



# **PRE-BUDGET SUBMISSION 2013-14 FEDERAL BUDGET**

## **Charting a comprehensive approach to tackling kidney disease**

***“Proposals to guide increased risk assessment,  
support early detection and improve the treatment  
of kidney disease”.***

# **Kidney Health Australia**

**January 2013**

***Kidney Health Australia is a national health care charity with a vision ‘to save and improve the lives of Australians affected by kidney disease’. As the national peak body, Kidney Health Australia promotes good kidney health through the delivery of programs in education, advocacy, research and support.***

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## Introduction – The Rising Burden of Kidney Disease

Chronic Kidney Disease (CKD) is a major health problem, and one that is growing. Without greater focus from the Australian Government, there is clear evidence based on current trends that the situation has the potential to worsen. Kidney Health Australia estimates that 1 in 3 Australians are at an increased risk of developing CKD<sup>1</sup>. Approximately 1.7 million Australians – a striking 1 in 9 – over the age of 25 years have at least one clinical sign of CKD. And the situation is much worse for at ‘risk groups’.

Yet to date, CKD has received little attention, particularly when compared to other chronic diseases. The treatment of those with CKD continues to cost governments in Australia approximately \$1 billion<sup>2</sup>, per year, and a recent economic study by Kidney Health Australia estimates that the cumulative cost of treating all current and new cases of end stage kidney disease (ESKD) from 2009 to 2020 is between approximately \$11.3 billion and \$12.3 billion. It is clear that kidney disease is a measurable cost to the health system, not to mention a considerable cost in forgone productivity.

Kidney Health Australia therefore presents this submission with a range of initial suggested actions to help address the increasing burden of CKD and ESKD. As the peak national body representing the needs of those with kidney disease in Australia, Kidney Health Australia is well placed to identify the current policy impediments to improved health outcomes and offer evidence based, sensible and cost effective solutions for consideration by government.

Kidney Health Australia advocates on matters relating to the welfare of kidney stakeholders and the delivery of services to people affected by CKD in all its stages. Furthermore, Kidney Health Australia has close ties with consumers, the medical community, renal units around the nation and is a member of the *Australian Chronic Disease Prevention Alliance (ACDPA)* and the *National Vascular Disease Prevention Alliance (NVDPA)*. Kidney Health Australia is committed to achieving its mission through engaging with renal sector professionals and consumer stakeholders in all initiatives and linking with other key chronic illness programs in an integrated way. Kidney Health Australia’s work is carried out in consultation with the nephrological community and with significant input from our national network of consumers.

In its 44-year history, Kidney Health Australia, has built a significant evidence base to support its activities and strong support from the community to continue to initiate efforts to reduce the incidence and impact of CKD. This submission represents the next key steps in tackling the problem by building on our existing achievements, and is an impetus for continued improvement. The submission presents a package of evidence-based and cost-effective interventions spanning strategic planning, improved early detection, education, the funding of ongoing treatment and organ donation.

The priority initiatives identified in this proposal focus on improving health outcomes, removing barriers to care for people with CKD, and making savings to the national health budget through either low-cost or no-cost initiatives, initiatives that return direct savings to the budget, or those which could be expected to alleviate a strain from the health system over time and improve national productivity. Each initiative addresses an area where there is good evidence that action is needed, and where there are clear potential benefits for people with CKD across the continuum of care.

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<sup>1</sup> Chadban SJ, Briganti EM, Kerr PG et al. Prevalence of kidney damage in Australian adults: The AusDiab kidney study. *J Am Soc Nephrol* 2003 July;14(7 Suppl 2):S131-S138.

<sup>2</sup> Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at: <http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837>

## Summary of Proposals

A small considered number of interventions and strategies are proposed in the attached Budget submission, which are summarised in the table below.

Kidney Health Australia has included proposals to address the full spectrum of the health sector – from strategic planning, early detection, education and support in the primary care sector, to acute care funding and organ donation. All of the proposals are realistic, designed to be low-cost, no-cost or generate savings and have one principle in common – they are all designed to improve the lives of those with kidney disease through smart, targeted interventions, which seek to support existing efforts and policy.

| Proposed Policy   | Investment  |
|---|---|
| <b>The development of a new <i>National Chronic Disease Strategy</i> and <i>National Service Improvement Frameworks</i> recognising the rising incidence and cost of chronic kidney disease.</b>  | Low cost/ No cost - Departmental resources to staff appropriate secretariat.                            |
| <b>Integrated Health Checks to streamline current approaches and promote early detection of those at high risk of developing cardiovascular disease, diabetes and chronic kidney disease and ensure effective, on-going management.</b>   | Potentially cost-saving.  |
| <b>Education to support General Practitioners with the increased detection of CKD in people with diabetes, following the January 2013 decision by Government to include a measurement of kidney function in the diabetes PIP payment.</b>   | Low cost ~ \$260,000.   |
| <b>A comprehensive approach to funding all modalities of dialysis through appropriate recognition and promotion of an increased uptake of home dialysis, including associated costs to the patient.</b>   | Potentially cost-saving.  |
| <b>The establishment of a <i>National Live Organ Donor Leave Scheme</i>. This scheme would provide federal funding to assist employers with the salary costs of providing leave for staff who wish to donate a kidney, and therefore work to remove one of the financial disincentives suffered by live organ donors.</b> | Significant savings to Government resulting from forgone dialysis and productivity (taxation receipts). |

## The Cost to the Health System

Approximately 1.7 million Australians - a striking 1 in 9 - over the age of 25 years have at least one clinical sign of existing CKD, such as reduced kidney function and the presence of proteinuria (protein in the urine) or haematuria (blood in the urine)<sup>3</sup>.

In addition, one in three Australians is at an increased risk of developing CKD<sup>4</sup>. Australians are at increased risk of CKD if they are:

- Are 60 years or older
- Are of Aboriginal or Torres Strait Islander origin
- Have diabetes
- Have a family history of kidney disease
- Have established heart problems
- Have high blood pressure
- Are obese
- Are a smoker

As outlined above, CKD continues to cost governments in Australia approximately \$1 billion<sup>5</sup>, per year, and the cumulative cost of treating all current and new cases of end stage kidney disease (ESKD) from 2009 to 2020 is estimated to be between approximately \$11.3 billion and \$12.3 billion. In addition, a recent study from the UK confirmed the sizable funding required to support treatment for kidney disease highlighting that the National Health Service (NHS) in England's annual spend on kidney care was estimated at £445 million in 2002 (£566 million in 2009-10 prices, or \$852 million Australian dollars). Furthermore the study indicated that program budget analysis by the Department of Health in England estimated that 'the total NHS expenditure on kidney care, including CKD, at £1.64 billion in 2009-10' (\$2.4 billion Australian dollars)<sup>6</sup>.

The nature of kidney disease dictates that it needs health initiatives to be ingrained across the full spectrum of the health policy making sphere, and do so in consideration with other chronic diseases, such as diabetes and vascular disease. Indeed, diabetes is the top cause of end stage kidney disease in Australia at 35%, while hypertension causes an additional 15% of cases.

The most recent data from the Australian Bureau of Statistics (ABS)<sup>7</sup> shows that kidney failure is a significant cause of death. In 2010, disease of the kidney and urinary tract were the 10<sup>th</sup> leading cause of deaths in Australia, with 3,315 deaths<sup>8</sup>. This represents a 21% increase in deaths from kidney disease since 2001 (2,741) – it kills more people each year than breast cancer, prostate cancer<sup>9</sup> or even road deaths. Furthermore, the ABS statistics for multiple causes of death indicates that diseases of the kidney and urinary tract contributed as a 'multiple cause' to the deaths of 19,147 people in Australia in 2010 – a striking average of more than 50 deaths per day.

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<sup>3</sup> White SL, Polkinghorne KR, Atkins RC, Chadban SJ. Comparison of the prevalence and mortality risk of CKD in Australia using the CKD Epidemiology Collaboration (CKD-EPI) and Modification of Diet in Renal Disease (MDRD) Study GFR estimating equations: The AusDiab (Australian Diabetes, Obesity and Lifestyle) Study. *Am J Kidney Dis* 2010;55(4):660-70.

<sup>4</sup> Chadban SJ, Briganti EM, Kerr PG et al. Prevalence of kidney damage in Australian adults: The AusDiab kidney study. *J Am Soc Nephrol* 2003 July;14(7 Suppl 2):S131-S138.

<sup>5</sup> Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at: <http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837>

<sup>6</sup> Kerr M, Bray B, Medcalf J, O'Donoghue DJ and Matthews B. Estimating the financial cost of chronic kidney disease to the NHS in England. *Nephrol Dialysis Transplantation*

<sup>7</sup> Australian Bureau of Statistics. Causes of death, 2010. 2012.

<sup>8</sup> Australian Bureau of Statistics. Causes of death, 2010. 2012.

<sup>9</sup> Australian Bureau of Statistics. Causes of death, 2010. 2012.

***Sadly there has been a 21% increase in deaths from kidney disease since 2001, killing more people each year than breast cancer, prostate cancer or even road deaths.***

The most recent data that is available from the Australia and New Zealand Dialysis Transplant (ANZDATA) Registry<sup>10</sup> shows that 2,453 people started kidney replacement therapy (dialysis or transplant) in 2011. The number of people on dialysis has increased by 4% from 2010 to 2011, resulting in nearly 11,000 people receiving dialysis treatment at the end of 2011.

With dialysis costing up to \$79,072 for hospital haemodialysis, \$65,315 for satellite, home haemodialysis \$49,137 and peritoneal dialysis \$53,112, it is clearly an expensive treatment. Current breakdowns indicate that 22% of Australian's receive dialysis at a hospital, 27% were dialysing at home 50% in satellite centres. However, despite the cost effectiveness to government and potential health benefits of home dialysis for the patient, there are significant state-by-state variations, ranging from 38% in NSW to as little as 12% in the Northern Territory and 19% in South Australia.

Even when averaging out the different modalities and their respective usage, Kidney Health Australia estimates that the average cost of supplying dialysis is still a considerable \$65,000 per person, per year. And of course, this does not take into account the lost productivity dividend resulting from these patients either being forced to reduce their work hours, or leave employment altogether. In light of these considerable costs, Kidney Health Australia therefore provides below a number of policy proposals, which together form a comprehensive 'next step' for policymakers in the federal government to consider.

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<sup>10</sup> ANZDATA. Australia and New Zealand Dialysis and Transplant Registry Interim Summary. 2012. [www.anzdata.org.au](http://www.anzdata.org.au)

## National Chronic Disease Strategy

The current National Chronic Disease Strategy, designed to provide an overarching framework of the national direction for improving chronic disease prevention and care across Australia, is now in need of revision. Agreed at the Australian Health Ministers' Conference 2005, the Strategy represents a national agenda to encourage coordinated action in response to the growing impact of chronic disease on the health of Australians and to guide a response to the increasing burden on the health care system.

Sitting under the Strategy are supporting National Service Improvement Frameworks covering the health priority areas of asthma, cancer, diabetes, heart, stroke and vascular disease, osteoarthritis, rheumatoid arthritis and osteoporosis<sup>11</sup>. As outlined in the strategy the "*Frameworks outline opportunities for improving prevention and care in relation to these diseases, while not prescribing the detail of individual services in the Australian health system*". A key part of the frameworks for the above health conditions was that they are structured to reflect the patient journey, ranging from the reduction of risk, early detection, managing acute conditions, long-term care and care in the advanced stage of the disease.

### The case for change

With seven years now having passed since the strategy was developed, Kidney Health Australia is of the view that it is now an appropriate time for an updated Strategy, along with the subsequent frameworks and dedicated action plans be redeveloped.

Since 2005, the health sector has undergone significant reform – covering the entire spectrum of the health system, starting with the *National Preventative Health Strategy* and the Government's response to the preventative taskforce, *Taking Preventative Action*. The resulting actions stemming from these documents need to be taken into any high level strategy to address chronic disease.

The changes made in response to the *National Health and Hospitals Reform Commission*, and the introduction of Activity Based Funding (ABF) for Hospital Services also need to be considered, recognising that for many with chronic disease, ongoing treatment within the acute healthcare sector represents a way of life. In particular, those with ESKD are required to utilise one of the many modes of dialysis in order to survive until such time as a transplant becomes a possibility - so any changes to the funding, and therefore delivery of these services for ESKD and chronic disease patients, must be reflected within the overarching chronic disease strategy.

Australia's first *National Primary Care Strategy* has also since been developed, with Divisions of General Practice now evolving into Medicare Locals and significant workforce, educational and training changes made in the primary care sector. Specifically, the *Primary Care Strategy* articulated one of the four key priority areas for change as the "Better Management of Chronic Conditions", while another was the "Increasing Focus on Prevention"<sup>12</sup>. Both of these key priorities, combined with the other two priorities of "Improving Access" and "Improving Quality, Safety, Performance and Accountability" need to be reflected and updated now within the *National Chronic Disease Strategy* in recognition of the fact that primary care can, and should, play a larger role in the detection and ongoing management of chronic disease, including CKD. This is particularly true of the *Primary Care Strategy's* statement that the system should have "*Strengthened, integrated and more systematic*

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<sup>11</sup> Australian Health Ministers' Conference (2005) *National Chronic Disease Strategy* p.3

<sup>12</sup> Building a 21<sup>st</sup> Century Primary Health Care System: Australia's Primary Health Care System.

[http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005FOA4/\\$File/6552%20NPHC%201205.pdf](http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005FOA4/$File/6552%20NPHC%201205.pdf) p.11

*approaches to preventative care with regular risk assessments, supported by data and best use of the workforce<sup>13, 14</sup>.*

With regard to the current situation surrounding kidney disease, the most recent report from the Australian Institute of Health and Welfare indicates that the incident rate of treated ESKD is projected to increase by nearly 80% between 2009 and 2020. In addition, the proportion of patients to commence treatment with diabetes is projected to increase nearly 20% between 2009 and 2012<sup>15</sup>.

***The incident rate of treated ESKD is projected to increase by nearly 80% between 2009 & 2020.***

These are striking increases, and it is clear they need to be accounted for within the *National Chronic Disease Strategy*, and clear linkages with other key health plans, frameworks and action plans created so that government and the health sector have a roadmap for tackling these increases.

Furthermore, with the recent release of the Australia Bureau of Statistics 'Australian Health Survey', the first national bio-medical survey, there is now an increased dataset to re-assess Australian's current health status, and in particular the number of Australians at risk of developing chronic diseases. This is particularly important when you consider that the Australian Health Survey identified a strong disconnect between actual health status and perceptions, with over 55% of Australian's believing themselves to be in very good or excellent health - despite the fact that nearly two thirds of Australians are overweight or obese<sup>16</sup>.

Finally, a revised approach will also provide the opportunity to align with recent international action in combating chronic disease, including kidney disease. In 2011, the United Nations has recognised kidney disease specifically, through Item 19 of the Resolution adopted by the General Assembly on the 'Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases', which stated that member states:

*"Recognize that renal, oral and eye diseases pose a major health burden for many countries and that these diseases share common risk factors and can benefit from common responses to non-communicable diseases."<sup>17</sup>*

This was only the second time in history of the United Nations that the General Assembly has met on a health issue. The meeting was undertaken with the aim of countries adopting a 'concise action-orientated outcome document that will shape the global agendas for generations to come'<sup>18</sup>.

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<sup>13</sup> Building a 21<sup>st</sup> Century Primary Health Care System: Australia's Primary Health Care System.

[http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005FOA4/\\$File/6552%20NPHC%201205.pdf](http://www.health.gov.au/internet/yourhealth/publishing.nsf/Content/3EDF5889BEC00D98CA2579540005FOA4/$File/6552%20NPHC%201205.pdf) p.12

<sup>14</sup> Kidney Health Australia, along with the Heart Foundation, Stroke Foundation and with the support of the Australian Medicare Locals Alliance are advocating for a proposal to specifically address risk assessments in primary care in this budget submission. Furthermore, Kidney Health Australia is also advocating for a dedicated education program to make best use of the primary care workforce in identifying CKD in those at high risk in an additional policy proposal outlined below.

<sup>15</sup> Australian Institute of Health and Welfare (2011) *Projections of the incidence of treated end-stage kidney disease in Australia 2010-2020*

<sup>16</sup> <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4364.0.55.001Chapter1002011-12>

<sup>17</sup> Political Declaration of the high-level meeting of the General Assembly on the prevention and control of the Non-communicable diseases (2011) available:

[http://www.who.int/nmh/events/un\\_ncd\\_summit2011/political\\_declaration\\_en.pdf](http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf) p.3

<sup>18</sup> [http://www.who.int/nmh/events/un\\_ncd\\_summit2011/en/](http://www.who.int/nmh/events/un_ncd_summit2011/en/)

In addition, the Australian Government has been an active participant in the global non-communicable disease (NCD) community and the development of a global NCD campaign, draft Global Monitoring Framework and Global Action Plan. This international leadership is seeking to develop a comprehensive global approach to tackling the leading causes of mortality and morbidity across the globe, and should therefore be complemented by a revised and more comprehensive national chronic disease strategy, that includes appropriate funding to implement lasting change.

### Budget Proposal for Consideration

Noting the fact that kidney disease is linked to most of the other chronic diseases and spans the full spectrum of the health continuum from health promotion and early detection to treatment in the acute sector, a revised *National Chronic Disease Strategy* should again consider chronic disease from the point of prevention through to ongoing management, while taking into account the above factors.

As page 3 of the existing strategy highlights “A continuum of chronic disease prevention and care interventions corresponds to different population groups – people without disease, those at risk of disease, and people currently coping with chronic disease.<sup>19</sup>” As outlined in the introduction to this submission the economic impact of CKD, combined with the rising and projected prevalence of the disease means that concrete action to tackle rising rates of chronic disease, while better supporting those already with chronic disease, are in need of review. Specifically, more needs to be done to prevent, slow the progression of, and delay the onset of CKD through greater recognition within a revised strategy, but also the creation of a dedicated Framework for CKD, matching those already developed for heart, diabetes and stroke.

The Department of Health and Ageing commit the necessary resources to commence the development of a new *National Chronic Disease Strategy* to address the changing nature of chronic disease in Australia, and develop new associated Frameworks, including a new *Framework for Kidney Disease* in recognition of the rising prevalence and impact of chronic kidney disease on the Australian population.

In the development of a new *National Chronic Disease Strategy*, Kidney Health Australia would advocate for a similar development processes employed last time, that is:

- The establishment of a reference group to provide guidance to the Strategy’s development
- The establishment of a working group of individuals representative of both the policy and medical community
- Strong collaboration with key stakeholders, such as the peak chronic disease, workforce and indigenous health bodies
- That appropriate funding be put aside in future years to fund the changes outlined in a new comprehensive *National Chronic Disease Strategy*.

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<sup>19</sup> Australian Health Ministers’ Conference (2005) *National Chronic Disease Strategy*, p.3

## Integrated Health Checks in Primary Care

This proposal advocates for the introduction of an integrated health check in general practice to assess for risk of cardiovascular disease (CVD), type-2 diabetes and chronic kidney disease with coordinated management of those diagnosed with chronic disease through Medicare Locals. This is a joint Heart Foundation, Stroke Foundation and Kidney Health Australia proposal with the support of the Australian Medicare Locals Alliance.

### The case for change

Cardiovascular disease (CVD) is Australia's largest killer, causing more than 46,000 deaths each year, almost one-in-three deaths.<sup>20</sup> It accounts for 18% of the overall burden of disease in Australia and is the most expensive disease group in terms of direct healthcare costs, at \$7.9bn a year or 11% of recurrent expenditure.<sup>21</sup>

CVD also has a strong relationship with other significant chronic diseases, in particular type two diabetes and of course, chronic kidney disease - the impacts of which are outlined extensively in this submission. Because they share risk factors, underlying causes and disease mechanisms, these major chronic diseases often occur together. For example, it is estimated that more than 400,000 Australians have both CVD and diabetes, and as outlined above, 35% of those who progress to ESKD have diabetes. Importantly, effective prevention and management of one condition can lead to reduction in the risk of related diseases.<sup>22</sup>

Unfortunately, too many people are at high risk of developing these diseases, or living with them, go unrecognised, leading to avoidable premature death and disease at significant social and economic costs to the nation.

Early detection and ongoing management of these chronic diseases is the key to reducing the number of CVD events (such as heart attacks and stroke) occurring each year while also reducing the incidence of diabetes and chronic kidney disease.

But the current suite of government-funded health checks are not effectively identifying those at risk primarily because of low access rates, non-integrated approaches to CVD risk assessment and the absence of a national program to support better management of risks for CVD and related diseases like type two diabetes and kidney disease.

In 2009, the Australian Institute of Health and Welfare published a framework for monitoring the prevention of vascular and related disease.<sup>23</sup> The framework cited evidence that existing vascular and related disease assessment and management programs had limited uptake and were not well integrated or promoted as part of a national preventative health system. It revealed that less than a quarter of those over 75 years and only 6% of those aged 45-49 were accessing regular health checks.<sup>24</sup>

These figures are alarming, especially given the high prevalence of a number of significant risk factors in the community, including overweight/obesity, high blood cholesterol and high blood pressure.

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<sup>20</sup> Australian Institute of Health and Welfare (2010) *Australia's Health 2010*

<sup>21</sup> Australian Institute of Health and Welfare (2010) *Australia's Health 2010*

<sup>22</sup> Australian Institute of Health and Welfare (2009) *Prevention of cardiovascular disease, diabetes and chronic kidney disease: targeting risk factors*

<sup>23</sup> Australian Institute of Health and Welfare (2009) *Prevention of cardiovascular disease, diabetes and chronic kidney disease: targeting risk factors*

<sup>24</sup> Australian Institute of Health and Welfare (2009) data summarised in National Vascular Disease Prevention Alliance Position Paper, May 2011, *Risk awareness raising, assessment and management for the prevention of vascular and related diseases*

Recent data shows that while some risk factors, such as tobacco smoking, are in decline (though still highly prevalent), other risk factors are becoming increasingly prevalent or remain at very high levels.

The Australian Health Survey (2011-12) reveals that 63% of Australian adults are overweight or obese, up from 56% in 1995. More than 60% of men had a waist circumference that put them at an increased risk of developing chronic disease, while 67% of women had an increased level of risk.<sup>25</sup> The survey also shows that just over three million adults had measured high blood pressure.<sup>26</sup> A coordinated approach is required to increase awareness of individual vascular and related disease risk, to provide high quality assessment of individual risk and to provide appropriate interventions to support risk management.

### Budget Proposal for Consideration

***The current suite of government-funded health checks are not effectively identifying those at risk of low access rates, non-integrated approaches to CVD risk assessment and the absence of a national program to support better management.***

The Heart Foundation, Stroke Foundation and Kidney Health Australia with the support of the Australian Medicare Locals Alliance propose a high quality assessment of disease risk through the collection of data on major risk factors through simple questions, tests and measurements.

Comprehensive vascular and related disease risk assessments and ongoing preventative care for those people identified to be at higher risk should occur in a primary care setting, including that of general practice and Aboriginal medical services.

The assessment should include recognised measures to assess risk including:

- A CVD risk assessment (an absolute risk assessment where appropriate and consideration as high risk if clinically indicated)
- AUSDRISK (+/- blood glucose tests)
- Serum creatinine and urinary albumin

Assessment and classification of moderate and high-risk individuals should result in provision of medical interventions to reduce individual risk and referral to quality-assured lifestyle modification programs.

GPs would prescribe necessary medication and refer people at risk to lifestyle interventions that could be delivered through a range of community settings. Medical interventions could include drug treatments for high blood pressure and high blood cholesterol.

Lifestyle interventions could include: smoking cessation services; weight management or exercise and behaviour change programs. Lifestyle modification programs incorporating weight reduction, healthy eating and physical activity (eg Life! in Victoria, Get Healthy in NSW) are currently available for people at high risk of type 2 diabetes and could be broadened to include people who may be at increased risk of vascular diseases.

Establishment of a systematic process for identification of risk of CVD, diabetes and kidney disease will increase referrals to such programs, increasing their efficiency.

<sup>25</sup> Australian Bureau of Statistics (2012) *Australian Health Survey: First Results, 2011-12*

<sup>26</sup> Australian Bureau of Statistics (2012) *Australian Health Survey: First Results, 2011-12*

Consolidating the current existing primary health care approaches into an integrated health check will help GPs determine a person's absolute risk of a cardiovascular event and the most appropriate preventive measure for people who are at risk, but not yet showing symptoms, of disease.

This will have potentially significant benefits to those at risk as well as to the healthcare system. The direct health cost of CVD (currently \$7.9bn a year) and of CKD could be contained with early identification and management of those at high risk before they develop disease, particularly for those aged over 45. Anticipated benefits include systemic efficiencies, substantial cost savings and reduction in chronic disease related hospitalisations. In addition, the proposal supports a number of priority areas within the *National Primary Health Care Strategy 2010*.

The need to develop an integrated health check has been recognised in the UK, where the British Government's *Putting Prevention First* program (commenced in 2009) is based on vascular checks for people in middle-age.

The UK Health Department estimated that the vascular health check program could:<sup>27</sup>

- prevent at least 9,500 heart attacks and strokes a year (2,000 of which would be fatal)
- prevent at least 4,000 people a year from developing diabetes
- detect at least 25,000 people a year earlier with diabetes or kidney disease.

The Australian Government should fund an integrated health assessment program linking assessment, prevention, coordinated care and management which encompasses the following elements:

- 1. Assessment:** Assessment of risk factors, including kidney function, diabetes status (using AusDrisk or blood glucose testing in high risk individuals), and the calculation of an absolute risk score assessment for stroke and heart attack risk.
- 2. Prevention:** Prevention for those at high risk of type 2 diabetes or with high absolute cardiovascular disease risk or high kidney disease risk. Those identified at high risk of chronic disease in the assessment phase are referred to appropriate community-based lifestyle modification programs.

It is proposed that chronic disease care coordinators should be funded to assist with care coordination and provision of self-management support. There is good evidence that this coordination role has a positive impact on patient outcomes, is best performed by a non-GP care coordinator and leads to a significantly lower use of health services. To enhance the capacity of the chronic disease care coordinators to deliver the range of activities required, a primary health care provider network should be established to support the coordinators and other primary health care providers to promote interdisciplinary communication, networking and collaborative practice.

- 3. Management and treatment:** Pharmacotherapy and lifestyle advice are among the management and treatment tools for those at high risk of developing cardiovascular and related diseases.

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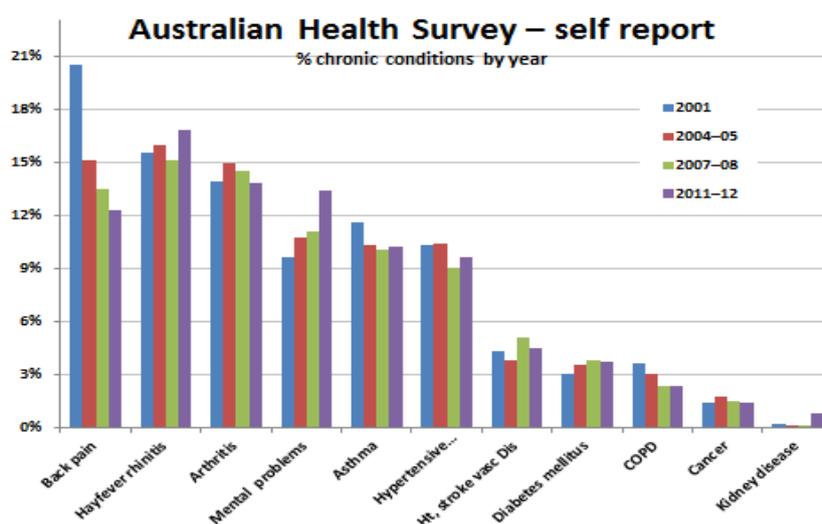
<sup>27</sup> UK Department of Health (2008) *Putting prevention first - vascular checks: risk assessment and management*

## Education to Support the Increased Detection of CKD in People with Diabetes

With the recent decision by the Federal Department of Health and Ageing to include a measure of kidney function as part of the GP Practice Incentive Payment (PIP) for the annual cycle of care people with diabetes, the below proposal outlines an education program to support GPs in undertaking this new work.

### The case for change

Population surveys have consistently shown that clinical evidence of CKD is present in about 11% of all adults<sup>28</sup>. The recent Australian Health Survey for the first time asked the question “do you have kidney disease? Only 0.8% responded “yes”, indicating that only one in 12 of those who had CKD was actually aware of it<sup>29</sup>. The low rate of awareness of CKD, particularly when compared to other chronic conditions, is highlighted in this figure and indicates a great deal more is required to be done in terms of education and awareness.



The last decade has seen the development of an International definition of CKD, which has led to a staging scheme with clinical action plans aligned to each stage. The recently amended staging scheme emphasises the need to ascertain the underlying diagnosis, establish the degree of kidney dysfunction and assess the presence of protein in the urine. This new staging scheme offers improved correlation with kidney and cardiovascular outcomes<sup>29</sup>.

Yet a recent report indicated that in rural general practice in Australia, there are significant shortfalls in the recording of kidney function and the recorded prescribing of appropriate kidney protective therapy<sup>30</sup>. Furthermore, the AusHeart study recently concluded that CKD is common, significantly under-recognised and under-treated in primary care<sup>31</sup>.

<sup>28</sup> AIHW 2009. An overview of chronic kidney disease in Australia 2009. Cat no. PHE 111. Canberra: AIHW

<sup>29</sup> Australian Health Survey, 2012. Accessed Dec 5, 2012

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/DC337D37739BC7BDCA257AC9001A845D?opendocument>

<sup>30</sup> Pilotto LS et al. Electronic records suggest sub-optimal management of CKD in general practice. *Aust J Rural health* 2012 :20; 195-199

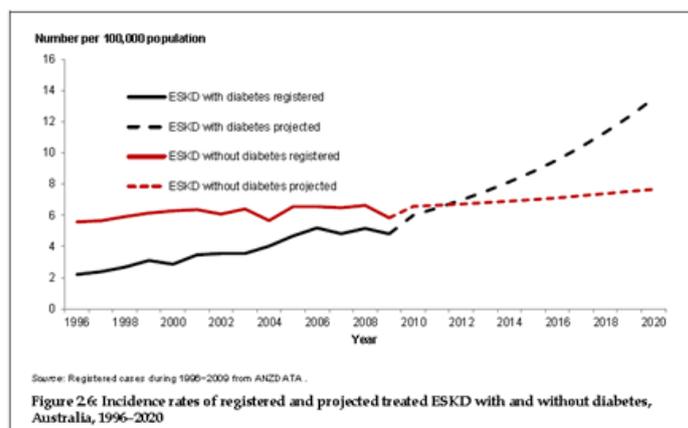
<sup>31</sup> Razavian M et al. Cardiovascular risk management in CKD in general practice (the AusHeart study). *Nephrol Dial Transplant*. 2012;27(4):1396-402.

Kidney Health Australia has recently distributed its booklet “Chronic Kidney Disease – management in general practice” to all practitioners in Australia<sup>32</sup>, in part to address this shortfall. This booklet captures the latest changes to the staging and management recommendations for people with CKD. This initiative was developed by the Kidney Check Australia Taskforce (KCAT) program that Kidney Health Australia has conducted for the last 10 years. The program, the only one of its kind in Australia, seeks to educate health professionals in primary care on the advances in knowledge and management of CKD. This program with limited funds has focussed its educational effort on face to face workshops, on-line learning and written material.

The broader Kidney Health Australia vision has been that all people identified to be at high risk of having CKD should be opportunistically offered a kidney health check (blood test, urine test and BP check) in primary care on a regular basis. Given that it has been estimated that 85-88% of all adults attend their general practitioner each year, this approach has the potential to be both effective and affordable. Yet, despite the obvious mechanism to carry out a kidney health check through such cost effective means by consolidating with existing GPs consultations, Australia remains a long way from achieving this vision, given the facts outlined in this submission.

In an effort to address this, one special focus of GP education for Kidney Health Australia have been people with diabetes. Studies have shown 50% of people with type 2 diabetes in general practice will have CKD, and 47% of all new people commencing dialysis in 2010 had diabetes (35% of the total had diabetes as the coded cause of their kidney failure). Projections indicate that the number of people with kidney failure secondary to diabetes will double in the next decade and will account for almost **all** growth in Australian dialysis numbers (Figure)<sup>33</sup>.

#### Diabetes is the likely growth factor in ESKD in the next decade



In recognition of this alarming state, measurement of kidney function has just been agreed (January, 2013) to be included in the annual cycle of care, which forms part of the documentation of the practice incentive payment (PIP) for people with diabetes in primary care. For this initiative to realise its full potential, Kidney Health Australia advocates an education program be delivered to GPs to support them in carrying out this new function under the PIP payment.

<sup>32</sup> Chronic Kidney Disease: Management in general practice. (2<sup>nd</sup> edition) Kidney health Australia , Melbourne 2012.

<sup>33</sup> Projections of the incidence of treated end-stage kidney disease in Australia. 2010–2020 AIHW . September 2011.

## Budget Proposal for Consideration

***A recent report indicated that in rural general practice in Australia, there are significant shortfalls in the recording of eGFR and the recorded prescribing of appropriate kidney protective therapy***

Kidney Health Australia, through its existing KCAT project is well positioned to roll out a national education program to support the Government's recent policy change to introduce a measure of kidney function as part of the diabetic annual cycle of care PIP payment, and do so cost effectively and with minimal start up time.

By leveraging off the existing program, Kidney Health Australia proposes rolling out an education program to GPs, to be delivered over two years, commencing on 1 July 2013. The program would deliver face to face workshops at each of the 61 Medicare Locals. These face to face workshops would be one-to-two hour workshops using a local nephrologist as the facilitator, and would be accredited by the Royal Australian College of General Practitioners (RACGP) and offer a high quality, evidence-based presentations backed up with hardcopy takeaway resources for participants. The program would have specific learning objectives for GPs, specifically:

- Knowing the eight major risk factors for Chronic Kidney Disease (CKD)
- Knowing how to measure Kidney Function and interpret the results
- Being able to outline the optimal management of Diabetic kidney disease
- Gaining a better appreciation of the need to screen high risk individuals for CKD
- Being able to implement a practice based system to perform a kidney health check for patient at increased risk of CKD

In addition, the program would involve developing a supplement to existing on-line learning modules on CKD and diabetes (the original of which was launched in February 2013 through 'Think GP').

The Kidney Health Australia's publication "*CKD – management in general practice*", already well recognised and used within General Practice will be updated to include a specific section on the annual cycle of care for people with diabetes. This will also be supplemented through a laminated factsheet on the changes to the annual cycle of care and mailed to all general practitioners as an attachment to the *Australian Family Physician* publication (or equivalent).

By leveraging off Kidney Health Australia's existing publications and through the delivery in Medicare Local's the total cost could be limited to approximately \$260,000. This represents a relatively small cost to support the Australian's Government decision to include a measure of CKD as part of the existing PIP payment. The breakdown would be as follows:

- Workshop – Development of Materials - \$10,000
- Running of the workshops (\$3,000 each at each Medicare Local) - \$183,000
- Development of an online supplement - \$10,000
- Amendment of Kidney Health Australia's booklet and distribution - \$7,000
- Laminated sheet production and distribution - \$50,000

## A Comprehensive Approach to Funding All Modalities of Dialysis

The most recent data available from the Australian and New Zealand Dialysis and Transplant Registry (ANZDATA) at the end of 2011 shows that nearly 11,000 patients are currently relying on dialysis to survive.<sup>34</sup> Dialysis is a high-cost, lifesaving treatment modality for people with end-stage kidney disease (ESKD), which is estimated to cost approximately \$1 billion each year in Australia<sup>35</sup>.

The move to activity based funding (ABF) - by setting a nationally efficient price (NEP) for hospital services - presents a significant opportunity to recognise the role dialysis plays in the health system, as well as the potential to generate significant savings by promoting a 'home first' approach for dialysis.

### The case for change

There are a number of important points to be made about pricing of dialysis services, their delivery and the setting in which they are undertaken. Currently the breakdown of dialysis is approximately 22% in an acute care setting, 49% in a free standing satellite centre or small units in country hospitals, and 29% in the home. Within the breakdown of home dialysis, 20 % is peritoneal dialysis and 9% is home haemodialysis.

Currently, the best available estimates indicate that the cost per person, per year, for an individual on dialysis is \$79,072 for hospital or unit-based haemodialysis, \$65,315 for satellite haemodialysis, \$49,137 for home haemodialysis and \$53, 112 for peritoneal dialysis. Clearly home dialysis represents a significantly cheaper modality, due to a range of factors, including the removal, to a large degree, of overheads and staffing requirements.

Most states governments have now enacted renal strategies designed to increase home dialysis, including the use of targets and incentives. Noting the expected costs to the health system in the future, Kidney Health Australia estimates that a saving of \$378 to \$430 million could be achieved over the next 10 years if the increased use of home dialysis was achieved<sup>36</sup>. The advent of ABF provides an opportunity to ensure that Home Dialysis is not only not disadvantaged, but actually promoted as a preferred option. Furthermore the shift to ABF which will highlight a clear Federal Government contribution will provide an opportunity to help end some of the state by state inconsistencies that have occurred, resulting in a varying uptake of modalities nationally.

### Budget Proposal for Consideration

Kidney Health Australia therefore advocates that not only should all modalities of dialysis be included within ABF, but this historic shift also be used as an opportunity to incorporate all the related costs that support home dialysis as part of these reforms.

This viewpoint stems from a desire to ensure that there is no favour for hospital or satellite models of dialysis to the detriment of home dialysis, but rather revised arrangements promote all the benefits that home dialysis can provide, both to the patient and to government, by striving for improved equity and access arrangements. Such an approach will also ensure that there are no adverse economic disincentives for service providers to favour one form of dialysis over another, inadvertently created in the move to ABF. Finally it would remove the barriers to an increased

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<sup>34</sup> [www.anzdata.org.au](http://www.anzdata.org.au)

<sup>35</sup> Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at:

<http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837>

<sup>36</sup> Cass A et al. The Economic Impact of End Stage Kidney Disease in Australia: projects to 2020. Published 2010. Available at:

<http://www.kidney.org.au/LinkClick.aspx?fileticket=vave4WFH73U%3d&tabid=635&mid=1837>

uptake of home dialysis, and by extension start to generate increased savings to both Federal and State Governments.

This can be achieved by ensuring that the price weightings or broader revised funding mechanisms accurately reflect the different costs associated with delivering home dialysis so that the prices allow for improved efficiencies without distorting the supply of sources or creating relative inequities between differing modalities.

***Noting the expected costs to the health system in the future, Kidney Health Australia estimates that a saving of \$378 to \$430 million could be achieved over the next 10 years if the increased use of home dialysis was achieved.***

Principally, the provision of home dialysis – either through haemodialysis or peritoneal dialysis results in reduced costs for both State and Federal Governments. Furthermore, home dialysis can bring with it a number of health benefits for the consumer and a greater level of rehabilitation. These benefits result from the ability for the patient to increase the frequency and length of haemodialysis, factors that have been associated with improved health outcomes and are increasingly being practised where feasible in Australia and overseas.

Such an approach would include allowing for the increased frequency of dialysis that dialysing at home allows, without adding an extra reporting burden to either the patient or the supporting health service.

In addition to reduced costs, dialysis in the home results in less travel for the patient which is a considerable benefit for those living in regional, rural and remote localities, or for patients lacking access to public or alternative transport. It also creates a cost saving as patients will not need to seek travel reimbursements or accommodation assistance, if a switch to dialysing at home is made.

It should be noted however that home based dialysis does still require some support from the local renal unit, including nurses visiting patients onsite. Therefore, some allowance should be made within the funding decisions to recognise the distance and location that medical professionals are required to travel from the dialysis hub/spoke to the patient on home dialysis. As such, such factors should be considered into the scaling, alongside or as part of the rural and Indigenous scaling, or where necessary, into the consideration of block-funded services for small rural hospitals, depending on how home dialysis in each rural location is treated under the pricing framework.

Where patients are still required to travel – be it for satellite or home dialysis, Kidney Health Australia is of the view that current reimbursements for travel and accommodation be incorporated into revised funding arrangements. Such a move would allow for the standardisation of rates across the country, but also more effectively allow the issues and reimbursements surrounding the enablers (travel and accommodation) to dialysis to be incorporated into the actual funding of dialysis, resulting in more effective policy and delivery of services rather compared to the current fractured approach.

Finally, currently the capital costs for dialysis machines and the associated plumbing and electrical requirements are covered, in varying degrees at differing levels across the states and territories. The introduction of ABF provides an opportunity to work with state and territory governments to standardise these. Even when taking into account the need to factor in the costs resulting from the increased frequency of dialysis, the related travel, water and capital costs it could still be expected to be significantly cheaper than the cost of in hospital dialysis.

It is important that when factoring in the above into ABF that no inadvertent burden of reporting for the patient or the medical professional is implemented which may act as a disincentive. Kidney Health Australia would be willing to work with the Australian Government and medical professionals to ensure that any reporting requirements on home dialysis activity both meets requirements for financial accountability, without adversely impacting patients and medical professionals.

The Federal Government in a move to better create a level of consistency nationally to improve patient access and support to dialysis promote a 'home first' policy through the new revised hospital funding arrangements, which will ultimately generate significant savings to both Federal and State/Territory Governments. This can be achieved by:

- Ensuring all modes of dialysis are included in Activity Based Funding and priced appropriately so as not to create economic disincentives to a home first policy;
- Ensuring that revised funding arrangements take into consideration the associated capital and support costs in supporting home dialysis – including as increased frequency without unnecessary burden on the patient for reporting usage;
- Ensuring that the revised funding arrangements take into account within rural and Indigenous loadings the location of those undertaking home dialysis and the need to support the dialysis centre in travelling to support these patients.

## Live Organ Donor Leave Scheme

The intent of this new policy proposal (NPP) is to establish a federally funded, live organ donor leave scheme (LDLS). This scheme would provide federal funding to assist employers with the salary costs of providing leave for staff who wish to donate a kidney.

### The case for change

Those who are willing to donate a kidney are currently subjected to a number of cost burdens including a minimum of four weeks annual leave forgone, time taken for extensive tests and a number of out of pocket expenses for the cost of the procedure. In addition, some are unable to secure paid leave, which either compounds their financial situation or acts as a disincentive to undertaking the procedure.

Currently, despite having some of the highest success rates for organ transplantation in the world<sup>37</sup>, Australia's rate of deceased organ donation has failed to keep abreast with demand for transplantation<sup>38</sup>. Indeed, the number of deceased organ donors will never meet the demand, no matter how efficient the retrieval process - therefore there is a need to increase the rates of kidney transplantation by increasing the number of living donors. Furthermore, kidneys that are transplanted from a live donor last on average, two to four years longer than those through cadaveric transplants.

The number of live kidney donation in 2011 was 255, representing a notable decrease from 296 in 2010<sup>39</sup>. One of the barriers to live kidney donation is the financial cost to the donor, with international experience indicating that 45% of living donors experience some form of financial hardship<sup>40</sup> and one international study highlighting that 24% of potential living donors choose not to donate because of anticipated financial hardship<sup>41</sup>. The continuing tightening of economic conditions will likely have an impact on live donors seeking to self fund their operation and time away from work. These financial strains can be eased, to some degree, by providing donors who work with the ability to access paid leave, for a specified period, via a reimbursement to the employer.

To address this situation it is argued that a scheme similar to the already established Employer Support Payment Scheme (ESPS) designed to subsidise and support employers of Defence Force Reservists be introduced. The ESPS utilises the Australian Weekly Ordinary Time Earnings (AWOTE), currently \$1,346 per week (based on 2012 / 13 pricing) and pays it to employers to reimburse them for the time the employee is undertaking reservist activity. This flat rate is paid to employers in respect of full-time employees (35 hours or more), regardless of the employee's salary. For part-time employment pro-rata rates can be paid. ESPS payments are considered taxable income under the *Income Tax Assessment Act of 1997* and must be declared in the appropriate tax return.

The LDLS would adopt this existing precedence (using the updated AWOTE price of \$1,351) and provide an employer support payment to those employers who provide leave for the purposes of

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<sup>37</sup> National Clinical Taskforce on Organ and Tissue Donation, 2008, *National Clinical Taskforce on Organ and Tissue Donation Final Report: Think Nationally, Act Locally*, Commonwealth of Australia, p. 77.

<sup>38</sup> Barniech L, McLaughlin K, Manns B, Klarenbach S, Yilmaz S and Hemmelgran B, 2010, *Barriers to living kidney donation identified by eligible candidates with end-stage renal disease*, *Nephrology Dialysis Transplantation*; 1.

<sup>39</sup> <http://www.anzdata.org.au/anzod/v1/TransplantsByYear.html>

<sup>40</sup> Stothers L, Gourlay W and Liu W, 2005, *Attitudes and predictive factors for live kidney donation: A comparison of live kidney donors versus nondonors*, *Kidney International*; 67: 1105-1111.

<sup>41</sup> Sickand M, Cuerden M, Klarenbach S, Ojo A, Parikh C, Boudville N and Garg A, 2009, *Reimbursing Live Organ Donors for Incurred Non-Medical Expenses: A Global Perspective on Policies and Programs*, *American Journal of Transplantation*; 9: 2825-2836.

their employee undergoing live organ donation. Such a scheme would assist in removing one major financial disincentive – the ability to secure paid leave – if they are considering donating a kidney.

Such a scheme would also support the principles of the Australian Government’s organ donation policy agenda and specifically the work of the *Australian Organ and Tissue Authority* to increase donor rates. It would also remove the current inequity whereby donors bear the cost, but Governments gain from the savings from forgone dialysis and the recipient returning to the workforce.

Over a longer period it still produces a **net benefit to the tax payer**, while vastly improving the health outcomes for the donor recipient and removing a considerable strain on the health system. From a policy perspective it remains in line with other proven policy models of a similar nature such as ESLS and Maternity leave, and highlights dedicated government action to arrest the declining live donor rates. A nationally administered scheme will provide the opportunity to reach all employers equally without creating state by state inconsistencies, and provides the opportunity to work with major corporations and national peak employer and professional bodies, as well as promote positive media coverage.

### Budget Proposal for Consideration

***Currently, despite having some of the highest success rates for organ transplantation in the world, Australia’s rate of deceased organ donation has failed to keep abreast with demand for transplantation.***

The creation of LDLS utilising AWOTE payments have been costed by Kidney Health Australia, utilising the following assumptions. Kidney Health Australia’s detailed financial modelling is available upon request.

- A low scale public service administration cost for the Australian Organ and Tissue Authority (AOTA) for policy ownership of the initiative and the Department of Human Services for administration of the payments, and funding for Communications, Marketing, Promotion, Events and Ambassador Program.
- Annual cost of dialysis avoided per kidney receiver is \$65,000 which represents an estimated average cost of the three modes of dialysis based relative usage - Hospital, Satellite and Home Dialysis. This figure includes medication usage but does not include the savings to be generated by reduced transport, electricity, water and any other reimbursements for dialysis
- Calculation of the savings is based on only the number of additional donors above most recent baseline – an increase of 5% from the base number, per year, for the first three years only at which point it stabilises at around 2010 levels of 293.
- Calculation of the payments to donor employers is based on \$1,351 per week, which is the latest AWOTE rate available on the ABS website, which equates to a \$70,252 per year, gross salary. The Defence Force Reserve Employer Support Payment Scheme (ESPS) utilises the AWOTE.
- Calculation of productivity is just represented in the form of income taxation, utilising an ATO online calculator and a gross yearly salary of \$70,252 without any deductions.
- Taxation estimated to be \$298 a week or \$15,496 per year.

It is envisaged that the policy sponsor, owner, implementer and reviewer for the scheme would be the *Portfolio for Health and Ageing* – ideally the *Australian Organ and Tissue Authority*, with the payment processing and administration carried out by the *Department of Human Services* (through either *Centrelink* or *Medicare* in the way that current employment and health payments are made). This new policy proposal would also provide the impetus and opportunity to formally include the

broader policy area of live organ donation under the remit of the *Australian Organ and Tissue Authority*, while also demonstrating a proactive and realistic first policy step.

A key part of the implementation would be the creation of a Live Donor Support Charter, to be adopted by Government Departments (State and Federal), a number of high profile private sector sponsors (major national corporations) and key stakeholders (Medical Bodies, Unions, Donor Stakeholders and Employer Associations).

The charter would outline the principles behind the LDLS, including the agreement to allow the employee to take short leave breaks to take the tests to confirm the ability to donate, support the policy principles of Live Organ Donation more broadly, increase the awareness of Live Donor opportunities in the organisation and provide a commitment to job and income protection for live donors during the transplant. Through a communication channel such as a charter, it would also provide the opportunity for the *Australian Organ and Tissue Authority* to highlight their work, including the donor register, therefore further supporting Federal and State organ donation initiatives.

While the provision of funding support to employers to encourage leave provision will act as one mechanism to remove some of the financial barriers to those considering organ donation, such a scheme will need a strong communication, media and support strategy. Such a strategy will need to develop and disseminate communication aimed at key target markets, through existing networks (such as Kidney Health Australia's established network with patients, carers, medical professionals, renal networks and clinics, and the broader kidney community).

Such a strategy should also incorporate a significant presence at key organ donation and kidney related events (such as Kidney Health Week and DonateLife Week), and be supported by a social media campaigns in order to raise awareness and generate an increased uptake.

Finally, such a strategy should also consider the implication and need for ongoing engagement and patient support – to assist the donor and the recipient to become part of the donor and kidney community, as well as provide a mechanism to seek feedback from donors and relay this back to policy makers and administrators. Furthermore, the development of a 'Ambassador' or 'Champions' program to support, reward and publicise those who have chosen to become a live donor, and selected employers, would not only provide a form of support and recognition, but also assist to further publicise the initiative to the wider public. Kidney Health Australia is very well placed to provide the necessary communication, events, marketing and patient support elements, and could for minimal cost draw upon existing events and already established networks with the target audience.

Based on a conservative estimate of a 5% increase resulting such a scheme for the first three years and then stabilising at a relatively low 293 total donors (i.e. essentially returning to 2010 levels), the below savings could be expected – representing the combined savings from forgone dialysis, the taxation paid by the patient returning to the workforce, and the taxation on the payments made to employers.

- A 3 year trial of a 4 and 6 week model, based on a 5% increase on the current 2011 (n=255) live donor numbers, offset against the savings generated by forgone dialysis and increased revenue resulting from taxation would generate a saving of \$5.43m by the fourth year under the 4 week scheme, and a saving of \$3.8m by the fourth year of a 6 week model.
- A 3 year trial of a 4 and 6 week model assuming that only 50% of donors will be eligible (with the other 50% either not active in the workforce, unemployed, retired and therefore not

eligible). The result of this is a model that generates a saving of \$1.8m in the fourth year under a 4 week scheme, and a saving of \$1m under the 6 week model.

- Over a 10 year period that assumes a 5% increase in the first three years, but then stabilises at a relatively conservative 293 total donors, the savings become considerable. Even with the cost of the additional transplant surgery added in, and the associated ongoing costs resulting from transplant surgery added in on top of the cost of the LDLS, it still generates a significant cumulative saving – over \$55m over the first 10 year period for the 4 week scheme and over \$50m for the six week scheme. If rates then continue to hold steady at the increased rate after this, the additional years could potentially produce even higher returns.
- A 10 year period utilising 50% uptake rate (again to account for those who would not be eligible), and including transplantation costs still produces a saving of \$26m in the four week scheme and \$22.7m in the six week scheme.

Kidney Health Australia argues for the establishment of a federally funded, live organ donor leave scheme (LDLS) to provide federal funding to assist employers with the salary costs of providing leave for staff who wish to donate a kidney.

By paying the employer the AWOTE rate to reimburse them the cost of providing leave for staff who wish to donate a kidney, the Australian Government would remove a financial disincentive for live donors, generate significant savings in the form of forgone dialysis and a productivity dividend (taxation receipts) and remove a considerable burden on the health system.

The scheme would preferably operate for a maximum of 6 weeks and a minimum of 4 weeks. The scheme would include the creation of a Live Donor Support Charter to be signed by key public and private sector employers. Furthermore, it would be backed up by a comprehensive, low cost communication, education and media strategy. Such a strategy would leverage off existing networks and key organ donation and kidney related events (such as Kidney Health Week and DonateLife Week).

Finally, such a strategy should include ongoing engagement and patient support – including the development of a ‘Ambassador’ or ‘Champions’ program to support, reward and publicise those who have chosen to become a live donor, and selected employers. Again, these could be leveraged off existing activities undertaken by Kidney Health Australia and the Australian Organ and Tissue Authority for a small cost.