Competition can help the NHS – but proceed with care

Launch of the Report of the OHE Commission on Competition in the NHS

31st January 2012

Members of the OHE Commission on Competition in the NHS:
Jim Malcomson (Chair) – Professor of Economics, University of Oxford; All Souls College
Mike Bailey – Medical Director and Deputy Chief Executive, St George’s Hospital, London
Anita Charlesworth – Chief Economist, The Nuffield Trust
Nigel Edwards – Senior Fellow at The King’s Fund, Global Healthcare Group at KPMG LLP
Julian Le Grand – Richard Titmuss Professor of Social Policy, London School of Economics
Carol Propper – Professor of Economics, Imperial College and Bristol University
Bob Ricketts – Director, Provider Policy, Department of Health
Jon Sussex – Deputy Director, Office of Health Economics
Adrian Towe – Director, Office of Health Economics
Remit of the OHE Commission

• Role for competition in the NHS
  • a hot political issue
  • highly polarized views
• Remit of Commission to:
  • assess evidence on competition among providers
  • make recommendations for use in NHS in England

Our Starting Point

• NHS provides a whole variety of services
  • with many different characteristics
  • no reason for competition to work the same for all
• When does competition serve public interest?
  • economics has studied characteristics that problematic for competition
  • some health services have such characteristics
  • which ones?
What the Commission Has Done

- Commissioned reviews of evidence on:
  - effects of competition in health services
  - effects of competition in market for care homes
  - economies of scope in A&E
  - evidence more limited than would have liked
- Developed a framework for effective competition
  - maps relevant attributes to specific health services
- Explored with NHS commissioners:
  - its framework for competition, with positive response
  - possible conflict with integration of care

Price Competition

- Evidence:
  - greater competition reduces costs & waiting times
  - but may also result in lower quality care for patients
- Not surprising in light of economic theory
  - particular danger where quality of care not visible to patients / GPs / NHS commissioners
- Not appropriate to recommend wholesale price competition
- But where commissioning one or a few providers for an area, with quality monitored directly, it makes sense to take cost of provision into account
Competition with Regulated Prices – Quality Competition

• Evidence that can be beneficial
  • without increased inequity in access to care
• Recent studies of heart attack NHS admissions
  • find increased competition from “payment by results” and patient choice reduced mortality
  • have weaknesses, as many point out
  • but critics have not done better statistical analysis reaching opposite conclusions
  • so still best evidence available
• Effects (300 fewer deaths per year?) too big to ignore

Conclusions for Competition with Regulated Prices

• Certainly not appropriate to re-organise NHS yet again by rolling back “payment by results” and patient choice

• NHS commissioners should:
  • promote competition where OHE Commission’s framework indicates effective
  • consider competitive tendering for other services
  • ensure data is collected to enable evaluation
Integrated Care

• Of great concern; considered very carefully
• Many areas outside health care where services need to be effectively co-ordinated
  • and competition does not appear to hinder it
• Not found evidence that health care different
  • NHS commissioners actually gave examples where potential for competition helped in getting integration
  • specifically, between hospital and community
• So, unless new evidence to the contrary is forthcoming, integration seems unlikely to be hampered by competition

Competition Does Not Mean Privatization

• Competition not same as privatization
  • there can be competition between NHS trusts
  • even in countries with much more competition in health care than England, most providers are not-for-profit institutions
• There would seem to be good reasons for this
• Commission has not addressed question of whether NHS would be better served by having a higher proportion of private providers
The OHE Commission Recommends

• Where current providers’ performance suggests health care could be improved, competition should be given serious consideration
• The likely effectiveness of competition be assessed before it is tried – using the analytical tool developed by the OHE Commission and described in the report
• “Any qualified provider” arrangements allowing patients, helped by their GPs, to choose where to get their health care are suitable in some cases
• In other cases competitive procurement by local NHS commissioners will be appropriate
• Routine collection and publication of patient outcome measures be expanded to enable evaluation of the effects of competition

In Summary: “Competition Can Help the NHS—But Proceed with Care”

• On the best available evidence, competition at regulated prices has improved the quality of some NHS services
• Health care consists of a whole variety of services with different characteristics
  • OHE Commission has produced a tool for evaluating where competition is most likely to be effective
• Competition can help integration of care – no evidence that it hampers integration
Framework for Assessing the Feasibility of Competition

- Priority areas for promoting competition are where it looks likely to be **beneficial** and **feasible**
- The framework is about **feasibility**
- Starts from economic principles
- Focused on the specific characteristics of health care ‘markets’

### Assessing Feasibility – 8 Main Dimensions (of 23)

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Density and stability of demand</td>
<td>Low</td>
<td>Medium</td>
<td>High</td>
</tr>
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<td>2. Willingness/ability to travel</td>
<td>Low</td>
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<tr>
<td>3. Ease of acquiring information about output quality</td>
<td>Difficult</td>
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<td>4. Economies of scale</td>
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<td>5. Economies of scope</td>
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<tr>
<td>6. Scope for cherry picking and/or dumping</td>
<td>Major</td>
<td>Minor</td>
<td>None</td>
</tr>
<tr>
<td>7. Asymmetric competitive constraints</td>
<td>Substantial</td>
<td>Modest</td>
<td>None</td>
</tr>
<tr>
<td>8. Politics: too important too fail</td>
<td>Yes</td>
<td>Maybe</td>
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1. Density and Stability of Demand

Competition is more feasible ....

- The greater is the demand for a service in a given area *relative to the minimum efficient scale of production* of that service
- The more stable and predictable is demand, and hence the more attractive is the market

<table>
<thead>
<tr>
<th>Density and stability of demand</th>
<th>Elective hip replacement</th>
<th>Major trauma services</th>
<th>Tertiary hospital care</th>
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2. Willingness/Ability to Travel

Competition is more feasible the greater the extent of the potential market and hence ....

- The more willing patients are to travel to receive the (non-emergency) service
- The less damaging to their health is the travel time to the (emergency) service

<table>
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<th>Willingness/ability to travel</th>
<th>Cardiac surgery</th>
<th>Elective hip replacement</th>
<th>GP consultations</th>
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3. Ease of Acquiring Information about Output Quality

- Competition is more feasible the easier it is for the ‘customer’ to determine the quality of the service, i.e. where ....
  - likely quality of output is visible in advance
  - quality of output can be defined and monitored
  - costs of switching between providers are low
- ‘Customer’ can effectively be the patient, their GP or the commissioning agency (PCT/CCG), depending on the service

<table>
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<tr>
<th>Ease of acquiring information about output quality</th>
<th>IVF</th>
<th>Cancer chemotherapy</th>
<th>Community based mental health care</th>
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4. Economies of Scale

Competition is more feasible where economies of scale are small or non-existent, i.e. where ....
- Fixed costs are small
- Sunk costs / highly specific assets are few or none
- Learning-by-doing conveys little advantage

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<th>GP consultations</th>
<th>Cardiac surgery</th>
<th>Radiotherapy</th>
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5. Economies of Scope

Competition is more feasible where there are few or no economies of scope, i.e. it is not significantly lower cost (for a given quality) to produce services separately rather than together.

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<th>Flu vaccination</th>
<th>Elective hip replacement</th>
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6. Scope for Cherry Picking and/or Dumping

- Competition is more feasible if service providers would find it difficult to select low cost patients and exclude high cost patients.
- Which arises when the provider can predict patient cost before treatment and the payer cannot detect that selection is occurring.

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<th>End of life palliative care</th>
<th>Cardiac surgery</th>
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7. Asymmetric Competitive Constraints

Existing providers may have different capacities to compete with one another. E.g. a hospital-based provider might be able readily to expand into community provision but a community-based provider would not be able to match the hospital-based providers’ back-up facilities. This imbalance could render the weaker party unwilling to try to compete.

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8. Politics: Too Important to Fail

- Say no more ....

| Politics: too important too fail | Flu vaccination | Elective hip replacement | Major trauma services |
# Assessing Feasibility

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