Case No: 71659
Event No: 694310
Dec. No: 113/14/COL

EFTA SURVEILLANCE AUTHORITY

EFTA SURVEILLANCE AUTHORITY DECISION

of 12 March 2014

on the financing of Norwegian public dental health care services ("DOT")

(Norway)

The EFTA Surveillance Authority ("the Authority"),

HAVING REGARD TO:

The Agreement on the European Economic Area ("the EEA Agreement"), in particular to Articles 61(1) and 62(1)(b) and Protocol 26,

Protocol 3 to the Surveillance and Court Agreement ("Protocol 3"), in particular Article 1(1) of Part I and Articles 18 and 19 of Part II,

Whereas:

I. FACTS

1. Procedure

(1) In 2011 and 2012, the Authority received two complaints from private parties regarding alleged cross-subsidies in the Norwegian public dental health care services (hereinafter also referred to as "dental care"). The complainants allege that the services provided by the Norwegian public dental health care services (in Norwegian: "*Den Offentlige Tannhelsetjeneste*", hereinafter "DOT") offered to adult patients for remuneration are cross-subsidised with public funds provided for the financing of free or discounted dental care services offered to certain parts of the population.

(2) By letter dated 11 May 2012, the Authority initiated an existing aid procedure in accordance with Article 17(1) of Part II of Protocol 3 (Event No 631636). The Norwegian authorities responded by letter dated 11 June 2012 (Event No 637332). The Authority requested additional information by letter dated 7 September 2012 (Event No 639550). The Norwegian authorities responded by letters dated 16 January 2013 and 10 July 2013 (Event Nos 659561 and 678347).

(3) On 5 November 2013, the Authority sent a letter in accordance with Article 17(2) of Part II of Protocol 3 (Event No 685054), informing the Norwegian authorities of its view that the financing of DOT involves state aid that is incompatible with the functioning of the EEA Agreement. The Norwegian authorities responded by letter dated 4 December 2013 (Event No 692258).

2. DOT's activities

2.1 General obligation

(4) Norwegian counties are responsible for providing free or discounted dental care to children and certain other groups, according to Sections 1-3(1) and (2) of the Act on public dental health services (the "DHSA").[1] The counties fulfill this obligation through DOT. The DOTs are administrative units found in each of the 19 counties in Norway. Accordingly, when this decision refers to "DOT" it hereinafter means the 19 separate administrative units, which form part of the legal person of the counties.[2] DOT is required to ensure that dental care is, to a reasonable extent, available to all citizens residing permanently in a county.[3] This requires DOT to offer public dental health care services, by way of permanent clinics or travelling dentists, in areas where private practitioners do not provide such services.

2.2 Section 1-3(1) group

(5) In accordance with Section 1-3(1)(a)-(d) of the DHSA, DOT provides free dental care to children, youth,[4] the elderly, the long term ill and handicapped in institutions or home care,[5] as well as the mentally handicapped. Some counties provide free dental health care to individuals who suffer from drug addiction, psychiatric patients and prison inmates on the basis of Section 1-3(1)(e) of the DHSA. Hereafter, these patient groups are collectively referred to as the "Section 1-3(1) group".

2.3 Section 1-3(2) group

(6) DOT is also obliged to provide subsidised dental care, in areas where there is a lack of private practitioners (the "Section 1-3(2) group"). This is the case in certain remote and sparsely populated areas,[6] especially in counties located in North, Mid, and Western Norway. By way of example, the Norwegian authorities have explained that only 6 out of 24 municipalities in Troms County have private dentists established and that these dentists alone could not possibly take care of all adults in need of dental care in the county.

2.4 Freedom to provide services to other patients

(7) DOT is allowed to offer dental services to adult patients who do not belong to the patient groups described above, that have a right to free or discounted dental care. They are neither required to keep separate accounts for the public service and commercial activities nor to generate a return on the commercial activities.

(8) Approximately 85% of the patients treated by DOT are under the age of 18. DOT presently treats approximately 6-7% of Norwegian adults.

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1 LOV-1983-06-03-54 Lov om tannhelsetjenesten.

2 Two counties (Buskerud and Rogaland) have organised their public dental health services as county municipal companies. It follows from the Act of 25 September 1992 No 107 on Municipalities and Counties (in Norwegian: "Kommuneloven" (LOV-1992-09-25-107)), that county municipal companies are part of the legal entity of the county.

3 Section 1-1 of the DHSA.

4 Youth between 18 and 20 years pay 25% of the full fee in accordance with Section 3 of Regulation of 24 May 1984 No 1268 on remuneration for dental services from DOT (in Norwegian "*Forskrift om vederlag for tannhelsetjenester i den offentlige tannhelsetjenesten*" (FOR-1984-05-24-1268)).

5 Cf. Section 2 of the Regulation of 24 May 1984 No 1268 on remuneration for dental services from DOT and Section 1.2 of Appendix 1 of NOU 2005:11 (Norwegian Official Report) (Available at: http://www.regjeringen.no/nb/dep/hod/dok/nouer/2005/nou-2005-11/15/2.html?id=153963).

6 Emphasised in the preparatory works to the DHSA (Innst. O. Nr. 86 (1982-1983)).

3. Changes to the DHSA since the entry into force of the EEA Agreement

3.1 Introduction

(9) The DHSA was adopted in 1983. Since its entry into force on 1 January 1984 the counties of Norway have been responsible for providing dental services through DOT.[7] Only a few administrative amendments to the DHSA have been made since the entry into force of the EEA Agreement. These administrative changes, set out in the following, have according to the information provided by the Norwegian authorities, not affected the main responsibilities of the counties.

3.2 Amendments to the rules on fees

(10) From 1995 until 2001, DOT's fees were set by the Ministry of Health and Care Services.[8] Since 2001, the counties set the fees.[9]

(11) Two counties set fees that reflect an average of what private practitioners charge for the same services. The remaining seventeen counties charge fees based on the tariffs that are set by the Ministry of Health and Care Services.[10] These tariffs are based on the benefits that the National Insurance Scheme provides to cover the tariffs of dental treatment for some dental diseases in accordance with the Act on National Insurance,[11] the Regulation on Compensation for Coverage of Expenses to Examination and Treatment by Dentists and Dental Hygienists in Cases of Disease,[12] and relevant circular letters.

3.3 Abolition of requirements on organisation

(12) Originally, chapter 3 of the DHSA divided the counties into dental health districts. Chapter 3 also required the appointment of chief district and county dentists, as well as the establishment of public dental clinics.

(13) On 1 July 2003, chapter 3 of the DHSA was repealed[13], leaving the counties free to organise DOT as they see fit.

4. Public financing of DOT

(14) The financing of DOT is the responsibility of the counties. However, the Norwegian State awards yearly block grants for partial coverage of the counties' expenses in relation to DOT.[14]

(15) In 2012, the gross operational expenses of DOT amounted to more than NOK 2.94 billion,[15] approximately EUR 350 million.[16]

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7 Section 1-1 and 5-1 of the DSHA.
8 Section 2.2 of Appendix 1 of Norwegian Official Report No 11 2005 (NOU 2005:11).
9 Section 2-2(1) of the DHSA.
10 See Section 1.2 of Appendix 1 of NOU 2005:11.
11 Act of 28 February 1997 No 19 (LOV-1997-02-28-19).
12 Regulation of 16 December 2012 No 1518 (FOR-2012-12-16-1518) e.i.f. 1 January 2014.
13 Through Act of 6 June 2003 No 37 (LOV-2003-06-06-37) on amendments to Act of 10 November 1982 No 66 (LOV-1982-11-10-66) on health services in municipalities and certain other Acts (simplification of government regulations aimed at local governments etc.).
14 Sections 5-1(1) and 5-2 of the DHSA.
15 According the Norwegian Statistical Office (*Statistisk sentralbyrå*), see http://www.ssb.no/helse/statistikker/tannhelse/aar/2013-07-09#content.
16 Using the Authority's 2014 conversion rate where EUR 1 equals NOK 8.4025.

II. ASSESSMENT

1. The presence of state aid

1.1 Article 61(1) of the EEA Agreement

(16) Article 61(1) of the EEA Agreement reads:

> *"Save as otherwise provided in this Agreement, any aid granted by EC Member States, EFTA States or through State resources in any form whatsoever which distorts or threatens to distort competition by favouring certain undertakings or the production of certain goods shall, in so far as it affects trade between Contracting Parties, be incompatible with the functioning of this Agreement."*

(17) It follows from this provision that, for state aid within the meaning of the EEA Agreement to be present, the following conditions must be met: (i) the aid must be granted through state resources; (ii) the aid must confer a selective economic advantage upon an undertaking; (iii) the recipient must constitute an undertaking within the meaning of the EEA Agreement; and (iv) the aid must threaten to distort competition and affect trade between the Contracting Parties. In the following, the financing of DOT is assessed on the basis of these criteria.

1.2 Presence of state resources

(18) Since DOT is financed by the Norwegian State and the counties (see chapter I.4 above) the Authority considers that the condition regarding the use of state resources is met.

1.3 Undertaking

1.3.1 Economic activity

(19) According to established case law, any entity engaging in economic activities qualifies as an undertaking regardless of how it is organised.[17] Offering services on a given market qualifies as an economic activity,[18] in so far as the activity does not fulfil an exclusively social function and is founded on the principle of solidarity. Dental services provided by public authorities (irrespective of legal form) will be deemed to be carried out by an undertaking provided that they are economic in nature.[19]

1.3.2 Section 1-3(1) group

(20) Whether or not the provision of public health care services is economic in nature depends on whether they "(...) *fulfil an exclusively social function, which is founded on the principle of national solidarity*".[20] In assessing whether a public health care service is to be considered as an economic activity one has to assess whether the service "*operates according to the principle of solidarity in that it is funded from social security contributions and other State funding and in that it provides services free of charge to its*

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[17] Case E-5/07 *Private Barnehagers Landsforbund* v *EFTA Surveillance Authority*, [2008] EFTA Ct. Rep. 61, paragraph 78, and Case C-41/90 *Höfner and Elser* v *Macroton* [1991] ECR I-1979, paragraph 21.

[18] See Case C-205/03 P, *FENIN* v *Commission*, [2006] ECR I-06295, paragraph 25 and Case C-350/07 *Kattner Stahlbau* [2009] ECR I-1513.

[19] Case C-172/03 *Wolfgang Heiser* v *Finanzamt Innsbruck* ("*Heiser*") [2005] ECR I-1627, paragraphs 29-35.

[20] Joined Cases C-264/01, C-306/01, C-354/01 and C-355/01 *AOK Bundesverband* [2004] ECR I-2493, paragraph 51.

members on the basis of universal cover".[21] In that regard, it is the view of the Authority that DOT's services provided to the Section 1-3(1) group, which are financed entirely by the public purse and thus provided free of charge on the basis of universal coverage, fulfil a purely social function. DOT does therefore not carry out an economic activity when providing these services and it does accordingly not constitute an undertaking when carrying out these duties.

1.3.3 Section 1-3(2) group – providing dental services where they are not readily available

(21) DOT is furthermore obliged to ensure that dental care is available to all citizens in a reasonable proximity to where they live and at a reasonable price. The Norwegian authorities have informed the Authority that in remote and sparsely populated areas, the provision of dental care is far more costly than in central and densely populated areas as it is more expensive to operate small practices or to provide travelling dentists.[22] In these areas, the fees charged by DOT do not reflect the full cost of the treatment. The question assessed in the following is whether the provision of these discounted services by DOT represents an economic activity.

(22) The fact that the national rules at issue represent social security legislation cannot as such exclude a service from being economic in nature.[23] The Authority notes that the prices DOT charges in this regard are not of a symbolic nature.[24] To the contrary, DOT prices the services provided in areas with insufficient dentist coverage at flat rates aiming to reflect either market prices for dentists that operate in less sparsely populated areas or insurance tariffs, as described in paragraph (11) above.

(23) In light of the above, it is the view of the Authority that the payment for these services should be regarded as consideration for the dental services as it represents remuneration for the dentist that receives it.[25] Accordingly, the Authority finds that DOT, in this regard, carries out an economic activity, and that it therefore constitutes an undertaking within the meaning of Article 61(1) of the EEA Agreement when carrying out this activity.

1.3.4 Providing dental services to adults where private dental services are readily available

(24) DOT also provides dental care services to adults for remuneration in areas where private dental services are readily available.

(25) Where health care services are mainly financed by the patients or from their insurance and where there is a certain degree of competition on the relevant market, such services must normally be considered as an economic activity.[26] In *Heiser*[27] the Court of Justice found that "*a medical practitioner specialising in dentistry, such as Mr Heiser, must be considered to be an undertaking within the meaning of that provision since he provides, in*

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[21] T-319/99 Case T-319/99 *Federación Nacional de Empresas de Instrumentación Científica, Médica, Técnica y Dental (FENIN)* v *Commission* [2003] ECR II-357, paragraph 39.

[22] The county of Troms explains that a normal dentist session can cost approximately NOK 1000 more in rural areas of the county, than in more urban areas.

[23] Case C-368/98 *Abdon Vanbraekel and others* v *ANMC* [2001] ECR I-5363, paragraph 42.

[24] Compare with Case E-5/07 *Private Barnehagers Landsforbund* v *EFTA Surveillance Authority* [2008] EFTA Ct. Rep. 61, where the EFTA Court found that the remuneration in question was symbolic, as it covered only approximately 20% of the actual cost of the provided service. The Court accordingly concluded that the social aim was so predominant that the service ought to be considered non-economic.

[25] Case C-157/99 *Geraets-Smits* v *Stichting Ziekenfonds VGZ and Peerbooms* v *Stichting CZ Groep Zorgverzerkeringen* [2001] ECR I-5473, paragraph 58.

[26] See for instance Case C-157/99 *Geraets-Smits and Others*, cited above, paragraphs 53-58.

[27] Case C-172/03 *Heiser*, cited above, paragraph 26.

his capacity as a self-employed economic operator, services on a market, namely the market in specialist medical services in dentistry".

(26) In the view of the Authority, there is no reason why DOT's provision of dental services on the market should not be regarded as an economic activity within the meaning of the case law referred to above. The Authority therefore concludes that DOT's provision of dental services to adults for remuneration constitutes an economic activity, and that DOT, when carrying out these activities, constitutes an undertaking within the meaning of Article 61(1) of the EEA Agreement.

1.4 Advantage

(27) The complainants allege that DOT is able to offer lower prices to paying adults than the rest of the market due to the advantages stemming from the public financing. The Authority has accordingly assessed whether the system of financing provides an economic advantage, which the recipient undertaking would not have obtained under normal market conditions.[28]

(28) The services offered to the Section 1-3(2) group are provided on the basis of a public service obligation.[29] In the *Altmark*[30] judgment, the Court of Justice held that compensation for public service obligations does not constitute an advantage when four cumulative criteria are met. The Norwegian authorities have not provided information enabling the Authority to conclude that the compensation meets the four cumulative *Altmark* criteria. To the contrary, the information provided does not indicate that any of the criteria are met.

(29) Firstly, DOT is not entrusted with a clearly defined public service obligation as required under the 1st Altmark criterion as the Norwegian authorities have not determined the exact scope of areas in need of the public service obligations.

(30) Secondly, the parameters on the basis of which the compensation is calculated have not been established in advance in an objective and transparent manner (the 2nd Altmark criterion).

(31) Thirdly, it cannot be determined at this stage on the basis of the information provided that the aid does not exceed what is necessary to cover the costs of discharging the public service obligations (the 3rd Altmark criterion).

(32) Fourthly, in view of the 4th Altmark criterion, the selection of the dentists is not based on a public tender in accordance with the first alternative under the fourth criterion and the Norwegian authorities have also not provided information enabling the Authority to conclude that the DOT is *"well-run and adequately equipped"* in accordance with the second alternative under the fourth criterion.

(33) A state measure which does not comply with one or more of the Altmark criteria must be regarded as providing an advantage to the recipient.[31] Accordingly, on the basis of the above, the Authority has to conclude that the compensation confers an advantage on DOT. It is the view of the Authority that the provision of dental care services to adults for remuneration in areas where private dental services are readily available represents an economic activity. It follows from the Authority's decisional practice that when an entity

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[28] Case C-280/00 *Altmark Trans GmbH and Regierungspräsidium Magdeburg* [2003] ECR I-7747, paragraph 84.
[29] See Chapter II.5.2 below.
[30] Case C-280/00 *Altmark*, cited above, paragraphs 89-93.
[31] Case C-280/00 *Altmark*, cited above, paragraph 94.

carries out both economic (non-public service) and non-economic activities, a cost-accounting system that ensures that the economic activities are not financed through state resources allocated to the public activities must be in place.[32] This principle is also laid down in the Transparency Directive.[33] The lack of a legislative framework or practices requiring a separation of accounts for DOT's economic and non-economic activities entails that the Authority cannot verify the absence of cross-subsidies. Accordingly, it cannot be ruled out that the economic activities of DOT, in certain or all the counties receive economic advantages.

1.5 Selectivity

(34) Only DOT benefits from the financing system at issue. It does not apply to all dentists operating in Norway. The financing system is therefore selective.

1.6 Distorts competition and affects trade

(35) It is settled case law that the mere fact that an aid strengthens an undertaking's position compared with that of other undertakings competing in intra-EEA trade is enough to conclude that the measure is likely to affect trade between the Contracting Parties and distort competition between undertakings within the EEA.[34] When the commercial activities of DOT are cross-subsidised as set out above, they receive an advantage in comparison with their competitors.[35] The cross-subsidies therefore threaten to distort competition.

(36) Dentists from other EEA states are free to establish themselves in Norway, and Norwegian clients can purchase dental services in other EEA States. In light of this, it is the view of the Authority that the public financing of DOT is likely to affect trade between the Contracting Parties, pursuant to Article 61(1) of the EEA Agreement.

1.7 Conclusion

(37) On the basis of the above, the Authority has come to the conclusion that the public financing of DOT when it provides services to the Section 1-3(2) group and to adults where private dental services are readily available involves state aid within the meaning of Article 61 of the EEA Agreement.

2. Classification of the aid as new or existing

(38) In the following the Authority assesses whether the aid must be classified as new or existing in nature.

(39) Article 1(b)(i) of Part II of Protocol 3 defines existing aid as "*all aid which existed prior to the entry into force of the EEA Agreement in the respective EFTA States, that is to say, aid schemes and individual aid which were put into effect before, and are still applicable*

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[32] See e.g. the Authority's Decision 142/03/COL *Regarding Reorganisation and Transfer of Public Funds to the Work Research Institute* (OJ C 248 16.10.2003 p. 6), Decision 343/09/COL *on the property transactions engaged in by the Municipality of Time concerning property numbers 1/152, 1/301, 1/630, 4/165, 2/70, 2/32* (OJ L 123 12.5.2011 p.72) and Decision 174/13/COL *Concerning the financing of municipal waste collectors* (OJ C 263 12.9.2013 p. 5).

[33] Act referred to at point 1a of Annex XV to the EEA Agreement, OJ L 266 11.10.2007 p. 15 and EEA Supplement No 48 11.10.2007 p. 12 (Commission Directive 2006/111/EC of 16 November 2006 on the transparency of financial relations between Member States and public undertakings as well as on financial transparency within certain undertakings ("Transparency Directive"), OJ L 318 17.11.2006 p. 17).

[34] Case C-280/00 *Altmark*, cited above, paragraphs 84 and 87-93.

[35] Case C-172/03 *Heiser*, cited above, paragraphs 29-35.

after, the entry into force of the EEA Agreement". By contrast, "*alterations to existing aid*" are defined as new aid; cf. Article 1(c) of Part II of Protocol 3.

(40) Whether aid must be classified as new or existing must be determined with reference to the provisions providing for it.[36] Negligible changes,[37] or purely administrative changes,[38] which do not influence "*any of the basic features of the previous system of aid*"[39] do not lead to existing aid being reclassified as new aid.

(41) The DHSA entered into force on 1 January 1984. The provisions concerning the counties' obligations to provide services and the financing of DOT have not been amended. Thus the Norwegian counties have provided public dental health care either free of charge, with a discount or for remuneration on the basis of the same unchanged provisions since before the entry into force of the EEA Agreement.

(42) Some amendments have been made to other provisions of the DHSA. In 2001, the counties took over from the State the responsibility for setting fees. In 2003, the rules on how to organise DOT were repealed. These changes have not affected the financing of DOT or the basic features of the counties' obligations to provide dental care. In this context the Authority recalls that alterations that have no bearing on the advantage that is conferred on the beneficiary by the aid do not make existing aid new aid.[40] Moreover, "*any change* [...] *which cannot affect the evaluation of the compatibility of the aid measure with the common market*"[41] is not sufficiently substantial to require a reclassification of a measure as new aid.

(43) Thus, the Authority concludes that since the provisions providing for the aid have remained materially unaltered since before the entry into force of the EEA Agreement, the aid must be classified as existing aid.

3. Compatibility – the view of the Norwegian authorities

(44) The Norwegian authorities have not argued that the cross-subsidisation of the purely commercial activities is compatible with the functioning of the EEA Agreement.

(45) The Norwegian authorities consider the obligation under Section 1-3(2) to ensure that dental care is available to all citizens to a reasonable extent to be a service of general economic interest ("SGEI") within the meaning of Article 59(2) of the EEA Agreement.

4. Proposed system of account separation

4.1 Abolition of aid to the purely commercial activities of DOT

(46) The Norwegian authorities have presented proposals for legislative amendments which are meant to ensure that the system of financing will not entail any state aid to the purely commercial activities of DOT.

(47) To that effect, the Norwegian authorities have, according to information in Norway's reply letters from 10 July and 4 December 2013, proposed for a revised DHSA, adding a new section on separate accounts and a new supporting regulation. The new section of the

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[36] Case C-44/93 *Namur-Les Assurances du Crédit* [1994] ECR I-3829.
[37] Opinion of A.G Warner in Case C-177/78 *Pigs and Bacon* [1979] ECR 2161, p. 2204.
[38] Opinion of A.G Darmon in Joined Cases 166 and 220/86 *Irish Cement* [1988] ECR 6473, paragraph 34.
[39] Opinion of A.G. Trabucchi in Case 51/74 *P.J. Van der Hulst's Zonen* v *Produktschap voor Siergewassen*, [1975] ECR 79, p. 105.
[40] Case C-44/93 *Namur-Les assurances du crédit*, cited above, paragraph 29.
[41] Article 4(1) of the EFTA Surveillance Authority Decision No 195/04/COL as amended, available online: http://www.eftasurv.int/media/decisions/195-04-COL.pdf.

DHSA will provide a legal basis for the adoption of the new regulation requiring the counties to keep separate accounts for the commercial segment of the business, in order to avoid cross-subsidisation.[42] The draft of the new regulation on the duty to keep separate accounts[43] requires DOTs engaged in both economic and non-economic activities to keep separate accounts for the two types of activities, and furthermore to ensure that the costs of activities are allocated proportionately.[44]

(48) The new draft regulation furthermore requires the counties to require a reasonable return on capital from DOTs engaging in economic activity.[45]

(49) The view of the Authority is that the implementation of these proposed changes appears to ensure that the purely commercial activities are not cross-subsidised.

4.2 SGEI account separation

(50) However, the Authority observes that the drafts do not require a separation of accounts for the services provided to paying patients under Section 1-3(2) of the DHSA, classified as an SGEI. Article 5(9) of Commission Decision 2012/21/EU ("the SGEI Decision"),[46] requires such an account separation. The Authority is accordingly of the view that there is a need to ensure that separate accounts will be kept for the SGEI activities, in order to separate them from the other services considered as economic as well as non-economic activities.

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[42] The draft Section 7-4, titled: "Duty to set up separate accounts" reads: "*The Ministry may issue regulations on separate accounts, demand for cost allocation, duty of information, control systems, profit regulation and other conditions to prevent cross subsidies of public dental health care services between counties outside a well functioning market and dental services that the county offers in a functioning market with private service providers.*" (The Authority's translation. The original text in Norwegian reads as follows: § 7-4, overskrift: "Plikt til å utarbeide atskilte regnskaper": *"Departementet kan gi forskrifter om separate regnskaper, krav tilkostnadsallokering, informasjonsplikt, kontrollsystemer, regulering av utbytte og andre krav for å hindre kryssubsidiering mellom fylkeskommunale tannhelsetjenester utenfor et fungerende marked og tannhelsetjenester som fylkeskommunen tilbyr i et fungerende marked med private tjenesteytere*").

[43] The draft Section 4 of the Regulation sub-section 2 states: "*The different parts of the undertaking" in this Regulation shall mean: 1. Dental care to groups of persons as referred to in DHSA Section XX 2. Dental care to paying adult persons as referred to in DHSA Section XX*" (The Authority's translation. The original text in Norwegian reads as follows: "*Med "de forskjellige deler av virksomheten" menes i denne forkriften: 1. Tannhelsetjeneste til grupper av personer nevnt i tannhelstjenesteloven § xx 2. Tannhelsetjeneste til voksende betalende personer etter tannhelstjenesteloven § xx*").

[44] The draft Section 1 of the Regulation states: "*The objective is to ensure access to the economic relation between the county and its undertaking offering dental care in order to control possible cross-subsidies and avoid anti-competitive behaviour.*" (The Authority's translation. The original text in Norwegian reads as follows: "*Formålet med denne forskriften er å sikre innsyn i de økonomiske forbindelsene mellom fylkeskommunen og dens virksomheter som yter tannhelsetjeneste for å kunne kontrollere mulig kryssubsidiering og unngå konkurransevridning*").

[45] The draft section 5 sub-section 5 of the regulation states: "*The county shall ensure the necessary cost allocation, regulation of yield and a reasonable profit. The duty to provide information and control systems is regulated in Section 8*" (The Authority's translation. The original text in Norwegian reads as follows: "*Fylkeskommunen skal sørge for nødvendig kostnadsallokering, regulering av utbytte og en rimelig avkastning utbytte på egen måte. Krav til informasjonsplikt og kontrollsystemer er regulert i §8*").

[46] Commission Decision of 20.12.2011 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) incorporated into the EEA Agreement in its Point 1h of Annex XV.

5. Compatibility of the compensation system for dental services in areas with insufficient provision of dental care

5.1 SGEI Decision

(51) The SGEI Decision sets out criteria for the assessment of compatibility of an SGEI measure with the functioning of the EEA Agreement. Measures that meet the conditions laid down in the Decision are exempt from the notification obligation laid down in Article 1(3) of Part I of Protocol 3.

5.2 Genuine SGEI

(52) As a starting point, the service in question must represent a genuine SGEI. SGEIs are economic activities that public authorities identify as being of a particular importance to citizens and that without public intervention, either would not be supplied at all or would be supplied under appreciably different conditions.[47]

(53) The definition of an SGEI is subject to a wide discretion on the part of the Norwegian authorities. However, the concept of an SGEI is a concept of EEA law and not a concept of national law. The Authority is therefore empowered to check the definitions provided by the Norwegian authorities for manifest errors.[48]

(54) In the *Ambulanz Glöckner* judgment,[49] the Court of Justice concluded that the operation of a public ambulance service qualified as an SGEI "*consisting in the obligation to provide a permanent standby service of transporting sick or injured persons in emergencies throughout the territory concerned, at uniform rates and on similar quality conditions, without regard to the particular situations or to the degree of economic profitability of each individual operation"*.[50] The Court furthermore expressed that the classification of ambulance services in certain geographical areas as SGEIs was warranted as it was "*in the general interest for prices not to vary according to the areas served.*"[51]

(55) Although the Norwegian authorities are of the view that the need for subsidised dental care to adults is only present in certain areas of certain counties, they have neither presented an overview of the exact scope of areas in need of the public service, nor the method deployed to determine the scope.

(56) The Authority agrees with the principle that the provision of subsidised dental care to patients in remote and sparsely populated areas where there are no private practitioners, qualifies as an SGEI. However, the Authority is of the view that the Norwegian authorities must establish and apply a method to distinguish the areas in need of such subsidies from the areas with sufficient dentist coverage without subsidies.

5.3 Entrustment

(57) The Authority notes that for the compensation to be in accordance with the functioning of the EEA Agreement, each provider of public dental health care (i.e. each county) must be entrusted with the service on the basis of an entrustment act satisfying the conditions laid down by Article 4 of the SGEI Decision, which specifies that:

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47 Case C-205/99 *Analir* [2001] ECR I-1271, paragraph 71.
48 Case T-17/02 *Olsen* v *Commission* [2005] II-2031, paragraph 216.
49 Case C-475/99 *Firma Ambulanz Glöckner* v *Landkreis Südwestpfalz* [2001] ECR I-8089.
50 Ibid., paragraph 55.
51 Ibid., paragraph 54.

"*Operation of the* [SGEI] *shall be entrusted to the undertaking concerned by way of one or more acts, the form of which may be determined by each Member State. The act or acts shall include, in particular:*

(a) the content and duration of the public service obligations;

(b) the undertaking and, where applicable, the territory concerned;

(c) the nature of any exclusive or special rights assigned to the undertaking by the granting authority;

(d) a description of the compensation mechanism and the parameters for calculating, controlling and reviewing the compensation;

(e) the arrangements for avoiding and recovering any overcompensation;

(f) and a reference to this Decision."

(58) The current system of aid does not satisfy this requirement. Hence, it should be amended to ensure that each county is obliged to provide dental services to paying adult patients by means of an act carrying legal force in national law. The form of the act may be determined by the Norwegian authorities. The act must meet the requirements of Article 4 of the SGEI Decision as listed above.

(59) The Authority underlines that the exemption from notification which follows the fulfilment of the conditions of the Decision only applies for a 10 year period, for which DOT is entrusted the operation of the SGEI.[52]

5.4 Transparency and a system of control

(60) For compensation to undertakings providing health care services, the SGEI Decision applies regardless of the amount of compensation.[53] However, a system must be in place providing for checks for over-compensation at least every three years and the recovery of any over-compensation exceeding 10% of the amount of the average annual compensation.[54] Furthermore, the Norwegian authorities must keep available, during the period of entrustment and for at least 10 years from the end of the period of entrustment, all the information necessary to determine whether the compensation granted is compatible with the SGEI Decision.[55]

5.5 The income tax exemption

(61) For the sake of good order, the Authority notes that it is in the process of assessing, in a separate case (Case No 73703), the state aid nature of the income tax exemption which applies to county municipal dental care.

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[52] Cf. Article 2(2) of the Decision.
[53] Cf. Article 2(1)(c) of the Decision.
[54] Cf. Article 6 of the Decision.
[55] Cf. Article 8 of the Decision. Furthermore, if the aid exceeds EUR 15 million on a yearly basis, the requirements of Article 7 of the SGEI Decision must be met.

6. Appropriate measures

(62) The Authority takes the view that the DOT's system of financing involves existing aid which is not compatible with the functioning of the EEA Agreement.

(63) The Authority proposes that the Norwegian authorities take the following appropriate measures to ensure that no aid is granted in the future to the economic activities of DOT:

- In accordance with the Authority's practice, separate accounts should be kept for the three following activities:
  - (i) the non-economic activities (in accordance with Section 1-3(1)(a)-(e) of the DHSA);
  - (ii) the services provided to paying patients in remote and sparsely populated areas with a market failure, classified as an SGEI; and
  - (iii) the services provided to paying patients in areas with sufficient private alternatives.
- All costs, both direct and indirect, as well as an appropriate contribution to the common costs (such as rent, equipment and personnel) and revenues should be allocated on the basis of clearly established, consistently applied and objectively justifiable cost accounting principles.[56]
- In addition, the commercial activities of DOT (point (iii) above) should be required to generate a reasonable return on capital (comparable to what a private investor would expect from a similar undertaking).
- the compensation system for dental services in areas with insufficient provision of dental care must comply with the SGEI Decision as set out in Chapter II.5 above.

HAS ADOPTED THIS DECISION

Article 1

The aid benefitting the services provided to paying patients in areas with sufficient private alternatives and the services provided to paying patients in remote and sparsely populated areas with a market failure constitutes existing state aid which is incompatible with the functioning of the EEA Agreement.

Article 2

The Norwegian authorities are recommended to take with effect from 1 January 2015 the necessary measures to amend the aid in accordance with Chapter II.6 of this Decision.

Article 3

The Norwegian authorities are invited to accept this proposal for appropriate measures by 14 April 2014.

Article 4

This Decision is addressed to the Kingdom of Norway.

[56] For the division between DOT's non-economic and economic activities, the requirements in Articles 5 and 6 of the SGEI Decision should be complied with.

Article 5

Only the English language version is authentic.

Decision taken in Brussels, 12 March 2014

For the EFTA Surveillance Authority

Oda Helen Sletnes
President

Frank Büchel
College Member