**QUEENSLAND**

***COMMISSIONS OF INQUIRY ACT 1950***

**BUNDABERG HOSPITAL COMMISSION OF INQUIRY**

**STATEMENT OF MICHAEL CARLO ZANCO**

1. I, **MICHAEL CARLO ZANCO, Acting Team Leader, Health Systems Development Unit, Statewide Health and Community Services Branch** of c/- Citilink Building, Bowen Bridge Road, Herston in the State of Queensland, acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

**My Role**

3. I have been the Acting Team Leader of the Health Systems Development Unit, Statewide Health and Community Services Branch since the start of February 2005. My responsibilities include:

    a) Development and implementation of systems to improve efficiency, appropriate practice and equity of access to emergency department and elective surgery services on a statewide basis.

    b) Provision of statewide information to guide the forward planning and ongoing management of emergency department and elective surgery services across QH facilities.

    c) Provision of advice and analysis relating to emergency department and elective surgery services.

**Elective Surgery**

4. In the 2005/2006 financial year Queensland Health ("QH") will spend over $5 billion delivering health services, of which approximately $2.7 billion is attributed to inpatient services. Of this, Medicine accounts for about 60% (or $1.6 billion) and Surgery accounts for about 40% (or $1.1 billion). In this regard, the election commitment funding for elective surgery activity constitutes roughly 1.2% ($33.2 million) of total inpatient services costs or 3% of total surgery costs.

5. More than 95% of all elective surgery done by QH is undertaken in 31 QH facilities ("31 reporting facilities"). **ATTACHMENT 'MCZ1'** is a list of those facilities.

6. QH uses the definition of "elective surgery" used by the Australian Institute of Health and Welfare ("AIHW") as that definition applies to its dealings with Commonwealth bodies, including in relation to the data it is required to supply under the AHCA.

7. The AIHW defines "elective surgery" as:

> *"... comprising elective care where the procedures required by patients are listed in the surgical operations section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians.*
>
> *Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours."*

8. The scope of procedures that constitute "elective surgery" is governed by the National Health Data Dictionary which is produced by the AIHW.

9. **ATTACHMENT 'MCZ2'** is a copy of an extract from the National Health Data Dictionary titled *"Waiting List Category"* setting out the scope of procedures that constitute "elective surgery".

**QH's Elective Surgery Program**

10. QH's elective surgery program commenced in November 1995. It was introduced by the then Minister for Health, Peter Beattie. It has changed over time as a result of the commitments of various Queensland Governments.

11. **ATTACHMENT 'MCZ3'** is a summary of the various QH elective surgery programmes between 1995 and 2005.

**Elective Surgery Policy**

12. The provision of specialist services by QH is governed by the *"Australian Health Care Agreement"* ("AHCA") and the QH *"Selected Specialist Services Direction Statement 2001-2010"* (**ATTACHMENT 'MCZ4'**).

13. QH's elective surgery program is directed by the requirements imposed on it by Queensland and Commonwealth Governments. It must:

    a) Enable QH to meet the reporting requirements in the AHCA in relation to elective surgery.

b) Implement the Queensland Government's *"Waiting List Reduction Strategy"*, which was released in July 1998 (**ATTACHMENT 'MCZ5'**). That policy enables facilities to establish and extend access to surgical services and elective procedures across the State. The Strategy is designed to:

i. Maintain or increase existing levels of elective surgical services and elective procedures;

ii. Establish new programs to treat patients who are unable to access existing surgical services or elective procedures within a reasonable timeframe; and

iii. Ensure that the treatment of patients from the elective surgery wait list is based on prioritisation according to clinical need.

Responsibility for the *"Waiting List Reduction Strategy"* rests with the Senior Executive Director of Health Services ("SEDHS") and Zonal Managers. The Executive Director of Statewide Health and Community Services Branch has responsibility for reporting to the SEDHS against the Strategy.

14. QH's current policy in relation to elective surgery is set out in the *"Policy Framework for Elective Surgery Services"* released in March 2005 ("the Policy") (**ATTACHMENT 'MCZ6'**). The Policy replaced previous QH policies such as the *"Guidelines for the Management of Waiting Lists"* and the *"Guidelines for Pre-admission processes, Discharge planning and Transitional Care"*.

15. The Policy has been developed according to national data definitions and following extensive consultation with clinicians. It is designed to:

a) Provide instruction, information and guidance to QH employees and other practitioners involved in the provision of elective surgery services.

b) Be the definitive source of information for the implementation and maintenance of elective surgery systems and management processes within QH.

c) Articulate individual policies dealing with clinical and administrative processes which guide facilities in developing protocols and procedures within local settings.

d) Provide specific guidance around clinical urgency categories, prioritising elective surgery, the elective surgery waiting list systems, the roles and responsibilities of key stakeholders, additions, removals and audit of the waiting list.

**Administration of the Policy**

16. Under the Policy (see page 11), each QH facility is required to identify an Elective Surgery Accountable Officer. In most QH facilities, the Elective Surgery Accountable Officer is the Director of Medical Services or the Director of Surgery. Most facilities also have an Elective Surgery Coordinator or Elective Surgery Liaison Officer who report to the Elective Surgery Accountable Officer.

**Access to Elective Surgery through QH**

17. The Policy sets out the referral sources for elective surgery (see page 11 of 'MCZ6'). Access to QH's elective surgery waiting lists is primarily (almost 98%) through specialist outpatient services.

18. To enhance current specialist outpatient services and maximise existing resources, QH has completed the implementation of the *Policy Framework for Specialist Outpatient Services* in June 2005. Under the Policy, QH's specialist outpatient clinics are required to operate as follows:

    a) All referrals received are required to be prioritised according to a clinical urgency category, a system similar to that used in elective surgery. The categorisation of referrals is designed to facilitate equitable and timely access to appropriate services according to urgency of need.

    b) Ensure their specialist outpatient waiting list contains details about all patients who require an outpatient appointment, from the time that the facility accepts the referral until the initial appointment has been allocated, or the patient has been removed from the waiting list. The system to register patients on the specialist outpatient waiting list may be manual or electronic. The type of system is usually dependent upon the size of the facility and the demand for specialist outpatient services.

    c) Following the initial consultation, the patient may be returned to the referring practitioner with recommendations for ongoing management; admitted to the facility; placed on an elective surgery waiting list; or followed-up in specialist outpatient clinics.

19. There is a waiting list in each Health Service District ("HSD") for patients to obtain outpatients specialist appointments.

20. From about November 1998 to about June 2003 QH collected data from the 31 reporting hospitals in relation to their specialist outpatient waiting lists. The data was provided monthly to the Elective Surgery Team by each of the 31 reporting hospitals through a form. **ATTACHMENT 'MCZ7'** is a copy of the form on which the 31 reporting hospitals provided the data to the Elective Surgery Team. The data was then entered into a database. The database is still in existence.

21. I am not aware what happened to the monthly reports from each of the 31 reporting hospitals after the Surgical Access Service was disbanded in January 2005.

22. During the period QH collected specialist outpatient waiting list data centrally; the data was reported to Cabinet, through the Minister for Health, every quarter.

23. **ATTACHMENT 'MCZ8'** is a copy of a table I prepared from the specialist outpatient waiting list database setting out the number of patients waiting for specialist outpatients appointments in the 31 reporting hospitals as at 1 July 2001, 1 July 2002 and 1 July 2003.

24. The data in relation to the waiting time for patients obtaining outpatient specialist clinic appointments was unreliable for a number of reasons:

    a) Because standards for outpatient clinics, such as what constitutes specialist outpatient services, had not been set at either a Commonwealth or State level. Consequently, the data that collected from HSDs was, and would continue to be, inconsistent.

    b) A minimum number of data items were collected manually.

    c) The data could not be audited or verified.

    d) Several hospitals submitted the same or similar data month after month.

    e) The emphasis of the manual data collection is the collection of numbers waiting and the waiting times to next available appointment. The waiting time for a patient until their next appointment could be misleading since one specialist may have an appointment available in 1 week's time and another specialist an appointment available in 9 months time. The shorter time is what was reported.

25. The Commonwealth has developed data sets for Outpatient Clinics dealing with issues such as the number of patients treated. However, the data sets do not yet deal with waiting times for appointments. The Commonwealth hopes to introduce a data set that will enable waiting times for outpatient services to be collected by 2008. QH has started to collect this data centrally as from 1 July 2005.

**Funding received by QH for Elective Surgery**

26. Over and above the elective surgery that can be funded within their normal operational budgets, HSDs may receive funding for elective surgery from 2 sources:

    a) Recurrent base elective surgery funding

        i. Total recurrent base elective surgery funding currently available is $83.7 million. This amount is made up of a combination of

Commonwealth Government funds, initially provided under the *"Waiting List Backlog Program"* introduced in 1995, and Queensland Government funds.

ii. QH facility activity targets associated with the base elective surgery funding have remained unchanged since 1995 despite increasing costs of surgery. This means that the same amount of activity (or roughly the same number of patients required to be treated) has been expected from the same pool of funds since the 1995/1996 financial year.

iii. Consequently, QH facilities have been required to either:

A. Cross-subsidise elective surgery activity from other clinical areas within the facility. This means that facilities have been required to make financial decisions on which clinical services will be compromised to ensure that elective surgery targets are met; or

B. Maintain clinical service levels at the detriment of budget integrity.

iv. At the end of the 2003/2004 financial year, the situation for HSDs was improved by the Director-General:

A. Releasing HSDs from general budget overrun debts in the 2003/2004 financial year. This relieved pressure on HSDs who had gone into debt.

B. The amount of funding that was provided to a particular HSD to relieve this debt, has been provided on a recurrent basis.

v. The Director-General also introduced a new funding model for 2004/2005 entitled the *Elective Surgery Program*. This Program consolidates all recurrent funding and associated activity from the previous funds and provides for indexation of new activity in line with increases in costs by paying HSDs the current benchmark price.

b) Election commitment funding

i. The Queensland Government has also provided a non-recurrent allocation of $110 million for the period 1 July 2004 to 30 June 2007. As part of the $110 million commitment, $40 million was provided for the 2004/2005 financial year to reduce elective surgery waiting lists. The Government provided this election commitment funding to purchase additional activity on top of that generated currently within base elective surgery budgets.

ii. The $40 million for the 2004/2005 financial year, has been allocated towards:

A. $25 million for more elective surgery for public patients, targeting areas with the longest waiting lists and highest demand.

B. $5 million for 300 patients statewide to receive joint replacement procedures, including hip and knee replacements.

C. $2.2 million for 1,000 patients statewide to receive cataract operations and $300,000 for the creation of 2 new eye specialist training positions.

D. $2 million for a new operating theatre and ten additional beds at Caloundra Hospital.

E. $1.5 million for a full specialist vascular service to be established at Nambour Hospital.

F. $1 million for additional orthopaedic surgery at Noosa Hospital.

G. $1.5 million to help address those Cairns patients waiting longer than normal for ear, nose and throat ("ENT") surgery, and to employ a specialist ENT surgeon at the Cairns Base Hospital.

H. $500,000 to employ six new nurses at Cairns Base Hospital to expand the hospital's capacity and treat patients in a critical condition.

I. $1 million for a "Fit for Surgery' initiative to avoid costly postponements and help patients prepare for elective surgery through programs aimed at weight loss, cardiovascular fitness and quitting smoking.

J. The Queensland Government introducing an independent audit of waiting lists to better target waiting lists around the State.

27. HSDs have a choice as to whether or not they want to seek election commitment funding available through the *"Elective Surgery Program"*. There is no requirement for QH facilities to undertake more complex work or cases of a certain competency to access funding for elective surgery. However, if the facilities that perform elective surgery ceased receiving the funding, waiting times for surgery would increase significantly because the amount of money available to them to perform elective surgery would drop.

28. The volume and types of surgery undertaken by a QH facility is determined by assessment of surgical capacity, including available human and physical resources, for example, equipment. The composition of surgical operating room lists is determined by the treating specialist and their training registrar in consultation with other members of the multidisciplinary team at the facility level.

29. The funding pays for the cost of performing the elective surgery, including labour and equipment costs. There is no financial bonus for facilities to undertake this work. The incentive in the program is purely to treat more patients than possible within normal operational budgets.

**HSD Elective Surgery Targets**

30. For the 2004/2005 financial year, Zonal Management Units, in consultation with HSDs, have negotiated elective surgery targets and associated funding for undertaking base and election commitment elective surgery activity. The SEDHS approved the overall funding and targets. In the past, there has been greater involvement in this process by what was known as the Surgical Access Service.

31. The targets are developed and measured in terms of "weighted separations" sourced from the Queensland Hospitals Admitted Patient Data Collection ("QHAPDC"). The associated funding is calculated using the cost weights from the QH Hospital Benchmarking Prices Model ("HBPM") (**ATTACHMENT 'MCZ9'**).

32. The Zonal Management Units are responsible for the reconciliation of base and election commitment activity against negotiated targets. Funding is allocated according to the actual activity achieved.

33. Payment is made to HSDs in advance based on the target level.

34. If a HSD cannot perform the amount of elective surgery it agrees to undertake, the elective surgery and associated funding is, if possible, redirected to another HSD within the relevant Zone with the capacity to perform that surgery. If it is not possible for another HSD in the Zone to perform the surgery, the surgery and associated funding is redirected to a HSD outside of the Zone.

35. If a HSD exceeds its elective surgery targets without having further elective surgery funding allocated to them from another HSD, they will not receive any additional funding.

**Funding Model for Elective Surgery**

36. The HBPM is the funding model used by QH for determining the amount paid, the cost weight, to HSDs for each Diagnosis Related Group ("DRG").

37. Under the HBPM, each DRG is assigned a cost weight to reflect the cost of each patient admission relative to the average for that DRG. The cost weight for each DRG is calculated using information from the National Hospital Cost Data Collection ("NHCDC"). For example, an admission for knee arthroscopy would

be classified to the DRG *I24Z – Arthroscopy* with a cost weight of 0.69 (cost $690), while a total hip replacement would be classified to the DRG I03C with a cost weight of 5.27 (cost $5,270).

38. A new phase of the HBPM is developed by QH each year. The cost weight for each DRG is revised for each new phase to reflect the projected costs for the DRG in the coming year. QH is currently using Phase 9 of the model.

**Elective Surgery Data**

39. QH is required to comply with the AHCA's requirement to supply annual "elective surgery" (as defined by the AIHW) waiting list data. QH has implemented a robust elective surgery information management framework that is compliant with the National Minimum Data Set requirements as set by the AIHW.

40. QH has 2 collections of elective surgery data. Information from both collections is provided to the AIHW under the AHCA. The collections are:

    a) QHAPDC

        i. This collection is managed by the QH - Health Information Centre ("HIC") and facilitates reporting of the number of patients discharged ("separated") from facilities in weighted and unweighted separations.

        ii. The data is sourced from District Health Services via the Hospital Based Corporate Information System ("HBCIS") Admissions Transfers and Discharges Module ("ATD").

        iii. This information is reported to the QH Executive and the Minister but is not used in the public arena for reporting progress against elective surgery election commitments.

        iv. QHAPDC is a collection of data which is based on international classification systems and definitions.

        v. QHAPDC forms the basis for QH's mandatory reporting requirements to the Commonwealth Government under the AHCA.

        vi. The HIC is responsible for managing the QHAPDC and generating hospital morbidity data.

        vii. The term "weighted separation" applies to a methodology used internationally to quantify the relative cost of one patient admission to another.

        viii. The process for determining weighted separations for a facility separation is as follows:

A. After discharge from the facility, the patient's medical record is reviewed and the details of relevant clinical diagnoses and procedures performed on the patient are coded and captured in the HBCIS ATD. This process is carried out within the facilities medical records department by staff qualified in using the International Classification of Diseases (ICDv10) to assign morbidity codes.

B. Software then assigns the patient admission a classification known as a DRG. DRGs group patients that are similar in terms of their diagnosis/treatment and also the costs/resources typically consumed.

C. The timeframes associated with processing facility weighted separation data are such that it is typically several weeks from the end of a month before data is finalised.

D. The release of final activity data is dependent on the data validation processes of the HIC. The close-off date for finalisation of data is 30 September each year.

E. Weighted separation data allows the monitoring of elective surgery operations in terms of relative cost and is a more robust method for negotiating and monitoring activity under the elective surgery program.

b) HBCIS Elective Admissions Module ("EAM"):

i. This module has been implemented in 31 reporting facilities which account for more than 95% of elective surgery undertaken within the State.

ii. The system is utilized to place all patients including medical and surgical on a hospital waiting list and to record planned admission and operation details.

iii. Elective surgery patients are allocated an urgency category of 1, 2 or 3 (in accordance with National Health Data Dictionary).

iv. Facility clinicians and administrators are provided with regular reports from this system. The reports are intended to assist them with planning and prioritising elective surgery services.

v. Due to the dynamics of the public hospital system, EAM information is constantly changing and requires significant data entry at the operational level.

vi. There is limited correlation between elective procedures treated through EAM and unweighted or weighted separations as reported through the QHAPDC. The reasons for this are multifactorial for example:

A. EAM records the number of procedures treated which can be multiple for a patient, whilst a separation refers to the entire episode of care (admission). Therefore if a patient undergoes multiple surgeries in the one episode this counts as one separation only.

B. Patients reported as elective from QHAPDC are those with a patient election status of 'elective' and have a surgical DRG.

C. Procedures reported from EAM can include medical procedures such as colonoscopies and endoscopies, which will not appear in a surgical DRG within the QHAPDC. This is because they are diagnostic procedures that do not fall within the AIHW's definition of "elective surgery". They fall within a medical DRG within the QHAPDC. Consequently, those procedures do not qualify as elective surgery under QH's funding rules.

vii. Reporting elective surgery as unweighted or raw procedures from EAM as opposed to weighted separations can also produce significant variation in the level of activity achieved under the elective surgery program. For example a systematic increase in the complexity and therefore cost of surgery performed over time would present as a trend of reduced raw procedures reported through EAM as less operations can be performed with the same funding. In the same situation, weighted separation data would reflect the increase in surgical complexity and therefore total costs under the elective surgery program.

**Monitoring Elective Surgery Performance**

41. Through the Policy, QH has instituted a Statewide elective surgery waiting times benchmarking program, with performance targets based on the national clinical urgency categorisation system. The clinical urgency categories are based on National Health Data Dictionary:

- Category 1 (Urgent) – 30 days
  Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.

- Category 2 (Semi-urgent) – 90 days

Admission within 90 days desirable for a condition causing some pain, dysfunction, or disability but which is not likely to deteriorate quickly or become an emergency.

- Category 3 (Non-urgent) – 365 days

  Admission some time in the future acceptable for a condition causing minimal pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

42. In 1996, the Queensland Government set performance targets in *"Surgery on Time"* to aim that no more than 5% of Category 1 and 2 patients should wait longer than clinically recommended. These targets were reaffirmed in July 1998. QH uses the performance targets as benchmarks to work towards. For the first time in the quarter leading up to 1 July 2005, QH did not meet the target in relation to Category 1 patients. In general, about 8% of Category 2 patients wait longer for surgery than clinically recommended each quarter.

43. The Statewide Health and Community Services Branch of QH compiles monthly and quarterly elective surgery performance reports from the 31 reporting facilities for the QH Executive and the Minister. The reports are compiled using EAM data.

44. Each quarter, the *"Elective Surgery Waiting List Report"* is released by QH on its Internet site.

**Key Achievements of Current *Waiting List Reduction Strategy***

45. The significant efficiency gains achieved as part of the program have resulted from substantial changes in work practices. The *"Waiting List Reduction Strategy"* has provided a vehicle through which the following clinical quality and efficiency practices have been introduced and implemented across the State:

    a) Pre-admission clinics;

    b) Day of surgery admission procedures;

    c) Discharge planning processes;

    d) Outpatient and surgical waiting list booking processes;

    e) Peri-operative management guidelines and procedures;

    f) Theatre management and utilisation strategies;

    g) Integrated bed management procedures;

    h) Post-acute and transitional care services; and

    i) Hospital in the home services.

46. Since 1995, QH has provided elective surgery waiting times information to the AIHW as part of the Elective Surgery Waiting Times National Minimum Data Set. All States and Territories provide these data for reporting against elective surgery waiting times performance indicators, in association with the AHCA.

47. The Australian Government's Productivity Commission's *Report on Government Services 2005* compares each State and Territory's elective surgery performance. In the latest publication:

    a) Queensland has the best average waiting time to admission in Australia (at both the 50th and 90th percentiles); and

    b) Queensland also reported the lowest proportion of patients waiting longer than 12 months for admission for surgery.

**Private Sector Arrangements**

48. In mid 2004, QH entered into partnerships with the private sector to assist with fulfilling activity targets related to specific election commitments for cataracts and joint replacements in 2003/2004 and 2004/2005.

49. This occurred primarily due to the inability of QH to fulfil activity targets related to specific election commitments for cataracts and joint replacements. The reasons for this are multifactorial and include limited available capacity, workforce deficiencies and other factors related to non recurrent funding arrangements, for example an inability to appoint staff permanently and therefore plan surgical services. QH facilities continue to experience difficulties with recruitment and retention of skilled staff – particularly anaesthetists, surgeons and theatre nurses

Signed at **Brisbane in the State of Queensland** on **13 September 2005**.

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Michael Carlo Zanco
Acting Team Leader of the Health Systems Development Unit of the Statewide Health and Community Services Branch
**Queensland Health**