



28 July 2015  
Independent Hospital Pricing Authority  
PO Box 483  
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## **Consultation paper on the Pricing Framework for Australian Public Hospital Services 2016-17**

The Pricing Framework for Australian Public Hospital Services is updated annually and outlines the principles, scope and methodology adopted by the Independent Hospital Pricing Authority (IHPA). The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) welcomes the opportunity to comment on the draft IHPA Pricing Framework for 2016/17.

RANZCO's mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy. Underpinning all of the College's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the general public in all matters relating to vision and the health of the human eye and advocates for accessible ophthalmology cost effective services for patients.

### **1. Ophthalmology key facts**

#### **Australian hospital statistics (AIHW, 2013/14) (1, 2)**

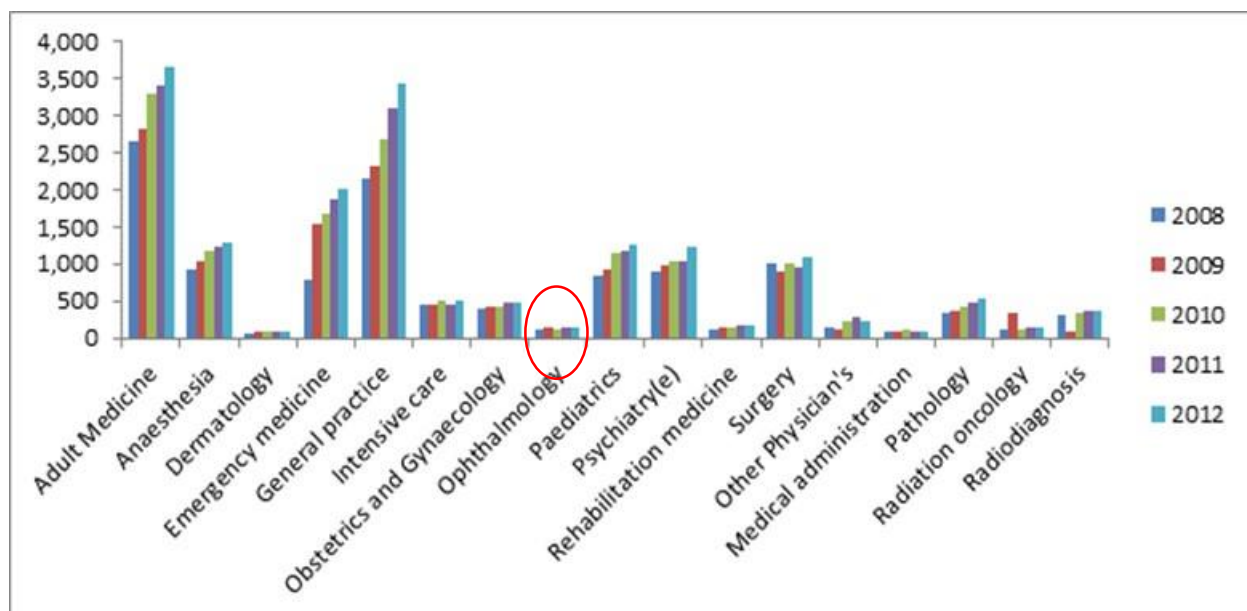
- The most common principal diagnosis for elective admissions involving surgery in 2013/14 was "Other cataract", with 69% of the surgical procedures performed in private hospitals. Overall 192,262 "Other cataract services" were reported in Australian hospitals, with 132,554 in the private sector and 59,708 in the public sector.
- Overall there were 52,836 elective admissions involving surgery with "Other retinal disorders", ranked 6 in terms of principle diagnosis.
- Overall 30,713 "Senile cataract" services were performed, ranked 13 in terms of principle diagnosis.
- The rates for cataract extraction vary between public and private sectors (2.7 and 6.2 per 1,000 population, respectively).
- Australia's proportion of cataract surgeries that were performed on a same-day basis was higher than the OECD average (96.6% and 85.6%, respectively).
- The unplanned readmission rate for cataract extraction in public hospitals is fewer than 4 per 1,000 within 28 days.
- Median public hospital waiting time of cataract surgery for indigenous Australians was 112 days compared to 81 days for non-indigenous Australians. Inner regional and outer regional areas in Australia have the highest public hospital waiting times compared to the rest of Australia.
- 478, 796 non-admitted services were performed for ophthalmology.

## Ophthalmology workforce

RANZCO conducted a Workforce Survey in 2014, which encompassed Fellows, Trainees and Registrars. A total of n=712 Australian Fellows responded, representing a high overall response rate of 64% (3). Total number of registered fellows is comparable to the volume estimated in the Health Workforce 2025 Medical Specialties report. The average age of respondents in the 2014 RANZCO workforce survey is also similar, equal to 53 years of age.

An analysis of the expected changes in the Australian workforce has been completed. A significant proportion of the Australian workforce would like to be employed part-time (23%) and a reasonable proportion of fellows expect to work part-time without performing surgical operations (9%). Based on the 2014 RANZCO workforce survey, it is expected that 5 percent of the workforce will retire within the next 5 years (3). The growth in training positions for ophthalmology has been lower than other specialties, refer to figure 1 (4).

**Figure 1: Growth in advanced vocational training positions 2008 – 2012**



Source: *The Australia's Future Health Workforce: Doctors report, Department of Health, 2014.*

The maldistribution of workforce in regional and rural areas is of key concern to RANZCO. The College supports initiatives to encourage Fellows to work within non-metropolitan areas. Training posts in regional areas are limited due to inability to meet accreditation requirements and lack of overall resourcing. In Western Australia, ophthalmologists are currently servicing approximately 36 000 people per full time equivalent. RANZCO supports the allocation of sufficient funding to ensure that the number of trained ophthalmologists is equivalent to 1 per 23,000 persons across Australia.

## 2. Public hospital resourcing

Visual impairment can significantly affect patients' daily living in many ways such as reading, watching television and driving. There are well-established correlations between visual impairment and higher risk of falls, hip fractures, motor vehicle accidents and depression - with risk of death elevated to 4.3% for those over 40 compared to 1.6% for the fully sighted. By 2020, health costs of visual impairment are conservatively projected to equal more than \$3.7 billion and indirect costs are expected to add another \$3.2 billion to the annual bill for visual impairment (5). Socio-economic impacts include lower employment rates, higher use of services, social isolation, emotional distress and may lead to an earlier need for nursing home care.

Public hospitals waiting lists are currently at unprecedented levels due to insufficient funding. Reduced overall financial resourcing to the public hospital sector will result in further fragmentation of services and potentially reduced patient care. In particular, further reductions to Commonwealth funding will likely have a detrimental impact on the State's ability to meet patient demand for eye care. The number of cataract extractions performed per 1,000 population currently varies across the States and Territories due to constrained funding, as highlighted in Table 1.

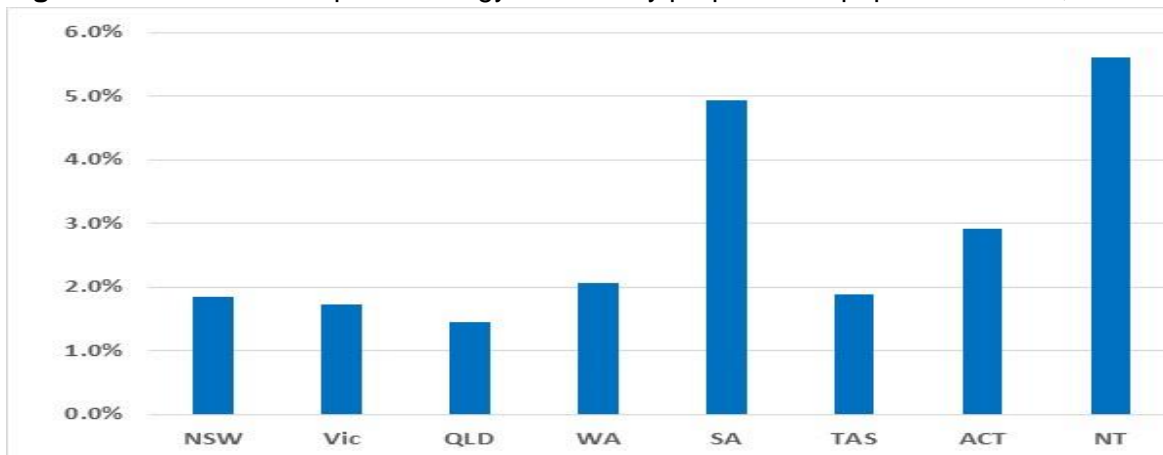
**Table 1:** Rates of Cataract extraction by Australian jurisdiction (AIHW, 2013/14) (1).

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Separations	71,682	56,738	47,030	26,233	17,206	7,039	2,503	1,262	229,693
Separations per 1,000 population	8.3	8.7	9.6	10.6	8	10.4	7.4	9.1	8.9

In Australia, age-related macular degeneration contributes to 50% of all blindness, making it the nation's most common cause of blindness. It is estimated that in 2010, there were 1.023 million Australians with AMD, equivalent to one in seven people over the age of 50 (6). In 2006, less than 20% of those with macular degeneration could be treated (6). Several medicines represent a revolution in care for patients with AMD. The results of multiple clinical extension studies suggest that long-term diligent care for patients with wet AMD, including individualised treatment depending on disease activity, may lead to the best long-term visual function.

Public outpatient clinics play a vital role in providing equitable access to AMD treatments for all Australians. In the 2014 RANZCO survey a number of States identified a lack of access to non-admitted services in the public sector. Recently published data from the AIHW suggests that access to non-admitted public hospital services varies significantly by jurisdiction, refer to Figure 2.

**Figure 2:** Non admitted ophthalmology services by proportion of population AIHW, 2013/14) (2)



All patients should get access to the best quality health care services in a timely manner, no matter where they live. We therefore support Australian funding models that incorporate population demographics based on age and indigenous status.

## RANZCO response to the IHPA Pricing Framework for 2016/17 consultation paper

### 3.2 Scope of Public Hospital Services and General List of Eligible Services

#### Consultation question

What additional evidence exists to support the inclusion or exclusion of specific services from the General List in 2016-17?

Primary Health Care (40.08).

Primary Health Care (40.08) is defined as the provision of primary health services by nurses and allied health professionals, with the care objective of maintaining optimum mental and physical health and preventing disease. RANZCO is concerned that complex ophthalmological problems such as glaucoma are considered as primary care issues.

Current NHMRC guidelines support the need for a comprehensive examination to diagnose all types of glaucoma accurately (7). This includes a comprehensive medical history, a full eye exam (including gonioscopy), an examination of eye function (visual field) and an assessment of intraocular pressure (IOP). The Blue Mountains Eye study demonstrated that systematic IOP errors of  $\pm 1$ mmHg may cause an apparent increase in the prevalence of IOP  $> 21$ mmHg by 58%, or 34% of individuals with OHT to be missed (8). A 2mmHg over-read would increase the diagnosis rate by nearly 300%, and a 4mmHg over-read by 700% (9). A preliminary diagnosis of glaucoma should be confirmed by an ophthalmologist and therefore should not be classified as a primary health care service.

RANZCO supports specific classification of ophthalmology services in the general list to reduce the risk of complex eye conditions being misclassified.

### 3.3.1 Pricing posthumous organ procurement activities

#### **Consultation questions**

- Should posthumous organ procurement activities be in-scope for pricing under the National Health Reform Agreement?
- Is posthumous organ procurement adequately accounted for in activity and cost data collections and, if not, how could it be improved?

#### **Management of Eye and Tissue donations**

Eyes and tissue donated altruistically can significantly improve the lives of recipients for example cornea and bone grafts and in some cases, such as heart valves and skin, can be life saving. EBAANZ is the professional association representing all eye banks in Australia and New Zealand (five eye banks in Australia, Lions NSW Eye Bank, Queensland Eye Bank, Eye Bank of SA; Lions Eye Donation Service Melbourne, and Lions Eye Bank of WA) and one bank in New Zealand (New Zealand National Eye Bank). Eye and tissue banks provide significant benefits within the health sector.

The five eye banks in Australia are funded from a range of private and government sources and are located in the majority of jurisdictions. The financial basis of eye and tissue banks varies, but they generally operate on a cost-recovery basis. The basis for cost recovery is Part B of the Prosthesis List – Human Tissue List, published by the Department of Health. Eye and tissue banks apply to have their cost-recovery charges identified on the Human Tissue List. Hospitals or State Health Departments through service agreements are charged the relevant fee identified in the Human Tissue List for the supply of human tissue in the case of public patients. The Human Tissue List sets mandatory benefits that private health insurers must pay for human tissue items provided to their members during insured hospital treatment.

The Organ and Tissue Authority (OTA) in collaboration with eye and tissue bank representatives completed a review of eye and tissue banking in Australia in 2011 (10). The review identified systemic gaps which include the need for national education of eye and tissue bank staff; improved data collection and analysis; the need for national allocation and distribution of eye and tissue products; implementation of unique identifiers to enable timely traceability of products; consistency of national legislation and consistency of practice across banks.

A three staged approach has been adopted by the Commonwealth Government to address these gaps. A health economic review of the costs associated with retrieval, processing, storage, distribution and allocation has recently been initiated by the OTA as part of stage 2 and 3 of the process. RANZCO is seeking to contribute to this process and will provide the IHPA further advice following the completion of the OTA review.





#### 4.5 Tier 2 Non-admitted Patient Services classification

RANZCO supports the IHPA in their continuing efforts to develop a new Australian non-admitted patient care classification scheme that will better describe overall patient complexity and accurately reflect the costs of non-admitted public hospital services. We note that non-admitted ophthalmology services in outpatients relate only to clinic consultations. RANZCO is concerned that the funding allocation for procedural items including intravitreal injections or laser treatment are not being accurately accounted. The College would therefore like to participate in the IHPA process to improve classifications relating to outpatient services.

#### 4.7 Teaching, training and research

Teaching, training and research (TTR) activities represent an important role of the public hospital system alongside the provision of care to patients. The consultation paper states that the National Health Reform Agreement (NHRA) requires that IHPA provide advice to the COAG Health Council on the feasibility of transitioning funding for TTR to an Activity Based Funding (ABF) system by 30 June 2018.

RANZCO would like to participate in further discussions relating any potential changes that result in the inclusion of teaching, training and research in the ABF system. Any changes to the funding mechanisms should not act as a disincentive for TTR activities to be sufficiently resourced across all regions within Australia. RANZCO requests that the IHPA forward a list of the trial hospitals, so we can determine whether the selected sites accurately represents ophthalmology clinical case mix.

#### 6.1.1 Alternative geographical classification systems

##### **Consultation questions**

- Should IHPA consider any further technical improvements to the NEP pricing model for 2016-17?
- What are the advantages and disadvantages of changing the geographical classification system used by IHPA?

The IHPA proposes to investigate the use of the Modified Monash Model as an alternative to the ASGS for determining patient and hospital remoteness. The Commonwealth Department of Health has adopted the Modified Monash Model for mapping District of Workforce Shortages. RANZCO supports the adoption of the Modified Monash Model for District of Workforce assessments.

RANZCO would like a health economic assessment to be completed comparing the various remoteness classification schemes in the context of hospital funding. The results of this review should be made publically available for comment.



## 6.2.2 Adjustments to be evaluated for NEP16

RANZCO supports improvements to cost allocations for Culturally and Linguistically Diverse (CALD) patients. The Western Australia government has requested that IHPA consider the issue of fly-in, fly-out workers and domestic tourists who are treated in outer regional and remote hospitals. Western Australia states that its hospitals are at a disadvantage as the patients do not receive a Remoteness Adjustment as this is based on their residential post code. RANZCO supports IHPA initiatives to undertake further analysis of this issue. RANZCO supports IHPA actions to explore whether an age-related adjustment should be introduced for EDs, admitted and non-admitted services.

## 8 Bundled pricing

### **Consultation questions**

- Do you support IHPA's expanded policy intention for bundled pricing in future years?
- What services or patient episodes of care would most benefit from this expanded bundled pricing approach?
- What issues should IHPA consider prior to implementing a bundled price and how can these issues best be resolved?

RANZCO does not support IHPA's proposal for bundled pricing of services. Too many variables would need to be considered and the proposal is likely to create an unnecessary administrative burden.

## 10. Pricing for Safety and Quality

### **Consultation questions**

- What implementation issues should IHPA consider when further investigating the feasibility of applying a best-practice pricing approach in future years?

The inclusion of quality considerations into the national efficient pricing (NEP) mechanism is a complex challenge. RANZCO considers that a framework based on clinical outcomes alone is not sufficient. The most complex, high risk and visually impaired patients attend major teaching public hospitals. Inclusion of quality standards in the NEP would need to account for different hospital categories and clinical complexity.

RANZCO considers the following general principles should apply to ophthalmic clinics and surgical practice;

## Clinics

1. Clinic funding should account for all the ophthalmic and non-ophthalmic co-morbidities relevant to each consultation. For example; diabetes, dementia, non-English speaking and comorbid eye conditions should be incorporated into the classification system. Adaption of the International Statistical Classification of Diseases and Related Problems, Australian modified, ICD-10-AM is therefore required prior to the implementation of changes to the NEP.
2. Adequate clerical support would be required to capture all these factors in order to justify claims based on activity.

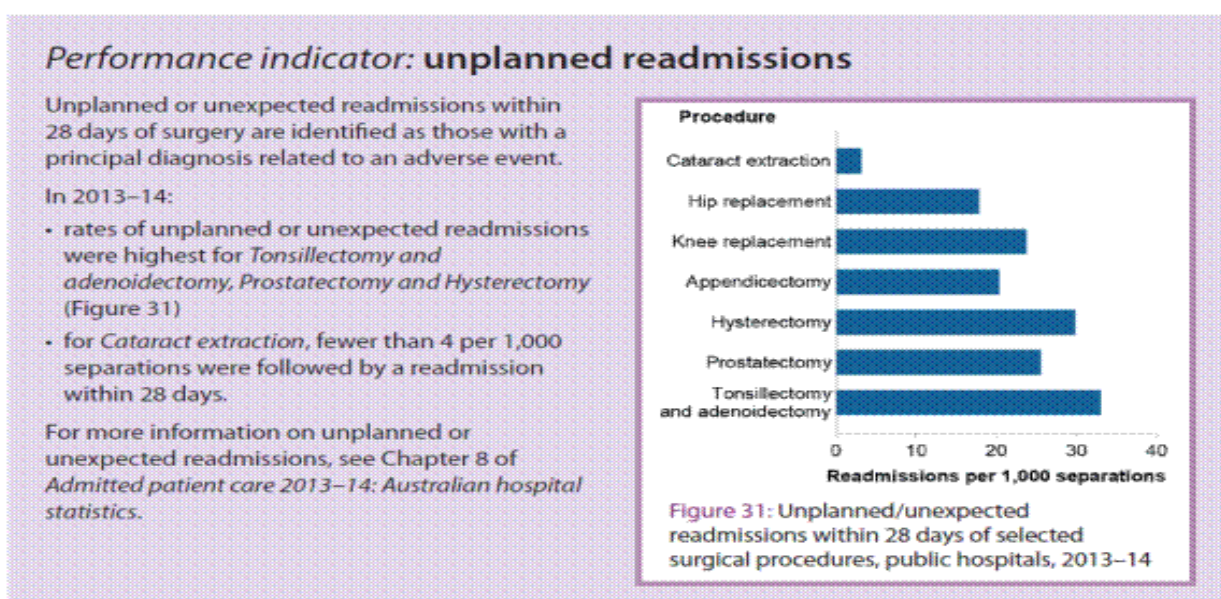
## Surgery

- Assessment of complication rates would have to differentiate between non-complex and complex cases.
- Outcomes should consider the multiple co-morbidities frequently seen in public and teaching hospital patients.

## Cataract clinical outcomes

Cataract extraction was the most common principal diagnosis for elective admissions involving surgery in 2013/14 (1). The AIHW has recently reported that the number of unplanned hospital admissions within 28 days is substantially lower than other surgical procedures including hip and knee replacements, refer to Figure 3 (11).

**Figure 3:** Comparison of unplanned readmissions within 28 days of surgery by principle diagnosis, (source: AIHW, 2013/14, 11).







Waiting time to surgery, readmission rate, are administrative parameters that can reflect the quality of care but often bear little relationship to clinical outcomes. A multicentre data extraction of electronic cataract surgery records has been undertaken as part of ophthalmic dataset development work in the UK (12). A total of 55,567 operations were available for analysis between November 2001 and July 2006. The electronic audit showed that higher-risk cases can be predicted, thus better informing the consent process and allowing surgeons to take appropriate precautions (12). It was found that case-mix is a major determinant of the probability of an intraoperative complication (12).

The measurement of intraoperative complications during cataract surgery should consider posterior capsular rupture (PCR) with or without vitreous loss because it is the most common intraoperative complication during cataract surgery (13, 14). This health outcome measure is important because it is associated with the need for additional surgical procedures, a greater number of follow-up visits and increased frequency of postoperative complications, which may adversely affect the final visual outcome (15). It is widely regarded as the benchmark complication to judge the quality of cataract surgery (12).

## Conclusion

Thank you for the opportunity comment on the draft IHPA Pricing Framework for 2016/17. Could contact RANZCO Advocacy Officer, Suzanne Lyon, at [slyon@ranzco.edu](mailto:slyon@ranzco.edu), regarding any requests for further information and responses to RANZCO queries.

Yours sincerely



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