IHPA Pricing Framework for Australian Public Hospital Services 2016-17

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MTAA response to public consultation paper

Medical Technology
ASSOCIATION OF AUSTRALIA

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INTRODUCTION

The Medical Technology Association of Australia (MTAA) is the national association representing companies in the medical technology industry. MTAA aims to ensure the benefits of modern, innovative and reliable medical technology are delivered effectively to provide better health outcomes to the Australian community. Member companies cover the spectrum of the industry in Australia, from subsidiaries of major multinational medical technology companies to independent distributors and small and medium sized Australian innovator companies. Our member companies also play a vital role in providing healthcare professionals with essential education and training to ensure safe and effective use of medical technology.

Medical technologies are products used in the diagnosis, prevention, treatment and management of disease and disability. Products range from consumable items such as bandages and syringes, to high technology implantable devices such as cochlear implants, cardiac defibrillators and orthopaedic joints, to diagnostic imaging and operating theatre equipment, to products which incorporate biological materials or nanomaterials. The industry is characterised by a high level of innovation, resulting in short life cycles for many products. Medical technology innovation is characteristically incremental in nature. Many medical devices undergo constant development based on feedback from medical practitioners and advances in other sciences relevant to medical technology.

The Australian medical technology industry[1]:

- had turnover of approximately $10.2 billion in 2012-13 (revenue is ~$11.8 billion if *in vitro* diagnostic (IVD) and dental products are included)
- included over 500 medical technology companies with products listed in the ARTG
- was responsible for ~44,000 medical devices listed on the 2014 ARTG, estimated to represent between 500,000 and one million different devices
- employed more than 19,000 people
- was mainly located in NSW (55%) followed by Victoria (24%) and Queensland (12%)
- imported goods to the value of $5.59 billion and exported goods to the value of $2.23 billion in 2014.

GENERAL COMMENTS

MTAA welcomes the opportunity to comment on IHPA's consultation paper on the Pricing Framework for Australian Public Hospital Services 2016-17. MTAA acknowledges and strongly supports the work that IHPA has undertaken to date across a variety of areas, including National Efficient Price (NEP) and National Efficient Cost (NEC) determinations, classification system development and revision, work on the application of safety and quality metrics to the pricing of public hospital services, as well as Activity Based Funding (ABF) research including the evaluation of the implementation of national ABF.

[1] Medical Technology in Australia: Key facts and figures 2014, Occasional Paper Series: Sydney. Medical Technology Association of Australia Limited (2014).

In the 2014-15 Budget, the Commonwealth Government announced that from July 1 2017, efficient growth funding will cease and its share of public hospital funding will be based on indexation for CPI and population growth. In addition, subject to consultation, the Government announced that it will work with the States and Territories to create a new Health Productivity and Performance Commission by merging IHPA and five other health agencies. MTAA is pleased to note that while the Government undertakes these consultations, IHPA will continue to deliver on its program of work. Regardless of the specific funding arrangements that will apply from 2017-18, it is critical that the valuable work that has undertaking in order to increase efficiency and transparency in the delivery of public hospital services is able to be continued.

Incorporating new technology in patient classification systems

IHPA's Pricing Guidelines state 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. A key concern of MTAA that has been expressed in previous submissions to IHPA is the lack of a timely mechanism to integrate new technologies into the classification and costing systems of public hospital services.

The development of new medical technologies is highly iterative with follow-on generations of products emerging in 18-24 months. Iterative development is led by feedback from clinician users, research and development undertaken by the developer, and changes in materials science. As a consequence of the rapid nature of product development, and to provide the opportunity for beneficial new technologies to be available to patients, funding mechanisms need to anticipate and provide for rapid technology upgrades.

The current Australian Refined Diagnosis Related Groups (AR-DRGs) classification has not been as responsive to new technologies as it should be, and lags behind many other countries with ABF models based on diagnosis related groups (DRGs).[2]

The fundamental drawback of the AR-DRG system is the length of time it takes to develop or modify a DRG. A new technology cannot be accounted for in the AR-DRG classification until it is in widespread use and costing data is collected. Under the current arrangements it is likely to take two to four years before the appropriate funding is attached to the AR-DRG. In a medical technology environment where innovation takes place in a rapid timeframe, a system that may take more than two years to catch up is not supportive of timely access for patients to cost effective technology, and contributes to budgetary pressures in hospitals by basing budgeting information on outdated data. The delays in processing DRGs has the potential to severely limit the ability of patients to access technology which is found to be cost effective, and is assessed positively for funding.

Two examples of medical technologies (from an MTAA member company) that are not able to be accounted for in the current AR-DRG classification system are outlined in Box 1.[3] Each of these technologies is an alternative to drug therapy and represents a changing model of care and a new category within the classification system.

[2] Scheller-Kreinsen et al. DRG-based hospital payment systems and technological innovation in 12 European countries. *Value in Health* (2011), 14(8): 1166-1172.

[3] Member company submission on 'Updating clinical classifications for new technology' to the IHPA Clinical Advisory Committee, January 2015.

Box 1 Examples of medical technologies not accounted for in the current AR-DRG classification system

Example 1: A procedure for the treatment of severe persistent asthma

The clinical issue

- Despite the abundance of medications to treat asthma, there are significant limitations and risks associated with the current standard of care, including limited efficacy in patients with severe asthma, side effects, significant ongoing healthcare burden and poor patient compliance.

The technology

- An innovative, non-drug procedure developed for the treatment of severe persistent asthma.
- The procedure uses thermal energy to reduce the muscle associated with airway constriction in asthma patients.
- Clinical studies of this treatment have demonstrated sustained improvements in asthma control up to five years following the procedure.
- The AR-DRG assignment for asthma patients receiving the procedure are as follows:

AR-DRG	Description
E42A	Bronchoscopy With Catastrophic Complication or Comorbidity
E42B	Bronchoscopy Without Catastrophic Complication or Comorbidity
E42C	Bronchoscopy, Sameday

- It is expected that the majority of patients will be treated under AR-DRG E42C; however, the funding allocated for E42C is insufficient to cover the costs for both the hospital admission and the single-use catheter used during the procedure.

Example 2: A medical device for left atrial appendage closure

The clinical issue

- Atrial Fibrillation (AF) is a major risk factor for stroke and research shows that in 90 per cent of patients with non-valvular AF, blood clots are developed in the left atrial appendage (LAA).
- Currently, AF patients are treated with warfarin or other anticoagulant drugs; however, patients who are contraindicated to oral anticoagulant therapy remain at high risk for stroke.

The technology

- A novel device for permanently closing the LAA and eliminating the risk of stroke from a thrombus.
- Clinical research has shown that by closing off the source of blood clot formation with this device, the risk of stroke may be reduced and the need for long-term oral anticoagulation therapy may be eliminated.
- The AR-DRG assignment for AF patients treated using LAA closure devices are as follows:

AR-DRG	Description
F09A	Other Cardiothoracic Procs Without CPB Pump With Catastrophic Complication or Comorbidity
F09B	Other Cardiothoracic Procs Without CPB Pump With Severe or Moderate Complication or Comorbidity
F09C	Other Cardiothoracic Procs Without CPB Pump, Without Complication or Comorbidity

- The majority of patients are likely to be treated under AR-DRG F09C; however, the funding allocated for F09C is insufficient to cover the costs of the hospital admission and the device.

MTAA acknowledges IHPA's 'Impact of New Health Technology Framework' which outlines the process by which IHPA through the Clinical Advisory Committee (CAC) will monitor and review the impact of new technologies. MTAA notes that the framework is currently undergoing an annual review, and that some of the issues that have been raised in previous submissions will be addressed as part of this review. The framework is an encouraging first step to introduce a planned process for incorporating new technologies into the pricing framework; however, MTAA is concerned that under this framework the uptake of new technology is still constrained by the classification development process.

A mechanism should be in place to make new technology available outside the AR-DRG updating cycle. MTAA recommends the introduction of alternative funding arrangements in the form of separate or supplementary payments which use a DRG payment as a basis. Most countries with DRG payment systems have developed short-term mechanisms such as separate or supplementary payments where there are substantial differences between incurred costs and standard payment rates. In previous submissions, MTAA has outlined the German approach to funding new technologies outside the DRG updating cycle, which involves two types of supplementary payments.[4] Another example is the New Technology Add-on Payment program (NTAP) in the US, which supplements hospital DRG reimbursement with temporary payments for high cost technologies.[5]

Scope of public hospital services

Increasingly, advances in medical technology and changing consumer expectations are shifting many health services from the resource intensive hospital setting into more cost effective community settings. For example, technologies with remote monitoring capabilities enable patients with chronic health problems to monitor and manage their condition at home, while being monitored by health care professionals remotely, reducing the chances of needing urgent care or hospitalisation. Studies have shown that remote monitoring reduced emergency room admissions by 71% in respiratory patients who had oxygen saturation monitored daily[6], while a 43% reduction in hospitalisations was observed in cardiac patients who transmitted daily electrocardiogram and blood pressure data.[7]

The scope of public hospital services eligible for Commonwealth funding under the National Health Reform Agreement includes hospital in the home programs, as well as a range of home and community-based services; however, remote monitoring services remain outside the scope of public hospital services eligible for Commonwealth funding. MTAA suggests that the General List of In-Scope Public Hospital Services should include innovative, cost-effective health services such as remote monitoring, in order to better reflect the changing healthcare environment.

Teaching, Training and Research

In Australia, the medical technology industry makes a significant contribution to the delivery of teaching, training and research (TTR) activities in public hospitals, and MTAA supports the work that IHPA is currently undertaking in order to inform the development of a TTR

[4] Henschke et al. Extrabudgetary (NUB) payments: a gateway for introducing new medical devices into the German inpatient reimbursement system? *Journal of Management and Marketing in Healthcare* (2010), 3(2): 119-133.

[5] Hernandez et al. US hospital payment adjustments for innovative technology lag behind those in Germany, France, and Japan. *Health Affairs* (2015), 34(2): 261-270.

[6] Vitacca et al. Tele-assistance in chronic respiratory failure patients: a randomised clinical trial. *European Respiratory Journal* (2009), 33: 411-418.

[7] Goernig et al. Ambulatory disease management in cardiac patients: 12 month follow-up of home care telemedicine in Thuringia by the management program Zertiva®. *Physikatische Medizin, Rehabilitationsmedizin, Kurortmedizin* (2009), 19: 9-13.

classification. MTAA acknowledges that developing a reliable and systematic approach for capturing all TTR activities undertaken within public hospitals (and their associated costs), in order for these activities to be funded under ABF, will be a technically challenging exercise.

MTAA notes that a TTR costing study that will inform the development of a teaching and training classification system has commenced, and that further work is needed in order to determine the feasibility of developing a research classification system for the purpose of funding under ABF. Capturing the inputs and outputs of research covered only by state and territory funding is likely to be challenging, as many hospital research units rely on a hybrid of public and private sources. The McKeon Review identified that it is very difficult to quantify the level of investment in health and medical research undertaken in hospitals. Public consultations undertaken as part of the Review revealed that in hospitals, funding originally allocated to research was often used to cross-subsidise other services, while the time spent by professional staff on research activities, as well as the outputs of research, were rarely audited.[8]

CONSULTATION QUESTIONS

Pricing for safety and quality

If feasible, would you support a best-practice pricing approach for hip fracture care in future years?

There is a lack of incentives built into the current pricing framework to encourage and reward public hospital compliance with quality and safety measures. Therefore, MTAA strongly supports the work that IHPA and the Australian Commission on Safety and Quality in Health Care (ACSQHC) are currently undertaking in order to identify potential approaches that will encourage safe, high quality care, including best-practice pricing for the provision of 'best practice' or evidence-based care for specified conditions.

IHPA's decision to focus initially on the feasibility of a best-practice pricing model for hip fracture care seems reasonable, given the significant health burden and expenditure associated with this condition in Australia, and the fact that performance-based payment programs for this condition are already in place in Western Australia (Performance-Based Premium Payment Program) and Queensland (Quality Improvement Payment). In addition, while there is limited peer-reviewed evidence on whether best-practice pricing models improve safety and quality in healthcare, initial findings from the NHS Best Practice Tariff (BPT) Program for fragility hip fractures in the UK (part of the largest best-pricing scheme in operation), suggest that the program has led to significant improvements in some quality indicators for this condition.[9]

The BPT for fragility hip fractures was developed to encourage two key clinical characteristics of best practice: prompt surgery and appropriate involvement of geriatric medicine. The proposed benefits of this approach include improved patient outcomes, shorter length of stay, reduced mortality, increased number of independent individuals and more cost-effective care. Attainment of BPT has increased since it was introduced in 2010. In the last quarter of 2013, care for 64% of patients met all BPT standards, up from 59% for the same period in 2012.[10] In 2014, 71.7% of patients underwent surgery on the day of

[8] Strategic Review of Health and Medical Research in Australia – Better Health Through Research, Commonwealth Government (2013).
[9] Royal College of Physicians. National Hip Fracture Database Annual Report 2014.
[10] Ibid.

admission or on the day after, up from 70.6% in 2013. In 2014, 81.6% of patients had access to an orthogeriatrician compared with only 25% of patients in 2009.[11]

Once a formal evaluation of the BPT Program is published, it will be interesting to observe whether these results translate into improved patient outcomes, shorter length of stay, and reduced mortality. If so, the MTAA would be supportive of a best-practice pricing approach for hip fracture care in the future, providing this is feasible in Australia.

What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

There are many issues to consider when implementing a best-practice pricing model[12]:

- It is important to consider whether all of the systems and structures that are required in order to achieve the change in practice are in place. For example, high quality care for patients with hip fractures can only be achieved through a multidisciplinary, multi-provider approach to implementation. The recommendation that hip fracture patients receive surgery within 36 hours requires hospitals to reconfigure their admission and operating room scheduling practices to support fast-tracking of these patients within the hospital.
- When developing the pricing model and deciding on what financial incentive will be used, it is important to consider the following:
    - Will providers view the incentive as substantial enough to generate the desired change in behaviour and practice?
    - Will the incentive be delivered down to the level of the clinical department or unit involved in changing behaviour, rather than at the Local Health Network or hospital level?
    - Will the incentive drive improvement across all hospitals, rather than rewarding hospitals that are already high performers?
    - Have any potential perverse incentives been identified? For example, an incentive for hospitals to select and treat patients with simple health needs, rather than those with more complex health problems. If so, have any measures been put in place to minimise or prevent them? For example, have any methods been developed to enable adjustments based on the risk profile of the organisation, so that hospitals treating a higher proportion of more complex patients are not unfairly penalised?

[11] Ibid.
[12] Deeble Institute (2013). Evidence Brief Number 11: Is it possible to incorporate quality into hospital pricing systems?