health and social housing SGEIs?

Efficiency

- What are the main cost and benefits of the 2012 SGEI package? How do these benefits compare with the situation prior to 2012?
- Would you say that the new rules have reduced the administrative burden/the costs for your members? If so, how (time allocation, cost, resources…)?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision?
- Are the SGEI rules justified for the sector?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

9.4.3 Interview Guide – Industry Associations

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.
This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package? What is your experience with regard to these rules?

Context of the national market

- Can you describe how the health/social housing market within the EU has evolved over recent years, particularly since the adoption of the 2012 SGEI Decision?
- How would you qualify the evolution of competition in the health/social housing sector in and between Member States?
- To what extent have policy and market developments in Member States impacted access to state aid?

Relevance

- What needs exist for your members with regard to state aid?
- Do you believe that your members' needs for financing have been better addressed following the modification of the SGEI rules in 2012?
- Considering the impacts of the COVID-19 crisis, would you say that the 2012 Package addresses the needs arising from this pandemic?
- To what extent do you think that the provision of health and social housing represent a low risk to the distortion of competition?

Effectiveness

- To what extent do you consider the SGEI rules to be clear and comprehensive?
- Can you elaborate on how your members in the Member States took these rules into account following the adoption of the 2012 Decision?
- To what extent has the SGEI Package clarified and simplified the application of rules at national and EU level? How does this compare to the situation prior to 2012?
- In your opinion, has the lowering of the block exemption threshold for aid from €30M in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the SGEI de minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?

- Do you believe that competition between economic providers has improved/deteriorated since the entry into force of the 2012 decision?
- To what extent have difficulties been faced by your members in relation to receiving state aid for your relevant sector? How have these difficulties evolved in comparison with the situation prior to the entry into force of the 2012 SGEI Decision?
- To what extent are the rules in place regarding state aid still considered to be an obstacle to the provision of services in relation to health/social housing?
- To what extent has the COVID crisis, impacted the provision of health and social housing SGEIs?

Efficiency

- Would you say that the new rules have increased the administrative burden/the costs for your members' operations? If so, how (time allocation, cost, resources…)?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision?
- Are the SGEI rules justified for the sector?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Would you have some documents or statistical data to share with us regarding the market?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

9.4.4 Interview Guide – Providers in health and social housing

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.
This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package? What is your experience with regard to these rules?

Context of the national market

- Can you describe your market with regard to health/social housing? For example who are your competitors, if any.
- How would you qualify the evolution of competition in the health/social housing sector both at national level and, if possible, between Member States?
- To what extent have policy and market developments in your Member State impacted access to state aid?

Relevance

- What needs exist for your organisation with regard to state aid?
- Do you receive State aid?
- Do you believe that your needs for financing have been addressed following the modification of the SGEI rules in 2012?

- Considering the impacts of the COVID-19 crisis, would you say that the 2012 Package addresses your needs arising from this pandemic?
- To what extent do you think that the provision of health and social housing represent a low risk to the distortion of competition?

Effectiveness

- To what extent do you consider the SGEI rules to be clear and comprehensive?
- Can you elaborate on how your organisation took these rules into account following the adoption of the 2012 Decision?
- Have you contacted national authorities in the past to receive clarification regarding the SGEI rules? If yes, on what aspects? In your opinion, is there a clear understanding of the SGEI rules at national level?
- To what extent has the SGEI Package clarified and simplified the application of rules at national level? How does this compare to the situation prior to 2012?
- In your opinion, has the lowering of the block exemption threshold for aid from €30M in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the de SGEI minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?
- Do you believe that competition between economic providers has improved/deteriorated since the entry into force of the 2012 decision?
- To what extent have you faced difficulties in relation to receiving state aid for your relevant sector? How have these difficulties evolved in comparison with the situation prior to the entry into force of the 2012 SGEI Decision?
- To what extent are the rules in place at national level regarding state aid still considered to be an obstacle to the provision of services in relation to health/social housing?
- To what extent has the COVID crisis impacted the provision of health and social housing SGEIs?

Efficiency

- Would you say that the current rules have increased the administrative burden/the costs for your operations? If so, how (time allocation, cost, resources…)?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision?
- Are the SGEI rules justified for the sector?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Would you have some documents or statistical data to share with us regarding the market?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

9.4.5 Interview Guide – Public Authorities competent for health and social housing

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.

This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package? What is your experience/role with regard to these rules?

Overview of the sector

- Can you please provide an overview of how the health/social housing sector is organised in your Member State? Who are they key actors? Is there a balance between public and private providers?
- What are the main funding schemes in place in the sector? In terms of budget expenditure, can you provide us with an overview of the total gross amount spent to support the health/social housing sector per annum?
- What are the key trends and overall evolutions in the sector since 2012? Have any policy reforms occurred? In your opinion, has there been a shift in budget expenditure in relation to health/social housing SGEIs since 2012?
- To what extent have changes in competition occurred?

Relevance

- What are the needs which exist in your Member State in relation to the financing of services of general economic interest (particularly in relation to the health and social housing sectors?)
- To what extent are health and social housing services considered as services of general economic interest in your Member State?
- How would you describe the evolution of the needs existing at national level since the adoption of the 2012 SGEI Package?
- In your opinion, are specific needs (e.g. societal, policy) not currently addressed by the 2012 SGEI Package? In particular, would you say that the 2012 Package addresses the needs arising from the COVID-19 pandemic?
- Do you consider that health and social housing SGEIs represent a low risk to the distortion of competition? If yes, why? Was the approach for exemption in the 2012 SGEI Decision justified for health and social housing SGEIs?

Effectiveness

- To what extent has the SGEI Package clarified and simplified the application of rules at national level? How does this compare to the situation prior to 2012?
- Are there instances where it is unclear for you whether to notify the Commission or not?

- In your opinion, has the lowering of the block exemption threshold for aid from €30M in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the SGEI de minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?
- What obstacles do you still encounter as national or local authorities in relation to the provision of aid? How do these obstacles compare with the situation prior to 2012?
- To what extent has the COVID crisis, impacted the provision of health and social housing SGEIs?

Efficiency

- Can you please describe the manner in which the SGEI provisions are followed in your Member State? Who are the key authorities who monitor the application of these rules?
- What are the main cost and benefits of the 2012 Package (i.e. non-notification to the Commission, increase of threshold)? How do these compare with the situation prior to 2012?

- How would you estimate the time and cost savings or increases linked to the exemption for prior notification? To what extent have the new rules in 2012 added greater burden your organisation to assess the extent to which specific services fall under the SGEI Decision?
- Would you have any specific examples of cases which demonstrate the costs and benefits associated with the new regime since 2012?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision? Can you identify specific advantages which occurred in comparison to 2005?
- Would you say that the same results could have been achieved without intervention by the EU?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Would you have some documents or statistical data to share with us regarding the application of SGEI rules?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

9.4.6 Interview Guide – Public Authorities in charge of the implementation of the SGEI Package or State aid

EY has been mandated by DG Competition of the European Commission to undertake a Study on Market Trends in health and social services and EU State Aid implications. The aim of the Study is to reply to Evaluation Questions regarding the relevance, effectiveness, efficiency and EU added value of the SGEI Decision in the sectors relating to healthcare and social housing since the Decisions entry into force from 31 January 2012.
The aim of this interview is to gain your opinion and insights on the application of the SGEI rules since 2012. This interview will be confidential and anonymous.
This interview guide provides questions that will serve as a basis for our discussion. Respondents may not consider themselves in a position to respond to all questions.

Introduction

- Please introduce yourself and your role within your organisation.
- What is your understanding of the SGEI rules in place, based on the 2012 SGEI Package?

Relevance

- What are the needs which exist in your Member State in relation to the financing of services of general economic interest (particularly in relation to the health and social housing sectors?)
- To what extent are health/ social housing services considered as services of general economic interest in your Member State?
- How would you describe the evolution of the needs existing at national level since the adoption of the 2012 SGEI Package? To what extent does the 2012 Package compare to the 2005 Package for addressing these needs?
- Considering the impacts of the COVID-19 on the health sector, would you say that the 2012 Package addresses the needs arising from this sanitarian crisis?
- In your opinion, are specific needs (e.g. societal, policy) currently not addressed by the 2012 SGEI Package?
- Do you consider that health and social housing SGEIs represent a low risk to the distortion of competition? If yes, why? Was the approach for exemption in the 2012 SGEI Decision justified for health and social housing SGEIs?

Effectiveness

- To what extent do you consider public authorities in your Member State to be fully aware of the SGEI rules in place and comfortable in their application?

- In your opinion, has the lowering of the block exemption threshold for aid from €30M per year in the SGEI Decision from 2005 to €15M per year in the SGEI Decision from 2012 had a positive impact on the provision of health/social housing SGEIs including an increase in the monetary compensation provided for these sectors?
- In your opinion, has the increase of the SGEI de minimis threshold for public compensation had a positive impact on the provision of health/social housing SGEIs?
- To what extent has the SGEI Package clarified and simplified the application of rules at national level? How does this compare to the situation prior to 2012?
- What obstacles are still encountered, in your opinion, in relation to the provision of aid? How do these obstacles compare with the situation prior to 2012?
- To what extent have factors, such as the COVID crisis, impacted the provision of health and social housing SGEIs?

Efficiency

- Can you please describe the manner in which the SGEI provisions are followed in your Member State? Who are the key authorities who monitor the application of these rules?
- What are the main cost and benefits of the 2012 SGEI package? How do these compare with the situation prior to 2012?
- To what extent have the new rules in 2012 added greater burden on the national authorities to assess the extent to which specific services fall under the SGEI Decision?

EU added value

- What are, in your opinion, the advantages associated with the 2012 SGEI Decision? Can you identify specific advantages which occurred in comparison to 2005?
- Would you say that the same results could have been achieved without intervention by the EU?

Additional points

- Are there any additional comments you wish to make or recommendations you would wish to see looking forward?
- Would you have some documents or statistical data to share with us regarding the application of SGEI rules?
- Are there any individuals/organisations you would recommend we contact for this Study?

Thank you for your participation!

10 Annex 3: Member State Fiches[281]

10.1 Croatia

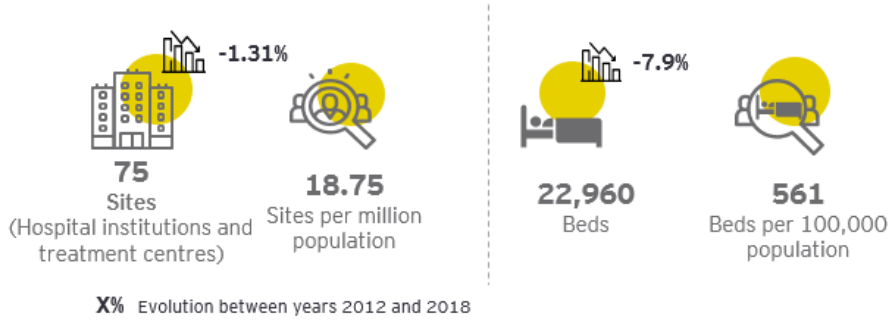
Member State: Croatia[282]		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing	• Croatia does not define healthcare as SGEI. • In 2018, the total current health expenditure in Croatia was € 3.52 billion (6,83% of GDP). • The health sector in Croatia is mainly funded by the social security scheme (around 80%). Compulsory contributory health insurance with € 2,345.70 million in 2013 represented 82.15% of total health expenditure (5.37% of GDP) and in 2018 with € 2,773.81 million represented 78.70% of total health expenditure (5.37% of GDP).	• Croatia does not define social housing as SGEI. • In terms of affordable housing, the total value of investment in construction of POS programme[283] buildings from 2000 to 2018 was HRK 4.3 billion (around € 570.7 million), out of which HRK 1.1 billion (around €148 million) were realised State subsidies. • In 2018, for the "first programme of housing loan subsidies" from 2017 until 2018 a total of around € 5.7 million was paid in terms of subsidies, while for the "second programme" around € 160,913.56 was paid in subsidies.
Key actors	• Public institutions: REPUBLIC OF CROATIA Ministry of Finance REPUBLIKA HRVATSKA Ministarstvo zdravstva • Fund providers: Hrvatski zavod za zdravstveno osiguranje / Croatian Health Insurance Fund • Healthcare providers: As defined according to the Healthcare Act.	• Public institutions: REPUBLIC OF CROATIA Ministry of Finance REPUBLIKA HRVATSKA Ministarstvo prostornoga uređenja, graditeljstva i državne imovine REPUBLIKA HRVATSKA Središnji državni ured za obnovu i stambeno zbrinjavanje • Implementation agencies ADN

[281] *All links included in the Member State Fiches were last accessed on 13 May 2021*

[282] *Croatia joined the EU on July 1, 2013 thus some of the data is not available prior the accession date. Also, due to the fact that Croatia is not an OECD member, some of the data that was used for other MS' fiches is not available for Croatia and will not be comparable with OECD statistics.*

[283] *Programme of state-subsidised housing construction (hrv. Program društveno poticane stanogradnje)*

Structure of health and social housing	• Pursuant to the Healthcare Act, healthcare activity is as an activity of interest for the Republic of Croatia performed as a public service by healthcare professionals providing healthcare in accordance with the professional medical doctrine and with the use of medical technology, according to the requirements and in the manner prescribed by the Healthcare Act. It is based on the principle of universality of healthcare. • The Croatian Ministry of Health (*Ministarstvo zdravstva*) is responsible for the organisation and monitoring of the health system by setting the national legislation, strategy, and budgeting including the financing of the hospital budget. • The Croatian Health Insurance Fund (CHIF) is the sole insurer in the mandatory health insurance system and the main purchaser. • Healthcare as a public service is performed within the public healthcare service network and outside the public healthcare service network. The public health service network determines the required number of healthcare institutions, the required number of beds by activities, the number of healthcare teams and private healthcare workers with whom the Croatian Health Insurance Fund (CHIF) contracts for healthcare services for the of the Republic of Croatia.	• Affordable housing in Croatia is usually identified with the programmes offered by the Agency for Transactions and Mediation in Immovable Properties(APN), connected to POS programme or housing loan subsidies. • Housing policies are implemented only partially, through a variety of acts and of authorities. • No competition exists in the affordable housing market as public housing is directly funded and implemented by the federal government or a local government authority.
Main conclusions	• The Croatian health system is highly centralized. Reforms and policies are mostly focused on publicly owned health institutions. • Many reforms were introduced in recent years but they have progressed slowly or are not completely implemented. • Croatia spends a large share of its health expenditure on pharmaceuticals and medical devices, while a very small share of health expenditure is spent on long-term care.	• There is no systematic approach towards housing in Croatia and housing policies are addressed only partially through a variety of acts and through a variety of authorities. • It is expected that the Strategy on (social) housing will define the sector and explore the available stock, as well as define needs in terms of social housing, and housing policies in general.

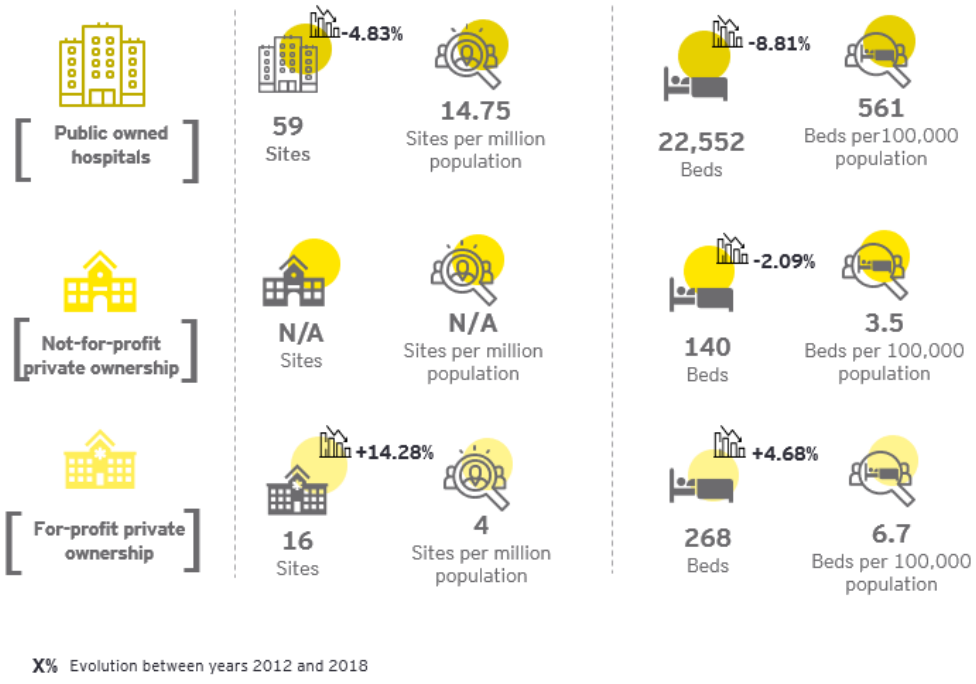
I. Health Sector	
The aim of this Section is to provide an overview of the health sector in Croatia as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.	
KEY FIGURES	**Number and share of hospitals and beds (and evolution)** Statistics on the number of hospitals in Croatia vary depending on the source and scope of the definition of the term "hospital". When counting only general and specialty hospitals, clinics, clinical hospital centres and clinical hospitals (regardless of the type of ownership[284]), according to the Croatian Health Statistics Yearbook for 2018 there was 68 hospitals as opposed to 69 in 2012, which represents a decrease of 1,45%. According to the 2012 yearbook, out of 76 hospital institutions and treatment centres, nine specialty hospitals and five treatment centres (medical resorts) were privately owned. In 2018, out of 75 hospital institutions and treatment centres, 11 specialty hospitals and 5 treatment centres were privately owned. According to Eurostat data[285] in 2018, the total number of available beds in "hospitals" was 22,960 against 24,933 in 2012, which represents a decrease of 7.9%.  The decrease in the number of hospital beds can be connected to the National Healthcare Strategy[286] 2012-2020's goal to streamline acute care services through strengthening day hospitals and increasing the capacity of long-term and palliative care. This process began with amendments of the Public Health Service Network (OG 101/12, 31/13 i 113/15) in 2015 and with the National Plan for the Development of Clinical Hospital Centres, Clinical Hospitals, Clinics and General Hospitals for 2014-2016 with an aim to reduce the acute hospitalisation rate (through the reduction in need for acute beds), increasing the average bed occupancy rate to 80% and reducing the average length of stay in hospitals. As the newest National plan for 2018-2020 states, these activities were carried out in the previous period, and their continuation is planned for the 2018-2020 period as well As stated in the National Healthcare Strategy mentioned above, the number of beds in all inpatient healthcare facilities, expressed per 1,000 inhabitants, decreased from 6.00 in 2001 to 5.66 in 2010, but despite making changes to the Public Healthcare Service Network, compared to 2009, the number of beds increased in 2010 in clinical hospital centres, clinical hospitals and clinics (by

[284] *The Croatian Health Statistics Yearbook offers only data on numbers of certain types of health institution but does not provide additional information on types of ownership or lists of subjects. It does mention the number of private special hospitals and health resorts within the text.*
[285] *Eurostat uses System of Health Accounts (SHA) which includes general and special hospitals, clinics, clinical hospital centers, clinical hospitals, treatment centres/health resorts. Thus we included the number of sites that also includes those to be comparable.*
[286] *National plans and Strategy only cover the public healthcare service network.*

13.8%), as well as in specialty hospitals and treatment centres (by 2.6%). The total annual utilisation of acute beds was 75.19% in 2010 compared to 85.5% in 2001.

Number and share of hospitals and beds (and evolution) per legal entity

According to Eurostat's estimate of hospital beds by hospital ownership, 22,552 (98.22%) out of 22,960 available beds in hospitals in 2018 were in public ownership, while only 140 were in not-for-profit private ownership, and 268 in for-profit private ownership. In 2012, out of 25,129 available beds in hospitals, 24,730 were in public ownership, 143 were in non-profit private ownership, and 256 in for-profit ownership.[287]

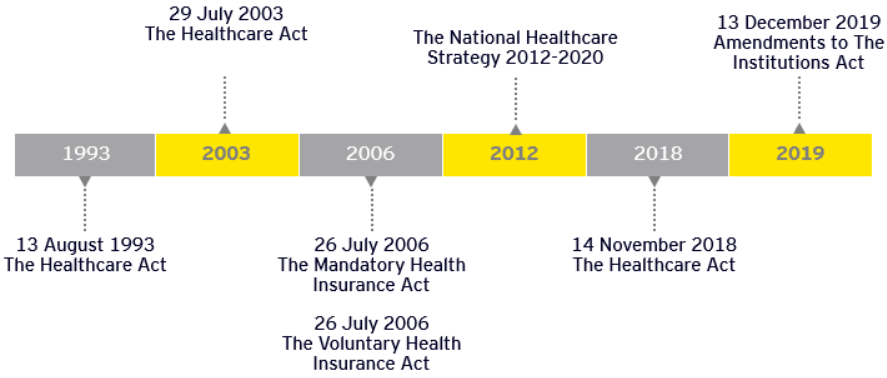


According to the Croatian Health Statistics Yearbook for 2018, during 2002, health centres (hrv. dom zdravlja) underwent a process of merger. Gradually, their number decreased from 120 in 2001 to 49 in 2009, without further change in their number. By the end of 2018, there were 4,882 (in 2012 had been 5,792) private practice units (doctors' offices, laboratories, private pharmacies, private physical therapy practices and home care services) registered.

The number of privately-owned health facilities is not publicly available. Data from the National Registry of Healthcare Providers, which contains the data on private and public providers, is published by CIPH on either its website or within yearbooks, but only offering data on natural persons working in healthcare. According to data from 2018[288] published by the Association of Polyclinics, Hospitals, Medical and Healthcare Facilities (hrv. Udruga privatnih poliklinika, bolnica, lječilišta i ustanova za zdravstvenu skrb, hereinafter: CEA Association) that operates within Croatian Employer's Association (hrv. Hrvatska udruga poslodavaca) more than 1,200 privately-owned facilities employed 16% of the health workforce.

[287] *Publicly available statistics on national level does not offer data on these types of ownership and thus a number of sites per ownership is not given within this fiche or on infographic, also data on Eurostat regarding number of beds is available only from 2010 thus no comparation comparison 2005-2012 is made. Categorisation of Not-for profit institutions may be connected to the Institutions Act that defined all institutions as not-for profit.*

[288] *Croatian Association of Employers, HP Association of HUP-Association of Private Polyclinics, Hospitals, Medical and Healthcare Facilities https://www.hup.hr/EasyEdit/UserFiles/Marijana/prijedlozi-hupuppbljuzs4-2018.pdf (hereinafter: CEA's proposals)*

	When comparing the data in Croatian Health Statistics Yearbooks from 2012 and 2018 regarding all types of health institutions in Croatia, regardless of the type of ownership, one can notice an increase of 25.89% as the total number of health institutions in 2012 was 1.263 and 1.590 in 2018. This change may be linked to the changes of The Healthcare Act in 2011 that simplified the establishment of companies as it defined that they do not need to employ healthcare professionals on a permanent basis.
LEGAL FRAMEWORK	**Presentation of the evolution of the legal framework** The legal framework regarding financing and organisation of the healthcare system in Croatia is based on the Healthcare Act (OG 100/2018 and 125/2019). the Mandatory Health Insurance Act (OG 80/2013, 137/2013 and 98/2019) and the Voluntary Health Insurance Act (OG 85/2006, 150/2008, 71/2010 and 53/2020).  ***Evolution of the legal framework before 2012:*** The legislation in the early 1990s was mostly connected to organising, re-establishing and stabilising the healthcare system after the Country declared independence in 1991. The Healthcare Act was introduced in 1993 and has since been either amended or renewed. The Health Insurance Act from 1993 established the Croatian Health Insurance Fund (CHIF) and regulated mandatory and voluntary insurance. The latter Act from 2001 allowed insurers other than the CHIF to offer complementary voluntary insurance as part of a continuous process of health system privatisation. The same act prohibited opting out from the CHIF in order to protect the financial stability of the public health insurance model[289]. In 2006, separate acts were introduced. The Mandatory Health Insurance Act (hrv. *Zakon o obveznom zdravstvenom osiguranju*) defines the right on mandatory health insurance, rights and obligations of insurers, CHIF's scope of work, as well as its financing and health contributions, and the Voluntary Health Insurance (hrv. *Zakon o dobrovoljnom zdravstvenom osiguranju*) regulates the types, conditions and manner of conducting voluntary health insurance. There were many other reforms of the healthcare system. According to Broz and Švaljek (2014), the Croatian reform plans from 2002, 2006 and 2008 did not serve its cause as they did not resolve financial issues of the health sector and its management. Most of the reform measures were focused on the income, while only few tried to manage and rationalise expenditures. Nevertheless, the 2008 Reform also had a positive impact on financial stabilisation of the healthcare system, but not for the long-term due to continuous expenditure growth.

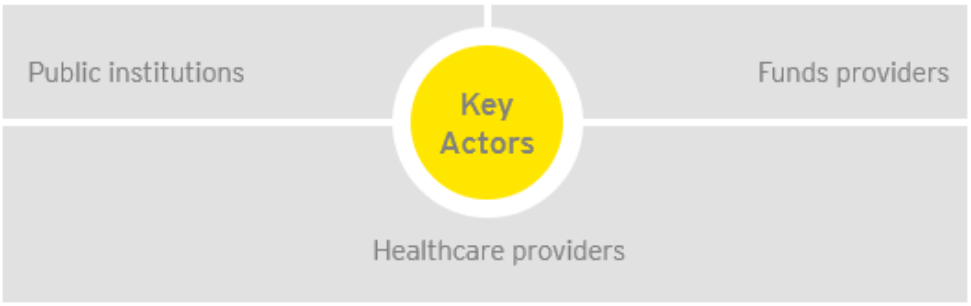
[289] *Voluntary health insurance in Europe: Country experience (Croatia profile author: K. Lončarek), available at: https://www.ncbi.nlm.nih.gov/books/NBK447703/pdf/Bookshelf_NBK447703.pdf*

	Evolution of the legal framework after 2012: After the Republic of Croatia became an EU Member State in 2013, the system was further adjusted to the EU legislation. Croatia also introduced the National Development Strategy of the Health System 2012 – 2020, which emphasised the need for cohesion and continuity in health system, improving health protection quality, increasing efficiency and accessibility of the health system, and improving population health indicators. It anticipated developing and implementing a hospital plan to streamline and modernise hospital services. The Strategy, as well as the national plans developed have been criticised by certain stakeholders. The newest Healthcare Act voted in 2018 dealt mostly with the primary health protection system, legal status of healthcare workers that leased medical offices within public health centres, and with creating conditions for functional merger and restructuring of the hospital system. The Act introduced the National Registry of Healthcare and regulated health tourism sector and widened the list of actors that can enter into contract with CHIF. According to healthcare providers in the private sector, one of the most welcomed changes to the legal framework was the amendment to the Institutions Act (hrv. *Zakon o ustanovama*) introduced in 2019. This Amendment allowed those institutions whose founder is a legal or natural person (not Croatia or self-governing local or regional units) to use their profits not only for reinvesting in the performance and development of the institution's regular activities as was the case prior the amendment, but also for other purposes and investments. As stated in the European Commission's Country Report for Croatia 2020, Croatia is preparing its e-Health Strategic Development Plan 2020-2025 and shall launch a national mobile application allowing patients to schedule appointments. It is also mentioned that preparatory work has been done to link hospitals to a central calendar to manage waiting lists more effectively; however, implementation may take longer than planned due to IT interoperability issues.
ORGANISATION OF THE SECTOR	**<u>Definition of SGEI for the hospital sector</u>** In Croatia, no activity in healthcare is defined as SGEI. Pursuant to the Healthcare Act, healthcare activity is an activity of interest for the Republic of Croatia performed as a public service by healthcare professionals in accordance with the professional medical doctrine and with the use of medical technology, according to the requirements and in the manner prescribed by that Act. It is based on the principle of universality of healthcare. The same act defines that healthcare as a public service shall be performed both within the framework of the public healthcare service network and outside the public healthcare service network. The public health service network determines the required number of healthcare institutions, the required number of beds by activities, the number of healthcare teams and private healthcare workers with whom the CHIF concludes a contract on healthcare for the territory of the Republic of Croatia.[290] A small percentage of those contracts are concluded with private providers for certain services.[291] Most of the interviewed stakeholders are not completely familiar with the SGEI package and its implications but defining some of the services within healthcare

[290] *Prior to new Act the public healthcare service network set out the required number of healthcare institutions and private practice healthcare professionals with which the CHIF is to conclude a contract on healthcare services for the area of the Republic of Croatia or the unit of regional self-government.*
[291] *Estimation (around 1.8% a year) available at Poslovni dnevnik (https://www.poslovni.hr/hrvatska/mogucnost-isplate-dobiti-dala-bi-novi-investicijski-zamah-privatnom-zdravstvu-347313)*

as SGEI is seen as a possibility to tackle some of the problems of the Croatian healthcare system.

There are 3 types of actors in the healthcare sector in Croatia:



Public institutions:

- **Ministry of Finance**: National authority responsible for setting the State budget.
- **Ministry of Health**: National authority which sets the national health strategy and coordinates overall health expenditures (including financing of the hospital budget) with the Ministry of Finance. It is also responsible for organisation and monitoring of the healthcare system.
- **Croatian Institute for Public Health (CIPH)**: Central public health institute in the Republic of Croatia. Its main objectives are to plan, promote and implement measures for the enhancement of population health and reduction of health problems.

Funds providers:

- **The State**: National budget allocations.
- **Croatian Health Insurance Fund (CHIF)**: the sole insurer in the mandatory health insurance system, which is also the main purchaser. Its main source of financing are health contributions from working population. CHIF also provides supplementary voluntary health insurance.
- **Private health insurance providers**: Companies providing additional and supplementary insurance.
- **Households through balance bills**: Up to a certain amount defined in The Mandatory Health Insurance Act.

Healthcare providers:

Healthcare in Croatia is performed by healthcare institutions, companies and private practice healthcare professionals.

Healthcare institutions are either State- or county-owned, or private. Clinical hospitals, clinical hospital centres and State institutes are State-owned. General and specialty hospitals, health centres, polyclinics, pharmacies, institutions for emergency medical aid, home care institutions, and county Institutes of public health are county owned.

► **Competition in the sector:**

	Due to the fact that Croatia does not define healthcare as SGEI, analysis on the competition in the sector cannot be conducted by comparing years prior implementation of the SGEI decision/package with later years. As stated before, healthcare in Croatia is based on the principle of universality of healthcare and CHIF is the sole insurer in the mandatory health insurance system. Some private stakeholders believe that healthcare and patients in Croatia would benefit if all health institutions (regardless of their ownership structure) and CHIF operated according to the market principles and under equal conditions. They stressed that private health institutions should be included in healthcare strategies and national plans, working in synergy with public sector.[292]
FUNDING OF THE SECTOR	**Funding arrangements** The CHIF became an extra-budgetary fund in 2015 (same as it was before 2002), which meant that health insurance contributions have been paid directly to the CHIF ever since, instead of to State Treasury, which resulted in higher revenues for CHIF. According to the Ministry of Health's website[293], during its time within the State Treasury, CHIF did not have access to all of the funds which were defined as a source of income according to the Mandatory Health Insurance Act. CHIF covers healthcare expenses for its insurers and the State finances hospital equipment and infrastructure in coordination with regional and local authorities. As the main purchaser of health services, CHIF also plays a key role in the definition of basic health services covered under mandatory insurance, the establishment of performance standards and price setting for services covered by the CHIF. Since 2009, hospitals contracted by the CHIF have been paid using a diagnosis-related group system and spending limits, with the aim of reducing costs and increasing efficiency. A payment reform introduced a so-called Payment for Results (P4R) scheme in 2015 linking payment to the achievement of certain quality and performance indicators, but with the change of government the reform was cancelled. **Health expenditure** According to the CIPH's *Report on Financial Healthcare Indicators for Croatia in 2018 in accordance with the System of Health Accounts (SHA) Methodology*[294](September 2020) and Eurostat, total health expenditure in 2018 was € 3.52 billion (6.83% of GDP). In 2013 total health expenditure was € 2.85 billion (6.53% GDP). Data shows an increase of 23.51% from 2013[295] to 2018. According to Eurostat, in 2013 government schemes with € 77.39 million represented 2.71% of total health expenditure (0.18% of GDP) and in 2018 with € 145.98 million 4.14% of total health expenditure (0.28 % of GDP). Compulsory contributory health insurance with € 2,345.70 million in 2013 represented 82.15% of total health expenditure (5.37% of GDP) and in 2018 with € 2,773.81 million

[292] *Information available in CEA's proposals, HUP.hr (https://www.hup.hr/usprkos-300-milijuna-kuna-investicija-privatno-zdravstvo-i-dalje-neravnopravan-partner.aspx) and on Poslovni dnevnik (https://www.poslovni.hr/hrvatska/mogucnost-isplate-dobiti-dala-bi-novi-investicijski-zamah-privatnom-zdravstvu-347313)*

[293] *https://zdravlje.gov.hr/vijesti/izlazak-hzzo-a-iz-drzavne-riznice-nuzan-je-preduvjet-stvaranja-boljeg-odgovornijeg-pametnijeg-i-odrzivog-zdravstvenog-sustava-za-sve-nas/284*

[294] *System of Health Accounts (SHA) is internationally accepted methodology comprising detailed classifications of different participants and functions in the healthcare. It is developed by the Organisation for Economic Co-operation and Development (OECD). CHIPH implements the System since 2012 (for expenditures in 2011). Expenditures for years 2011 and 2012 were prepared using the SHA 1.0 version, for expenditures from year 2013 (report prepared in 2014) and afterwards, SHA, Version 2011 has been used (SHA 2011).*

[295] *Data prior to 2013 was not collected using the same method and would thus be incomparable. According to the World Health Organization's (WHO) data, health expenditure in Croatia represented 6.2% GDP in 2002 and gradually increased until 2009 (8.2% GDP).*

78.70% of total health expenditure (5.37% of GDP), voluntary health insurance schemes with € 179.96 million in 2013 represented 6.30% of total health expenditure (0.41% of GDP) and 6.30% (0.45% of GDP) with € 234.45 million in 2018. Household out-of-pocket (OOP) payment in 2013[296] with € 252.18 million represented 8.83% of total healthcare expenditure (0.58% of GDP), while in 2018 with € 369.31 million they represented 10.48 % (0.72% of GDP).

Data regarding healthcare expenditure **by healthcare functions** shows the following structure in total current health expenditures in 2018:

- **Curative care** (includes healthcare contacts during which the principal intent is to relieve symptoms of illness or injury, to reduce the severity of illness or injury or to protect against exacerbation and/or complication of an illness and/or injury, including diagnostic and therapeutic procedures, surgeries and obstetric services -rehabilitation and palliative care are excluded): 52.85% (49.96% in 2013)
- **Rehabilitative care** (includes healthcare services focused on improvement of functioning in patients with functional difficulties due to illness or injury): 3.79% (3.34% in 2013)
- **Long-term care** (includes long-term nursing care of patients with chronic diseases and functional limitations): 3.03% (2.69% in 2013)
- **Ancillary services** (include laboratory services, services that use imaging technology, emergency rescue and patient transportation; only for patients who are not hospitalised): 9.77% (9.87% in 2013)
- **Medical goods** (include sales of prescribed and OTC pharmaceuticals, medical non-durable goods, glasses and other vision products, hearing aids, orthopaedic appliances and prosthetics and other medical durables): 23.22% (27.53% in 2013)
- **Preventive care** (includes provision of information, education and counselling, immunisation programmes, early disease detection programmes, healthy condition monitoring programmes, epidemiological surveillance, risk and disease control programmes and preparing for disaster and emergency response programmes): 3.16% (2.66% in 2013)
- **Governance and health system and financing administration** (planning and development of health policies, plans, programmes and budgets, preparation and enforcement of legislation and standards for the healthcare, collection, production and dissemination of information, technical documentation and statistics on health and healthcare, administration of Croatian Health Insurance Fund and private health insurances): 2.69% (3.17% in 2013)

It is noticeable that curative care and rehabilitative care together represented 56.64% of total current health expenditure in 2018. They amounted to € 1,996.37 million in 2018, as opposed to € 1,521.82 million in 2013, representing an increase of around 31.16% over 2013-2018.

It is also noticeable that "medical goods'' represent the second largest expenditure group with a share of 23.22% in 2018, but the decrease is visible when compared to 2013 as the share of "medical goods'' in total current health expenditure was 27.53%. In the group "medical goods'' pharmaceuticals and other medical non-durable goods represented 20.71% of total current health expenditure in 2018 and 25.35% in 2013 (prescribed medicines represented 14.66% in 2018 and 18.42% in 2013, over-the counter medicines were 3.57% in 2018, while 4.04%

296 Expenditure for 2013 in this category is estimated, according to Eurostat.

in 2013 and other 2.48, while 2.88 in 2013). As the "State of Health in the EU 2019" report indicates, Croatia spends a much larger share of its health expenditure on pharmaceuticals and medical devices than many other EU countries (the EU-28 spent 13.99% of total current health expenditure on pharmaceuticals and medical devices in 2018). While on the other hand,, a very small share of health expenditure is spent on long-term care, only 3.03% in 2018 and 2.69% in 2013. According to the State of Health in the EU 2019, this share is much lower than the EU average (16.3% in 2017), with such a low rate reflecting the fact that formal long-term care is still underdeveloped in Croatia and also mostly provided by public entities.

Since 2012, the hospital sector has faced more pressure to rationalise healthcare costs. Public hospitals, which previously procured all medical products and other goods individually, were directed to form joint purchasing bodies for items that account for the largest share of expenditure- those hospitals that had previously achieved best value for money for certain procurement categories were assigned to procure categories of goods for all participating hospitals.

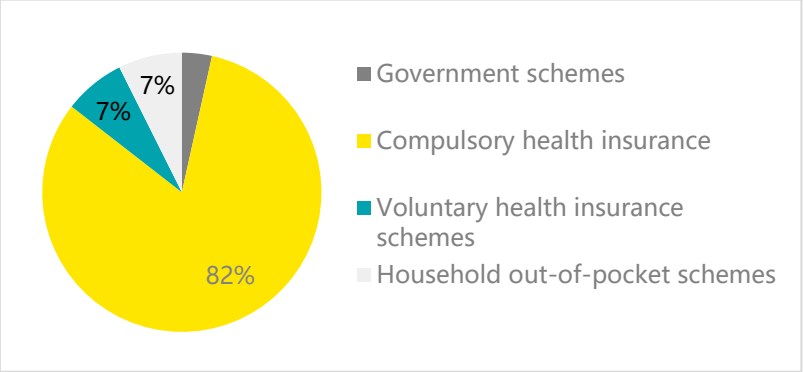
	Amount of expenditure in 2018 (in €)	**Evolution 2013-2018**
Total Health expenditure (in billion)	3.52	+23.51%
Curative and rehabilitative care (in billion)	1.99	+30.92%
Hospital care expenditure (in billion)	1.67	+35.72%

Data regarding ***healthcare expenditure by provider*** shows that expenditure in hospitals[297] in 2018 was € 1.66 billion (43.08% of total current health expenditure) against € 1.23 billion (47.37% of total current health expenditure) in 2013, which represents an increase of 34,96% in the period from 2013 to 2018. As stated in the EC's Country Report 2020, expenditure is expected to grow strongly in 2020 due to wage increases in the sector agreed in September 2019 and the Supreme Court's ruling from December 2019 which upheld doctors' claims on unpaid overtime.

The figures below showcase the distribution and evolution of curative and rehabilitative care expenditure per category of funder.

Distribution of curative and rehabilitative care expenditure per category of funder in 2018:

[297] *According to the Report and SHA 2011 method hospitals include general hospitals, mental health hospitals, specialised hospitals (other than mental)*



Government schemes represented 3.47% of curative and rehabilitative care expenditure in 2018, compulsory health insurance 82.05%, voluntary health insurance schemes 7.1% and household out-of-pocket (OOP) schemes 7.38%.

Evolution of the distribution of curative and rehabilitative care expenditure per category of funder:

	2013 – 2018
Government schemes	**+2.37 percentage points**
Compulsory health insurance	**-4.75 percentage points**
Voluntary health insurance	**+0.1 percentage points**
Household OOP schemes	**+2.28 percentage points**

Regarding the distribution **of hospitals expenditure per category of funder** in 2018, Government schemes represented 4.26% of hospitals expenditure in 2018, compulsory health insurance represented 86.16%, voluntary health insurance schemes 8.16% and household OOP schemes 1.41%.

The illustrated evolution of the distribution of health expenditure may signal a lack of structural changes, as already stated by the State of Health in the EU 2019. According to the same study, Croatia has maintained a high share of public spending in health expenditure, resulting in high levels of financial protection. However, levels of public debt still exert constraints on public spending on health. Furthermore, only around one third of the population is liable to pay health insurance contributions, thereby limiting the revenue base for the health system. It states that one of the main issues of the Croatian health system is net debt due to continuous losses since the 1990s and that most of the unpaid obligations are related to hospitals owing funds to wholesale pharmacies. It is stressed that strategic planning and financing of hospitals are key problems in Croatia's health system, with hospitals routinely accruing substantial debts. It also concludes that primary care is fragmented and seems to be underutilised compared to inpatient and hospital outpatient care. Long waiting lists for secondary and tertiary care are also a challenge.

- **Evolution of the amount of public aid**

Croatia does not define healthcare as a service of general economic interest and thus does not report on healthcare and hospitals within the SGEI reports. The analysis of annual State aid reports prepared by the Ministry of finance also showed there were no healthcare activities under the SGEI chapter.

Private health institutions often mention the inability to use EU funds allocated for healthcare, which is made possible in other EU Member States. According to the

	CEA Association[298], EU funds allocated for healthcare should be available, under equal conditions, to all forms of economic entities (both public and private).
II. Social Housing The aim of this Section is to provide an overview of the social housing sector in Croatia as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.	
KEY FIGURES	Currently, Croatia does not have a clear definition of the term social housing. The term is also not formally defined as such in any legal act, nor is there any Strategy on (social) housing. As mentioned in *Tenancy Law and Housing Policy in Multi-level Europe, National Report Croatia* the Constitution of the Republic of Croatia also does not explicitly mention the responsibility of the State to help its citizens in meeting their housing needs. There is no systematic approach towards housing in Croatia and housing policies are addressed only partially through a variety of acts and through a variety of authorities. Such segmentation and a wide variety of rules and conditions can lead to uncertainty on how and where to apply for measures on part of those that could benefit from them, as well as lead to uncertainty on which measures are the most suitable and affordable for their situation. Affordable housing in Croatia is usually identified with the programmes offered by the Croatian Agency for Transactions and Mediation in Immovable Properties (hrv. Agencija za pravni promet i posredovanje nekretninama, hereinafter: APN). Based on the above stated information, this section will provide a general overview of a selection of existing concepts or policies, focusing on those implemented by the APN and mention other stakeholders, which may be associated with social or affordable housing. According to the Annual Reports on the Work of APN for 2018 in Programme of State-subsidised housing construction (*hrv. Program društveno poticane stanogradnje*, hereinafter: POS programme) a total of 8,272[299] apartments were built in 253 buildings since the implementation of the programme until the end of 2018. Most of those, 5,553 apartments in 187 buildings were built before 2012.[300] In years 2012 to 2018 66 buildings with 2,719 apartments were built. There is no publicly available data on the number of persons living in POS apartments. The apartments are built in the name of the Republic of Croatia. According to governmental sources, POS apartments are built without profit, allowing for apartment prices to be lower and affordable[301]. From 2017 APN's work shifted to programmes of housing loan subsidies (widely known as "APN's loans'') which turned out to be very popular among the young creditworthy population, which can also be seen from data showing that 828 POS

298 *Ibid.*
299 *Number includes all apartments built by APN and decentralized local agencies: Javna ustanova gradski stanovi Varaždin, Agencija za društveno poticanu stanogradnju Grada Rijeke, Agencija za društveno poticanu stanogradnju Grada Dubrovnika i Agencija za društveno poticanu stanogradnju Grada Koprivnice*
300 *Numbers for 2018 are calculated according to the last data shown in total values in Report of 2018 where no yearly statistics was shown versus yearly statistics available in http://apn.hr/app/uploads/2018/09/POS-rekapitulacija-POS-a-od-2000-2018-kolovoz.pdf (the number in the latter document only contains data up to August 2018 thus those numbers were not used in comparation).*
301 *See Republic of Croatia, Ministry of Physical Planning, Construction and State Assets, Croatian Parliament adopts Law on Socially Encouraged Housing, 2018, (https://mgipu.gov.hr/vijesti/hrvatski-sabor-donio-zakon-o-drustveno-poticanoj-stanogradnji-pos/7560)*

	apartments were built in 2016 compared to a fraction of that number in following years. Regarding data on housing loan subsidies, APN's Annual Report on the Work of APN for 2018 states that during the "First programme of housing loan subsidies" introduced in 2017, APN concluded 2,315[302] contracts on subsidising housing loans. During the "Second programme of housing loan subsidies" in 2018, until 31st December 2018, APN authorised 2,986 subsidies requests and concluded 2,700 of contracts on subsidising housing loans. According to the APN's data regarding the housing loans subsidisation in 2017 and 2018, a total of 5,286 housing loan requests were authorised.
LEGAL FRAMEWORK	**POS programme**[303] - apartments built through the POS programme are available to all creditworthy citizens of the Republic of Croatia, with advantage given to the first-time buyers or those that do not own suitable/appropriate housing and to local self-governments that will use them for renting or insuring apartments for causes defined in the Act. Self-government units determine the priority list of buyers. The POS Programme allows the use of bank loans without guarantors, with a very low interest rate, and a repayment period of up to 30 or 31 years in case a person decides to use a 1-year grace period. The programme is implemented by APN and non-profit organisations set up by local self-governing units. The **subsidisation of housing loans** implemented through APN is available to permanent residents of the Republic of Croatia up to 45 years old who (and whose spouse or equivalent) do not own a suitable housing (or the current apartment is being sold to buy a bigger one needed to fulfil housing needs). The subsidy covers a portion of annuities/instalments (between 30% and 51% depending on the development index[304] of the location of the real estate) for 5 years, which can be prolonged by 2 years for each child born or adopted during the subsidisation period, or the applicant or a member of his family household has an established disability of more than 50%. Loans are approved for buying an apartment and buying or (re)constructing a house. These apartments and houses cannot be sold or leased following 2 years after the end of subsidisation period, except in order to buy a bigger apartment. The POS programme was also criticised by some of the experts because those apartments are both built and sold by the State on the free market, while the impact of the programme is still not properly evaluated[305]. The housing loan subsidies are often brought in connection with surge of housing prices in Croatia.[306] In the European Commission Country Report 2020 it is also noted that this subsidy is neither means-tested nor targeted at those areas where affordability is lowest. There is a variety of concepts in Croatia which could be connected to affordable or social housing such as:

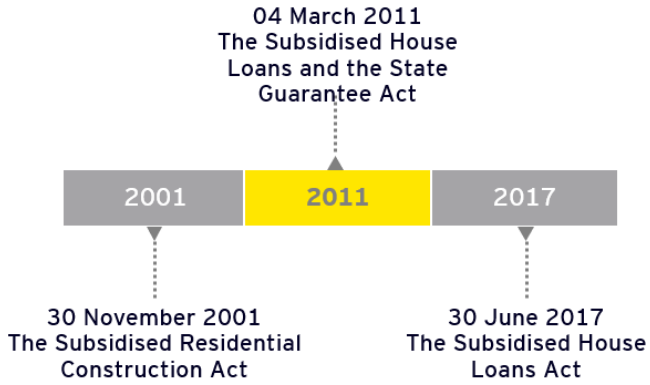
[302] *Number varies in documents publicly provided by the APN on its webpage and reports and justifications provided in Draft Amendments to the Act.*
[303] *This is ''A'' programme, POS, according to terms used by APN also includes ''B'' programme for loans to construct a family house and programme ''C'' for buying building material, more information available on APN.hr . There is also a special POS + programme that encourages buying any apartment on the real estate market, available to any creditworthy citizen of the Republic of Croatia who does not own a suitable apartment by financing it through a combination of loans provided by APN and bank loans (or own money).*
[304] *Cities and municipalities in Croatia are divided in 8 groups regarding their development level, available at (https://razvoj.gov.hr/o-ministarstvu/regionalni-razvoj/indeks-razvijenosti/112)*
[305] *Jutarnji, POS is unstable in the European Union (https://www.jutarnji.hr/naslovnica/pos-je-neodrziv-u-europskoj-uniji-3852720) and NET.hr (https://net.hr/danas/otkrivamo-zasto-su-cijene-stanova-eksplodirale-dva-lobija-stoje-iza-svega-stranci-su-zapanjeni-u-jedan-kvart-ih-se-ne-usudim-odvesti/)*
[306] *Davor Kunovac, Ivan Žilić, See Home sweet home: The effects of housing loan subsidies on the housing market in Croatia, HNB, 2020, (https://www.hnb.hr/documents/20182/3596318/w-060.pdf/955d2e9e-76d7-8b3e-3c1a-8a8732ff326e)*

- **Housing care model in assisted areas (those lagging behind according to development indexes) and areas of special State concern[307] (territories of municipalities and towns occupied during the Homeland War and those assessed as lagging areas based on economic, structural or demographic criteria) pursuant to Act on Housing Care in Assisted Areas (OG 106/18, 98/19)** aimed at encouraging the return, staying and settlement of the population in those areas, which contributes to the demographic and economic development of these areas and implemented by the Central State Office for Reconstruction and Housing Care. Housing care models (including renting and purchasing State-owned housing units on preferential terms, as well as by donating construction materials for the repair, construction or upgrade of a housing unit on land owned by the user or on State construction land) may be exercised by natural persons who reside in assisted areas and areas of special State concern or wish to settle there. They can apply on the "priority lists" in relevant county authorities provided that they do not (co)own another habitable or adequate housing in Croatia or other countries or did not sell it 15 years prior to submitting the application, have not acquired the legal status of a protected tenant and have not exercised the appropriate right to housing under some other regulation or other country. For example, the renting scheme under this is organised in such way that a user concludes the lease contract with the Office and pays "protected rent'' which is defined by the government decree (around 0.35 €308/m2), or less in cases defined by the Act. One of such cases is rent of 1 HRK (around 0.13€/monthly) for beneficiaries of a guaranteed minimum benefit.[309] The leased housing can later be bought.
- **Public renting and social renting as offered mostly in bigger cities based on priority lists prepared after a public tender:**
  - According to *Tenancy Law and Housing Policy in Multi-level Europe, National Report Croatia* public rental housing is an innovation in the housing policy in Croatia. In Grad Zagreb it is implemented according to its bylaw (*Odluka o najmu javno najamnih stanova*) which defines rent which is controlled, significantly lower than the market one and aimed at certain group of population, such as young families that are not eligible for social apartments and at the same cannot afford to rent (the applicant must have a prescribed minimum of income) in private market sector or are not creditworthy, or to individuals of special interest for the city, such as scientific, cultural and public workers. The mentioned Report states it targets younger families with more children and without proper housing.
  - Social renting which is, for Grad Zagreb defined in its bylaw (Odluka o najmu stanova) takes into account unaddressed housing needs, current housing, social and health status, as well as years of continuous residence in Grad Zagreb and participation in the Homeland war. Rent is lower than on both free market rent or rent for public rental housing, but higher than the "protected rent''.

[307] *Areas of Special State Concern Act*
[308] *According to the medium exchange rate of the Croatian National Bank (1€ = 7,530889 HRK on 15th December 2020).*
[309] *According to the Act on Social Welfare guaranteed minimum benefit (zajamčena minimalna naknada) is intended to secure basic needs of a person or a household that has no means to provide for themselves (in the amount of benefit) and can't acquire them through their work, property income or from persons obliged to support them.*

Presentation of the evolution of the legal framework

Following the schemes and measures presented in the text above, acts relevant to their implementation are the Subsidised Residential Construction Act (OG 109/2001, 82/2004, 76/2007, 38/2009, 86/2012, 7/2013, 26/2015, 57/2018 and 66/2019), The Subsidised House Loans Act (OG 65/2017, 61/2018 and 66/2019).



Evolution of the legal framework before 2012:

The Subsidised Residential Construction Act entered into force in 2001 and regulated systematically organised construction subsidised by public funds to meet the housing needs of the widest circle of population, as well as to improve construction. It focuses mostly on the POS programme. Pursuant to amendments to the Act in 2004, local authorities can set up non-profit housing associations to plan and implement the programme using the State budget funds. These amendments also introduced a possibility of usage of State funds for construction and reconstruction (upgrade and extension) of family houses and for purchase of construction, but as stated in the literature, this possibility did not achieve significant results in practice, mostly due to the complicated procedures.

The Subsidised House Loans and the State Guarantee Act from 2011 regulated subsidisation of house loans (50% of rate/instalment) until 31.12.2012 aimed at creditworthy Croatian citizens with permanent residence in the Republic of Croatia, not older than 45. The State guaranteed for the repayment of interests on housing loans from commercial banks in case a person loses means for the repayment due to the loss of employment.

Evolution of the legal framework after 2012:

The **Subsidised Residential Construction Act** has been amended several times after 2012. In 2013 the POS+ programme was introduced to incentivise buying of newly built apartments following the recession that affected the construction and real estate market, amendments in 2015 introduced the "Rent-to-buy" possibility of the apartments built in POS programme to lease the unsold stock implemented by APN, aimed at all citizens of the Republic of Croatia who, as well as members of their joint household, do not own a suitable housing in the area where the real estate for rent is located and for whom the amount of the future rent represents a maximum of 30% of the total monthly income of all members of the family household. The one in 2019 introduced the prohibition for buyers of POS apartments to sell them or lease during the 10 years following the purchase in order to stop such practice which was widely criticised and seen as abuse of this measure and public funds[310]. If a buyer sells such an apartment despite the

[310] *Dnevnik, They get POS flats, and then they rent or sell them (https://dnevnik.hr/vijesti/hrvatska/samohrana-majka-podstanarka-dobiju-pos-ove-stanove-a-onda-ih-iznajme-ili-prodaju---425802.html or*

	prohibition, he/she will have to pay the total amount of debt and interest on public funds, returning the subvention received by the State. The **Subsidised House Loans Act** was voted in 2017 in the Croatian Parliament and introduced the similar concept that was already implemented in the short-lived Subsidised House Loans and State Guarantees Act. The Act tends to stimulate demographic renewal of the population, decrease emigration of young families and help citizens with subsidised house loans, which citizens request from credit institutions. Croatia does not have a unified Strategy on (social) housing, but according to relevant authorities, the Strategy is currently in a process of drafting and will define the concepts of social and affordable housing, and an analysis undertaken within the Strategy will identify the available housing stock, as well as needs regarding housing in Croatia.
ORGANISATION OF THE SECTOR	**SGEI in the social housing sector** Social housing is not defined as a SGEI in Croatia. **Presentation of the categories of actors in the social housing sector**  ***Public authorities:*** • **Ministry of Finance**: National authority responsible for setting the State budget. • **Ministry of Physical Planning, Construction and State Assets**: National authority responsible for construction regulations and State assets disposal, including immovable. Monitors the work of the APN and decentralised local agencies in accordance with the law governing POS. • **Other State bodies pursuant to a variety of acts**, such as Central State Office for Reconstruction and Housing Care for housing care models (including renting and purchasing State-owned housing units on preferential terms, as well as by donating construction materials for the repair, construction or upgrade of a housing unit on land owned by the user or on State construction land) and regional housing. • **Local authorities**, such as Grad Zagreb that implements public and social renting of housings. ***Implementing agencies:*** • **The Croatian Agency for Transactions and Mediation in Immovable Properties (APN):** central public institution for providing social housing services. Together with decentralised local agencies acting as an investor pursuant the Subsidised Residential Construction Act and main institution for authorising subsidised loans. It acts in the name of the State.

https://net.hr/danas/hrvatska/drzava-odlucila-stati-na-kraj-spekulantima-tko-iznajmi-pos-ov-stan-stici-ce-mu-na-naplatu-citav-kredit/)

	• **Decentralised local agencies** acting as an investor pursuant the Subsidised Residential Construction Act: Javna ustanova gradski stanovi Varaždin, Agencija za društveno poticanu stanogradnju Grada Rijeke, Agencija za društveno poticanu stanogradnju Grada Dubrovnika and Agencija za društveno poticanu stanogradnju Grada Koprivnice For both POS programme and subsidised loans, consumers are creditworthy citizens who meet the conditions to use the measures. There is no available data on whether private social providers exist. **Distribution of the market per category of providers** It is not possible to set out the distribution of the market per category of providers in Croatia as the schemes are not comparable and since there is no market per se. Indeed, schemes are implemented through public authorities. Moreover, no data exists in relation to providers that are non-public providers. ► **Competition in the sector:** Due to the fact that Croatia does not define social housing as SGEI, analysis on the competition in the sector cannot be conducted by comparing years prior implementation of the SGEI decision/package with later years.
FUNDING OF THE SECTOR	**Funding arrangements for POS programme and loan subsidies**[311] The Subsidised Residential Construction Act sets out that organised housing construction is encouraged **by public funds** in order to meet housing needs and improve the quality of housing of the widest possible circle of citizens, as well as to improve construction. Public funds according to the act are financial and other funds provided by the Republic of Croatia and local self-government units. **This, for example in the POS programme,** means that part of the funds (subsidies) is drawn from the State budget, part is provided by the units of local government, and the remainder of the funds is provided by the apartment buyers through personal funds or their bank loans in commercial banks that partner up with APN. According to the Subsidised Loans Act, **funds for loan subsidies** are provided in the State budget of the Republic of Croatia. Loan subsidies shall be granted for a loan whose amount does not exceed € 100,000.00 in kuna (max 1500,00 EUR/m2) equivalent according to the middle exchange rate of the Croatian National Bank on the day of loan disbursement and whose repayment period is not shorter than 15 years. Loans can only be obtained in commercial banks that partner up with APN following the tender to which they apply offering low interest rates. The total value of investment in construction of those apartments from 2000 to 2018 was HRK 4.3 billion (around € 570.7 million), out of which HRK 1.1 billion (around € 148.7 million) were realised State subsidies. From 2000-2012 the total value of investment amounted to HRK 2.8 billion HRK (around € 373.9 million) investment, of which HRK 434.7 million (around € 58 million) were realised State subsidies. For 2012, the total investment amounted to HRK 68.6 million (around € 9 million), out of which HRK 15.6 million (around € 2.1 million) were realised State subsidies. In 2017[312] the total investment amounted to HRK 152.2 million (around € 20.3 million), out of which HRK 43.5 million (around € 5.8 million) were realised State subsidies. Data provided includes both APN and local agencies' investments.

[311] *Other housing options mentioned in Croatia are also financed through public funds.*
[312] *Data for 2018 only shows amounts spent until August.*

	Regarding data on housing loan subsidies, APN's Annual Report on the Work of APN for 2018 states that during the "First programme of housing loan subsidies" introduced in 2017, APN concluded 2,315[313] contracts on subsidising housing loans. Until 31.12.2018 total of HRK 42.8 million (around € 5.7 million) was paid in terms of subsidies for that programme (for instalments 1st and 2nd year). During the "Second programme of housing loan subsidies" in 2018, until 31 December 2018, APN authorised 2,986 subsidies requests and concluded 2,700 of contracts on subsidising housing loans. HRK 1.2 million (around 160,913.56€) was paid in subsidies for 1081 requests. **Aid granted as part of the SGEI Package** No aid was granted as part of the SGEI Package due to social housing not being defined as SGEI in the Republic of Croatia.
SOURCES	The following sources have been used for the elaboration of this Fiche: **Statistics** • Eurostat Healthcare data • WHO Healthcare data **Documents, websites and other data:** • Reports on APN's Work for year 2012 • Reports on APN's Work for year 2018 • APN's presentation on Subsidised loans in 2017 and 2018 • POS programme from 2000-2018 • SGEI reports for Croatia • Act on Housing Care in Assisted Areas (OG 106/18, 98/19) • APN's website http://apn.hr/ • https://sduosz.gov.hr/ • https://mgipu.gov.hr/ • Grad Zagreb's website • https://mfin.gov.hr/ • HUP.hr • https://www.hzjz.hr/ • https://zdravlje.gov.hr • Media outlets such as Dnevnik.hr, Net.hr, Jutarnji.hr and Poslovni dnevnik • Development index • Home sweet home: The effects of housing loan subsidies on the housing market in Croatia (Croatian National Bank, 2020) • Tenancy Law and Housing Policy in Multi-level Europe, National Report for Croatia (Jakopič, Žnidarec, Mežnar, Josipović, 2015) • The Subsidised Residential Construction Act (OG 109/2001, 82/2004, 76/2007, 38/2009, 86/2012, 7/2013, 26/2015, 57/2018 and 66/2019)

[313] *Number varies in documents publicly provided by the APN on its webpage and reports and justifications provided in Draft Amendments to the Act.*

	• The Subsidised House Loans Act (OG 65/2017, 61/2018 and 66/2019) • The Subsidised House Loans and the State Guarantee Act (OG 31/2011) • COMMISSION STAFF WORKING DOCUMENT Country Report Croatia 2020 Accompanying the document COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE EUROPEAN COUNCIL, THE COUNCIL, THE EUROPEAN CENTRAL BANK AND THE EUROGROUP 2020 European Semester: Assessment of progress on structural reforms, prevention and correction of macroeconomic imbalances, and results of in-depth reviews under Regulation (EU) No 1176/2011 (EC, 2020) • Croatian Health Statistics Yearbooks for year 2009 • Croatian Health Statistics Yearbooks for year 2018 • Croatian Health Statistics Yearbooks for year 2012 • Report on Financial Healthcare Indicators for Croatia in 2018 in accordance with the System of Health Accounts (SHA) Methodology • Report on Financial Healthcare Indicators for Croatia in 2013 in accordance with the System of Health Accounts (SHA) Methodology • State of Health in the EU (Croatia) 2019 (EC, 2020) • National Health Strategy 2012-2020 • IUS-INFO.hr • The Mandatory Health Insurance Act (OG 80/2013, 137/2013 and 98/2019) • The Voluntary Health Insurance Act (OG 85/2006, 150/2008, 71/2010 and 53/2020) • The Healthcare Act (OG 100/2018 and 125/2019) • Financiranje zdravstva u Hrvatskoj: od reforme do reforme (Broz and Švaljek, 2014) • Voluntary health insurance in Europe: Country experience (European Observatory on Health Systems and Policies, 2016; Sagan A, Thomson S, editors, Croatia profile author: K. Lončarek) • O zdravstvu iz ekonomske perspective (Institute for economy, 2014) • Public Health Service Network (OG 101/12, 31/13, 113/15) • National Plan for the Development of Clinical Hospital Centers, Clinical Hospitals, Clinics and General Hospitals for 2014-2016

10.2 Czech Republic

Member State: Czech Republic		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• In 2018, the total health expenditure in the Czech Republic was € 16.2 billion (8.1% of GDP). • The health sector is mainly funded by public sources (84%, including public health insurance, State budget, regional and municipal budgets), direct payments from households (13%), and private sources (3%). • The total amount of the public aid granted in 2019 for the hospital sector as part of the SGEI Package was € 5,5 billion, which is an increase of 449.5% since 2012.	• There is no official data on the amount of expenditure related to social housing. However, it is supported within the Integrated Regional Operational Programme co-financed from ERDF. Until 2018, it supported 115 projects for more than € 23 million, equivalent to the construction of 600 social housing dwellings. • The total amount of the public aid granted in 2019 for the social housing sector as part of the SGEI Package was € 8.1 million, against € 7.7 million in 2012 (+5%)..
Key actors	The key actors relating to health SGEIs in the Czech Republic are the following: • **Public institutions:** • **Fund providers:**	The key actors relating to social housing SGEIs in the Czech Republic are the following: • **Public institutions:** • **Fund providers**: • **Social housing providers:**

	• **Healthcare providers**:  	
Structure of health and social housing	• The Ministry of Health is responsible for the organisation and monitoring of the health system by setting the national strategy and budget including the co-financing of the hospital budget. The financing of the system is built on the model of compulsory statutory health insurance (SHI), providing universal coverage and a broad range of benefits the State guarantees to all citizens. The actors in charge of organising the sector at the local level are the Regions. They are also the hospital owners. There are also national agencies with a specific role to represent the interests of their respective professions such as the Czech Medical Chamber, the Czech Dental Chamber and the Czech Chamber of Pharmacists. Membership is compulsory for every practicing physician, dentist and pharmacist. They are also responsible for ensuring the ethical behaviour of their members, including the provision of due care. • In terms of fund providers for the health sector, the General Health Insurance Company and other six health insurance companies (quasi-public, self-governing bodies) act as payers and purchasers of care. • Healthcare providers include hospitals and specialised health prevention institutions.	• Social housing falls within the responsibility of the Ministry of Regional Development, which is in charge of housing policy, and the Ministry of Labour and Social Affairs, the guarantor and supervisor of social work. The local public authorities are in charge of establishing the local social housing permit and delivering building permits and also to build or buy premises. • In terms of funders, there are State funds (State Investment Support Fund) and the funds co-financed from ESIF (Integrated Regional Operational Programme to cover investments and Operational Programme Employment to cover the social work and innovations). Local authorities are co-funding the social housing with their own budgets. • The main providers are public authorities, followed by social enterprises.
Main conclusions	The health sector is mostly financed from public sources (public health insurance, State budgets, regional and municipal budgets). Financing of healthcare is mostly realised through the payments from the public health insurance, which is not perceived as public aid. Only support for hospitals through co-	There is still no specific legislation regarding social housing. However, this does not mean that there are no attempts in implementing the concept in the country. The only governmental document addressing the concept is the “Social Housing Concept of Czech Republic 2015–2025”. This is the reason as to why the sector is still under development.

	financing from the public budgets (regions or municipalities) is considered as SGEI financing. In terms of number of hospital sites, there has been no major change over the past 5 years.	In terms of funds, the sector is financed through different funds (national and EU level).

I. Health Sector

The aim of this Section is to **provide an overview of the health sector in Czech Republic** as well as **present an analysis of the application of the SGEI rules**, based on interviews undertaken with stakeholders.

KEY FIGURES

► **Number and share of hospitals and beds (and evolution)**

In 2018, the total number of hospital sites was 256 against 257 in 2014[314], which represents a tiny **decrease of 1 site**. In parallel, the **number of sites per million population slightly decreased** as well, by 1 %. However, rounded up to zero decimal places it remained at 24 sites per million population.

Overall, there has been **no major change in the number of sites**, and the availability of hospitals to people has also remained unchanged over the past 5 years.

The number of beds decreased more significantly. The **5% decrease between 2010[315] and 2012** was followed by a decrease of 3%, where the number of beds fell from 72,842 in 2012 to 70,351 between 2012 and 2018. The total number of beds in 2010 was 76,413. While there were 693 beds per 100,000 population in 2012, this number fell to 662 in 2018.

► **Number and share of hospitals and beds (and evolution) per legal entity**

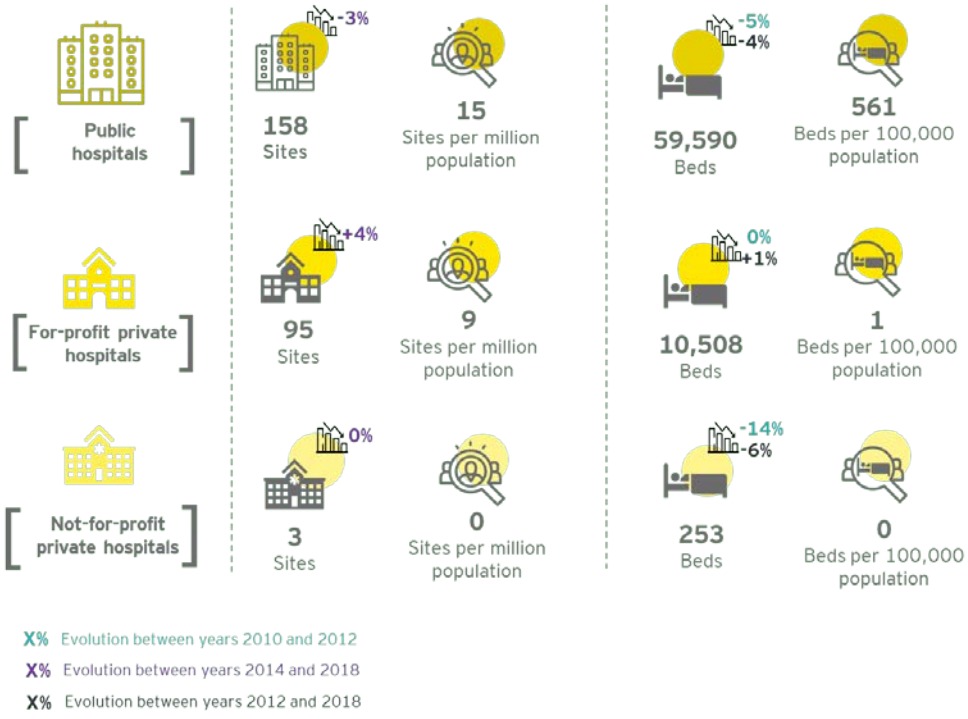
In 2018, there were 256 sites distributed by sectors as follows: 158 sites owned by public hospitals (62%), 95 sites owned by for-profit private hospitals (37%) and 3 sites owned by not-for-profit private hospitals (1%). There has been a **very small change in the proportions of the sectors** - since 2014 there has been 1%

[314] *The evolution of the number of sites regards the "2014-2018" period because of the break in the time series. Since 2014 the statistics include convalescent homes for children.*

[315] *The evolution of the total number of beds starts in 2010 because in that year major breaks in the time series took place:*

- *Since 2010 data refer to the number of contracted beds with health insurance companies.*
- *Since 2010 long-term patients are recorded differently: the institutes for long-term patients as the integrated facilities of the provider were terminated and transferred to the provider as a department.*
- *Since 2010 beds are monitored according to the fields of activity as opposed to departments and workplaces till 2009.*

decrease in the share of public hospitals on the market, while the share of for-profit hospitals has increased by 1%.



The sectors have been evolving differently between the years 2014 and 2018. While there has been a 3% decrease in the number of sites in the public sector, the number of for-profit private hospitals increased by 4%, which helps to explain the over-time changes in the sector structure. As the number of public sites falls, their share of the market falls slowly as well, but at a much lower rate, because of their large number of sites in comparison to the other two sectors. The number of sites remained the same for not-for-profit hospitals. However, they form only the marginal part of the stakeholders in the health sector.

In 2018, the share of beds was as follows: 85% for the public sector, 15% for the for-profit private sector, and 0.4% for the private not-for-profit sector. This share per type of ownership has not changed since 2012 or 2010.

Between 2010 and 2012, the number of beds declined significantly in the public and not-for-profit sectors (-5% and -14%, respectively), while the number of beds in the for-profit private sectors remained stable. A similar trend followed between 2012 and 2018, where the number of beds decreased by the largest in the not-for-profit and public sectors (-6% and -4% respectively), but these drops were not as sharp as between 2010 and 2012. The number of beds in the for-profit private sector, on the other hand, increased by 1% between 2012-2018. These changes in the absolute number of beds in each sector has not impacted the distribution of the market, i.e. although the number of beds has been changing, it has been changing in the way that the share of beds in the specific sectors remains the same as stated in the previous paragraph.

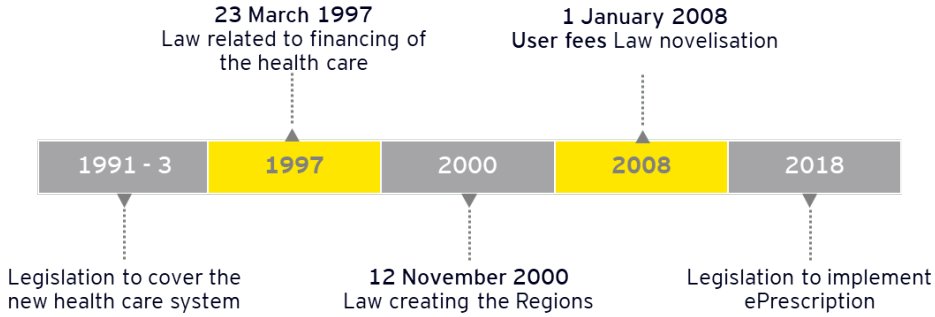
LEGAL FRAMEWORK

► **Presentation of the evolution of the legal framework**

The regulatory framework has been evolving in the Czech Republic, particularly over the last 30 years. After the political changes of 1989, **the new system was built on the model of compulsory statutory health insurance** (SHI), providing virtually **universal coverage and a broad range of benefits** the State guarantees

to all citizens. The laws introduced since 1991 have impacted the financing and organisation of the healthcare system.

The use of information and communications technology (ICT) is generally underdeveloped in the Czech Republic, and an infrastructure for using health technology assessment (HTA) of treatments and procedures is still lacking.



► ***Evolution of the legal framework before 2012:***

The **new healthcare system was established between 1991 and 1993**. Several key laws relating to the system were approved, including the General Health Insurance Act (1991), the Act on the General Health Insurance Fund (1991), and the Act on Departmental, Professional, Corporate, and Other Health Insurance Funds (1992). **The core health-care legislation has changed only marginally since then**. The Czech Republic has a **system of statutory health insurance based on compulsory membership of several health insurance funds** (health insurance companies). Since 2014, their number has stabilised at seven in total.

The medical facilities were largely privatised, and hospitals gained legal status. The State has become the guarantor of the provision of healthcare. It exercises this competence through the Ministry of Health. Initially, payments were based on a performance system.

In **1997**, there were **changes in the financing mechanism**, mainly because of the unsustainable increases in costs and the corruption potential of the system. Financing mechanism was **switched to a combination of flat rates and performance rates**. For outpatient care, the system of payment for a registered patient (capitalisation) applies; for specialists, payments for procedures are used, with the number of working hours or the number of procedures being limited. In the area of dental services, the agreed price list applies since then.

In **2003**, the ownership of approximately **half of the hospitals in the Czech Republic was transferred from the State to 14 newly formed Regions**. Some Regions decided to change the legal form of the hospitals, transforming them from entities directly subordinate to the Regions to joint-stock companies (of which regional authorities still owned the majority of shares).

In **2008**, **user fees were put in place to generate limited private resources** (but mostly to contain costs and to raise awareness about the inappropriate use of healthcare services). **These user fees were in place for all services**, at a comparably low level (between € 1.20 and € 4.00).

Patient rights were strengthened in **2011** by adopting **new legislation, which allows citizens to freely choose the health insurance company and the healthcare provider**.

► ***Evolution of the legal framework after 2012:***

The Czech **healthcare system has faced constant financial problems** since its establishment. This became **urgent again following the financial crisis** (higher

unemployment during the economic crisis and also population ageing will lead to a higher number of State-insured citizens and place a higher burden on general tax revenue). Nevertheless, the **attempts to increase the share of private expenditure** in health-care services, e.g. by user fees (put in place in 2008), **have been gradually reversed** by the later government in 2015.

This lack of political will and consensus poses an increasingly acute problem in the Czech health system. It results in several rather small changes each time a new political party comes into power, while the larger issues regarding sufficient resource mobilisation and massive revenue base creation are not addressed.

The information infrastructure for the health system is lacking, the implementation of the National eHealth Strategy (2016–2020) is slow. The strategy includes the creation of a shared information platform for providers and health insurance funds. In **2018**, the successful **introduction of ePrescription** (It is now widely used during the pandemic) highlighted the potential of the planned National Health Information System.

From the year **2021**, the Czech Republic is **changing the payment system, as implementing the diagnosis-related groups** (DRGs) to better describe hospital services and to improve the measurement and management of hospital production (services).

ORGANISATION OF THE SECTOR

► **<u>Definition of SGEI for the hospital sector</u>**

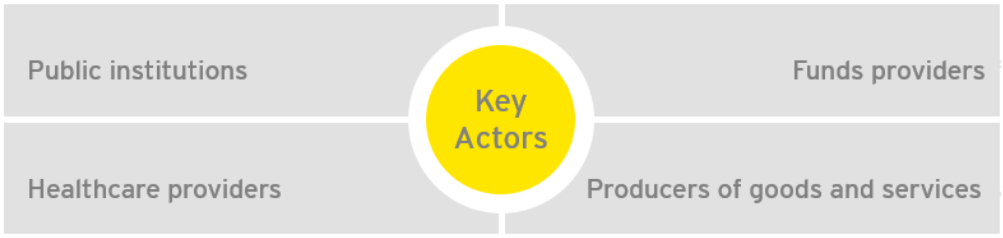
Healthcare **institutions provide inpatient care, outpatient care, day care or care in patients' home (home care)**. They are also in charge of general and/or specialised care (e.g. psychiatry), emergency services and the coordination between professionals working in office-based medical practices.

Healthcare institutions can have different legal status: (i) public, (ii) private non-for-profit and (iii) private for-profit. However, public hospitals are largely predominating.

The main bodies that form the structure of healthcare institutions in the Czech Republic are the Ministry of Health, the General Health Insurance Company and other health insurance companies and healthcare facilities.

The Ministry of Health of the Czech Republic is the central body of State administration. According to §10 of Act No. 2/1969 Coll. competences in the field of healthcare, protection of public health, medical scientific activity, medicines and means of medical technology. It directly manages medical facilities that fall within its competence, State medical facilities, the public health insurance system and the health information system.

► **There are 4 types of actors in the healthcare sector in the Czech Republic:**



Public institutions:

- **The Ministry of Health**: responsible to set up the health-care policy, supervising the health system and preparing health legislation, also administers certain health-care institutions and bodies

- **Professional medical organisations**: the Czech Medical Chamber, the Czech Dental Chamber and the Czech Chamber of Pharmacists. Membership is compulsory for every practising physician, dentist and pharmacist. Their role is to represent the interests of their respective professions and they are also responsible for ensuring the ethical behaviour of their members, including the provision of due care
- **14 regional authorities (Regions)**: responsible for the accessibility of healthcare, the former by registering health-care providers, the latter by contracting them. Also, hospital owners (direct or indirect)
- **The Office for the Protection of Competition**: creating conditions for the provision of State aid, consulting and monitoring the State aid providers

Funds providers:

- **The General Health Insurance Company and other health insurance companies**: the insurance companies are quasi-public, self-governing bodies that act as payers and purchasers of care
- **Private voluntary health insurance schemes**: covering co-payments, special care, dental and vision care. Still rare in Czechia, mainly as a benefit for employees of the international companies
- **Households**: co-payments for prescribed pharmaceuticals, direct payments for over-the-counter medicines, as well as co-payments for items such as medical devices and spa treatments

Healthcare providers:

- Health and paramedical professions
- Healthcare institutions such as hospitals (public and private)
- Multidisciplinary healthcare networks (health professionals, social workers…)
- Specialised health prevention institutions (ex: occupational health)

Producers of goods and services

Association of Innovative Pharmaceutical Industry (AIFP) is a representative association with 35 member companies in the Czech Republic

► **Competition in the sector:**

Healthcare institutions can have different legal status: public, private non-for-profit and private for-profit. However, public hospitals are largely predominating.

Within the Czech healthcare system, the reimbursement of healthcare is paid from public health insurance (with the above-mentioned exceptions, especially in the area of dental care). Nevertheless, patients are free to choose one of the insurers available with different services provided as well as different payment and reimbursement options. Competition between care providers (hospitals) takes place at the level of quality and availability of care. The quality of healthcare is therefore the main, but not the only tool of the competition for the patient between hospitals.

At present, reimbursement based on DRG is implemented in the reimbursement system, which should support competition between hospitals on the basis of comparable parameters. This system should reduce the waiting time of patients for procedures, strengthen competition between hospitals, control costs, facilitate hospital selection for patients and enhance the transparency of the reimbursement mechanism.

FUNDING OF THE SECTOR

The health sector is mostly **financed from public sources** (public health insurance, State budgets, regional and municipal budgets). Private sources form only a small part of funding. They include private health insurance, non-profit institutions, and preventive care in companies. The last source is direct payments from households.

Public funding arrangements

The **major source of financing health expenditure is public health insurance**, i.e. it is a **tax that is one of the pillars of social security** scheme. It is based on the principle of compulsory redistribution payment deducted from the amount of income. It is then used in case of illness and covers the necessary healthcare that is guaranteed by law.

The smaller proportion comes from public budgets, including both financial resources obtained for healthcare directly from the State budget (mainly from the Ministry of Health and the Ministry of Labour and Social Affairs) and local budgets, including resources obtained from healthcare from regional budgets.

Health expenditure

The total health expenditure in Czech Republic is composed of the following elements:

- Medical care
- Rehabilitative care
- Long-term care
- Additional services
- Pharmaceuticals and medical products
- Preventive care
- Healthcare system administration.

The biggest proportion of the total health expenditure goes to medical care, each year about 40% of total healthcare costs. It includes inpatient care, outpatient care, dental care, day care and home care.

	Amount of expenditure in 2018 (in €)	Evolution 2010[316] - 2012	Evolution 2012 – 2018
Total Health expenditure (in billion)	15.9	+2%	+26%
Medical care expenditure (in billion)	6.5	+0%	+26%

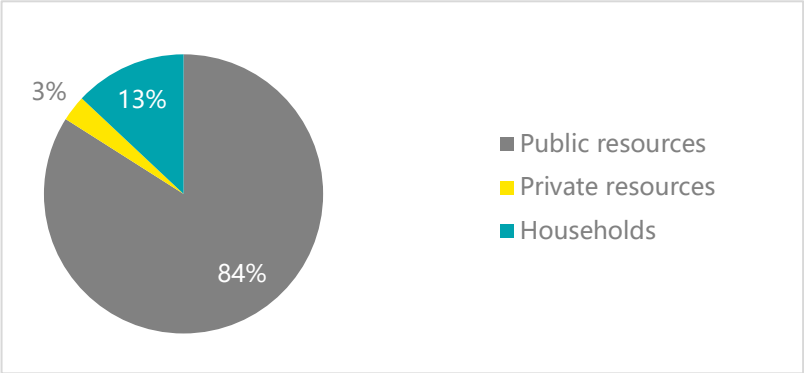
The **total health expenditure was € 16.2 billion in 2018** (8.1% of GDP). In 2012, this expenditure was € 12.8 (8.4% of GDP) and 2010 it was € 12.5 (also 8.4% of GDP). During the time period 2010 and 2012, the total health expenditure increased by 2%, and then further increased by 26% during the 2012 and 2018.

The expenditure on medical care amounted to € 6.5 billion in 2018, which makes up to 40% of the total expenditure on health. In comparison to 2012, this share did not change, and the amount expensed on medical care was € 5.2 billion.

[316] *The data before 2010 are not comparable. There was a change in methodology, since 2010 the data are calculated according to international standard SHA 2011.*

In 2010, this amount was the same (€ 5.2 billion), but the share of medical care was 1% higher – it constituted 41% of the total health expenditure.

Distribution of total health expenditure per category of funder in 2018:



The sources of the total expenditure on health are mostly public (84% of the spending in 2018). 13% comes from the direct payments of households, and 3% from the private resources (other than households). The more detailed data about the distribution of expenditure per different category in different elements (medical care etc.) is not available.

Public resources include:

- Public health insurance
- State budget
- Regional and municipal budgets.

► The public health insurance is the most important resource, it constitutes about 78% of the public sources. The private sources are composed of:

- Private health insurance
- Non-profit institutions
- Companies – preventive care.

Evolution of the distribution of health expenditure:

The share of each funder category was constant and did not change over the analysed time period. In 2010, 2012, and 2018, the biggest funding share comes from public resources (84%), private resources account for 3% of the funding and the direct payments from the households form the remaining 13%.

► **Evolution of the amount of public aid**

The total amount of the public aid granted **in 2019** for the hospital sector as part of the SGEI Package was **€ 5,5 billion**, which is an increase of **449% since 2012**.

Healthcare financing in the Czech Republic is mostly realised through the payments from the public health insurance, which is not perceived as State aid. Only support for hospitals through co-financing from the public budgets (regions or municipalities) is considered as SGEI financing.

Support to psychiatric hospitals – when they provide counselling services – may be addressed as SGEI in the near future.

II. Social Housing

The aim of this Section is to **provide an overview of the social housing sector in Czech Republic** as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

The **availability of data on social housing in the Czech Republic is poor**. The reasons are further explained in the next section (Legal framework). Unfortunately, the **only data available are from the year 2011**, so they should serve for illustrative purposes only.

20,354
Social housing

0.4%
Social housing stock within the total housing stock

1.4%
Households renting in the subsidised sector

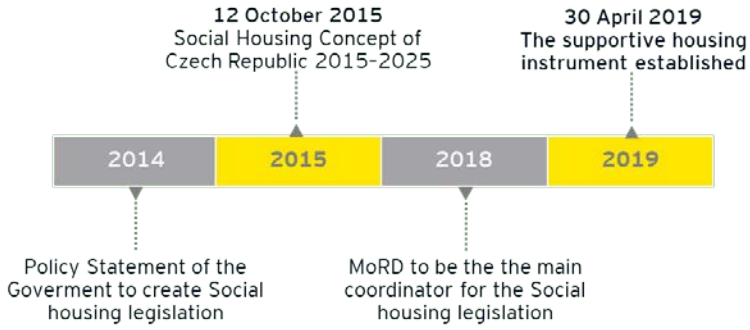
In **2011**, there were **20,354 social housing dwellings**, which made 0.4% of the total housing stock. This puts the Czech Republic at the very end of the OECD countries in the availability of social housing. In 2011, only 1.4% of households were living in the subsidised sector. Other data was not found.

LEGAL FRAMEWORK

In the Czech Republic, there is **no specific legislation regarding social housing**. However, this does not mean that there are no attempts in implementing the concept in the country. The concept of social housing is defined as follows: the **housing provided to people who are in danger of or facing a financial crisis related to housing**. This includes low-income households that spend a disproportionate amount of their income (more than 40%) on the rent. The **beneficiaries of social housing are, if necessary, also provided with the additional support of social work**. At the local level, it takes the form of a flat tenancy and can be connected to social services such as emergency houses or shelters.

The **only governmental document addressing the concept is the "Social Housing Concept of the Czech Republic 2015–2025"**. The material provides the theoretical and strategic basis for tackling the housing crises.

► **<u>Presentation of the evolution of the legal framework:</u>**



► ***Evolution of the legal framework before 2012:***

Before the year 2012, there was **no specific legislation regarding the social housing concept**. Partially because of the **lacking vision and unclear ownership of the concept between the two ministries**, the Ministry of Labour and Social Affairs and the Ministry for Regional Development. There was an attempt to solve it and the plan to prepare the legislation in the legislative work plan, but it was postponed several times. But with the financial crisis in 2008 and the fact that Czech

	municipalities were lacking accommodations to rent to people in need (the municipalities sold them in a large amount after the velvet revolution of 1989), the need to overhaul the social housing system was becoming even more urgent. ► ***Evolution of the legal framework after 2012:*** **In 2014, the social housing prerogative was attributed to the Ministry of Labour and Social Affairs**. The Ministry started the preparation of the strategy and the legislation process. During the strategy preparation, there were diverging views **of the concept between the government and the municipalitie**s. As for the implementation of the social housing concept, it is important to note, that the settlement structure in the Czech Republic is very fragmented, with over 80% of municipalities having fewer than 1,000 citizens. Also, the housing policies are locally designated at the municipal level with minimal input from the regional authorities. As a result of the situation, **the preparation process of the legislation was stopped**. The only governmental document addressing social housing is the "**Social Housing Concept of the Czech Republic 2015–2025**". The **material provides the theoretical and strategic basis for tackling the growing number of housing crises**. Furthermore, it outlines the goals and aims of the Czech Government, which are to be fulfilled by 2025. On **February 2018**, the new Government **approved the legislative work plan, which listed the Ministry for Regional Development as the main coordinator of the outline and the draft law** on social housing; the Ministry of Labour and Social Affairs was appointed a co-administrator of these works. In **August 2018 it was decided that the works on the Social Housing Act would be suspended**. Furthermore, it is anticipated in the coming years that the Ministry for Regional Development will prepare a Government Regulation providing the municipalities in the Czech Republic with specific grant support. In **2019**, the **supportive housing instrument** (the financial aid from the State Investment Support Fund) **was established** based on the Government Executive Order no. 112/2019 (novelised by the Government Executive Order no. 55/2020), **specifying the terms and extent of particular forms of assistance**.
ORGANISATION OF THE SECTOR	► **<u>SGEI in the sector</u>** All **investment activities related to social housing** - i.e. the construction, rebuilding or purchase of housing ownership addressed to people whose income is below a ceiling defined by the public administration (the Government Regulation no. 112/2019 and 55/2020) or to middle-income people under certain conditions defined also by this regulation **determine the SGEI**. The regulation also specifies the maximum amount of the subsidy per square meter. The SGEI de minimis Regulation or the SGEI Commission Decision are used, the regime involved depending on the amount of the investment. **The Office for the Protection of Competition** is the **central authority** of the State administration responsible for **creating conditions** that favour and protect competition and **consultation and monitoring in relation to the provision of the State aid**. Currently, social housing falls within the responsibility the Ministry of Regional Development (MoRD), which is responsible for housing policy, and the Ministry of Labour and Social Affairs (MoLSA), the guarantor and supervisor of social work.

► **Presentation of the categories of actors in the social housing sector**

Public institutions:

- **Ministry of Regional Development** (MoRD): the role of the MoRD is to organise and regulate the sector at the national level
- **Ministry of Labour and Social Affairs** (MoLSA): MoLSA is responsible for social policy, social work, social services (emergency houses, shelters, halfway houses etc.) and social benefits for housing (housing allowance and housing supplement, immediate emergency assistance).
- **The Office for the Protection of Competition**: creating conditions to the provision of the State aid, consult and monitor the State aid providers
- **The Agency for Social Inclusion**: established by MoRD to provide support to municipalities in the process of social inclusion and to ensure the equal access to social housing (help with proposals, strategies etc.).

Fund providers:

- **State through National Fund for the Housing Development**: under the Ministry for the Regional Development, responsible for investment funding (all kinds of housing, not only social, funds distribution in line with the Government Regulation no. 112/2019 and 55/2020.
- **Integrated Regional Operational Programme**: under the MoRD, financed through the ERDF and the national budget, investments to social services and social housing capacities
- **Operational Programme Employment**: under the MoLSA, financed through ESF and the national budget, support to social services and social work, testing the innovative approaches (housing first etc.)
- **Local authorities** through subsidies (delegation from the State)
- **Social housing providers** with their own financial resources.

Social housing providers:

- The State, local authorities, public organisations.

► **Competition in the sector:**

In social housing, as it is understood in the Czech Republic for the time being (ie. the housing provided to people who are in danger of or facing a financial crisis in the terms of housing), there is no fundamental competition. Logically, the public sector (municipalities) and non-profit organisations have entered the segment. These entities provide social housing not for profit, but rather with the provision of social assistance within the social policy of the State / within the mission of a non-profit organisation that receives subsidies for this purpose.

	The entry of private entities is not expected to a greater extent. The lower willingness to participate in the provision of social housing may be related to the lacking legislative, and thus legal certainty.
FUNDING OF THE SECTOR	► **Funding arrangements** As **a definition of social housing is lacking within the national legislation, there is a lack of data on funding of this sector**. Social housing was, however, **one of the supported activities within the Integrated Regional Operational Programme** (IROP), co-financed from the ERDF. The aim of this activity is to purchase apartments or other buildings and adapt them to the needs of eligible target groups. The parameters for social housing were specified in the specific call rules and were in line with the Social Housing Concept of the Czech Republic 2015–2025. Until 2018, **IROP supported 115 projects for more than € 23 million**. This has led to the construction of 600 social housing dwellings. The aim is to support 5,000 social apartments, the calls will be launched until 2022. Additionally, there exist multiple channels through which the Ministry of Labour and Social Affairs helps low-income groups: • Housing allowance (contribution to housing-costs for low-income families or individuals, provision is subject to testing of the income of the family for the previous calendar quarter), • Housing supplement (benefit of assistance in material need which helps to cover justified housing costs, it is set so that after the payment of justified housing costs the person is left with a living amount), • Other immediate assistance. **Aid granted as part of the SGEI Package**  The total amount of the public **aid granted in 2019** for the social housing sector as part of the SGEI Package was **€ 8.1 million against CZK 205 million in 2012 (€ 7.7 million)** (+5%). The social housing sector is still under development in the Czech Republic, mainly because of the lacking legislation. The sector is financed through different funds (national and EU level). Nevertheless, it is not considered as SGEI by all of them. The application of the rules is not coordinated, nor clear to all stakeholders involved. The Ministry of Regional Development, which is now responsible for the legislation process, is still considering a request for an exemption from the SGEI, as they see the sector as undeveloped and not mature. The application of the rules might slow down the capacity building process in their opinion.
SOURCES	The following sources have been used for the elaboration of this Fiche: ► **Statistics** • https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC • https://ec.europa.eu/competition/State_aid/overview/public_services_en.html • https://www.oecd.org/els/family/PH4-1-Public-spending-social-rental-housing.pdf

	• http://www.oecd.org/social/affordable-housing-database/housing-policies/ • https://www.czso.cz/csu/czso/vysledky-zdravotnickych-uctu-cr-2010-2018 • http://www.socialnibydleni.mpsv.cz/images/soubory/Koncepce_socialniho_bydleni_CR_2015-2025.pdf ► **Other resources** • Zákon č. 48/1997 Sb., Zákon o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů • Zákon č. 280/1992 Sb., Zákon České národní rady o resortních, oborových, podnikových a dalších zdravotních pojišťovnách • Zákon č. 2/1969 Sb., Zákon České národní rady o zřízení ministerstev a jiných ústředních orgánů státní správy České socialistické republiky • Nařízení vlády č. 112/2019 Sb., Nařízení vlády o podmínkách použití finančních prostředků Státního fondu rozvoje bydlení na pořízení sociálních a dostupných bytů a sociálních, smíšených a dostupných domů • Nařízení vlády č. 55/2020 Sb., Nařízení vlády, kterým se mění nařízení vlády č. 112/2019 Sb., o podmínkách použití finančních prostředků Státního fondu rozvoje bydlení na pořízení sociálních a dostupných bytů a sociálních, smíšených a dostupných domů

10.3 France

Member State: France		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• In 2018, the total health expenditure in France was € 275.9 billion (11.7% of GDP[317]). • The health sector is mainly funded by the social security scheme (78%); 13% is funded by private health insurance schemes, 7% by households through out-of-pocket (OOP) payments and 2% by the State (universal health coverage). • The total State aid granted to the hospital sector in 2019 was € 81.6 billion against € 74.5 billion in 2012, which represents an increase of 10%. • The total consumption of care and medical goods[318] for the hospital sector (public and private) was € 94.5 billion in 2018, funded at 92% by the social security scheme.[319]	• In 2018, the total public aid (allowances, subsidies, favourable tax measures and loans at preferential rates) granted to households and social housing providers in France was € 14.9 billion (38% of the public aid granted to the housing sector as a whole). • The State aid granted to the social housing providers as part of the SGEI Package in 2019 was € 5.5 billion against € 6.6 billion in 2017 (-16%) and €6 billion in 2012 (-8%).
Key actors	The key actors relating to health SGEIs in France are the following: Public institutions: MINISTÈRE DES SOLIDARITÉS ET DE LA SANTÉ; ars Agence Régionale de Santé; Haut Conseil de la Santé Publique Fund providers: L'Assurance Maladie; Harmonie mutuelle Healthcare providers: ASSISTANCE PUBLIQUE HÔPITAUX DE PARIS	The key actors relating to social housing SGEIs in France are the following: Public institutions: MINISTÈRE DE LA COHÉSION DES TERRITOIRES ET DES RELATIONS AVEC LES COLLECTIVITÉS TERRITORIALES; ANCOLS Contrôle Évaluation Études Agence nationale de contrôle du logement social Fund providers: Caisse des Dépôts GROUPE; ActionLogement Social housing providers: 3F Groupe ActionLogement
Structure of health and social housing	• The French Ministry of Solidarities and Health (Ministère des Solidarités et de la Santé) is responsible for the	• The Ministry of Cohesion of the French territories (Ministère de la cohésion des territoires et des relations avec les collectivités

[317] *GDP of France 2018: € 2,288.2 billion (https://www.insee.fr/fr/statistiques/2830613#tableau-figure1)*
[318] *' Consommation de soins et de biens médicaux ' or CSBM*
[319] *The difference of public amount granted to the hospital sector between the total State aid allocated through the ONDAM (("Objectif national des dépenses d'assurance maladie" or national objective regarding the health insurance expenditure) and the total consumption of care and medical goods corresponds (CSBM) to a difference of concept: the ONDAM takes into account the funding (income) and the CSBM takes into account the expenses (https://drees.solidarites-sante.gouv.fr/IMG/pdf/fiche29-3.pdf).*

	organisation and monitoring of the health system by setting the national strategy and budget including the financing of the hospital budget. • The actors in charge of organising the sector at local level are the regional health agencies (Agences régionales de santé or "ARS"). They are in charge of planning, monitoring, allocating budget and delivering services regarding inpatient care, outpatient care, health and social care to disabled and elderly people. • There are also national agencies with a specific role of advising the Ministry of Solidarities and Health such as the French Public Health Council (Haut Conseil de la Santé Publique); and other agencies with a role of advising and supporting a wide range of health stakeholders (public authorities, institutions, professionals…) such as the National Authority for Health (Haute Autorité de la Santé). • In terms of fund providers for the health sector, different types of actors exist though the main provider is the social security scheme. • Healthcare providers such as hospitals, specialised health prevention institutions also exist who are financed by the social security scheme, private insurance and households.	terrioriales) is responsible for facilitating access to housing by setting the national rules. The Ministry is also in charge of organising the sector at national level. • The local public authorities are in charge of establishing the local social housing permit and delivering building permit. • Moreover, the National Social Housing Agency's (Agence nationale de contrôle du logement social or "ANCOLS") role is to control the sector (funds and activities of the providers). • In terms of funders, there are public funders (National/Local authorities and the Deposit and Consignment Fund or CDC) and "Action Logement". • Finally, there are 5 types of providers: the Public Offices of Housing (Offices Publics de l'Habitat or "OPH"), Social Enterprises of Housing (Entreprises Sociales pour l'Habitat or "ESH"), Cooperative societies (Société cooperatives or "COOP"), Semi-public housing construction bodies (Sociétés d'Economie Mixte or "SEM") and other owners (Public authorities, authorised providers…). The first three categories constitute the HLM ("Habitation à loyer modéré" or Moderate rent housing) subsector.
Main conclusions	The healthcare sector is mainly based on a social health insurance system, with a strong role of the State. The health budget is voted annually by the Parliament for the following year. There are 3 type of hospitals: public, private not-for-profit and private for-profit hospitals. Since 2012, there has been a decline in the number of hospital sites and beds. These trends can be linked to the introduction of the territorial group of hospitals in 2016, to the decisions of reducing the surplus of hospital beds and of reorganising the offer with less hospital beds and more outpatient care.	The social housing stock has increased by 8% from 2012 to 2018. In 2018, social housing dwellings represented 14% of the total housing stock. Before and after 2012, laws regarding the social housing sector have aimed at reorganising the sector. After 2012, the objective specifically has been to encourage mergers, in particular by integrating small operators into bigger groups. A key objective underpinning the introduction of a new legal framework has been to reduce the public expenditure.

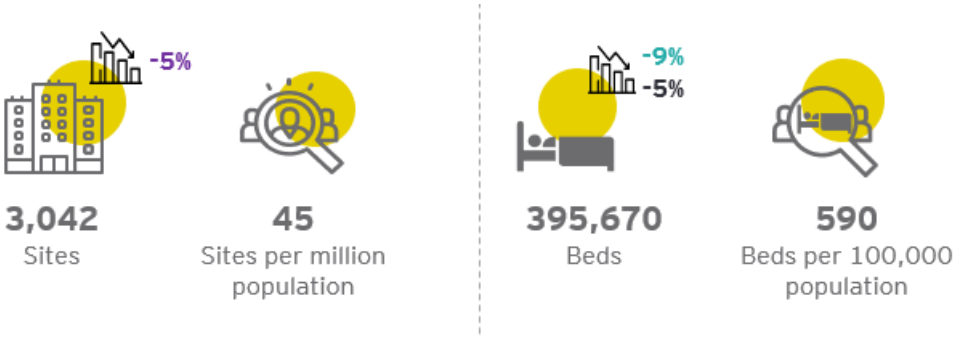
I. Health Sector

The aim of this Section is to provide an overview of the health sector in France as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

Number and share of hospitals and beds (and evolution)

In 2018, the total number of hospital sites was 3,042 against 3,125 in 2013[320], which represents a **decrease of 5**%. In parallel, the **number of sites per million population decreased** as well. Indeed, there were 45 sites per million population in 2018 against 49 in 2013.



The reduction in number of sites can be linked to the introduction of the territorial group of hospitals (*Groupements Hospitaliers de Territoire* or "GHT") by the 2016 law related to the modernisation of the healthcare system (*Loi de modernisation du système de santé*). On 1 July 2016, public legal entities had to join one of the 135 GHT to create a shared medical project and mutualise their human resources. The objective is to offer graduated care services in a specific territory by cooperation between public legal entities.

The number of beds also decreased from 414,840 in 2012 to 395,670 in 2018 (-5%), after a **decrease of 9% between 2005 and 2012**. The total number of hospital beds in 2005 was indeed 455,175. This evolution results from the choice of reducing the surplus of hospital beds and of reorganising the offer (less hospital beds and more outpatient care)[321]. Indeed, in parallel the number of places for care lasting less than a day has increased from 68,049 in 2012 to 77,297 in 2018 (+14%).

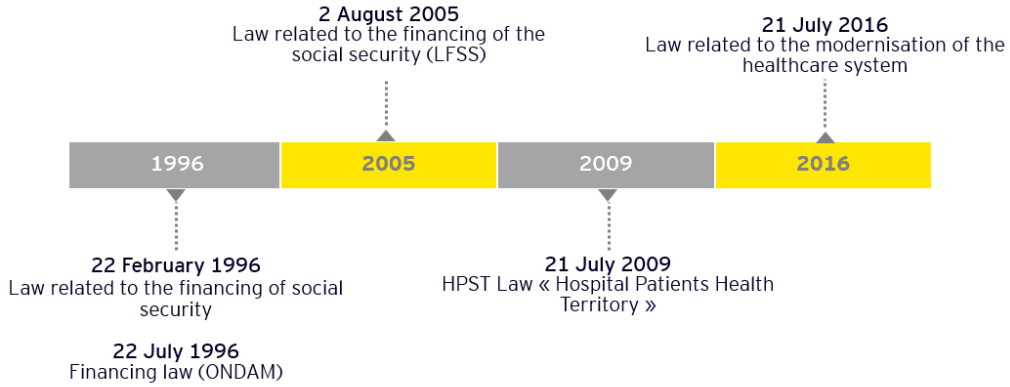
Number and share of hospitals and beds (and evolution) per legal entity

In 2018, there were 3,042 sites distributed by sector as follows: 1,360 sites owned by public hospitals (45%), 682 sites owned by not-for-profit private hospitals (22%) and 1,000 sites owned by for-profit private hospitals (33%). This share of the market has been stable since 2013.

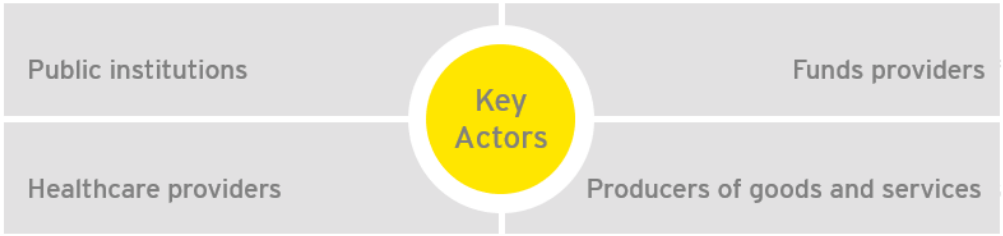
There has been a decrease in the number of sites in all sectors between 2013 and 2018. However, sectors have been impacted differently: the number of sites decreased by 7% in the public sector, 4% in the not-for-profit private sector and 2% in the for-profit private sector.

[320] *The evolution of the number of beds regards the "2012-2018" period while the data for the number of sites regards the "2013-2018" period because the data calculation of the latter has changed since 2013. In the public sector, a legal entity can be composed of several geographical entities. However, until 2013 only the legal entities were included in the calculation while, since 2013, the sites' figure regards the geographical entities.*

[321] *https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/panoramas-de-la-drees/article/les-etablissements-de-sante-edition-2020*

	In 2018, the share of the beds was as follows: 62% for the public sector, 14% for the private non-for-profit sector and 24% for the private for-profit sector. Compared to 2012, this share is stable. However, compared to 2005, there has been a decrease of 3 percentage points of beds in the public sector and an increase of 4 percentage points of beds in the for-profit private sector. Between 2005 and 2012, the **number of beds declined significantly in the public and not-for-profit sectors** (respectively -13% and -9%), while the number of beds increased in the for-profit private sector (+6%). This trend was different during the following period (from 2012 to 2018). Indeed, **there has been a decrease in all sectors between 2012 and 2018** (-6% in the public sector and -3% in the private sector). The decrease in the public sector can partly be explained by a strong reduction of the capacity in long-term care facilities for people over 60 (80,000 beds in 2003 against 31,000 beds in 2018[322]). These facilities were transformed into care home for the dependent elderly attached to the "medico-social" sector.
LEGAL FRAMEWORK	**<u>Presentation of the evolution of the legal framework since 1996</u>** The regulatory framework has been evolving in France, particularly over the last 25 years. The laws introduced since 1996 have **impacted the financing and the organisation** of the healthcare system.  ***Evolution of the legal framework before 2012:*** With regard to the financing of the sector, the adoption of the Law regarding the financing of social security (*Loi de la Sécurité sociale*) in 1996 has provided the **Parliament with the right to examine the financial balance**. A law introducing the ONDAM (*Objectif national des dépenses d'assurance maladie* or National objective regarding the health insurance expenditure) was voted the same year; this law established a forecast of the health insurance expenditure to be done on a yearly basis in order to **control the annual growth** of the spending in this sector. In 2004, the activity-based pricing built on the model of diagnosis-related groups was introduced by a reform. In 2005, a new law regarding the financing of the social security (*Loi de financement de la Sécurité sociale* or "LFSS") was voted. This law **reinforced the role of the Parliament** regarding this subject and **improved the expenditure monitoring**. In 2009 the HSPT ("*Hôpital Santé Patients Territoire"* or "Hospital Patients Health Territory") law, regarding the organisation of the sector, included the **creation a public regional body** in charge of the healthcare at local level ("ARS", *Agence régionale de santé* or regional health agencies) and the **modernisation of public health institutions**. ***Evolution of the legal framework after 2012:*** In 2016, the law related to the modernisation of the healthcare system (*Loi de modernisation du système de santé*) covered a number of topics including the **reorganisation of the health sector (creation of a "territorial group of**

[322] *https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/panoramas-de-la-drees/article/les-etablissements-de-sante-edition-2020*

	hospitals" (GHT)) and the care pathway, the reinforcement of the patients' rights. Since this law, public hospitals based in the same area have the obligation to form a "territorial group of hospitals" (GHT) with a shared medical project in order to mutualise their human resources and to offer graduated care services to patients.
ORGANISATION OF THE SECTOR	**Definition of SGEI for the hospitals sector** Healthcare institutions "provide inpatient care, outpatient care or care in patients' home including care home[323]". They are also in charge of general and/or specialised care (e.g. psychiatry), emergency services and the coordination between professionals working in office-based medical practices and "medico-social" institutions and services. The SGEI in the hospital sector are defined by these missions. Healthcare institutions can have different legal status: (i) public, (ii) private non-for-profit and (iii) private for-profit. However, any institution called "hospital" is public, and private healthcare institutions are called "clinics". **There are 4 types of actors in the healthcare sector in France:**  ***Public institutions:*** • National Authority: Ministry of Solidarities and Health (*Ministère des Solidarités et de la Santé*) which sets the national health strategy, prepare the yearly law of the financing of social security (with the Ministry of Public Accounts or "*Ministère de l'action et des comptes publics*") and monitor it. • Local Authorities: Regional Health Agencies (*Agences Régionales de Santé* or "ARS") are in charge of the planning, monitoring and service delivery in order to meet the needs of the population and to ensure the efficiency of the health system in the region. They are responsible for the coordination of health activities (inpatient care, outpatient care, health and social care for disabled and elderly people) and allocation of budget to institutions. • Agencies that have a specific role of advising the Ministry of Solidarities and Health (the French public health council or "*Haut Conseil de la Santé Publique*") and agencies with a role of advising and supporting a wide range of health stakeholders such as public authorities, health professionals, health institutions… (The National Health Authority or "*Haute Autorité de Santé*" / The French Agency for numerical health or "Agence du numérique en santé" / The Agency for Information on Hospital Care or "Agence technique de l'information sur l'hospitalisation"…) • Parliament: Control and orientation through the yearly law of the budget of social security ***Funds providers:*** • State through the universal health cover. • Social security scheme (ex: National Health Insurance Fund called "*Caisse Nationale d'assurance Maladie*") through the French mandatory's statutory health insurance system. • Private compulsory or voluntary health insurance schemes (ex: private insurances / mutual Funds) covering co-payments, balance billing and dental and vision care. Since 2016, all employees are covered by the employer's

[323] *Article L. 6111-1 of the French Public Health Code (Article L6111-1 - Code de la santé publique - Légifrance (legifrance.gouv.fr))*

	selected health insurance scheme. Employers have to finance at least 50% of this scheme. • Households through co-payments and balance bills (pricing charged for a medical act above the covered fees). **Healthcare providers:** • Health and paramedical professions • Healthcare institutions such as hospitals (public and private) • Multidisciplinary healthcare networks (health professionals, social workers…) • Specialised health prevention institutions (ex: occupational health) ► **Competition in the sector:** As stated in the "key figures" section, in France there are 3 types of hospitals: (i) public, (ii) not-for-profit private and for-profit private. They all provide acute medical, surgical and obstetric care, at different level. Most of this type of care is provided by public hospitals, especially full inpatient care (70% against 22% for the for-profit sector and 8% for the not-for-profit sector[324]). Public hospitals provide a wide range of surgeries, including complex procedures. Private for-profit hospitals specialise in predictable technical procedures that can be routinely performed, requiring only a short stay and that generate profits. Not-for-profit private hospital performs acute medical activity too and they are the main providers of cancer treatments. Since 2013, the number of hospital sites has decreased in all sectors: -7% for the public sector, -4% for the not-for profit private sector and -2% for-profit private hospitals. The decline in the public sector regards mainly long-term care facilities (for people over 60) and former local hospitals. The decrease is lower for the for-profit private sector. The rise of the aftercare and rehabilitations facilities has indeed compensated the drop in the number of short stay or multidisciplinary healthcare institutions (acute medical, surgical and obstetric care). Besides, the decrease in the number of beds in all sectors since 2012 comes from the choice of reducing the surplus of hospital beds and of reorganising the offer in order to provide more outpatient or ambulatory care.
FUNDING OF THE SECTOR	The health system is mainly based on a social health insurance system, with a strong role of the State which counts on taxes (employers, employees, excise duties on tobacco and alcohol[325], etc) to finance the health insurance funds. **Public funding arrangements** **For medical, surgery and obstetric activities**, there are two types of funding arrangements: 1. The main one is activity-based pricing (*Tarification à l'activité – "T2A", based on the diagnosis-related groups*), the rate is fixed on a yearly basis by the Health Minister. 2. The complementary sources of funding to finance activities that are not included in the scope of the T2A (e.g. services of general interest and support to the internal contracting procedure) or to support healthcare institutions on targeted topics. **For other activities**, there are different financing sources depending on the legal status of the institution. For example, in the psychiatric sector: ► Not for profit institutions (public and private) are financed by an annual operating allocation (*Dotation annuelle de fonctionnement – DAF*), ► For-profit institutions are financed through a daily basis rate.

[324] *https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/panoramas-de-la-drees/article/les-etablissements-de-sante-edition-2020*
[325] *The amount of excise duties on alcohol and tobacco is allocated to the entire social security scheme. However, the main recipient of this tax is the National Health Insurance Fund.*

The entrustment given to healthcare institution takes the form of a multi-annual contract of objectives and means (*Contrat pluriannuel d'objectif et de moyens – "CPOM"*) covering a period of 5 years. This contract is concluded between the institution and the regional healthcare agency.

Health expenditure

The French indicator for the total health expenditure in France is called "*Dépenses courantes de santé*". It is composed of the following elements:

- Consumption of care and medical goods ("*consommation de soins et de biens médicaux"* ' or CSBM)
- Long-term care for disabled and elderly people (*soins de longue durée*)
- Daily allowance for sickness, maternity or work accident (*indemnités journalières*)
- Prevention expenditure
- Healthcare system expenditure such as pharmaceutical/medical research, training courses…
- Healthcare system management cost

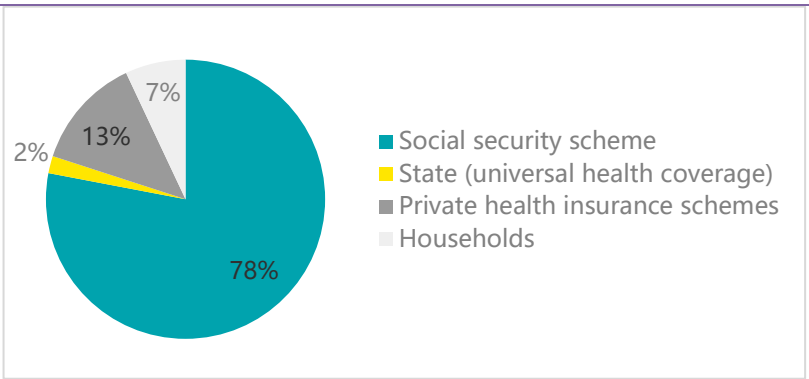
The Consumption of care and medical goods ("*consommation de soins et de biens médicaux"* or CSBM) represents more than 70% of the total health expenditure. It includes Inpatient care, Outpatient care, medical transport and pharmaceutical and medical devices.

	Amount of expenditure in 2018 (in €)	Evolution 2005 - 2012	Evolution 2012 – 2018
Total Health expenditure (in billion)	275.9	+29%	+12%
Consumption of care and medical goods (in billion)	203.5	+20%	+12%

The total health expenditure (*Dépense courante de santé*) was € 275.9 billion in 2018 (11.7% of GDP). This expenditure was € 246.4 billion in 2012 (11.8% of GDP) and €190.5 billion in 2005 (11.1% of GDP). This health expenditure has thus increased by 12% between 2012 and 2018, following an increase of 29% during the previous period of time (2005-2012).

The consumption of care and medical goods' ("*consommation de soins et de biens médicaux"* or CSBM) amount was € 203.5 billion in 2018. It constituted around 74% of the total health expenditure in 2018. Compared to 2012, this share is stable; however, it rose by 5.5 percentage points in the previous period (2005-2012).
In terms of evolution of the amount, the consumption of care and medical goods expenditure was € 181.8 billion in 2012 (+12% during the period 2012-2018) and € 151 billion in 2005 (+20% during the period 2005-2012).

Distribution of the consumption of care and medical goods ("consommation de soins et de biens médicaux" or CSBM) expenditure per category of funder in 2018:



The consumption of care and medical goods is mainly funded by the social security scheme (78% of the spending in 2017). 13% is funded by private insurance schemes, 7% by the households and 2% by the State through universal health coverage.

Evolution of the share of the consumption of care and medical goods ("consommation de soins et de biens médicaux" or CSBM) expenditure per category of funder:

	2005-2012	2012 - 2018
Social security scheme	**-1 percentage point**	**+2 percentage points**
State	**=**	**=**
Private health insurance scheme	**+1 percentage point**	**=**
Households	**-1 percentage point**	**-2 percentage points**

The share of the social security scheme in the consumption of care and medical goods' ("consommation de soins et de biens médicaux" or CSBM) expenditure declined by one percentage point during the 2005-2012 period, and then rose by 2 percentage points during the following period of time (2012-2018). The share of State's funding has been stable in both periods, while the share of private health insurance increased by 1 percentage point from 2005 to 2012 and has been stable between 2012 and 2018. Only the households' share decreased in both period (-1 percentage point from 2005 to 2012 and -2 percentage points between 2012 and 2018).

The decline of the households' share in the consumption of care and medical goods (CSBM) can be explained by the following[326]:

- Structural factors such as the ageing of the population leading to an exemption of health payments due to chronic illness
- Moderation of pricing charged for a medical act (balance billing) above the State-defined rates
- Generalisation of companies' private health insurance in 2016 leading to a better reimbursement of optical and dental care by these insurances

Hospital expenditure

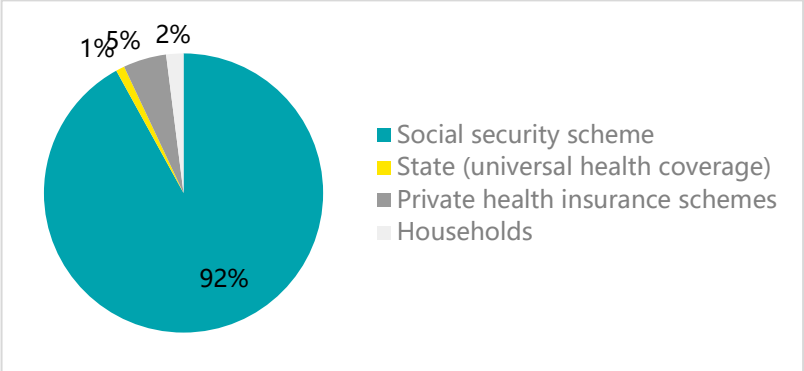
[326] *According to 2019 edition of the health expenditure report from the French direction of research, studies, evaluation and statistics (La direction de la Recherche, des Études, de l'Évaluation et des Statistiques or "DREES")*

	Amount of expenditure in 2018 (in € billion)	Evolution 2005 - 2012	Evolution 2012 – 2018
Hospital expenditure	94.5	+26%	+12%
Public sector[327]	73	+25%	+12%
Private sector[328]	21.5	+31%	+10%

The total hospital expenditure was € 94.5 billion in 2018, representing 46% of consumption of care and medical goods ("consommation de soins et de biens médicaux" or CSBM). This expenditure for 2012 was € 84.6 billion (47% of CSBM) and € 67 billion in 2005 (45% of CSBM). The amount increased by 26% from 2005 to 2012, and by 12% between 2012 and 2018.

In 2018, the public sector represented 77% of the hospital expenditure; this share being stable since 2005. In terms of amount, € 73 billion was spent in the public sector in 2018 against € 65 billion in 2012 and € 52 billion in 2005. The expenditure increased by 25% from 2005 to 2012 and by 12% between 2012 and 2018. With regards to the private sector, the hospital expenditure was € 21.5 billion in 2018, against € 19.6 billion in 2012 and € 15 billion in 2005. It increased by 31% from 2005 to 2012 and by 10% between 2012 and 2018.

Distribution of the hospital care expenditure per category of funder in 2018:



The social security scheme is the main funder of hospital care (92%). 5% is funded by private health insurance, 2% by households and 1% by the State. The share of social security scheme also represented more than 90% of the hospital care in 2005 and 2012.

Evolution of the amount of public aid as part of the SGEI package in the hospital sector:[329]

The ONDAM ("*Objectif national des dépenses d'assurance maladie*" or national objective regarding the health insurance expenditure), an expenditure objective that should not be exceeded, is voted each year by the Parliament and is fixed by the law related to the financing of the social security (LFSS: *Loi de financement de la Sécurité sociale*).

[327] *Public hospitals, military hospitals and private healthcare institutions of collective interest previously financed by a global grant (dotation globale)*
[328] *Private healthcare institutions of collective interest previously not previously financed by a global grant (dotation globale) and for-profit hospitals*
[329] *Report on Services of General Economic Interest 2016-2017 & 2012-2014, France*

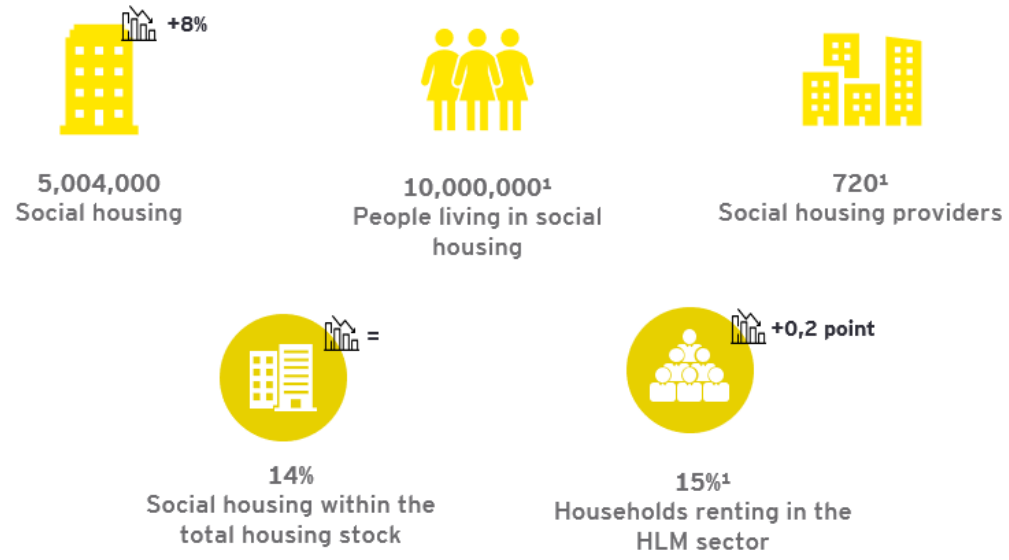
The total amount of the public aid granted **in 2019** for the hospital sector as part of the SGEI package was **€ 81.6 billion** through the ONDAM, which is an increase of **10% since 2012**.

II. Social Housing

The aim of this Section is to provide an overview of the social housing sector in France as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

In France, in 2018, there were more than 5 million social housing dwellings, which constitutes 14% of the total housing stock. The number of social housing dwellings is rising as there were 4.7 million social housing dwellings in 2012 (+8% from 2012 to 2018).

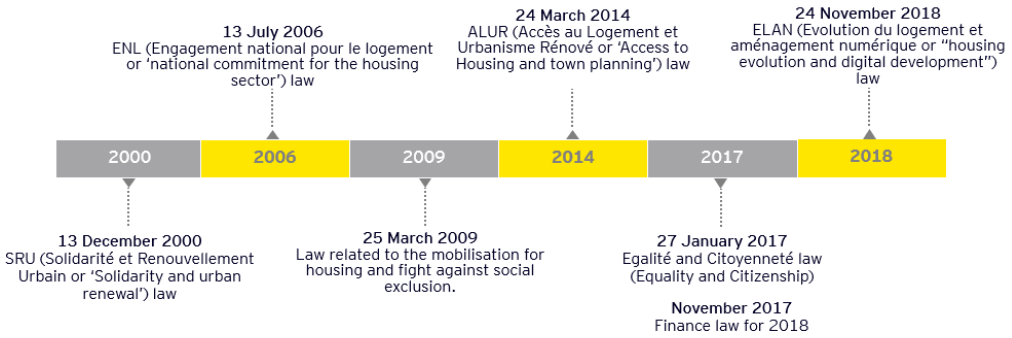


[1] 2018 data, only available for the HLM ("Habitation à loyer modéré" or moderate rent housing) sector

There are different types of social housing operators:

- **Public Offices of Housing (**Offices Publics de l'Habitat **– "OPH")** are public organisations with commercial activities attached to a local authority (one or more municipalities or "département")
- **Social Housing Companies (**Entreprises Sociales pour l'Habitat **– "ESH")** are not-for-profit private organisations with commercial activities regulated by the CCH (Construction and Housing Code), local authorities and tenants are represented in their board of directors
- **Cooperative Companies** (Société cooperatives – COOP)
- **Semi-public housing construction bodies** (Sociétés d'Economie Mixte – "SEM") are semi-public organisations mainly owned by local authorities. They are also called "local public enterprises".
- **Other social housing stock owners are:** the State, local authorities, public organisations and other authorised providers.

The Public Offices of Housing (OPH), Social Enterprises of Housing (ESH) and Cooperative societies (COOP) are part of the **HLM (Moderate rent housing) subsector**. This subsector is regulated in terms of funding, dwellings allocation and social housing stock management. In terms of information regarding tenants, more data is available for the HLM ("Habitation à loyer modéré" or moderate rent housing) subsector than for the social housing sector as a whole for 2 reasons: (i) the Ministry of French territories cohesion ensures a statistical monitoring of the HLM subsector,

	(ii) there is a lack of information regarding semi-public housing construction bodies (Sociétés d'Economie Mixte or "SEM") and other owners. It should be mentioned that the 720 social housing providers of this subsector own more than 80% of the total social housing stock. In 2018, there were 10 million of people living in a dwelling of the HLM ("Habitation à loyer modéré" or moderate rent housing, which represents 15% of the households. The share of the households renting in the HLM sector has been around 15% since 1984.
LEGAL FRAMEWORK	According to the French Ministry of ecological transition's website (*Ministère de la transition écologique*), social housing in France is defined as follows: housing built with public aid (tax benefits, public subsidies and loans at preferential rates) and intended to people with low incomes[330]. Allocation of social housings is based on income ceilings depending on the number of people composing the household and the geographic localisation. The social housing sector is regulated in terms of funding and allocation of the funds, but also in terms of management by social housing operators[331]. **<u>Presentation of the evolution of the legal framework since the early 2000s</u>**  ***Evolution of the legal framework before 2012:*** Before 2012, legislation was adopted to **reorganise the social housing sector**. In 2000, a Law introduced an **objective of social diversity** with a minimum of 20% of social housing in towns/cities. Then, in July 2016, the institution of the ENL (*Engagement national pour le logement* or "national commitment for the housing sector") has led to the reduction of the VAT TAX to 5,5% for home ownership in neighbourhood undergoing urban renovation and **the creation of the OPH ("*Offices publics de l'Habitat*" or Public Offices of Housing)** from the merger of 2 public offices[332]. Finally, in 2009, the Law related to the mobilisation for housing and fight against social inclusion covered a number of housing topics such as social accession to home ownership, eviction prevention but also the **increase of building in the HLM ("moderate rent housing") sector.** ***Evolution of the legal framework after 2012:*** In 2014, the ALUR law ("*Accès au Logement et Urbanisme Rénové"* or Access to Housing and town planning) reinforced the rights of applicants to social housing and eased the access to social housing in simplifying applications. The laws established since 2017 have had two objectives: **pursuing the reorganisation of the sector and reducing the public expenditure**. Indeed, objective of the law "Egalité et Citoyenneté" (or Equality and citizenship) is to combat territorial segregation and increase social diversity.The finance law for 2018, published in November 2017, aimed at reducing the public expenditure on housing allowance (Réduction du loyer

[330] *With regards social housing, the income ceiling for social housing depends on the number of dependents, the geographical localisation and type of housing funding.*
[331] *https://www.ecologie.gouv.fr/logement-social-enjeux-et-actions*
[332] *OPHLM (Offices publics d'HLM or Public offices of moderate rent housing) and OPAC (Offices publics d'aménagement et de construction or Public offices of construction)*

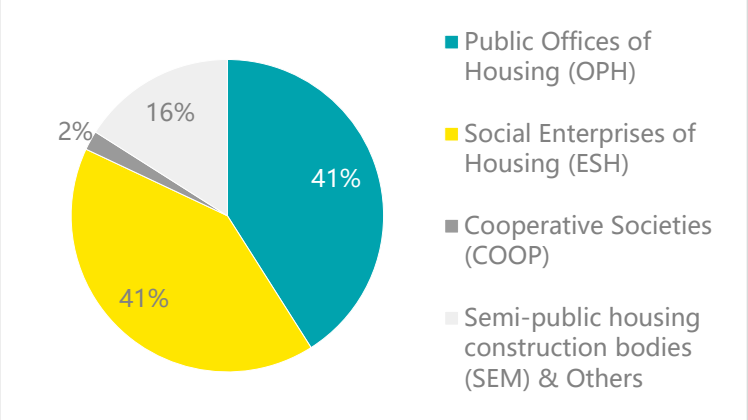
	de solidarité – "RLS") and the dependence of social landlords to public aid (ex: rise of the VAT tax from 5.5% to 10% for construction and renovation), which lead to a reduction of financial resources for providers. Then, in November 2018, the ELAN (Evolution du logement et aménagement numérique or "housing evolution and digital development") law encouraged **mergers or integration into a bigger group of social housing operators** with a stock of less than 12,000 social housing dwellings. Another tool was introduced by the 2018 ELAN law: Société de Coordination (Society of coordination). It enables social providers to have a common vision/project and to mutualise their resources in a specific area, while keeping their legal entity and identity. Social housing providers had to merge, integrate a bigger group or join a society of coordination by January 2021.
ORGANISATION OF THE SECTOR	**SGEI in the sector** According to the French report on SGEI (2018-2019), all activities related to social housing - i.e. the construction, purchase, management and transfer of capped rent rental accommodations or operations of housing ownership addressed to people whose income is below a ceiling defined by the public administration or to middle-income people under certain conditions defined by the law – determine the SGEI. Dwellings aimed at middle-income people are called "mid-range" dwellings and shall not represent more than 10% of the housing stocked owned by the provider. However, the report also mentions that from 2020, these mid-range dwellings do no longer fall under the SGEI rules. Additional operations are part of the SGEI such as: • Accession to ownership addressed to people with people whose income is below a ceiling defined by the public administration or to middle-income people under certain conditions by the sale of subsidised rental accommodation, • Management or purchase of accommodations based in joint ownership properties facing difficulties, with the agreement of local authorities (municipality and département). **Presentation of the categories of actors in the social housing sector**  • ***Public institutions:*** ► **National Authority:** the role of the Ministry of French territories cohesion (*Ministère de la cohésion des territoires et des relations avec les collectivités terrioriales*) is to organise and regulate the sector at national level by enacting the rules and setting the offer. ► **Local authorities:** territorial authorities ("*collectivités territoriales*") are in charge of establishing the local social housing programme, delivering building permit and setting town planning. ► **National Social Housing Agency** (Agence Nationale de Contrôle et du Logement Social – "ANCOLS"): this agency's role is to control the source of funding and activities of social housing providers.

- ***Funds providers:***

► **Deposits and Consignment Fund** (*Caisse des Dépôts et des Consignations* or "CDC"), a public financial institution, through loans for the construction or rehabilitation of social housing
► **The State** through subsidies and favourable tax measures
► **Local authorities** through subsidies (delegation from the State)
► **"Action Logement"** previously known as "1% Housing" as it represented the percentage of the wage bill that a company of more than 20 employees had to pay in favour of housing construction. Currently, it represents 0,45% of the wage bill. Their role is to manage employers' contribution and fund building of social housing.
► **Social housing providers** with their own financial resources

- ***Social housing providers***

Distribution of the market per category of providers in 2018



In 2018, 84% of the social housing stock was owned by HLM (moderate rent housing) operators:

- 41% by Public Offices of Housing (OPH)
- 41% by Social Entreprise of Housing (ESH)
- 2% by Cooperative companies (COOP)

The remaining 16% are owned by semi-public housing construction bodies (SEM) and other providers (the State, local authorities, public organisations and other authorised providers)

Evolution in the distribution of the market

	Evolution from 2012 to 2018
Public Offices of Housing (OPH)	**-3 percentage points**
Social Enterprises of Housing (ESH)	**+2 percentage points**
Cooperative Societies (COOP)	**+1 percentage point**
Semi-public housing construction bodies (SEM) & Others	**-1 percentage point**

The share of the social housing market owned by **HLM (moderate rent housing) providers is stable since 2012**, and the share of the market owned by other social housing providers has decreased by 1 percentage point. However, evolutions have been identified regarding the social housing providers within the HLM subsector. Indeed, the share of social housing stock has decreased by 3 points for "OPH" (public providers) and increased by 2 points for "ESH" (not-for-profit private providers). This

	evolution can be explained by the fact that ESH builds more social housing dwellings than OPH. In 2018, 60% of new social housing units in the market were owned by ESH against 29% for OPH[333]. ► **Competition in the sector:** Operators in the social housing sector in France are either public, semi-public, or not-for-profit organisations. There is no competition with private for-profit providers.
FUNDING OF THE SECTOR	**Funding arrangements** Public funds are the main source of funding in the social housing sector: • Public subsidies, • Favourable tax measures, • Long-term loans from the CDC, • Revenue from social housing sales, • Housing allowance (Aide personnalisée au logement – "APL") for low-income tenants, • Tenant's rent. The entrustment given to social housing operators takes the form of an official act from the public authorities. It has no time-limit and the operator has to comply with the French Construction and Housing Code. The fact that the entrustment systematically exceed 10 years is explained by the high level of investment made by these actors. **Total public aid granted to the social housing sector:** Total housing public aid was € 39.6 billion in 2018 against € 42 billion in 2012 (-5.7%).  The total public aid granted to the social housing sector (households and operators) in 2018 was **€ 14.9 billion** (38% of the public aid for the housing sector as a whole). The amount of this aid was € 13.7 billion in 2012; however, it should be noted that this data only regards the HLM subsector. **Aid granted as part of the SGEI Package:**  The total amount of the public **aid granted to** social housing providers as part of the SGEI package increased by 9.5% between 2012 and 2017. This amount was **€ 6.6 billion in 2017 against € 6 billion in 2012** (+**9,5%**). However, in 2018 it has decreased to € 5.3 billion to increase again to € 5.5 billion in 2019. This represents a decrease of 8% for 2012- 2019 and of 16% for the period 2017-2019.
SOURCES	The following sources have been used for the elaboration of this Fiche. • https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/panoramas-de-la-drees/article/les-etablissements-de-sante-edition-2020 • https://drees.solidarites-sante.gouv.fr/IMG/pdf/cns2019.pdf • https://drees.solidarites-sante.gouv.fr/IMG/pdf/cns2005.pdf • https://drees.solidarites-sante.gouv.fr/IMG/pdf/panorama2014.pdf

[333] *Commissariat général du développement durable, Le parc locatif social au 1er janvier 2019 (Novembre 2019) (https://www.statistiques.developpement-durable.gouv.fr/sites/default/files/2019-12/datalab-essentiel-194-rpls-janvier-2019-novembre2019_0.pdf)*

	• Report on Services of General Economic Interest 2016-2017 & 2012-2014, France • Report on Services of General Economic Interest 2016-2017 & 2012-2014, France • OCDE/European Observatory on Health Systems and Policies (2019), France: Profils de santé par pays 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels • https://www.ecologie.gouv.fr/logement-social-enjeux-et-actions • https://www.ecologie.gouv.fr/chiffres-et-statistiques-du-logement-social#e0 • "Les HLM un modèle français, les HLM en chiffres, septembre 2019" Union Sociale de l'Habitat • "Les HLM en chiffres, septembre 2014", Union Sociale de l'Habitat • "Les HLM en chiffres, septembre 2013", Union Sociale de l'Habitat • https://www.statistiques.developpement-durable.gouv.fr/sites/default/files/2019-12/datalab-essentiel-194-rpls-janvier-2019-novembre2019_0.pdf • https://www.insee.fr/fr/statistiques/3676693?sommaire=3696937 • https://www.insee.fr/fr/statistiques/1374118?sommaire=1374192dépense • https://ec.europa.eu/competition/state_aid/overview/public_services_en.html • https://stats.oecd.org/Index.aspx?DataSetCode=HEALTH_REAC# • https://www.commonwealthfund.org/international-health-policy-center/countries/france • Chevreul K, Berg Brigham K, Durand-Zaleski I, Hernández-Quevedo C. France: Health system review. Health Systems in Transition, 2015 (https://www.euro.who.int/__data/assets/pdf_file/0011/297938/France-HiT.pdf)

10.4 Germany

Member State: Germany		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• In 2019, Germany had the highest spending on health out of all EU Member States; total health expenditure was €400.41 billion (11,7% of its GDP); • The spending on health has increased by 34% from 2012 to 2019 to reach €400.41 billion; • 85% of the total health expenditure was financed by government schemes. Out-of-pocket (OOP) spending is rather low (12% of the total health expenditure) due to the universal coverage	• In 2018, the social housing stock was **estimated to be 1,210,000 housing units, which represents a decrease of -53%** since 2002. It represents around 3% of the total housing stock, one of the lowest social housing share in the EU. • The figures are declined in almost all of Germany's States. Three interlinked factors mainly explain this trend: 1. The progressive reduction of federal financial aid and the shorter timeframe of the subsidies. 2. The State-subsidised homes return to the private market after a certain period of time. 3. In connection to the previous point, few new social housing units have been recently built so there is little inventory on the market for social housing.
Key actors	The key actors are the Ministry of Health, the Länder, the professional federations, the Federal Joint Committee: Federal Ministry of Health Gemeinsamer Bundesausschuss Spitzenverband	The key actors are the Federal State, the Länder and the social housing providers: Federal Ministry of the Interior, Building and Community Baden-Württemberg.de SAGA Unternehmensgruppe
Structure of health and social housing	The responsibilities for health in Germany are split vertically between the Federal government and the Länder. On top of this division of powers, professional and expert bodies are	The competencies on social housing are in the Länder's hands. Therefore, **each *Land* sets its own** legal framework in order to foster social housing**.** The social housing market is characterised by a strong privatisation.

	playing a key role. The competencies distribution is presented below[334]: • **The Federal Ministry of health** is responsible for the policymaking at the federal level by drafting laws and guidelines; • The **Federal Joint Committee**: it includes representing bodies of healthcare professionals. • **Self-governance bodies and entities representing professionals:** for instance, the Federal Institute for Drugs and Medical Devices, the German Federal Insurance Authority. • **Healthcare funds:** The National Association of Statutory Health Insurance Funds represents the interest of the health insurance funds at the federal level and contribute to shape the conditions of healthcare in Germany. • **Other representatives' federations**: which represent their members' interest such as the German hospital federation, the German association for Patient Safety.	The sector is composed of four different categories of housing providers[335]: • **Individual builders** • **Housing companies** (municipal or private), which provide rental cooperative dwellings; • **Non-profit organisations** (welfare organisations) • **Social housing cooperatives** (religious and non-religious organisations) **The regional federations** represent these stakeholders' interests, which are in turn members of the national umbrella organisation, the GdW (*Bundesverband deutscher Wohnungsund Immobilienunternehmen*).
Main conclusions	The German health sector is considered performant overall. Its organisation is based on the sharing of competencies between the Federal State and the Länder. The professional organisations at the regional level are represented at the Federal level.	The Federal State is no longer financing the Länder. The social housing market in Germany is characterised by the privatisation of its actors.

[334] *CLEISS, Le système de santé allemand, 2020 (https://www.cleiss.fr/docs/systemes-de-sante/allemagne.html)*
[335] *These categories are a mix of the categories listed in the "UN Habitat, Financing Affordable Social Housing in Europe, 2009" (http://www.iut.nu/wp-content/uploads/2017/07/Financing-Affordable-Social-Housing-in-Europe.pdf) and the written contribution from Germany (Federal Ministry for Economic Affairs and Energy, in charge of State aid control policy and Länder of Brandenburg, Bavaria, Hamburg, Bremen, North Rhine Westphalia), December, 4th, 2020. In the written contribution, an interviewee highlighted that recipients of assistance -preferential loans or subsidies- agree to let accommodation for which they receive funds intended for social housing only to households who are entitled to it. Individuals builders are listed as part of these recipients who can receive funds intended for social housing.*

I. Health Sector

The aim of this Section is to provide an overview of the health sector in Germany as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

► **Number and share of hospitals and beds (and evolution) per legal entity**

In 2017, Germany had 37,31 hospitals per million population. Despite a decrease of 4% since 2012 in terms of **hospitals sites**, the density of hospitals per million population was still the third highest in Europe.

In 2017, the distribution of sites per sector was the following:

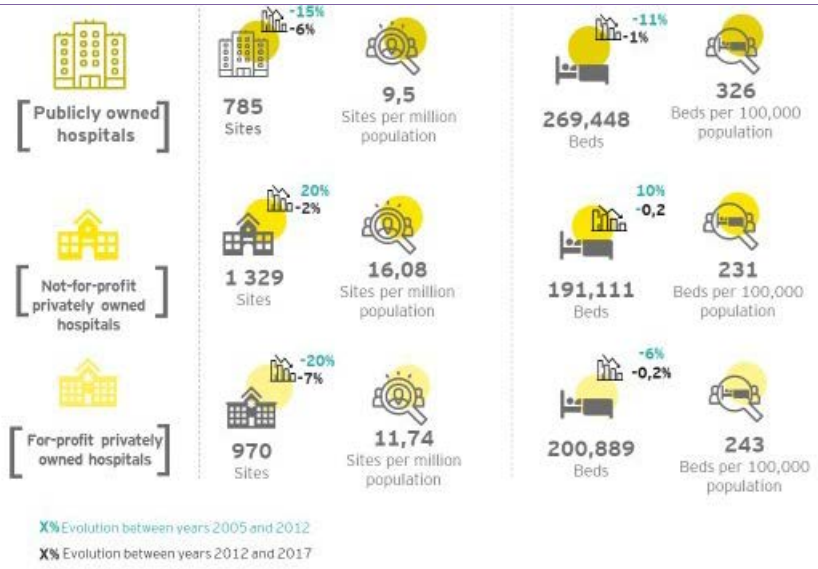
- 785 public hospitals;
- 970 for-profit privately-owned hospitals;
- 1329 not-for-profit privately-owned entities.

From 2012 to 2017, the number of beds in Germany has decreased by 1% to drop to 661,448 beds. However, in 2017, **Germany still had the highest bed density in the EU** with 8 beds per 1,000 population (total of 661,448)[336]. Because of this high density in hospital beds, there are relatively few doctors and nurses per bed in the country[337].

This high density in terms of care provision partly explains that in 2018 **only 0,6% of the population reported unmet medical needs**, which was the third lowest share in the EU[338].

► **Number and share of hospitals and beds (and evolution) per legal entity**

[336] *OECD health expenditure database, (http://www.oecd.org/Social/Expenditure.Htm#:~:text=The%20OECD%20Social%20Expenditure%20Database%20(SOCX)%20has%20been,level%20as%20well%20as%20net%20social%20spending%20indicators.)*
[337] *European Commission, State of Health in the EU Germany Country Health Profile 2019 (https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_de_english.pdf)*
[338] *Eurostat, Unmet healthcare needs statistics, (https://ec.europa.eu/eurostat/statistics-explained/index.php/Unmet_health_care_needs_statistics)*



The system in Germany is characterised as follows:

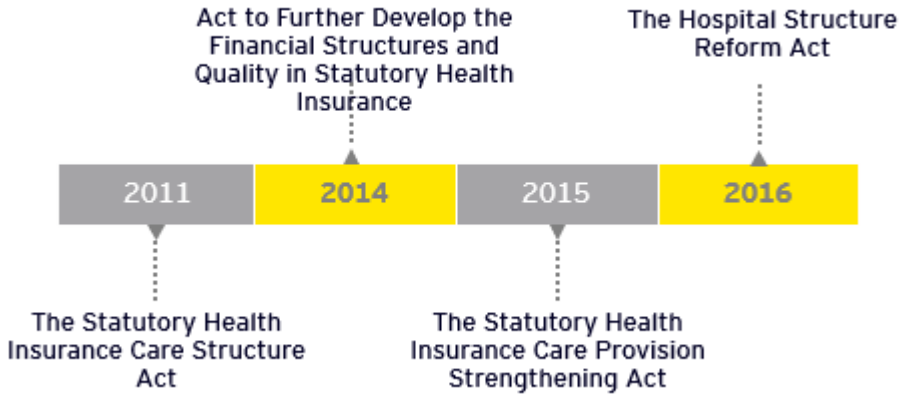
- Many non-for-profit private clinics with a relatively low number of beds and a tendency to stabilise this share since 2012;
- A few bigger public hospitals representing a large number of beds but a tendency to decrease both that numbers;
- A private owned sector representing 1/3 of the sites and the beds, that has been increasing its share between 2005 and 2012 and whose number of beds has been relatively stable since then.

The global decrease in the number of sites and beds (except for the private sector) is mainly explained by the general decrease in the average duration of hospital stay (7.3 days in 2018 versus 13.3 days in 1992), enabling hospitals to take care of more patients with less infrastructure[339].

LEGAL FRAMEWORK

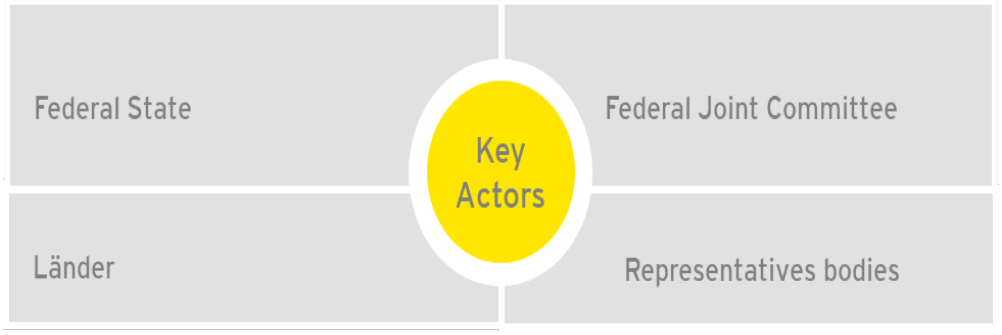
At the Federal level, reforms have led to the progressive introduction of competition between healthcare providers which are now able to attract people based on different tariffs and reimbursement schemes [340]. The following legislative acts have implemented the reforms of the German health system:

[339] *Anzahl der Krankenhäuser in Deutschland in den Jahren 2000 bis 2018, Statista, 2021 (https://de.statista.com/statistik/daten/studie/2617/umfrage/anzahl-der-krankenhaeuser-in-deutschland-seit-2000/)*
[340] *Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen, "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition", Lancet, 2017, (https://www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2931280-1)*

	Synthetic presentation of the evolution of the legal framework  ***Evolution of the legal framework before 2012:*** • **The Statutory Health Insurance Care Structure Act** (2011): amendments introduced in health-care financing ***Evolution of the legal framework after 2012:*** • **Act to Further Develop the Financial Structures and Quality in Statutory Health Insurance** (2014): changes brought on contribution rates for sickness funds; • **Statutory Health Insurance Care Provision Strengthening Act** (2015): new measures introduced for better access in ambulatory care and creation of an Innovation Fund to support new forms of Healthcare; • **The Hospital Structure Reform Act** (2016): development of Indicators for hospitals; financial support for hospitals to employ more nurses, improvement of emergency services[341].
ORGANISATION OF THE SECTOR	The healthcare German system is split between three main areas: **ambulatory care, hospital care and rehabilitation services**[342]. The Bundesländer mainly have a competency regarding hospital care and the public health provision. Prevention is also playing an important role with regard to Länder-activities. The German health system is complex, with shared responsibilities between different levels of government and self-governing bodies of payers and providers. Delegation of responsibilities to bodies of self-governance assures well informed decisions, but also contributes to the fragmented structure of the system with its plurality of payers and providers. The responsibilities for health in Germany are split vertically between the Federal government and the Länder. On top of this division of powers, professional and expert bodies are playing a key role. The competencies distribution is presented below[343]:

[341] *Ibid.*
[342] *CLEISS, Le système de santé allemand, 2020*
[343] *CLEISS, Le système de santé allemand, 2020*

► **Synthetic presentation of the type of actors**:



Federal State

The Federal Ministry of health is responsible for policymaking at federal level by drafting laws and guidelines.

Länder

As mentioned above, the competencies are shared between the Federal State and the Länder. If the national level is responsible for the national regulation of the national sickness fund, the Länder are responsible for the supervision of the regional sickness funds. Concretely, regarding hospital care, the Länder are responsible for the financing of the investments in hospitals but the national sickness fund pays for its functioning.

The health policy decided in the Bundesland is most of the time linked to a specific ministry on the Land level. The Health Land ministers regularly meet in the national frame of the Health minister conference[344].

Federal Joint Committee

The Federal Joint Committee [345] includes representing bodies of healthcare professionals (doctors, dentists, psychotherapists, the statutory insurers, hospitals) with a total of 13 members. The Committee translates the legislative objectives into specific regulation and decides the medical services which will be covered by insurance and the form of that coverage[346].

Representative bodies

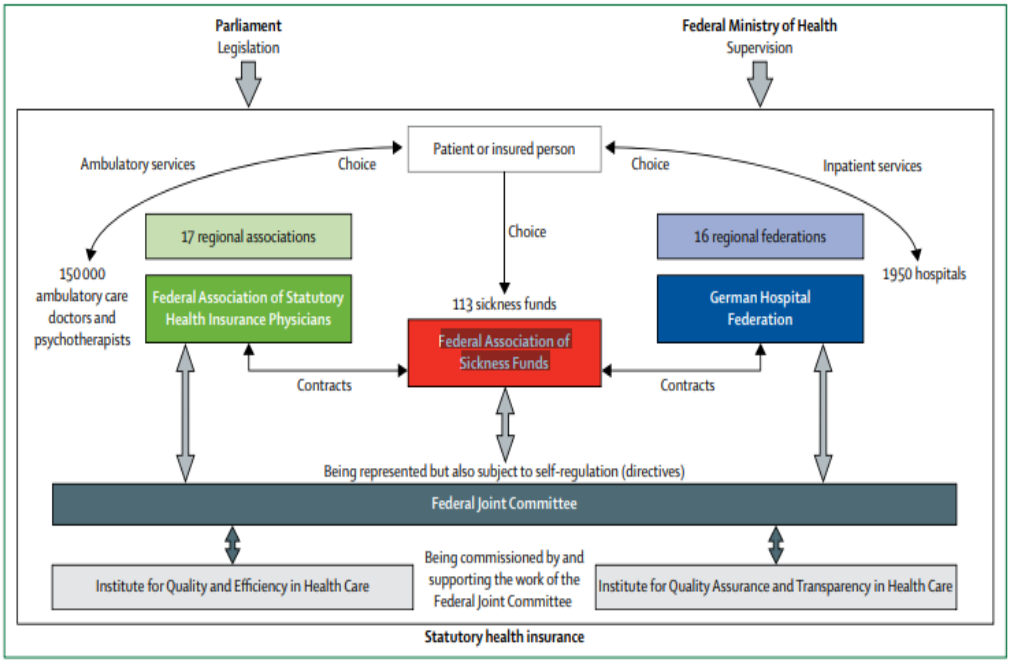
Representatives bodies are composed of Self-governance bodies and entities representing professionals: for instance, the Federal Institute for Drugs and Medical Devices [347], the German Federal Insurance Authority[348]. In addition, healthcare professionals such as physicians, doctors, dentists, psychotherapist, pharmacists must be registered in State's professionals' chambers which are then represented at the Federal level by national organisations[349] such as:

- The National Association of Statutory Health Insurance Physicians;
- the National Association of Statutory Health Insurance Dentists. etc.

Among the representative's bodies, there are also the National Association of Statutory Health Insurance Funds which represent the interest of the health insurance funds at the federal level and contribute to shape the conditions of healthcare in Germany.

Organisation of the health insurance system in Germany

[344] *German Federal Ministry of Health, State Healthcare (https://www.bundesgesundheitsministerium.de/themen/gesundheitswesen/staatliche-ordnung/bundeslaender.html)*
[345] *Gemeinsamer Bundesausschuss, Federal Joint Committee (G-BA), (https://www.g-ba.de/english/)*



Source: Lancet 2017

As mentioned above, the responsibilities are divided between the Federal State and the *Länder*. Hence, the **organisation of hospitals vary from one *Bundesland* to another**. For instance, the emergency services (*Rettungsdienst*) are framed by each *Land* and every *Land* has its own law regulating the *Rettungsdienst*. Another competency which is in the *Länder's* hands is the development, planning and investment financing of hospitals[350].

- **SGEI in the sector:**

Each Länder has its own definition of the hospital sector for the SGEI given their respective competencies in the area. Overall, the operations of hospitals included cover **services to provide medical care to the population, emergency services and ancillary services[351]** .

- **<u>Competition in the sector:</u>**

As detailed in the section on the funding of the sector, in Germany, about 87% of the population is covered by the public social health insurance and about 11% is covered by private providers[352].

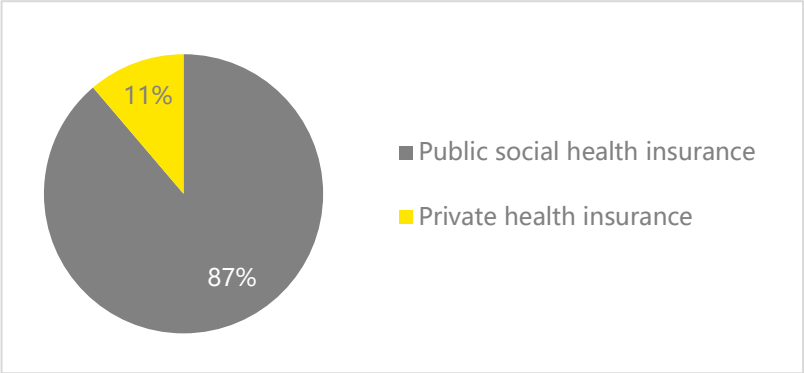
Public social health insurance is provided by sickness funds. The Healthcare Structure Act (1990) has introduced competition between the sickness funds. In response to this opportunity for citizens to freely choose between different sickness funds, sickness funds began to merge which reduced the number of funds by 70%

[346] *Healthcare in Germany: The German healthcare system, NCBI, 2018 (https://www.ncbi.nlm.nih.gov/books/NBK298834/)*
[347] *German Federal Institute for Drugs and Medical Devices, (https://www.bfarm.de/EN/Home/home_node.html)*
[348] *BaFin Federal Financial Supervisory Authority, (https://www.bafin.de/EN/DieBaFin/AufgabenGeschichte/Versicherungsaufsicht/versicherungsaufsicht_node_en.html)*
[349] *See for instance the German Medical Association which represents the States' chambers of physicians: (https://www.bundesaerztekammer.de/weitere-sprachen/english/work-training/work-and-training-in-germany/medical-organisations-and-associations/)*
[350] *Overview of the German Healthcare System, Healthmanagement.org, (https://healthmanagement.org/c/hospital/issuearticle/overview-of-the-german-healthcare-system)*
[351] *See the biennial report Germany has to send to the European Commission on SGEI implementation.*
[352] *European Commission, Sate of Health in the EU Germany Country Health Profile 2019 https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_de_english.pdf*

	between 2000 and 2015. From 2015 to 2019 the number of sickness funds decreased by 14% to reach 109. In addition to the individuals who can opt-out of the public health insurance, **the ones uncovered by the public social health insurance are covered by private providers**. Although no data are available to provide an evolution of the private insurance providers, in 2017 there were 41 substitutive private health insurance companies in Germany, of which 25 were for profit.
FUNDING OF THE SECTOR	**Funding arrangements:** ► In Germany, **health insurance is compulsory** and almost the whole population is covered. About 87% of the population is covered by the public social health insurance and about 11% is covered by private providers[353]. The system of universal health coverage is based on competing sickness funds[354]. ► The health insurance system is mainly financed through a **contribution from wage income** divided between employer and employees. Contributions are gathered in the Central reallocation Pool with an additional tax subsidy. The funds are then reallocated to sickness funds. Sickness funds then are free to charge additional fee[355]. ► Individuals who can opt-out of the public health insurance pay a risk-related premium to **private health insurance**[356]. ► **Sickness funds finance ambulatory care** (out-patient). For these ambulatory services care, there are different systems for patients covered under the public health insurance and the private health insurance which leads to the facts that treating patients under a private health insurance regime is more profitable for doctors[357]. ► With regards to hospital funding, **the patient treatments are mainly paid by the insurance funds** but investment in hospitals is the responsibility of *Länder*[358]. In 2019, the public social health insurance sector was composed of 109 sickness funds and there were 41 private health insurance companies.

[353] *Ibid.*
[354] *Reinhard Busse, Miriam Blümel, Franz Knieps, Till Bärnighausen, "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition", Lancet, 2017, (https://www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2931280-1)*
[355] *Ibid.*
[356] *Miriam Blümel, Reinhard Busse, International Healthcare System Profiles: Germany https://www.commonwealthfund.org/international-health-policy-center/countries/germany*
[357] *Germany: Country Health Profile: 2019, State of Health in the EU, OECD, 2019, (https://www.oecd-ilibrary.org/social-issues-migration-health/germany-country-health-profile-2019_36e21650-en)*
[358] *Overview of the German Healthcare System, Healthmanagement.org, https://healthmanagement.org/c/hospital/issuearticle/overview-of-the-german-healthcare-system*

Coverage of the population by type of health insurance providers[359]:



In Germany, 87% of the population is covered by the public social health insurance and 11% is insured by a private health insurance. People entitled to join a private health insurance are those with an income above a certain threshold, civil-servants and self-employed individuals.

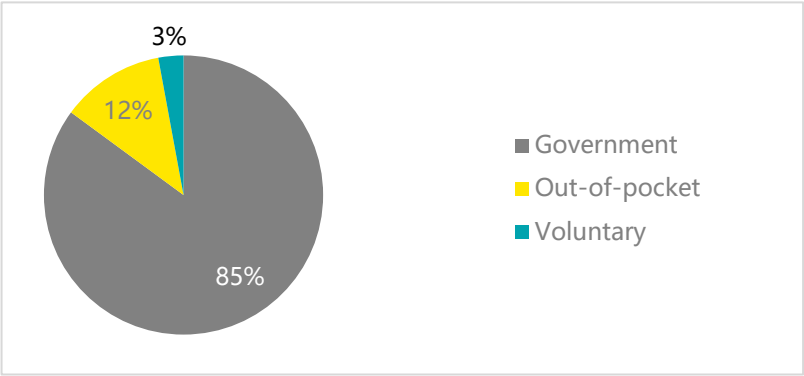
In June 2018, there were 41 substitutive private health insurance companies in Germany, of which 25 were for profit.

► **Health expenditure**

	Amount of expenditure in 2019 (in €)	Evolution 2005-2012	Evolution 2012 – 2019
Total Health expenditure (in billion)	400.41	+26%	+ 34%
In % of GDP	11,7%	NA[360]	+0,9 pts

Spending on health in Germany is high in comparison to other EU Member States since the country ranked first in 2019 with 11,7% of its GDP spent on health. The spending on health has even increased by 34% from 2012 to 2019 to represent €400.41 billion.

Distribution of health expenditure per category of funder:



Out of the total health expenditure, **85% was financed by government schemes** which is far above the EU average since Germany ranked fourth in the EU. Out-of-pocket (OOP) spending[361] is relatively low and accounted only for 12% of the total health expenditure[362]which can be partly explained by the fact that 98% of the population is covered by health insurance (private and public).

Evolution of the distribution of health expenditure:

	2005-2012	2012 - 2018
Government	**39%**	**31%**
Out-of-pocket	**27%**	**15%**
Voluntary[363]	**-64%**	**25%**

Evolution of the categories of healthcare spending

	2018 (€ per capita, current prices)	2012 - 2018
Inpatient care	1,213	+18%
Outpatient care	998	+20%
Long-term care	860	+47%
Preventive care	148	+27%
Medical goods	891	+24%

- All categories of health spending are **above the EU average**;
- Due to recent reforms of the German health system, **long-term care spending has grown more strongly** than other expenditures;
- **Spending on prevention has increased** since 2015 due to obligations for sickness funds to invest more in prevention[364].

Aid granted as part of the SGEI package

In 2016-2017, €*2.6 billion* were reported in the biennial report on SGEI provisions towards hospitals.

NB: In the German biennial reports, € 2.6 billion were reported for hospitals in 2016-17 and in 2014-2015 approximatively €1.4 billion / €1.7 billion per year was spent[365].

[359] *European Commission, Sate of Health in the EU Germany Country Health Profile 2019 Sate of Health in the EU Germany Country Health Profile 2019 (https://ec.europa.eu/health/sites/health/files/state/docs/2019_chp_de_english.pdf)*
[360] *The health expenditure as the share of the GDP was not available for 2005.*
[361] *Out-of-pocket is made of three sub-categories OOP excluding cost-sharing (HF.3.1); OOP cost-sharing with government schemes and compulsory contributory health insurance schemes (HF.3.2.1); and OOP cost-sharing with voluntary insurance scheme. This indicator provides a picture of the burden of health financing on households. See OECD, Classification of Healthcare Financing Schemes (ICHA-HF).*
[362] *OECD statistics, health expenditure and financing.*
[363] *Note as opposed to compulsory schemes which refer to schemes where membership is made compulsory by the government under voluntary schemes the access to health services is at the discretion of private actors and include for instance, voluntary health insurance, NPISH financing schemes and Enterprise financing schemes. See OECD, Classification of Healthcare Financing Schemes (ICHA-HF).*
[364] *European Commission, Sate of Health in the EU Germany Country Health Profile 2019 (https://www.oecd-ilibrary.org/social-issues-migration-health/germany-country-health-profile-2019_36e21650-en)*
[365] *European Commission, Biennial SGEI Report, Germany, (https://ec.europa.eu/competition/state_aid/overview/public_services_en.html)*

II. Social Housing

The aim of this Section is to provide an overview of the social housing sector in Germany as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

Until the 1960s, social housing programmes in Germany were ambitious and aimed at erasing the post war housing shortage. Later, social housing programmes began to focus on specific target groups of people in needs. Social housing provision today aims more to alleviate the consequences of tense housing markets.

Since 2012, there has been a growing demand in large cities for social housing due to increasing rents. In parallel, the housing shortage for vulnerable households can be explained by the expiry of controlled rent and restricted allocation term[366].

According to a study released in 2018 by the Federal Association of German Housing and Real Estate Companies (GdW), an estimated need of 140,000 additional new dwellings in cities is annually required of which 80,000 apartments should be social housing and 60,000 affordable housing. Based on these estimates, **currently only 70% of the needs for affordable housing are fulfilled** and a bit more than a third of social housing needs are met[367].

As of December, 31 2018, there were about **1,18 million social housing units in Germany which represents a decrease of 3.5 % in comparison with 2017 and -53% since 2002**[368]. The trend has been even stronger over the last ten year since Germany has experienced an estimate loss of around 68 400 housing units per year on average (in comparison 42 898 housing units lost from 2017 to 2018)[369].

The social housing stock represents **3% of the total housing stock**[370],one of the lowest social housing shares in the EU[371].

[366] *Contribution from Germany (Federal Ministry for Economic Affairs and Energy, in charge of State aid control policy and Länder of Brandenburg, Bavaria, Hamburg, Bremen, North Rhine Westphalia), December, 4th, 2020.*
[367] *Housing Europe, The State of Housing in The EU 2019, Urban, Economy, Social, Research, 2019 (https://www.housingeurope.eu/resource-1323/the-state-of-housing-in-the-eu-2019)*
[368] *Note that this report only presents the estimated decrease from 2002 to 2017. (https://www.housingeurope.eu/resource-1323/the-state-of-housing-in-the-eu-2019.)*
[369] *Written contribution received from the GdW Federal Association of German Housing.*
[370] *OECD database, Public Policies towards affordable housing and Housing Euope,2019. The State of housing in the EU.*
[371] *Ibid.*

Three factors can mainly explain this trend:

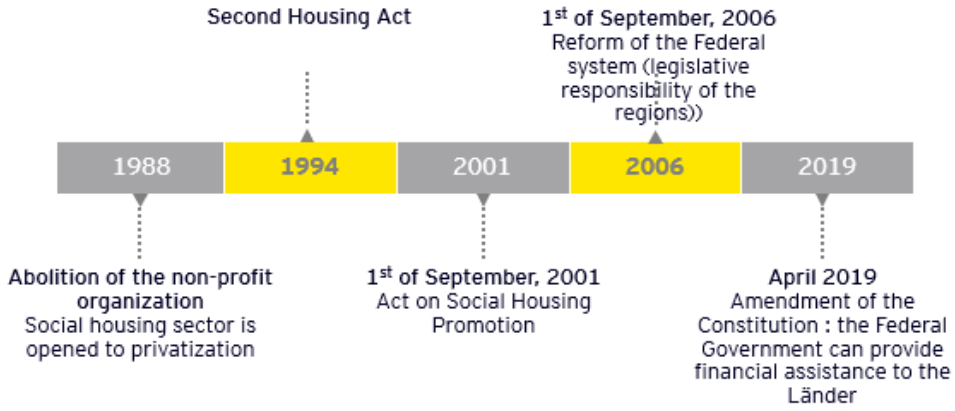
- One factor explaining the decreasing importance of the social housing stock **is the progressive reduction of federal financial aid and the shorter timeframe of the subsidies**.Subsidies are indeed often granted through loans and once the loans are reimbursed the financed housing loses its social status (e.g the special price)[372];
- Then, **State-subsidised homes return to the private market after a certain period of time** (approx. 30 years in most of the cases). They are then rented out under the same conditions as any other private apartment with much higher prices;
- In connection to the previous point, **few new social housing units have been recently built** so those that return to the market are not replaced. Even though the Federal State subsidises the building of new houses, with the ones not replaced it is not enough to keep the number of social housing constant[373].

The figures are declining in almost all of Germany's states except Bavaria, where 1,285 more social housing units were built last year than returned to the market. The eastern State of Saxony also increased its social housing stock by 161 units[374].

LEGAL FRAMEWORK

Germany was traditionally a big provider of social housing, but this changed at the end of the 1980s with the withdrawal of the German State from major social housing programmes.

Synthetic presentation of the evolution of the legal framework



Evolution before 2012

- The 1988 abolition of the non-profit organisation led to the fact that social housing was no longer bound by the housing non-profit law. Consequently, this led to a privatisation and the fact that generating a profit was then possible[375].

The regional housing programmes started to increasingly open to private investors.

- The 1994 2nd Housing Act (II. Wohnungsbaugesetz), formulated the goal of creating apartments that are intended and suitable for large sections of the population according to size, equipment and rent or burden (quote from § 1 II WoBauG).

[372] *Stefan Kofner, Social Housing in Germany: an inevitably shrinking Sector?, Critical housing analysis, 2017 (http://www.housing-critical.com/home-page-1/social-housing-in-germany-an-inevitably-shrinki)*
[373] *https://www.thelocal.de/20190814/number-of-social-housing-units-drops-by-42000-in-germany*
[374] *https://www.thelocal.de/20190814/number-of-social-housing-units-drops-by-42000-in-germany*
[375] *Jan Kuhnert, Olof Leps: Es ist Zeit für eine neue Wohnungsgemeinnützigkeit. In: Neue Wohnungsgemeinnützigkeit. Springer Fachmedien Wiesbaden, 2017*

	• This law was replaced on the 1st of September 2001 by the law on the reform of the housing law ("Gesetz zur Reform des Wohnungsbaurechts"). It contains the Act on Social Housing Promotion (Wohnraumförderungsgesetz - WoFG). It regulates housing construction and other measures to support households with rented housing, including cooperative housing, and the formation of owner-occupied housing for households that are unable to adequately provide themselves with housing on the market. In addition to the creation of affordable housing, the acquisition of owner-occupied housing was also made possible for a broader population. Since 1949, all federal governments have therefore seen it as necessary to promote social housing as an essential element of a socially responsible housing policy. Until the end of 2006, the federal government therefore provided annual financial aid in varying amounts in its budget. **Since 2006, the Länder have been responsible for more competencies among which social housing** Since the 2006 reform of the Federal system, Federal States have the legislative responsibility for promoting social housing. Regulations are ruled by specific subsidy laws decided by each Land. In case a Land does not have its own regional promoting law, the federal social housing promotion law continues to apply[376]. Furthermore, in order to compensate the financial loss, the Federal government was still funding the Länder until 2019 (Article 143c Basic Law)[377]. • Between 2007 to 2013, the federal government paid around €518 million annually per year to the Länder. ***Evolution after 2012*** • In order to fulfil the demand for social housing, the constitution was amended in April 2019 to enable the Federal Government to provide financial assistance to the Länder from 2020 onwards. For 2020 to 2021, about €2 billion were planned as a financial aid to the Federal States[378]. The federal government has dedicated €5 billion for the social housing promotion between 2018 and 2021. In addition, with the funds from the states and municipalities, more than 100,000 social housing units could be created.[379] This helped to increase the supply and ensure affordable rents. Since 21 April 2020 and an amendment to the Basic Law, the federal government can provide the necessary financial assistance for social housing construction. €1 billion has been dedicated to this purpose on a yearly basis, until 2024.
ORGANISATION OF THE SECTOR	**<u>Definition of SGEI for social housing sector</u>** Since 2006, competencies on social housing are in the Länder's hands. Therefore, **each *Land* sets its own** legal framework in order to foster social housing. Some States have no social housing programmes while others have created their own legislative framework. The definitions of the SGEI scope for social housing in the 9 Länder that have provided their report in the SGEI Biennial Report encompass the provision of housing **for the population unable to provide themselves with accommodations such**

[376] *Mitteilung der Bundesregierung der Bundesrepublik Deutschland an die Europäische Kommission, 26.08.2020, p.13*
[377] *https://www.btg-bestellservice.de/pdf/80201000.pdf*
[378] *https://www.housingeurope.eu/resource-1323/the-state-of-housing-in-the-eu-2019*
[379] *https://www.bundesregierung.de/breg-de/aktuelles/bauen-und-wohnen-1654766*

as refugees, low-income households, single-parent families, etc [380]. The eligibility of target groups entitled to benefit from social housing programs is defined on income criteria. Länder consider that ageing population could be considered as a target group with specific housing needs (care, support etc.).[381]

The construction and provision of social housing – new constructions and renovations of existing rental accommodations - are also considered by the Länder as a service of general economic interest[382].

Synthetic presentation of the type of actors:

Federal State:

Its role is to provide financial assistance to the Länder. There is also a federal social housing promotion law that is applicable to Länder that have not defined their own regional social housing promotion law.

Länder:

They set their regional legal framework including subsidy laws as they have the legislative responsibility for promoting social housing.

Social housing providers: the sector is composed of four different categories of housing providers[383]:

- **Housing companies** (municipal or private), which provide rental cooperative dwellings;
- **Non-profit organisations** (welfare organisations)
- **Social housing cooperatives** (religious and non-religious organisations)
- **Individual builders**

The regional federations represent these stakeholders' interests, which are in turn members of the national umbrella organisation, the GdW (*Bundesverband deutscher Wohnungs und Immobilienunternehmen*).

The German housing market is characterised by the significant size of **its private rental sector**. In 2017, this sector accounted for almost 80% of the rental market. The German social housing sector is thus relatively small. According to a study released by the Critical Housing analysis, "*the sector must be defined functionally as rental dwellings currently subsidised in a social housing programme comprising*

[380] *The target group of social housing is defined in the biennial national report on the SGEI implementation that Germany must send to the European Commission.*
[381] *Contribution from Germany (Federal Ministry for Economic Affairs and Energy, in charge of State aid control policy and Länder of Brandenburg, Bavaria, Hamburg, Bremen, North Rhine Westphalia), December, 4th, 2020.*
[382] *Ibid.*
[383] *UN Habitat, Financing Affordable Social Housing in Europe, 2009*

	special subsidies, rent ceilings and occupancy commitments"[384]. The situation is the same for the social housing market since private owners are also overrepresented by owning three fifths of the social rental housing stock. Private owners have gained a significant role by applying for public funding or by taking over public housing companies. One of the main factors explaining the growing privatisation of the social housing market is the **privatisation *of the Wohnungsgemeinnützigkeit* (the public interest housing)**. These entities, the "social landlords", were important suppliers of social housing. Private providers are now eligible to public funding and have taken over the stock of social housing public providers[385]. A German specificity is the existence of a *quasi-social housing* construction of municipal housing stocks. They are legally outside the regulations of social housing but are often subject to similar rental and occupancy regulations due to political decisions of their public shareholders. This quasi-social housing is composed of large parts of the complex housing construction of the former German Democratic Republic GDR as well as a part of the stock which previously belonged to the social housing stock and after a few decades fell into the general market[386]. ► **Competition in the sector:** As stated above, in Germany the social housing market is mostly composed of private actors since around three fifths of the social rental housing stock have private owners. As for the remaining stakeholders, although they are public ones a significant share of their stock is privately financed[387]. On a broader perspective, structural factors have been detrimental to the social housing market: over the recent years, low rates of interest on capital for privately financed housing construction projects also outside the social housing market have led to detrimental competition conditions for the social housing sector.

[384] *Stefan Kofner, Social Housing in Germany: an inevitably shrinking Sector?, Critical housing analysis, 2017 (http://www.housing-critical.com/home-page-1/social-housing-in-germany-an-inevitably-shrinki)*
[385] *Ibid.*
[386] *After a few decades the social housing stock which is subject to specific terms and arrangements fall into the general market, which is regulated by rental legislation.*
[387] *Stefan Kofner, Social Housing in Germany: an inevitably shrinking Sector?*

FUNDING OF THE SECTOR	**Funding arrangements** ► **Social housing programmes are *Länder's* competencies**. However Länder still receive a financial compensation from the Federal State (see section on legislation); ► **Expenditure towards housing allowances** have gained importance over the subsidies for building ("*In 2000 expenditure for housing allowances for the first time surpassed expenditure for bricks-and-mortar subsidies*"[388]) **Aid granted as part of the SGEI package:**  The total amount granted as part of the SGEI Package for 2016 & 2017 and reported in the biennial report was €2.7 billion.
SOURCES	• OECD, State of Health in the EU Germany Country Health Profile 2019 • Commonwealthfund, 2019. Germany country profile. • OECD database, government expenditures. • Housing Europe, 2019. State of the housing in the EU. • OECD database, Public Policies towards affordable housing. • Stefan Kofner, Social Housing in Germany: an inevitably shrinking Sector?, Critical housing analysis, 2017 (http://www.housing-critical.com/home-page-1/social-housing-in-germany-an-inevitably-shrinki) • Jan Kuhnert, Olof Leps: *Es ist Zeit für eine neue Wohnungsgemeinnützigkeit*. In: *Neue Wohnungsgemeinnützigkeit*. Springer Fachmedien Wiesbaden, 2017 *Mitteilung der Bundesregierung der Bundesrepublik Deutschland an die Europäische Kommission, 26.08.2020.*

[388] *Xing Quan Zhang,Financing affordable social housing in Europe, 2009 (https://www.researchgate.net/publication/342145750_Financing_Affordable_Social_Housing_in_Europe).*

10.5 Ireland

Member State: Ireland

Fiche Overview

	Health	Social Housing
Expenditure relating to health and social housing SGEIs	• In 2019, €23.8 billion were spent in health expenditures (6.8% of GDP), most of which was funded by the government (74%), with the balance funded by private sources through voluntary healthcare payment schemes [389] (14%) and household out-of-pocket (OOP) expenditure (12%). • In 2019, the amount of stamp duties collected through the Risk Equalisation Scheme based on the SGEI Package was estimated to be €757 million and the amount of credits paid was estimated to be €737 million[390].	• Total public expenditure on housing in 2018 was €2.08 billion, which is just 4% below peak level of 2008 as output has started to increase in line with Rebuilding Ireland targets. [391] National budget allocated for social housing the same year was €1.14 billion. • €6 billion were committed by the Irish government to support the delivery of 50,000 additional social housing homes from 2016 to 2021 (Rebuilding Ireland programme) and €11.6 billion over the 2018-2027 decade (National Development Programme). • State aid granted under the 2012 SGEI package towards social housing recipients amounted to only €55,390 in 2019 against €5,048 in 2012.
Key actors	• The Irish Government An Roinn Sláinte Department of Health • Regulatory actors An tÚdarás Árachas Sláinte The Health Insurance Authority • Private health insurance providers Vhi HEALTHCARE AVIVA laya healthcare proudly part of AIG	• The Irish Government An Roinn Tithíochta, Pleanála agus Rialtais Áitiúil Department of Housing, Planning and Local Government • Local Authorities Údaráis Áitiúla Éireann Local Authorities Ireland • Approved Housing Bodies oaklee housing clúid housing circle

[389] *Category in OECD and Eurostat databases which includes voluntary health insurance, Non-profit institutions financing schemes and Enterprise financing scheme*
[390] *https://ec.europa.eu/competition/state_aid/cases1/20214/288485_2230782_97_2.pdf*
[391] *Daniel O'Callaghan, Paul Kilkenny, Spending Review 2018 Current and Capital Expenditure on Social Housing Delivery Mechanisms, 2018, (https://assets.gov.ie/7306/1c928b26874e4433b3d11c1172702528.pdf)*

	• Healthcare services providers  [392] Feidhmeannacht na Seirbhíse Sláinte Health Service Executive	• Public funding provider HFA Housing Finance Agency Gníomhaireacht Náisiúnta um Bhainistíocht Sócmhainní National Asset Management Agency
Structure of health and social housing	• The Department of Health sets the strategy and regulations related to healthcare. • Healthcare is two-tier i.e. public (mostly run by the Health Service Executive (HSE)) and private, with eligibility depending on residency, age and socioeconomic status. • Voluntary public hospitals are important players in the Irish healthcare system. These are sometimes owned by private bodies, e.g. religious orders, but are often mostly funded by the State. Other voluntary public hospitals are incorporated by charter or statute and are run by boards appointed by the Minister for Health. There is in practice very little difference between public and voluntary hospitals. • Almost half of the population buys private insurance, because they are not eligible to a medical card and/or to bypass long waiting lists in the hospital public system. Such insurances are regulated by the Health Insurance Authority (HIA). • Medical Card holders (32.4% of the population in 2018) and General Practitioner Visit Card holders get reduced costs on health services based on certain conditions.[393] • Private health insurance services are recognised as SGEI given their role,	• The Irish Government sets the strategy, provides guidelines, legal certainty and full funding to all public structures providing social housing. • Local authorities are the biggest landlords in the State and the main providers of social housing at the county / regional level • Approved Housing Bodies (AHBs) - approximately 520- also play an increasing role in providing social housing, in collaboration with local authorities • Social housing is delivered through 5 main mechanisms i.e. construction, acquisition from private market developments, leasing, Rent Accommodation Scheme, Housing Assistance Payment.

[392] *Hospitals, health centres, ambulatory services and long-term residences.*
[393] *To qualify for a medical card, weekly income must be below a certain figure for the family size. Cash income, savings, investments and property (except for your own home) are taken into account in the means test. If the individual does not qualify for a medical card on income grounds, they may qualify for a GP visit card.*

	as per the BUPA law-case[394] as well as previous EC's decisions, and fall under SGEI obligations.	
Main conclusions	Ireland is the only country in the EU without universal **healthcare** coverage. With the Sláintecare Report of 2017, the government committed to the development of a 10-year plan for health reform through political consensus aiming to deliver a deep system reform and universal healthcare. Effectiveness of primary care access and hospital capacity are key tensions[395].	The social housing market in Ireland is going through major changes. Provision of social housing has transitioned from the direct provision of units by local authorities and cooperatives (AHBs), to reliance upon and collaboration with the private rented market via news funding schemes (acquisition, leasing, payments). Overall housing stock has been increasing due to major government programmes, but both social housing and affordable social housing needs must still be addressed. The Irish Government's strategy for the next years consists in maintaining the Level of Local Authority Social Housing, ensuring accelerated and flexible delivery of new social housing units with increased reliance on the private sector and AHBs as well as the identification / extension of financing schemes.
I Health Sector The aim of this Section is to provide an overview of the health sector in Ireland as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.		
KEY FIGURES	**Number of hospitals and beds (and evolution)[396]** When measured against other OECD countries, Ireland has a rather low supply of hospital beds[397] and records the highest rate of patient bed occupancy at 95%.	

[394] *Judgment of the Court of First Instance of 12 February 2008, British United Provident Association Ltd (BUPA), BUPA Insurance Ltd and BUPA Ireland Ltd v Commission of the European Communities, Case T-289/03, ECLI:EU:T:2008:29*

[395] *In 2014, waiting lists were the second reason for unmet medical needs, after financial incapacity. (Eurostat)*

[396] *The evolution of the number of sites and beds only regards the "2012-2018" period because of a break in time series in 2009. Until 2008, data included publicly funded acute hospitals, district/community hospitals, geriatric hospitals and psychiatric hospitals. Private short-stay hospitals were excluded. Since 2009, data refers to public and private general hospitals (HP1).*

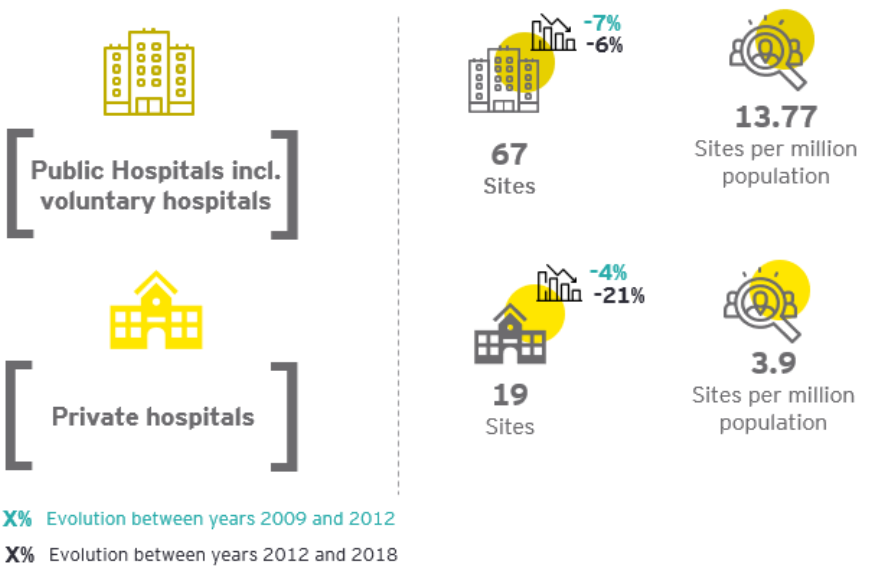
[397] *Fourth-lowest number of hospital beds relative to its population amongst OECD countries in 2018. Source: OECD, Health at a Glance Report, 2018*

The expected rapid growth and the ageing of the Irish population is projected to increase demand for hospital care further. Between 2015 and 2030, researchers from the Economic and Social Research Institute[398] projected a need for between 4,000 and 6,300 beds in public and private hospitals combined (increase of between 26.1% and 41.1% over the period). The trend since 2012 seems to support this direction as there has been an increase of almost 24% between 2012 and 2018, after a period of decrease (-9%) between 2009 and 2012, mainly because of financial constraints associated with the 2008 economic recession. Alternatively, the number of sites decreased during the same period (-9% between 2012 and 2018). The Irish Government committed in its National Development Plan 2018-2027 to increase public acute bed capacity by 2,600 in the years to 2027.

Number and share of hospitals and beds (and evolution) per legal entity[399] [400]

Public hospitals are funded, run and managed by the Health Service Executive (HSE), and account for most hospital sites in Ireland. The private hospital system, however, plays an important and interconnected role in meeting demand for hospital care in the Irish system as it represents almost 22% of all hospital sites in Ireland.

[398] *C. Keegan, A. Brick & al., How many beds? Capacity implications of hospital care demand projections in the Irish hospital system, 2015-2030, ESRI Research Bulletins, (https://doi.org/10.1002/hpm.2673)*
[399] *Missing data for the breakdown of beds by legal entity. The evolution of the number of sites and beds only regards the "2012-2018" period because of a break in time series in 2009. Also, categories proposed i.e. publicly owned hospitals and privately owned not-for-profit hospitals do not satisfactorily represent the nature of the Irish acute public hospital system as public voluntary hospitals can also be sometimes privately owned.*
[400] *Data for number of private sites prior to 2009 is not available. Data for number of public hospitals prior to 2016 is not available. This infographic is subject to further research.*



The number of sites decreased in all sectors. In the 2009-2012 period indeed, the number of public and voluntary hospitals decreased by 7% against 4% for private hospitals. In the following period (2012-2018), number of public and voluntary sites decreased by 6%, and by 21% in the private sector (which represents 5 sites). Despite this trend regarding the number of sites, between 780 and 1,200 additional hospital beds are expected to be required in the private hospital system by 2030.

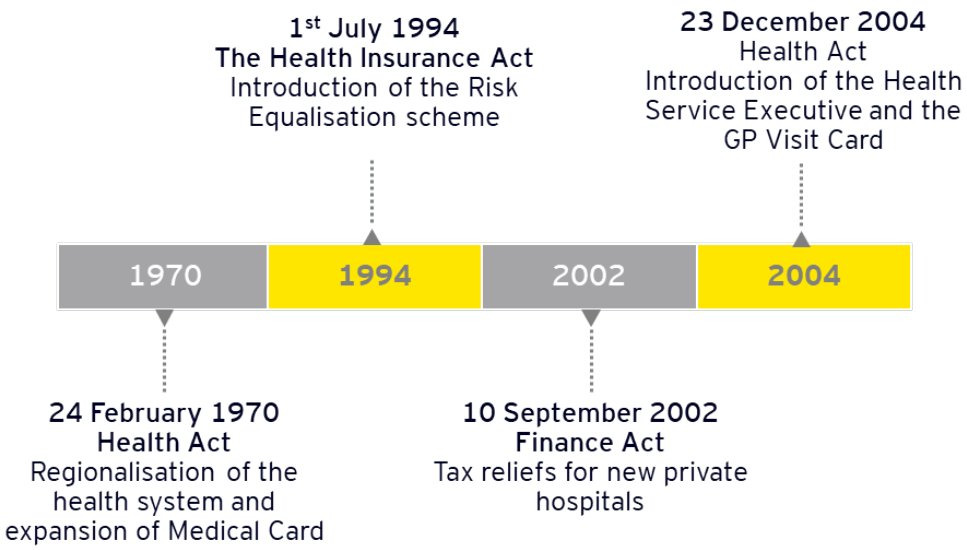
Voluntary hospitals -publicly or privately owned- are also of historic importance in the Irish healthcare system. These structures employed approximately 25,000 healthcare professionals in 2017. The annual budget for voluntary hospitals in 2017 was just under €2 billion, or 44% of total HSE funding for hospital services[401].

► **Evolution of private health insurance coverage**

	Private health insurance (2018)	Evolution 2005 - 2012	Evolution 2012 – 2018
%	45.7%	-5.5 percentage points	constant
Number (in million)[402]	2.22	-0.4%	+6%

There were 2.22 million people insured in 2018, representing an increase by 6% since 2012. In terms of share, 51.2% of the population was covered in 2005. This share decreased by 5.5 percentage points in the 2005-2012 period, and then was constant during the 2012-2018 period. According to the 2019 Country Health Profile for Ireland[403], voluntary health insurance plays a bigger role in Ireland than in the rest of the EU. In 2017, it accounted for 13% of the health funding against 4% for the EU average. It also has an impact on the households' OOP payments as people use their insurance for health expenditure. However, the coverage of the population

[401] *Voluntary Healthcare Forum (https://www.voluntaryhealthcareforum.ie/about-the-vhf/value-contribution/)*
[402] *The Health Insurance Authority, Market Statistics (https://www.hia.ie/publication/market-statistics)*
[403] *Report from the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission*

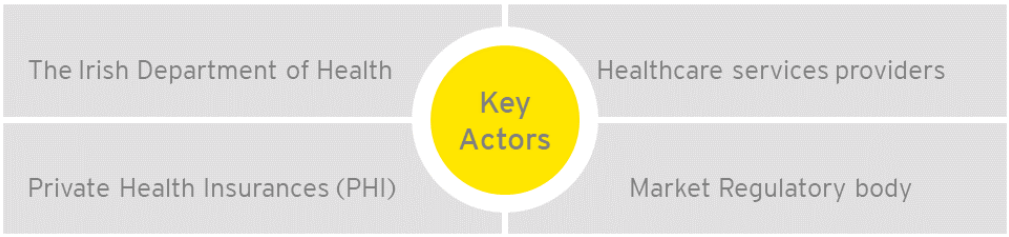
	is unequal. Private health insurances are more concentrated in higher socioeconomic groups. This could be explained by government subsidies through tax credit and by the fact that these socioeconomic groups are usually not medical and/or GP card holders. ► **Further key figures** • Medical Card holders[404] among the population (2019): 1.57 million or 32 % (lowest rate since 2008) • Share of GP Card holders[405] among the population (2019): 10%, which is 4 times higher than in 2008 • Share of the population with free access to GP and nurse care: 42 % (2017) down from 44 % in 2012 Reported unmet needs (2017): over 2.5% of the people surveyed (EU average: 2%) which doubles for low-income citizens
LEGAL FRAMEWORK	**Synthetic presentation of the evolution of the legal framework**  ***Evolution of the legal framework before 2012:*** **The Health Act 1970**[406] was a significant development in Irish healthcare as it introduced the regionalisation of Irish health with the county structure being disbanded and replaced by eight health boards[407]. This aimed at delivering an integrated and regional health system. The medical card system was also reformed with entitlement expansion.

[404] *The Medical Card allows for vulnerable residents to access primary care and hospital services free of charge but also medicines with limited co-payments.*
[405] *The GP visit card is available to everyone aged over 70 without an income test. It is also available for Irish residents under 70, based on means test i.e. income limits. GP Visit Card holders are exempted from GP charges but still need to pay for hospital services and medicines.*
[406] *The Health Insurance Authority, 2018, (The Irish healthcare system: A Historical and Comparative Review,)*
[407] *The number of boards increased to 11 in later years and until 2005 with the creation of the HSE.*

	Private health insurance is regulated by **The Health Insurance Act, 1994-2015**[408] which also introduced a risk equalisation scheme[409] to incentivise the insuring of otherwise "unprofitable" or risky individuals. In 2003, the European Commission decided that the Risk Equalisation Scheme does not constitute State aid. [410] With regards to the private health hospital system, tax reliefs were introduced (starting 2002) to encourage the financing of new private hospitals which led since then to an **increase in private hospital capacity / beds.** Today, the public healthcare system is mainly governed by the **Health Act 2004-2020**[411] which established the Health Service Executive in 2004 – a single national entity responsible for the provision of public healthcare services replacing the 11 regional boards created in 1999- but also the GP Visit Card (2005), and other provisions. ***Evolution of the legal framework after 2012:*** The Sláintecare report from 2017 discusses several reform propositions, some of which might be subject to new legislations in the near future. Amongst the suggested transformative reforms, we can mention the idea to rely further on community-level health structures and providers (primary care centres, GPs…) rather than public hospitals. The recommendation for greater cooperation between public and private hospitals to provide healthcare but also the reorganisation of the HSE into 6 regional boards with more autonomy in decision-capacity were also mentioned[412].
ORGANISATION OF THE SECTOR	► **SGEI in the sector** The SGEI regards the provision of private medical insurance through the Risk Equalisation Scheme. In Ireland, private medical insurers cannot establish the level of premium paid by an insured person based on their age, gender and/or health status. The objective of the Risk Equalisation Scheme is to address the differences of costs between insurers due to the health of their members. A stamp duty is levied against health insurers based on the number of insured lives by age (under or over 18) and the type of cover (non-advanced cover refers only to public hospitals and advanced cover include private hospitals). It is then redistributed to insurers inter alia by way of a credit for hospital utilisation (overnight or day case).

[408] *The Health Insurance Act was amended, clarified and enriched 7 times over the years (last to date: 2015). 4 principles are instituted: four principles of private health insurance in Ireland. They are: lifetime community rating, open enrolment, lifetime cover, minimum benefit.*
[409] *Risk equalisation is a process that aims to address differences in insurers' claim costs that arise due to variations in the health status of their members. Risk equalisation involves payments to or from insurers related to the risk profile of their membership.*
[410] *State aid N 46/2003. Risk Equalisation Scheme in the Irish Health Insurance Market). See: https://ec.europa.eu/competition/state_aid/public_services/2016_2017/ireland_en.pdf*
[411] *The Health Act was amended, clarified and enriched several times since its enforcement in 2005.*
[412] *These highlights were provided by a public hospital group's representative during our interview phase.*

Synthetic presentation of the type of actors:



- **The Department of Health's** role is to provide strategic leadership for the health service and to ensure that government policies are translated into actions and implemented effectively.
- Healthcare services are eventually performed by public **HSE hospitals, public voluntary hospitals, private hospitals**, **long-term facilities**[413], **ambulatory healthcare providers**, **GPs** and healthcare centres in towns and villages across the country (run by the HSE). **The HSE** is responsible for providing health and personal social services to everyone living in Ireland, under the aegis of the Department of Health. It is Ireland's largest employer (100,000 workers), it has 32 local offices and it holds the largest annual budget of all public sector organisations (€16 billion).
- **Private health insurances (PHI)**: health insurance is used to pay for private care in hospital or from health professionals in hospitals or in their practices. The arrangements vary from one company to another but most companies have agreements with hospitals to pay the hospital directly. Only four companies offer private insurance in Ireland: Irish Life Health, Laya Healthcare, VHI Healthcare and the Hospital Saturday Fund (HSF).
- **The Health Insurance Authority (HIA)** established in 2001, is the Irish statutory regulator of the private health insurance market. Its role is mainly to monitor the health insurance market and advise the Minister of Health, but also to ensure the Health Insurance Acts are well-implemented, and to raise awareness amongst the general public about their rights. Overcompensation is regularly checked by the HIA.

► **Competition in the sector:**

Competition in the healthcare sector has significantly evolved in Ireland with the presence in the Irish market of a number of private healthcare providers. Nevertheless, the Competition Authority in 2007 identified constraints in the private health insurance scheme due to it being a voluntary system and based on the concept of intergenerational solidarity. The Competition Authority found that "the legislative and regulatory framework designed […] significantly limits the scope for competition in private health insurance". The Authority found that elements such as lifetime cover and risk equalisation prevented many of the key features of competition in the market from emerging in private health insurance.[414]

[413] *including. nursing homes and residential facilities.*
[414] *Full analysis provided in 'Competition in the Private Health Insurance Market' January 2007 – The Competition Authority*

FUNDING OF THE SECTOR

Funding arrangements

The current Irish system is a multi-payer system i.e. several types of organisations purchase healthcare for different segments of the population.

It is primarily a tax-financed public system i.e. it is financed for its major part by the Irish State's own treasury ("government expenditures"). Health expenditures are however and to a significant extent also covered by private insurances purchased by households in addition to their entitlement to public healthcare services. The existence of such "voluntary healthcare" expenses is partly explained by the current issue on access to public healthcare services – citizens sometimes use this complementary insurance as a way to bypass long waiting lists in public hospitals. For the public system, medical cards can be assigned to citizens who are eligible under specific means-tested criteria.[415] Households OOP payments consist in payments made by service users at the point of use.

Health expenditure

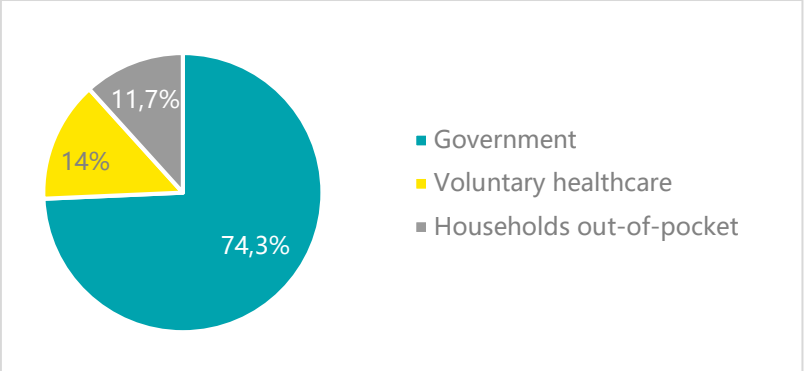
	Amount of expenditure 2019 (in € billion)	Evolution 2005 - 2012	Evolution 2012 – 2019
Total Health expenditure	23.80	+43.8%	+27.3%
Hospital cares expenditure	8.35	NA[416]	+27.8%

- During the late 1980s and early 1990s, the Irish health system went through important cutbacks in health expenditure which led for example to the closure of thousands of hospital beds, with the number of beds per population now below the OECD average (see "Key Figures" section above). Some consequences of this underfunding are still felt but the general trend goes in the direction of recovery.
- Total health expenditures have steadily increased between 2012 (€18.7 billion[417]) and 2019 (€23.80 billion[418]), especially towards hospital cares expenditures, part of which is explained by the 10-year commitment plan announced in 2017 (Slaintecare). However, the equivalent shares of GDP have decreased in the same period (10.7% in 2012 v. 6.8% in 2019). In fact, Ireland's health spending as a percentage of GDP was below the OECD average before 2007, but rose above it in 2008, not merely because of higher health spending but because of the economy contraction. Similarly, health spending as a percentage of GDP particularly declined sharply in 2015, despite an increase in health spending, as Irish GDP increased by 26%[419].
- Historic underspending, capacity constraints, a lack of universal primary care and long waiting lists all contribute to Ireland getting poorer value for money

[415] *Further information on medical cards available at https://www2.hse.ie/services/medical-cards/medical-card-application-process/what-a-medical-card-covers.html*
[416] *No data available (Eurostat) prior to 2011.*
[417] *OECD, Current prices, current PPPs*
[418] *ibid*
[419] *B. Turner, Putting Ireland's health spending into perspective, The Lancet, Correspondence| volume 391, issue 10123, p833-834, 2018, (https://doi.org/10.1016/S0140-6736(18)30461-6)*

in its health system. The European Commission has expressed concerns about the cost-effectiveness and sustainability of the Irish health system in 2017[420].

Distribution of health expenditure per category of funder:



The health system is mainly tax-based in Ireland, as more than 74% of health expenditures are funded by the Government.

Private Health Insurances play a more important role than in all other EU Member States (around four times higher) except Slovenia[421], which partly explains the important share of expenditures associated with such financing scheme (almost half of the population is covered by a private insurance as mentioned in sections above)

Despite these two funding schemes, households' payments account for 11.7% of total expenditures, which refer to direct payments, cost-sharing for services outside the benefit package and informal payments. This share is still below the EU average (app. 16%), as people will mostly use their private insurance to cover expenses. However, Ireland is unusual internationally as a relatively high proportion of the population must pay high charges to visit a general practitioner (GP[422]). High charges lead many people to put off seeing a GP on cost grounds (see "reported unmet needs" statistics in "Key Figures" section).

Evolution of the distribution of health expenditure:

The table below provides complementary information concerning funding and more specifically the evolution of the share per funding scheme of the health expenditure.

	2005 - 2012	2012 - 2019
Government	-7 percentage points	+2 percentage points
Households out-of-pocket	constant	-2 percentage points
Voluntary (insurance payment)	+6 percentage points	Constant

[420] *European Commission, Commission Staff Working Document. Country Report Ireland. Including an in-depth revise on the prevention and correction of macroeconomic imbalances. European Commission, Brussels 2017, (https://ec.europa.eu/info/sites/info/files/file_import/2019-european-semester-country-report-ireland_en.pdf)*

[421] *OECD, Health at a Glance, Country Health Profile: Ireland, 2019,(https://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm)*

[422] *The majority of GPs provide services on behalf of the HSE, to people with Medical Cards, GP Visit Cards and other schemes. Most people who do not have a medical card or GP visit card will pay a fee for a GP visit.*

Similar total health expenditures, the Irish Government has been dedicating each year since 2012 a smaller share of its GDP towards healthcare services (7.7% in 2012 v. 5.1% in 2019 i.e. -2.6percentage points). However, spending in absolute amounts has been steadily increasing (€10.3 billion in 2012 v. € 17.60 billion in 2019 i.e. +31%) which is linked to an important increase in GDP in the past decade. To note is the change in trend in public spending towards health services, which went from a decreasing dynamic from 2005 to mid-2000s, to an increasing one since then.

Voluntary health expenditures, mainly for Private Health Insurances purchase increased between 2005 and 2012 (+4%). Since 2012, they have been slightly fluctuating (peaking 15% in 2015,) and steadily decreasing to attain their initial 2012 share in 2019 (14%).

The share of households' OOP payments was constant between 2005 and 2012 (14%) and then decreased by 2 percentage points from 2012 to 2019 (12%[423]) while the government spending increased by 2 percentage points. In 2018, the share of households' OOP payments in Ireland was lower than EU average (12% against 15.8%).

► ***Amount of stamp duties and credits[424]***

In 2019, the amount of stamp duties collected through the Risk Equalisation Scheme based on the SGEI Package was estimated to be €**757 million and the amount of credits paid was estimated to be € 737 million**.

II. Social Housing

The aim of this Section is to provide an overview of the social housing sector in Ireland as well as to present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

The infographics below shows the main key figures with regards to the social housing sector in Ireland. [425][426]

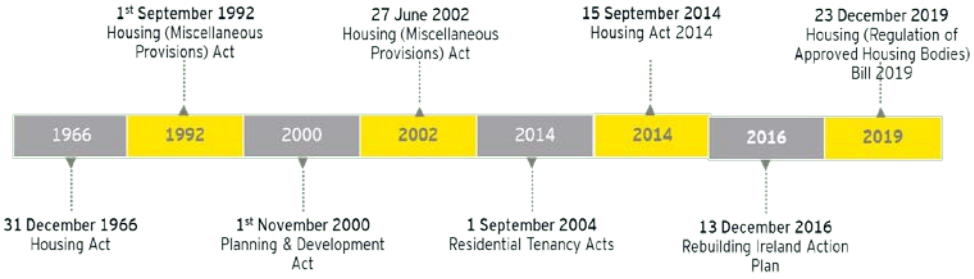
[423] *Provisional value*
[424] *https://ec.europa.eu/competition/state_aid/cases1/20214/288485_2230782_97_2.pdf*
[425] *Social housing units are estimated numbers from Corrigan, E. and Watson, D. (2018). The latest reported data is for 31 December 2016. The Department does not report the housing stock i.e. the total number of social housing units on hand. It does report the number of units being rented by local authorities to tenants, but this does not include the number of units being rented by the AHBs. Source: (https://www.audit.gov.ie/en/Find-Report/Publications/2018/2017-Annual-Report-Chapter-10-Funding-and-oversight-of-approved-housing-bodies.pdf)*
[426] *Percentage of households renting in the subsidised sector is extracted from the OECD Affordable Housing Database and is reported for 2018.*

	Note: Social housing stock essentially covers dwellings which are directly built or bought by the 31 Local Authorities (LA) and the 520 active Approved Housing Bodies (AHB)[427], old vacant social housing which has been brought back into active use, regeneration projects, social housing provided by private developers as part of their "Part V" obligations, and homes which are leased long-term (10-25 years) and where the LA or AHB is the landlord. In 2010, there were 2 social dwellings per 1,000 inhabitants, which rose to more than 5.5 social dwellings per 1,000 inhabitants in 2018 (+3.5 units). In fact, between 2010 and 2018, the **annual number of dwellings added to the social rental stock** through construction and acquisition increased in Ireland more than in any OECD countries on the same period[428]. However, the share of social rental dwellings within total housing stock only slightly increased between those two years, which indicates a general increase in stock for all types of dwellings. The **net need for social housing (supports)** [429] in 2019 was 68,693, which is -4.4% compared to 2018 and -23% compared to 2013. This is mainly explained by the fact that social housing output has been increasing in the past 5 years - after a continuous decrease since the Great Recession of 2008[430]- especially since the Rebuilding Ireland programme launched in 2016. Indeed, in 2014, less than 5,000 social dwellings were delivered, which almost quadrupled in 2016 (18,000). This decreasing number for social housing need could be further explored with national and local stakeholders. After significant retrenchment in the housing budget during Recession, which has seen Exchequer funding[431] fall by approximately 60% between 2008 and 2014, there has been a major shift away from resource intensive capital investment in building towards leasing and renting solutions, with increasing reliance on the private market. **The growth in use of the private sector for socially**-supported housing rose from 28% in the boom years to 42% during the recession before dropping back to 32.3% by 2016. In fact, in 2005, there were 61,000 socially-supported dwellings, which rose to 108,000 in 2011 and decreased back to 82,000 in 2016. The government set an output targets of 47,000 new long-term social housing homes by 2021 and flexible housing supports to an additional 87,000 households through the Housing Assistance Payment (HAP) and Rental Accommodation Scheme (RAS) between 2016 and 2021.
LEGAL FRAMEWORK	**<u>Definition of social housing in the Member State</u>** No official definition of "social housing" has been provided by Irish legislation. However, the Irish Department of Housing understands it as the provision of "appropriate and decent housing via defined providers -AHBs and local authorities- for lower income and social disadvantaged population groups, at an affordable cost,

[427] Additional 200 not for profit organisations are registered as AHBs, but not always very active.
[428] OECD, Social Rental Housing Stock, 2021, (https://www.oecd.org/els/family/PH4-2-Social-rental-housing-stock.pdf)
[429] 'Net Need' or the 'Total Number of Households Qualified' refer to the total number of households qualifying for social housing support whose social housing need is not being met.
[430] The Irish economy was one of the most severely affected by the 2008 crisis, especially in the health and real estate sectors.
[431] Annual exchequer funding is the main accounting aggregate/fund at the Irish State-level, which provides for the revenues and expenses of public departments. Revenues typically consists in tax and non-tax revenues, EU receipts and other capital receipts while expenditure includes Departmental/office spending, wages and pensions of the President, the C&AG, and the judiciary, running costs of the Oireachtas, debt servicing costs, and EU Budget payments.

with adequate standards as regards size, design and specifications"[432]. It also comprises the "provision by Government of housing supports -in the form of financial support- for those assessed as unable to provide for accommodation from within their own resources".[433] Income thresholds and "social disadvantage" categorisation depend on local authorities' assessment which will take into account various parameters for the household (resources, household composition, citizenship/permit of residence, housing situation, specific situations e.g. disability…). In principle, "households must not have previous rent arrears and there must be no suitable alternative accommodation available to the household"[434]. Eligibility criteria for housing support applications are different for each scheme (HAP, RAS,…).

Synthetic presentation of the evolution of the legal framework



Social housing is mainly regulated by several versions of the Housing Act. For example:

- 1966 Housing Act empowers local authorities to allocate publicly owned dwellings according to a scheme of letting priorities, with preference to households in greatest need.
- 1992 Housing Act enables local and national authorities, to provide assistance to AHBs for the provision of housing. The Minister grants approved status for this purpose.
- 2002 Housing Act enables the HFA to lend funds to local authorities.
- Part V of the Planning Act 2000 is a mechanism whereby local authorities can acquire land zoned for housing development at "existing use value" rather than "development value" for the delivery of social and affordable housing.
- Residential Tenancies Acts 2004-2019 also introduced schemes such as the Rental Accommodation Scheme (RAS, 2004) and the Housing Assistance Payment (HAP, 2014) to support households in the private rented sector.
- This reliance on the private sector to provide social housing had already been affirmed in 2011 with the introduction of the Social Housing Current Expenditure Programme (SHCEP) (see "funding" section below).
- The Social Housing Strategy 2020, published by the Government in November 2014, provided a framework for off-balance sheet delivery of social housing units underpinned by a multi-annual capital and current

[432] *Definition for 'affordable cost' will be further explored with stakeholders' interviews.*
[433] *Social Housing Support provided by local authorities (https://www.housing.gov.ie/housing/social-housing/social-housing-support)*
[434] *OECD, Key Characteristics of Social Housing, 2019, (https://www.oecd.org/els/family/PH4-3-Characteristics-of-social-rental-housing.pdf)*

housing programme. This acknowledged the potential leveraging of off-balance sheet mechanisms and Public Private Partnership (PPP) procurement opportunities to deliver social housing.

- With the Rebuilding Ireland435 Action Plan announced in 2016, the Irish government committed to the provision of new funding, initiate facilitating legislative reforms and significantly increasing social housing (and overall housing) supply, with 47,000 long-term social housing homes through Build, Acquisition and Leasing programmes and, a further 87,000 flexible housing supports through the HAP and RAS between 2016 and 2021.
- Housing (Regulation of Approved Housing Bodies) Bill 2019 provides for the regulation of Approved Housing Bodies (AHBs) to ensure the proper governance and the financial viability of that sector, given its reception of governmental funds.

ORGANISATION OF THE SECTOR

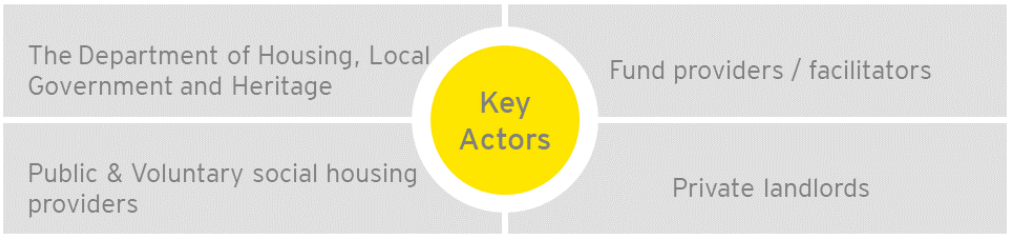
► **SGEI in the sector**

SGEI consist in funding through loans from the HFA to:

- Local authorities: acquisition, building and maintenance of social and affordable housing,
- AHBs: buying or building houses, that will be leased to local authorities. The loan is raised by the AHB with a guaranteed revenue stream taken out by local authorities up to 30 years (Payment and Availability Agreement or "PAA"),
- Higher Education Institutions (HEI): development of student accommodations in order to use existing rental stock freed up by these developments for social and affordable housing.

Up to 2012, the HFA only lent to local authorities. It lends to AHBs since 2012 and to HEI since 2019. The aid granted represents a 0.10% margin of the amount advanced, meaning the aid element is very low.

Synthetic presentation of the type of actors:



► **The National Department of Housing**, **Local Government and Heritage** is responsible for developing the regulation of the housing provision as well as financially supporting local authorities for their approved social housing programmes through capital grant subsidy transfers

[435] *Rebuilding Ireland, Action Plan for Housing and Homelessness, 2016, (https://rebuildingireland.ie/wp-content/uploads/2016/07/Rebuilding-Ireland_Action-Plan.pdf)*

► **Fund providers / facilitators:**

- **The Housing Agency** -a non-commercial government agency- provides the services for, and on behalf of, the Minister of Housing, Local Government and Heritage, and each local authority in the performance of their functions under the Housing Acts. It supports the delivery of housing policy as well as housing practitioners through advisory services, legal services, communication and good practices, data production.
- **The Housing Finance Agency** (HFA) -a government agency / company- advances loans to local authorities and the voluntary housing sector (AHBs) since 2012 The HFA raises funds on the capital market at preferential terms and also provides State guarantee, which the European Commission allowed in 2004[436] and 2005.[437]
- **Under the aegis of the National Treasury Management Agency (NTMA),** NAMA facilitates contact and negotiation between private debtor or receiver and the local authority or Approved Housing Body ("AHB") to acquire the property. Its special purpose vehicle (National Asset Residential Property Services "NARPS") can also take direct ownership of properties and lease them to an AHB or Local Authority.

► **Public & Voluntary social housing providers:**

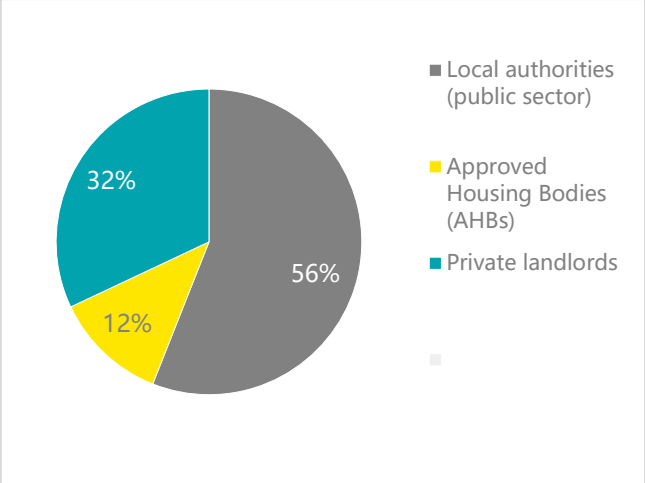
- **Local authorities (LAs)** through their Housing Services Departments have the statutory obligation to provide housing to people who are assessed as being unable to afford housing from their own resources. They can also lease and buy properties on the private market for social housing use.
- **Approved housing body (AHBs)** are not-for-profit companies (voluntary housing associations and co-operative housing societies) which can build, buy and lease properties. They use private finance to pay for housing development or to buy property. They also get State funding through local authorities to help provide housing.

► **Private landlords / developers:**

- The private sector is being increasingly involved on the social housing market, thereby supporting the delivery of social dwellings through PPPs with local authorities[438], but also through contractual arrangements with LAs and AHBs (leasing, rental payments, …)

Distribution of the market per category of providers[439]:

[436] *C (2004) 2205 final, Subject: 'State aid N 89/2004 – Ireland', Guarantee in favour of the Housing Finance Agency (HFA), 'Social housing schemes funded by the HFA', Brussels 30.06.2004.*
[437] *C (2005) 4668 final, Subject: State aid N 395/2005 – Ireland, 'Loan Guarantee for social infrastructure schemes funded by the Housing Finance Agency', Brussels*
[438] *e.g. Kilcarberry project in South Dublin or Housing Land Initiative in Dublin City providing mixed tenure units.*
[439] *As of 2016. These are estimated numbers from Corrigan, E. and Watson, D. (2018). The Department does not report the housing stock i.e. the total number of social housing units on hand. It does report the number of units being rented by local authorities to tenants but this does not include the number of units being rented by the AHBs. The latest reported data is for 31 December 2016. Source: https://www.audit.gov.ie/en/Find-Report/Publications/2018/2017-Annual-Report-Chapter-10-Funding-and-oversight-of-approved-housing-bodies.pdf*



The infographics above shows that "public" social housing is still predominant in the Irish housing sector with local authorities (LAs) owning, managing and renting more than 56% of the total social housing stock. It is almost twice the share of privately-owned dwellings associated to some form of subsidy or social housing support[440] (32%). Private landlords still account for an important share of total social housing stock, as compared to other European and OECD countries. The growth in the role of the private sector, which had begun in the boom years through the RAS programme, accelerated during the recession (see table below). In fact, researchers found that "the weak private sector supply and the reliance on the same sector [public] for the supply of social housing is likely to have contributed to the growth of homelessness"[441]which also might explain the shift towards the private sector.

Evolution of the distribution of the market:

	2005 - 2012	2012 - 2016
Local Authorities	-8%	+6.5%
AHBs	+0.5%	+0.8%
Private rented market	+7.5%	-7.3%

As presented in the section "Key figures" above, the private rented market accounted for an increasing share of total housing stock in the post-2008 crisis period. The Irish government, in its 2010 budget communication, announced a voluntary shift towards "cheaper" solutions for social housing delivery, such as "leasing" and rental supports as opposed to construction and acquisition. The private rental market rather than the traditional social housing sector filled much of the affordability gap resulting from the recession. This translated into an increase in share of total stock of 7.5% between 2005 and 2012 – peaking at 42% of market share during recession years.

Because of such constrained budgets and cuts in public funding transferred to local authorities (LAs) and AHBs, delivery of social housing dwellings significantly slowed down from those operators. Consequently, those two opposite dynamics between LAs and AHBs on one hand, and the socially supported private rental market on the

[440] *i.e. Rental Accommodation Scheme (RAS), Housing Assistance Payment (HAP)) and the Rent Supplement scheme operated by the Department of Employment Affairs and Social Protection.*
[441] *Corrigan, E. and Watson, D., Social Housing in the Irish Housing Market, Department of Housing, Planning and Local Government, 2018*

	other hand, resulted a decreasing share for LAs (-8%) on the 2005-2012, and a very slight increased share for AHBs (+0.5%) on the same period. However, since 2015 especially, the State has increased its investment in the supply of local authority and AHB-owned dwellings (respectively +6.5% and +0.8% of share between 2012 and 2016), while also supporting those with a long-term housing need to continue living in the private sector. The overall share of the latter category nonetheless decreased until 2016. ► **Competition in the sector:** While social housing is provided through public schemes, investment in social housing has been identified as the next big trend for Ireland, with a CBRE[442] report in 2020 identifying increased demand for investment in social housing with investors both from Ireland and internationally eager to acquire residential schemes and units leased to local authorities on long-term leases. The CBRE report identified one example of a long-term lease of social housing: a private institutional investor, the German fund Real IS, leased 87 units to South Dublin City Council.[443]
FUNDING OF THE SECTOR	**Funding arrangements** 3 main schemes are currently available to AHBs to support the provision of social housing[444]: • CAS (Capital Assistance Scheme): local authorities advance non-repayable loans up to 100% to assist AHBs with capital costs. • CALF (Capital Advance Leasing Facility): replacing the previous CLSS scheme[445], the CALF allows for AHBs to apply for a governmental capital advance (up to 30%). It enables them to raise remainder capital from the Housing Finance Agency or commercial banks, for the leasing, acquisition or construction of housing. • SHCEP (Social Housing Current Expenditure Programme): comprises 4 leasing schemes made by the Department of Housing, Local Government and Heritage to local authorities which transfer the funds to the AHBs, allowing them to lease housing units from the private sector and the tenant to pay a smaller rent. 3 main schemes are available to tenants to support their access to social housing: • Rent Supplement (RS): a short-term income support introduced in 1977 for people living in private rented dwellings. When income increases above a certain threshold, the RS is lost.

[442] *CBRE is an American and international real estate and investment services company*
[443] *Is Investment in Social Housing the Next Big Trend for Ireland? July 2020 CBRE*
[444] *Central Statistics Office, Review of Sector Classification of Approved Housing Bodies, Summary of Financial Schemes for Provision of Social Housing, 2017*
[445] *'The Capital Loan and Subsidy Scheme (CLSS) commenced in 1991 to provide capital funding to AHBs to meet the cost of constructing units of accommodation for renting to people on the local authority social housing waiting list. The LAs access the funding they provide to the AHBs from the Housing Finance Agency (HFA) which is repaid over a 30-year period to the HFA by the LA. In turn the LAs provide this funding to AHBs by way of a non-refundable loan as long as the AHB complies with the terms and conditions of the CLSS'. Source: https://www.cso.ie/en/media/csoie/methods/nationalaccounts/Summary_of_Financial_Schemes_for_Provision_of_Social_Housing.pdf*

- Housing Assistance Payment (HAP): the local authority pays the market rent for the household to the private landlord and the household pays an income-based rent to the local authority.
- Rental Accommodation Scheme (RAS): a long-term supplement administered by local authorities which source housing from the private rental market and enter a tenancy agreement with a private landlord and the RAS recipient.

Social housing expenditure

Social housing has been a **very small recipient of State aid** under the SGEI Package since 2012 as the aid granted represented a 0.10% margin of the amount advanced as indicated in the overview table. In 2019, this amount was € 55,390 against € 5,048 in 2012. In between, this amount was fluctuating; in 2015 & 2017, the amount was nil because of the redemption of loans.[446]

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[446] *Redemption of loans occur once an agreement entered into with the local authority which foresees capital advance ends.*

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10.6 Latvia

Member State: Latvia		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• Healthcare expenditure per capita was €1,213[447], or €1,6 billion in total (6% of GDP) in 2017. • 39% of all healthcare expenditures are out-of-pocket (OOP) expenditures, one of the highest in the EU. The State finances only 57% of healthcare services. The remaining 4% is private health insurance expenditure[448]. • Latvia granted €726.65 million under SGEI package in 2017, with €428 million being allocated to healthcare. Total healthcare spending was €839 million in the same year. The size of aid has remained relatively unchanged since 2012, when it amounted to €734.94 million, with allocation to healthcare of €332.62 million. The year-to-year change of the amount of aid granted in the 2012-2017 period fluctuated within a 5% margin in both directions.	• Social housing expenditure amounted to € 3,1 million in 2016, which is negligible both related to GDP and relative to other Member States[449]. • Latvia has an extremely low stock of social housing and low number of people using social housing. Social housing makes up less than 2% of the housing stock in Latvia. • Social housing used to fall under SGEI package for the period of 2012-2013 and received aid accordingly. Since then social housing has not been reported in the biennial SGEI Reports anymore as an SGEI. In 2013, €19.1 million was allocated to social housing under the SGEI package.
Key actors	• Ministries and their subordinates Veselības ministrija Labklājības ministrija Nacionālais veselības dienests	• Ministries and their subordinates Ekonomikas ministrija Labklājības ministrija Vides aizsardzības un reģionālās attīstības ministrija

[447] *OECD, Latvia: Country Health Profile, 2019, (https://read.oecd-ilibrary.org/social-issues-migration-health/latvia-country-health-profile-2019_b9e65517-en#page3)*
[448] *OECD statistics, (https://stats.oecd.org/Index.aspx?ThemeTreeId=9#).*
[449] *Ministry of Economy,*
Reports on municipal assistance in resolving housing issues (Pārskati par pašvaldību palīdzību dzīvokļa jautājumu risināšanā),
(https://www.em.gov.lv/lv/nozares_politika/majoklu_politika/petijumi_statistika/citi_petijumi_un_statistika/).

	• Hospitals • Funders Households ERGO aslimnica RĪGAS AUSTRUMU KLĪNISKĀ UNIVERSITĀTES SLIMNĪCA	• Funders • Providers LPSAIA Latvijas Pašvaldību savienība
Structure of health and social housing	• The Parliament (*Saeima*) has a significant role in the development of national health policy. It approves both the national budget and the budget of the National Health Service (NHS). • The Ministry of Health (MoH, *Veselības ministrija*) is responsible for national health policy and the overall organisation and functioning of the health system. The NHS, a subordinate institution of the MoH, implements State health policies, ensures the availability of healthcare services throughout the country, and is the main purchaser of publicly funded health services. • The Ministry of Welfare (*Labklājības ministrija*) is the main public authority responsible for social protection that includes some elements closely linked to healthcare, such as social care, social and professional rehabilitation, policies governing the provision of technical aids (e.g. wheelchairs) and a common policy on equal opportunities for people with disabilities. • Local governments are responsible for ensuring geographical accessibility and, depending on budget and local priorities, may	• The Ministry of Welfare is responsible for the organisation of group-homes[451]. The group-homes provide social services for their residents including increasing the self-care and social skills of residents, individual social-rehabilitation plans, personal support for gaining new skills and seeking employment as well as other necessary support such as consultations of varying nature (e.g. adaptation to everyday life), information and protection of personal interests and rights. • Ministry of Economy (*Ekonomikas ministrija*) is an executive government body responsible for enactment of economic policy in Latvia, proposes and enforces laws in their relevant sector. Responsible for housing policy. • Ministry of Environment Protection and Regional development (*Vides aizsardzības un reģionālās attīstības ministrija*) is an executive government body responsible for development and advancement of regional and municipal welfare. • Local authorities hold the main responsibility regarding social housing provision, including financing. • Social housing is notably funded by the State and municipal authorities as well as rent payments from tenants.

[451] *Ministry of Welfare, Group home (apartment) services for persons with mental disorders (Grupu māju (dzīvokļa) pakalpojumi personām ar garīga rakstura traucējumiem),(http://adm.lm.gov.lv/lv/nozares-politika/berni-un-gimene/15488-nozares-politika/socialie-pakalpojumi/grupu-majas)*

	invest in hospitals and long-term social care facilities. • Latvia has universal healthcare coverage and the healthcare system in Latvia is funded mainly through general taxation and OOP expenditure. • A mixture of payment schemes is employed in government's funding to hospitals, with hospitals being financed based on a fixed budget for specific functions (e.g. trauma care), per case payments (e.g. lump sum payment for treating a severe flu case), payments for bed-days and DRGs (Diagnosis related groups[450]).	
Main conclusions	• The economic crisis of 2008 has led to reduction in funding and thus a reduction of hospital capacity, while primary care was prioritised. • Hospital ownership is characterised by a high degree of fragmentation, where local and regional hospitals are owned by a unique municipality or set of municipalities. • A newly introduced reform set to be enacted in 2021 will introduce a separate Compulsory Health Insurance System, which would link entitlements to payment of social health insurance contributions and thus potentially increase revenues. • Latvian healthcare expenditure is one of the lowest in the EU. • Latvia has one of the lowest public healthcare expenditure proportions in the EU. Only 57% of the total healthcare expenditure is publicly funded, and private voluntary insurance expenditure at 4% of total expenditure. As a result, a large share (39%) of expenditure is	• Latvia has an extremely low stock of social housing and number of people using social housing. • Social housing used to be considered as an SGEI for the period of 2012-2013 and received aid accordingly. Since then social housing has no longer been reported as SGEI as Latvia does not consider social housing services provided individually by local governments to be of economic nature, but rather as having a social function. • Information on State and municipality budget allocation to social housing is scarce and is mostly related to data gathered by the Ministry of Economy related to municipality spending related to social apartments.

[450] *Diagnosis-Related Groups in Europe Moving towards transparency, efficiency and quality in hospitals, Open University Press, 2011, (https://www.euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf)*

covered by OOP payments

- Primary care providers are paid using a mix of capitation, fee for service (FFS), fixed practice allowances and quality payments (since 2013). Secondary ambulatory providers are mostly paid for by flat-rate fees for pre-defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutic interventions
- The recently approved National Development Plan 2027 [452] (Nacionālais attīstības plans 2027) includes healthcare as one of its priorities defining a goal of accessible, high quality and effective disease prevention.

I. Health Sector

The aim of this Section is to provide an overview of the health sector in Latvia as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

Number and share of hospitals and beds (and evolution)

Relative to other EU countries, Latvia has a relatively hospital-centric system, with a high volume of hospital discharges and a relatively low number of GP and specialist consultations per capita[453]. Both the number of beds and sites in Latvia have been decreasing since 2005, however the rate of the decrease has slowed since 2012.

The number of sites dropped by 39% in the 2005-2012 and by 7% in the 2012-2018 periods respectively. The amount of beds dropped by 32% in the 2005-2012 and increased by 11% in the 2012-2018 periods respectively. For the 2005-2016 period the number of beds per 100 000 population declined more rapidly than in the rest of the EU, but still remained above the EU average[454]. In the 2005-2012 period,

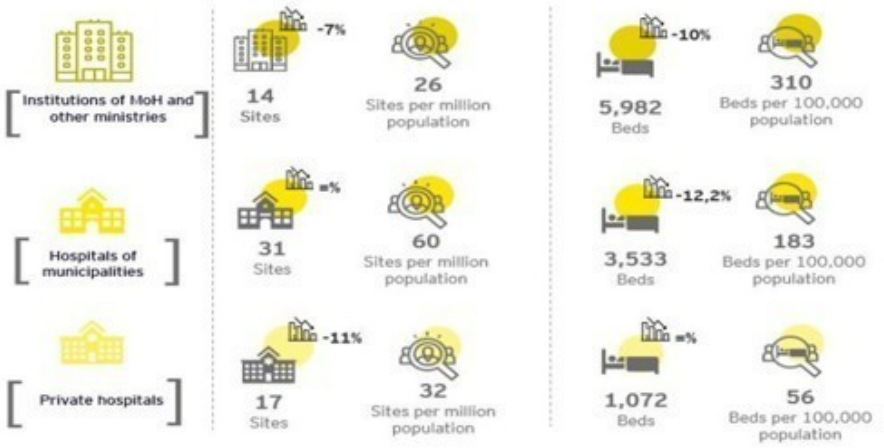
[452] *PKC, Nacionālais attīstības plāns 2027, https://www.pkc.gov.lv/lv/nap-2027/atbalsti-prioritates*
[453] *World Health Organization, Health Systems in Transition, 2019, (https://apps.who.int/iris/bitstream/handle/10665/331419/HiT-21-4-2019-eng.pdf?ua=1)*

[454] *https://ec.europa.eu/eurostat/databrowser/view/tps00046/default/table?lang=en*

the decline was more significant than in the 2012-2018 period. In 2019 the average number of beds per 100 000 population was 542 and the total number of hospital beds was 10,379[455]. Reductions in funding during the economic crisis of 2008 led to the reduction of hospital capacity, while primary care was prioritised. Recent reforms have been aimed at the concentration of specialised health services.

Number and share of hospitals and beds (and evolution) per legal entity

In Latvia, hospitals are divided by their ownership type. Hospitals are State-owned, municipality owned, or privately owned. State-owned hospitals are typically university and specialised hospitals, while regional or local level hospitals are usually municipality owned.



- Data indicates that the total **number of hospitals decreased since 2013** from 66 to 62, mostly due to a decrease in the number of State-owned and private hospitals.
- **The number of beds decreased across all types of hospitals**: by 10% in State-owned, 12,2% in municipality owned and remained the same (less than 1% change) in privately owned hospitals.
- **More than half of available beds are located in State-owned hospitals** while, private hospitals account only for a small proportion of total beds (approx. 10%), and a third are located in municipal hospitals.
- Hospitals in Latvia are divided into **five levels**, with defined mandatory and optional service profiles for each:
    - Level V are tertiary level hospitals (university or specialised), which must provide services in at least 22 care profiles (46% of hospitalisations in 2019),

[455] *SPKC, Health Statistics Database, (https://statistika.spkc.gov.lv/pxweb/lv/Health/Health__Veselibas%20aprupe__StacionaraMediciniskaPalidziba/?tablelist=true)*

- Level IV (regional) hospitals provide care in at least 13 care profiles (28% of hospitalisations in 2019)

- Level I, I and III (local) hospitals provide internal medicine, chronic care, general surgery, neurology, gynaecology, paediatrics, obstetrics and 24h emergency care profiles depending on the level (15% of hospitalisations)[456] [457].

► **Evolution of the amount of public aid**

The amount of public aid granted in Latvia under SGEI package has been stable for the 2012[458]-2017 period, with the average allocation of around €700 million per year.

Latvia's State aid amounted to €726.65 million under the SGEI package in 2017, with €428 million being allocated to healthcare. Most of the remaining funding was allocated to health and long-term care (€268.58 million). The size of aid has remained relatively unchanged from 2012, when it amounted to €734.94 million, with allocation to healthcare of €332.62 million, and allocation to health and long-term care of €211.5 million. The year-to-year change of the amount of aid granted in the 2012-2017 period is nearly unchanged, being within a 5% margin in both directions.

LEGAL FRAMEWORK

Presentation of the evolution of the legal framework

There were two major legislative changes in the Latvian healthcare system: the first in 2009, when new legislation for medical institutions was introduced and MoH began the reform to cope with the aftermath of the 2008 financial crisis, and the second in 2017, when a new reform plan was adopted.

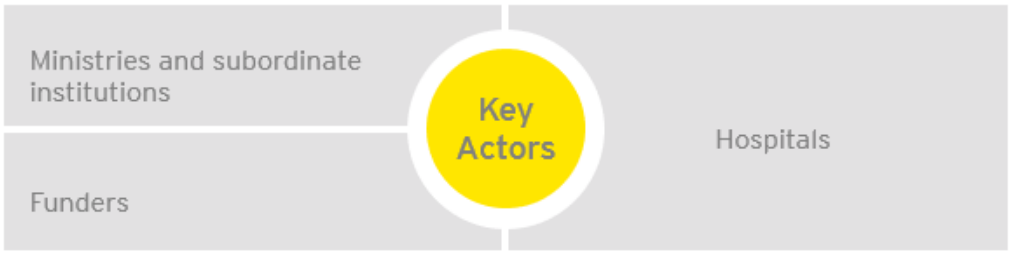
Evolution of the legal framework before 2012:

The period immediately prior to the economic crisis (2007–2008) was characterised by a process of institutional centralisation and a slow shift from inpatient to outpatient care. More hospitals were operating in the period from 2007 to 2008 than in 2017, healthcare funding was still relatively low in comparison to other Member States. From 2009–2012 a shock-type reform (healthcare spending went down from 2 546 million LVL (Latvian lats) or 3 623 million € in 2007 to 1 926 million LVL or €

[456] *SPKC, Latvijas veselības aprūpes statistikas gadagrāmata, https://www.spkc.gov.lv/lv/latvijas-veselibas-aprupes-statistikas-gadagramata*
[457] *NHS (2019). Gada publiskais pārskats: (http://www.vmnvd.gov.lv/uploads/files/5f28f7830d87b.pdf)*
[458] *The report for prior planning period is not available: (https://ec.europa.eu/competition/state_aid/public_services/reports_2016_2017_en.html)*

	2 740 million in 2010[459]), designed to primarily cope with the aftermath of the economic crisis of 2008, led to a reduction in funding and the number of hospitals (from 94 in 2007 to 66 in 2012). The number of hospitals was reduced as a result of new legislation that defined compulsory requirements for medical institutions. ***Evolution of the legal framework after 2012:*** • **Since 2013 there has been a focus on the financial sustainability of the system.** The Cabinet of Ministers introduced the "Procedures for organisation and funding of healthcare" (*Veselības aprūpes organizēšanas un finansēšanas kārtība*) after the enactment of the 2012 SGEI decision. Although references to the SGEI decision were not made directly, the content and the spirit of the Procedures correspond with the SGEI rules. • In 2016, the **Latvian Healthcare Facilities Master Plan** 2016-2025 (*Latvijas veselības aprūpes infrastruktūras ģenerālplāns 2016-2025*) developed by the World Bank Group detailed the shortcomings of the Latvian healthcare system, especially the hospital sector, and how these need to be tackled to establish a well-organised and sustainable health service network[460]. In addition to the Master Plan, in December 2016, the Cabinet of Ministers approved the "Informative Report on Systemically Important Healthcare Institution Mapping and Development Reform"[461](*Par sistēmiski svarīgo ārstniecības iestāžu kartējumu un attīstības reformu*, which was followed by the Conceptual report "On Healthcare System Reform" in 2017[462] (*Par veselības aprūpes sistēmas reformu*). **Both conceptual reports were aimed at optimisation of the hospital network based on five hospital levels referenced in section "Number and share of hospitals and beds (and evolution) per legal entity" above**. • In 2017, the Procedures were replaced by the new **Healthcare Funding Law** (*Veselības aprūpes finansēšanas likums*)**, which updated healthcare funding pledges to no less than 4% of the GDP**, as well as prohibited a year-to-year decrease in healthcare funding, except for one-off projects. In 2017, the national Parliament passed a law for the introduction of a Compulsory Health Insurance System, with the aim of increasing overall cash flow towards healthcare. Under the new system, entitlement to the full benefit basket would be linked to the payment of social health insurance contributions. However, the reform was postponed to 2022. • The recently approved **National Development Plan 2027**[463] (*Nacionālais attīstības plans 2027*) includes healthcare as one of its priorities defining a goal of accessible, high quality and effective disease prevention, diagnosis, treatment and rehabilitation to ensure good health throughout life.
ORGANISATION OF THE SECTOR	**Definition of SGEI for the hospital sector** For Latvia, hospital services fully fall under the SGEI package. Aid is granted to hospitals and long-term healthcare. The following activities fall under the SGEI package[464]: • accident and emergency medicine;

[459] *World Health Organization, Veselības sistēmas pārejas periodā: Latvija, (https://www.spkc.gov.lv/lv/starptautiskie-dokumenti/veselibas_sist_parejas_perioda_lv1.pdf#page=41&zoom=100,80,76)*
[460] *World Bank (2016). Latvia Healthcare Facilities Master Plan 2016-2025.*
[461] *Cabinet of Ministers (2016). "Informative Report on Systemically Important Healthcare Institution Mapping and Development Reform".*
[462] *Cabinet of Ministers (2017). Conceptual report "On Healthcare System Reform".*
[463] *PKC, Nacionālais attīstības plāns 2027, (https://www.pkc.gov.lv/lv/nap-2027/atbalsti-prioritates)*
[464] *Cabinet Regulation No 850 of 1 November 2011 National Health Service Regulation and the Cabinet Regulation No 1529 of 17 December 2013 Procedures for the organisation and financing of healthcare.*

	• primary healthcare; • secondary outpatient healthcare; • dentistry; • laboratory testing; • medical rehabilitation; • healthcare at home. The main national authority in the sector in Latvia is the MoH, while the funding is provided through the NHS via a single-payer system, alongside households and private insurers. **Synthetic presentation of the type of actors:**  ***Public institutions:*** • **National authority**: MoH is an executive government body responsible for healthcare system in Latvia, proposes and enforces laws in their relevant sector. • **National authority**: Ministry of Welfare an executive government body responsible for citizen welfare in Latvia, proposes and enforces laws in their relevant sector. The ministry's domain includes social and long-term care. • **National authority**: NHS a subordinate of MoH with administrative and regulatory power in Latvia's healthcare sector, which acts as the main public purchaser of healthcare services. • **Local authorities**: responsible for ensuring geographical accessibility, invest in hospitals and long-term care providers, provide social care. • **Parliament**: responsible for approving yearly budget including healthcare budget as well as changes to new and existing laws governing the healthcare sector. ***Funders:*** • The State funds the healthcare system through the NHS. • Latvia retains a large share of household OOP healthcare expenses. • Insurance companies offer private healthcare insurance. ***Care providers:*** • Hospitals (State, municipality and private). • Primary care providers, including GPs practices (public and private). • Secondary care providers, clinics and practices (public and private). • Mono-profile tertiary care providers (public). ► **Competition in the sector:** Competition in the Latvian healthcare sector has not been observed and was also not a topic that was raised in interviews or identified during desk research.
FUNDING OF THE SECTOR	Latvia has universal healthcare coverage that is mainly funded through general taxation, OOP payments, and to a lesser extent – voluntary private insurance. **Public funding arrangements**

Currently Latvia funds universal health coverage through general taxation. A newly introduced reform set to be enacted in 2021 would introduce a separate Compulsory Health Insurance System, which would link entitlements to payment of social health insurance contributions and thus potentially increase cash flow towards healthcare. This shall now be enacted in 2022.

Health expenditure

Latvian healthcare expenditure is one of the lowest in the EU[465].

Primary care providers are paid using a mix of capitation, fee for service (FFS), fixed practice allowances and quality payments (since 2013). Secondary ambulatory providers are mostly paid by flat-rate fees for defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutic interventions. Hospitals receive a fixed budget for emergency care services and observational wards, payments for treatment of patients based on predefined case payments, and payments for bed-days (defined for every level of hospital and/or individual hospital) and payments based on DRG[466].

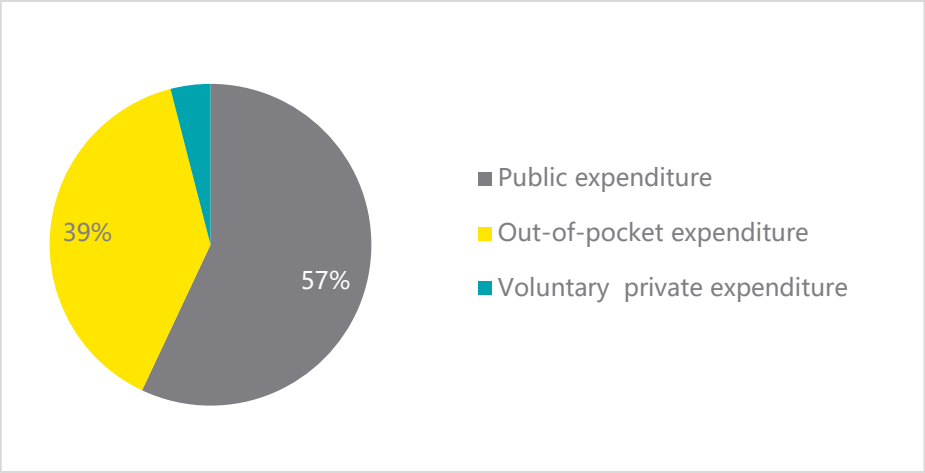
	Amount of expenditure in 2018 (in €)	Evolution 2005 - 2012	Evolution 2012 – 2018
Total Health expenditure (in billion)	1,8	+35%	+8%
Hospital care expenditures (in billion)	0,6	+22%	+25%

While the growth of total health expenditure has slowed down significantly since 2012, growth in hospital care expenditure increased by 3 percentage points, and is now at €1,8 billion, or 27% of the total health expenditure. Slower growth in hospital expenditure versus total health expenditure can partially be explained by the decrease in public funding allocated to hospital services following the 2008 crisis, while the State prioritised outpatient care.

Despite the economic crisis of 2008 and the consequent cut in funding for hospitals in the crisis period and overall austerity measures, the 2005-2012 growth in both hospital care expenditures and total health expenditures is significant.

[465] *OECD statistics, (https://stats.oecd.org/Index.aspx?ThemeTreeId=9#)*
[466] *Diagnosis-Related Groups in Europe, European Observatory on Health Systems and Policies Series, 2011, (https://www.euro.who.int/__data/assets/pdf_file/0004/162265/e96538.pdf)*

► **Distribution of health expenditure per category of funder in 2018:**



Highest shares of out-of-pocket payments are for expenditures related to medicines, inpatient care and ambulatory care[467, 468]. Latvia is in the first place in the EU in terms of the share of households that face catastrophic health spending, i.e. spending that is incompatible with a household's future ability to maintain a decent living standard (12%)[469].
General taxation is used as a primary source for public health funding. Authorities are trying to increase revenues by introducing a Compulsory Health Insurance System set to be enacted in 2021, and now due to be enacted in 2022.

► **Evolution of the distribution of health expenditure:**

	2005-2012	2012 - 2018
Public	**+40%**	**+6%**
Out-of-pocket	**+25%**	**+18%**
Private voluntary	**N/A**	**-9.2%**[470]

The overall growth of expenditure in the period of 2012-2018 has decreased in comparison to the 2005-2012 period, although the slow-down in OOP expenditure growth is less significant. Voluntary health insurance expenditure has decreased from 18.67million in 2013 to 16.96 million in 2018[471].

II. Social Housing

The aim of this Section is to provide an overview of the social housing sector in Latvia as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

Latvia has an extremely low stock of social housing and number of people using social housing. Social housing stock has increased by 1% from 2015 to 2016, however it still makes up less than 2% of the housing stock in Latvia.

[467] *OECD statistics, https://stats.oecd.org/Index.aspx?ThemeTreeId=9#*
[468] *OECD (2020). Latvia: Country Health Profile 2019; (https://read.oecd-ilibrary.org/social-issues-migration-health/latvia-country-health-profile-2019_b9e65517-en#page1)*
[469] *OECD & European Commission (2018). Health at a Glance: Europe 2018: State of Health in the EU Cycle, (https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf)*
[470] *Data available only from 2013.*
[471] *According to Eurostat statistics https://ec.europa.eu/eurostat/databrowser/view/hlth_sha11_hf/default/table?lang=en*

109
Social housing

13,300
Households living in social housing

4
Different types of social housing providers

Regular social housing

According to the **Law on Social Apartments and Social Housing** (*Par sociālajiem dzīvokļiem un sociālajām dzīvojamām mājām*), the definition of social housing in Latvia refers to housing that is rented at reduced price to low income individuals or individuals with special needs. The law, passed in 1997, defines social housing in the following way:

- A social apartment is defined as an apartment owned by a municipality or an apartment rented by a municipality, which is further rented to a person (family) who, in compliance with the aforementioned law, has been recognised as entitled to rent such an apartment.
- A social house is defined as a residential house in which all apartments are rented out to persons (families) who, have been recognised as entitled to rent a social apartment.

The quality of social housing is low due to a lack of adequate maintenance, for which many municipalities lack resources. Based on the most recent available data, around 13,300 households were living in social housing in 2016, representing less than 2% of all households. In 2015, there were about 109 social housing multi-unit buildings in Latvia for a total of 3,413 apartments.

The Ministry of Economy gathers data on people renting a social apartment as well as people living in a social apartment in all municipalities, however data is only available until 2016. The latest data represents that in 2016 a total of 2,524 people were renting a social apartment and 6,793 people were living in social apartments that were provided by their municipalities with the total expenditure amounting to approximately €3.1 million.

- Candidates for social housing can only apply in the municipality where they already live, making it difficult to move, for example, for employment.
- The Latvian government sets a **minimum income threshold for households to qualify as a low-income family at a monthly income of € 128** per person over the past three months (equivalent to around 30% of the minimum wage in 2018).
- Households who qualify are then eligible to benefit from social housing, which is operated by municipalities.
- **The income threshold to qualify for social housing has not been adjusted since 2009**, suggesting that – given inflation trends – even fewer households today would qualify for social housing today under the same income threshold compared to a decade ago. In fact, a recent OECD report points out a "missing middle" of **44% of households who cannot afford a mortgage but are too wealthy to qualify for social housing**[472].

[472] *OECD, OECD Economic Surveys: Latvia, 2019, (http://www.oecd.org/economy/surveys/latvia-2019-OECD-economic-survey-overview.pdf)*

Group homes:

	2017	2018	2019
Number of individuals living in group social housing: State funded	81	82	73
Number of individuals living in group social housing: municipality funded	241	253	254

According to the Ministry of Welfare's Register of Social Service Providers, currently **21 different actors are providing group-house services in Latvia**. The funding for group housing has increased from 170 200 € in 2017 to 213 557 € in 2019. Ministry of Welfare plans to use European Regional Development Fund support to open 53 additional group-houses that will be able to house 621 people until the end of 2022.

Latest available data for 2019 outlines that **73 people have received State co-funding for living in a group-home** and 254 people were funded by municipalities.

LEGAL FRAMEWORK

Presentation of the evolution of the legal framework:

Social housing and social services and their recipients are defined in law. Social housing and social apartments are regulated by the Law on Social Apartments and Social Housing, while group-housing is regulated by the Law on Social Services and Social Assistance.

Evolution of the legal framework before 2012:

- The **Law on Social Apartments and Social Housing**
- The Law on Social Services and Social Assistance (*Sociālo pakalpojumu un sociālās palīdzības likums*), passed in 1997, defines group housing as a house or a separate apartment where a person with mental impairments is ensured with a housing, individual support for resolving social problems and, if necessary, social care.
- A person is recognised as having a low-income if he or she complies with the provisions of the Law on Assistance in Resolving Housing Issues, passed in 2001.
- Social housing:

	o Common eligibility requirements for social apartments and social housing: ▪ being a low-income or a destitute person or family that rents an apartment owned by the local municipality and has expressed a wish to rent a social apartment; ▪ if the person is an orphan that is not provided with a living space; ▪ A person with a disability or who takes care of a disabled child or an adult with a disability. ▪ A person or a family recognised as destitute in accordance with the provisions of the Social Services and Social Assistance Law. ▪ Additional criteria determined by the local municipality. ***Evolution of the legal framework after 2012:*** ► No new legislation on social housing has been introduced. ► Social housing was put under the SGEI package for the period of 2012-2013 and was granted aid accordingly; however, it was not included in any subsequent periods. In 2020, the OECD published a report "Policy Actions for Affordable Housing in Latvia" that recommends actions to remedy existing challenges in the housing sector[473].
ORGANISATION OF THE SECTOR	**<u>SGEI in the sector</u>** Latvia does not consider social housing services provided individually by local governments to be of economic nature, but rather as having a social function. One of the autonomous functions of local governments, as prescribed by the Law on Local Governments[474] (*Par pašvaldībām)*, is to provide assistance to residents in resolving housing issues (Section 15(9)). However, in the SGEI report for 2016 and 2017 the authorities mentioned that considering the market development trends in some of the social services sectors, in future it may be necessary to define one of the respective services as SGEI. In this case, the responsible authorities may potentially encounter difficulties with defining the SGEI. **<u>Presentation of the categories of actors in the social housing sector</u>** • **Social housing services are split between three different ministries**: Ministry of Economy, Ministry of Welfare and Ministry of Environmental Protection and Regional Development. • Therefore**, there is no single public authority responsible for social housing policy**, although the Ministry of Economy holds the main responsibility over housing policy. The Ministry of Welfare gathers data on people living in group-homes for people with mental impairments, which represents a special type of social group housing.

[473] *OECD (2020). Policy Actions for Affordable Housing in Latvia.*
[474] *Par pašvaldībām, http://likumi.lv/doc.php?id=57255*

Ministries and their subordinates:

- National authority: Ministry of Welfare is an executive government body responsible for citizen welfare in Latvia, proposes and enforces laws in their relevant sector, specifically, social services and group housing.
- National authority: Ministry of Economy is an executive government body responsible for enactment of economic policy in Latvia, proposes and enforces laws in their relevant sector. Responsible for housing policy.
- National authority: Ministry of Environment Protection and Regional development is an executive government body responsible development and advancement of regional and municipal welfare.
- Local authorities: hold the main responsibility regarding social housing provision, including financing.

Providers (institutions that are allowed to provide social housing):

- Authorised association
- Authorised foundation
- Municipality and subordinate institutions, incl. social service
- National authority

Funders:

- Municipality budget
- State budget
- Rents of social apartment tenants
- Other unspecified funding sources

► **Competition in the sector:**

Only authorised entities (associations and foundations) or the authorities themselves are allowed to be the provider of social housing.
Data for current or historic trends of providers is limited. Given the low social housing stock in Latvia and the limited number of service providers, detailed statistics are not available.

FUNDING OF THE SECTOR	**Funding arrangements** Information on State and municipality budget allocation to social housing is scarce and is mostly related to data gathered by the Ministry of Economy related to municipality spending related to social apartments. Social housing and group houses are mostly funded from State and municipality budgets, and rent paid by individuals. Given the different ministries and providers involved in social housing policy planning and monitoring, joint data are not available for comparison. • **Regular social housing** In 2016, municipalities in Latvia spent in total €3,1 million on social apartments. In 2009, they spent €1,03 million on social apartments, which constitutes a 300% increase in funding in the period of 2009-2016, the relatively low funding in 2009 is most likely explained by the 2008 financial crisis and subsequent cuts in public spending. • **Group houses** The State provides 50% co-financing of the establishment and equipping of group houses by private enterprises or non-profit organisations for persons with mental impairments in the year of the establishment, according to provisions of the State Budget Law (*Valsts budžeta likums*) as determined by the Cabinet of Ministers. The State participates in the financing of expenditures associated with the maintenance of group houses (50%) for those persons with mental impairments who return from long-term social care and social rehabilitation institutions. The Cabinet of Ministers determines the volume of co-financing and the procedures for granting it. Expenditure which related to residence in group houses is provided to long-term social care and social rehabilitation institutions as part of the national programme of the European Regional Development Funds. **Aid granted as part of the SGEI package** Social housing been removed from coverage by SGEI package after 2013.  In the "Report on aid granted for the provision of services of general economic interest in Latvia" Latvia's officials have stated that social services such as childcare, access to and reintegration in the labour market, social housing, care and social inclusion of vulnerable groups are not of an economic nature and are the State's responsibility and therefore are not subject to SGEI rules.
SOURCES	The following sources have been used for the elaboration of this Fiche: Statistics • https://ec.europa.eu/eurostat/databrowser/view/tepsr_sp310/default/table?lang=en • https://ec.europa.eu/eurostat/databrowser/view/tps00046/default/table?lang=en • https://stats.oecd.org/Index.aspx?ThemeTreeId=9# • https://www.em.gov.lv/lv/nozares_politika/majoklu_politika/petijumi_statistika/citi_petijumi_un_statistika/

	• https://www.spkc.gov.lv/lv/latvijas-veselibas-aprupes-statistikas-gadagramata Other resources • Cabinet of Ministers (2016). "Informative Report on Systemically Important Healthcare Institution Mapping and Development Reform" • Cabinet of Ministers (2017). Conceptual report "On Healthcare System Reform" • http://www.oecd.org/economy/surveys/latvia-2019-OECD-economic-survey-overview.pdf • http://www.vm.gov.lv/images/userfiles/phoebe/ministrija_sabiedribas_lidzdaliba_ab75e1a6c38b637dc22573d800293aaa/dk_ievads_101212.pdf • http://www.vm.gov.lv/images/userfiles/public_health_strategy_2011_2017.pdf • http://www.vm.gov.lv/lv/tava_veseliba/veselibas_aprupe_slimnica/slimnicu_saraksts/ • https://apps.who.int/iris/bitstream/handle/10665/331419/HiT-21-4-2019-eng.pdf?ua=1 • https://ec.europa.eu/competition/_aid/public_services/2012_2014/latvia_en.pdf • https://ec.europa.eu/competition/state_aid/public_services/2015_2016/latvia_en.pdf • https://ec.europa.eu/competition/state_aid/public_services/2015_2016/latvia_en.pdf • https://likumi.lv/doc.php?id=263457 • https://likumi.lv/doc.php?id=44160 • https://likumi.lv/ta/id/187621-noteikumi-par-obligatajam-prasibam-arstniecibas-iestadem-un-to-strukturvienibam • https://likumi.lv/ta/id/296188-veselibas-aprupes-finansesanas-likums • https://likumi.lv/ta/id/56812-par-palidzibu-dzivokla-jautajumu-risinasana • https://www.pkc.gov.lv/lv/nap-2027/atbalsti-prioritates • OECD & European Commission (2018). Health at a Glance: Europe 2018: State of Health in the EU Cycle • OECD (2020). Latvia: Country Health Profile 2019,(https://read.oecd-ilibrary.org/social-issues-migration-health/latvia-country-health-profile-2019_b9e65517-en#page1) • OECD (2020). Policy Actions for Affordable Housing in Latvia • World Bank (2016). Latvia Healthcare Facilities Master Plan 2016-2025 • NHS (2019). Gada publiskais pārskats: (http://www.vmnvd.gov.lv/uploads/files/5f28f7830d87b.pdf)

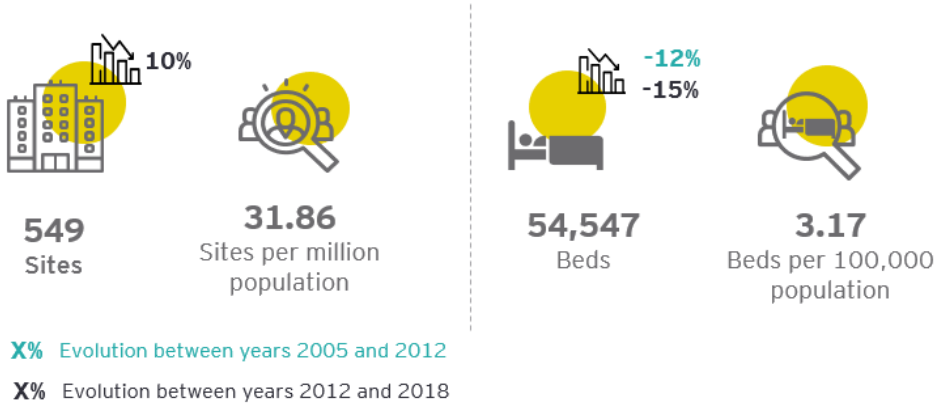
10.7 The Netherlands

Member State: Netherlands		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• The Dutch healthcare system is mainly governed by open competition between care providers. Although, there is a State regulation operated by the Dutch Healthcare Authority, there is little State aid directly granted to hospitals. • Almost 10% of GDP was spent on health in 2018 (+0.9% compared to 2005 and – 0.6% compared to 2012), which equals to €77.2 billion • In the same year, 82% of health expenditure is based on government's resources, voluntary healthcare payment schemes accounted for 7% and households' out-of-pocket (OOP) payments accounted for 10.8% of the expenditures[475].	• In the Dutch social rental housing system, 75% of the 3 million rental homes are owned by housing associations. Although these associations have national legal responsibilities, they remain independent organisations, with their own objectives and financial obligations. • €1 billion will be allocated to targeted tax reductions for social housing corporations building new homes between 2020 and 2030. • The Dutch authorities announced a package of housing market measures in September 2019, aimed primarily at boosting construction (75 000 homes per year until 2025), including in the private rental sector.
Key actors	The key actors relating to health SGEIs in the Netherlands are the following. Please note that this section gives only a few examples of the main existing actors. • **Public institutions:** National Health Care Institute Nederlandse Zorgautoriteit • **Fund providers:** CZ	The key actors relating to social housing SGEIs in the Netherlands are the following. Please note that this section gives only a few examples of the main existing actors. • **Public institutions** Ministerie van Binnenlandse Zaken en Koninkrijksrelaties huurcommissie • **Fund providers** vereniging van woningcorporaties aedes

[475] *Note as opposed to compulsory schemes which refer to schemes where membership is made compulsory by the government under voluntary schemes the access to health services is at the discretion of private actors and include for instance, voluntary health insurance, NPISH financing schemes and Enterprise financing schemes. See OECD, Classification of Healthcare Financing Schemes (ICHA-HF).*

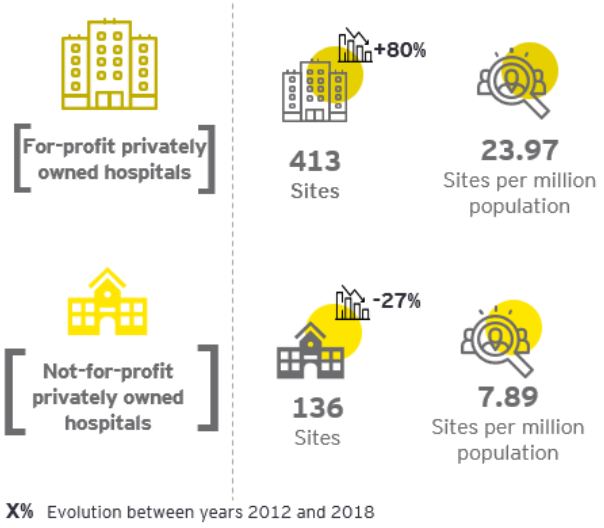
	• **Healthcare providers**: VUmc VU University Medical Center Amsterdam Striving together for excellence	• **Social Housing providers** gewoon goed in wonen PORTAAL
Structure of health and social housing	• The Netherlands has a universal healthcare system with compulsory private insurance. It features a mix of competitive insurance for curative care, a single payer system for long-term care and locally organised tax-funded systems. It is managed by the government and supplemented by private insurers / companies. • People with a lower income can apply for financial assistance for the basic healthcare or if they want supplemental services but cannot afford them.	• The Dutch housing market is characterised by large owner-occupied and social housing sectors (largest share of OECD countries and larger than many member States), each of which are subsidised through different channels[476]. • Due to subsidies in the social housing sector, the private rental market is the only non-subsidised housing sector and remains underdeveloped (13% of the total housing stock in 2018). [477] • Despite current shortage of the affordable and social housing stock in urban areas, housing production in 2024 could drop to 65 000, as compared to baseline predictions of around 75 000 new dwellings a year[478].
Main conclusions	• Since a reform in 2006, the role of Dutch government has evolved in healthcare regulation from a direct supervision of volumes and prices to an oversight of market rules. • The Dutch healthcare system has one of the highest level of expenditure in the EU but offers a good access to primary and secondary care providers as well as a dense network of long-term care providers.	• In the Netherlands, housing is divided into two sectors: social housing and the “free sector” (private market). • The Rent Liberalisation Threshold (Huurliberalisatiegrens) determines whether the apartment falls under social housing. The current threshold (2020) is €737,14 monthly rent.

[476] *For the social housing sector, it mainly stems from land values: by designating land as intended for social housing in zoning plans, it can be sold to social housing corporations at a fraction of the price of land intended for regular residential construction.*
[477] *Measures have been introduced to allow higher rent increases for middle- and high-income earners in social housing, thus facilitating more short-term rental contracts since 2016. This also led to the possibility for municipalities to designate a portion of dwellings as intended for the private rental sector in their zoning plans since 2017. These measures have however not translated into a meaningful expansion of the private rental sector relative to the overall housing market.*
[478] *Ministry of the Interior, 2019; Koops and Manshanden, 2019.*

I. Health Sector	
The aim of this Section is to provide an overview of the health sector in the Member State as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.	
KEY FIGURES	**Number and share of hospitals and beds (and evolution)**[479] In 2018, the total number of hospital sites was 549 against 499 in 2012 which represents an **increase of 10**%. In parallel, the **number of hospital beds decreased from 73,496 in 2005 to 54,547 in 2018. However, it should be noted that this number of beds only regards the not-for-profit sector as the data for the private for-profit sector is not available.**  This significant decrease in beds' capacity can be explained **with the abolition in 2008 of the central planning for hospitals**. At the same time this reform enabled to rise the number of acute hospitals and the number of outpatient's clinics (from 61 in 2008 to 112 in 2013).

[479] *The comparison between 2005 and 2012 is not possible for the number of hospital sites. The database used (OECD, Hospitals sites unit) contains a break in time series in 2009 due to inclusion of for-profit privately-owned hospitals.*

Number and share of hospitals (and evolution) per legal entity[480]



There are **3 types of hospitals in the Netherlands**: university hospitals, general hospitals, and teaching hospitals. They are either public or private not-for-profit. University hospitals are publicly owned but about 90% of hospitals are privately run[481]. However, in the OECD database, the data for the not-for-profit sector also includes the university hospitals.

The private for-profit hospitals in the OECD database correspond to Independent Treatment Centres. Their number increased by 80% between 2012 and 2018 (from 229 to 413).

Evolution of private health insurance coverage

Since the 2006 reform, Dutch citizens are entitled **to a basic health insurance coverage** which they are obliged to purchase from private health insurers. This coverage is mainly provided by private non-profit insurers competing with each other at the national level. In addition to this coverage, most of the population purchases a private supplementary voluntary insurance. The table below shows that although the share of this private supplementary voluntary coverage among the population has decreased it remains relatively high.

	Private supplementary health insurance holders among the population (2018)	Evolution 2005 - 2012	Evolution 2012 – 2018
%	84%	-4.8%	-4.4%
Number (in million)	14	-0.4	-0.34

Source: The Commonwealth Fund, Netherlands Profile

Four insurers covering different brands cover 90% of the market.[482]

LEGAL FRAMEWORK

Synthetic presentation of the evolution of the legal framework

The Dutch healthcare system is ruled by 4 major health acts. Each of these acts play a distinct role within the Dutch healthcare system:

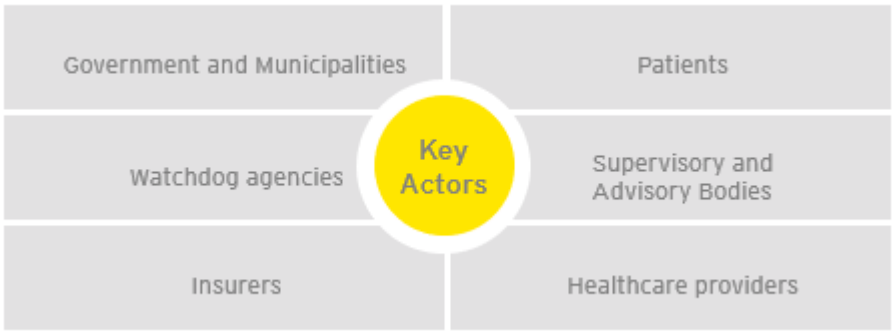
- the **Health Insurance Act** (Zorgverzekeringswet): provides for hospital care. This act is mainly implemented by private health insurance companies.
- the **Long-Term Care Act** (Wet langdurige zorg): implemented by the State and provides long-term care.
- the **Social Support Act** (Wet maatschappelijke ondersteuning), implemented by the 400 municipalities and provides other types of health??? cares;
- the **Youth Act** (Jeugdwet), implemented by the 400 municipalities and provides other types of healthcare

Evolution of the legal framework before 2012:

Before 2006, the Dutch health system was regulated under a mixed approach: a national social insurance scheme which was combined with a private insurance.

- **16 June 2005: The new Health Insurance Act** (Zorgverzekeringswet) has transformed the Dutch healthcare system from a supply-driven to a demand-driven system. It is providing for hospital care and conferring to **private health insurance companies** a key role in a system based on "regulated competition" as well as a number of specific public requirements.
- Since the Health Insurance Act, healthcare providers became subject of the market-oriented healthcare innovations. Hence, competition within

[480] *The comparison between 2005 and 2012 is not possible for the number of hospital sites. The database used (OECD, Hospitals sites unit) contains a break in time series in 2009 due to inclusion of for-profit privately-owned hospitals. The share of beds per legal entity on Eurostat is only available for the not-for-profit sector.*
[481] *Paying hospital specialists: Experiences and lessons from eight high-income countries - ScienceDirect.*
[482] *OECD, State of Health in the EU – Netherlands, Country Health Profile 2017, (http://www.oecd.org/publications/netherlands-country-health-profile-2017-9789264283503-en.htm).*

	these providers is encouraged by a **price negotiation done between providers and insurers**. Patients play a key role in this market, as they have a power of selecting providers creating a consumer-driven healthcare. **Since 2006, the healthcare sector is characterised by competition** and has reframed the role of the government (see section on the organisation of the sector). **The healthcare sector is now organised as a single private insurance market.** • **All residents of the Netherlands are entitled to a comprehensive basic health insurance package** which they are obliged to purchase from private health insurers. This package is implemented by these private, competitive health insurers and healthcare providers. Insurances companies must accept every applicant. Some groups of employees can benefit from insurance from collective insurers. • **1 October 2006: Healthcare Market Organisation Act** (WMG) establishes the Dutch Healthcare Authority (NZa) in charge of regulating this whole system to guarantee a fair healthcare provision (see the section on the organisation of the sector). **Evolution after 2012:** • **24 August 2012:** Decision availability contribution (WMG) is issued by the Ministry of Health, Welfare and Sport to compensate healthcare providers for the costs related to a public service • The **Long-Term Care Act** (Wet langdurige zorg) entered in force in 2015 and focuses on other types of care and governs healthcare across the country. It is strictly intended for the **most vulnerable categories of people.** • **The Social Support Act** (Wet maatschappelijke ondersteuning) entered into force in 2015 and provides for other forms of care and support, as well as the Youth Act (Jeugdwet), both of which are mainly implemented by municipalities. They are responsible for providing the support, assistance or care services. Municipalities are supported for delivering those kind of care services by local healthcare providers.
ORGANISATION OF THE SECTOR	**Synthetic presentation of the type of actors:**  • **State**: the role of the government since the national reform of 2006 is to ensure that **market competition results in safe, affordable and**

good quality healthcare. Only a few healthcare related activities have been directly left to the government:

- Definition of the budget for healthcare expenditures
- Definition of the content of the basic health insurance package, tariffs of health services when non-negotiable
- Setting the rules for risk adjustment among health insurers
- Overseeing the functioning of markets in healthcare.

- **Municipalities play a key role in overseeing some healthcare services (i.e preventive and healthcare priorities) and controlling.** For instance, they are responsible of the implementation of the Social Support Act and the Youth Act.
- **Watchdog agencies:**
  - **Authority for Consumers and Markets** supervising fair competition in the interest of patients and insured parties;
  - **Healthcare Authority**: has primary responsibility for ensuring that the health insurance, healthcare purchasing, and care delivery markets all function appropriately.
  - **Healthcare Institute**: in charge of care quality standards and for advising the government in the two statutory health insurance schemes: the Health Insurance Act and the Long-Term Care Act.
- **Supervisory and Advisory Bodies:**
  - **Care Assessment Agency** (Centraal Indicatiestelling Zorg) is acting under the Long-Term Care Act
  - **The Healthcare Insurance Board**: advises the Government on the content of the basic health insurance package.
  - **The Dutch Healthcare Inspectorate**, which oversees and enforces the quality and safety of healthcare
- **Insurers:** in charge of reimbursing services providers and implementing the national health insurance package. They have the mission to **negotiate services' prices with healthcare providers.** Leading health insurance companies in the Netherlands include among others *Achmea and VGZ.*
- **Healthcare providers:** in charge of delivering care and negotiating prices with insurers.
- **Patients**: the long-term care Act of 2015 deinstitutionalised care and made the Dutch system more patient-centred (patients are involved for evaluating care quality through questionnaires).

► **Definition of SGEI for the hospital sector**

The definition of what should be considered as SGEI has been defined by the Ministry of Health, Welfare and Sports (VWS). In the healthcare sector, the following services are regarded as SGEI[483]:

[483] *2018-2019 Biennial report on the SGEI from the Netherlands.*

- University hospitals
- Post-mortem organ removal
- Emergency hospital
- Acute obstetrics
- Mobile medical teams
- Expertise and coordination Trauma Care
- A&E Department
- Specialist Burns care
- Trauma care education, training and practice
- Specialised and tertiary psycho trauma care
- Emergency ambulance transport from the Wadden Islands by helicopter
- Post-mortem tissue removal (launched in 2019)

Healthcare providers that received a subsidy for 3 or more years are also included in the SGEI. They are entitled to funding for a maximum of years in order to adapt and reorganise their healthcare provision.

In the 2018-19 SGEI Report, 2 other schemes were included in the hospital section:

- The NIPT ("non-invasive prenatal test") subsidy scheme covering the years 2017 to 2019,
- The NODOK subsidy scheme ("further examination of the cause of death in children") covering the years 2016 to 2023.

► **Competition in the sector:**

In the Netherlands, only university hospitals are publicly owned and are in charge of delivering training for future specialists. However, competition between privately run hospitals is scarce as most specialists working in these organisations are self-employed.[484]

Since 2006, the healthcare sector is organised as a single private insurance market. Patients can choose their health insurers and providers freely.

As stated in the "key figures" section, hospitals are either public or private not-for-profit. University hospitals are public, and others are not-for-profit. However, there are also private Independent Treatment Centres (ITC) whose number increased by 80% between 2012 and 2018 while the number of hospitals decreased by 27% in the same period. ITCs compete with hospitals, however, they often specialise in providing "high quality healthcare with low prices, through specialisation, high-volume and routine".[485] ITCs are private but if they provide

[484] *Paying hospital specialists: Experiences and lessons from eight high-income countries, ScienceDirect, 2018, (https://doi.org/10.1016/j.healthpol.2018.03.005).*
[485] *Anouk Dorine Maria Tulp, Florien Margareth Kruse, Niek Waltherus Stadhouders and Patrick P.T. Jeurissen, Independent Treatment Centres Are Not a Guarantee for High Quality and Low Healthcare Prices in The Netherlands – A Study of 5 Elective Surgeries, International Journal of Health Policy and Management, 2020.*

	reimbursable care, they are classified as "not-for-profit", meaning they cannot allocate profits to third parties and have to reinvest it in the sector.
FUNDING OF THE SECTOR	Every Dutch adult (children are covered by the government) pays a **community-rated premium** to their insurer. Employers pay an **additional income-contribution**. This money is subsequently distributed among insurers on a risk-adjusted basis. **<u>Funding arrangements</u>** There are three funding schemes existing in the Netherlands: • **Competitive insurance for curative care, a single payer system for long-term care and local tax-funded social care**. ***Curative Care*** Since 2005, **Dutch hospitals** are paid through a system for funding called the **Diagnosis Treatment Combination (DBCs)** which replaced the fixed system budget that had existed since the 1980s[486]. Almost 70% of the DBC's rates are negotiated between providers and insurers and the remaining 30% are determined by the Dutch Healthcare Authority. There is a distinction between two segments under this financing system: • Services provided in the A segment have fixed rates; • For services provided in the B segment rates result from negotiations between healthcare and health insurances companies[487] **This system enforces hospitals to provide an overview of the total costs of each treatment from the first consultation until the final check-up**. The Ministry of Health, Welfare and Sport, hospitals, medical specialists and insurers have defined together **associated costs for each diagnosis.** The DBC system is updated regularly by the NZa. In 2012, a simplified DBS system was introduced reducing the number of DBCs (from 30 000 to 4 400)[488]**.**

[486] *Fleur hasaart, Incentives in the Diagnosis Treatment Combination payment system for specialist medical care A study about behavioral responses of medical specialists and hospitals in the Netherlands, 2011 (https://hsr.mumc.maastrichtuniversity.nl/sites/intranet.mumc.maastrichtuniversity.nl/files/hsr_mumc_maastrichtuniversity_nl/Publications/PhD_dissertations/incentives_in_the_diagnosis_treatment_combination_system_for_specialist_medical_care_hasaart.pdf).*
[487] *Diagnosis and treatment combinations, 2010, (https://www.cbs.nl/en-gb/news/2010/45/diagnosis-and-treatment-combinations).*
[488] *European Observatory on Health Systems and Policies, Health Systems in Transition (HiT) profile of Netherlands, 2018, (Online HiT for Netherlands - HSPM).*

Long-term care

With the 2015 Long Term Care reform[489], **more responsibilities were shifted to** municipalities**. The funding of long-term care insurance is fed by taxpayers who contribute through an income tax.**

Municipalities are in charge of organising social care. They pay directly the providers (under the Social Support Act - Wmo) of home care services. They purchase this type of care with resources collected via local taxes and can freely set the level of out-of- pockets payments.

- **Funding of GPs**

Compared to the acute and long-term care sector, GPs have a distinct funding system. A new payment system was introduced in 2015 composed of three segments:

- **Basic care of GPs**: funded through **capitation**, home visit and consultation billed directly to insurers, visit of nurse billed directly (tariffs established by the NZa). This segment covers 77% of the practice.
- **Integrated care**: **bundle payment** introduced in 2010 (care group organises all the necessary care for treating a disease and remunerates the healthcare providers involved)
- **Pay-for-performance and innovation**; these types of payment could be subject to insurers' contracting

- **Funding of health insurers**

Health insurers are funded through 3 different sources[490]:

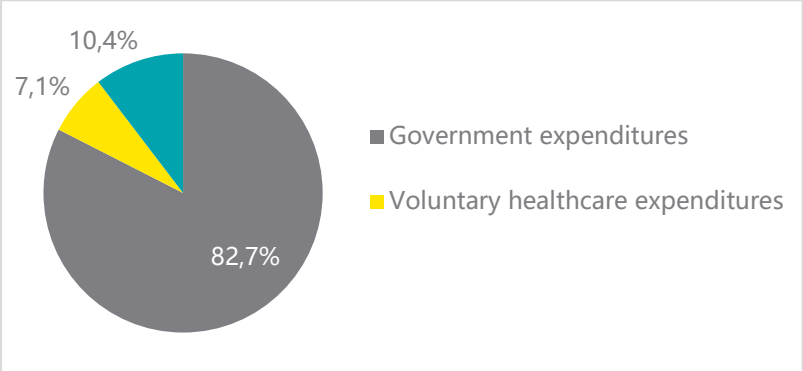
- A nominal premium paid by each person insured
- An insurance premium paid by citizens' employers which represents 50% of the total revenue of health insurers
- State contribution for the insured aged under 18 (10% of total revenue)[491]

Health expenditure[492]

	Amount of expenditure 2018	Evolution 2005 - 2012	Evolution 2012 – 2018
Total Health expenditure (in € billion)	77.2	+47%	+12%
Hospital cares expenditure (in billion)	26.2	+42%	+20%

Total health expenditure in 2018 was €77.2 billion, it has increased by 12% between 2012 and 2018 and by 47% in the period 2005-2012. With regard to hospital cares, the amount was € 26.2 billion in 2018 representing a higher increase than the total health expenditure between 2012 and 2018 (+20%).

Distribution of health expenditure per category of funder (2018):



In the Netherlands, healthcare expenditure is high and represents the fourth highest in the EU. More than **80% of healthcare spending comes from the State** although the OOP spending is slowly increasing (+0,2% between 2005 and 2012; +0,3% between 2012 and 2018) and is becoming a topic for public debate. The increase in OOP spending can be explained by the mandatory insurance deductible, which has increased in a substantial way (from €150 in 2008 to €385 in 2017)[493].

Evolution of the distribution of health expenditure:

	2005 - 2012	2012 - 2018
Government expenditures	+13.7%	-0.6%
Voluntary healthcare payment schemes	-14%	-0.9%
Household out-of-pocket	+0.2%	+0.3%

The share of expenditure per type of funder between 2012 and 2018 is quite stable (variation rates under 1%). However, during the period from 2005 to 2012, the share of the supplementary healthcare insurance schemes decreased by 14% while the share of the government expenditures increased by around 14%.

Evolution of the amount of public aid

The Netherlands have one of the highest level of expenditures towards healthcare with the expenditure on health amounted to 10% of the GDP. From 2012 to 2019, the health expenditures have increased by 24%, an increase which can be partly explained by a large long-term care and the reform since 2006 following which the State is financially supporting the healthcare insurers.

[489] *Peter Alders and Frederik T. Schut, The 2015 long-term care reform in the Netherlands: Getting the financial incentives right? ScienceDirect, 2019, (https://doi.org/10.1016/j.healthpol.2018.10.010).*
[490] *Risk equalisation occurs in the Netherlands with health insurers being compensated based on specific criteria such as age, gender and the presence of chronic diseases.*
[491] *The Commonwealth Fund, the Netherlands.*
[492] *Eurostat.*
[493] *OECD, State of Health in the EU – Netherlands, Country Health Profile 2017, (http://www.oecd.org/publications/netherlands-country-health-profile-2017-9789264283503-en.htm).*

	In 2019, the Netherlands spent €6120 per capita on healthcare. This represents an increase of 13% compared to 2012 and of 53% compared to 2005. **Evolution of the amount of public aid as part of the SGEI package in the hospital sector:** The total amount of the public aid granted **in 2019** for the hospital sector as part of the SGEI package was **€ 897,053 million**, which is an **increase of 6%** compared to 2018. *Source: SGEI Report, 2019.*
II. Social Housing The aim of this Section is to provide an overview of the social housing sector in the Member State as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.	
KEY FIGURES	 In 2018, social housing accounted for **38% of the total housing stock**, the largest among OECD countries and in Europe. There are about **three million social housing dwellings** in the Netherlands. About **75% (2,25 million) of them are owned by housing associations**, of which more than 90% are considered social housing units[494]. About 634,000 rental dwellings offered by private parties charge rents that are below the threshold of € 720.42, which sets eligibility for social rental benefits.
LEGAL FRAMEWORK	Social rental housing consists of dwellings rented at set prices that are operated by private non-profit housing associations[495]. **In the Netherlands, the rental price threshold for social housing is caped at €720.42 (in 2019).** This price is under the rent limit for liberalised tenancy agreements. Beyond this price, dwellings are subject to market prices. All social dwellings are allocated on the basis of **national and local rules**. Social housing associations may set their own rent policy within the limits of the national

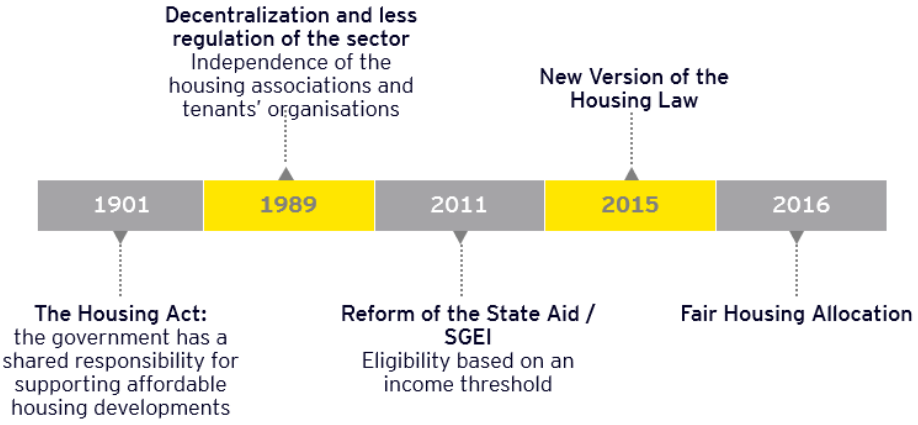
[494] *Government of the Netherlands, Housing, Rented housing, (Rented housing | Housing | Government.nl)*
[495] *OECD, Questionnaire on Social and Affordable Housing, 2019. (PH4-3-Characteristics-of-social-rental-housing.pdf (oecd.org)).*

rent regulations. On average, social rent levels are approximately 30% below the maximum permitted rent of € 720.42 (in 2019).

The principal target group are **low-income households** (e.g. families with an income below **€39,055 per year**)[496]. Each year, housing associations must let 80% of their vacant social housing to this target group. 10% of their housing stock may be allocated to households with an annual income between **€39,055 and €43,574** (in 2020), and an additional 10% to households with **higher incomes**.

However, the average rental price in the Netherlands is above € 1,000 a month and in the four largest cities this average price was of € 1, 156 in 2019. Therefore, **a large share of the middle-income households which are not eligible to social housing cannot afford housing in their target segment** (between €730 - €1,000) and written contributions from Aedes shows that 28% of middle incomes can't afford rent above this liberalisation limit[497].

Synthetic presentation of the evolution of the legal framework



Evolution before 2012:

In the 1800s, the "pillars" (religious, liberal, social and humanist) which structured The Netherlands, started housing associations for their members through small-scale housing construction. This model became the standard.

- **The Housing Act 1901** was a major compromise considered as a "Public Private Partnership" between the Ministry of Interior, and 16 Housing Corporations. This legislation made it official that the government had a shared responsibility for supporting affordable housing developments through policies but also subsidies. The implementation was however a task of the municipalities– the Sate did not explicitly regulate public housing itself but rather stimulated the "private initiative" by making loans available to housing associations approved by the government.
- After the World War II and up until **1985,** the demographic expansion and the housing shortage resulting from the war opened a flourishing period of social rental sector. This gave the municipalities a new role in

[496] *Ministry of the Interior and Kingdom Relations (Allocation rules | Allocation by housing associations | Dutch Housing Policy).*
[497] *Written contribution sent by AEDES.*

building, with the help also of housing associations -which were mostly controlled by local governments- involved in this effort to carry out not only renovation but also construction. **The central government then provided generous subsidies to housing associations to foster housing construction**. As a consequence, Private rental landlords massively left the rental sector (from 60% in 1947 to 10% in 1985).

- From the 1980s onwards, the Dutch housing policy paradigm shifted towards **decentralisation.** This marked the retreat of the government and autonomous social rental landlords. In 1989, the then State Secretary Enneüs Heerma laid the foundations for the independence of the housing associations along with the partial liberalisation of the rent regulation**. This resulted in** the **Memorandum on Housing, which** put an emphasis on deregulation, decentralisation (from the State to local scale) and self-sufficiency. The 1990s opened an era for private market stimulation, and municipal housing companies decreased significantly while (private) housing associations grew stronger along with tenants' organisations.
- **In 1995**, the government remitted outstanding loans to housing associations in exchange for the abolishment of future subsidies ("grossing and balancing operation") – this gave great financial independence to housing associations which started to sell off part of the social housing stock and broadened their activities. They not only provided affordable rental housing but increasingly invested also in social projects, public-purpose buildings and commercial real estate.
- **In December 2000** the final version of the Dutch Housing Memorandum "What people want, where people live" was published, covering the period 2000–2010.
- In the so-called "Article 17 letter" of 14 July 2005, the European Commission observes that the Netherlands should amend the public service definitions of housing associations in order to foster the access to social housing for disadvantaged citizens and thereby to comply with the definition of social housing as laid down in the 2005 SGEI Package[498].
- In a letter dated 3 December 2009, Dutch authorities made commitments to amend their social housing rules and notably the definition of social housing.

Following this letter, a decision from the European Commission was published[499] clarifying the scope of social housing in the Netherlands. It mentions that "social housing means the provision of housing for the most socially disadvantaged households". It determines the scope of the target groups:

- Socially disadvantaged are defined as individuals with an income not exceeding €33,000.

[498] *European Commission, State aid No E 2 /2005 (available at https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_SA_14175) and N 642 /2009 – The Netherlands Existing and special project aid to housing corporations, 2009, (available at https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_N642_2009).*

[499] *European Commission, State aid N642/2009 – The Netherlands Existing and special project aid to housing corporations, 2009, (available at https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_N642_2009).*

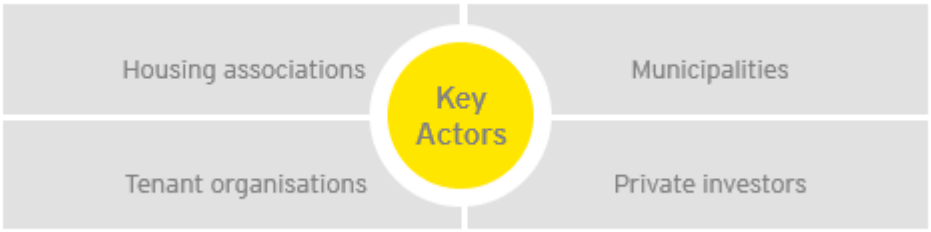
- The maximum rent in social housing shall not exceed €642,53.
- 90% of the dwelling in each housing corporation shall be allocated to individuals belonging to the target group. The remaining 10% will be allocated on the basis of objective criteria with element of social prioritisation[500].

The allocation of social housing is mainly determined at municipal level.

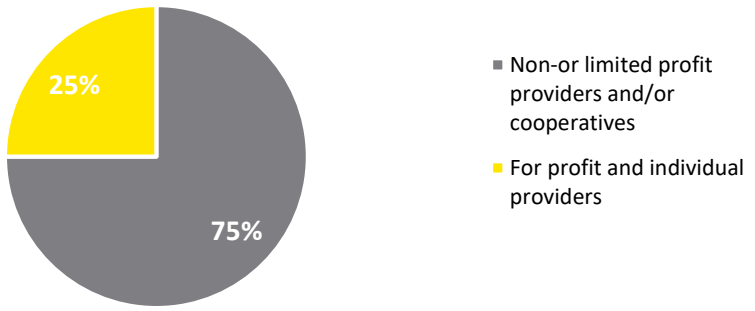
Evolution after 2012:

- In 2013, the new government took measure to **incentivise households with a higher income to move out of the social rental sector**, through income-based rent increases: households which did not belong to the 90% target group of the housing associations could be subject to a yearly rent increase up to 6.5% depending on the year and the household income.
- Following the Vestia scandal[501], a parliamentary enquiry of 2013 found that the governance and particularly the supervision of the housing associations was insufficiently developed. Other conclusions found that the lack of a good "moral compass" resulted in fraud and corruption amongst directors and supervisors, and that the boundaries within which housing associations were allowed to operate were not clearly defined.
- In **July 2015, the new version of the Housing Law** came into force. The law describes requirements and duties of housing associations. It claims that the **primary task of housing associations is to offer social rental housing for targeted groups**, as an SGEI. All other non SGEI activities had to be transferred to commercial parties. This law has also reformed the social rental sector supervision with the introduction of a new housing authority in charge of supervising activities, financial management and governance of the housing associations.
- **In January 2016:** introduction of the fair housing allocation (*passend toewijizen)* measure, implying that households with the lowest incomes shall be housed within the cheapest parts of the social dwelling stock in order to minimise government's expenditure.
- In **May 2019,** legislation was adopted to simplify the market criterion ("markttoets") for social housing corporations. This should allow them to engage in construction of mid-priced (non-regulated) rental housing more easily.
- In **September 2019**, a package of further housing market measures was announced, aimed primarily at **boosting construction**. Adjustments to the rent-setting system for social housing are lowering the weight of the value of the rented property ("WOZ-waarde") in setting the maximum rent for a property, which in turn determines whether it falls within the social (regulated) or private rental sector. This implies that more homes

[500] *European Commission, State aid No E 2 /2005 and N 642 /2009, (https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_N642_2009).*
[501] *This housing association, the biggest one in the Netherlands at that time (managing 80,000 dwellings), lost about 2 billion Euros as a result of irresponsible speculation with financial products. In September 2020, Vestia filed a claim with the High Court of Justice in London demanding compensation from BNP Paribas, for its role in this interest rate scandal.*

	remain in the regulated sector rather than transitioning to the private rental market.
ORGANISATION OF THE SECTOR	**SGEI in the sector:** The debate about the SGEI's scope in the social housing sector took place before the SGEI Package of 2012. After a complaint from the organisation for institutional investors in 2007, the European Commission urged the Netherlands to comply with the definition of social housing as laid down in the SGEI rules (see above)[502]. According to the European Commission, State aid for social housing should be limited to "social activities", i.e. "building and letting of social rental dwelling and building and letting of social real estate such as school and community centres". **Synthetic presentation of the type of actors:** Dutch social housing associations are private, non-profit enterprises that pursue social goals within a framework of national laws and regulations. They involve local government, tenants and other stakeholders in their policies and are accountable to society.  The key actors of the sector are the following: ► **Housing associations *(woningcorporaties* commonly referred to as *wocos*):** they do more than social housing developments and management. They are also responsible for the maintenance of the entire neighbourhood i.e. they should clean up and maintain children's parks, parkings, streets but also help to prevent any anti-social behaviour. ► **Aedes:** Since its founding in 1995, Aedes is the national association of housing associations, promoting the interest of almost every social housing organisation in the Netherlands. ► **Municipalities:** They issue social housing permits to people, as municipalities require people to have a legitimate reason for wanting to live in their municipality (e.g. work, family or school). This rule differs per municipality. In addition, municipalities and social housing associations are partners at the local level, each with their own responsibilities. ► **Tenant organisations** are involved in the social housing and help to determine the quality and quantity of housing needed. This results in "performance-agreements" with municipalities Tasks vary greatly between areas and regions. Different approaches are tailored to local and regional situations and require local cooperation.

[502] *N642/2009 - Case search - Competition - European Commission (europa.eu), (https://ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_N642_2009).*

	► The Ministry in charge of the social housing sector is the **Ministry of the Interior and Kingdom Relations.** **Distribution of the market per category of providers:** In 2019, housing associations play a key role in the housing markets, as they own 75% of the 3 million rental homes[503]. Distribution of the housing market per category of providers  ► **Competition in the sector:** Due to historical reasons, the social housing market is dominated by *wocos* (private not-for-profit organisations). Access to social housing remains mainly delivered by public operators, and few private providers offer an alternative.
FUNDING OF THE SECTOR	In the Netherlands, **there is strictly speaking no public spending** supporting the provision of social rental housing since 1995, except for a system of guarantees backed by the central government granted under the SGEI package which allows housing corporations to obtain credit at cheap rates, and income-tested rental subsidies to tenants[504]. In fact, investments are financed by housing associations' own equity and bank loans. A sectoral guarantee fund constitutes a risk management tool for housing organisations' financers. Housing associations can benefit from the three following national aid-schemes: • Support given to associations in financial difficulties by the Central Fund of Social Housing (CFV); • Support from a solidarity fund created by housing associations: Guarantee Fund for Social Housing (WSW). This fund enables housing associations to benefit from advantageous interest rates for financing their activities; • State and local authorities can intervene as a last resort. The social housing sector is a closed system in which all revenues must be reinvested. Essentially, it acts as a revolving fund. **In recent years, social**

[503] *Government of the Netherlands, Housing, Rented housing, (Rented housing | Housing | Government.nl)*
[504] *OECD, PH4.1 : Public spending on support to social rental housing, 2019, (PH4-1-Public-spending-social-rental-housing.pdf (oecd.org)).*

	housing associations were responsible for more than 50 percent of all housing construction in the Netherlands. **<u>Social housing expenditure</u>**  The total amount of the public aid granted **in 2019** for the social housing sector as part of the SGEI package was **€ 565,597 million,** which is a decrease of **-47%** compared to 2018. *Source: SGEI Report, 2019.*
SOURCES	• AEDES, Dutch social housing in a nutshell, 2016. • P.Boelhouwer, 2003. Social Housing Finance in the Netherlands: the road to independence. • J.Hoekstra, Rental Policy in the Netherlands. • Joris Hoekstra, 2017. Reregulation and Residualisation in Dutch social housing: a critical evaluation of new policies, Critical Housing Analysis. • Housing Europe, 2019. The State of Housing in the EU. • Hugo Priemus & Vincent Gruis (2011) Social Housing and Illegal State Aid: The Agreement between European Commission and Dutch Government, International Journal of Housing Policy, 11:1, 89-104. • OECD, 2019. Public spending on support to social rental housing. • PH4.1 : Public spending on support to social rental housing, OECD, December 2019. • Anouk Dorine Maria Tulp, Florien Margareth Kruse, Niek Waltherus Stadhouders and Patrick P.T. Jeurissen, Independent Treatment Centres Are Not a Guarantee for High Quality and Low Healthcare Prices in The Netherlands – A Study of 5 Elective Surgeries, International Journal of Health Policy and Management, 2020 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7557426/).

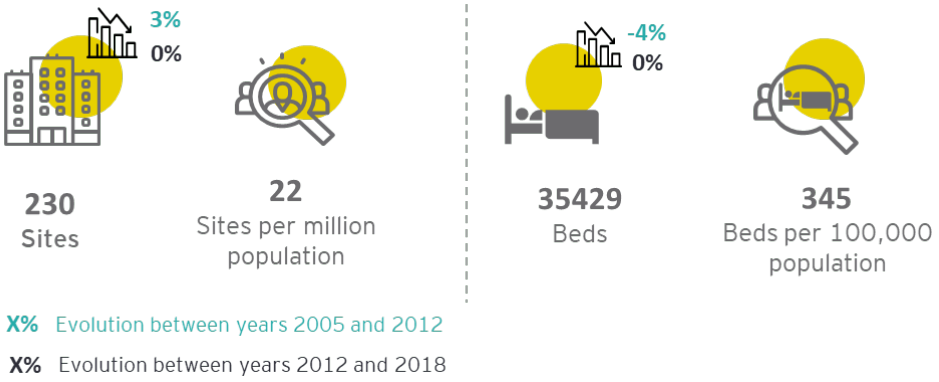
10.8 Portugal

Member State: Portugal		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• In 2018, the total health expenditure in Portugal was € 19.3 billion (9,5% of GDP[505]) • The health sector is mainly funded by the Central government and regional/local governments (together 59%); 30% is funded by households (out-of-pocket (OOP) payments), 8% by private health insurance schemes, and 2% by the Social Security scheme.[506] • The total State aid granted to the hospital sector in 2018 was € 6.9 billion against € 5.6 billion in 2012, which represents an increase of 23%.	• Social housing is not defined as a SGEI. • In 2015, the total social housing expenditure in Portugal was € 58.2 million (0.032% of GDP), representing 119.691 housing units (approximately 2% of the total housing stock). • The total social housing expenditure as percentage of GDP has been decreasing since 2009. Nonetheless, the absolute value increased between 2012 and 2015 (plus € 1.4 million).
Key actors	The key actors relating to health SGEIs in Portugal are the following: • **Public institutions:** • **Fund providers:**	The key actors relating to social housing SGEIs in Portugal are the following: • **Public institutions:** • **Fund providers**:

[505] *GDP of Portugal 2018: € 205.2 billion (https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_cnacionais).*
[506] *Together 99% instead of 100% due to rounding up differences.*

	• **Healthcare providers**:	• **Social housing providers:**
Structure of health and social housing	• The **Portuguese Ministry of Health** (*Ministério da Saúde*) and its institutions deal with the planning and regulation of the health system. The Ministry of Health is also in charge of the coordination of all healthcare provision and the financing of public healthcare. • The actors in charge of organising the sector at territorial level are the **regional health agencies** (*Agências Regionais de Saúde* or ARS). Each ARS has a health administration board accountable to the Minister of Health and responsible for the strategic management of population health, supervision and control of hospitals, management of the NHS primary care centres and implementation of national health policy objectives. They are in charge of planning, monitoring, allocating budget and delivering services regarding inpatient care, outpatient care and health and social care to disabled and elderly people. • There are also other national bodies related to healthcare that do not belong to the Ministry's administration, such as the **National Health Council** (*Conselho Nacional de Saúde*) which is responsible for issuing recommendations and advice on measures to enforce the implementation of health policies. Also, the **Health Regulatory Agency** (*Entidade Reguladora da Saúde*) is responsible for the supervision of healthcare institutions regarding operating requirements, patients' access to healthcare and it defends patients' rights, quality of healthcare provision, economic regulation, and	• The **Portuguese Ministry of** Infrastructure and Housing (*Ministério das Infraestruturas e da Habitação*) and its institutions deal with planning and regulation activities of the social housing sector. The Institute for Housing and Urban Rehabilitation (*Instituto da Habitação e da Reabilitação Urbana* or IHRU) is the public institute responsible for promoting and managing the access to social housing. • Other public institutions active in the social housing sector are regional authorities: Regional Government of Madeira, (*Governo Regional da Madeira)* through Housing Investments in Madeira (*Investimentos Habitacionais da Madeira* or IHM), and Regional Government of Azores (*Governo Regional dos Açores),* through Regional State Labor and Social Solidarity Secretariat of Azores (*Secretaria Regional do Trabalho e da Solidariedade Social dos Açores).* There are also local authorities, responsible for establishing the local social housing regulations and programmes: municipal councils and municipal public companies. • In terms of funders, the State, IHRU and regional or local authorities provide funding through their own financial resources, annual transfers from the national budget, or banking institutions, ensuring loans and grants to social housing providers. • Finally, there are different types of providers: public entities such as State, regional and local authorities, Municipal Public Companies, IHRU, the Institute for the financial Management of Social Security (Instituto de Gestão Financeira da Segurança Social or IGFSS), entities from the private sector designated as

	promotion of competition in the healthcare sector. • In terms of **fund providers** for the health sector, different types of actors exist. The NHS is predominantly financed through general taxation. • **Healthcare providers** such as hospitals, ambulatory healthcare centres or specialised health prevention institutions also exist. The healthcare providers in Portugal are financed by governmental schemes, the social security scheme, private insurance and households.	Private Institutions of Social Solidarity (Instituições Particulares de Solidariedade Social or IPSS), Housing Cooperatives and/or private landlords.
Main conclusions	**The National Health System was created in 1979 and is a universal tax-financed system**. Its creation was in line with the principle of every citizen's right to health. It is characterised by three co-existing and overlapping systems: the **universal NHS; special public and private insurance schemes for certain professions or companies (health subsystems); and private voluntary health insurance (VHI).** **Total health expenditure** is established within the annual government budget. Apart from direct transfers from the government budget, the NHS raises its own revenue, mostly generated by hospitals.	Social housing stock represents 2% of the total housing stock. The **total social housing expenditure** is established within the annual government budget. Traditionally, this has represented a low budget. Total social housing expenditure has been relatively stable from 2009 to 2015, with values ranging from €57 to €66 million euros per year, which stems from both rehabilitation and conservation costs, and fixed yearly costs. This expenditure represents between 0.03% and 0.04% of total GDP.
I. Health Sector The aim of this Section is to provide an overview of the health sector in Portugal as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.		
KEY FIGURES	**Number and share of hospitals and beds (and evolution)** In 2018, the total number of hospital sites was 230, with 229 in 2012, which represents a minimal **increase of 0,4**%. In parallel, the **number of sites per million population also slightly increased**. Indeed, there were 22 sites per million population in 2018 against 21 in 2013.	



Portugal has a relatively low supply of beds compared with other European countries, though it is higher than in other countries with similar NHS models. Nonetheless, the evolution matches the general international trend: a decrease over time. Although the number of beds has remained constant in recent years (having registered a small decrease from 35.478 to 35.429, between 2013 and 2018 (-0,1%)), **between 2005 and 2012 a decrease of 4% occurred.** In fact, the total number of hospital beds in 2005 was 37.372.

Number and share of hospitals and beds (and evolution) per legal entity

In 2018, there were 230 sites distributed by sector as follows:

- 111 sites were public hospitals (48%),
- 57 sites were not-for-profit private hospitals (25%),
- 62 sites were for-profit private hospitals (27%).

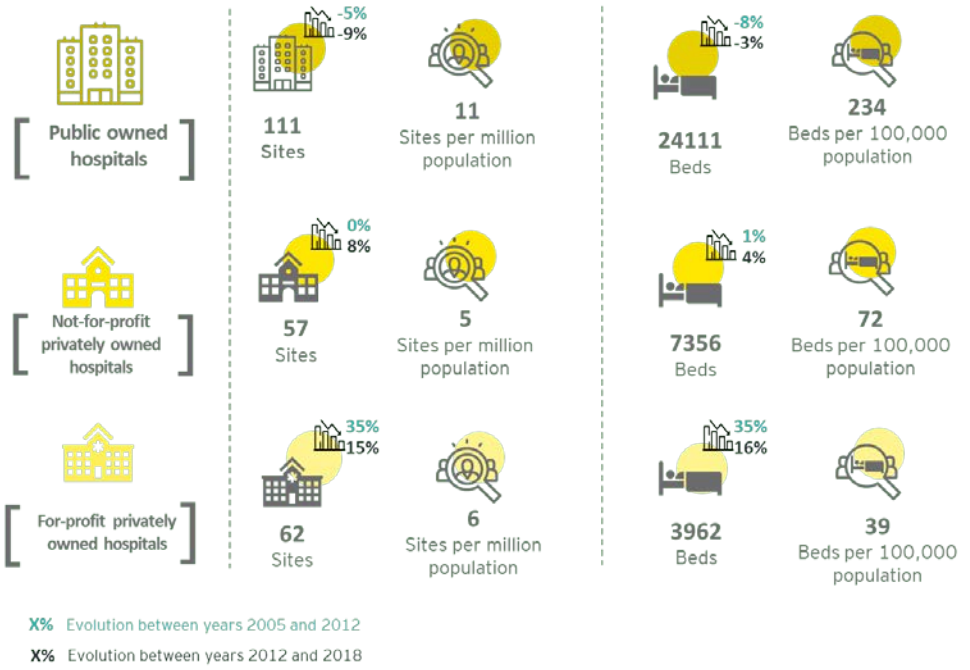
In 2018, **public hospitals were engaged in 4 Public-Private Partnerships (PPP)**.[507] The proportion of private for-profit hospitals has increased in recent years. The sites owned by for-profit private hospitals increased by 15% between 2012 and 2018. The sites owned by not-for-profit private hospitals increased by 8% between 2012 and 2018. This increase is explained by the fact that, in 2013, the return of hospitals to Misericórias[508] was established[509]. Until then, these sites were managed and controlled by NHS establishments and services.

The table below provides figures in absolute numbers for 2018.

[507] *According to the current Portuguese PPP legal framework (Decree-Law n.º 111/2012, of May 23rd), a PPP is defined as "a contract or union of contracts through which private entities, designated as private partners, oblige, in a durable way, before a public partner, to assure, upon payment, the development of an activity tending to the satisfaction of a collective need, in which the responsibility for the investment, financing, operation, and associated risks, falls, in whole or in part, to the private partner".*

[508] *Misericórdias are independent non-profit-making institutions with a charitable background.*

[509] *Decree-Law no. 138/2013 of October 9th.*



The public sector was the only sector that registered a decrease in the number of beds. This decrease was more intense in the period 2005-2013 (-8%)[510] than in the period 2012-2018 (-3%). Simultaneously, the number of beds owned by private for-profit hospitals increased in the period 2005-2012 (35%), as well as in the period 2012-2018 (16%).

In 2018, the share of beds was split as follows:

- 68% for the public sector;
- 21% for the private non-for-profit sector;
- 11% for the private for-profit sector.

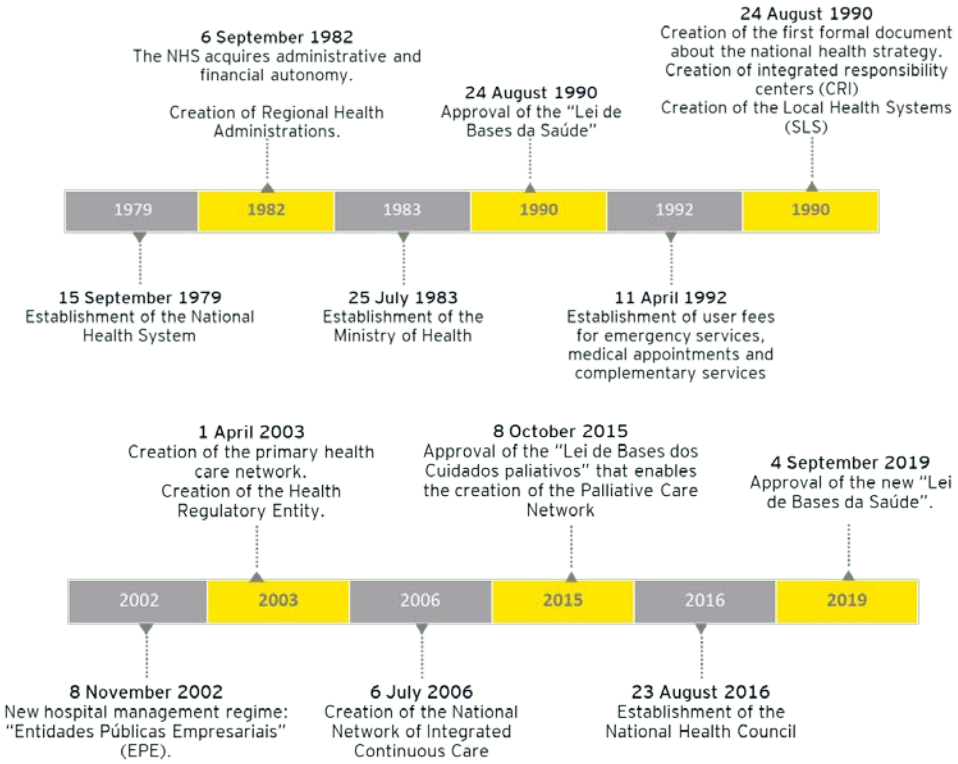
Compared to 2012, there has been a decrease of 4 percentage points on the share of beds in the public sector and an increase of 3 percentage points of beds in the for-profit private sector. This trend has been observed since 2005. In 2005, the public sector represented three quarters of the beds in Portugal.

LEGAL FRAMEWORK

Presentation of the evolution of the legal framework since 1996

The Portuguese National Health System was created in 1979 and is a universal tax-financed system. Its creation was in line with the principle of every citizen's right to health. Existing district and central hospitals as well as other health facilities, previously operated by the social welfare system and religious charities, were brought together under "a universal, comprehensive and free-of-charge National Health Service". The 1979 law establishing the NHS laid down the principles of **centralised control but decentralised management**.

[510] *The number of beds in public hospitals was 28,169 in 2005 and 25,786 in 2012. The number of beds in not-for-profit private hospitals was 6,970 in 2005 and 7,014 in 2012. The number of beds in for-profit private hospitals was 2,233 in 2005 and 3,015 in 2012*



Evolution of the legal framework before 2012:

The overall legal framework of the system is the **1990 Basic Law on Health** (Law No. 48/90, of 24 August), which introduces the principles for the organisation and functioning of the health system in Portugal. The 1990 Basic Law on Health is a pivotal legal act from the Portuguese health system that established:

- The possibility of privatising sectors of healthcare provision, by allowing the State to promote the development of the private sector and the private management of public healthcare facilities;

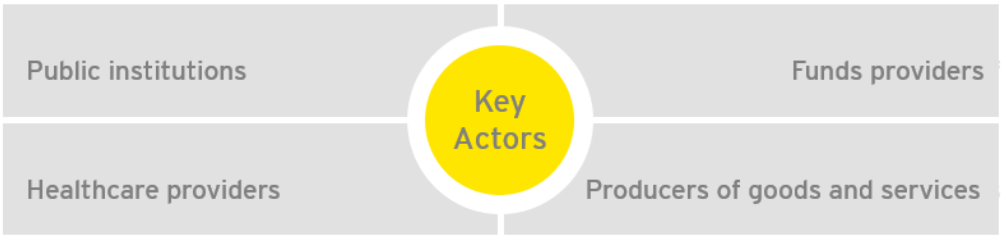
- The possibility of privatising sectors of healthcare financing, by promoting the option for voluntary health insurance (VHI) and the possibility of creating an alternative health insurance; and

- The geographic integration of healthcare, with the possibility of creating healthcare units that would assemble hospitals and primary care units within a single region.

In 1982, the **Regional Health Administrations (ARS) were introduced**[511], responsible for the NHS management at regional levels.

By the beginning of the 21st century, the **NHS became a mixed system**, based on the interaction between the public and the private sectors, integrating primary, secondary and long-term care. Reforms were enacted aimed at making the NHS more efficient. The late 1990s and the beginning of the 21st century featured **legislative changes that sought to increase the autonomy and efficiency of hospital management**. Moreover, with these legislative changes the concept of

[511] *Through the Decreto-Lei n.º 254/82 of July 29.*

	Public Corporate Entity[512] (*Entidades Públicas Empresariais*) was implemented in most public hospitals. ***Evolution of the legal framework after 2012:*** The 2012-2018 period was marked by the creation of **the Basic Law on Palliative Care** regarding services provided by and admission to palliative care facilities. In this way, the National Palliative Care Network was created. In 2016, through Decree-Law no. 49/2016, of August 23rd, the **National Health Council was created**. This independent body is responsible for issuing recommendations and advice on measures to enforce the implementation of health policies.
ORGANISATION OF THE SECTOR	**Definition of SGEI for the hospitals sector** Hospital activities are not defined as SGEI in Portugal. **Presentation of the categories of actors in the healthcare sector** The Portuguese health system is characterised by three co-existing and overlapping systems: The **universal NHS; special public and private insurance schemes for certain professions or companies (health subsystems);** and **private voluntary health insurance (VHI).** Healthcare institutions can have different legal status: (i) public, (ii) private non-for-profit and (iii) private for-profit. All hospitals belonging to the NHS fall under the Ministry of Health. Private sector hospitals, both not-for-profit and for-profit, have their own management arrangements. **There are 4 types of actors in the healthcare sector in Portugal:**  ***Public institutions:*** • **National Authority:** The **Ministry of Health** (Ministério da Saúde) is responsible for the regulation, planning and management of the NHS. It is also responsible for developing health policy, overseeing and evaluating its implementation. In addition, the Ministry of Health also regulates, audits and inspects private healthcare providers. The Ministry of Health comprises two State secretaries that are responsible for high-level coordination, under delegation of the Minister of Health. The Ministry of Health also comprises several institutions: some of them under direct government

[512] *A public corporate entity is an entity created by the State to carry out public missions and services, having administrative, financial and patrimonial autonomy, under the legal regime of the public business sector.*
Since 2003, the majority of NHS hospitals have been given similar status to those of a public-interest company (in what may be termed "autonomous public hospitals", whereby the government retains ultimate ownership but gives some autonomy to hospital management). This represents an attempt to introduce a more corporate structure into hospital management, with the expected effects on efficiency and cost-containment.

administration,[513] some integrated under indirect government administration and some having public enterprise status.

- **Regional Authorities:** The **Regional Health Administrations** (ARS) are responsible for implementing national health policy regionally, and coordinating all levels of healthcare. The NHS, although centrally financed by the Ministry of Health, has a regional structure comprising **five health administrations**. A health administration board, accountable to the Minister of Health, manages the NHS in each region. The management responsibilities of these boards are a mix of strategic management of population health, supervision and control of hospitals, and centralised direct management responsibilities for NHS primary care.
- **An agency that has a specific role of advising the Ministry of Health:** The **National Health Council** (Conselho Nacional de Saúde) is responsible for issuing recommendations and advice on measures to enforce the implementation of health policies.
- **Agencies with a role of advising, regulating and supporting a wide range of health stakeholders such as public authorities, health professionals, health institutions**: The National Authority on Drugs and Health Products (Autoridade Nacional do Medicamento e Produtos de Saúde, INFARMED), The National Institute for Medical Emergencies (Instituto Nacional de Emergência Médica, INEM), The Portuguese Institute for Blood and Transplantation (Instituto Português do Sangue e da Transplantação), National Institute of Health, Dr Ricardo Jorge (Instituto Nacional de Saúde Doutor Ricardo Jorge, INSA), etc…
- The **central Administration of the Health System** (Administração Central do Sistema de Saúde, ACSS) is in charge of managing financial and human resources, facilities and equipment, systems and information technology (IT) of the NHS. It is also responsible for the implementation of health policies, regulation and planning and health service contracting (along with the ARS).
- The **Health Regulatory Agency (Entidade Reguladora da Saúde)**, which is an independent body responsible for the regulation of the activities of healthcare providers.
- **National Parliament:** Control and orientation through the yearly law of the budget of social security

Fund providers:

The Portuguese health system draws on a mix of public and private financing. The **NHS is predominantly financed through general taxation.**

- The **Ministry of Finance sets the NHS budget annually**, based on historical spending and plans put forward by the Ministry of Health, within an overall framework of political priority setting across the different sectors. **The Ministry of Health allocates funds to the ARS**, based on a combination of historical expenditure and capitation. The ARS/Health regions pay for primary care and specific health programmes.
- **Public and private health subsystems** (insurance schemes for which membership is based on professional or occupational category) that are financed mainly through employee and employer contributions.

[513] *The institutions under direct government administration include: the General Secretary, the General Inspection of Health Activities (Inspeção-Geral das Atividades de Saúde or IGAS), the Directorate-General for Health (Direção Geral de Saúde or DGS) and Intervention Service in Addictive Behaviors and Dependencies (Serviço de Intervenção nos Comportamentos Aditivos e de Dependência or SICAD).*

- **Private health insurance schemes** covering co-payments, balance billing and dental and vision care.
- **Households** through co-payments and balance bills (pricing charged for a medical act above the covered fees).

Healthcare providers:

- Health and paramedical professions;
- Healthcare institutions such as hospitals (public, private and PPP);
- Multidisciplinary healthcare networks (such as health professionals and social workers);
- Specialised health prevention institutions (e.g. occupational health).

► **Competition in the sector:**

The healthcare delivery system in Portugal consists of a network of public (the NHS) and private healthcare providers; each connected to the Ministry of Health and to the patients in their own way.

Public provision is predominant in primary care and acute general and specialised hospital care, with a gate-keeping system in place for access to hospital care. Pharmaceutical products, diagnostic technologies and private practice by physicians constitute the bulk of private healthcare provision.

Although the NHS operates most of the health facilities in Portugal, private provision has always been available, for example laboratory tests, imaging, renal dialysis, rehabilitation and pharmaceutical products.

The establishment of contractual arrangements between the NHS and the private sector is possible (and common in certain domains) in Portugal. Contracting with private providers has allowed the NHS, as funder, to meet the needs of its users, mainly in diagnostic services, dental consultations, laboratory tests, imaging, renal dialysis and rehabilitation. However, waiting lists remain a major problem regarding financial protection (seeking in the private sector the response that the NHS is not able to provide), access and equity.

Despite the efforts of the NHS to reduce waiting times (meaning that utilisation and the offer of services has not decreased considerably) in recent years, both OOP payments and private sector activity have increased, with an increase in parallel in exemptions of user charges. This suggests that those with higher disposable income might have turned to private healthcare providers.

FUNDING OF THE SECTOR	A **budget for total health expenditure** is established within the annual government budget. Traditionally, the budget had to be increased as the year progressed. Apart from direct transfers from the government budget, the NHS raises its own revenue, mostly generated by hospitals. **Public funding arrangements** **For public health services**, there are two types of funding arrangements: 1. **Public Hospital budgets** are drawn up and allocated by the Ministry of Health via ACSS and ARS. At present, public hospitals are allocated **global budgets based on contracts** (contratos-programa) signed with the Ministry of Health. Traditionally, budgets had been based on the previous year's funding, updated for inflation, but since 1997 a growing proportion is based on Diagnosis Related Groups (DRG) information as well as on non-adjusted hospital outpatient volume. This new activity-based resource allocation model followed research that begun in the 1980s, involving systematic DRG grouping and the computation of hospital case-mix adjusted budgets. 2. **For primary care centres,** the Ministry of Health allocates funds to the ARS, which in turn fund the global activity of each health centre through the recently created groups of primary care centres (Agrupamentos de Centros de Saúde - ACES). The contract (contrato-programa) of each ACES, which is responsible for primary care delivery in a given geographical area, is negotiated between the ACES and the ARS. Apart from direct transfers from the government budget, the **NHS raises its own revenue**, mostly generated by hospitals. This includes payments from private insurers, income from investments, donations, user charges and fines for example for non-compliance or late payment of user charges. **Other activities**, such as social care, pharmacies and complementary activities are funded by the Ministry of Health and the Ministry of Labour, Solidarity and Social Security, through cost sharing with patients, based on a daily basis rate or fee for service rate. **Health expenditure** The total health expenditure is called **"*Despesas correntes em saúde*"**. It is composed of the following elements: • Curative, rehabilitative and long-term care; • Long-term care for disabled and elderly people (*soins de longue durée*); • Ancillary services; • Prevention expenditure; • Medical goods; • Preventive care; • Governance and health system and financing administration. Curative, rehabilitative and long-term care represented 70% of the total health expenditure in 2018. It includes Inpatient care, Outpatient care, Day care and Home-based care.

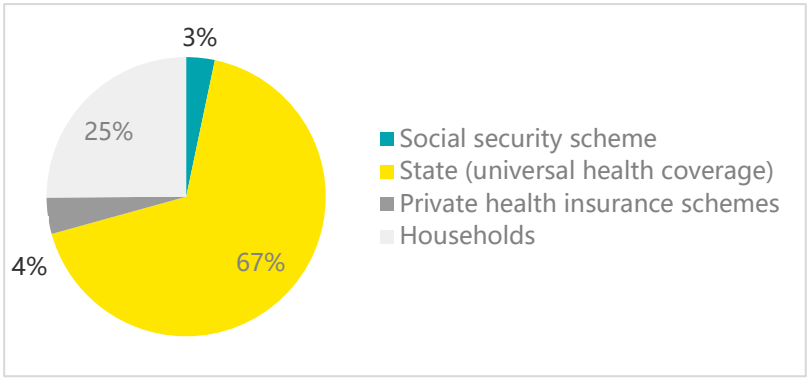
	Amount of expenditure in 2018 (in €)	Evolution 2005 - 2012	Evolution 2012 – 2018
Total Health expenditure (in billion)	19.3	+5%	+23%
Curative, rehabilitative and long-term care (in billion)	13.5	+14%	+27%

The total health expenditure was **€ 19.3 billion in 2018** (9,5% of GDP). This expenditure was € 15.7 billion in 2012 (9.4% of GDP) and €15.0 billion (9.4% of GDP) in 2005. This health expenditure then increased **by 23% between 2012 and 2018**, following an increase of 5% in the period 2005-2012.

The expenditure for curative, rehabilitative and long-term care was € 13.5 billion in 2018. It constituted around 70% of the total health expenditure in 2018. Compared to 2012, this share increased by 3 percentage points.

In terms of evolution of the amount, the curative, rehabilitative and long-term care expenditure was € 10.5 billion in 2012 (+27% during the period 2012-2018) and € 9.3 billion in 2005 (+14% during the period 2005-2012).

Distribution of the consumption of curative, rehabilitative and long-term care expenditure per category of funder in 2018:



Curative, rehabilitative and long-term care is **mainly funded by the State** (67% of the spending in 2018), 25% is then funded by the households, 4% by private insurance schemes and 3% by the Social security scheme.

Evolution of the expenditure on curative, rehabilitative and long-term care expenditure *per* category of funder in 2018:

	2005-2012	2012 - 2018
Social security scheme	**+1 percentage point**	**+1 percentage points**

State	-8 percentage points	-3 percentage points
Private health insurance scheme	+1 percentage point	-1 percentage points
Households	+6 percentage points	+2 percentage points

The share of the **social security scheme** in the expenditure on curative, rehabilitative and long-term care increased by one percentage point during both the 2005-2012 period and the 2012-2018 period. The share of the **State's funding** decreased in both periods, while the **private health insurance schemes** share decreased by 1 percentage point from 2005 to 2012 and also between 2012 and 2018. The share of **households** increased by 6 percentage point from 2005 to 2012 and by 2 percentage points from 2012 to 2018. The household payments in Portugal are among the highest in the EU (ranking fourth). Aware of the high OOP expenditure, the Ministry of Health implemented some measures to reduce its impact, with user charges reduced in 2016.

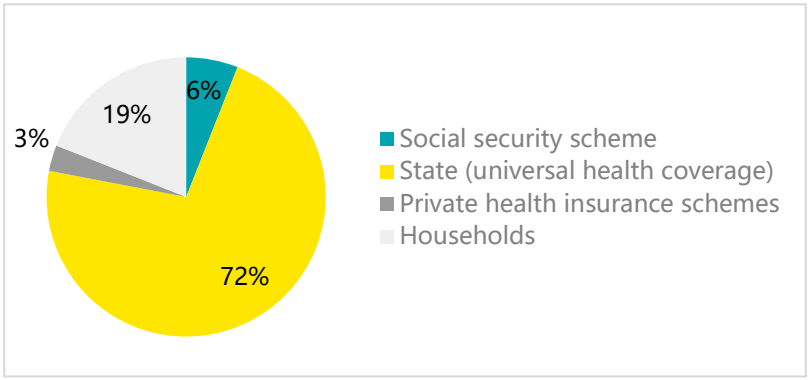
Inpatient care expenditure

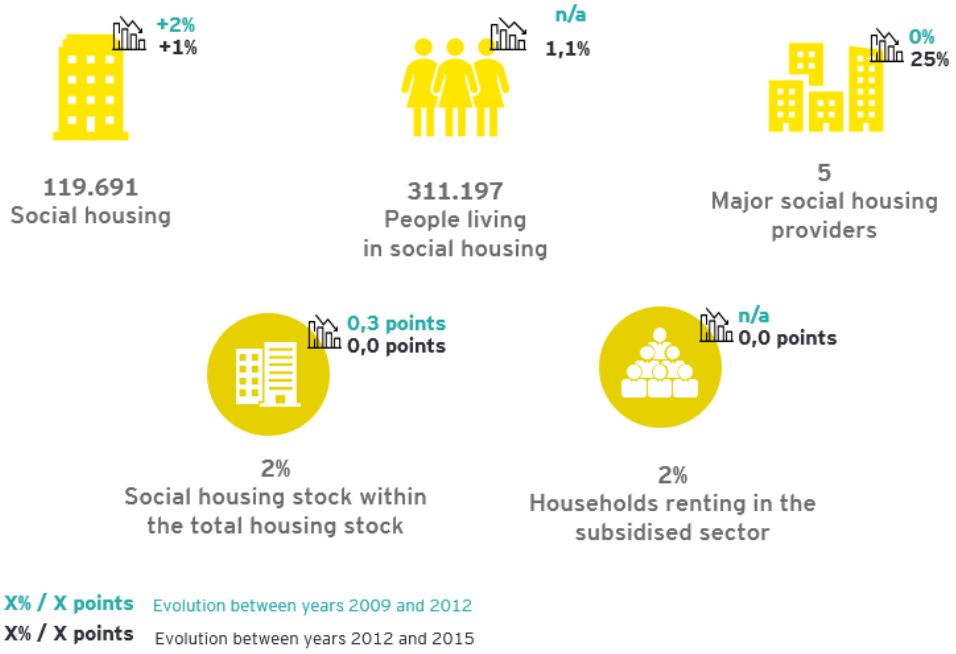
	Amount of expenditure in 2018 (in € billion)	Evolution 2005 - 2012	Evolution 2012 – 2018
Inpatient care expenditure	4.1	-9%	+32%
Public sector[514]	3.2	-16%	+23%
Private sector[515]	0.9	67%	+80%

The total **inpatient care** expenditure was € 4.1 billion in 2018, representing 30% of consumption of curative, rehabilitative and long-term care. This expenditure for 2012 was € 3.1 billion and € 3.4 billion in 2005. The amount decreased by 9% from 2005 to 2012 and increased by 22% between 2012 and 2018.

In 2018, **the public sector accounted for 78% of all inpatient care provided**; with this share declining since 2005 (in 2005, the public sector accounted for 85% of inpatient care). In terms of amount, € 3.2 billion was spent in the public sector in 2018 against € 2.6 billion in 2012 and € 3.1 billion in 2005. The expenditure decreased by 16% from 2005 to 2012 and increased by 23% between 2012 and 2018. With regard to the private sector, the inpatient care expenditure was € 0.9 billion in 2018, against € 0.5 billion in 2012 and € 0.3 billion in 2005. It increased by 67% from 2005 to 2012 and by 80% between 2012 and 2018.

[514] *National and Regional Health Service, public health subsystems and social security funds.*
[515] *Insurance corporations, non-profit institutions serving households, private health subsystems and households.*

	Distribution of the Inpatient care expenditure per category of funder in 2018:  **The State** is the main funder of Inpatient care (72%). 19% is funded by households, 6% is funded by social security schemes and 3% by private health insurance schemes. The share of the State represented more than 80% of the hospital care in 2005 and 2012. **Evolution of the amount of public aid as part of the SGEI Package** No aid was granted as part of the SGEI Package due to hospitals not being defined as SGEI in Portugal.
II. Social Housing The aim of this Section is to provide an overview of the social housing sector in Portugal as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.	
KEY FIGURES	In Portugal, there are about **120 thousand social housing dwellings, which constitute 2% of the total housing stock**. The number of social housing units increased by 2% from 2009 to 2012, and by 1% between 2012 and 2015. The proportion of social housing as part of the total housing stock increased until 2011 (from 1.7% to 2.1%) and slightly decreased between 2011 and 2015 (-0.1 percentage points).



Source: National Institute of Statistics (INE Portugal), Social Housing sector characterisation survey

The number of social housing dwellings slowly, but steadily, increased, at least until 2015 (no data is available post 2015). There are five major social housing providers in Portugal: IHRU, IGFSS, IHM, DRH, and Santa Casa da Misericordia. As of 2012, all social housing providers were from the public sector, being 16% national authorities / public agencies and 84% regional and/or municipal authorities / public agencies.

In 2015, 2% of the total housing stock was rented in the subsidised sector. This figure is virtually equal to the share of social housing in the total housing stock referred to above, since most rents in the social housing sector is subsidised (107.061 out of 119.691 dwellings).

The total budget for social housing is established within the annual government budget. Traditionally, this has been a low budget. Total social housing expenditure has been relatively stable from 2009 to 2015, with values ranging from €57 to 66 million euros per year, which stems from both rehabilitation and conservation costs, and fixed yearly costs. These expenditures represent between 0.03% and 0.04% of total GDP.

LEGAL FRAMEWORK

The concept of social housing in Portugal exists since 1983, consisting of cost-controlled housing ("*habitação a custos controlados*") available for sale or rent. Social housing can be obtained from the State, regional or local authorities and is intended for low-income families. The State is the key promoter and responsible for the management of social housing, mainly using public built dwellings for social housing programs.

Presentation of the evolution of the legal framework since the early 2000s:

Evolution of the legal framework before 2012:

Before 2012, changes in the legal landscape were associated with a **strategic reorientation from incentivising own housing acquisition to promoting the rental model**, resulting in the end of the subsidised credit of mortgage credit in 2002 (one of the measures of a vast budget containment package that resulted in an abrupt reduction in the number of new dwellings units completed).

Established in 2006, the implementation of the **New Urban Lease Scheme** -*Novo Regime do Arrendamento Urbano*, NRAU - (and its subsequent revisions that took place in 2014 and 2017) was an important transformation on the housing market, because it established a special regime for updating old rents. With this regulation, a package of new incentives was promoted to make rents affordable through tax incentives for landlords (total exemption from Personal and Collective Income Tax on property income). This had a significant impact on access to the market[516].

In 2007, an incentive for young people to rent houses for permanent residence was implemented through the public programme "Porta 65 — Arrendamento por Jovens" that provides a monthly subsidy directly to young people (aged 18-34).

Important instruments have emerged in this context such as the **Social Rental Market** (*Mercado Social de Arrendamento*, MSA), created in 2012 under the Social Emergency Programme, which consists of a stock of housing units for rent, spread throughout Portugal, with rent values lower than those available on the private market (discounts up to 30%). The Social Rental Market aimed at serving low-income families. Additionally, there have been two other programmes that transformed the sector with regards to social housing:

- The **Special Rehousing Plan** (*Programa especial de realojamento* or PER), created in 1993 for the metropolitan areas of Lisbon and Porto as a granting financial support programme for the construction or acquisition of housing, for the relocation of households living in tents and similar situations. The plan was reviewed in 2003, when the focus was put on rehabilitation instead of acquisition or construction of new houses;
- **Financing Programme for Access to Housing** (*Programa de Financiamento para Acesso à Habitação* or PROHABITA) [517], created in 2004 to solve situations of severe housing shortage, providing other local governments (other than metropolitan areas of Porto and Lisbon) to access advantageous loans similar to PER (*Programa Especial de Realojamento* – Special Rehousing Programme)

The global financial crisis led to the Economic and Financial Adjustment Programme (PAEF) in 2011, supervised by the Troika (European Commission, the ECB, and IMF)

	and aimed to reduce the excessive public debts and foster economic growth. The budgetary austerity in place led to a progressive reduction in the volume of credit provided by banking institutions to housing for a low-income families. ***Evolution of the legal framework after 2012:*** The laws established after 2012 had the main objective of **guaranteeing access to adequate housing for all**. In 2014, the **Supported Lease Scheme was approved**, that considers the net monthly income of the household, the household size, and the age of the tenants for the calculation of the social rent, establishing a maximum effort rate (rent price/monthly gross household income) of 23%. The introduction of the **New Generation of Housing Policies** (*Nova Geração de Políticas de Habitação*, NGPH) in 2018 positively impacted the access to housing encouraging affordable rentals (including Affordable Leasing Programme, *Programa de Arrendamento Acessível*, created in 2019), and improved the opportunity of choice within the several support offers for families. In this context, the First Floor Right Programme was launched (1.ºDireito, Programa de Apoio ao acesso à habitação), that aims to finance housing (new construction at controlled costs, rehabilitation of existing dwellings, rental, land acquisition to housing construction) for low-income families. The **Basic Housing Law** (*Lei de bases da habitação*), approved in 2019, highlights the importance of the social function of housing in pursuing the national objective of ensuring that all residents have the right to adequate housing. The law confers on the State the responsibility for efficiently mobilising public buildings for the purpose of reaching that national objective, while preventing the depopulation of low-density territories.
ORGANISATION OF THE SECTOR	**SGEI in the sector** Social housing is not defined as SGEI in Portugal. **Presentation of the categories of actors in the social housing sector** The activities related to social housing are mainly dealt with by the State. The public institute IHRU has a central role in managing, financing and promoting the sector. 

[516] *NRAU was complemented by other decrees of law to better regulate the lease market (contracts, degree of buildings conservation, construction on rented buildings, allocation of rent subsidies).*
[517] *IHRU (https://www.portaldahabitacao.pt/pt/portal/programas_de_financiamento/prohabita.html).*

Public institutions:

- **National Authorities -** Ministry of Infrastructure and Housing (*Ministério das Infraestruturas e da Habitação*) regulates and organises the sector at national level. The Institute for housing and urban rehabilitation (Instituto da Habitação e da Reabilitação Urbana or IHRU) is a public institute with the role of ensuring the implementation of housing and urban rehabilitation policies defined by the State for the whole country. IHRU is also responsible for 15.512 dwellings and 231 neighbourhoods for social housing throughout Portugal.
- **Autonomous Regions –** The Regional Government of the Azores (*Governo Regional dos Açores*) through the Regional Secretariat for Labour and Social Solidarity of the Azores (*Secretaria Regional do Trabalho e da Solidariedade Social dos Açores*) and the Regional Government of Madeira (*Governo Regional da Madeira*) through Housing Investments of Madeira (*Investimentos Habitacionais da Madeira* or IHM) are in charge of defining social housing policies and establishing regional social housing programmes.
- **Local Authorities:** Municipal Councils *(Câmaras Municipais*) and Municipal Public Companies oversee the establishment of the local social housing programme, delivering building permit and setting town planning.

Fund providers:

- **National Authorities:**

- **State -** through the annual budget, that transfer to IHRU, regional and/or local authorities. Favourable tax measures are also available to the social housing sector.
- **IHRU**, the public entity promoting the national housing policy, integrated in the indirect administration of the State, endowed with administrative and financial autonomy and its own assets under the supervision of the member of the Government responsible for this governmental area. It has responsibilities in the sectors of housing and urban rehabilitation, definition and evaluation of policies, coordination of policy measures for the sector, as well as financing housing programs of social interest

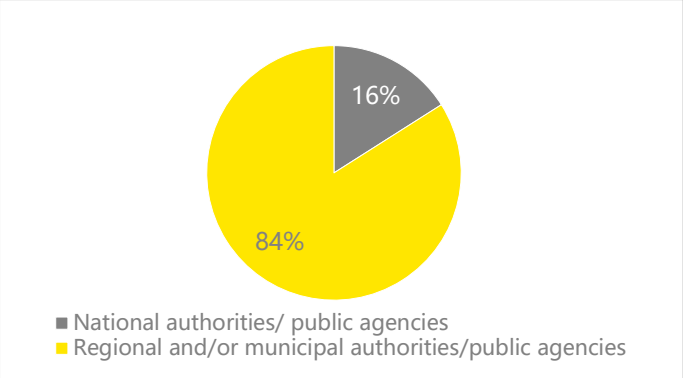
  Besides the State budget, IHRU provides funding through its own financial resources (revenue from social housing rents) or bank institutions, ensuring loans and grants to social housing providers. IHRU manages the allocation of grants, loans and ,subsidies and other forms of support and incentives to urban leasing. It is therefore able to borrow or carry out other operations that are linked to its activity.

- **Local authorities:** Through their own financial resources or transferred State budget they are responsible to manage and implement social housing programs and dwellings. They also have access to loans or grants from IHRU to be used for the management and implementation of social housing.
- **Banks:** Subsidised credit through IHRU agreements for social housing (constructing at controlled costs or purchasing housing).

Social housing providers:

There are different types of social housing operators:

- **Public social housing stock owners**: The State, IHRU (although, in the last few years it has been transferring some of the social housing stock to local authorities or it gave the possibility to tenants to buy their social housing dwelling), Institute for the financial Management of Social Security (*Instituto de*

	Gestão Financeira da Segurança Social or IGFSS), regional authorities (Regional Government of the Azores (*Governo Regional dos Açores*) through the Regional Secretariat for Labour and Social Solidarity of the Azores (*Secretaria Regional do Trabalho e da Solidariedade Social dos Açores*) and the Regional Government of Madeira (*Governo Regional da Madeira*) through Housing Investments of Madeira (*Investimentos Habitacionais da Madeira* or IHM)) and local authorities or Municipal Public Companies that have the to manage and allocate the most significant share of the total stock. • **Private sector / Private institutions of social solidarity (*Instituições Particulares de Solidariedade Social* or IPSS):** These actors are able to benefit from State support in promoting housing solutions designed to provide access to adequate and affordable housing for people and households. • **Housing cooperatives:** The provision of affordable housing, through State support. Housing Cooperatives are non-profit and have an associative form of control and provision by consumers, allowing the development of low-cost housing units Since the 1980s, their contribution as a social housing provider became less significant. • **Other Social Housing stock owner:** Private landlords. **Distribution of the market per category of public providers in 2018**  Source: OECD, Affordable housing database, consultation date 06/11/2020 Regional and municipal authorities, as **well as public agencies, represent 84% of the market (2018).** The local responsibility of social housing (construction, management, promotion) increased in the 1980s and 1990s, through agreements and the transfer of housing units from the State to the local authorities[518], allowing for efficiency gains due to geographical proximity and benefits in terms of local knowledge about the social situation. ► **Competition in the sector:** There is no competition in the sector. While private entities are active in the market (private landlords and private social welfare entities), they complement the public supply and are not competitors.
FUNDING OF THE SECTOR	Public funds are the main source of funding in the social housing sector: ► Transfers from State budget to IHRU, regional and local authorities; ► Grants through IHRU public programs; ► Long-term loans from IHRU or banks; ► Subsidised credit for the construction of housing at controlled costs or the purchase of housing;

[518] *Decree Law no. 32 -A/2002, of December 30th*

	► Own financial resources (revenue from social housing rents); ► Revenues from the Supported rent system (a programme that places houses controlled by public authorities on the rental market) The social housing main allocation criterion is the household income (for Portuguese citizens or people with a permanent residence in Portugal). Income level of families is accounted for in terms of the Social Support Indexation (*Indexante dos Apoios Sociais or IAS*). The most important eligibility criteria for social housing are household composition (size and composition of family), disability, age, housing situation and income level. **Aid granted as part of the SGEI Package:** No aid was granted as part of the SGEI Package due to social housing not being defined as SGEI in Portugal.
SOURCES	The following sources have been used for the elaboration of this Fiche: • SNS (2020), available at: https://www.sns.gov.pt/institucional/entidades-de-saude/ • OECD (2019), available at: https://stats.oecd.org/Index.aspx?ThemeTreeId=9 • European Observatory on Health Systems and Policies, Health System Review – Portugal (2018) • European Observatory on Health Systems and Policies, Portugal Health system review, Health Systems in Transition (2017) • Augusto Mateus e Associados (2016), final report "*Novo segmento de Arrendamento Acessível*" • IHRU (2018), "*Habitação: cem anos de políticas públicas em Portugal 1918-2018*", pages 463 - 506, available at https://www.portaldahabitacao.pt/web/guest/publicacao_100anos • INE (2015), National Institute of Statistics – Social housing sector characterisation sector, available at https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_destaques&DESTAQUESdest_boui=250034590&DESTAQUESmodo=2&xlang=pt • OECD (2018), available at http://www.oecd.org/social/affordable-housing-database/ • **Other resources:** legislation framework available at: https://dre.pt/

10.9 Romania

Member State: Romania		
Fiche Overview		
	Health	**Social Housing**
Expenditure relating to health and social housing SGEIs	• Romania does not define healthcare as SGEI. • In 2018, the total health expenditure in Romania was € 11.4 million (5.6% of GDP)[519]. • In 2018, 79.7% of health spending was publicly funded, out-of-pocket (OOP) spending accounted for 19.5% and private voluntary expenditures, such as private insurances, accounted for approximately 0.8% of health expenditure[520]. • Out of the total of € 257.9 million, SGEI government expenditure for the 2018-2019 period, the value of the aid paid for the service of supplying the medicines needed to prevent deaths and the worsening of diseases caused by a lack of human immunoglobulin was €3.5 million.	• Romania does not define social housing as SGEI. • In Romania, out of the total expenditure on social protection benefits[521] (€ 30,706 million in 2018), only € 24.2 million were spent on social housing in 2018, representing only 0.08%. • The number of housing built with both public and private funds has significantly decreased after 1990. • Public housing is generally financed from local budgets and transfers from the State national budget.
Key actors	• Public institutions, for instance: MINISTERUL SĂNĂTĂȚII Institutul Național de Sănătate Publică INSP • Fund providers, for instance: CNAS Casa Națională de Asigurări de Sănătate National Health Insurance House	• Public institutions, for instance: MINISTERUL LUCRĂRILOR PUBLICE, DEZVOLTĂRII ȘI ADMINISTRAȚIEI ANL Agenția Națională pentru Locuințe

[519] *Eurostat, Total healthcare expenditure, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.*
[520] *Eurostat, Healthcare expenditure by provider, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.*
[521] *Social protection benefits are transfers to households, in cash or in kind, intended to relieve them of the financial burden of several risks and needs as defined in ESSPROS. These include disability, sickness/healthcare, old age, survivors, family/children, unemployment, housing and social exclusion not covered elsewhere.*

	• Healthcare providers, for instance: REGINA MARIA REȚEAUA PRIVATĂ DE SĂNĂTATE	• Associations and NGOs, for instance: Habitat for Humanity®
Structure of health and social housing	• Romania has a universal healthcare system. • Romania's healthcare system is based on a Social Health Insurance model, with the State having a large presence. • The Ministry of Health is primarily responsible for healthcare in Romania. It is responsible for the regulatory framework and policies as well as the management of the healthcare system at large. • The National Health Insurance House (Casa Națioanlă de Asigurări de Sănătate - CNAS) is an autonomous public institution that administrates and regulates the social health insurance system. • Since 2010, local authorities have taken over some functions and competencies in health from the Ministry of Health, other tasks shifted to institutions at the central level, such as the National Agency for Medicines and Medical Devices (Agenția Națională a Medicamentului și a Dispozitivelor Medicale - ANMDM) and the National Authority for Quality Management in Healthcare (Autoritatea Națională de Management al Calității în Sănătate - ANMCS). • Both the Ministry of Health and CNAS have local level representation, through district public health authorities (Direcții de Sănătate Publică Județene - DSPs) and district health insurance houses (Case Asigurări de Sănătate Județene- CASs).	• The Ministry for Development, Public Works and Administration (MLPDA) is the key player in the housing sector at the national level. • The National Housing Agency (Agenția Națională pentru Locuințe - ANL) is responsible for administering financial resources for housing construction, and also to coordinate the sale, rehabilitation, consolidation and extension of the existing housing stock. • County councils have a general oversight and intermediation role with regard to housing, although they also retain important powers for prioritizing investments. • Local councils have shared responsibilities with higher administrative units. • There are also various associations and NGOs in the social housing sector.

	• The representative bodies of the Ministry of Health at the county level are the 42 district public health authorities (DSPs), with one in each of the 41 counties plus one in the municipality of Bucharest. • There are 43 CASs, including the Bucharest Health Insurance House and one insurance house for the employees of the Ministries of National Defense, Internal Affairs and Justice and the agencies related to national security. The CASs are mainly responsible for contracting services from public and private providers. • The National Institute of Public Health (Institutul Național de Sănătate Publică - INSP) is the main coordinator for data collection, analysis and reporting in the public health field.	
Main conclusions	• Romania has the lowest health spending in the EU, both per capita (€ 584, EU average € 3,068) and as a proportion of GDP (5.6%, EU 9.9%)[522] after Bulgaria. In relative terms, spending in the healthcare sector is low and the health system is significantly underfunded. • In 2018, the share of healthcare spending coming from public sources (79.7%) was in line with the EU average (79.3%)[523]. While OOP payments are generally low, informal payments are substantial and widespread [524] . Informal payments are direct cash/in-kind unofficial payments to healthcare providers and/or private purchases of healthcare services and other	• Romania has the highest home-ownership rate in Europe (98%), following the privatisation that Romania adopted after the fall of the communist regime. • The low volume of social housing is due to the fact that housing has not been a priority in Romanian social policy after 1990. In Romania, local authorities are the only ones who provide social housing for people in need.

[522] *Eurostat, Total healthcare expenditure, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.*
[523] *Eurostat, Healthcare expenditure by financing scheme, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.*
[524] *OECD/European Observatory on Health Systems and Policies (2019), Romania: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, available at https://doi.org/10.1787/f345b1db-en, accessed on 17 February 2021.*

	products meant to be covered by the health system[525].	

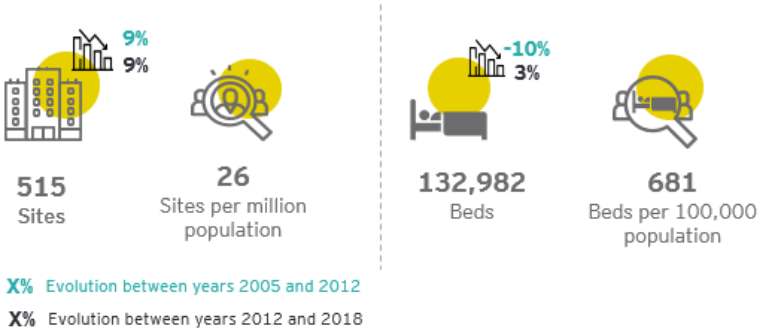
I. Health Sector

The aim of this Section is to provide an overview of the health sector in Romania as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

► **Number and share of hospitals and beds (and evolution)**

According to the Romanian National Statistical Institute, in 2018 the total number of hospital sites in Romania was 515 as opposed to 473 in 2012, representing an increase of approximately 9%.



Between 2005 and 2012 there was an increase in hospital sites of approximately 9%. In parallel, the number of sites per million population increased as well. There were 20 sites per million population in 2005, 24 in 2012 and 26 in 2018. The increase between 2005 and 2012 was of 20%, while between 2012 and 2018 only approximately 8%[526].

According to Eurostat data, the total number of available beds in hospitals in 2018 was 135,691 against 132,303 in 2012 and 146,529 in 2005, representing a decrease of 10% between 2005 and 2012 and an increase of 3% from 2012 to 2018.

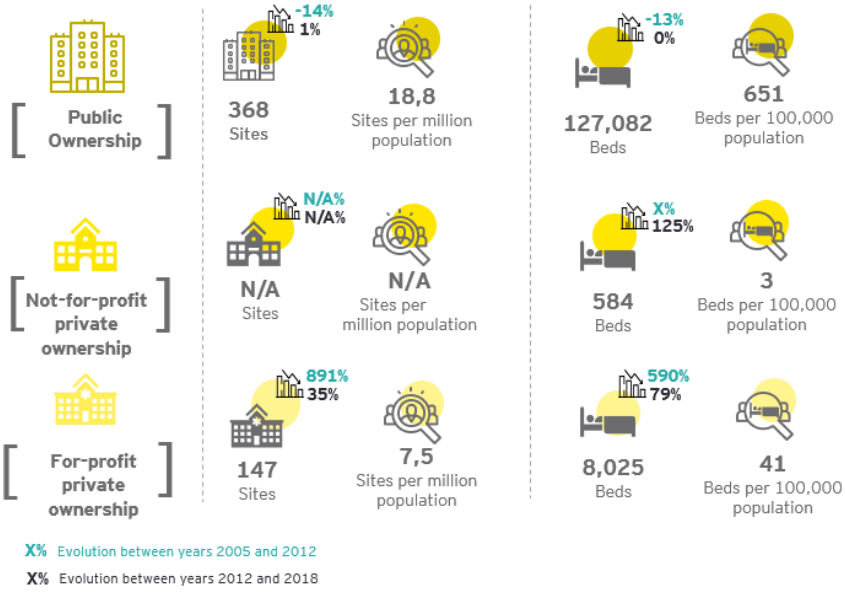
The number of beds in 2005 was 677 per 100,000 inhabitants compared to 660 in 2012 and 697 in 2018[527].

[525] *Tomini, S., Groot, W. & Pavlova, M (2012). Informal payments and intra-household allocation of resources for healthcare in Albania, available at https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-17#citeas, accessed 13 May 2021.*
[526] *National Institute of Statistics, Tempo Online, database SAN101A, available at TEMPO Online (insse.ro), accessed 15 February 2021.*
[527] *Eurostat, Hospital beds by hospital ownership, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.*

► **Number and share of hospitals and beds (and evolution) per legal entity[528]**

In 2018, there were 515 hospitals in Romania, over two thirds of which were public. While the number of public hospitals has fallen between 2005 and 2018, the number of private hospitals has seen the opposite trend.

Moreover, while the number of beds in public hospitals has decreased between 2005 and 2012, and remained relatively stable between 2012 and 2018, the number of beds in private hospitals has significantly increased between 2005 and 2018.



According to the Romanian National Statistical Institute, the number of public hospitals has decreased from 422 hospitals in 2005 to 364 hospitals in 2012. From 2012 to 2018, this number increased by 4 hospitals (to 368). In parallel, the number of private hospitals has significantly increased, from 11 hospitals in 2005 to 109 hospitals in 2012 and 147 hospitals in 2018[529]. Out of the total of 515 hospitals in Romania, in 2014 71.5% were public hospitals and 28.5% private hospitals. In 2012, out of the 473 hospitals 77% were public hospitals and 23% private hospitals and in 2005 public hospitals represented 97.5% out of the total number of 433 hospitals, while private hospitals represented only 2.5%.

The decrease in the number of public hospitals between 2005 and 2012 can be linked to the closure of 67 poorly performing public hospitals in 2011.

The National Health Strategy 2014-2020[530] envisaged a restructuring of the regional and national hospital network with the goals of reducing the number of hospital facilities and providing integrated services in order to improve coordination of treatment.

The private hospitals have increased in popularity, especially since the 2011 proposal of privatisation came up in discussion. The proposal caused great controversy and received extensive media coverage. The Romanian government withdrew the proposal in January 2012. In April 2019, the government approved an emergency decree that allowed co-payments by patients to private medical services providers[531]. Co-payments were not allowed in Romania until 2019. Another major change was brought by emergency ordinance 25/2020 [532] that allows private hospitals to provide emergency medical services and treat patients with chronic diseases and be paid for it by the State. The ordinance establishes the same regime of payment of medical services for private units and public units and eliminates the

	co-payment principle (Ordinance 27/2019). These changes have led to a growth of the private market. The increase in the number of private hospitals was also largely driven by the change of payment for day surgery and day care cases in 2014[533]. There is no officially available information regarding the condition of public hospital buildings; however, since the majority of these buildings were built in the 1970s and 1980s, and have not been well maintained, it is likely that their technical condition is rather poor. According to the Eurostat's estimate of hospital beds by hospital ownership, 127,082 (94%) out of 135,691 available beds in hospitals in 2018 were in public ownership, while only 584 were in not-for-profit private ownership, and 8,025 in for-profit private ownership. From 2012 to 2018 there has been a decrease of 0.4% in the number of beds in the public sector, an increase of 125% in the not-for-profit private and a 79% in the for-profit private sector. In 2012, out of 132,303 available beds in hospitals, 127,560 were in public ownership, 260 were in not-for-profit private ownership, and 4,483 in for-profit ownership. From 2005 to 2012 there has been a decrease of 13% in the number of beds in the public sector and an increase of 590% in the for-profit private sector. The increase in the number of private hospitals has also led to an increase in the number of beds. In 2005, out of 146,529 available beds in hospitals, 145,879 were in public ownership, none in not-for-profit private ownership, and 650 in for-profit private ownership. According to a 2021 study conducted by KeysFin[534] the turnover of the private medical services market in Romania increased by 18% compared to 2018 and was almost 330% above the 2010 level. This increase is linked to the better conditions offered by private hospitals, from the high-performance equipment to the professional personnel and the overall quality of the services offered. The increase can also be linked to the fact that a significant number of employees benefit from private health insurances from their employer. Therefore, private healthcare represents a growing segment in the healthcare sector, its growth fuelled primarily

[528] *The National Statistical Institute uses a general distinction for the recording of information on the hospitals by ownership type: public property or private property. There is no available information on the type of private ownership hospitals. The same applies for information regarding the number of beds in hospitals. However, Eurostat offers a more detailed estimate of hospital beds by hospital ownership, but offers no information on the number of sites by ownership. Therefore, data from the National Statistical Institute has been used for the analysis on the number of sites, while data from Eurostat has been used for the analysis on the number of beds.*

[529] *National Institute of Statistics, Tempo Online, database SAN101A, available at TEMPO Online (insse.ro), accessed 15 February 2021.*

[530] *National Health Strategy 2014 – 2020, available at http://www.ms.ro/wp-content/uploads/2016/10/Anexa-1-Strategia-Nationala-de-Sanatate-2014-2020.pdf, accessed on 15 February 2021.*

[531] *Emergency Ordinance No. 27/2019 for the completion of Article 230 of Law. No. 95/2006 on health reform, available at Ordonanța de urgență nr. 27/2019 pentru completarea art. 230 din Legea nr. 95/2006 privind reforma în domeniul sănătății actualizat 2021 - Lege5.ro, accessed on 23 February 2021.*

[532] *Emergency Ordinance No. 25/2020 for the amendment and completion of Law. No. 95/2006 on health reform as well as the Government Emergency Ordinance No. 158/2005 on sick leave and social security benefits, available at Ordonanța de urgență nr. 25/2020 pentru modificarea și completarea Legii nr. 95/2006 privind reforma în domeniul sănătății, precum și a Ordonanței de urgență a Guvernului nr. 158/2005 privind concediile și indemnizațiile de asigurări sociale de sănătate - Lege5.ro, accessed on 23 February 2021.*

[533] *European Observatory on Health Systems and Policy Monitor, Romania, available at Country page for Romania - HSPM, accessed 15 February 2021.*

[534] *Keysfin (2021) The Romanian private healthcare, at an all-time high in the year of pandemics , available at News Details (keysfin.com), accessed on 16 February 2021.*

	by the demand from patients. It is expected that the number of hospitals in private ownership will increase even more in the coming years. The decrease in the number of beds of public hospitals can be linked to decision of rationalising the hospital capacity, that was initiated by the Ministry of Health through the implementation of the National Plans for Hospital Beds for 2011-2013[535], 2014-2016[536] and 2017-2019[537]. Hospital bed numbers have been falling but remain among the highest in the EU. Patients in Romania often bypass the primary care setting and present directly to hospital emergency departments or hospital specialists, even for minor health problems. Initiatives to bolster primary care, combined with hospital bed closures, should help to tackle this source of inefficiency. **Evolution of the amount of public aid** According to Romania's 2018-2019 SGEI Report, the SGEI Decision has been used to entrust the National Company Unifarm S.A (in which the Romanian State is shareholder), with the activity of supplying medicines needed to prevent deaths and the worsening of diseases caused by a lack of human immunoglobulin in 2018. *Total SGEI government expenditure by legal basis was €257.9 million (€142 million in 2018 and €116 million in 2019) million. Total amount of State aid granted as part of the SGEI package for the provision of the medicines needed to prevent deaths and the worsening of diseases caused by a lack of human immunoglobulin was €3.5 million paid in 2018.*
LEGAL FRAMEWORK	Healthcare is regulated by a complex array of legislation of which the most important is Law No. 95/2006[538] on Healthcare Reform (Legea 95/2006 privind reforma în domeniul sănătății). Law 95/2006 on Healthcare Reform is the basic healthcare law in Romania, defining the role of social health insurance, private health insurance, hospitals organisation, community care, primary healthcare, pharmaceuticals, emergency services, public health, and national health programmes. Law 95/2006 has undergone more than 1,000 changes since its introduction. The reform of the Romanian health system has been considered since the 1990s. Another crucial part of the healthcare legislation is the Health Insurance Act[539], which was adopted in 1997 and entered into force in 1998. Law 145/1997 (Legea asigurărilor sociale de sănătate) replaced the old system of financing from one based on taxation at the national level, to one based on separate taxation on the payroll (as social insurance) and administered by regional health funds (counties). In Romania, health reform has been constant but frequently ineffective, partly due to a high level of political instability[540]. Since 2009 there have been at least 15 ministers of health and 10 presidents of the CNAS, undermining continuity and leading to fragmentation and reform paralysis.

[535] *Government Decision No. 151/2011 regarding the approval of the National Plan for Hospital Beds for 2011-2013.*

1.1.1 [536] *Government Decision No. 449/2014 regarding the approval of the National Plan for Hospital Beds for 2014-2016.*

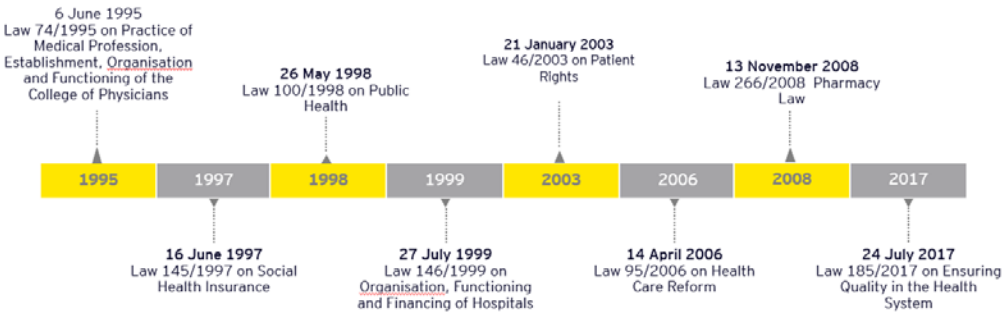
[537] *Government Decision No. 115/2017 regarding the approval of the National Plan for Hospital Beds for 2017-2019.*

[538] *Law no. 95/2006 on Healthcare Reform, including the subsequent amendments and additions, available at LEGE 95 14/04/2006 - Portal Legislativ (just.ro), accessed on 16 February 2021.*

[539] *Law 145/1997 on Social Health Insurance, including the subsequent amendments and additions, available at LEGE 145 24/07/1997 - Portal Legislativ (just.ro), accessed on 16 February 2021.*

[540] *Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A. Romania: Health system review. Health Systems in Transition, 2016; 18(4):1–170, available at Health Systems in Transition: Romania (Vol. 18 No. 4 2016) (who.int), accessed on 16 February 2021.*

Presentation of the evolution of the legal framework



Evolution of the legal framework before 2012:

Officially, the Romanian health system started functioning in 1874, when the first modern healthcare law came into effect. The State Law on Health Organisation passed in 1949 (Legea 10/1949 privind reforma sistemului de asigurări sociale) initiated a gradual transition from the pre-war Bismarck system into a so-called "Semashko"[541] healthcare system, which is based on the principles of universal coverage, State financing, central planning and free access to healthcare at point of delivery.

In 1990, after the collapse of the Soviet Union, the Romanian government embarked on a fundamental, albeit slow-paced, healthcare reform. Decentralisation of the healthcare system, which aimed to increase local autonomy, started with the Public Administration Law passed in 1991[542] (Legea fondului funciar). Public services belonging to Ministries were passed to the bodies under the authority of the Prefect (the political leader of a district) and 42 district health directorates were created, one for each district and one for the capital city. The district health directorates were responsible for funding and managing dispensaries.

The main legislative acts concerning the structure and organisation of the Romanian healthcare system have been passed between 1992 and 2002. The most important were the Law 74/1995[543] (Legea 74/1995 privind exercitarea profesiunii de medic, înființarea, organizarea și funcționarea Colegiului Medicilor din România) related to the practice of medical profession, establishment, organisation and functioning of the College of Physicians, Law 145/1997 on Social Health Insurance, Law 100/1998[544] on Public Health (Legea 100/1998 privind asistența de sănătate publică), and Law 146/1999[545] on Organisation, Functioning, and Financing Hospitals (Legea 146/1999 privind organizarea, funcționarea și finanțarea spitalelor).

The Law 74/1995 defines the physician's role and status. This law also establishes the College of Physicians as a professional, non-profit organisation that represents the physicians' interests. Law 145/1997 of social health insurance underwent numerous changes after its adoption and was then repealed by the Emergency Ordinance of the Government No. 150/2002, on the organisation and functioning of the social health insurance system. Currently, social health insurance is regulated in Title VIII of Law No. 95/2006 on health reform, a law repealing Emergency Ordinance No. 150/2002[546].

The Law 100/1998 regulates the activities in the field of public health.

Law 146/1999 on Hospital Organisation mainly stipulates forms of hospital financing, indicates the financing of teaching hospital, outlines procedures for contracting

between hospitals and health insurance funds, sets out payment of hospital staff, and identifies hospital accreditation, governance, and management.

Law No. 629/2001[547] approves and completes the Government Ordinance No. 124/1998 regarding the organisation and operation of medical practices (Legea pentru aprobarea Ordonanței Guvernului nr. 124/1998 privind organizarea și funcționarea cabinetelor medicale).

Law 46/2003[548] regarding the patient rights (Legea drepturilor pacientului) defines the patient as the user of medical services.

Only in 2006 the health insurance system began to prepare for substantial changes. Law 95/2006 on Healthcare Reform is the key legal act governing the Romanian health system. This comprehensive framework act brought together almost all existing main healthcare legislation.

The private sector in the field of healthcare was created in the 1993-1999 period, but its development has been very slow in most sectors except dentistry and pharmacy. The pharmaceutical assistance to the population is legislated via Pharmacy Law 266/2008[549] (Legea farmaciei). The private sector started to grow significantly after 2007.

Evolution of the legal framework after 2012:

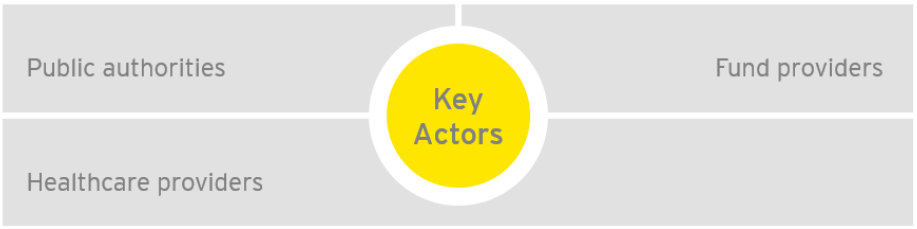
Due to several dysfunctionalities that were brought to light over the years, new legislative proposals were made to amend or even abolish Law No. 95/2006. A new bill in that respect has not been passed yet, the system continues to function on the basis of the 2006 law.

In 2011, the Government proposed a completely new healthcare system. The main change proposed was the privatisation of all hospitals and public clinics. The proposal was withdrawn in January 2012. It caused great controversy and received extensive media coverage.

In 2012, a new health law, similar to the one in 2011, was proposed. The proposal brought up a new initiative, namely the dissolution of the CNAS and did not include the privatisation of public hospitals.

Government of Romania's Decision No. 1028/2014[550] concerning the approval of the National Health Strategy 2014-2020 and the action plan for 2014-2020 attempted

[541] *Sheiman I, Shishkin S, Shevsky V (2018). The evolving Semashko model of primary healthcare: the case of the Russian Federation, available at The evolving Semashko model of primary healthcare: the case of the Ru | RMHP (dovepress.com), accessed 13 May 2021.*
[542] *Law 18/1991 on Public Administration, including the subsequent amendments and additions, available at LEGE 18 19/02/1991 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[543] *Law 74/1995 on the Practice of Medical Profession, Establishment, Organisation and Functioning of the College of Physicians, including the subsequent amendments and additions, available at LEGE 74 06/07/1995 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[544] *Law 100/1998 on Public Health, including the subsequent amendments and additions, available at LEGE 100 26/05/1998 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[545] *Law 146/1999 on Organisation, Functioning, and Financing Hospitals, including the subsequent amendments and additions, available at LEGE 146 27/07/1999 - Portal Legislativ (just.ro), accessed at 16 February 2021.*
[546] *Emergency Ordinance No. 150/2002 on the organisation and functioning of the health insurance system, including the subsequent amendments and additions, available at OUG 150 31/10/2002 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[547] *Law no. 629/2001 for the approval of Government Ordinance no. 124/1998 on the organisation and functioning of medical offices, including the subsequent amendments and additions, available at LEGE 629 13/11/2001 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[548] *Law no. 46/2003 on Patient Rights, including the subsequent amendments and additions, available at LEGE 46 21/01/2003 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[549] *Law no. 266/2008 Pharmacy Law, including the subsequent amendments and additions, available at LEGE (R) 266 07/11/2008 - Portal Legislativ (just.ro), accessed on 16 February 2021.*
[550] *Government Decision No. 1028/2014 regarding the approval of the National Health Strategy 2014 – 2020 and of the Action Plan for the period 2014 – 2020 for the implementation of the national strategy, available at HG 1028 18/11/2014 - Portal Legislativ (just.ro), accessed on 16 February 2021.*

	to implement the Europe 2020 WHO strategy[551] at national level. The Strategy aims to provide the general intervention framework to eliminate the weaknesses identified in the health sector and the Action Plan defines the measures, the timeline and the budget to implement the Strategy. Law No. 185/2017 [552] on ensuring quality in the health system (Legea 185/2017 privind asigurarea calității în sistemul de sănătate), including the subsequent amendments and additions regulates the quality management of health services provided within the national health system.
ORGANISATION OF THE SECTOR	The Romanian healthcare system presents the characteristics of Bismarck healthcare system. It is based on social insurance and one State-owned insurance organisation (National Health Insurance House) manages the funds collected from taxpayers. The Romanian health system is organised at two levels of governance: national and district. The national level is responsible for setting and achieving general objectives and ensuring the fundamental principles of the government health policy. The district level is responsible for ensuring service provision according to the rules set by the central level. ► **Synthetic presentation of the type of actors:**  ***Public institutions:*** • The **Ministry of Health** is the central administrative authority in the health sector. It is responsible for the stewardship of the system and for its regulatory framework, including regulation of the pharmaceutical sector as well as public health policies and services, sanitary inspection and the Framework Contract, which regulates the purchasing of health services. It is also in charge of monitoring and evaluation of population health, provision of public health education and health promotion, human resources policy and certain infrastructural investments in the healthcare sector. • The **National Authority for Quality Management in Healthcare (ANMCS)** was created in 2015. Its tasks include: further developing, in collaboration with the Ministry of Health, the National Strategy for Quality Assurance in Health; drafting legislative proposals to ensure harmonisation with international regulations; elaborating accreditation standards, methods and procedures for healthcare providers; accrediting training and technical consultancy providers in the field of health quality management; evaluating, re-evaluating and accrediting health providers; monitoring that appropriate quality standards are in place in healthcare facilities at all levels of care; and performing research activities in the area of health services quality. • The **National Agency for Medicines and Medical Devices (ANMDM)** is a public institution operating as a legal entity subordinated to the Ministry of

[551] *WHO (2013), Health 2020. A European policy framework and strategy for the 21st century, available at Health2020 (Long) (who.int), accessed on 16 February 2021.*
[552] *Law no. 185/2017 on ensuring quality in the health system, including the subsequent amendments and additions, available at LEGE 185 24/07/2017 - Portal Legislativ (just.ro), accessed on 16 February 2021.*

Health, following the merger of the National Medicines Agency with the Medical Devices Technical Office. The ANMDM develops national strategies and policies in the field of medicines and medical devices. The ANMDM is the national authority competent in the field of medical technology assessment, according to criteria developed by the Ministry of Health. The ANMDM is responsible for market authorisation and surveillance of the safety of medicinal products on the market but also for setting the prices for medicines and medical devices when reimbursed by the CNAS.

- There are 42 **District Public Health Authorities**, one in each of the 41 districts and municipality of Bucharest. These are mainly responsible for carrying out the functions of the Ministry of Health related to population health at the local level.
- There are 43 **District Health Insurance Houses**, including the Bucharest Health Insurance House and one insurance house for the employees of the Ministries of National Defense, Internal Affairs and Justice and the agencies related to national security. The DHIHs are mainly responsible for concluding contracts with health service providers at the local level and monitoring these contracts as well as certain quality aspects of service provision.
- The **National Institute of Public Health (INSP)** is the main coordinator for data collection, analysis and reporting in the public health field.

Fund providers:

- Social security scheme (National Health Insurance Fund) through the Romanian mandatory's statutory health insurance system.
- The **National Health Insurance House (CNAS)** is an autonomous public institution that administrates and regulates the social health insurance system. Established in 1999, it decides on resource allocation from the National Health Insurance Fund (Fondul Național Unic de Asigurări Sociale de Sănătate - FNUASS) to the District Health Insurance Houses (CAS); sets out annual objectives for its own activities and for the activities of the CAS; supervises and coordinates the activity of the CAS's it has the power to issue implementing regulations mandatory to all CAS's; and decides on the resource allocation between different types of care. It also elaborates the Framework Contract, which together with the accompanying norms, defines the benefits package to which the insured are entitled as well as the provider payment mechanisms.
- Apart from the National Health Insurance Fund (FNUASS), the social health insurance system also includes three other main pillars under the Ministry of Labour, Family, Social Protection and Elderly: the Pension Fund, the Unemployment Fund and the Work Injuries Fund.
- The implementation of preventive national health programmes, some emergency care and capital investments are funded by the Ministry of Health.
- Local budgets fund hospital maintenance, repairs and inpatient meals.

Healthcare providers:

- Public hospitals including university hospitals
- Private hospitals
- Private medical clinics
- Analytical service providers
- Other healthcare providers

► **Competition in the sector**

According to the National Statistical Institute, and as stated in the "key figures" section, the number of public hospitals has decreased from 422 hospitals in 2005 to 364 hospitals in 2012. From 2012 to 2018, this number increased by 4 hospitals (368). In parallel, the number of private hospitals has significantly increased, from 11 hospitals in 2005 to 109 hospitals in 2012 and 147 hospitals in 2018[553].

Since 2007, the number of private hospitals began to rise. Currently, there are 147 private hospitals/clinics in Romania. The private hospitals have increased in popularity, especially since the 2011 proposal of privatisation came into discussion.

The increasing number of private sanitary units with beds increases the competition for money from the Single National Health Insurance Fund (FUNASS), between State and private hospitals.

Many private hospitals have also used the good reputation of doctors from the State hospitals to increase their attractiveness. Some parties consider the work carried out by the State-employed doctor in a private unit as a form of unfair competition.[554].

With regard to changes in the legislation, in April 2019, the government approved an emergency decree that allowed co-payments by patients to private medical services providers. The document states that "Individuals with health insurance who choose to benefit from medical services provided by private providers concluding contracts with health insurance houses for continuous hospitalisation, clinic specialty ambulatory and outpatient clinics can pay a personal contribution to cover the difference between the tariffs for medical services charged by private providers and the fees charged from the budget of the National Social Health Insurance Fund settled by the health insurance houses"[555]. Co-payments were not allowed in Romania until 2019.

Another major change was brought by an emergency ordinance 25/2020 that allows private hospitals to provide emergency medical services and treat patients with chronic diseases and be paid by the State. The ordinance establishes the same regime of payment of medical services for private units and public units and the eliminates the co-payment principle (Ordinance 27/2019). These changes have led to an increase of the private market.

The private health sector represents a growing segment, its development depending primarily on demand from increasingly large part of patients to this segment. It is expected that the number of hospitals in private ownership will increase even more in the coming years.

► **Definition of SGEI for the hospital sector**

Hospital services do not fall under the SGEI Package. The only SGEI reported in the healthcare sector is the supply of medicines needed to prevent deaths and the worsening of diseases caused by a lack of human immunoglobulin (see Key Figures under *Evolution of the amount of public aid* above).

[553] *National Institute of Statistics, Tempo Online, database SAN101A, available at TEMPO Online (insse.ro), accessed 15 February 2021.*

[554] *Societatea Academică din România (2013). Stop concurenţei neloiale public-privat în sectorul sanitar românesc, available at POLITICA DE SĂNĂTATE: Stop concurenţei neloiale public-privat în sectorul sanitar românesc | Societatea Academica din Romania (sar.org.ro), accessed on 23 February 2021.*

[555] *Emergency Ordinance No. 27/2019 for the completion of Article 230 of Law. No. 95/2006 on health reform, available at Ordonanța de urgență nr. 27/2019 pentru completarea art. 230 din Legea nr. 95/2006 privind reforma în domeniul sănătății actualizat 2021 - Lege5.ro, accessed on 23 February 2021.*

FUNDING OF THE SECTOR

Public funding arrangements

80% of health spending is publicly funded. Most public funding comes from the health insurance contributions to the CNAS. Revenue of the CNAS comes from contributions paid by the insured population and employers, State budget subventions and transfers, and other sources (donations, interests etc.). Some revenue comes also from State and local budgets. The second largest source of revenue OOP. OOP payments in Romania include: direct payments for goods or services that are not included in the statutory health insurance benefits package or covered by the national health programmes; direct payments by uninsured patients; direct payments for (uncontracted) private providers; user charges for some healthcare services and pharmaceuticals; and informal payments.

Voluntary Health Insurance plays a marginal role in the financing of healthcare in Romania. Informal payments likely to be substantial, although their full extent is unknown. Any person entitled to the basic package provided by the statutory health insurance scheme is eligible to purchase Voluntary Health Insurance. It can be purchased individually or by employers as a health benefit for employees.

Health expenditure

Although health expenditure has systematically increased in recent years, in 2018 Romania spent € 584 per person on health, a lot less than half the EU average of € 3,068, or 5.6 % of GDP (compared to the EU average of 9.9%). Substantial migration from Romanians to other countries has led to a rise in per capita spending.

	Amount of expenditure in 2018 (in €)	Evolution 2005 - 2012	Evolution 2012 – 2018
Total Health expenditure (in billion)[556]	11.4 billion	+53%	+81%
Hospital cares expenditures (in billion)	5.3 billion	N/A%	+123%

The total health expenditure was € 11,371 million in 2018 (5.6% of GDP). This expenditure was € 6,282 million in 2012 (4.7% of GDP) and € 4,107 million (5.5% of GDP) in 2005. This health expenditure has then increased by 81% between 2012 and 2018, following an increase of 53% during the previous period of time (2005-2012).

The limited spending is skewed towards hospital and inpatient care. Expenditure in hospitals[557] in 2018 was € 5,287 million against € 2,366 million in 2012[558], which represents an increase of 123%.

[556] *Eurostat, Healthcare expenditure by financing scheme, available at https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en, accessed on 16 February 2021.*

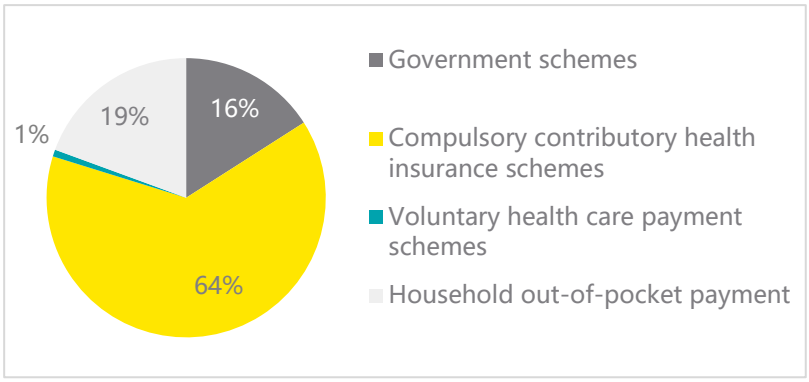
[557] *Hospitals include licensed establishments primarily engaged in providing medical, diagnostic and treatment services that include physician, nursing, and other health services to in-patients and the specialised accommodation services needed by in-patients.*

[558] *Eurostat, Healthcare expenditure by provider, available at https://ec.europa.eu/eurostat/databrowser/view/HLTH_SHA11_HP__custom_581148/default/table?lang=en , accessed 15 February 2021.*

The drop in the health expenditure as a percentage of GDP from 2005 to 2012 was influenced by the worsening of the general economic context, including the spending cuts implemented in order to meet the fiscal deficit target and the unstable political situation[559].

According to Romania's Country Health Profile of 2019[560], more than 42% of health spending is directed to inpatient care (compared to the EU average of 29%). Another 27% is spent on pharmaceuticals and medical goods. This is particularly high compared to other countries, and the third highest proportion in the EU after Bulgaria and Slovakia. Health spending on primary and ambulatory care remains the second lowest in the EU (18%, compared to the 30% EU average). Romania also spends very little on prevention (1.7% of total health spending, compared to 3.1% across the EU).

Distribution of health expenditure per category of funder in 2018:



Health expenditure is mainly funded by the compulsory health insurance scheme (64% of the spending in 2018). Approximately 19% is funded by OOP payments, 16% by Government schemes and approximately 1% by voluntary healthcare payment schemes. The exact share of private expenditure on health has always been difficult to estimate because of informal payments and the underreporting of incomes by private providers. Romania has a single pool and payer social health insurance system, with employer and employee contributions accounting for 82% of the National Health Insurance House (CNAS) revenue in 2017. This has declined from 97 percent in 2006, with central government transfers and a clawback tax on reimbursed pharmaceuticals increasingly subsidising the CNAS budget[561].

► **Evolution of the distribution of health expenditure[562]:**

	2012 - 2018
Government schemes	+191%

[559] *European Observatory on Health Systems and Policy Monitor, Romania, Section 1.2, available at Country page for Romania - HSPM, accessed 15 February 2021.*

[560] *OECD/European Observatory on Health Systems and Policies (2019), Romania: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, available at https://doi.org/10.1787/f345b1db-en, accessed on 17 February 2021.*

[561] *World Bank (2018), 'Romania Regional Hospital Analysis Study, Regional Referral Networks in Romania', Report No: AUS0000278, available at http://documents.worldbank.org/curated/en/798931530245678590/pdf/AUS0000278-WP-P165988-PUBLIC-RomaniaRegionalReferralNetworksfinal.pdf, accessed on 17 February 2020.*

[562] *Data for 2005-2012 is not available.*

Compulsory contributory health insurance schemes	+72%
Voluntary healthcare payment schemes	+126%
Household out-of-pocket payment	+57%

II. Social Housing

The aim of this Section is to provide an overview of the social housing sector in Romania as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

Romania has seen significant political and street unrest over the last few years, which focused everybody's attention on issues such as corruption and the rule of law. This has happened against a backdrop of rising economic inequality and poverty since 1990. As a result, social housing has never been a political priority, resulting in the fact that there has been no major housing reform since 1990.

Romania's current social housing stock is insignificant and has undergone extreme privatisation and residualisation[563] in the last 25 years:

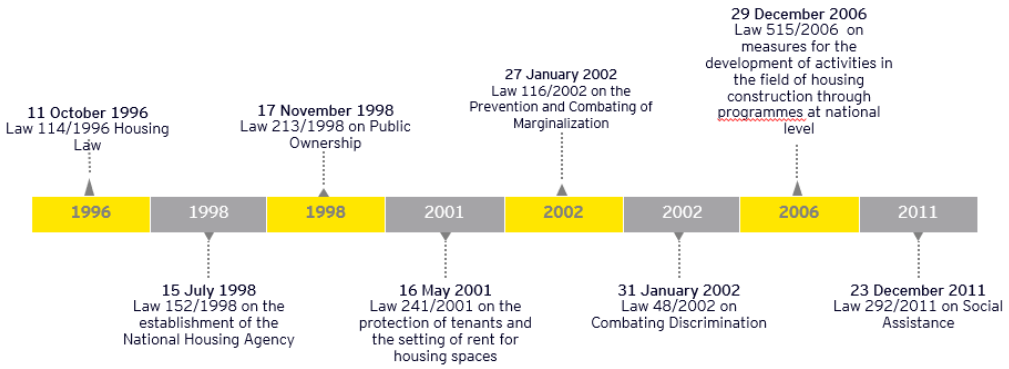
- From 1990 to 1996, there was mass housing stock privatisation through sale of units built with State funds and completion of collective housing blocks which were in different stages of execution in 1989 and whose construction began with State funds before 1989.
- From 1996 to 2006, the housing sector underwent legal and institutional reforms. Two important laws were introduced during this phase: Housing Law No. 114/1996 (Legea locuinței) and Law No. 152/1998 (Legea 152/1998 privind înființarea Agenției Naționale pentru Locuințe) on the establishment of the National Housing Agency (ANL). A massive restructuring of legislation combined with decentralisation and local government reform characterised this phase.
- From 2006 until the present, Romania has witnessed a multiplication of programs in the housing sector.

According to Eurostat[564], in 2012, in Romania the share of the population living in a dwelling with a reduced-price rent or occupying a dwelling free of charge was 2.9%. The share of the population living in a dwelling with a reduced-price rent or occupying a dwelling free of charge decreased to 2.4% in 2018. At the same time, the number of house owners increased from 96.3% in 2012 to 96.4% in 2018. Home-ownership increased in Romania from 67.3% in 1990 to over 93% in 1993 and 96% in 2018.

Romania has the highest home-ownership rate in Europe. This situation is explained by the widespread privatisation after the fall of the communist regime. Privatisation

[563] *The term "residualisation" refers to a process in which a residue is created. When people leave a neighbourhood or community because they believe it is no longer a desirable place to live, then what they leave behind is a social residue of less enabled people. Extract taken from 'Stemming the Urban Haemorrhage', part of a community document prepared by Brian Williams in 1999 for the Orchard Park Environment Redevelopment Association (OPERA), Hull, England, available at urbanrim.org.uk/residual, accessed 13 May 2021.*

1.1.2 [564] *Eurostat, Distribution of population by tenure status, type of household and income group - EU-SILC survey, available at Statistics | Eurostat (europa.eu), accessed on 19 February 2021.*

	of housing, namely the transfer of property rights from the State to the population, has enabled citizens to buy homes at prices lower than the market price. Privatisation was accommodated by a sharp decline in the maintenance and construction of social housing. Data on Romania's housing markets is severely lacking, and there is little to no data available on publicly funded housing at the national level. The National Statistical Institute uses a far too general distinction for the recording of information on the property of the dwelling: State/public property (which includes social housing) or private property. Due to this general description, no specific data is available for social housing.
LEGAL FRAMEWORK	Romania does not have a coherent housing policy and little space has been given to housing overall on political manifestos since 1990. The national legal environment for social housing provision is defined by the Housing Law 114/1996[565], the Law for Combating Discrimination 48/2002[566], and the Law for Preventing and Combating Social Marginalisation 116/2002[567]. ► **Presentation of the evolution of the legal framework:**  ► ***Evolution of the legal framework before 2012:*** The **Housing Law 114/1996** acknowledges the right to housing and defines social housing as subsidised housing to be attributed to individuals or families whose economic situation does not allow them to access property or a rental property under market conditions. It states that the income threshold for eligible social tenants needs to be below the national average and it limits the level of monthly rent paid by households must be below 10% of the household's monthly income. The Act also defines the social categories entitled to social housing. These categories notably are: those rendered homeless by natural disasters; those evacuated or that are to be evacuated from houses retroceded to the former owners at the end of the Soviet era; adults under 35; adults leaving social care institutions; the disabled;

[565] *Law No. 114/1996 on Housing, including the subsequent amendments and additions, available at LEGE (R) 114 11/10/1996 - Portal Legislativ (just.ro), accessed on 18 February 2021.*
[566] *Law No. 48/2002 for the approval of Government Decision No. 137/2000 on the Prevention and Sanctioning of all Forms of Discrimination, including the subsequent amendments and additions, available at LEGE 48 16/01/2002 - Portal Legislativ (just.ro), accessed on 18 February 2021.*
[567] *Law No. 116/2002 on Preventing and Combating Social Marginalization, including the subsequent amendments and additions, available at LEGE 116 15/03/2002 - Portal Legislativ (just.ro), accessed on 18 February 2021.*

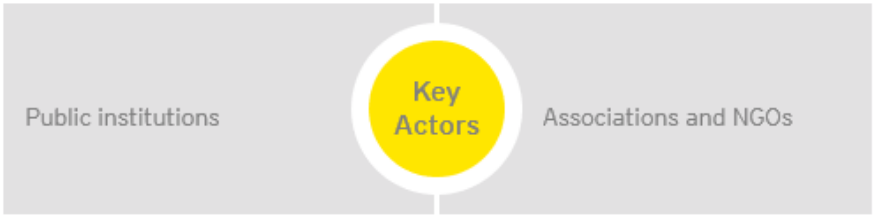
	pensioners; veterans and widows of war; political dissidents from previous communist regimes; and martyr-heroes who participated in the Romanian Revolution in December 1989. Local authorities are responsible for social housing, for subsidising rents and for building, allocating, managing, and maintaining social housing. They also have the responsibility to prepare development plans and provide infrastructure for such housing. Local authorities are free to prioritise allocation as they see fit but have to secure the necessary finance from local budgets or loans. **Law 213/1998**[568], **on public ownership** (Legea 213/1998 privind bunurile proprietate publică) and its juridical regime states that public ownership is the one subjective ownership right which belongs to the State itself and to its administrative-territorial units, upon the goods which either by their own nature or through a special statement of the law, are of public use or utility. The National Housing Agency was established under **Law 152/1998**[569], an institution of public interest with legal personality, in charge of coordinating sources of financing in the field of housing construction. **Law 116/2002 on Preventing and Combating Social Marginalisation** (Legea privind prevenirea și combaterea marginalizării sociale) aims to guarantee effective access of citizens, especially young people, to measures to prevent and combat social marginalisation. The Law also recognises the right to housing, and it stipulates that local authorities may (but they are not required to) raise funds in order to provide housing for young people (aged less than 35) who cannot afford to buy accommodation. Other important laws related to social housing are Law **241/2001**[570] for the approval of Emergency Ordinance No. 40/ 1999 on the protection of tenants and the setting of rent for housing spaces (Legea 241/2001 pentru aprobarea Ordonanței de urgență a Guvernului nr. 40/1999 privind protecția chiriașilor și stabilirea chiriei pentru spațiile cu destinația de locuințe), **Law 515/2006**[571] for the approval of Emergency Ordinance No. 68/2006 on measures for the development of activities in the field of housing construction through programmes at national level (Legea pentru aprobarea Ordonanței de urgență a Guvernului nr. 68/2006 privind măsuri pentru dezvoltarea activității în domeniul construcțiilor de locuințe prin programe la nivel național), **Law 84/2008**[572] for the approval of Emergency Ordinance No. 74/ 2007 on the provision of social housing fund for tenants evicted or to be evicted from dwellings returned to former owners (Legea 84/2008 pentru aprobarea Ordonanței de urgență a Guvernului nr. 74/2007 privind asigurarea fondului de locuințe sociale

[568] *Law No. 213/1998 on Public Property, including the subsequent amendments and additions, available at LEGE 213 17/11/1998 - Portal Legislativ (just.ro), accessed on 19 February 2021.*
[569] *Law No. 152/1998 on the establishment of the National Housing Agency, including the subsequent amendments and additions, available at LEGE 152 15/07/1998 - Portal Legislativ (just.ro), accessed on 19 February 2021.*
[570] *Law No. 241/2001 for the approval of Emergency Ordinance No. 40/ 1999 on the protection of tenants and the setting of rent for housing spaces, including the subsequent amendments and additions, available at LEGE 241 16/05/2001 - Portal Legislativ (just.ro), accessed on 19 February 2021.*
[571] *Law No. 515/2006 for the approval of Emergency Ordinance No. 68/2006 on measures for the development of activities in the field of housing construction through programmes at national level, including the subsequent amendments and additions, available at LEGE 515 29/12/2006 - Portal Legislativ (just.ro), accessed on 19 February 2021.*
[572] *Law 84/2008 for the approval of Emergency Ordinance No. 74/ 2007 on the provision of social housing fund for tenants evicted or to be evicted from dwellings returned to former owners, including the subsequent amendments and additions, available at LEGE 84 08/04/2008 - Portal Legislativ (just.ro), accessed on 19 February 2021.*

	destinate chiriașilor evacuați sau care urmează a fi evacuați din locuințele retrocedate foștilor proprietari) and Law 292/2011 on Social Assistance[573] (Legea asistenței sociale). ► ***Evolution of the legal framework after 2012:*** There have been no legislative changes in the field of social housing after 2012. However, there have been a number of documents aimed at improving the social housing conditions developed in recent years: the National Strategy on Social Inclusion and Poverty Reduction 2015-2020[574], the National Anti-Poverty Package 2016[575]. The main objective of the National Strategy on Social Inclusion and Poverty Reduction 2015 – 2020 is for "all citizens to have opportunities, the basic needs of citizens to be met (housing, hygiene, nutrition and safety), differences between members of society to be respected and all persons to be appreciated and to live with dignity'. Another document that approaches housing quality as an element that substantially contributes to all the other objectives of social inclusion is the Strategy of the Government of Romania for the Inclusion of the Romanian Citizens Belonging to Roma Minority for 2015 – 2020. A draft national strategy on housing[576] has been finalised in 2017 but has not yet been approved by the government. The draft document proposes two key objectives: increasing the public housing stock and improving the housing conditions of vulnerable groups.
ORGANISATION OF THE SECTOR	In accordance with Law 114/1996, housing is a shared responsibility between the national government and the local authorities (municipalities/ local councils). The main actors in charge of both the development, management and allocation of the social housing stock as well as with the provision and/or coordination of providers of social services, are the local authorities, through their public social assistance services. The construction of social houses is a shared responsibility between the authorities of the local public administration and the central public administration. The authorities of the local public administration can also build social houses entirely from their own funds and they can buy houses from the free market and use them as social houses. The amount of public stock is very small following mass privatisation representing about 2.4% of the national housing stock. ► **SGEI in the sector** Social housing is not defined as service of general interest (SGEI) in Romania.

[573] *Law 292/2011 on Social Assistance, including the subsequent amendments and additions, available at LEGE 292 20/12/2011 - Portal Legislativ (just.ro), accessed on 19 February 2021.*
[574] *Ministry of Labor, Family, Social Protection and Elderly, National Strategy on Social Inclusion and Poverty Reduction 2015-2020, available at 4. Strategy Social Inclusion.pdf (frds.ro), accessed on 23 February 2021.*
[575] *National Anti-Poverty Package 2016, available at Pachet_integrat_pentru_combaterea_saraciei.pdf (edu.ro), accessed on 23 February 2021.*
[576] *National Strategy on Housing, available at 2017-01-13_Strategia_Nationala_a_Locuirii_2016-2030.pdf (mmediu.ro), accessed on 23 February 2021.*

► **Presentation of the categories of actors in the social housing sector**



Public institutions

- The **Ministry for Development, Public Works and Administration** is the key player in the housing sector at the national level. It has two major roles: to establish a housing policy, and draft legislation as required to establish the legislative framework for that policy; and to obtain funds to implement housing programs.
- The **National Housing Agency** is a statutory body under the authority of the MLPDA with the mandate to implement public sector housing programs. It is primarily a technical arm of the central government, staffed by architects, engineers and building specialists. According to Law 152/1998, the role of the National Housing Agency (which is financially autonomous) is to administer financial resources for housing construction, and also to coordinate the sale, rehabilitation, consolidation and extension of the existing housing stock. The investments are covered from the State budget and/or local budgets, internal/external credits, private investors, and other legal sources. The ANL's projects are developed on land provided and serviced by local authorities.
- **County councils** have a general oversight and intermediation role with regard to housing, although they also retain important powers for prioritizing investments.
- **Local councils** have shared responsibilities with higher administrative units. Social housing is implemented in partnership between local councils and the MLPDA, while collaboration with county councils is required for assisted and sheltered housing for youth or homeless people, as well as other ANL run programs.

Associations and NGOs:

- The privatisation of public housing stock after the fall of communism created a need to address the common interests of homeowners in terms of maintenance of the common property and other matters of mutual concern. This need was met by the formation of **Homeowners Associations** (HOAs).
- Homeowner associations are currently grouped in **Federations of Homeowners** at city, county or national levels. The largest federation is the League of Homeowner Associations, "Liga Habitat", constituted in 1991 and currently representing over 15,000 HOAs from 31 counties in Romania. A similar network is FAPR (Federation of Homeowner Associations). Both structures offer advisory and specialized training (e.g. on housing administration and management), represent the needs of its members to

	third parties, organize events to disseminate information, as well as facilitate contact and discussion among members. • **Habitat for Humanity Romania** is a non-profit organisation active in the field of social housing. • **The Housing Block** is a decentralised network of organisations fighting to empower and politically organize communities against housing injustice. • **PACT Foundation** is a Romanian non-profit organisation supporting the sustainable development of communities from Southern Romania by encouraging, growing and promoting local and regional initiatives, partnerships and social responsibility at individual, corporate, authorities and institutional level. ► **Competition in the sector:** The social housing sector in Romania is managed by public institutions and therefore competition does basically not exist.
FUNDING OF THE SECTOR	The number of dwellings built with public funds after 1990 has significantly decreased, registering in 2000 only 1,160 homes, compared to 42,820 homes built in 1990. The number of homes built with public funds recorded a steady growth in 2001-2008, reaching 6,084 homes in 2008. The economic crisis influenced public funds housing to reduce the number in 2009-2011, reaching 2,357 homes in 2011. In 2018 only 2,004 dwellings were built, representing a decrease of 44% from 2012 (3,580 dwellings built) and a decrease of 61% from 2005 (5,126 dwellings built). Regarding dwellings finances with private funds, their number increased in 1990-1994 and 2005-2008 periods, but during 1995-2004 the number has remained approximately constant at 25,000 dwellings per year. The global financial crisis has reduced the number of dwellings from 61,171 (in 2008) to 43,062 (in 2011). The number of dwellings in 2005 was 27,742, against 40,436 in 2012 and 57,709 in 2018[577]. The total expenditure on social protection as % of the GDP in Romania was 15% in 2018, against 15.5% in 2012[578]. According to Eurostat, housing benefits represented in 2018 only 0.08% of the total benefits and 0.13% in 2012. Total expenditure on social benefits represented 98% in 2018 against 99% in 2012 of total expenditure on social protection. The total expenditure on social protection benefits was € 30,706 million in 2018, 20,511 million in 2012, 10,734 in 2005. Out of the total expenditure, € 24.2 million were spent on social housing in 2018, against € 26.2 million in 2012 and there was no expenditure in 2005[579]. Public housing is generally financed from local budgets and transfers from the State national budget. As the money allocated from the State budget does not represent a big amount, the number of social dwellings built each year is low. Other persons or companies could support the social housing construction through donations or contributions.

[577] *National Institute of Statistics, Tempo Online, database LOC104B, available at TEMPO Online (insse.ro), accessed 23 February 2021.*
[578] *Eurostat, Expenditure on social protection, available at Statistics | Eurostat (europa.eu), accessed on 23 February 2021.*
[579] *Eurostat, Expenditure: main results, available at Statistics | Eurostat (europa.eu), accessed on 23 February 2021.*

	The National Housing Agency receives State budget funds to build public housing, while the local authority could provide the land. In general, local authorities must raise their own funds to build and operate social housing[580]. A small amount of social housing has been built every year in Romania since 1990. This is explained by social housing not being a priority of Romanian social policy and by the sharp decline in funding for social housing since 1989. Funding for social housing, as a share of public expenditure, declined from 8.7 per cent in 1989 to 0.8 per cent in 2000[581]. At the same time, the share of new social housing in total new housing output decreased from 8.9% in 2005 to 3.9% in 2009. As such, State-owned housing, estimated at about one-third of the stock in 1990, declined significantly by 2018. **Aid granted as part of the SGEI Package** No aid was granted as part of the SGEI Package due to social housing not being defined as SGEI in Romania. Romanian stakeholders interviewed for this study were familiar with the SGEI package and its implications. Defining social housing as SGEI is seen as a possibility to tackle some of the problems of the Romanian social housing system.
SOURCES	The following sources have been used for the elaboration of this Fiche: ► **Statistics** • *Eurostat, Total healthcare expenditure, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.* • *Eurostat, Healthcare expenditure by provider, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.* • *Eurostat, Healthcare expenditure by financing scheme, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.* • *National Institute of Statistics, Tempo Online, database SAN101A, available at TEMPO Online (insse.ro), accessed 15 February 2021.* • *Eurostat, Hospital beds by hospital ownership, available at Statistics | Eurostat (europa.eu), accessed 15 February 2021.* • *National Institute of Statistics, Tempo Online, database LOC104B, available at TEMPO Online (insse.ro), accessed 23 February 2021.* • *Eurostat, Distribution of population by tenure status, type of household and income group - EU-SILC survey, available at Statistics | Eurostat (europa.eu), accessed on 19 February 2021.* • *Eurostat, Expenditure on social protection, available at Statistics | Eurostat (europa.eu), accessed on 23 February 2021.* • *Eurostat, Expenditure: main results, available at Statistics | Eurostat (europa.eu), accessed on 23 February 2021.* ► **Other resources** • *Emergency Ordinance No. 27/2019 for the completion of Article 230 of Law. No. 95/2006 on health reform, available at Ordonanța de urgență nr. 27/2019 pentru*

[580] *World Bank, Housing in Romania: towards a national housing strategy (2015), available at World Bank Document, accessed on 23 February 2021.*
[581] *Turcu, C (2017). Mind the Poorest: Social Housing Provision in Post-crisis Romania, available at Mind the Poorest: Social Housing Provision in Post-crisis Romania - Critical Housing Analysis (housing-critical.com), accessed on 19 February 2021.*

	completarea art. 230 din Legea nr. 95/2006 privind reforma în domeniul sănătății actualizat 2021 - Lege5.ro, accessed on 23 February 2021. • *Emergency Ordinance No. 25/2020 for the amendment and completion of Law. No. 95/2006 on health reform as well as the Government Emergency Ordinance No. 158/2005 on sick leave and social security benefits, available at Ordonanța de urgență nr. 25/2020 pentru modificarea și completarea Legii nr. 95/2006 privind reforma în domeniul sănătății, precum și a Ordonanței de urgență a Guvernului nr. 158/2005 privind concediile și indemnizațiile de asigurări sociale de sănătate - Lege5.ro, accessed on 23 February 2021.* • *European Observatory on Health Systems and Policy Monitor, Romania, available at Country page for Romania - HSPM, accessed 15 February 2021.* • *Keysfin (2021) The Romanian private healthcare, at an all-time high in the year of pandemics , available at News Details (keysfin.com), accessed on 16 February 2021.* • *Government Decision No. 151/2011 regarding the approval of the National Plan for Hospital Beds for 2011-2013.* • *Government Decision No. 449/2014 regarding the approval of the National Plan for Hospital Beds for 2014-2016.* • *Government Decision No 115/2017 regarding the approval of the National Plan for Hospital Beds for 2017-2019.* • *Law no. 95/2006 on Healthcare Reform, including the subsequent amendments and additions, available at* LEGE 95 14/04/2006 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law 145/1997 on Social Health Insurance, including the subsequent amendments and additions, available at* LEGE 145 24/07/1997 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law 18/1991 on Public Administration, including the subsequent amendments and additions, available at* LEGE 18 19/02/1991 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law 74/1995 on the Practice of Medical Profession, Establishment, Organisation and Functioning of the College of Physicians, including the subsequent amendments and additions, available at* LEGE 74 06/07/1995 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law 100/1998 on Public Health, including the subsequent amendments and additions, available at* LEGE 100 26/05/1998 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law 146/1999 on Organisation, Functioning, and Financing Hospitals, including the subsequent amendments and additions, available at* LEGE 146 27/07/1999 - Portal Legislativ (just.ro), *accessed at 16 February 2021.* • *Emergency Ordinance No. 150/2002 on the organisation and functioning of the health insurance system, including the subsequent amendments and additions, available at* OUG 150 31/10/2002 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law no. 629/2001 for the approval of Government Ordinance no. 124/1998 on the organisation and functioning of medical offices, including the subsequent*

	amendments and additions, available at LEGE 629 13/11/2001 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law no. 46/2003 on Patient Rights, including the subsequent amendments and additions, available at* LEGE 46 21/01/2003 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Law no. 266/2008 Pharmacy Law, including the subsequent amendments and additions, available at* LEGE (R) 266 07/11/2008 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Government Decision No. 1028/2014 regarding the approval of the National Health Strategy 2014 – 2020 and of the Action Plan for the period 2014 – 2020 for the implementation of the national strategy, available at* HG 1028 18/11/2014 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *WHO (2013), Health 2020. A European policy framework and strategy for the 21st century, available at* Health2020 (Long) (who.int), *accessed on 16 February 2021.* • *Law No. 185/2017 on ensuring quality in the health system, including the subsequent amendments and additions, available at* LEGE 185 24/07/2017 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *Emergency Ordinance No. 27/2019 for the completion of Article 230 of Law. No. 95/2006 on health reform, available at* Ordonanța de urgență nr. 27/2019 pentru completarea art. 230 din Legea nr. 95/2006 privind reforma în domeniul sănătății actualizat 2021 - Lege5.ro, *accessed on 23 February 2021.* • *Law No. 51/2006 on community utilities services, including the subsequent amendments and additions, available at* LEGE 51 08/03/2006 - Portal Legislativ (just.ro), *accessed on 16 February 2021.* • *European Observatory on Health Systems and Policy Monitor, Romania, Section 1.2, available at* Country page for Romania - HSPM, *accessed* 15 February 2021. • *OECD/European Observatory on Health Systems and Policies (2019), Romania: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, available at* https://doi.org/10.1787/f345b1db-en, *accessed on 17 February 2021.* • *World Bank (2018), "Romania Regional Hospital Analysis Study, Regional Referral Networks in Romania", Report No: AUS0000278, available at* http://documents.worldbank.org/curated/en/798931530245678590/pdf/AUS0000278-WP-P165988-PUBLIC-RomaniaRegionalReferralNetworksfinal.pdf, *accessed on 17 February 2020.* • *Law No. 114/1996 on Housing, including the subsequent amendments and additions, available at* LEGE (R) 114 11/10/1996 - Portal Legislativ (just.ro), *accessed on 18 February 2021.* • *Law no. 48/2002 for the approval of Government Decision No. 137/2000 on the Prevention and Sanctioning of all Forms of Discrimination, including the subsequent amendments and additions, available at* LEGE 48 16/01/2002 - Portal Legislativ (just.ro), *accessed on 18 February 2021.* • *Law No. 116/2002 on Preventing and Combating Social Marginalization, including the subsequent amendments and additions, available at* LEGE 116 15/03/2002 - Portal Legislativ (just.ro), *accessed on 18 February 2021.*

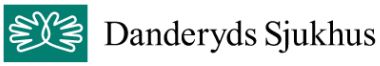
- *Law No. 213/1998 on Public Property, including the subsequent amendments and additions, available at* LEGE 213 17/11/1998 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Law No. 152/1998 on the establishment of the National Housing Agency, including the subsequent amendments and additions, available at* LEGE 152 15/07/1998 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Law No. 241/2001 for the approval of Emergency Ordinance No. 40/ 1999 on the protection of tenants and the setting of rent for housing spaces, including the subsequent amendments and additions, available at* LEGE 241 16/05/2001 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Law No. 515/2006 for the approval of Emergenct Ordinance No. 68/2006 on measures for the development of activities in the field of housing construction through programmes at national level, including the subsequent amendments and additions, available at* LEGE 515 29/12/2006 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Law 84/2008 for the approval of Emergency Ordinance No. 74/ 2007 on the provision of social housing fund for tenants evicted or to be evicted from dwellings returned to former owners, including the subsequent amendments and additions, available at* LEGE 84 08/04/2008 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Law No. 292/2011 on Social Assistance, including the subsequent amendments and additions, available at* LEGE 292 20/12/2011 - Portal Legislativ (just.ro), *accessed on 19 February 2021.*
- *Ministry of Labour, Family, Social Protection and Elderly, National Strategy on Social Inclusion and Poverty Reduction 2015-2020, available at* 4. Strategy Social Inclusion.pdf (frds.ro), *accessed on 23 February 2021.*
- *National Anti-Poverty Package 2016, available at* Pachet_integrat_pentru_combaterea_saraciei.pdf (edu.ro), *accessed on 23 February 2021.*
- *National Strategy on Housing, available at* 2017-01-13_Strategia_Nationala_a_Locuirii_2016-2030.pdf (mmediu.ro), *accessed on 23 February 2021.*
- *Sheiman I, Shishkin S, Shevsky V (2018). The evolving Semashko model of primary healthcare: the case of the Russian Federation, available at* The evolving Semashko model of primary healthcare: the case of the Ru | RMHP (dovepress.com), *accessed 13 May 2021.*
- *Societatea Academică din România (2013). Stop concurenţei neloiale public-privat în sectorul sanitar românesc, available at* POLITICA DE SĂNĂTATE: Stop concurenţei neloiale public-privat în sectorul sanitar românesc | Societatea Academica din Romania (sar.org.ro), accessed on 23 February 2021.
- *Turcu, C (2017). Mind the Poorest: Social Housing Provision in Post-crisis Romania, available at* Mind the Poorest: Social Housing Provision in Post-crisis Romania - Critical Housing Analysis (housing-critical.com), *accessed on 19 February 2021.*
- *Vlădescu C, Scîntee SG, Olsavszky V, Hernández-Quevedo C, Sagan A (2016). Romania: Health system review. Health Systems in Transition, available at* Health

	Systems in Transition: Romania (Vol. 18 No. 4 2016) (who.int), *accessed on 16 February 2021.* • *World Bank, Housing in Romania: towards a national housing strategy (2015), available at* World Bank Document*, accessed on 23 February 2021.*

10.10 Sweden

Member State: Sweden		
Fiche Overview		
	Health	**Public Housing**
Expenditure relating to health and public housing SGEIs	• In 2017, the total health expenditure in Sweden was € 51.8 billion (11% of GDP) • The health sector is mainly funded by public funds (84%), and especially regional and municipal taxes; 15% of the expenditure comes from households and less than 1% from other sources such as private insurances. • The amount granted to SGEIs related to health services in 2019 was: o Occupational health services: **SEK 55 million** (€ 5.2 million [582]), +8% compared to 2015, o Pharmacies in sparsely populated areas: **SEK 11 million** (€1 million [583]), +25% compared to 2014.	"Social housing" as defined in the SGEI Decision does not exists in Sweden as it is considered a public responsibility to provide decent and affordable housing to everyone. However, in 2016, Sweden introduced a SGEI in the housing sector for two categories of people: Students and the elderly. • The amount granted to SGEIs related to housing services in 2019 was: o Elderly housing: **SEK 581 million** (around € 60.3 million [584]), same amount was granted in 2017, o Students housing: **SEK 70 million** (€ 6.6 million), this amount fluctuated significantly since 2016.
Key actors	Key actors of the healthcare sector are: • **Public authorities, for instance**: Government Offices of Sweden Ministry of Health and Social Affairs Socialstyrelsen Folkhälsomyndigheten PUBLIC HEALTH AGENCY OF SWEDEN	Key actors of the public housing sector are: • **Public Authorities, for instance:** Government Offices of Sweden Stockholms stad

[582] *Average exchange rate in 2019: SEK to EUR = 0,09446 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[583] *Ibid.*
[584] *Ibid.*

	• **Funders, for instance**:  • **Healthcare providers, for instance**:   	• **Municipal housing companies, for instance:** 
Structure of health and public housing	The Ministry of Health and Social Affairs is in charge of setting the national health policy and of budget allocation. At local level, regions finance and deliver healthcare (primary care, specialists and psychiatric care). Main funders are counties. However, there are also grants and subsidies provided by the central government. Private health insurances are not developed in Sweden and only account for less than 1% of the health expenditure. In terms of healthcare providers, there are public hospitals (including university hospitals), private hospitals, and public and private primary care providers.	At national level, the Ministry of Finance is in charge of housing and community planning. Its role is to set the housing policy by providing the legal and financial framework. At local level, municipalities are in charge of implementing housing policies. Planning the housing provision, enabling housing construction and ensuring proper housing for elderly people are also within their remit. In terms of rental housing providers, there are municipal housing companies controlled by one or several municipalities and private providers.
Main conclusions	In Sweden, all types of hospitals are publicly funded. They are not considered a SGEI but are a non-economic activity. Health coverage is universal, and the enrolment is automatic for all residents. The healthcare system is decentralised, it is managed by local departments and is mainly funded by local taxes. In terms of SGEI, two health services have been reported on by Sweden after 2012: occupational health providers for the purchase of medical services and pharmacies in sparsely populated areas.	"Social housing" as defined in the SGEI Decision does not exist in Sweden, since Sweden has a universalistic approach of housing. Private and municipal housing companies target all people regardless of their financial situations. The "utility value", based on elements such as location, environment, quality, defines rents in both private and public sectors. Following complaints to the European Commission [585] regarding the compliance of the (social) housing system with State aid and EU competition rules, Sweden stopped reporting social housing as an SGEI since 2007. Since 2011, municipal

[585] *See section 3.4 in the report (Q1c. To what extent have the divergences in the Member State sectors caused differences in the application of SGEI concepts?)*

		housing companies have to operate on the basis of "business like principles" when competing with private owners. After 2012, two housing services have been added to the SGEI list: o Construction and renovation of housing adapted to elderly people, o Organisation and provision of rental housing to students and "socially vulnerable people".

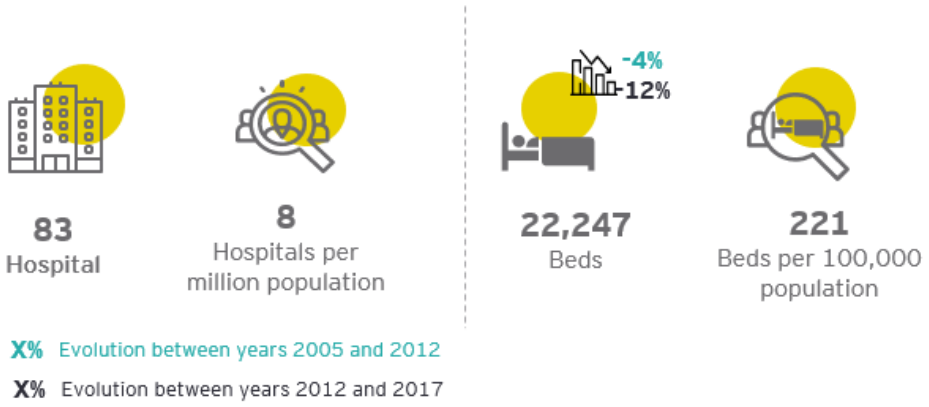
I. Health Sector

The aim of this Section is to provide an overview of the health sector in Sweden as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

► **Number and share of hospitals and beds (and evolution) per legal entity**

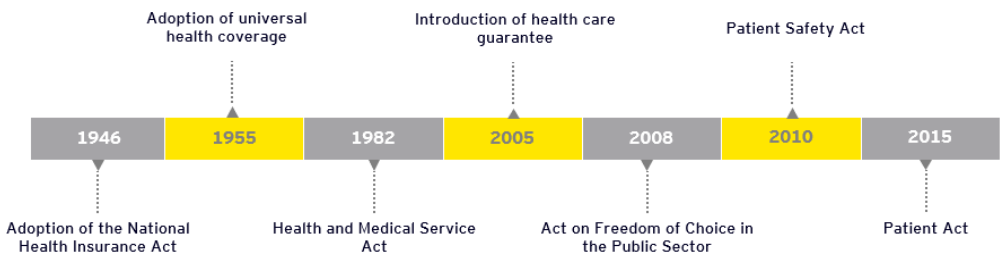
In Sweden, there are three types of hospitals, all publicly funded: (i) private hospitals, (ii) public hospitals and (iii) public university hospitals. Public hospitals provide the greater part of acute care; and university hospitals provides highly specialised care with advanced equipment, teaching services and conduct research.



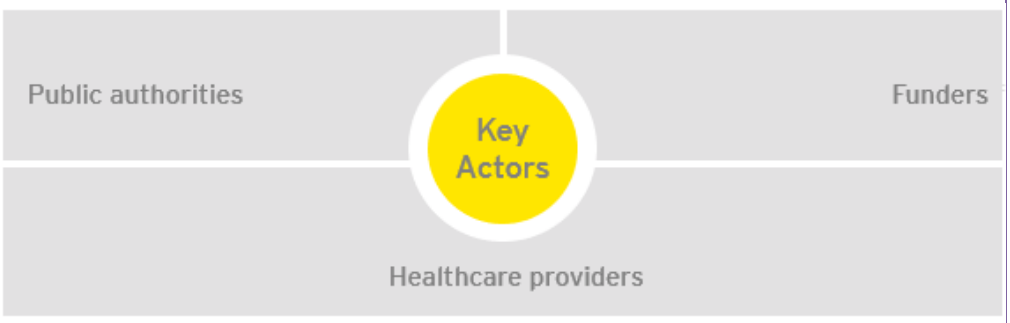
In total in 2017, there were 83[586] hospitals including 77 public hospitals (70 regionally owned and 7 university hospitals) and 6 private hospitals. This means that 84% of hospitals are regionally owned, 8% are university hospitals and 7% are private.

In terms of beds, there were 22,247 hospital beds which represents 221 beds per 100,000 population. The number of beds has decreased by 4% during the period 2005-2012 and by 12% from 2012 to 2017. Indeed, there were 26,478 beds in 2005 and 25,290 beds in 2012. This trend can be explained by the fact that, over

[586] *OECD/European Observatory on Health Systems and Policies (2017), Sweden: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, (https://doi.org/10.1787/25227041)*

	the past two decades, Sweden worked on moving services from inpatient to outpatient care.
LEGAL FRAMEWORK	► **Synthetic presentation of the evolution of the legal framework** The legal Framework of the Swedish health system has evolved since the end of the World War II.  ***Evolution of the legal framework before 2012:*** In **1982**, the Swedish government established the most important law regulating the health and social care system: **The Health and Medical Service act (***Hälso- och sjukvårdslag***)**. With this act, the counties became responsible of health promotion and equal access to healthcare. The laws introduced from the mid-2000s reinforced patients' care and rights. In **2005**, **the National Healthcare Guarantee** was introduced , as part of healthcare reforms to reduce the waiting time for elective care. The aim was to enable patients to see a specialist in less than 90 days, starting with an "instant contact" meaning that the patients have the right to get in touch with the health centre the same day they seek help. They then must be able to get a medical assessment within 3 days. This guarantee was added to the Health and Medical Service Act in 2010[587]. The adoption of the **Freedom of Choice in the Public Sector Act** (*Lag om valfrihetssystem)* in **2008** provides public and private health professionals with equal conditions for establishment, they have to fulfil the counties' requirements to get an accreditation and once they get the accreditation, the health professional is eligible for public funds. This act also enables patients to choose their providers (private or public). Patients only pay all costs themselves if the provider does not have an agreement with the county. The **Patient Safety Act (2010)** *(Patientsäkerhetslag)* introduced the personal responsibility of health workers for their own actions and provided patients and their relatives with the ability to easily report an incident or wrong treatment to the National Board of Health and Welfare. ***Evolution of the legal framework after 2012:*** Finally, the **Patient Act** (*Patientlagen)* from **2015** reinforced patients' rights by introducing a greater obligation for healthcare personnel to inform patients about choices, risks and opportunities as regards their treatment, in order to involve them more in their care. Moreover, it introduced the right to get medical care in another region. In that case the home county will still pay for care. The 2015 act also strengthened the obligation for health professionals to inform patients of the choices and opportunities they have and the risks they face.

[587] *Nordgren, Lars. (2012). Guaranteeing Healthcare: What Does the Care Guarantee Do?. Financial Accountability & Management. 28. 335-354. (DOI:10.1111/j.1468-0408.2012.00548.x)*

	The decentralisation of the Swedish health system led to differences in terms of access to healthcare services. Some consider this trend to be in contradiction with Sweden's objective of equal access to healthcare. In this regard, the government has announced a primary care reform in 2019, with the objective to improve access to health services in remote areas and to reduce disparities between counties[588].
ORGANISATION OF THE SECTOR	Health coverage in Sweden is universal and the enrolment is automatic, it must cover all legal residents (Health and Medical Services Act, see above) regardless of their nationality. Emergency coverage and essential healthcare that cannot wait until the return to the home country are provided to people from the EU, the European Economic Area and countries with bilateral agreements for the same patient fee as Swedish citizens. Undocumented adults and asylum-seekers are entitled to medical care that cannot be deferred; children, regardless of their legal status, have the right to access the same medical services as children who are resident in Sweden. Regions are in charge of financing and providing health services, they set the user fees (provider fees and co-payment rates) when the service is not free and provide subsidised healthcare to residents. Fees are set in advance for most of the healthcare services, except maternal and child services in primary care units and some services to people over 85 (such as emergency and necessary care). Only fees for dental care and prescribed medicines set at national level. The healthcare system is mainly financed from public sources through taxes. ► **Synthetic presentation of the type of actors:**  ***Public authorities***: • The Ministry of Health and Social Affairs is responsible for budget allocation (national agencies and regions) and setting the national health policy • Regions finance and deliver healthcare (primary care, specialist and psychiatric care) • Municipalities are in charge of care for the elderly and disabled people • Moreover, there are national agencies such as the National Board of Health and Welfare, the Health and Social care Inspectorate, Public Health Agency of Sweden, The Swedish eHealth Agency.

[588] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, (https://doi.org/10.1787/25227041)*

Funders:

- Regions and Municipalities through taxes (main funders). This type of funding has an impact on the health services available in the region as it depends on the level of taxes collected by the regional authorities
- Central government through grants and subsidies
- Private health insurance (less than 1% of health expenditure): this insurance is mainly provided by employers and covers 10%[589] of the population aged from 16 to 64 years old. It enables them to have quicker access to outpatient care and elective surgery. The share of the population with voluntary health insurance has increased quickly in the last years as in 2012, only 4% was covered by this type of insurance[590].
- Households through OOP payments.

Healthcare providers:

- Healthcare facilities (private and publicly owned) are all publicly funded, regulations and fees are applicable to providers in both sectors
- Public hospitals including university hospitals
- Private hospitals
- Primary care providers (private and public)

► **SGEI in the healthcare sector:**

Occupational health providers

In Sweden's biennial SGEI reports (2014/2015 to 2018/2019), the aid reported under the hospital section is aimed at occupational healthcare providers. Since the introduction of this aid in 2014, occupational healthcare providers are entitled to apply for a refund relating to the purchase of medical services from healthcare providers (private or public) such as "*investigation and laboratory analysis, radiology and clinical physiology"*[591]. The purpose of this aid is to "*prevent sickness and, in the event of sickness, to help the employee return to work*"[592].

In order to be reimbursed, occupational health providers have to fill in a form by the 1st of February of each year for medical services purchased during the previous calendar year. The maximum amount that the provider can receive is "*the number of employees affiliated to the provided multiplied by the sum of SEK 100 (€9,60*[593]*)*"[594]. Providers have to give a proof of the services for which they ask a refund. If they fail to comply with this obligation, they have to repay the aid.

Pharmacies in sparsely populated areas

In the biennial SGEI reports (2014/2015 to 2018/19), Sweden reported on aid provided to pharmacies in sparsely populated areas. Since the introduction of this aid in 2014, they are entitled to apply for a subsidy in order to maintain a good supply of medicine across Sweden and to offer easy access to pharmacies in those areas.

Criteria for pharmacies to be eligible for a subsidy:

- be located more than 20 kilometers from any other pharmacy;

- have had sales revenue from prescription medicines amounting to between one and ten million SEK for the financial year; and
- have had its premises open so that consumers have had access to prescription medicines during all calendar months (otherwise, aid is granted in relation to the number of calendar months during which the pharmacy has been open).

Pharmacies have to apply for the subsidy by the 1st of March for services provided in the previous calendar year. The subsidy is based on the sales of prescription medicines. However, there is a ceiling based on the pharmacy's overall sales revenue to ensure that there is no overcompensation. Therefore, pharmacies have to provide information regarding their operations, revenues and costs when applying for a subsidy. If they fail to comply with this obligation, they have to repay the grant.

► **Competition in the sector:**

As stated in the "key figures" section, most of hospitals are public (92%). University hospitals provide highly specialised care and public hospitals at regional level provide most of the acute care. Sweden considers that both types of hospitals provided non-economic activities.

However, the situation is different for primary care units. Since the 2010 legislation on primary care choice reform, private primary care providers are eligible for public funding. This has increased their numbers. In 2012, only one-third of 1,100 primary care units was private[595]. This share increased to 42% in 2017[596]. Price competition is not possible because the fees are set by the counties, therefore competition may exist on other elements such as quality and waiting time. Also, presence of private care units varies across the country as they are more present in densely populated areas.

With regard to private providers not affiliated with the government, their number is low. They are not publicly funded; therefore, patients have to pay the full price for the treatment.

[589] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, (https://doi.org/10.1787/25227041)*
[590] *Anell, Anders and Glenngard, Anna H. and Merkur, S (2012) Sweden: health system review. Health systems in transition, 14 (5). pp. 1-159. ISSN 1817-6119 (https://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf)*
[591] *European Commission, Sweden biennial reports to the Commission on SGEI, (https://ec.europa.eu/competition/state_aid/public_services/2018_2019/sweden_en.pdf)*
[592] *European Commission, Sweden biennial reports to the Commission on SGEI, (https://ec.europa.eu/competition/state_aid/public_services/2018_2019/sweden_en.pdf)*
[593] *Average exchange rate in 2020: SEK to EUR = 0,0958 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[594] *European Commission, Sweden biennial reports to the Commission on SGEI, (https://ec.europa.eu/competition/state_aid/public_services/2018_2019/sweden_en.pdf)*
[595] *Anell, Anders and Glenngard, Anna H. and Merkur, S (2012) Sweden: health system review. Health systems in transition, 14 (5), (https://www.euro.who.int/__data/assets/pdf_file/0008/164096/e96455.pdf)*
[596] *OECD/European Observatory on Health Systems and Policies (2017), Sweden: Country Health Profile 2017, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. (https://doi.org/10.1787/25227041)*

FUNDING OF THE SECTOR

► **Funding arrangements**

The healthcare system is mainly financed by social insurance through taxes. Most of the taxes that finance the healthcare system are collected at regional and municipal level. At central level, grants are used to fund specific actions such as a general the reduction of the waiting time and to provide resources to regions and municipalities based on their need. It should be noted that the share of government spending in overall public healthcare spending is low. Private health insurances and households represent other sources of funding.

There are fixed ceilings on OOP spending per type of service (for example specialist professional, hospital). Above this amount, the government for the rest of the year covers costs for the specific service.

In terms of SGEI, as stated in the "organisation of the sector" section, occupational health providers and pharmacies in sparsely populated areas are entitled to apply for a public subsidy. If they are eligible and comply with their obligation, they receive grants for the previous calendar year.

► **Health expenditure**

	Amount of expenditure in 2017	Evolution 2005 - 2012	Evolution 2012 – 2017
Total Health expenditure (in billion euro)[597]	**51.8**	**N/A**[598]	**+12%**
Health expenditure (% of GDP)[599]	**11**	**2,6**	**0,1**

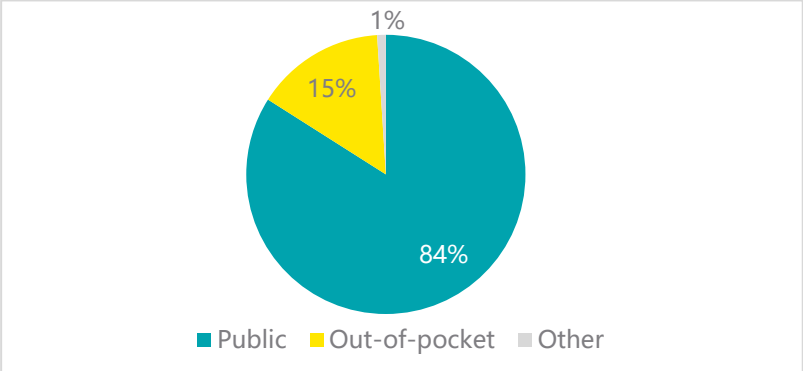
In 2017, total health expenditure was €51.8 billion which represented an increase of 12% compared to 2012 (€46.2 billion). Outpatient care represented 34%[600] of the total healthcare spending and is the largest category of health expenditure.

In 2017, the percentage of GDP spent on the health sector was 11% (EU average was 9.7%[601]). It is the third highest figure in the EU and has been constant since 2012 (when it was 10.9%). In 2005, the share was only 8.3%, meaning an increase of 2.6 percentage points between 2005 and 2012, This increase can be explained

[597] *Healthcare expenditure by financing scheme, Eurostat (https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en)*
[598] *2005 data of Eurostat (https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en) was not used as there was a break in time series in 2011*
[599] *Global health expenditure database – WHO (https://apps.who.int/nha/database/Select/Indicators/en)*
[600] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. (https://doi.org/10.1787/25227041)*
[601] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. (https://doi.org/10.1787/25227041)*

by the fact that the yearly growth in GDP was lower than the health spending. In turn, the lower growth in GDP can be explained by the economic crisis of 2008[602].

Distribution of health expenditure per category of funder[603] in 2017:



In 2017, the health expenditure was distributed as follows: 84% came from public sources (EU average is 79%[604]), 15% constitutes OOP (EU average is 15.8%) and 1% of other spending. This distribution is similar to 2012. Compared to 2005, there has been an increase of 2 percentage points of public spending and a decrease of 2 percentage points of households' OOP spending.

► ***Evolution of SGEI spending***

The following SGEIs were introduced in 2014:

Occupational health services: the amount **granted in 2019 for this service was SEK 55 million** (€ 5.2 million[605]), representing an **increase of 367% between 2014 and 2019**. However, the service was introduced in 2014. The increase for the period 2015-2019 is significantly lower (+8%).

Pharmacies in sparsely populated areas: the amount granted in **2019 for this service was SEK 11million** (€1 million[606]) **increased by 25% between 2014 and 2019.**

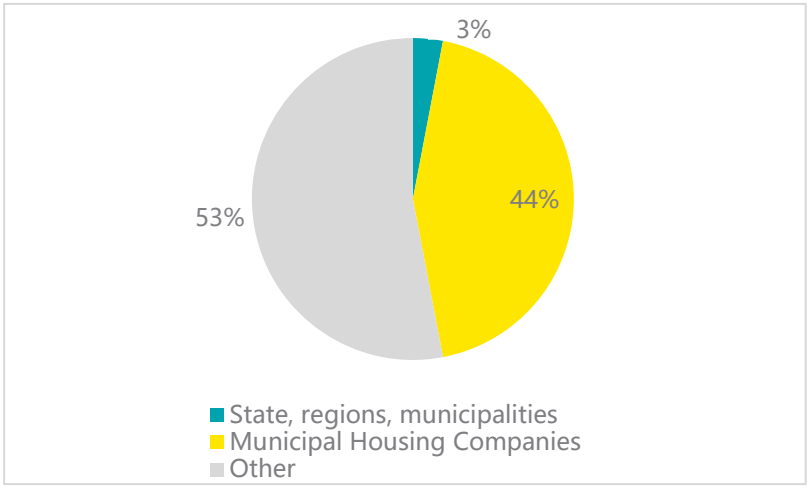
II. Public Housing

The aim of this Section is to provide an overview of the public housing sector in Sweden as well as present an analysis of the application of the SGEI rules, based on interviews undertaken with stakeholders.

KEY FIGURES

In Sweden, the rental sector is split between private landlords and municipal housing companies. The "social housing" sector as defined in the SGEI Decision does not exist as both private landlords and municipal housing companies target all people regardless of their means. In addition, rents are aligned since they are

[602] *OECD (2014), Health at a Glance: Europe 2014, OECD Publishing. (http://dx.doi.org/10.1787/health_glance_eur-2014-e)*
[603] *Health expenditure profile Sweden – WHO (https://apps.who.int/nha/database/country_profile/Index/en)*
[604] *OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.*
[605] *Average exchange rate in 2019: SEK to EUR = 0,09446 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[606] *Ibid.*

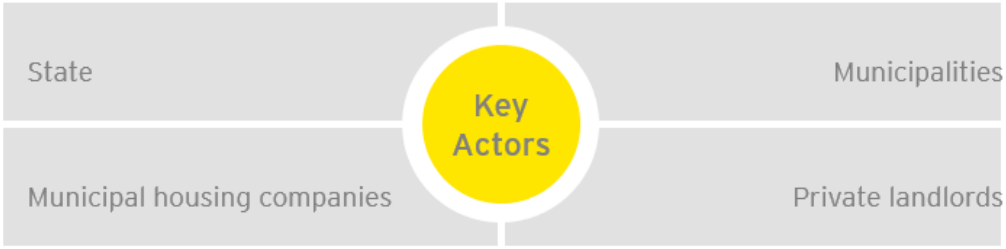
	defined by the "utility value", meaning that it is based on elements such as location, environment and quality. In 2019, there were around 1.9 million[607] rental dwellings (including special types of housing for example for elderly, disabled people and students) in the whole of Sweden, distributed as presented in the figure below.  47% of the total dwellings are publicly owned. Looking at the total housing stock in Sweden (so including privately owned housing), municipal housing companies represent approximately 20%.
LEGAL FRAMEWORK	Sweden has a universal approach to housing. The Swedish authorities take the view that it is a public responsibility to provide decent and affordable housing to everyone. Hence, the absence of social housing as defined in the SGEI Decision. The European Property Federation (EPF) has filed 2 complaints, in 2002 & 2005, to the European Commission regarding the rental housing market in Sweden (see the Swedish case in the final report – section 3.4.. **These complaints questioned the compliance of Sweden with EU laws regarding State aid and competition**. Rents in Sweden are based on "utility value" which applies to both sectors (private and municipal companies), meaning that 2 dwellings with the same characteristics should have equivalent rent whether it is owned by a private company or municipality. According to EPF, this practice created **distortion in the market** because municipal companies receive public grants but, in line with the Swedish universalistic model of housing, they target all citizens regardless of their income. Following these complaints, **in 2005, a governmental committee was asked to look into this topic**. The committee presented 2 solutions for Sweden in order to comply with EU laws: - **Municipal housing companies and private owners should behave the same way,** - **Municipal housing companies should mainly rent their dwellings to people with low income and difficulties to enter the rental housing market.**

[607] *Statistics Sweden (scb.se)*

	- In order to maintain their universal approach on housing without infringing EU laws on competition, **Sweden decided in 2007 to no longer consider municipal housing as an SGEI**. This is why, **since 2011, municipal housing companies have to operate with "business-like principles"** when competing with private owners. However, municipal housing companies are also responsible for the enhancement of social integration, particularly in places facing segregation.
ORGANISATION OF THE SECTOR	The rental market in Sweden is regulated, rents in both sectors (private and municipal housing) are based on the "utility value" (see above under the "key figures" section). They are set every year through collective bargaining between landlords and a tenant organisation. For new dwellings, the rent can be higher than older flats in the same area in order to reflect the cost of the construction and the land purchase. However, after 15 years, the rent must be in line with the utility value system. Costs of construction are very high in Sweden, they have increased more than the general inflation over years. In fact, construction costs in Sweden are the highest in the EU,[608] which has a negative impact on the construction of affordable housing. The majority of the municipalities in Sweden consider that they encounter housing shortages (255 out of 290)[609]; and according to the National Board of Housing Building and Planning, it is necessary to build 710,000 new dwellings before 2025[610]. This shortage can be explained by the combination of the increased number of people in Sweden and the low level of home building. People facing this shortage of affordable housing the most are students, young households, newly arrived migrants, old people with special care needs and the elderly with a minimum pension. In 2017, the Swedish State started to provide subsidies to companies with a housing project with a rent per square meter below a threshold in order to counter the construction costs and increase the number of dwellings. In parallel, some municipalities have introduced new strategies in order to tackle the high costs. For instance, the city of Gothenburg created an entity ("Framtiden Construction Development") to centralise the building projects of 4 municipal housing companies to achieve economies of scale. The role of this entity is also to attract more actors into this market such as local SMEs and foreign building companies[611].

[608] *According to the "the state of the housing in the EU 2017" report by Housing Europe, "It is approximately 70 per cent more expensive to build housing there than the European average".*
[609] *Housing Europe, The state of the housing in the EU 2017, (https://www.housingeurope.eu/resource-1000/the-state-of-housing-in-the-eu-2017)*
[610] *Welin, L., & Bildsten, L. (2017). The housing market in Sweden: a political-historical perspective. In Proceedings of the 9th Nordic Conference on Construction Economics and Organisation, (PDF) The housing market in Sweden: a political-historical perspective (researchgate.net)*
[611] *Housing Europe, The state of the housing in the EU 2017, (https://www.housingeurope.eu/resource-1000/the-state-of-housing-in-the-eu-2017)*

There are 4 categories of actors:



- **State:** Its role, through the Ministry of Finance, is to define the housing policy by providing the legal and financial framework (conditions and restrictions).
- **Municipalities**: Responsible for implementing housing policies, planning the housing provision and enabling housing construction. It is also their responsibility to ensure proper housing for the elderly.
- **Municipal housing companies**: Public companies controlled by one or several municipalities, meaning that municipalities own more than half of the shares. Their role is to manage the real estate and to promote the housing provision in one or several municipalities in order to diversify the tenants' profiles.
- **Private landlords**

► **Competition in the sector:**

As stated in the introduction, municipal housing companies and private owners have the same goal. Complaints to the European Commission led Sweden to implement changes in the public housing sector. In order to keep the universal system and to be compliant with EU laws, municipal housing companies have to operate with "business like principles" when competing with private owners.

► **SGEI in the sector:**

As stated in the introduction of the "public housing" section, "social housing" as defined in the SGEI Decision does not exist in Sweden. Indeed, all people are targeted by the private and public sectors. However, Sweden has introduced SGEI in the housing sector for two categories of people: Students and the Elderly.

The Elderly:

According to the 2016-2017 SGEI report, Sweden introduced in 2016 an aid scheme aimed at public and private construction companies in order to build or renovate housing adapted to elderly people (services housing or housing for people over 65). Aid is provided at a "given sum per square meter of usable area" for the following situations:

- "New construction or reconstruction of rented housing which counts as special housing within the meaning of Chapter 5, Section 5 of the Social Services Act (2001:453);
- New construction or reconstruction of rented housing for the elderly, on the regular housing market;
- Adaptation of communal areas (such as areas for residents' meals, communal activities, hobbies and recreation) in, or close to, buildings which

	are rental housing, cooperative rental housing or tenant-ownership housing". [612] The aid is provided to the construction companies when the project is completed. For the new constructions and reconstructions, aid is granted with the condition for the company to ensure that these houses are available for the elderly for a period of eight years. **Students:** Since 2016, aid can be provided for the organisation and provision of rental housing to students and to "socially vulnerable people" in order for them to enter the housing market. Moreover, beneficiaries of this aid have to determine a rent amount that does not exceed a certain level. In terms of housing allocation, Sweden has indicated that "Housing is made available according to the principles of openness, fairness and public utility and in a socially integrative way that will lead to a mixture of households with varying financial conditions and, if there are no clearly negative effects arising from this mixture of households, that preference when allocating housing is given to households who are in most need of housing at a reasonable rent."[613] Potential beneficiaries of this aid (property owners, site leasehold owners or anyone who builds housing on leasehold land) shall send their application to the county administrative board. The latter is in charge of making the decision with regards to the application and to determine the level of aid. If the award is granted to a beneficiary, it will only be paid when the housing service begins, with the condition of providing this service for a period of 15 years. Regarding temporary building permits with a period shorter than 15 years, the aid is prorated.
FUNDING OF THE SECTOR	**Funding arrangements** As presented in the "organisation of the sector" section, on the companies' side, SGEI compensation is provided for Elderly and Students (including "socially vulnerable people") housing. On the tenants' side, **housing allowance** is a key element of the housing policy. This allowance is aimed at people with low income and is composed of three schemes: • "Housing allowance for families and children and for young people aged between 18 and 28 years, • Housing supplement for pensioners, • Housing supplement for people receiving a disability pension (called sickness or activity compensation)."[614] The amount depends on various factors: income and capital, number of people in the households, size of the residence and housing costs. ► ***Evolution of the amount of public aid with regards to SGEI*** As stated in the "organisation of the sector" section, services of general interest in the housing sector were introduced in 2016.

[612] *Ibid.*
[613] *2018-2019 Biennial report on the SGEI from Sweden.*
[614] *Recent changes in housing policies and their distributional impact across Europe – European Commission*

	 Elderly: the amount granted in 2019 was SEK 581 million (€ 55million[615]); same amount was granted in 2017, while in 2016 - the year of introduction of the service - the aid granted to beneficiaries was at SEK 21.7 million (€ 2.3 million[616]) Students and socially vulnerable people: the amount granted the year of the introduction of the service was SEK 800,000 (€ 84,528). The following years, this amount was variable: SEK 1.1 billion in 2017 (€ 118.8 million[617]), SEK 755 million in 2018[618] (€ 76 million) and SEK 70 million in 2019 (€ 6.6 million).
SOURCES	• OECD/European Observatory on Health Systems and Policies (2019), Sweden: Country Health Profile 2019, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels. • Anell, Anders and Glenngard, Anna H. and Merkur, S (2012) Sweden: health system review. Health systems in transition, 14 (5). pp. 1-159. ISSN 1817-6119 • Sweden biennial reports to the European Commission on SGEI • Healthcare expenditure by financing scheme, Eurostat (https://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hf&lang=en) • Global health expenditure database – WHO (https://apps.who.int/nha/database/Select/Indicators/en) • OECD (2014), Health at a Glance: Europe 2014, OECD Publishing. http://dx.doi.org/10.1787/health_glance_eur-2014-e • Health expenditure profile Sweden – WHO (https://apps.who.int/nha/database/country_profile/Index/en) • Statistics Sweden (scb.se) • Housing Europe, The State of the housing in the EU 2017 • Welin, L., & Bildsten, L. (2017). The housing market in Sweden: a political-historical perspective. *In Proceedings of the 9th Nordic Conference on Construction Economics and Organization* • https://www.commonwealthfund.org/international-health-policy-center/countries/sweden

[615] *Average exchange rate in 2019: SEK to EUR = 0,09446 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[616] *Average exchange rate in 2016: SEK to EUR = 0,10566 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[617] *Average exchange rate in 2017: SEK to EUR = 0,10381 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*
[618] *Average exchange rate in 2018: SEK to EUR = 0,10067 (https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-sek.en.html)*

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