RANZCO
The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

1 October 2021

IHPA Secretariat
Independent Hospital Pricing Authority
Eora Nation
Level 6
1 Oxford Street
Sydney, NSW 2000
Australia

Via Email: submissions.ihpa@gov.au

**Re: Methodology for Determining the Benchmark Price for Prostheses in Australian Public Hospitals**

The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to provide feedback on methodology for determining the benchmark price for prostheses in Australian Public Hospitals.

RANZCO is the medical college responsible for the training and professional development of ophthalmologists in Australia and New Zealand. Our mission is to lead eye care by setting and improving standards, providing lifelong education, promoting research and innovation, and advocating on behalf of patients, their communities, and our members. We recognise that delivering on our commitment to best practice and patient outcomes requires a diversified collaborative approach to ensure balanced methods of mitigating issues that affect the overall patient experience and outcomes.

RANZCO supports overall prostheses reform but believes closing the gap between public and private hospital pricing should not be the basis for reform. There are many reasons for the observed pricing disparity. Prostheses list (PL) reform is better directed at providing privately insured patients with access to beneficial and cost-effective medical devices used in a medical procedure as part of an acute hospital or hospital-substitute care episode.

Nonetheless, outlined below are RANZCO's responses to two of the consultation questions:

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

RANZCO believes that the DRG groupings are fundamentally unsuited to prostheses management. Pricing by DRGs ignores clinical complexity within different DRG categories. Additionally, the DRG system of funding applies only to patients admitted to hospitals. So, DRG funding options do not apply to day surgeries where many ophthalmic prostheses are implanted. To summarise, using the DRGs would be rather unsuitable for managing prostheses grouping because it would cloud and confuse the prostheses' grouping system.

RANZCO has concerns relating to the use of DRG level information for the following reasons:

- The separation of funding for prostheses from other incidents related funding allows for clarity around prostheses pricing and choice. Bundling all the costs associated with a procedure will inevitably lead to using the cheapest option where possible. The insurer will most likely hold the DRG allocated bundle amount, and their interest is the high return to shareholders which mandates the use of the cheapest prosthesis.
- The choice of prosthesis will no longer be with the clinician. We can observe other countries where this is the funding model, like in New Zealand, patients do not receive optimal outcomes as evidenced by the low rate of toric IOL use. The only way to avoid the above problem would be to increase the number of DRGs to cover each type of lens implanted e.g., a DRG for a patient having a toric EDOF IOL, a DRG for a patient having a non-toric trifocal lens etc. The newly consolidated PL might end up being as fragmented as the existing system of PL.
- Furthermore, pricing by DRGs ignores clinical complexity within different DRG categories. DRG funding does not consider the potential functional outcomes of other prostheses used in the same type of patient. For instance, the allocation of one DRG dollar value regardless of whether an IOL is a mono-focal, toric, or multifocal. Yet the outcomes are very different and complex. Therefore, funding structures for IOL's should reflect their complexity of design and manufacture. Otherwise, there would be nothing to incentivise companies bringing IOLs with extra benefits to patients here in Australia.
- Pricing by DRG removes ophthalmologists, other clinicians, including presumably health economists, out of the decision-making process regarding different prostheses' socioeconomic value.
- A mechanism is still required to determine which prostheses are on the DRG and what price is attached to that device. The lack of a mechanism to determine appropriate pricing would result in the newly consolidated PL looking like the existing PL.

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

RANZCO proposes that the benchmarking process consider the factors below:

- IOL categories should be redefined based on current IOL technology, and many of the extra funding based on prefixes/suffixes abolished. Consider a system of tender/ bookbuild for the benchmark price for each category.
- A base price for each category (having enough categories to cover all functional applications) with a patient co-payment for devices within the category that the manufacturer seeks to sell at a higher price.

- Clinical input is required to assess the potential benefit of prostheses to patients. For optical devices, ophthalmologists, who frequently use them, may be asked to inform their pricing. This is because they would be able to judge their value or cost-benefit of a product. For example, tissue or fibrin glue cost compared to the cost of 10 (O) nylon suture when doing pterygium surgery. Cost of MIGs shunts compared to trabeculectomy.

We believe that strong partnerships and cooperation across all patient pathway points lead to better health outcomes. Therefore, RANZCO is ready to work with the IHPA to ensure that intended cost savings are not achieved at the cost of best patient outcomes.

If you require any further information, please contact RANZCO Policy Officer, Nosa Omokaro, at nomokaro@ranzco.edu, in this regard.

Kind Regards,

**David Andrews**
**RANZCO CEO**