# Solidarity and trust in European Union health governance: three ways forward

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## Summary

**Trust and solidarity are centrally important to the functioning of healthcare systems, and for societal resilience and stability more broadly. The European Union is increasingly shaping governance and norms that affect trust and solidarity in health—a process that has intensified with the announcement of the 'European Health Union' in response to the COVID-19 pandemic. In this context, how can the EU ensure solidarity in health while generating public trust as a pre-condition for solidaristic institutions? We propose three strategies to reach this goal. First, both at national and European levels, institutions and mechanisms of solidarity should be strengthened. Second, the Union should boost the resilience and stability of national healthcare systems through mechanisms of risk-sharing. Third, the Union should mandate or encourage its member countries to enhance prevention and other public health policies to strengthen pre-distribution, aimed to ensure a more equal baseline of public health before inequalities arise.**



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## Introduction

Recent Conclusions of the Council of the European Union (comprising the health ministers of the Union's member countries) on the future of the 'European Health Union' (see Box 1) refer to solidarity as a 'fundamental principle and pillar on which the Health Union should be built'.[1] This is against the backdrop of a long history of—particularly institutionalised forms of—solidarity in Europe. In the aftermath of the 1939–45 war, and more notably following the collapse of the Soviet Union in the 1990s and the end of the Yugoslav wars, Europe entered a prolonged phase of relative political and economic stability. The development of national healthcare systems in the build-up of the welfare state played a significant role in this context.[2] Population health, for which national healthcare systems are a foundation, is an important factor in economic development, and welfare states and healthcare systems strengthen the stability of societies. Healthcare systems, based on progressive taxation or social insurance, are examples of solidaristic institutions and rely on public trust for their functioning.[3,4] When the focus is on equity, such institutions are more effective than market-based approaches to ensuring everyone's basic needs are met.[4,5]

Nowadays, the need for Union-wide solidarity—understood as policies and institutions that realise mutual support between Union member countries, or between all Union residents—is particularly striking: European countries face common challenges in health, such as ageing populations, the effects of globalisation including international trade and migration, digital transformations and the increasing uptake of artificial intelligence, and ongoing health threats such as antimicrobial resistance. These challenges raise common questions such as how to balance the need for European or even international responses to crises while respecting national autonomy; or how to reap benefits from health data without losing public trust by being seen to sell people's health data.

European countries are increasingly seeking solutions of scale through the Union for some of these health challenges. The 'European Health Union' idea is one example. Yet the Union only has limited, and contested,[6] powers in health governance, particularly when it touches on solidaristic policies (Article 168 (5) (7) Treaty on the Functioning of the EU), such as redistribution through social insurance, taxation, or public spending on solidaristic institutions such as public healthcare systems. Since the Eurozone and global banking crisis of 2008, which resulted in Union-imposed austerity policies,[7,8] many European countries continue to experience a backlash of public distrust of the Union as a political actor.[8,9]

The question then is, what role does the Union to play in ensuring health solidarity, while bolstering the necessary public trust? The new context of 'European Health Union', we argue, offers an opportunity to determine concrete policy proposals (Box 2) answering that question.

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**Box 1.**
**What is the European Health Union?**
The COVID-19 pandemic highlighted the need for solidaristic action to solve a global health crisis. In her October 2020 State of the Union address, European Commission President Ursula von der Leyen announced plans for a more resilient 'European Health Union' that would see 27 countries collaborating closely to detect, prepare for, and respond to health crises. Recognising shared health challenges and the necessity for more efficient responses to health-related issues such as climate change, labour shortages in healthcare, and access to medicines, European countries initiated new legislation under this framework.[10,11] Measures include broadening the mandates of the European Medicines Agency and the European Centre for Disease Prevention and Control, establishing the Health Emergency Preparedness and Response Authority (HERA), increasing investment in research, and developing a European Beating Cancer Plan and European Health Data Space (EHDS) for improved best practice and information sharing.[12] The European Health Union also extends to a new 'pharma package'—a suite of legislative proposals aimed at improving the availability, affordability, and sustainability of medicines in the Union.

## Three solidaristic approaches to health governance

In European healthcare systems, solidarity refers to the collective commitment to organise healthcare in such a way that people contribute to it according to their means and receive support according to their need.[13] In its institutionalised form, health solidarity works through risk sharing (Box 3) and through redistribution (Box 4): in European healthcare systems health risks are collectivised through mandatory (public) insurance or tax funded healthcare, or both measures combined. Redistribution is organised through residents of a country contributing to a central entity according to their (economic or other) ability, and in turn receiving support from that entity on the basis of need.[6,14–16]

The implementation of solidarity in the organisation of public health and healthcare systems is key to ensuring 'universal access' to a politically determined 'basket of healthcare' in all European countries.[17,18] Universal access means that access needs to be granted to every person to whom a country accepts a duty to provide healthcare—which could mean all lawful residents, or everyone covered by mandatory insurance. The 'basket of care' approach means that, while essential healthcare services are covered for everyone, certain experimental or alternative treatments are not part of the (social) insurance and benefits package. In some countries, solidarity can also entail rationing care through networks where choice and access to specific healthcare providers is limited. In others, universal access is compromised by constricted budgets, which leads to waiting times and other consequences that make those who can afford it seek out-of-pocket alternatives. National choices on how to ensure health solidarity are thus always contingent on health insurance or taxation systems, political and ethical values, as well as economic ideologies.[19]

Solidarity in health can also take the form of a third approach: pre-distribution. Pre-distribution means policies that ensure access to goods and services for people before the inequalities that require redistribution materialise (Box 4).[20] The more pre-distribution exists in a society, the less re-distribution is necessary. Most European countries provide some forms of pre-distribution via public services and infrastructures that are free or widely affordable at the point of use, including education, healthcare, transportation, public housing, or the provision of clean air and water.[21,22] All public health infrastructure that is inexpensive or even free at the point of use—such as vaccines, population disease screening or access to healthcare—are instruments of pre-distribution. Pre-distribution makes for a more equitable—and in fact, equal—starting point in life than if people had to buy goods and services on market terms to meet their needs (Box 4). Strengthening pre-distributive mechanisms and institutions means to recognise that it is not only morally right, but also cost-effective, to satisfy people's *basic* needs through the provision of public services and goods that are made available to everyone, independent of means testing.[23] As such, solidarity in healthcare is not only a nice-to-have from an ethical standpoint, but a necessary requirement to ensure that people's health needs are met in an effective manner (i.e. without saving costs now and increasing both suffering and financial burdens later on) (Box 7).

Solidarity is thus inherently connected to a commitment to provide mutual support within societies without this support depending on personal acquaintance.[14] Society-wide systems of solidarity (such as nation-state-based European healthcare systems) are organised on the assumption that it could be anyone who will need support at some point throughout their lifetime. In contrast to charity, where the difference in power and resources between those who give and those who receive structures relationships or institutions (e.g. poor versus rich), solidaristic relationships and institutions focus on what people have in common.[24] Despite all the differences that inevitably exist between people, all humans are similar in that we will get older or fall sick, or need support in another way. These similarities are one way in which solidaristic healthcare systems, which rely on public trust for their functioning,[3,25] also build such trust.

**Box 2.**
**Three strategies for EU solidaristic health governance**
1. Strengthen solidaristic institutions with health benefits at national levels
2. Boost resilience and stability of national healthcare systems through risk-sharing
3. Enhance pre-distribution policies in health

## The EU's role in health solidarity

The European Union's role in health governance has changed significantly throughout the period that European integration evolved after the war in Europe in the 1950s. Union member countries have traditionally viewed health as within their jurisdiction, preserving

autonomy over internal aspects of healthcare systems such as funding, service delivery, and (to some extent) workforce planning.[26] Health collaboration through the Union took place only when the practical benefits were obvious and politically uncontested, such as sharing hospital capacity in remote border areas, or where they were spurred on by market dynamics, such as enabling cross-border healthcare for migrant workers and their families, or warranting the safety of medicines.[17] Nationally-based healthcare systems mean that, while solidarity is a shared European value, the reality of access to healthcare and public health protections on the ground has been and still is very different across European countries (Box 5). Out-of-pocket costs for healthcare in Eastern European countries and Greece vary from 23% to almost 50% of payments, compared to 12–15% in Western European and Scandinavian countries.[27] Medicines make up about 25% on average of national budgets for healthcare,[28] and access to medicines is very different across Union countries.[29] Life expectancies are also highly divergent across the Union, with Bulgaria at the lowest end with an average of 66.1 years and Spain at the highest with 88.2 for women.[30]

Market integration efforts have led to the establishment of Union-level safety and effectiveness standards for medicines, medical devices and equipment, and substances of human origin, as well as veterinary, plant, and food safety, through binding law.[17,18] Institutional structures, including the European Medicines Agency, support these efforts. In these domains, the Union functions as a regulator, rather than as an agent of redistribution (Box 5). But the Union facilitates credible pre-distribution commitments to population health through specialised agencies and the pooling of expertise at the Union level, determining acceptable levels of risk to health, and thus preventing ill-health, for the EU population as a whole.[31,32] By focusing on such regulatory market-creating strategies in health domains, the Union steers clear of the politically sensitive issues of redistribution or risk-sharing that are central to healthcare systems, particularly in terms of access to medical care (Box 5).

Nonetheless, a series of health crises, including vCJD, swine and Avian flu, Zika, and COVID-19 led the Union to develop modest capacity-sharing over some public health threats.[33,34] These activities, and the institutions which support them, such as the European Centre for Disease Prevention and Control, fall short of the types of solidaristic instruments associated with national welfare or healthcare systems, but they lay groundwork for deeper collaboration. Alongside these, the Union has had only very modest mechanisms of redistribution, through its development or 'structural' funding—including financial instruments to reduce regional disparities and promote economic and social cohesion across EU countries.[35]

**Box 3.**
**Risk sharing: medicines and medical equipment shortages**
During the COVID-19 pandemic, the Union financed the collective purchase and stockpiling of medical equipment, which was then redistributed to Member States in accordance with need. Risk sharing of this type is a practical act of Union level solidarity, where the Union can leverage its size and soft power. To combat supply chain fragilities, the Union should continue to undertake risk sharing through shortage prevention planning, collective purchase of essential medicines and equipment, using pre-purchase agreements with global pharma. Union-level capacity building, especially in manufacturing of active pharmaceutical ingredients, generics and essential medicines; and a more general 'reshoring' of Union healthcare capacities, is also merited.

The growing role for the Union in solidaristic health policies raises concerns that it could undermine national health solidarity. An example is the European Health Insurance Card (EHIC), which allows Union citizens to access healthcare services in other Union countries under the same conditions and at the same cost as residents of those countries, promoting cross-border healthcare access. However, this initiative can strain national healthcare systems when it leads to increased demand from residents of countries with less efficient health systems (Box 5). Another example concerns ageing and the availability of a health workforce. In Romania, 79 health professionals are available per 100,000 citizens, whereas in e.g. the Netherlands the equivalent figure is 182 professionals. At the same time, Romania is educating more than 50% more health workers than the Netherlands per 100,000 citizens.[28] This grave inequity arises because many health workers educated in Romania use their free movement rights to provide care in other Union countries with higher wage levels.[36]

How could a 'European Health Union' (Box 1), as a legal and policy space in which the Union's roles in health are to be carved out, respond to this kind of dilemma? We propose the following strategies based on the three approaches to organizing solidarity, taking into consideration the roles of the Union in health governance.

## Protect solidaristic institutions with health benefits at national levels

All Union governance should protect national solidaristic institutions that have a demonstrated positive

**Box 4.**
**Binding laws as part of Europe's Beating Cancer Plan: delays and industry compromise**
The Union has clear power to adopt pre-distributional policies in the domain of tobacco control. Smoking is an obvious determinant of health and effective Union action through binding laws can contribute—and has contributed—to an improved health status in Union countries, but more should be done. Health organizations have voiced concerns about the relative inaction of the Von der Leyen Commission, including delays in revising the 2009 EU Council Recommendation on Smoke-Free Environments, and the postponement of the Tobacco Taxation Directive revision, initially scheduled for 2021. Belgian Health Minister Frank Vandenbroucke told the European Parliament that the Beating Cancer Plan has been compromised by influential industry interests, to the detriment of public health in the EU.[57] Also, the European Ombudsman Emily O'Reilly has recently reported findings of maladministration concerning the European Commission's engagements with tobacco lobbyists.[58]

**Box 5.**

**Considerations for redistributive EU actions that affect health solidarity**

Union-level action is more solidaristic and in line with the objectives of the European Health Union when policies support national institutions that secure equitable access to healthcare services as well as equal opportunities in population health.

Union policies that affect national conditions for redistributive choices must navigate the constraints set by the Union's legal framework. Article 168 (7) of the Treaty on the Functioning of the European Union stipulates that while the Union can act in health-related areas, it must respect national responsibilities for defining health policies, organising and delivering health services, and managing and allocating resources for these services.

This provision ensures that the primary control over health policy and resource allocation remains with individual member countries, even when Union-level investments are involved. If a Union policy offers only conditional enhancement of equitable access to health, it is more likely to be justified if it is conditional upon solidaristic results, rather than prescribing the way these results must be reached.

impact on health: universal healthcare, public education systems, social and economic safety nets, affordable and high-quality housing, reliable and accessible public transportation, provisions for clean water and air, and public nutrition and food security programmes. Rather than competing with national solidarity, Union governance should support it (Box 5).[14] The Union's existing approach to health governance makes a start in this direction, but it needs to be expanded and strengthened.[17]

Union economic governance should conceptualise investments in health—whether directly in the health sector, or via investments in other public services and infrastructures that have proven health benefits–as a factor in a productive economy, not as an expensive 'luxury' that some Union countries cannot 'afford'. This means that the Union should abandon for good (not only as part of pandemic recovery) austerity policies that eviscerate health institutions and prevent Union member countries from making investments in health and healthcare capacities necessary for their populations.[8,37] In this regard the Union should reconsider its April 2024 fiscal rules that will require 'high and medium risk' Union countries to reduce their debts and deficits by 1 or 0.5 percentage points each year, because this constraint will detract from the ability of most Union countries to invest in healthcare.[9,38,39]

The Union should also continue to provide financial support and technical assistance to member countries to enhance their national healthcare institutions, especially in countries with less robust health infrastructures. To some extent, this is currently taking place under the banner of 'Next Generation EU', an unprecedented and creative use of Union competencies to borrow on capital markets. Next Generation EU's size–750 billion euros–represents the equivalent of almost three times the Union annual budget.[40,41] In addition, Union structural funding should support Union-level social insurance for small-scale patient groups, and 'niche' health education endeavours, where smaller European member countries are unable to build capacity by themselves.[42]

Union market and competition law should not be applied in ways that undermine solidaristic arrangements or institutions.[43] For example, considering the EHIC and Romanian health workforce examples above, national policies which seek to secure sustainable healthcare systems with defined 'baskets of care' or health or care workforces should be recognized as contributing to health solidarity and not only as impeding individual rights to free movement of people (Box 5).[44] When a court or a national administration considers whether a national healthcare system's policy (for example, about workforce, or service provision) is a proportionate (and therefore lawful) restriction on mobility, under Union market or competition law, the balance between protectionism and free movement of goods and services must be struck in favour of protecting solidarity. Such an approach, while supporting solidarity in Central or Eastern Member States, would also incentivise capacity-building policies in Northern Member States, because they could no longer rely so heavily on health capacity (particularly workforce) from the rest of the Union. Approaches to the dynamics of the relations between organisation of national healthcare institutions and Union market law like this already exist: they should be built upon.[17]

## Boost resilience and stability of national healthcare systems through risk sharing

The Union should deepen its support of national solidarity in health governance through its 'reinsurance' capacity by collectivising the risks of large-scale crises that affect the health sector and population health (Box 3).[45,46] The Union should also use its now considerable, and increasing, investment powers to strengthen health systems, especially where health inequities are most pronounced. At a small scale, the Union has done this for decades: Examples include the EU's food aid programme that began in the 1980s, and the European Solidarity Fund for natural disaster relief, established in 2002. These risk-sharing instruments were significantly expanded during the COVID-19 pandemic.[46,47] For example, the 'Coronavirus Response Investment Initiative' involved legal changes allowing existing structural funds to be deployed short-term to combat the economic, social, and public health effects of the pandemic; 'REACT-EU' provided an additional allocation to the structural funds of up to 47.5 billion euros for 2021 and 2022. We propose that this direction of travel should continue to secure collective resource for health crisis management at Union level (Box 6). For example, strengthening the Union's Civil Protection Mechanism; creating a network of rapid response medical teams for dispatch across the Union; establishing a centralized stockpile of essential medicines and equipment; Union-level capacity building (or 'reshoring') in medicines manufacturing, especially generics and essential medicines would all facilitate a more collectivized response to

future health emergencies (Box 6).[47–49] The recent cuts to the EU4Health programme are a step in the wrong direction.[50]

Collectivising risk from health emergencies should also continue through Union borrowing and loan schemes. The key examples here are the 'SURE' (Support to mitigate Unemployment Risks in an Emergency) scheme, to mitigate temporary employment risks arising from the pandemic; the Pandemic Emergency Purchase Programme, a quantitative easing scheme involving temporary purchase of private and public sector securities; and of course, the 'Next Generation EU' recovery plan. Next Generation EU in effect includes redistribution and pre-distribution between European countries to help regenerate their health systems in the aftermath of COVID-19, but also includes instruments to develop economic resilience, such as the green and digital transitions necessary for the Union's economy to flourish into the future and with it the health of its populations.[51]

### Enhance pre-distribution policies in health

Despite not being a fully-fledged fiscal entity,[52–54] and not having the power to create direct redistributive policies, the Union should support prevention and other public health measures as further forms of solidaristic pre-distribution to support a more equitable health status in the Union. In the prevention of ill-health (an aspect of pre-distribution), the Union should deploy its considerable regulatory capacities (Box 7). Union countries accept that the Union shares powers to regulate the health and safety of products circulating within the 'single market', including important vectors of public health such as medicines, medical devices, and blood and blood products.[55,56] Market integration efforts have led to the establishment of Union-level safety and effectiveness standards for these products, as well as preventing health damage in veterinary, plant, and food safety, through binding law. The EU standards for health and safety that are developed in this 'internal market mode of governance' have a real potential of improving the overall health and safety standards in its member countries (Box 7).[31,32]

For non-communicable diseases, regulation of factors of risk such as tobacco, alcohol, food and gambling contribute to pre-distribution by tackling some of the underlying structural causes of ill-health. The Union's success in these regulatory domains is mixed so far, with greater success in reining in the considerable power of the global tobacco industry than other industries, especially the alcohol and food industries, and concerns about more recent Commission inaction in all contexts. There is scope for a much more pro-active and explicitly health-focused approach to Union regulation here, by focusing on the Union's obligation to promote health in all its policies when adopting new legislation, and by allowing (groups of) European states to ask the European Commission together to make use of public health exceptions as these exist in EU internal market laws. For instance, on creating stricter health norms for food and food-advertising, smoking and alcohol as an exception to EU internal market law.

**Box 6.**
**Considerations and conditions for EU risk-sharing actions in health policy**

If so, Union action is likely to be justified, and politically advantageous, especially for the smaller states. Also, it is possible to benefit from 'multi-speed' Europe solutions here, building alliances across groups of European countries. Nonetheless, there are several further considerations and conditions to meet for truly solidaristic EU health policy options in this regard:

- Do we trust the expertise and legitimacy of EU health institutions to manage the risk-sharing policy or pooled funding?
- Can we build up the bureaucratic ability of the EU to re-insure us for this risk?
- Where EU countries are inter-dependent, (how) can we support the countries that have less capacity to participate in the scheme? Where proposals include solutions to variable national capacities, Union action is more likely to be justified.

**Box 7.**
**Leveraging the EU's legal capacity for pre-distributive health solidarity**

The Union has extensive regulatory powers in areas that affect health through 'market-making. For instance, in food, alcohol, smoking, gambling, (online) advertising, freedom of establishment and services which affect national local zoning capacity etc. These can all be leveraged as pre-distributive health instruments.

## How to build trust in Union health governance?

Solidaristic institutions both require and generate trust. Well-functioning solidaristic institutions rely on people being able to trust that they are not only contributors, but that they will also receive support when they need it. In healthcare and public health, trust refers to relational practices of health provision and organisation. Trust means the ability to rely on another person or institution to protect one's interests.[59] Trust increases people's commitment to solidaristic systems and reduces 'free-riding'.[59–61] Where a multi-level governance system like the Union is involved in building or sustaining solidarity in health, trust cannot be readily guaranteed.

The following section proposes several questions to help guide policy-makers and those who engage strategically in health governance to determine how responsibility for specific solidaristic health policies might be shared. These guiding questions should be answered with specific consideration of the *context* in which different forms of health solidarity are to be realised. In other words: is the policy proposed in the context of wider EU law, EU (fiscal policy), or specifically in the context of health law and policy?

### Guiding Union health governance toward health solidarity

In the policy context of all Union policies (internal market/competition, monetary, macro-economic, fiscal

### Search and selection criteria

References for this Personal View were sought through using legislative databases such as 'EUR-Lex' for legal sources, and policy documents, using legal data search methods including search terms for official legislative numbering and publication numbers. Furthermore, articles were also identified through searches of the authors' own files. The final reference list was generated based on originality and relevance to the broad scope of this Personal View.

policies) a guiding question for health solidarity as a matter of *redistribution* is:

- Will this policy enhance or restrain the ability of Union member countries to organise equitable access to healthcare services and/or public health?

In the policy context of Union health policies and creating new solidarity health policies through *risk-sharing*, ask:

- Are all countries similarly vulnerable with respect to their national ability to deal with health crises and shocks to the system?
- Will the benefit from pooling such risks be shared across European countries?

Last, in the policy context of mitigating inequities and inequalities in health status between Union countries through *pre-distribution*, ask:

- What other aspects besides access to preventive, medical and mental health care are determinants for health?
- Regarding which aspects that influence these health determinants does the Union have legal power?
- How can the exercise of this legal power–or the use of public health exceptions in the exercise of this legal power–support improved health status in all Union countries?

## Conclusion: treading carefully

With the financial crises, the exiting of the UK, the COVID-19 pandemic and the war in Ukraine, the European Union has entered a new phase where more deeply felt inter-dependencies could lead to a shift in governance. Health is a culturally and fiscally sensitive area that plays an important role in safeguarding solidarity—and the trust that follows it—at national levels. This is why the Union needs to tread carefully in this domain. We propose three strategies for the Union to enhance health solidarity across and within member countries: first, enhance re-distribution by supporting solidaristic institutions with health benefits at national levels. Second, support national healthcare systems through risk-sharing measures. Third, as a measure of pre-distribution, enhance prevention and other public health measures to reduce EU wide inequalities in health status. To support decision-making in this regard, in a way that fosters solidarity and trust, we also propose several guidance questions to bear in mind when assessing Union governance in all policies.

**Contributors**

Each author contributed to this manuscript equally.

**Declaration of interests**

None.

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