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Mary Guy, COMPETITION POLICY IN HEALTHCARE: FRONTIERS IN INSURANCE-BASED AND TAXATION-FUNDED SYSTEMS Cambridge: Intersentia (*www.intersentia.com*), 2019, xxxix + 262 pp. ISBN 978-1-78068-649-3 (Hardback) €79.00

In popular discourse in European contexts, and certainly in the UK, the idea that healthcare should be subject to the rules that apply to ordinary markets is highly controversial. Just this week (early June 2019), Trump's state visit to the UK was accompanied by extremely critical news reports to the effect that Trump seeks to use a post-Brexit UK-US trade deal to 'open up the NHS' to American firms. 'Hands off our NHS' is the common tone of these kinds of sentiments.

If, like me, you are regularly infuriated by the imprecision of broad-brush sentiments like these, Mary Guy's book will come as a delight. Its *starting point* is that it is more complicated than 'keep the market out of healthcare' versus 'we need the market to make healthcare efficient'. There is a world of difference between competition between, for instance, global pharmaceutical companies, supplying NHS hospitals and pharmacies where patients rely on free or heavily subsidised NHS prescriptions; and competition between independent physicians, or privately-owned companies, supplying long-term care, or emergency health services, to patients or to the social insurance entities with whom they are insured. There is a world of difference between looking at demand-side factors (like number of providers and availability of transparent information on services or products provided); supply-side factors (like barriers to entry to a market, for instance because of technology access); and institutional factors (like the formal legal forms of ownership of entities, including private capital, public/private initiatives, (re-)nationalised). And there is a world of difference between the specificities of how competition could, and does, apply within different health systems. In order to understand the implications, we need granular analysis, of actual healthcare systems, and the (competition) law that applies to them. That is what this book provides.

At the heart of the book is a carefully justified, rigorous and thorough analysis of the detailed rules of the two European healthcare systems that have gone the furthest with embracing competition law: the Netherlands and England. Guy is careful to distinguish the English NHS from the rest of the UK: Scotland, for instance, has not adopted the approach discussed here. The reader is treated to a historical and contemporary account which puts the reforms to the Dutch and English health systems, and the legislative changes that bring them into effect, into their context. One important contextual aspect – sometimes lost in solely doctrinally-focused treatises on the subject – is the difference between the potential (yet in the realms of merely theoretical) applicability of competition law in health systems, and its *actual application*. This latter goes to questions of practical enforcement, with all the resourcing implications that apply. The different institutional arrangements between the two systems (one essentially social insurance based, one essential taxation based) are carefully outlined, so that the reader is then equipped to understand how aspects of competition law and policy can (and do) apply in each system.

The book's key contribution is Guy's original analytical structure. Through this, the reader can understand each of the two systems, and thus how competition law and policy applies, and could apply in the future, leading to an assessment of its feasibility and desirability. The models are crucial for the reader to make sense of the nuance in the legal and conceptual analysis, and in this regard they work exceptionally well. Guy begins by distinguishing the macro, meso and micro levels of a healthcare system. At the macro level, ministers, competition authorities and health sector

regulators determine where competition can take place, and where (and what type of) regulation is necessary or desirable. The meso level, occupied by social insurers and/or commissioners of health services, links this level to the micro level, where healthcare providers (hospitals, clinics, general practitioners and specialists) offer healthcare services. Guy then develops two frameworks through which the detailed analytical work of the book is sustained. For the Netherlands, with its mandatory system of private health insurance introduced in 2006, Guy's three-part model distinguishes patients, insurers and providers. The logic of the system is that efficiency arises from competition between insurers, and between providers, which compete among and between themselves for patients. By contrast, for England, since the late 1980s, Guy's model helps us to understand the distinction between four different categories of English healthcare: essentially all the possible modalities between public/private and purchaser/provider. The logic here is about distinguishing strictly between the NHS and the private healthcare sector, and the reach of general competition law. The logic of competition law applies in the private purchaser/private provider context as if healthcare were the same as any other regulated market sector. But competition logics also apply in the public purchaser/public provider context, for instance, where public providers compete for contracts with NHS commissioners (now Clinical Commissioning Groups); and where the NHS contracts with private clinics to offer treatment to NHS patients (public purchaser/private provider).

Guy's comparative methodology allows her to draw out the bigger picture: a common starting point of solidarity as the lodestar of European health systems, and the underlying framework of EU competition law. The former explains why a narrative to the effect that healthcare is sufficiently similar to other sectors for the application of general competition law is deficient. A better justificatory narrative concerns competition as a means to an end: in particular, to modernise health systems and respond to increasing costs springing from increasing patient demands and an ageing population. Here, the key question is the extent to which values associated with solidaristic healthcare provision – equal access to high quality healthcare on the basis of medical need, not ability to pay – can be pursued within a competition policy framework, and how competition law can embed those values. EU competition law provides, through its exemption and exception measures, a significant margin of appreciation to domestic policy-makers. Hence, there is room for different member states (and devolved entities with competence over healthcare within those member states) to take quite different approaches to the application of competition law to their NHS. A focus on both solidarity and EU competition law highlights the benefits, and, crucially, the limitations, of competition reforms. Here, the Dutch and English cases of 'managed competition' provide important learning points for other European states.

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