Reaping Broader Economic Benefits from an Effective Healthcare System: a visual lens

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Michael Brennan, Chair

In my time I have heard of some pretty weird and wonderful conferences. Apparently there is a mermaids' conference each year somewhere in North Carolina; and a ventriloquists' convention in Cincinnati!

But now I have seen it all: when I heard that there was to be a conference focused on health policy but from a ***consumer*** or ***patient*** perspective, it seemed so outlandish, so exotic, that I knew I just had to be a part of it.

So it was a thrill to be asked by Alex and Peta to present on the theme of health and productivity.

Of course I am being facetious — but you understand the point: too often the interests of providers and producers hold sway over the wellbeing of the people the system is meant to serve, and one of the big policy issues of our time is how we move to a more patient-centred, integrated health system.

There is nothing I can tell you about health that you don't already know. But I do want to give you a sense of how we at the Productivity Commission think about health and how it forms part of a broader productivity agenda.

I want to sell you on three ideas:

- that health — and the quality of our health system — is fundamental to Australia's productivity and future prosperity
- that while our system does a number of things well, it is arguably not fit for purpose in dealing with some of our significant emerging health challenges like obesity and mental health
- and lastly, that the link between health and productivity is important, but should be construed in broad, not narrow, terms. I will come back to this point at the very end.

In 2017, the Productivity Commission under Peter Harris released *Shifting the Dial*. It sought to set out what a modern economic reform agenda should look like. Following the initial analysis, showing Australia's slowing labour productivity growth, the first substantive

chapter — supported by detailed background papers — was about health. Not tax, trade policy or industry policy, but health.

Why was that? First because health is a large and growing industry and improving productivity in the sector is a valid aim in its own right. We estimated, for instance, that some $900 million a year was being lost due to people having to sit in doctors' waiting rooms.

But also, the document spelled out the significant dividends to the economy that can come from better health. In short, if you can encourage and enable people to find work, work more and work more productively, then you can lift GDP per capita.

But it isn't just about measurable economic output — believe it or not, we economists care about broader wellbeing; and the point is that improving health outcomes can change lives for the better.

So how productive is our health system? That's a hard question to answer. Much of our system is predicated on outputs — like our fee for service primary care system and activity based funding in hospitals. But what do we know about the outcomes?

In one sense, the broadest indicator of how we are going is average life expectancy. When we compare life expectancy to health spending as a share of GDP, Australia comes up pretty well: we spend an amount comparable to the OECD average and achieve life expectancy at the high end of the scale. Could we do better? Absolutely. Our system has had some great successes — as I will outline, but it is less well configured to deal with some of our current and emerging challenges.

Two such challenges are diabetes and mental health, impacting 5 per cent and 20 per cent of the Australian population respectively.

Chronic illness is not just increasing, but it also has a strong socio economic and age profile. This has two implications: first, to the extent that the incidence of chronic disease increases with age, it is a growing challenge given our ageing population. Second, as people age, the inequities — between the incidence of chronic disease in the lowest income quintiles compared to the highest — start to open up.

Health inequality is different to income or wealth inequality. You can address the latter partly through redistribution — taking from some to give to others, and this is what our tax transfer system largely does. But you can't directly redistribute health outcomes. You actually have to tackle the underlying causes and conditions of those who suffer ill health.

Partly due to Australians' long life expectancy, we have among the longest duration of time spent in ill health. And the share of life spent in ill health (not just the absolute years) is rising.

Meanwhile, premature death continues to impose a big human and economic cost. There is relative stability in the causes of premature death, with notably lung cancer associated with smoking still the second most important source. This is an indicator of the long shadow of

past high smoking rates on subsequent health outcomes. It will take some years for this burden to fall, and among some disadvantaged communities that time will be very protracted.

The notable increase in Alzheimer's disease reflects the higher incidence of this disease in older age categories, and the rising share of the old. It is the leading cause of death among females. Higher life expectancy means higher exposure risks to the disease.

This story is accentuated when disability is concerned, with many of the prominent causes amenable to changes in environments and behaviours, and in the case of mental illness, changes in the structure and performance of the mental health system (a matter under consideration right now by the Commission).

Turning to direct economic impacts of poor health, these manifest in lower labour force participation and higher unemployment rates. There are, if policy measures are successful, potentially large economic benefits from dealing with disease more effectively.

In making this point, I want to add just a little caveat. There is some causal linkages that go the other way — namely that unemployment and disengagement can worsen or create poor health.

But this is an interesting area in its own right because it emphasises that economic policies can also affect health outcomes.

Not only do people in ill-health tend more often to be outside the labour market or to be unemployed, they are also likely to work fewer hours if they do secure a job, with that effect not much different between different age groups.

And in one sense, this situation is getting worse rather than better — the relative risk of being unemployed or not in the labour force (comparing those with, to those without, a disability) has increased since 1993. That is, the participation and employment gap has *widened*.

This is partly due to the broader rise in participation and fall in unemployment across the general population over that period. That side of the story is the good news, but it always pays to ask who is getting left behind, and those with a disability are increasingly facing labour market challenges.

Carers also bear an economic burden and are often unable to work — or if so, only for limited hours — with implications for household income and risk of poverty. Consequently, welfare dependence for carers is pronounced and often long lasting.

What much of this bears out is that in many cases there is a weak link between health treatment and getting people back to work or active in the community — unlike high quality workers' compensation and rehabilitation schemes, which focus on linking health goals with maximising work. We see this as an emerging issue in our Mental Health inquiry, and we found it to be a key deficit of Australia's veteran support system.

So what can we do about it?

The history of medicine tells us that technology and practice matter. Early reductions in morbidity reflected public health initiatives like clean water.

But some of the most profound reductions in mortality reflect technological developments, of which statins provide an extraordinary exemplar. While not the only factor at work, the reduction in mortality rates over the last century for people aged 60 years old is largely one that reflects technology. Technology has the advantage that it is relatively easy to diffuse and so can be applied to large populations.

Of course, a good system must ensure that technologies are safe, continue to be the best that there is, and past some sort of cost-benefit test.

What about prevention?

Designing cost effective early interventions is never quite as easy as it sounds. But history tells us that broad based prevention strategies can work.

The first example is in smoking, where Australia has achieved significant reductions in the daily smoking rate, and stands as an exemplar relative to global peers. How was this achieved? Through a combination of measures, including:

- ongoing education
- consumer-centred initiatives like plain packaging
- tax
- the availability of alternatives like gum and patches.

But also, as a lot of ex-smokers will tell you, the inconvenience and social stigma also played a big part in their decision to quit.

A second, and truly remarkable, example is road fatalities. If you looked at this chart of road deaths per 100,000 population in 1969 — say when Neil Armstrong set foot on the moon — you would likely have predicted that the road toll would continue to rise (just like you might predict that by 2019 we would have colonised space — you would be wrong on both counts).

You can see the stark impact that seat belts had in the early 1970s and the further falls — most likely led by random breath testing — in the 1980s. These two things were complemented by better and safer cars and better road technology, as well as consistent community education about the dangers of speeding, drink driving etc.

What I think is remarkable about this chart is that the fact that road fatalities per 100,000 population are materially lower today than in 1925 when a lot less people drove a lot less kilometres (and at lower speeds).

The epidemiological evidence in Australia and globally among the rich economies is that many of the factors driving death and disability could be subject to preventative strategies, rather than to direct health care for those already with disease and disability. Inevitably, this

requires interventions that are connected to the orthodox health system — taxes, psycho-social support, environmental changes, standards (as in vehicle emissions), labelling and education.

So both technology and broad based prevention will continue to play a role in the policy armoury.

However, the big innovation — the big reform challenge — is system change, to move to a more patient centred, integrated health system. This will probably take the form of innumerable small incremental steps which can nonetheless add up to radical change in totality.

It requires a change in clinical mindsets, to put patients at the centre of things, and develop patient-based performance measures such as patient reported experience and outcome measures (PREMs and PROMs).

Also, improving health literacy to empower consumers, and enabling real choice, which I maintain has a powerful role to play in health system reform.

It involves breaking down the funding, organisational and cultural silos in the system — accentuated by multiple actors and funders. The separation of primary care and hospital care is particularly problematic.

Professional jealousies between general practice and specialities and more generally among other health professionals can lead to uncooperative cultures.

Incentives for avoiding hospitalisation — the most costly part of the system — are weak given the funding mechanisms (ABF in hospitals and fee for service in primary care). Blended models with co-funding from LHNs to PHNs could help ameliorate this.

Data is critical for evidence-based assessment of the health care system — its effectiveness and efficiency — yet is not fully used.

And evidence about what works is often slow to diffuse through the system, and we see big variations in clinical practice, not to mention cost, across the system.

Of course we should never forget that patient empowerment is a good in its own right. I repeat: economists aren't just all about the dollars!

Finally, it's not just about the health system either. It's about the labour market too. As I mentioned before, there is a bit of two way causation at play here: better health leads to higher workforce participation, but having a job can also improve health outcomes.

So in summary, productivity matters to the health system.

And health outcomes matter for productivity.

Where can we go with this insight?

The last time this conference was held, participants agreed that:

'Health spending delivers economic benefits beyond the health portfolio. We can, and should, consider the flow on effects of new health technologies into other portfolios of government."

I couldn't agree more. But I would also urge you to construe that insight in a broad way: to point out the improved health outcomes that can come from a well targeted health budget, and health system reform.

But stay away from the narrow view — the idea that we should change the costing methodology or accounting policy to try and deduct estimated dollar savings from the upfront cost and thereby claim we are spending less than we really are.

That is a notoriously difficult exercise. It can also lead to distorted priorities because the dollar savings might differ according to whether the target cohort is old or young, rich or poor, etc.

In the end, every spending portfolio wants to try this approach and there are good reasons why Finance won't allow it.

It's much better to be armed with the arguments about the better outcomes being purchased.

Here's the analogy: don't be like the person who comes home from the Department store sales laden with new purchases saying: *"You won't believe how much I saved!"*

Much better and more accurate to say: *"Look at the great things I got for my money."*