

Submission by Abbott Medical Australia Pty Ltd

Introduction

Abbott welcomes the opportunity to respond to IHPA Consultation Paper on a Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals, issued on 6 September 2021. Comments on selected topics and questions are provided, and broadly consider how the approach to the methodology proposed by IHPA benefits private health insurers and policyholders by optimising prices paid by insurers for medical devices where required/applicable without compromising the sustainability of the medical device sector, doctor's choice and patient access.

About Abbott

At Abbott, we're dedicated to helping people live more fully, in everything we do. We're creating the future of healthcare through life-changing technologies and products that make you healthier and stronger, quickly identify when you have a medical need, and treat conditions to help you get back to doing what you love. With headquarters in north suburban Chicago, we serve people in more than 160 countries with leading medical devices, diagnostics, nutrition products and branded generic medicines. Our 109,000 colleagues are helping millions of people to live better and healthier, every day around the world.

Since 1935 in Australia, and 1941 in New Zealand, we have been dedicated to helping people live healthier lives through a diverse range of science-based nutritional products, diagnostic tools and vascular devices. We're working to find solutions to the serious health issues confronting people today such as cardiovascular disease, and diabetes. We are unique in Australia & New Zealand, because we offer support across the full spectrum of chronic disease management – prevention, diagnosis, monitoring and intervention – allowing people to live "Life to the Fullest".

Abbott integrates the work we do in Australia with our global development programs to bring new technologies to market around the world. We aim to inspire innovation and make a difference in healthcare. Abbott has been in Australia and New Zealand for more than 80 years. We are here to stay, and to positively impact and contribute to the well-being of all Australians and New Zealanders.

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Responses:

Data Sources

Which data source should IHPA utilise as the primary data source for determining the public sector benchmark price?

Abbott supports the utilisation of sales and volume data from industry at the billing code level as the primary data source. This option will provide the required input at the most granular level versus crude estimates extrapolated from other available incomplete data sets, which would create significant market distortions.

Purchase price data from States and Territories should be used only if data from industry is missing, since State level data may not be granular or accurate enough to be representative of reality at the product (billing code) level.

The National Hospital Cost Data Collection dataset is not specific enough to determine the public sector benchmark pricing as the data are reported at the episode level, not at the device level, and the data for prostheses is a summation of the costs of all the devices implanted in the episode of care.

The private volume data could be retrieved through the Hospital Casemix Protocol if needed, but this should also be cross checked with industry data to ensure the highest accuracy for this parameter.

As the Medical Technology Association of Australia (MTAA) has undertaken to provide a comprehensive data set collected by its members at the billing code level by 15 October, this data set should be the default option for IHPA.

Are there any other sources of data IHPA should consider for determining the public sector benchmark price?

No, all possible sources of data have been reviewed in the consultation report.

What risks should IHPA consider if DRG level information were to be utilised? Are there alternative approaches IHPA should consider?

DRGs are used in the public setting in Australia as a tool to allocate total prospective funding, not to calculate retrospective payment for a particular part of the procedure or accurately record the price or volume of PL products. Adopting this data source for the methodology increases the risk for error. This is particularly true in instances where multiple procedures map into a single AR-DRG code: The cost of prostheses captured in the prostheses cost bucket of the AR-DRG in question is unlikely to be representative of the actual cost of prostheses devices utilized for each procedure captured under that AR-DRG.

It is also important to note the cost of prostheses launched in-between the back-casting period might not be captured to accurately represent the actual cost of prostheses under a specific DRG.

For example, there are two AR-DRG codes within the ADRG that describe the implantation of an active cardiac device: major complexity or minor complexity. Yet the range of devices implanted vary according to the condition of the patient, not necessarily the complexity of the episode of care. A sophisticated device needed to track and alter multiple cardiac parameters (such as a Cardiac Resynchronisation Device – Defibrillator) may be implanted under a “minor complexity” DRG, and a single chamber pacemaker of less sophistication may be difficult to implant or be more resource intensive due to patient/hospital-related factors and be included under a “major complexity” DRG. In each case the prostheses costs captured under the AR-DRG assigned to that episode of care might not accurately reflect the value of the device being implanted. Efficient pricing can best be determined by measuring the actual cost of supply to the public markets, not inferred from episode of care level funding data.

Methodology for calculating the benchmark price

Do you support IHPA’s proposal to establish the public sector benchmark price using a volume weighted average approach? Please provide rationale.

Abbott supports IHPA’s proposal to use a volume weighted average approach to account for volume differences across States and Territories as well as in the overall public sector versus private sector. This approach would factor differences in price, volume and market share agreements which vary by State and even at the Local Health District (LHD) level in some instances in the public sector, which do not exist in the private sector.

The IHPA Pricing Methodology paper states the following:

“Table 1 in the Consultation Paper demonstrates that price is not a function of volume at a state level but is more significantly driven by product category market share and volume at an institutional or health district level.”

Given the price is not a function of volume at a state level, IHPA’s benchmarking model should account for product category market share and volume at an institutional or LHD level rather than at a State level. Collecting pricing data aggregated across suppliers, as MTAA has agreed to do, will ensure IHPA will work with a representative set of data taking account of volume-based arrangements.

Lastly, the other key factor in calculating the reference price for the private sector is to weight the public pricing by private volumes within the benefit group. While the proposed methodology references the public market, it is determining the prices for the private market hence why should reflect the volume mix in private market. The private volumes will essentially be the accurate representation of the patient population being treated in the private sector.

Are there any alternative approaches that IHPA should consider? Please provide rationale.

Abbott considers the volume weighted average method is the accurate approach, in addition to making appropriate adjustments to account for legitimate differences between the public and private hospital sectors. Any alternative approach would yield an inaccurate representation of the price, will potentially cause market distortions, and pose challenges to the sustainability of the medical devices sector in the Australian healthcare system.

Appropriate adjustments to account for legitimate differences between the public and private hospital sectors

What factors, if any, should be considered as legitimate and unavoidable difference between the private and public hospital systems with respect to prostheses pricing? How should the extent of any such differences be quantified?

There are unavoidable cost variations between public and private systems:

- **Service Costs**

Cardiac Implantable Electronic Device (CIED) Post Implant Technical Support Services

CIEDs consist of pacemakers, implantable cardioverter defibrillators (ICDs) and implantable loop recorders (ILRs). CIEDs require extensive ongoing technical support services by industry employed allied professionals (IEAPs) in the private sector post implantation and are essential to be maintained for the life of the device once implanted. These services are separate but complementary to the clinical services provided by the doctors and can range from providing technical advice about device features through to troubleshooting a device to reprogramming therapeutic parameters.

There is currently no funding mechanism for these services. If the PL reimbursement for CIEDs is reduced to a point where it is no longer viable for the companies to continue to provide these services, it would likely to fall to the public health system to meet the demand - i.e., to government and/or patients. Therefore, the gap between public and private prostheses prices cannot be reasonably eliminated for CIEDs without considering the cost of these services. Should the reform process not deliver an outcome which enables sponsors to maintain these services provided by IEAPs post July 2021 for privately insured patients, PL reform will compromise care for cardiac patients in private healthcare.

The extent of these services has been quantified through a thorough analysis by KPMG in a detailed report and is available as part of the MTAA submission to the Department's Consultation Paper: Options for Reforms and Improvements to the Prostheses List¹.

¹ Available at: https://www.mtaa.org.au/sites/default/files/uploaded-content/field_f_content_file/mtaa-submission_pl_reform.pdf (Appendix 1 of MTAA submission) [Accessed: 29 September 2021]

This analysis demonstrated that the cost of CIED services provided by IEAPs is estimated to be \$103 million by 2022, with growth estimated at over 7% per annum given the rise in the number of Australians with active implanted cardiac devices.

Number of Full Time Employee Support

As hospital provider sites are more dispersed and disaggregated in the private sector versus the public sector, there are more contact points in private care which imposes a higher servicing cost on industry. For example, over 20 corporate group sites exist in the private sector, versus around 6 tender groups in the public sector. The extent of the cost differences can be demonstrated through company data as part of the industry price data submission to IHPA.

- **Price Volume Trade-offs**

The Prostheses List benefit is effectively a list price and does not reflect guaranteed volume arrangements, whereas in the public sector even weighted average prices will reflect the impact of price/volume arrangements. Therefore, to achieve a like-for-like comparison this requires a % adjustment for private supply factored in addition to the price volume adjustment methodology. The extent of the cost differences can be quantified and provided through company data as part of the Industry price data submission to IHPA.

- **Cost of Supply**

There are several factors contributing to the higher cost of supply in the private sector than the public sector:

1. In the Interventional specialty space (e.g., cardiovascular), there are more private accounts than public; however, the average procedural volume in private accounts is lower than in the public sector which leads to higher cost of supply in private sector versus public sector.
2. Average quantities per purchasing order are higher in the public sector which leads to a higher cost of supply in private sector versus in public sector.
 - Fixed freight and warehouse costs are disproportionate to the size of orders in the private sector versus the public sector.
3. Percentage of “written off²” units to total consignment units are higher in private sector compared to the public sector for many product portfolios.

The extent of the cost differences can be quantified and provided through company data as part of the Industry data submission to IHPA.

² An inventory write-off is the formal recognition of a portion of the inventory that no longer has value. Write-offs typically happen when the product cannot be sold due to reaching its expiration date and needs to be destroyed which is a significant cost to the Industry.