Mr James Downie
Acting Chief Executive Officer
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PO Box 483
Darlinghurst NSW 1300

By email to: submissions.ihpa@ihpa.gov.au

Dear Mr Downie

Re: Pricing Framework for Australian Public Hospital Services 2016-17

The Australian Red Cross Blood Service welcomes the opportunity to provide input to the Pricing Framework for Australian Public Hospital Services 2016-17.

We note the statement in section 8 of the consultation paper that IHPA is currently working with jurisdictions to investigate how blood costs can more accurately be captured in the National Hospital Cost Data Collection (NHCDC). The Blood Service emphasises the urgent need for this work as a basis the development of a funding structure that drives sustainability of the blood system.

Summary

The need for financial and performance accountability for hospital use of blood and blood products has been recognised for a long time. It was a consistent theme of submissions to the Stephen Review 2001 and is a policy aim of the National Blood Agreement 2003. More recently this need has been recognised in the Sapere Research Group reports 2011, commissioned by the Australian Government and Dr Stephen Duckett's *Improving accountability for use of blood products* paper 2013, commissioned by the Blood Service. The latter document stated that there has been no uniform national progress in improving financial and performance accountability for hospital use of blood and blood products. [1] This remains the case.

The urgent need to address this issue arises from current demand trends that are creating challenges for the sustainable supply of blood and blood products. The Blood Service therefore seeks:

- incorporation of the price of blood into the national efficient price for hospital services, as recommended by the Sapere Report
- the introduction of differentiated pricing to provide an incentive structure for managing the use of blood products
- implementation of a multi-stage approach, as recommended in the *Improving accountability for use of blood products* paper 2013, commissioned by the Blood Service

In advocating a new funding model, the Blood Service proposes that blood budgets be fully devolved to public hospitals to achieve hospital accountability without duplication of funding.

Current financial situation

Australians have a proud history of voluntarily donating blood. The main cost of blood is incurred in procurement and processing. Australia's blood sector is funded by the Commonwealth and state/territory governments at a ratio of 63 percent and 37 percent respectively. In 2013-14 the nation's blood expenditure included $583.13M for the collection of blood components, and $488.13M for plasma-derived and recombinant products.[2] In the 11 years to 2013-14, expenditure for blood and blood products has increased at an average 6.6 per cent per annum – significantly faster than inflation.

The financial transaction for the purchase of blood and blood products occurs between the National Blood Authority (on behalf of the Commonwealth, state and territory governments)

and the blood and blood product suppliers. Health Providers (hospitals and other Health Providers) are completely removed from the direct funding and payment process. Blood and blood products are made available, free of charge to public and private patients. This unusual financial arrangement results in Health Providers missing the rigour imposed through the direct management, monitoring and payment for products supplied. For some hospitals, especially complex tertiary hospitals, it is estimated that up to 7% of their non-salary costs are blood or blood product related. The Blood Service strongly advocates that the price of blood be incorporated into the national efficient price for hospital services, however the Blood Service also believes in line with the requirements of the National Blood Agreement 2003, that under no circumstances should any charges be passed on to patients.

Small steps have been made to increase the awareness of the financial costs of blood and blood products. The use of BloodNet by most hospitals to order blood provides an indicative costing. Two years ago, the Blood Service, at the request of the National Blood Authority (NBA), started to print the product cost on the label for red cells, plasma and clinical plasma in an effort to improve visibility to clinicians, prescribers and transfusion health professionals. However this increased transparency has had limited impact as it is seen by the laboratory staff who place the orders, not the clinical decision makers or hospital management.

Blood and Blood Products

The Blood Service manufactures leucodepleted red cells, platelets and plasma for clinical use as well as plasma for fractionation. All manufacturing steps are governed by strict regulations and the entire supply chain is temperature controlled. Each component type has a different but limited shelf life.

The urgent need to address the costing of blood and blood products

Current demand trends are creating challenges for the sustainable supply of blood components and plasma-derived products. The effect of these trends is unlikely to diminish unless fundamental changes to usage occurs, which is most likely to be achieved through the introduction of differentiated pricing.

The introduction of patient blood management linked to efforts to reduce the unnecessary wastage has resulted in a significant decrease in red cell demand since 2011/12 however these decreases are inconsistent across blood groups. The Blood Service has received feedback from Health Providers of their reluctance to hold the less common blood groups primarily due to the high potential to experience expiry with these groups.

The ongoing trend of overall reductions in red cell demand and the more recent pattern of large reductions in groups B and AB are creating some major supply issues with both the universal blood group - O negative red cells and certain groups for clinical plasma. O negative plays an important role in emergency and trauma response. As such, it is not expected that usage will decrease at the same pace as other groups.

However Health Providers are favouring - O negative red cells. This is creating major supply issues where current demand for O negative runs at 14.8% whilst only 8% of the population is O negative. This is one of the highest percentages amongst international peer Blood Services.

The current wastage rate of O negative red cells in hospitals is 9%, a disappointing outcome against an average wastage rate of 4.4% for all other blood types. The introduction of differentiated pricing, allowing charging Health Providers a higher price for an O negative unit of blood, may enable a better balance of inventory in the sector by potentially reducing the volume of O negative inventory in the supply chain.

The sharp decline in red cell demand for the less common groups also impacts the availability of clinical plasma. The Blood Service operates with a policy of only collecting a whole blood donation when the red cell is required. As fewer red cells are required, fewer

whole blood donations are taken and this leads to fewer whole blood-derived clinical plasma units being available to support inventory for hospitals and Health Providers. This is felt most keenly for the cryoprecipitate product where clinical preference still errs heavily to the whole blood-derived product over the apheresis-derived.

Compounding the issue is the increase in cryoprecipitate demand, particularly in group AB. This creates a challenging situation where demand for the whole blood collections is declining, demand for the finished plasma derived product is increasing and thus far it has been problematic to move Health Providers over to apheresis derived cryoprecipitate. Again, the use of differentiated pricing would provide an additional lever to influence ordering behaviour.

Over the past decade the demand for IVIg, a key and costly blood product derived from plasma has averaged 12% growth per annum. Recent data indicates Australia's usage of expensive IVIg is now leading the world at 175g per 1,000 population, exceeding the US (168g). Forecasts by the Blood Service indicate that this trend is likely to continue into the next decade. IVIg is the biggest driver of the growth in blood sector costs. It also poses a significant challenge to Australia at many levels including our international commitment to self-sufficiency in the coming decades.

The basis for a future funding model

We propose the following principles underpin a new funding model:

- blood budgets should be properly devolved to public hospitals (not just nominally)
- under no circumstances should patients be charged (directly or otherwise)
- costs should be clearly identified as processing and procurement
- a nationally consistent price list should be introduced
- it should be a cost neutral exercise for governments
- it should provide for differentiated pricing by blood type
- the IHPA should develop a costing standard for blood and blood products

We propose that:

- future funding arrangements to be based on the principles above
- the Blood Service invoices AHPs (public hospitals initially) directly for blood and blood products
- direct payment by hospitals would increase the visibility of the value of blood and blood products
- charges for products can be implemented progressively. Not all products have to be invoiced immediately
- direct payment may not be the best strategy for all products especially if it creates perverse behaviours
- consideration should be given to including the high cost blood products in the PBS.
- the Commonwealth should take on full responsibility for the funding of blood and blood products in private hospitals (a new approach to funding should be considered).

These proposals are consistent with the Stephen Review 2001 and the National Blood Agreement 2003 policy aims, and are supported by the following:

- ***Improving accountability for use of blood products***
  The paper previously submitted to IHPA, *Improving accountability for use of blood products,* remains as relevant today.

  In early 2013, Dr Stephen Duckett was engaged by the Blood Service to develop a methodology incorporating the price of blood into the national efficient price for hospital services in Australia. The key issues and assumptions considered were:

- The introduction of the national efficient price should maintain the core philosophy that the patient should continue to receive blood and blood products free of charge, irrespective of hospital setting (i.e., public or private)
- price signals for blood, by blood type, should be established for both the public and private hospital system
- distinguishing between the costs for blood and blood products in the national pricing framework, and the cost of pricing should be nationally consistent
- costs should clearly reflect the processing and procurement cost of blood and blood products
- potential funding implications exist for states and territories as the National Health Reform Agreement is based on a 60:40 split, whereas blood and blood products are currently funded on a 63:37 split and should be recognised.

- **the National Health Reform Agreement**, which recommended that activity based funding be applied wherever practicable in public hospital funding. The publication of *Activity based funding for Australian public hospitals: Towards a Pricing Framework, 2011* provides a framework for establishing the national efficient price for public health services in Australia. We propose that this price should include the cost of blood and blood products, a critical and significant input to the Australian health system. Blood and blood product cost equates to approximately 7% of non-salary related costs in the hospital system. This is a substantial input cost.

- **The Sapere Report**
  Commissioned by the Commonwealth Department of Health and Ageing (DoHA), the 2011 Sapere Report *Analysis of Cost Drivers and Trends in the Blood Sector - Options to manage appropriate use of blood and blood products* emphasised that blood and blood products are currently provided free of charge to most hospitals (Tasmania, New South Wales and Queensland have nominally devolved their blood budgets to public hospitals but not via a 'casemix' funding method to hospitals) which sends the wrong signal to hospitals and users about the scarcity and value of blood, and blood products. It recommended that governments review systems and introduce initiatives that will encourage efficiency and sustainability in the blood sector.

  The recommendations of the Sapere Report were:
  - the national blood budget should be incorporated into the casemix system;
  - the national blood budget should be devolved to public hospitals; and
  - price signals for blood should be established for the private hospital system.

In recognition that blood and blood products are an integral part of health service delivery, the Blood Service recommends that the development of an appropriate funding structure be treated as a priority issue.

Yours sincerely

JENNIFER WILLIAMS
Chief Executive
27 July 2015

1. Duckett, Dr Stephen, Casemix Consulting Pty Ltd (2013), *Improving accountability for use of blood products* , p. 6
2. National Blood Authority Annual Report 2013-14, pp. 24-26