IHPA Pricing Framework for Australian Public Hospital Services 2021-22

Response to consultation

SUBMISSION
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Contents

Company Overview

Organisation: Johnson & Johnson Medical Pty Ltd
Type of Organisation: Proprietary Limited Company
Address: 1 – 5 Khartoum Road, Macquarie Park NSW 2113

Email and phone contact: Michelle Costa
Director, Health Economics Market Access ANZ
Johnson & Johnson Medical Pty Ltd
MCosta15@its.jnj.com

John Gillespie
Health Economics Market Access ANZ
Johnson & Johnson Medical Pty Ltd
JGilles4@its.jnj.com

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The Johnson & Johnson Family of Companies in Australia consists of:

- Johnson & Johnson Medical Pty Limited – medical devices and related technology;
- Janssen-Cilag Pty Limited – pharmaceuticals; and
- Johnson & Johnson Pacific Pty Limited – consumer health brands.

We employ approximately 1,500 Australians who bring innovative ideas, products and services to advance the health and well-being of the patients we serve. We recognise the impact of serious conditions on people's lives, and we aim to empower people through disease awareness, education and access to quality care. Our research and development focus on identifying medical needs and harnessing the best science, whether from our own laboratories or through strategic relationships and collaborations.

Johnson & Johnson Medical Devices Companies is the world's most comprehensive medical devices business, building on a century of experience, merging science and technology, to shape the future of health and benefit even more people around the world. With an unparalleled breadth, depth and reach across surgery, orthopaedics, vision and interventional solutions, Johnson & Johnson Medical Devices Companies are working to profoundly change the way care is delivered.

About the Janssen Pharmaceutical Companies of Johnson & Johnson At Janssen, we're creating a future where disease is a thing of the past. We're the Pharmaceutical Companies of Johnson & Johnson, working tirelessly to make that future a reality for patients everywhere by fighting sickness with science, improving access with ingenuity, and healing hopelessness with heart. We focus on areas of medicine where we can make the biggest difference: Cardiovascular

& Metabolism, Immunology, Infectious Diseases & Vaccines, Neuroscience, Oncology, and Pulmonary Hypertension.

Johnson & Johnson Pacific is the largest over the counter supplier to retail pharmacy in Australia, and one of the top five health and beauty suppliers to Australian grocery. Many of our products are household names and are found in 7 out of every 10 Australian households. Our brands bring value to people's daily lives, while our innovation in areas such as smoking cessation and sun protection are helping to advance the prevention of disease in the Australian population.

Comments on IHPA Pricing Framework 2021-22

Johnson & Johnson welcome the opportunity to provide comments on IHPAs Pricing Framework for Australian Public Hospital Services 2021-22. Comments on selected topics and questions are provided, and broadly consider how the Pricing Framework can support the optimization of both patient outcomes and healthcare spending.

8. Data collection

It is noted that:

1) IHPA continues to support the implementation of the routine collection of the Individual Hospital Identifier (IHI)
2) IHPA plans to make the National Benchmarking Portal (NBP) publicly available in 2021
3) IHPA is moving towards a requirement for the reporting of patient level data for non-admitted care reporting.

These plans are all consistent with key enablers required for effective implementation of Value-based Healthcare (VBHC) – namely data collection across a patient's care journey (including hospital and non-hospital care) and transparency in healthcare reporting. Both are of course key elements of improving care coordination. It is recognised that the IHI can enable patients to be followed across different hospital services, enabling more accurate classification and costing.

We support IHPAs plans with regards to data collection, recognising that these initiatives are important elements in improving patient outcomes, realizing cost efficiencies, and supporting the implementation of alternative funding arrangements.

11. Alternate funding models

We note that IHPA continues to explore how the Activity Based Funding (ABF) system can incorporate new approaches to funding that enable more innovate patient-centred models of care, with bundled payments/pricing and capitation payments under consideration as alternative funding models.

It is noted that IHPA are already considering key concepts to be included in the design of a national capitation model and have the objective of building on existing work to apply this model to complex chronic care. Furthermore, we note that IHPA has objectives to identify clinical cohorts and care types where a bundled pricing model could be applied.

Consultation Question: ***What comments do stakeholders have regarding the innovative funding models being considered by IHPA?***

In our response to consultation[1] on the Pricing Framework for 2020-21 we provided comments on bundled payments. These issues should be considered by IHPA. In brief:

- A requirement for enablers, including evidence-based treatment pathways and real-world data sets to allow the impact of interventions/care pathways to be assessed. Rigorous evaluation would be required to ensure that implementation of bundled payments does not affect patient outcomes.
- Clear parameters on what is included in bundled payments, recognising that across a patient's care pathway funding may come from Commonwealth and State budgets.
- The need for bundled payments to recognise that patients accessing the bundle of care can vary in age and co-morbidities – hence safeguards are needed to ensure bundled-payments don't inadvertently distort patient selection towards less complex patients.
- Recognition within quality improvement programs and an aligned appropriate funding mechanism whereby the acute care setting and providers are encouraged to embrace current best practices for patient management within well-established medical/surgical guidelines and programs that optimise health outcomes.

With regards to the latter two points, consideration would need to be given as to whether bundled payments would need to be adjusted to account for differences in patient cohort complexity between hospitals. This could help ensure that bundled payments are appropriately tailored to meet any differences in patients care and healthcare resource needs. Additionally, this would also enable the adoption of proven change by ensuring the appropriate funding is reflected in conjunction with the measurement of health outcomes.

The need for enablers and clear parameters informed by care pathways is evident from this point in the consultation paper:

Bundled payments for hip and knee replacements has consistently received stakeholder support due to the clear pathway of care and good data already available through Clinical Quality Registries. Developing bundles for specific conditions also provides the opportunity to 'scale up' once demonstrated to be effective and paves the way for further analysis and discussion. (Consultation paper, page 36).

However, it is not clear in the consultation paper how the 'effectiveness' of bundled payments would be assessed. The criteria by which alternative funding models are considered effective should be made explicit by IHPA in its framework for future funding models. In assessing the effectiveness of this funding approach, it is proposed consideration is given to whether health outcomes and the efficiency of healthcare delivery are improved using bundled payments.

[1] Johnson & Johnson: IHPA Pricing Framework for Australian Public Hospital Services 2020-21. Response to consultation July 2019

In neither the bundled payment/pricing nor capitation payments proposal it is explicit as to (i) how these funding models could improve patient outcomes or, (ii) the efficiency of healthcare delivery or, (iii) could help reduce the overall costs of healthcare. To motivate the adoption of best practice care, it is proposed that these funding models incorporate a best-practice tariff (BPT), whereby public hospitals are paid an additional amount (BPT) that is contingent on achieving pre-specified outcomes (e.g. achieving a reduced length-of-stay to a pre-specified 'best practice' duration). In comparison to a 'base' bundled payment based on average costs, a BPT recognises that best practice could require additional resources. In practice an additional BPT could incentivise hospitals while reducing overall healthcare costs. For example, if a hospital changes practice and significantly reduces length of stay this will translate to cost savings to State/Commonwealth health budgets. In this example the hospital costs are reduced and a BPT could be paid from the savings to health budgets – making this effectively a 'shared savings' funding model. Depending on the pre-specified outcomes BPT could be scaled, with BPT incentivizes varied dependent on how well outcomes compare with best practice.

In practice BPT incentivizes or any other bonus payment could be used to enable the implementation of value- or outcomes-based contracting. Through leveraging real-world data sets - e.g. such as those available in the Australian Orthopaedic Association National Joint Replacement Registry (AOANJRR) and the Australian & New Zealand Hip Fracture Registry (ANZHFR) – value-based contracting has the potential to become a complementary funding model to activity-based funding. The latter ANZ Hip Fracture Registry is complimentary, by its data collation, to a program adopted in the UK NHS for management of Fragility Hip Fracture Care, established in 2010. What is valuable about the UK program is the data collection was complimented per its adoption with an equal recognition by allocation of appropriate funding.

Consultation Question: ***Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?***

With regards to this question IHPA should consider how focus on specific patient groups could be aligned with the National Clinical Quality Registry Strategy[2]. For example, by considering where data from relevant clinical quality registries (CQRs) could be used to assess whether innovative funding models are having an impact on patient outcomes or by considering how registry design and data access arrangements can better support new funding initiatives. This use of CQRs is consistent with the provision in the Addendum to the National Health Reform Agreement (NHRA)[3] on how Australian Governments (Commonwealth, States and Territories) can work together to pay for value and outcomes: CQRs provide a means to assess where clinical practice is working well or where improvements need to be made[4]. The potential use of CQRs to demonstrate value in healthcare is

[2] Draft National Clinical Quality Registry Strategy: Maximising the Potential of Australian Clinical Quality Registries (2019-2029). Available: https://www1.health.gov.au/internet/main/publishing.nsf/Content/Draft_National_%20CQR_Strategy

[3] National Health Reform Agreement – Addendum 2020-25. See: Paying for value and outcomes, see pages 58 and 59. Available: http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

[4] Consistent with this comment - as described in the consultation paper – data available from CQRs is a factor behind stakeholder support for bundled payments for hip and knee replacements.

described in the Deeble Institute's Issues Brief no. 37[5] (pages 14 and 15). In particular, the authors note that CQRs can address significant gaps in current Australian health information and can provide feedback on whether new technologies are achieving value.

Additionally, IHPA should consider that alternative funding models can help address any equity of access gaps for specific patient cohorts or Adjacent Diagnoses Related Groups (ADRGs). Consideration should be given to how alternative funding models can help better identify individuals and patient groups who may have barriers in accessing care. This could involve consideration of patient groups who may typically engage with the healthcare system at a point when the severity of their condition is more likely to result in poorer health outcomes and higher care costs.

Consultation Question: *What other strategic areas should IHPA consider in developing a framework for future funding models?*

As medical technology and the delivery of healthcare continues to change how and where healthcare is delivered it is important to consider whether alternative or proposed future funding models can adapt flexibly to accommodate such changes. IHPA should consider whether the Clinical Advisory Committee (who monitor the potential impact of new technologies not yet classified or costed in public hospital services) could have a role in informing whether alternative or proposed funding models are better suited to enabling patients access and improving care co-ordination than activity based funding.

We request that IHPA give consideration to international examples which have had the effect of accelerating patient access to new medical devices within a DRG framework:

Example 1: Germany

Germany has introduced innovation funding for new diagnostic or therapeutic technology via the Neue Untersuchungs -und Behandlungsmethoden (NUB). The funding was introduced to incentivize the use of innovative technologies while cost-data is collected and analysed before the technology is included in the DRG system.

The program applies to innovative technologies that require significant extra expense and are not covered under the existing DRG tariff. The selection of technologies is made by the Institute for the Hospital Remuneration System (InEK) according to a set of inclusion criteria. If the technology is approved the hospital can enter into negotiations for NUB innovation funding to support accelerated access to the new technology.

[5] Deeble Institute Issues Brief No.37. 24/08/2020. Measuring value in new health technology assessments: a focus on robotic surgery in public hospitals. Available: https://ahha.asn.au/system/files/docs/publications/deeble_brief_no._37_-_measuring_value_in_new_health_technology_assessments.pdf

Example 2: United Kingdom

The NHS also includes a national system for high-cost tariff excluded devices (HCTED) which aims to accelerate the adoption of effective new technologies in the UK hospital network. Rather than individual hospitals paying for the devices and being reimbursed by NHS England as previously happened, providers will place orders for devices with NHS Supply Chain at zero cost to them. NHS Supply Chain will then place the order with suppliers and invoice NHS England. The full list of new technologies that have been approved under the program can be found on the NHS website: https://www.england.nhs.uk/commissioning/spec-services/key-docs/medical-devices/

12. Pricing and Funding for Safety and Quality

Consultation Question: ***What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?***

We note IHPAs proposal to deduct the cost of the readmission episode from the index episode and apply this at a jurisdiction level to account for readmissions to any hospital within the same jurisdiction. However, what is not explicit in the consultation paper is how this will incentivize a change in clinical practice to help reduce avoidable hospital readmissions. While it is noted that IHPA intends to use the National Benchmarking Portal to allow hospitals to access data on avoidable readmissions, it is suggested that IHPA consider how the Australian Commission on Safety and Quality in Health Care could play a role in facilitating learning between hospitals in order to help improve the consistency of patient care.

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 recognise 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.