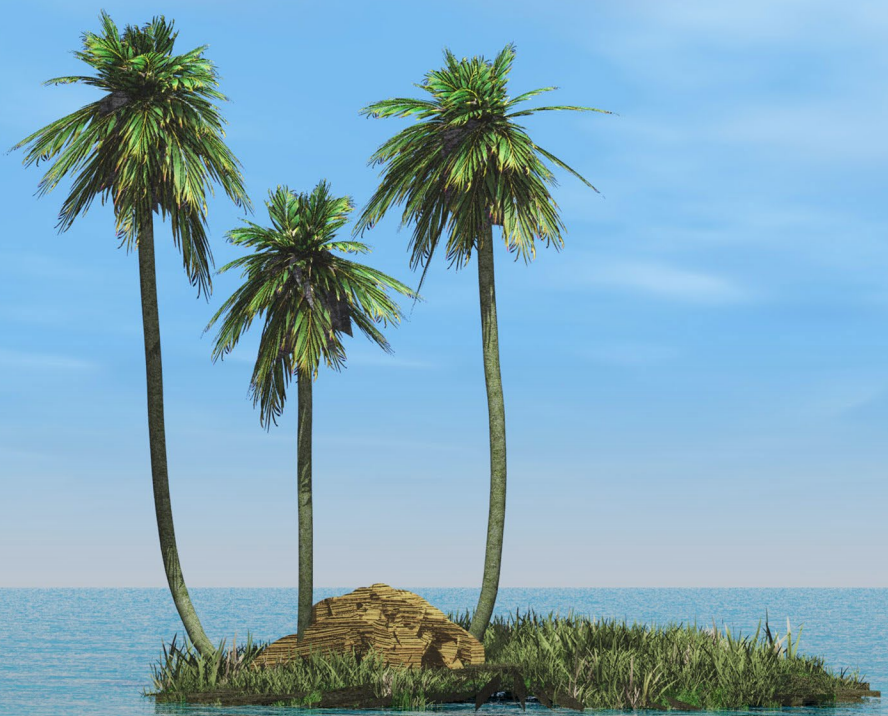
RETHINKING COMPETITION IN HEALTHCARE – REFLECTIONS FROM A SMALL ISLAND



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Rethinking Competition in Healthcare – Reflections from a Small Island

By Mary Guy

After approximately 30 years, and following a decisive move towards integrated care systems, competition reforms in English healthcare seem to be rejected, even though the underlying relationship between the public healthcare system and private healthcare market remains. This paper explains how competition in English healthcare has developed to involve the Competition and Markets Authority and a sectoral regulator (NHS Improvement), and how general UK merger control and the prohibition on anticompetitive agreements have been applied. Current legislative proposals call for a substantial refocusing of competition authority involvement and removal of the regulator's competition powers. These proposals are developing against a backdrop of closer cooperation between public and private healthcare providers in response to COVID-19. This paper concludes by suggesting that the current opportunity to rethink how competition works in English healthcare is a welcome development.

I. INTRODUCTION

Competition reforms in healthcare are often seen as a challenge, if not outright problematic, given the range of questions posed. Is competition intended as a means to an end, or an end in itself? Is the focus on competition on price, or quality, or both? Competition *for* or *in* the market? How much competition, and who decides this? What can be learned from other sectors, or other countries? Can competition only be antithetical to an overarching aim of delivering a healthcare system based on universal access?

Some of these questions can be answered by starting with the healthcare system type. Insurance-based systems can offer greater scope for competition than taxation-funded ones. Where a private healthcare market coexists with a public healthcare system, there may be both scope for both competition *for* and *in* the market, although the focus may differ: competition on price in the former, competition on quality in the latter. The experience from other sectors may help shape the corresponding regulatory framework – for example, introducing a licensing regime, or determining the relationship between the government, competition authority and sectoral regulator.

What emerges is that competition reforms can affect all three levels of a healthcare system: the macro level (interaction between government/competition authority/sectoral regulator), the meso level (healthcare purchasers) and the micro level (healthcare providers). Yet it is the final question which arguably proves the most challenging: the tension between solidarity and competition mean it is difficult to strike a balance, and the political sensitivities which can arise in connection with marketisation should not be underestimated. This can lead to further – more nuanced – considerations such as whether general rules are enough, or "healthcare-specific" modifications are needed, and who should apply the rules, with a general distinction emerging between government or regulators.

Between approximately 1989 and approximately 2019, the taxation-funded National Health Service ("NHS") in England[2] experimented with varying degrees of competition reforms under governments across the political spectrum. This period started with the introduction of the NHS quasi-market, characterized by the separation of purchasing and providing functions proposed by Alain Enthoven,[3] which underpinned successive competition reforms culminating in the Health and Social Care Act 2012 (HSCA 2012). This proved a highly controversial piece of legislation, but serious reform has emerged only recently, with the 2019 NHS Long Term Plan, which forms the basis for current legislative proposals. These were outlined in February 2021[4] to enshrine the current policy (since approximately 2015) of developing integrated care systems (ICSs) and move decisively away from competition. There have been further developments regarding competition with responses to COVID-19 which may also affect the evolution of these proposals.

This paper reviews the treatment of the prohibition on anticompetitive agreements and merger control under the HSCA 2012 reforms since these demonstrate clearly both some of the difficulties in setting out a competition regulation framework.

II. THE "FOUR CATEGORIES" AND A SHORT HISTORY OF COMPETITION IN THE NHS

Competition in English healthcare has two broad aspects.

Firstly, the sense of competition which has emerged with the coexistence of the NHS and the smaller, supplementary private healthcare market. This might broadly be considered a type of competition *in* the market insofar as patients have the option to "go private" to receive treatment, for example to avoid lengthy waiting lists, or to receive a particular treatment. It can also be possible to combine NHS and private treatment in certain circumstances.

Secondly, the successive concerted efforts to introduce competition reforms in the NHS in England by governments across the political spectrum. These efforts have sought to replicate the wider interaction between the NHS and private healthcare in some ways via patient choice policies, but mainly can be described as competition for the market.

2 But not Wales, Scotland or Northern Ireland. It should also be noted that the NHS is subject to different oversight regimes across the four countries of the UK.

3 Alain C. Enthoven, *Reflections on the Management of the National Health Service – An American looks at incentives to efficiency in health services management in the UK*, Nuffield Trust, 04/10/1985.

4 Department of Health and Social Care (DHSC), *Integration and Innovation: working together to improve health and social care for all*. CP381. February 11, 2021.

A combination of the wider relationship between the NHS and private healthcare and the separation of purchasers and providers which has characterized successive competition reforms, mean it is possible to speak of "four categories":[5]

1. Public Purchaser and Public Provider	2. Public Purchaser and Private Provider	3. Private Purchaser and Public Provider	4. Private Purchaser and Private Provider

Broadly, categories 1 and 2 relate to the NHS, and 3 and 4 to the private healthcare sector, so could represent the aforementioned "first aspect" of competition. This includes the development of the private healthcare market by the CMA.[6]

The "second aspect" is illustrated by the HSCA 2012 framework and successive policies to encourage expansion of private sector delivery of NHS services in category 2, and to develop NHS bodies (NHS Foundation Trusts) to have greater autonomy from central government and operate in a more commercial manner, for example, by running private patient units (in category 3).

The HSCA 2012 reforms were threefold: to reduce ministerial oversight of the NHS by introducing an "arms-length" oversight body (NHS England); to enshrine in legislation NHS competition policy inherited from previous governments; and to bring competition in the NHS into line with the experience of other sectors (such as energy) by NHS Improvement and the CMA sharing concurrent powers (or being "co-competent")[7] to apply general competition law. While these may appear overly ambitious with hindsight, the controversy surrounding the enactment of the HSCA 2012[8] led to a scaling back of the original scope for the competition reforms, and ongoing concerns limited these still further with the shift to integration. Part of the controversy surrounding the HSCA 2012 framework was the explicit involvement of the CMA in overseeing the NHS (categories 1 and 2), as well as the private healthcare market (categories 3 and 4) and providing for the application of general competition rules with regard to cases of providing healthcare services for the NHS.

The current legislative proposals represent a near total volte-face, in statements such as "[t]he NHS should be **free to make decisions on how it organises itself without the involvement of the [CMA]**";[9] and "[i]t has become clear that the CMA is not the right body to review NHS mergers."[10] Although draft legislation is pending, and further detail may yet emerge, references to the underlying substantive law framework are conspicuous by their absence, and the focus on oversight has been described as "deregulation, not demarketisation."[11] As the overarching purpose of the current proposals is to enable development of Integrated Care Systems, which are defined as "…new partnerships between the organisations that meet health and care needs across an area…,"[12] it is difficult to see how competition law may cease to be relevant totally. Indeed, the focus on partnerships raise questions about the scope of both the prohibition on anticompetitive agreements and the assessment of mergers, so new legislation should offer an opportunity to examine how current policy may benefit from competition law, or where exceptions can be used effectively.

5 M Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems*, Intersentia 2019, and developed from the relationships as set out in Office of Fair Trading (OFT), *Private Healthcare Market Study*, OFT1396, and Okeoghene Odudu, "Competition Law and the National Health Service," *Competition Bulletin: CompetiStion Law Views from Blackstone Chambers*, October 8, 2012.

6 CMA, Private Healthcare Market Investigation Final Report, CMA25, May 2, 2014.

7 The term used by Albert Sánchez Graells, "Monitor and the Competition and Markets Authority," (2014) *University of Leicester School of Law Research Paper*, No. 14-32.

8 Which included a three-month pause in the passage of the legislation to address some of the concerns.

9 Above n3, paragraph 3.15. Emphasis as per the original.

10 *Ibid.* paragraph 5.42.

11 Health and Social Care Committee, *NHS Long-Term Plan: Legislative Proposals* (HC 2017-19, 15), page 16, citing written evidence by Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded Services.

12 NHS England, "What are integrated care systems?," https://www.england.nhs.uk/integratedcare/what-is-integrated-care/.

III. PROHIBITION ON ANTICOMPETITIVE AGREEMENTS

The HSCA 2012 reforms introduced two levels of competition oversight and rules with regard to the prohibition on anticompetitive agreements.

The first had the effect of including this within a wider "NHS-specific" prohibition on "anticompetitive behaviour,"[13] which was then made specific to providers by the licensing regime,[14] and to NHS commissioners (purchasers) by specific regulations.[15] The intention was for NHS Improvement, the regulator, to apply these specific provisions as needed, although no recourse was ultimately made.

The second was the prohibition on anticompetitive agreements contained in the UK Competition Act 1998.[16] The HSCA 2012 introduced a new oversight regime here too in that the CMA and NHS Improvement were to share "concurrent powers" in applying the prohibition,[17] consistent with the interaction between the CMA and economic regulators in other sectors. This prompted questions about the application of competition law, with the CMA being clear that its enforcement priorities lay with category 4 rather than category 2,[18] after its predecessor had issued a compliance notice to NHS providers regarding the sharing of sensitive commercial information about their private patient units[19] (category 3), consistent with the wider focus on the private healthcare market.

Given the consensus that general competition law is applicable in connection with the NHS,[20] one explanation for the lack of recourse is seen with the controversies surrounding the HSCA 2012 reforms. As noted above, the CMA or NHS Improvement could apply general UK competition law to cases involving NHS provision, consistent with the wider "concurrency" framework within the UK competition regime. However, the effect of this was subsequently amended to reserve such cases to NHS Improvement only.[21] The current proposals for legislative reform would see this power being removed from NHS Improvement as well. Consequently, there exists a situation where general UK competition law may be applicable, but it is unclear who would apply it. Whether this would pave the way for private enforcement is moot.

However, the competition landscape in healthcare may be changing – or at least be being redefined – by COVID-19. In March 2020, an "historic deal" was signed between NHS England and the Independent Healthcare Provider Network enabling the vast majority of private providers to support the NHS in the initial response phases – a move which encapsulated all of the above 4 categories.

This was given effect in law by a Public Policy Exclusion Order, a temporary mechanism for relaxing competition law with regard to specific kinds of agreement which would otherwise be deemed anticompetitive. Examples include sharing information about capacity to provide certain services, coordination on deployment of staff, sharing or loan of facilities, joint purchasing of goods, facilities or services, and division of activities, including agreement to limit or expand the scale or range of services supplied by one or more providers.[22] Although the mechanism is intended to be temporary, it is defined by reference to the "healthcare disruption period," which may be considered to be longer than the "disruption period" of other sectors also receiving such orders (such as groceries) which lasted only a few months. Various collective agreements have been notified under this Order, so cover not only the initial crisis response, but also continuity responses as non-COVID-19 services have been restarted to run alongside crisis responses.[23] While the initial crisis response included all four categories, the subsequent agreements notified under the Order appear to focus increasingly on category 2 activity as the private healthcare market (specifically category 4) re-establishes itself to continue alongside the NHS, seemingly re-affirming the long-standing coexistence of the two.

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13 Section 64(2) HSCA 2012.

14 The Choice and Competition condition of the NHS Provider Licence. https://www.gov.uk/government/publications/the-nhs-provider-licence.

15 Regulation 10 of The National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013.

16 Section 2 CA 98.

17 Section 72 HSCA 2012.

18 CMA, "60-second summary: Private medical practitioners: information on competition law," December 3, 2015.

19 Office of Fair Trading (OFT), "OFT welcomes action by NHS trusts to ensure compliance with competition law," *OFT Press Release* 71/12, August 16, 2012.

20 O. Odudu, "Are State-owned healthcare providers undertakings subject to competition law?," (2011) 32(5) *European Competition Law Review* 231.

21 By Regulations 5 and 8 of the Competition Act 1998 (Concurrency) Regulations 2014.

22 Article 3(2) of the Competition Act 1998 (Health Services for Patients in England) (Coronavirus) (Public Policy Exclusion) Order 2020.

23 https://www.gov.uk/guidance/competition-law-exclusion-orders-relating-to-coronavirus-covid-19#history.

In light of the "four categories," the development of ICSs might appear to suggest an expansion of category 2 activity, if not a conflation of categories 1 and 2. However, the applicability of the prohibition on anticompetitive agreements with regard to ICSs may be in question insofar as ICSs are intended to remove "traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services."[24] What appears to be envisaged is collaborations between healthcare providers operating in different markets, so not competing directly. In addition, provided benefits can be demonstrated which outweigh anticompetitive effects, this may also serve to question whether arrangements may fall foul of the prohibition. However, it may be the case that there are also collaborations between providers who would typically compete, so in developing new legislation, it would be positive to provide explanations of how and why competition law may not be applicable[25] to help facilitate delivery of the reforms.

IV. MERGER CONTROL

Section 79 HSCA 2012 made provision for the UK general merger control regime to be applied to mergers involving NHS Foundation Trusts, with the other parties to the merger including NHS or private providers. Thus, NHS mergers were for the first time to be subject to at least a Phase I (and sometimes Phase II) examination of whether a merger would give rise to a substantial lessening of competition, as opposed to an "NHS-specific" version of this test. In contrast to the "antitrust" rules, questions of applicability of UK general merger control to the NHS have not arisen in the same way: the main question being whether a merger between NHS bodies represented the requisite "change in control," as different NHS bodies have lesser or greater autonomy from central government. The CMA was given sole responsibility for approving or blocking a merger, but NHS Improvement was given responsibility for identifying "relevant patient benefits," based on the general concept of "relevant customer benefits,"[26] which could offset a substantial lessening of competition. At the time the HSCA 2012 was enacted, there was a policy in place to encourage certain NHS bodies (NHS Trusts) to achieve greater autonomy and NHS Foundation Trust status, and it was anticipated that this would progress, but was discontinued around 2014.

The first hospital merger – between two NHS Foundation Trusts in Dorset – to be assessed under the HSCA 2012 regime was blocked in 2013, leading to much criticism, but was eventually approved in May 2020. Subsequent mergers were approved, with increasing reliance on the "relevant patient benefits" mechanism which was extended to cover evolving NHS policy, including the initial stages of ICS development. The effect of this has been that the majority of mergers have been approved at Phase I, and where complications were anticipated, merging parties have requested assessment under an expedited Phase II investigation, such as happened with the *Manchester Hospitals* merger in 2017. This merger also saw a significant intervention by the CMA in its acknowledgement of the changing NHS policy background to focus on integration. Although reform of the HSCA 2012 competition framework had been called for at various intervals and by various quarters since its enactment, to see the competition authority acknowledge that competition "…currently plays a limited role in the NHS and is not the basic organising principle for the provision of NHS services"[27] was striking. In approving the *Dorset Hospitals* merger in May 2020, the CMA effectively acknowledged that its role in such mergers was coming to an end in line with the NHS Long Term Plan proposals. This seems logical: what purpose is served by assessing whether a proposed merger gives rise to a substantial lessening of competition in a system which the competition authority acknowledges is not based on competition? And indeed, how can this be done?

The current legislative proposals envisage transferring authorization power from the CMA to NHS England "…to ensure that decisions can always be made in the best interests of patients."[28] It is clear, however, that this refers only to mergers involving two or more NHS Foundation Trusts, as distinct from a merger which involves, for example, an NHS Foundation Trust and a private provider. In the latter case, the CMA will still be involved,[29] which simply appears to reflect the current situation under HSCA 2012.

24 https://www.england.nhs.uk/integratedcare/what-is-integrated-care/.

25 As happened in the Netherlands in connection with recent healthcare reforms. The Netherlands Authority for Consumers and Markets (ACM), ACM Policy Rule on arrangements as part of the movement called "The right care in the right place." Case no. ACM/19/034968 Document no. ACM/UIT/524798.

26 Section 30(1)(a) EA02.

27 CMA, Central Manchester University Hospitals/University Hospital of South Manchester merger inquiry. Final Report. August 1, 2017.

28 DHSC (above n3), para 5.42.

29 *Ibid.* para 5.43.

A further notable aspect of the current legislative proposals is that a scaling-back of NHS England's powers is envisaged, with the Secretary of State for Health regaining more power of direction over day-to-day operation of the NHS. It appears that this may extend to merger assessment, in that where the minister directs a reconfiguration or a merger, this will be subject to a public interest test.[30] Whether this would take the form of the current Public Interest Intervention Notice mechanism within the UK merger control regime,[31] whereby the CMA would advise the minister on the decision, remains to be seen, but would represent a very distinctive change in direction.

V. CONCLUDING REMARKS

It is clear that the current legislative proposals represent a long-standing rethinking of competition in English healthcare. In light of the foregoing remarks about the complicated evolution of the prohibition on anticompetitive agreements and merger control within the HSCA 2012 reforms, it is not difficult to see why competition might be seen as "bureaucracy" in need of reduction. This perhaps suggests the problem lies more with the HSCA 2012 vision of competition, rather than competition law and policy in a general sense. Indeed, the HSCA 2012 experience highlights some of the pitfalls in designing legislation to enshrine a particular policy direction in healthcare, a sector with particular need for flexibility.

With the current legislative proposals, the underlying market structures of the NHS and private healthcare sector remain, although the shift towards integrated care models may suggest that the distinction between the NHS and private healthcare may ultimately outweigh the disaggregation of "four categories." In recognising the significant cultural shift away from the purchaser/provider separation, there is a need to clarify the parameters of applicability of competition law in the current environment, even if this means acknowledging where competition law is not expected to be applied.

Part of the failings of the HSCA 2012 reforms might be attributed to the attempt to map competition mechanisms (such as concurrent oversight powers and a licensing regime) onto the NHS in the erroneous belief that competition would simply work in the same way as in other sectors. This belief was erroneous because it failed to engage with the complexity of the tension between solidarity and competition and the associated political sensitivities attached to the core principles of the NHS, which favor solidarity.

Starting from the configuration of the healthcare sector – the interaction between the NHS and smaller, supplementary private healthcare market – would have been a more logical approach. More recently there has been some evidence of more nuance, and recognition that competition can work in different ways in healthcare. Notably, a distinction was drawn in the 2019 NHS Long Term Plan between the HSCA 2012 reforms, and the CMA's activity concerning pharmaceutical companies found to have charged the NHS excessive prices for certain drugs has been held up as a positive example of competition. This vision would see the NHS effectively cast in the role of consumer in need of protection against anticompetitive conduct, which could be extended beyond the realm of pharmaceutical regulation, to healthcare provision.

A shift towards integration enables a rethink of the scope for competition in healthcare reform. This is welcome, particularly at a time when benefits of collaboration between NHS and private providers have been in evidence in responding to COVID-19.

30 In response to Q142. Health and Social Care Committee Oral evidence: Department's White Paper on Health and Social Care, HC 1274, Tuesday, March 16, 2021. https://committees.parliament.uk/oralevidence/1881/pdf/.

31 Section 42(2) Enterprise Act 2002.

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