Ex 393

SUPPLEMENTARY STATEMENT OF GARY JOHN WALKER

I, **GARY JOHN WALKER,** Team Leader, Surgical Mortality Audit, Clinical Practice Improvement Centre, Innovation & Workforce Reform Directorate care of Royal Brisbane and Women's Hospital, Brisbane in the State of Queensland acknowledge that this written supplementary statement by me is true to the best of my knowledge and belief.

1. This statement is supplementary to my two previous statements each dated 14 September 2005.

2. This statement is made at the specific request of the Queensland Public Hospitals Commission of Inquiry to address a briefing note dated 24 August 2005 and, in particular, the statement in that briefing note that the then General Manager (Health Services), Dr Steve Buckland, directed that hard copies and electronic copies of a submission to him prepared on 30 July 2003 be destroyed.

3. From about 1998 I suspected that dedicated elective surgery funding being provided to some Queensland public hospitals was being used for funding of hospital services other than elective surgery. This suspicion arose from the fact that data collected from the hospitals indicated that the total surgical activity had not increased in proportion to the additional funding provided.

4. My concerns are illustrated by the chart which is attached to this statement and marked 'GW35', which displays the surgical outputs of the Bundaberg Hospital for the period 1997/98 to 2002/03. The data was provided by Bundaberg Hospital through the Queensland Public Hospitals Inpatient Data Collection. The chart was prepared for me by a staff member of the SAS. The data shows that Bundaberg Hospital delivered 6,907 surgical weighted separations in 2002/03 compared to the 8,308 surgical weighted separations in 1997/98, a decrease of 1,401 surgical weighted separations. The data also shows that Bundaberg Hospital treated 2,187 surgical patients in 2002/03 compared with 2,661 surgical patients in 1997/98, a decrease of 474 surgical patients.

5. As I noted in my original statement, in 2003 I was the Manager of the Surgical Access Service. Col Roberts was the Principal Project Officer, Funding and Incentives. Mr Roberts reported to me as the Manager of the SAS team. There were seven or eight other members of the SAS team. The SAS team worked on the 16th floor of the Queensland

Health Building in Charlotte Street, Brisbane. I reported to Glenn Cuffe, the Manager of the Procurement Strategy Unit. Dr Cuffe's office was on the 17th floor of the Queensland Health Building. Dr Cuffe reported to Dr Steve Buckland, the General Manager (Health Services).

6. In 2003, after Mr Roberts joined the SAS team, he informed me that he could identify instances where a public hospital had reclassified patients from emergency surgery to elective surgery after the patients had been admitted to the hospital through the hospital's emergency department.

7. Mr Roberts prepared a submission with supporting statistical data about the extent of reclassification of emergency presentations as elective surgery (the "submission"). On 30 July 2003 I approved the submission and sent it to Dr Cuffe for submission through him to Dr Buckland. A copy of the submission has been admitted into evidence in this Commission as exhibit 368.

8. To the best of my recollection, I did not receive the submission back from Dr Cuffe with any suggested amendments. I did not receive the submission back from Dr Cuffe with any comments or approval or non-approval from Dr Buckland.

9. In about August or September 2003 Dr Cuffe came to my work area and spoke to me and to Mr Roberts about the submission. Dr Cuffe said that he had had a telephone call from Cheryl Brennan about the submission. Cheryl Brennan was at that time the Executive Secretary to Dr Buckland. Dr Cuffe said that Ms Brennan had told him that Dr Buckland had directed that all hard copies of the submission should be destroyed and that the electronic version of the submission should be removed from the Queensland Health computer network.

10. To the best of my knowledge this is the only occasion during the period of my employment with Queensland Health that I have been instructed to destroy all copies of a document or to remove a document from the Queensland Health computer network.

11. Subsequently I destroyed all the hard copies of the submission at my desk. The submission was one of a number of submissions and briefing notes on the possible

misuse of dedicated elective surgery funding which I was involved in preparing and submitting during my period as Manager of the SAS team.

12. I was concerned to ensure that Dr Buckland was aware of the risks associated with ongoing reclassification of emergency records. For this reason on or about 15 October 2003 I prepared a briefing note for submission to Dr Buckland through Dr Cuffe (the "briefing note"). Conscious of the previous direction I marked the briefing note with "Confidential Brief for GMHS. This document has been removed from the Queensland Health Network." A true copy of the briefing note is attached to this statement and marked 'GW36'.

13. In early 2004, after the State Election, I had a conversation with Dr Cuffe. Dr Cuffe told me that he had had a telephone call from Dr Buckland in which Dr Buckland had raised two complaints about me. Dr Cuffe told me the two complaints were:

    (a) That a staff member had seen on my desk a copy of the document Dr Buckland had instructed be destroyed; and

    (b) That, at a Medical Superintendents Association meeting, I had quoted comments purportedly made by Dr Buckland.

14. I was concerned by this conversation. I asked Mr Roberts whether an electronic copy of the submission was still on the Queensland Health computer network. I cannot recall whether the electronic copy was on the Queensland Health network at that time or whether there was a copy of it on the hard drive of Mr Roberts' computer. I do recall that Mr Roberts could then access an electronic copy of the submission. I suggested to Mr Roberts that he make a copy of the submission on a transportable medium. At this time I also made an electronic copy of the submission on a floppy disk. I discussed with Dr Cuffe the question of retaining an electronic copy and my recollection is that he agreed that I should keep an electronic copy of the submission on a transportable medium.

15. I then telephoned Dr Buckland's secretary to make an appointment to meet with him. After some formal arrangements were made I met with Dr Buckland in the Director-General's office. Only the two of us were in attendance at the meeting. I told

Dr Buckland that the purpose of the meeting was to discuss the two matters that he had raised with Dr Cuffe.

16. Dr Buckland told me that Deb Miller had told him that she had seen the submission on my table. Ms Miller was the Principal Policy Officer attached to the General Manager (Health Services). I told Dr Buckland that this could not be the case because I had destroyed all hard copies of the submission. I told Dr Buckland that I thought Ms Miller may have been mistaken and had instead seen a copy of the briefing note. I provided Dr Buckland with another copy of the briefing note, which I had taken to the meeting. Dr Buckland appeared to accept my explanation.

17. I then discussed with Dr Buckland the comments I had made at the Medical Superintendents Association and provided him with a transcript of those comments. We then went on to discuss other matters.

18. In August 2005 shortly after the appointment of the current Director-General, Ms Uschi Schreiber, I received an email from Ms Schreiber addressed to all Queensland Health employees inviting anyone with information pertinent to the future of Queensland Health to provide it to her either on or off the record. I telephoned Ms Schreiber's office to inform her that I had some pertinent information. Ms Schreiber telephoned me within a day or so and I outlined to her briefly my concerns regarding the elective surgery funding issues. Ms Schreiber told me that she thought it would be appropriate to meet with me in person. A meeting was arranged and I gave Ms Schreiber an oral briefing about the issue. I think this meeting took place on about 23 August 2005. Ms Schreiber asked me to prepare a written briefing note of the matters that I had raised with her. I did this in the form of the briefing note for information dated 24 August 2005.

19. I subsequently received an email from Ms Schreiber informing me that she had forwarded my briefing note to her to the Queensland Public Hospitals Commission of Inquiry.

20. My previous statements came about in the following way:

21. On Monday 29 August 2005 I attended a meeting with Mr Peter Brockett and Ms Geraldine Weld, legal officers from Queensland Health, and Dr Cuffe and Mr Michael Zanco. At the meeting I was asked to assist the legal officers in extracting information I

was told had been requested by the Bundaberg Hospital Commission of Inquiry (the "BHCI"). I was the presented with a large volume of documents – principally submissions to Cabinet, the Minister for Health, the Director-General of Queensland Health and the General Manager (Health Services). I was asked to provide a short description of each of the documents.

22. I told Mr Brockett that I had some concerns about the possible misuse of dedicated elective surgery funding and that I had provided a confidential briefing to Ms Uschi Schreiber, the Director-General. He told me those concerns could be the subject of a separate statement by me at a later date, but that the present priority was to provide the information the BHCI had requested.

23. On Friday 2 September 2005, I had heard of the decision of the Supreme Court about the removal of the Commissioner and Deputy Commissioners of the BHCI. I asked Mr Brockett whether I needed to continue with the commentary on the documents. He told me it was no longer necessary.

24. The following week I heard that the Queensland Public Hospitals Commission of Inquiry had been established. On Friday 9 September 2005 I telephoned Mr Brockett and asked him whether I needed to do any further work on the documents. Mr Brockett asked me to come to a meeting to discuss the matter on the following Tuesday 13 September 2005. He said that I would be meeting with Ms Curnow.

25. On 13 September 2005 I met with Ms Curnow for about 5 or 10 minutes. Ms Curnow then left to take part in a telephone conference with some other persons. When Mr Curnow returned she informed me that the document I had been preparing would not be required. Later that day I received a call from Mr Peter Dwyer from Crown Law, who asked me to come to his office. I did so. At his office Mr Dwyer told me that the document I had been working on would be required. He presented me with a copy of it. I told him I was not happy with the document in its present form and would not sign it. He told me it would be submitted unsigned and stamped as a draft. That evening I received about eight telephone calls from Mr Dwyer asking me to clarify matters in the draft document. Mr Dwyer also asked me to come to his office early the following morning.

26. Early on 14 September 2005 I went to Mr Dwyer's office. Mr Dwyer asked me to sign the document which is my first statement. I told him I was reluctant to sign the statement, as I had not had time to consider whether any further documents or events should be referred to in the statement. He told me that if a signed statement was not provided to the Commission, Ms Schreiber would be required to appear before the Commission and explain why Queensland Health had not provided the documentation requested. I felt under pressure, because I did not want to be the cause of embarrassment or inconvenience to the new Director-General. I read through the statement to satisfy myself that it was accurate. I then signed the statement. About 30 minutes later, Mr Dwyer asked me to sign a second short statement identifying a few errors or clarifications he had found in the first statement.

Dated at Brisbane this 27th day of September 2005.

GARY WALKER

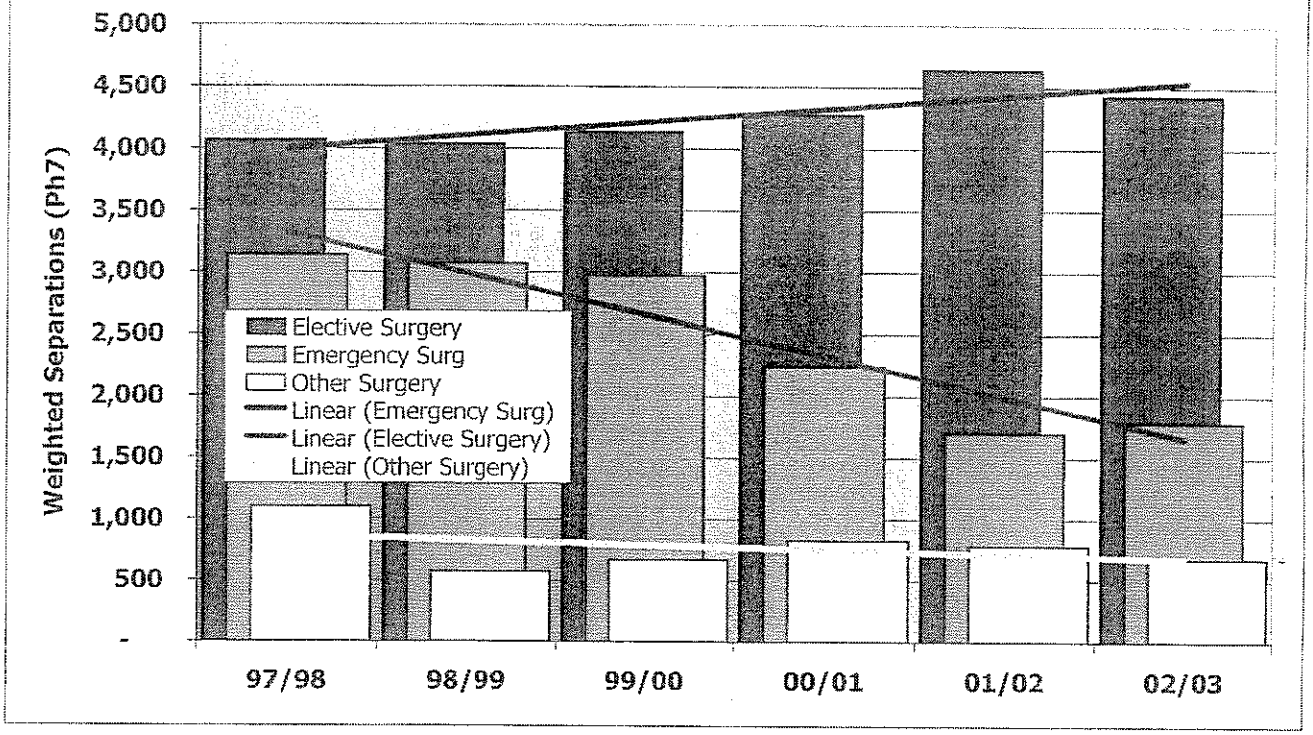
WITNESS

Bundaberg

"GH35"

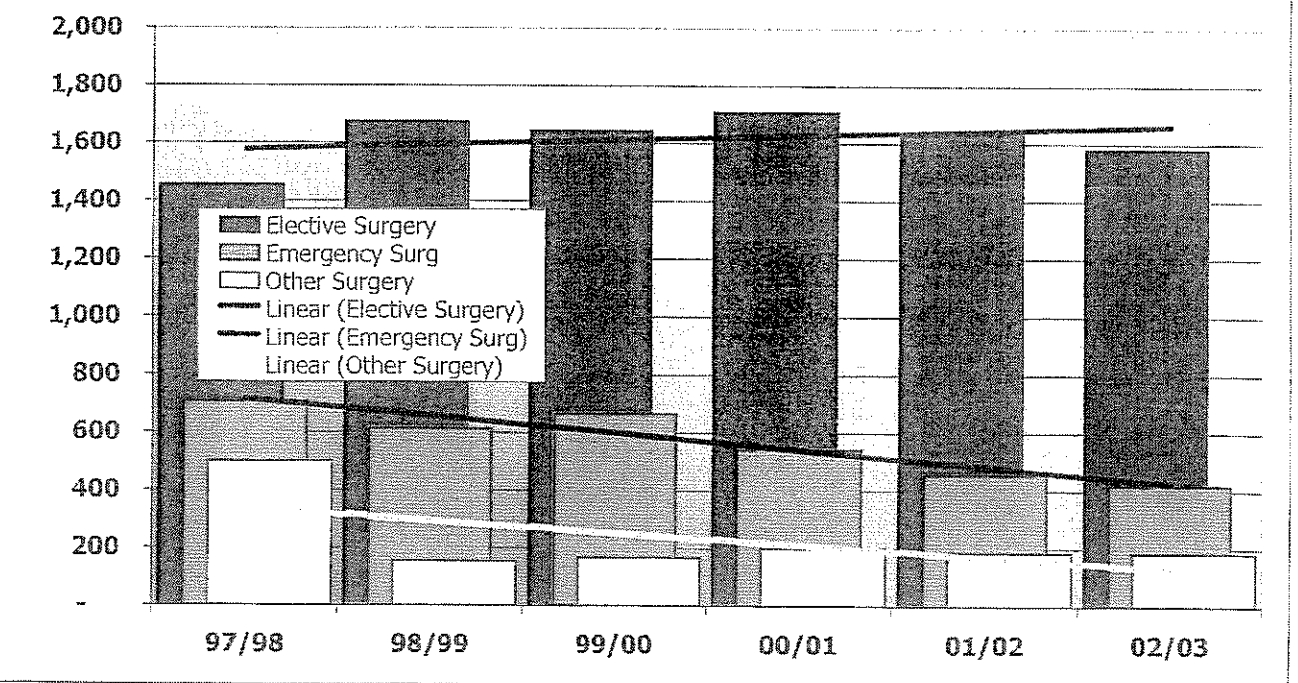
BBG Wseps	97/98	98/99	99/00	00/01	01/02	02/03	% Change
Elective Surgery	4,068	4,040	4,139	4,281	4,644	4,436	9%
Emergency Surg	3,141	3,073	2,974	2,240	1,704	1,790	-43%
Other Surgery	1,099	573	670	829	785	681	-38%
Total Surgery	**8,308**	**7,686**	**7,783**	**7,350**	**7,132**	**6,907**	-17%

Trended Surgical W/seps



BBG Cases	97/98	98/99	99/00	00/01	01/02	02/03	% Change
Elective Surgery	1,455	1,676	1,645	1,709	1,639	1,583	9%
Emergency Surg	706	613	666	543	457	420	-41%
Other Surgery	500	154	166	200	185	184	-63%
Total Surgery	**2,661**	**2,443**	**2,477**	**2,452**	**2,281**	**2,187**	-18%

Trended Surgical Discharges



BBG Funding	97/98	98/99	99/00	00/01	01/02	02/03	% Change
ES Activity Funding	1,796,595	1,476,236	1,417,904	1,407,451	1,301,701	1,301,701	-28%

"GW36"

Queensland Government
Queensland Health

A BRIEFING TO THE GENERAL MANAGER (HEALTH SERVICES)

BRIEFING NOTE NO:	
DATE:	15 October 2003
PREPARED BY:	Gary Walker, Manager, Surgical Access Team — 323 41125
CONSULTATION WITH:	Surgical Access Team Members
CLEARED BY:	Glenn Cuffe, Manager, Procurement Strategy Unit — 323 52361
SUBJECT:	Risks with ongoing Reclassification of Emergency Records

GENERAL MANAGER HEALTH SERVICES' COMMENTS:

(Dr) Steve Buckland
General Manager, Health Services
/ / 2003

PURPOSE:

To provide advice to the General Manager (Health Services) regarding the practice of reclassification of emergency admissions to elective surgery.

BACKGROUND:

- Successive Governments have provided dedicated funding for elective surgery to reduce public hospital waiting lists. Essentially, this was in response to the traditional reduction of elective surgery services and consequent impact on waiting lists when budget pressures were experienced by public hospitals.
- In the eight-year period commencing **1995/96**, Queensland Health has invested in excess of $510M for the purposes of improving access to and increasing throughput for elective surgery in Queensland public hospitals. Due to an ability of hospitals to shift activity across funding streams, particularly in the first three years from 1995/96 to 1997/98, a proportion of the funding has been directed to areas other than elective surgery.
- In **1998/99**, "Total elective surgery activity targets" were established from activity coded as *elective surgery* by individual hospitals in the "base year" of 1996/97. Activity associated with additional dedicated elective surgery funding has been added to 1996/97 targets to determine the current year's elective surgery activity target. This strategy was adopted because of an ability of hospitals to claim activity that was achieved "in base" in one year against the additional activity targets associated with additional dedicated funds. The result was that, in some hospitals, little additional elective surgery was being generated despite a considerable injection of new and dedicated funds. For example, an injection of an additional $2.79M at the Gold Coast Hospital in 1997/98 achieved 660 elective surgery weighted separations (phase 5) **less** in 1997/98 than was achieved in 1996/97.
- In **2000/01**, surgical activity dropped significantly across the public hospital system (by about 30,000 weighted separations). An attempt was made to regain this activity in August 2001 by resetting activity targets based on coding practices currently in place and by adding back lost activity into base activity targets. The Health Services Council rejected this option as unachievable in most hospitals, and, as a result, base activity targets are still calculated on 1996/97 coding practices.
- In **2001/02**, an additional $10M per annum was made available for additional elective surgery activity in Queensland public hospitals. In addition, the Director-General requested that a Total Surgery Target be instituted to dissuade hospitals from shifting activity between surgical classes.

KEY ISSUES:

- Significant changes in coding practices have occurred in the 6 years since base activity targets were established in 1996/97. Major movements of activity have occurred from Emergency Surgery to Elective Surgery as hospitals have focussed on maximizing activity claimed as Elective Surgery. In addition, coding practices have improved such that more co-morbidities are being identified and claimed, resulting in more claimable activity. Obviously, hospitals are not doing any more surgery, they are simply counting differently. Those practices have made it difficult to maintain the funding principle espoused by the Government and reinforced by the Director-General that "additional funding buy additional elective surgery".
- In 2000/01, a number of hospitals began reassessing morbidity data retrospectively and re-classifying records from emergency admissions to elective admissions. The extent of this re-coding exercise was to the tune of 2,500 weighted separations in 2000/01, 5,000 weighted separations in 2001/02 and 10,000 weighted separations in 2002/03. Once again, hospitals are not doing any more surgery, they are simply counting differently. The trend is expected to increase significantly unless direction to the contrary is provided.

- Total surgical cases have **decreased** by almost 12,000 cases compared with that delivered in 1999/2000, despite an injection of an additional $10M in 2001/02 and 2002/03. Both weighted elective surgery and weighted total surgery are similar in volume in both 1999/2000 and 2002/03 (hospital morbidity data).
- Elective surgery cases performed decreased from 88,178 in 1999/2000 to 83,255 in 2002/03. This is despite the injection of an additional $10M in 2001/02 and 2002/03 and despite the significant reclassification of emergency admissions to elective admissions (hospital morbidity data).
- The Health Service Districts have reported throughput as Elective Surgery Admissions via the Elective Admissions Management module of HBCIS since 1996. This collated data is provided to the ODG and Minister on a monthly basis. The Minister has quoted these figures in various public forums and it is recorded in Hansard that the extra $10M in 2001/02 and 2003/04 bought an additional 4,381 and 4,348 operations respectively. The reality is that the extra $10M bought no additional elective surgery when we know that 10,000 weighted separations (or about 3,500 cases) were generated from reclassifying patient records. That is, had the reclassification not occurred, less than 80,000 elective surgery cases would have been completed in 2002/03. See following table for comparison.

EAM Throughput vs. Elective Surgery Cases (Hospital Morbidity)

	1999/2000	2000/01	2001/02	2002/03
EAM	115,595	109,787	114,168	114,135
Hosp. Morb.	88,187	82,398	83,631	83,255

- The impact on waiting lists at this stage is worth examining. Financial incentives to achieve waiting list targets have been in place for two years and have resulted in the best Category 2 result since the reporting of data began in 1996. In this time, the size of the elective surgery waiting list has decreased from 39,303 to 35,064. In the same two-year period, the number of patients waiting for a surgical outpatient appointment has increased from some 32,000 to 34,000 (manual collection). It may be that access to elective surgery waiting lists has decreased as a direct result of a decrease in access to a surgical outpatient appointment. Support for this contention comes from the increased number of Ministerials that the Surgical Access Service has received regarding waiting times for an outpatients appointment.

Risks of Non-Intervention

- A significant change in the weighted activity of various classes of activity reported under the ACHA may warrant further investigation by the Commonwealth.
- The NSW Auditor-General report into elective surgery waiting times released in September 2003 found that the "Health Department had used misleading figures in its annual reports that disguised the problem". Such an adverse finding may inspire the scrutiny of Auditors-General in other States including Queensland.
- The extent of the reclassification of emergency admissions to elective in 2002/03 was 10,000 weighted separations (or $10 million). Effectively this means that the additional $10M injected by the Government into additional elective surgery has simply been utilised to pay for activity already funded from base budgets. One hospital alone (Nambour) claimed almost 3,000 weighted separations while others claimed 2,000 (PAH), 1,400 (Toowoomba) and 1,000 (Hervey Bay). Unless addressed, this reclassification of data is expected to increase significantly, thus further eroding the purchasing ability of the dedicated elective surgery funds.
- The number of patients treated from elective surgery waiting lists will continue to decrease.
- The excellent waiting list census result produced at 1 July 2003 will not be maintained.

CASE EXAMPLE – PRINCESS ALEXANDRA HOSPITAL

In 1999/2000, Princess Alexandra Hospital produced 60,600 elective surgery weighted separations (11,900 cases) for $6.54M provided from the quarantined funding pools. The following year this dropped dramatically to 45,242 weighted separations (9,200 cases) for an increased funding allocation of $8.14M. In 2002/03, PAH reported 50,100 elective surgery weighted separations (9,100 cases) for a total funding allocation of $11.4M. However, we know that 2,000 weighted separations (360 cases) is a result of reclassified emergency presentations. So compared with 1999/2000, PAH has provided in 2002/03, **12,500 less** elective surgery weighted separations **(3,060 cases less)** for an increase in funding of almost $5M.

Of interest is the fact that, despite significant reclassification of emergency admissions to elective admissions in 2002/03, PAH requested $2.25M in additional allocations from roll-over funds of which $1.0M was approved.

ACTIONS REQUIRED:

That the General Manager (Health Services) note the information provided.