…allowing US healthcare providers to share in cost savings appeared to lead to a reduction in costs without compromising quality.

CHOICE AND COMPETITION IN HEALTHCARE

The issue of choice and competition within the healthcare sector was discussed from a number of perspectives at the conference. Kate Ho (Columbia University) presented evidence that allowing US healthcare providers to share in cost savings appeared to lead to a reduction in costs without compromising quality. Carol Propper (CMPO) then showed that increasing patient choice in the UK appeared to lead to improvements in surgery outcomes. Both presentations indicated that market based reforms could improve the quality and efficiency of healthcare provision, while adding caveats that these results may not apply to other aspects of healthcare provision. These caveats were discussed in more detail, along with other reasons that competition and choice might not always have such desirable effects, in the Policy Panel (see page 18).

Incentive payments in the US

Kate Ho's research examined the impact of giving Accountable Care Organisations (ACOs) a share of any cost savings made. An ACO is a group of doctors and hospitals that provides care to blocks of patients (at least 5000). Incentive payments to ACOs based on cost savings are contingent on certain quality-based benchmarks being met. This structure was devised with the aim of improving quality and efficiency by avoiding duplication and aiding the flow of information when multiple providers are involved in the care of a single patient.

Ho exploited the variation in the use of such incentive plans across different insurers to analyse their impact on the quality and cost of care provided, focussing specifically on births and post-natal care. Ho found that where such incentives were in place, patients were admitted to lower-priced hospitals. Ho also found that this did not lead to a fall in quality, but rather that these patients were asked to travel to an equivalent standard hospital that was further away.

Right to choose

Propper's research analysed reforms introduced in 2006 that granted UK patients the right to choose the hospital in which they would be treated. Focussing on elective coronary artery bypass graft (CABG) surgeries, Propper found that patients appeared to respond to information on mortality rates by choosing better hospitals and that low-performing hospitals appeared to improve their quality in response. Propper's work indicated that extending patient choice improves outcomes via both demand-led and supply-response mechanisms.

Concerns that only more affluent patients were capable of utilising their choice effectively were then addressed. Not only was it found that this was not the case, but it also appeared that the sickest patients were the most responsive to information on mortality rates. Propper concluded by presenting estimated benefits accrued from the reforms. While acknowledging the inherent problems of such calculations, Propper estimated that 12 lives had been saved by the improvements in patient outcomes and ended by noting that, contrary to the opinion of the BMA, choice and competition can play an important role in the provision of healthcare.

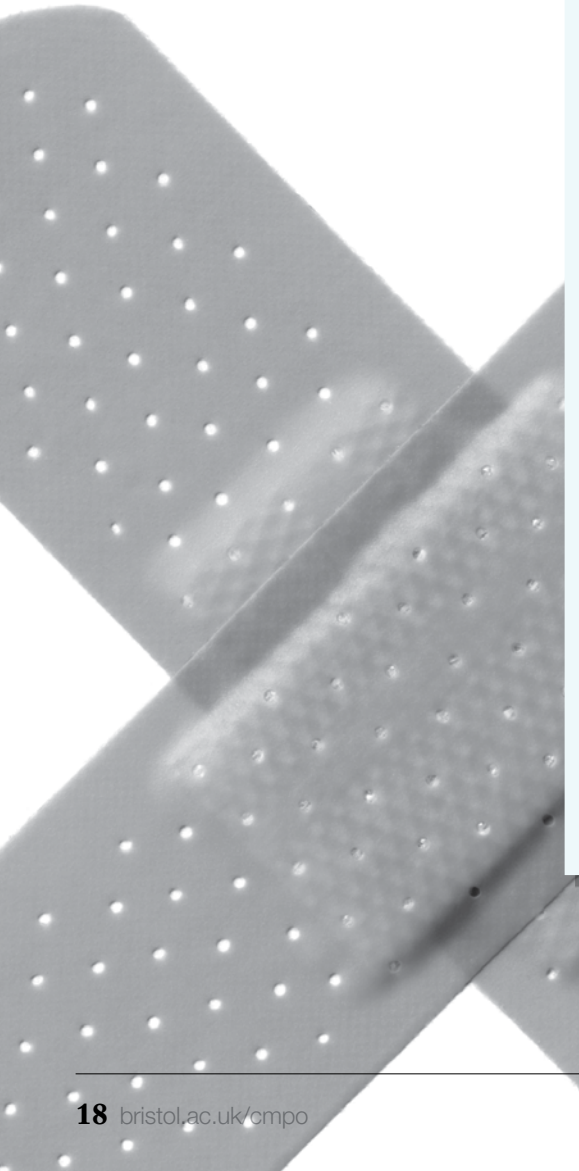
However, both presenters emphasised that the success of choice and competition as a policy lever is contingent on numerous aspects of the healthcare market's structure. The Policy Panel then elaborated on this point, discussing the views of different players in the sector.

Papers

Gaynor, M., Propper, C., & Seiler, S. (2011), *Free to choose: Reform and demand response in the British National Health Service*, Unpublished manuscript, Stanford University.

Ho, K., & Pakes, A. (2012), *Hospital Choices, Hospital Prices and Financial Incentives to Physicians*, Working Paper, March 2012.

Large providers tend to treat patients in an undifferentiated way, so those with particular needs will often receive a low quality service.



POLICY PANEL

CHOICE AND COMPETITION IN HEALTHCARE

The healthcare policy panel discussion was chaired by Carol Propper and the panel members were Fiona Scott Morton (Yale), Matthew Bell (Frontier Economics) and Catherine Davies (Monitor).

Fiona Scott Morton discussed the implications of the 'Obamacare' reforms, focussing on the need for a strong and competent regulator to monitor anti-competitive behaviour in particular. Catherine Davies of Monitor, the UK's healthcare regulator, then outlined her organisation's three objectives: aiding the proliferation of best practice, creating an environment that fosters innovation, and creating an environment in which high quality service providers are incentivised to expand.

Davies argued that competition, introduced in the right way, could be beneficial to all three, adding that Monitor should be seen by providers as an enabler of competition rather than a bureaucratic burden. Davies also rejected the notion that competition and choice can only be introduced at the expense of 'integrated' care. Scott Morton echoed this point, arguing that integration is a vertical issue while competition is a horizontal one.

Matthew Bell then outlined how providers saw the new commissioning process in the UK. Bell suggested that providers could be split into three categories. First, there are many that simply do not yet understand the new system – unsurprising given the scale of the reforms and the extent to which details are still being decided upon. Bell noted that some providers find it hard to decipher the overall 'direction of travel' because there have been so many conflicting initiatives over recent years.

Second, there are those that understand but do not agree: that group can be split into those that oppose the reforms on ideological grounds and those who are sceptical of the academic evidence because they believe the data collection processes that such research is based on is severely flawed. Bell also argued that there is frequently a disconnect between providers' views of what motivates them and the incentive structures policymakers implement to raise productivity.

Lastly, there are providers who believe the academic evidence on choice and competition but are not sure exactly what the new commissioning landscape is incentivising them to do. Foundation Trusts have a constitution that tells them to deliver healthcare services 'effectively, economically and efficiently', but these concepts are not defined any further, and so in the end providers see their role as simply to provide healthcare services. These providers also report that buyers of healthcare services are so weak that they cannot exert a true competitive pressure, hence providers make decisions on the basis of what is right for the healthcare system rather than their own interests, blunting the mechanism via which competitiveness is meant to raise standards.

The panel's discussion concluded with a Q&A session. When asked which patients would be the most likely beneficiaries of market-based reforms, the panel appeared to agree that small groups who previously received the poorest service had the most to gain. With very little competition, large providers tend to treat patients in an undifferentiated way, so those with particular needs will often receive a low quality service. These are therefore the patients that can benefit the most from innovation.