Competition and quality: rhetoric and reality

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Abstract

Despite the obvious differences between the USA and UK health care systems, they share the characteristics of being motivated and managed in relation to cost and process rather than quality (the improved health status of patients). Whilst governments and insurers across the world use the rhetoric of quality, they, as epitomized by the behaviours of UK and USA decision makers, fail to define, measure and implement quality outcome policies. These behaviours are examined and some of their causes are explored briefly. Competition, as designed and used in public (e.g. UK National Health Service) and private (e.g. USA managed care) markets is shown to fail both to identify quality outcome targets and to provide evidence-based and efficient mechanisms to motivate decision makers to be orientated towards continuous quality outcome improvement in health care. A central policy challenge is, consequently, not just the measurement of quality outcomes but also their management into practice.

Keywords: competition, cost effectiveness, quality

Nearly a decade ago the British Government, frustrated by the continuing demands for increased funding of the National Health Service (NHS) but convinced of the merits of tax-financed global budgets to produce cost containment, developed the ‘internal market’ to increase the efficiency of the supply side of the health care system. The Thatcher White Paper [1] emphasized the need for quality and effectiveness, often using the terms interchangeably and ambiguously.

After the failure of the Clinton health care reforms in the USA, the response of the private sector to cost inflation and observable variations in clinical practice was to develop managed care mechanisms the purpose of which was to purchase aggressively. The initial foci of managed care were practice variations (delivery volumes) and prices. Whilst there was much rhetoric about the quality of care the managed care industry, like Thatcher’s NHS, failed both to define it well and to invest in its identification, monitoring and improvement.

Quality is defined in the Oxford English Dictionary as ‘the degree of excellence’. The use of the word quality in the health care industry is often ambiguous, failing to distinguish between inputs, processes and outcomes. Thus, as in the old English joke – ‘The operation was a success but the patient died!’ The inputs to the intervention, in term of physicians, nurses, facilities and pharmaceuticals can be combined to produce an excellent patient procedure. However such process quality may produce death or disablement — not a quality outcome!

It is remarkable how public policy in the USA and the UK was dominated for decades by concern about expenditure. In the USA expenditure was seen as too high and growing ‘too rapidly’. In the UK expenditure was seen as ‘too low’ [2] and inadequate to meet public demands. In neither system until the last decade was the efficiency of the use of resources and the quality of care in term of patient outcome a central policy issue.

This is a nice example of the slow process by which the findings of researchers and policy advocates are translated into public policy. It was over 25 years ago that the British researcher Archie Cochrane [3,4] argued that much medical care was of unproven effectiveness. His remedy was the use of properly designed randomized controlled trials and systematic reviews of the knowledge base. The work of Jack Wennberg and others [5] measured the large variations in medical practice evident in all health care systems worldwide. The inference from this work was that all practitioners were unlikely to be producing quality health care if their practices were so variable.

In this paper these issues will be elaborated in the following context: if it is known that practice is variable.
systems why is it that, even now, so little is done to measure and to improve quality in a systematic manner? In particular, the effects of competitive mechanisms will be appraised to ascertain why both the NHS internal market and the USA managed care has, as yet, achieved only modest observable improvements in the quality of patient care.

The nature of competition

Competitive behaviour, the striving of actors in the health care market to improve their power in terms of either monetary rewards or other forms of power, exists in all health care systems, public and private. However, it is usually associated with markets and the pursuit of profits.

Markets are networks of buyers and sellers and their behaviour is a product of the ways in which they are regulated. It is extraordinary that some, particularly those in the political marketplace and the media, still advocate ‘free markets’. No market has ever been, or ever will be, free. Even in the absence of government action, buyers and sellers regulate transactions in order to ensure orderly exchange by curbing predatory practices. Coase [6], the market oriented Chicago Nobel Laureate, concluded the following when discussing the epitome of the market — the exchanges for stock and shares:

“It is not without significance that these exchanges, often used by economists as example of a perfect market and perfect competition, are markets in which transactions are highly regulated (and this quite apart from any government regulation there may be). It suggests, I think, correctly, that for anything approaching perfect competition to exist, an intricate system of rules and regulations would normally be needed.”

Thus, whether or not the State owns the means of health care production, regulation of decision makers is ubiquitous. The policy and research issue in public and private markets is the same: do the regulations, implicit and explicit, in that market facilitate the achievement of policy goals such as the delivery of quality care to patients?

Quality and market regulation

The UK case

Decision makers, public and private, design regulatory arrangements which control competitors. What is surprising is the naïve way in which this regulation is often designed and implemented. Thus, for instance, Thatcher’s government wished to ‘redisorganize’ the NHS so that competition was introduced into the supply (provider) side of the market. They failed to acknowledge, and were slow to learn, that the market is a means to achieve social goals and is not an end in itself [7].

The initial documentation [1] failed to set the rules for exchange in the NHS market. The reforms created the purchaser–provider divide and introduced contracting to govern exchange between those buying and those supplying health care. However, crucial rules to govern this exchange were not defined [8,9]. For instance, rules were necessary to determine how prices were to be set, how labour was to be paid and whether NHS providers could borrow capital from the private market. These rules were slow to emerge and are often constrained rather than sustained competitive pressures [10].

In addition, rules to guide and govern performance (i.e. the pursuit of quality) were needed for the NHS market. What did Thatcher’s rhetoric of ‘value for money’ mean? Of course, politicians like to use appealing but ill-defined terms, the latter characteristic making accountability to the electorate much more difficult! Ambiguity of terms confuses the definition and the implementation of new policies. The ambiguity of Thatcher’s value-for-money theme can be compared with that of ‘evidence-based medicine’ (EBM). Are these terms to do with inputs, processes and outcomes and in what combination?

EBM is a term produced by a profession beleaguered by health care reforms which threatened their power and whose members wish to use such techniques to improve the governance of clinical practice. For instance, Sackett et al. [11] argued that:

“Doctors practising evidence-based medicine will identify and apply the most efficacious interventions to maximize the quality and quantity of life for individual patients, this may raise rather than lower costs.”

As has been argued elsewhere [12], this emphasis on outcomes (efficacy and/or effectiveness) may lead to decisions which are inefficient and do not give value for money. For instance, if EBM practitioners could choose between therapy, which gives health status improvements of 5 years of healthy life (5 HYs) and therapy Y which gives 10 HYs, they would choose the latter. However, if X costs US$1500 and Y costs US$7000, the former is more cost-effective as it produces a healthy year for US$300, as compared with therapy Y, which produces a healthy year for US$700. Thus therapy Y, relative to therapy X, produces 5 more HYs for an additional US$5500 i.e. the marginal cost of production of HYs by therapy Y is US$1100.

If Thatcher’s value-for-money argument is interpreted in an economic fashion as value in terms of health outcome (HY) for the use of resources (cost), EBM may lead to inefficiency. Some physicians may argue that their individual ethic requires them to provide all care which is beneficial regardless of its costs. This ethic is in conflict with the social ethic of the public health physician and the economist who argue that the inefficient treatment of one patient deprives another patient of treatment which gives greater value i.e.
inefficiency is unethical. Thus, the reluctance of Sackett and some other advocates of EBM to incorporate opportunity cost into their management can produce inefficiency. They argue that ‘rationing’, i.e. allocating resources on the basis of their costs and benefits, is the business of evidence-based purchasers and not of physicians who should retain their role as the guide and advocate of the patient.

Despite the disagreement about who should ration there is, at the level of principle, acceptance of the need for better measurement of costs and outcomes. For instance, as a result of agitation by researchers and a report of the House of Lords in 1988, the English Department of Health created a Research and Development Strategy. This funded the creation of the Cochrane Centre in Oxford, where Iain Chalmers initiated the international Cochrane Collaboration (which is now producing systematic reviews across a wide range of therapeutic areas) and the NHS Centre for Reviews and Dissemination in York.

However, the use of such data was not enhanced by the use of competition and the NHS internal market. The performance rules in this system remained focused on costs and intermediate outcomes. The performance of hospitals was evaluated by ‘finished consultant episodes’ of care (FCEs) [13]. Performance (the efficiency index) was measured by the volume and rate of growth of FCEs, data that gave no indication of whether treatment was effective or appropriate. Other policy ‘initiatives’ focused on waiting times for in-patient and out-patient treatments. Elaborate goals were set, activity was measured and resources targeted at these objectives. Again their achievement or non-achievement did not reveal efficiency, appropriateness or quality.

With the advent of the new Labour Government, the challenge of translating the rhetoric of concern about quality into substance rather than evasion remains [14]. The Government uses the terms ‘clinical effectiveness’ and ‘cost effectiveness’ interchangeably, exhibiting either a desire to placate the medical profession or confusion about meaning. It will create a National Institute for Clinical Excellence (NICE), again confusing medical terminology with economic necessity (cost effectiveness). There will also be a Commission for Health Improvement (CHI) which will act both as a ‘hit squad’ and a systematic reviewer of providers’ performance. Discussion of NICE and the CHI emphasizes guidelines and protocols but ignores the extent to which such guidelines and protocols that exist are evidence-based, i.e. they contain clinical but not cost-effectiveness data.

An emphasis of the latest NHS White Paper is ‘clinical governance’ and quality, with the definition of the latter becoming better in some parts of the proposals. It seems that there is greater political awareness of the quality issue. However the new proposals offer relatively few incentives to ensure its effective pursuit other than command and control rules which may not be evidence based.

The Government expresses a preference for professional self-regulation (e.g. by the Royal Colleges) even though this has failed in the past. For instance the Thatcher reforms included the funding of medical, later clinical audit by which the medical profession was allocated hundreds of millions of pounds to manage its practice better and to improve quality. This system was controlled by the profession and it failed. Clinical governance will bring with it some useful new reporting procedures (e.g. CHI’s audit of the auditors and the Trust Board’s monitoring of quality). However these may prove inadequate if the Colleges deter or slow the institution of governance. At present the Government remains reluctant to augment their reforms with processes of reaccreditation of individual practitioners. However, with NICE, CHI and proposed investments in information technology (IT), it may create the conditions for reaccreditation procedures. These are long overdue and have been resisted tenaciously by the profession. To ensure their adoption and the implementation of continuous quality improvement, the Government will have to exert substantial and continuous pressure on all groups in the labour force so that they become more accountable and innovative. Such policy, if badly managed, can lose electoral support.

In conclusion, the pursuit of quality in the NHS during the last decade has been ill focused and driven by short-term political expedients (such as waiting lists and waiting times). These policies may have affected quality (in terms of economic efficiency) at the margin but this has not been quantified. The new Labour Government has abolished in principle, but less so in practice, the internal market and has created new institutions and incentives whose initial quality focus may be better but whose incentives are unclear and unproven. It continues to distort resource allocation by a politically driven focus on waiting time/list procedures, some of which are of little benefit to patients [15]. Its proposals for performance measurement are mainly process orientated and sometimes of ambiguous appropriateness [16]. For instance, the advocacy of increased levels of coronary artery by-pass grafts (CABGs) may not be cost-effective if the improved use of statins reduces disease.

Some progress (e.g. the Cochrane initiatives) has been made in reviewing and extending the evidence base but much of this knowledge has yet to be translated into practice changes. However, much of this research and development has been focused on the appraisal of clinical practice in well-designed trials. This is very useful but needs to be complemented by research and development investment in service organization and delivery. The result of investment in this area would increase knowledge of how institutions can be induced to gather and use knowledge about evidence-based practice and policy. The failure of the Department of Health to invest in this area demonstrates both medical domination of its research and development programme and reluctance to recognize that knowledge about service delivery issues is of crucial importance in identifying appropriate incentive structures to induce practitioners to improve the quality of the care they deliver.

The USA case

The efforts of the Clinton administration to reform the USA health care system were largely targeted at cost
containment and failed due to complexity and the investment of the insurance industry in anti-Government advertising. The response of the private sector was to recognize the public disquiet about cost escalation and to develop crude mechanisms of expenditure control which focused on inputs and processes, in particular input costs and process volumes.

These regulatory devices consumed large expenditures. To compete for market share by advertising, to administer controls affecting a broad range of provider activities and to inform those control systems with information, required managed care companies to invest in excess of 20% of their expenditure in these aspects of ‘non-patient care’ activity.

The companies devised ‘guidelines’ and ‘norms’ which were used as benchmarks to judge the performance of providers and to reduce medical practice variation. Patient choice and clinical freedom were constrained in a very un-American way by the use of second opinions and a variety of bureaucratic checks which obstructed access to care. Primary care was developed using both nurse practitioners and general physicians to act as gatekeepers to the secondary care system. Purchasers bargained aggressively and selectively to drive down the prices of pharmaceuticals, hospital beds and professionals.

The efforts of the purchasers to hold down total expenditure were remarkably successful but have required increasing investment as ‘the fruit on the lower part of the tree of economy’ were gathered in over the last 5 years. During the recent past (1993–1996) health care expenditure as a percentage of USA Gross Domestic Product (GDP) has been held at 13.6% although GDP, and hence health care expenditure, rose in this period [17]. However, there are signs that this is a temporary success: recently Kaiser premium rates in California rose by 11% and the profits accruing to commercial managed care firms are now very low [18].

The causes of this reversal of trends are a nice combination of provider and consumer reaction. There have been many consumer complaints, some merited and some unmerited, about access to care. For instance vigorous criticism by womens’ groups of the time permitted in hospital confinement led the Federal Government to legislate that all mothers had the right to 48 hours of hospital stay [19]. Such legal intrusion into the design of the benefit programme of managed care plans and other Congressional intrusions into clinical practice has led to professional concerns about their ‘endangered integrity’ [20].

Gradually this has led to a clearer focus on quality and outcomes. The performance management of managed care companies in the USA are remarkably crude and overly focused on inputs and processes. It might be expected that the market orientated USA health care system would measure quality if only to use this to compete for market share. In fact the managed care ‘revolution’ has largely ignored quality and outcome and competed on price and volume.

The main reason for this is perverse incentives, in particular the absence of risk rating. If, for instance, a managed care company has a good programme for HIV–AIDS or the treatment of angina with CABGs, it must proceed with caution. Such data will attract new customers many of whom may be bad risks. The expense of treating such patients in the absence of risk-related premiums can drive a managed care company out of business. By the year 2000 Medicare premiums will be risk rated and these data techniques may facilitate premium adjustment in the private sector. Without this, competition based on outcome quality will be risky and muted.

The National Committee for Quality Assurance measures and publishes ‘comparative information on the quality of care’ [21] from what it calls its Health Plan Employer Data and Information Set. Whilst this is a useful first step in that it standardizes measures and reports the extent of independent audit of returns, it fails to provide extensive quality outcome measures. This is surprising as, for instance, quality of life measures have been used in research for several decades e.g. Short Form 36 (SF-36) was derived from an instrument used in the 1970s in the Rand Health Insurance experiment and is now well validated and available in over a dozen languages [22]. Despite the existence and experimental use of SF-36 and a range of other generic and specific quality of life instruments, the managers of managed care firms in the USA (and their equivalents in the UK and elsewhere) have largely ignored them as a means of identifying, measuring and managing quality. This occurs despite the availability of patient-friendly access and electronic analysis of patients’ responses.

However, there are developments in the quality area which are encouraging. For instance, in Pennsylvania the era of ‘scorecard’ cardiovascular medicine has been implemented [23]. This system reports on mortality after heart attacks. It has been introduced with great care with participant hospitals being given time to develop appropriate risk adjustment methods and data validation techniques. The focus of this initiative is to create standardized data systems and this Pennsylvania example demonstrates ‘our potential to compare medical outcomes and identify the best practices’ [23, p. 986]. Such systems have also been developed elsewhere in the USA, e.g. California.

For such developments to be extended, considerable investment in data capture and analysis is unavoidable. Managed care firms recognize that this will be as expensive as it is unavoidable because, once risk-rating problems are mitigated, a company which lags behind market trends may lose comparative advantage and concede its market share to its rivals. Successful outcome quality data are likely to be a powerful mechanism, if validated, in winning new customers and identifying those providers with which a company does or does not wish to contract, provided premiums are risk related.

Thus the managed care ‘revolution’ has been rather disappointing because of its failure, until recently, to focus on, manage and market its products on the basis of outcome quality. The American marketplace, like that of
UK-NHS, remains badly informed about outcomes because so-called competition has led to price, cost and activity management with little focus on quality in terms of survival adjusted for quality of life [24].

The way forward

For decision making to be efficient, those who make choices, be they public or private bureaucrats, have to recognize that budgets are limited and costs and benefits (health outcomes) have to be traded off. Unfortunately in most health care systems decision makers rarely face cost and benefit constraints. Often physicians are motivated to manage benefits, in isolation from budgeting cost consequences (EBM). Managers are motivated to manage budgets in isolation from benefits. Rarely do physicians and other managers face choices which require careful and explicit trading-off of costs and benefits.

The efficient management of health care requires that decision makers, whether physicians or non-physicians, and at all levels of the resource allocation process, must identify and measure the balance of costs and patient benefits and trade these off carefully in order to ensure ‘value for money’. In the NHS the efficient management system is one where health authority purchasers and providers, in primary and secondary care, behave in this way. In the USA private system such management is also necessary. Such a system requires investment in IT, standardized data sets with appropriate risk adjustment, and management accountability based on performance in relation to investing in health care provision, the basis of the costs and benefits of competing medical interventions and organizational policies. Such management requires cost–quality orientated performance targets with incentives (e.g. reaccreditation and appraisal) which facilitate goal achievement. Their introduction is not dependent on competition, public or private, but on good management of costs, processes and outcomes: as Griffiths emphasized, labour relations, in particular goal setting and motivation, are the keys to success in the NHS as they are in supermarkets! [25].

Such an approach is an efficient management technique which would be used in any organization intent on marketing its product on the basis of outcome quality. If health care management remains ‘one-eyed’, that is, dependent on cost (managers) or quality outcome (physicians) in isolation, investment in quality measurement and outcome will be inadequate and will have insufficient effect on decision making.

Without such a management system, health care resource allocation will be distorted by cost and activity performance measures which waste resources but promote the interests of vote-maximizing politicians in the NHS and profit-orientated entrepreneurs in the USA managed care industry. It is remarkable that after nearly 10 years of the NHS internal market and USA managed care, this simple lesson has not been learned: poorly regulated competition, in public and private organizations, can distort processes and deliver inefficient outcomes. Only when such lessons are learnt will outcome quality be managed into health care choices and investment made in appropriate IT and management systems.

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