Cancer Institute NSW
cancer.nsw.gov.au

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Non-admitted care costing study

Public consultation paper 1 – data collection

The Cancer Institute NSW would like to thank the Independent Hospital Pricing Authority (IHPA) for the opportunity to submit a response to the *'non-admitted care costing study - public consultation paper 1 – data collection'*. Please find below responses to the questioned posed.

If you seek further clarification on any of these answers please contact Gemma Hearnshaw, gemma.hearnshaw@health.nsw.gov.au

1. What changes to the scope of the study, as described above, should be considered?
As the scope includes different modalities, including services provided by telephone, we request that this review also considers tele-health services such as Quitline and the Get Healthy service. These counselling services provide preventative health care, in addition to support for patients of health services to either quit smoking, or improve physical activity and healthy eating, both of which will improve health outcomes relating to their primary diagnosis.

8. Are there any data elements that are not on the list in Table 1 that should be included (i.e. features of patients/ service events that are likely to impact the cost of the care delivered to a patient)? For what reasons should these be collected in the study?
A data element for a patient's smoking status should be included, as a history of smoking will impact the cost of care delivered to a patient. We suggest this is included within the primary data collection under the 'secondary presenting conditions'. Studies comparing health care costs for smokers and non-smokers consistently report higher health service usage and costs for smokers[1]. Smoking impacts on the treatment of disease; for example, smoking reduces the effectiveness of cancer treatments, increases the risk of post-operative complications, and increases the number of IVF cycles required to conceive[2]. The estimated tangible healthcare net costs due to tobacco use in Australia are $318.4 million per year[3].

[1] Scollo, MM and Winstanley, MH. Tobacco in Australia: Facts and issues. 17.2 The costs of smoking. Melbourne: Cancer Council Victoria; 2018. Available from www.TobaccoInAustralia.org.au
[2] Hurley, S, Greenhalgh, EM & Winstanley, MH. 3.15 The impact of smoking on treatment of disease. In Scollo, MM and Winstanley, MH [editors]. Tobacco in Australia: Facts and issues. Melbourne: Cancer Council Victoria; 2015. Available from http://www.tobaccoinaustralia.org.au/3-15-smoking-and-complications-in-medical-treatmen
[3] Collins D and Lapsley H. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/5. P3-2625. Canberra: Department of Health and Ageing, 2008. Available from: http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/34F55AF632F67B70CA2573F60005D42B/$File/mono64.pdf

12. Appendix B provides a list of interventions that will be specified for the study. Is the list sufficient to capture differences in costs between patients treated in non-admitted settings? Are there any changes that should be made to the list?

Table 1 outlines the primary data elements to be collected and includes the values outlined in Appendix B 'ANACC interventions short list'. It is unclear in this list how interventions for smoking cessation counselling and/or smoking cessation brief interventions would be coded. There are several intervention codes under 'Alcohol and Other Drugs 40.3' (page 122) but these do not currently specify smoking cessation interventions.

It is important that codes for smoking cessation interventions are included, especially as 'preventative care' is included in the 'major reason for attendance' data element; and 'drug dependence, other (tobacco dependence)' is included as a 'presenting condition term'.

Smoking cessation brief interventions are effective in increasing quit attempts[4] and so should be incorporated into all health care provision. Smoking cessation behavioural counselling is also effective in increasing quitting.[5] Coding should therefore reflect both smoking cessation brief interventions and smoking cessation counselling/intensive interventions, to support this to be incorporated into routine health care.

17. Will the data elements outlined in the previous Chapter support investigations of complexity of non-admitted service events? Are there other markers of complexity for non-admitted patients that should be built into the data collection?

Is it unclear if the data elements collected will include a measure of a patient's smoking status as a factor relevant to the complexity of the service event, as smoking will impact the cost of care delivered to a patient and the health outcomes (as outlined above).

[4] Stead LF, Buitrago D, Preciado N, Sanchez G, Hartmann-Boyce J, Lancaster T. Physician advice for smoking cessation. Cochrane Database of Systematic Reviews 2013, Issue 5. Art. No.: CD000165. DOI: 10.1002/14651858.CD000165.pub4.

[5] Lancaster T, Stead LF. Individual behavioural counselling for smoking cessation. Cochrane Database of Systematic Reviews 2017, Issue 3. Art. No.: CD001292. DOI: 10.1002/14651858.CD001292.pub3.