Hospitals and competition: a view from the NHS and its reforms

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The background: the productivity challenge

- UK healthcare sector characterised by growth in expenditure over time long period
- Tends to outstrip GDP growth (as in other countries)
- Many estimates of productivity growth in sector are low
Greater competition in the healthcare sector

• Is competition one way to address this challenge?
  • UK (England) has been a pioneer in use of pro-market reforms in formerly heavily centralised and regulated systems
  • Several other European and OECD countries have also had major pro-market reforms in healthcare
• Lessons from the UK experience
Outline

• Brief overview of reforms
• Evaluation of impact on choice and outcomes
• Reflections and lessons for future
UK reforms

- Two waves of pro-market reforms
  - Part of pro-market reforms in general economy under Thatcher administration in 1990s
  - Labour administration mid-2000s which continued until around 2012 under Coalition administration
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
  - Focus on secondary care
  - Freedom for patients to choose hospital of care
  - Shift from selective contracting to DRG type pricing (for around 70% of hospital activity)
  - Greater autonomy for well performing hospitals (retain some surpluses; greater freedom over investment decisions)
What happened?

• Did the reforms change behavior and market structure?
• Did this have any effect on outcomes, processes, productivity, equity?
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 (as well as distance)

- Elective hip replacement surgery; heart surgery (CABG) (and from choice of GPs)
- Better hospitals attracted more patients post-reform (CABG surgery; hip replacements)
Quality (most evidence)
(1) D-i-d studies
  • Mortality rates - fell and fell by more in less concentrated markets (AMI - 2 studies, change pre-dated policy, 1 study; heart surgery - hospitals with higher quality elasticity has higher falls in mortality)
  • Other measures of patient gain – no clear effect and/or positive effects
(2) Structural studies
  • Mortality fell, patient utility rose by around 8% (CABG); hospital elasticity with respect to quality increased (hip replacement)
The impact on quality and process

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

Access/inequality
• No impact on waiting times
• Very few differential effects by income (deprivation) of local area
• Has increased utilisation of elective services
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
  • Management has been shown to result in greater firm productivity
  • Economies which are competitive have better management
  • Is this the case in hospitals?
Competition and Management in Public Hospitals
• Bloom et al (2015) use well-tried measure of management quality and examine relationship with competition

• Find that better management in England 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 local competition
Evidence from UK Hospital consolidation
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?
• 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 – mergers costly to bring about with few visible gains other than reduction in capacity
In sum….

• What do we know from the English experiments?
What do we know?

- 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

- But …..
Lessons and emerging issues

- Design issues in maintaining competition
  - Need to ensure mergers (networks) do not remove all competition and that market regulation does not become command and control by another name.

- Large political push back
  - Impact on overall expenditure is small; competition between public hospitals is seen as privatisation; choice is seen as a luxury in tough financial times.
  - Similar responses in other European countries where equity concerns limits amount of competition that is possible so effects are small.
The evidence from the UK

THANK YOU
The evidence from the UK

Additional material


Wynand P.M.M. van de Ven and Frederik T. Schut, "Universal Mandatory Health Insurance In The Netherlands: A Model For The United States?," *Health Affairs*, Volume 27, Number 3, May/June 2008


Centre for Health Economics (York University), research papers by Gutacker CHE Paper 111; Siciliani et al CHE Paper 123.
Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

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.
NHS Productivity 1998-2013

Health Economics
hec.3338, 4 APR 2016 DOI: 10.1002/hec.3338
Better hospitals attracted more patients (Gaynor et al)

<table>
<thead>
<tr>
<th>Quality (AMI mortality rate 2003)</th>
<th>Bottom quartile</th>
<th>Top quartile</th>
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<tbody>
<tr>
<td>Number of elective admissions</td>
<td>33,985</td>
<td>38,274</td>
</tr>
<tr>
<td>Average distance travelled by patients</td>
<td>11.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Share of patients bypassing nearest hospital</td>
<td>0.37</td>
<td>0.39</td>
</tr>
<tr>
<td>Number of hospitals</td>
<td>33</td>
<td>33</td>
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</tbody>
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Source: Gaynor et al Free to Choose
Change in market structure (actual provider HHI)

Herfindahl-Hirschman Index (HHI)

Kernel density

Market definition method: actual patient flows.
Where did freeing up choice have an impact?

Concentration levels: hospitals
2003/04

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

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

Source: Gaynor, Moreno-Serra, Propper
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”