

Chapter 2

The Prostheses List in Practice

Introduction

2.1 The Prostheses List Framework has been subject to a number of reviews since its introduction in 1985. Successive reviews have consistently raised similar issues suggesting that there are a number of challenges to reform. However, while the inquiry has shown that there is general support for reform, there is little agreement on the areas which require reform and how this should be achieved.

2.2 The absence of agreement may be a symptom of both a segregated system where stakeholders have limited interaction with each other and a system which lacks transparency.

2.3 This chapter provides an outline of previous attempts at reform in this area, the roles and relationships of each stakeholder and the impact of the Prostheses List (PL) on stakeholders, private health insurance premiums and consumers.

History of reform

Introduction of the Prostheses List

2.4 The PL was introduced in 1985 with a view to reduce hospital waiting list for procedures involving surgically implanted prostheses. The government passed legislation to require private health insurers to pay a benefit equal to the amount determined by the Minister, or the price of the prosthesis if it was less than the amount determined by the Minister.¹

Deregulation

2.5 In 1999 PL benefit amounts were deregulated in response to concerns raised by the private health insurance industry about the rate of increase of benefits.²

2.6 However, under the period of deregulation, private health insurers negotiated the benefit amount directly with device manufacturers on the condition that there would be no gap payment for patients. This condition undermined the private health insurers' ability to negotiate benefit amounts and prostheses benefits almost doubled between 2000-01 and 2002-3.³

Reregulation

2.7 The Government announced new arrangements in April 2003 in response to concerns about the rapid increase in prostheses benefits during deregulation.⁴ The new

1 Department of Health, *Submission 38*, p. 8.

2 Department of Health, *Submission 38*, p. 8.

3 Department of Health, *Submission 38*, p. 9.

4 Department of Health, *Submission 38*, p. 9.

arrangements were developed in consultation with private health insurers, private hospitals, clinicians, sponsors of prostheses devices and consumers.⁵

2.8 The new arrangements came in to effect on 31 October 2005 and ensured that independent clinical advice was integral to determining the clinical effectiveness of a device. The department advised the process for determining the benefit levels:

Prostheses for use in hip and knee replacement surgery, intraocular lenses and cardiac defibrillators, pacemakers and stents were clinically assessed and their benefit amounts negotiated with their respective sponsors.

Benefits for the remaining prostheses were determined by applying the weighted average benefit calculated using benefit levels and utilisation data on individual prostheses from each insurer that had an agreement in place with the sponsor as at 31 October 2004.⁶

2.9 Under the new arrangements, benefit levels for new prostheses were negotiated by the Prostheses and Devices Negotiating Group, acting on behalf of the Prostheses and Devices Committee (precursor to the Prostheses List Advisory Committee (PLAC)), who undertook commercial-in-confidence negotiations directly with medical device sponsors.⁷

Doyle Review

2.10 In accordance with section 12 of the *National Health Amendment (Prostheses) Act 2005*, The Honourable Robert Doyle undertook an independent review of the prostheses arrangements in October 2007 entitled the *Review of the Prostheses Listing Arrangements* (Doyle Review).⁸

2.11 The Doyle Review made 15 recommendations for structural, operational and administrative changes. However, few of these recommendations were adopted and most were deferred until completion of the *Review of Health Technology Assessment in Australia* (HTA Review).⁹

Review of Health Technology Assessment

2.12 The HTA Review was released two years later in 2009 and highlighted that the process to establish consistent groupings of prostheses with similar clinical effectiveness had been slow.¹⁰

2.13 The HTA review recommended that the process to establish consistent groupings be completed by a dedicated resource within the Department of Health (department) and that negotiations of benefits for individual prostheses should cease

5 Department of Health, *Submission 38*, p. 9.

6 Department of Health, *Submission 38*, p. 9.

7 Department of Health, *Submission 38*, p. 9.

8 Department of Health, *Submission 38*, pp. 9-10.

9 Department of Health, *Submission 38*, p. 10.

10 Department of Health, *Submission 38*, p. 10.

and that a single benefit level should be established for all prostheses in each particular group.¹¹

2.14 This led to a decision that in order to expedite the grouping process, a 25 per cent utilisation benchmark would be used to determine the minimum benefit amount for prostheses in each group.¹² The committee heard that this process entrenched benefit levels which had been negotiated in the preceding years when prices were high and negotiations lacked transparency.¹³

2.15 Submitters raised concerns during the inquiry that the 25 per cent utilisation rule was anti-competitive and did not provide an incentive for device sponsors to lower their prices.¹⁴ The department explained that the PLAC has moved away from that rule and is looking to at better ways to arrive at pricing, but clarified that prostheses are still added to groups on the PL which were subject to the 25 per cent utilisation rule.¹⁵

Industry Working Group on Private Health Insurance Prostheses Reform

2.16 The Industry Working Group on Private Health Insurance Prostheses Reform (IWG) is the most recent body to consider reform of the PL. The IWG operated between January and March 2016 and was established to examine opportunities for reform of the arrangements governing prostheses and pricing in the private health insurance sector.¹⁶

2.17 The IWG's report was the impetus for the Government's decision in October 2016 to reduce the minimum benefit amount for cardiac devices and intraocular lenses by 10 per cent, and reduce hip and knee replacement joints by 7.5 per cent. These reforms came into effect on 20 February 2017.¹⁷

2.18 At the same time the Government also announced the reconstituted PLAC, investigating a more robust and transparent price disclosure model and considering a transparent way to reimburse hospitals for the costs of maintaining inventory of medical devices.¹⁸ The IWG's final report and its recommendations will be discussed further in Chapter 3.

11 Department of Health, *Submission 38*, p. 10.

12 Department of Health, *Submission 38*, p. 10.

13 hirmaa, *Submission 12*, pp. 2-3, 5.

14 See, for example: Applied Medical, *Submission 41*; Private Healthcare Australia, *Submission 7*.

15 Mr Andrew Stuart, Deputy Secretary, Department of Health, *Committee Hansard*, 16 March 2017, p. 62.

16 Department of Health, *Submission 38*, Attachment A.

17 The Hon Sussan Ley MP, former Minister for Health and Aged Care, ["Turnbull Government to ease pressure on private health insurance premiums"](#), *Media release*, 19 October 2016.

18 The Hon Sussan Ley MP, former Minister for Health and Aged Care, ["Turnbull Government to ease pressure on private health insurance premiums"](#), *Media release*, 19 October 2016.

Effect of the Prostheses List Framework

2.19 The PL has been described as being left on 'set and forget mode' with almost half of all items on the list priced at the same benefit level in 2016 as they were in 2011.¹⁹

2.20 In any other market this would indicate that prices have not risen with inflation and were therefore below what they should be. In fact prostheses prices have not risen in real terms in the past seven years.²⁰ However, some submitters argued that prices were initially set artificially high and this cost is being passed on to consumers.²¹

2.21 An area of key concern is that '[t]he high price of prostheses impacts on health insurance premiums, and therefore contributes to concerns about the affordability of private health insurance.'²²

Private health insurance premiums

2.22 Private Healthcare Australia (PHA) submitted that price sensitivity modelling indicates that private health insurance premiums will become unaffordable for at least one-fifth of current customers in five to six years.²³

2.23 Already private health insurers are reporting that their members are decreasing their level of cover in an effort to reduce the premium paid.²⁴ New private health insurance customers are also choosing to take out less comprehensive policies with a higher excess amount in order to pay a lower premium. For example, HBF noted that '[i]n 2010, 32% of people taking out hospital cover with HBF chose "top hospital" or the equivalent but by 2016 this had fallen to just 13%.'²⁵ In 2013-14, 69 per cent of HBF hospital cover policies had zero excess but this declined to 54 per cent in 2015-16.

2.24 The committee heard that in the quarter ending September 2016, 14 per cent of private health insurers' hospital cover reimbursements were for prostheses. Medical benefits consisted of 16 per cent, whereas private hospital costs such as accommodation, theatre fees and nursing care accounted for 70 per cent of total reimbursements paid.²⁶ The Medical Technology Association of Australia (MTAA) therefore considered that a review of private hospital costs was more likely to result in

19 Private Healthcare Australia, *Submission 7*, [p. 8].

20 Mr Gavin Fox-Smith, Managing Director, Johnson & Johnson Medical Devices ANZ, *Committee Hansard*, 15 March 2017, p. 10.

21 See, for example: Private Healthcare Australia, *Submission 7*; [pp. 6-7]; Bupa, *Submission 31*, pp. 6-7; Applied Medical, *Submission 41*, Attachment 1, pp. 4-5.

22 Bupa, *Submission 31*, p. 6.

23 Private Healthcare Australia, *Submission 7*, p. [3].

24 HBF, *Submission 27*, [p. 3]; See also, Australian Medical Association, *Submission 40*, p. 1.

25 HBF, *Submission 27*, [p. 3].

26 MTAA, *Submission 2*, p. 12.

substantial savings, rather than reforming or decreasing the minimum benefit amounts of the PL.²⁷

2.25 Device manufacturers also noted that private health insurance premiums have increased by 40 per cent in the past seven years in contrast to PL benefits which have not increased in real terms over the same period.²⁸ Mr Fox-Smith of Johnson & Johnson Medical Devices ANZ pointed to an increase in utilisation of private health care in Australia as contributing to an increase in costs for private health insurers rather than the price of prostheses.

2.26 This view was supported by information provided by HBF. In their submission, HBF stated that in 2014 an average of 3.3 prostheses were used per procedure and that this number has increased to 3.6 prostheses per procedure in 2016. HBF attributed the increase in utilisation to changing technique, industry behaviour and the addition of new devices to the PL.²⁹

2.27 Medibank Private also noted that since 2011 the number of hospital admissions per customer has increased by 19 per cent and the average amount paid by Medibank Private per admission has increased 10 per cent.³⁰

2.28 It is estimated that the PL reforms announced in October 2016 will reduce costs for private health insurers by \$86 million in the first year.³¹ Medibank Private advised that this would result in a reduction of between \$22 million and \$24 million for their company and a 0.35 per cent reduction in fees for their customers.³² Both Medibank Private and Bupa, Australia's largest private health insurers, have provided assurances that any savings will be directly passed on to customers through lower premiums.³³

2.29 While hospital admissions and utilisation of prostheses has increased in recent years, the evidence heard by the committee does suggest there is a direct relationship between PL minimum benefit amounts and private health insurance premiums.

27 MTAA, *Submission 2*, p. 3.

28 Mr Gavin Fox-Smith, Managing Director, Johnson & Johnson Medical Devices ANZ, *Committee Hansard*, 15 March 2017, p. 10.

29 HBF, *Submission 27*, [p. 4].

30 Medibank Private, *Submission 14*, p. 3.

31 The Hon Sussan Ley MP, former Minister for Health and Aged Care, ['Turnbull Government to ease pressure on private health insurance premiums'](#), *Media release*, 19 October 2016.

32 Mr Craig Drummond, Chief Executive Officer, Medibank Private, *Committee Hansard*, 31 March 2017, p. 2.

33 Medibank Private, *Submission 14*, p. 4; Bupa, *Submission 31*, p. 3.

Price differences

2.30 A number of submitters described the price of prostheses in the private hospital system as 'inflated' or 'high', particularly in comparison to the prices paid by public hospitals for the same device.³⁴

2.31 This view is supported by a 2009 Productivity Commission report on the performance of public and private hospital systems which suggested that 'the cost of prostheses in public hospitals is considerably lower than in private hospitals.'³⁵

2.32 The Independent Hospital Pricing Authority (IHPA), an independent agency established under the *National Health Reform Act 2011* to contribute to reforms to Australian public hospitals, provided data to the committee on the number of episodes and cost of prostheses for intraocular lenses, cardiac, hip, knee and spinal prostheses. The tables below provide data for public hospitals in 2014-15 and for private hospitals in 2013-14. The IHPA urges caution in comparing the data given it was collected for different years, and was collected using different standards and different collection methods.

Table 2.1: Number of episodes and cost of prostheses provided to public hospital patients in 2014-15

Description	Episodes	Average Prosthesis Cost
Lens Procedures	59,087	\$282
Implantation and Replacement of Implantable Cardioverter-Defibrillator, Total System	2,465	\$18,923
Implantation and Replacement of Pacemaker, Total System	5,988	\$4,776
Insertion and Replacement of Pacemaker Generator	1,433	\$4,324
Hip Replacement	14,374	\$6,299
Knee Replacement	13,442	\$6,788
Other Hip and Femur Procedures	11,623	\$1,604
Spinal Fusion	2,502	\$10,963

Source: Independent Hospital Pricing Authority, *Submission 37*, [p. 2.]

34 Private Healthcare Australia, *Submission 7*; [pp. 6-7]; Bupa, *Submission 31*, pp. 6-7; Applied Medical, *Submission 41*, Attachment 3, p. 3; Department of Health, *Submission 38*, Attachment E, Industry Working Group on Private Health Insurance Prostheses Reform - Final report, p. 7.

35 Productivity Commission, *Performance of Public and Private Hospital Systems Research Report*, 10 December 2009, <http://www.pc.gov.au/inquiries/completed/hospitals/report> (accessed 1 May 2017).

Table 2.2: Number of episodes and cost of prostheses in private hospitals 2013-14

Description (Adjacent DRG)	Episodes	Average Prosthesis Cost (\$)
Lens Procedures	26,042	556
Implantation or Replacement of AICD, Total System	1,709	46,877
Implantation or Replacement of Pacemaker, Total System	4,645	12,014
Insertion or Replacement of Pacemaker Generator	1,402	10,797
Hip Replacement	12,982	9,626
Knee Replacement	17,766	7,496
Other Hip and Femur Procedures	2,864	2,210
Spinal Fusion	6,797	12,554

Source: Independent Hospital Pricing Authority, answers to questions on notice, 15 March 2017, (received 3 April 2017).

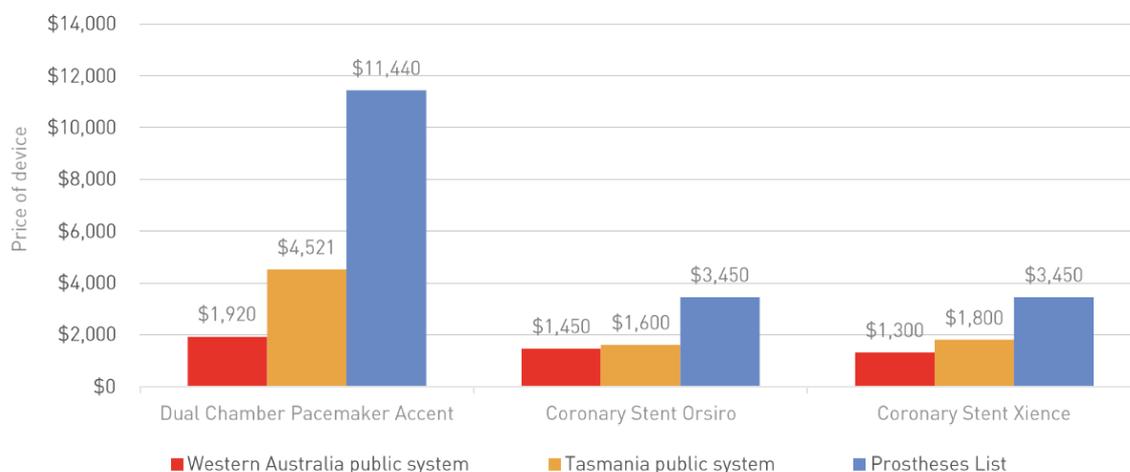
2.33 In its submission, Bupa cited the following examples which demonstrated the price difference between private and public hospitals:

- a standard branded ceramic hip is purchased by the Prince of Wales Public Hospital in Sydney for \$4,900 while a private patient in the hospital next door pays \$11,000;
- an uncemented Zimmer Trilogy cup cost Western Australia Health \$1939, which is just under \$1000 less than the listed benefit on the Australian Prostheses List of \$2,900;
- an implantable cardiac defibrillator cost Western Australia Health \$19,000 while the current listed benefit on the Prostheses List is \$52,000 - \$33,000 more expensive.³⁶

2.34 Medibank Private also provided examples of prostheses which it had funded at the PL minimum benefit amount and the price paid for the same device in the Western Australian and Tasmanian public health systems. Figure 2.1 below demonstrates the price difference paid.

36 Bupa, *Submission 31*, pp. 6-7 (footnotes omitted).

Figure 2.1: Examples of differences in pricing between the Prostheses List Minimum Benefit amount and public sector pricing



Source: Medibank Private, *Submission 14*, p. 5.

2.35 Medibank Private submitted that in the 2015 calendar year it had funded the Dual Chamber Pacemaker Accent 328 times and paid up to \$3.12 million more for the same device compared to a Western Australian public hospital.

2.36 Price information released by WA Health for cardiac, ophthalmic and orthopaedic prostheses showed that on average, public hospitals in Western Australia pay approximately 45% less than the price set by the PL.³⁷ This is consistent with the Doyle Review which found that 'some sponsors were willing to provide prostheses to public hospitals at 30 to 40 per cent less than the PL minimum benefit.'³⁸

2.37 Similarly, submitters noted that Australian private patients pay significantly more for the same device compared to international markets. For example:

- A Consulta CRT-P model C3TR01 triple-chamber pacemaker costs €4000 in France (approximately \$5 840 AUD) compared to \$13 520 on the PL.³⁹
- A St Jude Medical pacemaker costs £16 448 (approximately \$27 000 AUD) in the United Kingdom compared to \$52 000 on the PL.⁴⁰

37 HBF, *Submission 27*, [p. 2].

38 Department of Health and Ageing, *Review of Health Technology Assessment in Australia*, December 2009, p. 94
[https://www.health.gov.au/internet/main/publishing.nsf/Content/AF68234CE9EB8A78CA257BF00018CBEB/\\$File/hta-review-report.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/AF68234CE9EB8A78CA257BF00018CBEB/$File/hta-review-report.pdf) (accessed 3 May 2017).

39 Private Healthcare Australia, *Costing an arm and a leg*, October 2015, p. 6,
<http://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Report-Costing-an-arm-and-a-leg-Oct-2015.pdf> (accessed 1 May 2017).

40 Bupa, *Submission 31*, p. 8.

2.38 Private health insurance companies submitted that these price differences are contributing to the rising cost of private health insurance premiums.⁴¹ However, the MTAA who represents prostheses manufacturers disagrees with this view and noted that since December 2009 medical device inflation has increased by only 2.3 per cent, compared to medical and hospital services which have increased by 55.1 per cent in the same period.⁴²

Committee view

2.39 The committee recognises that in many instances the minimum benefit amount of a prosthesis listed on the PL and paid by private health insurers is significantly greater than the price paid by public hospitals for the same device and internationally.

2.40 The committee notes that the cost of prostheses is one aspect which influences the cost of private health insurance premiums, however, utilisations rates are also a factor. The committee is concerned that the rising cost of private health insurance premiums may make health insurance unaffordable in the future and therefore place greater pressure on the public health system.

2.41 The committee notes there is a wide range of views on the reasons for the price difference between public and private patients and overseas markets and that there is little consensus between stakeholders as to how this may be addressed. This will be explored further in Chapter 4.

Relationships between stakeholders

2.42 The framework within which benefits for prostheses paid for through private health insurance are set is complex, opaque and involves multiple stakeholders. Privately insured patients in public or private hospital settings are provided with prostheses that are:

- chosen by their surgeon or other relevant specialist;
- purchased by the hospital in which they are being treated; and
- paid for by a private health insurer at benefit levels recommended by a committee appointed by the Minister for Health.

2.43 The majority of benefit levels were set some years ago in an opaque process when prostheses prices had inflated substantially over a short period of time and seem, at least in some cases, to have been set at levels far in excess of what is paid in the public sector domestically or in comparable countries internationally.

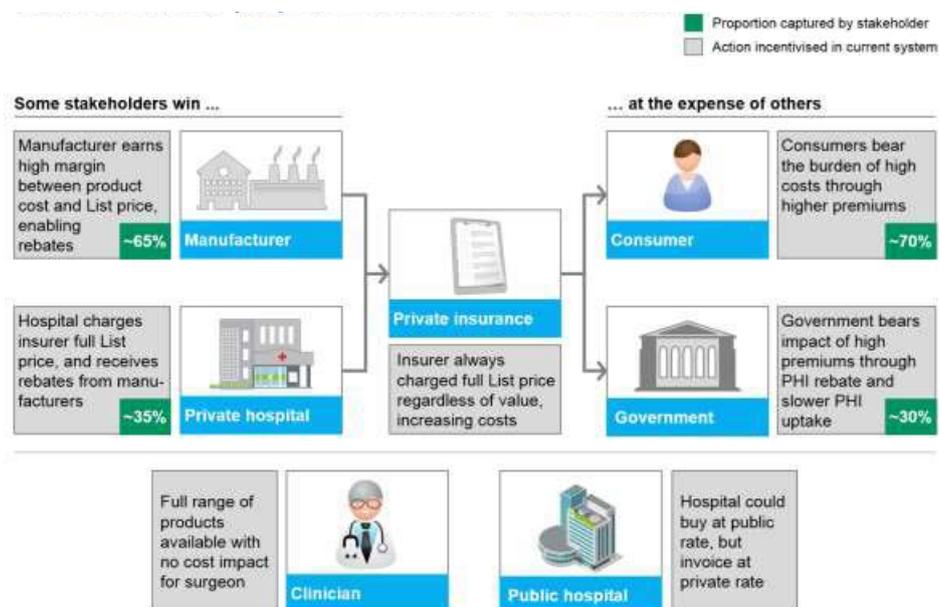
2.44 At the heart of this inquiry are the consumers, affected by rising private health insurance premiums, and taxpayers, who subsidise a significant proportion of private health insurance premium payments.

41 See, for example: Private Healthcare Australia, *Submission 7*; Medibank Private, *Submission 14*; BIB, *Submission 16*; HBF, *Submission 27*; HCF, *Submission 28*; Bupa, *Submission 31*.

42 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia, *Committee Hansard*, 15 March 2017, p. 1.

2.45 The committee heard that the relationships between stakeholders with a vested interest in the PL are not transparent and siloed which means each stakeholder has a limited understanding of the practices of other stakeholders and their relationships with each other. Figure 2.2 below outlines the interaction of stakeholders in the operation of the PL.

Figure 2.2: Prostheses value chain



Source: Private Healthcare Australia, *Submission 7*, [p. 15].

Private hospitals and doctors

2.46 The MTAA submitted that the PL enables patients in private hospitals to access a greater range of prostheses and more complex technologies than public patients as a patient's surgeon is able to choose the prostheses which best meets their patient's circumstances.⁴³

2.47 A surgeon simply advises the hospital of the prostheses required and the private hospital will acquire the prosthesis requested.⁴⁴ While some submitters raised concerns that this freedom of choice may lead to perceived conflicts of interest, the Australian Orthopaedic Association (AOA) told the committee that they recommend any surgeon 'involved in the manufacture, promotion or study of a device or is on a recommendation board'⁴⁵ disclose this information to their patient if they are using that prosthesis.

43 Medical Technology Association Australia (MTAA), *Submission 2*, p. 7.

44 Mr Michael Roff, Chief Executive Officer, Australian Private Hospital Association, *Committee Hansard*, 16 March 2017, p. 35.

45 Dr Peter Lewis, Deputy Director, Australian Orthopaedic Association, *Committee Hansard*, 16 March 2017, p. 53.

2.48 The AOA Code of Conduct also states that members 'must declare any conflicts of interest, in particular, financial relationships with prosthetic companies or hospitals and other corporate entities or persons.'⁴⁶ However, as there is limited development of prostheses in Australia it is unlikely for a need for disclosure to arise.⁴⁷

2.49 It is also important to note that surgeons do not work for the hospital in the same sense that doctors in the public sector work for a public hospital.

Manufacturers and private hospitals

2.50 The committee repeatedly heard that information around the price of prostheses paid by private hospitals to manufacturers was not available due to the commercial-in-confidence nature of the contracts between private hospitals and manufacturers regarding the purchasing of prostheses and other medical devices.⁴⁸

2.51 A representative of Catholic Health Australia told the committee that '[t]he commercial arrangements between vendors and hospitals are complex, opaque and vary in their structure.'⁴⁹

2.52 A further issue is the value of rebates which private hospitals receive for purchasing a number of medical devices from one manufacturer. An orthopaedic surgeon told the committee that at the hospital they performed procedures in, these rebates were referred to as Stryker dollars, Zimmer dollars and J&J dollars, and that these could be used to purchase other consumable products from the manufacturers.⁵⁰

2.53 The Australian Private Hospital Association explained how the rebates operate:

Those who are a bit larger and in a stronger negotiating position have arrangements, I am advised, that are typically on two bases. There is a volume basis. So, if you hit a particular target for a whole-of-business spend, for example, you spend X million dollars or X hundred million dollars a year—and that is not necessarily just on prostheses but also on

46 Australian Orthopaedic Association Code of Conduct for Members 2010, p. 8, https://www.aoa.org.au/docs/default-source/ecm-files/codeofconduct2010_240910_pdf.pdf?sfvrsn=2 (accessed 1 May 2017).

47 Dr Peter Lewis, Deputy Director, Australian Orthopaedic Association, *Committee Hansard*, 16 March 2017, p. 52.

48 Biotronik Australia Pty Ltd, *Submission 22.1*, [p. 2]; Australian Medical Association, *Submission 40*, p. 3; Mr Maurice Ben-Mayor, Managing Director, Stryker Australia, *Committee Hansard*, 15 March 2017, pp. 16-17; Dr Simon Woods, Executive Director, Malvern, Cabrini, *Committee Hansard*, 16 March 2017, p. 30; Mr Andrew Stuart, Deputy Secretary, Department of Health, *Committee Hansard*, 16 March 2017, p. 70; Mr Michael Craig Sammells, Chief Financial Officer, Healthscope Ltd, *Committee Hansard*, 31 March 2017, p. 7.

49 Dr Simon Woods, Executive Director, Malvern, Cabrini, *Committee Hansard*, 16 March 2017, p. 30.

50 Name withheld, *Submission 34*, [p. 3].

consumables, theatre equipment or whatever that particular company supplies—then a rebate regime will kick in.⁵¹

2.54 This practice nets Ramsay Health Care, Australia's largest private hospital company, rebates of between five and seven per cent of the \$700 million Ramsay spent on 650 000 individual prostheses last financial year, equating to between \$35 million and \$40 million.⁵²

2.55 PHA described the practice as 'price shielding' and suggested that the practice provides an incentive to choose devices on the PL with a higher minimum benefit amount to maximise the level of rebate paid, as private health insurers are required to pay the minimum benefit amount, regardless of the amount paid by the hospital for the device.⁵³

2.56 Some submitters argued that one third of the price difference between prostheses in public and private hospitals goes to the private hospital and the remaining two thirds to the manufacturers of prostheses.⁵⁴ However the opaque and confidential nature of the contracts which contain these rebates means it is difficult to quantify this amount.

Private hospitals and private health insurers

2.57 Private health insurers are required to pay the minimum benefit amount listed on the PL for a prosthesis received by one of their customers.

2.58 Dr Andrew Wilson of Medibank Private described private health insurers as merely bill payers who have no visibility of the relationship between private hospitals and manufacturers.⁵⁵

2.59 As outlined above, there is no transparency regarding the price actually paid by the private hospitals for a particular prosthesis compared to the amount paid by the private health insurer, as required by the PL.

2.60 Last financial year Medibank Private (including AHM) spent \$540 million on prostheses devices as part of the total \$5.1 billion spent on healthcare.⁵⁶ Excluding AHM, Medibank alone spent \$485 million on prostheses in the 2015-16 financial

51 Mr Michael Roff, Chief Executive Officer, Australian Private Hospital Association, *Committee Hansard*, 16 March 2017, pp. 34-35.

52 Mr Christopher Rex, Chief Executive Officer, Ramsay Health Care, *Committee Hansard*, 31 March 2017, pp. 13-14.

53 Private Healthcare Australia, *Submission 7*, [p. 9].

54 Applied Medical, *Submission 41*, Attachment A, pp. 6-7; Applied Medical, *Submission 41.1*, p. 18; Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 16 March 2017, p. 25.

55 Dr Andrew Wilson, Group Executive, Healthcare Strategy, Medibank Private, *Committee Hansard*, 31 March 2017, p. 4.

56 Medibank Private, *Submission 14*, p. 2.

year. This is in addition to \$904 million for hospital benefits and \$204 million on medical benefits associated with the cost of prostheses.⁵⁷

Private health insurers and consumers

2.61 An advantage of the PL for consumers is that it offers certainty for consumers that any prostheses which they receive from the PL will be covered in full by their private health insurer.⁵⁸ However, private health insurers then pass the cost of prostheses onto their customers through the price of health insurance premiums. PHA estimated that this adds \$150 per year to each private health insurance premium.⁵⁹

2.62 Consumers are required to place a significant amount of trust in the information provided to them by their surgeon. The committee heard that consumers are often unaware of the costs or rebates associated with the device chosen for them by their surgeon.⁶⁰

2.63 Applied Medical observed that consumers are the only advocates for lower prices in the current system. Only one of the twenty-one members of the PLAC represents consumers.⁶¹ Consumers are at a further disadvantage as they are under resourced and are not commercial entities so do not have the required knowledge or influence to negotiate within a complex system.⁶²

The role of government

2.64 The government is both the regulator of the PL as well as a purchaser/funder of medical devices in the public and private sectors. The government regulates private health insurance through a range of legislative instruments, including the *Private Health Insurance Act 2007* and, of particular interest to this inquiry, through the Private Health Insurance (Prostheses List) Rules.⁶³

2.65 The government is also a significant purchaser or funder of medical devices through its support for veterans, administered by the Department of Veterans' Affairs (DVA). In 2015-16 DVA provided access to a range of health services for approximately 200 000 veterans, war widows and dependants. Expenditure for

57 Mr Craig Drummond, Chief Executive Officer, Medibank Private, answers to questions on notice, 31 March 2017 (received 11 April 2017).

58 Ms Josephine Root, Policy Manager, Consumers Health Forum of Australia, *Committee Hansard*, 16 March 2017, p. 8.

59 Private Healthcare Australia, *Submission 7*, [p. 5].

60 Ms Josephine Root, Policy Manager, Consumers Health Forum of Australia, *Committee Hansard*, 16 March 2017, p. 8.

61 Department of Health, Prostheses List Advisory Committee, Committee Members, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-PLAC> (accessed 4 May 2017).

62 Mr Nicolas Taylor, Regulatory Consultant, Applied Medical, *Committee Hansard*, 16 March 2017, p. 6.

63 Department of Health, *Submission 38*, p. 3.

hospital services over this period was \$1.6 billion, with \$853 million in the private sector and \$743 million in the public sector.⁶⁴

2.66 DVA private hospital contracts use the PL as the basis for funding medical devices for veterans. The table below shows DVA's expenditure on medical devices in private hospitals over five years to 2015-16.⁶⁵

Table 2.3: DVA expenditure on medical devices in private hospitals

	2011-12	2012-13	2013-14	2014-15	2015-16
Expenditure	\$110 473 079	\$105 748 801	\$107 026 717	\$103 962 144	\$101 284 452
Items	116 580	111 352	110 274	103 276	101 769
Average cost	\$948	\$950	\$971	\$1007	\$995

Source: Department of Veterans' Affairs, *Submission 20*, p. 3.

2.67 DVA estimated that its public hospital expenditure for medical devices was \$9.6 million in 2015-16. DVA stated the difference in funding between the two sectors can be attributed to a number of things, including 'the expected economies of scale that can be realised by the public hospital system through purchasing arrangements.'⁶⁶

2.68 While the government regulates the PL, the Australian Medical Association (AMA) submitted that 'the current construct of the reimbursement system is currently swayed towards industry, ultimately at the expense of consumers and the Government.'⁶⁷

2.69 The department is similarly segregated from other stakeholders stating that 'there are financial transactions going on between private hospitals, prosthesis makers and private health insurers which are, at some level, opaque to the public and the department.'⁶⁸ This is a concern as the government is a key stakeholder, as the regulator of the PL, yet does not have full visibility of the system and how it operates in practice.

64 Department of Veterans' Affairs, *Submission 20*, p. 2.

65 Department of Veterans' Affairs, *Submission 20*, p. 3.

66 Department of Veterans' Affairs, *Submission 20*, p. 3.

67 Australian Medical Association, *Submission 40*, p. 3.

68 Mr Andrew Stuart, Deputy Secretary, Department of Health, *Committee Hansard*, 16 March 2017, pp. 69-70.

2.70 The complex nature of stakeholder relationships and the operation of the PL was reinforced by the department who noted that 'no-one has a complete understanding, and no-one has a complete dataset.'⁶⁹

Committee view

2.71 The committee notes that through the operation of the PL, the relationships between stakeholders are complex and not transparent and has resulted in some stakeholders having limited interaction with each other.

2.72 The committee believes that the complex relationships and competing interest of stakeholders has made past reform challenging. The committee is concerned that the lack of transparency has reinforced the operation of the existing PL Framework and contributed to the slow rate of reform.

2.73 The committee notes the role of the government as a significant funder/purchaser of medical devices on the PL and considers that government could achieve significantly cheaper prices if it purchased devices directly.

Issues identified by submitters

2.74 Submitters raised a number of issues during the inquiry which have been the identified by previous reviews of the PL and the subject of past attempts at reform. These issues are outlined below and will be further discussed in Chapter 4.

Lack of transparency

2.75 In addition to concerns around the transparency of relationships between stakeholders as discussed above, the committee heard that many aspects of the PL lack transparency including the benefit setting process.

2.76 Mr Glenn Cross of AusBiotech Ltd noted that the '[c]urrent benefit setting processes are opaque.'⁷⁰ This view has been consistently expressed throughout reform of the PL. For example, hirmaa submitted that in 2005 when the PL was reregulated, '[t]he underlying basis upon which benefit amounts were negotiated and determined is unknown.'⁷¹

2.77 Concerns were also raised by the AMA that the scope and methods which PLAC used to set prostheses benefits was unclear. The AMA pointed out that 'under "commercial in confidence" protection, the PLAC does not have access to all commercial and industry data to make an assessment on appropriate prostheses pricing.'⁷²

69 Mr Andrew Stuart, Deputy Secretary, Department of Health, *Committee Hansard*, 16 March 2017, p. 69.

70 Mr Glenn Cross, Chief Executive Officer, AusBiotech Ltd, *Committee Hansard*, 16 March 2017, p. 41.

71 hirmaa, *Submission 12*, p. 2.

72 Australian Medical Association, *Submission 40*, p. 3.

2.78 The department suggested that further reform was necessary to achieve transparency commenting that 'in order to get greater transparency, we need to change arrangements.'⁷³

Reducing duplication and redundancies

2.79 Submitters also identified areas of the PL Framework which should be reformed with a view to reducing duplication of processes between the PLAC and the TGA, for the PLAC to operate more efficiently and reduce the number of items included on the PL.

2.80 Ausbiotech observed that '[a] big opportunity for cost-saving is in reducing red tape and redundancy across the application and evaluation process of the prosthesis list.'⁷⁴ The MTAA shared this view and suggested that devices already approved by the TGA could be added to an existing group on the PL without review by the PLAC in order to improve the efficiency of the Health Technology Assessment process.⁷⁵

2.81 However, the benefits of the clinical advisory groups in providing advice on safety and effectiveness were affirmed through, for example, detection of safety concerns in relation to the 'VAIOS' prosthesis.⁷⁶

2.82 Bupa identified that reviewing the number of items on the PL and removing those which are not clinically effective or are rarely used would enhance the operation of the PLAC. Since 2008, 2,746 items from the current PL have never been used, accounting for 26 per cent of items on the list.⁷⁷

2.83 Minimising duplication and improving the listing process forms part of the PLAC's work program following the final report of the IWG.⁷⁸ The PLAC's work plan also includes undertaking a number of targeted category and benefit reviews such as low cost high volume items which could be rationalised.⁷⁹

International price benchmarking

2.84 As discussed earlier in this chapter, private health insurers identified a significant difference between the price paid by Australian consumers compared to

73 Mr Andrew Stuart, Deputy Secretary, Department of Health, *Committee Hansard*, 16 March 2017, p. 70.

74 Mr Glenn Cross, Chief Executive Officer, AusBiotech Ltd, *Committee Hansard*, 16 March 2017, p. 41.

75 MTAA, *Submission 2*, p. 5.

76 For information in relation to the VAIOS case, see: *Orthotech Pty Ltd v Minister for Health* [2013] FCA 230, <http://www.judgments.fedcourt.gov.au/judgments/Judgments/fca/single/2013/2013fca0230> (accessed 11 May 2017).

77 Bupa, *Submission 31*, p. 10.

78 Department of Health, *Submission 38*, Attachment F.

79 Department of Health, answers to written questions on notice (received 26 April 2017).

international markets. A number of submitters suggested that reform to the PL should include international price benchmarking.⁸⁰ However, a number of device manufacturers cautioned against this approach:

...we find that comparing prices in Australia's private and public healthcare systems or benchmarking to international healthcare systems is an incredibly simplistic notion—one which demonstrates no understanding of the reality or the complexity of the environment or why it is unworkable to directly compare without taking into consideration other factors.⁸¹

2.85 Medtronic agreed that an effective international price benchmarking system would be difficult to establish stating that:

An international referencing system would be extremely complex and fail to consider the varying factors impacting supply and purchase of medical devices in the Australian healthcare system:

- It does not take into account differences in healthcare market structures, local costs of doing business, market size, economies of scale, service provision and delivery models, currency volatility;
- Many types of products – not just medical devices – exhibit a range of price variation for a range of reasons both within and between countries for the same product; and,
- To our knowledge, no other Government price disclosure process, including for the PBS, uses international referencing.⁸²

Potential savings

2.86 PHA reported that a 45 per cent decrease in the private prostheses expenditure would amount to approximately \$800 million in savings.⁸³ However, this figure is disputed by a number of stakeholders on the grounds that it was based on flawed methodology and data.⁸⁴

2.87 For example, the MTAA argued that the calculation was made on a very small sample of only 41 of the approximately 10 400 devices of the PL. These devices were also from a narrow range of categories on the PL and were devices that were more likely to included additional services and ancillary support.⁸⁵

80 Private Healthcare Australia, *Submission 7*, p. 10; Bupa, *Submission 31*, p. 3.

81 Mr Glenn Cross, Chief Executive Officer, AusBiotech Ltd, *Committee Hansard*, 16 March 2017, p. 41.

82 Medtronic, *Submission 36*, p. 15.

83 Private Healthcare Australia, *Costing an arm and a leg*, October 2015, p. 6, <http://www.privatehealthcareaustralia.org.au/wp-content/uploads/PHA-Report-Costing-an-arm-and-a-leg-Oct-2015.pdf> (accessed 1 May 2017).

84 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia, *Committee Hansard*, 15 March 2017, p. 2.

85 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia, *Committee Hansard*, 15 March 2017, p. 2.

2.88 The department was also unable to verify the accuracy of the \$800 million savings figure.⁸⁶

Committee view

2.89 The committee acknowledges the concerns of stakeholders regarding the veracity of the \$800 million in potential savings from reforming the PL. However, the committee believes that there is significant scope for reform and savings in this area.

2.90 The committee notes that stakeholders identified a number areas in the PL Framework which would benefit from reform. The committee considers the lack of transparency in the PL framework to be a barrier to further reform and consideration of alternative models such as price benchmarking and reducing redundancies.

86 Mr Martin Bowles PSM, Secretary, and Mr Andrew Stuart, Deputy Secretary, Health Benefits Group, Department of Health, *Committee Hansard*, 19 October 2016, pp. 97-98; Mr Andrew Stuart, Deputy Secretary, Health Benefits Group, Department of Health, *Committee Hansard*, 16 March 2017, p. 69.