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Dealing with "unworkable ideas in primary legislation": Juridifying and dejuridifying competition in the English National Health Service[1]

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Abstract

Moving between policy and law, and the creation of "new" law in a controversial area generates a range of effects – from potential court intervention, and concerns about oversight and accountability at national and transnational levels, to expectations of an irreversible direction of travel. The experience of juridifying competition reforms in the English National Health Service (NHS) with the Health and Social Care Act 2012 offers important insights with its protracted enactment and subsequent limited implementation. The new Health and Care Act 2022 repeals the controversial provisions to enshrine current NHS policy regarding integration, but other forms of "dejuridification" have evolved in the intervening period to engage with ongoing controversies about the interaction between the NHS and private healthcare. This article provides a timely evaluation of the juridification and dejuridification of competition by the 2012 and 2022 Acts, by drawing on assessments of the 2012 reforms, Blichner and Molander's juridification typology, Veitch et al.'s conceptualisation of 'depoliticisation', and Magnussen and Banasiak's conceptualisation of 'privatisation'. This offers insights for other areas by highlighting how "Euro-ambivalent" perspectives may have overshadowed more "home-grown" aspects underpinning the development of the 2012 Act, how "repoliticisation" may need further elaboration, and how diverse both "juridification" and "dejuridification" may actually be.

Introduction

How law and politics interact is a multi-faceted subject which can highlight aspects of social change, as well as concerns about democratic legitimacy and political intervention in matters of law. Much can be learned about elements as diverse as accountability, the reach of supranational legal frameworks, and the extent and effectiveness of parliamentary scrutiny

[1] I am grateful for feedback from anonymous reviewers, audiences at SLS, the Northern/Ireland Health Law and Ethics Network, and Lancaster Law School Work-in-Progress Seminar, as well as for discussions with Dr Okeoghene Odudu (Cambridge) which have shaped the development of this article.

within the legislative process from contentious aspects, such as the interaction between the National Health Service (NHS) and the private healthcare sector in England. This can be seen by juxtaposing primarily the Health and Care Act 2022 with the Health and Social Care Act 2012. Where the latter instituted a range of controversial competition reforms in the NHS under the Liberal Democrat/Conservative coalition government amid concerns about the reach of European Union (EU) competition law, the former has evolved via legislative proposals developed by NHS England against the demonstrably more complex policy backdrop of Brexit and the Covid-19 pandemic.[2] Further distinctions are notable: the 2012 Act was subject to a protracted enactment (January 2011 – March 2012) punctuated by an unprecedented 3-month pause to try to address concerns, notably about the choice and competition aspects;[3] the latter saw scrutiny of the evolving NHS-private healthcare interaction limited broadly to a cross-party welcome of the rejection of competition amid a seemingly expedited Parliamentary passage (July 2021 – April 2022). While of course policy focus can shift in a generation, the experience of competition reforms in the NHS is particularly instructive regarding how policy was enshrined in legislation, how this largely failed to be implemented amid a major policy shift towards integration with enshrinement of this in legislation gaining momentum with the 2019 NHS Long Term Plan, and how new legislation may show that little was learned from the overall experience.

The apparent volte-face in NHS policy since approximately 2015 – away from competition and towards integration – led to the 2012 Act reforms being described as leaving "some pretty unworkable ideas in primary legislation".[4] This compounded ongoing controversies which saw the 2012 Act reforms representing the worst of all worlds: a competition policy found wanting by those actively in favour of competition as a principle in itself, but which also did little to allay the worst suspicions of those more sceptical of competition reforms in healthcare.[5]

Broadly, the fundamental controversies arising from the 2012 Act competition reforms can be summarised as comprising substantive and institutional aspects which seemed to set in train an irreversible direction of travel. Thus concerns arose that the New Labour policies of expanding both private sector delivery of NHS services, and NHS Foundation Trusts (bodies with greater autonomy from central government) would trigger applicability of EU (and UK) competition law[6] and UK general merger control.[7] These substantive concerns were compounded by institutional concerns regarding Competition and Markets Authority (CMA) oversight of the NHS, and the development of "arms'-length" bodies such as Monitor/NHS Improvement[8] with a correspondingly reduced oversight role for the Secretary of State.

These controversies were examined in an astute contemporaneous analysis of "juridification" from the perspective of accountability by Davies,[9] who drew on Veitch et al.'s

[2] Mary Guy and Jean McHale, 'Why this, and why now? Tracking the development of the Health and Care Bill', Lancaster Law School Blog 10 February 2022. Why this, and why now? Tracking the development of the Health and Care Bill | Lancaster University

[3] NHS Future Forum, *Choice and Competition – Delivering Real Choice*. A report from the NHS Future Forum, June 2011.

[4] Kieran Walshe, "Queen's Speech: We can't avoid legislation for ever", *Health Service Journal*, 28 May 2015.

[5] M. Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems* (Cambridge: Intersentia, 2019), p.222.

[6] The Competition Act 1998 which transposes Articles 101 and 102 of the Treaty on the Functioning of the European Union (TFEU).

[7] Enterprise Act 2002, Part 3.

[8] For the purposes of the current discussion, and ease of reading and research, reference is made to Monitor/NHS Improvement, but it is recognised that Monitor was incorporated into NHS Improvement in 2016.

[9] A.C.L. Davies, "This Time, It's For Real" (2013) 76(3) M.L.R. 564-588.

conceptualisation of "depoliticisation",[10] as well as "law's expansion and differentiation" and "increased judicial power" within Blichner and Molander's typology.[11] More recent literature has built on Davies' analysis to review what has happened since – using empirical research to assess the limits of "increased judicial power" resulting from the expanding role of Monitor/NHS Improvement,[12] and also Gill's framing of "new constitutionalism" to try and explain the effects of EU law on the 2012 Act reforms.[13]

With enactment of the 2022 Act, what becomes additionally directly relevant to this discussion, but has received little attention to date, is the disruption to the relationship between law and politics caused by "privatisation", as conceptualised by Magnussen and Banasiak.[14] This essentially sees markets challenging – and weakening – both law and politics as a control and coordination system in society. This conceptualisation offers a useful framing to analyse the involvement of the CMA and Monitor/NHS Improvement, and the influence of the experience of utilities liberalisation in shaping some of the 2012 Act reforms.[15] While some parallels can be drawn with the growth of regulatory frameworks at a supranational (EU) level, the UK's pioneering and prominent roles in privatisation reforms and the development of private sector techniques in public administration[16] appear to have been downplayed. The expansion of economic policies into diverse elements of public services should properly be seen as comprising a fundamentally national dimension, and not simply reflections of similar economic/social tensions at EU level.

Overall, implementation of the 2012 Act reforms was more patchy than might have been expected, with effects and implications we can only now start to really understand. One route to gaining understanding can be seen with concerns about the shift between policy and law with "juridification" by the 2012 Act – and, correspondingly, "dejuridification" by the 2022 Act. The latter can be defined as variously, the simple reversal of juridification,[17] law taking a step back (via repeal or non-enforcement),[18] or as "almost impossible" where transnational expectations are entrenched.[19] All three considerations have relevance to repealing the 2012 Act reforms.[20]

This article provides a timely evaluation of the extent of "juridification" by the 2012 Act, and "dejuridification" via workarounds instituted to curb the effects of this legislation. In addition,

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[10] S. Veitch, E. Christodoulidis and L. Farmer, *Jurisprudence: Themes and Concepts, 2nd ed* (Abingdon: Routledge, 2012), pp.260-261.

[11] Lars Chr. Blichner and Anders Molander, "Mapping Juridification" (2008) 14(1) European Law Journal 36-54.

[12] Dorota Osipovič, Pauline Allen, Marie Sanderson, Valerie Moran and Kath Checkland, "The regulation of competition and procurement in the National Health Service 2015 – 2018: enduring hierarchical control and the limits of juridification", (2019) 15(3) Health Economics, Policy and Law 308-324.

[13] David Benbow, "Juridification, new constitutionalism and market reforms to the English NHS" (2019) 43(2) Capital & Class 293-313.

[14] Anne-Mette Magnussen and Anna Banasiak, "Juridification: Disrupting the Relationship between Law and Politics?" (2013) 19(3) European Law Journal, 325-339.

[15] Chris Smyth, "Gas and power markets are a model for the health service", *The Times*, 25 February 2011.

[16] Tony Prosser, "Public Service Law: Privatisation's Unexpected Offspring" (2000) 63(4) Law and Contemporary Problems, 63-82.

[17] Blichner and Molander "Mapping Juridification".

[18] Cinzia Piciocchi, "The Definition of Health and Illness between Juridification and Medicalisation: A Private/Public Interest Perspective", (2018) 25 European Journal of Health Law 177-195.

[19] S. Veitch, "Juridification, Integration and Depoliticisation", Chapter 5 in *'Integration through Law Revisited' – The Making of the European Polity* (London: Routledge, 2012), 85-97.

[20] What is expressly excluded from the present discussion is dejuridification in the sense of "pausing" implementation of legislation in response to an emergency situation. This is because The Competition Act 1998 (Health Services for Patients in England) (Coronavirus) (Public Policy Exclusion) Order 2020 (SI 2020 No. 368) was unrelated to the development of the 2022 Act.

tentative legislative proposals which sought to "demarketise" the NHS are also analysed because these contrast with the "deregulation" approach thought to characterise the legislative proposals leading to the 2022 Act.[21] For context to the 2012 Act juridification, a brief overview of NHS-private healthcare interaction in England and the New Labour competition reforms (representing a policy approach) is given. The dynamic between juridification and dejuridification is then explored by reference to the 2012 Act reforms and the aforementioned subsequent developments through three lenses. Blichner and Molander's typology is used to set the scene and outline in positive terms what juridification has meant in the context of the 2012 Act reforms. This enables more normative considerations regarding oversight in light of Veitch et al.'s conceptualisation of "depoliticisation", and regarding the wider NHS-private healthcare interaction in view of Magnussen and Banasiak's conceptualisation of "privatisation" and the disruption of the relationship between law and politics. Concluding remarks follow.

Competition in the English NHS: Mirror reflections of law and policy?

Prior to the 2012 Act reforms

The relationship between the NHS and the private healthcare sector has been in existence since the inception of the NHS in 1948 and comprises both law and policy aspects. The parameters of the relationship have fundamentally been defined in statute – with section 5 National Health Service Act 1946 providing for consultants to continue private practice alongside their NHS workload,[22] while restrictions on patient movement between the NHS and private healthcare sector have been outlined at the level of policy.[23]

Correspondingly, competition reforms in the NHS started by following this model: the "NHS internal market" established by Conservative governments of the 1980s was outlined by the establishment of secondary care providers as NHS Trusts in statute.[24] Details of the operation of this quasi-market, and linkages with the general UK competition law regime, were clarified at the level of policy, with rules governing 'collusive behaviour' and processes for dissolving mergers[25] being framed in terms which reflected the wider contemporaneous UK competition law regime based on ministerial discretion.[26] While this guidance provoked concern about a competition policy designed for the private sector being applied to the NHS,[27] there was also

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[21] "Deregulation, not demarketisation" was a phrase coined to describe the 2019 NHS Long Term Plan proposals which eventually informed the White Paper and Health and Care Bill prior to the 2022 Act. Health and Social Care Committee *NHS Long-Term Plan: Legislative Proposals* (HC 2017-19, 15), page 16, citing written evidence by Andrew Taylor, former Director of the Cooperation and Competition Panel for NHS-funded Services.

[22] Thus giving legal effect to the concession described in colourful terms by Aneurin Bevan as "stuffing their mouths with gold". See, inter alia, Mary Guy, "Between 'going private' and 'NHS privatisation': patient choice, competition reforms and the relationship between the NHS and private healthcare in England " (2019) 39(3) Legal Studies 479-498.

[23] For example, Department of Health, *Guidance on NHS patients who wish to pay for additional private care*' (23 March 2009), and NHS Commissioning Board (now NHS England), *Commissioning policy: defining the boundaries between NHS and private healthcare* (NHSCB/CP/12, April 2013).

[24] See, respectively, sections 4 and 5 National Health Service and Community Care Act 1990, subsequently repealed by the National Health Service (Consequential Provisions) Act 2006.

[25] NHS Executive/Department of Health, The Operation of the NHS Internal Market: Local Freedoms, National Responsibilities, December 1994.

[26] For further discussion, see Guy, *Competition Policy*, pp.44-45.

[27] Diane Dawson, 'Regulating competition in the NHS. The Department of Health guide on mergers and anti-competitive behaviour', University of York Centre for Health Economics Discussion Paper 131, March 1995. See also Guy, *Competition Policy in Healthcare,* p.45.

the wider assumption that, at that time, "…the objective was to create a market without much use of law for fear of embroiling NHS bodies in costly litigation and embarrassing publicity."[28]

The development of New Labour "choice and competition" reforms (c.2000 – 2010)[29] similarly involved the clarification in legislation of the creation of NHS Foundation Trusts, with greater autonomy from central government and overseen by a dedicated independent regulator, Monitor,[30] raising questions about accountability.[31] These reforms also occurred alongside the shift towards a new general UK competition regime: the Competition Act 1998 and the Public Contracts Regulations 2006[32] which transposed EU competition law[33] and public procurement rules,[34] alongside wider national developments such as the Enterprise Act 2002 which included reforms of merger assessment and competition oversight. Thus New Labour NHS competition reforms might be characterised in part by response to these wider competition policy developments. For example, the NHS Principles and Regulations for Competition and Cooperation (NHS PRCC), initially introduced in 2007 and updated in 2010, can be seen as an attempt to indicate compliance with, while avoiding recourse to, the wider national and EU general regulatory frameworks in connection with the expansion of private sector delivery of NHS services.[35] A further dimension to these reforms saw the development of an "NHS-specific" merger control regime to facilitate the policy of NHS Trusts achieving NHS Foundation Trust status.[36] While this reflected in structure the wider general merger test, distinctions were made between different categories of NHS bodies based on financial turnover, and it was considered that all mergers were notified, despite attempts to reflect the voluntary notification system of the national general framework.[37] Both the NHS PRCC and merger control guidelines were overseen by the NHS Competition and Cooperation Panel (NHS CCP), located within the Department of Health and described as "the NHS' own Competition Commission".[38]

Thus the landscape at the time of the 2012 Act reforms comprised two linked, but ultimately discrete aspects: the general UK competition legislation regime overseen by the competition authority (with courts determining procurement cases), from which NHS activity was considered "exempt by fiat",[39] and the aforementioned "NHS-specific" policy regime. This latter, while considered designed to indicate compliance with the former, remained very much

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[28] Davies, "This Time".

[29] For further detail, see Guy, *Competition Policy*, pp.46-48.

[30] See Part 1, Health and Social Care (Community Health and Standards) Act 2003.

[31] For discussion, see A.C.L. Davies, "Foundation Hospitals: a new approach to accountability and autonomy in the public services?" (2004) Public Law 808, and Tony Prosser, "Monitor, the Independent Regulator of NHS Foundation Trusts" in T. Prosser, *The Regulatory Enterprise: Government, Regulation, and Legitimacy* (Oxford: Oxford University Press, 2010), pp.136–52.

[32] SI 2006 No. 5.

[33] Specifically the "antitrust" provisions of the prohibitions on anticompetitive agreements and abuse of dominance of Articles 101 and 102 Treaty on the Functioning of the European Union (TFEU).

[34] Commission Regulation (EC) No 1564/2005.

[35] See N. Timmins, *The Five Giants – A Biography of the Welfare State,* 3rd edn. (London: William Collins, 2017), p.643.

[36] NHS Co-operation and Competition Panel (NHS CCP), *Merger Guidelines*, 2010.

[37] Kiran Desai, "Public hospital mergers: a case for broader considerations than competition law?" (2013) 34(12) European Competition Law Review 646.

[38] By Ben Bradshaw MP. HC Deb, Column 66WH (24 February 2009). The Competition Commission and the Office of Fair Trading were superseded by the CMA in 2014.

[39] Martin Gaynor and Robert Town, "Competition in Health Care Markets" in M. Pauly et al. (eds.), *Handbook of Health Economics,* Vol. 2, (Kidlington: Elsevier, 2012), 559.

within the purview of the then Department of Health, consistent with the earlier rules governing the NHS internal market. While remaining at the level of policy, thus more easily amenable to straightforward change by successive Ministers and governments, it appeared to borrow the frameworks and terminology of the general legislation, and occupy a particular status. The NHS PRCC in particular have been characterised as "a new style of competition law" relevant to "quasi-markets" such as the NHS,[40] acknowledging the "dual status" of NHS patients and taxpayers,[41] as distinct from a focus on "consumers".

The 2012 Act reforms and beyond

The protracted passage of the 2012 Act saw various recommendations by the NHS Future Forum to refocus competition and facilitate enactment. A distinctive example is the reformulating of Monitor/NHS Improvement's initial duty to "promote competition" (consistent with other sectoral regulators such as OFGEM) being reformulated in unwieldy terms of "preventing anti-competitive behaviour in the provision of health care services for the purposes of the NHS which is against the interests of people who use such services".[42] However, despite various amendments both prior and subsequent to enactment, controversy continued.

Ultimately, the 2012 Act competition reforms can be considered to comprise three elements: a continuation of New Labour policies to expand both NHS Foundation Trusts and private sector delivery of NHS services; effecting a long-standing and divisive ambition spanning the political divide[43] to reduce ministerial oversight of day-to-day NHS functioning including via the roles of the CMA and Monitor/NHS Improvement; and a competition regulation approach borrowed from the experience of 1980s utilities liberalisation. This latter is characterised in legislation notably by the "concurrent powers" relationship giving scope for either the CMA or Monitor/NHS Improvement to investigate breaches of competition law or conduct market investigations.[44]

These three elements permeate the following discussions of juridification and dejuridification, but it is useful at this point to highlight the distinction between moving between existing policy and law, as well as creating law that was new for the NHS. Both attracted controversy and underwent notable revision prior to enactment of the 2012 Act. The design of new law for the NHS can be illustrated by the design of roles for notably Monitor/NHS Improvement in connection with reducing ministerial oversight and within competition regulation.

The move between existing policy and law can be illustrated by the coalition government's response to the NHS Future Forum report[45] by effectively putting the NHS PRCC into

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[40] Ioannis Lianos, "'Toward a Bureaucracy-Centred Theory of the Interaction between Competition Law and State Activities" in T.K. Cheng, I. Lianos, and D.D. Sokol (eds.), *Competition and the State* (Stanford: Stanford University Press, 2014).

[41] See Guy, *Competition Policy*, pp.149-150.

[42] This was eventually enshrined as 2012 Act, s.62, subs. (3). For discussion of the changes, see Guy, *Competition Policy*, pp.54-56.

[43] Apparently traced back to the creation of the NHS Executive by Kenneth Clarke MP, and linked to the proliferation of health regulators (including the National Institute for Health and Care Excellence, and the Care Quality Commission) under New Labour. N. Timmins, *Glaziers and Window Breakers: Former Health Secretaries in their own words*, 2nd ed., (London: The Health Foundation, 2020), pp.206-208.

[44] 2012 Act, ss. 72 and 73.

[45] Department of Health, *Government response to the NHS Future Forum report*, (HMSO 2011) CM8113, paragraphs 5.16, 44.

legislation with the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013,[46] rather than design new procurement and competition rules. However, the 2013 Regulations underwent further revision from the original version[47] in view of perceptions that compulsory competitive tendering would "imperfectly achieve" the policy objective[48] given the refocusing of competition during and beyond the passage of the 2012 Act.

It is also important to note that there can be different conceptions – or narratives – surrounding competition,[49] which become evident when juxtaposing the approaches of New Labour and the coalition government to competition as, respectively, "a means to an end" and "an end in itself". While different conceptions are arguably separate from the decision to make use of policy or law as the mechanism for implementing reform, they provide an additional perspective on the various attempts at juridification and dejuridification which have emerged subsequent to the 2012 Act. Thus the "demarketisation" approaches to reform can be seen with the Efford Bill[50] closer to the New Labour approach to competition, while the NHS Bill[51] reflects overall antipathy to market reforms consistent with the Labour party under Jeremy Corbyn's leadership (and which might be inferred from the Green Party's stance). Both can be contrasted with the "deregulation" implied by NHS England's 2019 NHS LTP proposals and the subsequent development of these culminating in the 2022 Act. Juridification and dejuridification of competition reforms in the English NHS as bookended by the 2012 and 2022 Acts are now considered in light of three lenses: Blichner and Molander's typology, Veitch et al.'s conceptualisation of "depoliticisation", and Magnussen and Banasiak's framing of "privatisation".

Lens 1: Blichner and Molander's typology

With their typology of five dimensions, Blichner and Molander set out to map understandings of "juridification", as distinct from, and as a necessary preparatory stage to, engaging with normative questions of the interaction of law and politics. Davies' consideration of accountability and the 2012 Act reforms referenced Dimension B, "law's expansion and differentiation", and Dimension D, "increased judicial power", to illustrate the "simplest" definition of juridification as the 2012 Act involving much greater use of law to structure and regulate the NHS, in place of traditional mechanisms like ministerial direction. Benbow's assessment touched on all five of Blichner and Molander's dimensions, including Dimension E, "legal framing", in a general linking of greater recourse to law to conclude that concerns

[46] SI 2013/500.

[47] SI 2013/257.

[48] See comments by the House of Lords Secondary Legislation Scrutiny Committee and the evolution of the 2013 Regulations discussed in Susie Smith, David Owens, Emily Heard, 'New procurement legislation for English Healthcare Bodies – the National Health Service (Procurement, Patient Choice and Competition) Regulations (No.2) 2013 (2013) 4 Public Procurement Law Review, NA109-NA115.

[49] See comments by the former Secretary of State for Health Alan Milburn in Tom Gash and Theo Roos, *Choice and competition in public services: learning from history* (London: Institute for Government, 2012).

[50] The National Health Service (Amended Duties and Powers) Bill was introduced by the Labour MP Clive Efford during the 2014-15 Parliamentary Session. It received significant support (241 votes to 18) in favour of progression beyond the second reading, but debates were discontinued by the calling of the 2015 general election. (Hereafter the "Efford Bill").

[51] The National Health Service Bill was initially introduced by the Green MP, Caroline Lucas, during the 2014-15 and the 2015-16 Parliamentary Sessions. It was re-introduced in subsequent parliamentary sessions by Labour MPs - Margaret Greenwood MP in the 2016-17 Parliamentary Session, and Eleanor Smith MP in the 2017-19 Parliamentary Session, but has yet to progress to a second reading. (Hereafter the "NHS Bill").

about juridification have been justified.[52] Osipovič et al. drew on Blichner and Molander's typology in a general sense to suggest that juridification has been more limited in practice, due to the use of internal mechanisms (within the expanding role of NHS Improvement) despite the greater scope for juridification afforded by the 2012 Act reforms.[53] Building on these analyses, dimensions B, D, and E are examined here, with corresponding 'dejuridification' framings given Blichner and Molander's definition of dejuridification as the reversal of juridification.

Dimension B: Juridification as "law's expansion and differentiation"

Blichner and Molander indicate that this dimension entails both horizontal and vertical aspects. With regard to the expansion of law by the 2012 Act, this has been interpreted most readily as the applicability of EU competition law by Davies and Benbow. However, while section 72 2012 Act indeed outlined the applicability of EU competition law (prohibitions on anticompetitive agreements and abuse of dominance), this appeared secondary to the equivalent national transposing provisions of the 1998 Act.[54] Further expansion can be seen with the extension of exclusively national 2002 Act provisions relating to market investigations to the NHS,[55] and the aforementioned "NHS-specific" assessment of mergers.[56] A sense of "vertical expansion" might be inferred from section 64(2) 2012 Act, which introduced the concept of "anticompetitive behaviour" in the NHS context with terminology which appeared to conflate the EU and national prohibitions on anticompetitive agreements and abuse of dominance.[57]

With regard to the *differentiation* of law, Blichner and Molander distinguish horizontal differentiation as the dividing of one law into two or more laws, from vertical differentiation between an increasing number of cases in a law. Certainly a form of horizontal differentiation might be inferred from the juxtaposition of national and "NHS-specific" frameworks arising from the 2012 Act and the 2013 Regulations. For example, section 72 2012 Act clearly referenced the applicability of EU and UK competition law to the *provision* of NHS services, thus reflecting the widely understood distinction drawn between healthcare providers and healthcare purchasers within the wider EU competition law framework.[58] However, the 2012 Act framework went beyond this: Regulation 10 of the 2013 Regulations comprised a prohibition on the aforementioned "anticompetitive behaviour" by NHS commissioners (purchasers), with equivalent wording used in the Choice and Competition condition of the

[52] Although not considered relevant to the present discussion, for the sake of completeness, and ease of reference, Dimension A comprises "constitutive juridification" and Dimension C "increased conflict solving by reference to law".

[53] See both Osipovič et al "The regulation of" and also the earlier work this builds on. Marie Sanderson, Pauline Allen and Dorota Osipovič, 'The regulation of competition in the National Health Service (NHS): What difference has the Health and Social Care Act 2012 made?' (2017) 12 Health Economics, Policy and Law, 1–19.

[54] A notable distinction between the two being the requirement for an effect on trade between Member States under EU competition law.

[55] 2012 Act, s.73. This is separate from the Market Investigation conducted into the Private Healthcare Market by the CMA in 2014, which incorporated NHS activity in the private healthcare sector (e.g. via private patient units).

[56] 2012 Act, s.79.

[57] 2012 Act, s.64, subs.(2) provided: " 'Anti-competitive behaviour' means behaviour which would (or would be like to) prevent, restrict or distort competition and a reference to preventing anti-competitive behaviour includes a reference to eliminating or reducing the effects (or potential effects) of the behaviour".

[58] See, for example, J.W. van de Gronden and C.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: Edward Elgar, 2017), pp.267-290.

NHS provider licence. This created a sense of balance between providing and purchasing activities which is absent in the general frameworks.

Further differentiation can be seen within the context of merger control. Section 79 of the 2012 Act clearly specified mergers involving NHS Foundation Trusts, which may indicate vertical differentiation between an increasing number of cases – consistent with the contemporaneous policy (between 2004 and 2014) of "upgrading" NHS Trusts to Foundation Trust status. The effect of this differentiation was that mergers with implications for NHS patients were not caught if they only included private providers. Such mergers[59] were only subject to the 2002 Act general merger control regime overseen by the CMA, and not the requirement to demonstrate "relevant patient benefits" under section 79(5) 2012 Act, which enabled NHS Improvement involvement in merger decisions determined by the CMA.

Dejuridification as "law's receding and generalisation"?

A first example of dejuridification of law receding might be seen in the total absence of action being taken under section 72 of the 2012 Act or Regulation 10 of the 2013 Regulations. This might be explained by reference to the fundamental distinction between *applicability* of (EU) competition law being a largely theoretical question, and actual *application*, which may be inhibited for a range of considerations beyond this,[60] including CMA prioritisation. At the level of the 2013 Regulations, an additional layer of complexity was added to interpreting Regulation 10 by policy guidance stipulating that only NHS Improvement could initiate investigations,[61] in contrast to, for example, private providers being able to initiate claims under the procurement and patient choice regulations.

A further dimension of law receding emerges with regard to questions of institutional oversight being clarified in legislation. Section 72 of the 2012 Act allowed for "concurrent powers", whereby either NHS Improvement or the CMA may apply competition law. However, ongoing controversy surrounding the 2012 Act reforms led to this relationship being revised in the wider review of the UK competition and concurrency regime with the Enterprise and Regulatory Reform Act 2013 as it became evident that NHS Improvement could not simply be treated as another sectoral regulator, such as OFGEM.[62] Debates in the House of Lords led to a clarification in the Competition Act 1998 (Concurrency) Regulations 2014 of the interaction between the CMA and NHS Improvement as meaning that, were competition cases involving NHS provision to arise, these would be investigated by NHS Improvement, and not the CMA.[63]

In addition to these "workarounds" pending legislative change to the 2012 Act, dejuridification in the sense of law "receding" can also be seen with the more straightforward calls for repeal of the 2012 Act provisions governing competition law, merger control and the 2013 regulations by the Efford Bill,[64] the NHS Bill, and latterly the 2022 Act.[65] Nevertheless, this did not equate to a total "dejuridification" insofar as the Efford Bill made provision for the Secretary of State to have oversight of NHS mergers subject to a public interest test-style legal framework,[66] and

[59] For example, CMA, *A report on the completed acquisition by Cygnet Health Care Ltd and Universal Health Services, Inc.of the Cambian Adult Services Division of Cambian Group plc*, 16.10.2017. For further discussion, see Guy, *Competition Policy*, Chapter 4.
[60] Guy, *Competition Policy*, p.112.
[61] Monitor, 'Substantive Guidance on the Procurement, Patient Choice and Competition Regulations', London, December 2013.
[62] See Guy, *Competition Policy*, pp 135-139.
[63] The Competition Act 1998 (Concurrency) Regulations 2014, (SI 2014/536), Regulations 5 and 8.
[64] National Health Service (Amended Duties and Powers) Bill, Clause 10.
[65] 2022 Act, ss. 80 subs.(2), 82 subs.(2), 83 subs.(2), 84 and Schedule 12 ss. 2-6.
[66] National Health Service (Amended Duties and Powers) Bill, Clauses 12 and 13.

the 2022 Act provides roles for the Secretary of State and NHS England regarding procurement,[67] mergers,[68] and patient choice.[69]

"Generalisation" offers an antonym to "differentiation", and with regard to "dejuridification", this might be understood as reverting to the pre-2012 Act situation, whereby the (EU and) national general laws governing competition, merger control and procurement were nominally applicable, but were not actively applied to the NHS. It might be considered that here too dejuridification amounts to repeal: with the Efford Bill explicitly proposing the disapplication of the 1998 Act to the NHS,[70] while the Health and Care Bill envisaged a power removing the procurement of healthcare services for the NHS from the scope of the Public Contracts Regulations 2015,[71] and section 79 of the 2022 Act enshrines the drafting of new procurement regulations to govern, inter alia, "a competitive tendering process".

What emerged with the 2022 Act in particular is a sense that removing CMA oversight of the NHS[72] has been a driving factor in reform, along with a recalibration of Monitor/NHS Improvement's functions as this body becomes subsumed into NHS England. We are also witnessing a form of "re-juridification" and "redifferentiation" with regard to NHS mergers, as mergers between NHS Trusts and Foundation Trusts are no longer to be subject to general UK merger control, but mergers which involve NHS Trusts/NHS Foundation Trusts and private or voluntary sector providers will be.[73]

Dimension D: Juridification as "increased judicial power"

The idea that juridification should entail greater involvement of the courts might appear self-explanatory, but how this has operated in connection with the 2012 Act reforms is arguably less so.

Davies had noted that the 2012 Act's approach was to create a market which was more "real", so would entail greater use of law, including via the courts. However, the main scope for involving the courts – as distinct from complaints to Monitor/NHS Improvement as sectoral regulator, or the CMA – was perhaps limited from the outset of the 2012 Act reforms. The focus for this dimension of juridification is unquestionably on procurement activity given the clear role of the courts here.[74]

The scope for competition in the English NHS is considered[75] greater in the context of competition *for* the market (i.e. procurement activity) than competition *in* the market (which might best be illustrated by patient choice policies). In view of this, the 2012 Act reforms might have been expected to herald a significant amount of court activity. However, while there were indeed cases reviewed by the courts involving both the Public Contracts Regulations 2015[76]

[67] 2022 Act, s. 79.
[68] 2022 Act, s. 65.
[69] 2022 Act, ss. 78 and 80.
[70] National Health Service (Amended Duties and Powers) Bill, Clause 11(b).
[71] Explanatory Notes to the Health and Care Bill HL Bill 71, 24 November 2021.
[72] Now enshrined by 2022 Act ss. 82 subs.(2), 84 and Schedule 12 ss. 2-9.
[73] 2022 Act, s. 83.
[74] Indeed, it was noted that the distinctive combination of competition law, procurement rules and sectoral regulation put NHS Improvement in a unique situation of (potential) structural conflict of interests regarding its competition functions. See Albert Sánchez Graells, 'Monitor and the Competition and Markets Authority' (2014) No. 14/32 University of Leicester School of Law Research Paper.
[75] Office of Health Economics, *Competition in the NHS*, (London: Office of Health Economics 2012).
[76] SI 2015 No. 102.

and the 2013 Regulations,[77] the focus was on procedural issues, rather than judicial review based on, for example, unwarranted use of competitive tendering.[78] An overall impression has thus been that juridification in the sense of court arbitration has been more limited than may have been expected, given the emphasis of the 2013 Regulations on procurement and the extension of the 2015 Regulations (relative to the preceding 2006 Regulations) to remove an exemption for certain healthcare services.[79]

Dejuridification as "reduced judicial power"?

Reducing court intervention appears a common feature across the different sets of legislative proposals. As indicated previously, both the Efford and NHS Bills were premised around a greater role for the Secretary of State, suggesting a greater focus on "repoliticisation" (considered further below). The Health and Care Bill not only indicated a greater role for the Secretary of State for Health and Social Care, but also suggested that the 2015 Regulations would no longer be applicable to the NHS,[80] thus obviating perhaps the most obvious route for court intervention.

In contrast, the seeming emphasis on removing CMA oversight in the 2019 NHS Long Term Plan proposals, and the subsequent White Paper and Health and Care Bill generated – inadvertently – scope for further court intervention in the context of the 1998 Act. This is because a failure to engage with substantive exceptions to applicability of competition law draws attention to scope for private enforcement of competition claims – by individuals, rather than the CMA (or Monitor/NHS Improvement). Private enforcement of competition cases via the courts is considered more common in the United States, but procedures exist for such enforcement in the UK via the High Court and the Competition Appeals Tribunal.

Dimension E: Juridification as "legal framing"

Blichner and Molander describe this dimension as "the most elusive", and as "the process by which people increasingly tend to think of themselves and others as legal persons and attach meaning to the particular social practice called law."[81] Further clarification suggests that juridification as legal framing entails a society developing a legal culture that extends beyond, or even replaces, other background cultures.[82] In the context of the 2012 Act reforms, Benbow defines legal framing simply as new legal statuses affecting the behaviour of NHS entities.[83]

What appears central to legal framing in the context of the 2012 Act competition reforms are the potential effects on NHS service delivery of moving towards a competition-based system, which can be illustrated by the experience of NHS mergers being assessed by the CMA under section 79 2012 Act between 2013 and 2020.

There is a clear cultural shift from hospitals collaborating to framing this in 2002 Act terminology of "enterprises" creating a "relevant merger situation" which needs to avoid resulting in a "substantial lessening of competition" if the collaboration is to be permitted. The costs involved of engaging with this framework, and scope for proposed mergers to be blocked, clearly raise concerns about the inhibiting effects on NHS service delivery and questions about

[77] Respectively, *Lancashire Care FT & Blackpool Teaching Hospitals FT vs Lancashire County Council* [2018] EWHC 1589 (TCC), and *QSRC v NHS England* (2015) EWHC 3752 (Admin) High Court.
[78] Osipovič et al., "The Regulation of" at 320.
[79] Ibid.
[80] Explanatory Notes, Health and Care Bill, HL Bill 71.
[81] Blichner and Molander, "Mapping Juridification", 47.
[82] Ibid.
[83] Benbow, "Juridification", 296.

the best use of taxpayer money, amid perceptions that innovative and effective working arrangements may be inhibited and discouraged. In view of these controversies, it is perhaps unsurprising that a late addition to the Health and Social Care Bill[84] was provision for NHS Improvement to have an advisory function to identify "relevant patient benefits" to a merger to enable clearance. In the 2012 Act, this is linked with the narrow "relevant customer benefits" exception to UK general merger control, but has taken on a wider conception as NHS policy such as "the 7-day NHS" and sustainability and transformation partnerships offered justification for clearing mergers which otherwise prove injurious to competition.[85]

The first merger to be assessed under the 2012 Act was *Dorset Hospitals*[86] in 2013, and was blocked by the CMA's predecessor for insufficient identification of "relevant patient benefits" were identified. Concerns about this response in the aftermath of the 2012 Act's protracted enactment led to a streamlining of approach between NHS Improvement and the CMA.[87] The effect of this was that no further mergers were blocked, and the vast majority were cleared at the initial Phase I assessment,[88] including a refocused merger between *Dorset Hospitals*, the final to be assessed by the CMA, in 2020.[89]

A further concern about legal framing can be seen with the persistence of formal assessments despite the significant shift away from competition, something which the CMA itself explicitly acknowledged in the 2017 *Manchester Hospitals* merger:

'Competition in the NHS is only one of a number of factors which influence the quality of services for patients…[I]t is not the basic organising principle for the provision of NHS services.'[90]

Nevertheless, similar wording was found in subsequent mergers up until the second *Dorset Hospitals* merger in 2020, suggesting that the assessment became merely a "rubber stamping" exercise in the absence of recourse to exceptions within merger control.[91]

Dejuridification as "legal deidentification"?

How dejuridification can be understood as a reversal of "legal framing" is arguably as elusive as Blichner and Molander suggest. A straightforward interpretation would seem to suggest that "legal deidentification" means that bodies no longer regard themselves as subject to a particular legal framework. This would seem to be achieved to varying degrees by repeal of the 2012 Act provisions and reinstatement of Secretary of State oversight, as envisaged broadly by the Efford Bill,[92] and by more extensive repeal underpinned by the abolition of NHS Trusts and

[84] Incorporated following Lords Debates in March 2012.
[85] 2012 Act, s. 79 subs.(5) references the "relevant customer benefits" exception of the 2002 Act, s.30 subs.(1)(a). For discussion of connections between this and "relevant patient benefits", see Guy *Competition Policy*, pp.164, 177.
[86] Competition Commission, Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust Merger Inquiry (CC), 17 October 2013.
[87] See Guy *Competition Policy*, p.207, and Osipovič et al. "The Regulation of".
[88] There appear to be only two notable exceptions. A Phase II investigation took place prior to clearance in CMA, *A report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust*, 16 September 2015. An expedited Phase II investigation was requested by the merging parties in CMA, *Central Manchester University Hospitals/University Hospital of South Manchester Merger Inquiry, Final Report*, 1 August 2017. This was also cleared.
[89] CMA, ME/6875-19 - Anticipated merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust Decision on relevant merger situation and substantial lessening of competition. 27 April 2020.
[90] Ibid.
[91] Guy, *Competition Policy*, p.227.
[92] National Health Service (Amended Duties and Powers) Bill, Clause 11(c).

Foundation Trusts with the NHS Bill.[93] The 2022 Act has indeed removed CMA oversight of mergers between NHS Foundation Trusts,[94] which addresses some of the "framing" issues indicated above. However, section 83 of the 2022 Act still facilitates CMA assessment and oversight of mergers involving two NHS bodies and another enterprise (which can be understood as a private provider) under general merger control. As this would facilitate closer cooperation within an integrated care model, the new provision might simply be considered a "legal reframing" as this could conceivably relate to NHS or private activity within the NHS, or NHS activity in the private healthcare market. This may again raise questions about the extent of ministerial accountability, and how the relationship between the CMA and NHS England (which now incorporates Monitor/NHS Improvement) will develop.

Given that "legal framing" entails a wider cultural shift, something which needs to be borne in mind is the scope for "dejuridification" to be premised on misconceptions and misunderstandings of the original "juridification", as well as appropriations across professional cultures. Certainly the confusion about the mandatory status (or not) of competitive tendering may be understandable within NHS culture, given the representations of this in the general media. What is more worrying is how this can seemingly directly influence the law-making process. This can be seen in the misconception that Monitor/NHS Improvement shares competence with the CMA "…to promote competition…" featuring in both the Explanatory Notes to the Health and Care Bill,[95] and the Research Briefing published ahead of the second reading of this in the House of Commons.[96] As noted above, such was the controversy which accompanied the passage of the 2012 Act that it ultimately reflected a scaling-back of the Conservative/Liberal Democrat coalition government's original ambitions.[97] As the final version of the 2012 Act does not impose a duty to "promote competition", debates of the Health and Care Bill risked being informed by misleading framings, which in turn may have contributed to a lack of detailed scrutiny. Certainly the approaches between the Efford and NHS Bills on the one hand, and the NHS Long Term Plan proposals preceding the 2022 Act on the other, represent a clear distinction in framing competition with regard to the NHS. The useful characterisation of "deregulation, not demarketisation" masks an important distinction which needs to be understood for reforms to be properly debated within a democratic lawmaking process. The Efford Bill – arguably representing a New Labour approach to competition in the NHS, with acceptance of private providers – saw attempts to engage with EU competition law and its exceptions curtailed by Conservative MPs. In contrast, while Commons debates of the Health and Care Bill saw awareness of the different facets of competition and recognition of the greater role played by procurement,[98] the White Paper framing of removing competition and associated oversight in uncontentious, even simplistic, terms of "reducing bureaucracy" likely also contributed to a lesser degree of scrutiny.

Lens 2: Veitch et al.'s conception of "juridification as depoliticization"

In contrast to framings of juridification as a crisis of the legal system, Veitch et al. outline juridification as an inherently *political* problem,[99] in that the legal system juridifies conflicts that should more properly be dealt with politically. While there are concerns about fitting

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[93] See, respectively, NHS Bill, Clause 17(3)(b), 14 and 15.
[94] 2022 Act, s. 83.
[95] Explanatory Notes to the Health and Care Bill, page 29.
[96] B. Balogan, D. Foster, L. Conway, M. Gheera, T. Powell, *Research Briefing, Health and Care Bill 2021-22*, 12 July 2021. Page 37.
[97] For further discussion see Guy *Competition Policy*, pp.51-56.
[98] Particularly by the Labour MPs Rosie Cooper, Jon Trickett and Daniel Zeichner. HC Deb, 14 July 2021, Vol 699, cols 443-464.
[99] Emphasis added. For discussion of this apposition, see Veitch et al. "Jurisprudence", 260.

political problems into legal categories, the development of regulation and the increased importance attaching to private law mechanisms can be seen as symptomatic of a general decline in politics, which may be evidenced by voter apathy and the decline of differences between political parties.[100] These considerations can inform how we view the "juridification as depoliticisation" effects of the 2012 Act reforms. On the one hand, these reforms can be seen as enacted at a time when the differences between the Labour and Conservative parties with regard to NHS reform were perhaps less extreme than had been the case previously, or indeed subsequently, given the shift to the Corbyn leadership of the Labour party and its embrace of the NHS Bill. On the other hand, linking the 2012 Act reforms and voter apathy is less straightforward. A more useful measure for the present discussion may be public levels of satisfaction with the NHS, but this too is fraught with complexities[101] – including the varying levels of funding available at the time of the New Labour and 2012 Act reforms. Regardless of fluctuating levels of voter turnout and public satisfaction, however, the controversy surrounding the 2012 Act reforms has generated a wide-ranging activism which has kept NHS reform high on the political agenda.[102] This can be illustrated, inter alia, by the establishment of the NHS Action Party to overturn the 2012 Act reforms,[103] the ongoing support for the (re)tabling of the NHS Bill, as recently as prior to the 2019 general election,[104] and claims that the Health and Care Bill would, or would not, "privatise" the NHS.[105]

With regard to the 2012 Act reforms, Davies saw "depoliticisation" as juridification "in a much more worrying sense" because decisions, such as expanding private sector delivery of NHS services, previously a matter of public policy, would become shaped and governed by legal rules. Thus a distinction can be drawn between a political decision to expand private sector delivery of NHS services, and the award of contracts to private providers based on "legal technicality", because the latter entails "potential to undermine political accountability for what goes on in the NHS".[106] The concern here appeared to be the expanding private sector delivery of NHS services activating applicability of competition law and setting in train a particular direction of travel, in the logic that "once competition law [was] found to be applicable, it [would] increasingly be applied",[107] which also had relevance for procurement activity.[108]

A transnational and a national dimension to "depoliticisation" can be discerned from concerns about accountability with the scope for transferring political decision-making to either the transnational (specifically the EU) level, or to bodies at one or more removes from central government, given the status of the CMA as a non-departmental public body, and of Monitor/NHS Improvement (and also NHS England) as an "arm's length body". Both

[100] Ibid.
[101] For an indication of the myriad factors, see D. Wellings et al., *Public satisfaction with the NHS and social care in 2021 – Results from the British Social Attitudes survey*, The King's Fund and the Nuffield Trust, London, March 2022.
[102] For further discussion, see Benbow, "Juridification".
[103] https://www.nhaparty.org/.
[104] The Guardian, Letters, 'Private contracts at the heart of the NHS crisis', 6 December 2019.
[105] Divergent views are encapsulated by Mark Dayan and Helen Buckingham, 'Will the new Health and Care Bill privatise the NHS?' The Nuffield Trust Blog post, 15 July 2021 https://www.nuffieldtrust.org.uk/news-item/will-the-new-health-and-care-bill-privatise-the-nhs, and Allyson Pollock and Peter Roderick, 'If you believe in a public NHS, the new health and care bill should set off alarm bells', *The Guardian*, 7 December 2021.
[106] Davies, "This Time".
[107] Okeoghene Odudu, "Are State-owned healthcare providers undertakings subject to competition law?" (2011) 32(5) European Competition Law Review 231.
[108] Ben Collins, "Procurement and Competition Rules – Can the NHS be exempted?", (London: The King's Fund, 2015).

dimensions can be seen with the corresponding processes of juridification and dejuridification outlined above, with the latter framed as ‘depoliticisation’ and ‘repoliticisation’.

Depoliticisation and the 2012 Act reforms: a transnational dimension

This transnational dimension is illustrated by – primarily – by the reach of EU competition law in connection with the 2012 Act reforms. Certainly a key question for the Labour Party in the UK parliament in 2011 was whether the 2012 Act reforms would expose the NHS to *EU*[109] (as distinct from UK) competition law. This would appear to suggest concerns not only about “depoliticisation” in the sense of ministers no longer retaining decision-making powers, but also that these powers may be “transferred” to entities outside the UK. In other words, concerns appeared to manifest not just about the substantive law applied, but also who applies it. Thus Benbow made use of Gill’s “new constitutionalism” framing to explain the “depoliticisation” inherent in the 2012 Act,[110] drawing also on connections with Veitch’s concerns raised about the “depoliticising” effects of the EU free movement rules on NHS rationing.[111] This approach can be linked with wider explanations of “depoliticisation” and juridification which reference the proliferation of regulatory governance at EU level[112] and – arguably as much coincidentally as consequentially – at a national level, including with regard to healthcare.[113]

However, a different – and more persuasive – narrative emerges when EU law is engaged with more directly. This suggests that the aforementioned framing can be explained as readily by “Euro-ambivalence”[114] reflecting limited engagement with, and mixed understanding of, EU law within the UK lawmaking process. This arguably transcends party political boundaries, notwithstanding mainly Labour MPs’ questions about “EU competition law” in debates preceding the 2012 Act.

In essence, this second framing is grounded in the dynamic and the tensions which exist between the national and EU levels with regard to national healthcare reforms. While national health policy and healthcare system organisation are clearly defined as a Member State competence,[115] this may generate different implications according to different aspects of EU law. Thus the emphasis on harmonisation underpinning the Patients’ Rights Directive[116] to enable patients to access healthcare across EU member states offers some explanation of why the finding of the *Watts* case[117] (concerning a UK national accessing healthcare in France and seeking to recoup costs from the NHS) may prompt concerns about NHS rationing.[118] However, this can be contrasted with the 2012 Act competition reforms, where questions of applicability of EU competition law may at once circumvent reservation of healthcare system

[109] Emphasis added.
[110] Benbow “Juridification”.
[111] Kenneth Veitch, “Juridification, Medicalisation and the Impact of EU Law: Patient Mobility and the Allocation of Scarce NHS Resources”, (2012) 20 Medical Law Review 362-398.
[112] Veitch “Juridification, Integration”, but also a related political science literature emerges with, notably, Giandomenico Majone, ‘The rise of the regulatory state in Europe’ (1994) 17(3) West European Politics, 77-101.
[113] Jan-Kees Helderman, Gwyn Bevan, George France, ‘The rise of the regulatory state in healthcare: a comparative analysis of the Netherlands, England and Italy’ (2012) 7(1) Health Economics, Policy and Law, 103-124.
[114] As distinct from outright Euroscepticism.
[115] Article 168(7) TFEU.
[116] Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients’ rights in cross-border healthcare.
[117] *Watts v Bedford Primary Care Trust* (Case C-372/04), EU:C:2006:325, [2006] ECR I-4325, 16 May 2006.
[118] Veitch, “Juridification, Medicalisation”.

organisation as a Member State competence,[119] and yet explain differences in approach between England and Scotland regarding market reforms in the NHS.[120] Further questions of interaction between EU and national provisions,[121] the complexities surrounding national enforcement of EU competition law[122] and concerns about inconsistent approaches at the EU level to applicability of EU competition law to national healthcare systems[123] would all seem to lend credence to the "Euro-ambivalence" explanation in shaping the 2012 Act reforms.

Indeed, far from the perceived threat posed by "EU competition law" to the English NHS by the 2012 Act reforms, we have seen the UK Competition Appeals Tribunal hand down a judgment in the 2002 *BetterCare* case[124] which established the applicability of UK competition law to purchasing activities by a Northern Irish NHS Trust, and clearly precedes the 2012 Act reforms. This finding was not only at odds with the approach taken by the EU courts both in contemporaneous cases and subsequently, but also led to clarification that the UK competition authority would follow the EU approach in 2011 policy guidance, which remains current in 2022.[125]

Depoliticisation and the 2012 Act reforms: a national dimension

The national dimension can be explained most readily by the adoption of new public management techniques (ongoing since at least the earlier stages of the New Labour reforms) and the subsequent reframing of public bodies by the coalition government. While both moves owe much to global theories, the direct link with EU law (or indeed any other transnational law regime) for the NHS context is arguably difficult to locate precisely. In contrast, the UK's position as a pioneer in adopting multigovernance techniques is clearer: the proliferation of bodies involved in assessing NHS activities both pre-[126] and post-2012 Act – NHS Improvement (comprising bodies created, or repurposed by the 2012 Act)[127] and the CMA demonstrate this. The creation of NHS England by the 2012 Act is arguably the most prominent example of an arm's length body being developed in law in the NHS context, but is of little direct relevance to the present focus on the 2012 Act competition reforms.

As indicated above, the New Labour policy of "upgrading" NHS Trusts to Foundation Trust status was continued with assessment under the 'NHS-specific' merger control framework of section 79 2012 Act. This allowed review and approval by the CMA under the general 2002 Act framework, subject to identification of "relevant patient benefits" by NHS Improvement.[128]

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[119] Under Article 168(7) TFEU. For discussion, see Tony Prosser, 'EU competition law and public services', Chapter 7 in (eds) E. Mossialos, G. Permanand, R. Baeten and T.K. Hervey, *Health Systems Governance in Europe: The Role of European Union Law and Policy*, (Cambridge: Cambridge University Press, 2010).

[120] 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) 43(2) Legal Issues of Economic Integration 145.

[121] See, inter alia, concerns about compatibility of the 2013 Regulations with EU law, Albert Sánchez Graells, "New rules for health care procurement in the UK: a critical assessment from the perspective of EU economic law" (2015) 1 Public Procurement Law Review 16, and regarding parallel application of EU law and the 2012 Act framework Guy *Competition Policy*, pp.92-93.

[122] For discussion, see L. Hancher and W. Sauter, *EU Competition and Internal Market Law in the Health Care Sector*, (Oxford: Oxford University Press, 2012), pp.256-257.

[123] Bruno Nikolić, "The Applicability of European Union Competition Law to Health Care Providers: The Dividing Line between Economic and Noneconomic Activities" (2021) 46(1) Journal of Health Politics, Policy and Law, 49-70.

[124] *BetterCare v Director General of Fair Trading* [2002] CAT 7.

[125] For further discussion, see Guy, *Competition Policy*, pp.84-85.

[126] For New Labour reforms pre-2012 Act, see Prosser, *The Regulatory Enterprise*.

[127] Monitor and the NHS Trust Development Authority, which became NHS Improvement.

[128] 2012 Act, s.79, subs.(5).

The adherence to this assessment regime despite the significant shift away from competition – acknowledged by the CMA, no less – would seem to exemplify Davies' "worrying sense" of juridification by generating a costly "rubber-stamping" exercise, as noted above. Further concerns emerge insofar as the creation of this "NHS-specific" merger assessment framework represents a political decision underscoring "depoliticisation". There is scope within UK general merger control for the Secretary of State to create "public interest categories" which involve CMA assessment of a merger, with mergers ultimately being approved or blocked at ministerial discretion. This option would have been available to "protect" NHS mergers,[129] but appears not to have been explored in the development of the 2012 Act reforms, thus seemingly indicating a categoric rejection of any ministerial involvement over a convoluted governance landscape.

Dejuridification as "repoliticisation" – transnational and national aspects

The corollary of "juridification as depoliticisation" might seem to suggest a move away from law and back towards politics, with an associated refocusing of accountability. As might be anticipated, how this has developed subsequent to the 2012 Act reforms demonstrates associated transnational and national aspects.

The aforementioned Efford and NHS Bills might be seen as the clearest example of this "dejuridification as repoliticisation", with the NHS Bill's proposal to abolish Monitor/NHS Improvement,[130] and the Efford Bill's proposal for Secretary of State oversight regarding procurement, patient choice and anticompetitive behaviour.[131]

While this reframing of accountability appears primarily domestic in nature, it is interesting to note both Bills' reliance on substantive exceptions to EU competition law. The Efford Bill drew heavily on the Services of General Economic Interest (SGEI) exception, generally considered to offer a serviceable,[132] if narrow exception in that it provides partial immunity with some activities considered exempt from competition law, but not others. What is more significant as regards accountability is that classification of activities as SGEI is reserved to Member States,[133] so would arguably have added an extra layer of national accountability. This curious interaction with EU law (hence "Euro-ambivalence") can perhaps be partially explained by the complexity and distinctiveness of the UK legal and political approaches to the provision of public services.[134] In contrast, the NHS Bill sought to exempt the NHS not only totally from the reach of EU competition law, but also the World Trade Organisation General Agreement on Trade and Services, thereby removing any suggestion of external intervention to dilute overall oversight by the UK parliament over the NHS.

As noted above, the 2022 Act has its origins in the 2019 NHS Long Term Plan. This is significant not only as a major policy document, but for indicating the growing importance of NHS England which (in combination with NHS Improvement) drafted the first legislative proposals for the new legislation. What these envisaged primarily was the removal of CMA oversight, and the curtailing of NHS Improvement's competition functions, partly in line with the latter's incorporation into NHS England. This prompted questions about oversight, thus claims of "deregulation" of NHS-private healthcare interaction. Interestingly, the development

[129] For a fuller explanation of this argument, see Desai, "Public hospital mergers".
[130] NHS Bill, Clause 17(1).
[131] Efford Bill, Clause 2.
[132] Odudu, "Are State-Owned".
[133] Official Journal 115, 09/05/2008 P. 0308-0308 Protocol No. 26 on Services of General Interest.
[134] Nina Boeger and Tony Prosser, 'United Kingdom', Chapter 18 in M. Krajewski, U. Neergaard, J. van de Gronden (eds), *The Changing Legal Framework for Services of General Interest in Europe – Between Competition and Solidarity*, (The Hague: TMC Asser Press, 2009).

of the 2021 White Paper incorporated an unexpected "repoliticisation" with an expanded role for the Secretary of State for Health and Social Care. This is now confirmed by the 2022 Act as ministerial oversight of merger and procurement tests. How these develop in practice remains to be seen, for example, whether these would once again amount to a "new style of competition law"[135] akin to the NHS PRCC New Labour policy guidance. However, it seems clear that this is not a simple reversion to ministerial oversight as it would have been understood in 2011, due to the continuing existence of NHS England and the increasingly complex frameworks of accountability and tensions between government and arms'-length bodies which have emerged subsequent to the 2012 Act reforms.[136]

Lens 3: Magnussen and Banasiak's conception of "privatisation"

Magnussen and Banasiak examine the implications that juridification can have for democratic politics – with democracy being defined in terms of a macro dimension (how society is organised in formal political institutions, such as the legislature, the executive public administration and the judiciary) and a micro dimension (how the integrity and agency of individuals are facilitated). They outline a framework of juridification disrupting the relationship between law and politics as a spectrum between "political juridification" and "privatisation", which, respectively, strengthen and weaken both law and politics. These two extremes are linked by "juridification of the political" (which strengthens law, but weakens politics) and "politicisation of the law" (which strengthens politics, but weakens law).

Various of these conceptualisations have particular relevance for examining competition law, an area where underlying economic concepts (such as allocative efficiency) can shape legal decisions. This can generate both cognitive and policy problems relating, respectively, to understandings of competition and possible restrictions thereof, and to the desirability (or not) of political intervention.[137] Magnussen and Banasiak's examples include aspects of Norwegian healthcare reforms, and the political salience of healthcare reform, coupled with a government and judiciary operating with varying degrees of engagement with supranational legal systems demonstrates the clear relevance of this framework for discussion of competition reforms in the English NHS.

Their conceptualisation of "privatisation" has particular relevance for the present discussion as being concerned less with balancing law and politics, and more with juridification taking place in parallel (not separately) with market organisation and politicisation.[138] Magnussen and Banasiak's micro dimension of democracy might be illustrated by the uncertain scope emerging from the enshrinement of patient choice policies by the 2013 Regulations, the new 2022 Act basis for patient choice regulations,[139] and indirectly by the NHS Constitution, which codifies a range of 'rights' with regard to the NHS.[140]

However, their macro dimension is more clearly in evidence in the evolving relationship between the government (Department/Secretary of State for Health and Social Care), NHS

[135] Lianos "Toward…".
[136] For further discussion, see Jonathan Hammond, Ewen Speed, Pauline Allen, Imelda McDermott, Anna Coleman and Kath Checkland, "Autonomy, accountability, and ambiguity in arm's-length meta-governance: the case of NHS England", (2019) 21(8) Public Management Review, 1148-1169.
[137] See K.J. Hopt, "Restrictive Trade Practices and Juridification: A Comparative Law Study", and R.S. Markovits, "Antitrust: Alternatives to Delegalisation", both in G. Teubner (ed.), *Juridification of social spheres: a comparative analysis in the areas of labor, corporate, antitrust and social welfare law*, (Berlin: De Gruyter, 1987).
[138] Magnussen and Banasiak, "Juridification", 337.
[139] 2022 Act, s.78.
[140] See Keith Syrett, 'The Organization of Health Care', Chapter 1 in (eds) J. Laing and J. McHale, *Principles of Medical Law*, 4th Edition, (Oxford: Oxford University Press, 2017). Section 1.74.

England/NHS Improvement, and the CMA. Here it is important to note the influence of the 1980s experience of liberalising utilities, where concerns about moving away from public ownership and perceptions of what a public service is towards a competitive marketplace indicated an inevitable process – with receding of government oversight, and anticipating that economic regulators (such as OFGEM) would merely "hold the fort" [141] pending the arrival of competition overseen by the competition authority. The extent to which such an inexorable move took place has arguably proven moot: anticipations that regulators would "wither away"[142] appears unfulfilled as they (and the CMA) engage with evolving concepts such as "vulnerable consumers". What emerged instead was a characterisation of regulators as "governments in miniature" having responsibility for inseparable economic and social/distributive goals,[143] and with tension between these goals finding expression in differing – economic and social solidarity – rationales for regulation.[144] This experience has also generated a distinctive "public service law",[145] with statutory obligations being placed on regulators regarding access to utilities, notably water.

The adoption of this liberalisation model for the NHS with the 2012 Act rightly invited the urging of caution in view of the significant differences in market structure, allocation of regulatory authority, and decision-making style.[146] We have seen that the juridification of the "concurrent powers" relationship between the CMA and Monitor/NHS Improvement (characteristic of wider UK competition policy) merely led to further juridification by the 2014 Regulations to curtail CMA oversight. The apparent effects of this have been to avoid political intervention and indeed the use of law, given Monitor/NHS Improvement's apparent preference for dealing with concerns internally.[147]

A further example of the more interconnected nature of juridification, market organisation and politicisation can be seen with NHS Foundation Trust mergers and the 2012 Act reforms. This started from the policy of NHS Trusts achieving Foundation Trust status (thus greater autonomy from central government), which entailed a significant sense of market organisation given that these bodies operate in the private healthcare market as well as the NHS via private patient units. As indicated above, there appears to have been a clear rejection of politicisation, either by making use of the "public interest" category and retaining ministerial decision-making,[148] even though this would also represent juridification. A consequence of the 2012 Act juridification – to make use of UK general merger control with no exceptions – has been to indicate scope for tension which is difficult to resolve between the competition authority applying the law and governmental ambitions for competition reforms, [149] as indicated by the CMA's comments in the *Manchester Hospitals* merger case.

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[141] S. Littlechild, *Regulation of British Telecommunications' Profitability*, (London: Department of Trade and Industry, 1984), para. 4.11.

[142] Tony Prosser, "Competition, Regulators and Public Service" in B. Rodger and A. Macculloch (eds.), *The UK Competition Act – A New Era for UK Competition Law* (Oxford: Hart, 2000).

[143] See, for example, Tony Prosser, "Introduction: Two Visions of Regulation and Four Regulatory Models", Chapter 1 in Prosser, *The Regulatory Enterprise*.

[144] For further discussion, see, respectively, Tony Prosser, "Theorising Utility Regulation", [1999] 62(2) M.L.R., 196, and Tony Prosser, "Regulation and Social Solidarity", [2006] 33(3) *Journal of Law and Society*, 364.

[145] Prosser, "Public Service Law".

[146] Lindsay Stirton, "Back to the Future? Lessons on the Pro-Competitive Regulation of Health Services" (2014) 22(2) Medical Law Review, 180-199.

[147] Osipovič et al., "The Regulation of".

[148] Desai, "Public hospital mergers".

[149] For further discussion, see Mary Guy, 'Competition law, inequalities and healthcare: insights from EU and national frameworks' in (eds) K. Cseres and J. Broulík, *Competition Law and Economic Inequality*, (Abingdon: Hart, 2022).

A final instance of where the closer linking of juridification, market organisation and politicisation might be anticipated is in connection with "NHS privatisation". Despite the terminology, this rarely invokes the general understanding of "taking into private ownership". Rather, "NHS privatisation" is generally used to frame the expansion of private sector delivery of NHS services, and sometimes extending to NHS patients paying for treatment, or the operation of NHS Foundation Trusts in the private healthcare market.[150] Thus "NHS privatisation" can be understood as a multidimensional term with definitions and operationalisations which are often implicit, unclear and conflicting.[151] The politicisation of "NHS privatisation" might be most clearly associated with the NHS Bill, with the emphasis on wholesale repeal not only of the 2012 Act, but the underlying structures of NHS Trusts and NHS Foundation Trusts in existence, respectively, since the 1980s and early 2000s. While it might be considered that enshrinement of the New Labour policies by the 2012 Act might amount to juridifying "NHS privatisation", this nebulous concept may also have contributed to the amendments made during, and subsequent to, enactment of the 2012 Act. Its significant political salience can also be seen in its linking with the 2022 Act despite the purported move away from competition. This might suggest that the apparent fluidity of the conceptualisation of "NHS privatisation" doubtless retains a significant political salience which transcends and disrupts both law and politics. That said, two aspects of the 2022 Act which might attract further scrutiny are the refocusing of CMA oversight on mergers involving NHS providers and private/voluntary sector providers,[152] and the new statutory duty for NHS England to provide assistance to the CMA[153] regarding competition cases, and mergers and market investigations in the private healthcare sector, which includes NHS providers via private patient units. Whether this offsets the apparent strengthening of politics with the extension of Secretary of State powers by the 2022 Act remains to be seen – as does the scope for these provisions to represent a weakening of law.

Concluding Remarks

The 2022 Act is an important piece of legislation and enshrines the current once-in-a-generation NHS reform. The limited space accorded to repeal of the 2012 Act competition reforms belies the controversy which these have attracted. In the cross-party enthusiasm for removing the 2012 Act competition provisions, little attention appeared to be paid either within the House of Commons, or the House of Lords to how the 2022 Act has framed the interaction between the NHS and private healthcare and the forms of competition which now emerge. More worryingly, facile framings such as "reducing bureaucracy" belittle important questions of how the NHS and private healthcare sector should interact: these deserve parliamentary debate given the taxation-funded status of the NHS.

By mapping the developments according to Blichner and Molander's typology it has been possible to demonstrate the complexity of the 2012 Act competition reforms and to examine more normative considerations about the relationship between law and politics (via Veitch et al.'s conceptualisation of "depoliticisation") and the disruption of this (via Magnussen and Banasiak's conception of "privatisation") in the context of NHS competition reforms (and the underlying wider interaction between the NHS and private healthcare). Juxtaposing the Efford and NHS Bills on the one hand, and the 2022 Act on the other, have provided further context to this analysis.

[150] See Guy, "Between 'Going Private'".
[151] Martin Powell and Robin Miller, "Privatising the English National Health Service: An Irregular Verb?" (2013) 38(5) Journal of Health Politics, Policy and Law, 1051-1059.
[152] 2022 Act, s.83.
[153] 2022 Act, s.82.n

This has generated at least three main insights.

Firstly, that some of the concerns about 2012 Act juridification can be as readily explained by "home-grown" UK developments regarding privatisation and the transposition of the utilities liberalisation experience as by the influence of transnational law. Reviewing the parliamentary debates preceding the 2012 Act in 2022, it is striking just how much emphasis appeared to be placed on "EU competition law", as distinct from "(UK) competition law" with the implication for party political divergence posed by the latter of tensions between economic and social considerations. Caution should be exercised in 'viewing 2012 Act framings through 2022 spectacles'[154] to avoid simplistic suggestions of the politicisation of EU law (and other transnational legal frameworks). However, the effects of apparently limited engagement with, and mixed understanding of, EU law in UK parliamentary debates (hence "Euro-ambivalence") in shaping national reforms should not be underestimated. It is clear that the UK vote to leave the EU transcends traditional party political boundaries, and this, together with the influence of EU law during the UK's membership, mean that this insight may offer scope for learning in other areas as wholesale removal of "European" laws appears envisaged.

Secondly, that concerns about accountability surrounding the 2012 Act reforms may have proven justified, but that dejuridification, and the 2022 Act framing of "repoliticisation" may pose more questions than they answer. Notably, how does ministerial oversight operate alongside a body such as NHS England, which was intended to reduce this? Certainly, the development of arms' length bodies offers an additional dimension to "depoliticisation" given the varying links these bodies retain with central government.

Thirdly, that the 'dejuridification' afforded by the 2022 Act, while indeed reducing the "bureaucracy" of the extensive 2012 Act competition reforms, does little to address underlying tensions in the interaction between the NHS and private healthcare sector and how these are perceived as "NHS privatisation". Rather, the 2022 Act appears to re-embed the focus on mergers between NHS and private providers, and indicate a role for NHS England in supporting the CMA. This may suggest a further dimension to concerns about "NHS privatisation" insofar as the CMA's focus would now appear to cover the private healthcare market and the expansion of NHS providers within this. The taxation-funded nature of the NHS means that these merit parliamentary consideration which was absent from the 2022 Act.

Finally, that "juridification" – and correspondingly, "dejuridification" – remain difficult to grasp conceptually – but certainly extend beyond any idea that policy matters simply move to court determination. The experience of the 2012 Act teaches us not only that juridification and dejuridification may take different forms (as evidenced by the Efford and NHS Bills, as well as the 2022 Act), but also that juridification does not necessarily set in train an irreversible direction of travel. This gives rise to the insight that juridification may assume different layers – as evidenced by the development of further law (the 2014 Regulations regarding CMA involvement) to counteract the effects of initial juridification. Whether there is "no cure for law but more law"[155] in a general sense is moot, but appears to have had the desired effect regarding the 2012 Act. Both juridification and dejuridification will benefit from further elaboration given the increasing recourse to law, and review of existing laws, by the current UK government.

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[154] To paraphrase Denning LJ's famous warning about greater knowledge, if not the benefits of hindsight "we must not look at the 1947 incident with 1954 spectacles" in *Roe v Minister for Health* [1954] 2 All ER 131.

[155] Karl Llewelyn, cited in Antonios Kouroutakis and Sofia Ranchordas, "Sunset Clauses, De-juridification, and Emergencies", (2016) 25(1), Minnesota Journal of International Law, 29-77.

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