Introduction

- Outline
  - Competition and Health Care Markets
  - Quality and Competition
    - Why Is This Important?
    - What Do We Know?
  - Conclusion
Is health care different?
(Pauly, Dranove & Satterthwaite, Gaynor, Gaynor & Vogt)

- Health care is not like a perfectly competitive textbook market
  - Almost nothing is
- All markets are different
  - The markets for computer operating systems and cement are very different.
    - Implies different economic and antitrust analysis and treatment
Competition and Health Care Markets

- Health care has some specific characteristics that we must take account of in economics and antitrust.
  - At one level, this is consistent with a standard antitrust view of case specific analysis.
    - Quality assumes particular prominence in health care.
Competition and Health Care Markets

- Can Markets Give Us What We Want in Health Care?
  - At present the U.S. relies on a market system for health care.
    - Unlikely to change anytime soon.
  - The presumption of antitrust is that (unregulated) monopoly is bad.
  - Is this true in health care markets?
What’s the alternative?

- No regulation at all.
  - Unchecked monopoly is clearly bad.
- Self-regulation.
  - How likely is this to give us what we want?
  - It’s very hard for market participants to self-regulate in a way that promotes social welfare.
Competition and Health Care Markets

- Where firms’ goals conflict with those of society, which will win?
  - Experience in medicine is not very reassuring.
    - Medical errors
    - Antitrust violations

- Self-regulating efforts important, but not sufficient. Need market incentives.
  - Markets and self-regulation complementary.
Competition and Health Care Markets

- Conclusion - antitrust enforcement is a critical element of health policy. It preserves the functioning of markets on which our system is based.
  - Relevant for public payers (Medicare, Medicaid) as well as private payers.
Why Is This Important?

- Quality is one of the aspects that is particularly prominent in health care.
  - A lot of variation.
  - Consequences of variation can matter a great deal.
What Do We Know?

- Economic Theory
  - General
  - Competition - Fixed Prices
  - Competition - Variable Prices
  - Buyer Power

- Empirical Evidence
  - Fixed Prices
  - Variable Prices
Theory - General

- Does competition have to result in lower prices and higher quality to be a good thing?
  - No - some people may be willing to accept lower quality if price is low enough, and some people may be willing to pay more if the quality is high enough.
Theory - Fixed Prices

- Competition is over non-price aspects of the product (i.e., quality).
- Competition leads to more quality.
  - Quality will vary with the price.
    - Can be too high, too low, or just right.
- Monopoly results in insufficient quality.

(see Allen & Gertler; Held & Pauly, Mankiw & Whinston; Pope; Schmalensee; Tirole, Dranove & Satterthwaite for surveys)
If firms choose both price and quality, anything can happen.

- Monopoly can under or over produce quality
- Competition - same

(see Spence, Dixit & Stiglitz, Shaked & Sutton, Tirole for an overview)
Theory - Monopsony

- Buyer Market Power (Monopsony)
  - “Countervailing power” unlikely to improve matters.
    - Increasing the market power of sellers when buyers have market power will make things worse under most circumstances.
  - Impacts on quality?
    - We’d expect monopsony to make things worse.
    - No results, to my knowledge.
Empirical Evidence

- Evidence comes from econometric/statistical studies using secondary data.
  - Not a lot of evidence at this point.
  - Entirely on hospitals.
  - I’ll divide the studies into those of markets where prices are fixed and studies where prices are variable.

(see Gaynor & Vogt for overview)
Evidence - Fixed Prices

- Medicare Enrollees with AMI (Kessler & McClellan)
  - All non-rural Medicare beneficiaries with AMI, 1985-94
  - Risk-adjusted 1 yr. mortality significantly higher in more concentrated markets.
    - Patients in most concentrated markets had 1.46 percentage points higher mortality than those in least concentrated markets; 4.4% difference.
Evidence - Fixed Prices

- Medicare Enrollees with AMI, Pneumonia
  (Gowrisankaran & Town)
  - Risk-adjusted mortality significantly lower in more concentrated parts of Los Angeles county.
    - AMI – 1991-93
    - Pneumonia – 1989-92
Evidence - Fixed Prices

- Dialysis facilities (Held & Pauly)
  - Fewer dialysis machines per patient in more concentrated markets.
  - “Medical Arms Race”
    - Prior to mid-1980s
    - Hospital costs, LOS, service offerings, excess capacity higher in less concentrated markets (Robinson & Luft; Dranove et al.; Joskow)
    - Over by early 90s
Evidence - Variable Prices

- Effect of # of hospitals on profits, quantity in the market.
  (Abraham, Gaynor & Vogt)
  - Isolated markets in U.S., 1990
  - Quantity increases with the # of hospitals in the market; profits decrease.
  - Why? Quality and price changed in a way that made people want to consume more, not less - better off.
Evidence - Variable Prices

- Hospital mergers (Hamilton & Ho)
  - California, 1992-95 - 130
    - No detectable impact on heart attack or stroke inpatient mortality.
    - Some mergers increase readmission rates for heart attack patients and early discharge of newborns.

- Patients receiving PTCA, CABG (Huckman)
  - NY State, 1992-99
  - Risk-adjusted mortality lower as a result of hospital acquisition where acquiring hospital provided PTCA or CABG, and target did not.
  - 28 such acquisitions
Evidence - Variable Prices

- All AMI patients (Volpp & Waldfogel)
  - New Jersey vs. New York, 1990-96

- HMO enrollees with AMI and pneumonia. (Gowrisankaran & Town)
  - Risk-adjusted mortality significantly lower in more concentrated parts of Los Angeles county.
Evidence - Variable Prices

- All PTCA patients
  (Sohn & Rathouz)
  - 116 California hospitals, 1995
    - Excess mortality lower for PTCA patients in less concentrated markets.
      - Effect stronger for lower volume hospitals.
A positive relationship between volume and outcome has long been observed.

- Hard to identify causal relationship

PTCA, California, 1984-96 (Ho)

- Outcomes: In-hospital mortality, emergency CABG
  - All hospitals achieved substantial improvements in outcomes over time.
  - Small effect of annual volume on outcome
Summary

What Do We Know?

- Evidence only for hospital markets
  - Empirical evidence is mixed.
    - Strongest evidence thus far is that quality is higher in less concentrated hospital markets.
      - There are conflicting results across studies.
What Don’t We Know?

- How does competition affect both quality and price?
- Non-mortality aspects of quality
- Evidence on other markets
  - Physicians
  - Insurers
Conclusions

- Quality is an important aspect of performance in health care markets.
  - It should be considered in economic and antitrust analyses of competition.
- Presumption in antitrust is that monopoly is bad, competition is good.
  - The scientific evidence at this point is not sufficient to reverse that presumption with regard to quality.
  - Quality should be considered in assessing competitive impacts.
References


References


References


