LW-7

Queensland Government
Queensland Health

A BRIEFING TO THE GENERAL MANAGER (HEALTH SERVICES)

BRIEFING NOTE NO:

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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.

ATTACHMENT 6

See graphical representation attached – entitled "All SAP Hosps"

Surgery	1997/98	2002/03	2002/03 (exp)
Elective	257,821	304,972	223,644
Emergency	201,933	176,949	238,616
Other	81,416	61,755	81,416
	541,170	543,676	543,676

*Phase 7 Weighted Separations

Reported surgical activity across all Surgical Access Program hospitals in 1997/98 and in 2002/03 is included in the table. This shows that emergency surgery decreased from 201,933 to 176,949 during the period. The separate collection of emergency department attendances, however shows an increase in emergency department presentations, as expected, to the extent of 3.633% per annum. Applying this factor to the emergency surgery activity reported in 1997/98 (201,933), results in an expected emergency surgery activity in 2002/03 of 238,616. Assuming "Other Surgery" remains constant over the period (81,416), the elective surgery activity component would then be 223,644. It was reported that 304,972 elective surgery weighted separations was achieved. Thus some 80,000 weighted separations or $80M has been used for funding non-elective surgery services.

Emergency Department Attendances

	1999/00	2000/01	2001/02	2002/03	Difference	% Diff
Queensland	674,076	694,392	744,289	747,832	73,756	10.9%

Assumptions:

1. **That the surgical component of emergency presentations remains constant over time.**

   In the absence of major influencing factors, this is probably reasonable.

2. **That the volume of "other surgery" remains constant over time.**

   The actual procedures that are incorporated in "other surgery" need to be examined in detail. However a large number are non-interventional "scope" type procedures. If anything, "other surgery" would be expected to increase over time.