Solidarity as a political determinant of health: insights from EU Competition Policy

As the common organising principle in European healthcare systems, with redistribution at its core, solidarity represents a political determinant of health given its clear connection with addressing health inequities and promoting health equity. A tension emerges between solidarity and competition in light of the gradual expansion of competition reforms in national healthcare systems across Europe, with the implication that competition undermines solidarity because "we do not come to the market as equals" (Prosser 2005). This distinction is particularly pronounced in Europe (as distinct from the US), where commitments to solidarity as an underlying, organising principle of healthcare systems remain paramount (Odudu 2022; Greaney and Odudu 2022). The juxtaposition of competition and solidarity takes on a particular dimension in the context of applying EU competition law (the prohibitions on anticompetitive agreements, abuse of dominance, and state aid), with cases indicating that fundamental questions continue to revolve around the extent of competition relative to solidarity in national healthcare systems, even though the expanded interaction between public and private healthcare has long meant that such a dichotomy is difficult to maintain (Boeger 2007).

The connection between law and political determinants of health in general terms appears difficult to pinpoint, but while the latter may not be explicitly defined, suggesting inferences that law might be construed as a product of a political system and history, it can be argued that law cannot be separated from political determinants of health (Ip 2021). Research analysing competition in healthcare in light of the underpinning law reforms has seen lawyers typically focus on governance structures and questions of governmental accountability. In contrast, fields as diverse as health economics and social policy have indicated a clearer focus on *health*, finding that UK competition reforms have variously led to better or worse health outcomes (respectively, Gaynor et al. 2013, and Goodair and Reeves 2022). While such findings can shape both policy and law, part of their significance lies in the support for not separating law

from political determinants of health, and highlights the importance of interdisciplinary research to underscore these alongside commercial and social determinants of health.

In light of these considerations, the specific contribution of this paper is to explore the different framings of solidarity as a political determinant of health within EU and national competition regimes and identify whether it may be possible to say that either level offers a 'better' (or 'more equitable') conceptualisation of solidarity. This engages with the idea that there may be 'competing interests' that change and shape the political determinants of health (Dawes 2020: 47) – with regard to solidarity this emerges particularly in connection with the respective competence of the national and EU levels, and the interaction between the two. The wider contribution of the paper is to illustrate how EU and national law (as a political institution) shapes and defines solidarity as a political determinant of health. The paper is thus underpinned by interdisciplinary research which has been deemed necessary, inter alia, to challenge narratives that health inequities result primarily from social rather than political factors, leaving no legal or political remedy to leverage (Mackenbach 2014; see also Dawes 2020: 45-46). Section 2 sets the scene by explaining in more detail what solidarity and competition law are, with regard both to EU-level and national structures. Section 3 presents findings of how solidarity has been framed in EU and national case law and EU legal documentation. Section 4 discusses factors shaping the framing of solidarity within EU competition policy. Section 5 concludes.

Context – solidarity and EU competition policy

A common theme in defining "solidarity" is the element of redistribution and acting in the collective good which can be disaggregated across three tiers: individual, group, and legal/contractual (Prainsack and Buyx 2018: 54-57). However, as a concept, "solidarity" has a complex history and provenance across diverse disciplines and political trends (Stjernø 2005).

If it can be accepted that there are certain common elements of "solidarity" across European healthcare systems, then it may seem logical for this to be reflected at an EU level, given that solidarity has been described as the "ideational point" upon which Member State healthcare systems converge (Hervey 2011: 186). This is despite the reservation of healthcare system organisation and health policy as a Member State competence by Article 168(7) TFEU. Certainly we find "solidarity" being given a high level of legal recognition in the treaties as a value of the EU (Article 2 Treaty on the European Union), and solidarity identified as a characteristic feature of EU membership (Case C-39/72 *Commission v Italy* cited in Frischhut 2022: 85-86). In the context of healthcare system organisation as a national competence, we see solidarity being portrayed as an overarching value sitting alongside, but distinguished from, equality and universality by a specific meaning of being "closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all" (Council of the European Union 2006). In the still more specific context of competition in healthcare, solidarity has been quantified as "70% publicly-financed" in research conducted under the auspices of DGSANTE (Commission EXPH 2015). Taken together, these considerations lend support to the definition of solidarity as a political determinant of health with scope to determine (at least social) determinants seemingly first and foremost at the national level. How this national definition of solidarity then influences the EU level, or whether it is influenced by the EU level, is moot: certainly a circular relationship may be inferred, whereby a country may adopt a commitment to solidarity which is in part shaped by its status as an EU Member State operating within the EU law framework. Questions of the extent of EU-level involvement in health have been reinvigorated by responses to the COVID-19 pandemic with calls for a European Health Union, but have also received attention in the content of the internal market and cross-border healthcare, where concerns about the effects on national healthcare systems (including commitments to solidarity) were identified (e.g. Vollaard et al. 2006, Veitch 2012).

Concerns about EU-level "overreach" into national healthcare systems have been connected to EU competition policy (Morton 2021 and 2022), but it is also considered that the influence of EU competition policy on national healthcare systems functions in a different way, so can be distinguished from concerns about general EU-level "overreach" emerging in the context, e.g. of patients accessing cross-border healthcare (Guy 2023a). For the purposes of the present discussion, "EU competition policy" is defined as the "antitrust rules" of the prohibitions of anticompetitive agreements and abuse of dominance (Articles 101 and 102 Treaty on the Functioning of the European Union (TFEU)), and the prohibition on state aid (Article 107 TFEU). Both sets of rules are concerned with preventing distortions of competition within the EU internal market. However, a conceptual distinction arises insofar as the antitrust rules regulate the behaviour of entities operating in the healthcare sector (typically providers or insurers), while the state aid cases may be read as attempts to regulate government decisions to support certain providers in order to deliver solidarity goals, which might be understood in terms of shaping a market. In particular, concerns are raised about distortions of competition, encompassing long-term dynamic effects on incentives to invest and compete, differentiated responses by competitors to effects on competition in the product market and effects on competition in input markets and locations of investment (Hancher and Sauter 2012: 261-2). The distinction between the antitrust and state aid rules also highlights the complex interaction between the EU and national levels in this regard. The antitrust rules may appear to indicate greater complexities due to the coexistence of EU and national regimes: legal technicalities complicate matters in light of the scope for not only parallel application of EU and national – transposed (EU) – competition law (Guy 2019: 90-93), but also varying interpretations creating "Euro-national competition rules for healthcare" (Van de Gronden 2011: 293). At a national level, applying EU and/or national antitrust rules to national healthcare systems is potentially problematic due to political sensitivities, and the consequences of enshrining policy in law and

vice versa as matters of public policy, such as private sector delivery of public healthcare services, become "juridified" and "dejuridified" (Davies 2013; Guy 2023a). In contrast to the antitrust rules, the state aid rules are concerned with Member States complying with an exclusively EU-focused framework, but this too clearly entails political sensitivities. Certainly the contours of the state aid framework have previously been considered better defined than that of the antitrust rules – and this arguably remains the case in view of recent judgments. Despite the conceptual differences between the antitrust and state aid rules, the starting-point is the same with the trigger of applicability being an "undertaking", defined by case law as an "economic activity"[1] which consists in "offering goods and services on a market".[2] This definition of the "undertaking" concept is widely recognised as "functional" in that national definitions of legal status, or type of financing, are irrelevant: thus a publicly-owned healthcare provider would not be automatically exempt from the reach of EU competition law by virtue of its state-run status, nor would a non-profit-making organization (Odudu 2011; Advocate General Tesauro 1992). There are two main ways in which solidarity features within this framework. Firstly, where there may be a finding that an activity is not economic, thus is exempt from competition law and may involve classification as a service of general interest (SGI). Secondly, where an activity is found to be economic, but may be classified as a service of general economic interest (SGEI) under Article 106(2) TFEU, and so made partially immune from the antitrust or state aid rules. Both instances can be found in the case law, while the Commission has also recently reviewed its guidance on SGEI in the healthcare context (European Commission 2022). The function of solidarity within the applicability of EU competition law, and determination of SGEI, suggests, as indicated above regarding definitions of solidarity, a similarly circular and complex relationship between the EU and Member State

[1] Case C-41/90, *Klaus Höfner and Fritz Elser v Macrotron GmbH*, ECLI:EU:C:1991:61.
[2] Case C-35/96, *Commission of the European Communities v Italy*, ECLI:EU:C:1998:303.

levels. On the one hand, Article 168(7) TFEU may indicate that Member States are free to experiment with competition reforms, given that healthcare system organisation is reserved as a national competence. On the other hand, it is considered that Article 168(7) TFEU represents the Member State's ability to make a decision to so experiment, but the consequence of such a decision is that EU competition law may become applicable (Prosser 2010). In addition, the State Aid Temporary Framework introduced in response to the COVID-19 pandemic also included cases which indicate a link between solidarity and the Article 107(3) TFEU justifications for breach of the Article 107(1) TFEU prohibition of state aid. These three routes are now considered, along with Commission guidance on SGEI in healthcare.

Findings

Solidarity in antitrust cases

A starting-point in landmark healthcare-related cases is the definition of solidarity provided in *Poucet & Pistre*,[3] which involved a challenge to paying social security contributions by persons wishing to have the option to take out private insurance (although the applicants in the case did not challenge the principle of compulsory affiliation to a social security scheme). The schemes at issue in this case covered sickness, maternity and old age, with the wider scheme being deemed to "pursue a social objective and embody the principle of solidarity" (paragraph 8). In the context of the sickness and maternity cover schemes, solidarity involved payment of contributions according to income in order to deliver identical benefits. A further consideration appeared to be the degree of state supervision of the schemes, but overall, the definition of solidarity to emerge from *Poucet & Pistre* is outlined thus (paragraph 18): "Sickness funds, and the organizations involved in the management of the public social security system, fulfil

[3] Joined cases C-159/91 and C-160/91, *Christian Poucet v. Assurances Générales de France and Caisse Mutuelle Régionale du Languedoc-Roussillon and Daniel Pistre v. Caisse Autonome Nationale de Compensation de l'Assurance Vieillesse des Artisans (Cancava)*, ECLI:EU:C:1993:63.

an exclusively social function. That activity is based on the principle of national solidarity and is entirely non-profit-making. The ben efits paid are statutory benefits bearing no relation to the amount of the contributions." Thus a definition of "national solidarity" imputed to Member States by the Court of Justice of the European Union (CJEU) might be considered to involve an activity which fulfils an exclusively social function, and is entirely non-profit-making – two criteria which might be deemed, if not inseparable, then at least cumulative (but not alternative). This assessment further involves a "comparative criterion" of whether a private entity could perform the same activity, and Advocate General Tesauro's finding that the social security scheme's activities in *Poucet & Pistre* were "not comparable to the insurance business transacted by private undertakings" (AG Tesauro 1992: para 12). This sense of "solidarity" was distinguished already in *FFSA*,[4] a case which questioned whether a non-profit-making organization managing an old-age insurance scheme intended to supplement a basic compulsory scheme was an "undertaking". The supplementary and optional nature of this scheme prompted the consideration that "…the principle of solidarity is extremely limited in scope…it cannot deprive the activity carried on by the body managing the scheme of its economic character" (para 19). A similar logic appears to have informed the 2002 UK *BetterCare* case,[5] which saw a private provider of nursing and residential care home places challenge the purchasing decisions of a (state-funded) National Health Service (NHS) body in Northern Ireland. The then competition authority had followed the approach taken by the EU courts primarily in *Poucet & Pistre*. However, the Competition Appeals Tribunal (CAT) conceptualised as "a kind of internal solidarity" (para 238) what had been at issue in cases such as *Poucet & Pistre* – that is, solidarity which existed within a social security scheme and

[4] Case C-244/94 *Fédération Française des Sociétés d'Assurance, Société Paternelle-Vie, Union des Assurances de Paris-Vie and Caisse d'Assurance et de Prévoyance Mutuelle des Agriculteurs v Ministère de l'Agriculture et de la Pêche*. ECLI:EU:C:1995:392.
[5] Case 1006/2/1/01 *BetterCare Group Limited v. Director General of Fair Trading* [2002] CAT 6, [2002] Comp.A.R. 229.

between members of that scheme. The CAT further held that this kind of solidarity was not to "be imposed externally on external trading partners such as independent [private] providers" (para 238). Thus the CAT appears to have followed the logic of *FFSA* inasmuch as the existence of solidarity did not preclude the activity being economic in nature. Despite this high-level national interpretation, and the expansion of private providers delivering solidarity-based activities which has emerged across European healthcare systems since *Poucet & Pistre* in the early 1990s, the original definition of "solidarity" at EU level appears to remain intact (including at least the CJEU's 2020 *Dôvera* judgment).[6] This explains findings, for example, that German sickness funds (Krankenkassen) were not considered subject to EU competition law in *AOK Bundesverband*,[7] and, via a convoluted logic disassociating purchasing and providing activities, that purchasing activities within the taxation-funded Spanish healthcare system were not subject to EU competition law in *FENIN*.[8] Nevertheless, there have been challenges to this approach, notably in Advocate General Maduro's Opinion in *FENIN* which distinguished third parties from members of a social security scheme (an approach seemingly favoured in the aforementioned *BetterCare* case) (Advocate General Maduro 2005). A further example is illustrated by the separation of bidding for, from delivery of, a public service in *AG2R*,[9] where the CJEU confirmed that a supplementary insurance scheme in France was characterised by "a high degree of solidarity" (para 52) yet nevertheless was subject to competition law due to limited State control.

This review indicates three aspects to how solidarity has been framed in antitrust cases. Firstly, solidarity may be determined by comparisons and distinctions not only between public and private providers, but also healthcare provision and purchasing. Secondly, solidarity appears

[6] Case C-262/18 P *Commission v Dôvera zdravotná poist'ovňa, a.s.*, ECLI:EU:C:2020:450.
[7] Joined cases C-264/01, C-306/01, C-354/01 and C-355/01, *AOK Bundesverband, Bundesverband der Betriebskrankenkassen (BKK) et al. v. Ichthyol-Gesellschaft Cordes et al.*, ECLI:EU:C:2004:150.
[8] Case C-205/03 P, *Federación Española de Empresas de Tecnología Sanitaria (FENIN) v. Commission of the European Communities*, ECLI:EU:C:2006:453.
[9] Case C-437/09, *AG2R Prévoyance v. Beaudout Père et Fils SARL*, ECLI:EU:C:2011:112.

underscored by a link between equal/universal access to healthcare and compulsory affiliation, whether in an insurance-based or taxation-funded healthcare system. Finally, that solidarity is a fundamentally national feature, rather than an EU-level concept, which determines applicability of the competition rules.

Solidarity in State aid cases

Among the state aid cases raised in the healthcare context, it becomes possible to identify three broad themes across cases: the implementation of risk equalisation schemes (RES) in insurance-based healthcare systems; state subsidy of public hospitals; and private sector delivery of state health insurance. We see different aspects of solidarity at play with the RES of the Irish and Dutch healthcare systems, and accordingly, gain different insights into national and EU interpretations of solidarity in this regard. What arguably unites the cases is the finding in both that the RES was compliant with the SGEI mechanism. Firstly, with regard to RES, in the Dutch healthcare system, clarification of compliance with EU law was sought in the context of the move away from state-run sickness funds (ziekenfondsen) to the introduction of mandatory private health insurance in 2006.[10] Within this new system, it was recognised that, in order to maintain the underlying "solidarity principle", restrictions would need to be placed on the private health insurers. What was envisaged that the RES would help ensure a "dual solidarity": between policyholders of differing health statuses, and between different incomes by means of a cap on healthcare costs. In the Irish healthcare system, which relies on a mix of public and private financing, the RES has evolved over time alongside various sets of reforms since approximately the mid-1990s and been regarded as the most contentious aspect of private health insurance (Turner and Smith 2020). Challenges under the state aid rules were brought at

[10] Case SA.18427 (N542/2004) Introduction of a Risk equalisation system in the Dutch Health Insurance.

EU level,[11] culminating in the General Court's 2008 *BUPA* judgment.[12] As the largest private provider on the Irish health insurance market (prior to its exit circa 2010), BUPA had articulated various concerns about the evolving RES and the payments it would be required to make. It therefore sought to challenge the Commission's findings that an SGEI mission could be associated with the RES on the basis, inter alia, that the RES associated obligations did not constitute a service that replaces the public social security system, but rather were designed to provide cover complementary or supplementary to the universal service. The General Court reaffirmed the Commission's finding of SGEI, clarifying that, while it may be most typical for a social security scheme to respond to a whole population need or to be supplied throughout a territory, there was no requirement for a universal service in the strict sense. Thus a relatively limited user group does not necessarily question the universal nature of an SGEI mission. While these challenges and clarifications clearly offer further insight into how "solidarity" can be understood at EU level, it is interesting – and important – to note that no reference is made to "solidarity" explicitly in the General Court's *BUPA* judgment. Rather, reference is made to constituent aspects which might be inferred from the abovementioned "antitrust" cases – such as open enrolment and minimum benefits, and universal service, continuity, quality of service and affordability. Secondly, with regard to public financing of public hospitals, the *IRIS-H* case has proved informative with regard to the Commission's and the General Court's approach.[13] This case involved a protracted examination of public and private hospitals in the Brussels region and the assessment of compensation of the deficits of the Brussels public hospital network (IRIS-H) by the Brussels municipalities since 1996. In 2009, the Commission had drawn on established principles from *Poucet & Pistre* and *FFSA* such as national solidarity and the absence of profit motive to conclude that solidarity in the Belgian healthcare system and

[11] Case SA.10138 (N46/2003) Risk equalisation scheme in the Irish health insurance market.
[12] Case T-289/03 *British United Provident Association Ltd (BUPA), BUPA Insurance Ltd, BUPA Ireland Ltd v Commission*, 12 February 2008, ECLI:EU:T:2008:29.
[13] T-137/10 *CBI v Commission*, judgment of 7 November 2012, ECLI:EU:T:2012:584.

management by public bodies did not preclude the existence of an economic activity, due in part to the fact that private hospitals delivered many of the same services. This established the applicability of Art.107(1) TFEU, but the Commission concluded that the payments complied with the state aid rules by virtue of classification of SGEI under Art. 106(2) TFEU in view of the compulsory character of the service provided to all and on the same conditions, even though only part of the population was covered. This decision was subsequently appealed by a group of private hospitals (CBI) for lack of adequate reasoning, and quashed by the General Court. In 2014, the Commission subsequently initiated another review of public financing measures benefitting IRIS-H, applying the same logic and reaching the same conclusion – that while Art. 107(1) TFEU was applicable, the payments nevertheless complied with the SGEI categorisation.[14] The *Casa Regina Apostolorum* case involves a religious hospital challenging the alleged compensation of costs incurred by public hospitals in the Lazio region. In particular, the complainant argued that public funds paid to public healthcare facilities in the Italian health system (SSN) to cover deficits without verification of their costs would be in breach of the principles of patient choice and competition and to the detriment of accredited private hospitals also delivering SSN services. The complainant further conceptualised the SSN as not being based on the principle of solidarity, but rather the principle of "freedom of choice of the patient" whereby the Italian authorities would have introduced competition in the SSN and made the services economic in nature. The Commission[15] found that Art.107(1) TFEU did not apply in this instance, relying in part on Art. 168(7) TFEU and the Italian government's commitment to the introduction of patient choice policies not displacing the underlying principle of solidarity in the SSN. The complainant appealed to the General Court on the basis, inter alia, that the

[14] Case SA.19864-2014/C (ex2009/NN54) implemented by Belgium Public Financing of Brussels public IRIS hospitals Brussels, 5.7.2016 C(2016) 4051 final.
[15] SA.39913 (2017/NN) Alleged compensation of public hospitals in Lazio. C(2017) 7973 final, 4.12.2017.

SGEI mechanism should be considered in this context. The General Court[16] and now the CJEU[17] have both rejected this argument, and the complainant's appeal before the CJEU criticises this.[18] Finally, the *Dôvera* case involved in essence a private insurer challenging payments to the Slovakian state health insurer in the context of the compulsory health insurance scheme. The Commission found that the system is centrally based on the solidarity principle, and concluded that the state aid prohibition did not apply.[19] Upon appeal, the General Court emphasised the competition aspects of the Slovak system, finding that the state health insurer was an undertaking.[20] This decision was appealed by the Commission to the CJEU, which appeared to adopt a narrower definition of "undertaking" based on earlier case law, concluding that the state health insurer was not subject to the state aid rules.

Solidarity and the Commission's SGEI packages

Since 2005, the Commission has issued SGEI "packages" comprising, inter alia, a Decision, which grants certain SGEI exemptions regarding notification under the state aid rules. The initial 2005 package[21] specified hospitals as an example of bodies entrusted with SGEI having certain characteristics which needed to be taken into consideration, and which would be exempt from notification, even if compensation exceeded specific thresholds (recital 16). The 2012

[16] Case T-223/18 *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v European Commission*, ECLI:EU:T:2021:315, 2 June 2021.
[17] C-492/21 P *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v Commission*, ECLI:EU:C:2023:354.
[18] Official Journal C471/24 2021, Appeal brought on 9 August 2021 by Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo against the judgment delivered on 2 June 2021 by the General Court (Seventh Chamber) in Case T-223, Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v European Commission (Case C-492/21 P) (2021/C 471/30).
[19] Commission Decision (EU) 2015/248 of 15 October 2014 on the measures SA.23008 (2013/C) (ex 2013/NN) implemented by Slovak Republic for Spoločná zdravotná poist'ovňa, a.s. (SZP) and Všeobecná zdravotná poist'ovňa, a.s. (VZP).
[20] Case T-216/15 *Dôvera zdravotná poist'ovňa and Union zdravotná poist'ovňa*, 5 February 2018, ECLI:EU:T:2018:64.
[21] Commission Decision of 28 November 2005 on the application of Article 86(2) of the EC Treaty to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document number C(2005) 2673) (2005/842/E).

SGEI package[22] reiterated the recognition of hospitals, but also extended this to SGEI regarding "health and long-term care" (recital 11). While neither Decision specifically referenced "solidarity", this can nevertheless be inferred in the Commission's recognition that "[h]ealth and social services form an essential part of the welfare system of each Member State and are of crucial importance for citizens" (European Commission 2019). The 2012 package was recently reviewed, with the Commission concluding in December 2022 that there was some scope for improvement, and a need to clarify further the distinction between "economic" and "non-economic" activities following *Dôvera* and *Casa Regina Apostolorum* (European Commission 2022). Where reference is made to "solidarity" in this review, it tends to be in connection with the aforementioned tension with competition arising in these two recent cases.

Solidarity in the State Aid Temporary Framework

In addition to cases where no "economic activity" is found to exist, or relying on the SGEI exception, recourse has also been made to some of the Treaty provisions (often in combination) regarding state aid and healthcare. Article 107(3)(c) TFEU makes provision for state aid to be deemed compatible where it facilitates the development of certain economic activities […] where this aid does not adversely affect trading conditions to an extent contrary to the common interest. This was found to be the case with the RES introduced in connection with the 2006 competition reforms in Dutch healthcare. This exception was also invoked in the Temporary Framework for State Aid, introduced as part of the Commission's response to the COVID-19 pandemic in March 2020 and in operation until 30 June 2022.[23] In this context, it facilitated COVID-19- relevant research and development, and production of COVID-19-relevant

[22] Commission Decision of 20 December 2011 on the application of Article 106(2) of the Treaty on the Functioning of the European Union to State aid in the form of public service compensation granted to certain undertakings entrusted with the operation of services of general economic interest (notified under document C(2011) 9380) (2012/21/EU).
[23] European Commission, 'Communication from the Commission – Temporary Framework for State Aid Measures to support the economy in the current COVID-19 outbreak' (2020/ C 91 I/01).

products, including medicinal products and treatments. This temporary framework also specified, with regard to the healthcare context, Art. 107(3)(b) TFEU, which is concerned with remedying a 'serious disturbance' in a Member State economy. Recourse was made to this exception to allow extended temporary payment of direct grants by the Dutch Ministry for Health, Wellbeing and Sport to cover costs associated with e-health applications to support providers of a range of healthcare services.[24] Recourse was also made to Article 107(3)(b) TFEU, albeit with an emphasis on supporting employment, in the Commission's decision to support the Czech Covid Spas subsidy programme which was extended over the calendar year of 2021, inter alia, to accept patients from hospitals.[25] While the Art. 107(3)(b) and (c) exceptions are clearly intended to have general application, it might be considered that solidarity-motivated aims shaped their use in the aforementioned cases and guidance in the COVID-19 context. Whether it can be extrapolated from this that they afford such flexibility under all circumstances is moot, but would seem to offer a useful mechanism in coexistence with the SGEI framework (Guy 2020).

This three-part review of how solidarity features in connection with state aid builds on some of the logic found in antitrust cases – such as comparisons/contrasts between public and private providers, and the importance of universal coverage. With the state aid rules, however, we also see more willingness to frame solidarity in connection with the partial exception of SGEI, perhaps suggesting a 'competing interest' (Dawes 2020: 47) in framing solidarity as a political determinant of health emanating from the EU as well as the national level. A final consideration is how solidarity may be imputed with regard to the State Aid Temporary Framework in operation as a response to the COVID-19 pandemic.

[24] Cases SA.57897 (2020/N) and SA.56915 (2020/N).
[25] Cases SA.58018 and SA.61912.

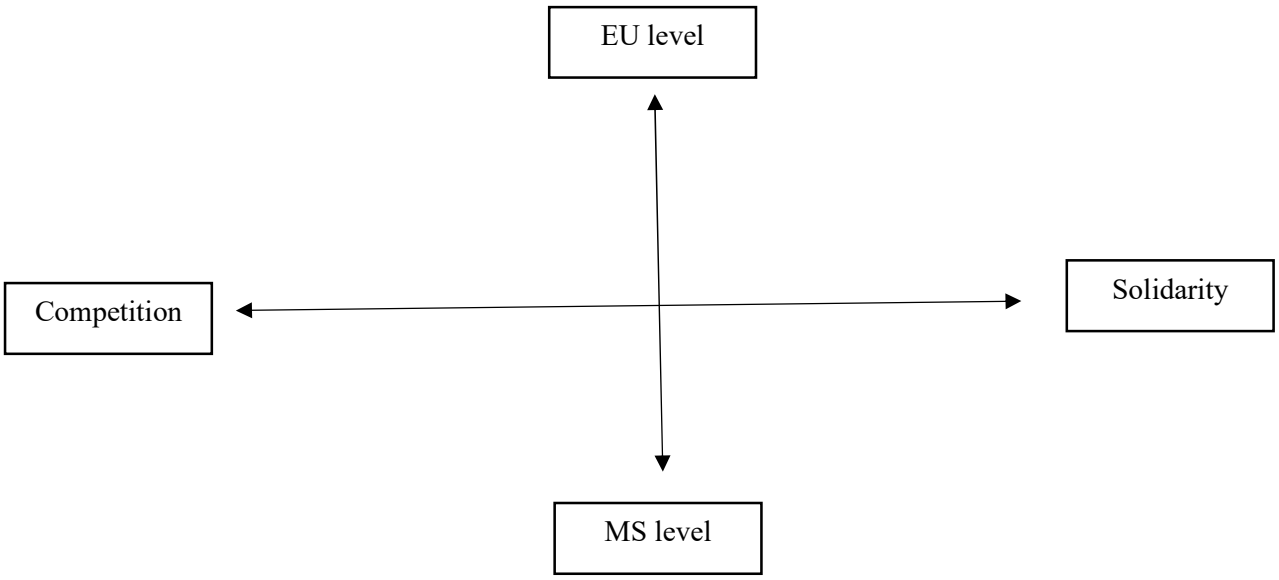
Discussion – what factors determine how solidarity is framed within EU competition policy?

The above analysis is now used to consider the question of how EU competition policy (as a political institution) may be framing and shaping the concept of solidarity (a political determinant of health). A starting-point may be to reiterate that EU competition policy fundamentally frames solidarity as very much an exception to the antitrust and state aid rules, whether via a finding that no "economic activity" exists, or that an activity is classified as an SGEI, or in the context of measures adopted during the COVID-19 pandemic, as a justification for state aid. This would seem to hold across a theoretical spectrum of healthcare systems spanning totally public and thus exclusively based on solidarity, to totally private and thus operating according to competition and market principles. This may be supported to a certain extent by the often-found coexistence of a public healthcare system (funded by mandatory contributions) with complementary or supplementary private health insurance as indicated in *Poucet & Pistre*. However, the gradual expansion of marketisation reforms in national healthcare systems in Europe and development of the interaction between public and private healthcare has long meant that such a dichotomy is difficult to maintain, hence the complexities surrounding solidarity in connection with EU competition policy (Boeger 2007). Overall, this may suggest that little, if any, distinction is being drawn between different types of healthcare system, despite suggestions that it is easier to develop competition within an insurance-based healthcare system rather than a taxation-funded healthcare system (Hancher and Sauter 2012: 232-3). Thus we see recourse to the SGEI exception explored in the context of the Belgian healthcare system in the *IRIS-H* case, which has been described as "hybrid" for combining taxation-funded aspects and private expenditure, while also belonging on the spectrum of insurance-based healthcare systems (Laible 2013). Italy's mixed public/private system based in part on general taxation with a strong regional focus (Garattini et al. 2022) has been

considered by the General Court in *Casa Regina Apostolorum* to maintain its commitment to solidarity despite the existence of patient choice policies being linked to the development of competition. In the case law to date, perhaps the largest challenge to this constant of solidarity has been seen in the General Court's assessment of competition within the Slovak health insurance system in *Dôvera*, although the CJEU reaffirmed the existence of solidarity consistent with earlier case law. The aforementioned case law has given rise to a framework in which a broad distinction might be drawn between EU competition policy being applicable to healthcare providers, but not to healthcare purchasing activities (van de Gronden and Rusu 2017; Guy 2019; Guy 2020). However, when considering solidarity as a political determinant of health, such a distinction may be of limited use insofar as the position, for example, of a healthcare provider delivering services within a solidarity-based system has not explicitly been explored at the EU level, an aspect notable by its absence in *FENIN* (Prosser 2010). Where this purchaser/provider distinction has been helpful, however, is in the identification of different approaches or tests suggesting differing levels of scrutiny of national healthcare systems, thus with greater scope for acknowledging solidarity. Thus it has been considered that cases involving providers tend to focus more on the "functional" definition of an "economic activity" in tests described as "abstract" (Belhaj and van de Gronden 2004; van de Gronden and Guy 2021), or as "classical functional" (Gallo and Mariotti 2017). In contrast, more attention has been deemed to be given to the wider national context, thus extent of solidarity, with regard to purchasing activities in a test described as "concrete" (Belhaj and van de Gronden 2004; van de Gronden and Guy 2021), or as "attenuated functional" (Gallo and Mariotti 2017). The latter tests focus on the wider national healthcare context, thus pay greater attention to how solidarity functions within a given healthcare system, and where it may – or may not – be displaced by competition (-related) reforms such as patient choice policies. Nevertheless, taken together,

there are clearly important juxtapositions of competition and solidarity, and between Member State and EU levels, which might be illustrated thus:

FIGURE 1



The juxtaposition of national and EU levels can be seen already in the *Poucet et Pistre* starting point, with the phrase "national solidarity", which, aside from *AOK Bundesverband*, appears not to be referenced as such elsewhere. This might be understood as a clear dissociation from definition at the EU level, consistent with the recognition of healthcare system organisation as a national competence: solidarity may be interpreted in different ways by different Member States. However, "national solidarity" may simply mean that solidarity is confined to the national level (but may include varying forms of redistributive goals within that, between different age groups, health risks etc). In other words, there is no attempt being made within the competition policy context to establish common solidarity-based activities across the range of Member States such that the classification of emergency ambulance services in Germany "translates" to emergency ambulance services elsewhere. The juxtaposition of competition and solidarity would seem to encapsulate the ambivalence about the role of the EU level in prompting a decisive move towards either competition or solidarity, as well as, at a national

level, the extent to which competition reforms should be developed and competition law used. In a sense the starting question appears to be concerned with the extent to which Member States choose to maintain solidarity as the basis for their healthcare systems, with the implication that EU (and perhaps also national) competition law may not apply. Concerns about these dynamics - between competition and solidarity, and between the EU and Member State levels – draw on a variety of elements: regarding perceptions of EU-level "overreach" over national healthcare systems (Morton 2021 and 2022); national uncertainty regarding the reach of EU competition law, and particularly exception mechanisms such as SGEI (Nikolić 2021); the scope for inconsistent interpretation at a national level of EU provisions, generating "Euro-national competition rules for healthcare" (van de Gronden 2011: 293); and scope for national reforms to be (mis)informed by "Euro-ambivalent" interpretations of EU law at a national level (Guy 2023a). Such distinctions perhaps explain a curious feature of the CAT's analysis in the 2002 *BetterCare* case was the additional layer of complexity implied between "internal" and "external" solidarity (para 242): "Any 'solidarity' in the sense indicated by the European Court which exists in the present case is at most between the residents and the generality of taxpayers who fund them, and not between [the NHS body] and its independent providers". While a similar logic may be discerned elsewhere, e.g. in Advocate General Maduro's Opinion in *FENIN*, as indicated above, it is notable that in 2023, this rationale may simply be seen as anomalous, even out of step with the approach taken by the CJEU in subsequent case law. Where Member States have made concerted efforts to enshrine wide-ranging competition reforms in healthcare, this has taken place against the backdrop of the aforementioned "EU competition framework", and notable examples remain the Netherlands and England (where reforms were enshrined while the UK was still an EU Member State). The reforms evolved in part by responding to the EU competition framework such that it is possible to juxtapose the two countries' experiences as building competition reforms around a "core" of solidarity (the

Netherlands via the approval of its RES in the state aid case), and within a "core" of solidarity with competition within the English NHS (Guy 2019: 76-83).

With this in mind alongside the findings of case law – broadly, that solidarity within a healthcare system is determined at the national, rather than the EU level – the role of solidarity as a political determinant of health becomes critical. Certainly it has been suggested that "…once solidarity is recognised as the organising principle for healthcare delivery, the game changes" (Guy 2019: 17), with the implication that the emphasis shifts from solidarity as forming a narrow exception to a wider framework of competition, to solidarity defining that framework. This has implications for solidarity as a political determinant of health both in terms of the national and EU levels. At a national level, if active competition enforcement flows from a governmental decision to enact competition reforms, then the latter is a (national) political decision, rather than activity which spontaneously invites the theoretical applicability of EU competition law (Guy 2022). This might be seen as an attempt to use competition (-related) reforms to deliver solidarity goals, thus indicating that the two are less antithetical than typically thought, and may even represent "two sides of the same coin" (Belhaj and van de Gronden 2004). The EU-level reluctance to establish applicability of competition law may then be as much explained from a constitutional, as a competition perspective (Guy 2023b). The reservation of healthcare system organisation as a national competence by Article 168(7) TFEU would appear to cover the eventuality of a national decision to introduce competition reforms to varying extents (Andreangeli 2016) without minimising commitments to solidarity. A final consideration is that speaking of "healthcare" may be too wide a framing – and that a more disaggregated approach may be needed to identify where competition may be beneficial (Guy 2019: 224). Thus this has been seen with differentiated guidance issued by the Dutch competition authority with regard to different aspects and treatments. Insofar as it is possible to distinguish different types of state aid case – relating to RES, support to public hospitals,

and support to public insurance systems – this approach may be beneficial at the supranational level as well. Certainly the appellant's appeal to the CJEU in *Casa Regina Apostolorum* suggested that it is not possible "simply to transpose the content of the judgment of the CJEU in *Dôvera*" (Official Journal C471/24 2021).

Conclusion

This paper has considered the framing of solidarity as a political determinant of health in the specific context of EU competition policy, amid suggestions of distinctions at national and EU levels which may have implications for solidarity as a political determinant of health. By focusing analysis on an "upstream" level of national and EU competition law, this paper has revealed the myriad considerations which arise, which might be grouped in two broad categories. Firstly, the complexities of applying (national or EU) competition law to the healthcare context and the distinction between "economic" and "non-economic" activities which raise questions of "how much" competition may be needed to displace the solidarity focus of European healthcare systems. This may seem to suggest that solidarity's predominance may well underscore its status as a "determinant of the determinants" (Dawes 2020:45), but only clarifies a lack of formal competition regulation, as distinct from any negative effects which may flow from expanding private sector delivery of public healthcare, and which may shape social and commercial determinants of health. Secondly, the dynamic between the national and EU levels, which is seemingly clarified by Article 168(7) TFEU but in reality complicated by questions of applicability of EU (as distinct from national) competition law. This offers further learning for outlining political determinants of health insofar as there may exist separate EU and national-level versions. With regard to the EU level in this specific context of competition policy, cases such as *IRIS-H* and now *Casa Regina Apostolorum* indicate an overall reluctance by the Commission and the courts to apply the state aid prohibition, which may suggest that determinations of solidarity are exclusively a national

matter. In contrast, the RES cases arguably suggest greater cooperation between the national and EU levels in recognising a solidarity-defined aspect of healthcare. This would seem to suggest that there is merit in disaggregating at least types of cases, although at a national level further disaggregation according to treatments may also be possible. The CJEU's April 2023 judgment in *Casa Regina Apostolorum* would seem to offer, for the time being, a conclusive statement on the delineation of the reach of EU competition policy as regards healthcare reforms which may hint at competition (for example with patient choice policies and expanded private sector delivery of public healthcare), but where the solidarity principles embedded in the healthcare system ultimately prevail. This would seem to indicate that concerns about EU-level "overreach" in this regard are not well-founded, and that determining political determinants of health at a supranational level remains elusive.

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