Submission to the Independent Hospital Pricing Authority Consultation Paper:

Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals

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About Arthrex

Arthrex, a global medical device company and leader in new product development and medical education in less invasive orthopaedics, arthroscopy, sports medicine, orthobiologics and arthroplasty with a strong presence in ANZ for more than two decades. Arthrex was established in 1981 in Germany, to champion the emerging arthroscopic surgery market.

With a corporate mission of Helping Surgeons Treat Their Patients Better™, Arthrex has pioneered the field of arthroscopy and develops more than 1,000 innovative products and procedures each year.

Arthrex continues to experience unprecedented growth and demand for our products throughout the world; however, we remain a privately held company with a family business culture committed to delivering uncompromising quality to the health care professionals who use our products, and ultimately, the millions of patients whose lives we impact.

Our Mission

To provide and deliver innovative medical devices and services to "Help Surgeons Treat Their Patients Better™."

Arthrex aims to provide the global medical community with leading healthcare technology, innovation, job growth, and employee development to make people better. We also promote a strong employee culture and support surgeons worldwide through our educational services.

Submission Information

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Arthrex Australia's Response

Thank you for the opportunity to participate in this consultation. Arthrex Australia appreciates being able to extend our involvement to the Prostheses List (PL) reform to shape the future of the PL and, as a result, sustainability of the private health care market in Australia. We have recently set up a direct model in Australia and investing significantly in the region, keeping choice and access for Australian patients at the forefront. Our response emphasises specific aspects and provides nuances that may be worth considering in ensuring that patient access and surgeon's choice remain uncompromised, access to the latest technology to aid patient outcomes, and the value proposition of the private health insurance is not diminished.

We support an appropriate PL pricing model such as a modified public pricing referencing system that reflects the product's value and support provided by medical device companies. We welcome the Government's 2021-22 Budget announcement however remain concerned about the execution of reforms, including the pricing methodology.

Private health insurance value proposition is based on privately insured patients' ability to choose their surgeon and surgeons' clinical choice in their patients' best interest. The PL has enabled this arrangement of choice and access over many years. If the PL is disrupted by creating a competitive price market, it will significantly erode the value proposition of private health insurance and ultimately affect Australians.

Nonetheless, Arthrex Australia supports the MTAA proposition of using public price referencing as appropriate. A competitive benchmark can ensure benefits on the PL reflect fair value over time, and ad-hoc cuts or time-consuming reviews are no longer necessary to ensure this. Price benchmarking is a reasonable approach to recognise the differences between the public and private markets for this PL reform's success and sustainable outcome. This benchmarking should consider the weighted average pricing methodology and mix adjustment for the private market to the set public price and price adjustment to allow for the expected value of the private market, which does not exist in the public. It should be noted that the user is not the payor. The payor does not experience the value and support provided by the medical devices industry to the hospitals, clinicians, and patients, and neither do they understand the burden of registration, clinical support and regulations.

Prostheses purchasing arrangements in the public and private sectors

The purchasing arrangements of prostheses in public hospitals in Australia are clearly described in the consultation paper. Commonly, the sponsors or suppliers of products negotiate prices with the buying institution in the public sector by tendering. Furthermore, typically, the terms of negotiation are based on specific market share arrangements gained through volume. Therefore, competitive pricing is still occurring with or without tendering.

It will be inappropriate for the PL to operate based on a price/volume arrangement. This arrangement will compromise the value proposition of private health insurance by reducing the choice and access away from the patients and surgeons, respectively, by restricting the entry criteria to allow any supplier's kind of products. As with other benefit setting arrangements, such as the Medicare benefits setting, there is no competitive market operating to set the benefit level. To ensure the benefit value reflects market forces, referencing the competitive public market may reset the benefit without sacrificing choice and ultimately patient care.

Again, in the private market, suppliers typically do not have any guaranteed volume due to the PL. Clinical choice that is best for patients drives the volume, and the hospitals commonly provide products requested by the clinician. Therefore, purchasing by hospitals for private patients are reactive with an "order as needed" basis and comparatively lower volumes per order than in the public system.

Data Sources

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

We propose that the medical device suppliers are the primary data source for public prices. Suppliers hold the sales and pricing data for their products and can provide these data for both markets. Suppliers provide actual market volume and pricing data to procurement agencies typically. There are also confidentiality arrangements between suppliers and procurement agencies that would limit sharing of data by the latter. Therefore, the industry is a more accurate and efficient source of data.

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

Aggregated data from procurement agencies could reasonably be used to validate industry data while ensuring confidentiality is not breached. IHPA has requested data from the industry broken down by state and territory for this purpose, and Arthrex Australia is considering this request.

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

Arthrex Australia highlighted its significant concerns with using DRG level information in principle in its submission in response to the Department's Consultation Paper: Options for Reforms and Improvements to the Prostheses List in February 2021.

The risk of using DRGs to set the benchmark public price for prostheses will not reflect the accurate benchmark price for individual devices. Prices may be overstated or understated depending on DRG, admission rules of each state, the type of technology, and whether the technology is diffused mainly in the public sector.

There is a range of other factors that go to the shortcoming of DRG.

1. Products can be used across multiple DRGs, for different diagnoses.
2. Within a DRG, there can be a range of interventions that can be used. Each of these would have a different price based on the specific characteristics of the device.
3. Classification of an episode of care is also influenced by patient characteristics and events whilst in a hospital, such as age, sex, mode of separation, length of stay, which can change the DRG allocation for the episode of care
4. Admission rules between the public and private sectors may result in PL items provided as hospital substitution or as day surgery may not be captured in the public as they may be provided as an outpatient setting.
5. Admission rules between states also may differ, which may result in different benchmark prices by state
6. Costing provided in DRG is provided as standard costs rather than actual costs, which may not reflect the true cost.

Data collection from the industry will make the discussion of DRG accuracy redundant.

Methodology for calculating the benchmark price

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

We support the private volume-weighted average private as it is critical to the success of the reform for several reasons.

Primarily, the PL benefit reflects a whole of the market price for the PL. Therefore, the quid pro quo market should be selected for benchmarking. The public market is price competitive and subject to confidential negotiations leading to different price points. These variations in price points between different hospitals or procurement agencies reflect a range of factors, and it would not be appropriate to select one of these price

points for the whole PL market. However, overall, these price points reflect a reasonable benchmark if adjustments for any differences between markets are included as described in IHPA's approach to setting the National Efficient Price. This notion corresponds to the Benefit Group as it does to the individual billing code. Since the benefit is set at a group level, the appropriate comparator is the collective weighted average price for that group in the public sector, not any individual product.

Furthermore, using the lowest price point in the public market would likely result in worse access in the private sector, undermining the value proposition of private health insurance, where patients should reasonably expect more choice. As a result, setting the PL benefit at this lowest point would make it non-viable for several products to continue to be sold in the Australian market, leading to their withdrawal. This loss of access may also lead to some procedures being pushed into the public sector. It will also signal the lowest price to the public sector, threatening the commercial in confidence arrangements of tenders and cause more products to exit the market. This approach will discourage market entry for small and medium enterprises with a smaller or niche range of products.

Lastly, to achieve an appropriate benefit setting that maintains patient access, it is vital that pricing methodology and grouping is appropriate. Volume mix of the private market should be reflected in setting the prices for this market, noting that inappropriately sized groups that combine a range of technology regardless of clinical differentiation will cause any pricing methodology to be dysfunctional and magnify any inherent issues it has.

Are there any alternative approaches that IHPA should consider? Please provide rationale.
No

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?

As described above, price/volume arrangements in public should not be mirrored in setting the PL benefit because of the difference in the public and private markets. It must be noted that suppliers may offer a lower price in public as a trade-off for efficiencies and predictability of ongoing business. A consequence of this approach is the narrowing of clinicians' choices to achieve higher volume on a preferred device from their supplier, potentially compromising patient outcomes.

In the private sector, the benefit level may be higher than in public. However, this does not necessarily mean price distortion because private hospitals are not committing to volume and can effectively cater for clinicians choices and, therefore, better patient outcomes. This trade-off supports the private to maintain their value proposition.

Again, a product available in the public system does not necessarily have the same level of clinical and cost-effectiveness data to be reimbursed and listed on the PL. Therefore, any product that meets the listing criteria can be listed at the same benefit level as competitors or higher if a superior clinical outcome can be demonstrated. Thus, the PL benefit level should not simply reflect a public sector price where price/volume trade-offs contribute to the outcome, and the private price needs to be adjusted to remove the impact of these trade-offs.

Finally, there is a range of additional costs to service the private sector that does not exist in the public sector. Public systems often assume or break out freight costs, for example, by setting up centralised distribution warehouses for some items, as happens in NSW. This supply chain arrangement means that the price reflects that suppliers only need to make large quantities of shipments to one location, and the state system manages the remaining distribution. Generally, the public system has more extensive warehousing and stock management capabilities, meaning that order sizes are prominent and ordering frequency is less, lowering overall costs for suppliers. In orthopaedics, instrumentation kits are consigned to public hospitals, while in private, they are typically shipped on loan for every procedure, which incurs significantly high handling costs. Furthermore, there are also instances where accessories are not covered by the PL, whereas in the public sector, they are explicitly priced.

Together, these factors accumulate higher overall service costs in the public sector than in the private sector. These may need to be accounted for when considering the appropriate public benchmark for the PL.

How should the extent of any such differences be quantified?

Arthrex Australia supports the set of methodologies developed by MTAA for accounting for these additional costs, which will be discussed with IHPA and the Department. Not every cost described above may be quantifiable, and there is a significant amount of data on the differences between public and private that the industry has not routinely collected in the past, as this has not been necessary. However, in each case, costs can be mapped if there is a reasonable expectation for justification that does not far exceed the requested adjustment.