MTAA Submission to the Consultation Paper on the Pricing Framework for Australian Public Hospitals Services 2022-23

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MTAA welcomes the opportunity to comment on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services (the Paper) and appreciates the extension of time granted.

MTAA welcomes some of the important reforms that were included as part of the National Health Reform Agreement Addendum 2020-25 and recognises the important role IHPA has been given to play in enabling some of these reforms through changed funding models. In particular, the focus on value-based funding models and avoidable/preventable hospital admissions has the ability to drive some of the most important reform since activity-based funding began. MTAA notes that value-based funding may conflict with System Design Guidelines (p.16) on prioritising activity-based funding approaches and even single unit of measure and price equivalence. As these models progress, IHPA may want to consider how these guidelines are weighed up and possibly provide some wording or explanatory clarification.

6.3 Harmonising price weights across care settings

This is an important feature of the NEP and MTAA notes that the intended price harmonisation of AR-DRG L16Z (Haemodialysis) with Tier 2 Non-admitted Services Classification code 10.10 (Dialysis) and AAR-DRG code R63Z (Chemotherapy) with Tier 2 code 10.11 (Chemotherapy). While MTAA does not have any specific recommendations on further price harmonisation, it would be important to understand what factors influenced the decision to defer these price harmonisations to help inform stakeholders on which issues to consider when making recommendations.

10 Future funding models

As noted, MTAA welcomes IHPA's progress in thinking about funding models to support value-based care. The indicative assessment of possible patients and other events in Table 1 shows that there is potential for momentous change to improve patient outcomes and costs.

MTAA notes that the distinction between a bundled payment and a capped payment is probably very blurred and seems mainly to be defined by the nature of the condition (one-off major event from which someone is expected to largely recover vs longer term condition which must be managed). Further information on how the patients and events in Table 1 were created would be welcome.

The key critical success factors seem to be clear. It is unclear whether the fundholder would always be under state jurisdiction or could be a private entity.

MTAA would like to highlight that enabling technology is also a critical consideration in determining options for payment reform. This also applied to trialling models of care. There will be some conditions or events that are particularly amenable not only to management in community health settings but even at home. Wearable devices are one such example of this kind of technology. If assessments are made based on purely on current technology use, opportunities may be missed.

11.6 Avoidable, preventable hospitalisations

There is a strong overlap between funding to reduce avoidable and preventable hospitalisations and value-based funding, particularly the kind of patient described in the capitated model. Reducing hospitalisations usually starts with patients who have an existing condition and are 'frequent flyers', unless it is to involve major public health campaigns e.g. smoking or motor vehicle accidents. It is recommended that these are considered in parallel. As for value-based funding it would also be good to clarify whether private practitioners or clinics might ever be considered for funding this. Certainly, any funding responsibility to lower avoidable, preventable hospitalisations would have to extend to engagement with primary care that is not directly funded through the state.

The following comments apply to both 10 Future Funding Models and 11 Pricing and Funding for Safety and Quality

Understanding the IHPA is investigating the feasibility of implementing pricing and funding approaches that use methodologies differing from ABF, including bundled payments and capitation models, MTAA submits that a critical piece is missing from the consultation paper, and that is the role of public health procurement.

Public health procurement refers to the process by which state and territory government departments or public hospitals purchase medical equipment or services from companies. Efficient and outcomes based public procurement can help to reduce the pressure on health budgets, deliver better value for money, and foster the development of high-quality products and innovative care models which improve patient outcomes.

MTAA submits that you cannot explore innovative funding models based on delivering improved value and outcomes without consideration of the role of public procurement, and without involving state and territory government health procurement agencies.

The role of medical technology in improving care outcomes

The medical technology sector is in a unique position to drive value-based health care due to its design innovations, therapeutic and business experience, and deep relationships with hospitals. However, the experience of medtech companies is that most hospitals and health systems purchase medical products primarily based on up-front purchase costs. This short-sighted approach does not address the needs of patients and clouds the true cost of care.

Often this focus on savings is driven by state and territory governments' whole of government savings initiatives which target procurement agencies to deliver savings through purchasing. Current hospital financing models do not correctly incentivise the focus on outcomes improvements, because budgets are usually siloed and targets are focused on savings by procuring at a cheaper unit price instead of delivering savings over the entire chain of care.

This is materialising into misalignments in strategic policy goals between governments. For example, IHPA's Risk-Adjusted Funding Methodology currently being trialled has the goal of providing 'funding signals so that hospitals can take action to reduce systemic risks related to the delivery of care'. However, because state-led procurement processes are 'price-based' rather than value-based, then products and services are not purchased based on how they contribute to reducing systemic risks

related to the delivery of care. Decisions are made in a silo with a different policy goal in mind – that is to achieve a savings target under the broader goal of fiscal repair.

The missed opportunity is that procurement processes do not allow for medical technology suppliers to work on a large scale with health and hospital services on initiatives which could deliver savings targets in more innovative ways rather than cutting the base price of products.

As well as improving the safety and quality of care for patients, there are savings to be made by government working with industry to combine product and service offerings to, for instance, reduce hospital acquired complications, prevent readmissions, reduce length of stay, increase operating theatre efficiency and reduce the incidence of device revisions. Redesigning the current state and territory tender processes could unlock substantial shared benefit.

Multi-stakeholder approach

An example of how state procurement agencies could reform procurement processes to focus on outcomes is to tender for outcomes, rather than a category of medical devices.

State tenders could negotiate clinical outcome commitment deals with suppliers based on their safety and quality challenges. For instance, with a robust surgical site infection (SSI) surveillance regime, a local area service can understand which of its hospitals require an intervention to reduce SSIs. Instead of simply tendering for wound closure products, it could tender for an outcome of reducing SSIs in identified hospitals. Medical technology suppliers would bring forward their products and related services and negotiate a value-based agreement (VBA) whereby an SSI reduction target is set, with an agreed price and market share arrangement. The critical provision in the VBA is the agreement for the supplier to reimburse an agreed amount if the SSI reduction target is not achieved.

Procurement activity could be focused on a range of areas where public hospitals are experiencing challenges which show evidence of underperforming against other hospitals, especially when underperformance impacts patients. This includes hospitals which show longer periods of patient length of stay, longer elective surgery waiting lists, or higher incidence of revision surgery. Refocusing public health procurement on outcomes, rather than product and price, requires a significant coordination across governments and the industry.

Health procurement agencies, healthcare providers and policy makers within departments should engage on clinical and organizational pain points and to measure and share data regarding outcomes. Expertise needs to be commissioned to measure the value proposition of a product, service or solution, and to measure patient-relevant outcomes through the total cost of care. Outcomes based procurement relies on a much greater partnership between government, public hospitals and medtech companies. It requires richer understanding of the problems that healthcare providers are trying to solve when it offers solutions instead of just responding to the technical tender specifications.

Recommendation: MTAA recommends that IHPA engage with health procurement agencies and state and territory departments of Treasury and Finance to explain how the Risk-Adjusted Funding Methodology works to help them better identify how they can consider this funding approach in purchasing. We believe that this education will maximise the impact of IHPA's commendable commitment to improving the quality and safety of care in public hospitals.