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Mr James Downie
Chief Executive Director
Independent Hospital Pricing Authority
Level 6, I Oxford Street
SYDNEY NSW 2000

Dear Mr Downie

Re: AMA comments on the proposed Australian Non-Admitted Care Classification

Thank you for the opportunity to comment on the proposed activity based non-admitted care classification (ANACC) which is intended to replace the existing public hospital Tier 2 Schedule by 2020. We appreciate the extended timeframe you have granted to provide our submission.

Our response is pitched at the conceptual level because at this stage much of the detail that will impact on clinicians and patient services is not yet clear, noting the wide range of Tier 2 in-scope treatments and jurisdictional differences in their approach to providing integrated care to reduce avoidable hospital readmissions.

Preliminary Comments

The AMA has no objection to a new ANACC providing it captures, records and resources all of the activities associated with delivering quality non-admitted Tier 2 services. The AMA agrees the ANACC will need to support innovative models of non-admitted care. However, it is also paramount the ANACC does not, in of itself, impose recipe book medicine, restrict clinician involvement in patient care, or restrict the independence of clinicians to assess the patient's clinical needs and determine the course of non-admitted treatment required.

The ANACC will need to be designed to record and fully resource all new activity associated with coordinated care for patients post discharge and integrated care for patients with complex or chronic health conditions. These activities represents an expansion in public hospital activity and should be counted and funded accordingly. Ideally, the classification should capture the full range of patient presenting problems in the first patient presentation to avoid the need for separate patient presentations to receive treatment for each condition.

The AMA notes the consultation paper foreshadows the new non-admitted care classification is likely to be eventually adopted beyond the current Tier 2 scope. The AMA looks forward to further advice on this and proposes the ANACC is subject to a robust external evaluation to identify any unforeseen adverse impacts on the quality of Tier 2 non-admitted patient care before it is rolled out beyond the scope of Tier 2. Additional stakeholder consultations based on evaluation findings would be appropriate for a reform of this magnitude.

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It seems sensible to use the My Health Record unique patient identifier to link patient health service utilization across care boundaries. The AMA agrees the new ANACC will need to interface with other healthcare classifications across the health system.

The proposal to use a slightly modified definition of the existing 'service event' as the unit of count in the first version of the ANACC also seems appropriate.

A non-admitted care classification system able to support innovative new and emerging models of care

High quality, cost effective, clinician led models of innovative care delivery can be both cost effective and beneficial for patients. However, the AMA considers some of the examples positively referred to in the consultation paper to be potentially problematic:

- *Hospital in the home trials*
  The AMA believes that the IHPA should give no weight to or draw any conclusions about the efficacy of the Health Care Homes as a funding approach that is worthy of replication. The trial is struggling having failed to sign up the targeted number of practices and patient interest remains very low. The patient outcomes achieved, and the cost/benefit of these trials will not be known until the program is evaluated, and it is becoming increasingly obvious that the timeframe for the evaluation is too short, it is inherently biased due the profile of practices that have been selected and it may prove meaningless if the level of patient disinterest in the trial persists as well as the high turnover of participating practices.

- *HealthLinks* – this is also a trial in its early stages. The cost effectiveness and patient outcomes achieved will not be known until it has been fully evaluated. At this stage, the AMA's main concern with HealthLinks is the funding model. It is unfortunate this innovative care trial relies on cashing out existing public hospital funding. The AMA report card illustrates the unsustainable pressure on public hospital budgets that force patients to wait longer for care than clinically recommended. Hospital involvement in coordinated care across the acute/non acute boundary extends public hospital responsibilities. These activities should be recognized as new, and fully resourced in the proposed ANACC with new funding.

- *Bundled pricing for treatments with predictable care pathways* – The AMA would not support a rushed introduction of bundled pricing ushered in under ANACC. The AMA considers the example of bundled pricing for maternity services positively referred to in the consultation paper to be seriously flawed. It risks undermining the standard of maternity services because in pursuit of savings, maternity patients could be shifted to lower cost care settings that put them and their baby at risk. Of course, it is important that services are women centred, recognize cultural differences and are equally accessible by all women.

  There is compelling recent Australian evidence that women accessing 'low risk' models of care delivered by midwife teams and birth centres in large public hospitals units have significantly higher perinatal mortality rates (2.3/1000) compared to that of women accessing obstetrician led care (1.2/1000) (Permezel & Milne, 2015).

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An obstetrician has broad medical education in addition to the specialty training spanning 15 years. Midwifery training is narrower in scope and much shorter. The AIHW 2016 report on National Core Maternity Indicators stage 3 and 4 results from 2010-13 shows that critical obstetrician assistance is required in almost half of all births amongst mothers from a 'low risk' group.

This example indicates the merit or otherwise of bundled pricing within the ANACC should be examined separately, case by case. It should only be considered in the context of transparent disclosure of all assumptions including the scope of services in the bundle, the level of clinician engagement allowed for and the quantum of funds allocated to each bundled service.

- *Technology assisted remote patient care/patient monitoring* – The AMA acknowledges a range of telecommunication systems do have a place in the delivery of health care into the future, particularly for less complex services where the doctor considers a face-to-face consultation is not necessary.

  This type of arms-length care should be accommodated in the new non-admitted care classification. However, AMA considers remote care is only appropriate when it is used:
  - as an adjunct to normal face to face consultations;
  - for regular patients under the care of the patient's treating doctor;
  - when it is clinically appropriate for the patient's circumstances.

  Where it is appropriate, the ANACC should capture and resource the full range of activities associated with clinical oversight of remote patient care. This includes, but is not limited to remote patient/clinician communication, clinician review of patient data collected remotely and full updates of this remote care delivery in the patient's medical record.

AMA is skeptical about the suggested shift to an ANACC classification system based on episode as the unit of count until the issues associated with bundled pricing referred to above are resolved.

The AMA is aware most of the above concerns about the above innovative funding models are downstream funding issues that are technically independent of the design of the ANACC. However, we consider it is important to register these concerns at this early stage so the design of the ANACC remains flexible and does not force clinicians into restrictive models of non-admitted clinical practice or impinge on the independence of their clinical decision making.

We hope these comments are helpful. Please contact me if you wish to discuss.

Yours sincerely,

Leonie Hull
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Medical Practice
Australian Medical Association