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Wages and Conditions of Clinical Coders in New Zealand. A report of surveys conducted in 1998 and 2004

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**WAGES AND CONDITIONS OF CLINICAL CODERS IN
NEW ZEALAND. A REPORT OF SURVEYS CONDUCTED
IN 1998 AND 2004**

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The opinions and views expressed in this paper are those of the author(s) and not necessarily those of AUT of the General Editor or Review Panel of *Enterprise and Innovation*.

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ETHICS

This study was conducted under the research guidelines and with the approval of the AUT Ethics Committee (AUTec).

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EXECUTIVE SUMMARY

This report reports on surveys on the wages and conditions of Clinical Coders in New Zealand's public health sector undertaken in 1998 and 2004. Human Resource Managers in Crown Health Enterprises in 1998 and District Health Boards in 2004 were asked to provide information relating to the wages and conditions of the Clinical Coders they employed. There was a 100% participation rate from the 23 Crown Health Enterprises in 1998 and an 86% participation rate by District Health Boards in 2004. General information relating to coding practice and coding education was sought from the Public Service Association, Ministry of Health, New Zealand Health Information Service, and the Faculty of Health at the Auckland University of Technology.

The 2004 survey showed growth in the number of Clinical Coders employed across the sector. There could have been falls within the six year period but surveys were not conducted to measure this. Overall there was a small movement in wages between 1998 and 2004. The average starting salary increased by 4.9% to \$29,867 *per anum*. At the top end of Coders' salaries, nearly half of the Crown Health Enterprises in 1998 paid within a range of \$34,000 to \$36,000. In 2004 eight of the District Health Boards paid Coders between \$42,000 and \$46,000. This shift in salary rates is an increase of approximately 26%.

During the period 1998 to 2004 there has been a change in legislation from the Employment Contracts Act 1991 to the Employment Relations Act 2000. The 2004 survey has shown an inconsistency with the goal of the ERA for increased collective employment arrangements. In 2004 more District Health Boards were utilising a mixture of collective and individual agreements whereas in 1998 the majority of Crown Health Enterprises employed Coders under collective contracts only.

Overall, the surveys revealed that Clinical Coders have had some gains at the enterprise level of wage increases as to be expected, although these did not appear to be in line with inflation. Despite the apparent keenness by this occupational group for improved standardisation of wages, conditions and training, (in part the impetus for this research), there has been no evidence that any such substantial improvements have occurred over the six years.

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1.0 INTRODUCTION

Clinical Coders are a reasonably small and highly specialised occupational group whose qualifications, training, wages and conditions have not been subject to much attention in the past. The research presented in this report is an attempt to remedy this situation and was prompted by concerns about disparities in the employment conditions around the country. The first survey was initiated through an approach by the Health Information Association of New Zealand because of its belief that Clinical Coders as an occupational group experienced a wide divergence of wages and conditions across the public health system, in particular.

This report focuses on an analysis of data relating to wages and conditions of Clinical Coders derived from surveys conducted in 1998 and 2004. The report is structured as follows. In Section 2, a description of Clinical Coders is given together with commentary from an industry observer which provides further impetus for the current research on Clinical Coders' wages and conditions. Section 3 offers a description of relevant industry context, and then in Section 4, the research method is outlined prior to the presentation of results in Section 5. Section 6 offers some discussion of the results, and tentative conclusions are given in Section 7.

2.0 CLINICAL CODERS AS AN OCCUPATIONAL GROUP

Clinical Coders are a group of health record management workers. Traditionally they have been a disparate group of clerical and nursing staff whose job is to convert clinicians' notes, collate and classify or code patient data into accessible and meaningful formats. Classification systems and coding standards are required for three main reasons: to facilitate clinical care; to permit statistical analysis; and to facilitate the transmission of information (New Zealand Health Information Service, 1993). In the public hospital sector in New Zealand, the number of Clinical Coders is less than 200. There are also Coders employed in the Ministry of Health and in the private health sector.

Richard Wagstaff, Health Manager for the Public Service Association in 1998 pointed out that skilled workers in the health sector have always been scarce, and

scarcity of labour meant improved bargaining positions. Some occupations in the public health sector had thus gained significant pay rises. Against this trend, clerical areas within the health sector had a considerable cultural barrier to overcome. There appeared to be a belief that clerical workers in the health sector are comparable with general non-medical clerical workers, and therefore, according to Wagstaff, were often seen by others as overpaid. There was little recognition that there is a level of expertise and specialisation required, particularly regarding terminology, that sets apart medical clerical workers. This, he claimed had resulted in a lesser ability to successfully argue for salary increments.

With the discontinuation of the Auckland University of Technology (AUT) clinical coding qualification in 2002, there is no longer a formal qualification for Clinical Coders available in New Zealand. While distance qualifications offered, through Health Information Association of Australia exist which many coders study for and complete on the job, many are trained on the job. Depending on the size of the hospital or workload, clinical coding has been carried out either by employees contracted solely to undertake coding work or as part of a larger job description.

Many of the concerns expressed by Health Information New Zealand and Richard Wagstaff are echoed overseas in both the UK and the USA. Northcott and Llewellyn (2002) report that in the UK there are concerns regarding the accuracy of work carried out by Clinical Coders. In the USA research has also shown that coding outputs can vary significantly and has led to some users of the information to distrust the data produced (Lorence, 2003).

In the UK, the introduction of examinations to ensure minimum coding performance standards produced a low pass rate amongst even experienced Clinical Coders. Contributing to this is the fact that wages for this profession are low and there is no link between qualification attainment and salary progression. Northcott and Llewellyn's (2002) research found that Clinical Coders generally feel that their work is undervalued and the significance of the role that they play is not recognised.

In the USA, Meyers (2004) reports that there is a critical shortage of Clinical Coders in the medical field. She suggests that the profession is becoming less

attractive as a career option due to both the complexity of the job and continual changing of the nature of the job. Retention of existing staff is also an issue and improving pay rates and non-economic benefits such as flexitime are being introduced.

The work that Clinical Coders carry out as part of health information management is critical in its requirement for accuracy (Northcott & Llewellyn, 2005 in press). The concerns expressed regarding low wages, inadequate qualifications and support, and a general feeling of undervaluing by the employer and health system are not confined to the situation in New Zealand.

The importance of the Clinical Coders' role in the health sector and how this impacts on funding from central government has changed since 1994.

3.0 INDUSTRY CONTEXT

3.1 *The Public Health Sector and Reforms*

Tax-payer funded public health has long been a feature of New Zealand's welfare state. Since its introduction in the 1930s, no government has made fundamental changes to it. That is, until the early 1990s. The Hospital and Related Services Taskforce Report, *Unshackling the Hospitals*, better known as the Gibbs Report, was released in 1988, prompting considerable discussion.

When the National Government swept to power in 1990, it indicated health, along with many other public services, would be under review. It went on to implement fundamental changes in the financial reporting and funding of hospital institutions, in keeping with the shift to a neo-liberal ideological position underpinning economic policy at that time. This shift included a change of focus from the collective to the individual. The restructuring resulted in the institutions that delivered hospital-based care being renamed Crown Health Enterprises. In a bid to reflect and recognise the business aspect of the activity and the need to develop a profit motive. State funding of health was reduced and there was a shifting of some health costs onto the individual (Ashton, 1992).

A loose population-based funding approach with annual increments had been used to fund hospitals, but from 1994 a tighter funding model was introduced. Regional Health Authorities purchased services from both public providers (including Crown Health Enterprises) and private providers, depending on cost and efficiency. The cost of the services was determined by the quality and accuracy of the data generated by the providers. This data required the detailed and specific recording of patient diagnosis, treatment and prognosis, giving more importance to the work of Clinical Coders.

This approach to funding health services remained until the change of government in late 1999. The incoming Labour Alliance Coalition Government embraced a different ideology. The major focus on a market-driven economy that prevailed for the preceding 16 years was replaced with a focus on positive social policies that aimed to drive economic growth through supporting and developing social justice. For hospital-based health services provision, this change in focus meant a return to democratically elected District Health Boards and a shift away from treating hospitals as profit-generating centres. There was little significance in these changes for Clinical Coders as the data used to determine health services' funding was still collected in much the same manner as before by Clinical Coders.

What was to change however was the overarching employment legislation, affecting all classes of employee in both the public and private sectors.

3.2 Employment Legislation

During the 1990s the Government had introduced ground-breaking industrial relations legislation. The Employment Contracts Act 1991 (ECA) rewrote the relationship in the workplace between employer and employee. Individualism and the discouragement of collective bargaining was sold as a positive for employees to gain a better advantage in the employment relationship as individuals could be acknowledged according to their efforts alone. The ECA prompted a dramatic change in the number of employees represented by unions and covered by collective contracts. National Awards that had covered many employees in the health sector quickly disappeared. The health sector had traditionally been highly unionised,

embracing a collective approach to industrial relations. Statistics reported by Harbridge, Honeybone and Kiely (1994) suggest that during the first three years after the ECA came into force there was a 40% drop in collective bargaining. Since 1997, the annual reporting from the Industrial Relations Centre at the Victoria University of Wellington has shown a steady decrease in the number of individual employment agreements being favoured in the health sector (Harbridge, Crawford, & Kiely, 2000, 1997; May, Walsh, & Kiely, 2004; Thickett, Harbridge, Walsh, & Kiely, 2003).

With the introduction of the Employment Relations Act 2000 (ERA) there has been a return to an industrial relations environment that encourages collectivism and collective bargaining. The emphasis in the ERA is on productive working relationships. Contained within the objectives of the ERA are specific references to workplaces needing to acknowledge and deal with the fundamental inequality of power between the employers and employees and the promotion of collective bargaining. Unlike the ECA which removed from the statute books any references to the legitimate role of unions in the employment relationship, the ERA deliberately targets unions as a critical part in good workplace relations, and gives them exclusive rights to aspects of the employment relationship. The ERA confines collective employment agreements to only employees that are members of the relevant union. Previously any group of employees could agree to and sign a collective contract to cover their employment conditions. The legislation though does stop short of dealing with the problem of freeloading whereby non union members in a workplace where a collective agreement exists are legally entitled to conditions in their individual employment agreements that are not inconsistent with those contained in the collective employment agreement in force. This, in effect allows conditions negotiated for by the union to be used to the benefit of all employees, both union members and non union members alike. Currently amendments to the ERA are being considered by parliament which includes the ability for non union member beneficiaries of union negotiations to be levied in an effort to acknowledge and contribute to the cost of the unions' work.

The two surveys in this report thus each refer to periods where different employment legislation was in force, the individualist-orientated ECA in 1998, and the collectivist ERA in the case of the 2004 survey.

4.0 RESEARCH METHOD

The surveys conducted in 1998 and 2004 have been conducted independently of the Faculty of Health (AUT) by a member of the Faculty of Business (AUT) with an interest in employment relations.

4.1 *Sample*

For the purposes of this report the term participants refer to the Crown Health Enterprises and District Health Boards that participated in the surveys. Respondents is used to refer to Human Resource Managers within the above organisations who responded to the surveys.

In August 1998, the Human Resource Managers of the 23 Crown Health Enterprises were sent a letter inviting them to provide information on the wages and conditions of the Clinical Coders employed by their organisation. Where no response was forthcoming, a second letter was sent and in several instances a phone call was made directly to the Human Resource Manager. The correspondence contained participant information and consent sheets. Individual employees were not approached as the Human Resource Managers were asked to provide the information, on behalf of the employer. In some cases this duty was passed on to the Clinical Coding Manager, by the Human Resource Manager.

In March 2004, a more formal survey instrument was developed and sent to the 21 District Health Boards. The initial approach was again by mail to the Human Resource Managers and follow ups were made by phone and email. Where a verbal indication was given that the Human Resource Manager would like to participate, an email was sent with the survey attached.

In 2004, prior to repeating the survey contact was also made with the Ministry of Health, the New Zealand Health Information Service and the Health Faculty at AUT to discuss general issues in Clinical Coding practices, particularly with regard to Ministry requirements and expectations.

The survey form used in 2004 asked the same questions as the survey conducted in 1998, but with additional questions relating to training and qualifications.

4.2 Categorisation of Participants

The compositions of the Crown Health Enterprises and District Health Boards are as identified by the Ministry of Health. As such the organisations are categorised as “Tertiary” (this includes “High Tertiary” and “Low Tertiary”), or “Secondary”. This categorisation relates to the level and nature of services offered. This categorisation is not clearly defined by the Ministry of Health. As populations increase and technological advances improve health services it is more difficult to delineate. Low Tertiary District Health Boards provide a limited range of tertiary services and High tertiary District Health Boards provide a more extensive range and also in some cases nation-wide services in speciality areas.

4.3 Response

In 1998, a 100% response was received from the Crown Health Enterprises with 23 responses collated. In 2004 of the 21 District Health Boards contacted, 18 responses were received, an 86% response rate. One District Health Board did not respond to any approaches made, one District Health Board indicated it would participate but failed to send information, and the other non participant indicated that it was unwilling to participate as it was concerned that the employment conditions of their Clinical Coders was confidential and feared poaching by other District Health Boards if the information was made public in any form. The contact at this District Health Board was also reluctant to be involved with a researcher from AUT, as AUT had ceased to offer the only New Zealand-based clinical coding education programme in 2002. The three non-participants represent one High Tertiary, one Low Tertiary and one Secondary District Health Board.

In both studies, apart from in one Crown Health Enterprise/District Health Board, all Clinical Coders are clerical workers carrying out coding duties. One organisation uses registered nurses to code data.

All organisations that participated in each survey used the same classification system at the time of surveying. In 1998 this was the International Classification of Diseases 9th Revision Clinical Modification, (ICD-9-CM) and in 2004 the participants surveyed were using ICD-10-AM 2nd edition with a change to ICD-10-AM 3rd edition in July 2004.

4.4 *Focus of Analysis*

The data collected from the two surveys was analysed to identify:

- salary ranges and trends across the occupational group and across the time period;
- the mechanisms used to determine salary progression;
- the type of employment contract/agreement coders were employed on; and
- the types of qualifications for Coders preferred by employers.

5.0 RESULTS AND ANALYSIS

5.1 *Number of Clinical Coders Employed*

In 1998 the survey collected information relating to all coders working in the system at the time, a total of 124 coders. In 2004, the District Health Boards that participated in this survey represent a total of 108 clinical coders employed. By adding to the 2004 figure of 108 the 1998 number of coders from the District Health Boards that did not participate in 2004, an indication can be given of the minimum probable increase overall of coders working in the system. Such extrapolation would put the 2004 figure at, at least 149 representing a probable growth in the occupation of at least 31% over this six year period. The number of coders employed by participants is summarised in Table 1.

Number of Coders employed	Number of CHEs		Number of DHBs		Total Number of Coders	
	1998	2004	1998	2004	1998	2004
0 - 5	16	11	47	40		
6 - 10	5	4	37	31		
11 - 15	0	3	0	37		
16 - 20	1	0	16	0		
Over 20	1	0	24	0		
Total	23	18	124	108		

Table 1: Numbers of Clinical Coders employed in Public Health Organisations

5.2 Type of Employment Agreement Employed Under

Of the 21 respondents that answered this question in 1998, 15 (71%) reported employing coders only under a collective contract. The other Crown Health Enterprises used a mixture of individual and collective contracts. There were no sites utilising only individual contracts in 1998.

In 2004, eight of the 18 participating District Health Boards employed coders only under a collective agreement, a further eight used a mixture of collective and individual agreements, and two District Health Boards employed Coders only under individual agreements. Table 2 shows a comparison of these figures.

	Number of CHEs/DHBs		%	
	1998	2004	1998	2004
Collective	15	8	71	44.5
Individual	0	2	0	11
Both individual and collective	6	8	29	44.5
Total	21	18	100	100

Table 2: Types of contracts/agreements covering Clinical Coders

5.3 Type of Contract/Agreement by Classification of Organisation

In 1998, of the seven tertiary Crown Health Enterprises, six (86%) employed Coders under a collective contract only; the one other tertiary CHE used a combination of collective and individual contracts.

In the 2004 survey, of the seven tertiary participants, four (57%) employed Coders on a collective agreement only, two (29%) employed coders on a

combination of individual and collective agreements, and one District Health Board employed its coding staff on individual agreements only.

When looking at the results for the secondary sector, we find the 1998 survey showed nine (64%) employed Coders on collective contracts and the remaining five CHEs (36%) used a combination of collective and individual contracts.

In 2004 in the secondary sector the figures were four (36%) employing Coders on collective agreements, six (55%) employing on a combination of collective and individual agreements and the remaining one (9%) on individual agreements only.

5.4 Salaries

Respondents were asked about steps or salary ranges that applied to clinical coders in their organisations.

In the 1998 survey responses to this question were received from all participants. One respondent gave only an average salary for all employees of \$33,000. This average figure is based on the Nurses' collective contract. A further respondent gave only the starting salary of \$30,046.

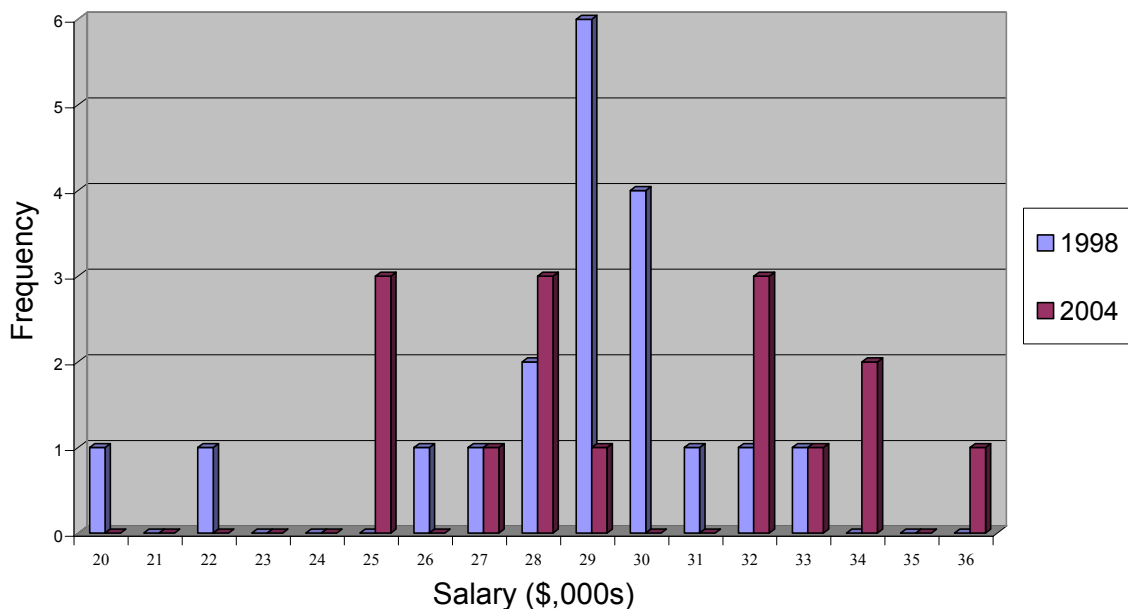
5.4.1 Starting salaries

The lowest starting salary for Clinical Coders in the 1998 survey was \$18,118. The predominant level for starting salaries was between \$29,000 and \$29,999, as shown in Graph 1. A total of six of the 22 respondents who furnished starting salary information initially employed staff in this range.

In the 2004 survey, one of the 18 respondents indicated that the organisation had no clear scale and therefore did not provide any information on salaries for their Coders. One other respondent indicated that their organisation employed Coders under the Nurses' agreement and did not provide information on the salaries this provided for. Therefore the results in this section relate only to the 16 respondents who provided salary information.

The lowest starting salary in 2004 was \$18,758 where the Coders sat on the general clerical scale in their agreement. No information was given as to whether Coders would actually start on the first step of the scale. There appeared to be two main bands of common starting salaries, the first with eight respondents indicating that the starting salary was between \$25,000 and \$29,000, and the second starting salary band with seven respondents indicating a starting range of between \$32,000 and \$36,000. These two bands are clearly shown in Graph 1, although it should be noted that the graph excludes the lowest starting point from the general clerical scale.

Graph 1: Starting Salaries 1998 and 2004 for Clinical Coders



5.4.2 Top end of salary range

In the 1998 survey, the highest salary for Clinical Coders was \$42,009. The top of the salary scale for Coders commonly fell between \$34,000 and \$35,999. Of the 21 respondents who supplied information on salary ranges, 10 reported a top end of the scale in this range, as shown in Graph 2.

In 2004 the top of the salary scale for Coders also fell into fairly distinct bands. The first band shows a top of salary scale of between \$35,000 and \$39,000. There

were six respondents in this band. The second band, also with eight respondents indicated a top salary of between \$42,000 and \$46,000. These results are also shown in Graph 2.

The highest salary indicated in 2004 was \$57,000. Again this salary was reported where the whole general clerical scale was given and it is unclear whether this includes higher management positions with this structure. There was no indication whether Coders were able to assume a role that would command this level of remuneration. The next highest salary level was \$49,234.

Graph 2: Top of salary range 1998 and 2004 for Clinical Coders



5.4.3 Salary range

In the 1998 survey, the size of the salary scale range varied considerably across the CHEs. The smallest range was a mere \$936, where the scale was \$29,487 - \$30,423. The largest range was \$16,228, where the scale was from \$18,118 to \$34,346. Across the 21 participants where information on salary ranges was provided the average range for Coders was \$6,637.

Four of the respondents indicated a salary range for trainees and a salary range for qualified coders.

In the 2004 survey, the size of the salary scale range varied across the District Health Boards. The smallest was \$4,563, where the scale was from \$34,572 to \$39,135. The largest range was \$38,791. This range was assumed to represent the whole of the general clerical scale and so the next largest range may be more useful in gaining a picture of salaries and trends in this occupational group. The next highest range in salaries was \$17,440, where the scale was \$28,560 - \$46,000. The average across all the information on salaries received (from 16 respondents) was \$13,576.

5.4.4 Salary range by classification

In the 1998 survey within the different classifications of organisations the evidence suggested little variation across the tertiary sector for salaries. The range of starting to top salary figures for all six tertiary hospitals were from \$29,500 to \$35,592. The average starting salary in the tertiary hospitals was \$30,109 and the average top salary in this sector was \$34,296.

The greatest variation of starting and top salaries was within the secondary hospitals, with the lowest starting salary at \$18,118 and the top salary at \$42,009. The average starting salary in the secondary hospital sector was \$26,185 and the average top salary in the same sector was \$33,803.

In the 2004 survey, the starting to top salary figures for the tertiary identified District Health Boards was from \$25,000 to \$49,234. The average starting salary for Coders in this group was \$31,206 and the average top salary was \$43,154.

The data from the secondary District Health Boards shows that the range of salaries from start to highest was \$18,758 to \$57,549. The average starting salary was \$28,197 and the average top salary point was \$41,150.

5.4.5 Average range of salaries by type of employment contract/agreement

Comparing the average range of salaries in 1998 and 2004 that Coders received on the basis of the type of employment agreement covering the work place shows a change over time, but little variation based on agreement type.

In 1998 the average salary range for Coders employed under a collective contract was \$6,393. For those employed at a site where there was a mixture of both collective and individual contracts the range was \$6,289.

In 2004 the average range for District Health Boards employing Coders on collective agreements was \$12,983, although this drops to \$10,182 when the District Health Board which included the whole general clerical scale is excluded from the analysis. Where there is a combination of individual and collective agreements in place, the average salary range is \$10,415. Of the two respondents that indicated Coders are covered by individual agreements only one District Health Board had no clear salary scale and the other had a salary range of \$17,000.

5.5 Qualifications

5.5.1 Prerequisite qualifications for employment

The question relating to a requirement for qualifications pre-employment was asked only in the 2004 survey. Results indicated a slight majority of District Health Boards not requiring any pre-employment qualifications. Of the 18 respondents 10 indicated their organisation had no prerequisite qualification needed for employment as a Coder and eight indicated that theirs did require pre-employment relevant qualifications. For these participants that did require pre-employment qualifications, the qualifications required varied considerably. The most commonly cited acceptable qualification by four District Health Boards, was a Medical Terminology qualification. The next most frequently cited qualification was at least an entry level to coding qualification from the Health Information Management Association of Australia (HIMAA), required by three District Health Boards. Other qualifications seen as acceptable for an entry level coder were the AUT Clinical Coding qualification,

general anatomy qualification, nursing qualification or other medical and health background qualifications and experience.

Once Coders were employed by the District Health Boards, they were generally expected to study towards and complete a formal qualification in Clinical Coding. The preferred qualifications currently for coders are the HIMAA coding qualification or the AUT Certificate in Clinical Coding which has not been offered by AUT since 2002.

5.5.2 Qualifications and links to salary progression

The question relating to qualifications being required to advance on the salary scale resulted in a mixture of information being received. The main area of interest to come from the data was the method by which advancement was decided, based on performance, annual increments through steps or a combination of both. These findings are presented in Table 3.

	Number of organisations		% of respondents	
	1998	2004	1998	2004
Advancement based on performance	13	0	56.6	0
Advancement based on annual increments	4	0	17.4	0
Advancement mixed steps & performance	3	17	13.1	95
Under review	1	0	4.3	0
Unknown	1	0	4.3	0
Nursing pathway	1	1	4.3	5
Total	23	18	100	100

Table 3: Method of Assessing Advancement of Salaries

In 1998, 20 of the 23 participants used a performance-based, annual increment method, or a combination of the two. The use of a combination of performance and annual increments mainly allowed for performance-based criteria to be used for advancement to higher salary levels. Some form of performance criteria was used by a significant percentage of participants (69.7%). For the other three participants one respondent indicated the system in this area was under review, one

stated that its organisations' Coders were covered by a nursing pathway and did not give details, and the last respondent did not give information on this question.

Of tertiary level hospitals only one of six in this category used an annual step progression for salaries. The other five used either a performance-based approach or as in the case of one, a combination of the two methods.

The results from the 2004 survey are more straight forward in that 17 of the 18 respondents indicated that their organisations use a combination of qualification attainment, merit and experience/tenure to advance Coders on the salary scale. The other District Health Board employed nurses to undertake coding, and no information was given as to how advancement was determined under the employment agreement.

Four of the participants link developmental stages of Coders' qualifications to progression on the salary scale. Another three respondents indicated that while there was an initial progression of salary increments on length of service, the higher levels of salary were merit-based and expertise had to be demonstrated to receive salary increments. The remaining five respondents either did not give any information regarding salary steps, or their organisations had straight steps but they gave no specific information about how these related to qualifications.

5.6 In-house training

This question was asked only in the 2004 survey. Of the 18 respondents in the survey 12, (67%), indicated that in-house training was conducted in an effort to keep Coders current with issues in coding. Their organisations provided training days to discuss clarifications on advice from the Ministry of Health, provide peer support and as a way to identify and train for specific areas of weakness.

The remaining six participants did not carry out any in house training for staff. One respondent in this group did indicate that their organisation was in the process of developing in-house training, and one other organisation reported providing orientation for new staff.

5.7 *Comments from Respondents*

Comments were received only in the 2004 survey. The comments received from the District Health Boards that participated in this study were:

- A desire for national standards in coding salaries and a New Zealand training programme (this comment was given by 3 of the respondents);
- An Auckland University of Technology qualification reinstated for at least senior coding training;
- Problems being experienced in recruitment of staff;
- Coders having to be sent out of the region for training and needing to contract in coders to deal with backlogs; and
- An issue with not being able to allow senior coders to undertake the auditors course due to restricted resources.

6.0 DISCUSSION

The 2004 survey was undertaken so as to be able to see whether the wages and conditions of Clinical Coders had significantly changed from the time the first survey was conducted in 1998. Consideration was given to legislative and political changes affecting New Zealand generally and the health sector in particular. Hence the follow up discussion does not focus on all of the aforementioned results. In 1998 a 100% response was received which enabled the results to be representative of the whole coding occupation at that time. Unfortunately, due to reasons explained above, three of the District Health Boards contacted in 2004 declined to be involved in this survey. There is a further slight misalignment of the data due to the fact that the structure of the health service provision in “hospitals” changed in 2000. As a result the earlier 1998 survey was with Crown Health Enterprises, and the 2004 survey is of the District Health Boards. While there were 23 Crown Health Enterprises in 1998 there were only 21 District Health Boards in 2004.

Even though 3 District Health Boards did not respond to this survey, the results show that since 1998 there has been an increase of Coders employed in the

health sector. One of the non-participants in the 2004 survey employed a substantial number of Coders in 1998 and indicated at that time they were planning to increase the number of Coders employed. Even with no information as to current numbers of Coders employed in the non participating District Health Boards it can be appreciated that if the 1998 figures are used as an indication and added to the current known 2004 figures the total number of coders would significantly exceed the 124 coders employed in 1998.

Interestingly the types of agreements that Clinical Coders are employed under seems to go against the desired trend of current employment legislation objectives which prefers workers to organise collectively around employment issues. The Employment Relations Act 2000 attempts to promote collective bargaining in workplaces. This study has shown a reduction in the number of hospitals that employ Clinical Coders on only collective agreements. Impacting on these figures is the fact that there are fewer organisations in 2004 than in 1998 and not all District Health Boards participated in 2004. These factors aside, there has been a significant drop in collective agreement only sites, 15 in 1998 to only 8 in 2004. Correspondingly there has been a slight rise in sites that use a combination of both collective and individual agreements for Clinical Coders (6 in 1998 and 8 in 2004). In 1998 no Crown Health Enterprise employed Coders on only individual contracts, but now in 2004 two District Health Boards use only individual agreements.

While this result does appear to be contrary to the direction that the current employment relations framework is encouraging, the sample size is small and therefore may not indicate any significant shift. To determine whether this result is significant would require knowledge of why the collective that had been on those sites had ended. It could be that with a change in staff there were no longer union members employed in those sites, and the Employment Relations Act 2000 limits collective agreements to union members only. This area thus requires further research.

In 1998 the lowest starting rate for Coders was given as \$18,118. This rate was identified as probably relating to the general clerical scale with the possibility that Coders may not necessarily start that low on the scale. Even if the later is the case,

it is worth noting that the general clerical scale was again submitted by one participant as the scale relating to Coders in the 2004 survey. Information on the scale shows that the lowest point on the scale is \$18,758. Whether or not Clinical Coders are ever employed on the lowest point on the scale it is disturbing to note that over a 6 year period the starting point on the scale has increased by only 3.5%.

Excluding this starting salary point of \$18,758 the next lowest starting point band for coders in the 2004 survey was \$25,000 - \$25,999 which was offered by three of the employing District Health Boards. In the 1998 survey the next lowest starting salary was \$20,000.

There has been a small shift upwards in starting salaries over the six year period. The average starting salary in 1998 was \$28,474 which increased to \$29,867. This result represents an increase of 4.9% over the six year period. The spread of starting salaries in 1998 was \$13,000, and in 2004 this spread was \$11,000. While the upper end of the starting salaries increased only by \$3,000, the lower end of the starting salaries increased by \$5,000.

There appears to be a shift upwards of the top level of salaries paid to Clinical Coders across the six year period. While the top salary paid in the earlier survey was \$42,000, the bulk of Coders' top end salaries fell into a band of between \$34,000 and \$35,999. This salary band accounted for 10 of the 21 Crown Health Enterprises.

In 2004 the figures show a top salary of \$57,000, but generally there are two bands that most of the Coders fell into. The first band had six District Health Boards in the \$35,000 to \$39,000 and eight hospitals were in the \$42,000 to \$46,000 range. This is approximately a 26% increase in the upper band over the 1998 results.

In respect of the salary ranges based on the type of employment contract/agreement, there appears to be little difference between collective only sites and sites using a combination of collective and individual agreements. This situation is likely to be due to the fact that while employers or employees may prefer the idea of individualism in employment arrangements, the reality of setting wages and conditions tends to stay comparable to that which the union has collectively

negotiated for. The collective agreement will therefore generally create the standard for individual agreement content.

It is reasonably surprising to find that over half of the 2004 District Health Boards (55%) did not require staff to hold any qualifications relating to the occupation of Clinical Coding before employment. The work undertaken by Clinical Coders is fairly exacting and contributes to the integrity of the funding received by the health provider. No information was given regarding the in-house training of new staff, but once employed Coders are expected to study towards a Clinical Coding qualification. The preferred qualification is either from the Health Information Management Association of Australia or the Certificate in Clinical Coding that was offered by the Auckland University of Technology until 2002.

The majority of District Health Boards in the 2004 survey (67%) indicated that they used in-house training sessions for all staff to keep updated on new developments, disseminate clarification on points and issues, provide peer support, and to provide training in identified weak areas. One District Health Board indicated that they have difficulties in training staff and have to send Coders out of the region to access training for them. Another response suggested that there was a need for a New Zealand based qualification for at least senior Coders.

7.0 CONCLUSION

Clinical Coders are a discrete well-defined occupational group that utilise specialised skills in medical clerical work. Research has shown their work is important but not always valued in terms of the rewards and conditions attracted by the profession. Over the six year period that the two surveys were conducted there has been no significant changes to the wages and conditions of Clinical Coders. The first study was initiated through an approach by the Health Information Association of New Zealand because there was a belief that as an occupational group there was a wide divergence of wages and conditions across the public health sector. This survey showed that with the demise of the National Award that covered Clinical Coders before the introduction of the Employment Contracts Act 1991 there was a loss of consistency in wages and conditions across the occupation group. Although many of

the Coders in the 1998 survey were still covered by collective contracts, these were at the enterprise level and did not result in any national standard.

The results from the 2004 survey did not show any improvement or move towards a national standard or narrowing of the gaps in Clinical Coders' wages and conditions when compared to the 1998 survey results. Although the employment legislation has changed and now specifically attempts to promote and encourage collectivity in bargaining and workplaces, there are now two District Health Boards that employ Coders only on individual agreements. The salary ranges have stayed relatively the same over the period, although there has been a greater shift in the top end salaries offered to Clinical Coders than the shift in starting salaries offered. Difficulties in attracting and retaining staff could be in part the reason for increasing the top end of the scale.

With regard to the qualification issue and the expressed desire for a reintroduction of a New Zealand-based Clinical Coding programme, the Health Faculty of the Auckland University of Technology is in discussions with the New Zealand Health Information Service with an aim to introduce a health information management major in the Bachelor of Health Science which would include clinical coding.

Even though there have been clear indications from Clinical Coders in 1998 that there were concerns regarding the comparability of wages and conditions in their occupational group across the public health sector, the evidence for these two surveys would suggest that little improvement has been seen for this occupational group. In addition comments in the 2004 survey indicate that there are attraction and retention issues for some of the District Health Boards in employing Clinical Coders.

Whether increasing unionisation levels amongst the group would lead to greater bargaining power and then the possibility of multi employer collective agreements, and therefore standardisation of wages and conditions across the sector is hard to ascertain. While this move to unionisation and collectivity may well work in the favour of Coders, it may not be seen as the best outcome by the District Health Boards who may prefer having greater control at the enterprise level.

Further research which may be able to enable better understanding of the seemingly slow progress towards standard conditions and training could take the form of qualitative interviews involving Clinical Coders, New Zealand Health Information Service and Health Information Association of New Zealand. These interviews with Clinical Coders could ascertain unionisation levels and attitudes to collectivity in workplace issues. Interviews with the state organisation and the Coders' Association could give insight into progress or plans to develop a more formal qualification system for clinical coding practice.

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