New private practice arrangements for senior medical staff

Why is private practice changing?

In late 2012, the Crime and Misconduct Commission (CMC) reported to Cabinet significant findings in relation to the operation of Right of Private Practice (RoPP) arrangements in Queensland public hospitals. The report highlighted that the scheme was not managed effectively and was vulnerable to fraudulent activity. The CMC identified that specialists earning undeclared extra money from private patients whilst on duty at public hospitals was going unnoticed due to inadequate monitoring and reporting of participant earnings.

On 12 November 2012, the Minister for Health engaged the Auditor-General to undertake an audit of the scheme to determine whether the arrangement was achieving its intended public health outcomes in a financially sustainable manner. The Queensland Audit Office (QAO) audit report was submitted to Parliament out of session on Thursday 11 July 2013.

The QAO found widespread confusion about the purpose of the existing private practice scheme and many thought it was ‘simply a mechanism for increasing the remuneration of senior medical officers (SMOs), albeit in an elaborate and complicated way.’ The QAO reported significant issues regarding the complexity of the scheme, its governance and its financial sustainability.

The report also highlighted that facility fees were last revised in 2001 and that subsequent changes to the Medicare Benefits Schedule (MBS) have not been reflected in the policy. The QAO further notes that as ‘fees are set as percentage rates of the MBS, they have increased proportionately with increases to the MBS, however such increments have not kept pace with the consumer price index’.

In addition to the above considerations, national health reforms being introduced from July 2014 will significantly change the way private patient activity is funded in the public health system. Queensland Health needs to reform private practice arrangements to introduce the new funding model in a fair and transparent way.

From July 2014, the Commonwealth will fund 45 per cent of efficient growth in public activity at the national efficient price. However, for private patients, the Commonwealth will reduce its contribution for private patient activity to compensate for gross revenue it provides through Medicare benefits and private health insurance. Increasing the portion of MBS fees retained by public hospitals will improve the financial sustainability of private practice in the public health sector.

Key changes

Complexity and inequity of existing options A / B / P and R will be discontinued

Current private practice arrangements will cease from 4 August 2014. Two new options will be made available at the Hospital and Health Service (HHS) or commercialised business unit (CBU) discretion:
Assignment arrangement

- In cases where a HHS/CBU requires a clinician to engage in private practice (in response to clinical need, business requirements or patient choice), private practice can be granted under this model.
- Performance measures in the employment contract can/may include a requirement to treat private patients.
- All revenue generated is assigned to the employing HHS/CBU.

Retention arrangement

- A HHS/CBU may grant a clinician permission to engage in private practice during employed time and retain private practice revenue after paying service fees and GST.
- Performance measures in the employment contract can/may include a requirement to treat private patients.
- An earnings ceiling (threshold) is applicable.
- Disbursement of service fee revenue and earnings ceiling (threshold) revenue to trust or operating accounts is at the discretion of the employing HHS/CBU.

Option A allowance will cease

Option A supplementary benefit, in its current form, will cease from 4 August 2014. However, the monetary value of these historical payments will be redistributed to Tier 3 (and linked to performance targets relevant to the individual's role) and Tier 4 (as a recruitment and retention incentive) within the remuneration structure of the employment contract. For more information on the new remuneration tiers please visit the medical contracts website.

All translating senior medical officers, regardless of their private practice option, will receive 25 per cent on top of their base salary in Tier 3.

Facility and administration fees have been rebased and simplified

Doctors currently engaged under private practice options B or R will transition across to the new granted private practice revenue retention arrangement. Under this model, as like options B and R, individual doctors retain billings from private patient services after paying applicable service fees (previously facility and administration fees).

In relation to facility and administration fees, the QAO found that existing facility fees had not been revised since 2001 and that fees were significantly misaligned with the actual cost drivers of private patient service delivery.

The former 83 facility and administration fees will be replaced with a single service fee, aligned to nine Medicare benefit sub categories. The implementation of new service fees will be equally phased in over a two year period with half of the increase in FY 2014/15 and the remainder in FY 2015/16.

Whilst options B and R doctors will notice an increase in fees compared to the existing facility and administration fees, this will be largely offset with the new amount payable in Tier 3 (25 per cent on top of their base salary in Tier 3).

Private practice trust funds

Unlike existing arrangements, it will not be a statewide policy requirement for revenue to be distributed to a study, education and research trust account. The decision to disburse revenue to operating or trust accounts will rest with the HHS/CBU chief executive.
No separate private practice contract

Private practice during employed time will be integrated into the employment contract as a schedule and will no longer be a separate contract.

How the existing RoPP options translate to the new arrangements

<table>
<thead>
<tr>
<th>Old option</th>
<th>% SMOs</th>
<th>New option</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>90%</td>
<td>Assignment</td>
<td>A and P - No change to supplementary benefit provided no change in work patterns and KPIs achieved</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>P - Historical incentive payment still being assessed at local level</td>
</tr>
<tr>
<td>P</td>
<td>10%</td>
<td>Retention</td>
<td>For majority, minimal impact due to new Tier 3 amount paid</td>
</tr>
<tr>
<td>B</td>
<td></td>
<td>Clinician retains billings after paying applicable fees</td>
<td>Some may experience reductions/gains in net billings due to new fees</td>
</tr>
<tr>
<td>R</td>
<td></td>
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</tbody>
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Process for senior medical staff who elect not to move to an individual contract

Staff who elect not to transition to individual contracts will continue to be covered by the MOCA3 agreement until its expiry in June 2015. However, existing supplementary benefits in lieu of private practice will cease from 4 August 2014. Private practice arrangements, including those for Option B and R doctors will only be available through the new employment contract.

Scheme governance

The governance of private practice requires significant reform at both the statewide and local level. HHS/CBU chief executives will delegate to an accountable officer the responsibility to oversee private practice activities.

A Health Service Directive will mandate that each HHS/CBU establish a private practice governance committee to oversee the administration of private practice arrangements operating within their jurisdiction and ensure it performs the following functions:

- provide clear governance and direction for private practice arrangements through ensuring activities comply with statewide and local directives and policies
- monitor performance criteria to ensure private practice arrangements achieve their desired outcomes in a financially sustainable manner.
The below diagram demonstrates the governance relationship between HHSs and the Department of Health.

Statewide coordination

Local HHS / CBU governance and monitoring

Accountability & Strategy

Escalation

Monitoring

Statewide responsibilities

• Issue the Health Service Directive, policy, implementation standard, framework and guideline.
• Maintain and update the Department of Health Fees and Charges Register - Granted Private Practice Service Fees and Thresholds.
• Maintain employment contract template, including the private practice schedule.
• Maintain licenced private practice agreement template example.
• Maintain recognised rural private practice agreement template example.

Local responsibilities

• Comply with statewide policies and directives.
• Develop and implement local operational policy.
• Comply with regulatory requirements.
• Negotiate private practice contracts and applicable performance measures.
• Ensure efficient operation of private practice across the health service.
• Maintain robust private practice governance and internal controls.
• Implement effective strategies to address private practice performance indicator shortfalls as required.

The following information provides an overview of the relevant board and committee responsibilities at the statewide and local level.

Statewide Private Practice Governance Board

The purpose of the Private Practice Governance Board is to work as an authoritative governance body providing oversight of the administration of private practice arrangements operating across HHS/CBU as follows:

• provide overarching governance and statewide strategic direction for private practice arrangements and associated frameworks, policies, directives and guidelines
establish and monitor performance criteria to ensure the private practice arrangements achieve their desired outcomes in a financially sustainable manner
• take remedial action where required and/or escalate the matter where appropriate (i.e. performance management team).

Local Private Practice Governance Committee

HHSs/CBUs are responsible for the successful operation of private practice at the local level, and shall implement a robust governance framework and oversight committee chaired by an accountable officer to ensure the following:
• compliance with statewide policies and directives
• local operational policy is developed and implemented
• objectives of private practice activities and outcomes are clearly defined and regularly measured against key performance indicators and remedial action is taken where appropriate
• maintain robust governance and internal controls
• take remedial action where required and/or escalate the matter where appropriate (Local Audit Committee, Jurisdictional Board, statewide Private Practice Governance Committee etc.).

Statewide Practice Management Advisory Network

The Practice Management Advisory Network is a multidisciplinary group focussed on developing tools and resources necessary to support, optimise and monitor private practice activities across Queensland Health. To contribute to the management and delivery of quality private patient services the Practice Management Advisory Network undertakes to provide a network structure that will:
• collaboratively develop resources and tools (e.g. protocols, procedures, guides, reports) that support the optimisation of the private practice scheme
• provide a platform for knowledge transfer between HHSs and CBUs, and the private sector on professional practice management
• promote a culture across Queensland Health recognising the benefits of private practice options and own source revenue.

Further Information

Further details of how the new private practice scheme will be operated can be found in the following supporting documents:

1. Private practice framework
A framework to support the delivery of quality and financially sustainable private patient services in the Queensland public health sector.
This document outlines the five integral components through which effective private practice should operate:
• regulation
• clinical practice
• business practice
• governance, performance and accountability
• staff education.
2. Private practice guideline

A guide to assist medical practitioners, practice managers and support staff in interpreting the requirements and arrangements of private practice activities in the Queensland public health sector.

This document provides information to employees and HHSs/CBUs for the implementation of best practice principles in relation to private practice.

3. Private practice fact sheets

- Summary (this document)
- Frequently asked questions
- Interim private practice arrangements (1 July 2014 – 3 August 2014)