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Competition Law, Inequalities and Healthcare: Insights from EU and National Frameworks

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I. Introduction

It is well-established¹ that healthcare is a sector which is characterised not only by high levels of spending, but also by expanding demand of caring for an ageing population, and by the increasing expectations of patients over time (suggesting a more consumer-like mindset).² Healthcare spending continued to outpace economic growth during the 1990s and 2000s, notwithstanding the economic downturn of 2008–2009. The effects of the COVID-19 pandemic arguably entrench this, with notable estimated increases in health spending to GDP ratio across OECD countries (from 8.8 per cent in 2019 to 9.7 per cent in 2020) combining with a reduction in economic activity.³ It is common ground that COVID-19 is producing not merely an economic crisis, but also exacerbating existing inequalities and developing new inequalities with regard to healthcare access and affordability. This suggests that the focus in responding to the pandemic needs to include how to minimise health inequalities for future generations.⁴

*I am grateful for feedback from the conference, ‘Should wealth and income inequality be a competition law concern?’ University of Amsterdam, 20–21 May 2021, and to the editors for comments on earlier drafts.

¹See B Nikolić, ‘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.

²For further discussion, see J Tritter, M Koivusalo, E Ollila and P Dorfman, *Globalisation, Markets and Health Policy – Redrawing the Patient as Consumer* (Abingdon, Routledge, 2010).

³OECD, *Health at a Glance 2021*, ch 7, Health Expenditure. www.oecd-ilibrary.org/sites/ae3016b9-en/1/3/7/index.html?itemId=/content/publication/ae3016b9-en&_csp_=ca413da5d44587bc56446341952c275e&itemIGO=oe&itemContentType=book accessed 20 February 2022.

⁴See, eg, C Bamba, R Riordan, J Ford, F Matthews, ‘The COVID-19 pandemic and health inequalities’ (2020) 74 *BMJ Journal of Epidemiology and Community Health* 964.

These factors combine to generate concerns about the long-term sustainability of healthcare systems based on the principle of solidarity (including universal access to healthcare), and about the affordability of, and access to healthcare. This has clear negative implications for population health and individual needs, particularly for those in lower socio-economic groups.⁵

Introducing marketisation and competition reforms into healthcare at the national level, and the linking of this with application of competition law at national and EU levels, has been seen as a way of attempting to address these concerns. This is evidenced by the range of competition reforms in healthcare taking place between, broadly, the 1980s and the first decades of the twenty-first century – with those in the US in turn influencing the Netherlands and England. This period has coincided with a focus on efficiency rather than equity within wider competition policy, although the focus may now be shifting in favour of questions of equity, and re-evaluation of the goals of competition law.⁶ Certainly, taking equity as a starting-point for competition reforms in healthcare implies that a different approach may be needed.⁷ Nevertheless, the dynamic between efficiency and equity continues to characterise approaches to competition reforms in healthcare in the US and Europe,⁸ where questions of solidarity predominate,⁹ and the concept of healthcare access being determined by clinical need, not the ability to pay, underpins healthcare system organisation.

Competition reforms in healthcare are generally framed around claims of improved efficiency or quality, and less explicitly linked with scope for addressing inequalities, or engaging with questions of healthcare access and affordability. However, it might be considered that there is scope for overlap: if a healthcare service is delivered more efficiently, this may have positive implications for addressing inequality.

⁵ Suggesting a link with health inequalities, which can be defined as ‘... the systematic, avoidable and unfair differences in health outcomes that can be observed between populations, between social groups within the same population or as a gradient across a population ranked by social position’. G McCartney, F Popham, R McMaster, A Cumbers, ‘Defining health and health inequalities’ (2019) 172 *Public Health* 22.

⁶ See, eg, I Lianos, ‘Competition Law as a form of Societal Regulation’ (2020) 65(1) *The Antitrust Bulletin* 3.

⁷ M Guy, *Competition Policy in Healthcare – Frontiers in Insurance-Based and Taxation-Funded Systems* (Cambridge, Intersentia, 2019) 17.

⁸ For further discussion, see TS Jost, D Dawson and A Den Exter, ‘The Role of Competition in Health Care: A Western European Perspective’ (2006) 31(3) *Journal of Health Politics, Policy and Law* 687. T Greaney and O Odudu, ‘Introduction to Antitrust and the provision of healthcare in the United States and the European Union – Common Challenges’, ch 16 in D Orentlicher and TK Hervey (eds), *The Oxford Handbook of Comparative Health Law* (Oxford, Oxford University Press, 2021).

⁹ In contrast to US healthcare, where equity has been deemed subservient to efficiency. M 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, 06.02.2012.

Certainly, the motivation for competition reforms in national healthcare systems is typically framed in terms of ensuring future sustainability,¹⁰ with a focus on improving efficiency, which may be read as a means to engage with questions of healthcare access and affordability as a proxy for health inequalities. Efficiency has further been linked with distributional aims,¹¹ and seen as encompassing quality,¹² with attempts being made to align interpretations of quality by healthcare professionals and the competition context.¹³

Given the absence of an explicit focus on healthcare access and affordability, it may seem unsurprising that analysis of the effects of competition reforms in healthcare on equity appear limited. However, there is some evidence to suggest that fixed-price competition based on quality in the English National Health Service (NHS) potentially generated a slight improvement in a small reduction in social inequalities in accessing non-emergency hospital admissions.¹⁴

Although competition reforms in healthcare have taken place against a wider backdrop of a focus on efficiency rather than equity, it is nevertheless possible to revisit cases and policy to identify and evaluate where competition law has attempted to engage with economic inequality in a healthcare context.¹⁵ These attempts have been framed in terms of two categories of concepts. First, in the juxtaposition of 'competition' and 'solidarity', with the latter (which can be linked with wider concepts of equality and universal access) indicating potential limits for competition law to engage with economic inequalities in healthcare. Second, in framings primarily such as 'accessibility' and 'affordability', although questions of 'quality' are considered to have linkages with these concepts as well.

Whether and *how* competition law *can*, and *should*, concern itself with economic inequality in the healthcare sector are questions which arguably have yet to yield clear answers, despite various levels of engagement at national and EU levels. When confronted with acknowledged problems, such as the prevalence of market power (of public or private providers) in the healthcare sector operating

¹⁰ Nikolić (n 1).

¹¹ A Donabedin, *An Introduction to Quality Assurance in Health Care* (Oxford University Press, 2003) 10, cited in T Stavroulaki, 'The Curious Case of Competition Law and Health Equity' *Competition Policy International Antitrust Chronicle* December 2019.

¹² W Sauter, 'The Impact of EU Competition Law on National Healthcare Systems' (2013) 38(4) *European Law Review*, 457, 459.

¹³ T Stavroulaki, 'Connecting the Dots: Quality, Antitrust and Medicine' (2019) 31(2) *Loyola Consumer Law Review* 175.

¹⁴ R Cookson, M Laudicella and P Li Donni, 'Does hospital competition harm equity? Evidence from the English National Health Service' (2013) 32(2) *Journal of Health Economics* 410. R Cookson, M Laudicella, P Li Donni and M Dusheiko, 'Effects of the Blair/Brown health reforms on socioeconomic equity in health care' (2012) 17(1) *Journal of Health Services Research and Policy* 55. R Cookson, M Dusheiko, G Hardman and S Martin, 'Competition and inequality: evidence from the English National Health Service 1991–2001' (2010) 20 *Journal of Public Administration Research and Theory* 181.

¹⁵ In line with contributions regarding competition policy more generally. See, eg, ch 1 in this volume.

to the detriment of patients,¹⁶ part of the difficulty lies in the sequencing of the *whether* and *how* questions when considering responses.

On the one hand, it might be considered that the *ability* of competition law to address economic inequality in general (and the healthcare sector in particular) is determinative, and thus the questions of *whether/how* competition law *can* engage is effectively the starting point. *Whether/how* competition law *should* then become normative considerations which follow from *whether/how* it *can*. This might be illustrated to a certain degree by the experience at both national and EU levels of investigating abuse of dominance claims by pharmaceutical companies, thus limiting the potential consequence of the anticompetitive conduct, namely reducing access to particular medicines.¹⁷ The questions of *whether/how-can* are answered in broad terms by the applicability of competition law being uncontroversial in this context, which might be attributed in part to the global character of the pharmaceutical market – coupled with the scope for interaction between competition law and pharmaceutical regulation.¹⁸ The questions of *whether/how* competition law *should* engage with economic inequalities in healthcare can then follow by making use of the pre-existing ‘toolbox’ of competition law and exceptions, which may form one solution among several to a given problem (eg limited access to medicines).¹⁹ However, this is not the case for other, less ancillary, aspects of healthcare provision, which may attract differing political sensitivities, and be of a local or national character.²⁰ The EU competition law framework, defined by the ‘undertaking’ concept and the Services of General Economic Interest (SGEI) exception mechanism,²¹ provide a reference framework for leading questions of *whether/how-can* with healthcare provision typically seen as subject to EU competition law, but less clarity emerging regarding healthcare purchasing activities.²² In response to COVID-19, the response at national and EU levels has been to relax

¹⁶ O Odudu, ‘Health Care Services and EU Competition Law’ ch 17 in D Orentlicher and TK Hervey (eds), *The Oxford Handbook of Comparative Health Law* (Oxford, Oxford University Press, 2021).

¹⁷ Notable examples are Aspen being investigated by the European Commission (as well as the Italian competition authority), and Pfizer/Flynn investigated by the UK Competition and Markets Authority (CMA). See, respectively, European Commission, ‘Press Release: Antitrust: Commission accepts commitments by Aspen to reduce prices for six off-patent cancer medicines by 73% addressing excessive pricing concerns’, 10 February 2021, ec.europa.eu/commission/presscorner/detail/en/ip_21_524 accessed 20 February 2022, and CMA, ‘CMA finds Pfizer and Flynn £90 million for drug price hike to NHS’, 7 December 2016 www.gov.uk/government/news/cma-fines-pfizer-and-flynn-90-million-for-drug-price-hike-to-nhs accessed 20 February 2022.

¹⁸ For discussion, see, eg, D Danieli, ‘Excessive Pricing in the Pharmaceutical Industry: adding another string to the bow of EU competition law’ (2021) 16 *Health Economics, Policy and Law*, 64–75.

¹⁹ In this particular example, it might be considered that the effect is the same, regardless of which questions are posed first, the *whether/how-can* questions, or the *whether/how-should* questions.

²⁰ Guy (n 7) 2.

²¹ For consideration of the SGEI mechanism more generally, see ch 5 in this volume.

²² See, eg, JW van de Gronden and CS Rusu, ‘EU competition law and policy and health systems’ in TK Hervey, CA Young and LE Bishop (eds), *Research Handbook on EU Health Law and Policy* (Cheltenham, Edward Elgar, 2017) 267.

applicability of predominantly the prohibition on anticompetitive agreements²³ and the state aid rules²⁴ (via Articles 101(3) and 107(3) TFEU). These relaxation frameworks extend to the whole economy, but might be expected to have different implications for the healthcare sector, given that the disruption for this sector may be considered to be of a different scope and scale to that experienced in other sectors.

On the other hand, however, the relative rigidity of the rules governing the applicability of competition law,²⁵ and the complexities inherent in introducing competition reforms in healthcare may indicate that the question of *how* competition law *should* engage with economic inequalities in healthcare can be subservient to the question of *whether it should*. In other words, a (political) decision to introduce competition reforms in healthcare is effectively answering the question of *whether* competition law *should* engage with economic inequalities in healthcare (albeit perhaps indirectly) as a first step. The questions of *whether* and *how* it *can* are then linked. Experiences from both England and the Netherlands of tensions between government and competition authority perspectives on competition reforms in healthcare²⁶ illustrate some of the complexities which can arise in this regard. The introduction of legislation in England and the Netherlands²⁷ to incorporate and develop competition in healthcare may be read as competition law being deemed to engage with questions of economic inequality in healthcare (by answering the *whether it should* question in the affirmative).

This chapter makes use of a matrix framework of *whether* and *how* competition law *can* and *should* address economic inequalities in the healthcare context to evaluate approaches taken at EU and national levels as follows. Section II considers in overview *how* competition *can* work in a healthcare system, juxtaposing this with *how* a competition policy framework *can* serve to regulate this, indicating engagement with the *whether-can/should* question. Section III examines the EU competition law framework, and the recourse to the SGEI exception in light of the wider *how* and *whether* questions, particularly when juxtaposed with the temporary relaxation of the antitrust and state aid rules to respond to COVID-19. Section IV considers the Health and Social Care Act 2012 (HSCA 2012) competition

²³ European Commission, 'Communication from the Commission Temporary Framework for assessing antitrust issues related to business cooperation in response to situations of urgency stemming from the current COVID-19 outbreak' [2020] C116I/02, *Official Journal of the European Union*, C 116I, 8 April 2020.

²⁴ European Commission, 'Communication from the Commission – Temporary Framework for State Aid Measures to support the economy in the current COVID-19 outbreak' (Consolidated Version) C(2021) 564 of 28 January 2021.

²⁵ See further on the distinction between introducing competition and competition policy, Guy (n 7) Introduction.

²⁶ For a discussion, see Guy (n 7) ch 3.

²⁷ Via the Dutch Health Insurance Act 2006 (*Zorgverzekeringswet*), the Dutch Healthcare (Market Regulation) Act 2006 (*Wet Marktordening Gezondheidszorg*), the Health and Social Care Act 2012 and the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013.

framework in England. This offers important insights on the *how* and *whether* questions in view of the limited scope for competition within a taxation-funded system (the NHS) and in light of the current Health and Care Bill legislative proposals to repeal the HSCA 2012 competition framework, and recent relaxation of the anticompetitive agreements prohibition in response to COVID-19. Section V concludes.

II. Framing Healthcare Access and Affordability in Competition and Competition Policy

An obvious, but useful, starting-point for any discussion of competition in healthcare is to recall that healthcare comprises myriad services, which leads to the implication that ‘... there is therefore no presumption that the desirability or feasibility of competition will be the same for all types of healthcare in all situations.’²⁸ Consequently, distinctions emerge between categories based on assessments of the scope for competition, including ancillary activities such as pharmacy distribution (‘good’), more focused healthcare services included within hospital care or primary care (‘average’), and emergency or trauma services being seen as separate again because conditions for competition are unlikely to be met.²⁹ While such distinctions do not clearly reference inequalities, they nevertheless suggest scoping for competition, which can underpin the positive and normative questions of *whether/how* competition law *can* and *should* address inequalities in a healthcare context.

A further consideration is the varying scope for competition according to the type of healthcare system, with insurance-based and taxation-funded representing two broad categories, and many European healthcare systems falling within these. Thus, it has been noted that there is greater scope for competition within an insurance-based system than a taxation-funded one in view of the greater scope for demand-driven competition in the former as distinct from the supply-driven nature of the latter, where governments are likely to determine the precise levels of benefits.³⁰

How economic inequalities are addressed in the healthcare sector can be linked with the concept of universal health coverage, which means that ‘... all individuals

²⁸ Office of Health Economics (OHE), *Competition in the NHS* (London, Office of Health Economics 2012), 8.

²⁹ European Commission Expert Panel on Effective Ways of Investing in Health (EXPH), ‘Competition among health care providers in the European Union – Investigating Policy Options’, 17.02.2015, Table 4: ‘Propensity to fulfil conditions for effective competition in health systems’, 72, ec.europa.eu/health/sites/default/files/expert_panel/docs/008_competition_healthcare_providers_en.pdf accessed 20 February 2022.

³⁰ L Hancher and W Sauter, *EU Competition and Internal Market Law in the Health Care Sector* (Oxford, Oxford University Press, 2012) 8.25, 232.

and communities receive the health services they need without suffering financial hardship.³¹ The relevance of this principle for addressing economic inequalities in the healthcare context is clear, and the challenge lies in sustaining and enhancing universal systems.³² Universal access to healthcare becomes disaggregated across different financing methods, which can be described in broad terms as compulsory packages of healthcare access (whether taxation-funded or insurance-based), and out-of-pocket expenses. Compulsory packages are thought to equate to 75 per cent, and out-of-pocket expenses 25 per cent across a range of countries.³³

Insofar as addressing economic inequality in the healthcare sector can be linked with a commitment to universal access, distinctions in competition reforms can be drawn between how a 'core' of universal access is defined, as distinct from supplementary or complementary healthcare services, regardless of whether the system is taxation-funded (such as the English NHS) or based on insurance (such as the Netherlands).³⁴ Thus in the Netherlands, elements of competition might be considered to focus primarily around the 'core' of the basic insurance package, while in England, competition reforms were located within the 'core' of NHS service delivery.³⁵

What emerges from this overview that scoping is vital: it is important to be clear about where competition may be beneficial in addressing healthcare access and affordability (so should be encouraged), and where it would prove detrimental. At an extreme, this approach explains why emergency or specialist services may be considered to fall outside the scope of competition reforms, but routine treatments such as cataract surgery, may not. An interesting example of how tensions can play out between healthcare access and affordability on the one hand, and competition reforms on the other is seen with dental services, because of the potential for significant disparities in access to, and affordability of, dental care as this is not always included within universal health coverage.³⁶ In the Netherlands, ongoing concerns about dental care costs have led to repeated calls³⁷ for more

³¹ World Health Organisation Fact Sheet, Universal Health Coverage, 1 April 2021. [www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](http://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)) accessed 20 February 2022.

³² OECD, Universal Health Coverage. www.oecd.org/els/health-systems/universal-health-coverage.htm accessed 20 February 2022.

³³ OECD (n 3).

³⁴ Odudu (n 16) takes a different approach, distinguishing three funding sources: 'discretionary' ('by which individuals exercise autonomy on how to make provision to pay for any treatment or care that may be required'); 'compulsory' ('by which individuals are mandated to participate in a particular scheme ... that will pay for treatment or care required'); and 'taxation', where payment may be made by the state. For the purposes of the present discussion, it is noted that 'compulsory' and 'taxation' dimensions of Odudu's matrix can be combined insofar as healthcare paid for out of general taxation is 'compulsory' and represents a notable majority of healthcare provision within taxation-funded systems.

³⁵ For further discussion in the context of the applicability of competition law, see Guy (n 7) 75–83.

³⁶ For a discussion, see TT Wang, MR Rathur and H Schmidt, 'Universal health coverage, oral health, and personal responsibility' (2020) 98 *WHO Bulletin* 719.

³⁷ For example, F Baltesen, 'Dokters van de Wereld wil tandartszorg in de basispakket' ('Doctors of the World want dental care to be added to basic health insurance') 19 August 2021. www.skiplr.nl/nieuws/dokters-van-de-wereld-wil-tandartszorg-in-basispakket/ accessed 20 February 2022.

dental treatment to be brought within the scope of basic health insurance since experiments with liberalising prices for dental care in 2012 were found to generate higher costs.³⁸ This experience may suggest that the question of *whether* competition law *can/should* engage with economic inequality with regard to accessing dental treatment may have taken priority over considerations of *how* it could. In England, dentistry has seen ‘private absorption’ of (NHS) patients in response to limited availability of NHS services³⁹ over many years, leading in 2012 to the then competition authority recommending reform of the NHS dental contract alongside development of the private dentistry market.⁴⁰ This experience appears to indicate ambivalence about whether competition law (if understood as restricted to antitrust and state aid rules) can engage with economic inequality regarding access to dental treatment, while acknowledging that there may be a role for some degree of competition regulation.

The questions of *whether/how* competition law *can/should* engage with economic inequalities in a healthcare context are given a further dimension in national reforms as substantive and institutional aspects combine, inter alia around the intersection of competition law and (economic) regulation. This in turn can reflect challenging political and social questions about the appropriate dividing line between market and state.⁴¹ As noted above, following a political decision to introduce competition reforms in healthcare, thus answering the *whether – can/should* questions, the focus is *how* competition law *can/should* engage, and which agencies oversee this (with a complex dynamic typically emerging between government, competition authority and sectoral regulator). Such a regulatory framework is intended to enable combination of expertise – of the healthcare sector (and, relatedly, questions of healthcare access and affordability) and of competition. The English experience is examined below, but the Dutch experience is also illustrative of this.

Following the competition reforms of 2006 in Dutch healthcare, broadly parallel competition regimes were in operation, with the Authority for Consumers and Markets (ACM) having competence to apply general EU and Dutch competition law (including antitrust rules and merger control), and the Dutch Healthcare Authority (NZa) applying sector-specific rules. With regard to addressing economic

³⁸ A-L Trescher, S Listl, O van der Gallien, ADVOCATE Consortium, F Gabel and O Kalmus, ‘Once bitten, twice shy? Lessons learned from an experiment to liberalize price regulations for dental care’ (2020) 21 *European Journal of Health Economics* 425.

³⁹ W Whittaker and S Birch, ‘Provider incentives and access to dental care: Evaluating NHS reforms in England’, (2012) 75 *Social Science & Medicine* 2515.

⁴⁰ Office of Fair Trading (OFT), Dentistry – An OFT Market Study, May 2012. OFT1414. docplayer.net/6194397-Dentistry-an-of-market-study-may-2012-of1414.html accessed 20 February 2022. Department of Health, ‘Government response to the Office of Fair Trading Market Study into Dentistry’, 24 August 2012. www.gov.uk/government/publications/government-response-to-the-office-of-fair-trading-market-study-into-dentistry (accessed 20 February 2022).

⁴¹ N Dunne, *Competition Law and Economic Regulation – Making and Managing Markets* (Cambridge, Cambridge University Press, 2015) 149.

inequality, this might be seen primarily in connection with the NZa's competence, and its obligation to prioritise the 'general consumer interest' in its activities⁴² – including advising on hospital mergers, or investigating cases of 'significant market power'.⁴³ While consumers and their interests have prompted questions of definition and framing within wider considerations of competition policy,⁴⁴ two particular aspects characterise the conceptualisation of the 'general consumer interest' in the healthcare context. First, the 'general consumer interest' serves as a proxy for the healthcare values of accessibility, affordability and quality⁴⁵ which then provide criteria for assessing effects of anticompetitive conduct, or mergers. Second, while the 'general consumer interest' ostensibly focuses on 'final consumers', there is also scope for distinguishing between individuals as both patients and policyholders which may create tensions.⁴⁶

The coexistence of two regimes (between approximately 2006 and 2015, prior to transfer of some NZa competition powers to the ACM), and the particular focus on the 'general consumer interest' indicate responses to the questions of *how* competition law *can* engage with economic inequalities in the healthcare sector. This can be illustrated by the scope for trade-offs and tensions between the aforementioned healthcare values⁴⁷ where, for example, a merger may contribute to quality and reduce prices, but inhibit accessibility⁴⁸ – which may have implications for engaging with economic inequalities in healthcare. The scope for tension within the 'dual identity' of patients and insurance policyholders also indicates engagement with economic inequalities in the healthcare sector as illustrated by proposals to change access to healthcare providers according to different types of health insurance policy.⁴⁹ In addition, the question of *how* competition law *should*

⁴² Wmg, Art 3(4).

⁴³ For further discussion, see Guy (n 7) 144–148.

⁴⁴ See, eg, A. Macculloch, 'The Consumer and Competition Law' in G Howells, I Ramsay and T Wilhelmsson (eds) *Handbook of Research on International Consumer Law*, 2nd edn (Cheltenham, Edward Elgar, 2018) ch 4, V Daskalova, 'Consumer Welfare in EU Competition Law: What is it (not) about?' (2015) 11(1) *Competition Law Review* 131, P Akman, 'Consumer' versus 'Customer': The Devil in the Detail' (2010) 37(2) *Journal of Law and Society*, 315, KJ Cseres, 'Controversies of the Consumer Welfare Standard' (2006) 3(2) *Competition Law Review* 121.

⁴⁵ Which also suggest a linking of governmental oversight of the public interests of affordability, accessibility and quality providing a framework for the NZa's focus on the 'general consumer interest'. For further discussion, and information about the definition of the values and their interaction, see NZa, 'Visiedocument: (In) het belang van de consument' ('Vision Document: (In) the general consumer interest') (Utrecht, NZa, 2007).

⁴⁶ W 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. M Canoy and W Sauter, 'Out of control? Hospital mergers in the Netherlands and the public interest' (2010) 31(9) *European Competition Law Review* 377. This can also be seen in the context of the English NHS, where individuals have a 'dual identity' as patients and taxpayers. For further discussion, see Guy (n 7) 149.

⁴⁷ Sauter (n 46).

⁴⁸ Interview with Chris Fonteijn (former CEO of the ACM) cited in ML Lousse and M Wiggers, ch 6 'Toezicht' ('Regulation') in M Wiggers and W Oostwouder, *Handboek compliance in de zorg* (Compliance in Healthcare Handbook) (Uitgeverij Paris, Zutphen, 2017) 134.

⁴⁹ Notably in proposals to amend Art 13 Dutch Health Insurance Act 2006 and the 'free choice of healthcare provider' (*vrije artskenauze*), and the political sensitivities which attached to this. See Guy (n 7) 28.

engage with economic inequalities in the healthcare sector has been revealed to encompass various complexities in the interaction between government and competition (with the sectoral regulator occupying a difficult place between the two). This was evidenced by the interactions regarding the assessment of Dutch hospital mergers, with the ACM being emphatic that its scope for intervention is limited: it can only intervene where competition law is breached, and this may be inconsistent with the Dutch government's ambitions for competition reforms.⁵⁰

If both the *how – can/should* questions, and the *whether – can/should* questions can be identified at a national level, albeit with potential for varying sequencing, other considerations come into play at EU level. While it does not follow that the EU level requires Member States to engage with competition reforms, its influence is undoubtedly notable, and can include explicit effects, such as the enactment of Article 122 Dutch Health Insurance Act 2006 to ensure that Dutch competition law applies to private health insurers even though EU competition law may not.⁵¹ The extent to which the overarching *whether* and *how* questions feature in the EU competition law framework is now considered.

III. The EU Competition Law Framework and Healthcare Access and Affordability

Connections between the EU competition law framework and economic inequality in the healthcare context can best be illustrated by breaking down the *whether/how – can/should* questions, since answers to these are not straightforward. Here again, it is moot which sequencing is most logical, since this appears determined by a range of factors. The ability of EU competition law to engage with economic inequality in the healthcare context is linked to both the overarching *whether* and *how* questions. In the present discussion these are distinguished to reflect questions of applicability of EU competition law (predominantly *whether*) and the position assuming applicability (*how*).

A. Whether EU Competition Law Can Engage with Economic Inequality in Healthcare

It is possible to discern a broad framework in which EU competition law is deemed applicable to healthcare providers, but not to healthcare purchasers⁵²

⁵⁰ Guy (n 7) 13. ACM, Position Paper Autoriteit Consument en Markt Rondetafelgesprek 'Kwaliteit loont' (ACM Position Paper on the 'Quality Pays' roundtable discussion) 17.04.2015.

⁵¹ Further on this, see JW van de Gronden and E Szyszczak, 'Introducing competition principles into health care through EU law and policy: a case study of the Netherlands' (2014) 22 *Medical Law Review* 238.

⁵² See, eg, van de Gronden and Rusu (n 22).

through cases explicitly concerned with healthcare such as *Pavlov*,⁵³ *Ambulanz Glöckner*,⁵⁴ *AOK Bundesverband*,⁵⁵ *FENIN*,⁵⁶ and reinforced recently by *Dóvera*.⁵⁷ This case law has followed the traditional approach to the functional definition of the trigger requirement of an ‘undertaking’ for competition law to apply, namely that there is an ‘economic activity’,⁵⁸ which consists in offering goods or services on a market.⁵⁹ While the latter criterion can explain the aforementioned distinction between healthcare *providers* and *purchasers*, the former requirement for an ‘economic activity’ has generated much comment. The emphasis has – logically – been on aspects such as whether the healthcare providers/insurers are engaged in profit-making activities, and whether the activity takes place within a system exclusively based on solidarity (as distinct from competition). While these suggest clear lines – either an activity is profit-making or not; a healthcare system is, or is not, exclusively based on solidarity – it is difficult to provide clear-cut answers when healthcare systems incorporate elements of both solidarity and competition within an overarching aim of addressing inequality via sustainability of the healthcare system. The contortions of both academic commentary and case decisions have generated assessments of whether there is enough competition in a healthcare system for competition law to apply, and what this means – with de facto, potential, and even hypothetical competition representing different thresholds.⁶⁰

An alternative approach to establishing an ‘undertaking’ has been proposed which foregrounds public interest rather than questions of profit-making within economic activities.⁶¹ This makes use of a three-prong test from *CEPPB*⁶² with three cumulative (not alternative) elements, which can be illustrated as follows:

- (i) the supply of the services or goods of these providers is mainly dependent on public funding;
- (ii) the aim of this funding is the attainment of an objective of public interest; and
- (iii) the activities concerned are closely related to this objective.

⁵³Joined cases C-180/98 to C-184/98, *Pavel Pavlov and Others v Stichting Pensioenfonds Medische Specialisten*, ECLI:EU:C:2000:428.

⁵⁴Case C-475/99, *Firma Ambulanz Glöckner v Landkreis Südwestpfalz*, ECLI:EU:C:2001:577.

⁵⁵Joined cases C-264/01, C-306/01, C-354/01 and C-355/01, *AOK Bundesverband, Bundesverband der Betriebskrankenkassen (BKK) et al. v Ichthyol-Gesellschaft Cordes et al.*, ECLI:EU:C:2004:150.

⁵⁶Case C-205/03 P, *Federación Española de Empresas de Tecnología Sanitaria (FENIN) v Commission of the European Communities*, ECLI:EU:C:2006:453.

⁵⁷Joined Cases C-262/18 P and C-271/18 P *European Commission and Slovak Republic v Dóvera zdravotná poisťovňa, a.s.* ECLI:EU:C:2020:450.

⁵⁸Case C-41/90, *Klaus Höfner and Fritz Elser v Macrotron GmbH*, ECLI:EU:C:1991:161.

⁵⁹Case C-35/96, *Commission of the European Communities v Italy*, ECLI:EU:C:1998:303.

⁶⁰See Nikolić (n 1), who links potential competition with *Ambulanz Glöckner*, and de facto competition with the *IRIS-H* state aid case. See also D Sinclair, “‘Undertakings’ in competition law at the public-private interface – an unhealthy situation” (2014) 35(4) *European Competition Law Review* 167.

⁶¹JW van de Gronden, ‘Services of general interest and the concept of undertaking: does EU competition law apply?’ (2018) 41 *World Competition* 197. JW van de Gronden and M Guy, ‘The role of EU competition law in health care and the ‘undertaking’ concept’ (2021) 16 *Health Economics, Policy and Law* 76.

⁶²Case C-74/16 *Congregación de Escuelas Pías Provincia Betania*, 27 June 2017, ECLI:EU:C:2017:496.

In a healthcare context, this test can be used to distinguish differing activities of healthcare providers, notably between the provision of ‘regular’ medical services (which would be subject to competition law) and ‘specialist’ medical services which cannot be provided effectively within the market (thus would not be subject to competition law).⁶³ The logic of the test is thus not to displace the option of designating activities as SGEI, but, recognising that this mechanism offers only a partial exemption, to provide further scope for a range of activities to be exempted from the reach of competition law. The Dutch case *Gendia v Ministry of Health, Wellbeing and Sport*,⁶⁴ which saw the provision of Non-Invasive Prenatal Tests and counselling at subsidised rates by Dutch university hospitals classified as SGEI, has been discussed in light of the *CEPPB* test with the implication that these services may fall outside the scope of EU competition law.⁶⁵ Maternity services provide an important aspect of healthcare provision which would benefit from particular treatment within competition law as these are typically linked more to emergency services (which may be more likely to fall outside the scope of competition law) than to elective services (which may be more likely to fall within the scope of competition law).

Both the standard, functional ‘economic activity’ test from *Höfner*, and the ‘public interest’-focused test from *CEPPB* offer useful insights into how different healthcare services can fall within or outside of the EU competition law framework. However, addressing inequalities and healthcare access and affordability may suggest that further nuances of healthcare provision need to be clarified, perhaps necessitating a fundamental rethink of the logic which suggests that competition and solidarity are more distant than being ‘two sides of the same coin.’⁶⁶ This is particularly evident with regard to private providers delivering public healthcare services, given the tension which arises between the logic suggesting that such providers are indeed subject to competition law,⁶⁷ and the grey area arising from the ‘implicit’ finding of the CJEU in *FENIN* that provision of public healthcare services was not an economic activity.⁶⁸

The idea that the ultimate purpose of an activity is what determines whether or not competition law applies as articulated in *FENIN* has attracted much criticism. However, it highlights an important consideration for developing how competition law can address questions of inequality, healthcare access and affordability. This is evident when it is recalled that standard medical procedures, such as cataract

⁶³ Van de Gronden and Guy (n 61).

⁶⁴ Case No 200.225.476/01, *Gerechtshof Den Haag*, 11 December 2018, ECLI:NL:GHDHA:2018:3331.

⁶⁵ Van de Gronden and Guy (n 61).

⁶⁶ S Belhaj and JW van de Gronden, ‘Some room for competition does not make a sickness fund an undertaking. Is EC competition law applicable to the health care sector? (Joined cases C-264/01, C-306/01, C-453/01 and C-355/01 AOK)’ (2004) 25(11) *European Competition Law Review* 682.

⁶⁷ Nikolić (n 1) relies on *Pavlov and Ambulanz Glöckner* to reach this conclusion.

⁶⁸ Nikolić (n 1).

operations, can be provided effectively by the market, but are done so in different ways for different groups of patients.⁶⁹ Where there is competition between private providers to deliver public healthcare services, this may require the delineation of a separate market, something which is long-standing in CMA assessments in England (where consideration of the interaction between the NHS and private healthcare is standard). However, the scope for this has also been identified with regard to the EU level by analogy with the possibility identified for competitive provision of public/universal service obligations,⁷⁰ and even in connection with merger assessment in the US.⁷¹

B. Whether EU Competition Law Should Engage with Economic Inequality in Healthcare

As Member States have started to experiment with marketisation reforms and expanded roles for the private sector within their healthcare systems, questions have been raised about the applicability of EU competition law, and challenges of anticompetitive conduct brought by private providers. This has generated much discussion about the extent of EU involvement in healthcare, and concerns about inconsistent approaches taken by the European Commission and the Court of Justice of the European Union (CJEU).⁷²

While EU-level commitment to tackling health inequality is not in doubt,⁷³ a seamless connection with EU competition policy is difficult to discern. Nevertheless, links may be drawn via EU fiscal policy, with competition reforms being viewed as a means to support financial sustainability of healthcare systems following the 2008–2009 economic crisis.⁷⁴

⁶⁹ For example, with a greater choice of lens being available to patients who can afford to pay, and a more basic service provided to patients accessing public healthcare.

⁷⁰ W Sauter, *Public Services in EU Law* (Cambridge, Cambridge University Press, 2015) 233–234.

⁷¹ With the identification of vulnerable, high-risk consumers as a separate relevant market. T Stavroulaki, 'Mergers that Harm our health' (2022) 19(10) *Berkeley Business Law Journal* 89.

⁷² For recent examples, see Nikolić (n 1) and AJB Morton, 'European Health Care Systems and the Emerging Influence of European Union Competition Policy', (2021) 46(3) *Journal of Health Politics, Policy and Law* 467.

⁷³ Council Conclusions on Common values and principles in European Union Health Systems, Official Journal of the European Union (2006/C 146/01), 1.

⁷⁴ For example, exhortations to remove restrictions on competition in medical services were included in structural reforms linked with the Economic Adjustment Programme for Ireland. For a discussion, see DGECFIN, 'The Economic Adjustment Programme for Ireland', *Occasional Papers* 76, February 2011, 66. ec.europa.eu/economy_finance/publications/occasional_paper/2011/pdf/ocp76_en.pdf, accessed 20 February 2022. In 2015, France received a Country-Specific Recommendation (CSR) in the context of the European Semester annual economic policy assessment exhorting the removal of restrictions on access to, and exercise of, regulated professions, in particular as regards the health professions. [eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32015H0818\(15\)&from=EN](http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32015H0818(15)&from=EN) CSR 4. Although not formulated as a CSR, these concerns had been articulated in 2012 as well. eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52012DC0313&from=EN, para 15.

At least part of the answer to *whether* EU competition law *should* engage with economic inequality in connection with healthcare appears to lie in the respective EU-level and national competences regarding healthcare system organisation. While Article 168(7) TFEU is described as a ‘subsidiarity clause’ for healthcare,⁷⁵ the rules governing applicability of EU competition law suggest that this is a porous barrier,⁷⁶ and one which sets out a ‘delicate and sophisticated balance’ with regard to competition cases.⁷⁷

This would seem to be reinforced by the Member State competences both regarding health policy and healthcare system organisation,⁷⁸ and the designation of SGEI.⁷⁹ It should be noted that the combination of these two competences is critical here: while the former can offer scope for differing degrees of experimentation with marketisation reforms,⁸⁰ consensus appears to grow around the view that a decision to engage with marketisation reforms may indeed be a national one, but that such a decision has consequences, namely triggering applicability of EU competition law.⁸¹

While the SGEI mechanism is considered to provide a serviceable exception for Member States wishing to experiment with competition reforms,⁸² it provides only a partial exception,⁸³ and has also been considered cumbersome to the point that countries may prefer to try and exempt their healthcare systems completely from the reach of EU competition law by scaling back their marketisation reforms.⁸⁴

C. How EU Competition Law Can Engage with Economic Inequality in Healthcare

How EU competition law *can* engage with questions of inequality may thus be considered perhaps to take place primarily in a negative sense, insofar as it is

⁷⁵ Hancher and Sauter (n 30).

⁷⁶ A 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.

⁷⁷ JW van de Gronden and E Szyszczak, ‘Conclusions: Constructing a ‘Solid’ Multi-Layered Health Care Edifice’ in JW van de Gronden, E Szyszczak, U Neergaard and M Krajewski (eds), *Health Care and EU Law* (The Hague, TMC Asser Press, 2011) 481.

⁷⁸ Treaty on the Functioning of the European Union, Art 168(7).

⁷⁹ Consolidated Version of the Treaty on European Union – Protocol (No 26) on Services of General Interest. Official Journal 115, 09/05/2008, 0308–0308.

⁸⁰ For example, the differing approaches taken in England and Scotland while the UK was an EU Member State. Andreangeli (n 76).

⁸¹ T Prosser, ‘EU competition law and public services’ in E Mossialos, G Permanand, R Baeten and TK Hervey (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge, Cambridge University Press, 2010). Nikolić (n 1).

⁸² O Odudu, ‘Are State-owned healthcare providers undertakings subject to competition law?’ (2011) 32(5) *European Competition Law Review* 231.

⁸³ van de Gronden and Guy (n 61).

⁸⁴ Nikolić (n 1).

the (partial) exceptions of Services of General Interest and SGEI which explicitly recognise solidarity and equality aims. Where these values may be more or less explicitly considered is in assessment of the SGEI exception. For example, in *Ambulanz Glöckner*, emergency ambulance services were considered to be designated SGEI by virtue of requirements under German law for the provision of public ambulance services. Perhaps unsurprisingly, such values have also featured in state aid cases, with subsidies to public hospitals in Belgium and Italy being approved by, respectively, the Commission⁸⁵ and the General Court.⁸⁶ The possibility of protecting values of affordability and accessibility alongside a competition-based system was also considered with regard to the Dutch Risk Equalisation Scheme being permitted.⁸⁷

Although it is typically the SGEI exception – and not, for example, recourse to Article 101(3) TFEU – which has been considered most serviceable in a social (thus healthcare) context,⁸⁸ the aforementioned temporary relaxation frameworks introduced in response to COVID-19 have relied predominantly on the narrower exceptions of Article 107(3) TFEU.⁸⁹

The State Aid Temporary Framework was introduced on 19 March 2020, has been updated six times, and is expected to be in operation in different forms during 2022 and at least into 2023.⁹⁰ The health-specific guidance relates to going beyond the exceptions permitting aid to facilitate development of certain economic activities or areas,⁹¹ or remedying a ‘serious disturbance’ in a Member State economy.⁹² Both the guidance and subsequent cases include a focus on ‘crisis’ response,⁹³ for example, facilitating COVID-19-relevant research and development,⁹⁴

⁸⁵ SA.19864 (NN54/2009 – 2014/C) Public financing of Brussels public IRIS hospitals. This positive decision in 2016 involved a re-assessment by the Commission following a lengthy unfolding of the case, with the original complaints being lodged in 2005 and the Commission’s 2009 decision being annulled by the General Court in 2012.

⁸⁶ Case T-223/18 *Casa Regina Apostolorum della Pia Società delle Figlie di San Paolo v European Commission* ECLI:EU:T:2021:315. This case is currently (as at October 2021) subject to further appeal to the CJEU, and follows approval by the Commission in SA.39913 (2017/NN) Alleged compensation of public hospitals in Lazio.

⁸⁷ SA.18426 (N541/2004) Retention of financial reserves by Dutch Health Insurance Funds. For discussion, see Hancher and Sauter (n 30) 274–5.

⁸⁸ T Prosser, *The Limits of Competition Law* (Oxford, Oxford University Press, 2005) 27.

⁸⁹ M Guy, ‘Can COVID-19 change the EU competition law framework in health?’, Opinion Paper No 25, September 2020, *Observatoire Social Européen*, Brussels.

⁹⁰ ec.europa.eu/competition-policy/state-aid/coronavirus/temporary-framework_en accessed 20 February 2022.

⁹¹ TFEU, Art 107(3)(c).

⁹² TFEU, Art 107(3)(b).

⁹³ With regard to the temporary relaxation framework for the antitrust rules, a primary focus is the need recognised for greater cooperation to ensure supply and adequate distribution of essential scarce products, including medicines and medical equipment used to test and treat COVID-19 patients or necessary to mitigate and possibly overcome the outbreak. However, the Commission recognised that cooperation in the health sector might need to go even further to overcome critical supply shortages, such as coordinating reorganisation of production to allow producers to satisfy demand for urgently-needed medicines across Member States. European Commission (n23), paras 4 and 14.

⁹⁴ European Commission (n 24), section 3.6.

producing COVID-19-relevant products,⁹⁵ and approving state aid for time-bounded UK and Italian schemes, respectively, to distribute free medical grade personal protective equipment (PPE) across various healthcare providers,⁹⁶ and to produce and supply medical equipment such as ventilators, masks and goggles.⁹⁷ While these examples may have only a tenuous link with seemingly specific questions of addressing economic inequality in healthcare (but are undoubtedly part of wider considerations), cases decided under the State Aid Temporary Framework also indicate considerations of healthcare access. For example, in the Czech Republic, restrictions on the operations of providers of curative rehabilitation spa treatment meant that this could only be provided if it is at least partially reimbursed from public health insurance.⁹⁸ The effect of this is that spas could accept patients from hospitals.⁹⁹ The Covid-Spas subsidy programme was initially extended from 1 January 2021 to 30 June 2021, but was extended to 31 December 2021 due to further disruptions in the latter part of 2020.¹⁰⁰ The Commission's decision not to raise objections to this subsidy¹⁰¹ is based on Article 107(3)(b) TFEU, and is couched in terms of supporting employment, but would appear to have benefits for some access to health treatments.

A further example was seen with the Netherlands, with the Commission permitting¹⁰² temporary payments of direct grants by the Dutch Ministry of Health, Wellbeing and Sport to cover costs for the purchase, leasing, licensing and implementation of e-health applications to support providers of general practitioner care, district nursing, mental health care and social support services. This was in operation between April and December 2020. The need for this subsidy has arisen from increased demand for 'virtual' access to healthcare provision among groups most affected by the social distancing rules imposed by the Dutch Government (such as the elderly, at-risk groups and mentally ill patients).¹⁰³

Outside the realm of different exception mechanisms, where EU competition law has been deemed applicable with regard to healthcare providers, the question

⁹⁵ Including medicinal products (such as vaccines), medical devices and equipment, disinfectants and data collection/processing tools. European Commission (n 24), Section 3.8.

⁹⁶ Case SA.58477.

⁹⁷ Case SA.56786.

⁹⁸ Resolution of the Government of the Czech Republic of 30 October 2020, No 116. www.vlada.cz/assets/media-centrum/aktualne/23_R_retail-sales-and-the-sale_1108_30102020.pdf accessed 20 February 2022.

⁹⁹ www.vlada.cz/en/media-centrum/aktualne/measures-adopted-by-the-czech-government-against-coronavirus-180545/ accessed 20 February 2022.

¹⁰⁰ *ibid.* Case SA.61912 ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_SA_61912 (accessed 20 February 2022) which extended Case SA.58018 ec.europa.eu/competition/elojade/isef/case_details.cfm?proc_code=3_SA_58018 accessed 20 February 2022.

¹⁰¹ Case SA.58018 and Case SA.61912.

¹⁰² Case SA.57897 ec.europa.eu/competition/state_aid/cases1/202030/287111_2174861_86_2.pdf accessed 20 February 2022. This decision extends an initial application under Case SA.56915 ec.europa.eu/competition/state_aid/cases1/202015/285387_2146214_33_2.pdf accessed 20 February 2022.

¹⁰³ *ibid.*, page 3.

of *how it can* engage with questions of healthcare access and affordability remain. Certainly it has been noted that EU competition cases concerning the healthcare sector have not taken account of the effects on patients deemed to be the 'end users' or 'ultimate consumers' of healthcare.¹⁰⁴ If EU competition law is to (explicitly) engage with questions of economic inequality in the healthcare sector, effects of competition law decisions on patients should be incorporated, particularly where these may prove disadvantageous to patients from lower socio-economic groups, in light of the governing principles of universal coverage underpinning healthcare systems. While the flexibility of EU competition law (and particularly Article 101 TFEU) to accommodate healthcare values,¹⁰⁵ and specifically equity,¹⁰⁶ have been discussed, these are open questions, with answers likely to be very much context-dependent, both on a specific allegation of anticompetitive conduct and the healthcare system in question.

D. How EU Competition Law Should Engage with Economic Inequality in Healthcare

The foregoing may suggest an ambivalence regarding EU competition law's engagement with questions of economic inequality in the healthcare sector. However, the apparent willingness to support use of the SGEI exception would seem to suggest less that the EU level is dismissive of questions of access and affordability in healthcare, and more that it regards this as a matter for national decision.

Given the parameters outlined above regarding the applicability of EU competition law between the 'undertaking' concept and the SGEI mechanism, calls for further EU-level clarification of the SGEI mechanism in the healthcare context continue to be welcome.¹⁰⁷

Where competition law is deemed applicable, then the scope for considering concerns about equity should be developed, for example to include considerations of how particular conduct (and subsequent decisions) may affect patients, and particularly those in lower socio-economic groups,¹⁰⁸ although defining such groups in a cohesive way across 27 Member States may prove a particular challenge.

¹⁰⁴ Sauter (n 12).

¹⁰⁵ JW van de Gronden, 'The Treaty Provisions on Competition and Health Care' in JW van de Gronden, E Szyszczak, U Neergaard and M Krajewski (eds), *Health Care and EU Law* (The Hague, TMC Asser Press, 2011) 265–94.

¹⁰⁶ Stavroulaki (n 11).

¹⁰⁷ Van de Gronden and Szyszczak (n 51); Guy (n 7).

¹⁰⁸ In an approach analogous to the distinction drawn between NHS and private patients in the UK by the CMA. A need to identify 'vulnerable, high-risk consumers' as a separate relevant market has also been identified in the US context – Stavroulaki (n 71).

IV. Experiences from England: Competition in Healthcare

In contrast to the EU level, it might be anticipated that the *whether/how-can/should* questions regarding competition law and economic inequalities in healthcare may be subject to a different kind of sequencing at a national level, given that healthcare system organisation is a matter for Member State competence. As suggested in section I, the decision to engage with competition reforms in healthcare is a political one, which might indicate – perhaps counterintuitively – that the question of *whether* competition law *should* engage with economic inequalities in healthcare not only predominates, but also is largely answered. The focus therefore falls on the questions of *how* competition law *can* and *should* engage with economic inequalities in the healthcare sector as a way to respond to the remaining *whether/can* question, even if this may be seen as a more logical starting point.

To illustrate these considerations, it is useful to consider the experience of making use of competition law in competition reforms in English healthcare. The distinction is important because while competition reforms started under the Conservative Government of the late 1980s and continued to develop under New Labour (1997–2010),¹⁰⁹ the explicit recourse to primary and secondary legislation (as distinct from policy) is much more recent. It is possible to speak of a defined period between the Health and Social Care Act 2012 (HSCA 2012)¹¹⁰ and the current progress of the Health and Care Bill in the UK Parliament, which removes the HSCA 2012 competition provisions, and is expected to be enacted by April 2022.¹¹¹

This time-bounded experiment suggests that it is possible to answer the (political) question of *whether* competition law *should* engage with economic inequalities in the healthcare sector both in the affirmative and the negative. This provides a framework for examining the *whether/can* question, as well as the *how – can/should* questions. Before unpacking the four questions, however, it is useful to bear in mind some considerations about the nature of English healthcare.

The structure of the healthcare system – as encompassing both the NHS and private healthcare – across the UK, but in England in particular, given the significant development of the private healthcare market,¹¹² offers significant potential to generate and exacerbate health inequalities. The capacity for providers to operate in the private healthcare market, the NHS, or both, and for patients to move between the two, indicate the scope for a broad sense of competition between

¹⁰⁹ For further discussion, see Guy (n 7) ch 1.

¹¹⁰ Introduced by the Liberal Democrat-Conservative Government (2010–2015).

¹¹¹ NHS England and NHS Improvement, 'Integrating Care – Next Steps to building strong and effective integrated care systems across England', November 2020. 2.

¹¹² CMA, 'Private Healthcare Market Investigation', Final Report, 2 April 2014. CMA25. 2.11, 2.25, 2.36, 2.73.

the two.¹¹³ This has led to the CMA regarding the two as separate markets which nevertheless can impact each other in cases of merger assessment and antitrust cases.¹¹⁴

The dynamic between the NHS and private healthcare market is further complicated by the NHS effectively fulfilling three functions: acting as the majority healthcare provider (in the public healthcare system), operating in the private healthcare market (via private patient units), and fulfilling the function of ‘provider of last resort’ relative to the private healthcare market, as evidenced by unplanned transfers of private patients to NHS hospitals.¹¹⁵

This complex coexistence of the NHS and private healthcare nevertheless provided a basis for successive competition reforms in the NHS.¹¹⁶ These revolved around the expansion of private sector delivery of NHS services underpinned by patient choice policies which hinted at the scope for economic inequality and questions of healthcare access and affordability:

The overriding principle is clear. We should give poorer patients ... the same range of choice [i.e. of private provider] the rich have always enjoyed.¹¹⁷

In order to engage with the question of how competition law can relate to economic inequality/healthcare access and affordability, it is useful to recall that competition reforms in English healthcare have been defined by reference to two parameters: the separation of purchasing and providing functions, and the interaction between the NHS and the private healthcare sector. This has made it possible to speak of ‘four categories’¹¹⁸ described in Figure 9.1, in which categories one and two represent the NHS and categories three and four the private healthcare sector. In essence, the applicability of UK competition law and oversight by the competition authority has not been in question with regard to categories three and four, but has proved controversial in connection with category two in particular.¹¹⁹

¹¹³For a discussion, see M Guy, ‘Between ‘going private’ and ‘NHS privatisation’: patient choice, competition reforms and the relationship between the NHS and private healthcare in England’ (2019) 39 *Legal Studies* 479.

¹¹⁴See, eg, CE/9784-13, Private Ophthalmology: investigation into anti-competitive information exchange and pricing agreements. Infringement decision. 20.08.2015.

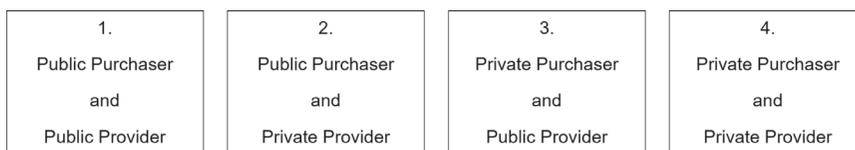
¹¹⁵In addition, this has served as a criterion for private patients in assessing private hospitals. CMA, Press Release, ‘Better information for private patients moves closer’, 1 December 2014.

¹¹⁶Broadly three phases: the Enthoven-inspired NHS internal market (1989–1997); New Labour choice and competition reforms (approx. 2000–2010) and the HSCA 2012 and ‘opening up public services’ reforms of the Conservative/Liberal Democrat coalition Government (2010–2015). For discussion, see Guy (n 7) ch 1.

¹¹⁷T Blair ‘We must not waste this precious period of power’, speech given at South Camden Community College, London, 23 January 2003, cited in Z Cooper Competition in Hospital Services, OECD Working Party No 2 on Competition and Regulation (DAF/COMP/WP2(2012)2, 2012).

¹¹⁸Guy (n 7) 40, and developed from the relationships as set out in Office of Fair Trading (OFT), *Private Healthcare Market Study*, OFT1396, 13, and O Odudu, ‘Competition Law and the National Health Service’, *Competition Bulletin: Competition Law Views from Blackstone Chambers*, 8 October 2012.

¹¹⁹With regard to category 1, Odudu has suggested that where the purchaser and the provider are the same legal entity there is no transaction to which competition law can be applied.

Figure 9.1 The four categories of English healthcare

A. Whether Competition Law Should Engage with Economic Inequality in Healthcare

The question of whether competition law should concern itself with economic inequality in the English healthcare context via engagement with the NHS, has proven contested over the course of successive competition reforms (from the late 1980s to approximately 2015). The contentions might be understood as comprising both substantive and institutional concerns, encompassing the ongoing criticism that the general UK competition regime designed to regulate private sector activity would be insufficient for the NHS;¹²⁰ concerns that expanding private sector delivery of NHS services would trigger both applicability and application of EU competition law; and concerns that the competition authority would have control over NHS activity.

What emerged from this was an ‘NHS-specific’ competition regime, initially policy-based under New Labour, with the NHS Principles and Rules of Competition and Cooperation (NHS PRCC), overseen by the NHS Cooperation and Competition Panel, a regulator located within the then Department of Health. These arrangements have been interpreted as meaning that NHS activity was ‘exempt by fiat’ from the general competition law frameworks and competition authority oversight,¹²¹ and considered, variously, to comprise the principles of competition law¹²² and an ‘alternative source’ of competition law.¹²³

The NHS PRCC have further been viewed as a means of demonstrating compliance with EU competition law while avoiding recourse to law.¹²⁴ This might also be seen as consistent with the view that competition law engages with questions of economic inequality in healthcare fundamentally via exceptions. The difference emerges in the starting point of the perspective insofar as ‘shielding’ the NHS from

¹²⁰D 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. Odudu (n 16) notes that this criticism persists.

¹²¹M Gaynor and R Town, ‘Competition in Health Care Markets’ in M Pauly et al. (ed), *Handbook of Health Economics*, Part 2 (Oxford, Elsevier, 2012) 559.

¹²²Odudu (n 82).

¹²³Odudu (n 118).

¹²⁴N Timmins, *The Five Giants – A Biography of the Welfare State*, 3rd edn (London, William Collins, 2017) 643.

the reach of competition law implies that competition law is likely to be either neutral or detrimental to questions of economic inequality in healthcare.

Perhaps unsurprisingly, the question of whether competition law should engage with the NHS met with resistance during the passage of the HSCA 2012, with a three-month pause being called to address concerns. Although the HSCA 2012 was eventually enacted, thus still indicating an affirmative political decision for competition law to engage with the NHS, the acceptance of this was much more qualified. What emerged from ongoing criticism and controversy included effective enshrinement of the NHS PRCC in legislation as the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013, and a scaling-back of the role envisaged for the CMA. Indeed, the changes introduced prior and subsequent to the HSCA 2012 can be seen as capable of uniting both those opposed to, and in favour of, competition reforms in healthcare.¹²⁵

B. How Competition Law Can/Should Engage with Economic Inequality in Healthcare

The HSCA 2012 reforms demonstrate that *how* competition law *can* engage with economic inequality in the healthcare context is by the coexistence of general, and sector-specific regimes, and by recourse to modifications of general frameworks. This can be illustrated by two examples, which also show that the *how – can/should* questions can be conflated.

First, section 64(2) HSCA 2012 enshrined the concept of ‘anticompetitive behaviour’¹²⁶ to reflect the terminology of primarily the prohibition on anticompetitive agreements, and form the basis of prohibitions imposed on purchasers (NHS commissioners)¹²⁷ and (NHS and private) providers delivering services for the NHS.¹²⁸ Furthermore, one of NHS Improvement’s general duties as a competition regulator was to ‘... exercise its functions with a view to 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.’¹²⁹ Indeed this might be read as a clear attempt to suggest *how* competition law *should* engage with questions of economic inequalities in the healthcare sector.

¹²⁵ Guy (n 7) 57–58, 222.

¹²⁶ HSCA 2012, s 64(2), which provides: ‘Anti-competitive behaviour’ means behaviour which would (or would be likely 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.

¹²⁷ Regulation 10 of the National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) 2013, SI 2013/500, prohibits ‘anticompetitive conduct.’

¹²⁸ Within the ‘Competition Oversight’ aspect of the Choice and Competition condition of the NHS Provider Licence.

¹²⁹ HSCA 2012, s 62(3).

The existence of section 64(2) HSCA indicated the development of an ‘NHS-specific’ competition regime *within* the ‘core’ of solidarity,¹³⁰ where applicability of EU competition law may be contested, or at least extremely politically sensitive. The total lack of recourse to either section 64(2) HSCA 2012 specifically, or to the aforementioned prohibitions regarding NHS purchasing or providing activity might suggest that merely replicating the terminology of general competition law is not sufficient, and more thought needs to be given to how to conceptualise competitive harms within the context of a public healthcare system intended to engage with economic inequality in healthcare.

Second, section 79 HSCA 2012 provides for a modified version of general UK merger control¹³¹ to apply to certain types of NHS hospital mergers. How this can indicate engagement with economic inequality in healthcare can be seen by the role afforded to NHS Improvement under section 79(5) HSCA 2012, to identify ‘relevant customer benefits’ to a merger, thereby obviating the need for a Phase II investigation, or to offset any substantial lessening of competition which may be generated. This was subsequently reconceptualised as ‘relevant patient benefits’, and extended to cover aspects of NHS policy, such as the move towards a ‘7 day NHS’,¹³² or the wider NHS policy move towards integrated care systems,¹³³ in contrast to the narrower ‘relevant customer benefits’ exception of UK general merger control.¹³⁴ However, it is important to note that this requirement to identify ‘relevant patient benefits’ only applied to certain NHS hospital mergers, and not all mergers with potential implications for NHS patients, thus a merger between two private providers delivering NHS services, would only be assessed under general UK merger control.¹³⁵

If the conceptualisation of ‘relevant patient benefits’ demonstrates *how* competition law *can* engage with NHS policy, then the approach taken by the CMA in such merger cases indicates *how* competition law *should*, and a conflation of the two questions. The 2017 Manchester Hospitals merger was notable for the CMA’s explicit recognition that competition played a limited role in the NHS and was not the basic organising principle for the provision of NHS services.¹³⁶ Although

¹³⁰ In contrast to the competition reforms in Dutch healthcare, which developed *around* a core of solidarity. For further discussion, see Guy (n 7) ch 2.

¹³¹ Enterprise Act 2002, Pt 4.

¹³² In a Phase II decision by the 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.

¹³³ See from the 2017 Manchester Hospitals merger onwards until the final merger assessed under this framework – 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.

¹³⁴ EA 02, s 30(1)(a), which defines ‘relevant customer benefits’ in terms of reductions in price or improvements in quality.

¹³⁵ 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. See further, Guy (n 7) ch 4.

¹³⁶ CMA, Central Manchester University Hospitals/University Hospital of South Manchester Merger Inquiry, Final Report, 1 August 2017.

NHS hospital mergers continued to be assessed by the CMA up until April 2020,¹³⁷ the changing focus of wider NHS policy – from competition to integration – and recognition of this in merger cases, prompted questions of whether NHS merger assessment had become effectively a ‘rubber stamping’ exercise in the absence of recourse to substantive exceptions.¹³⁸ This would appear to suggest a conflation of the *how* – *whether-should* questions.

C. Whether Competition Law (Actually) Can Engage with Economic Inequality in Healthcare

The foregoing reflections on the English experience suggest that answering the question of whether competition law (actually) can engage with economic inequality in healthcare via the proxy of supporting NHS reforms is not straightforward. With the current Health and Care Bill revocation of the HSCA 2012 competition provisions, it might be considered that it cannot.

However, policy documentation preceding the Health and Care Bill indicated an important distinction between competition in the sense of the HSCA 2012 provisions, and the application of competition law by the CMA to tackle excessive pricing abuses by pharmaceutical companies vis-à-vis the NHS.¹³⁹ This may indicate that the question to be asked is not at a very wide and general level of *whether*, but a more focused *where* competition law can engage with economic inequality in the healthcare sector, which may relate as much to specific healthcare services as to particular demographic groups.

Given the political sensitivities which have surrounded competition reforms in the NHS, it might further be considered that a further factor shaping the *whether-can* question is relative perceptions of flexibility at the levels of policy and law.¹⁴⁰ The NHS PRCC was largely enshrined by the subsequent National Health Service (Procurement, Patient Choice and Competition) Regulations (No 2) with the HSCA 2012 reforms, but lost an important aspect which may have facilitated a focus of competition on economic inequalities, namely acknowledging the nature of the complex interactions between NHS commissioners and NHS patients (with the additional identity of being taxpayers),¹⁴¹ thus underpinning a system better equipped to address economic inequalities and questions of healthcare access and affordability. This led to the NHS PRCC being described – persuasively – as a

¹³⁷ See n 127 above.

¹³⁸ Guy (n 7) 227.

¹³⁹ NHS England, The NHS Long Term Plan, January 2019, para 7.14, page 113.

¹⁴⁰ See further on this, ACL Davies, ‘This Time, It’s For Real’ (2013) 76(3) *Modern Law Review* 564, and M Guy, ‘Demarketisation, Deregulation, Dejuridification? Removing competition from the English NHS with the Health and Care Bill’ (2021) Lancaster University Law School Working Paper, 1 September 2021. papers.ssrn.com/sol3/papers.cfm?abstract_id=3915776 accessed 20 February 2022.

¹⁴¹ Guy (n 7) 49.

'new style' of competition law for quasi-markets,¹⁴² which did not transfer to the HSCA 2012 reforms which sought to align the NHS with more standard markets. The scope for general competition law to make assessments based on nuanced dual identities might be considered less than the ability for policy to do this.

Independent of the Health and Care Bill reforms, there has been a relaxation of the anticompetitive agreements prohibition in response to COVID-19 to enable closer cooperation between the NHS and private healthcare sector.¹⁴³ While this was introduced primarily as an initial crisis response, there have been a variety of agreements notified which extend into wider continuity responses, including cooperation to address lengthening NHS waiting lists. This may add further weight to a negative response to the question of whether competition law *can* (and *should*) engage with economic inequality in healthcare.

V. Conclusion

This chapter started from the premise that although few explicit links between tackling economic inequality in healthcare and competition law have been drawn, these may nevertheless be inferred from competition reforms being used as a mechanism to address ongoing issues regarding the sustainability of healthcare systems in the face of rising healthcare costs. From this starting-point, it quickly becomes apparent that while a matrix of *whether – can/should* and *how – can/should* questions provides a useful framework for analysing competition reforms and the application of competition law, other questions and considerations emerge when examination of the EU and national levels is juxtaposed. This has given rise to at least three main insights.

First, that the overarching *whether* and *how* questions can be difficult to sequence, and (may) be too easily intertwined. For example, it may appear that *how/whether-can* is a logical starting-point, but this can be displaced by considerations of *should*. This can be seen at EU level with regard to the Member State competence regarding healthcare (Article 168(7) TFEU) and the determinative role Member States play in identifying SGEI. At a national level, *whether-should* may prove the leading question, with considerations of *whether-can* and *how – can/should* being secondary.

Second, that a related question of *where* competition law *can/should* engage with economic inequality in healthcare assumes importance. This might be seen as an answer to the overarching *whether* question, or can form a separate, more focused question. The experience of excessive pricing in the pharmaceutical

¹⁴² I Lianos, 'Toward a Bureaucracy-Centred Theory of the Interaction between Competition Law and State Activities' in TK Cheng, I Lianos, and DD Sokol (eds), *Competition and the State* (Stanford, Stanford University Press, 2014).

¹⁴³ Competition Act 1998 (Health Services for Patients in England) (Coronavirus) (Public Policy Exclusion) Order 2020, SI 2020/368.

sector provides a clear instance of *where* a specific sector may benefit from using competition law. *Where* therefore suggests a more disaggregated approach which, by identifying specific treatments as a starting point, may move the analysis onto *how* competition law *can/should* engage with economic inequalities in terms of substantive assessments, rather than at the level of *whether* competition law applies. Thus, a question may be *whether/how* competition law assessments *can/should* accommodate economic inequalities with regard to basic dental treatment.

Third, that the EU and national levels demonstrate two different approaches – a case-by-case approach (EU level) and a macro approach of wider-ranging competition reforms (national level). This also has implications for the overarching *how* and *whether* questions.

Finally, there are a range of wider considerations which can affect responses to the overarching *whether* and *how* questions, beyond more standard considerations about competition law. These include interaction between EU and national levels, the use of legislation rather than policy, and the relationship between government, the competition authority and sectoral regulator.

