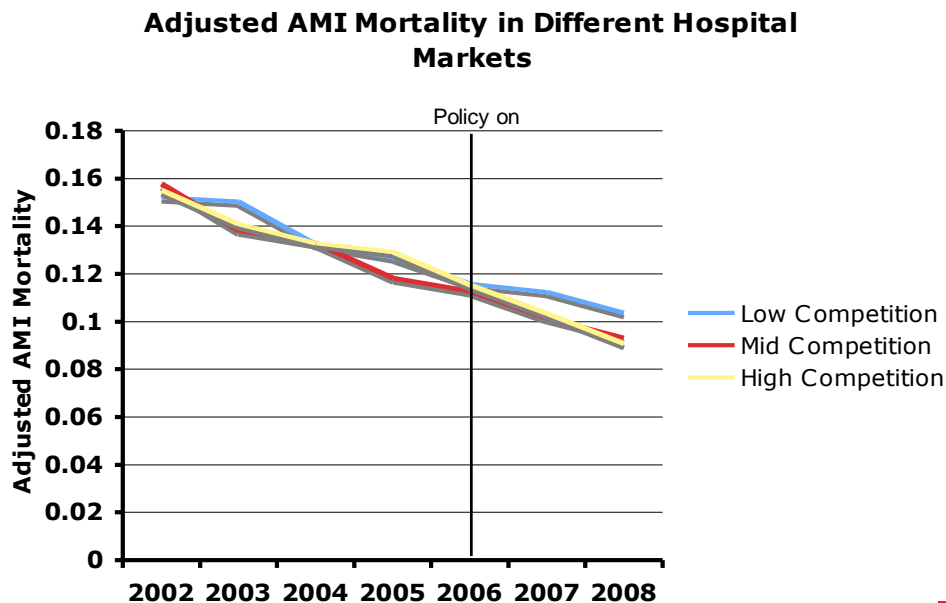


## Zack Cooper: Using competition to produce fairer care.

Choice really started in 2006 – did the hospitals exposed to relatively high levels of local competition change their behaviour? Yes and quite dramatically – there was a reduction in AMI mortality by 1% over 3-4 years.

**Hospitals located in competitive markets began to lower their mortality more quickly from 2006 onwards**



Source: Cooper et al. (2010)



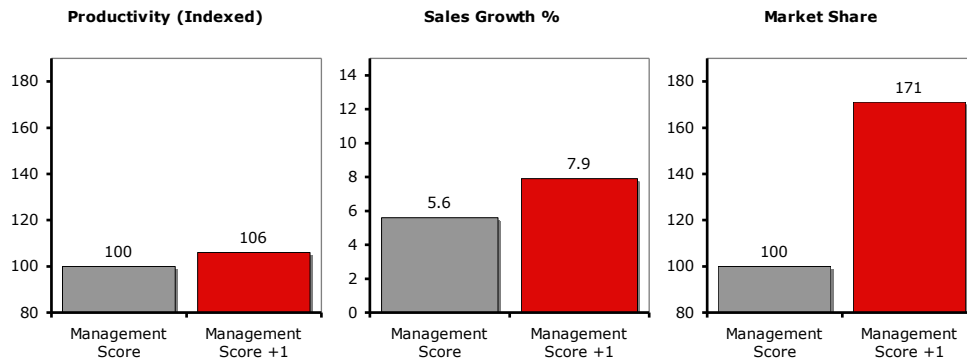
AMI is used as a general indicator of outcomes – the idea is that as clinical quality and management improves in clinical systems there is a spill over into other aspects of delivery. So the hypothesis is that getting smarter at elective care in response to choice impacts on general quality systems across the hospital. A confounder is the development of heart attack centres in London

The conclusion is not perfect, but robust: *more competition does seem to improve results for patients.*

Zack and his colleagues have been working on Bossonomics – what effect does management have on organisational performance? Unsurprisingly better managed firms produce better results. The same is true in hospitals. Exposure to competition and the involvement of doctors in management are key predictors of difference. There may be some confounding factors, such as that well

performing organisations tend to attract better managers, but some attempt has been made to control for this.

**Better management in the private manufacturing sector leads to higher productivity and sales growth**

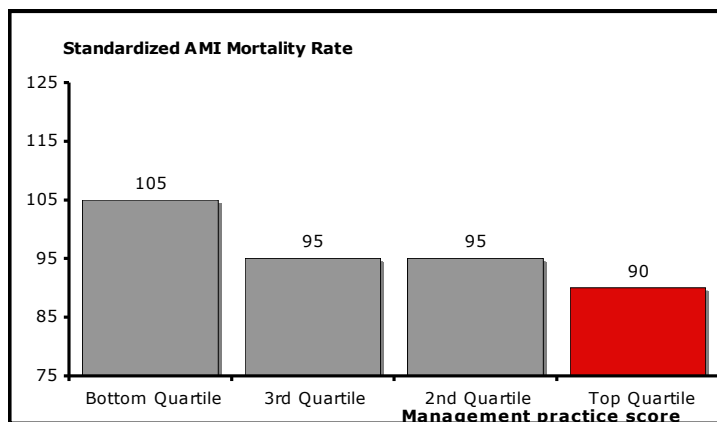


**But what about hospitals?**



Source: Van Reenen et al. (2010)

**Better managed hospitals have lower death rates and higher satisfaction. and competition prompted hospitals to improve their management**



- A 20% improvement in management quality resulted in a 6% drop in AMI mortality, a 33% increase in income per bed, and a 20% increase in patient satisfaction
- Greater competition prompts hospitals to improve their management
- The hypothetical addition of a rival hospital would increase management quality and lead to a 10.7% reduction in AMI mortality.

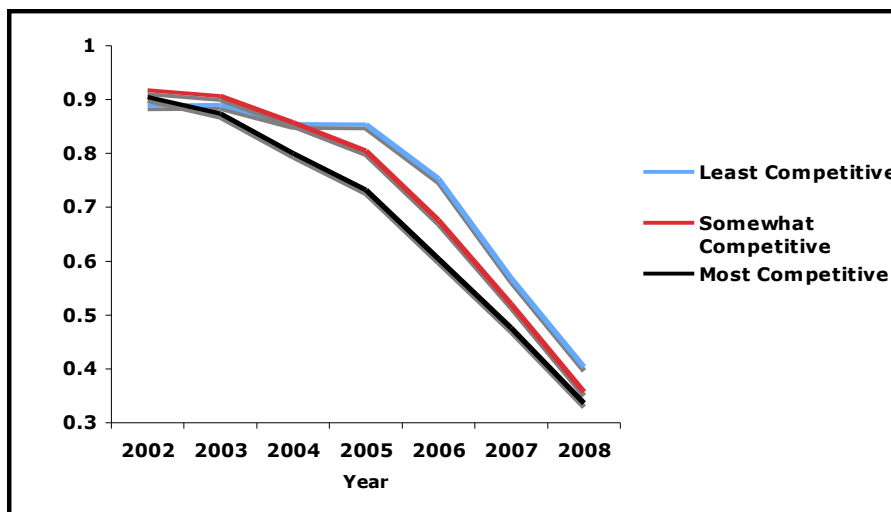


Source: Bloom et al. (2010)

More competitive markets seem to have shorter pre-hospital LOS and a faster improvement in day of surgery admission. In post surgery LOS there was no particular effect suggesting that competition was not leading to overly rapid discharge.

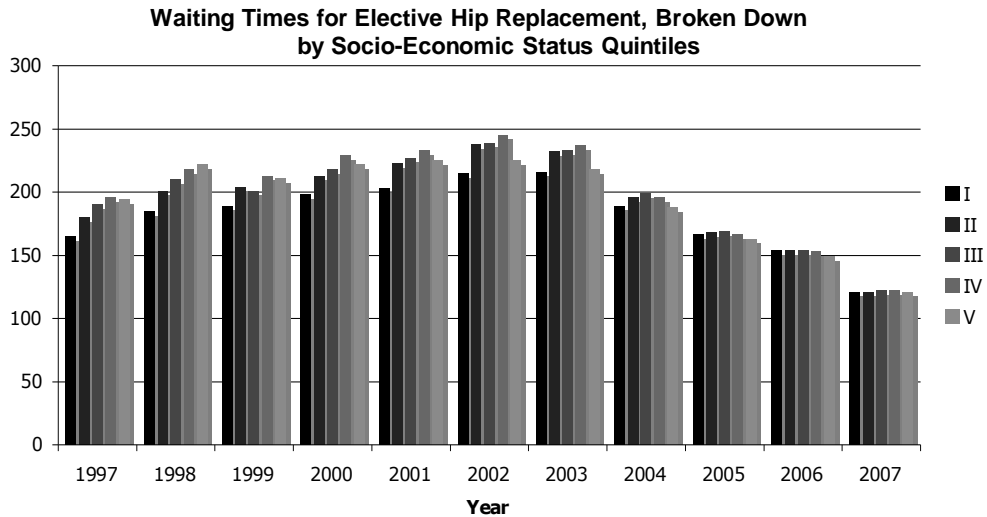
**It also appeared that hospitals facing more competition took steps to become more efficient**

**Trends on Pre-Surgery LOS in Hospitals in the Most Competitive, Somewhat Competitive, and Least Competitive Markets**



But what about the effects of this on inequalities in health across the population? It's worth remembering that the pre-choice system did not perform well; waiting times, access to hip replacement & CABG, and time with doctor appeared to depend on how wealthy you were. Poorer people were waiting up to 2 weeks longer and doctors were reported to spend about 5% less time with a patient for each 1-point drop in a seven point deprivation scale. By 2008, these disparities had disappeared- some of this is the effect of targets but these have a ceiling on results. Choice and competition did not necessarily produce these effects, but neither did they undermine them.

Waiting times were inequitable in 1997; by 2007, your wealth had little or no bearing on how long you waited for care

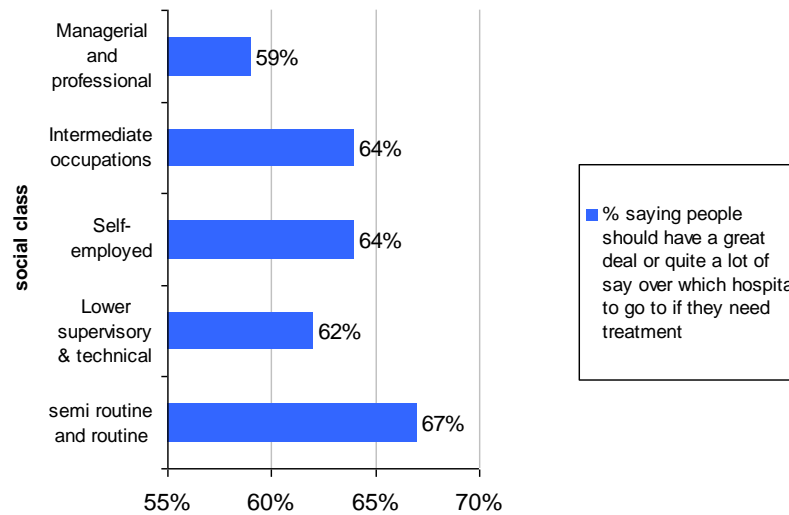


Source: Cooper et al. (2009)



Work by Cookson in 2010 found that equity stayed the same or showed a slight improvement during the period when choice was being introduced. In competitive areas the relatively poor got better access, with no evidence of 'cream skimming' of patients. What choice does is level the playing field – even in systems with no choice people who can navigate the system finds ways to do this. Introducing choice offers more opportunities to those who were excluded from this.

**The patients who want choice are the ones who historically have not had it**



Source: Public Responses to NHS Reform, Appleby & Alvarez, British Social Attitudes Survey 22nd Report (2005)



Choice and competition are neither a threat nor a cure to health inequalities. Systems designed to assure equality across the country are not particularly good for either quality or equity

If we are serious about inequality then we might think about:

- Providing means-tested travel subsidies to encourage patient movement
- Making the best provider, rather than the closest, the default option for patient's treatment.

Measuring quality would be the best bet for changing the way the system works.

## **Angela Coulter: Patients and healthcare choices**

3 myths:

- Patients don't want choice and won't travel for care
- People with low health literacy can't / won't take advantage of choice
- Patients can't distinguish between good and bad quality

Patients do want choice, but there are different types of choice and policy has tended to focus on areas that are of less interest to them:

- General practice
- Hospital
- Specialist team
- Provider type
- Appointment time
- Type of professional
- Commissioner/payer

As opposed to those they tend to be more concerned about:

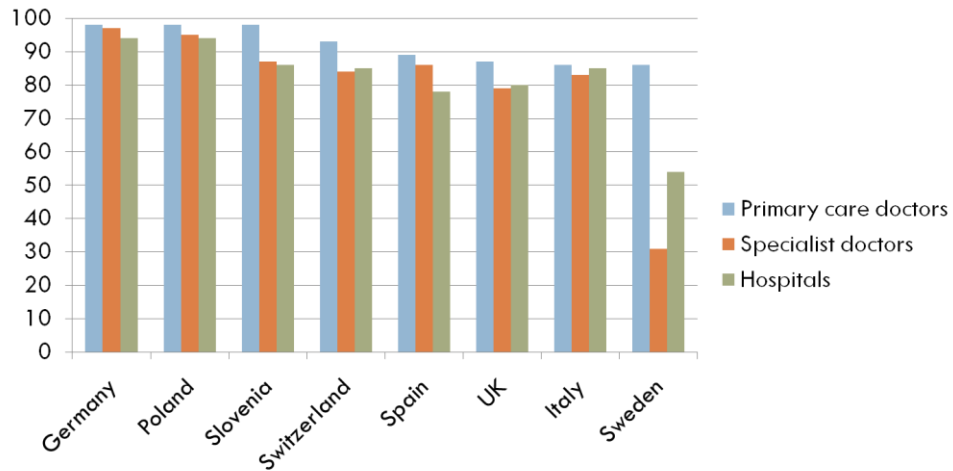
- Treatment
- Care package
- End-of-life care
- Maternity care
- Mental health care
- Access arrangements
- Care location

Provider choice is popular with people across Europe, but the UK does not do well in offering this. A greater desire for continuity of care in the UK is probably one complicating factor.

# Want free choice of provider

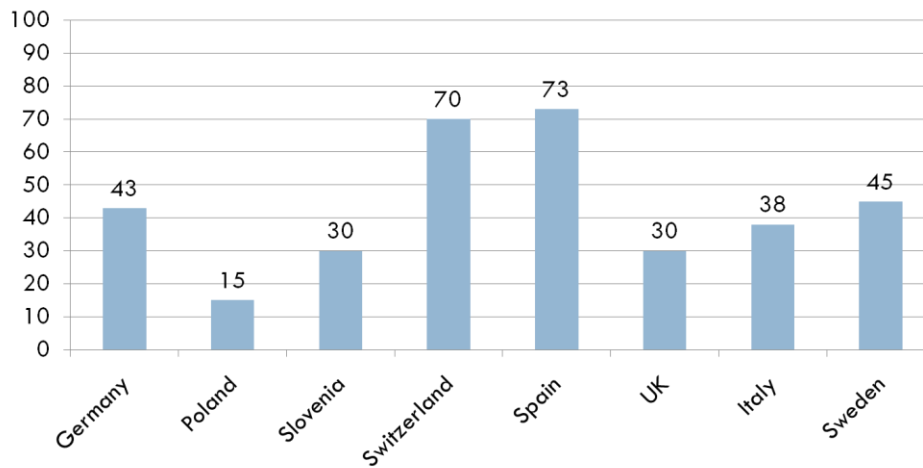
Population survey (1,000 in each country)

(Coulter and Magee 2003)

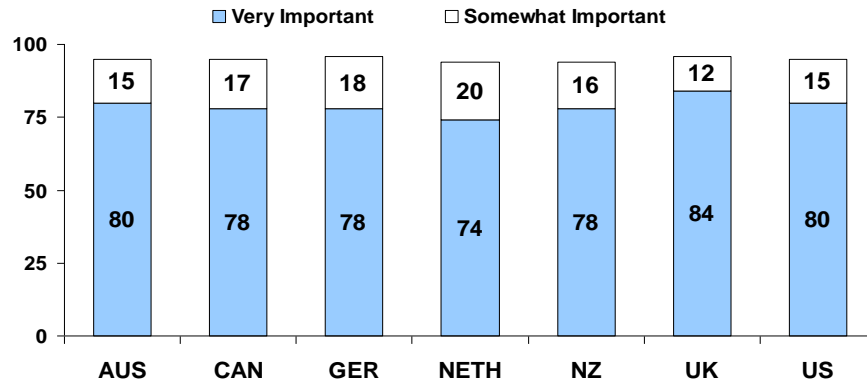


# Opportunities for choice very good or good

(Coulter and Magee 2003)



When you need care, how important is it that you have one practice/clinic where doctors and nurses know you, provide and coordinate the care that you need?

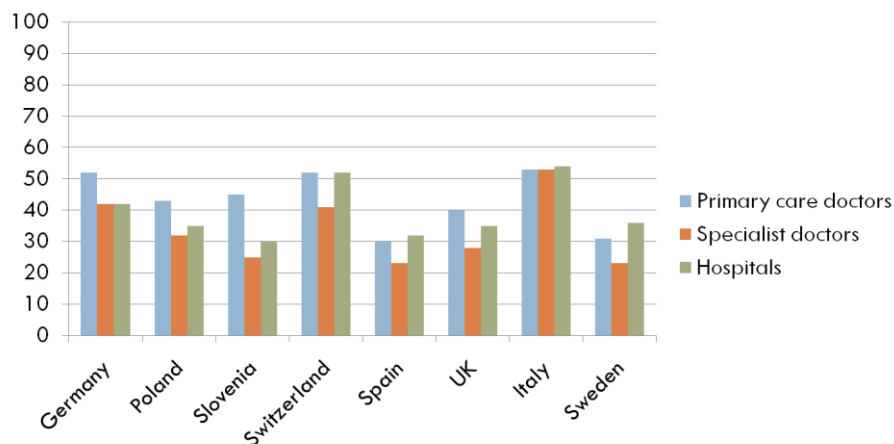


Source: 2007 Commonwealth Fund International Health Policy Survey. C. Schoen, et al. "Toward Higher Performance Health Systems: Adults' Experiences in Seven Countries, 2007," *Health Affairs* Web Exclusive, Oct. 31, 2007.

The London Choice project had high levels of uptake with very little difference between socio-economic groups, although people in employment used choice more. The patients were given access to advisors – this seems to be important in ensuring the effects of greater choice are fair.

Information is still an issue. NHS Choices only gives trust level information rather than procedure or speciality specific info.

## Have sufficient information to choose the best provider (Coulter and Magee 2003)



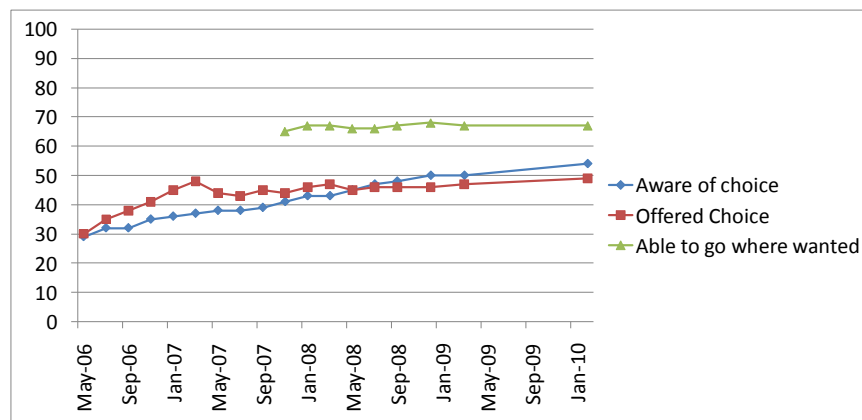
The factors that influenced choice were:

- Rapid access
- Convenience
- Quality assessment – about a third of patients

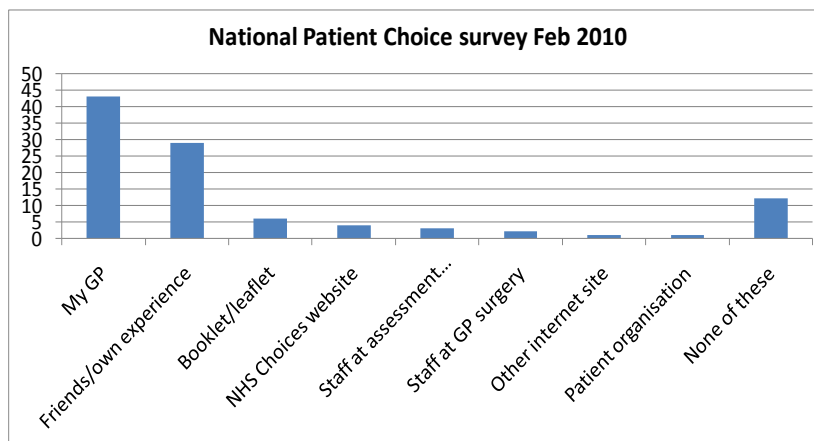
Awareness of choice is not high and GPs seem to be resistant.

## Choice at point of referral

National Patient Choice survey



## Information sources used by patients when choosing hospitals



There is still very limited awareness of NHS Choices or use of data to make choices. The information that people do use is:

- Location/transport/accessibility
- Waiting times
- Reputation of hospital (previous experience, familiarity, confidence)
- Cleanliness (infection rates, hygiene)
- Quality of care (treatment outcomes, standards, expertise)
- Feeling well-informed about the options
- Staff support and encouragement (68% not offered choice in LPCP)

These are required to make sure that patients make choices based on quality. Reputation is often used as a proxy for quality, but we need better measures for people to base these decisions on- reputation probably lags behind actual performance.

Health Literacy:

Health literacy is important and interventions to combat or circumvent it can help reduce inequalities and overcome poor health literacy. It is worth focussing on the most needy as information that isn't useful to them are not likely to help anyone else.

### Low health literacy need not be a barrier

- Studies in the US suggest that effective decision support + well designed information can close the gap between those who start out with more and less knowledge
  - Makoul et al 2009
  - Galesic et al 2009
  - Volandes et al 2008
- Information tools that are not helpful to the less literate tend not to be helpful to anyone.

The biggest barrier of all is staff attitudes.

Is there an irreconcilable tension?

- Building a vibrant market but with the spending and costs locked
- The inability to control hospitals activity when they lose cases

The good news is that more choice often means less resource use:

## Decision aids: the evidence

- In 55 trials addressing 23 different screening or treatment decisions, use has led to:
  - Greater knowledge
  - More accurate risk perceptions
  - Greater comfort with decisions
  - Greater participation in decision-making
  - Fewer people remaining undecided
  - Fewer patients choosing major surgery



O'Connor et al. Cochrane Database of Systematic Reviews, 2009

19

## Discussion and additional points

Choice-based systems are meant to drive improvement by publishing information on performance and letting patients 'vote with their feet'. In reality, there are other, more powerful factors which are more likely to have led to the improvements measured in Zack's work- particularly reputational incentives for organisations to compete against each other and, potentially, competition in the labour market so that the best staff move to the best hospitals.

So much we can observe from the past. The proposals in the Health Bill aim to take many of the choice and competition-based reforms of the last Government much further. So the question is- *if a little competition has been good for those with poorer health, to what extent will a lot more be even better?*

Choice and competition in primary care is also a factor worth considering. This is an area where choice of provider- that is, GP practices- has existed for much longer. Yet we do not see patients 'voting with their feet' in any significant numbers in this sector. They appear to stick even to poor practices. This is something we do not entirely understand but may be because patients find it harder to see when they are getting poor quality care. Primary care, and GPs in particular, are at the centre of the Health Bill's reforms, yet there seems to be little in the proposals to increase competition in this sector- and only a few patients near consortia boundaries will have effective choice of commissioner. A radical approach would be to require patients to re-register with their practice every five years.