Submission

Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2021–22

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Summary

Stryker supports the overall approach of the Independent Hospital Pricing Authority (IHPA) to the implementation of the Addendum to the National Health Reform Agreement with the aim of achieving overall payment parity between public and private patients in applying the national pricing model.

Stryker has made a number of comments about the processes involved in the development and implementation of this approach to ensure that stakeholders are fully informed of the changes and that the transition to new data collection and other systems required to support the new approach is as seamless as possible.

Stryker also supports the development of a pricing model for avoidable hospital readmissions and recommends considering a long timeframe for readmissions for joint replacements to determine meaningful differences in revision rates.

In relation to the exploration of alternate and value-based funding models, Stryker stresses the importance of including consumer input into pricing models and using available data sources on the outcomes of procedures, such as the Australian Orthopaedic Association National Joint Replacement Registry.

We also recommend that innovative funding include technologies that are regarded as peripheral, but make a large difference to patient outcomes and hence the cost to the health system, for example, robotic surgery and endovascular clot retrieval for ischemic stroke, which research suggests provide significant benefits compared to conventional treatments.

Further recommendations and feedback against the draft guidelines are provided as follows.

Guideline commentary

Section 6: Classifications used to describe and price public hospital services

Question

Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?

Draft Guidelines

Education on the new edition ICD-10-AM/ACHI/ACS was highlighted as an area for improvement; thoughts were:

- Comprehensive online education for new editions
- Create an electronic definitions manual
- Opportunities to provide an electronic version of ICD-10-AM/ACHI/ACS to replace the hard copies

Stryker's comments

Stryker supports IHPA's proposal of replacing the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions. This will allow for more effective utilisation and analysis of the data.

Question

How should AR-DRG education be delivered and what should it include?

Stryker's comments

Stryker proposes that AR-DRG education be delivered through a series of webinars with Q&A sessions. This should be accompanied with high-level recourses, such as infographics articles *(similar to those created by IHPA for the National Hospital Cost Data Collection Reports)*. Topics should include;

- Overview of AR-DRGs
- Utilisation of AR-DRGs
- How ABF and AR-DRGs are integrated
- How ICD10-AM and ACHI codes are captured/classified within AR-DRGs
- How diagnosis complexity is determined and the decision-making process for separating an ADRG into differing complexity AR-DRG's
- How the Impact of New Health Technology integrates within the AR-DRG's
- How AR-DRG changes / proposal are assessed and implemented
- Collection and assessment of AR-DRG data for inclusion in the NHCDC

Section 6: Classifications used to describe and price public hospital services

Question

How would activity that falls under these proposed new classes previously have been classified?

Draft Guidelines

The *Tier 2 Non-Admitted Services Classification* is the existing classification system that categorises a public hospital's non-admitted services into classes, which are generally based on the nature of the service and the type of clinician providing the service

- For NEP21, IHPA intends to continue using the Tier 2 Non-Admitted Services Classification for pricing non-admitted services.
- IHPA is committed to undertaking maintenance work to ensure relevancy of Tier 2 for activity-based funding purposes while a new Australian Non-Admitted Care Classification (ANACC) is being developed
- IHPA is developing the ANACC to better describe patient characteristics and the complexity of care in order to more accurately reflect the costs of non-admitted services
- IHPA commenced a national costing study in 2018 to collect non-admitted (including subacute) activity and cost data and test a shortlist of variables and potential classification hierarchies.
- The impact of COVID-19 on hospitals participating in the costing study has resulted in the study being suspended. Data collection was paused in March 2020 with a decision reached in August 2020 to indefinitely suspend the study

Stryker's comments

The delay in the development of the non-admitted care classification is understandable. However, it is important that a date for recommencing the study is decided soon to ensure that changes in service delivery in the near future are better accounted for, as services transition to a non-admitted setting and as new funding models are tested.

Section 7: Setting the national efficient price for activity based funded public hospitals

Question

Is there any objection to IHPA phasing out the private patient correction factor for NEP21?

Draft Guidelines

The implementation of Australian Hospital Patient Costing Standards Version 4.0 should have addressed the issue of missing costs in the NHCDC, meaning the private patient correction factor is no longer required. Stakeholders have previously supported phasing out the private patient correction factor when feasible.

- Therefore, IHPA intends to phase out the private patient correction factor for NEP21

Stryker's comments

Stryker also supports the new requirement to establish an additional data collection to ensure all hospital revenues are captured (complete Hospital Casemix Protocol-HCP data), to better allow IHPA to adjust the price for private patients in public hospitals to achieve overall patient parity between private and public patients.

Question

What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?

Stryker's comments

Stryker suggests that robotic surgery outcomes should be compared with conventional surgery outcomes and take any differences between these outcomes into account when determining the efficient price.

Clinical evidence has shown that robotic assisted knee replacements deliver improved outcomes, including shorter hospital stays, lower levels of need for opioid pain medication, shorter rehabilitation times, and increased function. Cost analyses of robotic-assisted vs. manual surgery have also demonstrated that robotic surgery has significantly lower average 90-day episode of care costs. This data, along with other relevant research on robotic surgery outcomes, should be considered by IHPA for NEP21.

Section 11: Alternate funding models

Question

What comments do stakeholders have regarding the innovative funding models being considered by IHPA?

Draft Guidelines

The new model addresses two key objectives. It removes the potential financial disincentive when shifting services from an ABF hospital to one that is block-funded. It is also more responsive to changes in activity levels in block-funded hospitals.

- IHPA introduced the 'fixed-plus-variable' model for the National Efficient Cost Determination 2020–21. IHPA will continue to use the 'fixed-plus-variable' model for National Efficient Cost Determination 2021–22.

Stryker's comments

Stryker supports IHPA developing bundles for specific conditions, particularly for hip and knee replacements.

Stryker also recommends that IHPA should take into consideration data that identifies which patient cohorts or ADRGs are amenable to specific funding models.

Question

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

Draft Guidelines

IHPA is developing a framework to guide work to investigate the feasibility of future funding models at a national level.

The key objectives of the framework are to:

- Promote consideration of different funding models at the national level
- Determine system design considerations, critical success factors and a pathway to implementation for any proposed funding models under the current ABF framework
- Provide reports to CHC as required regarding the outcomes of trials and their applicability to the national funding model.

Stryker's comments

Stryker agrees that reports to the CHC should occur and suggest they include guidance on 'scaling up' of successful funding models to the state and/or federal level (as applicable) to allow for more trials to be conducted and reported on.

In addition, Stryker suggests innovative funding should include technologies that are regarded as peripheral but make a large difference to the outcome, hence the cost to the health system e.g., robotic surgery and clot retrieval.

Research findings suggest that these technologies can provide significant benefits compared to conventional treatments.

For example, research has shown that compared with standard stroke treatment, mechanical thrombectomy (endovascular clot retrieval) delivers:

- Reduced risk of mortality by 17 per cent at 90 days and a sustained and statistically significant mortality benefit up to 15 years post-treatment, with associated benefits in disability-adjusted life years (DALY) and quality-adjusted life years (QALY) (based on simulated modelling).
- A "substantially greater level of disability in the standard medical treatment only group" compared to the mechanical thrombectomy group,
- Improved functional outcomes and chance of functional independence at 90 days; and
- A significant reduction in length of hospital stay and the need for ongoing nursing care.

An analysis of treatment costs comparing mechanical thrombectomy with standard treatment found that mechanical thrombectomy resulted in an average reduction of US$4,365 per patient in inpatient costs at 90 days.

Question

Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?

Draft Guidelines

A unique patient identifier such as the Individual Healthcare Identifier (IHI) is one way to enable a patient to be tracked across the different classification system data sets, and more accurately allow for the pathway of care to be classified and costs attributed accordingly

> IHPA will continue to work with jurisdictions individually to address concerns in providing the IHI to find a way forward in the collection of this data.

Stryker's comments

Stryker agrees that the development of the IHI is critical, in addition, to ensure that improved outcomes for patients and/ or a decrease in costs required to treat specific patient cohorts across a pathway of care can be adequately assessed.

Section 12: Pricing and funding for safety and quality

Question

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

Draft Guidelines

IHPA recognises the need to accurately capture and adjust for readmission episodes that occur across financial years.

IHPA intends to make avoidable hospital readmission rates available in the National Benchmarking Portal to allow hospitals to access and compare cost and activity data relating to readmissions

IHPA intends to implement the avoidable hospital readmissions funding adjustment to apply where there is a readmission to any hospital within the same jurisdiction.

IHPA has engaged 3M Australia Pty Ltd to develop a readmissions software tool, based on their existing Potentially Preventable Readmissions software

Stryker's comments

Stryker suggests considering readmissions beyond the short timeframe of 3 or even 12 months – for long-term implants, longer periods of several years would be appropriate to determine differences in revision rates with appropriate funding readjustments for poor performance in the long term.

From both a resource and patient experience perspective, differences in the performance of joint replacements over a period of years is significant, and these should be reflected in the National Benchmarking Portal.

The Australian National Joint Replacement Registry (ANJRR) has over 20 years of robust data on joint replacements, which can be used to identify the long-term outcomes of joint replacements.

Stryker suggests it would be beneficial to see if ANJRR data could be linked to the new readmission software tool.

Question

Do you support IHPA's proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?

Stryker's comments

Stryker agrees – variations should be negated by providing funding for the best possible treatment and outcomes.