AUSTRALIAN DENTAL ASSOCIATION

14-16 Chandos Street, St Leonards, NSW, 2065, Australia
Tel 02 8815 3333 | contact@ada.org.au | ARBN 131 755 989 | ABN 95 174 118 424

14 July 2023

Professor Michael Pervan
Chief Executive Officer
Independent Health and Aged Care Pricing Authority
PO Box 483
Darlinghurst NSW 1300

By email: submissions.ihacpa@ihacpa.gov.au

Dear Professor Pervan

Re: Consultation on Pricing Framework for Australian Public Hospital Services 2024-25

Thank you for providing the Australian Dental Association (ADA) the opportunity to comment on the Independent Health and Aged Care Pricing Authority's (IHACPA) consultation on the pricing framework for Australian public hospital services 2024–25.

About us
The Australian Dental Association (ADA) is the peak representative body for dentists in Australia. Our 17,000-plus members operate more than 7,500 small businesses across Australia. They include highly trained professionals who work across the public and private sectors, in general dental practice, or in one of 13 areas of dental specialisation, in education and research roles, as well as dentistry students currently completing their entry-to-practice qualification.

The primary objectives of the ADA are to encourage the improvement of the oral and general health of the public, promote the ethics, art and science of dentistry and support members to provide safe, high-quality professional oral care.

Key message
Under the Australian Refined Diagnosis Related Groups Version 10.0 (AR-DRG Version 10.0), DRG D40Z Dental Extractions and Restorations is the single 'catch-all' DRG used to classify dental treatment under general anaesthetic. This DRG fails to capture complexity.

The 'catch-all' arrangement of DRG D40Z is contributing to hospitals choosing not to make theatre space available for paediatric and special needs patients who need dental treatment under general anaesthesia (GA).

We request your consideration of creating a complexity split in future versions of the DRG.

Background
In 2018 the ADA wrote to the then Independent Hospital Pricing Authority contending that a complexity split should be introduced for '*DRG D40Z Dental extractions and restorations*'.

We understand that IHACPA has resisted a complexity split within D40Z because hospital data does not support the view that there are sufficient variations in the complexity and costs of episodes of dental care provided to

clinically distinct groups of patients to warrant a split.

However, the ADA and the affiliate organisations representing paediatric and special needs patients believe that hospital statistics on the time and costs associated with D40Z do not present an accurate picture of the number of episodes of care associated with complexities of either a medical or a dental nature, or both, nor of the costs and time involved in providing quality dental treatment that will improve patient outcomes.

Reasons for inaccurate hospital statistics for dental procedures under GA

- ***Coders not translating the original information:***

The ADA has been advised by dentists providing care under GA that coders are not translating information from clinical notes to hospital coding systems, including medical comorbidities (e.g. epilepsy, cardiovascular problems, muscular dystrophy or cerebral palsy) in addition to anatomical abnormalities that complicate intubation, anaesthesia and airway management.

The ADA is advised that in some public and private hospitals, a practice commonly followed is that for DRGs ending in 'Z', comorbidities are not coded.

- ***Inadequate activity-based funding allocations in public hospitals:***

Dentists providing treatment under GA advise us that only the shortest and most straightforward cases are recorded in hospital data resulting in inadequate activity-based funding allocations.

Due to inadequate activity-based funding for more lengthy and complex dental care procedures, public hospital administrators prefer to give operating theatre time to short dental cases rather than more prolonged dental issues that reflect the same clinical need. Hence, complex and lengthy procedures are not reflected in the hospital data.

- ***Low or non-existent rebates for dental treatment under private health insurance:***

Dentists providing treatment under GA advise us of low or non-existent rebates for dental treatment under private health insurance policies, often leading to patients asking the treating dentist to treat only the most urgent dental problem that is causing the most pain or distress, even if they have other treatment needs that would ideally be treated immediately, under the one anaesthetic, and that this results in inaccurate hospital statistics.

- ***Time limits on dental procedures:***

Dentists providing care under GA advise us that privately-run hospitals and day procedure facilities restrict dental surgery lists and length of theatre time provided to dental procedures and prefer scheduling medical procedures which are more efficient / profitable.

Private health insurers generally pay considerably more to hospitals and day procedure facilities to cover associated hospital costs for these other medical procedures. The often shorter and more predictable duration of these procedures also allows hospitals to schedule a greater number of patients per day.

Many private hospitals tailor the maximum length of dental procedures to the best payment that they can negotiate with private health funds while achieving profitability. In these cases, the dentist must either reduce the quality of care provided or complete the treatment over multiple GA procedures. Both options have negative implications for the patient.

For the above reasons, we believe the hospital data on which IHACPA has relied to make decisions about dental DRG complexity splitting is inaccurate in terms of cost profile and length of procedure. We believe the existing DRG categorisation disadvantages dental patients relative to patients with other medical conditions.

It is inefficient for preventable readmissions to occur and secondly, detrimental to a patient's health for dental problems to be left untreated.

ADA Recommendations:

- DRG D40Z be stratified, we suggest by:
    a. medical comorbidities,
    b. need for diagnostic procedures under GA,
    c. number of teeth treated, and
    d. weighted for complexity of dental treatments provided.

- IHACPA engage with organisations representing oral health services for paediatric, adult and special needs populations to establish precise parameters for a complexity split for D40Z. In addition to the ADA we recommend engagement with the:
    a. Australian and New Zealand Society of Paediatric Dentistry,
    b. Australasian Academy of Paediatric Dentistry,
    c. Australia and New Zealand Academy of Special Needs Dentistry,
    d. Australian Society of Special Care in Dentistry, and
    e. heads of hospital-based dental units who have significant expertise in this area of service delivery.

- A more equitable manner for calculating national efficient price and national efficient cost, based on accurate coding and costing of dental complexities should be developed.

- Remove activity-based funding incentives that lead hospital administrators to privilege theatre access for some medical procedures over dental procedures that reflect equivalent clinical need.

We enclose a copy of our 2018 submission which discusses these matters in more detail.

Thank you for your attention to this matter. Should you have any questions, please do not hesitate to contact Mr Damian Mitsch, ADA Chief Executive Officer, on 02 8815 3333.

Yours sincerely,

Dr Stephen Liew
President
Enc.