ENFORCING COMPETITION LAW IN THE ENGLISH HEALTH CARE SYSTEM

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The UK Department of Health and Social Care has published a white paper titled *Integration and innovation: working together to improve health and social care for all*. The White Paper promises to reform the way competition law is applied to health care service provides in the United Kingdom, reversing many of the changes introduced by the controversial Health and Social Care Act of 2012. In this article we set out the system in which health care is provided in England and the role of competition law within that system. We the describe the reforms now in view before gesturing towards a number of challenges that lie ahead.

I. INTRODUCTION

In February 2021, the UK Department of Health and Social Care published a white paper titled *Integration and innovation: working together to improve health and social care for all*.[2] The White Paper promises to reform the system of competition enforcement introduced by the Health and Social Care Act of 2012.[3] This follows a request made in the 2019 The Long Term Plan by NHS England for the legislature to "Remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care."[4]

In this article we set out (i) the system in which health care is provided in England and (ii) the role of competition law within that system (iii) a high-level overview of current mechanism for enforcement of competition law in the sector and (iv) the reforms now in view. We conclude by setting out some of the challenges ahead.

II. HEALTHCARE PROVISION IN ENGLAND

The founding principles of the National Health Service in England are that it should provide comprehensive medical care, that is universally available, and free at the point of use.[5] These principles are often described as principles of solidarity or equity. The challenge has always been to harness the power of market competition in a way that is consistent with the principles of solidarity on which the NHS is founded.

The attempt to use competition as a key organising principle of the health service began in 1989 with the publication of *Working for Patients*.[6] This proposed a division between bodies that provide care and bodies that purchase care, creating an internal market. The internal market would, for the first time, establish a link between the volume of activity being performed and the amount of money a health care provider received. It was hoped that this would create incentives for providers to invest in treating an ever-greater number of people more quickly and more efficiently than had been possible in the past.

The internal market was protected by two sets of rules. A first set of rules was ere designed to ensure that NHS bodies on the provider side did not acquire any greater market power than was necessary or desirable and did not abuse any monopoly power they possessed.[7] A second set of rules was designed to ensure the purchaser selects the most efficient provider of health care services. Underpinning these two sets of rules is the central idea that disputes between an NHS purchaser and an NHS provider are internal — such disputes should not be the subject of litigation in the courts but should ultimately be resolved by the Secretary of State.[8]

As the resources devoted to health care increased the protection of the internal market was strengthened, a key publication in this regard being *The future regulation in health and social care in England*.[9] This culminated in what became the Principles and Rules for Cooperation and Competition (PRCC), which covered four areas: (1) **procurement** of NHS services; (2) anti-competitive **conduct** by providers and commissioners; (3) **mergers** between NHS organizations; and (4) false and misleading **advertising** of NHS services.[10] It was argued strongly that account should be taken of social as well as economic objectives when enforcing these rules and that political input would be required to resolve the significant

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf.

3 Integrating care: next steps to building strong and effective integrated care systems across England: https://www.england.nhs.uk/publication/integrating-care-next-steps- to-building-strong-and-effective-integrated-care-systems-across-england/.

4 (Long Term Plan para. 7.14).

5 These principles are set out in section 1 of the National Health Service Act 2006.

6 Department of Health Working for Patients (HMSO, 1988/89).

7 Department of Health The Operation of the Nhs Internal Market: Local Freedoms, National Responsibilities (NHS Executive, 1994) and Diane Dawson "Regulating Competition in the Nhs: The Department of Health Guide on Mergers and Anti-Competitive Behaviour," Centre for Health Economics, University of York, UK: Discussion Paper 131 (1995), 4-5.

8 See J.V. McHale, D. Hughes & L. Griffiths "Disputes in the NHS Internal Market: Regulation and Relationships" Medical Law International (1996)2:215-227.

9 Department of Health "The Future Regulation of Health and Adult Social Care in England," Gateway Ref: 7377 (2006), and Department of Health "The Future Regulation of Health and Adult Social Care in England: Respone to Consultation," Gateway Ref: 8701 (2007), para. 1.7.

10 Department of Health "Principles and Rules for Cooperation and Competition," Gateway Ref: 14611 (2010), 3.

conflicts that arise between the economic and social objectives.[11] As a result, enforcement of the PRCC was not through the courts and remained internal. Instead, in January 2009 the Cooperation and Competition Panel (CCP) for NHS funded services was established under section 2(1)(b) of the NHS Act 2006 to provide advice to the Secretary of State in relation to disputes under the PRCC.[12] The advisory role meant that the CCP was reactive only, able to rule on complaints, but unable to launch investigations on its own initiative. The CCP also did not have power to award compensation or prevent infringement by means of injunction.

III. THE HEALTH AND SOCIAL CARE ACT 2012

Three constants since 1989 are the distinction between purchasers and providers; a body of competition rules to supervise the relationship between purchasers and providers; and a system of internal enforcement. A central weakness of the enforcement model is that compliance was not assured — the CCP made recommendations that are for others to implement and the influence the PRCC and CCP actually had on behavior within the sector was limited.[13] The key innovation in the Health and Social Care Act (HSCA) 2012 was to move from internal enforcement to external enforcement. This would make it clearer that compliance was necessary and that the rules would be backed by sanctions. External enforcement was affected by (i) providing a statutory basis to support the PRCC;[14] and granting the sector regulator, at the time styled Monitor, concurrent powers with the CMA so as to enable it to enforce Chapter I and II of the Competition Act 1998 in relation to health care service providers. Further, section 79 of the Health and Social Care Act 2012 would ensure that the Competition and Markets Authority could apply the Enterprise Act 2002 (in so far as it would not otherwise apply) to control mergers involving NHS foundation trusts.[15] Finally, the Public Contracts Regulations 2015 and section 75 of the HSCA 2012 would provide a route to court adjudication over decisions to allocate resources to particular providers.

The Health and Social Care Act 2012 struggled to bring about the change in behaviour envisaged.[16] By 2014 the idea of turbo-charging 1989 with enhanced enforcement was very much on the wane.[17] Regulators of NHS trusts and foundation trusts are often the instigators of a transaction with the potential to create market power.[18] The risks of market power are viewed as being outweighed by the advantages of dealing with clinical, operational or financial challenges by enabling highly regarded management teams to take struggling organizations under their wing. Providers have struggled to understand the nature of an objection to a transaction that the regulator has proposed, supports or encourages. Further, the Competition and Markets Authority has ultimately approved all transactions proposed and so the question as to what merger review adds to the process — other than cost and delay — has been asked. On the purchasing side, the perception was of there being only one possible outcome but demonstrating this in accordance with Public Contracts Regulations 2015 and Regulations promulgated under section 75 of the HSCA 2012 was costly, complex, and always subject to the threat of legal challenge.

11 King's Fund Response to the Department of Health Consultation on the Future of Regulation of Health and Adult Social Care in England(2007), para. 12 and 23.

12 Department of Health "Principles and Rules for Cooperation and Competition," Gateway Ref: 14611 (2010), 5.

13 This is a long standing criticism: see Diane Dawson "Regulating Competition in the Nhs: The Department of Health Guide on Mergers and Anti-Competitive Behaviour," Centre for Health Economics, University of York, UK: Discussion Paper 131 (1995), 5-8, 11.

14 Department of Health "Government Response to the Nhs Future Forum Report," command 8113 (2011), paragraph 5.16.

15 Health and Social Care Bill 2011: Impact Assessments: Annex B, B119. And EA 02, s 22.

16 See Nicholas Timmins, Never Again? The story of the Health and Social Care Act 2012 (The King's Fund and the Institute for Government, 2012) and Alderwick H, Ham C. NHS in England embraces collaboration in tackling biggest crisis in its history. BMJ2016;352:i1022.doi:10.1136/bmj.i1022 pmid:26902256:

17 (Five Year Forward View).

18 (Long Term Plan para. 1.53).

IV. THE NEW SYSTEM ARCHITECTURE: ENFORCEMENT DE-EMPHASISED

The new model for the health service in England is set out in the 2019 Long Term Plan.[19] The point of departure for the new model is to accept that focusing on volume of activity is not a good way to view the productivity of a health system and can instead incentivise behavior that is not productive. The aim of reform is to develop system architecture capable of preventing people becoming sick and enabling them to live health lives rather than a system capable of treating an ever-increasing number of sick. To do so, the first key change is to incorporate providers of primary, community, mental health, and acute hospital services into provider collaboratives. The second key change is to establish integrated care systems ("ICS") as statutory bodies that will decide "how to use resources, design services and improve population health."[20] Each ICS will be responsible for securing the provision of health services to meet the needs of the population from provider collaboratives.[21] Finally, rather than unit pricing, provider collaboratives will receive blended payments, comprising a fixed element to cover all treatment or care required by a population, plus a variable element designed to incentivise particular activity or behavior.[22]

Whether the new system architecture can achieve its objective is open to debate, but the new architecture clearly requires a modification of the role that competition law plays in the allocation of health care resources.[23] The HSCA 2012 modified the three constants in place since 1989 so that while a distinction between purchasers and providers and a body of competition rules to supervise the relationship between purchasers and providers were maintained, a system of external enforcement was introduced. Ending recourse to competition might have meant restricting the ability to provide NHS-funded services to NHS bodies, so that NHS organisations would not be in competition with other types of provider (though they would remain in competition with other NHS provider bodies). Ending competition might also have meant restricting the ability of NHS-funded patients to choose the provider of their treatment or care, with the money following the patient. Neither of these approaches are taken to ending competition in the White Paper and instead the White paper states that "It has become clear that the CMA is not the right body to review NHS mergers."[24] Rather than the CMA the White Paper proposes that it be for "NHS England, as overseer of the system, to ensure that decisions can always be made in the best interests of patients."[25]

The return to internal adjudication, or at least the remove of a threat of external scrutiny, is also proposed on the purchasing side. Purchasing decisions will not be subject to procurement law and the threat of court action, but instead, a bespoke health services provider selection regime that puts pragmatism at the heart of the system will be created.[26] The Government is currently consulting on the regime. There is a concern that absent a robust procurement regime there will be waste and cronyism.[27] What that regime will look like and whether it is capable of addressing the acknowledged risks in the purchasing decision is an open question.[28]

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19 NHS. The NHS long term plan. 2019. https://www.longtermplan.nhs.uk/ See also Alderwick H, Dixon J . The NHS long term plan. BMJ2019;364:l84. doi:10.1136/bmj.l84 pmid:30617185.

20 (NHS Long Term Plan, para. 1.51).

21 (White Paper; para. 5.7; para. 3.15 and para 5.8) The White paper says that within an ICS it will be necessary "To manage conflicts of interest, any procurement decisions – including whether to procure – would be reserved to the commissioner only." (para. 7.14).

22 NHS England, NHS Improvement. Developing the payment system for 2021/22: engagement on national tariff and related contracting policies for 2021/22. 2020. https://improvement.nhs.uk/documents/6779/Developing_the_payment_system_for_2021-22.pdf.

23 The National Audit Office considers that there is not yet a robust evidence base to show that integration leads to better outcomes for patients or lower cost of health care provision: See https://www.nao.org.uk/wp-content/uploads/2017/02/Health-and-social-care-integration.pdf.

24 (White Paper para. 5.42).

25 (White Paper 5.42).

26 (White paper para. 3.15. Also para. 5.47); (Long Term Plan para. 7.14).

27 R on the application of Good Law Project Limited and others v Secretary of State for Health and Social Care. 2021 www.bailii.org/ew/cases/EWHC/Admin/2021/346.html and Iacobucci G. Covid-19: Government has spent billions on contracts with little transparency, watchdog says. *BMJ*2020;371:m4474. doi:10.1136/bmj.m4474 pmid:33208349; Martin McKee. England's PPE procurement failures must never happen again. BMJ 2020; 370:m2858 doi: https://doi.org/10.1136/bmj.m2858 (Published July 17, 2020). ; Elisabeth Mahase. NHS reorganisation must not be rushed through during pandemic, leaders warn BMJ 2021; 372:n431 doi: https://doi.org/10.1136/bmj.n431 (Published February 11, 2021).

28 https://www.england.nhs.uk/publication/nhs-provider-selection-regime-consultation-on- proposals.

V. CHALLENGES

The future of competition in the English health care system remains to be revealed in detailed legislative proposals, though some of the challenges are now clear. For example, the Long-Term Plan acknowledges "the CMA's critical investigations work in tackling abuses and anti-competitive behaviour in health-related markets such as the supply of drugs to the NHS" and suggest that this will be maintained.[29] What also of the role played by the CMA and Competition Act 1998 when NHS bodies operate in markets that are not state-funded? NHS trusts and NHS foundation trusts remain specifically empowered to engage in activity with the specific aim of generating a profit, having been granted so-called "income generation" or "wider market" powers.[30] HM Treasury has opined that the exercise of such power is always subject to competition law.[31]

The model of health care provision retains separate provider organisations that still rely on obtaining resources from purchasers of health care services.[32] Patients and ICS must still choose their provider and that choice will still have implications for resource allocation. While not be a traditional model of competition, competition law's role had been to ensure that the choices offered are fair or made on a rationale, open and transparent basis. Changing the system level rules and the oversight regime does not eliminate competition in itself. Maintaining the fundamental market features while reforming the system of enforcement may be based ultimately on an acceptance that "competition" has proven to be effective.[33] The white paper makes clear the intention to retain a plurality of health care service providers, so that an ICS may purchase health care services from NHS trusts and foundation trusts, as well as from independent, voluntary and community providers. Will those outside the NHS family be content to participate in a system that is adjudicated on by NHS family members? Within the NHS there are institutions that are too big, or too important to fail, but which draw resources away from other institutions and organisations that are capable of making better use of those resources. Does the new system architecture provide a transparent mechanism for identifying when this is occurring and a mechanism to prevent it from occurring? Patients in England will continue to enjoy the right to choose the provider of their hospital and specialist healthcare *within* the State-funded system.[34] Will patient voice matter or will the need for resources to flow to a particular institution take precedence?[35] What mechanism will be in place to prevent such "market sharing"?

What is missing from the White Paper, and what we hope will reveal itself through the legislative process, is a clear articulation of what we are trying to achieve. What is clear is that external enforcement is not desired. What is not clear, particularly since so many market features are retained, is whether the idea of competition has been abandoned.

29 (Long term Plan para. 7.14).

30 National Health Service Act 2006 s 43(3). Health and Medicines Act 1988 s 7(2); National Health Service Act 2006 Sch 4 para 20(1). National Audit Office 'Income Generation in the Nhs' REPORT BY THE COMPTROLLER AND AUDITOR GENERAL (1993),.

31 Hm Treasury "Selling into Wider Markets: A Policy Note for Public Bodies," Enterprise & Growth Unit (2002), para. 18, also Annex B, para. 16. and Hm Treasury "Managing Public Money," (2007), box A.7.6A, noting that public entities operating in wider markets "must comply with general competition law."

32 (White Paper para. 5.8, 5.11-5.12) and (NHS Long Term Plan, para. 1.51).

33 See for example Zack Cooper, Stephen Gibbons, Simon Jones, Alistair McGuire, "Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms" The Economic Journal, Volume 121, Issue 554, August 2011, Pages F228–F260, https://doi.org/10.1111/j.1468-0297.2011.02449.x and Russell Whitehouse and Pasquale Schiraldi, "Does hospital competition reduce rates of patient harm in the English NHS?" (CMA Economics working paper January 2019): https://www.gov.uk/government/publications/does-hospital-competition-reduce-rates-of-patient-harm-in-the-english-nhs.

34 Department of Health "The Handbook to the Nhs Constitution," Gateway Ref: 17278 (2012), 51. (White Paper para. 3.11. See also paras 5.35 -5.38). also (Long Term Plan para. 7.14).

35 Richard Murray. NHS reforms: politicians will be back in the driving seat BMJ 2021; 372:n481 doi: https://doi.org/10.1136/bmj.n481 (Published February 19, 2021).

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