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KIDNEY HEALTH AUSTRALIA

Patron-in-Chief
Her Excellency Ms Quentin Bryce, AC
Governor-General of the Commonwealth of Australia

Patrons
Sir Jack Brabham, AO, OBE
Lady Margaret Brabham

9 October 2012

Attention:
'Submissions'
Submissions.ihpa@ihpa.gov.au
Independent Hospital Pricing Authority
Darlinghurst, NSW

Kidney Health Australia Submission:

Consultation Paper for the Pricing Framework for Australian Public Hospital Services 2013-14.

Kidney Health Australia is the only peak national body representing the needs of those with kidney disease in Australia. As the lead organisation in the kidney sector, Kidney Health Australia advocates on matters relating to the welfare of kidney stakeholders and the delivery of services to people affected by chronic kidney disease (CKD), in all its stages. Furthermore, Kidney Health Australia has close ties with consumers, the medical community, renal units around the nation and is a member of the Australian Chronic Disease Prevention Alliance (ACDPA) and the National Vascular Disease Prevention Alliance (NVDPA).

Kidney Health Australia welcomes the opportunity to comment on the Independent Hospital Pricing Authority's (IHPA) Consultation Paper for the *Pricing Framework for Australian Public Hospital Services 2013-14.* Kidney Health Australia agrees in principle with the broad pricing guidelines that the consultation paper outlines, but believes that a number of points are worth reiterating regarding the delivery of dialysis services and the current varying rates of uptake of the different modalities of dialysis and settings in which it is undertaken, particularly regarding home dialysis.

The Current Dialysis Situation

As outlined in Kidney Health Australia's submission on 14 February 2012 into the *Activity Based Funding (ABF) for Australian Hospitals: towards a pricing framework,* dialysis is a high-cost, lifesaving treatment modality for people with end-stage kidney disease (ESKD), which is estimated to cost approximately $1 billion each year in Australia[1]. Economic modelling commissioned by Kidney Health Australia conservatively estimates that the cumulative cost of treating all current and new cases of ESKD from 2009 to 2020 to be between $11.3 billion and $12.3 billion[2]. The most recent data available from the Australian

[1] Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at: http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837
[2] Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at: http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837

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and New Zealand Dialysis and Transplant Registry (ANZDATA) at the end of 2010 shows that nearly 10,600 patients were receiving dialysis treatments[3].

The location of dialysis can be in an acute care hospital (22 per cent of the total, as at the end of 2010), free standing as a satellite centre or in small units in country hospitals (49 per cent of the total), or performed in the home (29 per cent of the total)[4]. Of those utilising home dialysis, 20 per cent use home peritoneal dialysis and nine percent utilise home haemodialysis. It is important to note that within these figures the take-up of dialysis at home (both home haemodialysis and peritoneal dialysis) varies significantly on a state-by-state basis and unit-by-unit basis, ranging from nearly 40 per cent of all dialysis in New South Australia to as little as 15 per cent in the Northern Territory[5].

Currently, the best available estimates indicate that the cost per person, per year for an individual on dialysis is $79,072 for hospital or unit-based haemodialysis, $65,315 for satellite haemodialysis, $49,137 for home haemodialysis and $53,112, for peritoneal dialysis. Noting the expected costs to the health system in the future, Kidney Health Australia estimates that a saving of between $378 and $430 million would be achievable over the next 10 years if increasing the use of home dialysis was achieved.

While historically, the majority of dialysis cost has been provided through the hospital budget, the actual models of funding have varied by jurisdiction, which when combined with differing levels of health professional education[6] and advice, has contributed to significant inconsistencies in uptake of the different modalities nationally.

Issues for Consideration

The move to activity based funding (ABF) therefore provides an important opportunity. Kidney Health Australia is of the view that the definition of 'in scope public hospital services' needs to incorporate *all modalities and settings of dialysis* currently available to patients, and that this includes home dialysis. This viewpoint stems from a desire to ensure that there is no favour for hospital or satellite models of dialysis to the detriment of home dialysis, and that a transition to activity based funding underpinned by a nationally efficient price (NEP) recognises and promotes the benefits that home dialysis can provide, to both the patient and to government, by striving for improved equity and access arrangements. Furthermore, only by ensuring that all modalities and settings for dialysis are included in the new funding arrangements can we be sure that there are no adverse economic disincentives for service providers to favour one form of dialysis over another, inadvertently created in the move to ABF.

[3] www.anzdata.org.au
[4] www.anzdata.org.au
[5] www.anzdata.org.au
[6] Kidney Health Australia is currently developing a National Education Programme to provide high quality and comprehensive education for all Australia kidney health professionals and patients about ESKD treatment options to support the increased uptake of home dialysis. This projected is supported by funding from the Australian Government under the '*Chronic Disease Prevention and Service Improvement Fund*'.

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Secondly, it is important that future price weightings accurately reflect the different costs associated with each mode of dialysis available to patients, so that the prices allow for improved efficiencies without distorting the supply of sources or creating relative inequities between the differing modalities and settings. It is important that the price weightings for each of the differing types of dialysis are fair, both in absolute and relative terms.

The provision of dialysis in the home by either haemodialysis or peritoneal dialysis results in reduced costs for the health service, while also bringing with it a number of benefits, including an association with better health outcomes, improved well-being for the individual and greater rehabilitation. All of these benefits, while beneficial to the patient, also have the potential to reduce the burden on the health system (in particular home haemodialysis, as it allows the patient to increase the frequency and length of haemodialysis, factors that have been associated with improved outcomes and are increasingly being practised where feasible in Australia and overseas).

It is essential that any new funding arrangement for dialysis at home allows for the increase in those costs of this approach to dialysis treatment. In considering this, it is important to note that the costs of increasing the frequency of home dialysis are not as significant as would be expected, as the start-up and associated costs are already in place, resulting in improved cost efficiency for the additional treatments. Noting the different frequencies in which haemodialysis can be carried out depending on the modality and setting, Kidney Health Australia would therefore like to reiterate that the development of the appropriate price weighting for these services in any future shift to ABF should ensure that an economic disincentive is not inadvertently created that discourages the provision of increased frequency dialysis, where it is considered appropriate and noting the relative in expense compared to other forms of dialysis. In doing so, the mechanism to measure the varying frequency of dialysis resulting from the modality and setting of dialysis needs to ensure that it does not also add a burden to the individual or patient.

Furthermore, noting the pricing guidelines focus on 'Price Harmonisation' and that specifically, 'Pricing should facilitate best practice provision of appropriate site of care', the incorporation of home dialysis into ABF arrangements and using such arrangements to encourage a 'home first' policy for dialysis should be strongly considered.

In addition to reduced costs, undertaking any type of dialysis in the home also results in less travel for the patient, which is of particular importance for those living in regional, rural or remote localities, or for patients with lack of access to public or other transport. However, it should be noted that home based dialysis requires support from the local renal unit, including nurses visiting patients on site, which in some cases can be a considerable distance. As such, future funding decisions should appropriately recognise the distance and location that medical professionals/support staff will be required to travel from the hub/spoke to support the patient on home dialysis. This situation should be factored into the provision of price weighting and rural/Indigenous scaling as appropriate, or where necessary, into the consideration of block-funded services for small rural hospitals as outlined in Chapter 7 of the consultation paper,

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depending upon how home dialysis in rural locations is treated under the pricing framework in coming years.

Finally, currently the capital costs for the dialysis machine and associated plumbing and electrical requirements are covered, in varying degrees, by most state and territory governments. However, any move to include home dialysis within ABF should also extend to including these associated costs to ensure and promote consistency.

Conclusion

The development of a *Pricing Framework for Australian Public Hospital Services 2013-14* provides the opportunity to continue to refine and expand the ABF system to ensure that all types of dialysis are supported appropriately, and that once home dialysis is incorporated, there are not relative disincentives for the promotion and provision of a greater level of uptake. It could do this by ensuring that the price weightings accurately reflect the different capital and support costs for each modality and setting, and recognise these in any pricing rural or Indigenous pricing adjustments.

The development of the pricing framework also provides the opportunity to bring a level of national consistency to the funding of renal and dialysis which is certainly welcomed, noting the state-by-state and unit-by-unit differences outlined above. To date, some states have introduced targets and incentives for home dialysis – the move to ABF provides the opportunity to create a level of consistency nationally to further this agenda. In this respect, Kidney Health Australia welcomes the opportunity to highlight a number of issues for consideration, including:

- All modes of dialysis should be included when deciding the types of services that are considered 'in-scope' for consideration for ABF to ensure all are treated equally and economic disincentives to providing home dialysis are not inadvertently created;

- The funding model not disadvantage those who seek to undertake dialysis at home using either home haemodialysis or peritoneal dialysis, but rather price each modality and setting in a fair way, and in line with 'price harmonisation' that favours a home first approach - recognising the documented health and economic benefits associated with home dialysis, and seeking to replicate the past efforts by governments to increase it;

- Appropriate mechanisms for accounting for and measuring the increased frequency of dialysis in different settings to enable ABF to operate effectively are considered, while ensuring that they do not impose an additional burden on the patient or the health professional;

- That the appropriate loadings for rural and Indigenous patients be applied to all modes of dialysis and the associated support activity price weightings, including for home based dialysis, recognise

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the associated costs that arise from providing support to dialysis patients in rural and Indigenous settings; and

- That future pricing determination take into consideration monitoring and evaluation of the uptake of home dialysis to ensure that ABF is resulting in the desired outcomes, does not promote inequities or access issues between different modes of dialysis, and results in greater uniformity across the states and territories.

Kidney Health Australia appreciates the opportunity to again comment on the continuing evolution of the pricing framework for Australian public hospital services and would welcome the chance to provide further information to assist the IHPA in its future deliberations, to ensure that all forms of dialysis and associated issues are appropriately reflected and weighted accordingly. We would be happy to make representatives from Kidney Health Australia available at any nominated time to travel to the IHPA to discuss these issues further.

Yours Sincerely,

Anne Wilson
MD/Chief Executive Officer
Kidney Health Australia

Medical Director
Kidney Health Australia