IHPA Pricing Framework for Australian Public Hospital Services 2020-21

Response to consultation

SUBMISSION
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Company Overview

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Comments on IHPA Pricing Framework 2020-21

Johnson and Johnson welcome the opportunity to provide comments on IHPAs Pricing Framework for Australian Public Hospital Services 2020-21. Comments on selected questions are provided, and broadly consider how the Pricing Framework can support the optimization of both patient outcomes and healthcare spending.

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

Achieving the highest quality care and best possible patient outcomes – i.e. high value care - requires a flexible approach with regards to how and where care is delivered. To enable this flexibility, pricing models will need to support different approaches to funding healthcare delivery. The proposed addition captures this requirement.

If value is considered as what matters to patients, then the proposed addition doesn't fully reflect value from a patient's perspective because it is not explicit on supporting models of care that improve patient experience of healthcare (e.g. by providing care where it is convenient for patients).

Value in hospital and health services should also be considered as including the experience of providing care from the perspective of clinicians, nurses, allied healthcare professionals and others. This aspect of value is not explicit within the proposed addition.

These three aspects of value in hospital and health services are consistent with NSW Health's approach to Value-based Healthcare[1].

What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?
Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

Johnson and Johnson welcome IHPAs comprehensive review of the admitted acute care classification development process. We note IHPAs *'consideration of development timeframes, methods of incorporating new technologies faster*'. This approach is essential to ensure that classification systems can keep up with the pace of change in medical technology and healthcare practice. To facilitate this IHPA may wish to consider a 'horizon scanning' approach like HealthPACT[2], and proactively consider the impact of new and emerging technologies on classification needs, thereby enabling more timely changes to classification.

Complimentary to our public healthcare system adopting technologies that evolve both patient care and outcomes, we commend IHPA's consideration to review and include new technologies whilst re-

[1] https://www.health.nsw.gov.au/Value/Pages/default.aspx

[2] http://www.inahta.org/members/healthpact/

defining AR-DRG procedure inclusion. The recent transition of electrophysiological interventional treatment from diagnostic cardiology into PTCA is one such example.

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

A culture of transparency in healthcare reporting is widely regarded as a key enabler of Value-based healthcare (VBHC). Public availability of the NBP is consistent with this approach and is considered a positive step in the wider context of the VBHC agenda. Although alternative funding models are considered policy levers to drive improvements in the quality of care, it has been discussed whether public reporting of performance could be an alternative to paying for performance to drive care improvement[3]. Hence, initiatives to improve transparency are an important parallel to IHPAs work on alternative funding models – different funding approaches alone may be insufficient to improve care.

What initiatives are currently underway to collect PROMs and how are they being collated? Should a national PROMs collection be considered as part of national data sets?

Further to the initiatives described in section 6.5 (Consultation paper, page 24), the Health Services Research Association of Australia and New Zealand (HSRAANZ) held a conference in 2018[4] that focused on members sharing their experiences in collecting PROMs data (in many cases using alternative tools to ICHOM/Europe-based Questionnaires) and in ultimately using PROMs research-findings/evidence to improve health services that patients receive. These speakers represented views from a diverse array of clinical specialty areas and should be consulted to learn from their first-hand knowledge and experience of what has and has not worked well.

Specifically, the conference included speakers from: Monash University Australian Stroke Clinical Registry; Australian Orthopaedic Association National Joint Replacement Registry (who are currently carrying out a PROMs pilot); patient advocacy group Kidney Health Australia; St George Hospital Renal Supportive Care Service; Aged Care Evaluation and Research Team, Australian Institute of Health Innovation (AIHI) Macquarie University; Child and Adolescent Cancer Research, Queensland University of Technology; and Menzies School of Health Research, University of Sydney.

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

We endorse the collection of PROMs as part of national data sets. In doing so, we would recommend consideration of the following:

(1) **Generic or condition-specific data collection instruments** - generic instruments intended for use across clinical conditions allow for comparisons while condition-specific instruments might provide insights on clinical outcomes that are more relevant to a specific cohort of patients.

[3] Milstein & Schreyoegg. *Pay for performance in the inpatient sector: A review of 34 P4P programs in 14 OECD countries*. Health Policy 120 (2016) 1125–1140. Available: https://www.sciencedirect.com/science/article/pii/S0168851016302147?via%3Dihub

[4] The Pros and Cons of Patient Reported Outcome Measures (PROMs) and Patient Reported Experience Measures (PREMs) – 26 November 2018. Programme and Presentation Slides available at: http://www.hsraanz.org/past-events/

(2) **Consistency -** with the Commission's Clinical Quality Registry strategy, and other initiatives; to facilitate effective and timely benchmarking and feedback for clinical care improvement.
(3) **Proportionality** - data collection should be proportional to the intended use of the data; also does not unnecessarily burden patients and healthcare professionals.
(4) **Control** - consider using patients as "controls" by collecting PROMs before and after an intervention.

Further to the above considerations, PROMs data could be made available to inform research and decisions relating to the adoption of new medical technologies and healthcare practice. Appropriate safeguards would need to be in place to protect patient privacy.

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

A new funding approach suggested by the Productivity Commission could be explored. This approach involves creating a **Prevention and Chronic Condition Management Fund** (PCCMF) in each local health district, funded by a share of current ABF (initially two to three per cent)[5]. Local Health Networks in each district have the flexibility to decide how and where funds from the PCCMF are spent. This flexibility would enable piloting of new approaches to care and avoid care being directed to hospitals simply because hospitals have funding. As proposed by the Productivity Commission, the PCCMF could enable new collaborations with other stakeholders. The scope of the PCCMF could be broadened beyond chronic conditions to enable piloting of new care models where regardless of condition, care could be provided or better integrated into non-hospital settings.

Like current ABF, the Productivity Commission described the new approach as creating a 'new compensable non-admitted hospital activity'. Hence, a potential role for IHPA would be to guide the pricing and classification of non-admitted care to enable successful pilots to be rolled out more broadly in the Australian Healthcare system. This could be a significant step forward in improving healthcare integration and sustainability in Australia.

Several funding models have been proposed that could enable Commonwealth and State Governments to focus on value[6]. These funding models have the potential to be implemented within the existing ABF framework. These models include:

- **Shared savings**: providers are incentivised to improve outcomes for a patient population by giving them a share of the resulting savings.
- **Outcomes-based funding**: some or all of a contractual payment is conditional on certain outcomes being achieved.
- **Alliance contracting**: In this model a group of providers enter into a single, joint agreement with a commissioner of services. The risks and responsibilities for delivering agreed

[5] Chapter 2, section 2.5. Productivity Commission 2017, *Shifting the Dial: 5 Year Productivity Review*, Report No. 84, Canberra. Available: https://www.pc.gov.au/inquiries/completed/productivity-review/report/productivity-review.pdf

[6] Price Waterhouse Coopers. *Funding for Value*. Available: https://www.pwc.com.au/publications/pdf/funding-thought-leadership-18apr18.pdf

outcomes sit with all providers. The intent is to incentivise the discovery of new ways to deliver higher quality and more efficient care across a care continuum rather than any one provider.

Avoiding unintended consequences of alternative funding models (e.g. underservicing or 'cherry picking' lower cost patients) is of course essential. Blended payment models, specific tailored to best meet the needs of specific patient populations may help avoid unintended consequences[7]. Of note, the need to have wide stakeholder engagement has been described as a key catalyst in gaining buy-in to healthcare payment reform[7].

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

A bundled payment model may offer opportunities for efficiencies, however international experience indicates that the design of these payments would need to be carefully evaluated to avoid the drawbacks that this payment system has encountered.

The consultation paper describes a bundled payment as combining payments across a number of settings and generally over a longer period of time, to allow healthcare providers more flexibility in how they provide services to patients, without facing financial disadvantages.

In order to be successful, bundled payments require enablers such as clear evidence-based treatment pathways and real-world data sets to assess the value of treatment and to determine the best value intervention. It would also require rigorous evaluation methods to ensure that patient outcomes were not being affected.

Bundled payments require clear parameters about what is included in the bundle. Due to the Australian health system's mixed funding model, there would be significant complexity in developing a bundle from payments that are currently drawn from both Commonwealth and state budgets. Related to this will be the challenge of allocating any savings that are realised. For example, a patient undergoing a knee replacement may interact with the primary care system (funded by the Commonwealth); acute care system, including pre and post-surgical care (funded by State Government if in a public hospital); and again with the primary care system for rehabilitation and associated after care. As such, it would be preferable to prioritise the development of bundled payments for conditions for which the pathway of care has a single payer – as is the case with Queensland's consolidation of state-wide renal funding.

Patients accessing bundled payments will vary in age and co-morbidities which will be difficult to account for in a bundled payment model. For example, while some patients may undergo joint replacements at a relatively young age and be in otherwise good health, many patients seeking treatment for joint pain will have co-morbidities and will require additional support from a broader clinical team. A bundled payment may distort patient selection and prioritise treatment for younger

[7] OECD 2016. *Better ways to pay for healthcare*. Available: https://www.oecd.org/els/health-systems/Better-ways-to-pay-for-health-care-FOCUS.pdf

patients without complications or co-morbidities. It will also make it difficult to identify the pre and post-operative care that will be included in the bundle.

Bundled payments and other conditions

Bundled payments should encourage multi-disciplinary team work and care coordination across a continuum of providers and settings. Hence, bundled payments may be well suited to clinical conditions requiring admitted, non-admitted and community care across a treatment episode.

At the National Obesity Summit held in Canberra on 15th February 2019, it was noted that:

- *In the health system, reform is needed to realign and coordinate resources to manage the complex and long term nature of obesity treatment, and increase resourcing for prevention. This will need to include developing new models of care and funding structures to ensure all parties are incentivised to work together*[8].

Bundled payments could be investigated as a means to better coordinate resources required for the treatment of obesity.

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

IHPAs funding approach should enable hospitals to keep up with current evidence-based best practice. The following example considers how IHPA can help hospitals align with evolving clinical practice guidelines.

The National Health and Medical Research Council (NHMRC) has recently updated its guidelines for the prevention and control of infection in healthcare[9]. These guidelines include evidence-based technologies and solutions to address the burden of infection within the Australian healthcare setting and represent current knowledge and best health practice, reflecting other international guidelines.

The 2019 NHMRC guidelines for preventing Surgical Site Infection (SSI) states that "*Using antimicrobial-coated sutures (included on the ARTG e.g. triclosan-coated sutures) can help to reduce SSI rates*". Triclosan-coated sutures have been evaluated in multiple peer-reviewed, randomised controlled trials to show clinical effectiveness in the prevention of SSIs.

Per IHPA's pricing guidelines under "Fostering Clinical Innovation" (Consultation paper, Figure 1, page 6), it states that pricing of public hospital services should respond in a timely way to the introduction of evidence-based, effective new technology and innovations in the models of care that improve patient outcomes. We suggest that IHPA collaborate with the Commission to ensure the HACs information kit for Hospital Acquired Infections to reflects the latest evidence-based technologies/solutions recommended by NHMRC. We recommend updating content for clinicians

[8] Department of Health National Obesity Summit. Summary of Proceedings. Available: https://www.health.gov.au/internet/main/publishing.nsf/Content/Overweight-and-Obesity

[9] Available" https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019

and Infection Control Professionals on SSI prevention - i.e. by inclusion of direct reference to the new NHMRC guidelines for SSI prevention.

Implementing infection prevention strategies could be challenging for hospitals already dealing with significant resource constraints. For this reason, IHPA could also look at developing a national technology fund to generate resources for public hospitals to invest in evidence based effective technologies. This will allow IHPA to play a pivotal role not just in pricing. but also in implementation strategies that could positively change clinician behaviour and open up opportunities for benchmarking.

Our Credo

We believe our first responsibility is to the patients, doctors and nurses, to mothers and fathers and all others who use our products and services. In meeting their needs everything we do must be of high quality. We must constantly strive to provide value, reduce our costs and maintain reasonable prices. Customers' orders must be serviced promptly and accurately. Our business partners must have an opportunity to make a fair profit.

We are responsible to our employees who work with us throughout the world. We must provide an inclusive work environment where each person must be considered as an individual. We must respect their diversity and dignity and recognize their merit. They must have a sense of security, fulfillment and purpose in their jobs. Compensation must be fair and adequate and working conditions clean, orderly and safe. We must support the health and well-being of our employees and help them fulfill their family and other personal responsibilities. Employees must feel free to make suggestions and complaints. There must be equal opportunity for employment, development and advancement for those qualified. We must provide highly capable leaders and their actions must be just and ethical.

We are responsible to the communities in which we live and work and to the world community as well. We must help people be healthier by supporting better access and care in more places around the world. We must be good citizens — support good works and charities, better health and education, and bear our fair share of taxes. We must maintain in good order the property we are privileged to use, protecting the environment and natural resources.

Our final responsibility is to our stockholders. Business must make a sound profit. We must experiment with new ideas. Research must be carried on, innovative programs developed, investments made for the future and mistakes paid for. New equipment must be purchased, new facilities provided and new products launched. Reserves must be created to provide for adverse times. When we operate according to these principles, the stockholders should realize a fair return.