Consultation Response on the Pricing Framework for Australian Public Hospital Services 2020-21

BIOTRONIK Australia Pty Ltd

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Attention: IHPA Secretariat at submissions.ihpa@ihpa.gov.au.

Introduction:
Biotronik Australia Pty Ltd thanks IHPA for the opportunity to respond to the Consultation on the Pricing Framework for Australian Public Hospital Services 2020-21 below:

Background:
Biotronik Australia Pty Ltd is the wholly owned subsidiary of Biotronik SE & Co. KG. , a private company headquartered in Berlin with key manufacturing facilities in the advanced economies of Germany, Switzerland and USA. The Health Technology manufactured and marketed by Biotronik includes both Active Implantable Devices and Passive Implanted Devices supporting Cardiac Applications and Combination Therapy Technologies (Drug/Devices) which support the cardiac and peripheral vasculature. Common recognisable terminology for the devices marketed includes pacemakers, defibrillators, cardiac and peripheral stents where the company holds in the order of 10-15% worldwide market shares. To that extent we consider ourselves to be a SME relative to our competitors in the Cardiac and Peripheral medical devices market.
Biotronik Australia Pty Ltd is an active member of our industry association Medical Technology Association of Australia (MTAA).
Biotronik Australia Pty Ltd response to the consultation is offered in good faith and is supportive of the Activity Based approach to funding adopted by the State and Federal Government. In seeking a renewed NHRA we look forward to IHPA's continuance and maturity of approach as demonstrated at all levels of stakeholder engagement with its growing evidence base in an evolving and changing health landscape.

Michael Reynolds
Director Healthcare Economics & Advocacy

BIOTRONIK Australia Pty. Ltd.
Level 4 Building 2
20 Bridge St., Pymble
Sydney NSW 2073 Australia
M: +61 (428) 763 288
P: +61 (2) 9497 3713

E michael.reynolds@biotronik.com

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2. Pricing guidelines

Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

Overarching Guidelines-

Evolving: Consider in-line with innovation in federal/state funding reform agenda flexibility around place and provider networks within and outside hospital environments in engaging patient care pathways/journeys rather than models of care delivery.

Efficient: identifies value from a public investment perspective. Consider wider and multiple value propositions especially from the patient/consumer perspective. Leads on to the System design where you are seeking to Promote Value. Note NSW Health's wider scope of value proposition.

Fair: Biotronik question the issue of equity across all business models of health delivery, especially where private or charitable capital is engaged. These have fundamentally different drivers in attracting engagement and if these are not catered for then these models will over time move away from public health care markets. A sensible synergistic approach which considers the wider eco-system of human engagement around health is required to transparently account for and cater to these differences, which will deliver fairness over a longer time scale. This is a significant policy piece in itself.

Governance: Seek to engage all stakeholders with a focus on Patient Centred/Clinician Leadership

Scope: Consideration of pricing beyond activity funding as it effects and drives capitalisation of health especially around health technology and infrastructure investment

Process Guidelines-

No Comment

System Design Guidelines-

Foster health care delivery innovation: widen scope outside clinical and health technology considerations alone.

Single unit of measure: transferability should accommodate between care types/service streams and along patient journeys which needs to accommodate all care delivery/disease state environments.

Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

Promoting Value: Funding processes should follow and support value generation through innovation and transparent competition of resources. Similarly it should account for each stakeholder's different perspectives and relativities in creating definitions around value.

3. Scope of public hospital services

Concern Criteria for Services within scope does not encourage innovation around service delivery, an example being

- demonstrate regular and intensive contact with the target group (an average of eight or more service events per patient per annum);

Consider balancing patient focused outcome driven activity as opposed to activity intensity in total

As per our 2019-20 consultation response BIOTRONIK would like to ensure there is clarification around the process of innovation with health technology and models of care. There needs to be clear scope around incentives to scale, clinical and process evidence around this scalability, current block funding linked to activity measures, process efficiency gains sharing across funding silo's, cost effective methods to capturing metrics along the length of the care pathway and finally but crucially clinical engagement and those financial drivers.

Also as raised previously BIOTRONIK support cardiology clinics for CIED's in the public hospital system and we are concerned that this external industry support through education and technical support which happens with a multitude of technologies is not transparent or captured within the current Tier 2 arrangements or more importantly in the inpatient environment. This applies to the support provided by health technology sponsors in the innovation, introduction and support of changing technology bases across the full scope of the public market. Transparency and contestability around technology inputs needs attention as IHPA develops its program of work.

4. Classifications used by IHPA to describe public hospital services

What should IHPA prioritise when developing AR-DRG Version 11.0 and I C D-10 - A M /AC H I/AC S Tw e l f t h E d i t i o n ?

Where activities are clearly wrapped around the Health Technology that delivers the therapy or diagnosis and they represent a significant proportion of the activity costs and value delivered, then there is management efficacies to be gained in ensuring dedicated coding's.

We note for BIOTRONIK's core technologies for Pacemaker and ICD technologies the ARDRG bundles both initial implantation and replacement activities under the one code. A

separation of these at a higher DRG level would be useful in managing these health technologies. Similarly with Drug Eluting Stents identification of the cost associated with these procedures is now bundled under a composite code. A review of all these high acuity high cost Health Technology inclusive coding's should be a consideration of any review of the AR DRG system.

Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

Facilitated data linkages would inform management and clinical improvement around these activities.

Similarly it would be beneficial to ensure coding processes are mimicked between public and private as can best be achieved to allow dynamic efficiency comparisons in benchmarking around best practice.

Reporting on transitional shadowing processes and seeking feedback from multiple stakeholders may inform the final transition.

Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

Biotronik welcome the evolution in coding to capture costs through all areas of health delivery, noting the need for stability trade-offs. We would welcome the ability to link these cost components on mapping a full episode of care. We recognise the need and investment in Patient Identifiers with privacy safeguards through this process.

.Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

As above. We look forward to the shadowing report.

5. Setting the National Efficient Price for activity based funded public hospitals

Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

A process for merit based adjustments should be available as proposed in the Framework Document V2.3. Utilisation of legitimate seems unwarranted terminology. The mechanism should be available for both local and global unplanned cost changes- whether activity or cost , patient/hospital/service unit based the process needs clear rules to ensure expedient use.. Considering that changes are usually unplanned due to external factors or outlier activity then the system needs to maintain flexibility in delivering public health. Potential use case studies which support such potential events which may be considered through such a process could include health epidemics (adherent flu strain), national/state based labour rate adjustments, input cost adjustments based on significant balance of trade issues or inflation rates etc.

Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

Biotronik suggest that in light of the continual drift of private patients to public health delivery which is a choice available to those electing for private health insurance that the correction factor be maintained. The workload balance rather than revenue continues with a need to be monitored as the implementation of policy levers in changing the reimbursement landscape to drive utilisation will be ongoing.

To that extent the business rules established around sources of funding with private activity may adequately compensate for the need of a correction factor. However a simple (-/+) correction factor is a potential tool to change utilisation, especially when an accurate cost picture is difficult to obtain. We note the differential in Biotroniks experience with input costs for cardiac procedures. Biotronik offer devices under a different paradigm for public vs private patients, where device offers differ as do both procedural and post procedural service structures and costs.

6. Data collection

Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

BIOTRONIK as a Health Technology stakeholder would favour industry access vi the NBP portal detailed data sets at hospital level . Through such a process we would seek to understand where we contribute to the models of care delivery value through the hospital system.

As such we seek to with provider stakeholders in investigating process improvement and accessing the cost/value generation through effective utilisation of our Health Technology.

Visibility within and between public hospitals around a common activity metric allows transparent identification of opportunities and innovation across the industry.

Publishing around procedure variability at as many levels as available – cost, safety, quality and outcome metrics would be invaluable to the industry as a whole.

What are the estimated costs of collecting the IHI in your state or territory?

N/A

Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?

IHI should be the basis of current accounting practices within any health or business operation. Hence any incentive should be one off limited to the costs of set up as the IHI granularity is something the whole of health will benefit.

What initiatives are currently underway to collect PROMs and how are they being collated?

PREM's & PROM's can be an expensive subjective engagement and monitoring tools and hence their use should be measured. Where the Patient metrics drive improvement in technical processes at a quantifiable level then they should be funded ongoing. The key issue is at what point in the delivery processes is most effective as an improvement point and should it be through a PREM or PROM? Where it informs clinical care its incorporation into the EMR is probably of more value.

Should a national PROMs collection be considered as part of national data sets?

Where key points have been identified it should be included in the NBP in driving process improvement.

7. Treatment of other Commonwealth programs

"For 2020–21, IHPA proposes no changes be made to the treatment of other Commonwealth programs"

Biotronik would suggest IHPA include a quantity of work around suggested rules to account for government changes to regulatory and policy instruments on Public Hospital funding outside the potential for any stakeholder to be unfairly assigned costs or accountabilities.

e.g MBS review –limiting or expanding public access to procedures

PBS speciality Drugs – ongoing review of access.

PL Reform Agenda – service cost subsidies across markets

8. Setting the National Efficient Cost

Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?

Agree with the model concept of a fixed and variable component in developing a more accurate process map. We would note that delivery models of care for rural and remote services are supplemented by other synergistic health delivery resources so it is important to take a patient centred approach to this model in reviewing the shadowing results. Noting the difficulty of attracting on ground clinical resources to support different models of care, the fixed component of the health delivery as it accounts for capital resources and infrastructure should not be driven by benchmarked ROI's.

9. Alternate funding models

Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

Biotronik would welcome IHPA publishing the results of its global horizon scan to inform public debate around this issue. The lessons learnt from the ACO introduction in the US. How structural alignment evolved and achieved technical efficiency is not evident in US health performance statistics.

Funding models designed to move delivery systems beyond technical efficiency drivers to allocative efficiency assume a degree of structural integration which has not fully evolved in an Australian health delivery context. Hence any models trialled should not risk technical efficiency gains in searching for obvious allocative efficiency opportunities.

Establishing value criteria, other than the established cost or activity metrics, needs considerable public debate. A balance of value from all stakeholders context is important in ensuring sustainable attractive human engagement. Competitive drivers in a public context however should be based on sound business principles which encourage innovation around delivering health care value.

IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

Consider inclusion of subsets of the two highest disease burdens being Cancers & Cardiovascular diseases. State based learning around CHF offer up opportunities but separation of quality performance indicators in driving improvements needs to be clearly delineated.

10. Pricing and funding for safety and quality

Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

Monitoring function of safety and quality outcomes should be transparent at the highest level to allow engagement and ownership by all stakeholders impacting the result. It is expected that IHPA should be reporting on the cost/benefit of such a program in justifying inclusion of wider indications or incidences in the program.

Integral to reporting events is the outcomes details from Clinical Quality Registries where linking can create opportunities for technical efficiency gains.

What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

Suggest digital engagement with high impact stakeholders where granular patterns may identify global opportunities for improvement.