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[redacted]
Chief Data Officer
Technology and Data Division
Australian Prudential Regulation Authority (APRA)
1 Martin Place
Sydney NSW 2000

Dear Madam

The Medical Technology Association of Australia (MTAA) welcomes this opportunity to comment on the conse-quential amendments to private health insurance (reporting) standards.

MTAA represents the innovative medical device industry in Australia. By value, our members account for more than 80% of the Prescribed List of Medical Devices and Human Tissue Products (the PL).

The PL is an essential part of Australia's healthcare system. By enabling timely access to state-of-the-art medical devices, it helps Australians to live longer, healthier, and more productive lives. The PL is also one of the most dynamic and contested parts of our healthcare system. Since 2017, it has been the subject of constant reforms; some of them relatively minor; but most of them major, intended to improve the operation of the PL and to manage its "growth", whilst maintaining clinician choice and patient access to innovative technologies.

As much now as ever, the data which APRA publishes on PL benefits both impels and moulds these reforms; sometimes, even in ways which are based on purposely flawed interpretations of the data.

For instance, it is claimed by Private Healthcare Australia that the 2022 Memorandum of Understanding between MTAA and the Australian Government, which enabled certain reforms to be implemented that would ensure the PL's long-term viability, has 'transferred up to $400 million from the pockets of consumers to the profit line of multi-national medical device companies.'

This erroneous claim is based on recent APRA data which shows an overall growth in PL benefits since the MoU commenced. The fact that this growth is the result of increased utilisation (Figure 1) is never mentioned by critics such as PHA; nor is the fact that the average cost per (PL) item has been declining since 2017 (Figure 1); *nor* is the fact that PL benefits as a share of total hospital benefits (Figure 2) have remained virtually unchanged since 2013 – that is, despite wider macroeconomic instabilities like supply chain disruptions and generalised inflation.

Figure 1: Prostheses Benefit Number vs. Protheses Benefit Paid Per Number

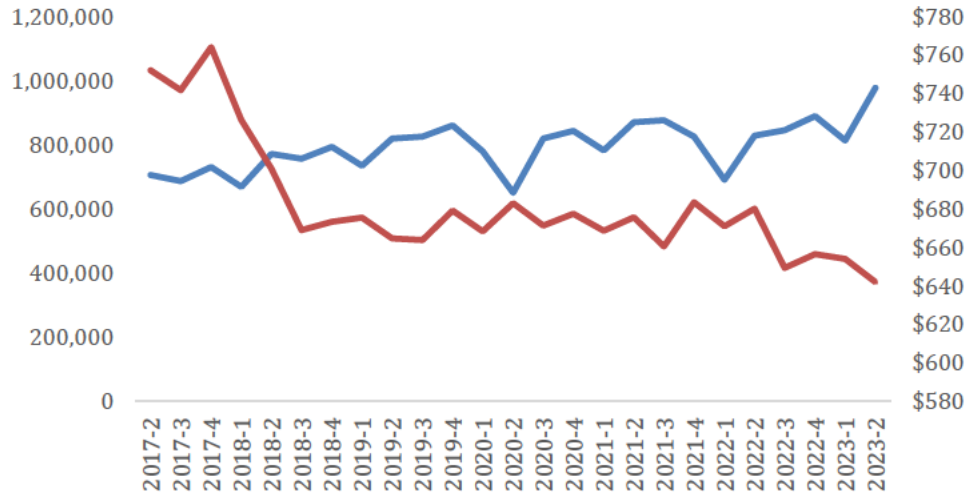
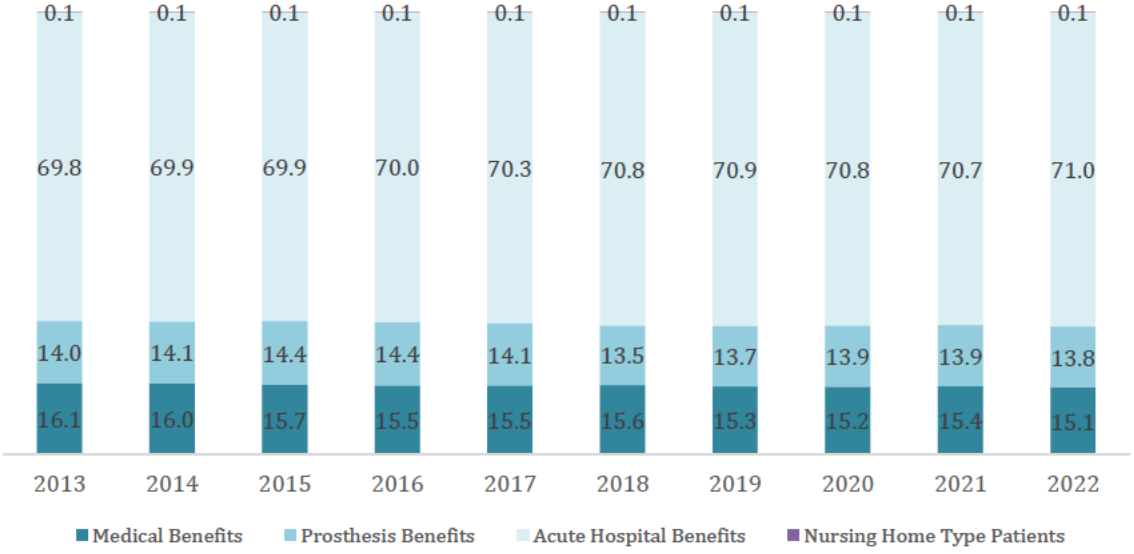
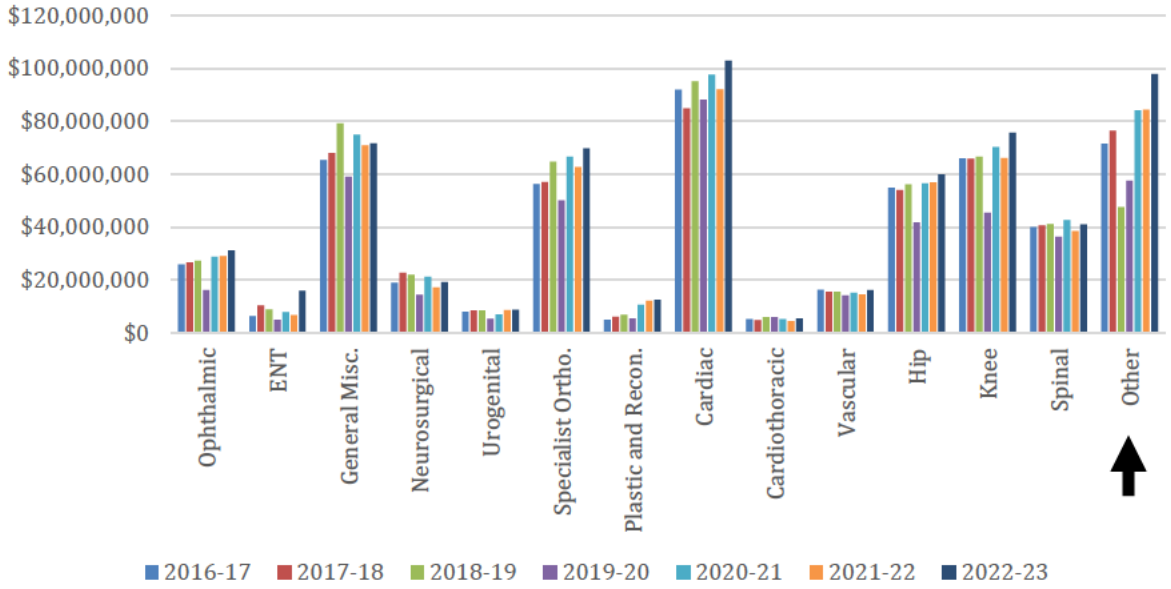


Figure 2: Total Hospital Benefits - Share by Type



Sometimes, however, it is APRA's data itself which is misleading and which, as a result, can (mis)lead both policy-makers and stakeholders. For instance, according to APRA, since 2017, "Other" has consistently been one of the largest categories of PL benefits (Figure 3). This is unhelpful information.

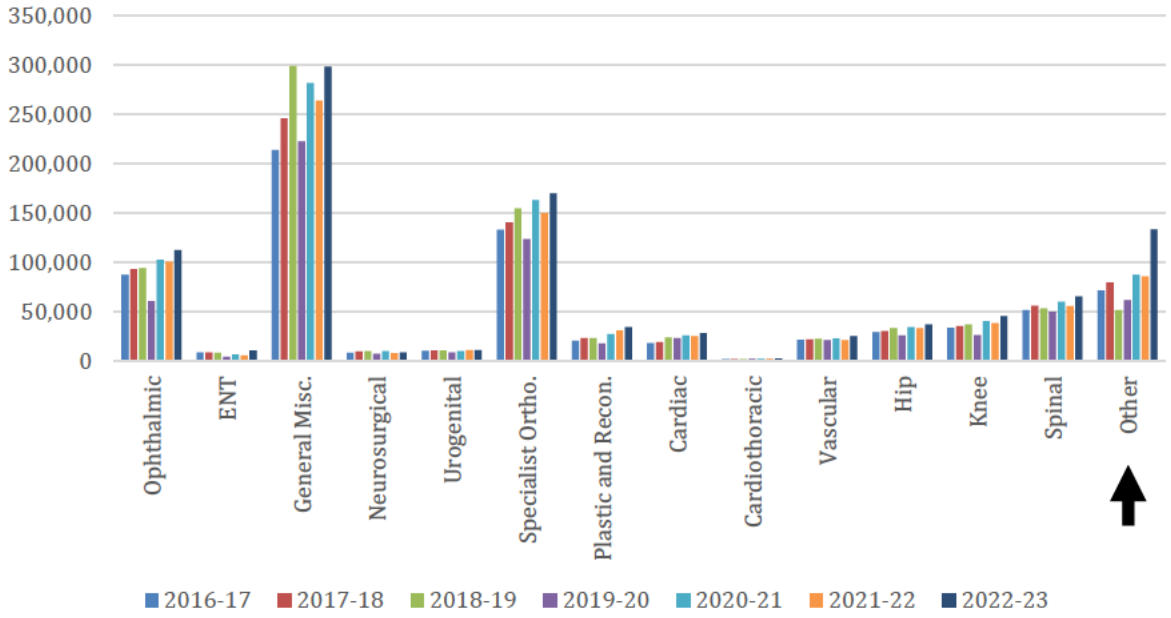
Figure 3: PL Benefits by Therapeutic Categories, Public + Private



The over-generalisation of such a large share of PL benefits means that even if "Other" were one of the main drivers of overall expenditure growth, APRA's reporting standard(s) would not offer any meaningful insights into underlying causes (that could then be used to inform the development of appropriate and targeted reforms, if these were required).

This problem of interpretation is exacerbated when one compares benefits with utilisation (Figure 4) in this category: whilst the "Other" category accounts for a relatively large share of PL benefits in terms of expendi-ture, it does not account for a correspondingly large share of utilisation. This implies that a sizeable number of specialised, high-cost medical devices, which could (and probably should) be properly categorised under specialist therapeutic areas, are being frequently (mis)categorised as "Other". If that is indeed the case, then the problem of (mis)reporting seriously and fundamentally challenges the ability of policymakers and stakeholders to make informed decisions.

Figure 4: PL Number by Therapeutic Categories, Public + Private



It goes without saying that evidence-based policy making is essential for effective governance. But what is sometimes overlooked (and thus bears repeating) is that evidence-based policy making is only possible when the relevant information – that is, the information required to make policy decisions – is as complete, as accurate, and as unambiguous as possible.

Consequently, MTAA recommends that as part of the current update of the PHI reporting standards, APRA should:

- abolish the "Other" category in the reporting of PL benefits and PL number,
- require that future reporting of PL benefits and PL number be by corresponding product categories contained in Schedule 1 of the *Private Health Insurance (Medical Devices and Human Tissue Products) Rules* (MDHTP Rules),
- create a new field for PL Part B to enable the reporting of human tissue products listed in Part B of Schedule 1 of the MDHTP Rules,
- provide guidance on how insurers should report benefits for billing code items that are not classified in the MDHTP Rules (including those which are currently labelled as "non-surgical prostheses (such as wigs)", and which are currently grouped with "Aids and Appliances"),
- include timely and accurate reporting of PL benefits and PL number by corresponding product categories con-tained in the MDHTP Rules as a mandatory condition of compliance with APRA standards, and
- ensure that the (existing) annual audit program undertaken by external auditor(s) includes measures or checks to ensure PL benefits are reported in accordance with the product categories for each billing code on the MDHTP Rules.

We hope that the issues raised in this submission and our recommendations will be helpful to APRA as it finalises amendments to private health insurance (reporting) standards. If you have any questions, or if you would like to meet to discuss these issues further, please do not hesitate to contact us.

Yours sincerely

Ian Burgess
Chief Executive Officer