10 October 2012

The Independent Hospital Pricing Authority
PO Box 1414
Woden ACT 2606

Re: The IHPA Draft Pricing Framework Consultation paper for public hospital services (dated 31 August 2012)

This submission is made on behalf of the Australian Diabetes Society, Australian Diabetes Educators Association, the National Association of Diabetes Centres and Diabetes Australia.

The Australian Diabetes Society is the expert organisation in Australia on medical and scientific matters related to diabetes, and is devoted to the medical and scientific advancement of diabetes care and research.

The Australian Diabetes Educators Association is Australia’s peak professional organisation in diabetes education.

The National Association of Diabetes Centres is a collective of specialised multidisciplinary Diabetes Services which collaborate to ensure that services are provided by Centres of Excellence.

Diabetes Australia is the national peak body for diabetes in Australia providing a single, powerful, collective voice for people living with diabetes, their families and carers.

Our 4 organisations are concerned about the current failure for the IHPA Draft Pricing Framework to recognise and adequately fund specialised Multidisciplinary Diabetes Services. We refer to our previous submission to the IHPA dated the 21st February 2012 (attached).

We make the following additional specific comments to the consultation questions:

3. Pricing guidelines

Are any amendments required to the pricing guidelines in Box 1?

If we consider the pricing guidelines in Box 1 of the document we would make the following comments:
a) **Fairness** – the costs of providing diabetes services across public, private and NGO’s are certainly variable in terms of the out of pocket expenses to the consumer: what is not clear is whether there are any differences in terms of the ABF payments to the various public hospitals in this situation. In other words, are public hospitals currently recognised for the complexity of patients they are providing services for.

b) The document also talks about **System design guidelines** covering several issues including the fostering of clinical innovation. We would thus like to highlight that current diabetes services are providing complex yet innovative hospital services across all areas of both admitted and non-admitted patients. These services are providing best practice in models developed over long periods of time and yet to be replicated, with patient care and efficiency the prime goal.

**What have been the consequences of the introduction of ABF on 1 July 2012?**

In response to the broader question about the impact of ABF on services since its introduction on July 1, we believe it is absolutely fair to say that we have not noticed any impact on services to this point as these services in many cases are not recognised as hospital based activities.

4. In-scope public hospital services

**Have there been any recent clinical developments that IHPA should be taking into account when examining the scope of public hospital services in 2013-14?**

There is absolutely no doubt that existing hospital based diabetes services meet the definition of a service event related to interaction between one or more providers and containing therapeutic/clinical content but we would draw to your attention that there is no evidence that this occurs simply to attract funding, but rather due to historical development and the absence of equivalent affordable services and skilled providers anywhere else in the health system.

**Are there any particular areas of concern that IHPA should consider in reviewing State/Territory Government submissions on the scope of public hospital services?**

Most hospital based diabetes services meet the eligibility criteria around substitution for inpatient admission or emergency department attendance and should have their funding considered for that activity. In other words these services are actively operating as a **Chronic disease hospital avoidance program**.
The funding model for outpatient services needs to consider funding of group education services, and telehealth (in particular telephone / email) consultations. These are particularly important as they are more efficient and generate savings to the health system. The funding model needs to encourage the adoption of such services.

Box 2, Appendix 1.

Whilst Diabetes is included as a Category A Tier 2 clinic (40.26), it would be helpful to amend this to “Diabetes and Diabetes Education” to better reflect the range of diabetes outpatient services.

5. The national efficient price for activity based funded public hospital services

There continues to be a need to look at the robustness of costing data as outlined in 5.1 of the document. The need to review and refine the costing data for various groups of patients is also important and particularly for those hospitals with a complexity of patient groups e.g. transplants, steroid induced complications, mental health and the homeless.

We would also totally support the need to review the business rules around the counting of services delivered to families and carers, a critical part of the role of providers of diabetes care and education.

5.2 Classifications, counting and costing inputs

What are the key factors that IHPA should examine that influence the efficient cost of providing community based public hospital mental health services for different patient groups?

In the section on Mental Health services we would like to highlight the issue of other chronic diseases in this group of patients and that it adds to the complexity of their management. In refining the classification costing and pricing of these Mental health services, the IHPA should consider the contribution of other services to the management of chronic disease in this population.

5.3 Setting the level of the national efficient price for public patients

Are there any other factors that IHPA should consider in setting the level of NEP in 2013-2014?

Many of the issues we have raised here need to be considered as having an impact on the setting of levels for 2013-14 and into the future.
5.5 Incorporating new technology in the national efficient price

Have there been any significant changes in technology or service delivery models that impact on costs in the period between the last round of the NHCDC (2010-11) and the period for which IHPA is currently pricing (2013-14)?

Those specialised diabetes services geared to the provision of services for patients with type 1 diabetes would attest to the technological advances for this group particularly around the initiation and management of those on insulin pump therapy and the technology and resource drain that sits around that process. It is also relevant to the way specialised diabetes service providers interact with this group in particular i.e. email, phone and telehealth options being a case in point. Also specialised diabetes services are increasingly in a position of having to download data from pumps and blood glucose monitoring systems to assist in clinical decision-making. This activity means that consideration must be given to adequate funding provision of these services to allow for the necessary technology to be supported.

5.6 Setting the level of the national efficient price for private patients in public hospitals

Many of the hospital based diabetes services provided are largely not supported in the private system or are inadequately reimbursed by private insurers, which has significant cost implications for the consumer. This is now leading to many of these consumers coming back into the public hospital system.

The issue of prosthetic downloads (the downloading of data from insulin pumps and continuous blood glucose monitoring systems) should be considered here as well.

5.7 Adjustments to the national efficient price

We would totally support the notion that patient complexity must be considered in this process, particularly those with a chronic disease and multiple co-morbidities. In addition, teaching hospitals, where many tertiary services are located, are often in a position of having to manage those from out of area until appropriate services can be identified locally, if available, and should not be penalised in any way for this.
6. Pricing for safety and quality

The very first paragraph in this section epitomises what public hospital diabetes services, whatever their scope of practice is, are all about. That is the provision of high quality care in order to prevent the short and long term complications, which might have future implications for an already strained health system. Thus the need for IHPA to consider best practice pricing of specialist diabetes services.

What mechanisms for pricing safety and quality are in operation in jurisdictions or health systems both within and outside of Australia across the various health care delivery settings?

Incentives in parts of the health system may be perversely influencing care and not guaranteeing quality and safety. People with diabetes need to receive services as outlined in a raft of guidelines. The health system needs to ensure that these services are provided by appropriately skilled and qualified health professionals.

Yours sincerely

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