CHAPTER 9

FUNDING ISSUES

9.1 The chapter begins with a consideration of general funding issues which have been repeatedly brought to the Committee's attention as having an adverse impact upon the quality and appropriateness of antenatal, intrapartum and post natal care.

Fragmentation and cost shifting

9.2 Fragmentation and cost shifting are features of health provision generally in Australia and maternity and neonatal care are no different.

9.3 Antenatal care for public patients may be funded by the Commonwealth, if it is provided by a general practitioner or specialist outside hospital, or by the State, if it is provided through a hospital antenatal clinic or community service. Care during birth is funded by State governments where the birth takes place in a public hospital labour ward or birth centre and the woman is attended by salaried nurses and/or salaried registrars or obstetricians.

9.4 If the birth takes place in a country hospital and the woman is attended by a nurse and general practitioner/obstetrician the costs for public patients are also met by the State as the general practitioner/obstetrician normally has Visiting Medical Officer status, that is, they are employed by the hospital. In fact the position is more complex than this since about half of all hospital funding is provided directly to the States by the Commonwealth through the Medicare Agreements and the remainder is provided indirectly through financial assistance grants.

9.5 Post natal care for public patients in the period immediately following birth is normally funded by the States, from their hospital budgets, regardless of whether it is provided in hospital or in the community. However, as noted earlier in the Report, with the increase in early discharge some of the costs of this care are now being met by the Commonwealth, where it is provided by general practitioners, or jointly by the Commonwealth and States where it is provided by programs such as Home and Community Care. Most post natal care is provided by infant welfare sisters (whose titles vary from State to State) and are State funded.

9.6 The antenatal care of women with private insurance may be paid for by their health fund in cases in which it is provided in a private hospital antenatal clinic, with the woman paying the difference in costs between the fee charged and the Medicare rebate. Some women with private insurance choose to receive their antenatal care at public hospitals as public patients and in this case the costs are met by State governments through their hospital budgets.

9.7 The costs of care for women with private health insurance who give birth in public hospitals as private patients or in private hospitals are normally met by the

health funds, with women paying for the gap between clinicians' charges, the Medicare rebate and health fund rebates. The same situation generally applies to post natal care although for women with private health insurance such care is normally provided only in hospital.

9.8 Some private health insurance funds will cover some, but not necessarily all, of the costs of employing an independent midwife for women who choose to give birth at home or, more rarely, for women who give birth in hospital in the care of an independent midwife accredited to that hospital. This option is severely restricted as very few hospitals extend accreditation to independent midwives. Most women, who employ independent midwives, for either a home birth or a hospital birth, must meet the full costs themselves.

9.9 A major problem with the current fragmentation of funding arrangements is that it contributes directly to fragmentation in service provision. This is an issue for health care generally in Australia, and is not confined to obstetrical care. Instead of encouraging a seamless episode of care extending from the beginning of pregnancy, through birth and into the post natal period existing funding arrangements break that care into episodes centred around the groups which provide it and the settings in which it is organised. This has adverse consequences for the quality of care.

> As a result of this fragmentation consumers typically have to "navigate" their own way through the various approaches and services offered. This often results in duplication and lack of continuity in information sharing and generally a sub-optimal service delivery system.[1]

9.10 The fragmentation of service provision is exacerbated by attempts at cost shifting between jurisdictions. Again, quality of care is adversely affected.

> It is part of the difficulties with having state and federal relations; it becomes really complicated as to who pays for what health care. The woman is the one that gets stuck in the middle. She gets pushed from one side to the other, getting more and more fragmented care and not knowing when to put out her Medicare card and when to give her other card. If we are talking about woman centred care, at the moment it is the kind of system and practitioner–centred care that is chaotic.[2]

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> In "protecting" or optimising their particular role in the start-to-end process, service providers make resource allocation decisions that are necessarily driven by internal imperatives rather than by the best interests of the consumer (for example, budget cuts on hospitals drive shorter lengths of stay). Thus while elements of the start-to-end system may be "optimised",

1 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

2 *Committee Hansard*, 14.9.99, p.440 (Midwifery Practice and Research Centre, NSW).

> the overall system is often compromised and functions in a sub-optimal way.[3]
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> Public hospitals are increasingly looking for ways to reduce costs, particularly in the provision of antenatal care. This organisation of services, however, potentially impinges on women receiving high quality, cost effective care that meets their needs. Currently, in many public hospital antenatal clinics women are "bulk billed" for their care if they have been referred by an obstetrician. This occurs in general clinics as well as specialised 'day only' clinics for high risk women. This system means costs are shifted from the state to the federal system. However, it also means women must see an obstetrician, essentially, increasing costs for no proven benefit.[4]

9.11 A separate but related issue is the impact on service provision of cost cutting by State governments, especially to antenatal and post natal care services and especially in Victoria. These issues are discussed earlier in the Report.

The impact of casemix funding

9.12 Casemix funding is a means of measuring and tracking hospital expenditure on the treatment of groups of related conditions called diagnostic related groups (DRG). In essence it is funding based on the mix of cases which the hospital treats. It is possible to compare the costs of treating patients with similar conditions in one hospital with the costs of doing so in another hospital. These costs form the basis of resource allocations to hospitals in subsequent years. Casemix funding was introduced initially in Victoria in 1993 and has been progressively extended since then to most other States. It includes 18 related conditions affecting the mother in DRGs related to pregnancy, childbirth and the puerperium (that is, the first six weeks after birth). A further DRG relates to newborns.

9.13 Evidence to the Committee suggested that the casemix system has the potential to impact adversely on the quality of care provided to women during pregnancy and birth. The DRGs assume a degree of homogeneity among patients that does not always exist, despite the fact that DRGs make allowances for serious divergences from the norm. Also, because the DRGs focus on medical and obstetrical needs they do not take adequate account of psychosocial issues which, in the case of a relatively small group of women, require quite intensive support. In effect therefore, hospitals which provide this support are not adequately compensated for doing so, which is a disincentive to its provision.

9.14 A further consequence of the DRG approach, as currently administered, is that funding is provided according to the diagnosis at discharge rather than at admission. A

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3 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

4 Submission No. 51, p.2 (Midwifery Practice and Research Centre, NSW).

woman who is admitted to hospital 10 weeks before giving birth because, for example, she requires monitoring and care for preeclampsia, and who subsequently gives birth to a healthy baby attracts funding only for the birth. The same funds would be provided in the case of a woman admitted during labour who gives birth to a healthy baby, despite the fact that the hospital's costs in the former case are obviously far greater.

9.15 The same inequities are evident with respect to post natal funding and also to the treatment of newborn babies.

> The way in which hospitals in most states, and certainly in South Australia, are funded is on Casemix and casemix is a very broad based lumping of patients. If you are in a postnatal ward being admitted for breastfeeding, you are linked to other patients who are conventional patients having had a baby. It is the same case payment for being readmitted for four hours of breastfeeding versus five days of postnatal care, which means that the Casemix income for those real patients is then diluted. The people who are admitting these patients are blissfully unaware of what they are doing.
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> …Another good example is the admission of the newborn…The admission rate for neonates in hospitals varies from about 18 per cent to 75 per cent. The criteria for admission vary enormously across the country, and the variation is largely Casemix driven. The real need for newborns to be admitted to a special care or intensive care nursery is probably somewhere between 15 and 20 per cent.[5]

9.16 Casemix payments are adjusted over time and will thus partly overcome these anomalies. In the case of women readmitted for four hours of breastfeeding care and funded for five days of post natal care, for example, funding adjustments over the longer term will result in a payment to the hospital which represents a mean of the costs of caring for women staying five days and those staying four hours. Thus in the future the hospital will be financially penalised if it admits a greater proportion of women for five day stays (until a subsequent funding adjustment catches up with the reality of the hospital's current practice).

9.17 In the cases referred to above, many witnesses suggested, funding arrangements are illogical. They provide opportunities for manipulation of the funding system by doctors (rather than by governments). They do not encourage either the most effective use of scarce resources or the most appropriate care. The deficiencies in current arrangements were succinctly summarised in a submission from Flinders Medical Centre.

> Contrast, for example, the incentive provided by a fee-for-service (GP's medicare rebate) with an episodic fee (Hospital case mix or DRG

5 *Committee Hansard*, 7.9.99, pp.186-187 (Professor P Marshall, Flinders Medical Centre).

> reimbursement); one rewards over-servicing, the other rewards cost shifting, but neither reward or encourage cooperation.[6]

9.18 Casemix funding has a number of deficiencies but it is generally an improvement on the previous funding system, which involved the allocation of funds to a public hospital according to what the hospital spent the year before.

9.19 The Committee considers that casemix funding needs to be evaluated to minimise the practices referred to above, which have developed in an effort to deal with funding shortages and the time lags involved in funding adjustments through casemix.

9.20 Current funding arrangements contain perverse incentives, as noted above. They may, for example, encourage hospitals to admit newborn babies when there is no medical requirement to do so, or discharge women after birth without adequate support. It is alleged by some that current funding arrangements encourage the use of Caesarean section and that this explains the increase in the use of the procedure in Australia.

9.21 The Committee has found no evidence to support this view. While it is true that casemix funding allocates more money to hospitals for Caesarean section than for vaginal births, it is also the case that hospitals incur higher costs in the former case. The funding differentials are not so great as to enable them to profit from the performance of a large number of Caesarean sections in preference to vaginal deliveries.

9.22 Births by Caesarean section have increased slowly but steadily for thirty years. The rate has not been radically affected by the introduction of casemix funding. Indeed, the rate is highest for privately insured women, as noted, but there has been far less comprehensive use of casemix funding by private hospitals.

9.23 Nor did the deletion of a separate Medicare Benefits Schedule (MBS) item for Caesarean births in 1988 have any measurable impact on the increase in the rate of Caesarean section. (The most recent change to the MBS, for complex births, will be discussed later in this chapter.)

> There have been changes over recent years in the Medicare Benefits Schedule, which for a time included caesarean section as one item. We do not have any evidence that I know of that says that the changed practices are due to changes in the Medicare Benefits Schedule funding arrangements.[7]

9.24 There also appears to be no direct financial incentive for Caesarean section in the arrangements of private health funds.

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6 Submission No. 108, p.1 (Professor P Marshall, Flinders Medical Centre).

7 *Committee Hansard*, 7.9.99, p.250 (Department of Human Services, Vic).

> To the best of my knowledge, there are no actual financial incentives for one procedure as against another. It is not a case of differential benefits being paid by the health fund for a caesarean or for natural childbirth, although if it is an episodic payment there may be a higher payment for a caesarean because of the longer expected length of stay.[8]

9.25 The Committee formed the view, on the basis of evidence presented during its Inquiry, that there is a link between funding arrangements and the Caesarean section rate but that it is not a direct link. In the current situation, where an obstetrician is paid the same for a delivery, regardless of whether it is a vaginal birth or by Caesarean section, it is in the obstetrician's financial interest to opt for the Caesarean and get it over with quickly rather than waiting for hours through a natural birth to obtain the same financial reward.

> Rather than acting as a deterrent, it seems that a global fee might actually work as an inducement to intervene, on the grounds that a caesarean section is often a much quicker option for a busy obstetrician than dealing with the uncertainties involved in the expectant management of natural labour and birth. If the monetary reward is the same regardless of the type of delivery then caesarean section could be seen as a preferred option, potentially involving less work than the alternative.[9]

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> …in the Medicare confinement fee there is absolutely no reward for the effort involved in managing a difficult confinement through to a normal vaginal delivery and for using one's clinical skills. In the same way, there is no reward for effort for delivering a baby as a breech.[10]

9.26 While financial considerations do not necessarily affect clinical decisions on the performance of Caesarean sections, current arrangements are unsatisfactory, both for the women concerned and for obstetricians. The Committee suggests that a positive financial incentive should be considered for vaginal births where such an approach would not jeopardise the health of the mother or baby. This would reward obstetricians for their skills and help to reduce the deskilling now causing concern in the profession. It is possible that the new rebate might have this effect because it rewards, for example, trial of vaginal breech delivery and trial of scar following a previous Caesarean section. However, some witnesses suggested that it was more likely to encourage intervention than to reduce it, as discussed later in this chapter.

9.27 Some funding initiatives have encouraged a less interventionist approach to birth, notably the Alternative Birthing Services Program. This was initially funded by the Commonwealth and has now been subsumed into a broader public health program

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8 *Committee Hansard*, 27.8.99, p.81 (Australian Health Insurance Association Ltd).

9 King, James E. *Obstetric intervention and the economic imperative*, British Journal of Obstetrics and Gynaecology, April 1993, Vol. 100, p.303.

10 Committee Hansard, 6.9.99, p.171 (National Association of Specialist Obstetricians and Gynaecologists).

with seven other health programs. These are funded through the Public Health Outcome Funding Agreements which the Commonwealth signed with each State government for the period 1997-1999. As with other broadbanded funding arrangements, it is extremely difficult to track what happens to individual program funds once they are subsumed into broader programs. In the Committee's view it cannot be concluded that funds formerly earmarked for alternative birthing initiatives are continuing to be spent on such initiatives. This is a further example of the potential for cost shifting inherent in current funding arrangements.

9.28 An issue related to the funding of obstetricians is the pressure on them to perform Caesarean sections in circumstances where they are caring concurrently for women in a number of different hospitals.

> The other thing that has been suggested is that one of the financial incentives is the physician convenience – that you can do five deliveries in a day fairly readily if they are all lined up to go into the theatre. But if you are actually hanging around in five labour wards for five long labours that is much more difficult to do. So part of the financial incentive comes in time management of a busy practice.[11]

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> If a private provider has admitting rights at four different maternity hospitals and who has a theatre list, rooms, patients booked and three or four women in labour on different sides of the city at once, that is an enormous pressure to be under. If you have to actually deliver to collect the fee, then the very structure of a practice can influence patterns of behaviour in subtle ways. I am not suggesting that people go out of their way to surgically deliver every pregnancy, but one has to take account of the pressures that people are working under and which direction those pressures are pushing them in.[12]

9.29 To avoid the extension of these pressures to midwives a number of witnesses opposed the granting of an MBS item number to midwives.

> I personally feel that fee-for-service remuneration is not a good model for practice of any description. I cannot see that that should not apply to midwives as well.
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> … But I would fear – and there is evidence to back this up, particularly from New Zealand – that, if this were given a fee-for-service remuneration – a Medicare thing – we would see the same kinds of problems with midwifery fee-for-service. It would not be exactly the same because midwives do not wield knives, but they will be just as open to commercial pressures for testing, laboratories, induction at the weekends and so on. I cannot see any

11 *Committee Hansard*, 6.9.99, pp.98-99 (Dr Jane Fisher, University of Melbourne).

12 *Committee Hansard*, 14.9.99, p.461 (NSW Pregnancy and Newborn Services Network).

> reason why that would be a better model for midwifery than it is for current obstetrics, of which I have been a critic.[13]

The inverse care law

9.30 A disproportionate amount of funding for antenatal, birth and post natal care is channelled to the 80% of women at no risk, especially those with private health insurance, rather than on those with high needs. This is sometimes referred to as the inverse care law. Many healthy women receive specialist obstetrical care when there is no medical indication for it and where midwifery care would be equally appropriate and less expensive. At the same time, many women at high risk receive inadequate general health care.

> In no other "condition" are well people expected to visit medical specialists for primary health care. Yet this is the main option for women with private health insurance, and for many rural women regardless of health insurance status, for care during pregnancy. Rates of medical intervention have been shown to be greater than average in the privately insured group of women, who receive care from a specialist obstetrician. This phenomenon, described as the "inverse care law" is obviously a huge waste of resources, and much of the cost is borne by the tax payer.[14]

9.31 The Committee was advised that childbirth is a major reason for women to take out private health care. They do this, it is said, to ensure continuity of carer (a specialist obstetrician) through pregnancy and birth. Evidence to the Committee during the course of the Inquiry reinforced the importance to women of continuity of carer. When this option is more generally available in the public sector (as discussed in chapter 2) it is possible that fewer women will take out private insurance.

Funding inequities between antenatal, intrapartum and post natal care

9.32 At present the bulk of funding for care during pregnancy, birth and in the immediate post natal period is directed to antenatal care. This accounted for a total of $68.6 million in the year to June 1999, while funding for labour, delivery and post natal care totalled $27.6 million.[15] The largest and fastest growing component of antenatal care is routine ultrasound scanning, the cost of which totalled $35.8 million. The remaining $30 million spent on antenatal care was to cover the costs of antenatal visits. There were over 1.4 million such visits in the year ended June 1999.

9.33 Given that over a third of total funding for antenatal, birth and post natal care is spent on a procedure for which there is no proven medical benefit in the majority of

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13 *Committee Hansard*, 15.9.99, p.513 (Professor James King, Qld Council on Obstetrical & Paediatric Morbidity and Mortality).

14 Submission No. 14, p.5 (Australian College of Midwives Inc, Vic Branch).

15 All figures in this section are from Health Insurance Commission Medicare Benefits Schedule Item statistics generated 5 October 1999 (excluding services provided by hospital doctors to public patients in public hospitals).

cases and about which there are growing concerns, there is a strong case for reviewing the costs of this procedure.

9.34 Recommendations on antenatal and post natal funding appear in the chapters discussing these aspects of maternal and infant care.

Conclusion

9.35 Existing funding arrangements for antenatal, intrapartum and post natal care are seriously flawed. They encourage fragmentation in service provision, cost shifting and overservicing and direct a disproportionate amount of funding to those who least require it. They encourage a level of intervention for the majority of women for whom this is not necessary and indeed for whom it may be inappropriate.

9.36 This issue is part of the broader problem facing Australia's public hospitals. This Report is obviously not the place to make recommendations about overall changes to funding. However, evidence to the Committee during this Inquiry points overwhelmingly to the fact that current funding arrangements and the fragmentation of services consequent upon them have adverse effects on the quality of care.

9.37 The Committee concludes that major improvments in the quality of maternal and neonatal care will not be achieved until the funding issue is resolved.

The impact of the new Medicare rebate

9.38 On 1 November 1998 a new Medicare Benefits Schedule (MBS) item was introduced for complex births. It increased the Medicare fee to $950 for complex births ($964 since 1 November 1999). This compares with a fee of $404 (now $410) for a standard delivery (either vaginally or by Caesarean section) and $472 for a Caesarean section in cases in which the patient's care has been transferred to a doctor who has not previously provided care. (There is only a small number of such cases.) The rationale for its introduction was to eliminate the high gap payments faced by privately insured women whose confinements were deemed to be complex, while ensuring that obstetricians received adequate remuneration for difficult obstetrical cases. It was estimated that about 20% of births would fall into the complex category.[16]

9.39 The Committee has received conflicting advice on whether or not the rebate has reduced gap payments and by how much. Some witnesses believed that it has had no effect on the size of gap payments.

> The Medicare rebate for complex births was intended to reduce gap payments. AHIA [Australian Health Insurance Association Ltd] supports the increase in the rebate. However, it did not of itself reduce medical gap payments. Indeed, the experience at the time in relation to the health fund

16 See Senate Community Affairs Legislation Committee, *Committee Hansard,* estimates 31.5.99, p.102.

> which was providing a gap benefit for childbirth was that some doctors increased their fees.[17]
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> Following the introduction of the complicated confinement item (Item No 16522) in November 1998, Health Insurance Commission data to date suggests that gap payments do not appear to have fallen. The AMA contends that it is still too early to be clear as to the level that gap payments will eventually settle at. A longer period will be required before more definitive conclusions can be drawn as to the level of gaps for this item.
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> Nevertheless, in view of the above identified pressures on the incomes of obstetricians, the AMA would also argue that the fact that gap payments have not increased is a positive outcome for consumers.[18]

9.40 Others considered that gap payments had been reduced as a result of the new rebate.

> Certainly the impact of the new Medicare rebate provided for complex births has assisted in the reduction of average gap payments.[19]
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> NASOG [National Association of Specialist Obstetricians and Gynaecologists] has data suggesting there has been a significant drop in gaps in Australia after the introduction of this Item number.[20]

9.41 The Commonwealth Department of Health and Age Care estimated that gap payments had fallen slightly, from $300 for the standard confinement item (MBS no. 16519) to $218 for the new complex item (MBS no. 16522).[21] In other words, most of the additional $478 now paid by Medicare for complex births is retained by the obstetricians and not passed on to the insured women in the form of reduced gap payments. The Department advised that 56% of claims under the new complex item were for services where women were charged above the schedule fee (compared with 72% for the standard confinement item).[22]

Views on the new Medicare rebate

9.42 Some witnesses welcomed the new rebate.

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17 Submission No. 146, p.3 (Australian Health Insurance Association Ltd).

18 Submission No. 175, p.7 (Australian Medical Association Ltd).

19 Submission No. 89, p.12 (Catholic Health Australia).

20 Submission No. 100, p.1 (National Association of Specialist Obstetricians and Gynaecologists).

21 See Senate Community Affairs Legislation Committee, *Committee Hansard*, estimates, 31.5.99, pp.102-103.

22 Additional information to Senate Community Affairs Legislation Committee estimates, 31.5.99.

> This initiative has had a significant impact on rural GPs and has enabled many to consider staying in obstetrics that might have otherwise pulled out. It was welcomed by all rural GPs and is recognition of the difficulty with high risk Obstetrics. The government is to be applauded for this. It has certainly reduced the gap payment.[23]

9.43 Others opposed it, mainly because they feared it would encourage overservicing.

> The new rebate was supposed to be spread through obstetricians' practices to reduce "gaps" for women. In reality it seems that most obstetricians view it as being paid appropriately for difficult cases. The concern is whether the additional fee acts as an inducement to intervene.[24]

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> I think it is a considerable concern that the financial incentive that used to exist for intervention that was removed has now been replaced and that there will be a further incentive – if any further incentive is needed.[25]

9.44 Others felt that the rebate should be more closely linked to health outcomes for mothers and babies.

> …the sizeable increase in the rebate for "complex births" introduced a financial incentive for more births to be categorised in this way, particularly since the recipient of the benefit was the person making the judgement as to whether the criteria was met. This concern was alleviated in some way by the list of criteria included in the Medicare item, but a review of the impact on outcomes is necessary for assurance that the changes have not unduly influenced health care decisions.[26]

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> The impact of the new Medicare rebate for complex births should be closely monitored by the Health Insurance Commission (HIC) to determine its effect on patterns of provider services and to detect any associated changes in perinatal morbidity. For example, the inclusion of "fetal distress" in the definition of a complex birth is problematic. Given the existing diagnostic uncertainties surrounding this condition, the definition has the potential to increase the already high levels of interventions such as routine fetal heart rate monitoring in normal pregnancy.[27]

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23 Submission No. 70, p.7 (Royal Australian College of General Practitioners).

24 Submission No. 51, p.13 (Midwifery Practice and Research Centre, NSW).

25 *Committee Hansard,* 6.9.99, p.98 (Dr Jane Fisher, University of Melbourne).

26 Submission No. 153, pp.15-16 (Maternity Alliance, NSW).

27 Submission No. 109, p.21 (NSW Pregnancy and Newborn Services Network and Centre for Perinatal Health Services Research).

9.45 Given the divergence of opinion on the potential of the new Medicare rebate for complex births to act as an incentive for overservicing, the Committee considers the rebate should be monitored to ensure that it does not result in an increase in Caesarean sections and other interventions where these are not indicated on medical grounds.

Recommendation

The Committee RECOMMENDS that the Health Insurance Commission monitor the new Medicare rebate for complex births to ensure that it does not lead to overservicing.

Qualified and unqualified neonates

9.46 The issue of funding arrangements for qualified and unqualified neonates is quite separate from the issue of the Medicare rebate for complex births and predates it by many years.

9.47 When Medibank was first introduced in 1975 Commonwealth and State governments agreed to provide a bed subsidy for all hospital patients. It was decided that healthy new babies housed with their mothers should not 'qualify' for the bed subsidy because there was no clinical need for them to be in hospital, except to be near their mothers, who did have such a need. Accordingly, they were not classified as patients. They were defined as patients only if they were less than nine days old (originally seven days old) and required treatment which could only be provided in an intensive care or special care unit (in other words, separate from their mothers). However, the second and subsequent children of a multiple birth were defined as patients.

9.48 Under the current Australian Healthcare Agreement no bed subsidy is paid for hospital patients so the original reason for the exclusion of new babies from the definition of 'patient' no longer exists. However, modifications to the Act from 1 July 1996 did not address this fundamental legislative flaw.

9.49 It can have serious funding implications. For example, a woman who is privately insured but whose baby is unqualified can make no claim upon her health fund or Medicare for care and treatment provided to the baby.

> "Unqualified" neonates that require Specialist treatment while still by the mother's bedside do not attract a gap rebate if privately insured, which is a significant vexation to insured families, and indeed is a discrimination against the baby.[28]

9.50 There are wide discrepancies between States in the number of neonates gaining qualified status. This varies from 10% to 70%.[29] Where unqualified neonates

28 Supplementary information, 7.9.99 (Royal Women's Hospital, Vic).

29 Submission No. 78, p.37 (Mater Misericordiae Mothers' Hospital, Brisbane).

are admitted the costs of their care are attributed either to the mother's admission and/or across all qualified neonate admissions. This can have the effect of artificially inflating the costs of other obstetric DRGs and of disadvantaging hospitals caring for unqualified neonates, which is why so many hospitals reclassify them as qualified.

9.51 The differentiation between qualified and unqualified neonates can also have an adverse impact on the care of the newborn. It provides a financial incentive to classify babies as qualified and to treat them separately from their mothers in situations where such a separation is not medically necessary and in fact is inimical to their development because it deprives them of the benefits of early bonding and maternal support.

> Even worse, to attract the bed payment for an inpatient stay, babies are sometimes moved from their mother's bedside into the nursery for treatment there, when the baby could have been equally well treated without separation from the mother, if this anomaly were not in place. This is encouraging bad medical practice.[30]
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> The term Qualified and Unqualified Neonates is counter productive to good neonatal care; it encourages the admission of mild to moderately sick neonates to special Care Nurseries, when many of them could be better (and more economically) cared for at their mother's bedsides. It also makes clinical costing difficult because of the failure to recognise "unqualified" neonates as individual patients.[31]

9.52 In both medical and financial terms it is important that all neonates be recognised as qualified. At the very least, definition as qualified should be based on diagnosis and type and intensity of care required rather than on physical location.

Recommendation

The Committee RECOMMENDS that the Health Insurance Act be amended to define as 'patients' all neonates in hospital who require medical attention, regardless of whether they are located with their mothers or not.

30 Supplementary information, 7.9.99 (Royal Women's Hospital, Vic).

31 Submission No. 46, p.10 (Royal Women's Hospital, Vic).