Department of Health

Private practice in the Queensland public health sector framework

A framework to support the delivery of quality and financially sustainable private patient services in the Queensland public health sector

May 2014

Great state. Great opportunity.

Queensland Government

Private practice in the Queensland public health sector framework

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An electronic version of this document is available at www.health.qld.gov.au

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Beyond the framework, the *Private practice in the Queensland public health sector guideline* provides additional best-practice guidance to improve private practice in public health facilities.

Introduction

For the purpose of this document, *private practice* relates to the treatment of private patients in public health facilities. A *private patient* is a patient who elects to be treated as a private patient, and by doing so is responsible for paying applicable fees and is offered a choice of doctor (where available). Private practice in the Queensland public health sector facilitates patient choice, helps to retain a highly skilled workforce and enhances the overall financial sustainability of the public health system.

Effective operation of private practice will achieve the following outcomes:

- quality patient services
- attracting and retaining a quality workforce
- financial sustainability
- optimal resource use (fixed assets and human capital).

This framework contains five integral components to which private practice must adhere:

1. **Regulation**

   Private practice is provided in accordance with relevant legislation, regulation and policy.

2. **Clinical practice**

   Private practice supports evidence-based practice with a focus on achieving positive clinical outcomes.

3. **Business practice**

   Private practice supports the business requirements of Hospital and Health Services (HHSs) and commercialised business units (CBUs) in achieving efficient and cost-effective delivery of health services.

4. **Governance, performance and accountability**

   Private practice is effectively managed and monitored to achieve key deliverables and desired outcomes in a financially sustainable manner.

5. **Staff education**

   Staff who undertake duties specific to private practice are supported by an education framework that provides access to training resources to enable them to successfully undertake those duties.

Implementing the framework

Hospital and Health Services (HHSs), the Department of Health commercialised business units (CBUs) should use this framework to guide private patient service delivery. Appendix 1 provides more specific recommendations for improvements against the framework components.

Furthermore, the department will use the framework to guide whole-of-public health system improvement projects and scheme monitoring through the Statewide Private Practice Governance Board.

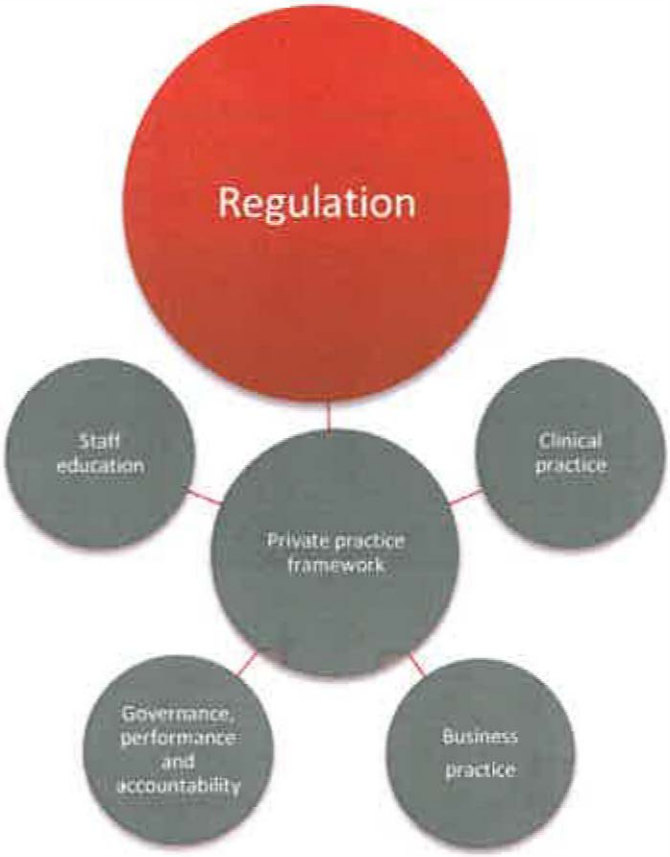
Regulation

- Compliance with all regulatory requirements, including relevant policies, directives and standards.
- Identify and articulate regulatory requirements to all staff involved in private practice.

Overview—regulation requirements

It is imperative that HHSs, CBUs and individuals operate with probity and propriety and comply with regulatory obligations when engaging in private practice activities.

This includes compliance with Australian and Queensland Government legislation, intergovernmental agreements, regulatory instruments and other documents. Examples of these include the *Health Insurance Act 1973*, the Medicare Benefits Schedule, the National Healthcare Agreement, the National Health Reform Agreement and the *Hospital and Health Boards Act 2011*.



The following principles underpin the regulation component of the framework:

- HHSs, CBUs and individuals will provide Medicare Benefits Schedule billed services in compliance with the *Health Insurance Act 1973*.
- A professional service provided by a clinician engaging in private practice is rendered under a contract between the clinician and the patient.
- Where support staff are involved in providing a service, the treating clinician is responsible for meeting the supervision requirements and must also attend to the patient where there is a requirement to do so (e.g. Medicare benefits for consultation items).
- Where contractually agreed, a clinician engaging in private practice authorises the HHS or CBUs as the agent to undertake the billing process on their behalf, and facilitate payment of service fees relating to the clinician's private practice.
- Clinicians are obliged to fulfil the terms and conditions of their employment contract, including any private practice arrangements and set performance targets as scheduled in the employment contract.

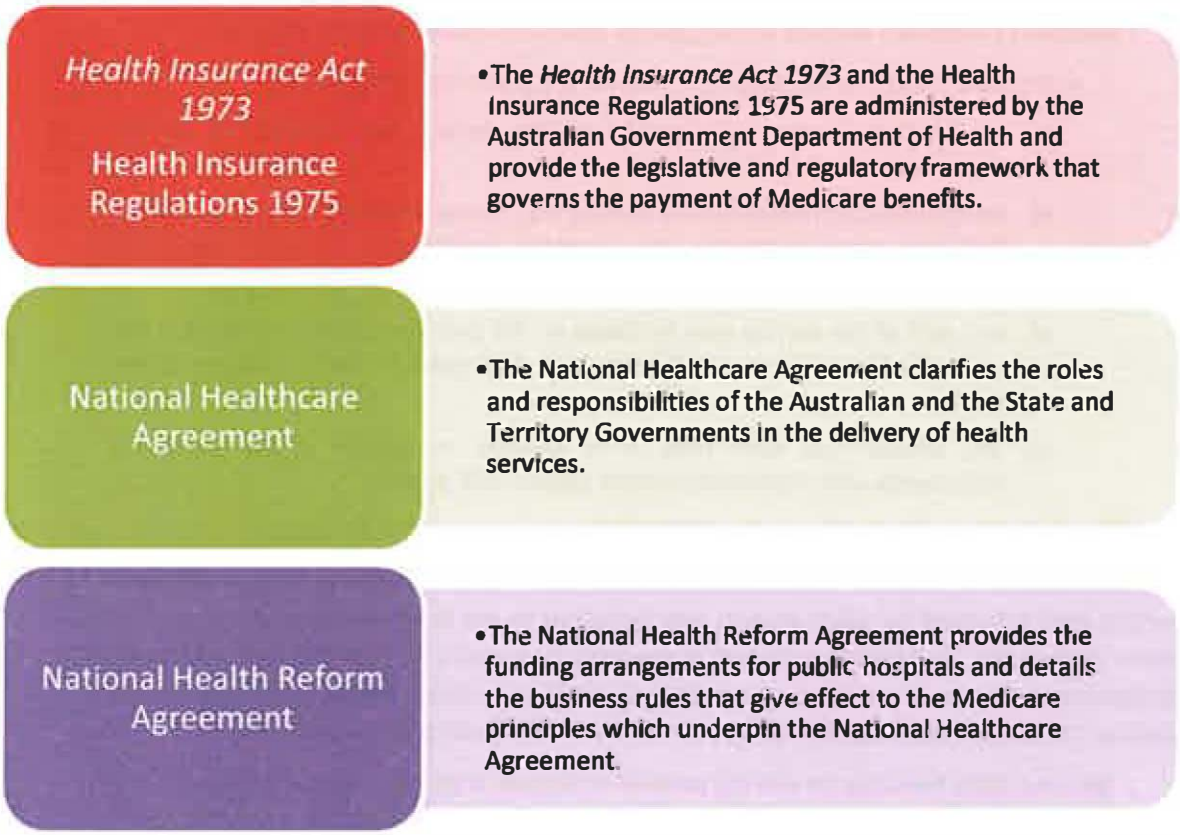
The department has implemented the following key documents relevant to private practice activities delivered in public health facilities:

- *Private practice in the Queensland public health sector health service directive*
- *Private practice in the Queensland public health sector policy*
- *Private practice in the Queensland public health sector implementation standard*
- *Private Practice in the Queensland public health sector framework (this document)*
- *Private practice in the Queensland public health sector guideline.*

The relationship between the documents is depicted in the diagram below. Individuals will benefit most from reading the Framework in conjunction with either the *Policy and implementation standard* or the *Health service directive*. The Guideline provides additional information for practice managers, clinicians and support staff. The Policy, Implementation Standard and Health Service Directive are mandatory, while the Framework and Guideline are supporting documents.

Table 1 Relationship of Queensland Health private practice policy documents

To support the regulation component of the framework, the key Australian Government legislative documents are:



Health Insurance Act 1973

The *Health Insurance Act 1973* and the Health Insurance Regulations 1975 are administered by the Australian Government Department of Health and provide the legislative and regulatory framework that governs the payment of Medicare benefits for primary and private patient services. Relevant provisions relate to claiming restrictions (ss.17 and 19(2) *Health Insurance Act 1973*), and other restrictions on payment of Medicare benefits for services rendered by certain medical practitioners (s.19AA) and certain overseas trained doctors (s.19AB).

Restrictions on claiming and ministerial directives

Section 17 Medicare benefits not payable in respect of certain medical expenses

1. A Medicare benefit is not payable in respect of a professional service if:
    a) the medical expenses in respect of that service have been paid, or are payable, to a recognised hospital
    b) the clinician who rendered the service was acting on behalf of an organisation that was, when the service was rendered, an organization prescribed for the purposes of this paragraph
    c) any part of the service was rendered on the premises of an organisation that was, when the service was rendered, an organisation referred to in paragraph (b) or
    d) any amount has been paid, or is payable, in respect of the service in accordance with a scheme to which section 42B applies.

Source: s.17 Health Insurance Act 1973 (Cth)

The objective of s.17 of the *Health Insurance Act 1973* is to avoid double payment for a service that is funded by other means and therefore, is not to generate a Medicare benefit claim. Relevantly, no Medicare benefit is payable for a claim for medical expenses where a professional service is provided to a public patient in a public hospital, and the professional service has been funded under Commonwealth-State funding arrangements.

Section 19(2) Medicare benefit not payable in respect of certain professional services

2. Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional service that has been rendered by, or on behalf of, or under an arrangement with:
    a) the Commonwealth
    b) a State
    c) a local governing body or
    d) an authority established by a law of the Commonwealth, a law of a state or a law of an internal territory.

Source: s.19 *Health Insurance Act 1973 (Cth)*

Ministerial directives have been granted under s.19(2) to permit Medicare rebates to be claimed for state-remunerated primary health care services—that is, public, non-admitted, non-referred primary care services in certain locations. The revenue generated from these initiatives is used to enhance primary care services at the site where the revenue is generated. The Rural and Remote Medical Benefits Scheme has been operating since 1997 in Queensland under a s.19(2) exemption and applies to a number of communities with significant Aboriginal and Torres Strait Islander populations together with an exemption for the Inala Indigenous Health Service. In addition, an exemption scheme applies to various other rural communities as part of a Council of Australian Governments (COAG) 2006 agreed suite of measures designed to improve primary health care in rural communities of less than 7000 people with an identified general practitioner shortage.

Queensland Health's interpretation of the boundaries of s.19(2) is that an exemption is not required where a clinician exercises private practice. For example, the Australian Government Department of Health has indicated that a s.19(2) exemption is not required where a payment is made by the State, or a state agency to a clinician, with respect to:

- premises
- staff
- travel
- equipment
- any other support services.

In the absence of any case law on the issue, reliance has been placed by the State on the understood view of the Australian Government Department of Health that a professional service rendered by a practitioner pursuant to his or her private practice, would be rendered under a contract between the practitioner and the patient, and *not by, for; or on behalf of or under an agreement with the government or statutory authority* that has granted the private practice.

Medicare Benefits Schedule

The Medicare system was introduced by the Australian Government in 1984 to provide eligible Australian residents with financial rebates when accessing medical, optometrical and dental services as a private patient.

The Medicare Benefits Schedule is developed from the *Health Insurance Act 1973* and Health Insurance Regulations 1975 and sets out the requirements that must be met for claiming payment for professional services from Medicare. Medical practitioners and practice support staff must be aware of the general requirements of the Medicare Benefits Schedule and those specific to each item being claimed.

The Medicare Benefits Schedule itemises professional services eligible for benefits from Medicare. Medicare benefits are payable only for clinically relevant services that are listed in the Medicare Benefits Schedule. A clinically relevant service is defined in the Medicare Benefits Schedule as one which is generally accepted by the relevant profession as necessary for the appropriate treatment of the patient.

Each professional service is associated with *a* unique item number, service description, schedule fee and benefit payable. The types of services in the Medicare Benefits Schedule are reviewed and amended annually effective from 1 November each calendar year with minor updates occurring during the year. The updates are posted on the Commonwealth Department of Health Medicare Benefits Schedule website.

Medical practitioners must meet eligibility criteria for providing professional services that will attract Medicare benefits as specified under the *Health Insurance Act 1973*.

Section G.1.3 provides information on Medicare and billing practices.

G.1.3. Medicare benefits and billing practices

Key information on Medicare benefits and billing practices
The *Health Insurance Act 1973* stipulates that Medicare benefits are payable for professional services. A professional service is a clinically relevant service which is listed in the MBS. A medical service is clinically relevant if it is generally accepted in the medical profession as necessary for the appropriate treatment of the patient.

Medical practitioners are free to set their fees for their professional service. However, the amount specified in the patient's account must be the amount charged for the service specified. The fee may not include a cost of goods and services which are not part of the MBS service specified on the account.

Source: s.G.1.3. Medicare Schedule Benefits Book

Section G.2.1 provides key information on provider eligibility for Medicare.

G.2.1. Provider eligibility for Medicare

To be eligible to provide medical service which will attract Medicare benefits, or to provide services for or on behalf of another practitioner, practitioners must meet one of the following criteria:

(a) a recognised specialist, consultant physician or general practitioner

(b) in an approved placement under section 3GA of the *Health Insurance Act 1973*

(c) a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973* and working in accord with that exemption.

Any practitioner who does not satisfy the requirements outlined above may still practice medicine but their services will not be eligible for Medicare benefits.

Note: New Zealand citizens entering Australia do so under a special temporary entry visa and are regarded as temporary resident doctors.

Note: It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the MBS).

Source: s.G.2.1. Medicare Schedule Benefits Book

National Health Reform Act 2011

The object of the *National Health Reform Act 2011* (Cth) is to establish the:

- Australian Commission on Safety and Quality in Health Care
- National Health Performance Authority
- Independent Hospital Pricing Authority
- Office of Administrator of the National Health Funding Pool
- National Health Funding Body.

The *National Health Reform Act 2011* is relevant to private practice insofar as it governs the establishment and functioning of national bodies associated with health reform. It does not prescribe specific rules relating to private practice, however, the Independent Hospital Pricing Authority sets the National Efficient Price for private patients treated in the public health sector.

Intergovernmental agreements

The National Healthcare Agreement 2012 and National Health Reform Agreement 2011 have been developed by Council of Australian Governments to facilitate implementation of health reform as an area of national importance identified in the Intergovernmental Agreement on Federal Financial Relations.

The national healthcare agreement clarifies the roles and responsibilities that guide the Commonwealth and states and territories in the delivery of health services.

Clause 20 of the National Healthcare Agreement 2012 requires that eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided, by hospitals. Clause 27(d) requires the state to ensure that eligible persons who have elected to be treated as private patients have done so on the basis of informed financial consent.

The National Health Reform Agreement 2011 sets out the funding arrangements for public hospitals and details business rules that give effect to the Medicare Principles, which underpin the National Healthcare Agreement 2012.

Schedule G of the National Health Reform Agreement 2011 contains business rules with which service providers comply.

Relevant clauses include:

G14 Requires all admitted patients to make a written election to receive admitted patient care as either a public or private patient. It states, 'election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the minimum standards set out in this agreement' (p.58).

G15 Provides that 'private patients have a choice of doctor and all patients will make an election based on informed financial consent' (p.58).

G16 Indicates that 'where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms' (p.58).

G17 Specifies that 'services provided to public patients should not generate charges against the Commonwealth MBS:

i) except where there is a third party payment arrangement with the hospital or the state, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services

ii) referral pathways must not be controlled so as to deny access to free public hospital services

iii) referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services' (p.58).

G18 Requires that 'an eligible patient presenting at a public hospital emergency department will be treated as a public patient, before any clinical decision to admit. On admission, the patient will be given the choice to elect to be a public or private patient in accordance with the National Standards for Public Hospital Admitted Patient Election processes (unless a third party has entered into an arrangement with the hospital or the state to pay for such services). If it is clinically appropriate, the hospital may provide information about alternative service providers, but must provide free treatment if the patient chooses to be treated at the hospital as a public patient.

However:

i) a choice to receive services from an alternative service provider will not be made until the patient or legal guardian is fully informed of the consequences of that choice

ii) hospital employees will not direct patients or their legal guardians towards a particular choice' (pp.58-9).

G19 Expressly recognises that private practice occurs in public sector health services. It states that 'an eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless:

i) there is a third party payment arrangement with the hospital or the state or territory to pay for such services

ii) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient' (p.59).

G20 States that 'where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging procedures) will be regarded as a part of the patient's treatment and will be provided free of charge' (p.59).

G24 Stipulates 'a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to the following:

i) patients who are admitted for a particular procedure but are found to have complications requiring additional procedures

ii) patients whose length of stay has been extended beyond those originally and reasonably planned by an appropriate health care professional

iii) patients whose social circumstances change while in hospital (for example, loss of job)' (p.60).

Source: section G. National Health Reform Agreement 2011

Private Health Insurance Act 2007

The *Private Health Insurance Act 2007* (Cth) and associated business rules impact on private practice with respect to payment of private health insurance benefits. For example, it prescribes default benefits for hospital accommodation.

All public hospitals in Queensland must be recognised hospitals under the *Private Health Insurance Act 2007* (Cth) to deliver healthcare to privately insured patients.

Health Practitioner Registration National Law Act 2009

The *Health Practitioner Registration National Law Act 2009* (Qld) (National Law) regulates practitioner registration and compliance. Registration of health practitioners is provided for in Part 7 and performance and conduct matters are set out in Part 8. Medical registration is a prerequisite for obtaining a Medicare provider number.

A New Tax System (Goods and Services Tax) Act 1999

A goods and services tax is payable on taxable supplies and taxable importations. Therefore, the goods and services tax is payable on medical reports, and any service fees payable by a clinician engaging in the granted retention private practice arrangement.

Income Tax Assessment Act 1997

Private practice-related remuneration is assessable income (s.6-5). Allowable deductions (subsection 8-1(1)) may include the amount of billings assigned to a HHS or Department of

Health. Clinicians must obtain independent taxation advice about the impact of private practice on their income.

The HHS or Department of Health (as applicable) is responsible for providing relevant information required by clinicians for taxation purposes.

Competition and Consumer Act 2010

The provisions of the *Competition and Consumer Act 2010* (Cth) bind the Crown in right of the state to the extent that the Crown carries on a business, either directly or by an authority of the state.

Government entities do not typically have to be concerned with the prohibitions under competition law where they are carrying on governmental or welfare functions. Activities performed in a statutory duty or government function or engaged solely for traditional government purposes are unlikely to amount to 'carrying on a business'. However, where government entities are considered to be 'carrying on a business' because the activities are commercial, care needs to be taken to ensure no unlawful conduct occurs including:

- contracts that substantially lessen competition
- price-fixing
- third line forcing
- misleading conduct.

Hospital and Health Boards Act 2011

Section 45 of the *Hospital and Health Boards Act 2011* (Qld) sets out the functions of the Director-General, Department of Health, which include:

- employing staff in the Department or HHSs other than a prescribed HHSs
- managing statewide industrial relations, including the negotiation of certified agreements and making applications to make or vary awards
- establishing the terms and conditions of employment for health service employees (s.45(e)-(g)).

Health Service Directives for purposes specified in the *Hospital and Health Boards Act 2011*.

- s.47(1) The Director-General may develop and issue Health Service Directives to support the application of public sector policies, state and Commonwealth acts and agreements entered into by the state.
- s.47(2) The Director-General may develop and issue Health Service Directives about the setting of fees and charges, including for the provision of services to private patients, for residential care and for the supply of pharmaceuticals
- s.47(6)(iv) The Director-General may develop and issue Health Service Directives to HHSs relating to matters that support the delivery of health services, including private practice arrangements for health professionals.

Financial legislation and related instruments

The *Financial Accountability Act 2009* (Qld) and related regulatory regime including the Financial Accountability Regulation 2009 (Qld), Financial Performance and Management Standard 2009 and the local Financial Management Practice Manual govern many aspects of the private practice schemes.

A HHS or CBU's financial management practice manual identifies the key internal financial controls and other governance practices that collectively constitute a financial management framework. Parts of it are relevant to private practice. For example, it sets out accounting practices and aspects relating to maintenance of appropriate documentation and debt recovery.

HHSs and CBUs must comply with the Health Service Directive - Own Source Revenue - Central Coordination of Fees and Charges Increases and Category 'C' Negotiation and Acquisition. The Own Source Revenue Health Service Directive states that the intent of a central administration approach is to achieve efficient administration of ongoing fee increases and achieve commercially viable cost recovery for fee paying patient services. The Department of Health's Fees and Charges Register is established under the directive and outlines the fees and charges applicable for fee paying patient services.

Other key internal documents

Human Resources Policy I2—Indemnity for Queensland health medical practitioners

Queensland Health provides indemnity for clinicians when they are treating public patients and private patients in accordance with Human Resources Policy I2—Indemnity for Queensland Health Medical Practitioners ('I2') subject to certain limitations.

Policy I2 has been updated to include cover for legal representation and legal assistance for a Medicare Australia investigation or inquiry relating to a practitioner's participation in private patient activities during the course of their employment. The doctor must have acted diligently and conscientiously in complying with relevant Queensland Health policies and procedures.

Credentialing and defining the scope of clinical practice for medical practitioners

All registered medical practitioners practicing in public health facilities are to be credentialed and have an approved scope of clinical practice prior to providing clinical services. The practitioner's approved scope of clinical practice must be consistent with their registration status and consistent with the approved clinical services capability framework level for that clinical service. For more information, refer to the *Credentialing and defining the scope of clinical practice* policy.

Code of Conduct for the Queensland Public Service

The Queensland Public Service Code of Conduct applies to all staff employed in the Department of Health and HHSs and applies to employees when conducting private practice.

Clinical practice

- Private practice is conducted in a way that enhances public practice as the primary mode of care.
- Promote private practice as a mechanism to support public practice.
- Patient safety and quality patient care is prioritised above private or public patient election status.

Private practice is to be conducted in a manner that is consistent with, and supportive of, the clinical requirements and standards of public patient care. That is, the provision of private patient services must:

- be delivered in a manner that is consistent with the Medicare Principles that underpin the National Health Reform Agreement
- adhere to the same clinical standards and requirements that are applied to public service delivery
- support and enhance the clinical objectives and outcomes of public service delivery (i.e. teaching, training, research etc.)
- enhance access to patient care and clinical outcomes without discrimination on ability to pay (i.e. private patient services must support access to care and the quality of treatment provided in the public sector regardless of a patient's ability to pay)
- not compromise patient safety and clinical outcomes at the expense of income generation
- be conducted in accordance with the Credentialing and Defining the Scope of Clinical Practice Policy.

Business practice

- Private practice is used in line with strategic business and operational objectives of the employing facility
- HHSs and CBUs should ensure all appropriate revenue sources are considered and optimised for the sustainable delivery of quality healthcare services to their community
- Appropriate fees are levied to clinicians and patients by HHSs and CBUs to ensure private practice is not delivered to the financial detriment of public sector health services
- Clinicians are contracted to provide private practice as agreed by the parties.

Business principles

HHSs and CBUs hold the prerogative to grant a clinician limited rights to conduct private practice on the terms and conditions of the private practice schedule within the employment contract **(granted private practice)** or otherwise, licence a clinician to conduct private practice in their own time via a contractual agreement **(licenced private practice)**.

HHSs and CBUs should use private practice to optimise:

a) patient service choice and access
b) patient health outcomes and models of care
c) clinical workforce employment, engagement and capacity to provide public and private services
d) use of resources, increase work satisfaction and professional skills of the clinical workforce
e) public health system revenue sources
f) public health system service access and throughput and use of resources.

General business rules

- HHSs and CBUs are to charge clinicians fees for private practice activities in accordance with the Department of Health's Fees and Charges Register, unless other fee arrangements are approved by the Director-General.
- Clinicians are permitted to conduct private practice on the terms and conditions of the employment contracts and applicable schedules in Health Service Directive—Private Practice in the Queensland Public Health Sector, unless other contractual arrangements are approved by the Director-General.
- HHSs and CBUs are to provide clinicians with a statement detailing private practice earnings and all fees paid on a monthly basis, within 21 days of the month ending, to assist the clinician with reporting obligations (e.g. taxation reporting).
- Private patients have a choice of doctor (where available) and all patients will make an election based on informed financial consent.
- HHSs and CBUs should develop a business plan for the management of private practice to manage achievement of objectives in accordance with specific local requirements and general business requirements, including:
  - Where acting as the agent of clinicians conducting private practice, administering that role in a simple, efficient and professional manner.
  - Having the clinician actively involved in all aspects of their private practice activities. This includes ensuring all billings are approved by the clinician, providing monthly reports of billings against the clinician's Medicare provider number and ensuring support staff provide clear, prompt communication to the clinician when informed financial consent has been obtained from a patient to be treated privately.
  - Developing processes for recovering outstanding debt.
  - Undertaking regular analysis of private practice activities to determine if these activities are being delivered in a sustainable manner and notifying the accountable officer where there is material risk of this being achieved.
- HHSs and CBUs are to investigate funding source implications of a professional service being delivered to a patient being treated publically or privately to determine best funding source value. These activities may form the basis for health service planning, strategic business approaches and will ultimately guide the decision to offer a private practice arrangement to a clinician.
- HHSs and CBUs may nominate an assignment or retention remuneration model for clinicians conducting granted private practice during their employed time.

Granted private practice options

Assignment

- In cases where a service 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.
- This will be the default arrangement.
- Performance measures in the employment contract can/may include a requirement to treat private patients.
- All revenue is assigned to the Hospital and Health Service or commercialised business unit.

Retention

- A service may grant a clinician permission to engage in private practice during employed time and retain private practice revenue after paying the applicable 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 service.

Billing

- HHSs and CBUs will take on the functions of billing, collection and distribution of granted private practice revenue. Strict process monitoring mechanisms are to be implemented.
- Where a clinician is engaged under the assignment arrangement, HHSs and CBUs, as the billing agent acting on behalf of the clinician, retain 100 per cent of revenue through the tax invoice method.
- Where a clinician is engaged under the retention arrangement, HHSs and CBUs, as the billing agent acting on behalf of the clinician, raise service fees in accordance with the Department of Health fees and charges register. Service fees are to be deducted from gross revenue through the tax invoice method.

Fees and charges

- Fees for professional services can be set by the individual clinician under agreement with the HHSs or CBUs, however the default fee rates are those contained in the Medicare Benefits Schedule of fees (generally 85 per cent of the schedule fee for non-admitted patients and 100 per cent of the schedule fee for admitted patients).
- Service fees and other fees and charges to be levied by a HHS or CBU are detailed in the Department of Health fees and charges register.

Service fees for granted retention arrangement

- Private practice is granted on the proviso that private patient activities are performed alongside employment to treat public patients. Service fees are payable by individuals engaged under the retention arrangement as contribution to costs relating to private patient service delivery. Service fees are calculated as a percentage of the collected gross billings for a private inpatient or outpatient service.
- Service fees aim to recover some of the costs in relation to:
  - use of equipment (including capital, depreciation and maintenance)
  - provision of technical, clinical and administrative support including the provision of practice staff and administration, including billing
  - use of consulting rooms and other infrastructure
  - clinical and other consumables
  - professional indemnity.
- MBS rates in many categories are not designed to fund full practice costs and hence generating income solely from MBS fees may not cover costs regardless of the level of service fee charged. HHSs and CBUs will need to undertake local financial analysis to determine if private patient service models are viable, with particular regard to the private patient activity based funding model.

Service fees have been set based on the following principles:

Clinical area / item category	Medical specialist	Clinical and other supplies	Practice staff / resources	Infrastructure	Minor capital	Major capital
Pathology	■	■	■	■	■	■
Medical imaging	■	■	■	■	■	■
Radiation oncology	■	■	■	■	■	■
Nuclear medicine	■	■	■	■	■	■
Diagnostic procedures	■	■	■	■	■	
Surgical procedures	■	■	■	■	■	
Services not contained in the MBS	■	■	■	■	■	
Miscellaneous services	■	■	■	■		
Therapeutic procedures (exc rad. onc.)	■	■	■	■		
Professional attendances	■	■	■			

Note: Service fees and the annual earnings ceiling (threshold) will be set annually and gazetted in the Department of Health fees and charges register.

Note: Service fees for the granted retention arrangement are not to vary from what is prescribed in the Department of Health fees and charges register. This fee structure only applies to granted private practice. Fees applicable for commercial arrangements including licenced private practice are to be determined at HHS or CBU level.

Examples of cost drivers within the abovementioned item categories include:

Medical specialist	• Expenses in relation to clinician's employment i.e. salary, superannuation, indemnity, on costs
Clinical and other supplies	• Minor clinical consumables, pharmaceuticals and general supplies
Practice staff/ resources	• Administration, accounts receivable and clinical support
Infrastructure	• Clinic rooms, building maintenance, minor equipment
Minor capital works	• Medium cost equipment and consumables
Major capital works	• High cost equipment

Disbursement of service fees

Service fees received by the HHS or CBU are able to be credited to either an operating account or trust account, at the chief executive's discretion. The return of service fees to the actual division generating that revenue is a decision for the HHS or CBU. However, returning revenue to the division generating the revenue is considered best practice as it ensures transparency and incentivises participation.

Group revenue retention arrangements

- A HHS or CBU may decide to grant an individual the ability to engage in the retention arrangement on the proviso that the individual agrees to be a member of a group (e.g. radiology group practice).
- The private practice schedule of the employment contract provides the ability for a clinician to direct their net earnings to a third party. If an individual enters into a group retention arrangement with his/her colleagues, net earnings will be subject to the combined threshold level of all group participants.At a minimum, HHSs and CBUs shall provide to clinicians entering into a group revenue retention arrangement:
  - monthly payment into the group's nominated bank account(s)
  - timely information identifying medical fees billed and disbursed to enable the group participants to manage their group obligations.
- Agreements are to be developed and managed locally.

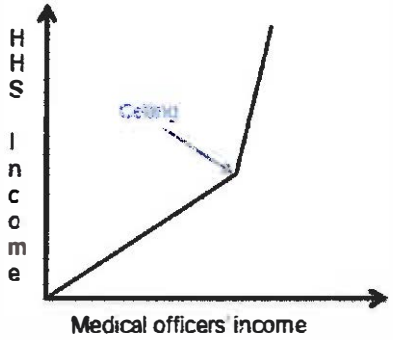
Earnings ceiling (threshold)

- Clinicians engaged under the retention arrangement may retain granted private practice revenue after payment of the applicable service fees, up to the earnings ceiling published annually in the Department of Health fees and charges register.
- Once the clinician retains a net amount (i.e. balance after paying service fees) equal to the ceiling, only $1 in every $3 is available to be retained by the clinician from that point forward for the remainder of the financial year, with the balance being credited to the employing HHS or CBU. Revenue retained by HHSs and CBUs may be disbursed to specific trust or operating accounts at the discretion of the HHS or CBU chief executive.
- When a clinician starts their employment part way through a financial year, the ceiling amount is to be adjusted as per the following formula:

$$\left(\frac{\text{Number of months remaining in financial year}}{12}\right) \times \text{Ceiling Amount}$$

Note: Number of months remaining is to be calculated to the nearest full month

The diagram below demonstrates the effect of the earnings threshold:



Incentive payments

- Incentive payments as advised by the Australian Government Department of Health (Medicare) should be considered on an individual incentive scheme basis by the Private Practice Governance Board.
- Any fees determined by the Private Practice Governance Board will be managed through the fees and charges register.

Taxation

The taxation treatment of income derived from private practice varies with the contract option of the clinician.

Note that the information provided below is generic in nature and is provided only as a guide and it is recommended that all medical officers engaging in private practice should seek individual tax advice. It is a policy requirement that hospitals provide clinicians with monthly and annual earnings statements, identifying services billed and receipted, charges levied and any GST withheld to enable the clinician to meet his or her Australian Taxation Office reporting obligations.

Taxation—revenue assignment arrangement

- Under this arrangement, the clinician provides the HHS or CBU with the right to render accounts in the clinician's name (or related entity) and collect all fees payable by private patients which is then assigned to the HHS or CBU.
- Regardless of whether a clinician is engaged under the assignment or retention arrangement, private practice income from fees and charges billed under the clinician's provider number for private patient activities is regarded as assessable ordinary income of the clinician under Section 6–5 of the *Income Tax Assessment Act 1997*, and the gross amount billed under the clinician's Medicare provider number should be disclosed as such in the clinician's tax return.
- Revenue generated by clinicians that is assigned to the HHS or CBU, represents work related expenses and is therefore an allowable deduction under Section 8–1 of the

Income Tax Assessment Act 1997. Such expenses should be disclosed as allowable deductions in the clinician's tax return and in effect will generally result in a netted off position. However, it is advisable that clinicians do disclose both the private practice gross billings (income) and the amount assigned (deductions) relating to the private practice in their tax return.

Taxation – revenue retention arrangement

- Under the retention arrangement, the HHS or CBU grants a clinician the right to provide medical services to private patients alongside public employment duties. In return the clinician provides the employer with the right to render accounts in the clinician's name (or related entity) and collect all fees payable. From this revenue, clinicians are entitled to the net amount remaining after deductions of GST and Service fees payable up to the applicable earnings ceiling.
- The fees retained by the clinician are not salary and wages as defined in the *Income Tax Assessment Act 1997*. As a consequence of this, the income paid to the clinician arising out of private practice is not subject to the deduction of PAYG tax withholding. Private practice income may be seen to be derived as ordinary 'business' income and as such is assessable income under Section 6–5 of the *Income Tax Assessment Act 1997*.

Licenced private practice

- Licenced private practice includes, but is not limited to, clinicians conducting private practice:
  - outside work hours (if the clinician is also employed by the HHS or CBU)
  - in the course of a university or honorary appointment
  - in circumstances where the clinician is not an employee or appointee of the HHS or CBU.
- Licenced private practice is an arrangement granted by the HHS or CBU for an individual to undertake private patient activities at a public health facility during unpaid time.
- The arrangement is to be formally agreed between the parties in writing as like any other commercial agreement, to be developed at the local level.
- Patient billings for services such as accommodation, consumables, prosthetics, etc., provided by the hospital will be processed by the HHS as the billing agent.
- Clinicians engaged under a licenced private practice arrangement can elect to use the HHS or CBU as the billing agent for their professional services, however administration fees may apply.
- Individuals participating in a licenced private practice arrangement will need to maintain their own indemnity during these activities.
- Licenced private practice activity will be assigned to the correct payment class in the patient administration system (e.g. HBCIS account code for overnight patient = GSEL).
- Resources, support services and infrastructure access are to be negotiated at the local level to address community, professional and service needs. However, these arrangements are to be conducted on a purely commercial basis and will be publicly defensible.

Medical superintendent with private practice (MSPP) and medical officer with private practice (MOPP)

As per section 30(2) of the employment contract, schedule 3 of the employment contract does not apply to medical superintendents with private practice (MSPP) or medical officers with private practice (MOPP).

Due to the unique nature and long standing history of private practice arrangements for MSPPs and MOPPs, private practice arrangements for MSPPs and MOPPs are to be negotiated at the local level through an exchange of letters or written agreement.

The arrangements outlined in the exchange of letters or agreement will form part of the terms of employment in conjunction with Industrial Relations Manual 2.7-4. HHSs are to develop the exchange of letters / agreement locally however an example template and applicable guideline can be obtained by contacting PrivatePractice_Secretariat@health.qld.gov.au

Governance, performance and accountability

- Appropriate and effective governance is established and sustained. Meaningful key performance indicators are set and used as a tool to measure scheme performance
- Establish a local performance and governance approach that clearly defines objectives and performance expectations, with a central point of accountability to ensure that local private practice activities achieve their objectives in a financially sustainable manner
- Internal controls are in place to ensure overall business integrity and compliance with policies, directives and frameworks

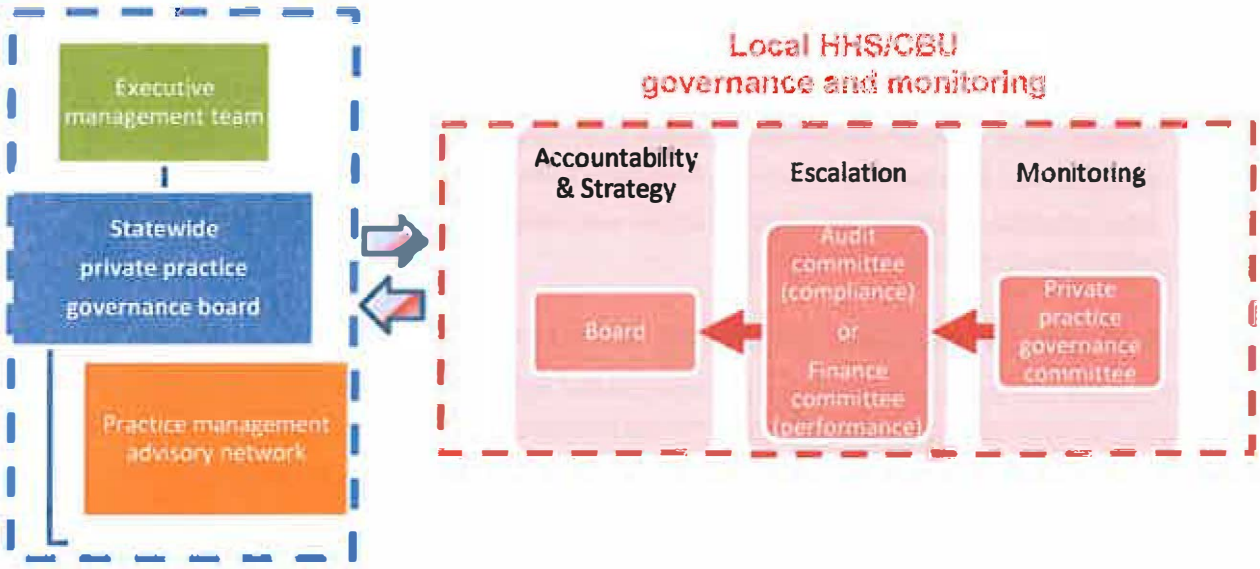
Governance approach

- An accountable officer will be assigned by the HHS or CBU chief executive the responsibility to oversee private practice activities.
- HHSs and CBUs will establish a private practice governance committee (or delegate an alternative 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.

Private practice governance approach:

The below diagram demonstrates the governance relationship between HHSs and the Department of Health.

Statewide coordination



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 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 HHSs and CBUs 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 and CBUs are responsible for the successful operation of private practice at the local level, and will 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
- robust governance and internal controls are maintained
- 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 focused 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.

Governance process

- Systems are required to be developed and monitored (and efforts documented) to maximise private practice revenue where appropriate and be reviewed periodically in line with funding source changes.
- The officer responsible for executing the contract with clinicians engaging in private practice will ensure performance reviews occur at least annually.
- The accountable officer will ensure that benefits of private practice are demonstrated to reasonably recover costs at the HHS or CBU level.
- HHSs and CBUs should investigate opportunities to streamline processes to realise private practice system efficiencies.

Internal controls

Internal controls will be in place to ensure:

- the activities of private practice are conducted in a manner that facilitates the achievement of its objectives and the delivery of its services in an orderly and efficient manner
- error, fraud and other irregularities are prevented as much as possible and promptly detected through a systematic approach if they do occur
- assets and consumables used in private practice activities are safeguarded from unauthorised use or disposal and are adequately maintained and monitored
- financial and management performance reports are timely, relevant, reliable and accurate.

The system of internal controls will:

- be documented
- be embedded in the operations of management and governance processes and form part of its culture
- be capable of responding quickly to evolving risks in the delivery of private practice activities
- include procedures for reporting significant control weaknesses that are identified, together with procedures to undertake corrective action.

The diagram below (right) demonstrates the internal control approach that should be engaged at the local level to ensure effective coordination and achievement of performance objectives.

Governance: Defines objectives and performance expectations with a central point of accountability.

Control environments: Standards, processes and structures that form the basis of internal control.

Risk assessment: Basis of determining how risks will be managed.

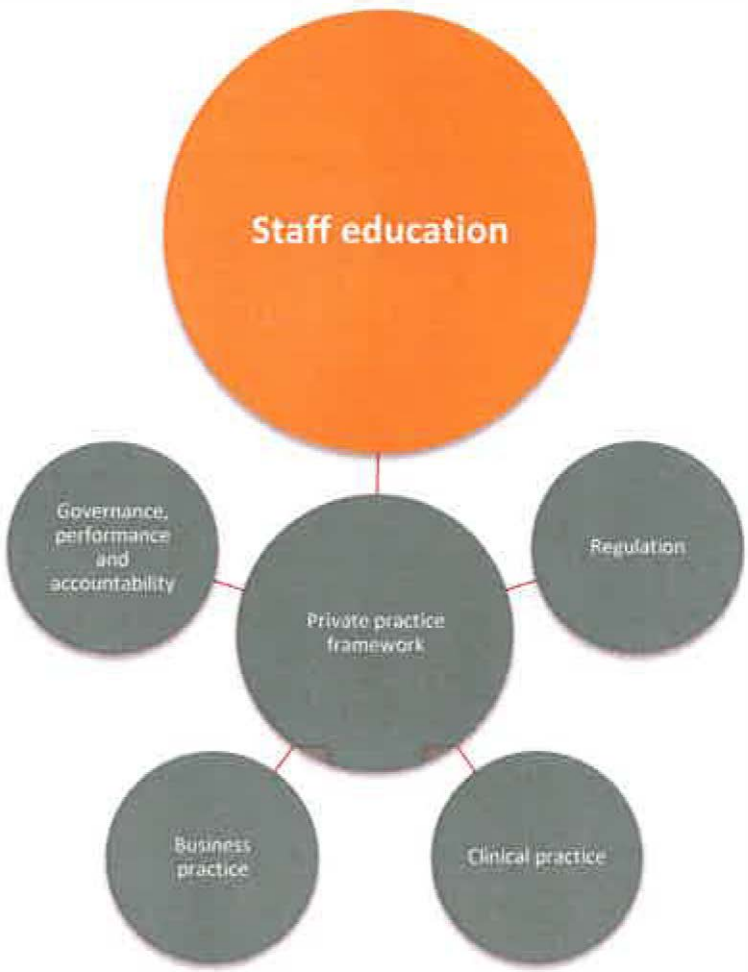
Control activities: Actions established through policies and procedures that help ensure that management's directives to mitigate risks to the achievement of objectives are carried out.

Monitoring activities: Ongoing evaluations are used to ascertain whether the components of internal control are correctly designed and implemented and are operating effectively.

Information and communication: Establish information systems so accountable officers may obtain timely, accurate and relevant information designed to assist in the strategic and operational management of their agency.

Staff education

- All staff involved in private practice are to have access to and regularly participate in appropriate education activities.
- Comprehensive training programs and educational material should be provided to target audiences in various forms to facilitate compliance and support clinicians in the effective delivery of private patient services.



This section of the framework specifies the education and training standards in which private practice is conducted within the public health sector.

The regulatory and legislative instruments that govern the business operation of individual participation in private practice conducted within the public health sector, are complex and should be well understood prior to engaging in private practice activities. Staff (both clinical and support) require information that clearly defines their roles and responsibilities and outlines the correct processes to be undertaken.

Education and training standards are aimed at achieving greater capability and consistency in the way clinicians and support staff engage in private practice. These standards identify learning objectives, desired knowledge and capability requirements and performance measures that will optimise private practice conducted within the public health sector.

Education and training standards establish the required education and support elements that in turn will ensure:

- regulatory compliance and assurance
- incentivised participation
- service sustainability
- financial integrity.

The following principles should be followed in developing local education and training standards and programs:

To foster and support a collegiate environment for employees to participate in private practice through the terms of their engagement by:

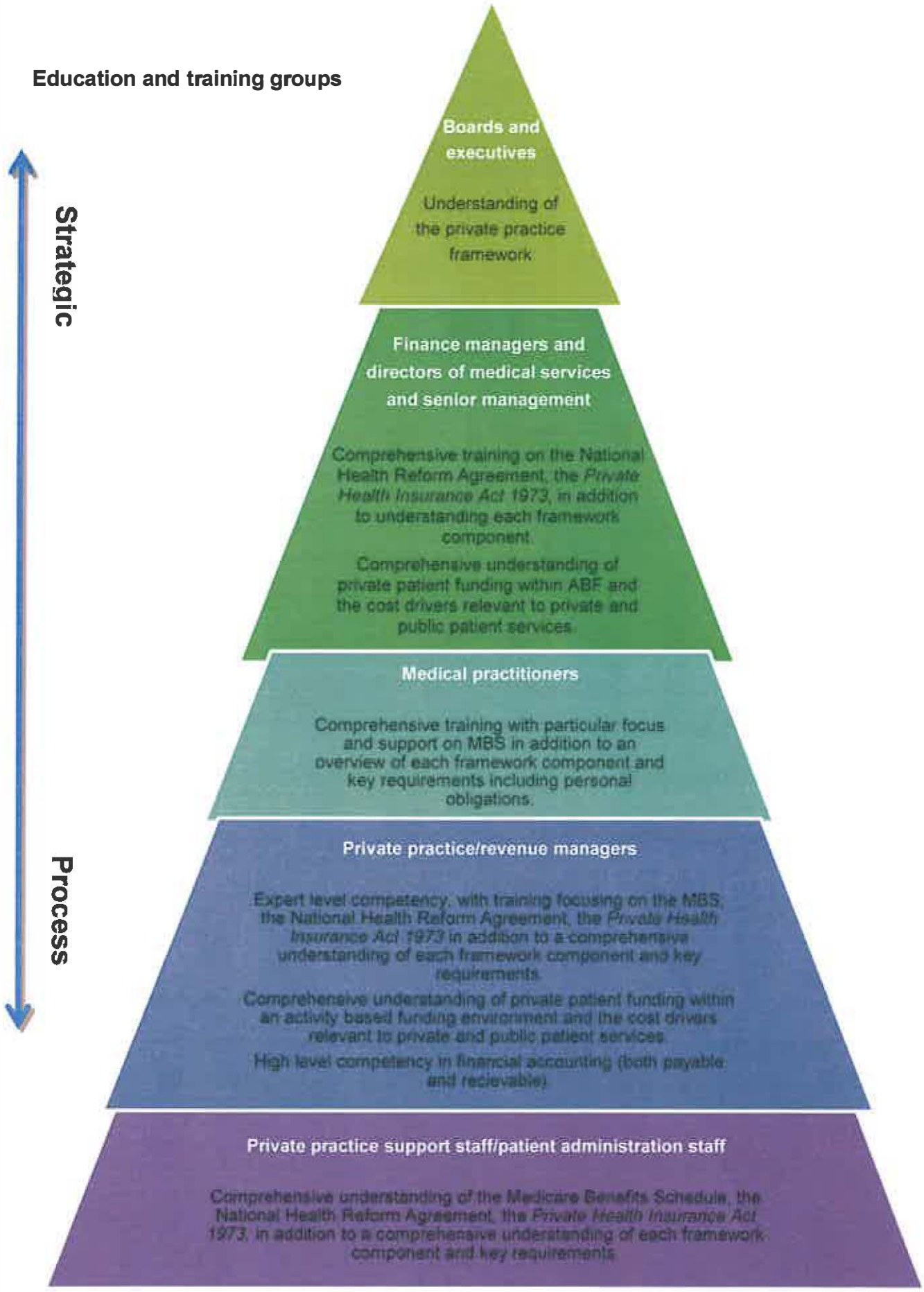
- providing educational tools and training to facilitate compliance, and support clinicians and support staff in the effective delivery of private patient services
- developing and maintaining high quality teaching and learning resources for all staff involved in private practice activities.

To facilitate best practice it is desired that staff have a working knowledge of the *Private practice in the Queensland public health sector framework* and *guideline*.

Training packages and educational material should be provided in various forms to suit the audience (e.g. power point presentations, online training, etc.).

Locally tailored training packages should be delivered as detailed in the diagram on the following page.

Education and training groups



Definitions

Term	Definition
Activity based funding	A system for funding public hospital services provided to individual patients using national classifications, cost weights and efficient prices developed by the Independent Hospital Pricing Authority.
Clinician	An individual who provides diagnosis, or treatment, as a professional: a) medical practitioner b) nurse c) allied health practitioner or Health practitioner not covered by paragraph a), b) or c) (*National Health Reform Act 2011*).
Commercialised business units (CBUs)	Health Services Support Agency (HSSA) and other commercialised business units employing clinicians that support or engage in private practice activities in the public health sector.
Department of Health	The Department of Health includes employees working in and for: • Health Service and Clinical Innovation Division • System Support Services Division • System Policy and Performance Division • Office of the Director-General • Health Services Support Agency • Health Services Information Agency • Queensland Ambulance Service (QAS).
Granted private practice	A limited right to provide professional services to private patients on the terms of Schedule 3 of the Employment Contract.
Hospital and Health Service (HHS)	A statutory body responsible for the provision of public sector health services for a geographical area which includes one or more health facilities.
Independent Hospital Pricing Authority (IHPA)	The authority established by the Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8. (*National Health Reform Act 2011*).
Licenced private practice	An arrangement granted by the HHS or CBU for an individual to undertake private patient activities at a public health facility during unpaid time.
Medical officer/practitioner	A medical practitioner who is registered with the Medical Board of Australia under the *Health Practitioner Registration National Law Act 2009*.
Medical services	Any of the medical services set out in Schedule 1 of the *Health Insurance Act 1973*.
Medicare Benefits Schedule (MBS)	The Commonwealth government's scheme to provide medical benefits to Australians established under part II, IIA, IIB and IIC of the *Health Insurance Act 1973* together with relevant regulations made under the act.
Medicare principles	The principles set out in Clause 4 of the *National Health Reform Agreement*.

National efficient price	The base price(s) which will be determined by the IHPA and applied to those services funded on the basis of activity for the purpose of determining the amount of Commonwealth funding to be provided to public health services. The IHPA may determine that there are different base prices for discrete categories of treatment, for example admitted care, sub-acute care, non-admitted emergency department care and outpatient care. In the event that there are multiple national efficient prices, the IHPA will determine which national efficient price applies.
Pharmaceutical Benefits Scheme (PBS)	The Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the *National Health Act 1953* together with the *National Health (Pharmaceutical Benefits) Regulation 1960* made under the National Health Act.
Private patient	A person who could receive treatment free of charge under the *National Health Reform Agreement 2011* but who has elected to be treated privately in the public system, or a person who agrees to be a fee paying patient of the medical officer and makes this election on the basis of informed financial consent.
Private practice (retention arrangement)	Private practice performed during employed time where the clinician retains billings after paying applicable Service fees.
Private practice (assignment arrangement)	Private practice performed during employed time where the clinician assigns all billings to the HHS or CBU.
Private practice	Any contractual arrangement between the Department of Health, a HHS or CBU and clinical staff with these features: • The medical treatment of a patient who has elected to be a private patient in respect to informed financial consent • Clinical staff treating the private patient uses their Medicare Provider Number to facilitate billing where applicable
Public patient	In relation to a hospital, means a person in respect of whom the hospital provides comprehensive care, including all necessary medical, nursing and diagnostic services and, if they are available at the hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements (*Health Insurance Act 1973*).
Queensland Health	The accumulative body of the Department of Health, CBUs and HHSs.
Scope of clinical practice	The extent of an individual practitioner's approved clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the organisation to support the practitioner's scope of clinical practice.
Service fees	The fees applicable to granted private practice retention arrangement participants, as specified in the Department of Health Fees and Charges Register

Appendix 1: Framework implementation

Regulation	Clinical practice	Business practice	Governance, performance and accountability	Staff education
High level deliverables				
• Compliance with all regulatory obligations, including relevant policies, directives, standards and areas such as patient rights and financial accounting standards.	• Clinical practice is conducted in a way that enhances public practice as the primary mode of care.	• Private practice is used in line with strategic business objectives of the employing facility.	• Appropriate and effective governance of private practice is established and sustained. Improvements are measured against key performance indicators.	• All staff involved in private practice are to participate in appropriate education activities and private practice managers are adequately trained and qualified.
Supporting activities				
• Identify and articulate regulatory requirements to all staff involved in private practice.	• Promote private practice as a tool to support and enhance overall clinical services.	• Investigate funding sources to determine best value (i.e. private versus public funding).	• Establish an accountable executive officer to oversee private practice.	• Develop standards and tools for education and training relevant to staff groups
	• Patient safety and quality patient care is prioritised without regard to private or public patient election status.	• Monitor funding source data to develop a strategic business approach.	• Clinician performance is reviewed annually against a set of agreed performance indicators.	• Monitor education uptake and set education key performance indicators.
		• Appropriate service fees are levied against individuals engaging in private practice.	• Collect private practice data, set key performance indicators and measure against the objectives.	• Educational activities are evaluated and evidence-based updates conducted as appropriate.
		• Clinicians are appropriately contracted to provide private practice.	• Investigate opportunities to streamline processes to realise efficiencies.	• Contractual obligations should be clearly understood by all involved parties at the time of agreement.

Document revision and approval history

Version No	Developed/modified by	Approved by	Date
1.0	Private Practice Reform Program	Chair - Private Practice Governance Board	22 January 2014
2.0	Private Practice Reform Program - (updated to align with corporate style guide and amended 'disbursement of fees section.	Chair - Private Practice Governance Board	27 February 2014
3.0	Private Practice Reform Program – update the Service fees for granted retention arrangement table	Chair – Private Practice Governance Board	28 March 2014
4.0	Private Practice Reform Program – update terminology of MSPP/MOPP Insert comments on incentive payments	Program Senior Director – Private Practice Reform	17 April 2014
5.0	Private Practice Reform Program – update licenced private practice to allow HHSs to negotiate specific agreements / templates.	Program Senior Director – Private Practice Reform	22 May 2014
6.0	Private Practice Reform Program – Final style guide, amend MSPP/MOPP section with added link for example template	Program Senior Director – Private Practice Reform	29 May 2014