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Submission to IHPA Consultation Paper

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

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About Cabrini Health:

Operating since 1948, Cabrini is a Catholic, private, charitable organisation, inspired by the spirit and vision of Saint Frances Xavier Cabrini and the Missionary Sisters of the Sacred Heart of Jesus (the Cabrini Sisters).

Cabrini provides a comprehensive range of high-quality acute, rehabilitation, mental health, palliative care, residential aged-care, diagnostic and community-based health services across south-east Melbourne, including at our hospitals in Malvern, Brighton, Prahran & Elsternwick.

Our services span cancer care, chronic disease, emergency medicine, heart services, homecare and community-based care, maternity services, paediatric care, palliative care, rehabilitation and residential aged-care, as well as education, health promotion and research.

Cabrini is a not-for-profit health service and any surpluses are used to develop our services and facilities to provide the best possible care for patients and families.

Cabrini Health is supported by the work of Cabrini Technology, Cabrini Research, Cabrini Outreach and Cabrini Foundation.

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

Cabrini Health appreciates the opportunity to respond to the Consultation Paper recently released by Independent Hospital Pricing Authority (IHPA) dated September 2021. Cabrini Health has been an active participant in promoting Prostheses Reform and fully support a considered methodology that references pricing in the public hospital sector for use in the private hospital sector at an individual device level – and maintaining the integrity of the Commonwealth Prostheses List.

Cabrini Health actively supports the use of evidence-based data to determine pricing and to preserve the principles that enshrine the value proposition of the Private Health Care. Importantly these principles include:

- promote the sustainability of privately insured health care to help maintain the affordability of private health insurance for all Australians,
- minimise patient out-of-pocket costs, thereby protecting the value proposition of private health insurance,
- preserve patient access to the device recommended by their doctor, and
- support a viable, innovative and diverse medical technology sector in Australia

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

Cabrini Health would recommend the use of data provided by states and territories and device manufacturers to cross corelate price points against the generic aggregate NHCDC data. Subject to the confidence intervals NHCDC data may be of some useful utility, however we believe it is important to achieve benchmark pricing at a single unit level in the first instance. We note that states and territories may not purchase some 11,700 items that are currently listed on the Prostheses List (PL) in which case there is a greater reliance on the device manufacturer cooperation.

If device manufacturers are unwilling or unable to provide appropriate data sets at the time IHPA should approach Minister of Health for further support and potential intervention. In considering the variability of state pricing IHPA will have to give due regard to the significant volume purchasing arrangements that exist in each state. Specifically, the narrow choice of items purchased by states provides greater discounts than what otherwise potentially could be achievable in the private sector.

Additionally, some states classify prostheses data utilising methodology that is different to that outlined by IHPA's technical documents for NHCDC submissions. As an example, VCDC - Prostheses Costing Guidance has a different list to the PL to be included in the costing data.

Rule Title	Rule Code	Rule Name	Episode filter	Report Level	Compares	Rule Description	Tolerance	Tolerance Exceptions
	AD15	CCU costs – no CCU hours	All	Campus x Episode	Current Year	Identifies episodes where CCU hours have been reported but no corresponding CCU cost	CCU hours = 0	
Low theatre or medical costs	AD16a	Surgical or procedural DRGs with low theatre or medical costs	All	Campus x Episode	Current Year	Identifies those episodes that have a surgical or procedural DRG total theatre or medical cost that is low	Total cost (sum of dcost+icost) for (ThearteOR+TheatreNonOR) cost bucket is =0	
	AD16b						Total cost (sum of dcost+icost) for (Medical+MedNonSurg+MedSurg) cost bucket is less $50	
Prostheses costs	AD17**	Prostheses procedures where prostheses cost falls outside the upper or lower boundary	All	Campus x Episode	Current Year	Identifies those episodes that have a procedure code containing a prostheses however the prostheses costs fall outside the upper and lower boundary costs	Where dcost for Prostheses cost bucket is outiside the upper and lower boundary costs then flag	
Pharmacy costs	AD19	Sum (PBS, S100) cost > PHARMACY cost	All	Campus x Episode	Current Year	Identifies those episodes that have a higher (PBS+S100) cost than Pharmacy cost by DRG	Where the difference between the (PBS+S100) cost bucket total cost (dcost+icost) is greater than Pharmacy cost bucket (dcost+icost) total cost	

**The prostheses procedure codes and the upper and lower boundary points have been reviewed and endorsed with the VCCUG members. The details and lists can be found at Appendix 2 -Prostheses boundaries

GuidelinesTo Prostheses.pdf

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

Essentially no. There is little value in considering Public hospital data for Private patients that may have been treated in a Public hospital as these episodes of care are generally priced in accordance with the PL. International reference pricing does not have any immediate value as the pricing reform conversation is not mature enough to encompass the many variabilities between different markets. This may be a consideration for second or third iterations.

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

Cabrini Health does not support the use of aggregated DRG pricing information as significant variability would impact the provision of care in hospitals that have variable weighting of their case mix. Some value may exist in applying DRG allocations where those DRGs are very specific and have narrow parameters for prostheses cost variability. For example, DRG I04 has a price band width of $5,000 to $12,000 according to the surgeon preference, clinical need and consumer preference.

Unless there is a level of granularity between the Public and Private data set, DRG level information could be used only if the prostheses bucket allocation matches the private sector allocation for that DRG. HCP data from private and public sector could be used to work out the difference in the type of prostheses used. If there is substantial variation in the type of prostheses, then weighted average price should inform the prostheses cost for that DRG.

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

Cabrini Health cannot offer a comment at this point until data outputs are available but will be pleased to be involved in further discussions.

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

Cabrini Health reinforces the need for unit-based reference pricing for like for like items across the PL. Price disclosure although outside the remit of IHPA would require device manufacturers to provide ongoing inputs on an annual basis if adopted by the Department of Health in a similar fashion as the Pharmaceutical Benefit Scheme.

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

(i) Types of procedures being performed
(ii) Clinician choice and the ability to perform the procedure at an alternative hospital that will provide the consumables and prostheses of the clinician's choice.
(iii) Technical support provided to Private consultants in performing operations or managing equipment pre and post procedures
(iv) Volume discounts
(v) Managing transport costs and in-to-store costs associated with loan kits and maintaining the integrity of the products (hospital costs)

How should the extent of any such differences be quantified?

Cabrini Health has estimated that for some specialities in particular cardiac, neurosurgery and orthopaedics that an additional 6-10% loading may be required to allow these variables to continue.

Cabrini Health acknowledges the enormous weight of responsibility that IHPA has adopted in undertaking this very crucial work. Should we be of further assistance please do not hesitate to contact us via email healthfunds@cabrini.com.au.

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