

Monitor and the Competition and Markets Authority

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Abstract:

As part of its enforcement duties under the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, and in exercise of the powers assigned to it by the Health and Social Care Act 2012, the health care sector regulator for England (Monitor) is co-competent with the competition watchdog (Competition and Markets Authority) to enforce competition law in health care markets. Oddly, though, unlike other sector regulators, Monitor does not have a duty to promote competition but ‘simply’ to prevent anti-competitive behaviour. Monitor is also competent to carry out reviews and to decide bid disputes concerning procurement carried out by health care bodies, provided there is no formal challenge under the Public Contracts Regulations 2006.

This paper contends that such a concentration of regulatory, competition enforcement and procurement review powers puts Monitor in a unique situation of (potential) structural conflict of interest that can diminish significantly its ability to act as an effective (co-competent) competition authority. This paper focusses on this difficult structure for the enforcement of competition law in the health care sector in England, in particular due to the asymmetrical, sui generis concurrency regime created by the Enterprise and Regulatory Reform Act 2013 and the Concurrency Regulations 2014. As examples of such conflict of interest and its implications, the paper assesses Monitor’s incentives to bend the interpretation of both art.101(3) TFEU and the new special regime on procurement of social services (arts.72-77 dir 2014/24). The paper concludes that this situation requires regulatory reform to devolve powers to the Competition and Markets Authority.

Keywords: Competition, public procurement, institutional design, enforcement, review, regulation, health care.

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Monitor and the Competition and Markets Authority

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Abstract

As part of its enforcement duties under the *National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, and in exercise of the powers assigned to it by the *Health and Social Care Act 2012*, the health care sector regulator for England (*Monitor*) is co-competent with the competition watchdog (*Competition and Markets Authority*) to enforce competition law in health care markets. Oddly, though, unlike other sector regulators, *Monitor* does not have a duty to promote competition but 'simply' to prevent anti-competitive behaviour. *Monitor* is also competent to carry out reviews and to decide bid disputes concerning procurement carried out by health care bodies, provided there is no formal challenge under the *Public Contracts Regulations 2006*.

This paper contends that such a concentration of regulatory, competition enforcement and procurement review powers puts *Monitor* in a unique situation of (potential) structural conflict of interest that can diminish significantly its ability to act as an effective (co-competent) competition authority. This paper focusses on this difficult structure for the enforcement of competition law in the health care sector in England, in particular due to the *asymmetrical, sui generis* concurrency regime created by the *Enterprise and Regulatory Reform Act 2013* and the *Concurrency Regulations 2014*. As examples of such conflict of interest and its implications, the paper assesses *Monitor's* incentives to bend the interpretation of both art.101(3) TFEU and the new special regime on procurement of social services (arts.72-77 dir 2014/24). The paper concludes that this situation requires regulatory reform to devolve powers to the *Competition and Markets Authority*.

Keywords

Competition, public procurement, institutional design, enforcement, review, regulation, health care.

JEL Codes

H57, K21, K23, K42.

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1. Introduction

One of the relatively recent novelties in the regulation of competition in the English health care sector revolves around the creation of *Monitor* by the *Health and Social Care Act 2012*.² *Monitor* is a new sector regulator under the form of an executive non-departmental public body, sponsored by the Department of Health and entrusted with a significant number of powers. The creation of *Monitor* was first discussed in the *Health and Social Care Bill 2011*,³ which s.52 indicated that ‘*The main duty of Monitor ... is to protect and promote the interests of people who use health care services—(a) by promoting competition where appropriate, and (b) through regulation where necessary*’. To that end, *Monitor* was made co-competent with the then *Office of Fair Trading* for the enforcement of competition law (Ss.60-61). Moreover, it was required to promote competition in the procurement and commissioning of NHS services (s.63(1)(c)). The creation of *Monitor* was riddled with controversy,⁴ particularly regarding its duty to promote competition and the detrimental impact that more (non-quality based) competition could have on the National Health Service (NHS England).⁵ The *Health and Social Care Bill* raised awareness about the limitations that (EU) competition law imposes in the reform of the health care sector,⁶ and this triggered rejection of the proposals aimed at increasing competition in the provision of health services in England. Such controversy resulted in a misinformed Parliamentary debate around the *Health and Social Care Bill*, where the applicability of (EU) competition law to the sector was seen and presented as something optional—and, consequently, as something that could and should be removed from the proposed reform package.⁷ This anti-competition discourse threatened ‘to kill’ the *Health and Social Care Bill* due to the social and political opposition it spurred.

² Ss. 61–71 of the Health and Social Care Act 2012, c.7. Available at:

<http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted> (Accessed: 6 November 2014) (*Health and Social Care Act 2012*). See E Speed and J Gabe, ‘The Health and Social Care Act for England 2012: The extension of “new professionalism”’ (2013) 33(3) *Critical Social Policy* 564–74. For general information on *Monitor* and its activities, see <https://www.gov.uk/government/organisations/monitor> (Accessed: 6 November 2014).

³ Available at: <http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.pdf> (Accessed: 19 November 2014).

⁴ Eg, see a clear summary of the issues in consecutive editorials by C Ham, ‘Competition in the NHS in England’ *BMJ* 2011;342:d1035 (Published 14 February 2011). Available at: <http://dx.doi.org/10.1136/bmj.d1035>; and *ibid*, ‘What will the Health and Social Care Bill mean for the NHS in England?’ *BMJ* 2012;344:e2159 (Published 20 March 2012). Available at: <http://dx.doi.org/10.1136/bmj.e2159> (Both accessed: 19 November 2014).

⁵ Available at: <http://www.england.nhs.uk/> (Accessed: 19 November 2014).

⁶ For discussion, see A Sanchez Graells & E Szyszczak, ‘Modernising Social Services in the Single Market: Putting the Market into the Social’, in JM Beneyto and J Mailló (eds), *Fostering Growth: Reinforcing the Internal Market* (Madrid, CEU Ediciones, 2014) 61-88. Available at: <http://ssrn.com/abstract=2326157> (Accessed: 19 November 2014). See also O Odudu, ‘Are State-owned health-care providers undertakings subject to competition law?’ (2011) 32(5) *European Competition Law Review* 231–41.

⁷ See debate on the Health and Social Care Bill, HC Deb 13 March 2012, vol 542, part 278, cols 159-215. Available at: <http://www.publications.parliament.uk/pa/cm201212/cmhansrd/cm120313/debindex/120313-x.htm> (Accessed: 18 November 2014). The debate was misinformed, as some of the speakers considered that the UK Government could actually prevent the application of (EU) competition law to the healthcare sector, which is clearly not something up to their discretion. That was somehow highlighted in the intervention by Joan Walley: ‘*The key issue for the House [of Commons] is whether the NHS will be subject to the full force of domestic and EU competition law, and that has not yet been clarified. The Government maintain that it will not, but the changes brought about by the Bill make certain that it will. In any event, it is not in the Government’s gift to decide, because the issue will be decided in the courts, so I genuinely believe that we are entitled to clarification on that issue—[Interruption.] I will not give way on that point. It is absolutely essential*

After an important consultation exercise to ‘pause, listen and reflect’ on the content of the *Health and Social Care Bill*, and taking into account those worries about a significant structural change leading to the privatisation of the NHS England by means of increased competition, the NHS Future Forum stressed that ‘*competition should be used to secure greater choice and better value for patients – it should be used not as an end in itself, but to improve quality, promote integration and increase citizens’ rights*’.⁸ This overarching shift in focus was reflected in the NHS Future Forum’s recommendation to ‘*remove Monitor’s primary duty ‘to promote competition’ and be clear that their primary duty should be to protect and promote the interests of the patient*’.⁹ However, the Forum was still convinced of the value of entrusting *Monitor* with competition enforcement powers, given that ‘*[t]here needs to be an effective regulator that tackles abuses that are not in the interest of patients or the taxpayer*’.¹⁰ It supported a specific proposal to keep the concurrent powers for *Monitor* on the basis that competition enforcement ‘*would be best done by a dedicated regulator with a greater knowledge of the unique nature of healthcare, including the importance of cooperation through clinical networks and the benefits of integrating services to improve quality*’.¹¹ The concurrency system was consequently finally kept in the *Health and Social Care Act 2012*, and it has developed in a *sui generis* way on the basis of these contradictory tendencies to, on the one hand, try to restrict promotion of competition ‘for its own sake but use it as a tool to improve quality’ (sic) and, on the other, entrusting *Monitor* with ‘standard’ competition enforcement powers in this sector *on equal footing* with the CMA (§3).

With that background in mind, for the purposes of this paper, it is worth stressing the simultaneous empowerment of *Monitor* regarding: 1) the *enforcement of both UK and EU competition law* in the provision of health care services in England, as a co-competent authority with the ‘general’ competition watchdog, the now *Competition and Markets Authority (CMA)*;¹² 2) the *regulation of the health care sector* in England, particularly in terms of licensing of providers and

that the Government, not the law courts of this country, determine NHS policy’ (cols 184-185, emphasis added). The conflation between legal and policy elements seems evident and the assumption that the Government could design the enforcement of competition law in the health care sector in a way that actually excluded it from the application of (EU) competition rules is pervasive. The most sensible remarks on that point came from Valerie Vaz, who stressed that ‘*So why have the Bill? The Secretary of State says that Monitor did not have a duty to promote competition. So why did the Government not approve the amendment tabled by Lord Clement-Jones that sought to designate the health service as “a service of general economic interest”, taking it out of EU competition law? That was not accepted*’ (col 181). Indeed, triggering the application of art.106(2) TFEU would be the only way of preventing the application of (EU) competition law to the NHS. However, that would still not be a free regulatory choice for the government. However, that discussion exceeds the possibilities of this paper. For a first approach to the controversy, see W Sauter, *Public Services and the Internal Market: Building Blocks or Persistent Irritant?* (June 2014). TILEC Discussion Paper No. 2014-022. Available at SSRN: <http://ssrn.com/abstract=2445373>. (Accessed: 18 November 2014).

⁸ NHS Future Forum, *Summary of Recommendations* (13 June 2011). Available at: <http://webarchive.nationalarchives.gov.uk/20130805112926/http://healthandcare.dh.gov.uk/future-forum-report/> (Accessed: 19 November 2014).

⁹ NHS Future Forum, *Choice and Competition. Delivering Real Choice* (June 2011), recomm. 2. Available at: <http://webarchive.nationalarchives.gov.uk/20130805112926/https://www.gov.uk/government/publications/nhs-future-forum-recommendations-to-government-on-nhs-modernisation> (Accessed: 19 November 2014).

¹⁰ Ibid, 9.

¹¹ Ibid, recomm. 2.

¹² Ss. 72(1) and 73(1) *Health and Social Care Act 2012*. S.80 establishes certain requirements of co-operation between *Monitor* and the CMA, but they are largely limited to exchanges of information.

determination of prices and public tariffs payable by commissioners for NHS services;¹³ and 3) the *review of public procurement carried out in the health care sector*.¹⁴ Consequently, *Monitor* is simultaneously the sector regulator, a co-competent competition authority and a (main) procurement review body in the health care sector in England. This creates an enforcement structure that ultimately results in a structural conflict of interest for *Monitor*, which may be called upon to carry out *ex post* competition or procurement reviews of situations created, or at least facilitated, by its *ex ante* regulatory decisions (in terms of licensing, promotion of integration and cooperative provision, or pricing/tariff determination). For instance, *Monitor* may receive complaints of anticompetitive behaviour that ultimately result from previous licensing decisions (if they create a market setting that enables collusion), or of procurement actions that are ultimately based in its previous decisions to authorise certain forms of collaborative/integrated provision of services. This conflict of interest is structural and hence unavoidable for *Monitor* (as discussed below, §2.2).

This situation is clearly peculiar and different from those in most other EU jurisdictions, including those with a health care sector regulator such as the Netherlands,¹⁵ where the accumulation of powers is more restricted (at least, as procurement is concerned). Moreover, the Dutch health care authority (NZa) clearly frames its mission in terms of the oversight of '*properly functioning healthcare markets*', and the importance of competition to further patients' interests is duly stressed by the sector regulator: '[t]he promotion of competition is a natural process of tailoring to the wishes of consumers. Therefore, in principle, other methods such as the simulation of market forces are only employed as a secondary measure'.¹⁶ This paper criticizes the peculiar approach of the UK to the design of the competition mandate and powers of its sector regulator for health care.

In criticising the peculiar statutory approach to *Monitor*'s competition duties and powers, this paper contends that such a concentration of regulatory, competition enforcement and procurement review powers puts *Monitor* in a unique situation of (potential) structural conflict of

¹³ Ss. 81 and ff *Health and Social Care Act 2012*.

¹⁴ In virtue of The National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013, No.500. Available at: <http://www.legislation.gov.uk/uksi/2013/500/made> (Accessed: 6 November 2014) (*NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*). See S Smith, D Owens and E Heard, 'New procurement legislation for English Health care Bodies—The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013' (2013) 22 *Public Procurement Law Review* NA109. *Monitor* is competent except where the complainant has commenced a formal procurement challenge before the High Court under The Public Contracts Regulations 2006, No.5. Available at: <http://www.legislation.gov.uk/uksi/2006/5/contents/made> (Accessed: 6 November 2014) (*Public Contracts Regulations 2006*). See reg.13(3) of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*. See reg.47(6) *Public Contracts Regulations 2006*, as amended by reg. 47C(2) The Public Contracts (Amendment) Regulations 2009, No.2992. Available at <http://www.legislation.gov.uk/uksi/2006/5/contents/made> (Accessed: 6 November 2014) (*Public Contracts (Amendment) Regulations 2009*). See M Trybus, 'An Overview of the United Kingdom Public Procurement Review and Remedies System with an Emphasis on England and Wales', in S Treumer and F Lichère (eds), *Enforcement of the EU Public Procurement Rules* (Copenhagen, DJØF, 2011) 201.

¹⁵ A close system may be identified in the Netherlands, with the creation of the Dutch Health Care Authority (Nederlandse Zorg Autoriteit, or NZa). For discussion see J van de Gronden and E Szyssczak, 'Introducing competition principles into health care through EU law and policy: a case study of the Netherlands' (2014) 22 *Medical Law Review* 238. However, the NZa has no powers regarding public procurement. Generally, , see W-J Berends, 'Judicial Protection in the Field of Public Procurement: The Transposition into Dutch Law of Directive 2007/66/EC Amending the Remedies Directives' (2010) 27(71) *Merkourios* 17-25.

¹⁶ Available at: <http://www.nza.nl/organisatie/sitewide/english/> (Accessed: 19 November 2014).

interest that can diminish significantly its ability to act as an effective (co-competent) competition authority (§2). It also argues that the absence of general *concurrency checks and balances* prevents the CMA from compensating for that faulty institutional design (§3). More specifically, as an example of such conflict of interest and its implications, the paper assesses *Monitor's* incentives to bend the interpretation of both art.101(3) TFEU (§4) and the new special regime on procurement of social services (arts.18(1) and 72-77 dir 2014/24) (§5). Some critical remarks follow and the paper concludes that regulatory reform to 'devolve' powers to the CMA is necessary (§6).

2. Monitor's structural conflict of interest and its role as co-competent competition authority

2.1. A structural conflict between regulators and competition authorities in the EU?

As a background for the assessment of *Monitor's* position as a co-competent competition authority (§2.2) and the *asymmetrical, sui generis* concurrency regime that regulates its relationship with the CMA for the enforcement of EU and UK competition rules (§3), it is worth stressing some basic points concerning the interaction between EU competition law and sector regulation generally.¹⁷ The general approach to the interaction (or overlap) between competition and sector regulation in EU law can best be seen in the difficulties for the enforcement of art.102 TFEU in regulated industries.¹⁸ In a simplified and streamlined fashion, it can be understood that sector regulation and competition need to be applied as two overlapping layers of economic regulation. Hence, *ex ante* regulatory interventions are insufficient to alter the *ex post* competition analysis of (unilateral, discretionary or 'free') behaviour that can restrict or distort competition. In the words of the CJEU, '*the competition rules laid down by the [Treaty on the Functioning of the EU] supplement ..., by an ex post review, the legislative framework adopted by the Union legislature for ex ante regulation of the telecommunications markets*';¹⁹ or, put differently, '*Article 102 TFEU is of general application and cannot be restricted, inter alia ... by the existence of a regulatory framework adopted by the EU legislature for ex ante regulation*'.²⁰

In that regard, the 'EU model' of 'supplementary or phased application' of competition law and sector regulation diverges from the approach in other jurisdictions and, notably, from the (emerging) 'US model' of 'alternative or single application', where sector regulation/intervention aimed at promoting competition in the regulated market pre-empts (separate) competition law enforcement.²¹ The discussion of which model is superior exceeds the possibilities of this paper. Suffice it to stress, however, that the 'EU model' makes it very difficult (if not impossible) for a single

¹⁷ This is not a new area of difficulty for competition enforcement. See P Nicolaides, 'The enforcement of competition rules in regulated sectors' (1997) 21(3) *World Competition* 5–28. For an interesting critical assessment, see N Dunne, 'Between competition law and regulation: hybridized approaches to market control' (2014) 2(2) *Journal of Antitrust Enforcement* 225–69.

¹⁸ *Ibid.*, 35.

¹⁹ *Deutsche Telekom v Commission*, C-280/08 P, EU:C:2010:603 92 (emphasis added).

²⁰ *Telefónica and Telefónica de España v Commission*, C-295/12 P, EU:C:2014:2062 128 (emphasis added).

²¹ See *Credit Suisse Securities (USA) LLC v Billing*, 551 US 264 (2007). See RA Jablon, AG Patel and LM Nurani 'Trinko and Credit Suisse Revisited: The Need for Effective Administrative Agency Review and Shared Antitrust Responsibility' (2013) 34 *Energy Law Journal* 627. Cf. J Baker, 'Antitrust Enforcement and Sectoral Regulation: The Competition Policy Benefits of Concurrent Enforcement in the Communications Sector' (2013) 9 *Competition Policy International* 4.

sector regulator to be able to comply with competition law enforcement duties to the adequate standard, particularly if they require a ‘revision’ of situations already assessed under its regulatory powers. In some jurisdictions, certain doctrines linked to the protection of legal certainty and legitimate expectations (such as estoppel or regard to their own acts) could legally prevent them from doing so. In the specific case of the UK and *Monitor*, the protection of the legitimate expectations of the market agents subject to *ex ante* supervision could clearly restrict *Monitor*’s ability to depart from previous views or to contradict itself when exercising competition powers *ex post*.²² Indeed, such difficulty would derive from ‘*the basic principle ... that public law remedies will be available where a public authority reneges on a representation such as to breach the legitimate expectation that it will not act so unfairly that its conduct amounts to an abuse of power*’.²³ Imposing competition sanctions or other remedies on the basis of market/economic behaviour previously authorised in the exercise of its regulatory powers would clearly be subjected to that basic principle and would be likely to prevent *Monitor* from doing so, or at least require compensation to the affected undertakings. Either way, refraining from enforcing competition *ex post* or providing compensation for doing so would be difficult if not impossible to square with the duty of *Monitor* (and any other sector regulator or administrative authority)²⁴ to ensure the effectiveness of the EU competition rules (*ex arts.3(3) and 4(3) TEU, and arts.3(1)(b), 119 and Protocol (No 27) TFEU, together with arts.101 and 102 TFEU*).²⁵

Overall, the conflict of interests or duties that pervades the activities of the sector regulator is bound to contaminate any competition intervention it carries out. Consequently, as a point of departure, the EU model of ‘supplementary or phased application’ of competition law and sector regulation does not fit well with the accumulation of regulatory and competition enforcement powers in a single authority such as *Monitor*. If the regulatory and competition regimes are supplementary, and in order to avoid implicit ‘deformations’ of competition enforcement requirements, the regulator should not be granted competition enforcement powers and, reversely, the competition watchdog should refrain from regulating market activities. That being said, such accumulation of powers has driven recent reforms in the competition enforcement institutional design in certain EU Member States (such as Spain),²⁶ or exists in a softer form by means of concurrent enforcement powers (such as in the UK).²⁷ Hence, this does not seem to be an absolute impediment, or one that Member States necessarily take into account when designing their

²² See eg Lord Mackenzie Stuart, ‘Legitimate Expectations and Estoppel in Community Law and English Administrative Law’ (1983) 10(1) *Legal Issues of Economic Integration* 53–73; R Thomas, *Legitimate Expectations and Proportionality in Administrative Law* (Oxford, Hart Publishing, 2000) 41–75. See also S Wilken, *The Law of Waiver, Variation and Estoppel*, 3rd edn (Oxford, Oxford University Press, 2012).

²³ G Weeks, ‘Estoppel and Public Authorities: Examining the Case for an Equitable Remedy’ (2010) 4 *Journal of Equity* 247, 258. Available at: <http://ssrn.com/abstract=1684374> (Accessed: 19 November 2014).

²⁴ On the duty to ensure effectiveness of EU competition rules, J Temple Lang, ‘National Measures Restricting Competition and National Authorities under Article 10 EC’ (2004) 29 *European Law Review* 397, 399–404.

²⁵ For a recent recast of the *State action doctrine*, see *Soa Nazionale Costruttori*, C-327/12, EU:C:2013:827 37–38. Previously, it had been recast in *Cipolla and Others*, C-94/04 and C-202/04, EU:C:2006:758 46–47; and *Doulamis*, C-446/05, EU:C:2008:157 19–20.

²⁶ For a critical assessment, see F Trillas, *The Institutional Architecture of Regulation and Competition: Spain's 2012 Reform* (April 2013). IESE Business School Working Paper No. WP-1067-E. Available at SSRN: <http://ssrn.com/abstract=2353526> (Accessed: 13 November 2014).

²⁷ M Lodge and J Stern, ‘British utility regulation: Consolidation, existential angst, or fiasco?’ (2014) *Utilities Policy*. Available at: <http://dx.doi.org/10.1016/j.iup.2014.08.002> (Accessed: 13 November 2014).

regulatory and competition enforcement systems. Nonetheless, such accumulation of powers is not a desirable regulatory option.²⁸

2.2. Monitor's role as co-competent competition authority

As briefly mentioned above (§1), concurrently with the CMA, the *Health and Social Care Act 2012* entrusts *Monitor* with responsibility for enforcing rules on competition in the health care sector in England.²⁹ More specifically, the enforcement of most of Part I of the *Competition Act 1998*³⁰ is a concurrent function of *Monitor* and the CMA.³¹ Equally, the carrying out of market investigations under Part 4 of the *Enterprise Act 2002*³² is a concurrent function of *Monitor* and the CMA as well.³³ The system of co-competence is strengthened by clarifying that '[n]o objection may be taken to anything done by or in relation to Monitor under the Competition Act 1998 or Part 4 of the Enterprise Act 2002 on the ground that it should have been done by or in relation to the [CMA]'.³⁴ Consequently, from a theoretical/regulatory design perspective and for all purposes, *Monitor* is a co-competent competition authority on equal footing with the CMA for the enforcement of competition law in the health care sector in England.³⁵ It bears emphasising that *Monitor's* activity should be oriented towards discharging its main duty 'to protect and promote the interests of people who use health care services by promoting provision of health care services which—(a) is economic, efficient and effective, and (b) maintains or improves the quality of the services'.³⁶ In that regard, it is worth stressing that '*Monitor must 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*'.³⁷

In that regard, a cursory look at the powers and duties of *Monitor* could seem to indicate a superiority or priority of competition concerns in the discharge of all of its duties (and, remarkably, its regulatory and procurement oversight powers). However, that is not necessarily the case (for the reasons outlined above §1). Indeed, *Monitor* has competing duties concerning the objectives of:

²⁸ Along these lines, it has been emphasised that '[i]t is conceivable that Competition Act enforcement might occasionally give rise to a conflict with one or more of the other regulatory objectives', which creates a problem of prioritisation; H Weeds, 'Concurrency between OFT and regulators' (2004) 12(2) *Utilities Policy* 65–9. Cf. DM Newbery, 'Regulation and competition policy: longer-term boundaries' (2004) 12(2) *Utilities Policy* 93–5. Clearly supporting the benefits of concurrency, see V Smith, 'Competition concurrency between the OFT and sector regulators' (2004) 12(2) *Utilities Policy* 61–3.

²⁹ *Monitor, Enforcement guidance on the Procurement, Patient Choice and Competition Regulations*, IRCP (R) 08/13, December 2013, available at <http://www.monitor.gov.uk/s75> (Accessed: 6 November 2014) 11.

³⁰ *Competition Act 1998*, c.41. Available at: <http://www.legislation.gov.uk/ukpga/1998/41/contents> (Accessed: 6 November 2014) (*Competition Act 1998*).

³¹ S.72(1) *Health and Social Care Act 2012*. All references to the Office of Fair Trading must be understood as being made to the Competition and Markets Authority; s.26 *Enterprise and Regulatory Reform Act 2013*.

³² *Enterprise Act 2002*, c.40. Available at: <http://www.legislation.gov.uk/ukpga/2002/40/contents> (Accessed: 6 November 2014).

³³ S.73(1) *Health and Social Care Act 2012*.

³⁴ S.74(1) *Health and Social Care Act 2012*.

³⁵ However, note that *Monitor* will actually be shown as a 'primary' or 'preferred' institution under the applicable concurrency rules, below §3.

³⁶ S.62(1) *Health and Social Care Act 2012*.

³⁷ S.62(3) *Health and Social Care Act 2012* (emphasis added). S.64(2) *Health and Social Care Act 2012* clarifies that "'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'.

enabling health care services to be provided in an integrated way,³⁸ and to be integrated with the provision of health-related services or social care services.³⁹ Such duties to facilitate integration and aggregation in the provision of different sorts of health care, health-related⁴⁰ and social care⁴¹ services may trigger conflicting needs when compared to the task of preventing anti-competitive behaviour in the provision of health care services. This is particularly true when that behaviour results from actions that would infringe the applicable requirements in terms of cooperation, integration and concentration of providers.⁴² For instance, if *Monitor* endorsed commissioning decisions that required integrated provision of certain sorts of services and, consequently, allowed for the exclusion of specialist competitors that then complained that the integrated suppliers (jointly) abused their market position or coordinated their behaviour in the provision of the services in an anti-competitive way, or that such decision on integrated provision for the purposes of NHS services had a restrictive competition effect in the neighbouring market for private provision.⁴³ Moreover, *Monitor* has important licencing and pricing powers and it is entrusted with the difficult task of regulating the market *ex ante* and (jointly with the CMA) policing it *ex post*. This accumulation of duties creates a structural conflict of interest (as discussed above §2.1). The safeguards created by the statutory rules applicable to *Monitor* and the concurrency regime

³⁸ S.62(4) *Health and Social Care Act 2012*. See *Complying with Monitor's integrated care requirements*. Available at: <https://www.gov.uk/government/publications/integrated-care-how-to-comply-with-monitors-requirements/complying-with-monitors-integrated-care-requirements> (Accessed: 6 November 2014).

³⁹ S.62(5) *Health and Social Care Act 2012*. See *Making sure health and social care services work together*. Available at: <https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together> (Accessed: 6 November 2014).

⁴⁰ S.62(11) *Health and Social Care Act 2012*: “health-related services” means services that may have an effect on people’s health but are not health care services or social care services.

⁴¹ S.62(11) *Health and Social Care Act 2012*: “social care services” means services that are provided in pursuance of the social services functions of local authorities within the meaning of the *Local Authority Social Services Act 1970*, c.42. Available at: <http://www.legislation.gov.uk/ukpga/1970/42/contents> (Accessed: 6 November 2014).

⁴² For discussion, see L Mynors-Wallis, ‘Cooperation or competition? Proposed changes in health care provision in England’ (2011) 35 *Psychiatric Bulletin* 441–43; J Davies ‘Changes and Challenges in UK Social Services: Social Services of General Interest or “Welfare” Services of General Economic Interest?’, in U Neergaard et al (eds), *Social Services of General Interest in the EU, Legal Issues of Services of General Interest* (The Hague: Springer, TMC Asser Press, 2013) 513–40; and ACL Davies, ‘This Time It’s for Real: The Health and Social Care Act 2012’ (2013) 76(3) *Modern Law Review* 564. Generally, on the anti-competitive risks derived from certain forms of horizontal and vertical cooperation for the provision of services, see Commission Regulation No 1218/2010 of 14 December 2010 on the application of Article 101(3) of the Treaty to categories of specialisation agreements [2010] OJ L335/43; and Guidelines on the applicability of Article 101 of the Treaty on the Functioning of the European Union to horizontal co-operation agreements [2011] OJ C 11/1. See also Commission Regulation 330/2010 of 20 April 2010 on the application of Article 101(3) of the Treaty on the Functioning of the European Union to categories of vertical agreements and concerted practices [2010] OJ L102/1; and Guidelines on Vertical Restraints [2010] OJ C 130/1.

⁴³ Even if NHS and private healthcare services are considered separate markets for the purpose of competition analysis, they at least exercise (asymmetric) competitive pressure. See 6-41 and ff of the CMA, *Final report on the private healthcare market investigation* (CMA 25, 2 April 2014). Available at: https://assets.digital.cabinet-office.gov.uk/media/533af065e5274a5660000023/Private_healthcare_main_report.pdf (Accessed: 19 November 2014). The relationship between public and private provision of health care in England is a highly controversial issue. See S Arora, A Charlesworth, E Kelly & G Stoye, *Public payment and private provision. The changing landscape of health care in the 2000s*. Understanding competition and choice in the NHS (May 2013). Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130522_public-payment-and-private-provision.pdf (Accessed: 19 November 2014). For general discussion, see KR Brekke & L Sørsgard, ‘Public versus private health care in a national health service’, (2007) 16(6) *Health Economics* 579–601.

regulating its relationship with the CMA fail to provide for the proper enforcement of (EU) competition law if *Monitor* prioritises regulatory activity over competition enforcement duties (§3).

For the purposes of this paper, and in view of the potential conflicts derived from conflicting duties, it is relevant to stress that *Monitor* is obliged to dismiss any of its duties as a sector regulator when it enforces competition provisions,⁴⁴ except if they relate to issues that the CMA could take into account if it was the acting competition authority.⁴⁵ A parallel provision on the avoidance of conflicts between the several duties to be carried out by *Monitor* clearly indicates that '*Monitor must ignore the functions it has under sections 111 and 113 [ie certain regulatory functions concerned with licensing] when exercising— (a) its functions under Chapter 2 (competition)*'.⁴⁶ Even if these additional indications as to the prioritisation of competition duties seem to clearly try to address the difficulties derived from *Monitor*'s accumulation of powers, it is hard to see how they can properly tackle the problem. Particularly because *Monitor*'s over-arching general duty is to protect and promote the interests of people who use health care services by promoting provision of health care services which is economic, efficient and effective, and maintains or improves the quality of the services,⁴⁷ which it can read as implying that "patients' interest" trumps competition considerations.⁴⁸ And, in any case, because *Monitor* is likely to be exercising its regulatory (and other) powers in a continuous manner, which makes it difficult to accept that it will be able to adopt decisions in the vacuum (eg, deciding that certain behaviour is anti-competitive despite the fact that it had adopted previous or related regulatory decisions that did not prevent it). Moreover, it is hard to ask an institution that is trying to regulate a market to have the sufficient objectivity to assess the effects of its regulatory activities and, where warranted, to enforce competition rules on economic agents which market decisions it is entrusted with overseeing.

Generally, these difficulties have been in the background of the relatively poor enforcement of competition rules by (other) co-competent sector regulators in the UK⁴⁹ and, ultimately, led to the creation of a revised concurrency regime in 2013. However, that system does not (fully) apply to *Monitor*—which benefits from an *asymmetrical, sui generis* status (§3)—and the problems derived from this (structural) conflict of interest or statutory duties remains unsolved⁵⁰ (below §6).

3. The *asymmetrical, sui generis* concurrency regime for *Monitor*

As briefly mentioned, one of the peculiarities of the UK system for the enforcement of EU and UK competition law is the concurrency of the CMA as competition watchdog and sector regulators.⁵¹ Generally speaking, the system relies on a number of checks and balances created by the *Enterprise*

⁴⁴ S.74 *Health and Social Care Act 2012*.

⁴⁵ ie, *Monitor* should apply competition rules as they would be applied by the 'general' competition authority.

⁴⁶ S.67 *Health and Social Care Act 2012*.

⁴⁷ S.62(1) *Health and Social Care Act 2012*.

⁴⁸ See reg.10 *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, and below §4.

⁴⁹ Where '*regulators have tended to under-enforce their competition powers, preferring to resolve market difficulties through regulatory interventions*'; N Dunne, 'Recasting Competition Concurrency under the Enterprise and Regulatory Reform Act 2013' (2014) 77(2) *The Modern Law Review* 254.

⁵⁰ Despite the explicit rules in Ss.67 and 74 of the *Health and Social Care Act 2012*.

⁵¹ [C Graham, *Decentralised enforcement of EU competition law by sector regulators—the UK model, forthc.*?].

and Regulatory Reform Act 2013⁵² and further developed in the *Concurrency Regulations 2014*.⁵³ Their purpose is to ‘strengthen the priority of competition enforcement and to provide plausible sanctions—including, ultimately, the removal of competition jurisdiction from regulators—for continued underuse’.⁵⁴ This should help minimise the effects of the (structural) conflict of interests or duties that *by definition* affects all sector regulators (above §2.1) and *Monitor* in particular (§2.2).

However, the competition enforcement structure derived from the *Monitor–CMA* concurrency rules is further complicated by the *asymmetrical, sui generis* regime created by those same *Enterprise and Regulatory Reform Act 2013* and *Concurrency Regulations 2014*, which have carved out very significant provisions that apply to sector regulators other than *Monitor*. This peculiar regime for the English health care markets stresses the special (and limited?) remit of *Monitor’s* competition-related statutory duties. Indeed, in the *CMA’s* view, ‘unlike other sectoral regulators, *Monitor* does not have a duty to promote competition’⁵⁵ but its powers (simply?) ‘enable it to protect choice and prevent anticompetitive behaviour’.⁵⁶ In other words, ‘*Monitor* has a duty to exercise its functions with a view to preventing anti-competitive behaviour which is against the interests of people who use health care services in England, but not to promote competition’⁵⁷ (for the origins of this, see above §1). This is particularly reflected in reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*, where *Monitor* is allowed to tolerate ‘anti-competitive behaviour’ in NHS procurement and commissioning of services if that is in ‘the interests of people who use health care services for the purposes of the NHS’⁵⁸ (discussed below §4).

Generally, one can wonder if truly prohibited (and non-exemptible) anti-competitive behaviour can ever be in the interest of patients.⁵⁹ In a sector where price competition is fundamentally excluded by the pricing decisions adopted by *Monitor*, and where undertakings need to compete in quality,⁶⁰ it is very hard to understand how patients’ interests could ever be

⁵² Enterprise and Regulatory Reform Act 2013, c.24. Available at: <http://www.legislation.gov.uk/ukpga/2013/24/contents/enacted> (Accessed: 6 November 2014) (*Enterprise and Regulatory Reform Act 2013*).

⁵³ The Competition Act 1998 (Concurrency) Regulations 2014, No.536. Available at: <http://www.legislation.gov.uk/id/uksi/2014/536> (Accessed: 13 November 2014) (*Concurrency Regulations 2014*).

⁵⁴ Dunne, above (n 49) 254.

⁵⁵ This derives from the specific interpretation of s.62(3) *Health and Social Care Act 2012*. However, a *functional* interpretation of that provision on the basis of art.4(3) TEU and arts. 101 and 102 TFEU may provide different results and immediately align *Monitor* with the rest of the co-competent sectoral regulators. This would be supported by the *obiter* in *Deutsche Telekom v Commission*, C-280/08 P, EU:C:2010:603 91. However, this is not the approach followed by the UK legislator and the *CMA*, so it is not pursued any further.

⁵⁶ Competition and Markets Authority, ‘Baseline’ annual report on concurrency – 2014 (CMA 24, 1 April 2014) 82. Available at: <https://www.gov.uk/government/publications/baseline-annual-report-on-concurrency> (Accessed: 13 November 2014).

⁵⁷ Competition and Markets Authority, *Regulated industries: Guidance on concurrent application of competition law to regulated industries* (CMA 10, 12 March 2014) 17, fn 44. Available at: <https://www.gov.uk/government/publications/guidance-on-concurrent-application-of-competition-law-to-regulated-industries> (Accessed: 13 November 2014).

⁵⁸ Unless it is prohibited by or under any enactment, or by or under the EU Treaties or the EEA agreement and having legal effect in the UK without further enactment.

⁵⁹ For extended discussion, see A Sanchez Graells, ‘New Rules for Health Care Procurement in the UK: a Critical Assessment from the Perspective of EU Economic Law’ (2015) 24 *Public Procurement Law Review* 16–30.

⁶⁰ Provided minimum necessary and proportional standards are met, in accordance with the applicable rules.

legitimately or effectively favoured by restrictions of competition.⁶¹ One would expect the sector regulator to recognise that ‘*properly functioning healthcare markets*’ are the best tool to protect patients’ interests, as ‘[t]he promotion of competition is a natural process of tailoring to the wishes of consumers’, even if competition is limited to the non-price or quality dimensions of the provision of health care services.⁶² However, from a *lege data* perspective—and if any proper consideration to Parliamentary intention is to be given⁶³—the limitation derived from the ‘mantra’ that *Monitor* must not necessarily promote competition but ‘solely’ avoid anti-competitive practices not in the interest of patients or NHS users cannot be overseen. The specific implications of this difference in statutory duties between *Monitor* and the rest of the sector regulators are not very clear,⁶⁴ but it is used as a justification or a *clef de voûte* for the design of a much more limited concurrency regime than those applicable to other sector regulators that do have the statutory duty to promote competition. Indeed, *Monitor*’s concurrency regime is much more limited despite this deviation from the standard statutory duties of sector regulators to promote competition (or precisely because of it). Notably,

*[i]n contrast to the other concurrent sectors (where either the CMA or the relevant Regulator may take responsibility for a case depending on which one is better or best placed to do so), under the Concurrency Regulations Monitor will normally be responsible for any case that is principally concerned with matters relating to the provision of health care services for the purposes of the NHS in England, though Monitor may nevertheless agree with the CMA that the CMA shall act in a case.*⁶⁵

This is highly counterintuitive and sets up an *asymmetrical, sui generis* concurrency regime that seems difficult to reconcile with the fact that co-competent authorities are fundamentally on *equal footing* and, if anything, the CMA must play a prominent role.⁶⁶ Indeed, the concurrency regime generally relies on

*the coordination and leadership role of the CMA in relation to concurrent competition law application and enforcement, for the purpose of enhancing the efficient application and enforcement of Articles 101 and 102 of the TFEU and Chapters I and II of the [Competition Act 1998] in the regulated sectors.*⁶⁷

However, that is clearly not the case when *Monitor* is concerned. Consequently, the effectiveness of competition policy in health care markets can be jeopardised if *Monitor* does not uphold high standards of competition enforcement *motu proprio*. Within this system, the CMA will also struggle to ‘engage in a broad strategic dialogue with [Monitor] and look for opportunities to

⁶¹ Ultimately, the approach in the *Health and Social Care Act 2012* and the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* rests in the result of the ill-informed Parliamentary debate and the following excessively biased public consultation, which made the anti-competition discourse prevalent and imposed a drafting of the competition-related provisions that simply makes very poor (or no) sense.

⁶² As clearly indicated by the Dutch NZa. See above (n 16).

⁶³ The discussion is endless and recently relates fundamentally to the interpretation of the UK Human Rights Act 1998. For a critical assessment of the erosion of the principle, see TRS Allan, ‘Parliamentary Sovereignty: Lord Denning’s Dexterous Revolution’ (1983) 3(1) *Oxford Journal of Legal Studies* 22–33; and *ibid*, ‘Parliament’s Will and the Justice of the Common Law: The Human Rights Act in Constitutional Perspective’ (2006) 59(1) *Current Legal Problems* 27–50. For a ‘hard core’ approach to the restrictions of Parliamentary intention, G Marshall, ‘The lynchpin of parliamentary intention: lost, stolen, or strained?’ (2003) 2 *Public law* 236–48.

⁶⁴ And, indeed, a deviation from standard competition law requirements may not be possible without infringing EU competition (and public procurement) rules. See Sanchez Graells, above (59).

⁶⁵ CMA, *Regulated industries*, above (57) 17, fn 44 (emphasis added).

⁶⁶ This is, arguably, one of the drivers of the recent institutional upheaval in the UK. See S Wilks, ‘Institutional Reform and the Enforcement of Competition Policy in the UK’ (2011) 7(1) *European Competition Journal* 1–23.

⁶⁷ CMA, *Regulated industries*, above (57) 2.

promote effective competition’ as generally required by the ‘strategic steer’ issued by the UK Government to the CMA in October 2013.⁶⁸

Following from this point of departure regarding the *asymmetric concurrency* with *Monitor*, the CMA faces further limitations in the *management* of its concurrency with *Monitor*, as the CMA: 1) cannot determine that it rather than *Monitor* should exercise competition enforcement functions in relation to a new case;⁶⁹ and 2) cannot take over a case previously (self)allocated to *Monitor*, even if it is satisfied that doing so would further the promotion of competition for the benefit of consumers, unless the case is not principally concerned with matters relating to the provision of health care services for the purposes of the NHS in England.⁷⁰ Moreover, *Monitor* is not affected by the power of the Secretary of State to remove the competition functions from a sector regulator if it considers that it is appropriate to do so for the purpose of promoting competition, within any market or markets in the UK, for the benefit of consumers.⁷¹ Finally, *Monitor* is not a member of the United Kingdom Competition Network (UKCN), but solely has observer status.⁷²

Generally, then, the *asymmetrical, sui generis* concurrency regime designed for *Monitor* does not comprise any of the fundamental safeguards that would allow the CMA or, in extreme circumstances the Secretary of State, to correct deviations in the way in which *Monitor* applies UK and EU competition law. Additionally, its participation in the UKCN can be much more limited and passive than that of other sector regulators. Overall, this is fundamentally a suppression of the only significant checks and balances generally existing under the concurrency regime applicable to the other sector regulators in the UK and leaves *Monitor* free to keep competition enforcement cases away from the CMA. To be sure, *Monitor*’s decisions can be appealed to the Competition Appeals Tribunal by the affected undertakings.⁷³ However, this seems insufficient to guarantee a proper functioning of the system.⁷⁴ Thus, from an institutional design perspective, this is problematic. It particularly creates difficulties when EU competition law must be enforced by *Monitor*—which, given the structural conflict of interest that affects *Monitor* and the lack of checks by the CMA, can fail to meet the requirements derived from Regulation 1/2003.⁷⁵ Moreover, this is bound to create problems in the proper enforcement of EU public procurement rules—particularly, in view of the

⁶⁸ Department for Business, Innovation and Skills, *Strategic steer for the Competition and Markets Authority 2014-17*, in Annex 1 to its Response to consultation on statement of specific priorities for the CMA (1 October 2013), paragraphs 6 and 9. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/245607/bis-13-1210-competition-regime-response-to-consultation-on-statement-of-strategic-priorities-for-the-cma.pdf. (Accessed: 20 November 2014).

⁶⁹ Reg. 4(2) *Concurrency Regulations 2014*. Though the CMA and *Monitor* may nevertheless agree that the CMA is to act in such a case. See CMA, *Regulated industries*, above (57) 18, fn 47.

⁷⁰ Reg. 8(1)(b) *Concurrency Regulations 2014*. CMA, *Regulated industries*, above (57) 19.

⁷¹ S.52 *Enterprise and Regulatory Reform Act 2013*. CMA, *Regulated industries*, above (57) 54.

⁷² CMA, *Regulated industries*, above (57) 10 and Annex B.

⁷³ This is uncontroversial. <http://www.catribunal.org.uk/242/About-the-Tribunal.html> (Accessed: 13 November 2014).

⁷⁴ Which ultimately rests on the (self-imposed) compliance by *Monitor* of the (optimistic?) rules in Ss. 67 and 74 of the *Health and Social Care Act 2012* (above §2.2).

⁷⁵ Council Regulation (EC) No 1/2003 of 16 December 2002 on the implementation of the rules on competition laid down in Articles [101] and [102] of the Treaty [2003] OJ L1/1. See also CMA, *‘Baseline’ annual report on concurrency – 2014*, above (n 56) 34.

pro-competitive requirements included in art.18(1) of Directive 2014/24.⁷⁶ The remainder of the paper looks into these two issues in more detail, as examples of the need for a regulatory reform that avoids potential clashes with and infringements of EU law derived from the (structural) conflict of interest or conflict of duties that affects *Monitor* and that its *asymmetric, sui generis* concurrency regime fails to mitigate (below §6).

4. *Monitor's* incentives to bend art.101(3) TFEU

One of the areas in which *Monitor* can have a conflict of interest in the interpretation and enforcement of EU competition law relates to the exemption of otherwise prohibited agreements on the basis that, despite being anti-competitive, they further “patients’ interests”. The conflict would derive from *Monitor's* conflation of its duties in a way that tries to avoid sanctioning *ex post* anti-competitive practices that it generally (or *ex ante*) views as supporting goals such as enabling health care services to be provided in an integrated way, or to be integrated with the provision of health-related services or social care services (above §2.2). This risk would materialize if *Monitor* decided that whatever is considered in the “interest of patients” or NHS users could trump pro-competitive requirements and allow for distortions of competition. That would create a risk of incompatibility with the interpretation and enforcement of EU competition law—and, ultimately, it would risk infringing the UK’s obligations under Regulation 1/2003. Such incompatibility could only be avoided if “patients’ interest” could be reconciled with “consumer-benefitting (qualitative) efficiencies” under the exception provided for by art.101(3) TFEU. In simpler terms, then, the temptation is there for *Monitor* to adopt an excessively broad interpretation of art.101(3) TFEU and to exempt restrictive practices on the basis of the quality improvement they create in cases where any other competition authority (and notably, the CMA or the European Commission) would not.

Interestingly, *Monitor* has published guidance on how it plans to interpret the requirements of “patients’ interest” and when this consideration can trump pro-competitive requirements.⁷⁷ It must be stressed that the guidance has not been issued in relation to the exercise of its competition powers, but rather of its public procurement oversight powers. Nonetheless, the substantive elements of the guidance should remain valid throughout. Generally, the balancing test proposed by *Monitor* can be described in the following terms:

*In assessing whether or not anti-competitive behaviour is in the interests of health care service users, Monitor will first consider the impact of the behaviour on competition. [Monitor] will assess whether the behaviour affects competition in a way that gives rise to an adverse effect for patients by removing or materially reducing the incentives on providers to provide high-quality services, provide value for money and/or improve services. If it does, [Monitor] will consider whether it also gives rise to benefits that could not be achieved without the restriction on competition. Monitor will then consider whether any benefits outweigh any adverse effects from the loss of competition in order to establish whether the behaviour is in the overall interests of patients.*⁷⁸

⁷⁶ Directive 2014/24/EU of the European Parliament and of the Council of 26 February 2014 on public procurement and repealing Directive 2004/18/EC [2014] OJ L 94/65 (*Directive 2014/24*).

⁷⁷ *Monitor, Substantive guidance on the Procurement, Patient Choice and Competition Regulations* (19 December 2013). Available at: <http://www.monitor-nhsft.gov.uk/s75> (Accessed: 19 November 2014). For an interesting comment, see P Henty, “Monitor guidance on the NHS Procurement, Patient Choice and Competition Regulations 2013” (2014) 23 *Public Procurement Law Review* NA84.

⁷⁸ *Monitor's Substantive Guidance 2013*, above (n 77) 61-62, emphasis added.

This is presented as a clearly qualitative approach to the balancing of competing interests and *Monitor* seems to have clearly departed from the apparently more precise and economic (ie financially-oriented) cost/benefit analysis that it had proposed in the draft substantive guidance published in May 2013.⁷⁹ In the earlier draft guidance, *Monitor* aimed at ‘costing’ the distortions of competition and ‘pricing’ the benefits created by the less than fully competitive procurement scenarios.⁸⁰ Under the revised and more qualitative guidance, the negative impacts on competition will be assessed according to a rather standard competition appraisal. Such analysis will be concerned with i) the nature of the restriction on competition, ii) the number of providers of a particular health care service that are affected by the commissioner’s conduct and their importance as suppliers of that service, iii) the extent to which those providers affected by the conduct are close alternatives, and iv) the expected duration of the conduct or its effects. In this regard, the screening that *Monitor* intends to carry out to identify the negative effects of anti-competitive NHS commissioning broadly follows the accepted analytical methods of most non-sectoral competition authorities.⁸¹ Hence, it should be expected that the negative effects identified under this methodology are mainly of an economic nature and primarily concerned with static and dynamic reduction of competition and, eventually, with an overall restriction of choice in case of exit of some of the suppliers from the given market.

However, the assessment of the benefits that may compensate for such negative implications of a restriction of competition in NHS procurement and commissioning creates some analytical difficulties. Those derive from the fact that *Monitor* will not exclusively focus on economic efficiencies, or even on efficiencies that can easily be translated into economic terms. As clearly spelled out

Monitor will also consider whether the behaviour gives rise to any material benefits to users of NHS health care services, such that the behaviour would be considered to be in the interests of health care service users... Benefits can arise in a number of different ways. In addition to improvements in quality through co-operation and the delivery of care in an integrated way, benefits may arise as a result of improvements in efficiency that lead to better value for money. Behaviour may result in better value for money for a number of different reasons, for example, through a reduction in duplicated patient assessments, etc. Improvements in quality may consist of clinical or non-clinical improvements:

- *clinical benefits may include a variety of improvements that lead to better patient outcomes (for example, by increasing the number of patients treated by a provider where higher patient volumes result in better outcomes); and*

⁷⁹ The previous drafting of the same section of the substantive guidance was formulated in more financially-driven terms: ‘When will behaviour be anti-competitive and not in the interests of users of health care services? ... In assessing whether or not anti-competitive behaviour is in the interests of health care service users, *Monitor* will carry out a cost/benefit analysis. *Monitor* will consider whether by preventing, restricting or distorting competition behaviour gives rise to material adverse effects (costs) for health care service users. If we find that behaviour gives rise to material costs, we will consider whether it also gives rise to benefits that could not be achieved without the restriction on competition. *Monitor* will then weigh the benefits and costs’. *Monitor, Guidance on the Procurement, Patient Choice and Competition Regulations: consultation response*, 29-30. Available at: <http://www.monitor.gov.uk/sites/default/files/publications/ConsultationDec13.pdf> (Accessed: 19 November 2014).

⁸⁰ For discussion on similar issues, mainly in the US, see the contributions to the special bulletin on ‘Cost-Benefit Analyses for Health Care’ (2014) 9(2) *Competition Policy International*. Available at: <https://www.competitionpolicyinternational.com/sep-142> (Accessed: 20 November 2014).

⁸¹ E.g. see European Commission, *Guidelines on the applicability of Article 101 of the Treaty on the Functioning of the European Union to horizontal co-operation agreements* [2011] OJ C11/1.

- *non-clinical benefits may include a range of improvements such as better patient experience, better access for patients (for example, longer and/or more convenient opening hours, improved surroundings or better amenities).*⁸²

Monitor will then assess those benefits taking into consideration their materiality, such as the relevance of the qualitative improvements and the number of patients that can benefit from them, their lead time (*ie* period necessary to achieve them) and duration, and the robustness of the analysis and evidence that supports them. It will also consider whether the restrictions on competition are actually necessary to achieve the benefits. More specifically, '*Monitor will consider the extent to which achieving the benefits more quickly or cost-effectively outweighs the cost resulting from the reduction in competition as part of its cost/benefit analysis*'.⁸³

This analytical framework creates uncertainty, as it revolves around qualitative elements that differ from the standard 'efficiency analysis' that competition authorities usually consider in their enforcement of competition rules and focuses on parameters that are difficult to define and to measure in an objective manner (as further discussed below).⁸⁴ It may also be sometimes difficult to justify the acceptability of a costly restriction of competition where the expected benefits may be diffuse or not rank very highly in terms of the priorities for the improvement in the provision of health care services. That will require *Monitor* to engage in regulatory and policy-led decision-making, which may lead to conflicts with its own competition law enforcement duties (above §2.2). In the end, the methodology for the cost/benefit analysis (in both clinical and non-clinical dimensions) results in the consideration that

*This is not a mathematical exercise, but a qualitative assessment. Relevant benefits might outweigh the restriction on competition when, for example ... there is a reduction of competition between a small number of providers, but a significant number of other providers of the relevant services remain and the clinical benefits of the initiative are significant and well evidenced.*⁸⁵

It is then necessary to clarify to what extent *Monitor* can take into consideration 'qualitative efficiencies' (*ie* non-economic or medical/clinical aspects of the concept of "patients' interest") within the framework provided by the relevant EU competition rules. Before that, it is important to acknowledge that a potential conflict of substantive assessments will only arise where EU competition law is applicable,⁸⁶ which triggers the question of whether a cross-border competition effect needs to exist for EU law to be relevant. However, given the relatively unclear state of the law

⁸² *Monitor's Substantive Guidance 2013*, above (n 77) 63, emphasis added.

⁸³ *Ibid.*

⁸⁴ See European Commission, *Guidelines on the application of Article [101(3)] of the Treaty* [2004] OJ C101/97. The guidelines treat qualitative efficiencies in paragraphs 69-72, where the approach clearly supports the taking into account of qualitative efficiencies related to technological development or increased choice. That seems to indicate that qualitative elements such as clinical outcomes may be more difficult to bring in line or consider covered by that guidance. Regarding the difficulties of taking into consideration qualitative efficiencies, see the note prepared by the European Commission to the OECD, *Roundtable on the Role and Measurement of Quality in Competition Analysis* (DAF/COMP/WD(2013)32, June 13, 2013). Available at: http://ec.europa.eu/competition/international/multilateral/2013_june_roundtable_quality_en.pdf (Accessed: 19 November 2014). For a view considering that there is a broad array of goals and considerations that would be covered by Article 101(3) TFEU, C Townley *Article 81 EC and Public Policy* (Oxford: Hart Publishing, 2009). *cf.* O Odudu, 'The Wider Concerns of Competition Law' (2010) 30(3) *Oxford Journal of Legal Studies* 599–613.

⁸⁵ *Monitor's Substantive Guidance 2013*, above (n 77) 64, emphasis added.

⁸⁶ *ie*, where there is a "prevention, restriction or distortion of competition within the internal market".

on the territorial boundaries of EU competition law,⁸⁷ clashing substantive assessments should be avoided as a matter of *bona fide* compliance with art.3(2) of Regulation 1/2003.⁸⁸ Moreover, such harmonisation of substantive assessment would increase legal certainty, since undertakings would know that they are bound to be subjected to the same rules regardless of any eventual final finding on the existence (or not) of a cross-border distortion of competition.

In that regard, it is important to stress that under paragraphs 69 to 72 of the *Guidelines on the application of Article 101(3)*,⁸⁹ the European Commission has indicated that the ‘qualitative efficiencies’ it is willing to take into account as a justification for an otherwise anti-competitive agreement are primarily concerned with research and development efforts leading to: i) the offer of new or improved goods and services, or ii) products and services of higher quality or with novel features, or iii) services that are better tailored to customer needs or iv) to provide quicker delivery or better quality assurance. In that regard, it seems possible to reconcile “patients’ interest” understood as significant qualitative clinical and non-clinical advantages with the type of qualitative efficiency that the European Commission would in principle be willing to take into account.⁹⁰

When it comes to the assessment of the degree to which those efficiencies are passed on to the final users, it is also relevant to take into account that the *Guidelines on the application of Article 101(3)* also acknowledge that ‘[a]ny such assessment necessarily requires value judgment. It is difficult to assign precise values to dynamic efficiencies of this nature. However, the fundamental objective of the assessment remains the same, namely to ascertain the overall impact of the agreement on the consumers within the relevant market’.⁹¹ Additional informal guidance provided by the Commission strengthens this point by acknowledging that ‘[t]he assessment of quality is thus often a complex and imprecise exercise in itself, and involves the balancing of evidence which is often of subjective nature such as different perception of customers’,⁹² or that ‘[t]he possibility to use more exact quantitative tools is – contrary to an assessment focused on prices – more limited’.⁹³ A similar approach was followed by the Office of Fair Trading (now CMA) in the assessment of qualitative efficiencies that create direct economic benefits and to the inclusion of non-economic efficiencies under art.101(3) TFEU.⁹⁴

⁸⁷ And, more generally, of EU economic law related to the internal market fundamental freedoms. For an interesting discussion, see P Caro de Sousa “Catch Me If You Can? The Market Freedoms’ Ever-expanding Outer Limits” (2011) 4(2) *European Journal of Legal Studies* 162.

⁸⁸ Which *de facto* imposes substantive harmonisation of non-unilateral anti-competitive behaviour, at least where there is scope for the joint application of EU and domestic competition rules. On the impact of Regulation 1/2003 on the substantive competition rules of the Member States, see K Cseres ‘Comparing Laws in the Enforcement of EU and National Competition Laws’ (2010) 3(1) *European Journal of Legal Studies* 7. For a more critical approach to the harmonisation process, K Ceres, *Questions of Legitimacy in the Europeanization of Competition Law Procedures of the EU Member States* (2013) Amsterdam Centre for European Law and Governance Working Paper Series 2013–02. Available at: <http://acelg.uva.nl/publications> (Accessed: 19 November 2014).

⁸⁹ European Commission, *Guidelines on the application of Article [101(3)] of the Treaty* [2004] OJ C101/97.

⁹⁰ Always provided that they are demonstrated to exist to the required standard of proof.

⁹¹ Para. 103, emphasis added.

⁹² *Role and Measurement of Quality in Competition Analysis*, above (n 84) para. 10, emphasis added.

⁹³ *Ibid*, para. 12, emphasis added.

⁹⁴ Office of Fair Trading, *Article 101(3) – A Discussion of Narrow versus Broad Definition of Benefits* (2010). Available at: [http://www.oft.gov.uk/shared_of/events/Article101\(3\)-summary.pdf](http://www.oft.gov.uk/shared_of/events/Article101(3)-summary.pdf) (Accessed: 19 November 2014).

Therefore, the general approach anticipated by *Monitor*⁹⁵ seems fundamentally aligned with the approach indicated by the European Commission and the concurrently competent UK authority (CMA), although the ultimate way in which the value judgment is achieved may differ.⁹⁶ Thus, it will be important for *Monitor* to be very strict in the assessment of the perceived efficiencies (or, rather, of the efficiencies claimed by the undertakings engaged in anti-competitive practices in the patients' interest), given that the European Commission subjects qualitative efficiencies to strict evidentiary requirements. Indeed, despite the general acceptability of such efficiencies,

*the Commission will not simply accept quality improvement claims without further assessment. Parties that successfully want to rely on such claims must substantiate them in a way that allows the Commission to verify, inter alia, the causal link between the agreement and the quality improvements; their likelihood and magnitude; how and when the quality improvements would be achieved. To this end, the parties must bring forward convincing arguments and evidence.*⁹⁷

Therefore, in order to avoid breaching EU competition law, *Monitor* should keep a demanding approach towards the assessment of non-competitive dimension of "patients' interest". In that regard, and to ensure that *Monitor* sticks to its disclosed guidance and to the generally accepted enforcement practices, it would be highly desirable to reinstate the CMA's general concurrency powers, so that it can act and intervene should *Monitor* deviate from the expected interpretation and enforcement approach (below §6). A similarly strict approach will be required under EU public procurement law, as the following section shows.

5. *Monitor*'s incentives to bend arts.18(1) and 72-77 of Directive 2014/24

The second area where *Monitor* can have an incentive to deviate from pro-competitive enforcement activity concerns public procurement review and, in particular, those cases where the complainants' main concern identifies a (net) negative impact on competition in the market. As mentioned in passing, reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* allows for anti-competitive behaviour in the commissioning or procurement of services for the purposes of the NHS if doing so is in the interests of people who use health care services. This allows *Monitor* to refrain from investigating and sanctioning that behaviour in the exercise of its procurement review powers. This possibility is clearly at odds with its competition enforcement powers, unless a very strict approach to the assessment of "patients' interest" is carried out to ensure that there is actually no deviation in the interpretation and enforcement of art.101(3) TFEU in order to determine whether there is (net, inefficient or non-exemptible) anti-competitive behaviour (above §4). In such a case, though, it can be argued that reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* would be void of content, as no actual illegal or prohibited 'anti-competitive' behaviour would exist or indeed be tolerated by *Monitor*.⁹⁸

⁹⁵ 'This is not a mathematical exercise, but a qualitative assessment'.

⁹⁶ The differences can be derived from *Monitor*'s already discussed potential bias towards a lenient or soft approach, which should be countervailed by its obligations not to take into account regulatory powers and discretion when enforcing competition rules (above §3).

⁹⁷ *Role and Measurement of Quality in Competition Analysis*, above (n 84) para. 25.

⁹⁸ This point may be moot if one focusses exclusively on the definition provided in s.64(2) *Health and Social Care Act 2012*, according to which "'Anti-competitive behaviour" means behaviour which would (or would be likely to) prevent, restrict or distort competition'. However, it seems preferable to understand 'anti-competitive' behaviour that needs preventing as only that which cannot be exempted under art.101(3) TFEU.

On the contrary, if reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* was used to expand the remit of art.101(3) TFEU or to authorise behaviour that would otherwise be prohibited under the applicable competition rules, there would be a breach of EU competition rules and the duties imposed on *Monitor* as a co-competent competition authority.⁹⁹ Hence, it could be argued that this discussion is superfluous. However, given that *Monitor* accumulates the third layer of procurement oversight to the previously discussed powers of regulation and competition enforcement, it is worth assessing its potential conflicts of interest or duties in the interpretation and enforcement of the new 2014 EU public procurement rules.¹⁰⁰

Setting competition law consideration aside for now, the concept of “patient’s interest” as potentially encompassing less than competitive procurement practices raises a *prima facie* case of incompatibility with EU public procurement law and, more specifically, with the goal and principle of competition thereby embedded. As formulated in art.18 of Directive 2014/24, it is a general principle of EU procurement law that it has to run in a way that avoids distortions or restrictions of competition; and, more precisely, ‘[t]he design of the procurement shall not be made with the intention ... of artificially narrowing competition. Competition shall be considered to be artificially narrowed where the design of the procurement is made with the intention of unduly favouring or disadvantaging certain economic operators’.

Given that reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* precisely creates a justification for anti-competitive commissioning or procurement in the “patients’ interest”, at least as a matter of principle, there seems to be scope for a clash between these two rules. *Monitor* seems to have taken a different general view on this point of compatibility, as it has clearly indicated that compliance with the ‘requirements in the *Procurement, Patient Choice and Competition Regulations* create a framework for decision making that will assist commissioners to comply with ... other legislative requirements [that] include: ... the *Public Contracts Regulations 2006*, the *Public Sector Directive (Directive 2004/18/EC)* and general *European Union (EU) law*’.¹⁰¹ In view of this seemingly sweeping understanding or assumption of compatibility by *Monitor*, it is important to assess to what extent reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* can actually be considered compatible with the general requirements of the EU public procurement rules and, more specifically, of the general principle of competition.

It should be stressed that Directive 2014/24 creates a new light-touch regime for health care contracts included in Annex XIV¹⁰² and of a value above the financial thresholds defined in art.4(d) of

⁹⁹ Art.3 Regulation 1/2003. This provision clearly encapsulates a convergence rule that would be infringed if such substantive deviations occurred; see K Wright, ‘The European Commission’s Own ‘Preliminary Reference Procedure’ in Competition Cases?’ (2010) 16(6) *European Law Journal* 736, 739. For a critical assessment, see MC Lucey, ‘Unforeseen Unintended Consequences of Article 3 of EU Regulation 1/2003’ (2006) 27(10) *European Competition Law Review* 558–63.

¹⁰⁰ These are bound to be transposed in the UK by April 2016. For an update on the transposition process, see the results of the consultation finished on 19 September 2014 on the basis of the Draft Public Contracts Regulations 2015. Available at: <https://www.gov.uk/government/consultations/transposing-the-2014-eu-procurement-directives> (Accessed: 19 November 2014).

¹⁰¹ *Monitor’s Substantive Guidance 2013*, above (n 77) 8. There is no indication that *Monitor* has a different view where the new Directive 2014/24 is concerned.

¹⁰² Annex XIV covers virtually all health care related activities.

the Directive.¹⁰³ Those contracts will be subjected to the special award procedures regulated in arts.74 to 77 of Directive 2014/24. Without necessarily derogating art.18, art.76 of Directive 2014/24 introduces a specific set of additional special principles to be taken into account in the award of social services contracts, including health care contracts. Art.76(1) expressly requires that the domestic rules transposing Directive 2014/24 ensure that contracting authorities comply with the principles of transparency and equal treatment of economic operators. According to art.76(2),

Member States shall ensure that contracting authorities may take into account the need to ensure quality, continuity, accessibility, affordability, availability and comprehensiveness of the services, the specific needs of different categories of users, including disadvantaged and vulnerable groups, the involvement and empowerment of users and innovation. Member States may also provide that the choice of the service provider shall be made on the basis of the tender presenting the best price-quality ratio, taking into account quality and sustainability criteria for social services (emphasis added).

Overall, there seems to be nothing in art.76 that deactivates the requirement in art.18 that procurement for social services, including health care, shall be conducted without the intention of artificially narrowing competition. Or, in more natural terms, that such procurement is conducted in at least a competition-neutral manner. It also seems to be lacking any specific rule that would deactivate the presumption that competition shall be considered to have been artificially narrowed where the design of the procurement is made with the intention of unduly favouring or disadvantaging certain economic operators. The fact that art.76(1) only expressly mentions the principles of transparency and equal treatment (so that, *a contrario*, there could be a deviation from the requirement for competition) seems unsatisfactory as a reason to exclude pro-competitive requirements. Consequently, the proposed interpretation of the specific criteria listed in art.76(2) of the new Directive is that they still need to be identified and implemented in a manner that falls short from introducing unjustified restrictions or distortions of competition.

If that general approach is correct, then, even if it could be understood that the standard of “patients’ interest” in reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* is the domestic equivalent of the “quality-related” elements in art.76(2) of Directive 2014/24,¹⁰⁴ the authorisation of anti-competitive procurement still seems to fall outside the increased scope for flexibility created in Directive 2014/24 for the procurement of social services. This is so, at least, as a matter of a general authorisation to completely exclude competition in the tendering of those contracts—and, concomitantly, to allow for anti-competitive practices in the procurement of services for the NHS. Consequently, even taking into account all the flexibility and leeway created in the special regime for the award of social and other specific services of the new Directive, EU public procurement rules are at odds with a general authorisation for “anti-competitive procurement in the patients’ interest” that could be read in reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*. Such an incompatibility is rightly created by the Directive because, even in cases where there are particular patients’ needs, competition between all providers potentially able to satisfy them is the only way of ensuring that, ultimately, there is an actual delivery of the services or goods necessary to satisfy that need to the highest possible quality level. In other words, NHS commissioners can specify as demanding

¹⁰³ 750,000 Euro; currently approximately 600,000 GBP.

¹⁰⁴ Particularly in terms of the needs of different categories of vulnerable users, such as patients requiring long-term or intense care.

requirements as they consider appropriate and proportionate to satisfy the perceived patients' needs—but, once they have done so, they must refrain from engaging in any artificial restriction of the competition for the award for the contract. Consequently, from the procurement perspective, any reduction of competition for the contract that does not stem from an objectively verifiable need¹⁰⁵ should be deemed an artificial restriction of competition that would be in breach of arts.18 and 76 of Directive 2014/24. Indeed, according to *Monitor* itself,

*Competition ... to obtain contracts to provide services can incentivise providers to improve both the quality of the services they provide and value for money. Competition can therefore give rise to a range of benefits for users of health care services, including improved clinical outcomes, safer health care and a better patient experience (as a result of, for example, better amenities and surroundings or through care being delivered in a more integrated way with other services).*¹⁰⁶

Therefore, the potential conflict between patients' interests and badly-designed competition for the provision of services should not be sorted out by excluding competition. The reconciliation of these competing goals should rather derive from improved procurement techniques that are better suited to the proper identification of the patients' needs and their translation into technical specifications and contractual requirements, or contract compliance clauses. To be sure, the distinction between necessary and unnecessary procurement requirements will be difficult and may entail certain value judgments, but this is in line with the 'competition-dimension' of the enforcement of reg.10 and, consequently, should be subjected to equally demanding standards of evidence.

From a purely technical perspective, then, reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* can only be reconciled with the general requirements of the principle of competition consolidated in art.18 of Directive 2014/24 and the specific criteria of art.76(2) of the same Directive for the procurement of social services if NHS commissioners can discharge a demanding standard of proof in justifying that: i) the inclusion of any qualitative requirements in the "patients' interest" that imply a reduction of potential competition for the contract is clearly and soundly justified from the perspective of the clinical/medical needs to be satisfied; and ii) no potential supplier that could have satisfied those needs has been artificially excluded from the tendering/award process. Otherwise, at least for contracts covered by Directive 2014/24,¹⁰⁷ reg.10 of the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013* would not justify anti-competitive public procurement.¹⁰⁸ It would be in breach of EU public procurement law, regardless of it being considered justified on the basis of the standard of "patients' interest" created under the *NHS (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013*. Hence, *Monitor's* general position that compliance with the latter ensures compliance with EU public procurement law needs being revised. Further, *Monitor* may not be in a position to objectively do so and intervention by the *CMA* to ensure that health care-related procurement markets are not affected by distortions of competition would be beneficial (§6).

¹⁰⁵ Or, in other words, any imposition of a requirement that is not necessary to achieve the 'qualitative efficiencies' that would justify the practice from a strict competition law perspective.

¹⁰⁶ *Monitor's Substantive Guidance 2013*, above (n 77) 31.

¹⁰⁷ *ie* health care contracts included in Annex XIV with a value above 750,000 Euro or 600,000 GBP.

¹⁰⁸ *ie* procurement that artificially narrowed down competition and, particularly, as a result of a design made with the intention of unduly favouring or disadvantaging certain economic operators, such as the incumbent providers of health care services.

6. Conclusion: a (devolution) of powers to the CMA as a superior option

As mentioned throughout the paper, the main problem derived from *Monitor*'s accumulation of regulatory, competition and procurement enforcement powers lies in the structural conflict of interest or conflict of duties in which it is placed (§2). This conflict affects its incentives in the discharge of *ex ante* regulatory powers and *ex post* enforcement of competition law—as well as procurement law, although possibly to a more limited extent. The conflict is apparent when it comes to the interpretation of competition or procurement law provisions that would allow it to tolerate and not sanction anti-competitive behaviour that it considers to be in the “patients’ interest” or, in other words, to the benefit of the users of the NHS in England. This has been shown in relation to art.101 TFEU (§4) and arts. 18 and 72-77 of Directive 2014/24, as two areas where *Monitor* will have incentives (or pressures) to depart from the ‘standard’ interpretation of EU economic rules (§5). There can be other instances, as the analysis did not intend to be exhaustive.

Generally, most of these issues would be captured by a full concurrency regime that allowed the CMA to claim competence to instruct cases and, if *Monitor*'s conflict of interest/duties is as prevalent as considered here, to even request the Secretary of State to suppress *Monitor*'s competition enforcement powers.¹⁰⁹ However, the concurrency regime applicable to the *Monitor*-CMA relationship is *sui generis* and *asymmetrical*. The CMA cannot in any meaningful way be seen to impose any appropriate checks and balances on *Monitor*, which remains free to keep competition enforcement cases away from the CMA (§3).

All these difficulties are not diminished by *Monitor*'s and the CMA's understanding of the statutory duties related to competition and, in particular, by the ‘mantra’ that ‘*unlike other sectoral regulators, Monitor does not have a duty to promote competition*’. In the end, the proper functioning of these markets seems to rely on the self-imposed restrictions that *Monitor* may from time to time decide to abide by (or not)—with the exception, of course, of the judicial review before the Competition Appeals Tribunal. However, this minimal safeguard seems to come in too late and to be insufficient in terms of adequate institutional design. The general anti-competition discourse that resulted in the complicated drafting of *Monitor*'s competition-related statutory duties in the *Health and Social Care Act 2012* rather exacerbates these problems.

In the end, given the existing political pressures and the generalised acceptance that *Monitor* can (and should) manage competition in English health care markets in ways that can deviate significantly from ‘standard’ enforcement and promotion of competition, there is a particular need for an effective supervision of the way *Monitor* applies EU and UK competition and public procurement law. Not least, in order to avoid the UK being exposed to infringement procedures under art. 258 TFEU if the Commission takes issue with this institutional design. The best and easiest way to introduce some checks and balances to alleviate *Monitor*'s conflict of interest/duties would be to subject it to the ‘general’ concurrency regime applicable to other sector regulators under the *Enterprise and Regulatory Reform Act 2013* and the *Concurrency Regulations 2014*. This can and should be done quickly.

¹⁰⁹ The aspects concerned with the conflict in the enforcement of procurement rules would not be directly captured. However, if the CMA could open investigations in markets relating to the provision of health care services for the purposes of the NHS in England, this would provide an indirect solution that could suffice.