Classified used to describe and price public hospital Services.	**Feedback insert:**
Consultation question 12 Page 20: What potential risks should IHACPA consider in progressing price harmonisation of chemotherapy and dialysis for future NEP Determinations? Background: In June 2023, ANZSN, the Renal Society of Australasia (RSA), The Australian and New Zealand Paediatric Nephrology Association (ANZPNA) and Kidney Health Australia (KHA) wrote to the IHACPA to share their serious concerns regarding the reduction by the Independent Hospital Pricing Authority (IHACPA) of the NWAU (activity-based funding) allocation for peritoneal dialysis (PD). Recent changes would result in a drastic reduction in income for kidney units and have devastating consequence nationally. The changes represent a major drop in PD funding in 23/24 that will create a significant financial disincentive for commencing patients on PD despite the benefits to patients and cost savings for the health system. The benefits to the patient can be separated into a mortality benefit, particularly early following the onset of kidney failure, satisfaction/quality of life, autonomy and lower costs, which are detailed below. - A 2015 PWC Report into *Home Delivered Dialysis Costing study to inform the National Efficient Price 2015,* determined that in 2013-14 the cost for delivering PD serviced per person was $46,950 per year. The current proposal reduced the NWAU payment for PD to only 66% of what was estimated in 2013-2014. This is perplexing and has not been explained.	The proposed change of peritoneal dialysis to a Tier 2 non-admitted activity requires adjustment and does not accurately reflect costs. • Only one service event can be counted per month. • Weighting for 22/23 was .94 NWAU per service event ($65K per patient per year) • For 23/24 FY the weighting drops to .43 NWAU ($31K per patient per year) A 54% drop in PD funding in 23/24 will create a significant financial disincentive for commencing patients on PD, where clinically appropriate, despite the benefits to patients and cost savings for the health system. Encouraging patients with kidney failure to be treated with PD represents a key strategy for relieving pressure on overcrowded in-centre haemodialysis units, which are currently experiencing unprecedented capacity pressures around Australia, particularly in the Northern Territory. Placing a severe financial disincentive on commencing patients on PD will greatly exacerbate these pressures thereby increasing the risks of serious clinical incidents and death. Also requested is a review of the coding relating to dialysis in hospital day patients. This patient group has complex clinical needs and care requirements. Currently blood transfusions, infusions, plasma exchange, IVIG, parental nutrition, debridement etc that are vital for optimal care do not trigger an uplift to the DRG if the primary reason for admission is for dialysis. This is placing an excessive cost burden on the system and should be reviewed.

- ANZSN, RSA, ANZPNA and KHA are concerned that the methodology used to calculate the NWAU for home PD may be flawed. PD is delivered as a daily home-based therapy. The costs of delivering PD include: home dialysis training costs, costs for dialysis equipment and dialysis fluids, costs of providing 24/7 availability of nursing, medical and technical support, drug costs, utility costs, and allied health costs. It is essential that the NWAU allocation for PD includes all these components. - This proposed cut fails to consider the societal financial advantages of encouraging PD uptake, rather than encouraging the more expensive option of facility haemodialysis. - Kidney units with patients who do not live close to available facility haemodialysis are more dependent on being able to provide PD to patients living in remote or disadvantaged areas. The 2022 ANZSN, RSA, KHA and Kidney Health New Zealand (KHNZ) Position Statement on Equity in Kidney Care advocated that equity of access should exist across all kidney care. ANZSN, RSA, ANZPNA and KHA are concerned that this funding cut to PD will disproportionately impact services and patients already most disadvantaged in terms of access to kidney replacement therapy. PD helps to reduce the burden on patients, facilitating their ability to undertake work, educational or caregiver roles and for many means that they can still participate in life activities, such as social outlets, hobbies, travel and exercise, that are vitally important for well-being. In addition, PD provides cost benefits compared to other forms of dialysis. PD offers many benefits including: 1. Convenience and flexibility: Patients can perform dialysis treatments at home, eliminating the need for frequent visits to	

a dialysis centre and providing greater convenience and flexibility in scheduling treatments. 2. Improved quality of life: Home-based PD allows patients to maintain a more independent and flexible lifestyle, enabling them to continue working, pursuing education, participating in hobbies, and spending time with family and friends. 3. Continuous therapy: PD is performed daily, providing continuous therapy that helps maintain a more stable internal environment and better control of fluid balance, blood pressure, and electrolyte levels. 4. Lesser dietary restrictions: PD allows for more liberal dietary choices compared to hemodialysis, resulting in fewer fluid restrictions and more flexibility in food choices. 5. Lower risk of infections: With proper hygiene practices, PD carries a lower risk of bloodstream infections compared to hemodialysis, as it does not involve accessing large blood vessels. 6. Preservation of residual kidney function: PD may help preserve residual kidney function for a longer period, which is associated with better health outcomes and reduced complications. 7. Training and support: Patients receive comprehensive training and support from healthcare professionals to ensure they feel confident and competent in managing their treatment at home, this ensures there is partnering of patients in their own healthcare, directly addressing a key Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Standard. The Deloitte report also outlined the annual cost of CKD was estimated to be $9.9 billion in Australia in 2021, equivalent to an average cost per	

person living with CKD (across all stages) of nearly $4,800. This rises to over $182,000 for those with stage 5 CKD. Peritoneal dialysis (PD) provides cost savings to the patient and health system. Compared to other forms of dialysis, such as in-centre haemodialysis. PD: 1. Reduces healthcare facility expenses: PD eliminates or reduces the need for regular visits to a dialysis centre, which can significantly lower healthcare facility costs. Patients do not incur expenses related to the use of dialysis machines and associated infrastructure. 2. Lowers transportation costs: With PD at home, patients do not need to travel to a dialysis centre for treatments, thereby reducing transportation expenses. This can be particularly beneficial for individuals living in remote areas or those without convenient access to dialysis centres. 3. Decreases caregiver costs: PD at home allows for more active involvement of caregivers, such as family members or friends, in the treatment process. This can potentially reduce the need for professional caregivers, leading to lower caregiver costs. 4. Decreases hospitalisations: PD has been associated with a lower risk of hospitalisation compared to in-centre haemodialysis. Hospitalisations can be expensive due to the costs of medical care, medications, and extended stays. By reducing hospital admissions, PD at home can help lower healthcare costs. 5. Potentially preserves residual kidney function: PD may help preserve residual kidney function for a longer duration compared to other dialysis modalities. Preserving kidney function is associated with better health outcomes and reduced healthcare costs, as individuals with residual kidney function	

typically require lower doses of medications and experience fewer complications. 6. PD has a lower carbon footprint in comparison to facility haemodialysis, which required large quantities of electricity for the operation of haemodialysis machines and haemodialysis facilities, and fossil fuels for the transportation of patients to and from haemodialysis locations. 7. PD consumes far less water than haemodialysis, which can require up to 500 litres of water per treatment session.	
Setting the national efficient price. Page 13 Consultation question 4: Are there any other proposed refinement areas for the Tier 2 Non-Admitted Services Classification for 2024–25? Background: Facility haemodialysis patients are classified as day-case admissions and currently make up 16% of hospital admissions and are the most common reason for admission to hospital. Any changes to this admission classification would increase pressure on an already stretched system.	**Feedback insert:** ANZSN wants to ensure there is no change to the current facility haemodialysis patient classification. There are many benefits for admitting these patients as day-cases. It allows patients to receive their scheduled dialysis treatment in a controlled environment and ensures that they receive the necessary care during each session. By admitting patients as day cases, healthcare professionals can closely monitor their vital signs, assess their response to treatment, and provide any necessary medical interventions during the session. This level of monitoring and support helps ensure the safety and effectiveness of the dialysis treatment. Day case admission allows patients to receive their dialysis treatment and return home on the same day. This provides flexibility and convenience for patients, as they can plan their treatment sessions around their daily routines and responsibilities, such as work, family, and other activities. It also helps the utilisation of healthcare resources, including dialysis machines, nursing staff, and facility capacity. It allows dialysis centres to treat a larger number of patients efficiently and accommodate more individuals in need of dialysis treatment.

	It is also cost effective as admitting patients as day cases for dialysis treatment is often more cost-effective compared to prolonged inpatient stays. It reduces the need for hospital beds and associated hospitalisation costs while still providing the necessary care and treatment for patients. We are also concerned that any changes to Tier 2 Non-Admitted Services Classification for 2024–25 may adversely impact Home Haemodialysis Training Units. Home haemodialysis is associated with better patient outcomes, greater patient convenience and reduced healthcare costs compared with facility haemodialysis. Application of any financial disincentive to home haemodialysis will undermine these benefits and further exacerbate the facility haemodialysis capacity crises that currently exist in many parts of Australia, particularly the Northern Territory. First Nations Australians, culturally and linguistically diverse populations and people living in rural and remote locations are the ones most likely to be most disadvantaged by any classification refinement that adversely impacts home haemodialysis.