

**COMPETITION AND SECTORAL REGULATION IN DUTCH AND ENGLISH
HEALTHCARE: FACTORS SHAPING THE COMPETITION FOCUS OF THE
NEW HEALTHCARE REGULATORS AND THEIR RELATIONSHIP WITH THE
COMPETITION AUTHORITIES**

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INDEX

1. INTRODUCTION

**2. COMPARATIVE ANALYSIS OF COMPETITION AND SECTORAL
REGULATION IN DUTCH AND ENGLISH HEALTHCARE**

A) Competition in Dutch healthcare

B) Competition in English healthcare

*C) Points of similarity underpinning competition in Dutch and English
healthcare*

*D) Framing the discussion: the applicability of competition law as a starting-
point for defining the framework within which the sectoral regulators operate*

3. THE REGULATORS' FOCUS

A) The Netherlands

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B) England

C) A coherent narrative?

D) “Dual identity” - patients/policyholders, patients/taxpayers

**4. THE EVOLVING ROLE OF MINISTERIAL OVERSIGHT AND
EXPANDING ROLE OF THE COMPETITION AUTHORITY**

A) The Netherlands

B) England

5. CONCLUDING REMARKS

ABSTRACT

This article considers comparable and near contemporaneous competition reforms in modernising Dutch and English healthcare: specifically, the development of sectoral regulators – the Dutch Healthcare Authority in 2006 and NHS Improvement as a result of the Health and Social Care Act 2012 reforms - with a competition focus and a defined relationship with the competition authorities. Despite distinctions between the Dutch health insurance system and the taxation-funded National Health Service in England, there are sufficient common aspects evident in competition policy development and the functional equivalence of the new sectoral regulators to make this comparative analysis beneficial for those interested in competition policy and healthcare modernisation.

The aim of this article is to examine two factors shaping the competition focus of the sectoral regulators and their relationship with the competition authorities: the regulators' focus on patients and evolving ministerial oversight of healthcare modernisation. These factors are significant because they reveal not only tensions in equating patients and consumers, but also counterintuitive developments in the two countries. Taken together, these factors help explain why implementation of competition reforms in Dutch and English healthcare has proven difficult, so provide a better understanding for subsequent developments in both countries, or for other countries considering similar reforms.

Key words: NHS, the Netherlands, competition, healthcare, regulation

1. INTRODUCTION

Both the Netherlands and England have recently experimented with developing competition as a means to modernise their healthcare systems and meet ongoing challenges such as rising costs and increasing innovation. This need for healthcare system modernisation is emerging regardless of healthcare system type: the Netherlands represents an example of an insurance-based system, while English² healthcare comprises the taxation-funded National Health Service (NHS) which provides the majority of healthcare on the one hand, and the smaller, supplementary private healthcare market³ underpinned by private medical insurance and self-paying patients on the other.

This distinction between insurance-based and taxation-funded⁴ healthcare system models has implications for the development of competition reforms. In Dutch healthcare these include the introduction of mandatory private health insurance in 2006 and the liberalisation of some hospital service prices. In England there have been successive competition-based reforms of the NHS, inter alia to expand private sector delivery of NHS services and promote patient choice, culminating recently in the Health and Social Care Act 2012 (HSCA 2012). Unsurprisingly, this distinction was also evident in the extent to which the Netherlands and England were inspired by “managed competition” – in essence, a

² The reference to England is explicit in light of divergent management of, and approaches to, the National Health Service (NHS) across the United Kingdom.

³ Which is UK-wide in its scope.

⁴ Reference is made throughout the article to “insurance-based” and “taxation-funded” healthcare system models in preference to “Bismarck” and “Beveridge” models. This is due in part to the narrow focus of the article on competition regulation, where a key factor is how solidarity is handled, as distinct from wider features of these designations, and also to an apparent ambivalence about the ongoing use of these designations. See further on healthcare system typologies, Tamara K. Hervey and Jean V. McHale, *European Union Health Law – Themes and Implications* (CUP 2015). “EU internal health law: the systemic focus”, pages 211-226.

purchasing strategy to obtain maximum value for consumers using rules for competition⁵ – a model developed by the US health economist Alain Enthoven. Whereas the Dutch healthcare reforms of 2006 have been considered a “living model of managed competition”,⁶ the approach to competition in the English NHS has been more piecemeal, encompassing not only Enthoven’s recommendation of separating purchasing and providing functions,⁷ but also the conflation of these - ultimately in the Clinical Commissioning Groups introduced by the HSCA 2012.

Despite the differences between the Dutch and English healthcare systems, common elements can be found in their development of competition reflecting the experience of opening other sectors up to competition. Most notably, both countries’ reforms included the establishment of sectoral regulators – the Dutch Healthcare Authority⁸ and NHS Improvement.⁹ These are independent agencies with a twofold competition remit: to develop scope for competition sometimes in connection with the Ministers for Health, and to work with the competition authorities to police anticompetitive behaviour, typically by reference to general competition law (the provisions governing anticompetitive agreements and abuse of dominance at national and EU levels).¹⁰ This twofold remit –

⁵ Alain C. Enthoven, “The History and Principles of Managed Competition” (1993) *Health Affairs* 12(1) 24.

⁶ Alain C. Enthoven, “A Living Model of Managed Competition: A Conversation with Dutch Health Minister Ab Klink” (2008) *Health Affairs* 28(3) 196.

⁷ 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” *The Nuffield Trust* 4 October 1985.

⁸ *Nederlandse Zorgautoriteit* (NZA).

⁹ Formerly known as Monitor.

¹⁰ Articles 101 and 102 Treaty on the Functioning of the European Union (TFEU), transposed by Articles 6 and 24 Dutch Competition Act 1998 (*Mededingingswet*, Mw) and Sections 2 and 18 Competition Act 1998 (CA 98) (also known as the Chapter I and Chapter II prohibitions) in the UK.

which situates the healthcare regulators between government and competition authority - has proved problematic in light of the idea that there may still remain unresolved tensions between a universalist model of health service emphasizing the principles of equal access and equal treatment of patients, and a market-driven model emphasizing efficiency, innovation, and patient choice.¹¹

The experience of other sectors has also been instrumental in developing the sectoral regulators for healthcare. This finds reflection, for example, in the Dutch Healthcare Authority initially being granted a competence to investigate significant market power,¹² a concept developed in the context of EU telecommunications regulation. This competence was intended to complement the power of the Authority for Consumers and Markets¹³ to investigate abuse of dominance, but an absence of such cases has been attributed to the blurred distinction between the two competences.¹⁴ In England, NHS Improvement shares “concurrent powers” – effectively an equal competence – with the Competition and Markets Authority to apply general competition law¹⁵ by analogy with sectoral regulators such as Ofgem in the energy sector.

This article starts from the premise that this template – of looking to other sectors - for developing sectoral regulators in healthcare was too simple. A comparative methodology is used to explore other common factors instrumental in shaping the competition focus of the new healthcare regulators and their relationship with the

¹¹ Tony Prosser, *The Limits of Competition Law* (Oxford 2005), page 9.

¹² Originally under Articles 47-49 Wmg.

¹³ *Autoriteit Consument en Markt* (ACM).

¹⁴ Wolf Sauter, ‘The balance between competition law and regulation in Dutch healthcare markets’ (2014) TILEC Discussion Paper, DP 2014-041.

¹⁵ Section 72 HSCA 2012.

competition authorities. In so doing, it is submitted that a better insight is gained into why “healthcare” may be distinguished from other sectors, and that there may yet be further considerations emerging in light of significant differences between Dutch and English healthcare.

The primary purpose of this article is to explore two factors shaping the regulators’ competition focus and specifically their relationship with the competition authorities.

Firstly, the healthcare regulators’ apparent focus on patients – as distinct from, for example, healthcare providers - as defined in statute. This highlights that new directions for regulator legitimacy evident in the Netherlands¹⁶ may also hold for England.

Secondly, the wider evolution of ministerial oversight and expansion of the competition authorities’ roles in healthcare. This reveals the emergence of counterintuitive developments in the two countries, which is underscored in England by wider HSCA 2012 reforms which reduce ministerial oversight and create NHS England as the body responsible for day-to-day management of the NHS.¹⁷

These factors have received at best limited attention thus far, so the present article builds on previous considerations of general frameworks for competition, wider perceptions of declining government intervention and increasing regulatory oversight¹⁸ and significant changes to the constitutional framework by the HSCA 2012 reforms.¹⁹

¹⁶ Wolf Sauter, 'Is the general consumer interest a source of legitimacy for healthcare regulation? An analysis of the Dutch experience' [2009] 2-3 *European Journal of Consumer Law* 419-434.

¹⁷ Section 9 HSCA 2012. NHS England was initially known as “the NHS Commissioning Board”.

¹⁸ Tony Prosser, “Regulation and Legitimacy”, in J. Jowell and D. Oliver (eds.), *The Changing Constitution*, 7th edition (Oxford 2011), ch.12.

¹⁹ A.C.L. Davies, “This Time, It’s For Real” (2013) *M.L.R.* 76(3) 564.

The unique contribution made by this article is to provide a comparative perspective on these two factors in order to move beyond the view that common features link “healthcare” as a sector with, for example, energy or telecoms, and to articulate that the specificities of individual healthcare systems – even within the broader insurance-based / taxation-funded system typologies – may need to find expression within the competition function of the healthcare regulators and particularly their relationship with the competition authorities.

This examination is timely in view of the current potential for change in both countries. The constitution of a new government in the Netherlands following the general election in March 2017 raises questions about whether the refocusing of competition will happen in the way originally envisaged by legislative proposals in the 2015-16 parliamentary session. These involved the transfer of the majority of the Dutch Healthcare Authority’s competition functions to the Authority for Consumers and Markets.²⁰ In England, the House of Lords has recently called for a Department of Health consultation to review the HSCA 2012 reforms,²¹ and there is a growing recognition of the limited role for competition in the development of new integrated care models in the NHS²² outlined by the NHS Five Year Forward View in 2014 and currently implemented by Sustainability and Transformation Plans.

²⁰ Kamerstukken II, 2015-16, 34 445, Wijziging van de Wet marktordening gezondheidszorg en enkele andere wetten in verband met aanpassingen van de tarief- en prestatieregulering en het markttoezicht op het terrein van de gezondheidszorg. (Second Chamber documentation, Parliamentary Session 2015-16, 34 445, Amendments to the Wmg and other laws to apply tariff regulation and market regulation in healthcare).

²¹ House of Lords Select Committee on the Long-Term Sustainability of the NHS. Report of Session 2016-17, “The Long-term Sustainability of the NHS and Adult Social Care”, 5 April 2017. Recommendation 4 (Paragraph 101).

²² Evident in the Competition and Markets Authority’s recent comments in connection with the Central Manchester University Hospitals / University Hospital of South Manchester merger inquiry. Final Report. 3 August 2017.

The article develops as follows. Section II outlines the comparative approach underpinning the present discussions by considering in overview differences and similarities in the development of competition and how it functions in Dutch and English healthcare. Section III examines the regulators' apparent focus on patients as defined by the concept of the "general consumer interest" in the Netherlands and in light of the distinctions drawn between NHS patients and private patients in England. Section IV considers the evolving role of Ministerial oversight and the expanding role of the competition authorities in both countries. Section V concludes.

2. COMPARATIVE ANALYSIS OF COMPETITION AND SECTORAL REGULATION IN DUTCH AND ENGLISH HEALTHCARE

The distinction between the Netherlands as representing an insurance-based healthcare system and England as a taxation-funded healthcare system has implications for the development of competition. In essence, it is considered that, in a supply-driven, tax-based system, governments are likely to determine the precise levels of benefits, whereas governments that rely on a health insurance scheme are more likely to leave some room for demand-driven competition with regard to the benefits that the insured persons are entitled to (for instance, based on supplementary insurance).²³ Thus competition *within* the English NHS is restricted: the ability of NHS patients to exercise choice of provider is limited, for example, to certain elective care services.²⁴ In the Netherlands, there has been a greater

²³ Leigh Hancher and Wolf Sauter, *EU Competition and Internal Market Law in the Health Care Sector* (OUP 2012), pages 232-3.

²⁴ Rather, the focus is on competition *for* the market (procurement activity), which is beyond the scope of this article. See further, Office of Health Economics (OHE), *Competition and the English NHS*. January 2012.

focus on competition *in* the market as Dutch patients can choose their health insurer and, depending on the type of policy selected (and cost paid), have a lesser or greater choice of healthcare provider. It may also be possible to speak of competition *in* the market in England insofar as patients move *between* the NHS and private healthcare sector for treatment. However, the competition reforms of the HSCA 2012 focus primarily on the NHS, not the private healthcare market.

Nevertheless, despite this significant distinction in the scope for developing competition in Dutch and English healthcare, there are similarities which influence the regulator role and competition focus. This section first sets out the context of competition in Dutch and English healthcare which inevitably emphasizes difference, before outlining two significant underlying similarities and considering the framework within which the regulators operate which is arguably defined by the applicability of competition law.

A) Competition in Dutch healthcare

The Dutch system of mandatory private health insurance is underpinned by interaction between patients, healthcare providers and health insurers and associated markets. This can be illustrated by a “healthcare triangle”²⁵ as follows:

²⁵ See Sauter (2009), *supra* n15.

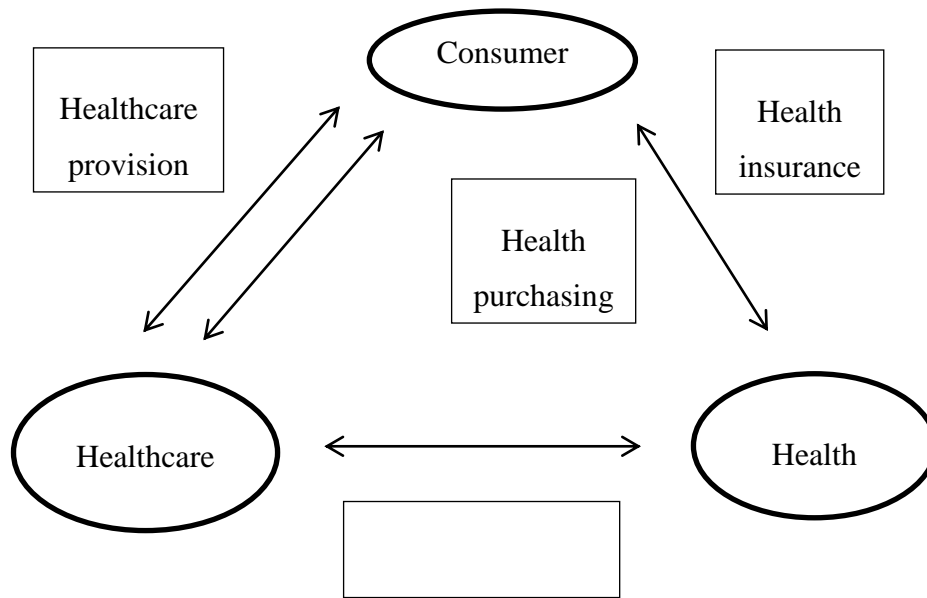


Figure 1: the Dutch "healthcare triangle".

In essence, the framework established by the Dutch Health Insurance Act 2006²⁶ requires all adults living and working in the Netherlands to take out a basic package of health insurance, and this underpins the development of a competitive health insurance market. From this, it was intended that competition will filter through to healthcare provision markets as insurers try to gain competitive advantage by securing the best deal possible from healthcare providers, and that consultants would be put under pressure to

²⁶ *Zorgverzekeringswet (Zvw)*.

provide high quality competitive services by provider combinations such as hospitals.²⁷ Within this system, patients provide an impetus for competition by exercising choice of health insurer and depending upon the type of policy chosen – “reimbursement”, “combination” or “benefits in kind” – will have a greater or lesser choice of healthcare provider.

B) Competition in English healthcare

In order to understand the HSCA 2012 (and wider NHS competition) reforms, it is essential to be aware of the paradoxical scope for both distinction and cooperation between the English NHS and private healthcare sector. This includes the possibility for an individual to move between the two (insofar as they are eligible for NHS treatment), and be classified as either an “NHS patient” or a “private patient”, subject to Department of Health and latterly NHS England rules.²⁸

Market-based reforms of the English NHS began with the separation of purchasing and providing functions by the “NHS internal market” in 1991.²⁹ Since then, it has been

²⁷ Wolf Sauter, “Experiences from the Netherlands: The Application of Competition Rules in Health Care”, in J. Van de Gronden, E.Szyszczak, U. Neergaard, M. Krajewski (eds.), *Health Care and EU Law* (TMC Asser Press, 2011), ch.11.

²⁸ Department of Health, ‘Guidance on NHS patients who wish to pay for additional private care’, 23 March 2009. NHS Commissioning Board (now NHS England), ‘Commissioning Policy: Defining the boundaries between NHS and Private Healthcare’. April 2013. Ref: NHSCB/CP/12.

²⁹ Elaborated by the White Paper, “Working for Patients” and introduced by the National Health Service and Community Care Act 1990.

possible to conceptualise the interactions between the NHS and private healthcare sector as comprising four categories thus:³⁰

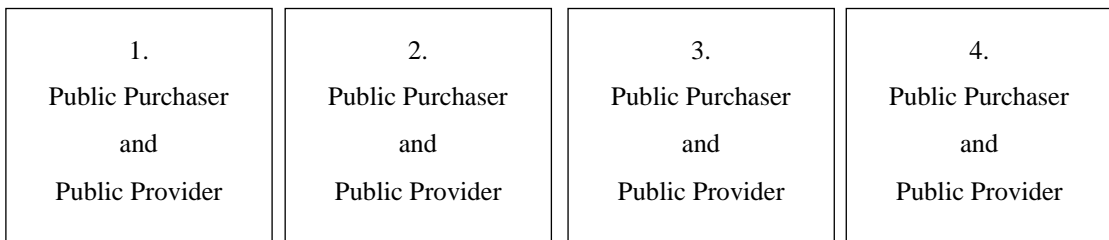


Figure 2: Relationship between the NHS and PH sectors as demonstrated by the purchaser/provider separation.

In essence, categories 1 and 2 comprise the NHS and treatment of NHS patients by NHS providers³¹ (category 1) or private/voluntary sector providers of NHS services, such as Independent Sector Treatment Centres – private clinics dedicated to treating NHS patients (category 2). Correspondingly, categories 3 and 4 relate to the private healthcare

³⁰ These have also been used to delineate the private healthcare market and discuss the applicability of competition law. See, respectively, Office of Fair Trading (OFT), “Private Healthcare Market Study”, December 2011, OFT1396 at page13, and Okeoghene Odudu, “Competition Law and the National Health Service” (*Competition Bulletin: Competition Law Views from Blackstone Chambers*, 8 October 2012).

³¹ Secondary care providers (typically hospitals and ambulance services) within the NHS have operated as “NHS Trusts” since 1990 or as “NHS Foundation Trusts” since 2003. Although successive government policy was for NHS Trusts to achieve greater financial autonomy and Foundation Trust status between approximately 2004 and 2014, the introduction of the NHS Five Year Forward View and new integrated care models suggests that alternative conceptions are emerging, such as Accountable Care Organisations. These may include primary care providers such as GPs. These have had an independent status so might be considered to belong in category 2 as much as category 1.

sector and treatment of private patients by private providers – for example, private patient units within NHS hospitals (category 3) or private hospitals (category 4).

Following the introduction of the NHS Five Year Forward View in 2014 there has been an emphasis on integrated models of care which are currently being implemented via Sustainability and Transformation Plans. These have been hailed by the CEO of NHS England as marking the end of the separation of purchasing and providing functions.³² However, the underlying distinction between the NHS and private sector remains pertinent with regard to discussions of competition, particularly as the nature of these markets differs.

The development of market-based reforms led to the NHS being described as a “quasi-market”: a concept which can share various common features with “standard” markets (such as competition and the use of financial incentives),³³ but can also be distinguished on both the demand and supply side.³⁴ Thus purchasers typically comprise the state via agents (NHS Commissioners), rather than patients using their own resources, while providers may include both not-for-profit as well as for-profit organisations. As there is evidence in 2017 of ongoing governmental commitment³⁵ to maintaining the NHS as a service based on clinical need, not the ability to pay, the designation of the NHS as a “quasi-market” remains apt since the HSCA 2012 reforms do not change this underlying characteristic.

³² Rebecca Thomas, Dave West, “STPs will end the purchaser-provider split, says Stevens”, *Health Service Journal*, 27 February 2017.

³³ Julian Le Grand, “Quasi Markets: The Answer to Market Failure in Health Care?”, in P. Day, D.M. Fox, R. Maxwell and E. Scrivens, *The State, Politics and Health: Essays for Rudolf Klein*, (Oxford, 1996), ch.3.

³⁴ Will Bartlett and Julian Le Grand, “The Theory of Quasi-Markets” in J. Le Grand and W. Bartlett (eds.), *Quasi-Markets and Social Policy*, (London, 1993), ch.2.

³⁵ Department of Health, ‘The Government’s Mandate to NHS England for 2017-2018’, March 2017. Para 1.1.

In contrast, the private healthcare market is more akin to standard markets in light of the greater scope for provider entry and exit and as “self-pay” patients use their own resources.

A failure to engage with, or even recognise this distinction between the NHS and private healthcare market has arguably characterised the HSCA 2012 reforms and offers some explanation of why their implementation is both controversial and difficult. This is considered further in light of the regulator’s focus on patients in Section III below.

C) Points of similarity underpinning competition in Dutch and English healthcare

As noted previously, the significant distinction between insurance-based and taxation-funded healthcare system models has implications for the scope for developing competition. Nevertheless, there are at least two significant similarities underpinning the development of competition policy and application of competition law within Dutch and English healthcare.

Firstly, both countries are (currently) EU Member States. At a fundamental level, this common heritage reveals the significance of solidarity – defined in limited terms for the purposes of the present discussion as universal access to necessary healthcare - as an organising principle for both Dutch and English healthcare demonstrates this. Solidarity represents the “ideational point” upon which EU Member State healthcare systems converge,³⁶ regardless of where they fit within the wider typologies of insurance-based / taxation-funded healthcare system. It also marks a contrast with healthcare in the United

³⁶ Tamara K. Hervey, ‘Public Health Services and EU Law’, Chapter 7 in Marise Cremona (eds), Market Integration and Public Services in the European Union (Oxford University Press 2011). Page 186.

States, where competition is considered to be more developed because efficiency concerns have been prioritised over equity.³⁷

In terms of the legal framework, EU membership is also notable for highlighting an absence of EU-level harmonisation in healthcare (as distinct from other sectors such as telecommunications or energy), and the consideration that healthcare system organisation is a Member State competence.³⁸ While this suggests that individual Member States have some freedom to experiment with market-based reforms,³⁹ this may be constrained by reforms such as public-private interactions (inadvertently) triggering application of general competition law.⁴⁰ This highlights that the EU competition law framework provides a broad basis upon which comparative analysis in this area can build.

This EU competition law framework comprises two broad distinctions: between healthcare providers and purchasers, and between healthcare delivered in line with the principle of universal access and healthcare which may be considered supplementary to this.⁴¹ In very general terms, healthcare providers have been deemed subject to competition

³⁷ Martin Gaynor, 'Competition in Hospital Services', OECD Directorate for Financial and Enterprise Affairs Competition Committee, Working Party No.2 on Competition and Regulation, DAF/COMP/WP2(2012)3 06 Feb 2012.

³⁸ Article 168(7) Treaty on the Functioning of the European Union.

³⁹ Arianna Andreangeli, 'Healthcare Services, the EU Single Market and Beyond: Meeting Local Needs in an Open Economy – How Much Market or How Little Market?', [2016] *Legal Issues of Economic Integration*, 43(2), 145-172.

⁴⁰ For further discussion, see Tony Prosser, 'EU competition law and public services' in Elias Mossialos, Govin Permanand, Rita Baeten, Tamara Hervey (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (CUP 2010).

⁴¹ See further Johan W. van de Gronden and Catalin S. Rusu, "EU competition law and policy and health systems", in T.K. Hervey, C.A. Young and L.E.Bishop (eds.), *Research Handbook on EU Health Law and Policy* (Cheltenham, 2017), ch.11.

law,⁴² while purchasing activities in the context of delivering universal access to healthcare have been considered exempt.⁴³ These distinctions are reflected in the development of competition policy within Dutch and English healthcare.⁴⁴ In essence, Dutch competition law is applicable to healthcare providers and health insurers,⁴⁵ while in England, the Competition and Markets Authority has drawn a distinction between private providers working in the private healthcare market (category 4) and in the NHS (category 2) in its guidance on competition law.⁴⁶

Secondly, as noted in the motivation for this analysis, a fundamental feature of the development of competition policy in both countries has been the influence of the experience of liberalising other sectors.

This might be interpreted in terms of similarities between healthcare and other sectors such as energy. If so, such comparison is arguably tenuous: distinctions are quickly revealed by the complexity of healthcare provision, which relates not only to the variety of providers and services, but also the difficulty of measuring quality (relative to technical standards applied in other markets) and the tension between competition and integrated healthcare provision.⁴⁷ Unsurprisingly, caution has been urged with drawing comparisons

⁴² Case C-475-99, *Ambulanz Glöckner* [2001] ECR I-8089.

⁴³ Case C-205/03, *FENIN* [2006] ECR I-6295.

⁴⁴ This is developed further and examined in detail in Mary Guy, *Competition Policy in Healthcare Systems – A Comparative Study of the Netherlands and England* (Intersentia, forthcoming 2018).

⁴⁵ Johan van de Gronden and Erika Szyszczak, “Introducing Competition Principles into Health Care Through EU Law and Policy: A Case Study of the Netherlands” (2014) 22(2) *Med. L. R.* 238.

⁴⁶ CMA, ‘60-second summary – Private medical practitioners: information on competition law’, 3 December 2015.

⁴⁷ Anna Dixon, Tony Harrison, Claire Mundle, “Economic regulation in healthcare – what can we learn from other regulators?” *The King’s Fund*, November 2011.

with other sectors as these are better suited to identifying issues in need of resolution, rather than suggesting the appropriateness of a “model” of utility regulation.⁴⁸

However, a more pertinent comparison emerges with the sense of a wider cultural shift in the premise that sectoral regulation is a temporary feature within an overarching direction of travel towards a competitive marketplace overseen exclusively by a competition authority. This is evidenced, *inter alia*, in criticism by competition lawyers of the regulator’s role, and in the suggestion at the outset of the 2006 reforms by Edith Schippers, now Minister for Health, Wellbeing and Sport, that the Dutch Healthcare Authority’s competition function would ultimately be subsumed into the Authority for Consumers and Markets.⁴⁹ This wider cultural comparison is both reminiscent of the purpose of UK sectoral regulation being to “hold the fort” pending the arrival of competition,⁵⁰ and finds reflection in the Netherlands by the balancing of “competition where possible, regulation where necessary” in the context of the development of market regulation within the 2006 reforms.⁵¹ Interestingly, the actual experience of other sectors – where regulation has proved a more permanent feature than originally envisaged – appears to have been overlooked in designing the competition focus of the healthcare regulators.

⁴⁸ Lindsay Stirton, “Back to the Future? Lessons on the Pro-Competitive Regulation of Health Services” (2014) 22(2) *Med.L.R.*180.

⁴⁹ As discussed by S. van der Heul and F. Cornelissen, “Markttoezicht in de gezondheidszorg na wijziging Wmg” (“Market regulation in healthcare after Dutch Healthcare (Market Regulation) Act 2006 (Wmg) amendments”), *Markt & Mededinging* (2016) 5, 175.

⁵⁰ Stephen Littlechild, ‘Regulation of British Telecommunications’ Profitability’, Department of Trade and Industry, London, 1984. Para 4.11.

⁵¹ Kamerstukken II, 2004-05, 30 186, 3 “Regels inzake marktordening, doelmatigheid en beheerste kostenontwikkeling op het gebied van de gezondheidszorg (Wet marktordening gezondheidszorg)”, Nr.3 Memorie van Toelichting. (Second Chamber documentation, Parliamentary Session 2005-06, 30 186, 3 (Explanatory Memorandum) “Rules governing market organisation, efficiency and managed cost development in healthcare (Dutch Healthcare (Market Regulation) Act 2006 (Wmg))”.

Rather, at first glance, this temporary characteristic of sectoral regulation appears borne out in the Netherlands, where the majority of the Dutch Healthcare Authority's competition powers have recently been transferred in practice to the Authority for Consumers and Markets. However, this does not resolve more fundamental questions about *ex ante* and *ex post* intervention: it is simply in the hands of a single agency when to act and what tools to use.

It is acknowledged that this comparative analysis is shaped by factors over and above substantive law. However, a comparative law approach is fundamental to understanding the derivation of Dutch and English healthcare competition policy ultimately from EU competition law and the scope for divergent approaches to this – a concept termed “Euro-national competition rules for healthcare”.⁵²

D) Framing the discussion: the applicability of competition law as a starting-point for defining the framework within which the sectoral regulators operate

The foregoing overview of similarities and differences between the development of competition in Dutch and English healthcare provides a helpful starting-point for understanding the framework within which the sectoral regulators (and competition authorities) work, which in turn helps to shape the competition focus of the sectoral regulators and their relationship with the competition authorities.

This framework is determined primarily by the applicability of competition law⁵³ and may lead to two general inferences which can be tested in light of the further factors

⁵² Van de Gronden and Szyszczak (2014) supra n44.

⁵³ A separate framework emerges in connection with merger control and the assessment of hospital mergers.

considered in this article, namely the regulators' apparent focus on patients and the evolving role of ministerial oversight and expanding role of the competition authority.

One inference is that where competition law is applicable, we may expect to see greater intervention by the competition authority and a reduced role for the regulator and limited ministerial oversight.

Conversely, a second inference arises where the applicability of competition law is in question, so we may expect to see less competition authority intervention and a greater role for regulator and ministerial oversight.

As regards the underlying applicability of competition law, interesting and potentially significant distinctions between the Dutch and English systems are already in evidence.

In the Netherlands, there is greater scope for competition within its insurance-based model and in principle the applicability of competition law to both healthcare providers and purchasers is relatively uncontroversial. The relationship between the Authority for Consumers and Markets and the Dutch Healthcare Authority appeared initially predicated on a "separate powers" model. Thus the Authority for Consumers and Markets had exclusive competence to apply competition law, but the Dutch Healthcare Authority's competition powers – intervention regarding significant market power and the drafting of terms of healthcare and tariff-related agreements – were intended primarily as complementary to this. While the current transfer of the significant market power competence removes this sense of separation, it is still evident in the Dutch Healthcare Authority retaining its aforementioned drafting competence. Furthermore, a separation remains evident in whether *ex ante* or *ex post* intervention is desirable – that is, whether the Authority for Consumers and Markets will use its new significant market power competence or take action in connection with the prohibition on abuse of dominance.

In England, there is less scope for competition within the NHS taxation-funded model and the applicability of competition law vis-à-vis the NHS (but not the private healthcare sector) remains unclear, even controversial.⁵⁴ The choice of a “concurrent powers” model for NHS Improvement or the Competition and Markets Authority to have equal competence in applying competition law to cases involving “the provision of healthcare services” under section 72 HSCA 2012 is therefore curious. It suggests that NHS Improvement and the Competition and Markets Authority have equal oversight of the NHS and private healthcare sectors, something which is certainly not borne out in practice. Although the White Paper preceding the HSCA 2012 clearly articulated ambitious proposals for the Competition and Markets Authority to have oversight of the NHS, these were ultimately diminished by the Enterprise and Regulatory Reform Act 2013 (ERRA 2013) reforms⁵⁵ of the wider concurrency regime and specifically the Competition Act 1998 (Concurrency) Regulations 2014, which reserve cases concerning “matters relating to the provision of health care services for the purposes of the NHS in England” to NHS Improvement.⁵⁶ This effectively enshrines the situation which existed prior to the HSCA 2012 reforms, whereby the Competition and Markets Authority’s predecessors (the Office of Fair Trading and the Competition Commission) had oversight of the private healthcare sector (categories 3 and 4), and the Department of Health oversaw the NHS (categories 1 and 2). This represents a variation on a “separate powers” model, where the Competition and Markets Authority applies general competition law to providers in the private healthcare sector, and NHS Improvement applies a “NHS-specific” regime (the Choice and

⁵⁴ See, for example, Duncan Sinclair, “Undertakings” in competition law at the public-private interface – an unhealthy situation’, [2014] ECLR 35(4), 167-171. Okeoghene Odudu, ‘Are State-owned healthcare providers undertakings subject to competition law?’ [2011] 32(5) European Competition Law Review 231-241.

⁵⁵ See the House of Lords debates - Enterprise and Regulatory Reform Bill, HL Deb, 12 December 2012, Col GC362.

⁵⁶ Competition Act 1998 (Concurrency) Regulations 2014, SI 2014/536, Regulations 5 and 8.

Competition condition of the NHS Provider Licence⁵⁷ and the Regulation 10 prohibition on anticompetitive behaviour of the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013⁵⁸ within the context of the NHS “quasi-market”.

In light of the aforementioned inferences, the foregoing suggests, as might be expected, the role of the competition authority regarding the application of competition law has assumed greater significance in the Netherlands, but not in England, where the regulator and sector-specific regime appears to play a larger role in connection with the NHS, not only relative to the competition authority, but also in terms of extending its remit beyond its competition focus.

However, two further factors play a role in shaping the competition focus of the regulators and their relationship with the competition authorities, namely, the regulators’ focus on patients and the evolving role of ministerial oversight in connection with the competition reforms. These are now considered.

3. THE REGULATORS’ FOCUS

Both the Dutch Healthcare Authority and NHS Improvement have a distinct focus articulated in statute which appears directed towards patients as distinct from, for example, healthcare providers or purchasers operating within their respective markets. This focus has

⁵⁷ Monitor, The New NHS Provider Licence, 14 February 2013. Annex: NHS Provider Licence Standard Conditions.

⁵⁸ SI 2013/500.

been considered both a source of legitimacy⁵⁹ and grounds for concern about possible contradiction of competition law standards.⁶⁰

In view of the foregoing discussion of the development of competition and applicability of competition law, it might be anticipated that the Dutch Healthcare Authority's focus may be more market-oriented and focused on the interests of policyholders, while NHS Improvement's focus may perhaps be directed towards patient interests.

A) The Netherlands

From its inception, the Dutch Healthcare Authority has had a duty to promote the “general consumer interest” under Article 3(4) Dutch Healthcare (Market Regulation) Act 2006.⁶¹ The Dutch Healthcare Authority has interpreted the “general consumer interest” as encompassing the public values of accessibility, affordability and quality, and these have been elaborated further in different ways. For example, “affordability” has both micro and macro dimensions, relating respectively to affordable basic insurance and a lack of reduction in purchasing power or dramatic increase in public spending.⁶² “Accessibility” distinguishes physical and financial aspects,⁶³ and the Dutch Healthcare Authority has

⁵⁹ See Sauter (2009), supra n15.

⁶⁰ Albert Sánchez Graells, “New rules for health care procurement in the UK: a critical assessment from the perspective of EU economic law”, (2015) P.P.L.R 1 16.

⁶¹ *Wet marktordening gezondheidszorg (Wmg) 2006.*

⁶² NZa, ‘Visiedocument: (In) het belang van de consument’ (‘Vision Document: (In) the general consumer interest’) (November 2007). Section 2.1.

⁶³ *Ibid.*

elaborated this as meaning access to the right care within a reasonable distance and period of time, based on norms regarding waiting time for non-emergency care and that ability to pay is no barrier to receiving medical care, respectively. “Quality” in connection with the Dutch Healthcare Authority⁶⁴ relates to the proper functioning of markets. It has been suggested that tension may arise with trade-offs emerging between the individual values⁶⁵ of accessibility, affordability and quality. Nevertheless, the interplay between accessibility, affordability and quality has provided a framework for Dutch Healthcare Authority assessment of significant market power and its contract intervention competences.⁶⁶ It appears that the Authority for Consumers and Markets would similarly need to have regard to the “general consumer interest” with the transfer of the significant market power competence.⁶⁷ Nevertheless, with the wider refocusing of competition in Dutch healthcare, for example regarding the assessment of hospital mergers, the Authority for Consumers and Markets has called for further clarification of what it terms “public interests”⁶⁸ – which appear to comprise accessibility, affordability and quality – in connection with the competition rules.

⁶⁴ As distinct from, for example, the Dutch quality regulator (the IGZ).

⁶⁵ See Sauter (2009), supra n. 15.

⁶⁶ Also seen in Dutch Healthcare Authority Opinions within merger assessment between 2006 and 2015.

⁶⁷ Kamerstukken II, 2015-16, 34 445, 3 - Wijziging van de Wet marktordening gezondheidszorg en enkele andere wetten in verband met aanpassingen van de tarief- en prestatieregulering en het markttoezicht op het terrein van de gezondheidszorg. Nr. 3 Memorie van Toelichting. (Second Chamber documentation, Parliamentary Session 2015-16, 34 445, 3 - Amendments to the Wmg and other laws to apply tariff regulation and market regulation in healthcare, Document No.3, Explanatory Memorandum). Page 40.

⁶⁸ See ACM, ‘Position Paper Autoriteit Consument en Markt Rondetafelgesprek “Kwaliteit loont”’ (‘ACM Position Paper on the “Quality Pays” roundtable discussion’). 17 April 2015.

This definition of the “general consumer interest” in terms of public values suggests an interesting tension between a market focus on the one hand, and a focus on patients on the other which is considered further below.

B) England

Under section 62(1) HSCA 2012, NHS Improvement has a main general duty to “protect and promote the interests of people who use health care services by promoting provision of healthcare services which (a) is economic, efficient and effective, and (b) maintains or improves the quality of the services.” The terminology of “people who use healthcare services” appears somewhat unwieldy as “healthcare services” appear to extend beyond the NHS.⁶⁹ Prima facie, this suggests that the general duty is owed to all patients in England, whether accessing NHS and/or private healthcare services. So this may include instances where a patient receives a hip replacement operation in an NHS hospital (as an NHS patient), but for reasons of personal convenience may seek follow-up physiotherapy with a private provider⁷⁰ (as a private patient).

However, with regard to competition in the NHS, section 62(3) HSCA 2012 qualifies this general duty thus:

“[NHS Improvement] must exercise its functions with a view to preventing anti-competitive behaviour in the provision of healthcare services for the purposes of the NHS which is against the interests of people who use such services”.

⁶⁹ Section 64(3) HSCA 2012 defines “healthcare services” as “[...] all forms of health care provided for individuals, whether relating to physical or mental health [...]; and [...] it does not matter if a health care service is also an adult social care service”.

⁷⁰ See Department of Health guidance supra n27, example cited at page 10.

This clearly directs NHS Improvement’s general duty towards NHS patients (as “people who use such services”), which is consistent with its practice of focusing on the NHS, not the private healthcare sector. As “provision of healthcare services for the purposes of the NHS” (whether by NHS or private providers) represents an area (categories 1 and 2) where the extent of the *applicability* of general competition law is questionable, this is also consistent with the existence of the aforementioned separate regime for the NHS “quasi-market”.

The regulators’ focus on patients entails two further considerations – regarding a coherent narrative underpinning competition reforms and recognising dual identities of patients – which are now examined.

C) A coherent narrative?

Overall, the Dutch Healthcare Authority’s focus on the “general consumer interest” has been interpreted as relating to a general body of consumers and long-term interests, thus ensuring the effective working of the market mechanism.⁷¹ This is logical as the competition reforms in Dutch healthcare comprise a consistent market narrative (at least relative to the English reforms), underpinned inter alia by the suggestion above that the Authority for Consumers and Markets will have similar regard to the “general consumer interest”.

In contrast, it is difficult to see such coherence emerging within NHS Improvement’s focus on “people who use healthcare services” which appears both to reference the interaction *between* NHS and private healthcare provision, and yet in practice to mean “NHS patients” as s.62(3) HSCA 2012 explicitly references the NHS “quasi-market”. This can be explained in part by the refocusing of competition in the face of

⁷¹ Thus has been related to the market failure rationale for regulation. See Sauter (2009), supra n. 15.

significant criticism during the enactment of the HSCA 2012⁷² – and expressed in the obligation to prevent anticompetitive behaviour, not promote competition (in contrast to other sectoral regulators).

D) “Dual identity” - patients/policyholders, patients/taxpayers

A common point between the regulators’ focus, despite functioning within very different systems, is the apparent missed opportunity to engage explicitly with the “dual identity” of patients.

In the Netherlands this comprises a tension between policyholders (consumers of health insurance) and patients.⁷³ The regulator’s focus may vary according to whether it is considering the health insurance market (thus insurance policyholders as “consumers”) or the healthcare provision market (thus patients as “consumers”) – it being recalled that competition was intended to develop from the health insurance market to the healthcare provision market.⁷⁴

This sense of a dual identity is illustrated by a rejection of a controversial legislative proposal which precipitated a near collapse of the Dutch Liberal/Labour coalition government in December 2014.⁷⁵ The legislative proposal included a

⁷² NHS Future Forum, ‘Choice and Competition – Delivering Real Choice. A report from the NHS Future Forum’, June 2011.

⁷³ See Sauter (2009), supra n. 15.

⁷⁴ See Sauter (2011), supra n. 26.

⁷⁵ EUObserver, “Dutch PM misses EU summit to save coalition”, 18 December 2014. <<https://euobserver.com/news/126994>>.

recommendation to amend Article 13 Dutch Health Insurance Act 2006⁷⁶ which mitigates the limited choice of providers available to patients with cheaper “benefits in kind” policies.⁷⁷ On the one hand, amending this provision may have led to lower premia, a benefit to insured parties and in keeping with the apparent overall aim of competition in Dutch healthcare of reducing costs. However, on the other hand, precluding choice of provider may have negative impacts on a patient’s health outcomes. Thus potential curtailment of “free choice of provider” not only proved decisive in the voting down of the legislative proposal, but also remains a sensitive issue.⁷⁸ This example from 2014 suggests that there can well be a tension – or at least a lack of alignment – in the dual identity between “patient interests” on the one hand, which benefit from maintaining the “free choice of provider”, and “policyholder” interests on the other, which would benefit from cheaper premia. With the current refocusing of competition within a wider modernisation of Dutch healthcare, the Minister for Health, Wellbeing and Sport has referenced the interests

⁷⁶ Contained in a legislative proposal mainly concerned with a prohibition of integration of healthcare providers and health insurers. Kamerstukken II, 2011-12, 33 362, 2 – Wijziging van de Wet marktordening gezondheidszorg en enkele andere wetten, teneinde te voorkomen dat zorgverzekeraars zelf zorg verlenen of zorg laten aanbieden door zorgaanbieders waarin zij zelf zeggenschap hebben. Nr. 2 Voorstel van wet. (Second Chamber documentation, Parliamentary Session 2011-12. 33 362, 2 – Amendments to the Wmg and other laws to prohibit health insurers from providing healthcare themselves, or allowing care to be delivered by providers in which they have a controlling interest. Document No. 2, Legislative Proposal).

⁷⁷ By requiring insurers to offer some degree of compensation if a patient chooses (subsequent) treatment with a provider who has no contract with the insurance company.

⁷⁸ See, for example, discussion of a recent case in which this issue arose. “Twijfel over echt vrije artskenkeuze” (“Questions about real free choice of provider”), Commentaar, Het Financiële Dagblad, 5 Januari 2017. Furthermore, financial advisor websites include explanations of the “free choice of provider”. The VvAA, the largest network of legal and financial support for members of the medical profession in the Netherlands, also supported a campaign following the development of the right to a “free choice of provider” - <https://www.vvaa.nl/levensloop/vrije-artskenkeuze/manifest>

of both “patients” and “policyholders”,⁷⁹ which arguably suggests an awareness of the scope for dual identity.

In England, this “dual identity” comprises patients and taxpayers. While NHS Improvement has not explicitly recognised this, the Chief Executive of NHS England has previously articulated the organisation’s motivation as being to “think like a patient, act like a taxpayer”.⁸⁰ In view of NHS Improvement’s commitment to the NHS as a taxation-funded service free at the point of delivery⁸¹ and its close partnership with NHS England, the failure to couch its general duty in terms of “patients and taxpayers” in the HSCA 2012 appears overlooked, even remiss, for at least three reasons.

Firstly, competition within the English NHS predominantly comprises competition *for* the market, thus commissioning activity linked with securing value for money for taxpayers, as distinct from competition *in* the market, linked with consumer choice.

Secondly, there is arguably a tension between the respective identities of “patient” and “taxpayer”. Thus taxpayers’ interests may best be served by a continued commitment in practical terms to an NHS which remains free at the point of use and ensures continuity of care. However, individual patients may also value a continued ability to move between the NHS and private healthcare sectors to receive treatment as needed – which suggests a scenario closer to that experienced in other sectors than the limited patient choice policies

⁷⁹ Edith Schippers, ‘Kwaliteit loont’ (‘Quality Pays’), Letter from the Minister for Health, Wellbeing and Sport to the Chairman of the Second Chamber, 6 February 2015.

⁸⁰ Simon Stevens (CEO of NHS England) speech, 1 April 2014.

⁸¹ Monitor, ‘Monitor’s Strategy 2014-17 – Helping to redesign healthcare provision in England’.

which offer a choice of NHS or private provider, for example, for a first outpatient appointment regarding elective care.⁸²

Thirdly, the concept of a “dual identity” is found in economic regulation in other sectors yet, curiously, has not influenced the design of NHS Improvement. It can be considered that there is sufficient precedent in the dual duty of the UK communications regulator (Ofcom) to consumers and citizens⁸³ to have justified NHS Improvement adopting a similar “dual identity” approach.⁸⁴

However, the lack of explicit reference to taxpayers may be explained by at least two factors.

Firstly, the refocusing of competition within the implementation of the HSCA 2012 included an emphasis on competition on quality, rather than price competition. This may prompt an inference that competition on quality is something patients may be responsive to (in light of information asymmetry between patients and providers), whereas taxpayers may favour competition on price insofar as this can achieve value for money.

Secondly, the taxpayers’ and patients’ interests may align to such a degree that the distinction becomes superfluous. It has been suggested that, in public service delivery, the

⁸² Enshrined by Regulation 12, National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013 (SI 2013 No.500) and Regulations 47-49, National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (SI 2012 No.2996). The “right” of NHS patients to exercise choice is also referenced in The NHS Constitution (July 2015), “Patients and the Public – your rights and NHS pledges to you”, page 9.

⁸³ Section 3(1) Communications Act 2003. Discussed in Tony Prosser, “Regulation and Social Solidarity”, (2006) *Journal of Law and Society* 33(3) 364.

⁸⁴ This comparison with other sectoral regulators is perhaps more logical than other agencies, which may routinely refer to “patients and taxpayers” in relation to the NHS. See, for example, Public Accounts Committee Sixtieth Report, “Achievement of Foundation Trust Status by NHS Hospital Trusts”, 7 December 2011.

preferences of a state's citizens as taxpayers are unlikely to differ significantly from their preferences as users.⁸⁵ So a good public service may be simultaneously responsive to users' needs and accountable to taxpayers. However, interests may differ with regard to geographical distribution such that taxpayers in one part of the country subsidize public service users in another⁸⁶ – an example being the “postcode lottery” allocation of drugs.

A third consideration may be that as NHS Improvement's role is to operate alongside the Competition and Markets Authority in policing anticompetitive behaviour (evident in the existence of concurrent powers), their respective focus of the two agencies may reflect each other.

Overall, the regulators' explicit focus – whether on the “general consumer interest” or “patients' interests” – can be conceptualised as a means of incorporating public interests within competition-based tests as these may otherwise receive, or be perceived to receive, less attention – something that may raise concerns from a political perspective. Thus, from a strict competition perspective, there is an inference that it is possible to regard not only quality, but also arguably other consumer values of access, affordability and choice, as dimensions of efficiency.⁸⁷ However, the current intention for the Authority for Consumers and Markets to focus on the “general consumer interest” in the context of significant market power investigations suggests its ongoing importance in this regard.⁸⁸

⁸⁵ See Julian Le Grand, *The Other Invisible Hand – Delivering Public Services through Choice and Competition*, (Woodstock, 2007).

⁸⁶ *Ibid.*

⁸⁷ Wolf Sauter, “The Impact of EU Competition Law on National Healthcare Systems” (2013) E.L. Rev. 38(4) 457.

⁸⁸ This appears to mark a contrast with the reformed merger control, where the need to pay attention to “public interests” is suggested to be the exception, rather than the rule. Kamerstukken II, 2015-16, 34 445, 3 – “Wijziging van de Wet marktordening gezondheidszorg en enkele andere wetten in verband met aanpassingen van de tarief-

However, concerns about a perceived lack of alignment between NHS Improvement’s general duty to prevent anticompetitive behaviour which is against the interests of NHS patients under s.62(3) HSCA 2012 and the standards of general competition law⁸⁹ are perhaps less persuasive in view of the NHS’ “quasi-market” status. Admittedly the wording of s.62(3) HSCA 2012 suggests that a distinction can be drawn between “good” anticompetitive behaviour which may well be in patients’ interests, and “bad” anticompetitive behaviour which is contrary to patients’ interests. However, this inference between “good” and “bad” anticompetitive behaviour can simply be read as another way of delineating the scope for intervention, which is consistent with the refocusing of competition within the NHS arising out of the enactment of the HSCA 2012 and arguably an appropriate approach for a “quasi-market”.

Ultimately, it may be considered that questions of “dual identity” are also shaped by the evolving role of ministerial oversight and the competition authorities’ expanding roles. These are now considered.

en prestatie-regulering en het markttoezicht op het terrein van de gezondheidszorg“, Nr. 3 Memorie van Toelichting. (Second Chamber documentation, Parliamentary Session 2015-16, 34 445, 3 - Amendments to the Wmg and other laws to apply tariff regulation and market regulation in healthcare (Explanatory Memorandum)). Page 23.

⁸⁹ For a critical view, see Sánchez Graells (2015), supra n. 59.

4. THE EVOLVING ROLE OF MINISTERIAL OVERSIGHT AND EXPANDING ROLE OF THE COMPETITION AUTHORITY

In both the Netherlands and England, the competition focus of the sectoral regulator and its relationship with the competition authority has developed alongside evolving ministerial oversight of healthcare provision.

In general terms, this can be conceptualised as a simple continuum which has as its starting point “the provision of a public health service [as] the quintessential public service”⁹⁰ overseen by government and its end point a market-based system overseen exclusively by the competition authority. This is influenced by the narrative of the purpose of (UK) sectoral regulation being to “hold the fort” pending the arrival of competition,⁹¹ and the implication that regulation is inherently second best⁹² within such a system.

The apparent intended direction of travel towards a competitive marketplace suggests that, in terms of oversight, it would be logical to expect a reduction in ministerial oversight and an expansion in the competition authority’s role in connection with the relative certainty surrounding the applicability of competition law (and inferences outlined in Section II). Indeed, this offers a framework to consider the developments in the Netherlands and England.

⁹⁰ Prosser (2005), supra n10, p.7.

⁹¹ Littlechild (1984), supra n. 49.

⁹² See Prosser (2006), supra n. 82.

A) *The Netherlands*

The greater scope for developing competition and the lesser controversy surrounding the applicability of competition law in Dutch healthcare suggests that reduced ministerial oversight and an expanded Authority for Consumers and Markets role could be anticipated. The latter may be true in view of the transfer of the Dutch Healthcare Authority's significant market power competence, as this is intended to refocus the application of competition powers with regard to the healthcare sector.⁹³ However, as regards the former, it is to be noted that other aspects of competition – such as determining which hospital service prices may be opened up to competition rather than remaining subject to a government tariff – will remain with the Dutch Healthcare Authority and the Minister. Furthermore, ministerial oversight arguably appears to be assuming a different dynamic vis-à-vis the Authority for Consumers and Markets, rather than diminishing per se. This is because the Minister for Health, Wellbeing and Sport will retain powers to issue policy rules as the “responsible Minister”⁹⁴ (it being noted that the Authority for Consumers and Markets is overseen ultimately by the Minister for Economic Affairs), apparently in keeping with shared regulation in other sectors. The Authority for Consumers and Markets' response has been (appropriately) to define its scope for intervention in terms of the applicability of competition law,⁹⁵ acknowledging that the existing substantive law may be insufficient to achieve governmental ambitions regarding competition in healthcare.

⁹³ Edith Schippers, “Kabinetsreactie rapport commissie Borstlap en evaluatie Wmg en NZa” (“Cabinet response to the Borstlap and AEF reports”, Letter from the Minister for Health, Wellbeing and Sport to the Chairman of the First Chamber), 2 April 2015.

⁹⁴ See Schippers (2015), supra n. 78.

⁹⁵ ACM, “Spreekpunten Henk Don bij rondetafelgesprek ‘kwaliteit loont’ in de Tweede Kamer op 17 april 2015”. (“Points for discussion by Henk Don at the “Quality Pays” round table discussion in the Second Chamber 17 April 2015”).

B) England

In light of the lesser scope for developing competition within the English NHS (as distinct from the private healthcare sector), it might be considered that Ministerial oversight may remain the same (if not increase) and, correspondingly, the role of the Competition and Markets Authority would diminish. However, an interesting combination of circumstances has emerged to question such an interpretation.

On the one hand, the wider HSCA 2012 reforms included the establishment of NHS England as an independent body with responsibility for setting strategic policy direction for the NHS in England. This reduced the scope for intervention by the Secretary of State for Health in apparent achievement of a long-standing ambition to “de-politicise” the NHS.⁹⁶ Although curiously little attempt was made to align NHS England’s ambitions with NHS Improvement’s competition remit in the drafting of the HSCA 2012, the combining of the two agencies is increasingly called for.⁹⁷

A further instance of the reduction in intervention by the Secretary of State for Health is evident in the decision to enshrine as secondary legislation previous policy guidance. This has been termed the “juridification” of matters of public policy,⁹⁸

⁹⁶ Nicholas Timmins, “‘Teflon’ Jeremy Hunt and the de-politicisation of the NHS”, *The King’s Fund Blog*, 22 February 2017. However the idea of, and desire for, the day-to-day running of the English NHS to be removed from Ministerial control is arguably not new and has been endorsed by both Labour and Conservative governments. Points of divergence emerge in connection with *how*, as opposed to *whether*, this might be achieved. Thus previous Secretaries of State for Health have revealed differing views about the establishment of NHS England and the associated restriction of the role of politicians. See the discussions in Nicholas Timmins, Edward Davies, *Glaziers and Window Breakers – Secretaries of State for Health in their own words*. (The Health Foundation, London, 2015), pages 160-164.

⁹⁷ For example, by a House of Lords Select Committee. See *supra* n. 20.

⁹⁸ For an excellent discussion, see Davies (2013) *supra* n. 18.

specifically, encouraging private sector delivery of NHS services. In consequence, NHS and private providers have standing to challenge, inter alia, the awarding of contracts or the referral of NHS patients and ask NHS Improvement for a determination under the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013. Although few cases have emerged thus far, while such provision exists, it offers an alternative recourse to the public procurement rules⁹⁹ or general competition law (insofar as this is applicable). Overall, it might be considered that there has indeed been a reduction in Ministerial oversight of the English NHS, however counterintuitive this may be with regard to the competition reforms.

On the other hand, the role of the Competition and Markets Authority has, paradoxically, been both restricted and expanded by the HSCA 2012 reforms. The original ambition of the White Paper preceding the HSCA 2012 was for the Competition and Markets Authority to have oversight of the NHS inter alia by sharing concurrent powers with NHS Improvement with regard to applying competition law. The aforementioned changes brought by the Competition Act 1998 (Concurrency) Regulations 2014 have effectively reflected the pre-HSCA 2012 situation insofar as NHS Improvement has sole oversight of the NHS in practical terms. Overall, this would seem to suggest a restriction of the Competition and Markets Authority's oversight of the NHS.

However, it is important to note that the 2014 Concurrency Regulations restrictions apply only to the concurrent powers under section 72 HSCA 2012 in relation to competition law. There are at least two further ways in which Competition and Markets Authority oversight of the NHS might be considered to have expanded.

Firstly, section 73 HSCA 2012 provides for the Competition and Markets Authority and NHS Improvement to share concurrent powers relating to market

⁹⁹ S. Smith, D. Owens, E. Heard, "New procurement legislation for English healthcare bodies – the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013", (2013) P.P.L.R. 4, 109.

investigations under Part 4 Enterprise Act 2002 (EA02). Although this provision has yet to be tested, by analogy with general Competition and Markets Authority guidance, it would appear that *either* the Competition and Markets Authority *or* NHS Improvement could carry out a market study to establish whether the NHS (quasi-) market¹⁰⁰ (presumably defined as categories 1 and 2 to distinguish it from the private healthcare market of categories 3 and 4) is working well. If not, *either* the Competition and Markets Authority *or* NHS Improvement could make a reference to the Competition and Markets Authority Board for a market investigation, an in-depth examination of whether there is an “adverse effect on competition”.¹⁰¹ While this division of effort may seem less contentious than applying competition law, it could still lead to the imposition of requirements on NHS or private providers delivering NHS services. Therefore having explicit Competition and Markets Authority intervention in such a “market developing” role *vis-à-vis* the English NHS may nevertheless prove extremely controversial, so it is questionable whether this power will be used, particularly in light of recent movements away from a competition-based system towards integrated care models.

Secondly, in a further contrast to the explicit restriction of Competition and Markets Authority competence regarding the application of competition law, a lesser-noted, but nevertheless potentially significant expansion of its oversight function is evident in other competition-related aspects of NHS provision. Thus the Competition and Markets Authority serves as a review body in cases where NHS Improvement proposes to include or modify a special condition in the NHS Provider Licence but this is rejected by the applicant or licence holder,¹⁰² and where consultations yield objections to the National Tariff

¹⁰⁰ Presumably defined as categories 1 and 2 to distinguish it from the private healthcare market of categories 3 and 4.

¹⁰¹ CMA, ‘Market Studies and Market Investigations: Supplemental Guidance on the CMA’s approach’, January 2014 (revised July 2017), CMA 3.

¹⁰² Health and Social Care Act 2012, s. 101.

Payment System agreed by NHS England and NHS Improvement.¹⁰³ While the former intervention power is new, the latter was originally the preserve of the Department of Health, suggesting perhaps as much evidence of receding ministerial oversight as expansion of Competition and Markets Authority functions. However, what emerges from the foregoing is a complicated picture in which the relationship between NHS Improvement and the Competition and Markets Authority is not only dependent upon it sharing concurrent powers with regard to competition law under s.72 HSCA 2012, although a distinction is drawn between these and the separate roles under HSCA 2012 and the importance of maintaining the importance of the Competition and Markets Authority’s impartiality and fairness in carrying out those functions.¹⁰⁴

A further example of Competition and Markets Authority expansion vis-à-vis the English NHS is evident in connection with merger assessment, which has proved the most active area of competition in terms of the number of cases subsequent to the HSCA 2012 reforms.¹⁰⁵

Overall, there has been a clear, even substantial, receding of ministerial oversight of the NHS “quasi-market” with the creation of NHS England and NHS Improvement on the one hand, and the allocation of Competition and Markets Authority review functions on the other. The receding of ministerial oversight is thus indeed accompanied by an expansion of Competition and Markets Authority functions vis-à-vis the NHS “quasi-market”. While this would be consistent with the desire to move from healthcare provision

¹⁰³ Health and Social Care Act 2012, s. 120(1)(b).

¹⁰⁴ CMA and NHS Improvement, “Memorandum of Understanding between the Competition and Markets Authority and NHS Improvement”, 1 April 2016. Paragraph 7.

¹⁰⁵ Section 79 HSCA 2012 provides that mergers involving NHS Foundation Trusts (typically hospitals) are subject to the general merger control regime of the Enterprise Act 2002. This is examined further in Guy (2018), supra n. 43.

overseen by government to a market-based system overseen by the competition authority, it is arguably counterintuitive in light of the nature of the NHS “quasi-market” and the political sensitivity surrounding this, which has arguably formed the basis for amending concurrent powers in respect of applying competition law under s.72 HSCA 2012. In light of the questionable extent of applicability of competition law to the English NHS, this might be considered a “belt and braces” approach to circumventing explicit Competition and Markets Authority intervention regarding the NHS.

What emerges from the foregoing is that the intuition of a correlation between ministerial and competition authority oversight relative to scope for competition is not borne out in practice based on the experiences of the Netherlands and England thus far.

5. CONCLUDING REMARKS

This article started from the premise that the experience of other sectors as a starting-point for developing sectoral regulation in healthcare, and particularly the relationship between the Dutch Healthcare Authority and Authority for Consumers and Markets in the Netherlands and NHS Improvement and the Competition and Markets Authority in England, provided a template which was too simple. This premise has been explored by means of a comparative analysis examining two specific factors, namely the regulators’ focus on patients and the evolving role of ministerial oversight.

Although the development of competition in both Dutch and English healthcare has been influenced by Enthoven’s model of “managed competition”, the varying extent to which competition is possible within an insurance-based model and a taxation-funded model arguably outweighs this. Consequently, it does not necessarily follow, for example, that transferring the regulator’s competition powers to the competition authority would be a

logical step¹⁰⁶ in both countries. Conversely, there may not necessarily exist a need for a strict separation of competition authority and regulator oversight where there is a single, unified “healthcare” sector as opposed to the distinctive interaction between the NHS “quasi-market” and the smaller supplementary private healthcare market. A general finding of this article is that such distinctions alone could justify a departure from regulatory models used in other sectors.

Indeed, the differing nature of markets in Dutch and English healthcare go some way to explaining the difficulties surrounding the development of coherent narratives regarding the regulators’ focus on patients, as opposed to either purchasers of health insurance or taxpayers, or to NHS Commissioners in the English context. This demonstrates that parallels between “patients-as-consumers” and consumers of other services are at best limited. For example, there is a need to consider whether oversight values could or should differ depending on whether the focus is patients (as a proxy for consumers) or purchasers of healthcare or taxpayers, so a future development of this should acknowledge dual identities. While it is acknowledged that NHS procurement activity is fragmented, a more consistent narrative for competition reforms in English healthcare nevertheless emerges if “the NHS”, or “NHS patients” as a collective group, is regarded as a consumer of private healthcare services.

Furthermore, the evolving landscape of ministerial oversight and the expanding role of the competition authorities beyond the application of competition law is arguably distinctive in healthcare in both countries. Indeed, what we are seeing is counterintuitive, with explicit ministerial oversight apparently greater in Dutch healthcare and seemingly minimal, even non-existent with regard to the English NHS.

Finally, the framework established by EU law for developing competition in Member State healthcare systems is undoubtedly expansive: Member States have

¹⁰⁶ Previously argued for in the English context by Albert Sánchez Graells, ‘Monitor and the Competition and Markets Authority’, (2014) University of Leicester School of Law Research Paper No. 14-32.

significant flexibility in deciding the degree and extent of market reforms.¹⁰⁷ Thus far, the Dutch and English reforms have attempted to build on this framework by using the experience of other sectors to create regulatory relationships and tools. This has proved an insufficient basis and needs further elaboration in light, inter alia, of the factors analysed in this article.

¹⁰⁷ Andreangeli (2016) supra n. 38.