Consultation Response on the Pricing Framework for Australian Public Hospital Services 2019-20

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 2019-20 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. We are pleased to see the introduction of quality and safety metrics into the Pricing Framework and welcome IHPA's investigation around value based models of care.

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1. Pricing guidelines

“Whilst these Pricing Guidelines are used to explain the key decisions made by IHPA in the annual Pricing Framework, they can also be used by governments and other stakeholders to evaluate whether IHPA is undertaking work in accordance with the explicit policy objectives included in the Pricing Guidelines.

IHPA considers that the Pricing Guidelines are working well and therefore no changes are proposed for the Pricing Framework 2019-20.

System Design Guidelines to inform the options for design of ABF and block grant funding arrangements:

- Public-private neutrality: ABF pricing should not disrupt current incentives for a person to elect to be treated as a private or a public patient in a public hospital.”

BIO Comment: BIOTRONIK would like to highlight IHPA’s engagement with costings in the public private divide in the Prostheses cost and benefits debate and suggest it is outside guidelines. This is particularly disconcerting when the request for information is used in seeking health technology neutrality at a simple monetary level through private pricing instrument adjustments. The emotive and political agenda has obscured an objective analysis of the differences based on different models of care, payment models, the cost around choice and the different approach to marketing/logistics support, supply chain competitive dynamics let alone consideration of clinical and process outcome differences achieved. The private patients in public hospital will no doubt keep the focus on this obvious cost/benefit discrepancy and we would seek IPHA maintain its neutrality and injects informed objectivity as the debate evolves.

2. Scope of public hospital services

Consultation question

- What changes, if any, should be made to the criteria and interpretive guidelines in the *Annual Review of the General List of In-Scope Public Hospital Services* policy?

Category A: Specialist outpatient clinic services – Tier 2 Non-Admitted Services Classification – Classes 10, 20 and 30

This comprises all clinics in the Tier 2 Non-Admitted Services classification, classes 10, 20 and 30, with the exception of the General Practice and Primary Care (20.06) clinic, which is considered by the Pricing Authority as not to be eligible for Commonwealth funding as a public hospital service.

Support for innovative funding models

IHPA recognises that service delivery models are not static and innovative models of care offer the potential to provide more effective health services. The Pricing Guidelines outline the policy objectives to guide IHPA's work and reference fostering clinical innovation whereby "the pricing of public hospital services should respond in a timely way to introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes".

IHPA will consider jurisdictional proposals to block fund patients to support the introduction of new innovative funding models on a case-by-case basis. For 2018-19, the Pricing Authority has determined that enrolled chronic care patients in the capitation funding model in Victoria ('HealthLinks: Chronic Care') will be block funded to support the introduction of this program.

BIO Comment: 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. The consultation paper around this issue proved that IHPA is informed and flexible around this opportunity and we look forward with interest the action points emanating from this consultation.

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 is not transparent or captured within the current Tier 2 arrangements. 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.

3. Classifications used by IHPA to describe public hospital services

Consultation question

- How could 'Australian Coding Standard 0002 *Additional Diagnoses'* be amended to better clarify what is deemed a significant condition for code assignment?
- Do you support the proposed timeframe to phase out support for AR-DRG classification versions prior to AR-DRG Version 6.X from 1 July 2019?
- Do you support the current biennial AR-DRG development cycle. If not, what is a more appropriate development cycle?

BIO Comment: BIOTRONIK understands by applying Additional Diagnoses to code assignments may add clarity to understanding the impact of co-morbidities contribution to the cost picture and allow greater definition around acuity assignment of DRG's but at what cost?. Suggest that such an approach would be undertaken as a shadowing exercise on a pilot basis to see the expected cost and value.

Similarly the cycle times of DRG reviews is best analysed via a retrospective analysis of the cycle of change. We would comment that such an approach may make the process more responsive to change in practice but it is unlikely to provide statistically relevant outcomes data around process or clinical efficacies if the Activity base is continually shifting.

Considering models of treatment or care is usually clinician lead through a rigorously scientific approach which requires the accumulation of at least 2 years evidence a conservative approach is favoured.

Cost bucket variability around labour force efficiencies or procurement practices can be managed through individual management unit accounting processes.

Consultation question

- What areas should be considered in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification?

BIO Comment: BIOTRONIK mentioned previously the desire to see the outcome of the recent consultation. We are pleased to see the shadowing around MDCC's and look forward to it driving activity around our area of interest in multi-morbid cardiac disease patients and their care outside hospitals. Such a process has documented value to health delivery.

4. Data collection

Consultation question

- Should access to the public hospital data held by IHPA be widened? If so, who should have access?
- What analysis using public hospital data should IHPA publish, if any?

BIO Comment: BIOTRONIK as a Health Technology stakeholder would favour industry access to detailed data sets. 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.

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

Consultation question

- What are the advantages and disadvantages of changing the geographical classification system used by IHPA?
- What areas of the National Pricing Model should be considered as a priority in undertaking the fundamental review?
- Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2019-20?

BIO Comment: BIOTRONIK notes the attempt to ensure geographical classification is an accurate coding process in grouping costs associate with service access, disease incidence and socioeconomic determinates as reflected through geography.

As IPHA aggregates datasets around the political and management constructs that support the range of health constituencies across Australia it should be considered as a tool in determining strategic opportunities in re assembling resources around geographies.

Consultation question

- What are the priority areas for IHPA to consider when evaluating adjustments to NEP19?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.
- Do you support price harmonisation for the potentially similar same-day services which are discussed above?
- What other services, which can be provided in different settings of care, could benefit from price harmonisation?

BIO Comment: BIOTRONIK would suggest that criteria for robust outcomes evidence development that supports any price harmonisation activity. We note the utilisation of CAC's but would seek some transparencies around the decision process within the Committees that supports any change. Care settings may impact on the short term cost of engagement but be reflected in long term clinical outcomes or QoL for the patient.

Consultation question

- When should IHPA implement a shadow period for ABF classification systems and the National Pricing Model?

BIO Comment: BIOTRONIK considers where major changes occur to ARDRG's especially around the engagement of Health Technology that the changes be shadowed before implementation. We note the movement of coronary stenting between AR-DRG's and its impact on prostheses cost especially in a private setting. Such changes need to be tracked to contextualise a historic analysis.

6. Setting the National Efficient Price for private patients in public hospitals

Consultation question

- Do you support the proposal to phase out the private patient correction factor for NEP20?

BIO Comment: BIOTRONIK would support phase out as long as neutrality is maintained between public and private hospitals. Concern is that gaming may occur around the Prostheses List benefit paid by funds and the tender limiting activities of public hospitals. By isolating prostheses and medical costs then transparency will be enhanced. The range of devices on offer may be limited in a public hospital context or if available not part of standard inventory file management. Note that the benefit paid to sponsors for private patients also accounts for the post implantation support and functioning of the active implantable devices outside the hospital environment. Such costs may be separately tender by the public hospitals or absorbed into their Tier 2 costings.

7. Innovative funding models

Consultation questions

- What countries have healthcare purchasing systems which can offer value in the Australian context and should be considered as part of the global horizon scan?

BIO Comment: BIOTRONIK suggest that through the global horizon scanning process that sovereignties' should be limited to those that achieve close too or better health outcomes than Australia. We note the move to value driven models being tested in the US and the mixed outcomes being achieved. Value in that sense is subjective around whom and what the value drivers are. The drive towards improved health outcomes and innovation in delivering this is directly related to the total investment in the industry across all activities. Bundling by activity, per diem or capitation models have all been attempted in one shape or form over many years of health delivery.

Two significant megatrends which will drive changes to funding models are - Digitisation of all aspects of health and Consumerisation of health engagement. These will significantly change models of care but from a public context they should be based on evidence and incentivised where value is measured and delivered. To this extent the US, Netherlands, Denmark, Sweden , France and the EU generally are engaged at various levels which it is understood that IHPA is already engaged. Consumer engagement as an informed payer in managing their risk in a public context may be a long term opportunity currently outside scope.

8. Setting the Pricing and funding for safety and quality

Consultation questions

- Do you agree with the proposal that pricing and funding models for avoidable hospital readmissions should be based on readmissions within the same Local Hospital Network (either to the same hospital or to another hospital within the same Local Hospital Network)?
- Do you prefer an alternative scope for measuring avoidable hospital readmissions and, if so, how would this be measured?
- What evidence or other factors have informed your views?

BIO Comment: BIOTRONIK focus on readmission would be around complex disease states such as Heart Failure where readmission would be triaged prior to presentation to the most appropriate heart failure services. Such service may regularly lie outside a regional LHD so may not capture opportunities to better handle these patients at that level. We note the high readmission rate to the same hospital by numbers but would suggest that this be analysed through the lens of acuity, cost and disease as it may change considerations.

Consultation questions

- What are the advantages and disadvantages of use of the Medicare PIN and/or the Individual Healthcare Identifier for the purposes of pricing and funding of hospital readmissions?
- What strategies can be used to overcome existing disadvantages for each of these approaches?

BIO Comment: BIOTRONIK would favour an identifier that can track the patient across care settings in developing innovative models of care. Hence we would agree to the ADHA's suggestion or approach to this issue.

Consultation question

- Do you support the proposal to limit the measurement of readmissions to those occurring within the same financial year?

BIO Comment: BIOTRONIK would suggest that such readmissions be carried forward to ensure consistency in treating the total cohort. We cannot comment on the required financial adjustment or the administrative cost imposition but understand carry forwards have well defined accounting standards and should not be onerous.

Consultation question

- Do you agree with the proposal to include funding options, but not pricing options, for avoidable hospital readmissions?

BIO Comment: BIOTRONIK agrees with a funding approach as it incentivises where the issue is noting that 85% of readmissions are at a LHD level and the resources and management accountability to address safety and quality. Measurement at an episodic level is critical in understanding the source of issues to target resources at higher levels if required.

Consultation question

- What patient-specific factors should be examined in a risk-adjustment approach to avoidable hospital readmissions?

BIO Comment: BIOTRONIK suggests that an approach adopted by England or Germany may be more appropriate as it leaves no patient behind in incentivising against an event and simplifies the process for all. Considering geography is already accounted for in the pricing model then it should be reflective of the key external risk factors.

Consultation questions

- What are the advantages and disadvantages of Option 1?
- Do you agree with IHPA's assessment of this option?

BIO Comment: BIOTRONIK agrees this option is the most transparent and simple to administrate and as such would offer the highest incentive for hospitals resourcing around safety and quality. Suggest application at an LHD funding level would capture 85% of events simplifying , improving transparency and achieve the same degree of focus at the hospital/episode level.

Consultation questions

- What are the advantages and disadvantages of Option 2?
- Do you agree with IHPA's assessment of this option?

BIO Comment: BIOTRONIK considers this is a compromise which may result in some hospitals living with the quality failures and implement lower cost longer term outcome changes.

Consultation questions

- What are the advantages and disadvantages of Option 3?
- Should benchmarks for avoidable hospital readmissions be measured and calculated at the level of individual hospitals or at the level of Local Hospital Networks?
- How should the threshold be set for 'acceptable' rates of avoidable hospital readmissions? How should the funding adjustments be determined for 'excess' rates of avoidable hospital readmissions?
- Do you agree with IHPA's assessment of this option?

BIO Comment: BIOTRONIK questions the value of the complexity introduced in setting and reviewing benchmarks plus the achieving agreement around the adjustment levels. Option3 introduces greater complexity while removing direct incentives that translate down to episode level of care.