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Dr Sherbon
Chief Executive Officer
Independent Hospital Pricing Authority (IHPA)
P.O. Box 483
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Dear Dr ~~Sherbon~~ Tony

**Development of the Australian Mental Health Care Classification – Public Consultation paper 1 – February 2015**

Thank you for the opportunity to provide feedback on the development of the Australian Mental Health Care Classification (AMHCC).

ACT Health welcomes the opportunity for mental health to have a standardised national classification that enables the grouping and categorisation of mental health services and activity for the purposes as outlined in your consultation paper.

The following feedback is in point form to highlight some concerns and issues.

1. There are two purposes outlined for the development of an AMHCC:
    a. IHPA Activity Based Funding (ABF) modelling for 2016-17 budget allocation under the National Health Reform Agreement (NHRA).
    b. Ongoing improvement in clinical meaningfulness of mental health classification, that may lead to improvement in cost predictive ability and support new models of care across all settings.

The first purpose is clear and understood as the core work IPHA. It is less clear that IHPA has a mandate to undertake the work for the second purpose. It is also not clear that the IHPA and its subcommittees are best placed to be the driver of mental health reform. It is noted in the paper:

*"A number of states and territories have signalled that the development of the AMHCC remains a priority for them irrespective of its association with pricing for Commonwealth funding, noting the benefits of the classification still apply at a local level."*

2. There is a time constraint to IHPAs imperative to have the AMHCC and its subsequent ABF Mental Health Data Set Specification (MH DSS) implemented by jurisdictions for IHPA ABF use for the 2016-17 budget period only.

   As stated in the consultation paper:
   *"In the Budget 2014-15, the Commonwealth Government also announced its intention that, from 2017-18, the Commonwealth will index its contribution to hospital funding by a combination of the Consumer Price Index and population growth, rather than through ABF."*

   Given the main driver of the time constraints is activity reporting for one financial year, under an ABF model it appears the proposed time line of development and implementation will have considerable impact on the ability of the AMHCC and the ABF MH DSS to be fit for purpose. This purpose will also not be present in subsequent years. It is understood the Mental Health Information Strategy Standing Committee (MHISSC) and the National Health Information Standards and Statistics Committee (NHISSC) had concerns regarding the DSS being fit for purpose and did not endorse the DSS for inclusion in Metadata Online Registry (METeOR). It is noted the IHPA as a registry authority in their own right have included the ABF MH DSS in METEOR at this time.

3. The consultation paper also points out that:

   *"The Commonwealth Government announced its intention to work with states and territories during 2014-15 with the intention to create a new Health Productivity and Performance Commission. Subject to consultation, the new Health Productivity and Performance Commission would be formed by merging the functions of the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare (AIHW), IHPA, the National Health Performance Authority, the National Health Funding Body and the Administrator of the National Health Funding Pool."*

   ACT has some concern regarding Commonwealth support and funding for the ongoing long term development of the AMHCC once IHPA no longer has a presence and if the Commonwealth will continue to have a focus for national standardisation of the AMHCC. Whilst some states and territories may wish to continue development of the AMHCC for the benefits that may apply at the local level there is no guarantee this will be a national standardisation across all jurisdictions. The previous experience with MH-CASC is an example of what may be repeated with the AMHCC.

4. In the AMHCC the scope of what constitutes mental health care clearly covers all mental health services across all ages using the same definition that IHPA apply to in-scope services for ABF. IHPA have pointed out that CAMHS services are in-scope to in be included in the classification. However IHPA have also noted that CAMHS services will be excluded from the IHPA ABF modelling for Commonwealth contribution to funding mental health services. This is a mixture of the two purposes of the AMHCC in point one.

It would appear then that the IHPA ABF purpose of developing the AMHCC is not suitable for developing an AMHCC given the contradictory nature of ABF modelling. IHPAs main imperative for ABF modelling may unduly influence the AMHCC in favour of the ABF purpose leaving mental health services such as CAMHS under-developed in the AMHCC.

5. IHPA have stated in the paper that ABF costing will be derived from other sources not just the AMHCC or the subsequent ABF MH DSS. These other sources are not detailed in the paper.

6. ACT Health will be committed to significant cost and resources as a requirement to implement the ABF MH DSS and the AMHCC. The new data elements and concepts discussed in the paper are being pilot tested amongst some jurisdictions at this time. This pilot and results are not yet available. ACT are would not be in a position to commit to the significant changes required without some evidence that the AMHCC has proven validity for the second purpose outlined in point one.

7. ACT Health has concerns regarding the details of phase of care, collection of NOCC, changing the NOCC protocol and introduction of the Mental Health Intervention Classification (MHIC) .

   The chief concerns are:

   a. Significant change to the established NOCC protocol to be adjusted to accommodate the new concept of 'phase of care' as a trigger for data collection.
   b. Increased burden of collection by clinical staff (NOCC)
   c. Reliance on clinical decision making that has a direct impact on additional data collection by the clinician – NOCC for each phase of care change
   d. The existing NMDSs do not have these new data elements and will require major reworking or a separate NMDS for ABF purposes delivered to IHPA, separately from robust validation processes for delivery of other NMDSs to AIHW.

8. A 'best efforts' approach to submissions by jurisdictions over the next two years may lead to a large amount of discrepancy in data quality and usefulness for ABF purposes and little or no comparative capacity between jurisdictions for some considerable time, particularly when developmental and design changes are being applied on an 'as needs' basis.

The ACT is committed to mental health reform and development of improved ways to group and categorise mental health services, the AMHCC looks like a promising start to enhance and contribute to our understanding of mental health in terms of cost and clinical care provision. We congratulate IHPA and its working groups for the progress to date in addressing a very complex and difficult area of health care and look forward to the continuing work being progressed whilst the opportunity is available.

The contact officer for this matter is Phil Ghirardello, Director, Performance Information Branch. Mr Ghirardello can be contacted on (02) 6025 0549.

Yours sincerely

Dr Peggy Brown MBBS (Hons) FRANZCP
**Director-General**
ACT Health

26 February 2015