24 December 2004

Ms Helen Owens
Medical Technology
PRODUCTIVITY COMMISSION
Locked Bag 2
Collins Street East
MELBOURNE VIC 3000

Dear Ms Owens,

I refer to the Productivity Commission's current study, involving the impact of advances in medical technology on HealthCare expenditure in Australia.

BUPA Australia wishes to offer this submission in support of this study.

BUPA Australia operates a private health fund nationally and has about 463,000 memberships, covering almost a million Australians. BUPA Australia's membership and market share in each State is as follows:

	Memberships	**Persons Covered**	**Market Share**
VIC	247,783	516,824	22.9%
NSW	15,175	34,757	1.1%
QLD	17,045	40,171	2.4%
SA	172,550	345,018	43.5%
WA	5,054	11,949	1.1%
NT	4,377	10,196	11.9%
TAS	922	2,180	0.1%
AUSTRALIA	**462,906**	**961,095**	**10.3%**

This submission focuses particularly on prostheses, costs of which continue to escalate rapidly, placing significant pressure on the ability of health funds to maintain affordable health insurance premiums.

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The following table shows total yearly prostheses benefits paid by BUPA Australia since 2001. There are hefty percentage increases each year and the trend continues in 2004.

Year	Prostheses $ Benefits	% Increase
2001	40,196,000	
2002	56,885,000	42%
2003	70,148,000	23%

These increases have attributed to at least 25% of required contribution rate Increases over the last two years. It is noted that the government currently contributes to 30% of these increases.

Part of the prostheses increase is due to the cost of advances in new technology, and it is acknowledged that much of this is inevitable as the Australian community seeks the best in available health care.

However, under the current system, there are other factors contributing to this cost which warrant particular scrutiny and for which there seems to be substantial room for improvement. Discussion on these other factors follows.

Utilisation

There is very little control of utilisation of prostheses within the private sector. The problem is that the doctor, the patient and the manufacturer have no price signal at the point of service. They are aware that health funds are required to fully pay for prostheses with no financial accountability to themselves. Prescription of high cost devices can and does occur without any regard to cost effectiveness.

A comparison to utilisation patterns within the public sector highlights the problems within the private sector.

Utilisation of cardiac stents is a good example. Drug eluting stents (at a cost of $4000) are more expensive than the previously used stents (at about $1500) and are now used almost exclusively in the private sector, whilst in the public sector the majority of patients continue to be given the less expensive stents. This raises questions about the clinical value of drug eluting stents and suggests that these are not always the most cost-effective option.

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Utilisation (Cont.)

Another example is the cardiac defibrillator, which at a cost of over $50,000, will itself have a significant impact on health expenditure in this country. BUPA Australia has paid for 109 defibrillators in 2003 and 141 in 2004 (ytd). The picture is completely different in the public sector. Public hospitals are controlled by cardiac pacemaker budgets and, as such, prefer to treat 10 people with normal pacemakers rather than 1 person with a defibrillator. Use of the device in the public sector is rare. For instance, the entire Queensland public system has used only 2 defibrillators in the last year. Only a handful has been used in the Victorian public system.

A recent entry onto the prostheses list is the intra ocular lens (IOL) that as well as cataracts also corrects refractive error. This new device is priced at about $1000 whilst an ordinary IOL is around $300, however, it is the utilisation increase that this type of device will create that is more of the issue. It is likely that this will stimulate more demand from people with refractive error and minor cataract problems, who previously may not have bothered with the operation. Correction of refractive error is considered a cosmetic issue rather than a medical one and, as such, health funds have historically not paid benefits. However, funds will have to be wary of paying benefits for this device when only refractive correction is involved. This may prove to be difficult. It is unlikely that this IOL issue will exist in the public sector.

Unit Prices

Unit prices of prostheses within the private sector are significantly higher than they should be. These prices are fuelled by the legislative restrictions which prohibit health funds from effectively negotiating prostheses prices on behalf of their members. Health funds, as payers of prostheses, have no market power in this area. This is brought about by the current inequitable system that mandates that health funds must pay the full price of prostheses charges, and that there can be no out-of-pocket cost for consumers. This allows prostheses suppliers an easy path to put significant upward pressure on their prices. Whilst the current system is meant to have a negotiation process, in actual fact, this does not exist.

There is also meant to be an arbitration process within the Department of Health and Ageing for instances where funds and suppliers fail to negotiate prices. However, no documented procedures have been supplied for this process.

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Unit Prices (Cont.)

In contrast, the public sector is not faced with the out-of-pocket constraints that exist within the private sector and is also affected by budget limitations. Accordingly, the public sector is able to effectively negotiate with prostheses suppliers.

The following table illustrates the difference in negotiating power between the two sectors:

Prosthesis Item	BUPA Price	Public Hospital Price	Private % Mark-up
Boston Scientific Drug Eluting Stent	$3,600	$2,400	50%
Alcon Intraocular lens	$310	$180	72%
Provisc Viscoelastic Solution	$85	$52.50	62%
DePuy Charnley Hip System	$2,630	$1,450	81%
Medtronic Kappa 700 Pacemaker	$9,872	$6,040	63%
Guident Fineline Sterox Pacemaker Lead	$1,500	$625	140%

There are many similar examples, all evidence of the extent of inflated prices within the private sector. This will not change unless the system allows health funds to have some form of bargaining power.

Replacement Prostheses

Another factor contributing to the cost of prostheses is the increasing occurrence of insertion of very expensive devices, only to be replaced shortly after on the basis that the new model might be slightly better. There is a fine line between clinical need and minor improvements in function. Some very costly replacement items are being prescribed, some of which may not be clinically required, simply because there is no cost to the clinician or the patient.

The following examples bring the subject to light:

A member had a cochlear implant at a cost of $24,000. Within a month, a request is received from the audiologist for a spare replacement processor at a cost of over $7,000. This was to be used just in case the initial processor (only a month old) broke down and required repair. This scenario could be catered for in the manufacturer's guarantee of the product.

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Replacement Prostheses (Cont.)

Another member had a diabetic insulin pump inserted at a cost of over $7,000. This model beeps when it gets low in insulin. The member has trouble hearing and now wants a newer model that vibrates when it gets low. We are requested under the guise of clinical need to fund the new model. There is nothing wrong with the initial model however the health fund is being asked to fund another $7,000 for the sake of a slight gain in convenience. If the patient had to fund any portion of the newer model, it would be likely that the older model would continue to suffice as it did before. It seems that some manufacturers are able to exploit the market by introducing subtle changes to their products, knowing that their customers do not have to bear any costs for these changes.

No benefits were paid for these two examples on the basis that there was no clinical need. However, these are the types of requests that health funds are receiving and it is likely that some of them do get through the system and benefits do get paid for negligible clinical advantage.

As mentioned above defibrillators are a major concern, but of equal concern is the replacement of defibrillators. Manufacturers advise that the devices have a battery life of about five years and that total replacement is then required. This will become a very expensive exercise. Our first defibrillator recipients will soon be ready for their replacements. Recently, a member had a replacement defibrillator after only 3 years, and whilst there was some clinical reason for the replacement, it illustrates the level of concern.

New Regulatory Environment

The National Health Amendment (Prostheses) Bill 2004 is currently before Parliament and it is expected that it will be enacted shortly.

The move towards this new regulatory environment for prostheses shows some improvement to the current predicament, however, major issues will continue to persist in this area. Unless these are addressed, prostheses costs will continue to increase by double-digit percentages.

The issue of clinical effectiveness and evidence based utilisation of prostheses items is of prime concern. Whilst the new environment is attempting to address these issues, it will be some time before its effect can be properly evaluated.

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New Regulatory Environment (Cont.)

The new process will assess each device for clinical efficacy, taking into account likely clinical utility, safety, absolute clinical effectiveness and cost effectiveness. Evidence to justify devices under these criteria is plentiful and it is hard to see many prostheses items failing these tests. Having passed these criteria, the main problem then becomes the lack of consideration of clinical or cost effectiveness of devices relating to an individual's needs.

Again, a good example relates to cardiac stents. All current stents would pass the clinical efficacy criteria of the new process. The imbalance of usage of these devices in the private and public arenas would still continue under the proposed process.

Cardiac defibrillators will also pass the clinical efficacy tests of the new process quite easily. However, there are no guidelines or limits relating to the utilisation of these devices. There will be, of course, many people where there is demonstrated clinical value for use of this expensive device and access for these people should be protected. Unfortunately, there will be many others where the device is prescribed with little regard to clinical need or cost effectiveness and this, in the future, may jeopardise the availability for those really in need.

More emphasis needs to be placed on evidence based utilisation to help doctors make better informed decisions relating to the use of new and expensive technology. A new generation of evidence is emerging in the form of decision support systems based on up to date evidence interpreted by the best doctors in the field. These systems will allow doctors to make clinical recommendations applicable to each circumstance, based on the best evidence and clinical guidelines as interpreted by a consensus of experts in the field. Development of these ideas has the real potential to change the way doctors operate and approach the take up of new technology. This sort of work is already in progress but will need government and industry support.

Excessive margins on unit prices for prostheses were discussed above and this is another factor that requires further attention. In this regard, the new process is not likely to go far enough. Whilst it will reign in the prices of some prostheses, it should be recognised that we are starting with a base of very high prices which are the legacy of the previous inequitable systems. Firstly, government set benefit levels by simply requesting prices from suppliers. The prices were not subject to any market forces. Accordingly, high prices were generated. The government then changed this system to introduce the ability to negotiate prices, but left the health funds with negligible bargaining power because of the no gap requirement.

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New Regulatory Environment (Cont.)

For example, the new process may contain the price of defibrillators at around the $50,000 mark. However, the starting point needs to be questioned. Suppliers would argue that the high price is justified because of research and development costs. This may be acceptable, but one would think, as in most other industries, prices would decrease as technology improved and demand increased. An exponential increase in demand for defibrillators has seen no downward pressure on prices.

The new process will not rectify the imbalance between private and public hospital prices. For instance, pacemakers are currently at least 60% more expensive in the private sector. This starting point remains within the new process.

Another significant flaw in the new pricing process is that prostheses manufacturers that "lose" a competitive bid can still charge and receive the same benefit as "winners". There is therefore no incentive to negotiate a low price.

The public sector is truly able to negotiate with prostheses suppliers. A similar model bears reflection in the private sector. The introduction of this is not easy, however, there is a clear need to have some semblance of market forces existing between the payers and suppliers of prostheses in the private sector.

In conclusion there are two main issues that need attention. Firstly, decision support systems should be developed for clinicians, consumers and their GPs so as to promote evidence based utilisation of new medical technology.

Secondly, market forces should be freed to allow downward pressure on the current prices. BUPA Australia will continue to work on finding solutions to these issues and would welcome any relevant suggestions.

I trust that this submission is useful to your study. I would be happy to provide you with any further information that you consider important, in particular, access to any of our prostheses data.

Yours sincerely,

Keith Finney
General Manager
PROVIDER & PROCUREMENT