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Competition in health care
And what can we learn from the UK?

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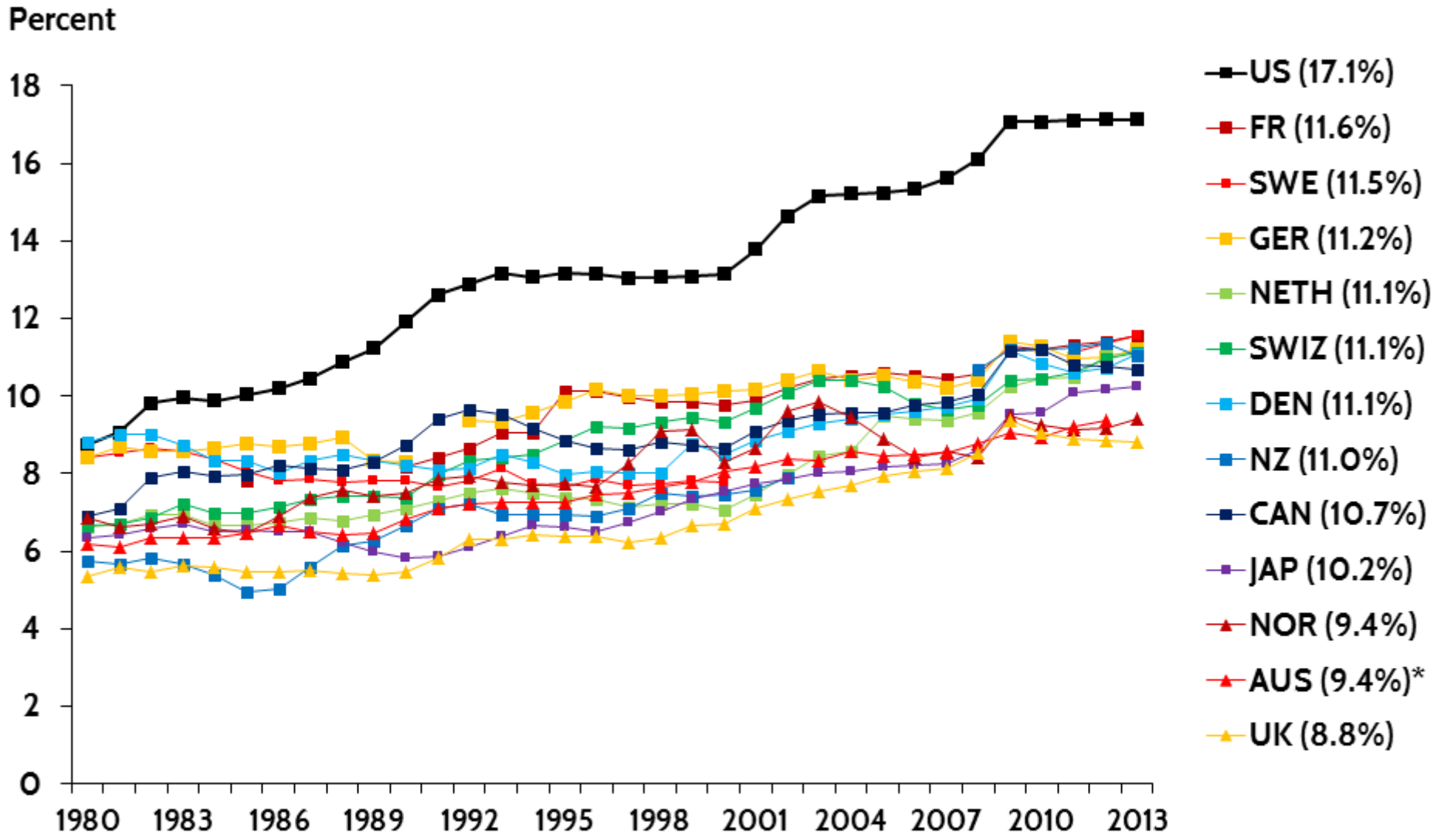
The background: the healthcare sector

- Characterised by growth in expenditure over time long period
- This tends to outstrip GDP growth
- Large amount of innovation, but innovation tends to be cost increasing (as well as enhancing quality)
- Policy makers therefore concerned about cost and productivity

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

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The healthcare sector

- Two ways to tackle growth
  - Demand side: Alter the incentives facing the consumer
  - Supply side: Alter the incentives for the supplier
- Demand side changes tend to increase the prices facing consumers to make them more responsive but have undesirable equity consequences
- Use is limited especially in European context

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The healthcare sector

- Focus is on supply side reforms – aimed at altering incentives for hospitals, clinicians and insurers
- One currently favoured approach is the introduction of market mechanisms into heavily regulated centralised systems
- Components are
  - Decentralisation of decision making
  - Promotion of competition between suppliers
  - Changes in payments/incentives

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Is this a good thing?

- Appeal of competition
- The theoretical support
- Can competition work in a (formerly) centralised system? Lessons from the UK
  - Outline the reform agenda in the UK
  - Summarise recent empirical studies to see what the evidence suggests
- Concluding thoughts

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The appeal of competition

- Competition in rest of the economy argued to promote growth
- Simple political appeal in heavily regulated healthcare markets with low productivity growth
- But consolidation in US markets has led to questions about functioning of markets in health care
- Is competition useful in healthcare?

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Definition

- In healthcare can have either competition on insurer side and/or competition on provision side
- Both: USA, the Netherlands (started with the insurance side); Switzerland (very regulated)
- Provider only – UK; Nordic countries
- Focus here on the latter

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Theoretical support

- Many models not very specific to the health care sector (though growing interest)
- Bottom line
  - Competition generally beneficial when prices are regulated (similar to simple models of school competition)
  - Anything could happen when they are not and results are sensitive to model specification
- Implications – empirical evidence is needed

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Non-UK evidence

- Mostly from USA
  - Where prices are regulated prices competition increases quality
  - Less clear when there are market determined prices
  - Effects are different across different types of buyers
  - Market structure may be endogenous to quality
- So …evidence from policy experiments very valuable

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Evidence from the UK

- Big experiment in introducing competition

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The Blair pro-choice reforms

- Blair regime started with ‘co-operation’ and targets
- Mid-2000s shifted to policy of ‘choice and competition’
- Key elements of the reform
  - Freedom for patients to choose hospital of care
  - Shift from selective contracting to administered, centrally fixed prices (for around 70% of hospital activity)
  - Greater autonomy for well performing hospitals (retain some surpluses; greater freedom over investment decisions)

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What happened?

- Did the reforms change behaviour and market structure?
- Did this have any effect on outcomes, processes, productivity, equity?

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Behaviour and market structure: choice

- Patient knowledge of choice
  - Around 50% of patients recalled being offered choice within two years of the reform
  - But also a view from some GPs that their patients did not want (or need) choice
- Increasing evidence that patients can choose on the basis of quality (evidence from choice of GPs; hip replacements)
- Better hospitals attracted more patients post reform

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Better hospitals attracted more patients

	Quality (AMI mortality rate 2003)					
	Bottom quartile			Top quartile		
	2003	2007	% change (2003-07)	2003	2007	% change (2003-07)
Number of elective admissions	33,985	38,274	12.6%	41,398	45,132	9.0%
Average distance travelled by patients	11.4	11.7	2.4%	10.0	10.1	1.1%
Share of patients bypassing nearest hospital	0.37	0.39	5.4%	0.45	0.43	-4.4%
Number of hospitals	33	33		32	32	

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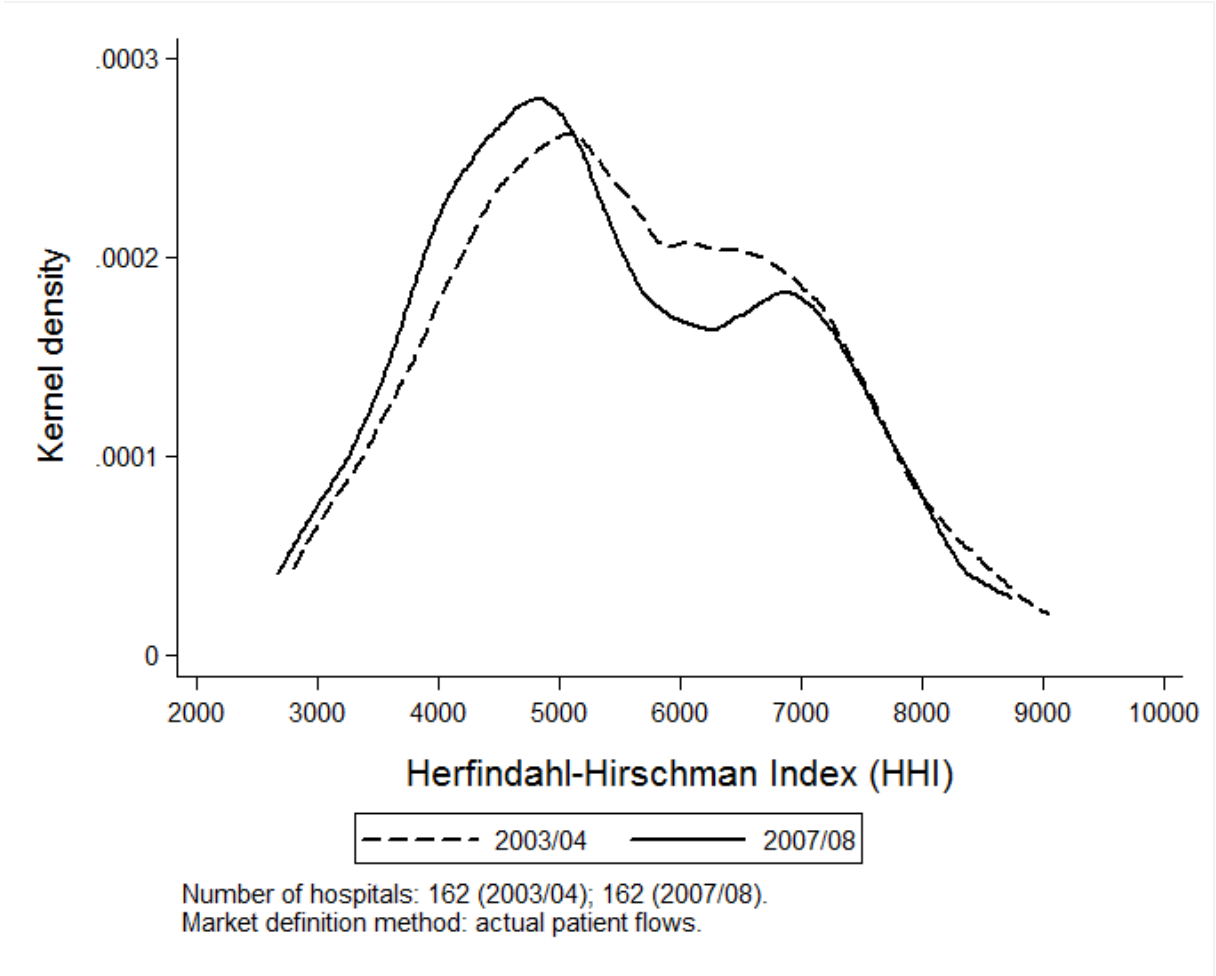
Change in market structure (actual provider HHI)



Number of hospitals: 162 (2003/04); 162 (2007/08).
Market definition method: actual patient flows.

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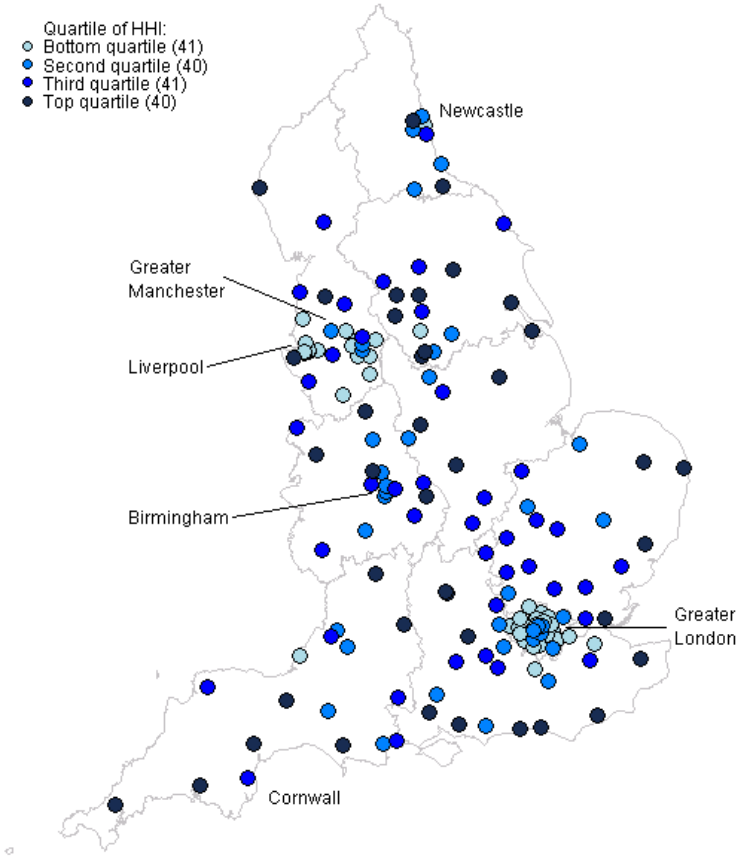
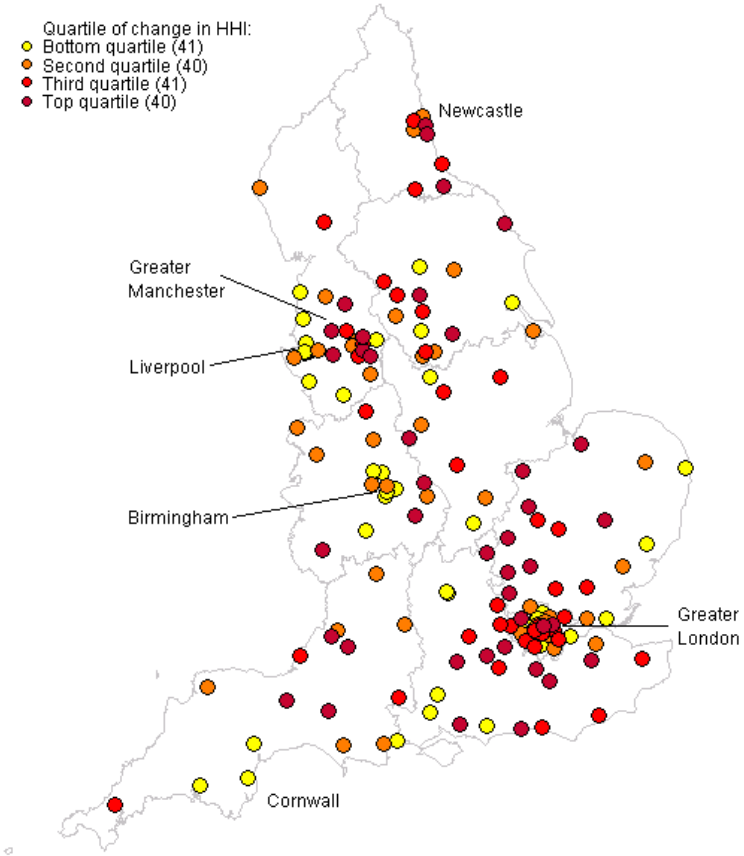
Where did freeing up choice have an impact?

Concentration levels: hospitals
2003/04



Measure: HHI based on actual patient flows.
Each dot in the figure represents a hospital.

Changes in concentration: hospitals
2003/04-2007/08



Measure: HHI based on actual patient flows.
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The impact on quality and process

Quality

- Mortality rates fell and fell by more in less concentrated markets
- Other measures of patient gain – no clear effect

Productivity

- Length of stay fell in less concentrated markets post reform
- No evidence of greater spending

Access/inequality

- No impact on waiting times
- No differential effects by income

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How did the reforms bring gains?

- Relatively little study of the mechanisms by which competition might bring benefits
- One approach has been to study the relationship between competition and management

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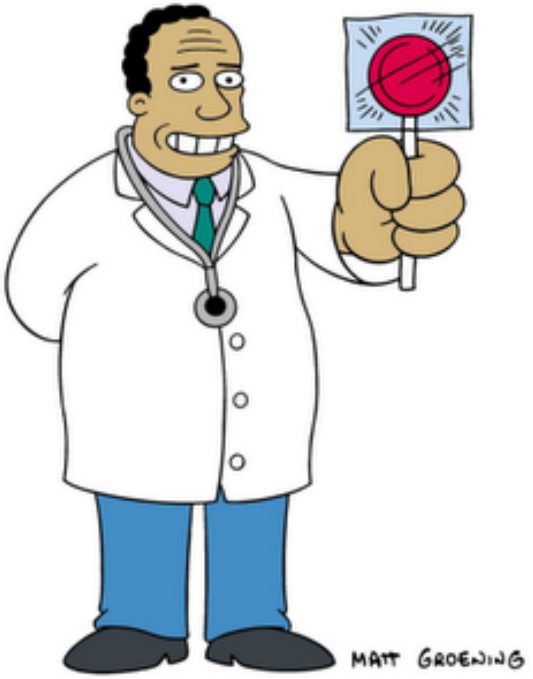
Competition and Management in Public Hospitals



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Motivation

- Management has been shown to result in greater firm productivity
- Economies which are competitive have better management
- Is this the case in hospitals?

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- Bloom et al (2015) use a well tried measure of management quality and look at the relationship with competition
- Find that better management is
  - Associated with a range of better outcomes (quality, financial performance, waiting times, staff satisfaction and regulator ratings)
  - Management is better in hospitals facing more competition

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MY (co-author's) FAVOURITE QUOTE:

Don't get sick in Britain

Interviewer : "Do staff sometimes end up doing the wrong sort of work for their skills?

NHS Manager: "You mean like doctors doing nurses jobs, and nurses doing porter jobs? Yeah, all the time. Last week, we had to get the healthier patients to push around the beds for the sicker patients"

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Evidence from UK Hospital consolidation

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Evidence from UK Hospital consolidation

- US evidence: consolidations raise prices, mixed impact on quality, reduce costs only slightly (Vogt 2009)
- Is this the same for a public system?
  - 1997 onwards UK experienced a wave of hospital reconfigurations
    - Over half of acute hospitals were involved in a reconfiguration with another trust
    - Median number of hospitals in a market fell from 7 to 5
- What was the impact on hospital production?

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- Gaynor et al (2012) find that consolidations resulted in:
  - Lower growth in admissions and staff numbers but no increase in productivity
  - No reduction in deficits
  - No improvement in quality
- Summary - costly to bring about with few visible gains other than reduction in capacity

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What do we know from the UK experiment?

- Impact of reforms appears positive
  - Patients and hospitals appear to have responded
  - Better hospitals attract more patients
  - Quality rose without an increase in expenditure
  - Some of this might be due to increased managerial effort
- Merger policy appears to have opposite effect
- Many outstanding questions e.g. role of private providers
- But there was/is a large political push-back

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Lessons and emerging Issues

- Pro-competitive policies appear to have brought about gains for patients
- Need market regulation to ensure mergers do not remove all competition
- Need to ensure market regulation does not become command and control by another name
- Need to address political issues that competition between public hospitals is seen as privatisation

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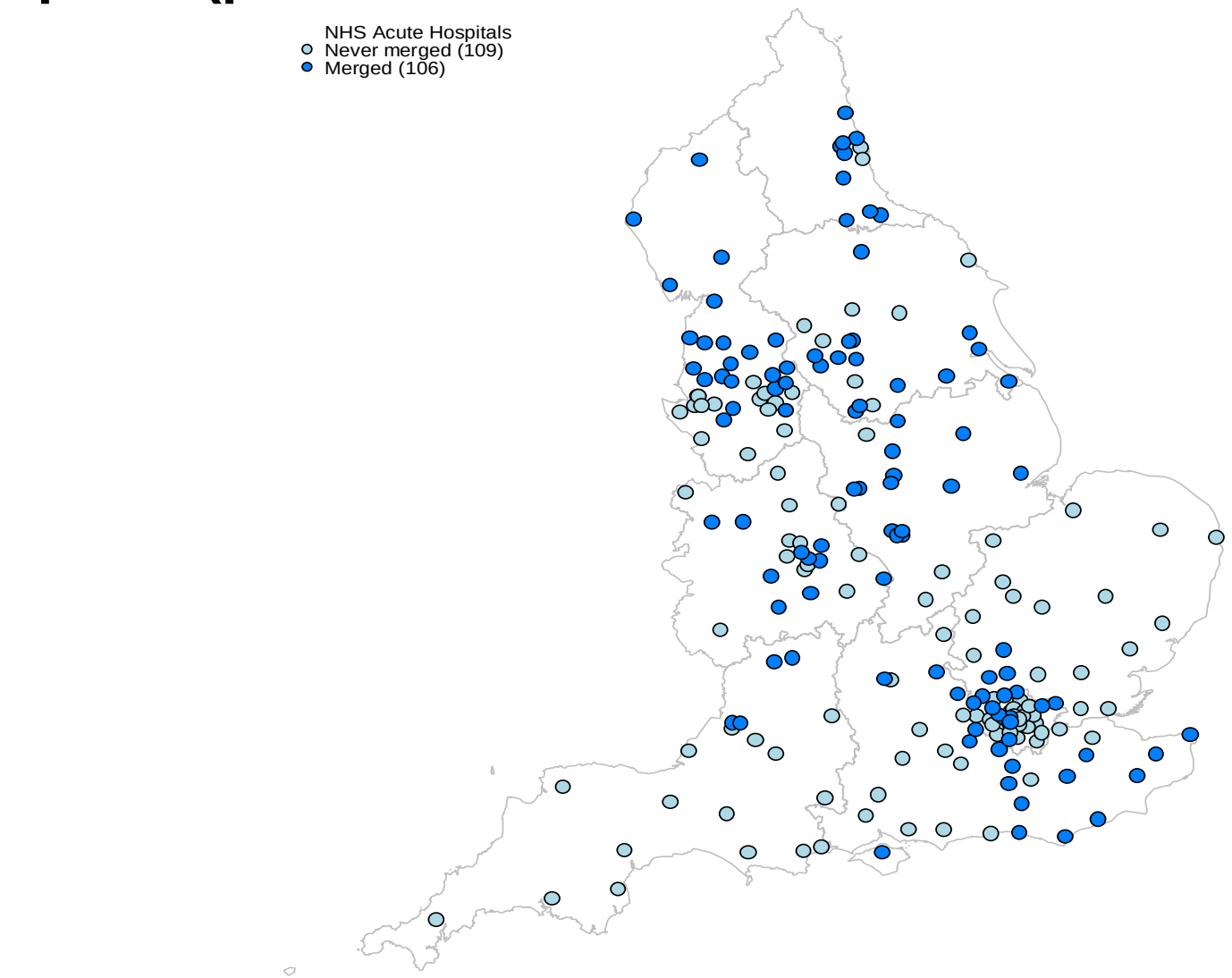
The evidence from the UK

THANK YOU

Widespread merger activity: merged and unmerged hospitals (pre merger)



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