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Markets and health care: contradiction or conundrum?

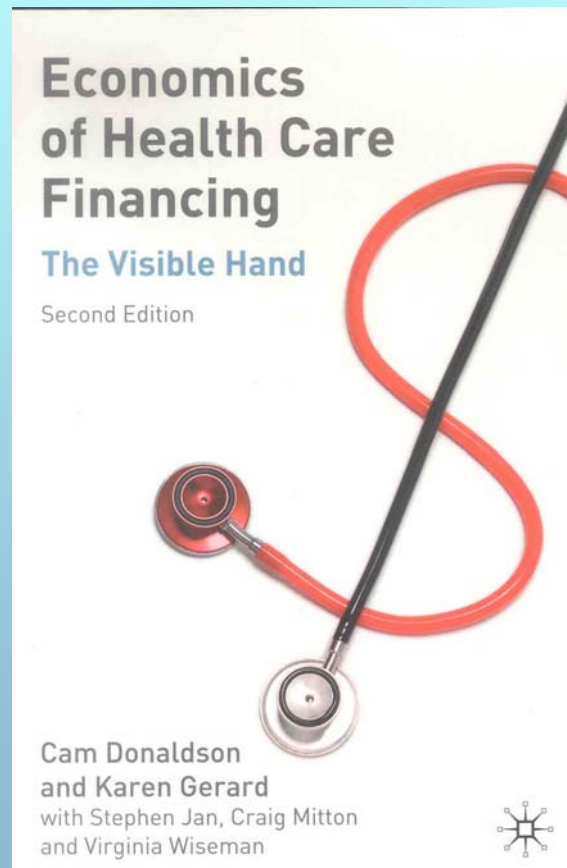
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Shameless promotion



Outline

- Market failure and its consequences
- The anomaly of user charges
- Competitive mix in financing and provision
- Moving to markets in public systems:
 - internal markets/contracting out
- Moving away from markets in the US
- Recent UK reforms; how Tony Blair got caught out and would the UK be better off with John Deeble?!



Percentage of health care expenditures from public purse

	<u>1990</u>	<u>1998</u>
Australia	67%	70%
Canada	75%	70%
UK	84%	83%
US	40%	45%

Moral and political reasons for these percentages, but also...



Market failure in health care results from:

- 1) Uncertainty, leading to health care insurance and failure due to:
 - diseconomies of small scale;
 - moral hazard;
 - adverse selection.
- 2) Externalities
- 3) Asymmetry of information resulting from consumer ignorance and leading to licensure.



Alan Williams and the tail of the duck-billed platypus!

“The method of reasoning that you employ here is not adequate to sustain the conclusions that you draw, in fact the conclusion is itself a non sequitur. What you do is consider various characteristics of medical care...and you show that each of these in turn is to be found in some other (non-collective) good or service. You then draw the quite unwarranted conclusion that medical care is not markedly different...This conclusion is unwarranted because what you need to show...is that there are ‘other goods in the market’ each of which exhibits all of these characteristics. Let me illustrate my point by analogy. What is peculiar about the duck-billed platypus? It has a duck-type bill, a furry body like a mole, it lays eggs, and it suckles its young! Now the type of analysis you have employed would run as follows...many birds have duck-type bills, and lots of animals have furry bodies, and as for laying eggs, this is common among birds and reptiles, and all mammals suckle their young, therefore the duck-billed platypus ‘would appear to have no characteristics which differentiate it sharply from other...’ etc. I hope my point is clear.”

(Alan Williams, in a letter to Dennis Lees, November 1961)




'Public' systems

Key differences relative to private insurance:

- organised on basis of groups/contributions based on income
- economies of scale
- universality/compulsory
- cost control through administrative mechanisms, such as binding fee schedules, global budgets, limits on capacity

Evans (1987), White (1995)





“...in all developed countries, Wildavsky’s (1997) law of medical money (‘costs will increase to the level of available funds...that level must be limited to keep costs down’) has been understood and acted upon though the development of countervailing public authority”.

Evans (1997)



User charges: an exception?

- Not a great proportion of the spend
- Administratively cumbersome
- Fallacy of composition
 - related to supplier-induced demand
- Equity implications in terms of use and health
- Blunt instrument

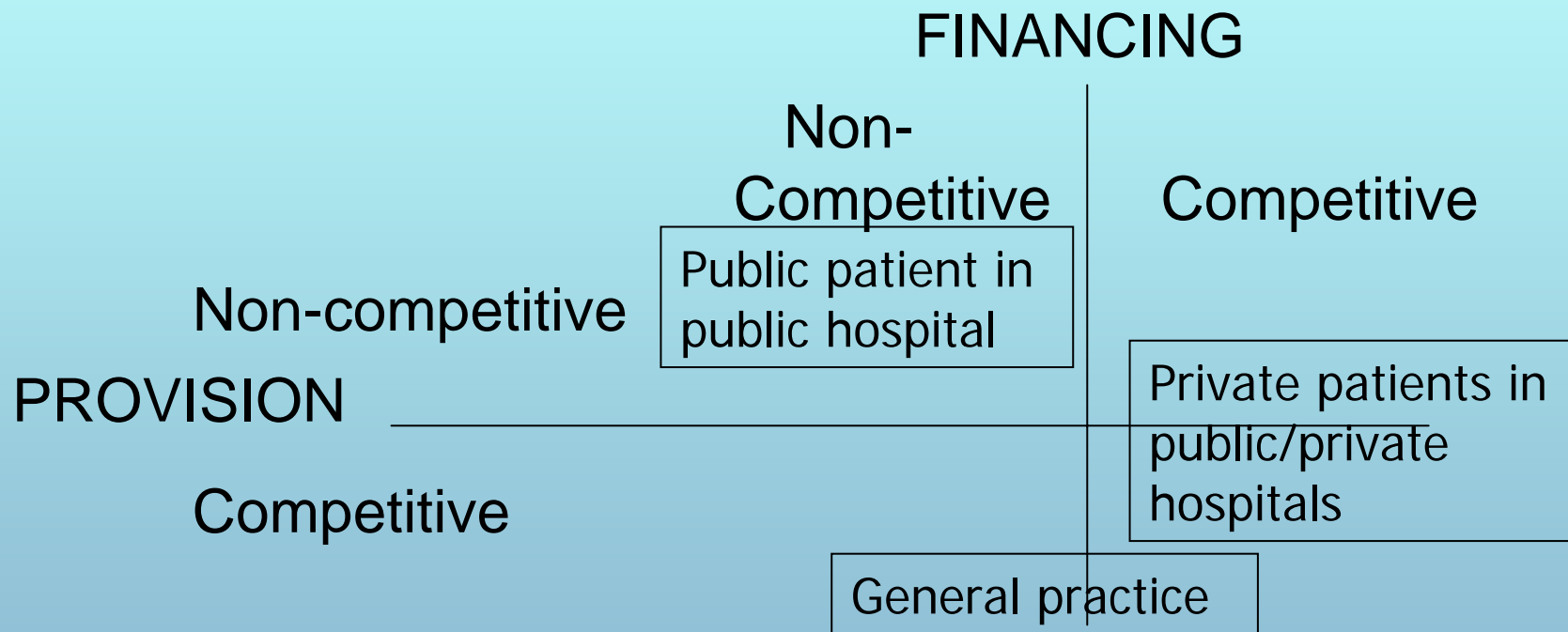


Competitive mix

		FINANCING	
		Non-Competitive	Competitive
PROVISION	Non-competitive	(1)	(2)
	Competitive	(3)	(4)



Competitive mix: Australia



Typical perverse incentives of health care

- Health authorities - responsibilities without power
 - ▶ internal markets?
- Providers of care - efficient practices not rewarded
 - ▶ internal markets/make hospitals independent
- Physicians - power without responsibility
 - ▶ give budgets to primary care physicians?
- Consumers - neither power nor responsibility
 - ▶ charges/medical savings accounts?



Internal markets

- Money goes into the hands of HAs, as before
- But, providers have to compete to win contracts from HAs
- Contracts are struck
- Aim is to improve quality and reduce costs
- HAs don't get bogged down in micro-management
- Realignment of balance of power
- 'Consumers' unaware of change

Main countries: UK, New Zealand, Sweden



How is equilibrium established?

“...the hospital must solve this capacity problem with a wide variety of non-price related decision rules. There are loosely enforced standards, rules of thumb, side bargains, cajoling, negotiations, special contingency plans and in some cases literally shouting and screaming.”

Harris (1977)



Evidence on internal markets

- Little rigorous evaluation - more scope in Sweden (where - costs reduced by 13%)
- Opportunities for competition existed, but were hampered by:
 - policy directives from ‘the Centre’
 - lack of sensitivity in contracting
 - enormity of task
 - potential to de-stabilize
- Good combination of the market and planning
- Clearer definition of roles-more as advocates for the population
- Equity unaffected



GPs as purchasers

- An alternative to HA purchasing.
- Given a budget for limited range of hospital services, specialist services and drugs.
- Thinking was they'd be more effective purchasers than HAs because they are 'closer' to their patients.
- Entry was voluntary - half population covered by 1997.
- Evolved, for some, into 'total fundholding'.
- Could keep savings and re-invest in the practice/services.
- Could switch between budget heads.
- Expenditure limit per patient, beyond which HA covered it.
- Initially, budgets set historically, but later by use of a formula.



Evidence on fundholding

- Most studied part of UK reforms - but confounded by other changes to general practice and the NHS
- Initial drug cost savings, but leveled off
- Referral evidence – initially conclusive but more recently in favour of fundholding
- Price reductions were achieved
- High admin costs
- Equity:
 - little evidence of cream-skimming
 - preferential treatment (form of ‘2-tierism’)
 - Pro-poor ‘bias’ maintained



Real expenditures by the UK NHS: 1980-1993

Year	Real expenditure (£ billion 1991-2)	Percentage change (annual)
1980-1	30.5	- 0.7
1981-2	31.6	3.6
1982-3	32.3	2.2
1983-4	32.7	1.2
1984-5	33.1	1.2
1985-6	33.2	0.3
1986-7	33.4	0.6
1987-8	33.9	1.5
1988-9	33.8	- 0.8
1989-90	34.5	2.1
1990-1	36.0	4.3
1991-2	37.4	3.9



Maynard and Bloor's summary of UK reforms

“The reforms were introduced with a considerable increase in NHS Funding. Disentangling the short-term effects of the funding and the medium-term effect of managerial reform from the NHS reforms themselves is impossible”

The market reforms in the UK are not an end in themselves, but a potential means of improving efficiency while cost control is maintained. It is necessary to distinguish between, on the one hand, the political need to claim success and, on the other hand, evidence of improved efficiency - which is incomplete at best, and ambiguous and uncertain at worst.... The mere “redisorganization” of the service’s structures which has preoccupied politicians for decades, does little to ensure that resources are allocated efficiently in a cash-limited NHS that provides universal coverage.”

NEJM, 1996; 334:604-608



Contracting out

- Systematic review (Currie et al., 2003, *Canadian Public Policy*):
 - no evidence on cost-effectiveness of publicly-funded health authorities contracting out surgical services
- for-profit versus not-for-profit debate (Currie et al.)
 - many of these comparisons are irrelevant
- system-wide issues – training, capacity
- recent UK expansion of ‘independent treatment centres’



Lessons from managed care

- Main innovations are HMOs and PPOs
- ‘Cost-consciousness’ is ‘incentivised’
- NB: all this takes place within a competitive system
- Main messages:
 - cost and use is lower in HMOs etc.
 - but, is it due to selection?
 - prices lowered in more competitive areas
- Is managed care dead?



Where is the UK now?

Why Tony Blair got caught out

- 1997: new Government
- Replaced HA/fundholding purchasing with PCTs
- All practices covered; 75% of resources; 'commissioning' not 'purchasing'
- Accompanied by many central directives
- Productivity negatively impacted (1997-2000)
- Markets rediscovered, but not fully understood:
 - Foundation Hospitals/franchising
 - Why we wait (and will continue to do so)
 - Target culture
 - Payment by results and patient choice
- Incentives in general practice
 - GP contract
 - Practice-based commissioning



Reflections on Australia

- market failure recognised and acted upon
- but differently (and similarly):
 - Intervening with fee structure
 - Capacity controls/regulating on bed use
 - Do user charges work? Have DRGs worked?
 - Lifetime community rating with subsidy?
 - Scope for internal markets?



Conclusions

- If we want competition, it has to be OUR kind of competition
- We need a greater understanding of complex markets
- We need to know what our objectives are
- Proper experimentation?
- Purchaser-provider systems might work:
 - someone looking after population health
 - small positive impact, but potential not realised
 - efficiency not the only objective
 - is UK becoming more provider dominated?
- What about the US? Failure, due to:
 - selection problems
 - free to choose
 - ‘bite-back’ from providers
- Challenges for the UK (and other public systems) and US
 - And where is Australia in this mix?

