practice at the University of Pennsylvania, "I've come across virtually every malady you could think of," he said in an interview.

But if he's working on a story outside his area of expertise, he'll run his report by a colleague in the relevant specialty. For example, he said, "if one of the Phillies has an orthopedic injury, I know what I'm going to say, but I will fact-check with an orthopedist just to make sure."

**Crossing the Line?**

As Samadi sees it, Oz has crossed the line into entertainment. "Mehmet Oz is trying hard to give good medical information, but good medical information sometimes can be boring," said Samadi, adding that he knows Oz from his time at Columbia. "Is he purposely trying to deceive the public? I highly doubt it. But it's the nature of TV.... Do I think he's made mistakes? I think there have been some cases where he's probably exaggerated more than he should."

Christina Korownyk, MD, and colleagues at the University of Alberta in Canada wondered how much of what television physicians such as Oz recommend is supported by evidence.

"We had so many patients asking us about recommendations they had seen on different shows," Korownyk, a family medicine physician, said in an interview. So she and her coauthors, mostly primary care physicians, randomly selected 40 episodes of "The Dr. Oz Show" and 40 of "The Doctors," another popular TV show that features 6 physician co-hosts, and identified and evaluated recommendations made on each program.

They found at least 1 case report or stronger evidence to support 46% of the recommendations in the Oz show and 63% of the recommendations in "The Doctors" (Korownyk C et al. BMJ. 2014;349:g7346). They also found evidence that contradicted 15% of the Oz show recommendations and 14% of "The Doctors" recommendations. And they found no evidence related to the rest of the recommendations on the shows.

Although a large portion of their recommendations lack supporting evidence, no one has formally assessed how many viewers actually follow them, Korownyk noted.

**For Love, Not Fame and Fortune**

Cirigliano has no network aspirations, and with a busy practice closed to new patients, he's not on television to attract business. "This is just a part-time little hobby," he said of his 2-minute "Dr. Mike" segments, for which he typically spends an hour preparing. "I do it because it's fun and I love it."

His television segments provide a creative outlet that he finds medicine lacks, said Cirigliano, a trumpet player who majored in music and intended to teach and perform until volunteering in a hospital emergency department steered him toward medicine.

"In my opinion, [reporting on television] has made me a much better doctor. I'm familiar with every new study that comes out even before it comes out," Cirigliano said, referring to the fact that journals often share embargoed copies of studies with reporters so they can prepare their stories.

Like Cirigliano, Samadi said he doesn't do television for the money or the publicity it generates. "It's a great way to educate the public." ■

The JAMA Forum

**Learning About Competition From the UK’s National Health Service**

Austin B. Frakt, PhD

The United Kingdom’s National Health Service (NHS) is a nationalized health care system—meaning its physicians are employed by the government. From that familiar fact, many conclude that the United States—with its competitive, private market-based delivery system—has nothing to learn from the NHS. That’s wrong.

What’s wrong with this thought is that it equates “competition” with “private.” In fact, competition can exist even in a nationalized health system, and it does among NHS hospitals. Moreover, studies of NHS hospital competition illustrate just how important it is, leading to better management, higher quality, and lower mortality.

Since 2006, NHS general practitioners have been required and paid to ensure that their patients are aware of 5 choices of hospital. Hospital quality data are available to patients to help them make this choice. Those choices affect hospital revenue because the government’s diagnosis-based payments follow the patient. This encourages hospitals to compete for patients on quality. The only way for a hospital to thrive is to improve its attractiveness to patients. Hospital managers who do so can receive higher pay. Those who don’t might be fired. And failing hospitals are at heightened risk of closure.

In a study published in the American Economic Journal: Economic Policy in 2013 (http://bit.ly/1CBEcKg), researchers found that this 2006 policy increased competition among hospitals, changed where patients chose to receive care, and decreased length of stay and mortality. They estimated that a 10% decrease in hospital market concentration would result in a 2.3% reduction in length of stay (the baseline mean length of stay was 1.2 days) and a decrease of 2.9% in 30-day mortality after
myocardial infarction (a reduction in the baseline of 6.9% of patients who were hospitalized for a myocardial infarction dying within 30 days). The authors calculated that the net benefit of the policy change was just less than a half-billion dollars per year, for which they valued the additional life-years gained at $100 000 per year.

These are not isolated findings. They are consistent with earlier work by Daniel Kessler, JD, PhD, and Mark McClellan, MD, PhD (http://bit.ly/1Sjw8HJ), and findings by Zack Cooper, PhD, and colleagues (http://bit.ly/1lVP7aO) that also show that lower mortality rates stem from greater hospital competition.

A more recent study suggests the mechanism by which greater competition improves outcomes: management. Earlier this year, in a study published in The Review of Economic Studies, Nicholas Bloom, PhD, and colleagues examined the effect of UK hospital competition on management performance and quality (http://bit.ly/1fD9uO8). In a sample of 61% of UK hospitals, they posed questions to managers and physicians in cardiology and orthopedics about operations and quality monitoring, as well as performance targets and incentives used to achieve them. These formed the basis of their measure of hospital management performance.

Relating hospital competition to this measure of management performance and clinical outcomes, and controlling for many other potentially confounding factors, the authors found that greater competition is associated with better management. In turn, better management is associated with better outcomes, including lower rates of myocardial infarction and emergency surgery mortality. In addition, better management is associated with lower staff turnover, higher composite quality scores, lower lengths of stay, lower methicillin-resistant staphylococcus aureus (MRSA) infection rates, shorter waiting times, and better financial performance.

According to the study by Bloom et al, adding another hospital in competition with existing ones in a region would have substantial effects. It could reduce myocardial infarction mortality by nearly 10% and length of stay by nearly 12%.

Again, these findings are consistent with prior work. K. John McConnell, PhD, and colleagues also found that US hospitals facing greater competitive pressure have better management practices (http://bit.ly/1SjwsWs). A comprehensive literature review by Martin Gaynor, PhD, and Robert Town, PhD (http://bit.ly/1jxvVPK), found that quality diminishes when US hospitals consolidate, reducing competition (http://bit.ly/1HY3jA2).

The conclusion is clear. Hospital competition is an important and significant driver of quality and outcomes improvement. That’s true both for a nationalized health system like the NHS and the private system in the United States. Management is an important mechanism in these relationships. Where management improves in response to competition—better streamlining operations, setting targets, and establishing incentives to obtain them—outcomes do as well.

To be sure, one can attempt to improve management and outcomes without competition. Perhaps better training and payment incentives could move the needle. But nothing focuses the mind like an existential threat from a competitor. Today US health care markets are going the other way—they’re consolidating, reducing competition (http://bit.ly/1Je43fA). Perhaps the United States has something to learn from the UK’s nationalized health system after all.

Author Affiliation: health economist with the Department of Veterans Affairs and an associate professor at Boston University’s School of Medicine and School of Public Health. He blogs about health economics and policy at The Incidental Economist and tweets at @affrakt. The views expressed in this post are that of the author and do not necessarily reflect the position of the Department of Veterans Affairs or Boston University.

Published online: July 8, 2015, at http://newsatjama.jama.com/category/the-jama-forum/.

Disclaimer: Each entry in The JAMA Forum expresses the opinions of the author but does not necessarily reflect the views or opinions of JAMA, the editorial staff, or the American Medical Association.

Additional Information: Information about The JAMA Forum is available at http://newsatjama.jama.com/about/. Information about disclosures of potential conflicts of interest may be found at http://newsatjama.jama.com/jama-forum-disclosures/.

Downloaded From:  on 06/18/2018