Private Healthcare Australia
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Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We collectively represent 97% of people covered by private health insurance. PHA member funds today provide healthcare benefits for over 14 million Australians.

Introduction

The overriding principle that should be adopted by all in the private health insurance industry is maximising the public interest. Australian consumers should have access to the best possible medical technology at the best possible prices.

Prices for medical devices in the private system in Australia are, on average, 30% higher than comparable markets. It is unclear how high prices are in the public sector, but greater scrutiny, transparency and accountability should ensure prices across all states and territories and the private system trend downwards toward international benchmarks. There is no policy justification for an "Australia tax", yet for a range of products and services from large multinational countries, Australia has been seen as Treasure Island.

The Australian Government has decided the first step towards this objective is to gradually reduce the price differentials that are believed to exist between the Australian Government's Prostheses List and prices paid by state and territory organisations for devices in their public hospital systems. The first stage is to determine a benchmark public price, and from 1 July 2022, reduce any differential between these prices by at least 40%.

This context is important for the task set for IHPA, to determine the base price from which reductions in price will be made to benefit consumers. A higher base means less benefit for consumers. A clear and transparent base price methodology will provide government greater scope to capture consumer benefits through policy tweaks.

As pointed out in the discussion paper, the task of setting a base price is not simple. It requires value judgements; and will inevitably throw up errors. The more transparent the process, the less likely that the inevitable errors will lead to consumer harm (or foregone consumer benefit).

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

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

What risks should IHPA consider if DRG level information were to be utilised?

Are there alternative approaches IHPA should consider?

IHPA should utilise and publish all data sources to best inform policy decisions.

There are three levels of data which should be used to inform decisions:

- Individual device cost
- Costs of items in the product category, and
- Cost of items at the procedure level.

Each of these data levels provides key information required by policy makers to extract maximum consumer benefit.

The cost of individual items provides a key benchmark. However, prices by individual items alone are not sufficient, as many items are used (or at least priced) in the private system. These are not used in the public system because they are too expensive, not effective, or simply not preferred.

Prices by product group are most useful, as the cost of items predominantly used by the public system in the product group will provide a key benchmark for suitable prices in the private system.

These prices should be checked against costs by diagnostic reference group (DRG). The cost per procedure is an important benchmark to determine pricing, while noting casemix may be markedly different in some areas between public and private systems. These data have the advantage of being already available to IHPA.

Clearly, the best source to use will be data provided by state and territory governments on actual prices paid for devices. Where commercial-in-confidence arrangements currently prohibit price disclosure, suppliers should be asked to waive such restrictions. Their peak body, the Medical Technology Association, has called for greater transparency.

Data collected from suppliers is another important source, noting the obvious conflict of interest. Suppliers should also be asked to provide data on prices from international jurisdictions.

IHPA should also provide commentary on comparisons between international prices and Australian prices. There is no obvious reason that prices in other jurisdictions should be so much lower and knowing that products are available at lower prices in comparable countries will increase transparency and public benefit.

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

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

PHA is comfortable with a weighted average, subject to commentary below.

Where a weighted average is used, the lowest available price should also be quoted. There are two reasons the lowest price should be published.

First, it will act as a signal to other jurisdictions/purchasing agencies that lower prices are available and should be pursued. Basic economic theory demonstrates that the more information is available in the market, the higher the consumer benefit.

Second, where the numbers of items used is small and/or the item is used predominantly in the private sector, publishing the lowest price will provide policy makers more information on which to base their pricing decisions. (Similarly, commentary on international prices will inform decision makers.) The government has stated that they will seek to reduce the gap by at least 40% in the first year, and if there are items rarely used in the public sector with widely varying prices, relying wholly on the weighted average may not be appropriate.

When determining the weighted average, any prices above the existing Prostheses List price for an item or category should be excluded from the calculations (or deemed to be the Prostheses List price through a data cleaning/trimming process). In the example on page 8 of the discussion paper, two jurisdictions are paying rates above the Prostheses List price. This distorts the national average price to the detriment of consumers. Any prices above the Prostheses List price risk harming the integrity of the model.

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?

The proposed approach of identifying legitimate and unavoidable cost differences between the public and private sectors is supported. It is not immediately obvious why costs should be different for supply costs such as freight, and any technical support provided by suppliers will generally be for the benefit of the supplier. It is important to separate services provided which yield a measurable patient benefit from sales and distribution activities.

There are some items of the Prostheses List where it is claimed that services are provided after the provision of goods, such as cardiac monitoring. In that instance, the department's Cardiac working group found there was no justification for additional service payments supporting cardiac devices.

If such services are being provided, they must be clearly described and disclosed. The services should be backed by evidence, and clinically relevant. In determining this evidence, an explanation of why these are not performed outside the private sector will need to be provided. Lastly, any such services must be cost effective.

Should any such services be deemed cost-effective, the efficiency of funded them through an uplift on the price of a device is unlikely to pass scrutiny. If there are services identified that provide value to the patient, the remuneration for those services should be determined separately to the device cost. Basic economics notes that paying upfront for a service that may or may not be provided is a poor model for the consumer. Likewise, paying for services that may or may not be provided as a baked-in add-on to the price is generally a poor deal for consumers.