WOMEN'S HEALTHCARE AUSTRALASIA

Independent Hospital Pricing Authority
Via email: submissions.ihpa@ihpa.gov.au

Women's Healthcare Australasia (WHA) response to the IHPA's Consultation paper on the Pricing Framework for Australian Public Hospital Services 2017-18

Women's Healthcare Australasia (WHA) would like to thank the Independent Hospital Pricing Authority for the opportunity to comment on the Pricing Framework for Australian Public Hospital Services 2017-18. As always; we have distributed the consultation paper widely, and have received numerous comments from our member services across Australia.

Women's Healthcare Australasia (WHA) now represents 90 hospitals and health services across Australia delivering almost 2/3 (140,000) of the public births occurring within Australia. This broad membership and the deep experience of maternity service clinicians and hospital administrators from across the country inform our response to this consultation.

Our response in detail

4. CLASSIFICAITONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

4.5 Tier 2 Non-Admitted Services Classification

WHA members are in favour of the introduction of additional data items for the counting, costing and classification of **non-admitted multidisciplinary case conferencing where the patient is not present**. Multi-disciplinary case conferences form a vital adjunct to the clinical care of maternity patients with either complex health conditions themselves, or complexity in the care of their fetus or newborn. As an example multidisciplinary case conferences are often undertaken with child protection services for particularly high risk women who will not engage with the Department of Child Protection themselves to coordinate safety planning for the birth.

4.6 Emergency Care Classification

WHA members support IHPA's work towards developing an emergency care classification that is more patient focused. We have appreciated opportunities to provide comment and advice on aspects of this work over the past year and are happy to continue to do so as this work progresses. **It is important to ensure that the needs of maternity patients are considered in the development of a new classification**, particularly presentations to Women's Assessment Services for pregnancy and gynaecology related emergency care. We have no further comments at this point in time.

4.7 Teaching, Training and Research

WHA members note the work IHPA is doing to develop a teaching and training classification, and that data around research activity does not currently lend itself to classification development. **We support the continued block funding of teaching, training and research in NEP17.**

4.8 Australian Mental Health Care Classification

WHA members have taken an active interest in IHPA's work on developing a new classification to describe and price mental health services. WHA member hospitals providing perinatal mental health care would like to participate in any future costing study, to ensure that **perinatal mental health care is appropriately described and costed** as the classification is further developed.

6. THE NEP FOR ABF FUNDED PUBLIC HOSPITAL SERVICES

6.1 Technical Improvements to the Pricing Model to determine the NEP

Consultation question 2 – Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price (NEP) for 2017-18?
WHA agrees that the criteria as outlined for assessing pricing and funding options (preventability, equitable risk adjustment, proportionality, transparency and ease of implementation) is congruent with a patient focused best practice approach.

6.2 Adjustments to the NEP

WHA supports the recommendation that IHPA include all high cost outlier episodes in the calculation of the **Patient Remoteness Area Adjustment**.

6.3 Stability of the National Pricing Model

Consultation questions 3 - 5 – Should IHPA further restrict year-on-year changes in price weights? What are the priority areas for IHPA to consider when evaluating adjustments to NEP17? What patient-based factors would provide the basis for these other adjustments?

WHA proposes that priority be placed on price stability. Particular priority should be placed on leaving the NEP as it is. There is probably an 18 month to 2 year lag in the timeframes in which hospitals and health services can respond to price signals in the market. Some time is required for the effect of changes that have already been made, to be integrated into service thinking and for strategies to enhance efficiency to be implemented. Given this, we believe that the effect of the current NEP should be known before further steps to modify it are undertaken.

Although there are future changes planned with the safety & quality options outlined in this Consultation Paper, WHA members believe that the example as set by the UK in publicly publishing timely safety & quality information (down to clinician level[i]) is one of the most appropriate methods in which to change clinical practice and improve performance in line with safety & quality principles.

7. SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

7.2 Costing Private Patients in Public Hospitals

Consultation question 6 - Should IHPA phase out the private patient correction factor in 2018-19 if feasible to do so?

WHA agrees with the phasing out of the private patient correction factor in 2018-19 as suggested in the consultation paper.

9. BUNDLED PRICING FOR MATERNITY CARE

Consultation questions 7 - Do you support IHPA's intention to introduce a bundled price for maternity care in future years?

WHA members are interested to work with IHPA on the design and development of a Bundled Price for Maternity Care that is workable and credible with the maternity services sector. WHA is aware that a number of health services and jurisdictions have responded to this consultation paper indicating either opposition to, or the need for caution when considering bundled pricing of maternity care. WHA agrees that this is a new concept for the Australian public maternity sector. Details regarding the options for a bundled maternity price, and the feasibility of streamlining implementation are areas that are yet to be determined. WHA believes that more education for the sector as a whole is required to assist services to understand the drivers for such a change and the potential impacts and benefits, as well as to advise on implementation issues that will need to be resolved if a bundled price is to be achievable and useful.

In recent weeks, WHA has provided tertiary member services in particular with an overview of potential opportunities and risks associated with any move to a bundled payment for maternity care. Given their already high and increasing workload with implementing and improving hospital activity and costing functions Business Analysists and Health Service Performance Leads have been cautious to embrace more change. Tertiary services are also wary about the potential for a bundled price to reduce the resources they may have available to provide care to women requiring complex pregnancy, labour and birth and/or postnatal care. These are legitimate concerns. WHA has been advising member services that there is still time and opportunity for them to have input to the design and implementation of any policy on bundled pricing, to ensure that any final proposal for bundled pricing for maternity care would be credible and workable for hospitals providing maternity care.

WHA would like to emphasise that while some services have expressed significant reservations about the merits of considering a bundled price for maternity care, clinicians in many public hospitals across the country have been positive about the concept of a bundled price for maternity care, and have expressed their support. They see the introduction of a bundled price as providing an opportunity to introduce systemic change that has the potential to help stem the rising tide of interventions in labour and birth care. WHA members currently participate in annual activity and costing benchmarking and are aware of significant variation in costs for similar cohorts of patients across Australia. Members also recognise that there is significant observed variance in clinical practice, as reflected in clinical outcomes indicators for similar cohorts of patients collected and reported by WHA to members each year. WHA agrees that introduction of a bundled price for maternity care could assist service managers to develop and deliver innovative models of care for maternity patients, to reduce unwarranted variation and to provide safe, high quality maternity care at lower cost.

The current reliance on occasions of service to fund maternity care has a number of limitations. One key limitation is that because the price for a caesarean section is higher than that for a

vaginal delivery, there is an inherent perverse disincentive to reduce rates of surgical birth. The Australian Commission for Safety & Quality in Healthcare in its 2014 paper *Exploring Healthcare Variation in Australia* notes that "Australia has a high rate of caesarean section compared to the OECD average",[ii, iii] with 322.3 Caesareans per 1000 live births reported in 2011.[iv] This includes for example a 4-fold unexplained variation in casemix-adjusted caesarean section rates by hospital in New South Wales.[v] Leading researchers comment that "caesareans are not changing maternal or infant mortality rates, and the rate rise is unwarranted[vi]."

WHA members agree that rates of caesarean section are currently higher on average than is warranted for achieving healthy outcomes for women and babies. This situation imposes significant costs on the health system, as well as increasing the burden of morbidity on women and their newborns both short[vii] and long term[viii]. Preventing a primary caesarean birth is of utmost importance given that two-thirds of the overall caesarean section rate is due to primary caesarean section and the latest national data shows that 85% of women who had a previous caesarean section had a repeat caesarean section in Australia.[ix] While the caesarean section rate has stabilised in our dataset at around 30% of women giving birth over the past few years, only a few services have succeeded in lowering their rates despite mounting evidence of benefits to women and newborns from avoiding surgical birth where appropriate.[x xi] Further research shows that less than half of the variation in hospital caesarean section rates was explained by differences in hospital's patient characteristics and practices. Therefore strategies aimed at modifying caesarean section rates for these women should not affect morbidity rates.[xii]

There is a complex array of factors influencing this, of which funding is only one element. When an uncomplicated caesarean section is undertaken rather than vaginal delivery the rewards include; operator and health service convenience of completing the procedure during daylight hours when more effort is required to see a vaginal delivery through the night, the hospital receiving a higher NWAU, and an ability to roster more staff during the day. Beds can also be freed up more quickly in labour ward for other patients. WHA believes there is scope for considering how funding policy might influence service delivery in positive ways through a bundled maternity price.

Other limitations of the current funding model are that women requiring admission during the antenatal period for a complex condition such as pre-eclampsia are funded only by the DRG of their labour and birth. Similarly women requiring longer postnatal admission, for perinatal mental health issues, for example, are also funded only by the birth DRG. This situation impacts tertiary maternity hospitals in particular.

There are also few incentives in the current funding system for services to provide postnatal visits in the home following discharge, despite significant evidence that the early days and weeks after the birth of a baby is a critical time for successfully establishing mother/baby attachment, breastfeeding and family wellbeing.[xiii,xiv] The National Maternity Services Action Plan specifies that all women should receive midwifery care postnatally at home for up to 14 days[xv]. IHPA's analysis estimated recently that only 69% of women receive at least one outpatient postnatal visit, and that presentations to EDs by women in the first few weeks following discharge for childbirth may be as high as 10% nationally. WHA members believe it may be more cost effective to fund a higher number of postnatal visits to as close to 100% of women as possible in future to reduce more costly ED presentations and avoidable readmissions of women and/or newborns.

There is evidence that children who are breastfed to 6 months of age are less likely to develop a range of conditions that may result in hospitalisation during childhood,[xvi] [xvii] and that Australia's breastfeeding rates drop significantly in the first few weeks following birth.[xviii] Provision of professional support for women in the early days and weeks following discharge could be an effective strategy for mitigating longer term hospital costs in children.

WHA believes the dichotomy of perspectives on a bundled price that is currently apparent across the sector is positive. It shows a high level of engagement with the subject, and will lead to some engaging conversation and hopefully innovative solutions. As is the case with all of IHPAs funding principles we look forward to the patient centred outcomes that can be achieved through this process.

Consultation question 8 - What stages of maternity care and patient groups should be included in the bundled price?

Stages of care: WHA believes that a bundled maternity price will only provide flexibility to service managers to innovate, if it includes all three stages of maternity care – antenatal, intrapartum and postnatal care. A bundled price should include: childbirth education, antenatal consultation, intrapartum care, care of the 'unqualified' neonate on a postnatal ward and postnatal domiciliary visits after discharge. One WHA member hospital believes that postnatal care could be bundled alone. For many country services antenatal care is provided on a shared care basis with community General Practitioners and many women may receive antenatal care locally, but are required to relocate for birth, then may return for postnatal care before discharge. If bundled pricing is staged, this would minimise the likelihood of services declining to transfer or accept return transfers for care provision on the basis that the portion of care would not be funded as the entire bundled cost for that episode of care has gone to the birth hospital.

The national Clinical Practice Guideline on Antenatal Care provides an evidence based guide to the number of antenatal consultations that should take place for primiparous and multiparous women and should be used as the basis for determining the number of visits to be funded. However, IHPA should also consider how antenatal education is funded. In Midwifery or maternity group practice models of care, antenatal education is provided as part of the antenatal visits. For women accessing outpatient antenatal clinics, appointments are typically 15 minutes and antenatal education occurs in separate group sessions. Consideration also needs to be given to public hospitals being funded for a minimum number of antenatal visits where women elect to have shared care with a private GP, obstetrician or midwife.

WHA also encourages IHPA to consider including a minimum number of domiciliary visits in the postnatal period in any bundled price, for the reasons outlined above. Unfortunately there is a lack of evidence based clinical practice guidelines on the minimum duration of postnatal care. Midwifery group practice models, for which there is now Level I evidence as to safety and effectiveness,[xix] provide for daily home visiting in the first few days following discharge, spanning up to a total of 6 or 7 visits in the 4-6 weeks following birth. At this time, care of the woman and baby is transitioned to GPs or maternal & child health services. Members are concerned that if an average number of 2-3 visits is provided for, then MGP models, which are now widespread across all jurisdictions, may be unable to sustain appropriate postnatal domiciliary care. Further

analysis is warranted of the relationship between effective postnatal visiting and rates of presentation to ED, or readmissions for preventable common problems such as mastitis in the mother, or jaundice in the newborn. There is potentially significant public health benefits, and downstream savings to the Commonwealth vis a vie public hospitals, from making a greater investment in providing postnatal care to women and their families than happens at present.

A further consideration is the inclusion or exclusion of diagnostic tests in the bundled price. There appears to have been a proliferation in the number and types of tests (including pathology and ultrasound) that are now offered to significant numbers of women. We suggest that consideration should be given to the specific tests to be included within the bundle and that this would help to reduce the potential for double dipping and repeated testing, i.e. more ultrasounds done than the routine ultrasound for fetal anatomy at 19 weeks gestation; multiple screens for Group B strep antenatally other than between 35 – 37 weeks gestation.

Patient groups:

IHPAs consultation paper flags that the original intention has been to consider introducing a bundled price for "uncomplicated maternity patients" and outlines analysis IHPA has been undertaking of the impact of different factors, like age and parity on the cost profile of a maternity patient. The Consultation paper further notes "some patients may be unsuitable for inclusion in the bundle, as their service utilisation differs from other patients for clinically warranted reasons". Options are canvassed about a bundled price applying for women who have had a vaginal birth (with or without operating room procedures), because "this group encompasses women likely to have the least complex care"

Some WHA member hospitals are supportive of limiting the focus of any bundled price to uncomplicated care (notwithstanding the thorny question of how this cohort is to be described and identified). For other members, there is significant concern about ruling some women in and others out of a bundled price. Member hospitals fear that this may introduce an unnecessarily complex system, requiring a significantly increased workload to track and accurately describe women's care and which funding model they come under – bundled price or ABF based on Tier 2 and DRGs. There is also concern from clinicians that excluding caesarean sections from a bundled price would potentially defeat the purpose of introducing a bundle in the first place. At present, services that successfully lower their rates of surgical birth receive less funding than those that have higher rates. Inclusion of women who have a caesarean section in a bundled price would provide appropriate funding to enable hospitals to innovate to reduce their caesarean section rate without being financially disadvantaged and conversely, hospitals with higher caesarean section rates for a similar cohort of women would not be financially better off than their peers with lower rates as is the case now.

WHA urges IHPA to consider modelling a bundled price that includes not only all stages of care but also all maternity patients, regardless of complexity. In order to address the legitimate concerns of tertiary services with more complex casemix, a cost weight could be developed that allows for different complexity in the care given. The details of this would need to be developed based on analysis of existing costing data, and in consultation with the sector. One possibility is that low, medium and high complexity for the whole maternity episode could be defined, with a base bundled price determined on which a loading is placed for medium and high complexity

patients. Alternatively, if the bundled price was paid on a modular basis, with payment for all antenatal care, intrapartum care, and postnatal care occurring in 3 'instalments' for example, it would be feasible to determine a price for low, medium and high complexity antenatal care; low, medium and high complexity labour and birth care and low, medium or high complexity postnatal care. A range of tools could be used to assess the level of complexity. Existing DRG coding for complexity could be applied to intrapartum care. Postnatal care could be linked to complexities, medium complexity (including funding for unqualified neonates), and more complex postnatal care could be considered complex. An alternative tool for assigning complexity could be the National Midwifery Guidelines for Consultation & Referral, which have been endorsed by the Royal Australian & New Zealand College of Obstetricians & Gynaecologists, as well as by many state health departments for use in public hospitals.[xx]

Many of our members emphasised that would not be in favour of Bundling based on mode of delivery alone as this does not accurately reflect the complexity of care during the antenatal and postnatal periods. Some women have complex care needs during pregnancy but proceed to give birth without medical interventions. Others have an uncomplicated and healthy pregnancy but end up requiring complex care during labour and birth. While the Average Length of Stay (ALOS) for labour and birth has seen a sustained decline over the past 5 years, with more and more women being discharged home directly from the labour ward within hours of birth, all women require postnatal care for a minimum of 5 days (usually as an outpatient), and some women & babies require ongoing postnatal care for weeks. Sometimes the needs of the 'unqualified' baby, not unwell enough to be admitted to a nursery but needing tests or observations, keep a mother in a postnatal bed.

Consideration of a modular approach to the bundled price might also assist with scenarios where women access antenatal care in one hospital but give birth in another. It may also assist with funding the majority of patients whose care crosses financial years.

To price the outpatient (Tier 2) component effectively it will be valuable to review the impact of the introduction of the new multidisciplinary Tier 2 payment for non-admitted patients (for MFM and Complex Pregnancy care). We note that the initial data provided by IHPA (in the consultation paper) does accommodate the impact of this. The introduction of the multidisciplinary Tier 2 non-admitted item constitutes a substantial change to the landscape of service delivery in the maternity setting, and the full impact of this should be understood before progressing the introduction of the bundled price.

Consultation question 9 - Should IHPA include postnatal care provided to the newborn in the bundled price?

WHA believes that in answering this question it is important to distinguish between babies that are admitted to newborn care nurseries as a patient in their own right, from those who still require medical care as an unqualified newborn 'rooming in' with their mother.

Qualified newborns: These babies are already coded to a range of DRGs relative to the basis for their admission to Special Care or Intensive Care services. This should continue to be the case. Revisions in recent years to the AR-DRG classification for newborns has helped to improve the

capture of differential costs involved in caring for admitted newborns based not only on weight, but on gestational age.

Unqualified newborns: The current definition of an unqualified baby is that of a well, healthy term newborn baby, who doesn't require medical treatments and hence is not admitted to a NICU or Special Care cot. The care of these babies is assumed to be solely provided by their mothers and has long been assumed to be covered by the payment made for the labour and birth care of the mother. However this policy was last reviewed was in 2001 and clinical practice has changed significantly in the past 15 years. In a one-off survey of member hospitals on a randomly selected weekday April 2015, WHA found that 50% of all unqualified babies being cared for on the postnatal ward with their mothers were receiving at least one form of medical treatment including diagnostic testing, antibiotics, close observation for jaundice or other illness, phototherapy, etc. The rise in annual birth-rate in Australia, together with advancements in technology making it possible to keep newborns alive from as early as 23 weeks gestation has put increasing pressure on NICU and SCN cots across all jurisdictions. Major providers of maternity and newborn care routinely care for many unwell babies on wards to support breastfeeding, mother/infant attachment and for want of sufficient cots in nurseries. WHA members encourage IHPA to investigate this situation in more detail to determine an appropriate allocation of funding within any bundled price to care for these babies.

Consultation question 10 - What other issues should IHPA consider in developing the bundled price?

Implementation issues

While WHA members are interested to work with IHPA to explore the potential benefits of a bundled maternity price, there is considerable concern about a range of implementation issues. Among the key issues of concern are:

- How hospitals with more complex casemix can be appropriately funded if maternity care is bundled
- The fact that 70% of maternity patients' care crosses financial years
- The feasibility of providing a single payment for care that is provided over a 9 month period
- How funding will be organised for patients who are transferred between hospitals within the same LHD and/or across LHDs
- How funding will be priced for patients who may have a complex pregnancy but who have an uncomplicated labour and birth or well women who have a complex labour and birth
- The influence of a bundled maternity price on shared care with GPs and other private providers
- Situations where patients leave the care of a provider part way through their maternity episode, e.g. following loss of a fetus, moving interstate or overseas, etc.
- The funding of babies cared for on a ward so that they remain with their mothers (currently deemed 'unqualified') that nonetheless require medical care
- Consideration of the impact of significant postnatal admission for other areas of complexity. WHA members suggest the inclusion of a 'care type change' arrangement for women who suffer postnatal depression
- The administrative burden on hospitals if some patients are in a bundle, and some are not, some change their status etc. This would pose enormous increased workload on

hospital information, finance & coding teams and is likely to be overly complex and confusing.

A number of WHA members have indicated their willingness to assist IHPA with testing any bundled price before it is introduced across the sector as a whole. Ideally the preferred policy for any bundled price could be modelled in collaboration with some large tertiary maternity hospitals, metropolitan medium sized units, and some regional hospitals (not block funded), from different jurisdictions to test and validate the solutions to the above implementation issues before any decision is taken to formally adopt a bundled price across the sector.

11. PRICING AND FUNDING FOR SAFETY & QUALITY

11.4 Scope and Approaches to Pricing and Funding for Safety & Quality

Consultation questions –
11. Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?
12. What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?
13. Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing for safety and quality? Are there other criteria that should be considered?

WHA members support IHPAs general direction to consider safety and quality factors in pricing and funding of care but are not in favour of the early introduction of a pricing system for safety and quality. Members felt that significantly more work is required to identify the right datasets and information to capture these patients and that considerable focus is required to make sure that the right behaviours are being incentivised through this approach. Rather than moving forward quickly, a measured and staged approach needs to be taken. It would be preferable that the expected outcomes of reporting were identified and qualified so that when a system of reporting is introduced known outcomes will be achieved.

The assessment criteria identified by IHPA are appropriate and relevant. WHA members were united in the opinion that, in the first instance, effort should be directed towards incentivising good quality health care rather than penalising poor outcomes.

Factors that should be considered in the calculation of risk adjustment include co-morbidities, chronic health conditions, age, gender, ethnicity & socioeconomic status.

11.5 Sentinel Events

Consultation questions –
14. Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?
15. Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

16. Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

WHA members agree in principle with the concept of adjusting for the occurrence of sentinel events that are clearly preventable including wrong site surgeries, suicide, retained instruments, intravascular gas embolism, haemolytic blood transfusion reactions, medication errors leading to the death of a patient, and discharge of a baby to the wrong family.

Members are concerned that maternal death associated with pregnancy, and the puerperium – requires further consideration of the available evidence on preventability before being included in a list of sentinel events for which financial penalty is applied. While maternal death remains rare in Australia's tertiary maternity services, it not the case that they are necessarily (by definition) associated with poor quality care for which financial penalty for the service is warranted. Every maternal death associated with maternity care in Australia is reported and fully investigated. In many cases, investigations conclude that the death was not preventable.

As IHPA acknowledges, any introduction of a pricing policy focused on sentinel events will be reliant upon further national agreement and infrastructure around data collection and reporting. Ideally findings from sentinel events would be distributed for analysis followed by the development of action plans to address systemic issues that may be relevant to many hospitals. WHA supports the proposal that a flag be developed to identify sentinel events to improve the timeliness and consistency of the data.

11.6 Hospital Acquired Conditions (HAC):

WHA members agree that it is important to take account of Hospital Acquired Conditions, including many of the conditions listed on page 36 of the consultation paper.

One large tertiary service provided 6 months of data to provide a comparison of the impact of the HAC listing as presented in the consultation paper (see Table 1 below). WHA points out that the numbers identified by this one hospital over 6 months are significantly different from the national numbers suggested in the consultation paper. Significant work would be required, in the first instance, to ensure appropriate identification of these elements.

	Hospital Acquired Complications	6 months July-Dec 2013
1	Pressure injury	1
2	Falls resulting in fracture or intracranial injury	2
4	Healthcare associated infection	165
5	Surgical complications requiring unplanned return to theatre	30
7	Respiratory complications	4
8	Venous thromboembolism	2
9	Renal failure	14
10	Gastrointestinal bleeding	0
11	Medication complications	17
12	Delirium	5
13	Persistent incontinence	1
14	Malnutrition	1
15	Cardiac complications	17
16	Third and fourth degree perineal laceration during delivery	83
17	Neonatal birth trauma	36

Table 1: 6 months HAC data - for to the period July to December 2013

WHA is concerned that there are significant risks to basing hospital funding on a variance in HAC rates that may be influenced by poor coding practices as opposed to true performance around hospital-acquired complications.

WHA members have a particular concern about the inclusion of '3rd and 4th Degree tears' and 'Neonatal Birth Trauma' in the HACs and recommends that these 2 conditions be removed from the HAC listing.

In relation to 3rd and 4th degree tears, WHA members agree that these injuries are serious adverse events to be avoided whenever possible. WHA benchmarking monitors rates of 3rd and 4th degree tears and it has regularly been the focus of safety & quality meetings among members, aimed at reducing overall rates, and helping services with higher rates to learn from those that are achieving lower rates. However WHA is not aware of any OECD country in which all tears have been eliminated. While there are now some good evidence based care bundles, and there is opportunity to increase the consistency with which these bundles are followed across the sector, it is not the case that all 3rd or 4th degree tears are preventable or that they arise as a result solely of care provided, or not provided by the hospital at which the woman is giving birth.

Further, contemporary best practice in Australia's major maternity services now includes the promotion of a culture of reporting as many perineal tears, and the details of them, as possible. The reporting of perineal laceration is the first step in recognition of perineal tears, and this recognition helps the service to improve service delivery in the post-partum treatment of tears. Australia's best maternity services have increased their vigilance in respect to perineal tears, and subsequently can have an apparently high rate of 3rd & 4th degree tears. These services should not be penalised for their better practices in identifying and reporting tears. It is important that tears continue to be accurately identified and reported, to ensure that women receive appropriate care and support with recovery and any ongoing impairment they may suffer.

An additional consideration is that recent research into 3rd & 4th degree perineal tears appears to indicate that women of Asian ethnicity are more vulnerable to 3rd & 4th degree tears than women of other ethnicity.[xxi] The causes of such variation in outcomes are not yet understood. Utilising this indicator to signal pricing for quality and safety could result in a decrease in funding to services with larger proportions of patients from Non English Speaking Backgrounds (NESB) creating pockets of reduced funding without the clinical evidence to support such funding limitations.

Neonatal Birth Trauma has not been clearly defined in the consultation paper, and this term alone is not sufficiently specific to be able to identify a critical incident type event. There are also instances when neonatal birth trauma may be induced because a clinician intends to avoid the more serious consequences of other highly complex conditions. Good examples of this include shoulder dystocia where the clinician will manoeuvre the baby to effect delivery which may result in a break to the clavicle of the baby. Also, bruising from the use of forceps, or haematoma formation resulting from ventouse extraction at birth may be utilised to prevent the otherwise adverse outcomes of an extended labour (such as Hypoxic Ischaemic Encephalopathy (HIE)). Experts also note that a neonate may sustain spontaneous bruising during birth as an entirely

normal birth outcome. They also note that Australian rates for spina bifida have not changed in 30 years. If pricing for safety & quality is to be applied it should be applied in areas that are amenable to improvement. Given this we suggest that neonatal birth trauma should either be carefully defined (with a linked expected outcome) or removed from the list of HACs. Our preference is that Neonatal Birth Trauma be removed from the listing until such time as evidence based criteria are established.

Lastly, experts note that many countries now have a separately constituted national level body that has been established to decide if adverse outcomes are clinically induced or the result of other adverse factors that are outside of the clinician's control. It may be that if Australia were to implement penalties for HACs that we would need such a body as well.

Our members also feel that each of the 3 options for HACs has a downside that needs to be considered before progressing the pricing of HACs. They are outlined below.

Consultation questions 17-18 What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC? Do you agree with IHPA's assessment of this option [1]?

Withdrawal of funding for HACs may perversely result in under-reporting of HACs to avoid financial penalty and ultimately disadvantage quality of care.

If HACs are removed from the DRG assignment this would lead to a less DRG weight, but does not allow for detailed analysis of the conditions at the hospital site/local level. Best practice care should allow for review of data/cases and rectification of practice at the local level in the first instance.

Consultation questions 19-21 What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates? Do you agree with IHPA's assessment of this option [2]? What are the advantages and disadvantages of the approaches to risk adjustment?

This option adjusts funding made on the basis of differences in HAC rates across hospitals, it is a more preferable option, but our members have concerns as to the transparency of the application of the funding reduction, and believe that detailed reporting and education from IHPA would need to accompany this.

Consultation questions 22-23 What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties? Do you agree with IHPA's assessment of this option [3]?

Option 3 that combines funding incentives as well as penalties, is probably best implemented further down this journey.

Consultation question 24 Are there any other pricing or funding options that IHPA should consider in relation to HACs?

Consultation question 25 - How should IHPA treat hospitals with poor quality Condition Onset Flag (COF) reporting?

Avoidable Hospital Readmissions

Our members worry about the consequences of penalising re-admission. Attempts to reduce length of stay will inevitably result in some increase of re-admission of patients found in retrospect to have been not quite ready for discharge. A short re-admission for one maternity patient or newborn baby may be an acceptable risk for another 19 who are successfully discharged a little earlier.

Identifying avoidable readmission to hospitals is a complex issue and this is particularly the case for specialist services. We would suggest that monitoring the inter-LHD/network readmissions be undertaken to ensure that there is equity in the system for this adjustor by identifying the extent to which this may occur.

Our members suggest that a variety of models of care need to be considered in the determination of which conditions would be tagged as preventable.

Member hospitals also comment that in many circumstances re-admission to services is routine. Instances in which this might occur include where a neonate is delivered at one hospital and that neonate is transferred to another hospital for surgical procedures/care, and then readmitted back to the original or another hospital for post op/ongoing care. This is routine in many services. Examples might include the relationships set up between Mater Mothers Hospital in Brisbane and Lady Cilento Children's Hospital, those between King Edward Memorial Hospital in Perth and the Princess Margaret Hospital, and those between Westmead Hospital and the Children's Hospital at Westmead. We would like to point out that this is also the case between tertiary centres and regional centres and step-down services in metropolitan areas as well.

Consultation questions 26-29 What approach is supported for setting timeframes within which avoidable hospital readmissions are measured? Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes? Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN? When should a pricing and funding approach for avoidable readmissions be implemented?

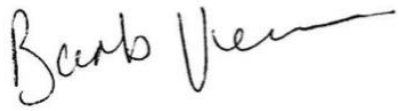
Our members believe that because these types of practices are new and that reliability of the data needs to be determined in the first instance. This form of pricing should not proceed until this is implemented, and it is known that the data truly reflects local rates.

Our members believe that until a unique identifier exists across all hospitals, readmissions need to be limited to the same hospital. If a timespan was implemented we would suggest a 28 day readmission rate as per many other current reporting mechanisms. Our members suggested that re-presentations to the Emergency Department, including Women's Assessment Services, post

an admitted episode should be excluded from the definition of re-admission unless this results in a further admission.

We thank you for the opportunity to provide comment in response to the Consultation paper on the Pricing Framework for Australian Public Hospital Services 2017-18. We would be happy to expand on any points in our submission if required. We also look forward to continuing to work closely with IHPA to explore workable options for bundled pricing for maternity care through the Bundled Pricing Advisory Group.

Yours sincerely,



Dr Barbara Vernon
Chief Executive Officer

31 October 2016

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