3rd April 2018

Independent Hospital Pricing Authority
PO BOX 483 Darlinghurst NSW
submissions.ihpa@ihpa.gov.au

To Whom it May Concern,

RE: Stakeholder consultation paper: IHPA Australian Non-Admitted Care Classification Development

Thank you for providing the Australia and New Zealand Society for Geriatric Medicine (ANZSGM) with an opportunity to feedback on the Independent Hospital Pricing Authority (IHPA)'s Australian Non-Admitted Care Classification Development.

Our response to this request for comment draws on the expertise of our Clinical Issues Committee, which is made up of experienced Consultant Geriatricians - including Service and Divisional Directors - responsible for the delivery of both admitted and non-admitted services to predominantly (but not exclusively) older people across Australasia. Rather than specifically address each of the twelve suggested questions in turn, we provide below a summary which addresses much of the content included in the questions.

Firstly, the ANZGM welcomes and supports the development of a new classification system to replace the current Tier 2 classification. The current Tier 2 system represents a significant limitation to providing innovative, person-centred models of care for frail older people with multiple co-morbidities and consequent activity limitation and participation restriction.

The best care of older people needs integrated and flexible approaches to both care and resourcing that places optimal value on community, team-based based care which responds to patient need by including the patient, their family and carers, the primary care team (including general practitioners) and any medical specialists that may be involved.

The current Tier 2 systems makes delivering such person-centred models of care difficult as they:

- undervalue complexity and co-morbidity;
- create barriers to interdisciplinary approaches to care, especially joint assessments and shared therapy provision between several allied health clinicians;
- provide limited recognition of important non face-to-face work with the patient including discussion with other care providers, carers and family;
- overly reward "group work" and specific intervention;
- undervalue health promotion and primary, secondary and tertiary prevention.

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Because of this, the ANZSGM absolutely agrees that what is required is a classification system that is based on patient need rather than service configuration.

Any classification system needs to reflect the nature of work with older people and should take into account that:

- Often, multiple body systems contribute to older patients' clinical presentations and these so-called 'geriatric syndromes' are not easily captured in current taxonomies. Therefore, if 'presenting problem' is to be used as the diagnosis variable, IHPA's proposed list will need development and adaption as what is currently drafted will not be able to classify many of the ways older people commonly present (eg. with nonspecific symptoms or symptoms that don't reflect the severity of the underlying problems, the 'domino-effect' of illness in older people whereby one problem can result in a cascade of secondary problems that equally need to be assessed and actively treated). In addition, some underlying conditions, separate to the presenting problem, can be significant modifiers of resource need (eg. the presence of dementia);
- In the context of sometimes irreversible disease, clinical intervention is often directed at activity limitation and participation restriction. Psychosocial factors can be significantly modifiable in this regard. With this in mind, the World Health Organisation's International Classification of Functioning, Disability and Health (ICF) is a framework that needs to be considered carefully;
- Care systems are most effective when they are inter-disciplinary with good integration across both the continuum of care and different settings;
- Best aligning assessments and treatments with patient choice and the avoidance of futile care can sometimes mean there is significant value in judiciously deciding not to intervene in appropriate clinical circumstances. The importance of this kind of care delivery must be recognised and rewarded, rather than only classifying traditional 'active' interventions.

A key outcome of the classification review should be to develop and embed a set of quality, patient experience and performance measures. This should be joint work between funders, jurisdictions, consumers and clinicians.

The classification principles stated in the discussion paper are all appropriate and sensible and are supported. Additional factors to consider are that:

- While self-management of chronic disease can be important, it is of variable relevance in some older patients, especially in those with cognitive decline, frailty and functional dependence;
- Drivers that support reablement and recovery are important considerations and should be considered in the set of principles alongside self-management.

Finally, episode of care funding is supported as a principle and should be considered as a unit of count in most patient cohorts. Overall, we anticipate that this approach will help to drive innovation. However, more consideration needs to be given to circumstances where it will not work. For example, patient groups such as those with progressive neurological disease will likely have ongoing need for service input over a longer time frame (and indeed often indefinitely). Enforced end dates for care based on funding might, in these situations, result in clinical decision making, risking leaving vulnerable patients 'stranded'.

The ANZSGM thanks you again for the opportunity to provide feedback on this important initiative.

Yours Truly

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