# THE CURIOUS CASE OF COMPETITION LAW AND HEALTH EQUITY

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## I. SETTING THE SCENE: WHY DO EU HEALTH SYSTEMS MOVE TOWARDS MARKET DRIVEN HEALTHCARE DELIVERY?

Healthcare systems are an essential part of Europe's high levels of social protection and contribute significantly to Europe's ideals of social justice and social cohesion.[2] As highlighted by the Council's statement on the common values and principles of the EU healthcare systems ("The Statement"),[3] there are some core values and principles that are shared across the EU about how health systems should respond to the needs of the populations and the patients they serve.[4] Essentially, these are universality, access to good quality care, equity, and solidarity.[5] *Universality* means that "no-one is barred access to health care";[6] The notion of *solidarity* closely relates to "the financial arrangement of the national health systems and the need to ensure accessibility to all";[7] *equity* relates to "equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay."[8] EU Health systems also strive to reduce the existing health inequalities, a major concern for most States in Europe.[9]

Along with the common values and principles they share, European health systems share also some common concerns, in particular increasing health expenditures that are due mainly to three factors: rising life spans, (and therefore, ageing populations) increasing expectations, and the emergence of healthcare technologies.[10] Undoubtedly, whereas these factors contribute to the well-being and quality of life of EU citizens – especially in terms of life longevity – they also drain resources from national health budgets.[11] This, in turn, has led some European countries, such as the UK and the Netherlands to introduce to some degree competition in the delivery of healthcare services as a device to curb continuous increases in healthcare spending.[12]

2 Council Conclusions on Common values and principles in European Union Health Systems, Official Journal of the European Union (2006/C 146/01), 1. This specific document builds upon discussions that have taken place in the Council and with the Commission as part of the Open Method of Coordination, and the High-Level Process of Reflection on Patient Mobility and development in the field of health.

3 *Ibid.*

4 *Ibid.* at 2.

5 *Ibid.*

6 *Ibid.*

7 *Ibid.*

8 *Ibid.*

9 *Ibid.*

10 W. Sauter, "The Impact of EU Competition Law on National Healthcare Systems," (2013) 38(4) *European Law Review*, 457, 459.

11 *Ibid.*

12 *Ibid.*

The role of competition in healthcare is a hotly debated topic with some considering it "anathema" and others seeing it as "a magic bullet."[13] For instance, proponents of the introduction of competitive forces in healthcare vigorously support the claim that hospitals and other medical facilities owned and operated by the State often fail to operate efficiently and respond to the needs and wants of their patients.[14] Because these institutions, they contend, are directly funded from government, with budgets that are determined historically and bear little relationship with their performance, they lack the incentives to restrain their costs and invest in quality.[15] If, however, the argument goes, patients were given the opportunity to choose where they could go for treatment, and if the money followed this choice, so that medical facilities would only obtain funding from the public purse if they successfully attracted patients, then the resultant competition among these facilities would strongly incentivize them to improve the efficiency and quality of their services.[16]

Nonetheless, opponents of the introduction of market forces in healthcare often tell a different story. Essentially, they allege than any healthcare system based on market-driven healthcare delivery carries within it the danger of reducing quality, restricting access to healthcare services and exacerbate the existing health inequities.[17] More than that, they warn that while the empirical literature on the impact of competition among healthcare providers on their performance has primarily assessed the effect of hospital competition on outcome measures, such as mortality rates, it has not adequately examined the impact of competition on the social objectives that health systems at the macro level pursue, such as equity and access.[18]

In further enriching this topical, albeit complex, debate, this article puts forward two additional concerns: *First*, it argues that the risk that the introduction of market values in healthcare may harm core objectives of EU health systems, such as equity, cannot always be excluded. This is because the goal of competition in healthcare and the pursuit of core values of EU health systems, such as equity or access to healthcare, may in certain cases clash; *Second*, it indicates that when conflicts between these objectives actually emerge, the main actors involved in the provision of healthcare, notably physicians acting as gatekeepers or purchasers of healthcare services (e.g. in the case of the English national health service "NHS") may be encouraged to enter into agreements that restrict quality competition among providers with a view to ensuring access and continuity of care. Such agreements, this article claims, may under certain conditions catch the attention of competition law which generally assumes that consumers are better off if competition between market players is preserved.[19]

Shedding some light on these competition concerns, this article asks: can competition authorities in Europe consider in their competition analysis the core objectives that their health systems strive to attain, such as equity? In delving into this question, this article first briefly discusses the main aspects of the procompetitive regime that promoted competition among providers in the English NHS since the early 1990s. It also identifies some of the potential conflicts between the goals of competition and equity this regime may create and the antitrust concerns that may emerge as a result of these conflicts. By bringing to the fore these competition concerns and by examining the extent to which distributive concerns can be injected in an antitrust analysis on the basis of article 101 TFEU, this article takes the stance that the answer to the core question it poses should not necessarily be a negative one.

13 For a robust discussion on the debate: European Commission, Expert Panel on Effective Ways on Investing in Health ("EXPH"), "Competition among health care providers, investigating policy options in the European Union," The EXPH adopted this opinion at the 10th plenary meeting of May 7, 2015 after public consultation, 8.

14 J. Le Grand, "Choice and Competition in publicly funded healthcare," (2009) 4(4) *Health Economics, Policy and the Law*, 479-80.

15 *Ibid.*

16 *Ibid.*

17 European Commission, *supra* note 13 at 8.

18 *Ibid.* at 40-41, 49-50.

19 Theodosia Stavroulaki "Connecting the Dots: Antitrust, Quality and Medicine," (2019) 31(2) *Loyola Consumer Law Review* 175, 19.

## II. TOWARDS THE MARKETIZATION OF EU HEALTH SYSTEMS: A SHORT TRAVEL TO THE UK EXPERIENCE

The extent to which European countries have introduced competition among the market players in the field of healthcare varies across Europe. The English NHS, for example, embraced the introduction of market mechanisms within it as early as the early 1990s when the then Conservative Government implemented the National Health Service and Community Care Act (the "Act"), establishing the "Internal Market."[20] By separating the purchasing ("commissioning") and the provision of healthcare services across the UK, the Act essentially sought to reinforce competition among providers of healthcare.[21] Providers and purchasers were linked by a contract. Purchasers' main goal was to buy more elective care in order to reduce the long waiting lists existed for many elective procedures.[22] Therefore, they had powerful incentives to negotiate lower prices.[23] As the scope of competition among providers under the internal market was limited, it did not have a dramatic impact on NHS.

The late 1990s brought an end to this "internal market" experience with a move to a system that focused more on quality and less on prices.[24] The new Labour Leadership did not abolish the purchaser-provider split. However, it introduced an activity-based payment system for hospitals known as "Payment by Results" ("PbR").[25] In order that money could follow the patients and provide an incentive for efficient providers to increase their activity through output, the Government implemented a system of fixed national prices (tariffs) that were set by the Department of Health.[26] Given that this new scheme limited the possibility of any negotiation in terms of prices, competition among providers was theoretically based on innovation and quality.

To enhance quality competition, the Government also implemented policies that allowed patients to exercise choice at the point of referral. On the basis of these policies, patients could choose between any provider, private or NHS, that had agreed to provide care at the national tariff system (PbR).[27] Therefore, from around 2002 onwards the provision of NHS services was gradually opened up to several accredited healthcare providers including both publicly owned and independent providers, mainly NHS Foundation Trusts ("NHS FTs") and Independent Sector Treatment Centers ("ISTCs").[28] These institutions were established to provide high volume and low-risk surgery to patients.[29] The government also sought to enhance quality competition by allowing elective patients to choose any provider who met NHS standards and tariffs through the so-called "choose and book" system.[30] This was an electronic appointment booking system that was installed in hospitals and general practitioner ("GP") surgeries to enable GPs and patients to book their appointments online, in the GP surgery, or from home.[31]

As with the Labour Government, the Coalition Government under the Health and Social Care Act of 2012 ("HSCA") also attempted to promote quality by (a) facilitating patients' choice and competition among healthcare providers; (b) limiting competition in terms of prices; and (c) by enforcing quality regulation and ensuring that multiple bodies and regulators are responsible for supervising the quality of NHS services,

20 National Health Service and Community Care Act 1990, available at http://www.legislation.gov.uk/ukpga/1990/19/contents.

21 For a comprehensive review of the market reforms of the healthcare system in the UK, J. Cylus, E Richardson, L. Findley, M. Longley, C. O'Neill, D. Steel, (2015) 17(5) *United Kingdom: Health system review. Health Systems in Transition*, 16.

22 C. Propper, S. Burgess & D. Gossage, "Competition and Quality: Evidence from the NHS Internal Market 1991-9," (2008) 118(525) *The Economic Journal*, 138, 142.

23 *Ibid.*

24 European Commission, *supra* note 13 at 47.

25 N. Mays, A. Dixon, L. Jones, "Return to the Market: Objectives and Evolution of New Labour's Market Reforms," in N. Mays, A. Dixon & L. Jones (eds) in *Understanding New Labour's Reforms of the English NHS*, (London: The King's Fund: 2011) 12.

26 *Ibid.* at 7.

27 A. Dixon, R. Robertson, "Patient Choice of Hospital," in N. Mays, A. Dixon & L. Jones (eds) *Understanding New Labour's Reforms of the English NHS*, (London: The King's Fund 2011), 53.

28 M. Sanderson, P. Allen, D. Osipovic, "The regulation of competition in the National Health Service (NHS): what difference has the Health and Social Care Act 2012 made?" (2017) 12 *Health Economics, Policy and Law*, 1, 4-6.

29 *Ibid.*

30 L. Stirton, "Back to the future, lessons on the procompetitive regulation on health services," (2014) 22(2) *Medical Law Review*, 180, 191.

31 A. Dixon, R. Robertson, *supra* note 27, at 55. Since 2015 this system is called: NHS e-Referral Service (e-RS).

notably the Care Quality Commission, NHS Improvement and the purchasers of NHS services (the NHS commissioners) [32] Additionally, the HSCA "made a direct correlation between competitive behavior in the NHS and competition law."[33] Specifically, the HSCA gave NHS Improvement (former Monitor) competition powers in the Competition Act 1998 concurrently with the Competition and Markets Authority (CMA).[34] On the basis of the clause 62(3) of the HSCA, NHS Improvement is obliged to exercise its functions with a view to preventing anticompetitive behavior, which *is against the interests of people who use these services*. Thus, NHS Improvement can investigate anti-competitive agreements or allegations of abuse of market power.[35] It is also responsible for ensuring that NHS commissioners respect patients' right to choose and do not engage in *anti-competitive behavior* when purchasing services unless it is in the interests of NHS patients.[36]

What type of equity and access concerns could such a regime create? To begin with, a regulatory regime that extends choice and competition as a means to achieve quality improvements may incentivize providers to compete on the dimensions of quality that can be easily verified by consumers, commissioners or regulators, such us waiting times or mortality rates. The NHS, for instance, disseminates information on providers' performance with regards to mortality rates.[37] This disclosure, however, may incentivize providers to alter their conduct to improve their performance on these indicators.[38] Hospitals, for instance, may avoid attracting high-risk patients by limiting their contracts with high quality surgeons specialized in complex high- risk surgeries.[39] Extending, therefore, patients' choices with a view to fostering quality may, in certain cases, raise equity and access concerns.

More than that, extending patients' choice by allowing private entities to offer more profitable elective services may leave NHS organizations with the complex, high-risk, intensive care, which they had previously been able to cross-subsidize with revenue from their lower risk elective procedures.[40] ISTCs, for instance, that were established in the UK during the Labour Leadership were specifically intended to treat low-risk, elective patients rather than high-risk, high-cost NHS patients.[41] Thus, the risk that these entities may pose a threat to equity or access by cherry-picking the more profitable low-risk cases that previously allowed the NHS bodies to cross-subsidize their high-risk intensive care cannot be excluded.

To reduce these risks and ensure core objectives of their health systems, the NHS commissioners may agree with the GPs in their role as gatekeepers to restrict patients' choice and refer more patients for elective care to NHS bodies engaging also in risky non-elective procedures so that these entities can cross-subsidize these costly procedures and ensure continuity of care.[42] Arguably, such agreements may reduce pa-

32 During the Labour period, the Primary Care Trusts (or "PCTs") that involved all GPs were responsible for the commissioning of NHS services. After the introduction of the HSCA 2012 the PCTs were abolished and replaced by Clinical Commissioning Groups ("CCGs") that are consortia of GPs. NHS England is also responsible for commissioning specific services. See L. Stirton, *supra* note 30 at 192. For the purpose of this paper, I will call the CCGs "NHS commissioners."

33 *Ibid.*

34 Article 72 HSCA 2012.

35 *Ibid.*

36 See Regulation 10(1) of "the Procurement, Patient Choice and Competition Regulations" and Monitor's Enforcement Guidance on the Procurement, Patient, Choice and Competition Regulations: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/283508/EnforcementGuidanceDec13.pdf.

37 For instance: https://www.nhs.uk/news/medical-practice/guide-rates-best-and-worst-hospitals-in-2011/. Patients also rate hospitals on the basis of their experiences: https://www.nhs.uk/Review/List/P95971?currentpage=2.

38 European Commission, *supra* note 13 at 47.

39 *Ibid.* at 48 (for an analogous example in health insurance). See also R. H. Palmer "Using health outcomes data to compare plans, networks and providers," (1998) 10(6) *International Journal for Quality in Healthcare*, 477, 482.

40 P. Allen & L. Jones, "Diversity of Health Care Providers," in N. Mays, A. Dixon & L. Jones (eds), *Understanding New Labour's Reforms of the English NHS*, (London: The King's Fund, 2011), 22.

41 *Ibid.* at 18.

42 In a report published by the Cooperation and Competition Panel (or else "CCP") to inform commissioners on the extent to which specific restrictions of competition can be justified on the basis that they can benefit patients, it is mentioned that NHS commissioners (PCTs during the labor period) constrained patients' ability to choose their routine elective care provider by influencing GP referral decisions and in some cases, asking GPs to refer patients to (or away from) certain providers. Ensuring providers' stability and the continuity of services were some of the justifications that, among others, were raised, by the NHS commissioners for such restrictions. GPs, the report says, agreed with NHS commissioners' recommendations. See CCP panel, "Review of the operation of 'Any Willing Provider,' for the provision of routine elective care," London: Cooperation and Competition Panel Curtis, LE, 2014. The CCP was established during the Labour Leadership to advise the Secretary of Health and Monitor on how restraints of competition should be resolved, See https://www.ccpanel.org.uk/.

tients' choice and restrict competition among providers on quality in the elective services market. At the same time, though, they may ensure the financial stability of NHS organizations and therefore secure access to high-risk complex procedures. How should competition authorities evaluate these potentially "equity-enhancing" agreements? Should they consider, for example, that they may promote access and health equity and balance these goals against the harm caused to competition? And if so, under what legal techniques?

These questions become even more important if we consider clinical evidence demonstrating that the conditions you are born, live and work have a significant impact on health inequalities.[43] Indeed, the physical environment is an important determinant of health variations.[44] Poorer neighborhoods, for instance, "are disproportionately located near highways, industrial areas, and toxic waste sites, since land there is cheaper."[45] Childhood asthma incidence "is also rising in urban neighborhoods among poor children, and the severity is greater among these children."[46] The poor individuals that lack stable housing are also more likely to use the emergency department rather than a regular clinic as their primary source of care.[47] This reality may incentivize NHS commissioners to agree with the GPs acting as gatekeepers to refer more patients for elective care to NHS hospitals that offer high-risk non-elective services in disadvantaged areas so that these hospitals can cross-subsidize their high demand for respiratory and emergency care services. How should competition authorities respond to the entities' claim that their agreement does nothing more than ensure the financial stability of the NHS bodies offering high-risk costly services in poor and disadvantaged areas and should be exempted from the application of competition law?

To the extent these entities are not considered to act as "undertakings" they may escape antitrust scrutiny.[48] If, however, they are considered to be "undertakings" on the basis that they engage in an economic activity, then they may be subject to competition law. Importantly, the term "undertaking" focuses exclusively on the nature of the activity carried out by the entity concerned.[49] Therefore, it is irrelevant whether the entity is of public or private nature or whether it is engaged in profit or non-profit activity. Consequently, a given entity might be regarded as an undertaking for one part of its activities while the rest may fall outside the competition rules.[50]

The question of whether the GPs in the case at issue are undertakings might entail less complexity. GPs offer their services in the context of the English NHS as independent providers[51] and compete to attract patients on the basis of their performance.[52] Considering *Pavlov*[53] where the Court ruled that physicians perform an economic activity when they receive remuneration for the services they offer, and bear the financial risks associated with them, it may be argued that the GPs in this case are "undertakings."

However, the question of whether the NHS commissioners act as "undertakings" in this case is a more difficult one to address. For instance, in *FENIN*[54] the Court held that hospitals that are part of the Spanish national health system do not perform an economic activity when they purchase their medical equipment in order to provide free healthcare services to patients. Therefore, there is no breach of competition law

43 M. Marmot, *The Health Gap, The Challenge of An Unequal World* (Bloomsbury, 2015) 27.

44 N. Rice & P. C Smith, "Ethics and geographical equity in health care," (2001) 27 *Journal of Medical Ethics*, 256.

45 N. E. Adler & K. Newman, "Socioeconomic Disparities in Health: Pathways and Policies," (2002) 21(2) *Health Affairs,* 60, 66.

46 *Ibid.*

47 C. A. Jones, A. Perera, M. Chow, I. Ho, J. Nguyen & S. Davach "Cardiovascular Disease Risk Among the Poor and Homeless – What We Know So Far," (2009) 5 *Current Cardiology Reviews*, 69, 70.

48 For a discussion on whether NHS commissioners and medical professionals are undertakings: Mary Guy, *Competition Policy in Healthcare, Frontiers in Insurance Based and Taxation Funded Systems*, (Intersentia 2019) 64-90. The author also notes that NHS has not been formally categorized as a Service of General Economic Interest but the possibility that the legislation governing the NHS may be considered as "an act of entrustment" cannot be excluded.

49 A. Jones, B. Sufrin, *EC Competition law*, (OUP 2014), 124-125.

50 C-475/99. *Ambulanz Glöckner v Landkreis Südwestpfalz*, [2001] ECR I-8089, Jacobs AG para 72.

51 https://www.healthcareers.nhs.uk/explore-roles/doctors/pay-doctors.

52 *iWantGreatCare.org*, for instance, allows patients to compare the quality of GPs on the basis of reviews. In case they are not happy with the services they are offered they can change their GP. See also: https://www.nhs.uk/Services/GP/ReviewsAndRatings/DefaultView.aspx?id=42367.

53 Joined cases C-180/98 to C-184/98 *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten* [2000] para 76.

54 Case C-205/03, *Federacion National de Empresas de Instrumentacion Cientifi ca Medica Tecnica y Dental (FENIN) v. Commission of the European Communities* [2006] ECR I-6295.

when they systematically delay payment of their debts. As these hospitals, the Court held, are funded by social security contributions and operate *on the basis of the solidarity principle*, they cannot be held to be undertakings.

The Court's test, however, in *FENIN* may not necessarily apply in the case of purchasers, such as the NHS commissioners that perform their duties in market-based systems that strive to promote a wider set of goals: choice, competition *and* solidarity.[55] It may also not necessarily apply in the case of entities, such as the NHS Commissioners, that purchase but also provide healthcare services in the relevant market.[56] In *BetterCare*,[57] for instance, the UK Competition Appeal Tribunal (the "CAT") held that a local authority ("NHS Trust") was an undertaking when it purchased social care services from independent providers at considerably low prices. In reaching this conclusion, the CAT took into consideration that the activity performed by this entity had both "business" and "social dimensions."[58] Indeed, the local authority ensured access to care for elderly populations by entering into commercial transactions with independent providers.[59] Since, this entity operated in a competition-based system[60] and acted not only as a purchaser but also as a seller in the relevant market,[61] the CAT was not convinced by the OFT's initial findings that the entity in question was not an undertaking. The CAT remitted the case back to the OFT which ultimately found no abuse of dominance on the grounds that the entity in question did not set the prices at which it purchased social services.[62]

Following *BetterCare and FENIN*, the OFT published a policy report[63] clarifying the conditions under which public bodies may be considered undertakings. In this report, the OFT underlines that these entities do not perform an economic activity when they exercise public powers, (e.g. when they act "in a purely administrative capacity").[64] In contrast, it alleges that they engage in an economic activity when they supply goods or services and this supply is of a commercial, and not of a wholly social nature.[65] Upstream purchasing, the report further contends, is an economic activity only to the extent the "purchased goods or services are subsequently used to conduct an economic activity downstream."[66]

As noted, the agreement in question between GPs and NHS commissioners may restrict quality competition among healthcare providers in the elective services market. The provision of elective services can be considered an economic activity. Indeed, in this profitable market[67] multiple healthcare providers (including independent entities) compete to attract patients on the basis of the quality of their services. In this market, NHS commissioners may also participate in their role as medical professionals offering their services. Considering that the NHS commissioners may be active players in the elective services market, the possibility that they may be considered "undertakings" when they enter into agreements with GPs that may restrict competition in this market, cannot be excluded.

The above analysis implies that agreements between NHS commissioners and GPs acting as gatekeepers aiming to promote health objectives, such as equity, may not necessarily be exempted from the application of competition law. Therefore, NHS Improvement, the CMA or other competition authorities in Europe applying competition law in healthcare may not always avoid the difficult exercise of balancing the goal

55 For a thorough discussion on why NHS commissioners ("CCGs") are undertakings especially because they operate in a competition-based system: A. Sánchez Graells, "Why are NHS Commissioners "undertakings" and, consequently, subject to competition law ?" available at https://www.howtocrackanut.com/blog/2014/06/why-are-nhs-commissioners-undertakings.html?rq=%E2%80%98Why%20are%20NHS%20Commissioners%20%E2%80%98undertakings%E2%80%99%20and%2C%20consequently%2C%20subject%20to%20competition%20law%3F%E2%80%99.

56 CCGs in the UK are GP practices that can also provide medical services: https://www.england.nhs.uk/commissioning/who-commissions-nhs-services/ccgs/.

57 Case 1006/2/1/01 *BetterCare Group Limited v. Director General of Fair Trading* [2002] CAT.

58 *Ibid.* at 230.

59 *Ibid* at 234.

60 *Ibid.*

61 *Ibid.* at paras 199-201.

62 OFT, Case No. CA98/09/2003, *BetterCare Group Ltd v. North & West Belfast Health & Social Services Trust* (Remitted case) 18.12.2003, para 58.

63 OFT, "The Competition Act 1998 and Public Bodies, Policy Note1/2004," OFT443.

64 *Ibid.* at 11. See also C-343/95 *Diego Cali & Figli SrL v. Servizi Ecologici Porto di Genova Spa* [1997] ECR I-1547 ('*Diego Cali*'), paras 22 to 23.

65 *Ibid.* at 13-18. A commercial activity is, for instance, one that is "undertaken for profit in direct competition with private sector companies." The report also clarifies that exclusively social is usually an activity that cannot by its nature be carried out for profit without State support or is carried out according to the principle of solidarity.

66 *Ibid.* at 12-14.

67 See for instance, Competition Commission, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust at 6.132:

of competition against the pursuit of health objectives, such as equity.[68] In this light, the question that ultimately emerges is whether such a balancing act can be performed by NHS Improvement or competition authorities in Europe when they face analogous conflicts on the basis of Article 101 TFEU (or the respective articles in their national competition rules). Therefore, the last part of this piece shines a light on this topical question.

## III. CAN COMPETITION LAW TAKE INTO ACCCOUNT THE NOTION OF EQUITY IN THE CONTEXT OF ARTICLE 101 TFEU?

While the pursuit of public policy goals, such as solidarity, has strongly influenced the Court's assessment when it examines whether a specific entity is "an undertaking,"[69] it has also shaped the core of its *Pluralistic Approach* in the context of Article 101 (1) TFEU. On the basis of this approach, the Court accommodated conflicting policy objectives by establishing the principle that competition rules should be interpreted "*in light of the Treaty as a whole*."[70] Under this approach, any competition law assessment must first examine the overall context in which the agreement was concluded and more particularly its legal and economic context.[71] In line with this principle, the Court has excluded agreements from the application of Article 101(1) TFEU on the basis that they are necessary for the attainment of a legitimate objective. In *Wouters*, this objective was the integrity of the legal profession. [72] In *Meca-Medina*, the legitimate objectives the Court thought deserved special attention were athletes' integrity and ethical values in sport.[73] In line with this case law, competition authorities may, therefore, argue that an agreement that aims to protect equity, pursues a legitimate objective, and therefore should be exempted from the application of article 101TFEU.

The question that entails higher complexity is whether the goal of access or equity can be considered by competition authorities on the basis of Article 101(3) TFEU. Considering the European Commission's decision-making practice following the adoption of Regulation 1/2003[74] that arguably induced economic thinking in the application of competition law, most scholars and commentators would argue that the pursuit of social goals and objectives, such as equity, can no longer play a meaningful role in the context of Article 101(3 TFEU). In line with the Commission's White Paper on the modernization of the rules implementing Articles 101 and 102 TFEU, they would claim that the main goal of Article 101(3) TFEU is to provide a legal basis for the *economic* assessment of restrictive practices rather than an analytical framework under which public policy goals can be weighed against restraints to competition. Since, in the context of the Commission's more economic approach the main goal of Article 101 TFEU is the protection of competition in the market "as a means of enhancing consumer welfare" most antitrust scholars would insist that the pursuit of public policy goals can no longer affect a competition assessment on the basis of Article 101(3) TFEU.

The Commission's 2004 Guidelines on the application of Article 81(3) (now 101(3) TFEU), also support this line of thinking. They say: "Goals pursued by other Treaty provisions can be taken into account to the extent that they can be subsumed under the four conditions of Article 101(3)." Additionally, they clarify that the purpose of the first condition of Article 101(3) TFEU is to identify *the types of efficiency gains* that can be considered. These can be either cost efficiencies or efficiencies of qualitative nature.

Considering the analysis above, it may therefore be argued that in cases where the goals of equity and efficiency (in the form of maximizing consumer welfare) clash, unless competition authorities attached an economic value to the notion of equity or widened the notion of consumer welfare, they may not be able to integrate equity concerns into their competition analysis. Is this *mission possible* in the context of the competition problems that the previous section brought to the fore? This point is crucial and, therefore, deserves further analysis.

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68 For a similar discussion: A. Sánchez Graells, "New rules for health care procurement in the UK: a critical assessment from the perspective of EU economic law," (2015) 1 *Public Procurement Law Review* 16. It should be noted that NHS Commissioners are not required by public procurement rules to enter into such agreements to promote equity. See Monitor, "Substantive Guidance on the Procurement, Patient Choice and Competition Regulation," (2013).

69 *FENIN*, *supra* note 54. See also Joined Cases C-159/91 and 160/91, *Poucet and Pistre* [1993] ECR I-637.

70 A. Witt, "Public Policy Goals Under EU Competition Law—Now is the Time to Set the House in Order," (2012) 8(3) *European Competition Journal*, 443, 466.

71 *Ibid*.

72 Case C-309/99 *Wouters v. Algemene Raad van de Nederlandse Orde van Advocaten* [2002] ECR I-1577.

73 Case C-519/04 P, *David Meca-Medina and Igor Majcen v. Commission of the European Communities*.

74 Council Regulation (EC) No 1/2003 of 16 December 2002 On the Implementation of the Rules on Competition laid down in Articles 81 and 82 of the Treaty.

In the previous section, it was submitted that GPs in the UK in their role as gatekeepers may agree with NHS commissioners to refer more patients for elective care in NHS bodies located in disadvantaged areas so that these bodies can cross-subsidize their high demand for high cost, emergency care services. Arguably, such an agreement restricts the choice of consumers seeking routine, elective services in order to ensure choice and access to less advantaged consumer groups seeking non-elective costly services. In this case, the parties' anticompetitive agreement may analogize to an exercise of distributive justice since it restricts choice for consumers seeking elective services to ensure access to consumers seeking urgent non-elective services in disadvantaged areas. At the same time, it involves an economic taking from entities specializing in elective care to entities specializing in complex non-elective care.

In this light, it may be argued that if competition authorities chose to protect equity they may have to perform *an act of redistribution* between different consumer groups. They may, for example, have to take the view that ensuring choice for the vulnerable groups of society seeking urgent non-elective care in poor areas weighs more than protecting choice for the consumer groups seeking elective routine care. This, however, may be in contrast with one of the main goals of EU competition law, the *maximization of consumer welfare*, which is an efficiency objective and not a distribution one.[75] Indeed, the use of a consumer welfare standard may treat the same people unequally in their roles as workers and producers but entails treating all consumers *as equally* deserving with respect to the activity of consumption.[76] This is because competition law is primarily concerned with the overall welfare of society, without distinguishing between different consumer groups.[77] To promote equity, therefore, on the basis of Article 101(3) TFEU competition authorities may choose to adopt an alternative consumer welfare standard; one that takes into consideration that consumer welfare is "the aggregation of individual interests" that do not always align and "that can be combined only by some process of weighing the circumstances of different groups."[78]

Arguably, weighing the diverse interests of different social groups may not be an easy exercise for competition authorities. It may be defended, however, on the grounds that health systems that strive to promote access and equity are not indifferent as to who consumes healthcare. For this reason, in societies promoting health equity healthcare resources are not unevenly distributed, clustered in urban and more prosperous areas and scarce in less advantaged, rural neighborhoods.[79] For the same reason, Avedis Donabedian argues that the notion of efficiency in healthcare also incorporates the notion of "distributional efficiency" that requires "the distribution of care among different classes of patients (characterized by age, sex, economic status, place of residence, economic status) in a way proportionate to expected improvements in health."[80] In line with this principle, healthcare resources may be allocated to social groups who are sicker or are more likely to benefit from access to healthcare.[81] In light of these concerns, competition authorities may take the stance that unless they adopted an alternative notion of consumer welfare, one that takes distributive concerns into account, they may apply competition law in healthcare in a manner that underestimates how their societies have democratically decided to allocate their healthcare resources. Hence, they may raise the claim that the adoption of an alternative consumer welfare standard may in certain cases be necessary so that they apply competition law in their health systems in line with their core values and principles.

Competition authorities, however, may also protect equity by adopting an alternative approach. They may take the view, for instance, that the pursuit of equity creates benefits not only for the vulnerable parts of health populations but for the society as a whole. Protecting health equity contributes to the reduction of health inequalities. This may benefit *all members of society* on the basis that some types of health disparities "have obvious spillover effects on the rest of society;"[82] these may include the dissemination of infectious diseases, the adverse impact of alcohol and drug misuse or increases in crime rates.[83] Promoting equity therefore may reduce these negative externalities.

75 For a criticism of how narrowly the term 'consumer welfare' has been interpreted see, indicatively, K. Bania, *The Role of Media Pluralism in the Enforcement of EU Competition Law* (Concurrences, 2019).

76 B. Von Rompuy, *Economic Efficiency, The Sole concern of Modern Antitrust Policy*? (Kluwer Law International, 2012), 48.

77 K J Cseres, "The Controversies of the Consumer Welfare Standard," (2007) 2(3) *The Competition Law Review*, 121, 124.

78 A. Atkinson, *Inequality, What can be done*? (Cambridge, HUP, 2015) 126. For a thorough discussion on whether distributive concerns should be considered by competition law see also: I. Lianos "The Poverty of Competition law: The Short Story" in D. Gerard & I. Lianos, *Competition Law: between Equity and Efficiency* (CUP 2019), 45-87.

79 M. Whitehead, WHO (2000) Policy Report EUR/ICP/RPD 4147734r "The concepts and principles of equity and health," 9.

80 A. Donabedian, *An introduction to Quality Assurance in Health Care, (*OUP 2003) 10.

81 *Ibid.*

82 Woodward A, Kawachi "Why reduce health inequalities?" (2000) (54) *Journal of Epidemiology & Community Health,* 923-929.

83 *Ibid.*

The reduction of health inequalities has an economic value for an additional reason: because health improvements for all parts of society lead to economic growth. This is because health is not only the consequence but also a cause of wealth.[84] For example, health relates to labor productivity. Indeed, healthy workers "lose less time from work due to ill health and are more productive when working."[85] Access to health also promotes education. Childhood health, for example, "can have a direct effect on cognitive development and the ability to learn as well as school attendance."[86] Health is also closely linked with investments. This is because a longer lifespan can increase the incentive for business investments and savings for retirement.[87]

By acknowledging the economic benefits access to healthcare may create for all members of society, competition authorities may raise the claim that an agreement that protects equity contributes significantly to *economic progress* in the parlance of Article 101(3) TFEU. This interpretation may be in line with the Commission's position in the 1999 White Paper emphasizing that the purpose of Article 101(3) TFEU is to provide a framework for the *economic assessment* of restrictive practices. Indeed, by considering the impact of access to healthcare on the reduction of health inequalities and, ultimately economic progress, competition authorities may integrate equity concerns into their competition analysis.

Surely, these proposals can be challenged on several grounds, and their applications may entail considerable difficulties for competition authorities. Elaborating on these challenges will definitely shape the core of a future paper. However, this paper shined a light on why competition authorities should not necessarily exclude the possibility of considering the goal of health equity in the context of their competition assessment on the basis of Article 101 TFEU.

## IV. CONCLUSION

This paper asked the question of whether competition law can consider the goal of health equity in the context of article 101 TFEU. First, it argued that competition authorities may consider this objective by applying the Court's more *Pluralistic Approach* on the basis of article 101(1) TFEU. Additionally, this piece raised the concern that competition authorities may protect the goal of health equity by adopting an alternative notion of consumer welfare standard; one that takes into consideration distributive concerns. Although adopting this approach may not be an easy exercise for competition authorities, it may, however, safeguard that their competition analysis is in line with the core values and principles of their health systems. It also put forward the claim that the pursuit of health equity has an economic value as such. This is because the reduction of health inequalities contributes to economic progress in several ways. These economic benefits, this paper claimed, can be considered by competition authorities in the context of article 101 (3) TFEU.

84 D. E. Bloom, D. Canning "Population Health and Economic Growth," Commission on Growth and Development, The World Bank, Working Paper No.24, 1.

85 *Ibid.*

86 *Ibid.*

87 *Ibid.*

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