

General use items – utilisation, expenditure and integrity

APHA CONSULTATION SURVEY ANSWERS

September 2024

Contents

GUI consultation questions	3
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List of tables and figures

Table 1 General use separations, item utilisation and benefits	6
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Figure 1 GUI benefit per separation.....	6
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Figure 2 GUI utilisation per separation	7
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GUI consultation questions

Q1. What do you see are the key areas of concern for the integrity of the PL settings in the context of the GUIs?

- There is insufficient evidence and stakeholder engagement to support concerns around the integrity of the current PL settings in relation to GUIs.
- Management of rising costs associated with inflation and other financial pressures
- Risks to necessary clinical utilisation of GUIs and restrictions on the ability of health professionals to adequately treat patients
- Reductions in PHI benefits to the PL in general and the specific impact of those reductions on GUIs
- Lack of certainty about the stability of the government's policy on GUIs. This decision to retain GUIs on the PL followed consistent feedback from multiple stakeholders that removing the GUIs from the PL without an alternative funding arrangement would have negative clinical implications and potential adverse outcomes for patients.
- There is also concern that some stakeholders are able to exert a disproportionate influence over the department's monitoring and compliance outcomes due to the asymmetry of information resulting from a lack of equal access to the relevant data.

Q2. If you were to prioritise options for improved integrity, what order would deliver the most meaningful outcomes?

- Greater availability of data related to GUI utilisation and subsequent details on growth or fall in use per episode
- Positive steps such as engaging with clinical peak bodies to encourage the considerate use of resources by health professionals where the data shows this is not the case
- Alternate mechanisms to fund necessary GUIs to prevent adverse impacts on patients and private hospitals
- Investment in the domestic manufacturing capacity for GUIs to lower purchase costs of GUIs.

Q3. What are some potential system-based actions that could be taken to improve integrity?

- Enhanced data collection and statistical publications
- Evidence-based policy adjustments to ensure that GUI usage aligns with clinical need and that policy does not restrict the effective provision of care by health professionals.
- Engagement with insurers on the clinical perspective on appropriate GUI usage and the importance of accurate reporting
- Development of a national index to benchmark GUI usage per episode of care for the purpose of identifying potential signals of compromised integrity
- Conducting regular audits and reviews of GUI usage to ensure compliance with guidelines and identify any discrepancies (where appropriate and in line with data collected).

a. By who and when?

- The Department to provide robust and transparent evidence for any proposed changes to settings (immediate, medium and long-term)

- Health Practitioners to reporting on GUI use under exceptional clinical circumstances requiring unusually high utilisation (medium and long-term)
- Engagement between government, clinicians and hospitals on evidentially determined statistical benchmarks of levels of GUI utilisation (medium and long-term).
- Private Hospitals to support efforts to collect data on GUI use (medium and long-term)

b. How would you suggest the success of these actions is measured?

- Against a uniform data set that presents details on the growth or fall in utilisation of GUIs with consideration of differences in procedures and the clinical needs of different patient cohorts.

c. What are the likely consequences – positive/negative and who would they affect?

- Positive Consequences include:
 - Enhanced data collection and reporting leading to more accurate assessments of GUI utilisation and its impact on patient care
 - With precise data, resources can be allocated more effectively, ensuring that GUIs are used where they are most needed.
 - By aligning GUI use with clinical needs, patient outcomes can improve.
- Negative Consequences include:
 - Health practitioners and hospitals facing additional administrative burden related to data collection and reporting.

Q4. Are there specific sub-categories of GUIs on the PL that represent concerning areas of growth in utilisation per episode of care that are driving increases in benefit expenditure?

There is insufficient data or evidence to support any concerns in relation to specific categories of GUI. Private hospitals are unlikely to experience overutilisation of GUIs due to the commercial constraints on the quantities of inventory they can procure and hold.

Q5. Are there specific types of procedures/episodes of care that represent higher growth in utilisation based on standard of care/clinical practices?

There are potentially some types of procedures and episodes of care that have shown higher growth in utilisation based on changing standards of care and clinical practices. There is potentially a trend towards more frequent utilisation, in terms of the number of general use separations, reflecting a larger number of patients receiving treatment with GUIs. Meanwhile, there is evidence of less intensive utilisation, in terms of the number of items used per separation (Table 1).

Q6. If there are concerns that the growth in use is not related to clinical need, how is this determined/measured? Who can validate this?

Determinations of growth in use and the relationship between GUI usage and clinical outcomes requires analysis of GUI usage over time to identify any significant increases that do not correlate with changes in clinical guidelines or patient demographics. Comparative studies on GUI usage across different hospitals and regions to identify outliers may indicate overuse or misuse may also be helpful. It may also be helpful to assess whether increased GUI usage is associated with improved patient outcomes.

Government should gather feedback from healthcare providers, patients, and insurers to understand the reasons behind increased GUI usage, if identified, and engage with clinical experts to review and validate the necessity of the levels of utilisation in specific cases.

This can be measured using utilisation metrics, clinical outcomes, and by engaging in a cost analysis. IHACPA, healthcare providers, regulatory bodies, and academic and research institutions will be helpful to validate assumptions and facts.

Q7. What system-based mechanisms are either in place or need to be put in place to address this problem?

- Implementing robust utilisation review processes to ensure that GUIs are used appropriately and efficiently.
- Reviewing, developing, and encouraging the use of clinical guidelines to standardise the use of GUIs based on best practices.
- Providing ongoing education and training for healthcare providers, through specialist colleges, on the appropriate use of GUIs.
- Using data analytics to monitor utilisation patterns and identify areas of concern.

a. Would these mechanisms be different if there was a demonstrated clinical need?

If there is a demonstrated clinical need, the mechanisms might include those previously recommended but also require the application of adjustments to funding algorithms to support financially sustainable utilisation without reducing the clinical benefit to patients.

b. Would a national index that benchmarks the usage per episode of care (based on the IHACPA bundled benefit work) provide a reasonable measure from which to determine actions to adjust the PL benefits per grouping?

Yes, this would be useful. However, the success of this as a measure will rely on the factors that it considers, and the degree of standardisation that can be attained.

Q8. How would you suggest the success of these actions are measured?

- Against a comprehensive implementation plan with KPIs and milestones
- Quarter-by-quarter comparison of GUI usage

Q9. What are the likely consequences – positive/negative and who would they affect?

Excessive compliance requirements and disproportionate consideration given to them may cause adverse impacts to patients, health practitioners, and private hospitals by undermining clinical needs, restricting the necessary use of resources and increasing the administrative costs for private hospitals at a time when the industry is already under immense pressure. This may eventually result in greater out-of-pocket costs for patients.

Q10. Are there other areas of concern with the retention of GUIs on the PL that need to be considered?

The positive impacts of retaining GUIs on the PL need to be more pronounced and should be presented in an impact analysis. Data released by the Australian government has shown a downward trend in both the GUI use per separation and GUI benefit paid per separation.¹ It is unreasonable for some stakeholders to argue that GUI utilisation has increased and reflects wastage in the sector. This is a misrepresentation of the situation. In the period between the calendar years (CY), CY2019-CY2022, the GUI use per separation reduced from an average of 2.90 to 2.64. Furthermore, during

¹ [Hospital Establishment – Type by Prostheses list product group | Australian Government Department of Health and Aged Care](#)

the same period, the GUI benefit paid per separation reduced from an average of \$635.58 to \$557.77.

Period	Number of General Use Separations	Number of GUI Items	GUI use per separation	Total GUI Prostheses Benefits Paid (\$)	GUI Benefit Paid per separation (\$)
CY2019	368,408	1,069,913	2.90	234,156,000	635.58
CY2020	348,557	960,948	2.75	213,174,000	611.59
CY2021	383,018	1,041,116	2.71	233,532,000	609.71
CY2022	346,383	918,735	2.64	193,203,000	557.77

Table 1 General use separations, item utilisation and benefits

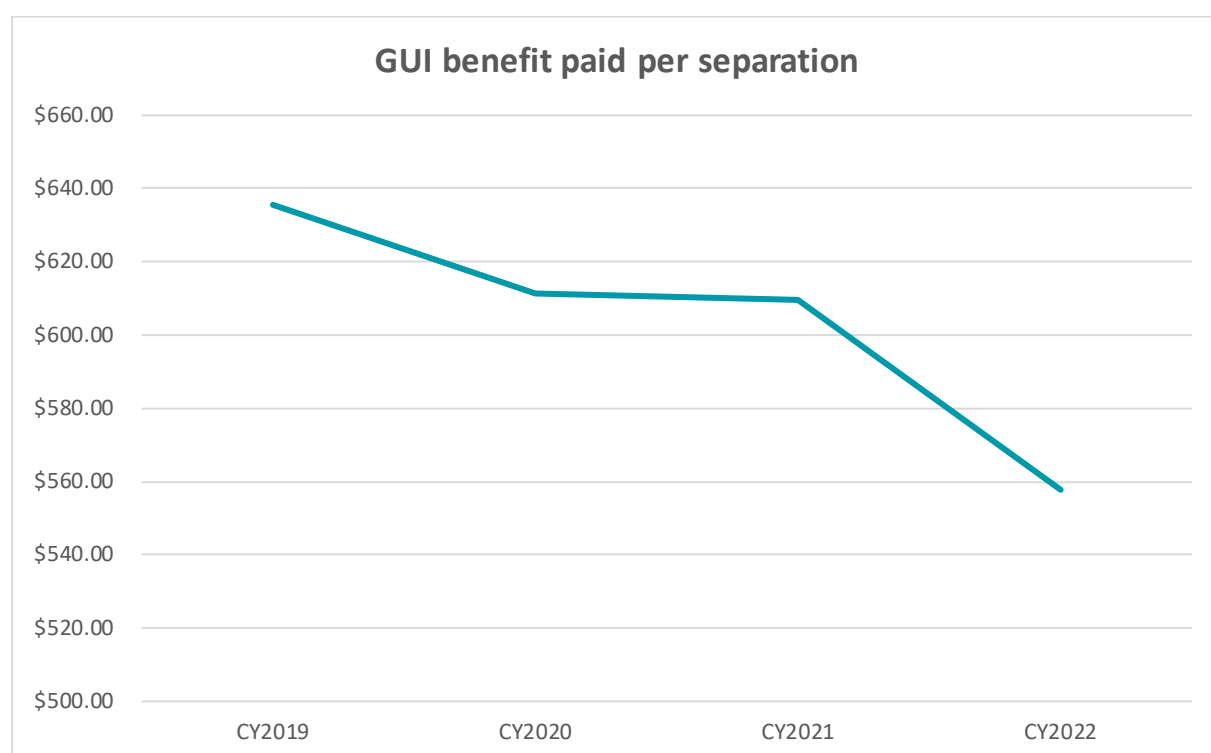


Figure 1 GUI benefit per separation

Source of data: Hospital Establishment – Type by Prostheses list product group | Australian Government Department of Health and Aged Care (last updated 28 September 2023)

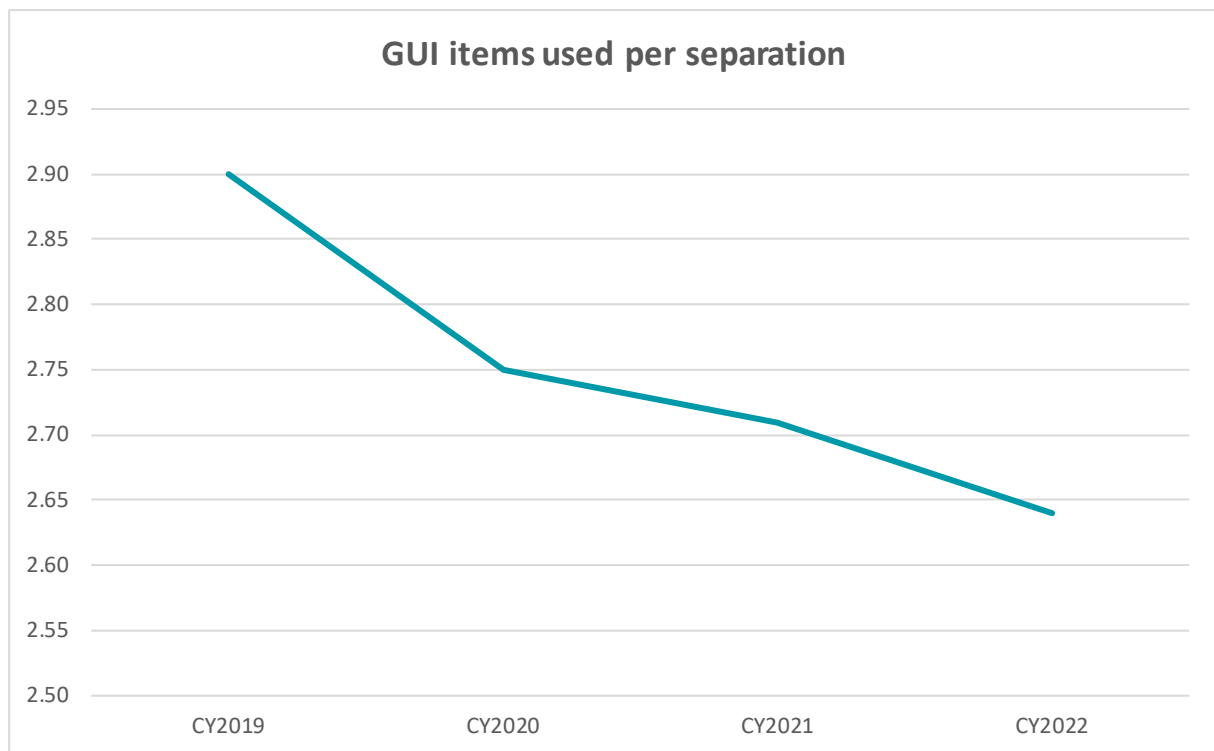


Figure 2 GUI utilisation per separation

Source of data: Hospital Establishment – Type by Prostheses list product group | Australian Government Department of Health and Aged Care (last updated 28 September 2023)

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