From: Jerry Burong [redacted]
Sent: Tuesday, 17 November 2015 19:28
To: submissions ihpa
Cc: [redacted]

Subject: Draft Australian Mental Health Care Classification (AMHCC): some comments from a MH primary carer (retired) [SEC=No Protective Marking]

Dear Mr Shane Solomon,
AMHCC Pricing Authority Chair

Thank you for the opportunity to submit my ideas.

With respect, the "Draft Australian Mental Health Care Classification released for public comment" invokes deep personal dismay for reasons described below.
Please find below some observations, and suggestions, for your consideration.

Australia's operating realities going forward

Unfortunately, both State and Federal governments face a decade of declining tax receipts due to our domestic political economic circumstances and the global deflation roiling world-wide.

We face significantly lower commodity export receipts, very high private debt levels and a deflating housing bubble exposed to the risk of higher unemployment and higher interest rates beyond the control of policies from Canberra. International economic and trade realities will ultimately decide how high our interest rates will be and how much demand will arise for our exports.

Our aggregate productivity is very low and we are reliant on offshore capital for growth in an economy where housing is a major driver of our GDP growth.

Economic imperatives require our Healthcare System to become more affordable and Australians will not tolerate cuts to their levels and extent of quality healthcare enjoyed to date. Political imperatives will require redesign of the system - http://www.oecd.org/australia/oecd-reviews-of-health-care-quality-australia-2015-9789264233836-en.htm

My comments on AMHCC Draft MHC classification

Please find below some comments for your consideration:

- In my view, austerity constraining funding will be an existential imperative for the Australian healthcare sector.

- The proposed costing strategy is based on "industry standardised Average – DRG+ Cost weights" and the manner in which the solutions are framed encourages conformity to a process oblivious to operational cost efficiency and deliverable outcomes innovation.

  It is the wrong strategy for our time of economic uncertainty and austerity.

The imperative should be to reduce funding can only increase and the IHPA proposal is “business as usual” proposing that MH criteria be included as its only “big idea”.
It is framed by academics and data specialists rather than from a business and operations perspective.

- We need a more operations oriented strategy encouraging coal face best practice innovation.

  The strategy should be based on Cost Centres supported by use of cost line items for all relevant inputs involving resources such as people, overheads, medications, consumables deployed by coal face managers for a particular “Mental Health DRG” for suitable clinical and psycho-social criteria.

  Use the “Industry Standardised Average Mental Health DRG + Cost weights” as the benchmark reference so that coal face managers have a performance reference to compare with.

  Provide incentives and disincentives for coal face managers to innovate their own “Mix of Cost Elements” for, say, a particular psycho-social solution to be assessed based on objective costs incurred and outcomes efficacy.

- Develop objective standard measurable outcomes for “Mental Health DRG” clinical and psycho-social criteria.

  Objective metrics measuring resource usage and delivered outcomes with Mental Health inputs is fundamental towards creating a culture, and process, to achieve both innovation and better deliverables over time.

  DSM is a behavioural and semantics based taxonomy that over time will be replaced by an alternative biological origin based criteria should the USD 100 million NIMH Research Domain Criteria (RDoC) initiative succeed.

  DRG for psycho-social programs also require objective measureable criteria to facilitate cost-benefit and efficacy assessments. Perhaps the criteria should include emphasis on intended outcomes to encourage innovation at the coal face.

I am not familiar with how much information system integration exists between hospitals or the degree of compatibility in their mix of mainframe/server/desktops, or in their accounting systems sector wide.

Best wishes,

Jerry Burong
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