Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
By email: submissions.ihpa@ihpa.gov.au

Dear Mr Downie,

Re: Australian Non-Admitted Care Classification Development

Thank you for the opportunity to provide feedback on the stakeholder consultation paper for the proposed Australian Non-admitted Care Classification (ANACC). As you may be aware, Women's Healthcare Australasia's (WHA) membership comprises both specialist women's hospitals and general hospitals providing maternity and women's health services, large and small. We have consulted our members about the questions posed in the consultation paper on the proposed Non-Admitted Care Classification. This submission offers feedback related only to women's and maternity services non-admitted care.

WHA supports IHPA's efforts to develop a non-admitted care classification that is better focused on patient need than on simply the type of clinic the patient attends. IHPA's review of the women's health related clinic descriptions in the existing Tier 2 classification a few years ago improved the relationship between funding for non-admitted women's health care & the cost of services being delivered, e.g. through creating a new Maternal Fetal Medicine Clinic category. However it remains the case that there is significant variance in the needs of women accessing maternity & gynaecology outpatient clinics, and the Tier 2 classification provides only a proxy for predicting the costs involved in providing these services. A classification that captures data on patient complexity in non-admitted care will also be helpful in analysing effective models of care for women accessing maternity and gynaecology services. We look forward to the contribution a more patient-centred classification might make to strengthening the relationship between measures of cost and women's and newborns' care needs in clinics, in the community and in the home.

The anticipation of the ways non admitted care might be delivered in the future is welcome. This paper recognises that improvement in technology allows for more care that previously required admission to be delivered in an outpatient setting e.g. outpatient hysteroscopy, LLETZ, cystoscopy etc. Models of care will also continue to change. Efforts to ensure the classification is agnostic about the setting of care, focusing instead on the provision of a healthcare service to a patient with specified healthcare needs will be vitally important to supporting future innovation & efficiency.

IHPA is seeking written comments on the following questions:

1. **Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?**

The non-admitted care classification will have a key role to play in helping to facilitate integration of care across settings and providers but, as the consultation paper acknowledges, a range of other conditions will also have to be present for this to be achieved – particularly much improved exchange of digital information about a patient's clinical needs, care plan and receipt of care. The lack of coordination & exchange of clinically meaningful patient level information between care providers and across settings is currently a driver not only of inefficiency, but of suboptimal patient care in many instances. For example, implementation a recent plan developed by the Australian Commission on Safety & Quality in Healthcare to reduce unwarranted variation in rates of hysterectomy for women with sustained heavy menstrual bleeding will not be able to be monitored within most services because of a lack of access for any would-be auditor to information capturing the woman's care by GPs, registrars, gynaecologists, radiologists and others.

WHA does not have the answer to 'how' such integration could best be achieved. But at the very least, the use of descriptors of patient clinical need & care in non-admitted settings should be readily linkable to the inpatient care classification where hospitalisation is an expected or typical part of a given care journey. The My Health Record will be a foundational tool for sharing information among providers and across settings, but it is still essential that the data thus shared is meaningful to all involved in providing care – and ideally to the patient as well.

Good information sharing will allow the patient's journey for a particular condition to be easily accessible to all care providers. This will have an impact on reducing duplication of tests and provision of inappropriate clinical advice. This will be a real challenge as currently patients may move from the private to the public sector and vice versa and there is no way of knowing what is being done where. Even when care is transferred from one public hospital to another, there is no clear way to share information. MyHealth Record may be the way forward but the privacy rules need to be taken into account.

2. **Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?**

The need to ensure that any new classification for non-admitted services does not inhibit innovation, or create artificial barriers based on care providers is self evident. For example, a woman attending a Maternal Fetal Medicine clinic because of an identified fetal condition is as much in need of antenatal care from midwives to help prepare for labour and birth, as she is of sub-specialist medical care related to the specific clinical circumstances of her unborn child. The challenge will be in identifying the classification design elements that succeed in capturing patient complexity and differential need without becoming provider-centric.

An increasing number of specialised clinics are multidisciplinary e.g. in the MFM clinics, women are quite often seen by a MFM specialists, the MFM midwife and at the very least will also have an ultrasound scan. The new classification needs to take this into account and to enable, not inhibit, emerging models of care such as telehealth, public homebirth, telephone follow up of postnatal women or post-discharge neonates.

3. As the types of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?

Presumably there will be need for ongoing regular review of the design of the ANACC which can take into account changes in practice over time. In any event, there are some types of care that should be setting agnostic. For example pregnancy check-ups can be done in GPs rooms, in the rooms of private obstetricians or midwives, in midwifery clinics at public hospitals, in clinics in the community, in the woman's home. Antenatal care is now guided by national clinical practice guidelines, but we know there is still significant variation in actual care and the duration of appointments as well as use of diagnostic testing between settings and providers. For example, compare a postnatal visit on day 4 in the community or home where the woman has significant breastfeeding issues and the newborn baby is potentially at risk of failing to gain weight which may require a 1.5 hour midwifery assessment as opposed to a woman with no feeding issues with a thriving newborn that may only need a 20 minute assessment.

At present there is not only disparity in funding for this routine care among settings, there is also disparity depending on whether the provider is funded by the patient's insurer, the Commonwealth or the relevant state/territory. Ideally, a national non-admitted care classification should be used consistently across care providers and funding models, in much the same way that the inpatient classification is consistent across public and private patients, and public & private hospitals, as well as across levels of care – primary through to secondary/tertiary & back again.

4. The classification principles have been designed to guide and support the development of the future classification. Do you agree with these and/or are there other principles that should be considered in developing ANACC?

The principles are appropriate and relevant. Is there a need to add one more – related to the need to ensure this classification will integrate with others, such as the inpatient, emergency, & mental health care classifications? For example, it will need to be clear if there is a postnatal woman receiving non-admitted follow up care who is experiencing perinatal depression, whether the provision of care is captured under the ANACC or the AMHCC. The importance of the classifications complementing one another is clearly articulated in the consultation paper.

5. Should IHPA continue to use service event as the ANACC unit of count? If yes, do you agree with the proposed revised definition of a service event? How could it be improved?

There are merits to retaining the service event as the unit of count for the new ANACC. Even in maternity care, where there is a reasonably predictable trajectory of non-admitted care, with women receiving at least 5 antenatal non-admitted check-ups, ideally 8 (if a multiparous woman) or 10 (if primiparous), there are still women who have or develop the need for more complex care, and may need one or more consultations. For example a pregnant Aboriginal woman with Diabetes needs to see the midwife for birth preparation, the Obstetrician for suspected fetal growth abnormalities, the social worker for welfare issues and the diabetes educator for blood sugar management. This should happen during the same antenatal visit/check up or there is significant risk the woman may not access one or more of these services, especially if she lives some distance from the hospital or clinic.

WHA supports IHPA's recognition that some patients require multidisciplinary input to their care, and that this is best done within a single visit to a clinic, rather than requiring a woman to make multiple visits to different outpatient clinics across different days for the care to be funded. WHA also supports the proposed revision to the definition of a non-admitted service event to include care provided during a non-admitted multidisciplinary case conference where the patient is not present.

There are many examples e.g. an Antenatal/Diabetic Clinic will consist of an obstetrician, endocrinologist, diabetes educator, midwife, trainees, dietitian and they commonly have an ultrasound scan as well. This is usually done in one visit. Sometimes they are seen by the registrar who will consult with the specialist without necessarily the specialist seeing the woman. In this current Tier 2 classification, these patients are allocated to the same clinic as a woman with a comparatively straight forward pregnancy who might only need to see the midwife or registrar. The new classification needs to provide a more patient-centred way to recognise and capture complexity.

In gynaecology, more procedures are being moved to the outpatient setting i.e. hysteroscopy, LLETZ and the classification needs to recopgnise that quite often, these are done on a 'one-stop' basis. Such innovations should be incentivised as they are lower cost to the health system and better experience for the woman. Also, development of nurse led clinics such as pessary clinics should be recognised and supported. With the focus on mesh, the importance of a multidisciplinary approach to the management of women with pelvic organ prolapse should be emphasised and recognised.

6. **Should an episode be considered as a unit of count in the new ANACC? If not for all conditions, then for which specific conditions?**

Maternity care lends itself quite well to an episode unit of count. As previously identified in IHPA's Bundled Pricing Advisory Group, there is a clearly defined time period for antenatal and postnatal care, and national guidelines on minimum numbers of consultations during pregnancy at least, if not for the postnatal non-admitted care. However, WHA would support IHPA's proposed approach of retaining the service event for the introduction of the new classification, then considering the use of episodes later one, once data has been collected for a few years and costs evaluated.

7. **Non-admitted patients often present with multiple comorbidities, and may be treated under a chronic disease management model. Should the future ANACC system have a separate path for classifying chronic disease patients?**

Increasing numbers of women requiring maternity care have either chronic physical or social complexities. The percentages of women with very high BMI and/or with diabetes continues to climb in WHA's clinical benchmarking datasets. WHA would be supportive of there being stronger provision within the new ANACC for describing & pricing care for such patients. It is important that the definition used for chronic or persistent conditions includes social factors, as a small but significant percentage of women requiring maternity care are very high intensity in terms of both non-admitted and admitted care – where they are coping with situations of domestic violence, substance dependency, mental illness and other vulnerabilities. We would welcome the opportunity to better identify these women in activity datasets and better capture the costs involved in providing their care. Typically a wide range of multidisciplinary expertise is required

over much longer periods of time than for a socially uncomplicated non-admitted patient.

8. **What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?**

WHA has no comment on this, other than to flag an interest in seeing implementation progress in as uniform and timely a way as possible. Use of the classification directly influences the data that is collected and shared, and therefore the opportunity to identify effective models & the potential to improve outcomes and lower costs of providing women's healthcare services.

9. **What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?**

WHA agrees that the main reason for the patient to receive a non-admitted care service should be the first and dominant variable in a patient-based classification system, as it provides scope for non-admitted occasions of service to be patient focused, to occur in the absence of a diagnosis, and to reflect the patient need. A consideration unique to maternity care is that the majority of pregnant women accessing routine antenatal or postnatal care do not have a 'presenting problem', so language that is inclusive of the well woman receiving clinically indicated antenatal or postnatal care would be preferable. Perhaps 'healthcare need that the patient presents with'?

WHA acknowledges the additional data burden likely to arise from introducing a diagnosis type to recording of non-admitted care. However we believe the benefits will outweigh the costs in the medium term. It is interesting that the analysis undertaken by IHPA found that only a small portion of services in Clinics 20:40 and 40:28 were captured with the diagnosis Chapter 15: Pregnancy. It would be helpful to understand the underlying reasons for this poor alignment, as pregnancy is a clear cut diagnosis.

A further factor to consider when designing the classification, is how it might assist with accurately identifying and distinguishing between routine care and urgent non-admitted care. For example in pregnancy, women receive a number of routine antenatal checkups which are scheduled visits. However there is also need for some women to access urgent non-admitted care – such as when seen in a Pregnancy Assessment Service for an antepartum bleed.

10. **Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?**
11. **What are your views on the proposed list of initial presenting problem/diagnosis-type and intervention-type groups presented at Appendix A? What refinements should be considered?**

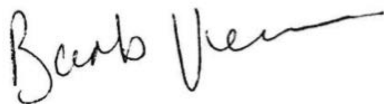
WHA members have made a number of suggestions for refinements that should be considered in relation to non-admitted care of women for both maternity & gynaecology healthcare needs. The current list of patient level grouping variables in Appendix A for Pregnancy and Newborns falls short of all the variables that are applicable to non-admitted clinical services e.g newborns receive phototherapy in the home, pregnant women have real-time ultrasounds in antenatal clinics, etc. In order to illustrate the changes that members believe are important we have provided edits in track changes to the relevant sections of the proposed classification.

12. Do you agree with the list of complexity variables presented in Section 5.3? What other variables should be considered for the new ANACC system?

Yes. WHA supports the proposed variables – age, comorbidities, multidisciplinary, new/review, provider. Again we would reiterate the need for psychosocial comorbidities to be captured. And several members queried whether, given the gap in health outcomes, it would also be prudent to provide for ethnicity, or at least Aboriginality in the classification?

WHA would be happy to facilitate further discussion with members about these matters if you require clarification or further explanation for any of the proposed changes. Please don't hesitate to contact me if we can assist further. Thank you again for the opportunity to provide advice on these matters. We look forward to the next round of consultation as the new classification is developed.

Kind regards



Dr Barbara Vernon
Chief Executive Officer
Women's Healthcare Australasia

4 April 2018

MDC 09 Diseases and Disorders of the Skin, Subcutaneous Tissue and Breast	
Proposed presenting problem / diagnosis-type groupings	**Proposed intervention-type groupings**
Neoplasm of skin	• Biopsy of skin • Debridement of skin • Excision of lesion of breast (lumpectomy) • Fine needle aspiration (FNA) breast • Skin cancer procedures • Wound management (dressings) - vacuum-assisted closure (VAC) dressings • Other minor skin procedures
Skin ulcer - pressure injury	
Infection of skin (except post-traumatic) - abscess - cellulitis - inflammatory disorder of skin	
Signs or symptoms of skin, subcutaneous tissue or breast	
Other disorder of breast - benign neoplasm	
Mastitis	
Other disorder of skin - acne - benign neoplasm of skin - dermatitis (allergic) - psoriasis	

WHA Comment: Consider including mastitis in this MDC.

MDC 13 Diseases and Disorders of the Female Reproductive System	
Proposed presenting problem / diagnosis-type groupings	**Proposed intervention-type groupings**
Neoplasm of female reproductive system	• Destruction procedures on cervix - cautery - diathermy - large loop excision of transformation zone (LLETZ) - laser • Dilatation and curettage (D&C) • Endometrial biopsy • Gynaecological endoscopy - hysteroscopy
~~Infection of female reproductive system~~ - ~~pelvic inflammatory disease~~	
Menstrual or other female reproductive system disorder - endometriosis - benign neoplasm of female reproductive system (polyps) - female infertility - female reproductive management - menstrual disorders	

MDC 13 Diseases and Disorders of the Female Reproductive System	
Signs or symptoms of the female reproductive system	- colposcopy • Procedures for assisted reproduction
Other disorder of female reproductive system	• Procedures for contraception including insertion and removal of intrauterine devices and contraceptive implants • Insertion of hormonal implants • Insertion of vaginal pessaries

MDC 14 Pregnancy, Childbirth and the Puerperium	
Proposed presenting problem / diagnosis-type groupings	**Proposed intervention-type groupings**
Abortion and post abortion care	• Amniocentesis • Cardiotocography (CTG) • Chorionic villous sampling • Dilatation and curettage (D&C) • ~~Minimally i~~Invasive[LB(1)] fetal therapy • Iron infusion
Ectopic pregnancy	
Assessment and management of women and fetuses during high risk pregnancies affected by fetal conditions - **counselling, either before pregnancy or after a complex pregnancy and/or labour and birth** - **pre-natal screening and diagnosis including chorionic villus sampling and amniocentesis** - **management of suspected or confirmed fetal abnormalities, including inutero fetal therapy** - **management of complex pregnancies involving maternal medical and or surgical disorders** - **management of termination of pregnancy due to fetal abnormalities** - **management of perinatal loss, including investigations, bereavement counselling and planning for future pregnancies**	
High risk (complex) pregnancy (antenatal and postnatal care) - **abnormalities of the placenta, uterus, and cervix**	

MDC 14 Pregnancy, Childbirth and the Puerperium	
- alcohol use - autoimmune disease - cardiac disease - endocrine disorders (pre-existing diabetes mellitus, gestational diabetes mellitus, thyroid conditions) - haematological disease (anaemia, haemoglobinopathy) - HIV - hypertensive disorders of pregnancy (eclampsia, gestational hypertension, HELLP syndrome, pre-existing hypertension) - malignant neoplasm - mental health disorder - multiple pregnancy - obesity - poor obstetric or reproductive history (history of abortive outcome~~, habitual~~ or repeated abortion~~er~~, previous fetal congenital anomaly) - renal disease - respiratory disease - rhesus isoimmunisation - social problems (complex) - substance use - thromboembolic disorder - viral hepatitis B or C - disorders of fetal growth, including fetal growth restriction - reduced fetal movement - postdates pregnancy - malpresentation - next birth after Caesarean Section - antepartum haemorrhage - perineatal loss	
Low risk pregnancy (antenatal and postnatal care) - treatment and review of women during pregnancy, childbirth and the	

MDC 14 Pregnancy, Childbirth and the Puerperium	
period during which they recover from childbirth - childbirth education - support and advice for families with new born babies - lactation advice - assessment of reported reduced fetal movement	
Other condition related to pregnancy, childbirth or the puerperium - what would this cover?	

MDC 15 Newborns and Other Neonates	
Proposed presenting problem / diagnosis-type groupings	**Proposed intervention-type groupings**
Premature neonates with complications (<37 completed weeks gestation)	Phototherapy
Premature neonates without complications (<37 completed weeks gestation)	
Term neonates with complications (≥ 37 completed weeks gestation)	
Term neonates without complications (≥ 37 completed weeks gestation)	