Bevan's Run

January 10-15th, 2012. 160 miles in 6 days from Aneurin Bevan's Statue in Cardiff to the Department of Health, Richmond House, Whitehall, London. To protest against the Health and Social Care Bill and NHS privatisation. Calling at Witney (David Cameron's constituency). Follow me on Twitter @cepeedell and #bevansrun.

Monday, 2 January 2012

Market Failure in Healthcare Part 1: Market Failure in Theory

Market Failure in Theory

All 3 main political parties in England are publicly signed up to a single payer (ie tax funded) system of funding the NHS. There is major evidence to support this model of healthcare funding including the Guillebaud report (1953), the Commons expenditure committee report (1973), and the Wanless review (2001).

In fact, Wanless identified a £267 billion NHS underspend between 1972-1998. One of his conclusions was as follows: “The surprise may be that the gap in many measured outcomes is not bigger, given the size of the cumulative spending gap”.

All 3 political parties also support the idea of a market based system of healthcare delivery based on a purchaser provider split internal market. The key levers of the current NHS market (mainly introduced by New Labour) are the mutually reinforcing policies of:

1. Purchaser-Provider split between primary care (PCTs) and secondary care (introduced by Thatcher’s Working for Patients White Paper)
2. Patient choice to promote competition between providers
3. Plurality of providers - Foundation Trusts, Any Willing/Qualified Provider Policy (AQP) - Private companies (eg Independent Sector Treatment Centres), “Third sector” non-profit organizations
4. Payment by Results (PbR) using a tariff system

“PbR is the reform which makes everything else possible” Timmins BMJ 2005
5. Patient held budgets

The market will be expanded under the proposed new legislation in the Health and Social Care Bill to an even more full blooded system, with over a third of the bill legislating for a new regulated external economic market.

So what is a market system?

The economist Roger Bootle eloquently described what a market system is, in his book The Trouble With Markets. Saving Capitalism from Itself: “The essence of the market system is that free “agents” try to maximize their own “utility”, or wellbeing, by comparing the market prices for goods and services with what they are worth to them. Buyers buy when their own expected utility is greater than the price; sellers sell when the price is greater than their costs. Provided that prices are free to move, they will adjust to the competing forces of supply and demand. When demand exceeds supply, prices will be forced up. When supply exceeds demand, they will be forced down.

The price changes send signals to producers to bring the amount of the different goods and services that are produced into line with what is possible to produce, given the constraints imposed by limited resources and existing technology. In essence, this signaling mechanism enables the market system to bring the most out of any economic situation – not the best of all worlds, but the best possible result in the circumstances.

This mechanism has two drivers; self interest and competition. Self interest drives “economic agents” to try and gain the most they can from any situation, and competition works to constrain how much they actually get. The success of the market mechanism depends on a continual interplay between these forces. Firms try to use any technological advance or economic change as a way of boosting their profits; the chance of doing this acts as a spur to seek improvements in efficiency and advances in technology. But as competition subsequently eats away any advantage they are temporarily able to acquire, the benefits are spread throughout society through lower prices”.

Market systems have brought great prosperity to the world and lifted...
millions of people out of poverty, but markets don't work well in all situations, especially where there is significant information asymmetry between buyers and sellers, and imperfect competition. Healthcare is a particular area where market failure is a problem. In fact, market failure is an inherent problem in healthcare.

The theory of market failure in healthcare was first described by Professor Kenneth Arrow in 1963 in his seminal paper, "Uncertainty and the welfare economics of medical care".

Gordon Brown also addressed this issue in a speech to the Social Market Foundation (SMF) in 2003, which summarized the problems of market failure very well. In fact Brown was so concerned that he stated the following:

"Indeed, the case I have made and experience elsewhere leads us to conclude that if we were to go down the road of introducing markets wholesale into British health care we would be paying a very heavy price in efficiency and equity and be unable to deliver a Britain of opportunity and security for all"

“The very same reasoning which leads us to the case for the public funding of health care on efficiency as well as equity grounds also leads us to the case for public provision of healthcare”. Gordon Brown, SMF speech 2003

Despite this statement, his Government was busily incorporating and implementing a market based system into the NHS!

The following non exhaustive list gives the main reasons for market failure in healthcare as outlined by Arrow, Brown and others:

1. “Information asymmetry”

Markets are most efficient when buyers and sellers have equal information. However, in the case of the health care market, information is not equally shared between buyers and sellers. Instead the seller, the doctor, has far more information than the buyer, the patient. Patients are not sovereign in this situation ie patients are not well enough informed to make choices and the doctor (the seller) is actually their main “agent” or advocate. This means we are expecting our doctor to divide him/herself in half - on the one hand to act in our interests as the buyer of health care for us, but on the other to act in her own interests as the seller of health care. In a free market situation where the doctor is primarily motivated by the profit motive, the possibility exists for doctors to exploit patients by advising more treatment to be purchased than is necessary – this is known as supplier induced demand. Hence doctors’ behavior has been controlled by a professional code of practice and a system of licensure. As Kenneth Arrow put it “The control that is exercised ordinarily by informed buyers is replaced by internalized values”. These “internalized” professional values disrupt the efficient functioning of the market.

In the same mould there is asymmetry of information between “purchasers” (Primary Care - General Practitioners/PCT commissioners/Clinical commissioning Groups (CCGs)) and “providers” (Secondary care – hospitals) of healthcare in the purchaser provider split model of a market system. If GPs are buying specialist care from hospitals, it is the hospital specialists who have the information advantage because they are the experts in their chosen fields. This results in provider domination in the market and once again the problem of supplier induced demand. Hence, the growth of secondary care and super-specialism in medicine. Furthermore, it’s not just overtreatment that is problem. Undertreatment of non profitable conditions is also a problem.

2. Healthcare is difficult and expensive to commodify

In a healthcare market, the illnesses and diseases of patients, and their treatments and investigations are the commodities that are traded. Thus illness and diseases and their investigations and treatments have a market value. Complex layers of bureaucracy are required in the commodification process such as HRG coding and pricing of procedures, “double accounting”, legal contracts, auditing, IT costs etc.

3. Excess capacity is needed for market choice to work

If patients want to choose between hospitals in order to stimulate the competition that drives the market, there must be excess capacity in the system to accept extra patients, otherwise there will be waiting lists and a poorer service. This means some services will be idle in the system, creating inefficiency.

4. “Exit” from the market is very difficult
Hospital closures are deeply unpopular with local communities and therefore a political hot potato. The Kidderminster Hospital and Wyre Forest episode of the election of the local health campaigner, Dr Richard Taylor, to Parliament is a classic case in point. Even closure of some individual services can have a huge knock on effects, because many specialties are interrelated and rely on each other to provide comprehensive services to patients. You cannot run a trauma service without a vascular surgeon, for example – Someone needs to stop the bleeding! In addition, since income is related to hospital activity, closure of services and loss of income creates a vicious circle of financial pressures leading to further closures.

5. Market “entry” is prohibitively expensive

Hospitals are very expensive complex buildings and contain expensive equipment and staff. To date, most private sector provider involvement in the NHS has been with smaller units such as Independent Sector Treatment Centres and “Darzi centres”. This links in with the issue of the costs of excess capacity.

6. Problems with private insurance systems

Private insurance gives the cheapest and best coverage to the well, and the most expensive and least coverage to the sick. This is a classic case of the Inverse Care Law - the poorest and most vulnerable need healthcare the most, but will get least access.

7. Price signals don’t work

Payment occurs after care in most cases. Illness is unpredictable and healthcare costs can be prohibitive e.g. a stay on an Intensive Care Unit due to an accident could cost hundreds and thousands of pounds, which the vast majority of the population could not afford. Hence there is a need for risk pooling and insurance systems. As stated above, private insurance disadvantages the most vulnerable, so national insurance systems are naturally the best choice.

8. Medical professionalism is anti-market

Market theory in the form of Public Choice Theory rejects the public service ethos and professional ethics. Medical professionalism is fundamentally anti-market in nature because Doctors (GPs) control access to the healthcare market and want to refer unwell patients to good local services. The doctor-patient relationship and the social contract is fundamentally based on trust. Market systems rely on self-interest and distrust. The market is a blind power without any social or ethical orientation. I’ve previously discussed the problems of medical professionalism and the market here and will return to it.

9. Patients want local services

Just as doctors like referring to local service, patients also like to use local services. The influential work by Professor Julian Le Grand on the British Social Attitudes survey, which showed the public did want choice of hospitals is fundamentally flawed, because it was a survey of the public, not patients. When you feel ill you don’t want to travel far and you also need to be close to your support network of loved ones and friends. It is therefore not surprising that Barr et al’s detailed analysis of patient choice had very different conclusions.

10. Markets provide for wants rather than needs

Markets are driven by the wants of consumers rather than needs. This focus on citizen-consumerism, disguised as patient choice, serves to drive up healthcare expenditure, not reduce it.

11. Need for specialty clusters, high volume workload and regional and national planning

Rare conditions or conditions that require highly complex treatments require specialty clusters and high volume workloads to ensure enough expertise for safe and effective care. This often requires the development of clinical networks and specialist centers, through local, regional and national planning based on local, regional and national population needs. This is again anti-market in nature.

12. First duty of investor owned firms is to their shareholders, not patients

This results in the problem of “cream skimming”, where private sector companies will only treat the most profitable conditions, leaving the unprofitable cases to state providers. In a competitive external market system, the state providers (which provide
comprehensive services to local populations) are therefore most at risk of failure.

This list is not exhaustive, but goes a long way to explain why market failure is inherent in the delivery of healthcare, which is close to a natural monopoly. It also explains why market systems are so costly and will eventually bankrupt a single payer system, where there is a finite amount of money.

My next blog will focus on market failure in practice, which will then be followed by another blog about why the market model of healthcare has been adopted on a global scale by the political classes, despite the inherent flaws in this model of healthcare delivery.