Opunake Pty Ltd is a consultancy on healthcare funding for day and short-stay hospitals. Many clients of Opunake Pty Ltd will be affected by changes in the funding arrangements for prostheses.

We offer only a response to Question 11.

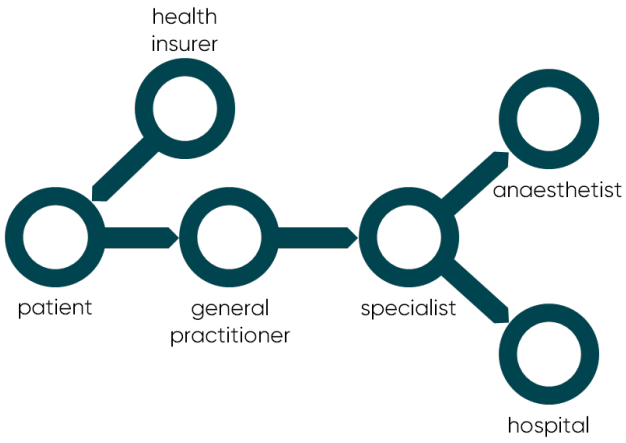
Are there any other issues of relevance to the formulation of advice on alternative bundling arrangements? If so, please provide details on these issues and their materiality with regard to the formulation of advice.

The consultation paper mentions doctors only once, in relation to the requirement of the CIRG to ensure that the devices remain available.

Any analysis of the private healthcare market is incomplete without including the vital and powerful role of specialists. Unlike most other healthcare systems including the Australian public system, ours is made up of several independent entities working together for the patient:

- the patient's general practitioner
- the admitting specialist
- an anaesthetist
- sometimes a surgical assistant
- the hospital
- the patient's insurer

Each of these entities has a range of incentives, which balance the motivation to provide the patient with the best possible care, and the requirement to earn a margin while doing so.



In the same way as GPs must appeal to patients in order to build a practice, hospitals must appeal to specialists in order to be chosen as the venue of care for some proportion of each specialist's patients. Specialists often have admitting rights at multiple private hospitals and will chose the hospital that can provide the best care for a particular patient's condition. The selection criteria include the range of equipment, devices and prostheses that are available for carrying out procedures.

In this way, specialists determine which prostheses a hospital purchases, and this is communicated through their preference cards. This choice is not up to the hospital. If a hospital chooses to disregard the preference card, they risk that specialist taking patients elsewhere.

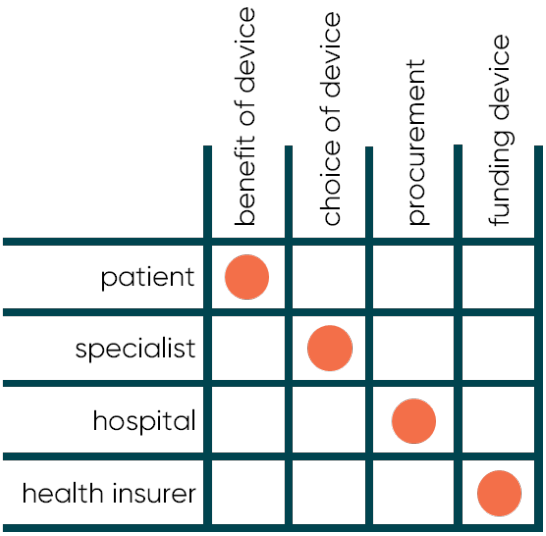
Secondly, it is not necessary to point out in this context that there is a wide range of pricing for various brands of prostheses within a Product Group or Product Sub Group.

Thirdly, not all hospitals are paid the same for a given procedure. Publicly available data (HCP, PHDB) demonstrates that day hospitals are paid substantially less for a given procedure than overnight hospitals. In general, larger and longer established hospitals that are part of a group are paid more than smaller, newer, independent hospitals, and there is a spectrum in between.

These three factors taken together mean that smaller, newer, and/or independent hospitals operate on much smaller gross margins for any given procedure. As such, they do not have the excess margin to pay for more expensive prostheses, whereas this is more likely to be possible for larger, more established hospitals with higher rates of reimbursement. This gives larger, more expensive hospitals the ability to continue to stock higher cost medical devices as requested by specialists.

Were smaller, newer and independent hospitals unable to continue to stock the medical devices requested by specialists as a result of prostheses list reforms, those specialists are likely to take their patients to higher cost hospitals where those devices are available – increasing the total cost of providing care.

The fundamental cause of this is that there is misalignment between choosing and paying, and price signals are not communicated.



This is in contrast to any other market, where the entity choosing the device must make a cost-benefit trade-off.

This misalignment should be addressed when designing any bundling system. Otherwise private healthcare costs are more likely to increase, instead of decrease. Worked examples can be provided if IHACPA deems this useful.