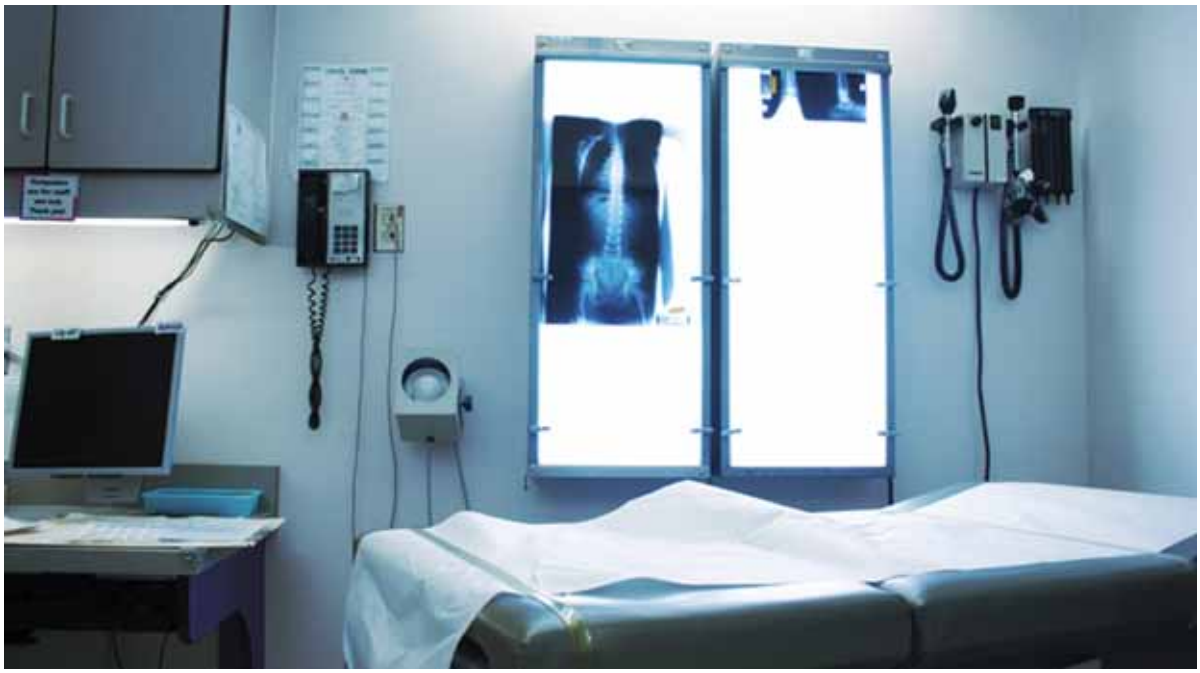
The White Paper, competition and the NHS



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With the White Paper advocating greater choice in public services, CMPO's Carol Propper explores what choice and competition have delivered in healthcare to date. She weighs up the evidence on the impact of the 1990s 'internal market' and the 2000s NHS reforms in England.

The White Paper advocates choice in public services as the way to bring about higher quality services that are more appropriate to individuals' needs and better value for money. Health services are a central part of this vision, and the White Paper makes several references to the existing choice-based reforms in healthcare as being one component of the desired direction of travel.

As articulated by politicians, the appeal of choice – and its natural associate, competition between providers of services – is simple. Competition delivers greater productivity in the rest of the economy and choice is generally valued by consumers. Extending this to the healthcare sector seems a logical way of improving productivity. Competition between suppliers will encourage efficiency and raise quality, while increasing choice will meet demands for more personalised services and potentially make consumers more responsive to differences in quality and price.

Two decades ago, competition in healthcare was confined to the United States among OECD countries. But in the last 20 years, competition has been widely advocated as a model for reform. The UK has been a leader in trying to introduce competition on the delivery side, albeit confined to patient choice of hospitals and the competition between them that results.

Yet at the same time as competition was being proposed as a model for Europe, US healthcare providers were consolidating, leading to a large rise in market concentration. From other quarters, there is growing evidence of an association between volume and outcomes, particularly for high-tech services. This has driven an interest in the consolidation of specialist services with an attendant decrease in the number of providers of these services and growing integration of primary and secondary care.

All these developments raise questions about the role of choice and competition. So what have we learned from our experience in the UK?

Differences in the outcomes of the 1990s internal market and the 2000s choice reforms highlight the importance of information

Evidence from the 1990s

The evidence from the NHS 'internal market' of the 1990s is relatively limited but it suggests the following. First, costs may have fallen more where there were more hospitals in a local area and buyers of healthcare had more options from which to choose.

Second, the buyers of healthcare who were also primary care providers (GP fundholders) seemed able to extract better deals from hospitals than larger area-based purchasers. This was perhaps because the former had stronger financial incentives, in that any gains from purchasing could be retained within their

businesses. The larger purchasers were also concerned about the viability of local services if they moved services at the margin, while the fundholders were less concerned with this issue, as they had no remit for provision of all secondary care services.

Third, hospitals facing more competition focused on bringing down waiting times but at the expense of unobserved quality. This finding is uncomfortable for proponents of competition but it fits with the predictions of simple models of competition with imperfect information. These show that as competition increases, sellers will focus on those aspects of care for which demand is more responsive. As buyers of care in the internal market were primarily interested in increasing volume and reducing waiting times (and care quality was not made public), it is unsurprising that sellers engaging in competition focused on bringing down waiting times at the expense of unmeasured quality.

Fourth, despite political fears about 'two-tier' services, there is little evidence that patients whose secondary elective care was purchased by GP fundholders received more care than those patients covered by the larger health authorities.

Evidence from the 2000s choice reforms in England

The reforms of the 2000s – of which the centrepiece was the 'choose and book' policy, from the mid-2000s – were only in England. This time, choice was accompanied by a system of prospective payments for acute hospital care, and by more information on the quality of care provided at NHS hospitals. The latter went from a base of almost none in the 1990s to a large battery of measures, albeit at a relatively aggregate level – the hospital trust level rather than site, individual doctor or ward level.

Evaluation of this set of choice reforms is still in progress, but the following stylised facts have emerged.

First, the take-up of choice was slow and GPs did not offer it to all patients. Some have interpreted this as choice not working. But this is to misinterpret the nature of competition in markets. It is not necessary for all individuals to switch services for competition to occur: it simply requires sellers to know that buyers could switch for competition to have an effect. And there is evidence that patterns of care-seeking changed after the reforms. Research has shown that hospitals with shorter waiting times and higher quality (as measured by lower death rates) were chosen more often.

Second, there is evidence that hospitals located in more competitive areas had improvements in quality. Quality in hospital care is very difficult to measure, so to date researchers have only examined crude proxies measured at the hospital level. Research has shown that quality in hospitals located in areas with the most potential competition did not fall and, on some measures (mortality rates), quality actually rose.

Third, despite fears that poorer patients would be disadvantaged by increasing choice and competition, there seems to be little evidence that this is the case.

The differences between the findings from the 1990s internal market and the experience of the 2000s highlight the importance of information. While the information available in the 2000s was not perfect, it was greater than in the 1990s and perhaps allowed doctors (as agents for their patients) to steer patients away from poorer performing local hospitals. The fact that prices were not part of the choice process meant that they did not have to trade off price against quality.

The research agenda

We have learned much in the last 10 years about the impact of competition in UK healthcare, but there are still lots of areas we know little about. These include the fact that the outcomes that have been measured are only a small part of the activities of hospitals. Some would argue that these are not well enough measured to base strong conclusions on them.

The White Paper offers an opportunity to try to understand where exactly choice may work and where it may not

Furthermore, the mechanisms by which apparent improvements have occurred are not well understood. There is some evidence that competition brings about better management and that, as in the rest of the economy, this is associated with better outcomes. But more research needs to be done to understand the link between competition and outcomes.

The drive for competition is also taking place at a time when there are emerging calls for consolidation and vertical integration to achieve higher clinical quality. As a response, there are already efforts to reduce the number of hospitals in England and to consolidate high-tech services into high volume centres. While there is evidence that there are gains from this for particular services, such as trauma and cardiac care, the extent to which this applies to all services that might be consolidated is unknown.

Finally, we know little about competition in primary care in the UK (or indeed elsewhere). More broadly, the impact of competition in community services, including mental health services, has been a neglected area. Yet these services, where patient choice may be easier, are arguably those on which the White Paper is focused.

So, in summary, the evidence base for choice is small and the extent to which choice has been used is quite limited. But this is not an argument for a return to 'command and control': rather it is a call to try to understand where exactly choice may work and where it may not. The White Paper may offer that opportunity.

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