

**The British United Provident Association Limited**

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Dear Mr Maes,

Questionnaire on 'Social Services of General Interest'

We received this questionnaire from contacts in Brussels. May we offer some observations concerning our own activities in connection with social health services which may be considered 'in the general interest'?

Your questionnaire is evidently intended for Member State authorities so we are not ourselves entitled to respond in any formal sense. We welcome however the attention the Commission services are giving to these matters.

The 'British United Provident Association' is UK-based and specialises in non-State health finance ('health insurance') and health provision. We are the largest health insurer in the UK, the second operator in Ireland and significant as 'Sanitas' in Spain. We own and run a number of private hospitals in these three countries and over 250 'homes for the elderly'. Although our worldwide turnover exceeds €5 billion, we are not a 'shareholders' company and all financial surpluses are reinvested solely in health businesses.

The fields of health finance, cure and care, where we are active are everywhere very close to services of general interest for which States must maintain sovereign guarantees to citizens. We are used to working in each of those countries alongside those guarantees, often supplementing them and sometimes contracting to provide some of the guaranteed services ourselves.

Health finance

In **health insurance**, we operate within the scope of the Insurance Directives, but we nowhere intend to operate 'substitutional' systems as envisaged by article 54 of the Third Non-Life Insurance Directive.

We have however had difficulty in agreeing to what extent the broader requirements of 'General Good' should be permitted to inhibit our freedom to compete across borders (on some related matters concerning Ireland we have a case before the Court of First Instance at present).

We would like therefore to register an interest in the 'grey zone' to which the questionnaire refers in paragraph 8. Specifically, if representations on any such matters are made in responses from Ireland, we would welcome the opportunity to present our own perspective.

Incidentally, 'health insurance' should properly be interpreted as 'the economic activity of insurance', typically as applied to indemnity for treatment costs. (The expression is sometimes used more loosely across Europe to describe entitlements under social benefit schemes which are not in fact 'insured', but funded by salary contributions or taxes.) Availability of necessary treatment services may well be determined to be a social service of general interest but any true 'insurance' process should be regarded as an economic activity – which may or may not, in a particular jurisdiction, be permitted to contribute to that service.

### Health provision

In health provision by means of **hospitals** we have some experience in the UK of bidding for work which the State system chooses to contract-out. In addition, we operate one hospital wholly on behalf of the State system, for public-paid patients.

There has been genuine competition for contracted-out work in the UK, including competition from operators in other EU countries. That seems wholly satisfactory and we have no critical comments to make. The situation well illustrates one way in which private-sector competition, including freedom of cross-border services, can add value to established social services of general interest, under proper control from State-system authorities.

We do not ourselves have experience of operating hospitals as '**concessions**' – as might be the case with some 'public-private partnerships' which have begun in the UK, nor in Spain where State health authorities experiment with regional private contracts. So we cannot comment on these, although they might be worth noting in the context of your questionnaire.

Our '**care homes**' for elderly and otherwise-dependent people operate mostly on a 'fully private' basis – residents or their guardians pay in full, or supplement individual public entitlements, and private insurance is seldom used for such services. But we find a growing demand for capacity from Local Authorities (who have the legal responsibility to satisfy State guarantees for people needing such care who cannot pay for themselves).

These Authorities typically contract with us either for patient-places in our established private care homes, or to run complete care homes on their behalf. It is perhaps no surprise that as operators we find the public payment rates available to do this are never enough, but we do pride ourselves that we can supply better quality at lower fully-attributable cost than many Local Authorities can do when they run their own homes.

Competition can thus deliver good value in this area. We have efficient methods of managing 'capital' by re-financing completed and profitable homes so that such services can be continually expanded elsewhere to meet ever-growing demand.

You may be aware of the case of *'Bettercare'* in Northern Ireland, which was resolved (2002) by a British Tribunal in line with ECJ principles. This seems to have established that where State authorities are contracting with one another for economic activities, normal competition principles should apply: *"the fact that a particular activity has a social aim is not in itself sufficient to preclude the activity in question from being classified as an economic activity"*. That result must be wholly welcome in the interests of efficiency as well as single-market opportunity more generally.

We operate care homes in the UK and Spain, and would like possibly to consider wider EU opportunities. But we are well aware of the case of *'Sodemare'* which seems to have established (1997) that there are conditions in which a State Authority can justify determining that only certain kinds of contractors can tender for such services. While understanding the local context of this judgement, we do feel that it sets an expectation of artificial barriers to legitimate activity.

Each of our care homes runs as a 'for profit' business unit (even though it is ultimately owned by a 'not-for-profit' holding company). That is an efficient business model which we know can be better and less costly than some alternatives. The profit-basis produces the very surplus which allows re-financing and subsequent expansion, which we believe must be desirable to serve ageing EU demography. Why should such models be excluded because of that structure? We would ask that the EU criteria for procurement in even this kind of 'service of general interest' should not permit discrimination against business structures which are legitimate elsewhere.

Generally, therefore, we invite attention in the analysis of the questionnaires to the fundamental difference between the social services of general interest, however designated, and the potentially-competitive economic mechanisms by which certain of them can be efficiently provided.

Although our concerns may not strictly be within the scope of your enquiry, we would of course be very willing if requested to answer any questions or assist in any relevant further analysis.

Yours sincerely

<signed>

Stephen Withers  
Director, European Affairs  
The British United Provident Association Limited