



CATHOLIC HEALTH Australia

30 January, 2017

Jeanette Radcliffe
Committee Secretary
Senate Inquiry into Price regulation associated with the Prostheses List Framework
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Secretary,

Senate Inquiry into Price regulation associated with the Prostheses List Framework

Thank you for the opportunity to provide a submission to this inquiry. Please find the attached Catholic Health Australia's submission to the Senate Inquiry into Price Regulation Associated with the Prostheses List Framework. As the largest grouping of not-for-profit hospitals in Australia, our providers are invested in ensuring an effective platform be developed to rein in unnecessary costs and ensure the sustainability of the private sector.

In 2016 the Department announced it would require a 10% price reduction for cardiac and intra-ocular lenses and 7.5% price reduction for hip and knee replacements. With recent reports of price discrepancies, CHA recognizes the opportunity for cost savings and supports a diligent and informed remodelling of the sector. With the current legislation and architecture in place, the Government can design an effective platform to make the necessary improvements in prostheses reform and we will continue to support the Government's ongoing involvement in these issues.

If you require any further information, please contact the Catholic Health Australia Office as we welcome the opportunity to give further evidence to assist the Inquiry in its work.

Yours sincerely,

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Introduction

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for around 10% of hospital based healthcare in Australia. Our members also provide around 30% of private hospital care, 5% of public hospital care, 12% of aged care facilities, and 20% of home care and support for the elderly.

CHA acknowledges there are discrepancies in the cost of some prosthetic devices between public and private hospitals. In 2014, private health insurers contributed \$1.8 billion to prostheses, equating to 14% of all private health expenditure. Benefits for some prostheses were found to be up to five times higher in Australia than comparable overseas jurisdictions. While this does not apply to all devices in equal measure, it does underscore the need for better transparency in the market.

From a historical perspective, the price of devices in the private sector increased when the arrangements for the supply of prostheses in the private sector was deregulated in 2001. This resulted in additional administrative imposts on hospitals and doctors, with each health fund establishing its own list with different benefit levels and time periods for adjustment of benefits. Negotiations between health funds and device suppliers saw the benefits for prostheses increase by 25% per annum until the government intervened in 2005, resulting in reimbursements becoming fixed at those levels.

The Prostheses List (PL) was introduced by the government to curb the spiralling costs resulting from deregulation by designating a minimum benefit for each device on the PL. As outlined in the Private Health Insurance Act (2007), health funds are required to pay the minimum benefit for a range of prostheses designated on the PL. The Prostheses List Advisory Committee (PLAC) consists of an expert panel from across the sector that assesses the clinical efficacy and benefit of each listed item. They are supported by Clinical Advisory groups (CAG's) and subcommittees that consist of experts from their respective clinical professions as well as health economists that advise members of the PLAC using clinical efficacy cost equations. The PL and PLAC have been instrumental in slowing the rising costs of devices and ensuring that patients continue to have access to appropriate and up to date technologies. CHA recommends that the PL and existing architecture of the PLAC be maintained and incorporated into any future model that is adopted by the Government and private health industry.

CHA is supportive of the appropriate use of the Australian healthcare dollar and the importance of developing a platform that reduces the price appropriately. International frameworks have been successful in reducing the price of prostheses through government involvement. The legislation and regulation can be maintained along with a range of improvements that need to occur to make the system more efficient and easier to manage. This requires cost controls to reflect any changes in the benefit are true price reductions and not cost-shifting to consumers, hospitals, or other stakeholders. For the Government to remain involved, the system will need to be augmented with the adequate mechanisms and controls in place that reduce price and improve affordability; link clinical outcomes to listing; and advance clinical choice.

Applications for transparency and controlling costs

The PL currently consists of over 11,000 items for potential use by clinicians in the private sector. This extensive list is in need of a range of improvements to the inventory that would make the process more efficient with high level cost controls that extend to the suppliers.





When a new device is submitted for review and listing, the PLAC and relevant subcommittees assess the criteria and set the benefit to that of similar devices within the same class. This reduces the incentive for suppliers to compete for price because new items are listed on the PL at the group price determined by similar products. Requiring a form of price disclosure would encourage companies to be more competitive, ultimately reducing the price of competing devices.

Of the over 11,000 items on the PL, efficacy reviews do not often occur to meet changes in technology and innovation. While clinician choice is a driving force in the private sector, robust testing of price efficacy and linking outcomes to each device will assist in removing outdated and underperforming prostheses from the private sector. As many as half of unplanned readmissions that occur within 28 days of surgery have involved prostheses were identified by the National Joint Replacement Registry as having a higher rate of revision. This amounts to increased hospital costs which are passed on to the health funds who reflect this additional expenditure in the form of higher premiums and reducing insurance coverage.

Every year, AOANJRR releases a report that assesses the prostheses in this category and publishes those that have been attributed to higher revision rates. Other peak bodies conduct similar efficacy reviews to make recommendations to clinicians about which devices have a demonstrated impact on clinical outcomes. CHA recommends the PLAC and relevant subcommittees establish a process of clinical review to assess the efficacy of each device over time and determine milestones each device must meet in order to remain on the PL.

The current working definition of “prostheses” means some technologies that contribute to improved patient outcomes cannot be listed on the PL. CHA suggests that the PLAC review their requirements to consider new technologies that do not currently satisfy the listing criteria in order to incorporate technologies that have been shown to have clinical efficacy. Specific examples include guidewires that assist with implanting prostheses but are removed during surgery and therefore do not meet the listing criteria.

While the price of prostheses has been shown to vary between public and private sectors across states and countries, CHA warns against the unintended consequences of price benchmarking in different markets. If the price of the device is made public, this may not include the additional ancillary components and support that are involved in managing and handling the device until it is implanted. If the Department follows through with a model that includes price disclosure, the PLAC and its subcommittees of clinical professionals will need to develop a rigorous process that would ensure these additional costs are factored in to the final benefit amount.

Concerns have been expressed that reducing the price of prostheses could potentially force some manufacturers out of the market if their product is no longer viable at a lower benefit. In order for manufactures to receive adequate compensation for their products, they could provide evidence of superior outcomes to justify listing at a higher price than items of the same class.

Impacts of Prostheses List framework on private health insurance

Private health insurers are under increasing pressure to find avenues for savings in a market that has seen health costs and premiums increase faster than wages. Consumers are finding the price of private health insurance to be increasingly unaffordable while the quality of health plans and degree of coverage has also diminished. With prostheses representing approximately 14% of benefits paid in the private market, this could potentially be an area with room for savings.

CHA recognises that while the PL architecture has been successful in maintaining cost stability, many devices are listed at higher price levels than would appear to be the case in the public





sector and in overseas jurisdictions – adding to pressure on premiums and ultimately private health insurance membership levels. CHA members support the exploration of proposals to provide a more competitive approach to benefit setting whilst maintaining the benefit of certainty and access to technology provided by the PL and PLAC processes.

Ensuring the public has affordable access to quality insurance packages should be a priority for Government and relevant stakeholders. Private hospitals provide services for nearly half of all Australian surgical patients which greatly reduces the burden on public hospitals. Consumers also benefit from greater choice in the services and care they receive from private providers. Improving the affordability and clinical efficacy of items on the PL would serve to improve the long-term sustainability of the private sector.

Pricing models for prostheses

Various proposals for pricing models have been recommended to lend greater transparency to the price of prostheses and rein in costs currently borne by health funds.

The Department has recently engaged the University of Melbourne's Centre for Health Policy in the research and design of a benefit-setting framework for prostheses. Recognizing there are international examples where government regulations have proven successful in controlling costs through price disclosure and reference pricing, CHA offers some previously proposed models in the Australian context and potential impacts on the health sector.

Reference Pricing

Reference pricing has been listed as a potential model - using domestic public sector and international benchmark prices to bring the Prostheses List benefits closer to levels in these other markets. Recent claims from health insurers have asserted the prices paid by funders for prostheses being used in public hospitals are estimated to be significantly lower than those used in public hospitals, while in overseas jurisdictions they are closer to half the price of those in the Australian private sector. In this model, price data from Australia and abroad would be compiled and submitted to the PLAC for review to determine the appropriate benefit on the Prostheses List.

This option would require the establishment of a comprehensive collection of data that does not currently exist. While many devices on the PL may be listed at a benefit level higher than the price paid by public hospitals, this is not consistent across all devices or all categories. Each device would need to be reviewed individually as significant across the board cuts applied equally to all devices could make some individual devices unviable to supply in the Australian private market.

Acquiring reference prices from overseas jurisdictions may also prove challenging as many countries face similar concerns regarding incomplete pricing data and price discrepancies between public and private hospitals. This process will not take into account the major factors influencing price differences in these countries that are associated with the political and economic systems under which these arrangements are made.

With the large volume of surgical work done in the private sector, current public prices negotiated between the public sector and suppliers may be lower partly as a result of cross-subsidization from the private sector due to the PL's higher benefit amounts. (That is, suppliers may be willing to forgo higher prices for the smaller volumes they sell into the public sector knowing that they will achieve a higher return from their private sector). There is a risk that future public sector supply costs could increase if the private sector benefit levels are significantly reduced.



There is some concern as to whether reference prices for the private sector can be reasonably compared with the narrower purchasing profile of the public sector. Products in the public sector consist of a limited range of devices where purchasers benefit from economies of scale by purchasing larger volumes of these specific products. Using this narrow range of products to establish a reference price for devices in the private sector may not be reflective of the actual costs of production and supply and could make some devices unviable, further restricting consumer choice.

Price disclosure model based on the Pharmaceutical Benefits Scheme (PBS)

In the PBS price disclosure model, pharmaceutical companies must declare the actual prices they charge pharmacies and other purchasers to the Government along with sales revenue, sales volume, and value of incentives for each brand of medication they wish to be included on the PBS schedule. The purpose is to ensure that the PBS subsidy amount is brought in line with the market price with only a limited time delay.

While the PBS price disclosure model has been relatively successful in lowering the cost of medications to Government, the differences between the prostheses and pharmaceutical markets may prove challenging when applied to prostheses. Pharmaceuticals are a defined entity, specifically a molecule or active ingredient, while prostheses are variable in their physical composition and ancillary support services that contribute to the overall price.

Arrangements under the PBS are complex and cycles can take longer to complete resulting in new technologies that take longer to reach the market. CHA recommends for any framework that is adopted similar to the current PBS price disclosure arrangement, complete costs are taken into account in the benefit amount. (Complete costs may include technical support and geographical distribution).

Any price disclosure framework would also need to be designed in a way that minimizes the potential for variations in interpretation to occur. This risk is greatest where entities are able to set a price for the purposes of reporting to Government that do not reflect wider commercial arrangements between those entities. Potential variations can be addressed through transparency – however, the provision of private health services is by nature competitive and relies on parties being able to enter commercial arrangements in confidence.

Value-based reimbursement

Recent health reforms have explored options that move away from “volume-based care” models to “value-based care” models where a set payment is delivered to a provider for patient care. A value-based reimbursement (VBR) model would integrate the devices and additional associated costs into a bundled payment. This is an alternative to the fee-for-service model that is designed to control costs and improve patient outcomes. The price of the prostheses will be considered in the broader benefit that also accounts for ancillary components and the medical benefit associated with the device. In order to join a device and associated costs to the medical benefit, PLAC would be responsible for linking these devices to a DRG or MBS item number. If linked to the DRG, the full cost of the device and services will take into account the complexity of the patient’s condition while linking to an MBS item number will designate a benefit that is more reflective of the medical services. Providers would be encouraged to deliver quality services with a set bundled payment and manufacturers would be encouraged to compete to incorporate all necessary components into more cost effective arrangements. This model would also more closely align products to patients that will deliver improved clinical outcomes based on individual needs.

Using a VBR model that assigns the benefit to a DRG would be designed to improve the quality of servicing. However, this model runs the risk of putting undue pressure and financial burden on hospitals that run the risk of being penalized by the supplier's high costs. Additional expenses to the hospitals for managing and handling of the device might not be fully captured under a DRG assignment. Calculating a reimbursement rate for each DRG that accounts for the different subtypes of procedures would be challenging and may result in providers selecting the subtypes that differ in the type of device required. This would also mean that procedures requiring multiple prostheses would not be adequately represented by a single DRG.

Linking a VBR to a to the MBS item number would be the most likely to equate the cost of the device to the total cost of the procedure, as they provide a greater range to match the prostheses and MBS items are already included for each prostheses on the PL. Any device listed would be required to undergo some form of mandatory price disclosure or benchmarking which would then be incorporated in an MBS item number for each prostheses. Special consideration must be made to ensure this does not negatively impact consumer or provider choice in the selection of a device or impact the uptake of innovative technologies which may require additional incentives.

Tendering

The market for prostheses currently lacks transparency in the price of devices, of which public information is limited but has been shown to vary between states, hospitals, devices, and volume utilization. As a result, a price disclosure arrangement for prostheses would not necessarily take into account the additional costs that contribute to the net price of the device and further complicates the development of a pricing framework for prostheses.

Tendering has been a practice used by government agencies to deliver goods and services in the broader market and has been successfully applied for a range of health products and services. In order to encourage a competitive market for prostheses that ensures value for money while supporting the innovation of new technologies and quality products, device manufacturers could enter into a tendering arrangement with the Department of Health who would issue a list of devices for the most expensive items on the PL. In order to gain inclusion on the PL, manufacturers would submit an application of offer that details their lowest price and PLAC would select devices based on specified criteria and price. This would enhance competition between manufacturers to bring down the price level of comparable devices.

Whilst using a tendering process would improve price transparency and reduce the potential for hidden payments in the form of rebates (or volume discounting) it should also be noted that these discounts have helped hospital cost management in general and lower health price indexation increases which would otherwise increase at a greater rate than consumer price indexation.

While tendering in Australia has been a widely-accepted practice, tender specifications and design are crucial to the success of this process. Further consultation with the PLAC may be required before the Government enters into any tender agreements. Tendering can also be an expensive process for government and companies and, therefore, may serve as an interim solution to assist stakeholders in gathering more information while the development of a long-term price disclosure framework is being implemented.

Further concerns over tendering are directed at consumer choice, disruptions to the system and consumer access, and sustainability of the sector. Tenderers that are unable to meet the minimum benefit may become unviable. Gaps in the market may place unforeseen pressure on other suppliers of comparable devices who cannot readily meet the market demands. Larger suppliers who benefit from



economies of scale could loss-lead in order to obtain contracts or push out suppliers who are unable to compete with the minimum benefit in the short-term, disadvantaging smaller suppliers. This may have the unintended consequence of reducing the range of products available due to an emphasis on cost that may not take into consideration value-for-money whereby certain devices may be shown to have greater clinical efficacy than a lower cost competitor. The design of tender specifications will need to take into account any anti-competitive practices and ensure there is adequate choice of products on the PL based on their clinical relevance.

If this tendering process occurs every two years, it has the potential to be expensive and time intensive. To prevent new technologies from having to wait until the next tendering process, these devices may be listed at the prevailing list price until the next tender.

Conclusion

CHA favours Reference Pricing or Tendering as a future pricing framework in order to provide opportunities for greater transparency in prostheses pricing. If applied with due consideration for potential consequences, they have the opportunity to reform the current prostheses sector and provide savings for government, health funds, and consumers.

In order to achieve savings in prostheses that does not negatively impact on patient safety and quality, CHA emphasises the need for a rigorous clinical efficacy review of currently listed products that link outcomes to each device and ensure clinicians have access to their choice of clinically relevant devices; ensure the listed benefits are comprehensive and take into account the cost of all components and support; and legislate cost control to establish that any reduction in the price of a device is reflective of a true price reduction and not cost-shifting to an alternative revenue stream.

CHA recommends that any future frameworks that are adopted by the Government involve a rigorous evidence-base and further consultation with stakeholders. We look forward to participating in future discussions regarding the Prostheses Reform process.

