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

WOMEN'S & CHILDREN'S HEALTHCARE AUSTRALASIA

Dear James,

Re: Pricing Framework for Australian Public Hospital Services 2023-24

Thank you for the opportunity to provide feedback on the IHPA stakeholder consultation paper for the Pricing Framework for Australian Public Hospital Services 2023-24.

As you are aware, Children's Healthcare Australasia's (CHA) membership comprises over 95 paediatric services, including all specialist children's hospitals and a variety of general hospitals providing paediatric services, large and small. CHA's sister organisation, Women's Healthcare Australasia (WHA), represents 155 maternity services across Australia including all tertiary maternity hospitals and a large number of regional & rural sites.

We have consulted our members of both organisations about the questions posed in the consultation paper for the Pricing Framework 2023-24. This submission offers feedback related only to the provision of women's and children's healthcare services.

1. Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

CHA members have seen a significant increase in mental health presentations among children & young people, especially (but not exclusively) related to eating disorders. Mental health services for children & young people were already oversubscribed before the pandemic. Analysis by CHA of data from the children's hospitals indicates that ED presentations for mental health reasons have risen over the past 7 years by more than 130% from 1.4% (n=4,590) to 3.4% (n=12,139) of total presentations. Inpatient numbers have also increased by 70% from 1.5% (3,306) to 2.7% (5896) of total admissions. Increased mental health presentations & admissions have been particularly pronounced since the commencement of the COVID pandemic. This period's effect on the paediatric population will be likely to have long term impacts on service costs.

Our members have been experiencing the longer term COVID-19 implications, such as ongoing delays in elective surgeries and significant workforce shortages, as noted in the consultation paper. Members support IHPA's proposal of assessing those long term impacts with the latest activity and costing data.

2. Are there any barriers or additional considerations to using AR-DRG Version 11.0 to price admitted acute services for NEP23?

<u>Newborns requiring subspecialty care</u>

CHA members remain interested to see changes to the pricing for neonates admitted to specialist children's hospitals, to better reflect the costs of providing care to newborns that require sub-specialty peadiatric care beyond neonatology.

The high cost of treating patients in Intensive Care Units (ICU) is recognised in the NEP through the provision of a price adjustment based on the time a patient spends in ICU. This adjustment is applied to all patients utilising ICU except those assigned a Major Diagnostic Category (MDC) of 'Newborns and Other Neonates' (Neonates), where the AR-DRG price is inclusive of a 'Bundled ICU' component.

This differential model for patients requiring treatment in Paediatric Intensive Care Unit (PICU) creates issues in understanding productivity and efficiency as the level of funding is impacted by the proportion of neonates and associated PICU bed utilisation which is subject to variation. This issue is most evident for long

stay, complex patients receiving ventilatory support where age is a prime factor in determining the level of funding received, with neonatal patients significantly impacted despite being managed under the same model of care as older (non-neonatal) infants.

Two years ago, a case study conducted by a CHA member, Queensland Children's Hospital (QCH), indicated considerable variation in funding between patients aged 27 days or less and 28 days and above. QCH estimated how much funding is received for providing care to a patient with elective admission from a NICU at a transferring hospital via a QCH Operating Theatre to PICU and then discharged home after 226 days in PICU. If the patient is 27 days old on admission, this episode will be coded to P06A (with bundling ICU payment) and the hospital receives $379,670. However, if the same patient is 28 days old on admission, this episode can be coded to A13A (with unbundling ICU adjustment) and QCH can receive an additional $848,688 for providing the same care.

A recent analysis conducted by another CHA member, Sydney Children's Health Network (SCHN), replicates QCH's findings. SCHN's analysis shows the NWAU impact was seen in a majority of cases where patients had Mechanical Ventilation and tracheotomy procedures in ICU.

CHA members understand that unbundling the ICU adjustment for neonates may not be feasible as it could result in over-funding of other hospitals providing 'routine' newborn intensive care. Further development and refinement of paediatric adjustments for neonates admitted to a tertiary children's hospital may be an alternative to improving the fit between cost and price for the relatively small volume of newborns requiring subspecialty care. Consideration is encouraged for a neonate adjustment where the newborn is admitted to a specialist children's hospital (for specialist paediatric surgical or medical care beyond that typically provided in the NICU of a hospital providing birthing care). While overall volumes are low, the clinical complexity of these neonates is by definition different from that of newborns admitted for NICU care in a maternity hospital. Another alternative approach IHPA could consider is allowing specialised children's hospitals to statistically discharge and readmit those neonates that require ICU stay when they turn 28 days old during hospital stay. So specialised children's hospitals can group those patients to relevant DRGs that have ICU adjustments.

Antenatal admissions

WHA members have suggested refining ADRG O66 Antenatal Admissions based on diagnosis. There is currently only one ADRG (O66) for all antenatal admissions. WHA has identified that members have different criteria for admitting women for antenatal care. QLD services usually have lower admission thresholds than other states, with significantly more volume, shorter length of stay, and lower average complexity and costs for ADRG O66 than peer services in other jurisdictions. Their lower cost and high volumes are having a significant impact on the national efficient price and NWAU determination for antennal admissions. For example, WHA 2020/21 benchmarking data for large Tertiary Maternity services (> 4,000 births per year). shows the separations of ADRG O66 vary from 1,000 to 9,664 per year, with the average costs varying from $990 per patient to $4,816.

While it is important not to establish an incentive to admit women in pregnancy when alternative care can be provided (e.g. in outpatient services or day-only Assessment Units), there would be value in assessing the relative costs of different principal diagnoses of women admitted for antenatal care under ADRG 066 and to determine if there is a case for improving the fit between costs per patient and price.

3. Do you support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation? Please provide suggestions for any specific 'readiness' projects you would like to see progressed.

Yes, members support IHPA's proposal to refocus some resources on projects that prepare for ICD-11 implementation and suggest the Australian system needs to consider the issues of education and coder competence in preparation for the introduction of the new system.

ICD-11 has potential impacts on the coding workforce. Coders need to learn the new classification system and adapt to the changes to feeder systems and established databases and dashboards that rely on ICD-10-AM data. An aging workforce of coders is likely to retire and not be invested in learning a new classification system. New coders currently invested learning ICD-10-AM and gaining coding qualifications are not yet employed. Qualifications in ICD-10-AM will not be valid, and they will be unable to apply for coding positions requiring an ICD-11 skill set. As a result, there is potential shortfall of coders.

A transition period would be needed to minimize impact on coding turnaround times and service delivery whilst coders learn and adapt to the new system. Hospitals may need to run dual systems for data access and reference.

Apart from testing the impact on AR-DRG grouping, the ICD-11 system with its expanded scope of concepts, could be tested with regard to its suitability in enhancing the Mental Health, Emergency Department and SNAP classifications. IHPA should consider including both maternity/newborn and paediatric sites for testing or learning reflective of specific diagnosis and procedure codes relevant to these populations of patients.

In terms of 'readiness' projects, a mapping table between ICD-10 and ICD-11 will be very valuable when diagnosis level analysis needs to be conducted across two ICD versions.

4. Are there any barriers or additional considerations to using AN-SNAP Version 5.0 to price admitted subacute and non-acute services for NEP23?

No objections or additional considerations were shared with us by our members.

5. Are there any barriers or additional considerations to using AMHCC Version 1.0 to price community mental health care for NEP23?

CHA members appreciate the significant work that has gone in to developing the AMHCC, and see its potential to support greater visibility & investment in mental health care services and models of care in the future. There is currently apprehension about the transition from existing classification of care to the AMHCC as outlined under Question 6. below (although these comments relate primarily to admitted MH care rather than to community MH care).

6. Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

CHA recommends IHPA consider providing paediatric adjustments to the specialised Children's Hospitals for AECC and refine paediatric adjustments of AMHCC.

In consultation with our members, CHA has recently assessed the potential financial impact of AECC on the specialised children's hospital using 2020/21 ED data. The analysis indicates a significant reduction of NWAU when children's hospitals recoded their ED activity data to from URG to AECC. Although AECC considers age as a variable for complexity grouping, NEP 22 doesn't provide any paediatric adjustment to specialised children's hospital. NEP 22 does not reflect the higher complexity of the patients presenting to those specialised paediatric ED comparing to paediatric patients in the mixed EDs.

CHA members also raised concerns that the paediatric loading for AMHCC doesn't reflect the complexity of patients they are looking after. A CHA member, Women's & Children's Health Network (WCHN), did some modelling earlier this year to assess the financial impact if they use AMHCC to classify acute Mental Health admissions. They found a 20% reduction in their revenue when they switched the classification from DRG to AMHCC for acute Mental Health patients before any paediatric adjustment is applied. NEP22 provides a flat 10% paediatric loading to all specialised children's hospitals which is still not enough to cover the reduction of NWAU for mental health patients. It is our understanding that IHPA only had access to Children's Hospital at Westmead's data when the NEP22 and the 10% paediatric adjustment were determined for AMHCC. CHA would be pleased to see further consideration of the appropriate paediatric adjustments in NEP23 taking into account costings from other children's hospitals' as well.

Additionally, mental health legal status is only considered for 18-64 years acute mental health admissions. CHA members suggests that mental health legal status is also an important factor when considering the complexity of paediatric mental health admissions.

Further, CHA notes the comment under section 6.1 (p.20) of the consultation paper that *"IHPA will also investigate the criteria for assessing specialist paediatric hospitals".* Our members will be very interested in contributing to such an investigation, and CHA will be happy to assist with identifying relevant contacts, sourcing data, facilitating opportunities for IHPA staff to present/consult with key stakeholders, etc.

7. What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

Both WHA and CHA have members services that have been affected by either bushfires or flooding in the past few years. These dramatic events, while localised, have placed significant strain on local services. One of the immediate impacts has been accommodation for staff directly affected by a natural disaster. Without timely access to alternative accommodation, some services have seen staff leave the region, sometimes permanently. With climate change predicted to increase the frequency and severity of extreme weather events, there is a need to give consideration to funding of sustainability initiatives and emergency responses.

8. Which initiatives to refine the national pricing model should IHPA prioritise?

WHA members remain concerned to see changes to the funding of care to unqualified neonates, many of whom are continuing to be provided with clinical care on postnatal wards with their mothers rather than in a nursery but whose care is not adequately funded by the birth DRG of the mother. This situation has continued to be a pressing issue for maternity service providers as unprecedented levels of demand for nursery cots in recent years has resulted in higher numbers of comparatively less unwell newborns requiring medical care being looked after on postnatal wards, that are historically poorly staffed and lacking in dedicated neonatal expertise. WHA Clinical Benchmarking indicates that the rate of nursery admissions has risen by 26% in the past 10 years, from 9.7% of births in 2011 to 12.2% of births in 2021. This has resulted in increasing numbers of newborns requiring some form of medical care, who would once have been admitted to a nursery, instead being provided that care on a ward with their mother but without dedicated funding.

WHA has made detailed submissions on this in the past, and we appreciate that the power to change the qualified baby regulations rests with the Commonwealth Government and not with IHPA. Nevertheless IHPA's interest in determining whether there is sufficient data available to accurately assess the costs of unqualified newborn care is most welcome, and WHA is willing and able to assist IHPA to connect with service leaders and costing experts for this project if that would be helpful.

Further, there continues to be an unfunded cost related to care of babies who are effectively borders to mothers admitted for mental health reasons following childbirth. Some of our larger tertiary member health services report this care (of the babies) is costing $1m annually.

Models for more accurate funding and quality assessment of family-based services such as child protection, intimate partner violence support, social work, and trauma care should also be further considered. Anecdotally members are reporting significant increased prevalence of psycho-social risk factors among patients, requiring increasing amounts of planning and care coordination that is not currently funded adequately by ABF. The social and economic pressures associated with the pandemic appears only to have increased the numbers of pregnant women requiring additional time, support and expertise to be provided for their maternity episode of care, yet there are no additional resources available in already stretched services to respond in a sustainable way to these needs. Has consideration been given to some way of codifying psycho-social complexity and its impacts on the costs of care? WHA members would be very interested to support such analysis should IHPA wish to undertake work in this area.

9. What additional data sources are available to support refinement of the national pricing model in relation to adjustments, price harmonisation, unqualified newborns, private patients or organ donation?

Most, if not all, women's hospitals are currently capturing data identifying newborns receiving medical care as unqualified babies on post-natal wards. WHA's members now care for 86% of public births annually, including all tertiary services, so while not all public patents are included, it is a reasonably broad range of service types. We would be happy to liaise with the sector to identify how these data could be brought together and made accessible to IHPA for analysis if relevant.

10. What cost pressures for regional or remote hospitals should be considered in the development of NEC23?

There are currently nation-wide shortages of qualified healthcare staff. These shortages are being felt by all hospitals, city and country alike, but in rural and remote services they can be particularly acute and impactful. Demand for casual nursing, medical and allied health staff is at such high levels that the costs for locum staff or causal nurses has skyrocketed in recent times. There seems to be no quick fix on the horizon for the influence of the pandemic on health workforce, with more people retiring early, and fewer new graduates staying on. It will take many years to address current shortfalls. So rising costs for rural and remote services to access vital locum/casual skills are likely to continue to be a challenge for the foreseeable future.

11. What specific areas of the Local Hospital Networks and Public Hospital Establishments National Minimum Data Set would you recommend IHPA focus on when developing its independent quality assurance process?

WCHA members provided no comment on this question, presumably because block funded hospitals tend to have very small, if any maternity or paediatric service.

12. What should IHPA consider when transitioning standalone hospitals providing specialist mental health services to ABF?

NA – there are no such hospitals dedicated to the care of children or perinatal patients.

13. How is virtual care delivery captured in information systems and data collections?

Most services that we are aware of among our members are currently being captured and reported through non-admitted data systems. There would be value in developing more sophisticated ways to record and analyse virtual care costs to inform future pricing policy and service planning and delivery. For example, our members would be supportive of virtual ED care for children being able to be classified under the AECC, with some kind of additional code to show that the care was delivered virtually, since the same child presenting to an ED in person would receive the same care, albeit with a likely wait time of many hours.

Similarly, women's services pivoted to virtual antenatal care when the pandemic commenced and have largely continued to utilise this method of checking on women antenatally due to consumer demand and ease of providing care for staff who are required to work from home (e.g. while caring for a sick child). These episodes of care are being captured in non-admitted clinic data in the same way that they would be if the care takes place face to face.

14. IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?

This is a welcome commitment. Several children's hospitals are developing, or have recently developed, virtual EDs to cope with unmanageable demand on the back of ongoing and widespread reductions by GPs in seeing children with any kind of respiratory symptoms. The Women's & Children's Hospital in Adelaide, and the Northern Hospital in Melbourne both have functioning models of virtual ED that are proving effective in reducing some of the Cat 4 and 5 patient load from crowded ED waiting rooms and providing timely care.

Funding of these services has been time limited, project based, to date as we understand. Exploration of ways to ensure the viability of these virtual services if they prove to be required in the medium to longer term will be vital.

Another innovative model is occurring at Sydney Children's Health Network, where children requiring sleep assessment are now able to be tested at home with remote monitoring. This model has been developed to relieve pressure on beds in order to assist with efforts to reduce elective surgeries. Sleep testing otherwise requires an overnight admission for a largely well patient for diagnostic purposes. However, SCHN advises that people under the age of 18 are not currently eligible to be funded for sleep apnoea testing under HITH (unless I have misunderstood their advice…)

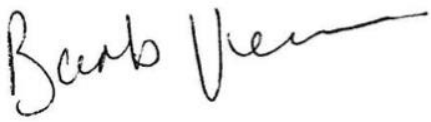
15. What changes, if any, to the national pricing model should IHPA consider to account for innovative models of care and services related to virtual care?

WHA members remain interested in returning to the development and implementation of bundled pricing for public maternity care.

There is also interest in exploring a funding model with the flexibility and ability to manage inflow from the districts where paediatrics services are yet to be established. Allowing for more transparent and consistent service sharing and chargebacks, including incentivising virtual care (telehealth) services from specialist hospitals to support non-specialist regional & rural services to keep women and children closer to home at lower cost to both health services and the families.

Thank you for the opportunity to comment on the design of the 2023-24 pricing framework. We appreciate IHPA's ongoing commitment to consuilting with the women's and children's healthcare sectors and are happy to help facilitate any further discussions IHPA may wish to have with experts in these sectors on any aspect outliend above.

Yours sincerely,



Dr Barbara Vernon
Chief Executive Officer
Women's & Children's Healthcare Australasia

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