Medical Technology Association of Australia

6 November 2009

Commissioner David Kalisch
Hospitals Performance Study
Productivity Commission
LB2 Collins Street East
MELBOURNE VIC 8003

Dear Mr Kalisch

PUBLIC AND PRIVATE HOSPITALS - DISCUSSION DRAFT OCTOBER 2009

On behalf of the members of the Medical Technology Association of Australia (MTAA) I am responding to the invitation to comment on *Public and Private Hospitals*, Discussion Draft, released by the Productivity Commission in October 2009. I specifically wish to comment on the data in the Discussion Draft that attribute a substantial difference between the cost of prostheses in the public and the private hospital systems, notwithstanding the comparable overall equivalence of costs between the systems.

MTAA shares the concern of Catholic Health Australia'(CHA) on data deficiencies and concurs with CHA's suggestion[1] that prostheses cost comparisons "should be excluded from this particular study". We also endorse the need for the NHCDC to address problems with the reporting of prostheses costs[2]. For these reasons, and for the reasons outlined below, we question the inclusion and reliance on data indicating differential cost as justification for any significant recommendations involving prostheses.

MTAA offers the following additional observations regarding the costing differentials of prostheses between public and private hospitals:

- Although there are established criteria for the reimbursement of prostheses by private health insurance funds, it is unclear whether there is equivalent clarity in public sector reporting. When informed bodies such as the Prostheses and Devices Committee struggle with consistent application of criteria, it is possible that reporting across the diverse public sector is beset by even more challenges.

[1] Productivity Commission 2009, *Public and Private Hospitals*, Discussion Draft, Canberra, page 95
[2] Page 106

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With respect to the public sector, we suspect that the lack of a similar imperative combined with variable purchasing and accounting regimes in some jurisdictions detracts from the reliability of aggregated data.

- It is generally the practice in the public sector to purchase prostheses under competitive tendering arrangements by which the supplier exchanges competitive pricing for commitment to volume purchasing. Suppliers are able to achieve economies of scale which do not translate to the private sector.

- Specialist clinicians in the private hospital sector are afforded a greater choice in product selection to ensure the most appropriate product is used on a patient. Health technology assessment will ensure that product selection is based also on clinical and cost effectiveness considerations. Patient choice of doctor and access to the latest advances in medical technology is one of the primary motivations for taxpayers to also pay for private health insurance.

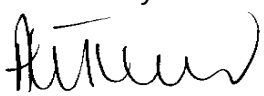
- The AR-DRG classification system presents particular difficulties. The costing used in the Discussion Draft assumes that this classification methodology can be applied equally to both the public and private hospital systems and therefore the cost of treating patients in each environment can be directly compared[3].

  Despite the objective to group patients with similar resource demands within a single AR-DRG, there can be significant divergence in terms of average length of stay, theatre time and prostheses costs (see example attached). In addition, extensive delays associated with the introduction of new AR-DRG codes within an existing revision cycle mean that troublesome heterogeneity within an AR-DRG code is rarely addressed.

  These delays can also adversely impact upon hospital treatment practice when the AR-DRG cost weight does not adequately cover the potential increased cost of providing rapidly emerging new technologies which have been proven to offer significant benefits to the healthcare system in terms of patient outcomes and overall healthcare expenditure. This is particularly relevant in situations where a medical device has evolved over a short period of time to become the internationally accepted first line treatment option for a specific patient sub-group. As the AR-DRG is often established prior to introduction of the new technology (and may even represent a non-surgical treatment), the associated cost weight would be insufficient to cover the costs associated the new technologically-advanced, cost-effective medical service. A new technology may also shorten theatre time and length of hospital stay.

I would welcome the opportunity to discuss these matters further with the Commission.

Yours sincerely



Anne Trimmer
Chief Executive Officer

[3] Page 249

Attachment 1

AR-DRG Example

The AR-DRG code B02B (Craniotomy W Severe or moderate CC) is used to fund a variety of surgical procedures in which a bone flap is removed from the skull to access the brain to treat patients usually suffering from brain lesions or traumatic brain injury.

This procedure is not typically associated with an implantable prosthetic device. The average theatre time for this surgical procedure ranges from 80.17 to 437.17 minutes[4] and the national average length of stay ranges from 10.14 (public hospital) to 9.87 (private hospital) days[5]. These factors influence the the cost weight associated with this AR-DRG. For example, when this procedure is performed in a private hospital in metropolitan Melbourne, the hospital would receive $9,212 for a private patient and $11,269 for a public patient [6].

Over the past decade, Deep Brain Stimulation (DBS) has emerged to offer a safe, effective and cost-effective treatment option for patients with advanced Parkinson's Disease who have exhausted all available drug therapies. This procedure involves the drilling of burr holes in the cranium (for the insertion of leads into brain), and in the absence of a specific AR-DRG for DBS, hospitals performing this procedure will code to B02B (Cranial procedures w Severe CC).

However, in contrast to the typical procedures within the B02B category, the length of this surgical procedure can be over 360 minutes and the average length of hospital stay is 16.43 days (1). In addition, the reimbursed benefit of the implantable prosthesis devices is $38,000[7]. The cost of DBS treatment is not sufficiently covered by the existing cost weight for B02B with consequent financial repercussions.

Impact on Hospital Comparisons: The majority (90%) of DBS cases in Australia are performed in private hospitals. The example provided clearly demonstrates that the heterogeneity within the AR-DRG code B02B is likely to prejudice any cost comparison between hospitals and it would be erroneous to rely upon AR-DRG corrections to enable cost comparisons between public and private hospitals (i.e. analyses based on "Section 5.3: cost per casemix-adjusted separation").

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[4] *Private Hospital Data Bureau 2005/06,* Department of Health and Ageing

[5] *National Hospital Cost Data Collection Cost Weights for AR-DRG Version 5.1, Round 12 (2007-08)*

[6] *WIES calculator 2009-2010 http://www.health.vic.gov.au/casemix/wcc*

[7] *Prostheses List August 2009 http://www.ahia.org.au/prostheses/prostheses.php?cat=5*