Comments on Productivity

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1. **What is the issue being addressed?** Health care productivity.

2. **Where does this issue touch the TR?** Productivity relates to OACT analyses of estimates of sustainability in light of ACA productivity updates to hospitals and certain other providers. The TR assumes that total hospital MFP in health care is 0.4 (vs. 1.1 percent for economy wide). This is based on 2007 research updated in 2016 by OACT, and it assesses resource-based productivity (productivity defined by a service, i.e., hospitalization).

3. **Why is this important?** There is some debate regarding productivity in health care, which figures into questions of the sustainability of payment updates under the ACA. New research on productivity offers alternative methods to measure productivity, beyond those shown by Romley et al. in a 2015 paper. In the Sheiner and Malinovskaya 2016 review, the authors raise two problems with resource-based productivity estimates. The first question is whether a service, i.e., hospitalization, is the right "good" in health care. Second, resource based estimates have no quality adjustment in health care, so the value of a hospital visit in 2016 equals that of a hospital visit in 2000. The vast majority of alternative estimates reviewed by Sheiner and Malinovskaya (though not all) suggest resource based approach understates productivity in health care.

4. **How does this relate to the charge to the Panel?**

   a. Productivity affects assessments of sustainability of productivity updates under ACA, MACRA payment updates.
   b. Indirectly, this relates to questions regarding shifting utilization, because resource-based measures ignore gains conferred by major health innovations (i.e., Hep C anti-virals) which would suggest rising prices without valuing the benefits.

5. **What would/could a recommendation look like?** Recommendation could vary from research based recommendation (a) to an explicit recommendation to change practice (b).

   a. OACT should use updated research to develop productivity estimates that account for the fact that services are intermediate goods and to adjust for quality. Would be more in line with move towards alternative payment more bundled from episode to person.
   b. OACT should estimate productivity in health care using disease based measures that adjust for quality changes over time.

6. **TR justification for resource-based approach – Medicare is still predominantly fee for service and pays for services rather than quality adjusted disease outcomes.**

7. What information would we need to table/justify a recommendation?

a. Comments from outside speaker/participant in recent work on productivity
b. Information about the feasibility of moving from productivity estimates for a single disease to allocating ALL spending to a disease-based approach. Experimental disease-based price indices are computed by the Bureau of Labor Statistics, but do not adjust for quality.
c. Information on methods to aggregate disease-based measures of productivity. Sheiner and Malinovskaya summary cites National Research Council 2010.