Policy Forum: ‘Shifting the Dial’, The Productivity Commission’s Productivity Review

Pump Up the Volume: Making Health and Wellbeing the Centre Stage of Economic Growth

Anthony Scott*

Abstract

The aim of this article is to comment on ‘Healthier Australians’, Chapter 2 in the Productivity Commission’s report Shifting the Dial. The report elevates health and wellbeing to a central role in lifting the nation’s productivity. The main recommendations centre around better information in the health care system and improving the architecture of the system to ensure more decentralised decision making. If acted upon, these solid building blocks could provide significant opportunities to save lives and improve the health of the population and the wealth of the country.

1. Health, Wealth and the Role of Governments

The chapter ‘Healthier Australians’ is the first in the Productivity Commission’s report, Shifting the Dial, and has been given prominence due to its importance for the wellbeing of the population. This places health at the centre of wealth generation and economic growth and signals its fundamental role in the economy. The report notes that: ‘Delivering [health] much more efficiently, and with a serious focus on what improves outcomes for the users of these services, will deliver bigger benefits than even traditional industry reform’ (Productivity Commission 2017a, p. 88).

The report also strongly recognises the role of governments in raising productivity in Australia. Governments’ finance the largest sectors of the economy, including health, which is now over 10% of GDP. The Commission has chosen the topics in its report because they affect the quality of people’s lives from across the income distribution, and are areas that have in the past had little exposure to economic reform. These are also areas where user needs have not been given priority and where the benefits of reform occur well into the future. Such a long-term and inclusive view is welcome. The areas chosen, however, are also the most difficult to change.

The report’s recommendations on health include four general recommendations and two which are quite specific, all supported by three substantial supporting articles including modelling of expected impacts. The four general recommendations are:

(i) implement nimble funding arrangements at the regional level;

* Melbourne Institute of Applied Economic and Social Research, The University of Melbourne, Victoria 3053 Australia; email <a.scott@unimelb.edu.au>.
(ii) eliminate low-value health interventions;
(iii) make the patient the centre of care; and
(iv) use information better.

The two more specific recommendations are:

(i) embrace technology to change the pharmacy model; and
(ii) amend alcohol taxation arrangements.

These recommendations are focused around better information and smarter system design that will give some market power back to consumers and help decentralise decision making. These issues are usually the hallmarks of many economic regulatory reforms though they have sensibly not been couched in terms of ‘letting loose’ markets in healthcare, since this is not what they are about. The Productivity Commission recognises that governments set the institutional and governance arrangements of markets, with these rules influencing behaviours in ways that improve efficiency and equity in the healthcare system. The report clearly recognises, in the final chapter, that governments and state–federal relations also need to be strengthened to provide stronger national leadership and governance but combined with more decentralised funding responsibilities and decision making so that resource allocation better reflects community needs. Getting this balance right is difficult, but in health care the recommendations move strongly in the right direction. The current federal–state funding split in health prevents much sensible reform.

2. The Value of Information

Information has long been recognised in economics as central to the efficient functioning of any market, giving consumers the power to make choices that drive productive efficiency and ultimately improve social welfare. An imbalance of information between consumers (patients) and producers (doctors) in healthcare is a central reason for market failure in healthcare as first outlined by Nobel Laureate Kenneth Arrow in 1963. Asymmetry of information in healthcare gives market power to the providers of healthcare services. Uncertainty leads to health insurance that can distort price signals and removes awareness of opportunity costs, for both patients and providers. The usual drivers of efficient market outcomes, consumer sovereignty and prices, either do not exist or are heavily distorted. As a result, consumers (patients) are not as healthy as they could be. Though individual healthcare providers are altruistic and so are intrinsically interested in helping patients, their collective market power helps set the institutional arrangements in their favour. These same information problems, particularly a lack of market prices, are also why the productivity of the health sector cannot be properly measured in the national accounts. This is the subject of the Productivity Commission’s (2017b) Supporting Paper No. 2 Non-Market Productivity.

The main response to these market failures has been regulation and licensing of healthcare providers and the monitoring of patient safety and quality at the bottom end of the distribution of health outcomes—‘to do no harm’. This has led to a focus on minimum standards of quality and health outcomes, rather than a focus on the best health outcomes that can be achieved with the available resources. In addition, there has been a focus on how best to remunerate healthcare providers to improve health outcomes and other aspects of their performance (Scott et al. 2018). Note these policies, though necessary, do not directly address the information problems that are the source of market failures.

In healthcare, if information exists at all, it is hidden and kept from public view and even from the view of healthcare providers. Part of the issue is that key pieces of information, such as routinely measured health outcomes, do not exist. The maxim of ‘doing no harm’ means that the system can measure harm, such as death rates and complication rates after surgery, but does not measure health gains.
Though this is too often espoused it is nonetheless astounding that healthcare providers do have data on the outcomes of their activities, and that patients do not know the relative quality of healthcare providers based on these measured outcomes.

Another part of the issue is that where the information does exist, its custodians (mainly governments) do not seem to trust anyone to use it. The Productivity Commission (2017c) has previously reported on these issues. Privacy is often raised as an issue by those who curate and own the data, but this is fallacious when one considers the amount of private information used for commercial purposes (and not always for the public good) that individuals routinely give away to their banks and internet-based companies.

One issue that economists often assume away in their models, as well as in their policy recommendations, is that information is costly to produce and use, especially in healthcare. A patient’s journey through the system, from one health professional to another and to another, sometimes over a long period of time, and with patients with the same medical condition having very different journeys, means it has been difficult to systematically record the pathway, the use of resources at each step, and the health gains during the journey and at its end. Billions of dollars are spent and often wasted on computer information systems in health care, but progress is being made. The cost of storing and linking electronic data is falling. However, the cost of capturing high quality data, creating information and knowledge from these data, and then making good use of it, is still in its infancy and requires human judgment rather than machine learning and artificial intelligence. Sharing information between health care providers is key and the report’s recommendations about better integration in health care rests on different providers knowing the same information as patients transit through the system without falling through the cracks.

We know that simply publishing information or creating a website will not lead to the use of that information since there are costs to accessing it and interpreting it in specific contexts. In the United States, publishing information to enable consumers to choose health insurers does not lead to more people switching or making ‘better’ choices (Gruber 2017). Publishing information on surgeon’s mortality rates can lead to higher costs and worse health outcomes (Dranove et al. 2003) as providers choose to treat only more healthy patients.

Consumers will never have the same information and knowledge as doctors who can take up to 15 years to be fully qualified, and this should not be an objective of policy. Shared decision making and improved health literacy are very important interventions to pursue, but they are more likely to benefit the healthy rich rather than the unhealthy poor. Those most in need of healthcare often do not have the capabilities to be ‘active’ and informed consumers and do not have the ability to navigate around and within a complex health system. They trust their doctor to do the best for them and would not want to ‘choose’ themselves. Finding out the values and preferences of patients is a key skill required by health professionals to assist them make better decisions on their patient’s behalf. The main target of policies to produce and use better information on health outcomes, the effectiveness of treatments, and their costs, should be doctors in the first instance, who will remain advocates for their patients and will better act in their best interests with improved and trusted information.

Healthcare providers already have a strong incentive to use information on the health improvements of their patients: that is to improve their health. This suggests that the first step of the information revolution in healthcare is to be able to feed information back to healthcare providers so they can use it to alter their use of resources (including spending their time more wisely) to where health gains are the greatest for the least cost. Low value care, the subject of the Productivity Commission’s second recommendation, would disappear if doctors were shown, and more importantly believed and trusted, what little health gain they were producing.
from providing certain types of treatment. If doctors had the data at their fingertips, they would feel much more confident in telling their patients (with high expectations) that particular treatments simply will not work. They could then spend their time on more valuable activities. Disinvestment in low value healthcare interventions is a key recommendation in the report and should be a major effort given the extensive under-provision of high value care and over-provision of low value care. But this requires significant change by doctors who rely on their experience much more than new evidence, which may not be relevant to ‘their’ patients. Doctors believe that what they recommend is the best thing for their patients, and changing these beliefs will be difficult. Doctors are trained to do something, and doing nothing can sometimes remove the hope that patients hold so dear. Doctors also need credible and evidence-based alternatives so some hope remains. Doing ‘something’ is also supported by the current system of fee-for-service and the high expectations of patients who will go to the next doctor if they are not satisfied. More randomised trials are needed on the role of information and knowledge to change doctor’s behaviour so we know what works. Feedback of information to physicians can work, but it is unclear what aspects of such interventions drive behaviour change (Ivers et al. 2014). There is also a role for behavioural economics in understanding the mechanisms through which behaviour can be changed, but this is not a panacea (Scott et al. 2017).

3. Smarter System Design

Information is a necessary, but not sufficient, condition to improve the system. Improved coordination and integration also depends on redesigning institutional structures. Unlike many other industries, the health workforce cares about providing the best care to patients. Doctors and nurses and many others who provide clinical care are strongly motivated to help people and improve their health. The problem is that they work within a system that prevents them doing this. Rules and regulation, professional boundaries and state–federal funding splits all lead to a fractured system where these fractures not only cut across and interrupt the patient journey to better health, but divert patients down irreversible pathways that lead to worse health than could have otherwise been achieved.

In 2011, two types of regional health care organisation were created: Local Hospital Networks (LHNs) and Primary Health Networks (PHNs). LHNs are managed by state governments whilst PHNs are funded by the Commonwealth Government but have not been given strong roles for funded services. With closely aligned boundaries, these organisations represent a blueprint for the potential for better integrated health care and increased community involvement in decision making. Shifting the Dial recommends that these organisations become more closely aligned and be given more control to address local population health needs through a devolved budget aimed at the prevention and management of chronic disease. The issue of integration is much discussed in healthcare but is often difficult to define and implement. It is clear that patients being at the centre of care is an important goal but institutional arrangements and divided responsibilities prevent this.

A potential major reform would be the Productivity Commission’s proposal to allow LHNs to commission services from general practitioners (GPs). Direct funding of GP practices by LHNs, in collaboration with PHNs, would enable the provision of primary care to be tied to local population needs and efforts to prevent people from being admitted to hospitals. Pooling funding across organisations gives more flexibility to integrate services but can be difficult when organisations are trying to protect their patch and their own level of funding. How best to run and manage services at a regional and local level is a key issue that has yet to be solved, and one that requires strong health care management. The general issue of who is able to provide funding to GPs is an important one that should be pursued and could lead to more innovative payment models with funding and resource allocation ties to local needs. Trying to merge
what are now separate Commonwealth and state funding pools at a local level would do much to smooth out the patient journey through various parts of the system, though the Productivity Commission does not go as far as recommending the merger of LHNs and PHNs into new regional commissioning organisations responsible for the health of their populations.

The fee for service system of payment for doctors and activity-based funding for hospitals reward volume of care. Both have been heavily criticised by health economists for many years and again in Shifting the Dial. Fee for service creates a serious conflict of interest between doctors acting in the best interests of patients and their own financial interests, which will not always align. Australia is the only health system amongst high income countries that retains a system where fees are entirely unregulated and where price discrimination, that is varying prices according to patients’ characteristics, such as income, is common practice (Johar 2012). In combination with asymmetry of information, this serves to strengthen the market power of doctors to the detriment of patients’ health. To support doctors to improve the health of patients, a different payment system is needed.

What is lacking from the report is a call to strengthen the evidence base for such proposed reforms. Every Productivity Commission report should generate a research agenda that should be commissioned by governments or through the research councils. Such evidence is difficult to produce for large scale organisational changes. However, the opportunity for trialling and testing the effect of information feedback, on both the behaviour of consumers and healthcare providers, should be a priority. There is much experience and evidence from other countries that is unfortunately ignored in this report but could help shape the direction of reform. Many countries are dealing with the issues of low value care, improved information and data, integration, and patient centeredness. Finding out what truly works is difficult. Policy makers and politicians also need to recognise that change may not be delivered by the new trend of the day such as behavioural economics or artificial intelligence, but by more basic polices such as better information and system design. Some of this is rocket science, but much of it is not.

4. Conclusions

The recommendations of Shifting the Dial should serve as guiding principles for any government, though of course how best to translate these principles into effective policy change is where governments will differ. Modelling of future impacts is always fraught with substantial difficulty, significant uncertainty and many untestable assumptions, and so modelling of these should always be taken with a grain of salt (Productivity Commission 2017d). Nevertheless, the report presents a range of new ideas that deserve serious consideration. Some are challenging and difficult but need to be addressed and should not be shied away from.

Health care should no longer be placed in the ‘too hard’ basket of microeconomic reform. The consequences of ignoring these issues are literally fatal. Though people and politicians are often blinded and beguiled by the hope provided by shiny new technology, in reality this will not solve the structural problems in the system. The issues have always been, and will remain, as the report notes, fairly rudimentary and the basis of any well-functioning market: information and system design. Getting these right in themselves will not necessarily improve the system, but will provide a solid basis to open up significant opportunities to do so. They will provide both consumers and healthcare providers with more flexibility and choice, and remove some of the shackles that are costing us lives and impeding improvements in the health and wealth of Australians.

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