**QUEENSLAND**

***COMMISSIONS OF INQUIRY ACT 1950***

**QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY**

# FURTHER 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.

3. I have previously provided two statements to the Commission of Inquiry dated 13 September 2005 and 14 September 2005.

4. Prior to my present role as Acting Team Leader of Health Systems Development Unit in the Statewide Health and Community Services Branch, I was a member of the Surgical Access Service, formerly known as the Surgical Access Team ("SAT") from July 1998 until January 2005. Prior to that time, I was the Manager of Admissions, Transfers and Discharges at the Royal Brisbane Hospital from June 1997 to July 1998.

## Overview of Data Collection

5. Hospitals are required to provide data for each patient to the Queensland Hospital Admitted Patient Data Collection ("QHAPDC"), managed by the Health Information Centre ("HIC") of Queensland Health. The QHAPDC has a minimum data set for which hospitals must supply information in relation to each admitted patient separated from hospital. The purpose of the data collection is three-fold:

   (a) to comply with Commonwealth reporting requirements under the Australian Health Care Agreement ("AHCA"), as defined in the National Health Data Dictionary ("NHDD");

   (b) to comply with State reporting requirements; and

   (c) to allow Queensland Health to determine the amount of elective surgery funding to be allocated to each hospital.

6. Data entry into the Hospital Based Corporate Information System ("HBCIS") is done by hospital administrative staff, firstly, at the point of admission by Admission Clerks and subsequently at the point of discharge by Health Information Managers, who have obtained specialist training in health information coding and health information management.

7. There is also a process of internal auditing done by each hospital to ensure that each patient episode is coded in compliance with the Commonwealth and State reporting requirements. Health Information Managers within each hospital manage the process of coding, auditing and providing admitted patient data to the HIC.

8. The admitted patient data is sent to the HIC, which scrutinises the data at a patient by patient level. If there are any inconsistencies or anomalies with the data, HIC will send a request back to the Health Information Managers at hospitals seeking further explanation and auditing of the relevant files. Once the data is finalised, HIC is responsible for providing the data to the Commonwealth.

9. The role of SAT was to utilise admitted patient data after it had been finalised by the Health Information Centre to determine if a hospital met specific criteria set down by Elective Surgery Business Rules ("ESBR") in order to identify that hospital's eligibility for funding. The ESBR rules for 2002/2003 and 2003/2004 are Exhibits 347 and 348 received by the Commission of Inquiry.

**Funding of Elective Surgery**

10. The funding model for elective surgery was incredibly complicated and I do not intend to comprehensively deal with it in this statement. Simplistically, hospitals were eligible to receive funding from the elective surgery funding pool held under the control of SAT for elective surgery performed that met the Commonwealth criteria for elective surgery. Refer to Exhibit 326 received by the Commission of Inquiry, which is my previous statement dated 13 September 2005, particularly paragraphs 26 to 40.

11. Under the ESBR established by SAT, there are many specific data conditions required to be met to qualify for funding. If only one of these data conditions is not satisfied then funding would not be provided. Under ESBR hospitals had no choice but to scrutinise their data to meet the business rules' requirements.

12. These criteria established by SAT are unique to QH. No other state or territory has established a funding model like this. The NHDD defines elective surgery as comprising elective care where the procedures required by patients are listed in the surgical operation section of the Medicare Benefits Schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians. The NHDD definitions are set out in annexure 'MCZ2' to my previous statement dated 13 September 2005 (Exhibit 326 received by the Commission of Inquiry). SAT requires additional criteria (four items) to qualify for elective surgery funding.

13. The QHAPDC definition for elective patient status is set out at pages 729, 730 and 731 of the DSU QHAPDC Manual Date of Issue 1 July 2005. Attached and marked 'MCZ1' is a copy of that extract.

14. Under the NHDD and QHAPDC rules (refer to my previous statement dated 13 September 2005, Exhibit 326 in the Commission of Inquiry), , if a patient is admitted through the emergency department, they may be appropriately classified as elective surgery as long as they meet the specified criteria. The QH ESBR also support this scenario.

15. In 2003/2004, the ESBR were changed so that patients could only be reclassified from emergency to elective surgery if they were already present on an elective surgery waiting list or were transferred from another hospital. An excerpt from the 2003/2004 ESBR alludes to the large scale reclassification of records by stating: "Blocks of records adjusted retrospectively will not be accepted for funding purposes. Hospitals are expected to have processes in place to ensure that the elective status of patients proceeding to theatre is confirmed and data entered within a reasonable timeframe, preferably prior to the patient's discharge from hospital."

16. In the beginning, hospitals were paid from the Hospital Access Bonus Pool ("HAPB") for additional elective surgery activity. Activity achieved in 1995/6 was used as the base year from which to determine additional elective surgery activity.

17. In 1995/6, the data collection system in place in Queensland Health hospitals were still in the early stages of development. During this period, one of the criticisms by the hospitals has been that there was no accurate way to properly determine what surgery was being undertaken by hospitals. In 1995/6 when the elective surgery program first commenced, only ten hospitals had in place the Elective Admissions Module ("EAM") of the HBCIS computer system. Even those hospitals that did have EAM were only collecting basic data items that were required by the Commonwealth at that time. However, after the new Australian Health Care Agreement (AHCA) was negotiated in 1998, a number of extra data items were required to be collected by jurisdictions. This was the first time that data was collected across all hospitals in relation to elective surgery. As mentioned above, hospitals were only to be paid from the elective surgery funding pool for that elective surgery performed in addition to what had been performed in 1995/6. However, because there was no accurate picture of what did occur in 1995/6, SAT used additional data items collected in 1997/1998 to create a mathematical conversion to retrospectively calculate elective surgery activity achieved in 1995/6. In effect, this process was used to re-base 1995/1996 elective surgery targets according to new measurements.

18. Whilst this was the most accurate picture and method at the time, it was this retrospective mathematical conversion which formed the basis for all elective surgery funding from 1995/1996 until 2003/2004.

19. There are many problems expressed by hospitals and District Managers about the way in which this conversion process has influenced all future elective surgery funding. For example, if in 1995/6 a hospital exceeded its budget by performing elective surgery procedures additional to base targets, they were required in every future year to perform those same number of procedures before being able to access funding from the separate elective surgery funding pool. This means that roughly the same amount of activity has been expected from the same pool of funds since 1995/1996.

20. Another difficulty with the elective surgery funding model was that hospitals were only paid for elective surgery up to their targets. Therefore, if a hospital exceeded its target in a financial year, it would have performed surgery in excess of what it was paid to perform. The hospitals could apply to SAT in the following financial year to negotiate to undertake additional activity for that year from surplus funds that the Team had drawn back from other Districts which had not met their targets. However, the distribution of those surplus (or rollover) funds were discretionary and not guaranteed. Regardless of whether or not hospitals were successful in their funding claim for additional activity performed in the previous year, the surplus elective surgery activity was counted towards the elective surgery figures provided to Cabinet and announced by the Government. Therefore, hospitals were expected to continue to provide the additional services in the following year despite the fact the previous year's funding did not cover the cost of that activity.

21. SAT had significant control over the distribution of funds from the separate elective surgery funding pool and the drawing back of unspent funding. From 2003/2004, Zones were required to endorse this process.

22. Another very important role that the team was playing was the training of Elective Surgery Coordinators, Health Information Managers and other staff at hospitals to ensure

that they understood the ESBR and managed their elective surgery waiting lists in accordance with State and Commonwealth requirements. It took hospitals quite a number of years after the commencement of the elective surgery program in 1995 to understand the complexity and difficulties associated with the program. They sought guidance and training from SAT and especially me, to improve their processes within the hospital to ensure that they managed the waiting list effectively and were appropriately classifying and receiving funding for which they were entitled.

23. SAT also provided consulting services in relation to 'grey areas' within the ESBR. An example is where an elderly patient presents to the Emergency Department ("ED") with a headache and is left in the ED observation ward to be monitored. While in the observation ward the ED doctor notices the patient has a hernia. It has nothing to do with the headache and the original reason the patient was put in the observation ward. There are then two options: one is to send the patient back to the nursing home and admit them at a later date to fix the hernia, or admit them and take the patient to theatre as part of this admission. SAT would give assistance to hospitals in cases such as these regarding appropriate classification within the scope of QHAPDC.

**Re-classification argument**

24. For a significant number of years, some in the SAT have expressed the belief that hospitals have been improperly changing the coding of patient records from emergency to elective surgery to increase their access to elective surgery funding. This belief had been challenged by others in the SAT and others on the ground (eg Medical Superintendents) and was not supported by an independent audit.

25. My view has always been that if hospitals are complying with the Commonwealth and QHAPDC elective surgery definitions, there is nothing improper if the coding for the patient has, at some stage, been re-classified.

26. There are many good practical reasons why hospitals may need to re-classify patients originally admitted with an emergency status to an elective status:

    (a) the definition of an elective admission for Commonwealth and QHAPDC reporting requirements does not preclude a patient from being classified as elective because they were admitted through the Emergency Department,

    (b) during the professional indemnity crisis in 2002 and 2003, many elective surgery lists were cancelled and cases that would normally have been performed as elective surgery were being performed as emergency surgery as a means of continuing to treat patients despite the industrial action;

    (c) patients may be on waiting lists awaiting elective surgery but their condition deteriorates rapidly requiring an emergency admission;

    (d) many minor elective surgery procedures are performed in emergency facilities in regional centres but are not emergency cases;

    (e) in hospitals with a high proportion of junior medical staff, the method of safe practice includes junior staff admitting the patients into emergency before review by senior staff and an assessment to schedule the patient for elective surgery;

    (f) if a patient is admitted for a condition unrelated to the reason they are on the elective surgery waiting list, they often have their elective surgery performed

while they are in hospital. This may occur due to the inadequacy of support for them at their home, the distance they must travel or because the next available space in the elective surgery list allows them to be treated sooner rather than later;

(g) in some districts, the Emergency Department acts as a transition lounge or admission portal for patients awaiting elective surgery admission outside normal working hours.

27. I also believe that the reclassification argument is flawed because it relies on a number of assumptions. It assumes that at the commencement of the elective surgery program in 1995/6, hospitals were accurately recording data, without the support of comprehensive information systems, processes and data items that were introduced years later. In addition, it ignores the reality that hospitals took time to properly understand and apply the ESBR and State and Commonwealth definitions for elective surgery and implement effective processes once the program was fully developed. SAT provided a significant amount of support and guidance to hospital staff over this time to improve the recording processes and knowledge of the elective surgery program.

28. Further, the reclassification argument relies on the assumption that the cost of elective surgery has remained the same since 1995/6. It assumes that the same amount of money should buy the same amount of elective surgery activity, despite the increasing costs to perform surgery. The political imperative was that additional funding must buy additional activity. The price paid for the majority of elective surgery activity associated with the elective surgery program did not change between 1995 and 2004, despite the benchmark price increasing progressively throughout this period. It ignored the reality that hospitals were subsidising the cost of performing elective surgery from their base operating budget and this would have a negative impact on other services that hospitals could provide.

29. The reclassification argument also assumes that data entry errors at hospitals do not occur. It ignores the reality that there are often several admission points in hospitals where staff with varying degrees of competency are entering data. For example, the RBWH had more than 30 admission points for a period of time. It ignores the processes which occur in hospitals where highly qualified staff members audit the patient files to ensure they are accurately coded and often re-classify patients where they find that it was incorrectly coded. The HIC provide hundreds of data error reports back to hospitals to correct each month. Changes to QHAPDC data are accepted up to at least three months after the end of the reference period.

30. The reclassification argument also assumes that, where elective surgery activity increases but total surgery does not, it can only be a result of reclassification. However, it does not take into account that services being offered can change at hospitals from year to year depending on the specialist staff it can attract. For example, if a trauma surgeon leaves a hospital and is replaced by a general surgeon, it often results in a lesser number of emergency cases and a greater number of elective cases.

31. The reclassification argument relies on the assumption that every re-classification does not comply with NHDD, QHAPDC, or the ESBR. This assumption is flawed for the reasons mentioned above. In addition only hospital staff have access to the patient files to verify their accuracy. Any problems with compliance with QHAPDC is the responsibility of the HIC.

32. SAT conducted workshops and site visits on numerous occasions, specifically in some instances to assist hospitals in recording elective surgery activity. Reports were

developed by SAT staff and distributed to hospitals so they could identify those surgical records admitted through the emergency department who were on the elective surgery waiting list. If appropriate these could then be changed and counted towards the Government's achievements. That is, SAT was encouraging re-classification where it complied with the NHDD and QHAPDC definitions.

33. In 2002, KPMG was commissioned by Queensland Health to look into this issue in addition to their usual casemix audit. KPMG was provided with details of cases that, from the data held by the SAT, looked most likely to be cases where re-classification had occurred. KPMG reviewed these and other actual clinical files across a sample of hospitals and services within hospitals. See attached and marked "**MCZ2**" is a copy of the audit report by KPMG. The report identified that there were issues relating to recording the appropriate admission codes for patients presenting through emergency departments. However, they identify that a number of patients were coded as emergency that should have been elective. The audit highlighted the need for further training and auditing within hospitals to ensure the accuracy and compliance with the Commonwealth and State requirements. This essentially is the opposite of the reclassification argument and demonstrates hospitals were in fact missing out on activity and funding they could claim against the program. .

34. To address ongoing management of the elective surgery waiting list, the SAT held a number of specific statewide workshops with Medical Superintendents and Elective Surgery Coordinators from over 30 hospitals. Application of State and Commonwealth requirements for recording and reporting elective surgery was dealt with as part of these forums. Hospitals have also often sought advice on a case by case basis, or general example basis, on how to classify certain cases where it was not clear from the ESBR or QHAPDC requirements.

Signed at **Brisbane in the State of Queensland** on **4 October 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**