

Mr James Downie  
Chief Executive Officer  
Independent Hospital Pricing Authority  
By email: [submissions.ihpa@ihpa.gov.au](mailto:submissions.ihpa@ihpa.gov.au)



Dear Mr Downie

**Re: Australian Refined Diagnostic Related Groups (AR-DRG) classification Version 10.0**

As IHPA is aware, Women's Healthcare Australasia (WHA) is the peak body for hospitals providing maternity and women's health care services. WHA membership currently consists of more than 100 maternity services across Australia including the majority of tertiary hospitals, as well as many medium metropolitan, regional and rural maternity services. Collectively our members support more than 150,000 births per year, which is around 60% of all births occurring in public hospitals. WHA supports member hospitals to achieve excellence in maternity and women's healthcare.

Thank you for the opportunity to provide comment on the maternity and neonatal related aspects of the Australian Refined Diagnosis Related Groups Classification as you work to design Version 10.0. WHA has consulted its membership on the Consultation paper published by IHPA and offers comments in response to selected consultation questions for your consideration. We are always of course happy to engage in further dialogue about any of these matters if that would be of assistance.

**Consultation questions:**

- 1. Are there diagnoses proposed for exclusion (refer to Appendix B) that are considered significant in contributing to the complexity of treating a patient in an admitted episode of care that should remain in the complexity calculation for AR-DRG V10.0?**

WHA consulted the CEOs of Women's Hospitals, as well as Health Information Managers and senior medical and midwifery clinicians across the general hospitals providing maternal and newborn care to seek advice on the complexity codes related to obstetric and neonatal care that are proposed to be excluded. There was general agreement that some of the codes are ill defined, and/or not clinically significant. Pruning the complexity codes for these is supported.

However there are a few proposed complexity codes on the list that we received consistent advice from member hospitals should not be removed, as they continue to capture patient complexity that explains differences in patient care, resource allocation and clinical workload.

Excluding the codes listed below from the complexity calculation would make an obstetric hospital admission significantly more complex. If admitted, these women would require additional nursing time, additional medication, additional involvement of allied health. Some of these conditions would make an admission for threatened preterm labour more complex (steroid administration and subsequent difficult BGL control), admission for labour and birth more complex and could also cost more (example- more monitoring, potential use of insulin in labour).

**Codes WHA members propose be retained:**

Obstetric

- O23.5 Infections of the genital tract in pregnancy
- O24 0, 12, 13, 14, 22, 23, 24, 29, 32, 33, 34, 39 pre-existing Type1 and Type 2 diabetes codes.

There would be little argument that diabetes either pre-existing or gestational are contributing factors to increased complexity in terms of managing pregnancy and delivery.

- O25 Malnutrition codes
- O26.6 Liver disorders in pregnancy, childbirth and the puerperium
- O28.3 Abnormal ultrasonic finding on antenatal screening of mother
- O98.4 Viral hepatitis in pregnancy, childbirth and puerperium
- O98.8 Other maternal infectious and parasitic diseases in pregnancy, childbirth and the puerperium
- O99.1 Anaemia in pregnancy
- O99.2 Endocrine, nutritional and metabolic diseases in pregnancy, childbirth and the puerperium
- O99.3 Mental disorders and diseases of the nervous system in pregnancy, childbirth and the puerperium
- O99.4 Diseases of the circulatory system in pregnancy, childbirth and the puerperium
- O99.7 Diseases of the skin and subcutaneous tissue in pregnancy, childbirth and the puerperium

Neonatal

- PO7: 1, 2, 3, 11, 12, 13 Low birthweight codes
- P92.0 Vomiting in newborn
- P29.82 Benign and innocent cardiac murmurs in newborn

If IHPA would like to share more detailed analysis with WHA members about the frequency or otherwise with which the above listed codes are currently being used to capture complexity we would be happy to facilitate further consultation, if in your view there remains a strong case for their exclusion.

**2. Are there other diagnoses not proposed for exclusion that should be added to the exclusion list?**

At this time WHA has not identified any further diagnoses for addition to the exclusion list.

**3. Do you support the introduction of stabilisation methods to the AR-DRG complexity model?**

There is general support for the proposed approach in the consultation paper among WHA members.

**4. Are there other areas of the complexity model IHPA should be investigating to ensure stability between AR-DRG versions?**

The recalibration of the vaginal birth codes in version 7 to ensure the O60 code distribution between A, B and C level complexity matched the normal distribution in other DRGs, has since been replaced in version 8 by a breakdown that looks remarkably similar to the original proportions in version 6.0x, where by the majority of women having a vaginal birth are allocated to the O60B complexity DRG. We would be interested to see greater stability in the O60 DRG as the classification continues to be developed in future, as such significant changes can be disruptive in terms of analysis of budgeting and performance for our members.

**5. Do you support the proposal to differentiate caesarean section types in the AR-DRG classification?**

WHA members are supportive of the proposal to differentiate caesarean section types in the AR-DRG classification, while retaining capture of the varying complexity as it applies to both 'Elective' and 'Emergency' Caesarean sections.

**6. Do you support using in labour or not in labour as the measure for differentiating caesarean sections in the AR-DRG classification?**

WHA membership are supportive of moving away from the descriptors of 'elective' and 'emergency' caesarean sections in the descriptors for caesarean sections. The terms "Elective" & "Emergency" are emotive and value laden for the general public. Women who are told they had an "emergency" caesarean section are often left with the impression that either their or their baby's life were in immediate danger, which in the majority of cases was not the case. This in turn results in increased anxiety about the delivery method for subsequent pregnancies which is not always warranted. Often "Emergency" caesareans are for such things as breech presentation with Spontaneous Rupture of Membranes etc.

The term "Elective" is likewise misleading as it infers that it was simply a matter of choice for either the woman or treating clinician when in the vast majority of cases there is a sound clinical reason for the caesarean. With either the traditional interpretation of "Emergency" / "Elective" or that which FMC has adopted, the urgency is poorly differentiated.

Women's Healthcare Australasia

Submission to IHPA re Australian Refined Diagnostic Related Groups – June 2018

Regarding an alternative classification for caesareans, there were some different views among member hospitals. Many were comfortable with the proposal to use 'in labour' or 'not in labour' however some hospitals point out that this may make classification unreliable, as there can be dispute about how the commencement of labour is measured.

An alternative proposed is "planned" vs "unplanned" caesareans.

There are conditions that can require an emergency caesarean section, such as antepartum haemorrhage or severe pre-eclampsia, where the patient may not have been in labour. It will be important therefore that any split of the caesarean DRGs still provides for different levels of complexity.

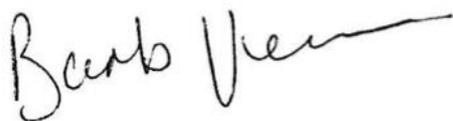
Members proposed that Caesarean sections should have a 2 tier classification. First they should be classified as "Planned" or "Unplanned" according to the definition above which is basically "intention to treat". We should then apply the RANZCOG definitions of urgency, i.e. Category 1, 2, 3 or 4. This would allow for more meaningful classification and could also help better analyse and resource different episodes of care.

For example if a woman who was booked for a planned caesarean for placenta praevia at 38 wks had a torrential bleed at 28 weeks and proceeded to a caesarean section, then it would be a "Planned, category 1 " CS, whereas if she had proceeded uneventfully to 38 weeks it would be a "Planned, category 4" caesarean

WHA would be happy to facilitate discussion by IHPA with a focus group of experts to tease this out further if that would be of assistance.

Thank you for the opportunity to comment. We look forward to seeing the final Australian Refined Diagnosis Related Groups Classification Version 10.0.

Yours sincerely,

A handwritten signature in black ink that reads "Barb Vernon". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

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