Dr Brendan Murphy
Secretary
C/- Prostheses Reform Branch
Australian Government Department of Health
Email: prosthesesreform@health.gov.au

Dear Dr. Murphy,

Thank you for the opportunity to provide feedback on the Department of Health Consultation Paper: Options for reforms and improvements to the Prostheses List.

Catholic Health Australia (CHA) is the peak body for Australia's largest non-government grouping of health, community, and aged care services accounting for around 15 per cent of hospital-based healthcare in Australia. Our members provide around 30 per cent of private hospital care, 5 per cent of public hospital care, 12 per cent of aged care facilities, and 20 per cent of home care and support for the elderly. CHA not-for-profit providers promote the ministry of health care as an integral element of the mission and work to fully provide health care to the sick, the aged and the dying. This ministry is founded on the dignity of the human person, giving preference to the needy, suffering and disadvantaged.

Private hospitals fulfil an essential role in the Australian health care system – in 2018-19, private hospitals provided more than 4.6 million hospital separations out of a total of 11.5 million across Australia – around 40 percent of total hospital separations. They provided nearly half of the day stay separations in Australian hospitals in 2018-19 (46 percent), more than 80 percent of inpatient rehabilitation separations as well as nearly 60 percent of mental health separations. Across the Australian health system, there is a heavy reliance on the private health care sector to care for millions of Australians and the effectiveness of the Australian public hospital system is heavily reliant on the effective operation of the Australian private hospital sector.

CHA supports careful and considered evidence-based reform to the way prostheses are funded and utilised in Australia, and we remain committed to working with the Government and other stakeholders on such reforms. A sound funding model for prostheses is critical to being able to provide high quality patient care, as it ensures that patients are fully covered for the products that they need, and secures patient and doctor choice. In turn, ensuring that patients can access device technology as they need underpins the value proposition for the private hospital sector, and indeed the private health insurance sector.

Our proposal is what we consider to be a fair and responsible reform pathway. It aligns to the following key principles:

- Reform must support evidence-based patient-centred clinical decision making
- Reform must minimise patient out-of-pocket payments
- Reform must improve transparency in benefit setting
- Reform must be responsiveness to change
- Reform must achieve fair value for all stakeholders
- Reform must ensure financial sustainability of the private sector

CHA Prostheses Reform Proposal

Our proposed reform comprises the following:

1. **Implementing market-based pricing for the Prostheses List**

    - Changing the Prostheses List (PL) benefit setting process to one based on market pricing would be best achieved through the use of public hospital sector pricing – either through reference pricing or price disclosure – for PL items available in the public system, and a combination of international reference pricing, tender pricing, and other such mechanisms for all other items.
    - This process should commence with items in the PL General Miscellaneous category and progress through all items on the PL, where commonality exists between the two sectors (public and private). This will produce an immediate reduction in prostheses costs and benefits paid, with the financial benefit to increase over time.
    - Once the list has been re-priced, the government should ensure that the market prices are up to date through regular reviews and updates.
    - A price adjustment, known as a 'product integrity fee', should be made to the public sector price (or applicable pricing methodology) to reflect reasonable differences in public and private sector prices, such as transport, product handling, loan kits, and storage. A starting point would be an additional 5 percent.
    - This methodology should also nullify rebates and other incentive mechanisms. However, for clarity, all rebates on prostheses should be banned as this reduces price transparency and distorts the market.

2. **Strengthening Governance over the Prostheses List**

    - The Governing Body overseeing the PL should have the authority to maintain an appropriate definition for prostheses, remove redundant and low-value items, introduce new technology as required (including a framework for custom-made devices, and retention of non-permanent and semi-permanent devices), and ensure that the pricing reflects market value.
    - The Governing Body should be a proactive manager of the PL, supported by compulsory use of clinical registries and other evidence-building processes. Critically, it must have powers to take action against false or misleading representations - akin to ACCC if required, or a pathway to refer.
    - The Pharmaceutical Benefits Advisory Committee (PBAC) could serve as an effective model for managing prostheses benefits as it has already shown to work extremely well in managing the listing and price of medicines.

3. Protecting Patient Benefits

- The PL is the appropriate mechanism for ensuring consistent access to essential medical devices in the private hospital sector – regardless of whether they conform to a narrow or broad definition of prostheses.
- Removal of any items from the PL (such as those flagged in the Department of Health's *Review of the General Miscellaneous Category of the Prostheses List)* must be accompanied by equivalent, distinct and ongoing compensation through another patient benefit mechanism.
- The Catholic hospital not-for-profit sector, and indeed the entire private hospital sector, is not in a position to absorb a loss in revenue that would otherwise derive from reduced patient prostheses benefits. The GM category alone accounts for $250 million in benefits to PHI members that are patients at private hospitals. This is a significant and material amount that cannot simply be absorbed by our Catholic not-for-profit hospitals that would exceed $80 million in benefit losses every year. The dismantling of the GM category funding with no feasible alternative, will necessitate a number of severe but unavoidable actions including rationalisation of services, closure of hospitals, and higher out-of-pocket costs for services. A funding source for these items will be required to provide certainty to the sector.
- We note the letter to the Minister for Health from six Catholic health group CEOs on 10 December 2020, which pointed out the misleading title of the General Miscellaneous (GM) category, the clinical importance and relationship of the items in the GM category, and the impact to both patients (through higher out of pocket costs) and the sector (particularly in service closures in rural and regional areas) should funding changes, such as removal of GM items, be made without an alternative funding mechanism.

4. Managing risks around utilisation

- While the Catholic hospital sector rejects any assertion of over-utilisation of PL products, we recognise the need for judicious use of products and suggest initiating a process of usage analysis (overlayed with a greater understanding of changing surgical techniques and interventions) and justification for products which are considered by the new governing body to appear to have an unexplained increase in use.

5. Managing the risk around 'cost shifting'

- Unlike the pharmaceuticals industry, the vast majority of high profile, international device manufacturers also manufacturer hospital consumable items, instrumentation, patient monitoring equipment and other technology – not purchased via a PL mechanism. Consideration needs to be given to 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. This raises the consideration for whether hospitals should be required to report associated annual increases in 'consumable spend' related to similar companies to avoid a concealed cost shifting phenomena. This becomes particularly critical, as unlike private health insurers who are required to provide consistent reporting to a regulator with prostheses spend being a transparent item, any cost shift to hospitals would not be transparent, with hospitals needing to rely upon negotiations with insurers to off-set any inflation in this segment. If this was to occur, and material price increases could not be off-set, viability and affordability would simply be shifted to a different setting.

- It must not be forgotten that the current pricing of prostheses devices guarantees a fixed price an insurer must pay for an item under legislation. There is no such protection for hospitals – list pricing may be reduced resulting in a decrease in the rebate paid by an insurer. Inability to negotiate with large manufacturers may see hospitals significantly impacted, with a resultant failure to actually reduce device pricing to 'best price' expectations.

Consideration of a Diagnostic-Related Group (DRG) Model

An alternative to CHA's proposed approach, which has been floated in the Department's consultation paper, is the implementation of a DRG-based payment mechanism. CHA notes that, at this time, the Departments' understanding of what that model might look like is either not fully formed or has not been clearly articulated to the sector. Having said that, while CHA recognises that an appropriately developed model might deliver some benefit, we do recognise the many risks and drawbacks that it would entail. These risks and drawbacks would be amplified should the model be implemented in the short-term due to the many logistical and data challenges that first need to be overcome. Indeed, the greatest risk is creating perverse incentives for patient care without necessarily delivering any additional financial benefits beyond the CHA proposal.

Should the Department wish to pursue a DRG-based payment mechanism, the longer lead time required for such a model does provide a window for the immediate implementation of the CHA proposal, including market-based pricing under the current PL structure. The two-phased approach will allow for the appropriate lead time to address the necessary system changes for a potential DRG-based model, such as more robust costing data, while creating the necessary improvements and financial savings to the system now.

In order to facilitate a DRG-based prostheses funding model, a significant number of protections and safeguards need to be developed, in parallel with improvements to data and costings across both the private and public systems. The lead time for some of these is around five years or more. The key system changes and safeguards required are identified below:

- **Improvements to data**
    - The data that feeds the IHPA DRG cost weights are not nearly accurate enough to be the foundation for a commercial payment system. Public sector

prostheses costing is often based on estimates and high-level apportionment of theatre costs – using these data as benchmarks for private sector benefits will create more problems that it would solve. In addition, IHPA 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. Implementing a market-based pricing structure in the PL now would establish a path towards a DRG 'average' in the private sector, and will mean the private sector data can provide a much better framework to attempt an appropriate DRG-based payment system for prostheses.

- **Improvements to IT and billing infrastructure**

    - Private hospital and PHI billing systems will not readily adapt to a change to DRG pricing for prostheses, so a long lead time is required for these IT adjustments to ensure billing can take place and cash flow is not disrupted.

- **Protections for rural, regional, small and specialty hospitals.**

    - Rural, regional, small and specialty hospitals are most vulnerable to a DRG model. Similar hospitals in the public system are given special dispensation with regard to DRG funding and similar accommodation needs to be developed in the private sector.
    - Such rules will take time to develop, as they will be necessarily complex, particularly to prevent unforeseen outcomes such as lower access to healthcare for people in regional and rural areas.

- **Ramp-up of procurement for private hospitals**

    - Prior to the current prostheses list mechanism being implemented, the sector saw rapid price escalation in devices. There is no reason to think the same will not happen again if the PL is abolished and private hospitals are once again required to directly procure from, and negotiate prices with, device companies.
    - A mechanism for group procurement (perhaps as an opt-in system), or a centralised procurement process through the DOH, will provide a more level playing field in negotiations.

- **Finding appropriate clinical categorisation, at a more granular level than DRGs**

    - DRGs work best over large hospital systems, where procedures which cost over or under the "average" payment can be absorbed. Critically, in these models, the DRG cost-weight is used to drive efficiency, not profit margin. There is a real risk that the DRG prostheses model, in its proposed form, will drive behaviour not aligned to a universal health system in Australia, and may see some hospitals necessarily focus only on profitable procedures or cherry picking "profitable" specialties and patient groups. This will also drive costs into the public system.

- To prevent this, the system needs high quality and transparent analysis across the full gamut of DRGs, overlayed with the range of prostheses costs applicable to each DRG, to find if/where the likely perverse behaviour will occur; followed by development of an appropriate level of clinical categorisation to minimise any such adverse behaviour.
- There is a great deal of variability in public pricing and no standard definition of a consumable across both public and private sectors, creating a fundamental barrier to comparing the cost of components on a DRG basis. When matching prices, there will need to be a comprehensive assessment in the differences of what components are considered consumable and what are considered prostheses in order to set a benchmark price.
- The vast majority of medical device manufacturers are international (approximately 98 percent) and this impacts on the global market for certain devices. When examining price adjustments for a DRG model, consideration must be given to the medical device inflation rate rather than the general inflation rate. This will better account for inflationary changes that occur in the global market as exchange rates have a significant potential to impact pricing.

- **Patient and Clinician Choice**

  - The DRG model simply shifts financial risk to hospitals, which have no control over clinician choice of devices. The choice of device has always been between the clinician and patient, and never been subject to control or negotiation by any hospital. This notion is integral to the value proposition of private health, where patients have access to a wider range of products and clinicians have autonomy to make the most appropriate clinical choices for the patient. To have any organisation intervene in clinician and patient choice, particularly on the premise of financial benefits, compromises quality care and is counter to the aims of this reform process.
  - Therefore, a mechanism needs to be developed which allows clinicians to provide prostheses which cost above the DRG price allocation. Otherwise, patients may be charged out of pocket costs or clinicians may need to be restricted in the prostheses they can use.

Conclusion

The need for reform to the funding of medical devices for patients has long been recognised. The funding mechanisms that were originally designed to bring stability to the medical devices market are no longer fit for purpose. In short, the current PL prices, broadly speaking, do not reflect value for money nor market value.

The CHA proposal – introducing market pricing across the entire PL, strengthening governance, maintaining current patient benefit structures including for items on the General Miscellaneous category, and a review mechanism for unexplained increases in volume – directly addresses the current flaws in the system, while maintaining patient / clinician choice and improving the long term financial sustainability of the private health system. CHA believes

that its proposal is more easily implementable because it does not over-extend or suggest more than is necessary.

A DRG-based funding model for prostheses will introduce an additional level of risk – particularly in driving perverse outcomes – and unnecessary upheaval, without a commensurate financial gain, or indeed any other recognised benefit. These issues will be greatly amplified if such a model is implemented without an appropriate lead time for the sector to ready and prepare. Data, systems, models and processes – across hospitals, health funds and device companies - will all need attention and additional resources; with very little, if any, upside to be gained beyond the CHA proposal.

CHA cautions against settling on a pre-pared blueprint without understanding the full implications to the sector. In providing our proposal on prostheses reform, CHA strongly recommends a further round of multilateral discussions and negotiations with key stakeholders to ensure that the critical issues and nuances pertaining to each stakeholder's views, and the various reforms being proposed, are not lost in these written submissions. Regardless of the model chosen by Government, the Catholic sector will continue to work with the Department and the Government to ensure that it delivers the necessary benefits for patient care and the broader health system.

If you would like any further information on CHA's response, please contact Mr James Kemp, Director Health Policy at jamesk@cha.org.au.

Yours sincerely

Pat Garcia
Chief Executive Officer

15 February 2021