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

AMA submission to the Independent Hospital Pricing Authority's (IHPA) Consultation Paper on a Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals

Via email
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The AMA supports reform of the Protheses List, to deliver not just a more efficient pricing structure, but to improve the evidence supporting prostheses use and therefore clinical effectiveness going forward into the future. The AMA strongly believes that the key underlying principle for all reforms to the Prostheses List should be improving the clinical and health outcomes of the patient.

The AMA in earlier submissions supported a benchmark model of pricing where the price of items on the Prosthesis List reflected the prices paid by the public sector, with some allowance to cover any additional costs that were unique to the private sector such as technical support. We welcome the involvement of the Independent Hospital Pricing Authority (IHPA) in the further development of this pricing model but would urge IHPA to take a cautious approach to avoid unintended policy consequences

The private sector is not the same as the public sector, especially when it comes to elective surgeries. The AMA does not believe that the philosophies and assumptions used by IHPA in determining the funding approach for public hospital services, using Activity Based Funding (ABF) based on a national efficient price, are applicable. Whereas IHPA has used ABF to drive public sector productivity and efficiency, their role in this instance should be much more limited. It must simply focus on ensuring a fair pricing model that preserves access to the full range of prosthesis and does not limit patient or clinician choice.

As we have with all the prostheses list reforms, the AMA now urges the IHPA and the Government to take an appropriate length of time to work through and test thoroughly, the work being done to establish an appropriate benchmark pricing system. The AMA believes that it must be a priority to ensure that there no unforeseen consequences arising from these reforms, especially ones that could reduce patient health outcomes or undermine the viability of Australia's strong private health sector.

Data sources

1. *Which data source should IHPA utilise as the primary data source for determining the public sector benchmark price?*
2. *Are there any other sources of data IHPA should consider for determining the public sector benchmark price?*
3. *What risks should IHPA consider if DRG level information were to be utilised? Are there alternative approaches IHPA should consider?*

The AMA does not have the specific technical and data expertise to comment on questions relating to the data requirements to support benchmark pricing for prostheses.

Methodology for calculating the benchmark price

The AMA believes that IHPA and the Commonwealth Government need to be cautious in their approach to establishing the methodology for benchmark pricing for protheses list items. We do not support the any pricing model that simply results in patients in the private sector only having access to the same prosthesis that are funded in the public sector because suppliers focus on those items where there is sufficient volume to justify supply at lower price levels.

In this regard, choice is fundamental to Australia's private health system. It is why so many Australians have purchased private health insurance treatment policies. They expect to receive quality health service in the private health sector, guided by their chosen clinician. Undermining the value proposition offered in a hospital treatment policy is likely to reduce the uptake of private health insurance policies.

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

The private sector does not operate in the same way as the public system. State and Territory health departments have purchasing policies that can take significant advantage of economies of scale. Even then, we know from IHPA's own paper (p8) that there is significant variation in the prices paid across the public sector

Unlike the circumstance in the public sector, the rebate paid by private health insurers for items on the prostheses list, is paid out regardless of the location or setting that the item is used. Accordingly, the AMA believes that the IHPA needs to apply a whole of market benchmark when determining the pricing structure for the private sector.

It makes sense to the AMA that the best way forward would be to calculate whole of market prices through a weighted average pricing methodology. The AMA does not support any approach that chooses the lowest price selectively from the public sector and applies that across the prostheses list. There is a considerable difference between the ability of the State and Territory health departments to purchase prosthetic items, compared with small, independent private hospitals.

Prices in the public sector vary for protheses list items for a range of reasons which include:

- Volume arrangements;
- Negotiations based on market size, freight, distribution and services offered;
- Different approaches to tendering and contracting;
- Individual arrangements with hospitals reflecting their specific circumstances and patient mix; and
- Clinical choice in different hospitals by different groups of specialists

Considering the range of prices that occur in the public sector across Australia, it seems only appropriate that a weighted methodology must be used to smooth out these variations.

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

The AMA believes that public sector benchmark pricing, with allowance for factors unique to the private sector, is the least risky model going forward. It will preserve access to a wide range of prosthesis and mean that the assessment of the clinical merits of a prosthesis is left to a medical specialist working in collaboration with their patient. It will also ensure that patients do not face additional out of pocket costs as a result of hospitals being unable to cover the costs of prosthesis, a situation that could arise under alternative pricing models.

The AMA has also specifically rejected the use of DRG funding for the prostheses list because of its impact on patient and clinician choice as well as the viability of the private hospital sector.

Additionally, the AMA has significant concerns that if prostheses pricing is set too low, this may cause hospitals to charge patients a new category of out-of-pocket fees to maintain viability. Also, that this could drive different behaviour from suppliers of devices and may see some devices no longer being offered in the private sector in Australia.

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

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

The AMA is aware that our patients want three things from their insurance products – they want transparency, choice, and value. These attributes give our patients value from their insurance and are supported by the current Prostheses List process. Going forward the AMA believes that the prostheses list needs to retain the following key criteria:

- support the clinical choice of prosthesis by the medical practitioner, to ensure that the best prosthetic product is used for any particular patient;
- provide for the medical device companies to support Australian specialists in their use of specific prostheses;
- provide access to a full range of prosthetic items to suit patients' different clinical needs; and
- ensure that patients do not have out of pocket costs for a prosthetic item regardless of its expense.

The AMA has always agreed that the one criterion that current arrangements do not support well is price, but moving to a benchmarking methodology should not imperil the other mainstays of protheses provision in the private sector.

The AMA is aware that some of the key differences between the public and private hospital sectors include:

- Choice – the prostheses list needs to ensure pricing supports patient and clinician choice;
- Volume arrangements – volume and purchasing power is increased in the public sector as they are bound less by a diversity of clinician choice and have an increased ability to take advantage of bulk purchasing;
- Diversity – a greater diversity in size of hospitals across the public sector, especially the greater number of larger hospitals;
- Technical support - provision of a greater level of technical support in private hospitals – this is due the to more limited access clinicians have to other expert staff for teaching purposes, especially when we are talking about new or complex procedures using protheses.

The AMA does not have the detailed knowledge of running public or private sector hospitals so is unable to provide any commentary on how the extent of any such differences should be quantified

The AMA is committed to ensuring Australia has a strong and healthy private health sector. We have participated with all Government reforms in a responsible and meaningful way. We stand ready to work with all stakeholders and especially the IHPA to bring about the quality reform of the Prostheses List.

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