

Comments on Romley  
“Productivity Growth in Health Care”

Louise Sheiner

Hutchins Center on Fiscal and Monetary Policy

The Brookings Institution

# Background

ACA lowered statutory updates for most non-physician providers from

- Changes in input costs  
to
- Changes in input costs less economy-wide MFP growth

Because *measured* productivity growth in hospital sector is low, concern that this payment would be increasingly insufficient over time.

# Mismeasurement in hospital productivity

Most measures don't adjust for quality/severity.

Romley: Calculate changes in costs per successful outcome after adjusting for case severity: productivity growth much higher

Important contribution to understanding hospital productivity

But this measured likely understates *true* productivity growth: Costs per successful outcome can increase while society is made better off.

## Welfare based approach

Year 1: Treatment has 20% probability of success. Costs \$5,000.  
Cost per successful outcome is \$25,000

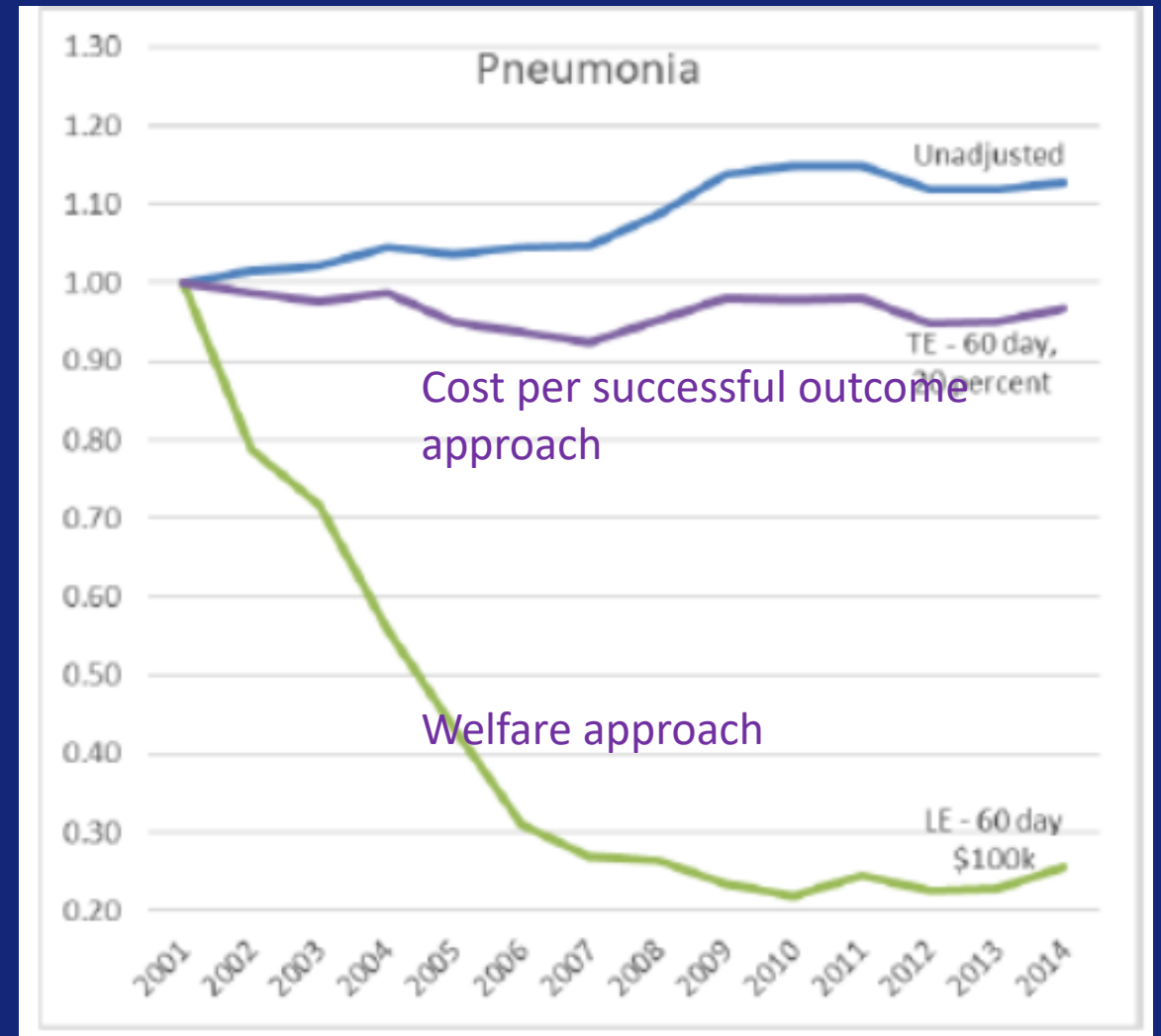
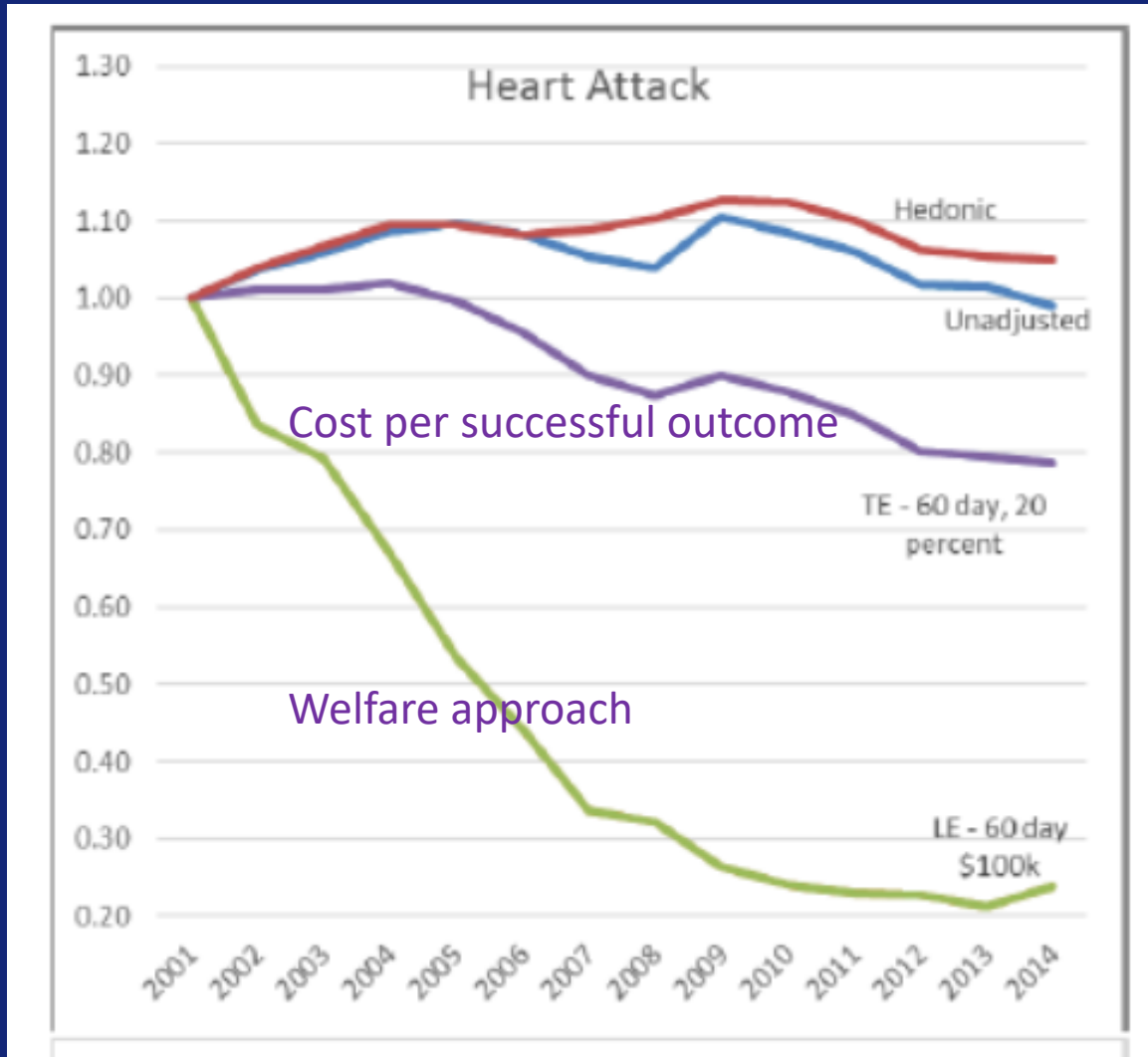
Year 2: New treatment has 50% probability of success. Costs \$15,000.  
Costs per successful outcome is \$30,000

Say successful outcome give you an additional year of life.

From year 1 to year 2, get an additional .3 year of life for an additional \$10,000.

If year of life worth  $> 33,333$  ( $10,000/.3$ ), health care is more valuable in year 2 than in year 1 even though Romley measure would show productivity decline (rising price of successful outcome)

In practice, welfare approach shows far larger price declines (so larger increases in real output and productivity.)



# Implications

- If productivity growth in the health sector  $<$  economy-wide MFP, Medicare payments will fall below cost of maintaining constant bundle of services
- Either Medicare beneficiaries will have less access/worse quality or more cost shifting, putting pressure on politicians to undo cuts

BUT,

- If productivity growth actually  $\geq$  economy-wide MFPR, ACA updates sufficient to finance constant or even growing quality of care

# Even with high hospital productivity growth, questions about sustainability

If productivity growth = same quality of care for less, then productivity adjustment might just prevent excess profits (showing up as...?)

If productivity growth manifests as improved quality, then likely could cut payment while maintaining quality, but would be giving up valuable improvements.

More complicated when consider one health system with multiple payers. If private payers willing to pay more to get more, then how do the two systems coexist?

- Medicare “free rides” on private
- Medicare beneficiaries access becomes limited
- Private payers eventually follow Medicare’s lead?

# Conclusion

Productivity measures in health sector typically don't account for quality improvements. Productivity is understated, perhaps substantially.

But question of sustainability of ACA Medicare payment updates isn't ensured just because hospital productivity  $\geq$  economy-wide MFP.

If wedge between private and Medicare payments continues to widen, possible some access problems could result.

But complex interplay between Medicare and private might mean that lower Medicare payments ultimately lead to lower private payments.