Ramsay Health Care

1 October 2021

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority

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

Dear James

Thank you for the opportunity to respond to this consultation, pricing in the private sector is materially different to the public sector – given the differences in clinical models, funding models and market economics.

Ramsay Health Care Australia (**RHCA**) is very supportive of:

- retaining the Prostheses List;
- the staggered reduction of prices, towards a domestic reference price;
- an ongoing economic evaluation of the impact of reforms (such as unintended pricing consequences for the public sector and other goods acquired as OpEx or CapEx); and
- development of improved pricing mechanisms for the ongoing management of the Prostheses List.

Given the interdependent nature of the questions posed throughout the consultation paper, we have elected to respond to each section as a whole, rather than the individual questions within each section.

INTRODUCTION

With the parallel consultation by the Department of Health regarding the 'Purpose, Definitions and Scope' of the Prostheses List, it is our understanding that IHPA's scope of works may not include products categorised as 'General & Miscellaneous'.

With the outcome of that review not predetermined, it is recommended that all products on the Prostheses List be included in IHPA's report to the Department of Health regarding the benchmark price for prostheses in the public sector.

DATA SOURCES

To determine the public reference price for every 'Billing Code' on the Prostheses List, it requires access to the public pricing information for every 'Billing Code' (to neutralise variation in: clinical practice; demographics; access; epidemiology; and casemix).

In this context, the optimal data source would be the:

- actual rate schedules from every State / Territory procurement team (collected through the relevant Department / Ministry of Health); else
- actual rate schedules for every jurisdiction (collected through the MTAA / individual suppliers and manufacturers).

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Given all other public hospital data sources involve the aggregation of 'Billing Codes' to the level of episode / AR-DRG, there are no other appropriate data sources for this report.

Evidence of why it is not appropriate to use data sources which aggregate 'Billing Codes' is demonstrated by:

<u>Percutaneous Coronary Intervention</u>

Without knowing the prevalence of each of the four PCI prostheses 'Product Groups' within an aggregated data source, it is impossible to make the necessary adjustments for clinical / patient variation in order to create a comparable price comparator at the 'Billing Code' level.

	Bare Metal Stents			Drug Eluting Stents
Supplier...	<150mm	≥150mm	Large diameter aortic dissection disease	Drug Eluting Stents
Supplier 1	$1,625	$2,681		
Supplier 2	$1,625	$2,681		
Supplier 3	$1,625	$2,681		
Supplier 4	$1,625	$2,681		$2,166
Supplier 5	$1,625	$2,681		
Supplier 6	$1,625			
Supplier 7	$2,153		$4,197	
Supplier 8	$1,625	$2,681		
Supplier 9	$1,625			
Supplier 10	$1,625	$2,681		
Supplier 11	$1,801	$2,681		
Supplier 12	$1,625	$2,681		
Supplier 13	$1,625	$2,681		
Supplier 14	$1,625			
Supplier 15	$1,625	$2,681	$4,197	$2,166
Per Unit DRG Average Price (1.5 stents per admission)	$1,995			

For example, using a public data source (with a ratio of 70:30 for bare metal and drug eluting stents) and a private data source (with a ratio of 40:60), a benchmark price would incorrectly assume a 9% reduction.

Product Group	PL Price	Public Mix	Private Mix
Bare Metal Stent <150mm	$1,625	70%	40%
Drug Eluting Stent < 150mm	$2,166	30%	60%
Average PL Price (aggregated)		$1,787	$1,950

<u>Total Joint Replacement</u>

Without knowing the prevalence of cemented / uncemented within an aggregated data source, it is impossible to make the necessary adjustments for clinical / patient variation in order to create a comparable price comparator at the 'Billing Code' level.

AVERAGE PROSTHESIS COST BY SUPPLIER	Total Hip Replacement		Total Knee Replacement	
Supplier...	Cemented	Uncemented	Cemented	Uncemented
Supplier 1			$7,142	
Supplier 2	$8,792	$9,935	$8,407	$10,109
Supplier 3		$10,301	$11,724	
Supplier 4	$8,103	$10,001	$6,725	
Supplier 5		$11,447	$8,409	$8,685
Supplier 6		$9,866		
Supplier 7	$9,046	$10,744	$7,431	$7,186
Supplier 8		$9,759		
Supplier 9	$8,289	$10,472	$7,819	$7,799
Supplier 10			$7,527	$10,475
Supplier 11		$11,151		
Supplier 12			$13,301	
Supplier 13	$6,970	$10,136	$7,419	$7,752
Supplier 14			$7,103	
Supplier 15	$8,409	$10,660	$7,218	$7,837
Supplier 16		$9,279	$7,507	$7,198
Supplier 17			$6,533	$8,089
Supplier 18	$5,088	$9,841		
Supplier 19	$7,897	$10,548	$8,066	$7,292
Supplier 20	$7,966	$11,063	$7,335	$7,723
Supplier 21		$11,991		
Supplier 22	$7,469	$9,882	$7,920	$7,943
Average DRG price	$9,391		$7,478	

For example, using a public data source (with a ratio of 70:30 for cemented and uncemented total hip replacements) and a private data source (with a ratio of 40:60), a benchmark price would incorrectly assume a 9% reduction.

Product Group	PL Price	Public Mix	Private Mix
Cemented Total Hip Replacement	$7,803	70%	40%
Uncemented Total Hip Replacement	$10,416	30%	60%
Average PL Price (aggregated)		$8,587	$9,371

AR-DRG Variability

Before an aggregated data source, such as AR-DRG, can be used as a price comparator between public and private prices, a further refinement of AR-DRG is required to address the clinical / patient variability (such as separate AR-DRGs for cemented hip replacements and uncemented hip replacements).

This concern is evidenced in a comparison of public and private cost weights, whereby 17% are lower in the private sector and 43% more than twice the public cost weights:

% higher/lower of private cost weights compared to public cost weights	Surgical	Other	Medical	Total	Observation
<100%	39	8	88	17%	Private lower prices
100% - 199%	98	10	36	18%	Private higher prices
200% - 299%	127	4	37	21%	Private higher prices
300% - 399%	54	8	38	12%	Prices not comparable due to casemix variance public / private hospitals
400% - 499%	20	2	22	5%	
>499%	32	14	165	26%	

METHODOLOGY
RHCA generally supports the use of 'weighted average price' as set out by IHPA.

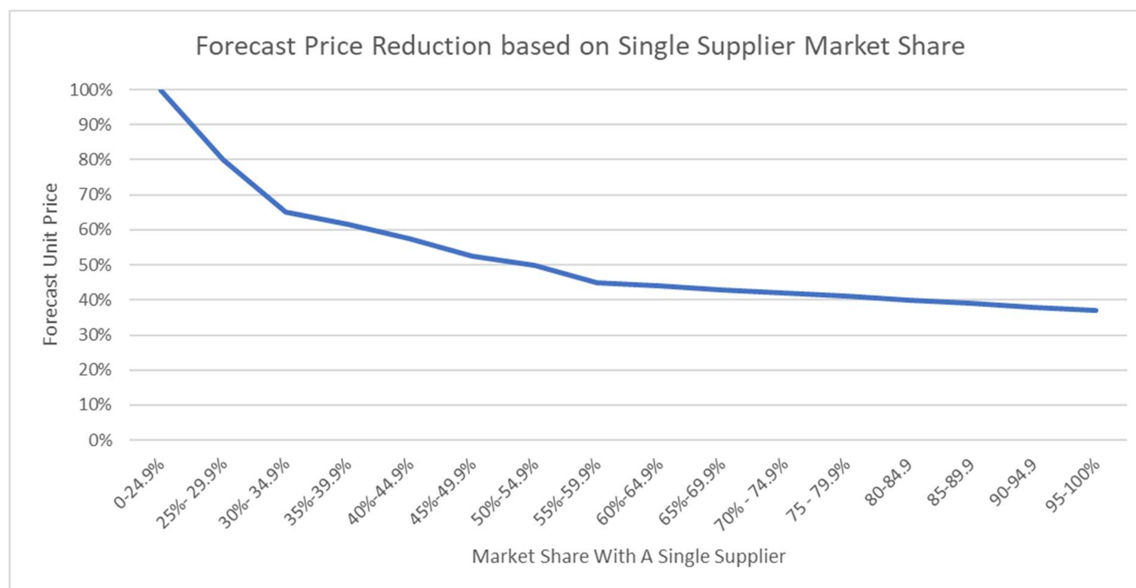
As outlined throughout the consultation paper, there are a number of differences in the market economics of the public sector and private sector, which materially contribute to what amount of price reductions are realistically achievable by the private sector:

- group purchasing arrangements, whereby a State / Territory negotiates on behalf of 100s of its hospitals (compared to the private sector, where most of the 600+ hospitals negotiate on their own);
- preferred supplier arrangements, whereby a smaller range of supplier and prostheses are available to doctors / patients in order to negotiate volume/price reductions;
- guaranteed volume arrangements, whereby the size and diversity of a public purchasing authority, and its ability to mandate which prostheses a doctor / patient, minimise the risk of pre-purchasing significant volumes of prostheses at a discount.

If we compared the:

- public sector economic / clinical model (whereby there is a direct and causal relationship between reductions in unit price and limiting choice of prostheses to as single supplier), to
- private sector economic / clinical model (whereby >20% market concentration in a particular product is unusual),

there is an insurmountable price gap which must be excluded from benchmark pricing.



To overcome the issue of benchmark pricing differences which are unattainable for the private sector, it is advisable to only include State / Territory rate schedules which have been negotiated at the Department / Ministry of Health (minimising the impact of local hospital arrangements that leverage increased market concentration).

Additionally, IHPA should cap the reported benchmark price reduction at 15% until a robust evaluation of the economic / clinical models in the private sector is completed – to understand the achievable price reductions in the private sector.

Where no benchmark price for an individual 'Billing Code' can be calculated (because insufficient data exists), the weighted average price should be calculated by reference to the weighted price differential for the:

- 'Suffix', where it exists; else
- 'Product Sub Group', where it exists; else
- 'Product Group'.

ADJUSTMENTS

RHCA understands the Prostheses List unit price for cardiac prostheses includes additional goods and services that are inherently required for the proper implementation and functioning of the prostheses for their lifetime.

In this context, we defer to the recommendations of the Cardiac Technical Support Services Industry Working Group as documentary evidence of the matters which should be taken into account when setting the benchmark price.

It is important that, if IHPA were to recommend a reduction on the basis that goods and services which are currently bundled into a 'Billing Code' now be excluded for the purpose of benchmarking, that it also recommends alternate funding arrangements are in place for those excluded goods and services as part of any reforms (to avoid negative consequences for hospitals and patients).

RHCA is not aware of other prostheses or scenarios in which special adjustments need to be considered, but this may not be the case for hospitals with more dispersed geography or concentrated casemix.

We recommend a yearly review the benchmarking and its impacts is conducted, as this will provide private hospitals with the ability to share real-life insights into the reforms as they are implemented.

Thank you again for the opportunity to contribute to this important reform agenda.

Regards,

Dean Breckenridge
Chief Policy Officer
Ramsay Health Care Australia