1 October 2021

Consultation Paper on a Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals

Catholic Health Australia (CHA) continues to broadly support the Government's commitment for reform to the Prostheses List (PL) with the implementation of public sector reference pricing.

Establishing a sustainable funding model for prostheses without resorting to further patient out of pocket expenses is critical to the sustainable provision of high quality patient care and the maintenance of patient and doctor choice. Ensuring that patients can access contemporary evidenced based device technology underpins the value proposition for the private hospital sector, and indeed the private health insurance sector.

Any prostheses pricing methodology adopted by the government must ensure good patient outcomes. CHA notes the consultation paper charts a path towards a market-based model. CHA is grateful to the Authority for the opportunity to comment on its consultation paper.

Data

CHA cautions the Authority on the utility of data sources that are used in the public system given they do not typically provide the granular level of detail required for commercial pricing. The Authority has limited data from the National Hospital Cost Data Collection (NHCDC) to compare cost weights across private overnight hospitals and no data from the day hospitals.

Hospital Casemix Protocol (HCP) data provides a valuable source of information on private hospital volume data and should be incorporated into the methodology. CHA notes that the Department of Health engaged a forum of private hospitals for research and analysis on general miscellaneous (GM) items using HCP and government data. The outcomes from this analysis will need to be incorporated to inform this methodology, particularly where GM items might be bundled into procedures.

Methodology

CHA recognises there are multiple prostheses reviews operating concurrently and continues to respond to other related consultations. However, these consultations should not be run in isolation.

Private hospitals have been consistent in their support for good prostheses reform. We recognise that many of the prices on the prostheses list do not reflect market cost. The adoption of public sector reference pricing across the entire PL is a sensible and widely supported approach that will ensure that patients are not paying anything but fair prices for items they need for their health care. This reform, on its own, is expected to deliver hundreds of millions of dollars into the pockets of consumers, as well as protecting clinical choice and supporting the sustainable provision of high-quality patient care.

The Government's push to remove most items from the GM list is a questionable reform strategy. If the primary purpose of reform is to ensure a market price is paid for each device, the Authority should advise the Department against this measure until an adequate pricing methodology is developed and

applied across all categories. Attempting to restructure the PL in a piecemeal way will deliver little, if any, additional benefit to privately insured patients. Given that it will limit clinical choice during procedures, it will also likely result in poorer health outcomes for patients.

CHA supports the Authority's contention that the lowest available public price is not a fair comparator. There are various reasons for differences in prices paid across the public system. This methodology does not take these factors into account. As a result, the adoption of this methodology could result in significant disruptions to the delivery of devices in the public system and the departure of some manufacturers from the market.

Public and Private Differences

It is established that the public sector prices do not include costs associated with ancillary components of some devices. The service components including technicians and equipment are typically provided by the public hospital and are not captured in the public price.

In the private sector, hospitals pay the prostheses benefit that includes the provision of professional services to accompany the administration of the device. Hospitals do not have direct visibility of the cost for each component as these are inclusive of the PL benefit. CHA recommends these costs be included in the methodology, particularly for cardiac devices, using information gathered from MTAA and device suppliers.

Reforms should be enacted so that savings are delivered for patients without creating cost pressures in other areas of healthcare , that is, to take a systems view of the reforms rather than narrowly focus on one aspect of health expenditure. International device manufacturers also manufacturer hospital consumable items, instrumentation, patient monitoring equipment and other technology – not purchased via a PL mechanism. The Authority should also consider how monitoring can occur across a whole of portfolio spend to ensure that any reduction in pricing for prostheses does not then produce a corresponding increase in the cost of other goods purchased by hospitals. There are also risks to private hospital costs if manufacturers of medical products are able to drive price rises in consumables, to counter the anticipated losses resulting from the PL price reductions.

Private hospitals also incur costs-to-serve which can vary by hospital group due to size, geographic distribution, and volumes. A price adjustment, known as a 'product integrity fee', should be made to the public sector price to reflect reasonable differences in public and private sector prices, such as transport, product handling, loan kits, and storage.