Queensland Audit Office

Right of private practice in Queensland public hospitals

Report to Parliament 1 : 2013–14

Queensland Audit Office

Location	Level 14, 53 Albert Street, Brisbane Qld 4000
PO Box	15396, City East Qld 4002
Telephone	(07) 3149 6000
Email	qao@qao.qld.gov.au
Online	www.qao.qld.gov.au

Front cover image is an edited photograph of Queensland Parliament, taken by QAO.

ISSN 1834-1128

Queensland Audit Office

Your ref:
Our ref: 00-3757A

July 2013

The Honourable F Simpson MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Madam Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Right of private practice in Queensland public hospitals.

In accordance with s.67 of the Act, would you please arrange for the report to be tabled in the Legislative Assembly.

Yours sincerely

Andrew Greaves
Auditor-General

Queensland Audit Office
Level 14, 53 Albert Street, Brisbane Qld 4000
PO Box 15396, City East Qld 4002

Phone 07 3149 6000
Email qao@qao.qld.gov.au
Web *www.qao.qld.gov.au*

Contents

Summary

This interim report, prepared under section 62 of the *Auditor General Act 2009*, is the first of two reports dealing with our performance audit of the right of private practice arrangements in the public health system. The audit considered whether these arrangements are achieving their intended public health outcomes and are financially sustainable.

In conducting the audit, we pursued three lines of inquiry to determine if:

- the intended health and financial benefits of the scheme are being realised
- the scheme is being administered efficiently
- practitioners are participating in the scheme with probity and propriety and in full compliance with their contractual conditions.

This first report deals with systemic issues that arise from the first two lines of inquiry. The second report, expected to be tabled later this year, will primarily deal with practitioners' compliance with their contractual obligations.

Right of private practice (RoPP) scheme

At the core of the scheme is the ability of senior medical officers (SMOs) who are employed in the public health system to also treat those patients who come into the public system and elect to be treated as private patients. This facilitates patient choice, one of the underlying principles embedded in the Australian Government's National Health Reform Agreement with the states and territories.

The fees charged for these services flow into the public health system. There are two major variants of the scheme operating in Queensland. By far the more prevalent of the two, in terms of the numbers of SMOs participating (86.1 per cent of full time equivalent SMOs), involves the SMO receiving a private practice allowance as well as a base salary.

In exchange for being paid this allowance, these SMOs assign all the private practice revenue they generate to the Hospital and Health Service (HHS) facility where they are working. In turn, the HHS fully absorbs the direct and indirect costs—facility, administrative and other overheads—associated with these services including, for example, the cost of billing and collection of revenue. Today, this scheme is called Option A. It is also referred to as the 'assignment' model.

The other major scheme variant, involving far fewer numbers (9.0 per cent of full time equivalent SMOs), allows SMOs to retain a proportion of the private fees they earn, with the balance being paid into a trust account for the HHS facility to apply to research by, and education of, all staff at the facility. The HHS recovers a facility charge and administration fee from each participating SMO to defray the overhead costs of service provision. Today, this scheme is called Option B, and there is a variant called Option R which is available only for radiologists. It is also referred to as the 'retention and revenue sharing' model.

A third model is a combination of the assignment and revenue sharing models. It is available only to pathologists and is known as Option P (3.8 per cent of full time equivalent SMOs).

Queensland Health has offered the Option B retention and revenue sharing model since 1986 and introduced the Option A assignment model in 1992.

Both models, and their later Option P and R variants, were introduced with two primary benefits for the public health system in mind: first, to capture private patient revenue in a cost neutral manner and second, to improve the rate of recruitment and retention of SMOs, thereby improving the level of access to highly qualified specialists by patients using the public health system.

Conclusions

Far from being cost neutral, the scheme has cost the public health system at least $804.24 million over the last decade. The actual cost is higher than this because Queensland Health continues to subsidise the facility charges and administration fees that should be charged to those SMOs in retention and revenue sharing models.

Option A is the largest contributor to the shortfall, generating cumulative deficits over the nine years to 30 June 2012 of $725.69 million; from inception Option A has failed to be self-sufficient. The primary reasons for the shortfalls are the cumulative percentage increases in the allowance rates paid to SMOs since its introduction in 1992, and the extension of the scheme in early 2006 to SMOs who were either unable, or had a limited ability, to generate revenue. The revenues generated by most Option A SMOs have been significantly less than the allowances they are paid.

At the core of this issue is that the 'system' itself, and the SMOs participating in the scheme, have lost sight of, or never had sight of, the objective of cost neutrality—which was one of the two primary justifications for the scheme's introduction.

Our experience during this audit is that there is significant confusion and misinformation about this matter. The belief and attitude of administrators and SMOs alike is that the Option A arrangement, today and in the past, has always been about salary supplementation to achieve the second objective of recruitment and retention.

The scheme appears to have been successful in this respect—there are more SMOs in the public health system per head of population, and in proportion to other medical staff than before. This is because new SMOs have been attracted to the public health system at a far greater rate than the rate of their loss from the system. This is to the good but, without understanding how many SMOs are required by the system and in the absence of clear targets for growth in SMOs, it is impossible for Queensland Health to calibrate this apparent success properly.

What can be calibrated is the private practice revenue being generated by SMOs, the share of this revenue and the allowances being paid to SMOs. It is clear that the concept of cost neutrality is now a foreign consideration to all involved. This is typified by the experience in 2011–12 when almost half of those SMOs on Option A allowances generated no private practice revenue.

Accountability for this outcome does not rest solely, or indeed largely, with the SMOs. While they are bound contractually to participate in private practice arrangements and generate revenues, the system has never held them properly accountable for this. Their contractual terms do not promote a clear understanding of their revenue obligations as SMOs with a right of private practice. This is supported by our survey of SMOs, where 73 per cent of Option A respondents indicated that, from their perspective, their allowance payment is not contingent upon achieving a level of billing activity.

The rostering practices and legacy information systems in place also work against the ability of administrators, particularly the Directors of Medical Services (DMS), to monitor and oversight the scheme and its operation effectively.

The present situation casts significant doubt on whether Option A can be properly referred to as a right of private practice, and whether in fact it is simply a mechanism for increasing the remuneration of SMOs, albeit in an elaborate and complicated way. The retention and revenue sharing model is more closely aligned to the original intent of the scheme.

In light of the new funding framework with the Commonwealth, Queensland Health now needs to look at how it can best utilise private practice arrangements to benefit not just SMOs, but the public health system and its patients.

Key findings

Scheme outcomes

Recruitment and retention

Queensland Health has been successful in recruiting and retaining SMOs in major metropolitan and regional hospitals, when compared to the growth in Queensland's population. Queensland now has 1 262 more full time equivalent SMOs than it did in 2003–04 and the ratio of SMOs and visiting medical officers (VMO) per 100 000 Queensland residents has risen from 31.7 to 56.6 between 2003–04 and 2011–12.

However, Queensland Health has not quantified what it considers success to be in terms of a target for the level of recruitment and retention; nor has it reviewed the outcomes of the scheme in this respect. If Queensland Health has 'over recruited', it will have been 'too successful'; it does not have clear metrics to measure this, so it does not know.

As a result, Queensland Health cannot demonstrate whether it has a sufficient SMO workforce for the size of Queensland's population or if SMOs are in the right locations.

Cost neutrality

The right of private practice scheme has cost Queensland Health $804.24 million over the last nine years to 30 June 2012, being the $752.47 million difference between the payments to SMOs and its share of revenues earned and $51.77 million of unrecovered administrative support costs.

From this perspective Option A is financially unsustainable, which is counter to the advice provided to decision makers when it was established in 1992. It has generated shortfalls totalling $725.69 million over the last nine years to 30 June 2012 and now attracts 86.1 per cent of all participating SMOs.

Emergency department SMOs are a cohort with a limited ability to generate private practice revenue, yet they receive an additional supplementary benefit percentage (25 per cent) compared to other Option A SMOs. The cumulative value of the additional allowance is estimated at $46.00 million since its introduction in 2006 to 30 June 2012.

Options B and R are more financially sustainable by design. They are intended to be cost neutral, but this rests on the assumption that the facility charges and administration fees deducted from SMO revenues fully recover such costs.

To help in recruiting and retaining radiologists, Queensland Health is providing Option R SMOs with a 50 per cent discount on the standard facility charge and administrative fee, equating to a cumulative susbsidy of $23.92 million since its introduction in 2006 to 30 June 2012.

Option P also has historically made losses, resulting in a cumulative shortfall of $26.78 million over the last nine years to 30 June 2012.

The facility charges and administration fees levied on Option B, R and P SMOs have not been revised since before 2001. Queensland Health therefore does not know the extent to which it is further subsidising these SMOs by charging them less than full cost for the facilities and administrative services they use.

Patient outcomes

The right of private practice scheme is not attracting significant patient activity away from the private sector; however, the pattern of evidence, prima facie, is that category 2 elective surgery patients who do choose to be treated privately receive priority access, compared to public patients. Private patients however do not, prima facie, enjoy priority access to outpatient clinics.

Scheme design and oversight

Scheme design and evolution

The quality of the business cases supporting the introduction and amendments to the scheme varied significantly, particularly in the rigor of analysis, which was absent in some cases, and in the level of detail provided to support decision making. In the case of the significant 2006 amendments to the scheme, Queensland Health was unable to provide financial and workforce analysis or other documentation to support the substantial increases in the Option A allowance (also affecting Option P) and the establishment of Option R.

Expanding the scheme to those ineligible to bill and to non-specialists, and increasing the Option A allowance above the standard rate for emergency department SMOs, further entrenched the cultural belief that the right of private practice was a mechanism to effect a pay rise.

In designing the various scheme options, Queensland Health has failed to analyse adequately their financial implications, to quantify success or to schedule and complete reviews—including reviews requested by the Queensland Government. This has resulted in the scheme being implemented and governed poorly and has led to confusion and misunderstandings amongst SMOs and medical administrators.

Scheme oversight

Queensland Health has been unable to demonstrate there was any effective system level oversight from 1986 up to the introduction of Option A in 1992 when the Private Practice Review Committee was formed, and from the late 1990s up to the creation of the Private Practice Management Committee in 2009. These committees assumed limited responsibility for the oversight of the scheme. However, as the putative governance bodies, they do not have the necessary authority and responsibility to oversee delivery of the twin objectives of the scheme effectively.

The DMS are charged with managing the scheme in public hospitals. The DMS have not been held accountable for the scheme's performance, nor held their staff accountable for their obligations under their right of private practice contracts. This is due, in part, to the conflicting messages from Queensland Health, which resulted in the DMS managing the scheme as a pay increase with the opportunity to raise some additional revenue.

The ability to obtain timely and meaningful management information about the overall performance of the scheme and of individual SMOs is compromised because of the disparate systems and limited ability to integrate information across the variety of computer platforms used. This impedes the ability of clinical directors, DMS and Queensland Health to manage and monitor the scheme.

The scheme in operation

Revenue management and control

The Option A contract requires only that SMOs use 'their best endeavours' to identify private patients. This passive wording has also contributed to almost 50 per cent of Option A participants failing to record any revenue for the 2011–12 financial year. In total, over 90 per cent did not generate enough revenue to cover their allowance payments.

These low levels of active participation by SMOs result from deficiencies in the scheme design and from weak engagement with the medical workforce about their contractual obligations and responsibilities. SMOs lack knowledge of what, and in what circumstances, services are billable. Our survey of SMOs indicated that 64 per cent of Options B and R SMOs and 82 per cent of Option A SMOs reported they did not receive an adequate introduction into identifying billable services and a combined 65 per cent stated that they do not receive adequate ongoing support in identifying billable services. Furthermore, our discussions with SMOs revealed that some are reluctant to participate due to their concerns that the scheme is operating outside the bounds of the *Health Insurance Act 1973* (Cth).

Revenue that could be derived under the scheme is being foregone across all specialties due to a lack of active participation by SMOs and complex, inefficient and inconsistent systems and practices, all of which require substantial manual processing for the billing cycle. We estimate that in 2011–12, an additional $22.76 million of revenue across a variety of billable activities could have been derived under the scheme. For the 2013–14 year, Queensland Health has identified a further revenue uplift of $17.73 million in outpatient bulk billing.

Expenditure management and control

Claims for extended hours overtime for Options B and R SMOs are not allowed to occur on days where these SMOs conduct significant periods of private practice. There is no management mechanism to monitor and enforce this requirement. We have identified that, in 2011–12, almost one in ten Option B SMOs is likely to have breached this policy requirement.

Overtime across the medical workforce is not closely linked to clinical activity. In three of the four hospitals we visited, the level of extended hours' overtime claimed on Fridays was higher than any other day. Rostering practices are contributing to increased overtime payments to SMOs.

Recommendations

All recommendations need to be considered in light of the final model of activity based funding under the National Health Reform Agreement.

It is recommended that Queensland Health and the Hospital and Health Services (HHSs):

1. **redesign private practice arrangements to incentivise practitioners so the scheme is financially sustainable**
2. **establish clear targets for the optimal medical workforce in the context of desired clinical, patient access and financial outcomes**
3. **develop an appropriate governance framework for private practice arrangements, which includes:**
    - **an oversight body comprising members with sufficient skill, authority and responsibility statewide**
    - **board oversight with appropriate delegation of responsibilities at the facility level to monitor and enforce contractual obligations**
4. **develop for all administrative, clinical and billing systems supporting private practice:**
    - **standards to ensure the quality of data captured is meaningful and relevant**
    - **integration to realise efficiencies and enable monitoring of clinical and non-clinical (including financial) activity**
    - **a single common doctor identifier**
5. **make immediate attempts to recover foregone revenue, if cost effective, and investigate further revenue uplift opportunities**
6. **develop a strategy and engage with private practice participants, medical administrators and support staff to communicate a consistent message aligned with the objectives of the redesigned scheme, including contractual obligations**
7. **redesign end to end business processes and systems to support enhanced revenue and expenditure management, including rostering and overtime**
8. **review the objectives and the principles governing the use of the study, education and research funds (SERTA and SERTF) to ensure maximum benefits are derived for the state.**

Reference to agency comments

In accordance with section 64 of *the Auditor-General Act 2009,* a copy of this report was provided to:

- Queensland Health
- Metro North HHS
- Metro South HHS
- Townsville HHS
- Gold Coast HHS

with a request for comments.

In accordance with section 64 of *the Auditor-General Act 2009*, relevant extracts of this report were provided to:

- Cairns and Hinterland HHS
- Sunshine Coast HHS
- Children's Health Queensland HHS
- Mackay HHS
- Wide Bay HHS
- Darling Downs HHS

Their views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report.

The full comments received are included in Appendix A of this report.

1 Context

1.1 Funding public hospitals

Public health services provide access to free medical care for those who wish to be treated as public patients. Queensland's public hospitals are jointly funded by the federal and state governments. The National Healthcare Agreement (NHA) outlines the respective roles of each level of government. The Queensland Government has primary responsibility for the delivery of health services through the state's public hospital system. The Australian Government subsidises public hospitals through the NHA, and the public predominately through the Medicare Benefits Schedule (MBS) and the Pharmaceutical Benefits Scheme (PBS).

Medicare benefits are payable to eligible private patients for services provided in Australia. The benefits payable and the rules for billing are set out in the MBS.

In July 2011, Queensland and the other states and territories entered into the National Health Reform Agreement (NHRA) with the Commonwealth. The NHRA operates in conjunction with the NHA, but introduces new financial and governance arrangements whilst building on the policy and reform directions and outcomes outlined in the NHA.

1.2 Patient choice in public hospitals

Under both the NHA and the NHRA, public hospitals must offer Medicare-eligible patients a choice to be treated publicly or privately.

Using the public system

When a patient attends a public hospital and elects to be treated as a public patient, services (including overnight stays) are provided free of charge. Alternatively, patients can elect to be treated privately in a public hospital and, in doing so, agree to be responsible for meeting the costs of their care.

A private patient has the choice of treating doctor—provided the doctor has a right of private practice (RoPP) at that facility—and access to a private (single or shared) room where available. These costs can be met from their own pocket (self-insurance); or defrayed by using private health insurance or third party funding sources (such as Workcover and Department of Veterans' Affairs); Medicare benefits where applicable; or met by a combination of these.

Using private health insurance

Private health insurance is aimed at meeting the cost of private treatment in a private or public hospital and some costs not covered by Medicare, including dental and optical care. Many private health insurance policies have front end deductibles (FEDs) or co-payments. FEDs are an agreed amount that the privately insured member pays before the private health insurer funds the balance of the hospital stay, regardless of length of time. FEDs are similar to a co-payment except that co-payments are often required for each day of the hospital stay.

Over the last five years, Queensland Health has developed a policy of meeting the cost for patients' FEDs or co-payments to encourage them to use their private health insurance.

Using Medicare benefits

The federal Department of Human Services administers the MBS which lists the medical procedures, consultations and tests that are subsidised by the Australian Government. Each item on the MBS has its own schedule fee and Medicare pays a set percentage of this fee. Medicare does not cover the cost for overnight stays (bed) when being treated as a private patient.

The Medicare benefit is paid to the patient when he or she elects to be treated privately; however, the patient can assign this payment to the treating practitioner. The term ‘bulk billing’ is used where the practitioner accepts the Medicare payment as full settlement of the account.

Many Queensland public hospital outpatient clinics, pathology and radiology services 'bulk bill' Medicare for private patient services. Certain private inpatient services, including pathology and radiology, are also able to be billed to Medicare.

1.3 Senior medical workforce

The term ‘senior medical officer’ (SMO) is generic and covers the following job designations: a medical superintendent, deputy medical superintendent, assistant medical superintendent, senior staff specialist, staff specialist, general practitioner and medical officer.

The only requirement to be eligible to participate in the RoPP scheme is to be employed as a medical officer (MO) or higher in a public hospital. On commencement of this band (or higher), all medical officers are offered a RoPP contract. Some scheme options are restricted and require practitioners to be specialists or specialists in particular fields of practice.

Eligible medical officers are employed by, and separately sign a RoPP contract with, Queensland Health representing the State of Queensland and not the Hospital and Health Services (HHSs) in which they work. The employment contracts are written under the *Hospital and Health Boards Act 2011*.

Throughout this report, the term ‘SMO’ is used to cover all eligible practitioners, both specialists and non-specialists, unless otherwise stated.

In addition to SMOs, the senior medical workforce in public hospitals includes Visiting Medical Officers (VMOs). VMOs are private doctors who provide sessional services under part time arrangements in Queensland public hospitals. At the time of the audit, VMOs did not have a contractual RoPP option in which they could participate.

VMOs are typically engaged as either:

- salaried—engaged for a period spanning several years and paid through the payroll system or
- contract—paid through the finance system on the submission of invoices.

1.4 Right of private practice

To take advantage of the MBS, the scheme and its options, must comply with the *Health Insurance Act 1973* (Cth)(HIA). This Act establishes where a Medicare benefit is payable.

RoPP schemes have been operating across Australia for several decades. Typically, they adopt one (or a combination) of three primary models:

- **an assignment model**—all revenue generated is assigned to the hospital and, in exchange, an allowance is paid to the SMO
- **a retention model**—the SMO retains all revenue generated but pays a facility charge and administration fee to the hospital; the earnings may be capped at a specified level
- **a revenue sharing model**—the SMO and the hospital share in the revenue generated.

Figure 1A sets out the five main options available in Queensland, governed by three Queensland Health policies.

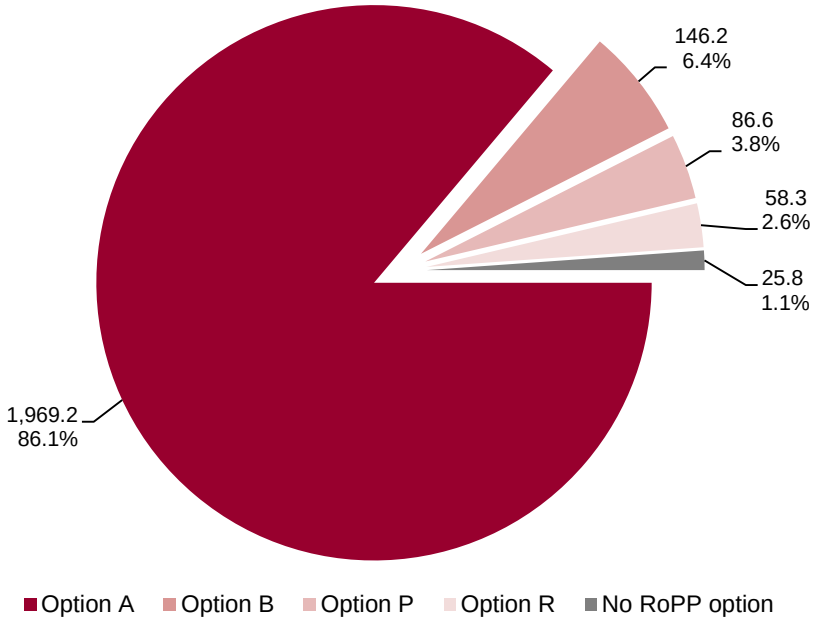
Figure 1A
Current right of private practice options in Queensland's public hospitals

Option (Policy no.)	Open to	Key aspects
	Assignment models	
A (B49)	All senior medical officers; excluding specialists and pathologists	An allowance is paid to the SMO and all private practice revenue is paid to the HHS. Fees charged by SMOs cannot exceed the schedule fee contained in the MBS.
A (B48)	All specialists including radiologists, excluding pathologists	An allowance is paid to the SMO and all private practice revenue is paid to the HHS. Fees charged by SMOs cannot exceed the schedule fee contained in the MBS without prior approval from the Director of Medical Services.
	Combined retention and revenue sharing models	
B (B48)	Specialists, excluding pathologists, who may be individuals, partnerships or companies	All private practice revenue is retained by the specialist up to an earnings cap, net of facility charges and administration fees paid to the HHS. After the cap is reached, one third is retained by the specialist and two thirds is paid to a Study, Education and Research Trust Account, available to all HHS personnel. Fees charged are set by the specialist.
R (B48)	Radiologists who may be individuals, partnerships or companies	The facility charges and administration fees paid to the HHS are half those in Option B with all other aspects remaining the same.
	Combined assignment and revenue sharing model	
P (B50)	Pathologists	An allowance is paid to the specialist and a portion of the private practice revenue is shared equally amongst all pathologists (net of facility charges and administration fees) with the balance paid to the Health Services Support Agency. Ten per cent of all private practice revenue is paid to the Study, Education and Research Trust Fund, available to HSSA personnel. Fees cannot exceed the schedule fee contained in the MBS.

Source: Queensland Health Policy documents B48, B49 and B50 effective from September 2012

Figure 1B shows the numbers and relative proportion of full time equivalent SMOs employed by Queensland Health in 2011–12 per RoPP scheme option.

Figure 1B
Full time equivalent SMOs per RoPP scheme option
2011–12



Note: 'No RoPP option' refers to non-specialist SMOs who did not receive the Option A allowance.

Source: QAO using data extracted from Queensland Health payroll system

In terms of the overall dollar value significance of the right of private practice arrangements, Figure 1C outlines the proportion of RoPP revenues and expenses in terms of Queensland Health's 2011–12 financial statements.

Figure 1C
Proportion of RoPP elements to Queensland Health financial results
2011–12

RoPP elements	Financial statement elements	Amount $ million	RoPP per cent
Revenue Net billing[1] $100.71 million	Hospital fees	620.66	16.2%
	User charges	901.46	11.2%
	Total revenue	11 325.07	0.9%
Expenditure Payments to SMOs[1] $231.79 million	Total SMO remuneration	874.45	26.5%
	Total employee benefits[2]	6 339.64	3.7%
	Total expenditure	11 314.75	2.0%

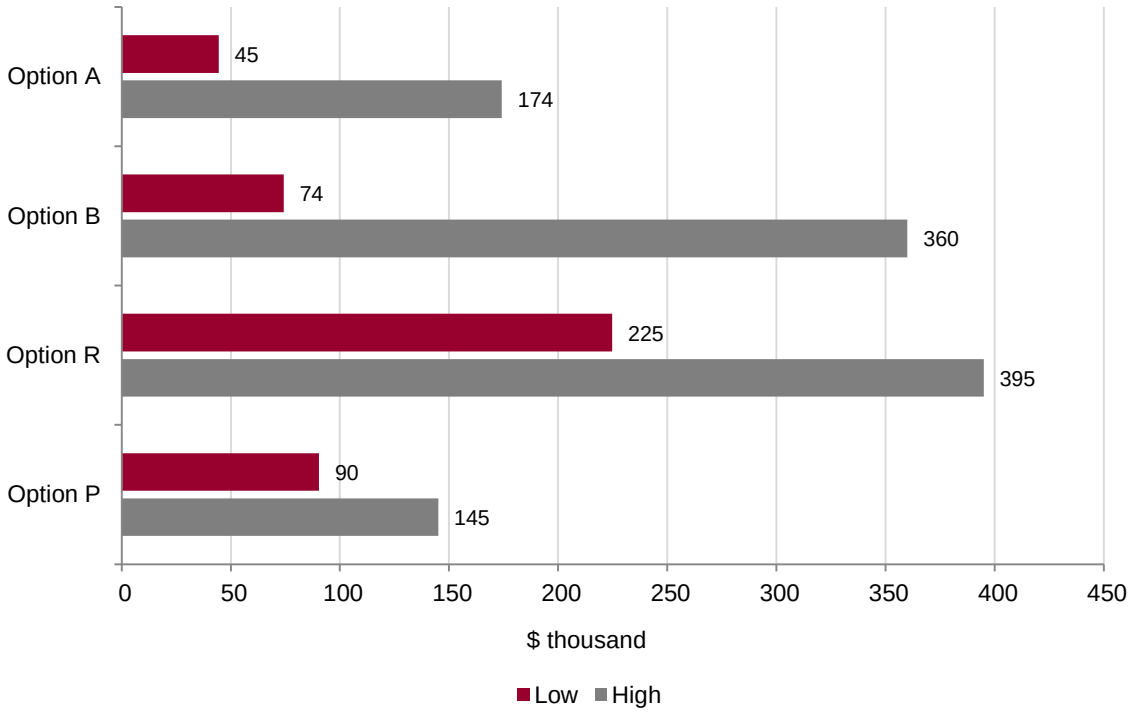
1 Refer to Figure 2F

2 Excludes annual leave expense and long service leave levy

Source: QAO using data extracted from Queensland Health payroll and billing systems, general ledger and annual report

Figure 1D shows the 2011–12 range of actual private practice payments to full time SMOs under each option. These payments are in addition to their base salaries, overtime and other allowances.

Figure 1D
RoPP actual payments range
2011–12



Source: QAO using data extracted from Queensland Health payroll and billing systems and general ledger

Rural arrangements

In the rural setting, Queensland Health employs a 'segregated' model in which a medical officer practises privately but is retained to provide limited public service. They practise in facilities of their choosing, though Queensland Health commonly provides a private practice facility.

These arrangements have been in operation since at least the 1970s. Under these arrangements, medical officers (medical superintendents and medical officers with a right of private practice) are engaged to perform a limited level of service in a public hospital (inpatient, ambulatory and emergency) but are required to be available for public service 24 hours a day, seven days a week, subject to a roster and prescribed rostered days off duty. With this limited engagement in public service, for which they are paid a salary, the medical officers conduct full private practice.

This report does not focus on this aspect of the scheme.

1.4.1 Evolution of the RoPP scheme in Queensland

Options B and R

Queensland's RoPP scheme has evolved over time, beginning for specialists in 1986 as a combined retention and revenue sharing model. This original scheme is now referred to as Option B. In 2006, Option R was introduced specifically for radiologists.

Figure 1E
Option B / R scheme changes since inception

Effective date	Revenue limits applied to SMOs' private practice income
1 July 1986	Earnings capped at 25% of Level 5 (of 10) classification under the Award for Senior Medical Staff—Public Hospitals, Queensland and the Queensland Radium Insitute In 1986 the earnings cap was $15 450 Earnings after reaching the cap is paid to the Study, Education and Research Trust Account (SERTA)
1 January 1988[1]	Earnings cap increased to 35% of newly created C3–2 salary level In 1988 the earnings cap was $28 278
Circa 1 January 1992[2]	Earnings cap increased to 50% of C3–2 salary level In 1992 the earnings cap was $43 899
1 July 1995[3]	SERTA payments amended; two-thirds after reaching the earnings cap is paid to SERTA In 1995, the earnings cap was $44 107 (salary band converted to MO1–7 by this time)
1 July 2001	Part time specialists became eligible to access the RoPP scheme
1 July 2002	Earnings cap increased to 100% of MO1–7 In 2002 the earnings cap was $96 750
1 January 2006	Earnings cap increased to a combined value of 100% of MO1–7 and the professional development allowance (approximately $20 000); indexed with enterprise bargaining agreements (EBA) increase of 4.0% In 2006 the earnings cap was $160 000 Option R established for radiologists
1 July 2007	Earnings cap annual ceiling increased to $166 400 (indexed with EBA increase: 4.0%)
1 July 2008	Earnings cap annual ceiling increased to $173 056 (indexed with EBA increase: 4.0%)
1 July 2010	Earnings cap annual ceiling increased to $180 846 (indexed with EBA increase: 4.5%)
1 July 2011	Earnings cap annual ceiling increased to $191 318

1 Circular 88/50, Queensland Health

2 Cabinet submission number 02057, decision 02152, 1 July 1992

3 Cabinet submission number 2747, decision 3410, 1 July 2002

Source: QAO based on Queensland Health Policy B48

Options A and P

An 'assignment' model was first introduced in 1992 with the major feature that SMOs are paid an allowance and all private practice revenues are assigned to the HHSs. This scheme is now referred to as Option A. In 2000, Option P was introduced for pathologists.

Figure 1F
Option A / P scheme changes since inception

Effective date	Allowances paid to SMOs
1 July 1992	Allowance based on individual base salary: • 17.5% for metropolitan hospitals (including Redcliffe, Logan, Ipswich and Caboolture) • 22.5% for non-metropolitan hospitals In 1992 base salaries ranged between $67 459 and $99 554
1 July 1995	Allowance based on individual base salary increased to: • 35% for metropolitan hospitals (including Redcliffe, Logan, Ipswich and Caboolture) • 45% for non-metropolitan hospitals In 1995 base salaries ranged between $69 990 and $93 604
1 July 1995	Access granted to part time specialists
1 July 2000	Option P established for pathologists only Pathologists receive the Option A allowance and their share of the incentive pool Billing revenue allocated in the following proportions: • 60% paid to the Health Services Support Agency as a facility charge and administration fee • 20% paid to the Health Services Support Agency to fund the Option A allowance • 5% shared between pathologists statewide as an incentive pool payment • 15% contributed to Study, Education and Research Trust Fund (SERTF)
1 August 2002	35% for specialists employed at Gold Coast and Sunshine Coast hospitals
1 July 2003	Option P incentive pool increased to 10% and the SERTF revenue decreased to 10%; no financial impact on Queensland Health
8 September 2005	Cabinet approved incorporation of 50% of the Northside Pathology license fee into the Option P incentive pool
1 January 2006	Specific areas established: Area 1—Brisbane, Gold Coast and Sunshine Coast Area 2—Toowoomba, Cairns and Townsville Area 3—all locations not included in Areas 1, 2 or 4 Area 4—Torres Strait–Northern Peninsula, Cape York and North West Hospital and Health Services
	Specialists (including public health specialists) and medical superintendents receive allowance percentages for Options A and P on individual base salary as follows: Area 1—50%; Area 2—55%; Area 3—60%; Area 4—65%
	Medical officers (classification levels C1, C2 and C3) and medical superintendents, public service medical officers and contract medical officers receive allowance percentages for Option A on individual base salary as follows: Area 1—35%; Area 2—40%; Area 3—45%; Area 4—50%

Source: QAO based on Queensland Health Policies B48, B49 and B50

1.4.2 RoPP roles and responsibilities

The RoPP policy documents issued by Queensland Health outline who is responsible for oversight and administration of the RoPP scheme.

At the system level, RoPP policies outline the role of the Private Practice Management Committee (PPMC) to:

- develop, implement and manage Queensland Health's private practice arrangements
- oversee the administration of and provide advice on current private practice arrangements operating at the HHS level
- undertake reviews and offer recommendations to the Director-General, Queensland Health on enhancements to private practice arrangements.

For options A, B and R (Policy B48 and B49) the Director of Medical Services at each hospital is responsible for managing the RoPP scheme and is accountable to the HHS chief executive (or delegate) for its efficient management and financial aspects.

Under Option P (Policy B50), the chief executive of the business unit—the Health Services Support Agency (HSSA)—reports to the Director-General of Queensland Health and is responsible for managing pathologists providing private practice services. The Pathology Private Practice Review Sub Committee (PPPRSC) has wide-ranging advice and oversight responsibilities including:

- monitoring total revenues, costs and the appropriateness of disbursement of funds
- providing the HSSA chief executive with an annual report on the activity of the private practice scheme.

1.4.3 RoPP objectives

The original RoPP arrangement, implemented in 1986 in public hospitals, was designed to serve two purposes:

- to attract and retain SMOs that would otherwise be lost to the public hospital system by enhancing their remuneration arrangements
- to generate additional revenue for the hospital.

The subsequent option (Option A), introduced in 1992, modified the order of these two objectives, placing greater emphasis on revenue generation, as follows:

- to capture more privately-insured patients in a cost neutral manner
- to assist in the recruitment and retention of full time specialist staff in the public hospital system.

As Option A SMOs equate to 1 969 full time equivalents (86.1 per cent of all SMOs) in 2011–12, references in this report to 'the primary objective of the RoPP scheme' refer to the Option A perspective and its objectives from 1992.

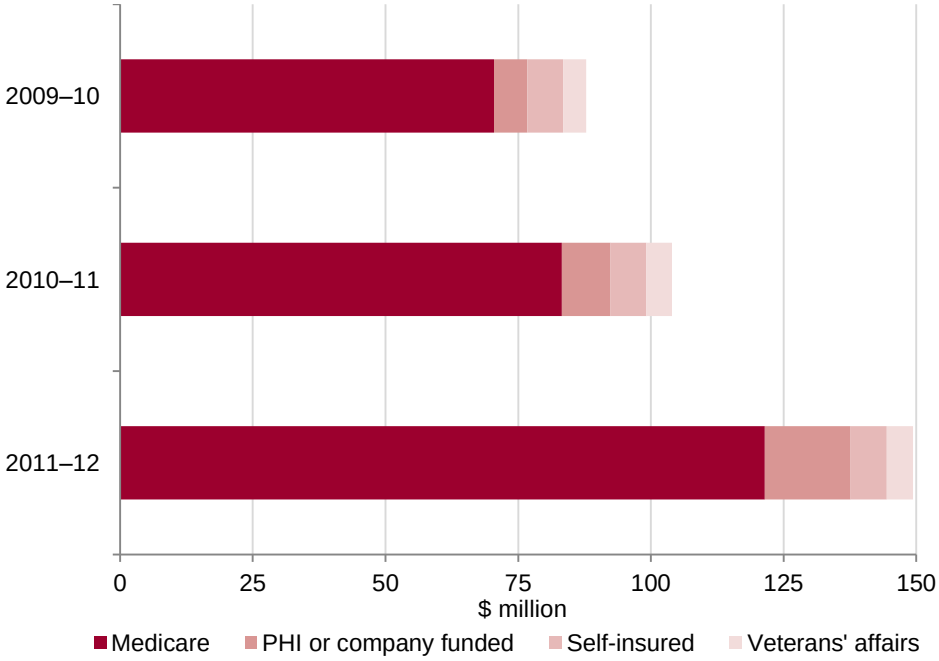
Generating professional medical services revenue

HHSs have two major sources of revenue: contributions from the Australian and state governments under the NHA to fund public hospital services directly and 'own-sourced' revenue earned by each HHS, including revenue from private practice arrangements.

Figure 1G shows the sources of major professional medical services revenue (private practice revenue) between 2009–10 and 2011–12 for inpatients and outpatients combined.

It shows that private practice revenue has grown by around 70 per cent in this period from $87.81 million to $149.41 million. The growth in private practice revenue is attributable to increased revenue capture from existing patients electing to use private health insurance and through the introduction of bulk billing for outpatient and diagnostic services. It is not the result of substantial increases in the level of clinical activity. The relative contribution attributed to Medicare benefits has stayed roughly the same, at just over 80 per cent of total private practice revenues; but there has been a shift away from self-insurance to private health insurance, which accounted for around 11 per cent of these revenues in 2011–12, up from approximately 7 per cent in 2009–10.

Figure 1G
Growth in private practice revenue
2009–10 to 2011–12



Source: QAO using data from Queensland Health billing system

Granting SMOs the ability to treat private patients in a public hospital enables hospitals to raise additional revenue for items such as overnight bed fees. Generating this additional revenue, however, incurs further costs, including:

- a subsidy for bed fees which represents the difference between the bed fee revenue rates approved by directive, compared to the cost of providing the accommodation—the revenue derived from bed fees in 2011–12 was $105.22 million while the approximate cost, based on Queensland achieving the National Efficient Price, is $129.02 million, resulting in a subsidy of $23.80 million
- meeting the costs of an inpatient's front end deductibles (patient's private health insurance excess or co-contribution) and ancillary costs—the discounting of front end deductibles represented $3.75 million in 2011–12, an increase of $2.11 million over the previous year.

In this report, we have excluded these revenues and expenses as they do not form part of the private practice revenue billed by SMOs exercising a right of private practice. Our report also excludes revenue generated in sites exempted under s19(2) of the HIA, as outlined in Appendix E of this report. Billing in these sites is not contingent on SMOs being granted a right of private practice.

1.5 National Health Reform Agreement

Some of the funding reforms in the NHRA will have implications for rights of private practice of SMOs employed by Queensland Health.

The NHRA:

- maintains existing federal funding for public hospital services in 2013–14
- provides indexation and growth payments for eligible services based on National Efficient Prices (NEP) from 2014–15.

Under a determination by the Independent Hospital Pricing Authority (IHPA), private inpatients receive a lower National Weighted Activity Unit (NWAU) than public inpatients (known as discounting). A NWAU is a standard unit of activity around which all hospital activity is based and for which the NEP is paid. Very intensive and expensive activities are worth multiple NWAUs whereas simple and inexpensive activities are worth fractions of NWAUs.

Outpatient services with a component of MBS or PBS funding are not eligible under the new funding system of indexation or growth payments.

The IHPA continues to refine its pricing models for both 2012–13 and 2013–14 in readiness for transition to the new funding system.

Under the new funding model, the price of a service provided in Queensland—as in all jurisdictions—is compared to the NEP. The model does make higher payments for regional and remote health services and for Aboriginal and Torres Strait Islander patients. If Queensland payments to SMOs through mechanisms such as the RoPP scheme result in service costs that are higher than the NEP, the state must fund the difference.

The implications of the new funding arrangements with the Commonwealth are still in development and the IHPA is still resolving a number of technical issues. The discounts and exclusions to activity counting used with private services will affect Commonwealth payments directly. Well integrated systems that allow active monitoring and oversight of the level of clinical activity, including the identification of private services, provide the platform to ensure that all possible funding is received.

1.6 Audit objective, method and cost

The objective of this audit was to determine whether the RoPP arrangement in the public health system is achieving its intended public health outcomes in a financially sustainable manner.

In conducting the audit, we pursued three lines of inquiry to determine if:

- the intended health and financial benefits of the scheme are being realised
- the scheme is being administered efficiently
- practitioners are participating in the scheme with probity and propriety and in full compliance with their contractual conditions.

This report focuses on the first two lines of inquiry. The third line of inquiry will be included in a future report to Parliament.

The audit was conducted in accordance with the Auditor-General of Queensland Auditing Standards, which incorporate Australian Auditing and Assurance Standards.

The cost of the audit as at 28 June 2013 was $982 000.

1.7 Structure of the report

The findings in this report are structured as follows:

- Chapter 2 Scheme outcomes
- Chapter 3 Scheme design and oversight
- Chapter 4 The scheme in operation.

All analysis in this report is based on data that has been extracted from Queensland Health systems and matched as outlined in Appendix C. Payroll data was integral to the analysis in this report and was only available in a consistent format from the first pay period in July 2003. Consequently, analysis in this report commences in the 2003–04 financial year.

We have not audited the data provided to us in the course of this audit but have performed high level comparisons for reasonableness.

All graphs are presented in financial years unless otherwise stated.

2 Scheme outcomes

In brief

Background

The Queensland right of private practice (RoPP) scheme was approved to capture privately insured patients receiving treatment as public patients in a cost neutral manner; and additionally to assist in the recruitment and retention of full time specialist staff in the public hospital system.

Public patients were not to be affected adversely by the introduction of scheme options.

Conclusions

The number of senior medical officers (SMOs) recruited and retained has increased significantly. However, in the absence of clear targets aligned to patient demand, Queensland Health cannot demonstrate if it has 'over achieved', has the right numbers or still needs to recruit more SMOs.

In increasing the number of SMOs, little regard has been given to managing the cost consequences or to monitoring whether patient outcomes have been equitable.

Key findings

- The number of full time equivalent SMOs has increased by 1 262 (123.3 per cent) between 2003–04 and 2011–12, but Queensland Health has not determined the optimal number of SMOs.
- The scheme's cumulative shortfall over the past nine years is $804.24 million, comprising direct costs of $752.47 million and indirect costs of $51.77 million; Option A has contributed $725.69 million to this shortfall.
- The predominant increase to overall SMO earnings has been an increase in average RoPP earnings of 146.0 per cent, brought about by changes to the scheme in 2006.
- The scheme has not attracted significant patient activity away from the private sector.
- There is prima facie evidence that private patients get priority for category 2 elective surgery at some Hospital and Health Services; this is not being monitored.

Recommendations

It is recommended that Queensland Health and Hospital and Health Services:

1. **redesign private practice arrangements to incentivise practitioners so the scheme is financially sustainable**
2. **establish clear targets for the optimal medical workforce in the context of desired clinical, patient access and financial outcomes.**

2.1 Background

The right of private practice (RoPP) scheme was introduced to capture private patient income and aid in recruiting and retaining senior medical officers. Operation of the scheme was expected to be cost neutral.

The original scheme identified several potential benefits, the main ones being:

- for patients—a wider range of specialist treatment and the ability to choose specialists
- for hospitals—additional source of funds for study, education, research and equipment and access to private patient income not previously captured
- for specialists—additional remuneration and enhanced professional standing and satisfaction.

2.2 Conclusions

The RoPP scheme provides direct benefits to senior medical officers (SMOs) and has brought significant improvements to their overall remuneration. To this end, RoPP has boosted SMO numbers in Queensland Health and stemmed SMO losses to the private sector and to other Australian states and territories.

The increased numbers of SMOs mean patients have greater access to services in public hospitals and choice in electing private treatment. In return, Queensland Health receives revenue. However, private practice revenue generated by the RoPP scheme falls far short of that envisaged or approved by government.

Far from being cost-neutral, the trade-off for increasing the numbers of SMOs in public hospitals has been a net cost to the state of more than $804.24 million over the last nine years.

While the original right of private practice (now known as Option B) had the primary objective of recruitment and retention of medical practitioners into the public health system, over time, this has become the major focus of the scheme at the expense of the cost neutrality objective. Subsequent changes to scheme options and the way they are administered to this day bear this out.

Tying the remuneration of SMOs and the revenues of Hospital and Health Services (HHSs) to a patient election creates an inherent conflict of interest; one risk being that those who elect to be treated privately will receive preferential treatment compared to those who are treated as public patients. There is prima facie evidence, with regard to category 2 elective surgery wait times, that this is occurring at some HHSs.

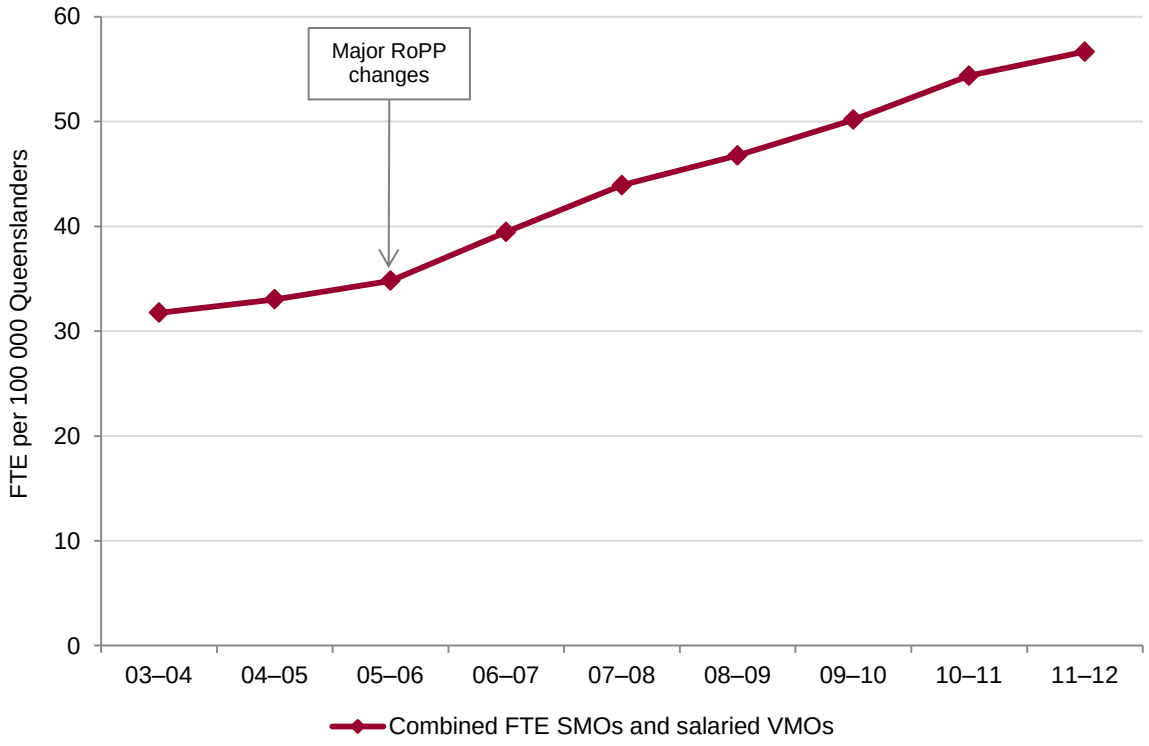
2.3 Recruitment and retention

The RoPP scheme was introduced to aid in recruiting and retaining SMOs in a cost neutral manner. Medical practitioners and administrators maintain that RoPP is a key component of the recruitment and retention strategy.

Figure 2A shows the rate of growth in the combined senior medical workforce (full time equivalent SMOs and Visiting Medical Officers (VMOs)) has outpaced the rate of population growth in Queensland. This means there are more SMOs and VMOs combined per head of population in 2011–12 than there were in 2003–04, providing increased access to practitioners for the public and an increased capacity in the health system to treat more patients.

The ratio of SMOs and VMOs per 100 000 Queensland residents has improved over the last nine years from 31.7 to 56.6 in 2011–12.

Figure 2A
SMOs and salaried VMOs (combined) (full time equivalent) per 100 000 Queenslanders 2003–04 to 2011–12



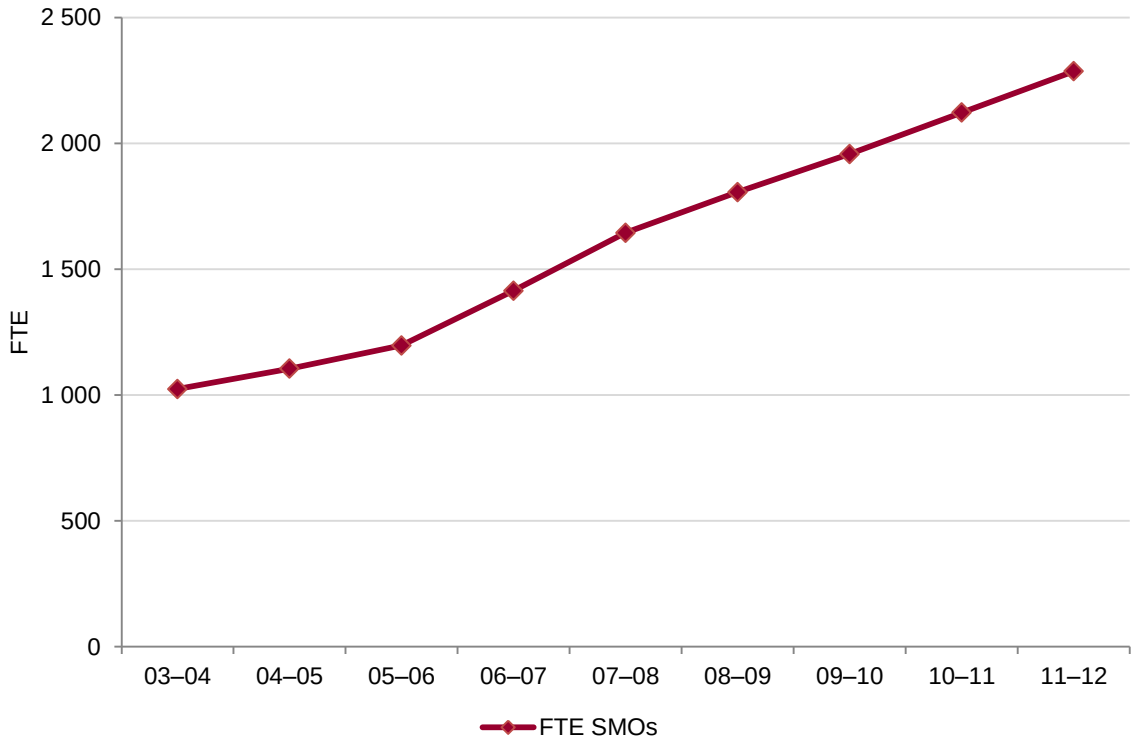
Note: Salaried VMOs paid through the payroll system are included; contracted VMOs paid through the finance system are not included.

Source: QAO using data extracted from Queensland Health payroll system and population estimates from the Office of Economic and Statistical Research

In 2011–12, there were 297 salaried full time equivalent VMOs which comprised 11.5 per cent of the combined full time equivalent SMOs and salaried VMOs working in Queensland public hospitals. Due to the manner in which contracted VMOs are paid, Queensland Health was unable to quantify the number of full time equivalent contracted VMOs.

For SMOs only, there were 1 262 more full time equivalents working in Queensland public hospitals at the end of June 2012 than in 2003–04. This represents an increase of 123.3 per cent, from 1 024 to 2 286 SMOs. Figure 2B shows the growth in SMOs over the past nine years.

Figure 2B
Growth in SMOs (full time equivalent)
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

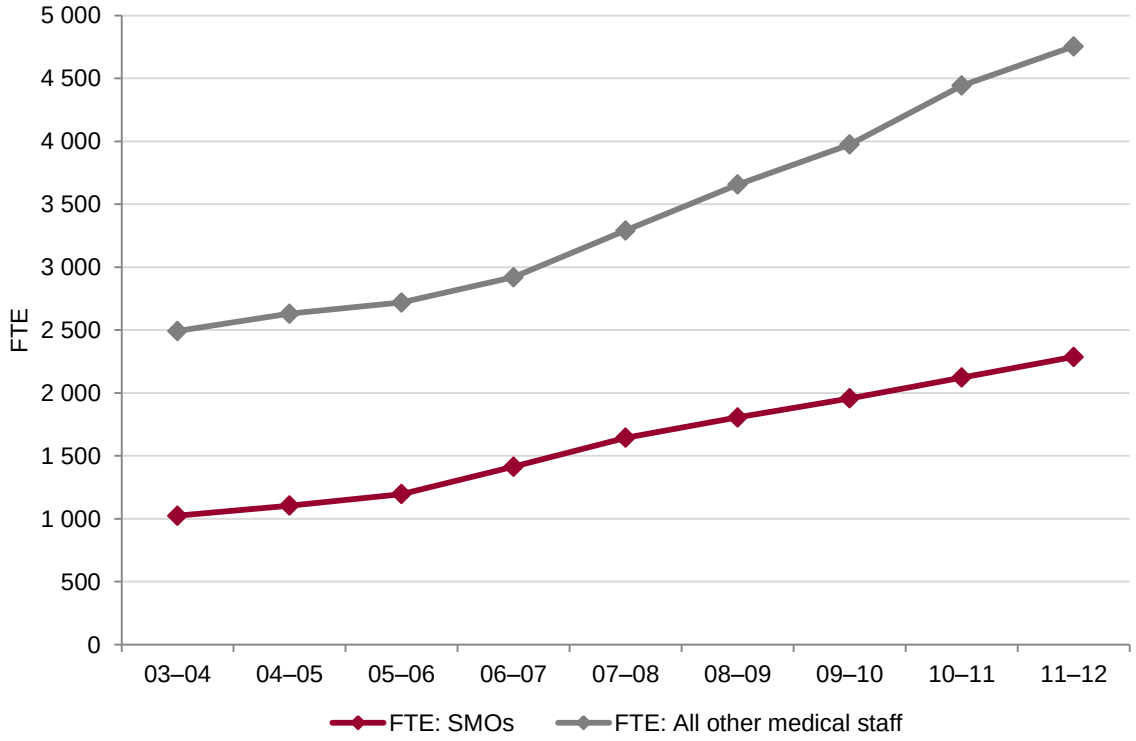
The sustained increase in the supply of SMOs is evidence that the RoPP scheme has aided in recruitment. However, as Queensland Health did not establish targets, such as the optimal ratio of SMOs per Queenslander, the department is unable to determine if it has over achieved, has the right number or still needs to recruit more SMOs.

The rate of growth in SMOs has been slightly lower in regional hospitals. Over the period 2003–04 to 2011–12, regional SMO numbers have increased by 218.0 per cent, while in south-east Queensland, the increase was 226.4 per cent. Appendix G has further details on metropolitan versus regional growth in SMOs.

Queensland medical graduates have also increased at a sustained rate since the 2005 calendar year. Appendix H has further details on medical graduate growth.

Figures 2C shows the rate of growth in the SMO workforce compared to the rest of the public medical workforce. Since 2006–07, the rate of growth between the two has been equivalent, indicating that the growth in health budgets, not just RoPP, has contributed to increased growth in the medical workforce.

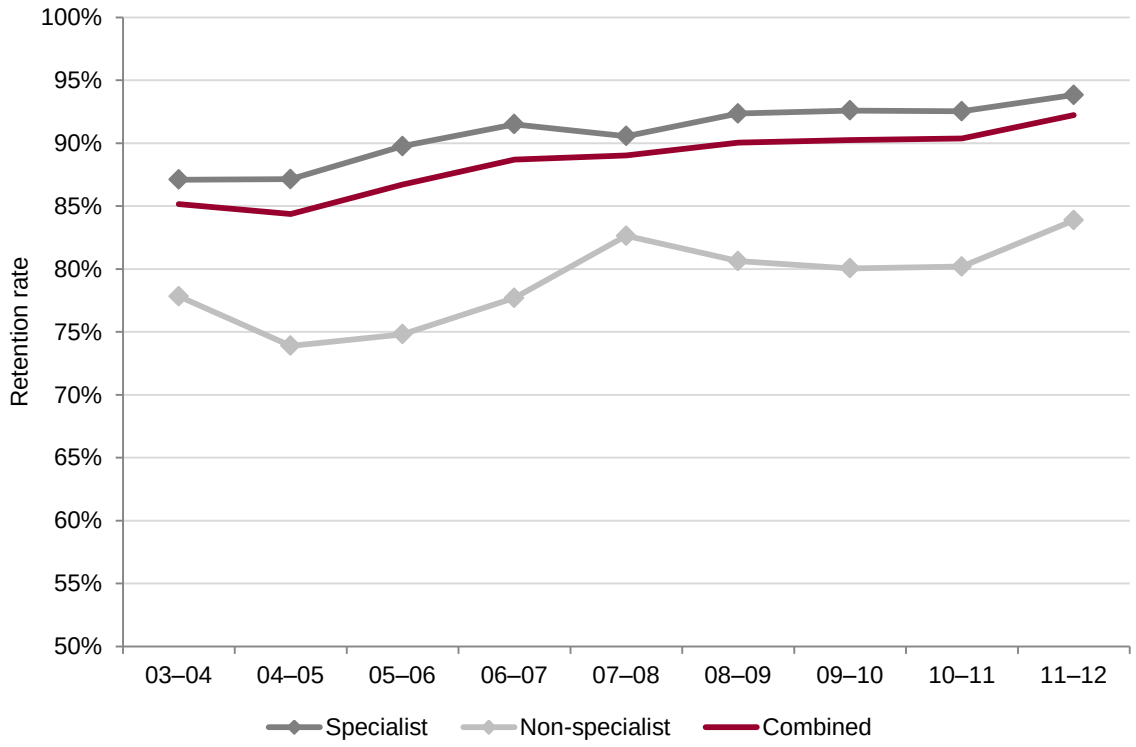
Figure 2C
Growth in SMOs vs public medical workforce (full time equivalent)
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

Improved retention rates have been a contributing factor to the overall growth in SMO numbers. Figure 2D shows that retention rates have improved by 8.3 per cent over the last nine years. This is particularly evident from 2005–06 when the scheme was extended to include non-specialists.

Figure 2D
Retention rate of SMOs
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

Prior to major RoPP changes in 2005–06, the *2005 Health Action Plan* implemented a variety of mechanisms to boost the medical workforce through improved remuneration and other changes to workplace conditions.

The attractiveness of Queensland Health as an employer for SMOs was enhanced through significant changes to the industrial environment in 2005–06, including:

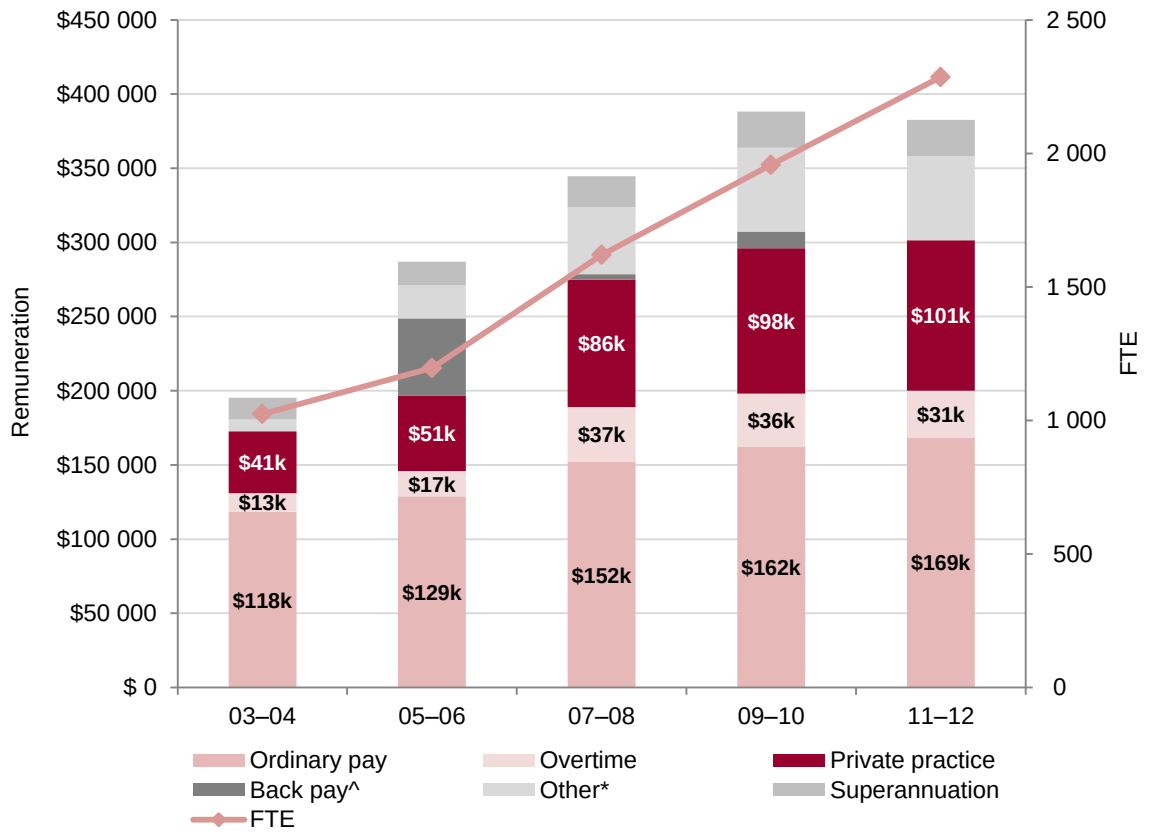
- changes to the industrial award
- conditions within the new Medical Officers' (Queensland Health) Certified Agreement (No. 1) 2005 (MOCA 1)
- changes to the policies governing private practice.

These changes included:

- the ability for SMOs to complete a full time workload of 40 hours a week over four days
- improved allowance provisions for practitioners in relation to overtime, professional development, and motor vehicles; for example, a professional development allowance up to $20 000 plus 3.6 weeks of professional development leave and a car allowance up to $24 500 was provided.

Figure 2E shows the average total remuneration for SMOs, including base salaries, RoPP income and other benefits (such as the allowance provisions and overtime).

Figure 2E
Average total remuneration per full time equivalent SMO (nominal $)
2003–04 to 2011–12



^ Back pay includes adjustments for MOCA 1 (2005–06), MOCA 2 (2009–10) and late pay adjustments

* Other pay includes termination pay and allowance payments. However due to the manner in which the professional development allowance (paid on a reimbursement basis) and car benefit / allowance were provided, they have not been captured prior to 2005–06.

Source: QAO using data extracted from Queensland Health payroll and billing systems

Broadly, the rate of growth in SMOs, especially after major RoPP changes in 2005–06, is positively correlated with the overall increase in their average total remuneration. The average RoPP income has increased by 146.0 per cent between 2003–04 and 2011–12.

Average total remuneration for an SMO increased by approximately 86 per cent since 2003–04 (excluding the car entitlement from 2011–12 figures), compared to an approximate 51 per cent increase in the full time adult cash earnings in the public sector for Queensland.

2.4 Cost neutrality

The original scheme (now Option B) was approved on the basis of cost neutrality, with the facility charges and administration fees intended to recover the costs incurred by the public hospital system in treating private patients.

Facility charges were intended to cover the costs of:

- administration
- technical nursing, clerical and secretarial staff support
- consumables
- use of hospital facilities
- use of hospital equipment including some capital cost component.

Administration fees were set to fund the costs associated with:

- raising accounts
- collecting fees
- disbursing collections
- issuing reports to SMOs, hospitals and Queensland Health.

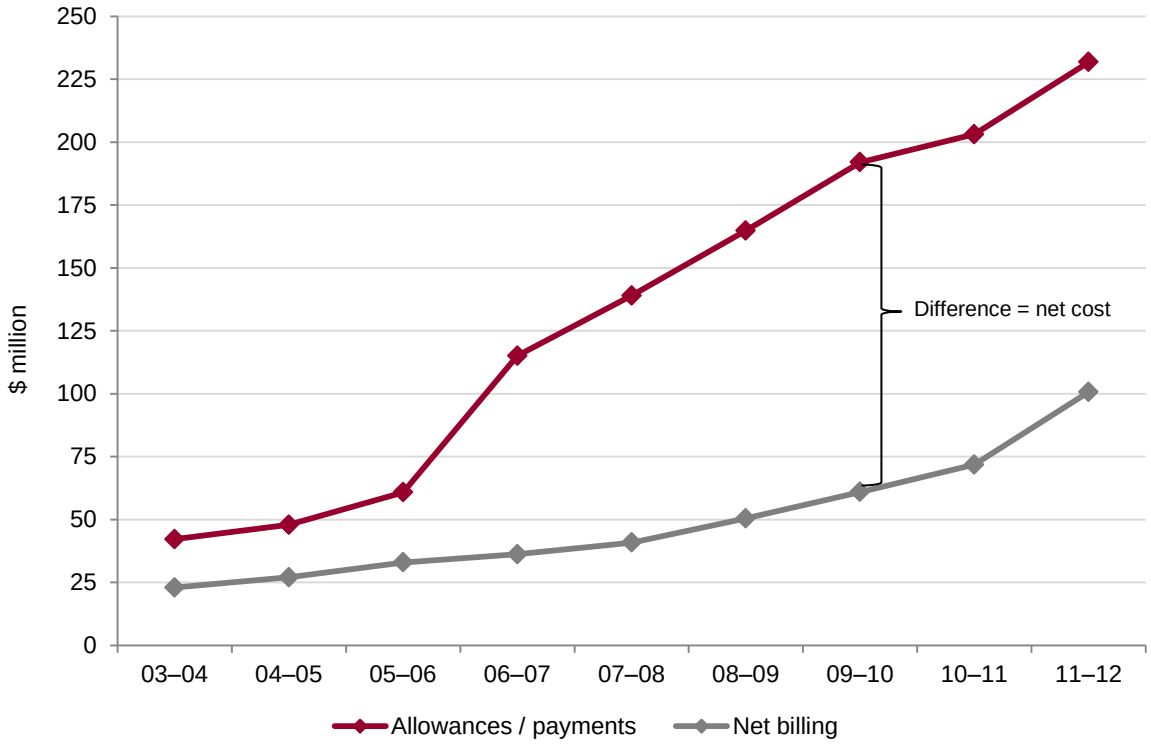
Option A was approved on the basis that it was to capture more revenue from privately insured patients which would supplement hospital budgets and be redirected to increasing and improving services.

Figure 2F shows the relationship between private practice net billing revenue and the allowances and payments made to SMOs under the scheme. It illustrates a significant and widening disparity between the net billing revenues generated by SMOs and the direct cost of payments to SMOs participating in Options A, B, R and P. It shows that the scheme has not been cost neutral throughout the period 2003–04 to 2011–12.

From 2003–04 to 2011–12, the cumulative effect of the shortfall between payments to SMOs and net billing revenue generated was $752.47 million (net of study, education and research trust account / fund (SERTA / SERTF) contributions and GST).

For 2011–12, Queensland Health paid $231.79 million to SMOs. Net billings from private practice were $100.71 million, leaving a shortfall of $131.08 million (net of SERTA or SERTF contributions and GST).

Figure 2F
RoPP revenue vs allowances and payments—combined A, B, R and P options
2003–04 to 2011–12



Notes: the cost and revenue associated with bed fees and prosthetics that are billed by the hospital are excluded from this analysis as these do not form part of the professional medical services that are billed by participating SMOs. Facility charges and administrative fees have also been excluded on the assumption that they cover the costs of facilities and administration as intended and are unavailable for payments to SMOs.

Source: QAO using data extracted from Queensland Health payroll and billing systems and general ledger

Option A accounts for 96.4 per cent of the scheme's direct cumulative shortfall over the last nine years. The Option A scheme has the highest net cost, with revenues over 2003–04 to 2011–12 averaging 21.6 per cent of payments to SMOs.

For Option P, revenues averaged 72.3 per cent of payments to SMOs. By contrast, for Options B and R—the options used by significantly fewer SMOs—revenues exceed direct cost, with the balance paid into SERTA. Figure 2G shows the relative contribution of each scheme option to the overall net cost.

Figure 2G
Revenues and costs of the scheme
2003–04 to 2011–12

RoPP Option	FTE[1] 2011–12	Net billings[2] $ m	Payments to SMOs $ m	SERTA / SERTF[3] $ m	(Deficit) $ m
A	1 969.2	200.00	(925.69)	—	(725.69)
B / R	204.4	272.01	(212.03)	(59.98)	—
P	86.6	42.64	(58.99)	(10.43)	(26.78)
Total	**2 260.2**	**514.65**	**(1 196.71)**	**(70.41)**	**(752.47)**

1. Excludes non-specialists who did not receive an Option A allowance
2. Net billings = Gross billings less facility charges and administration fees (where charged)
3. Restricted funds for study, education and research available to all HHS or Health Service Support Agency (HSSA) personnel

Source: QAO using data extracted from Queensland Health payroll and billing systems and general ledger

2.4.1 Scheme outcomes by option

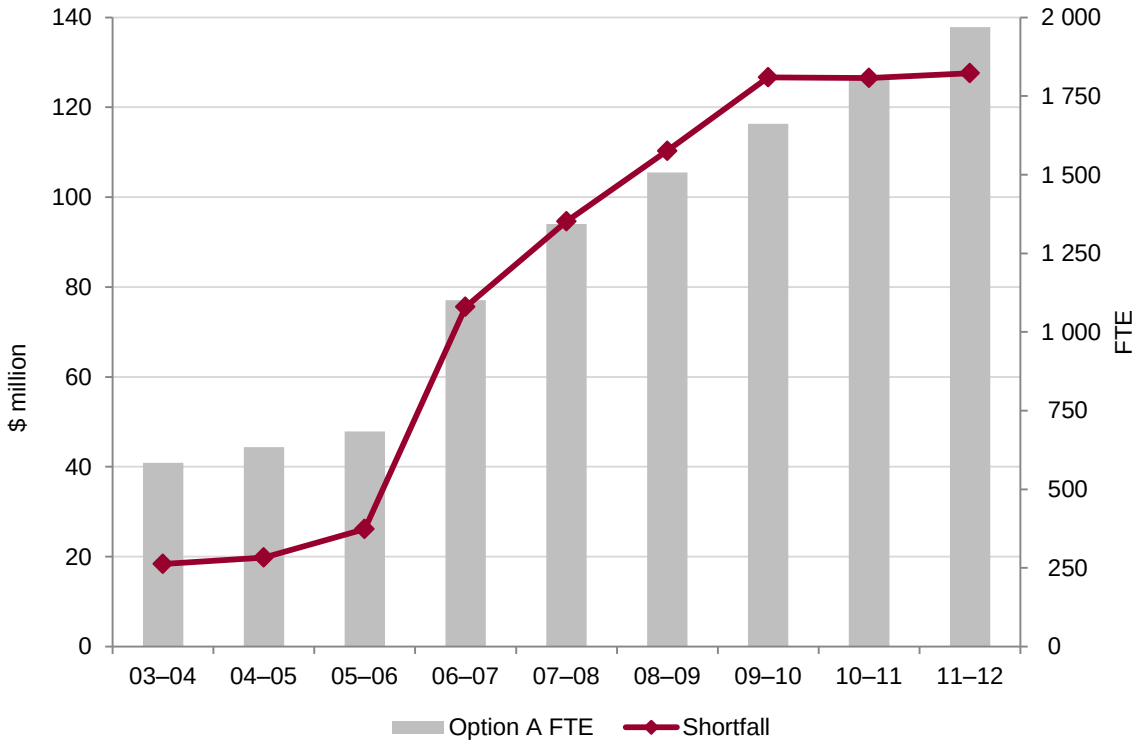
Option A

Figure 2H shows that Option A has resulted in year on year growth in annual shortfalls, reaching a peak of $127.58 million in 2011–12 (nine year cumulative shortfall of $725.69 million).

Since the major scheme changes in 2005–06, the number of full time equivalent SMOs increased by 1 285 (187.9 per cent) to 2011–12. As there is no relationship between the allowance paid and the revenue generated, the growth in full time equivalent SMOs exacerbated the shortfalls through to 2009–10. In subsequent years, increased billing revenue has stabilised the shortfalls, despite continued growth in full time equivalent SMOs.

How Option A works:
An allowance is paid to the SMO; all private practice income is paid to the HHS. Patient fees charged by the SMO cannot exceed the schedule fee contained in the MBS.

Figure 2H
Option A shortfall vs full time equivalent growth
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll and billing systems

Emergency department extended hours benefit

Typically, emergency department SMOs elect Option A. They are required to work 'extended rostered hours' and sign a contract which defines this as:

> *"…with respect to the hours of operation of an emergency department, when 'Senior Medical Officers' rostered ordinary hours coverage is provided in accordance with the Certified Agreement at least from 8:00am until 10:00pm Monday to Friday and weekend coverage."*

Since 2005–06, in exchange for working under these conditions, emergency department SMOs receive an additional 25 per cent allowance, provided they elect to participate in Option A; for example, an emergency department SMO in a metropolitan area receives the base Option A allowance of 50 per cent plus 25 per cent: a total allowance of 75 per cent.

The value of the additional 25 per cent allowance for eligible SMOs is estimated at $11.15 million in 2011–12 (an average of $41 361 per full time equivalent SMO) and $46.00 million since its introduction in 2005–06. The increase in emergency department SMOs between 2004–05 and 2011–12 was 155.4 full time equivalents, growing 24.0 per cent quicker than the general cohort of SMOs. The combination of a higher level of entitlement and faster growth has further contributed to the Option A shortfall.

Options B and R

Both Options B and R are cost neutral by design in that an SMO receives a percentage of the billing revenue after deducting the facility charges and administration fees. Cost neutrality assumes that charges and fees adequately cover their costs.

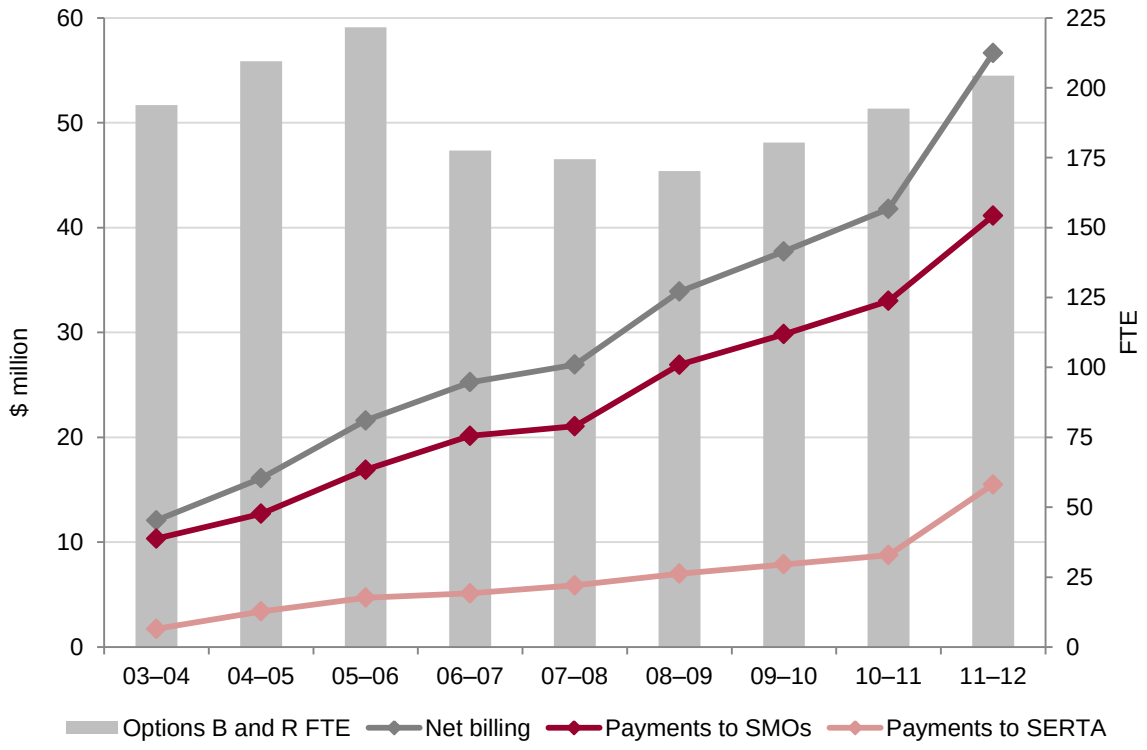
Figure 2I shows the number of participants against the net billing and how this is split between the SMOs and SERTA. The scheme has been successful in increasing the level of billing year on year, despite a drop of 51 full time equivalent SMOs (23.2 per cent) between 2005–06 and 2008–09. Between 2008–09 and 2011–12, there has been an increase of 34 full time equivalent SMOs (20.0 per cent).

How Option B works:
All private practice income is retained by the specialist up to an earnings cap; net of facility charges and administration fees paid to the HHS. After the cap is reached, one third is retained by the specialist and two thirds is paid to a SERTA. Fees charged are set by the specialist.

How Option R works:
As per Option B but the facility charges and administration fees are halved.

This growth in billing has, in turn, increased the private practice income paid to SMOs by $24.23 million (143.4 per cent) between 2005–06 and 2011–12.

Figure 2I
Options B and R combined–net billing vs full time equivalent SMO growth 2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll and billing systems and general ledger

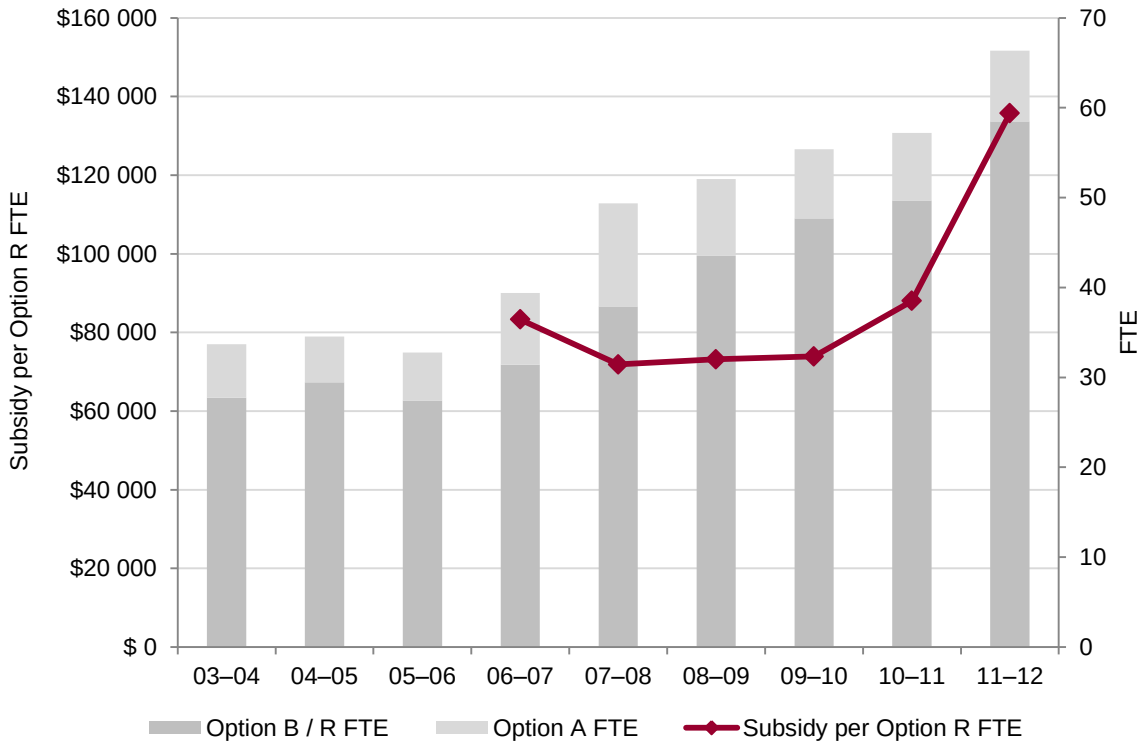
Option R discount on facility charges and administration fees

The 50 per cent discount on facility charges and administration fees for Option R equates to $7.88 million in 2011–12 and $23.92 million between its introduction in 2005–06 and 2011–12. These funds would otherwise have flowed to the hospital for their direct use. This discount is estimated at $135 000 per Option R SMO in 2011–12.

Based on the 2011–12 data we estimate that, if the discount was unwound, Option R SMOs collectively would receive $3.15 million (40 per cent) less per annum and SERTA would receive $4.73 million (60 per cent) less per annum.

Figure 2J shows the split of radiologists between Option R (and B prior to 2005–06) and Option A; it also outlines the average subsidy per Option R radiologist. The graph illustrates that, between 2003–04 and 2011–12, the number of full time equivalent radiologists in Option R (or B) increased from 27 to 59, while the growth in radiologists electing Option A is negligible. The average Option R subsidy per full time equivalent radiologist has grown by approximately $52 000 since being introduced in 2005–06, in line with the increased billing by radiologists.

Figure 2J
Option R subsidy vs full time equivalent radiologist growth
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll and billing systems

Option P

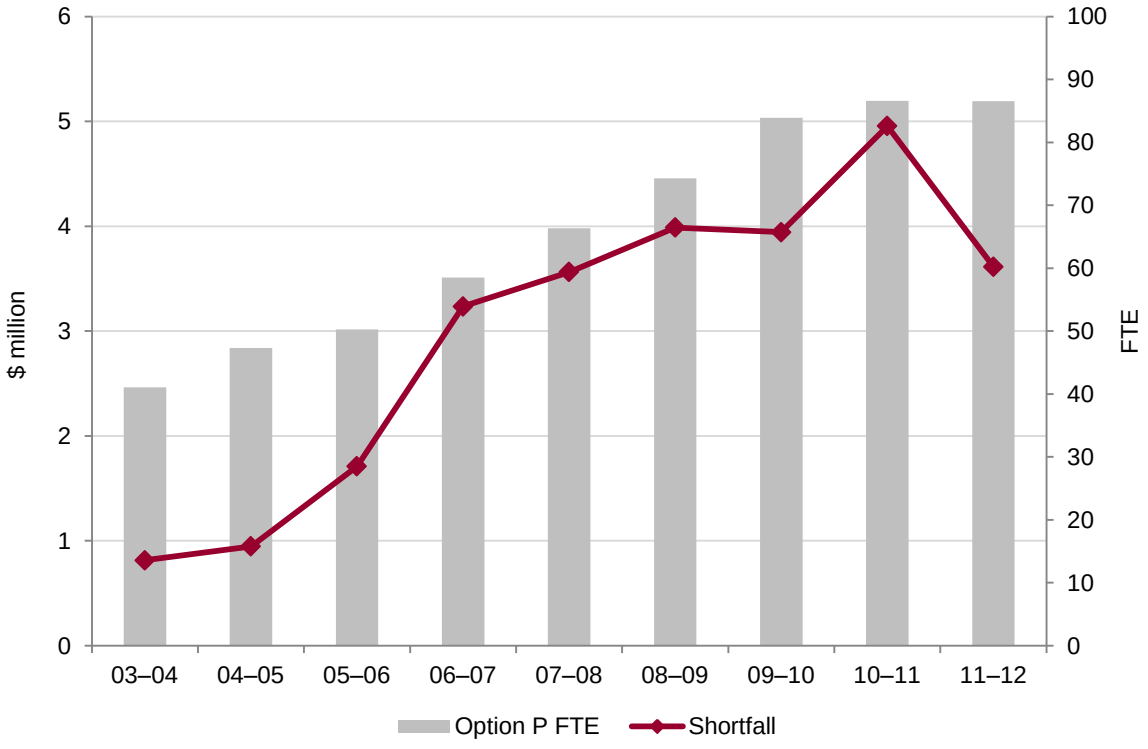
Although Option P is designed to be more financially viable than Option A due to its mix of allowance and incentives, it has generated cumulative losses of $26.78 million over the nine years to 30 June 2012.

The incentive pool is based on a percentage of private practice billings (currently 10 per cent) and is shared between all pathologists. Over the last nine years to 30 June 2012, the incentive pool payments have grown per full time equivalent pathologist from a low of $14 968 in 2004–05 to a high of $24 687 in 2010–11 ($24 526 in 2011–12).

How Option P works:
An allowance is paid to the specialist and a portion of the private practice revenue is shared equally amongst all pathologists (net of facility charges and administration fees) with the balance paid to the HSSA. Ten per cent of all private practice income is paid to the SERTF, available to HSSA personnel. Fees cannot exceed the schedule fee contained in the MBS.

Figure 2K shows that Option P has grown by 46 full time equivalent pathologists (110.7 per cent) over the nine years to 30 June 2012, while accumulating deficits of $26.78 million. The annual deficit peaked in 2010–11 at $4.96 million, but improved by $1.34 million (27.1 per cent) to a deficit of $3.61 million for 2011–12. The decrease in the deficit is due to improved billing practices. While full time equivalent pathologists remained constant from 2010–11 to 2011–12, the average billing per pathologist has increased by $65 366 (34.3 per cent). Since 2004–05, billing has increased by $15.23 million or 220.8 per cent (average billing per pathologist has improved by $109 935 or 75.4 per cent).

Figure 2K
Option P shortfall vs full time equivalent pathologist growth
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system and general ledger

2.4.2 Administrative support costs

In addition to the direct cost of allowances and other payments made to SMOs participating in the RoPP scheme, other costs are incurred that can be attributed to all SMOs exercising a RoPP. These include labour and systems costs to capture private practice revenue.

Facility charges and administration fees are recovered from SMOs to defray such overheads, but these were last revised prior to 2001. The administration fees that are charged by Queensland Health to Option B, R and P SMOs recover only a portion of the administrative support costs incurred. No separate administration fees are charged to Option A SMOs, as all revenue generated is assigned to Queensland Health.

Based on the data provided by three of the facilities visited, we estimate that average administrative support costs were 23 per cent of the private practice revenue generated. Based on this analysis, we estimate the statewide shortfall between the administration fees charged to SMOs and the actual costs for the provision of administrative services is approximately $12.7 million for 2011–12, and $51.8 million for the period 2003–04 to 2011–12.

Taking into account all costs and revenues reasonably attributable to the RoPP scheme, as shown in Figure 2L, we estimate that the total scheme 'cost' is approximately $804.24 million for the past nine years.

Figure 2L
Total revenues and costs of the RoPP scheme
2003–04 to 2011–12

	Net billings[1] $ m	Payments to SMOs $ m	SERTA / SERTF $ m	(Deficit) $ m
Total of A, B, R & P per Figure 2G	514.65	(1 196.71)	(70.41)	(752.47)
		Unrecovered administrative support costs		(51.77)
			Shortfall	**(804.24)**

1. Net billings = gross billings less facility charges and administration fees (where charged)

Source: QAO using data extracted from Queensland Health payroll and billing systems, general ledger and information provided by facility finance teams

2.5 Patient outcomes

Business cases supporting the introduction and evolution of the RoPP scheme included the principle that public patients should not be adversely affected.

The potential for full time specialists to devote less time to the care of public patients was a risk that was identified at inception of the scheme. In response, the original right of private practice was only to be undertaken after discharging public patient responsibilities; and the Director of Medical Services at each facility was to be responsible for determining what time was available for right of private practice.

Private patients in a public hospital

Private patients in a public hospital are patients who either:

- elect private treatment only after arriving in the public hospital or
- seek out specialists in a public hospital with the intent to be treated as a private patient.

The purpose of the scheme is not to draw patients from the private system but to offer public patients the option of being treated privately. To test whether the scheme is attracting patients from the private system inadvertently, we:

- obtained data from both public and private hospitals, using data from the Queensland Health admitted patient data collection for public and private admissions
- reviewed a sample of clinical procedures
- compared the relative public and private hospital proportions, focusing on the level of insured patients.

Complex and/or high cost patients in areas such as stroke, intensive care units, neo-natal intensive care and burns are largely treated in public hospitals, reflecting the emergent nature of these procedures and consistent with the role of a public hospital.

For most elective procedures, where public hospital wait times can deter private patients, we saw a higher proportion in the private hospitals and relatively small proportions in public hospitals. Activity in public hospitals for these conditions has a small private component. Overall, we found this data supports a conclusion that the scheme has not attracted significant hospital activity away from the private sector.

Elective surgery waiting times

We examined the elective surgery data to understand if patients who elect to be treated privately in public hospitals are given priority over public patients. In this respect, we note that in selected HHSs a greater proportion of SMOs' private patients receive category 2 elective surgery on time (recommended within 90 days) in comparison to public patients. There was not a statistically significant difference for urgency category 1 (surgery recommended within 30 days) and category 3 (surgery recommended within 365 days).

In reviewing the private patient data, we identified a class of patient called 'intermediate patients'. 'Intermediate patients' are the private patients of a VMO who receive their elective surgery in a public hospital.

VMOs bring their private patients into the public hospital system for elective surgery outside their contracted hours to Queensland Health. Unlike other public hospital patients, the intermediate patients are captured as 'waiting' for elective surgery only when surgery is scheduled, not when they are first identified as requiring surgery. This typically results in an intermediate patient being recorded as 'waiting' for surgery between ten and twenty days and therefore contributes positively to elective surgery performance reported by Queensland public hospitals. Queensland Health is unable to demonstrate that these patients are not receiving a benefit over public patients—in terms of being treated sooner or effectively out of turn. These patients are generally listed as category 2 patients.

This VMO arrangement is in effect a right of private practice, despite not being described as such by Queensland Health, or granted in a formal sense.

It is likely some intermediate patients would have been treated in the public hospital system if they were unable to be treated as intermediate patients (these patients typically have limited capacity to meet the cost of their treatment); however, it is not possible to quantify this. Without VMO intermediate arrangements, the demand for elective surgery through the public hospitals may increase.

Figure 2M shows the percentage and number of elective surgery patients that were seen within the clinically recommended time for category 2, split between public and private patients. Categories 1 and 3 are included in Appendix I.

We excluded intermediate patients from our analysis in Figure 2M, as we sought to determine whether private practice may be influencing behaviour of participating SMOs in treating patients within the clinically recommended time. However, we have provided a complete view of all statewide elective surgery in the last row of this figure. This includes elective surgery performed by SMOs, VMOs and registrars split into public and private patients (including intermediate patients).

Not all HHSs had statistically significant differences between public and private patients and these have not been listed separately in Figure 2M. We reviewed data for the 2010–11 and 2011–12 financial years combined.

Figure 2M
Category 2 elective surgery patients seen by SMOs within the clinically recommended time 2010–11 and 2011–12 combined

Hospital and Health Service	Category 2 (within 90 days)			
	Public		Private	
	Per cent seen in time	Total patients	Per cent seen in time	Total patients
Children's Health Queensland	75%	1 127	92%	121
Metro North	71%	8 002	90%	933
Metro South	83%	7 872	91%	303
Sunshine Coast	67%	2 548	84%	207
Townsville	66%	3 131	81%	140
Listed HHS	**74%**	**22 680**	**89%**	**1 704**
Statewide patients (SMOs)[1]	**72%**	**38 756**	**88%**	**2 210**
Statewide patients (all)[2]	**69%**	**78 547**	**97%**	**20 404**

1. Statewide (SMOs) includes all category 2 elective surgery performed during 2010–11 and 2011–12 including HHSs not listed.
2. Statewide (all) includes all surgeries performed, including those by registrars and VMOs and in HHSs not listed.

Source: QAO using data extracted from Queensland Health clinical and payroll systems

While the department's policies state that patient treatment is to be on the basis of clinical need, the evidence is that category 2 private patients are seen more consistently within the clinically recommended timeframes than public patients. As Figure 2M shows, when treated by SMOs, at a statewide level 88 per cent of category 2 private patients received their surgery within the clinically recommended time whereas only 72 per cent of public patients (74 per cent for listed HHSs) received similar surgery within the clinically recommended time.

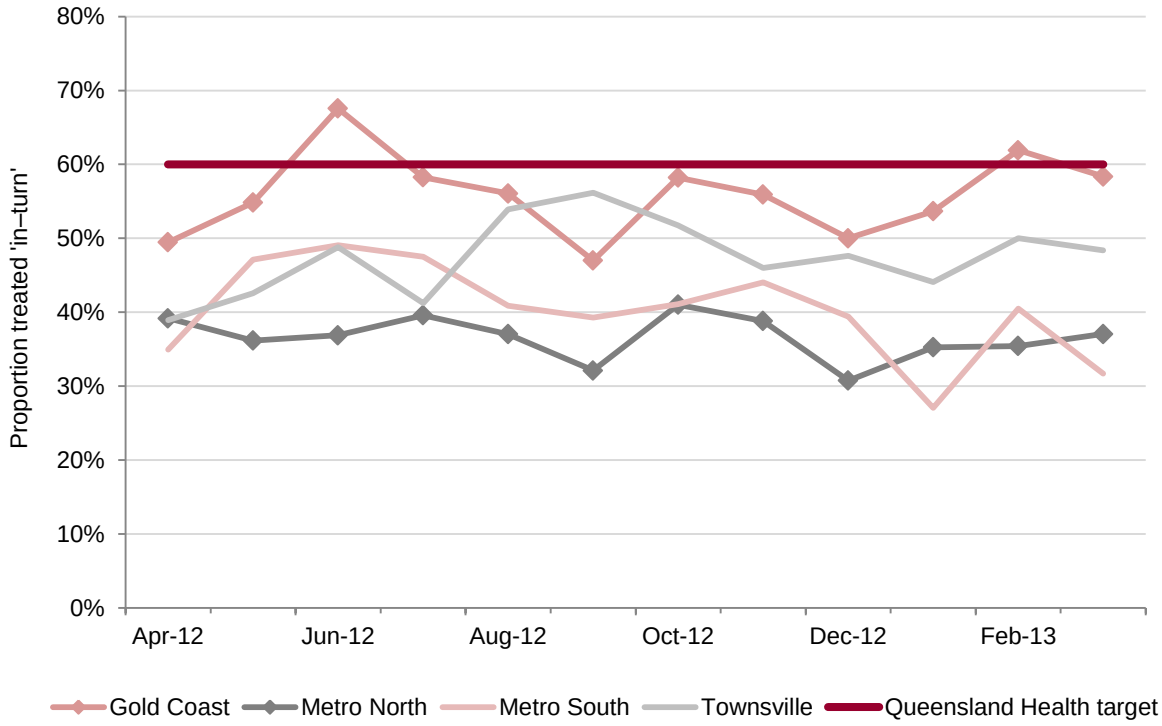
The absence of any current monitoring of this aspect of clinical activity at the SMO level increases the risk of the RoPP scheme influencing behaviour. However, Queensland Health is unable to demonstrate whether the category 2 disparity is due to this or to a range of other factors.

For example, there is potential for a private patient, faced with a long wait in the public hospital system to elect to be treated in a private hospital which would reduce the number of private patients waiting to be seen. Additionally, some patients may only elect to be treated privately on or after admission—at the time surgery is scheduled, each patient's private health insurance status may not be known.

To further explore the public patient experience in elective surgery, we investigated the percentage of patients treated in turn; that is, in the order they were placed on the waiting list. Queensland Health set a statewide target of treating 60 per cent in turn, with the balance at the discretion of the surgeon. The surgeon is influenced by a variety of competing considerations, including the need to develop the skills of registrars.

Figure 2N illustrates the proportion of public patients treated in turn over the past twelve months at the HHSs we visited. The results highlight that hospitals are failing to achieve their treat-in-turn targets and a greater level of monitoring and oversight is needed to understand why targets are not being achieved.

Figure 2N
Proportion of category 2 public patients treated 'in-turn'
April 2012 to March 2013



Source: QAO using data from Queensland Health, Health Service and Clinical Innovation Statistics

Intermediate patients

The economic impact of VMO intermediate lists on the provision of public services was not understood by hospitals. None of the hospitals we visited had completed analysis to identify the costs and benefits resulting from their arrangements with VMOs.

Queensland Health levies bed and/or accommodation fees to these patients, but limited or no facility charges are levied to cover the operating theatre, equipment, nursing assistance and medical consumables.

Based on the level of VMO intermediate patient activity in 2011–12, we estimate the cost of the VMO subsidy borne collectively by HHSs is between $36.5 million and $38.5 million. We identified that public hospitals levied facility charges totalling $0.35 million during the equivalent period (or 1.0 per cent of cost).

Dedicating resources to VMO intermediate patients reduces the availability of theatres for public patients and gives priority access to surgery for these intermediate patients.

Outpatient wait times

Private outpatients of SMOs did not have reduced waiting times in comparison to public patients. There is no evidence to suggest that the billing of outpatients affected service provision to public outpatients.

We analysed outpatient activity across all reporting hospitals within Queensland Health, excluding the Royal Brisbane and Women's Hospital and the Princess Alexandra Hospital, for the period July 2012 to March 2013 and found 62.3 per cent of all private outpatients were seen within the clinically recommended timeframe. In comparison, this percentage was higher for public outpatients, with 66.7 per cent being seen within recommended timeframes. Data for the Royal Brisbane and Women's Hospital was unable to be provided in sufficient time for it to be analysed and included in this report. The outpatient system used at the Princess Alexandra Hospital is currently unable to provide the required data.

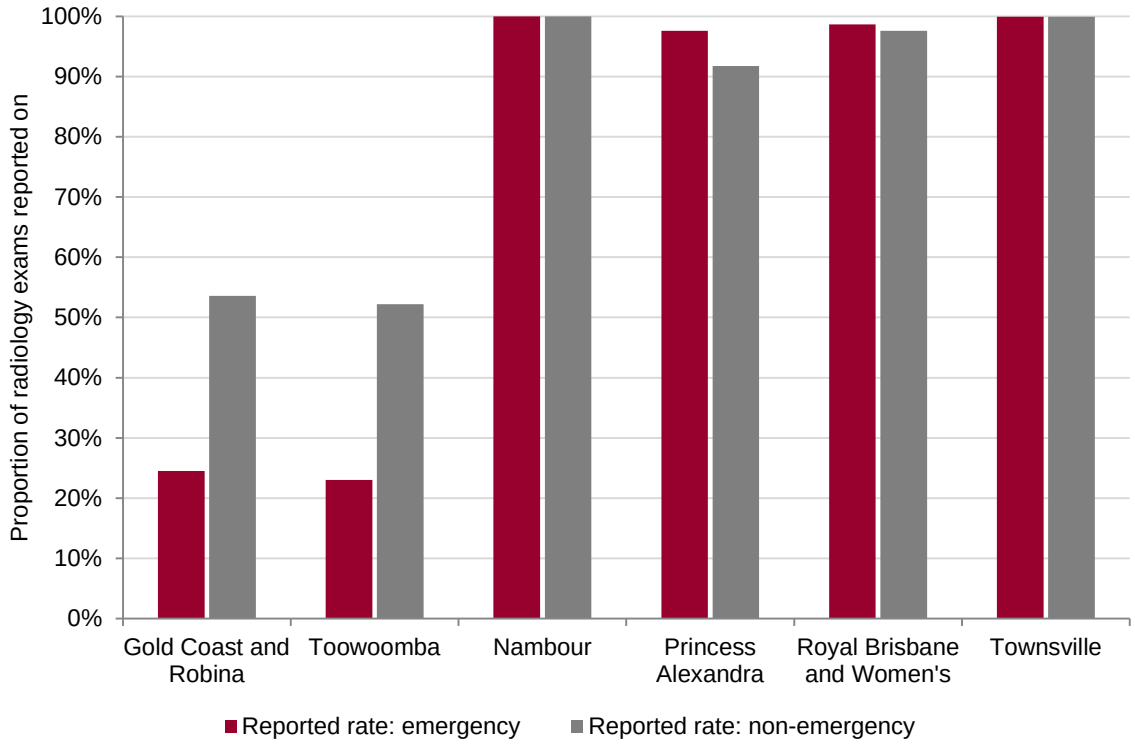
Unreported radiology examinations

The Queensland Health policy on radiology examinations requires that all diagnostic imaging services performed by, or on behalf of, Queensland Health, must be reported by an appropriately credentialed radiologist or medical practitioner within a clinically appropriate timeframe. We reviewed radiology clinical data and observed that specialists or registrars at two facilities were not reporting a significant number of radiology examinations. We explored this further to identify if there was a clinical reason, or if this behaviour was influenced by the right of private practice.

Radiology examinations (such as computerised tomography or CT scan, magnetic resonance imaging or MRI and X-rays) for private patients that have been analysed and reported by radiology specialists are billable (excluding examinations ordered from the emergency department prior to the decision to admit the patient).

Figure 2O contains the proportion of reported radiology examinations for 2011–12 at selected facilities.

Figure 2O
Reported radiology examinations by facility
2011–12



Source: QAO using data extracted from Queensland Health radiology systems.

We observed that the lowest rate of reported examinations originated from emergency departments; where the opportunity to bill is often limited.

For this class of radiology examination, the reported rate at facilities in the Gold Coast (including Robina) was 24.5 per cent and the rate in Toowoomba was 23.0 per cent. The rate for all other reported examinations in the Gold Coast (including Robina) was 53.6 per cent and the rate in Toowoomba was 52.2 per cent.

While we acknowledge that workforce and workload issues may affect the ability to report on all examinations, the low level of reporting at these facilities presents a clinical risk requiring more active management.

2.6 Recommendations

All recommendations need to be considered in light of the final model of activity based funding under the National Health Reform Agreement.

It is recommended that Queensland Health and Hospital and Health Services (HHSs):

1. **redesign private practice arrangements to incentivise practitioners so the scheme is financially sustainable**
2. **establish clear targets for the optimal medical workforce in the context of desired clinical, patient access and financial outcomes.**

3 Scheme design and oversight

In brief

Background

The implementation of the right of private practice (RoPP) arrangements, involving significant expenditures and revenues, should have been supported by a robust proposal that included clear objectives, definitive measures, risk assessments, financial analysis and clearly defined roles, responsibilities and accountabilities.

In operation, effective oversight of the scheme's performance and periodic evaluation of its design are needed to be assured that its objectives remain relevant and are achieved.

Conclusions

There are systemic weaknesses in Queensland Health's approach to the assessment, implementation and ongoing review of its right of private practice scheme with no evidence of adequate rigour being applied to its design, alignment to its objectives or governance of the scheme over the previous decade.

By the time limited oversight was established (via the Private Practice Management Committee) over the RoPP scheme in 2009, the embedded view was that the RoPP scheme was a mechanism for pay increases. This led to a focus on maximising revenue opportunities, rather than administering a financially sustainable scheme.

Key findings

- The scheme's design does not reflect all its original objectives (recruitment, retention and cost neutrality), being openly described as a mechanism to effect pay increases with no regard to financial sustainability.
- The introduction of various scheme options, increased payments to senior medical officers (SMOs) without commensurate financial return to Queensland Health and the scheme extension to a broader range of participants has eroded financial sustainability of the scheme.
- Governance arrangements are lacking with limited scheme oversight; Directors of Medical Services are not held accountable for the scheme's performance, nor are SMOs' RoPP contractual obligations enforced.
- Management information to monitor the RoPP scheme is lacking because of fragmented IT systems, data quality issues and the lack of focus on scheme outcomes.

Summary of recommendations

It is recommended that Queensland Health and the Hospital and Health Services (HHSs):

3. **develop an appropriate governance framework for private practice arrangements, which includes oversight at a statewide and HHS level to monitor and enforce contractual obligations**
4. **develop data quality standards, greater systems integration and a single common doctor identifier across all administrative, clinical and billing systems supporting private practice.**

3.1 Background

Queensland's first right of private practice (RoPP) arrangement was introduced in 1986 as a combined revenue retention and revenue sharing model. Since 1986, the scheme has been expanded to include four options for specialist and non-specialist senior medical officers (SMOs).

Queensland Health is currently reviewing the RoPP arrangements and, in October 2012, appointed the Chief Human Resources Officer as the executive sponsor.

Option B

The primary objective of the initial RoPP scheme, set out in the approved business case for its introduction, was to aid in recruiting and retaining full time specialists by increasing their remuneration at no net cost to the state. This option became known as Option B once Option A was introduced in 1992.

On top of their base salaries, SMOs participating in Option B retain the net revenue (up to an earnings cap) from private practice billings, after deducting facility charges and administration fees paid to the hospital.

Option B was extended to part time specialists on 1 July 2001.

Option R

In 2006, a modified Option B model for radiologists was introduced—known as Option R. Documentation supporting the rationale and business case for this scheme is absent.

Queensland Health advises that the intention of Option R was to prevent the loss of radiological services in public hospitals and prevent the failure of radiological training in the state.

Participating SMOs follow the same arrangements as Option B, but with 50 per cent lower facility charges and administration fees.

Option A

In 1992, an ‘assignment’ model was introduced—referred to as Option A. The primary objective of Option A, set out in the business case presented to government in 1992, was to capture revenue from private patients in a cost neutral manner. The secondary objective was to assist in the recruitment and retention of full time staff.

On top of their base salaries, participating SMOs are paid an allowance in exchange for assigning all revenue from private practice to the hospital. Option A was extended to part time specialists in 1995 and non-specialists in 2006.

Option P

In 2000, a ‘derivative’ model for pathologists was introduced—known as Option P.

The primary objectives of Option P are to provide a fairer distribution of benefits to all pathologists, incentivise pathologists to identify private patients and improve turnaround times.

Option P is a derivative of Option A and Option B. The Option A allowance is retained and pathologists receive an incentive payment based upon statewide pathology private practice billing.

3.2 Conclusions

There is no evidence of adequate rigour in the design of the scheme or in subsequent analysis of the impact of further changes. Queensland Health has not reviewed the overall scheme performance since its implementation in 1986. That Option A was failing its cost neutral objective was highlighted in an Auditor-General's report to Parliament in December 1993.

Where business cases were present for subsequent changes to the RoPP scheme, they were incomplete; they were lacking analysis in viability; and they were untimely in responding to and addressing known issues.

Queensland Health did not 'follow through' by establishing effective governance or ongoing monitoring at the scheme level. Overall accountability for the performance of the scheme is not clear after 1987 with different committees providing some level of oversight for varying periods of time.

From 2006, the overriding belief and culture was that the allowance payment in Options A and P was not contingent on generating a level of revenue and this was reflected in the way that the changes were implemented and managed. The lack of clear accountability for the achievement of intended outcomes approved in the scheme's design, both for individual SMOs and at the system level, has translated into weak monitoring at these levels.

From 2009, some focus returned to the objective of ensuring the scheme was financially sustainable via the Private Practice Management Committee (PPMC) and the team in the Revenue Strategy and Support Unit (previously known as the Statewide Own Source Revenue Unit) in Queensland Health. However, Queensland Health's responsibility to deliver appropriate management and reporting structures for the right of private practice otherwise remains largely unfulfilled.

Neither the PPMC nor its predecessor, the Private Practice Review Committee (PPRC), constitutes a governance body with the necessary authority and responsibility to oversee the RoPP scheme effectively.

The scheme did not have an executive sponsor with a mandate to deliver on the objectives of recruitment, retention and financial sustainability. Consequently, there were no performance reviews and only limited monitoring of the scheme's operation.

3.3 Scheme design and evolution

Against a background of ongoing changes to the scheme, we examined how well informed decision makers were about its initial design and the subsequent changes, and also considered the effectiveness of oversight and evaluation since the scheme's inception. A timeline for the RoPP scheme is shown at Appendix F.

1986

The original proposal in 1985 to establish a 'retention' model RoPP scheme in Queensland was developed by a Queensland Health taskforce which was asked to adhere to three key principles:

- the public practice was to experience no reduction in physician hours in a scheme of private practice
- a scheme of private practice was to impose no extra costs upon the public hospital system
- a scheme of private practice was not to impose a requirement for extra staff upon the public hospital system.

No detailed financial modelling was included in the design of this scheme. The facility charges and administration fees to be recovered from SMOs were established with reference to comparative rates in other states and territories and with a commitment to ongoing review of these fees.

The scheme was approved on 17 June 1986.

1992

Prior to the introduction of Option A, the earnings cap for Option B was increased to 50 per cent of the top of the then-current medical officer salary band.

The initial business case for Option A, implemented in 1992, presented only a small number of relevant facts and an incomplete analysis to justify its introduction. While the anticipated revenues and expenses of Option A were outlined, we found that these original assumptions were overly optimistic, in that the scheme has never been self-sustaining.

Queensland Health was unable to provide any evidence of pre-implementation analysis or post-implementation evaluation for the subsequent changes made to Options A and B.

1993

The Auditor-General reported to Parliament that Option A was not achieving the objective of being cost-neutral, recording a shortfall of $1.55 million in 1992–93.

1995

Three years after the introduction of Option A, both options were varied in conjunction with the 1995 Health Action Plan. The Option A allowance payments were doubled for both metropolitan and non-metropolitan regions.

The SERTA arrangements were modified so that Option B SMOs would receive one in every three dollars after reaching their earnings cap.

There was no evidence of an assessment of the financial impacts of these changes.

2000

In 2000, Option P was approved with the introduction of an incentive payment in addition to an allowance payment. The business case highlighted the shortcomings in the Option A scheme; primarily, the lack of incentive to treat patients privately, as Queensland Health 'guaranteed' paying allowances, regardless of the level of private work performed. Significant shortfalls had been experienced between private practice revenue received and allowances paid out for Option A.

While attempts were made to address these shortcomings in the design of Option P, no action was taken to remediate Option A.

2001

The contractual obligations under Option A were strengthened in 2001 by including the requirement for six-monthly individual performance assessments that focused on the obligation of an SMO to capture revenue from privately insured patients. There is no evidence, however, that these contractually required six-monthly reviews were undertaken.

2002

The government was advised in 2002 about the financial implications of the large number of SMOs moving from Option B to Option A, and of the large number of newly recruited specialists electing Option A. In response the government approved three actions:

- the Option B earnings cap was to be increased to 100 per cent of the MO1–7 salary level on 1 July 2002 to make that option more attractive to new and existing SMOs
- a review of the facility charges and administration fees under Options B and P was to be undertaken and changes implemented by 1 July 2003
- a review was to be undertaken to ensure Options A and B were achieving their aims and objectives and did not result in adverse effects on public patient waiting times, prior to contracts being renewed in 2004.

We could find no evidence that the two reviews requested were undertaken, or that the impact of the change to the Option B earnings cap was subject to a financial assessment or subsequent review. Queensland Health was not able to provide any documentation that indicated the government received these reports, or to explain why they were not completed.

2006

Major revisions to the various scheme options in 2006 were reactions to significant workforce crises, including the closure of the Caboolture emergency department and the allegations of malpractice in Bundaberg resulting in the Davies Commission of Inquiry and the Forster Review into Queensland Health.

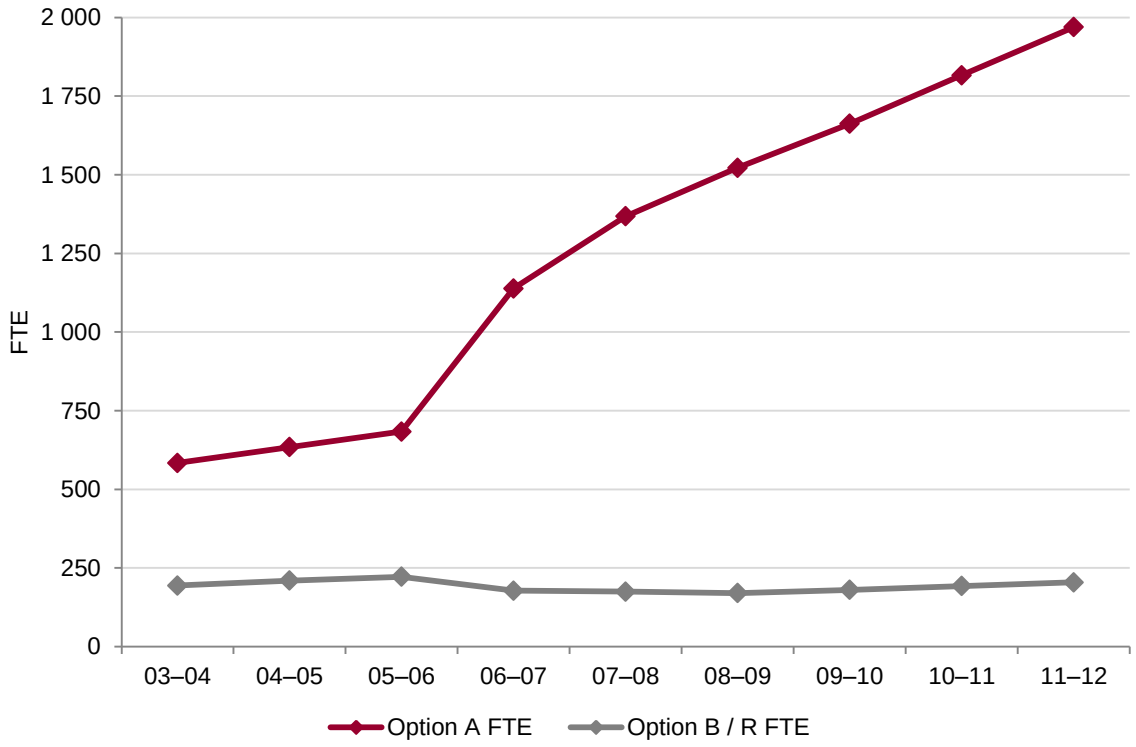
At this time several key changes were made:

- Option A was widened to include allowances ranging from 35 to 50 per cent for non-specialist SMOs and those unable to generate private practice income, depending on their locations
- Options A and P allowance payments were increased from 35 per cent to a minimum of 50 per cent of a specialist's base salary in metropolitan hospitals (from 45 per cent to a maximum of 65 per cent in non-metropolitan hospitals)
- Option R was established, based on Option B except for a 50 per cent discount on facility charges and administration fees
- Options B and R earnings caps were increased by including the $20 000 professional development allowance.

Queensland Health could provide no evidence that these scheme changes were supported by any analysis of their financial impacts.

The impact of the 2005–06 changes on Options A, B and R is shown in Figure 3A. While Option A was successful in attracting more participants, it is in contrast to Option B, which has still not recovered to its 2005–06 peak.

Figure 3A
Full time equivalent participants in Options A and B / R
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

The establishment of the Option R scheme in 2006 also lacked documented aims or objectives. Queensland Health could provide no documentation in support of the establishment of the Option R scheme—neither a business case nor cost-benefit analysis, specified roles and responsibilities, expected outcomes or performance measures and targets.

2010

Queensland Health commissioned an external review of Option B in 2010 to review the cost and relative attractiveness of Option B compared with other private practice options. While that review found that Option B was attractive, it identified a number of shortcomings, including how the facility charges and administration fees were set. Queensland Health took no action in relation to the findings in this report.

2012

In negotiating the Medical Officers' (Queensland Health) Certified Agreement (No. 3) 2012 (MOCA 3), Queensland Health agreed to review the right of private practice arrangements before the end of the Agreement (nominally expiring on 30 June 2015). A taskforce has been established to drive the reform project, reviewing current arrangements and making recommendations on future reforms and potential models that could be implemented to both simplify and optimise the scheme.

3.4 Scheme oversight

We reviewed the effectiveness of the oversight of the scheme in terms of its governance arrangements; the management information available and used to support decision making; and the alignment of actions to scheme objectives.

3.4.1 Governance arrangements and oversight

Governance over the RoPP scheme has been ineffective at the statewide and facility levels of Queensland Health.

Original taskforce to 2009

The taskforce established in 1985 to design the original RoPP scheme was to continue to operate for a period of 12 months to supervise and monitor its operation. Queensland Health was unable to demonstrate that this role was undertaken by the taskforce after the scheme's inception in 1986; or to clarify when the taskforce was disbanded.

The PPRC was established on or around the introduction of Option A in 1992 and disbanded during 1996. The PPRC comprised Queensland Health officers and medical specialists. The terms of reference provided for the PPRC to advise medical administrators on operational matters and to Queensland Health on the scheme's design and oversight. The PPRC provided at least one annual report to the Director-General of Queensland Health in 1994. Queensland Health was unable to provide evidence that the PPRC was able to fulfill their terms of reference effectively.

Between this period and 2009, Queensland Health was also unable to provide evidence of oversight of the RoPP scheme. Major RoPP scheme changes (2006) occurred within this period.

Private Practice Management Committee

The PPMC was formed in 2009, with membership comprising Queensland Health officers and medical specialists employed by Queensland Health. Medical specialists nominate themselves to sit on the committee. While Queensland Health policy established limited oversight objectives for the committee, its composition and terms of reference preclude it from fulfilling these objectives.

The PPMC has met monthly or bi-monthly (suspended since the second half of 2012 during MOCA 3 negotiations) to focus on revenue issues. PPMC reports do not make recommendations for improved performance of the overall scheme.

In practice, the PPMC operates as a 'working group' to optimise revenue opportunities, rather than overseeing the scheme objectives of recruitment, retention and cost neutrality. As such, neither the PPMC nor its predecessor, the PPRC, constitutes a governance body with the necessary authority and responsibility to oversee the RoPP scheme effectively. This leaves a continued gap in governance arrangements for the RoPP scheme.

Revenue Strategy and Support Unit

Driven by the team in the Revenue Strategy and Support Unit, the PPMC has increased private practice revenue by $61.6 million (70.2 per cent) since 2009–10. The Revenue Strategy and Support Unit is responsible for the development of statewide revenue targets and also prepares regular reports focusing on revenue aspects of the scheme.

The revenue reports provide a variety of detail at a Hospital and Health Service (HHS) level. However the reports do not make linkages to the recruitment and retention rates of SMOs and prior to 2011–12 provided limited recommendations for improvements. During the 2011–12 and 2012–13 financial years, the Revenue Strategy and Support Unit revised revenue performance reporting to include recommendations for HHSs to identify and optimise own source funding opportunities.

Directors of medical services and medical superintendents

The directors of medical services and medical superintendents (DMS) have been given a broad remit to manage the right of private practice scheme in the hospitals. They have not been held accountable for the scheme's performance, in part due to conflicting messages from Queensland Health about the aims of the scheme. The DMS are managing for revenue optimisation, not for a cost neutral position.

For example, in 2001 the Option A standard contracts were updated to require a six-monthly performance review against criteria defined by the DMS. The performance review was to encompass the requirement of each SMO to treat private patients as directed by the DMS. The DMS were to report the performance criteria they were applying for each specialty group back to Queensland Health. The intention was for Queensland Health to ensure these reviews were consistently performed. We saw no evidence that this occurred.

In December 2010, Queensland Health again identified that active participation in private practice by Option A SMOs was very poor, with a significant difference between the actual allowance paid and the revenue generated. However, there was no coordinated systematic approach to managing compliance with the contractual obligations, nor were there any consequences identified for non-compliance with these obligations. Part of the reason for this is that no framework was in place to provide guidelines to DMS about how to manage the contracts with SMOs. While business rules were drafted by Queensland Health to assist in the enforcement of Option A contractual obligations, these business rules were not finalised, nor translated into action.

In addition to the mixed messages received and lack of 'follow through' on intended actions, DMS have not been given adequate support by Queensland Health to ensure scheme compliance. Little practical consideration has been given to the information required by DMS to discharge their responsibilities. For example, to enforce the policy requirement that Option B SMOs can only claim extended hours' overtime on days when they have not undertaken significant private practice would require a report to monitor extended hours' overtime after it had been paid. This requirement cannot be monitored efficiently as the data in the billing and payroll systems has not been matched by Queensland Health at the level of detail necessary.

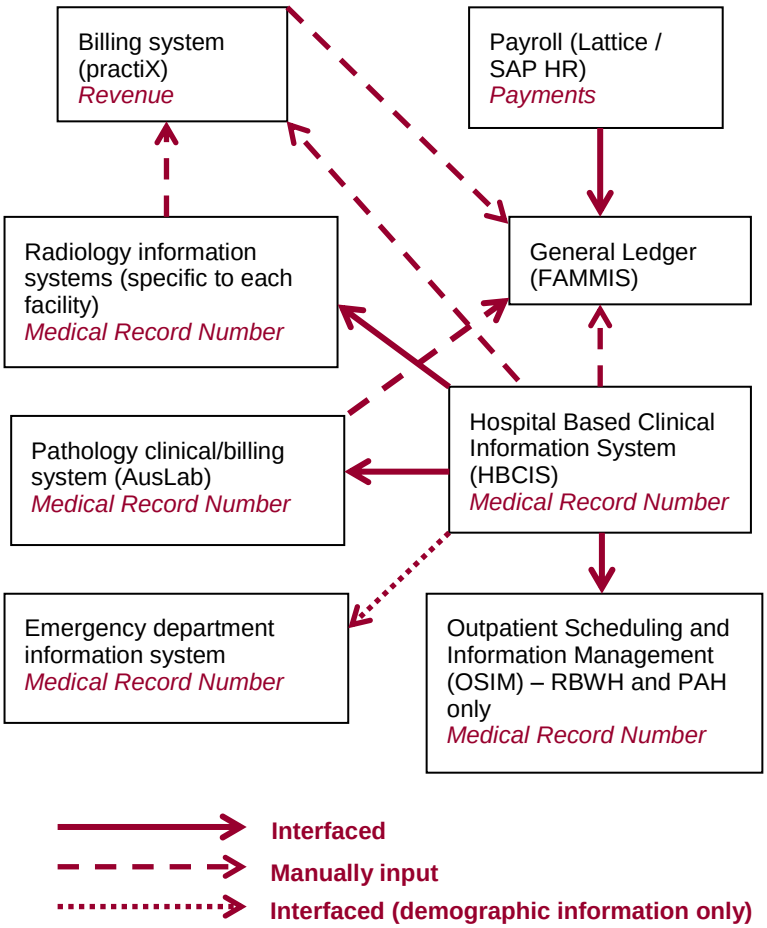
Despite several attempts over more than 12 years, none of the facilities we visited in 2013 had effective processes in place to review and enforce contractual obligations. The key tenet that right of private practice should not adversely affect the care of public patients is also not well monitored.

3.4.2 Management information

Queensland Health's information systems cover a broad spectrum of clinical and financial activity; however, we found little alignment between scheme oversight objectives and the management information to support effective decision making or to address risks to operational delivery.

Figure 3B provides an overview of the disparate Queensland Health systems that relate to the RoPP scheme.

Figure 3B
Overview of right of private practice systems integration



Source: QAO

In the present environment, insufficient information is available for DMS to monitor and discharge their obligations adequately under the scheme; or for proactive governance of the scheme at the Queensland Health level.

The desire for more in-depth management information and analysis increased as the push for own-source revenue grew in 2009, but this has not been supported with well-targeted and sufficient investment in integrated information technology infrastructure and amalgamated reporting.

However, some functionality was added to the billing system in late 2010 to allow management reporting of billing at the SMO level.

Case study: Enhanced management information

Royal Brisbane and Women's Hospital : Medical Imaging Unit

A good practical example of enhanced management information to improve service delivery was identified at the Medical Imaging Unit at the Royal Brisbane and Women's Hospital (RBWH MIU). In this unit, the various clinical systems have been overlaid with a dashboard-style reporting tool which provides real-time statistics on the activity levels of practitioners and the unit as a whole. This provides management with key information about the unit's performance against established targets and helps to identify pressing areas of service demand.

The RBWH MIU stated that, combined with a redesign of other business processes, it has increased its overall output and reduced waiting lists for services such as computerised tomography and ultrasounds.

The RBWH MIU sees scope for greater system integration with further efficiencies to be gained in the future; for example the clinical systems are still not interfaced with the billing system. While the nature of medical imaging services is more readily suited to this type of monitoring, it provides an example of what can be delivered.

Data quality

Integrating data from different systems to provide meaningful management information relies also on the quality of the data in each system.

We identified several serious data integrity issues within Queensland Health systems; examples for the 2011–12 year include:

- over 2 million records (29.8 per cent) in the clinical system used generic identifiers for the treating doctor, such as 'Practitioner', 'Registrar' or 'Public Renal'; and therefore we are unable to determine which individual practitioner cared for the patient (97.1 per cent pertain to outpatient records)
- over 197 000 records (13.1 per cent) in the billing system did not specify a private practice option; this included SMOs billing at multiple facilities, VMOs, outsourced radiology providers and doctors working at section 19(2) exempt sites—Appendix E provides information on section 19(2) exempt sites
- over 14 500 records (1.0 per cent) for inpatients billed did not have a unique medical record number from the clinical system.

If not addressed, these data integrity issues will inhibit the ability of Queensland Health and HHSs to integrate key information successfully across their systems.

3.5 Recommendations

All recommendations need to be considered in light of the final model of activity based funding under the National Health Reform Agreement.

It is recommended that Queensland Health and the Hospital and Health Services:

3. **develop an appropriate governance framework for private practice arrangements, which includes:**
   - **an oversight body comprising members with sufficient skill, authority and responsibility statewide**
   - **board oversight with appropriate delegation of responsibilities at the facility level to monitor and enforce contractual obligations**
4. **develop for all administrative, clinical and billing systems supporting private practice:**
   - **standards to ensure the quality of data captured is meaningful and relevant**
   - **integration to realise efficiencies and enable monitoring of clinical and non-clinical (including financial) activity**
   - **a single common doctor identifier.**

4 The scheme in operation

In brief

Background

Efficient and effective systems and procedures are needed so that all private patient services provided are billed legitimately and correctly and the revenues generated are distributed appropriately. Directors of Medical Services at each facility are responsible for the effective management of day to day operations of the right of private practice (RoPP) scheme.

Conclusions

There has been insufficient focus on the operating systems and processes supporting revenue and expense management.

Key findings

- Queensland Health has paid allowances to senior medical officers (SMOs) with little or no ability to recover these costs. In 2011–12, 93.5 per cent of Option A SMOs (2 423 individuals) did not generate sufficient revenues to cover their allowance payments.
- Poor inductions and a lack of ongoing support have contributed to SMOs being unclear as to the services that are billable and under what circumstances.
- A combination of a lack of active participation by SMOs, inadequate understanding of requirements, poor integration of clinical and billing systems and inefficient manual processes has led to an estimated $22.76 million in revenue being foregone in 2011–12.
- Facility charges and administration fees have not been revised in over a decade and are unlikely to recover Queensland Health's costs.
- Control over overtime payments is weak. The evidence indicates that it is likely overtime payments have been made to Options B and R SMOs outside their entitlements.
- Current rostering practices are contributing to excessive overtime with the average extended hours overtime not decreasing significantly as SMO numbers increased.

Recommendations

It is recommended that Queensland Health and the Hospital and Health Services:

5. **make immediate attempts to recover foregone revenue, if cost effective, and investigate further revenue uplift opportunities**
6. **develop a strategy and engage with private practice participants, medical administrators and support staff to communicate a consistent message aligned with the objectives of the redesigned scheme, including contractual obligations**
7. **redesign end to end business processes and systems to support enhanced revenue and expenditure management, including rostering and overtime**
8. **review the objectives and the principles governing the use of the study, education and research funds (SERTA and SERTF) to ensure maximum benefits are derived for the state.**

4.1 Background

Directors of Medical Services and Medical Superintendents (DMS) at individual hospitals are delegated the responsibility for day to day management of the right of private practice (RoPP) scheme.

This requires DMS to establish and maintain systems and processes to manage and monitor compliance by participating senior medical officers (SMOs) with their RoPP contractual obligations and to ensure the efficient management of the scheme at the facility level. The contractual and policy obligations for SMOs are:

- seeing private patients referred to them
- using their best endeavours to identify private patients (for billing purposes)
- notifying hospital administration promptly of private patient details and billable services provided.

In this chapter we examine how well the scheme is working at the Hospital and Health Service (HHS) level, focusing on:

- revenue management and control–particularly whether all billing that can be undertaken is; and its timeliness and accuracy
- expenditure management and control–focusing on the distribution of revenue earned between the SMOs, the facility and the trust accounts and payment of overtime
- the information systems used to support these processes–focusing on the extent of their integration and level of automation.

4.2 Conclusions

Maintaining financial sustainability of the RoPP scheme is not a focus for Queensland Health.

Nearly all Option A SMOs do not recover their allowance payments. Contributing to this result are allowances being paid to SMOs who have limited or no capacity to generate revenue, and misinformation and misunderstanding about the RoPP scheme due to poor induction and lack of ongoing support structures.

There is weak revenue management and control evidenced by revenue opportunities foregone by Queensland Health and HHSs.

There is also weak expenditure management and control evidenced by excessive overtime payments likely to be in breach of policy and based on poor rostering practices; and facilities charges and administrative fees which have not been revised in over a decade and which are unlikely to recover costs.

Deficiencies in the operating model are exacerbated by the systems and practices to support the billing, collection and disbursement of revenue which are complex, inefficient, inconsistent and prone to error.

While efforts have been made in more recent times through guidelines on billing practices and maximising revenue opportunities, a more holistic approach is required.

4.3 Revenue management and control

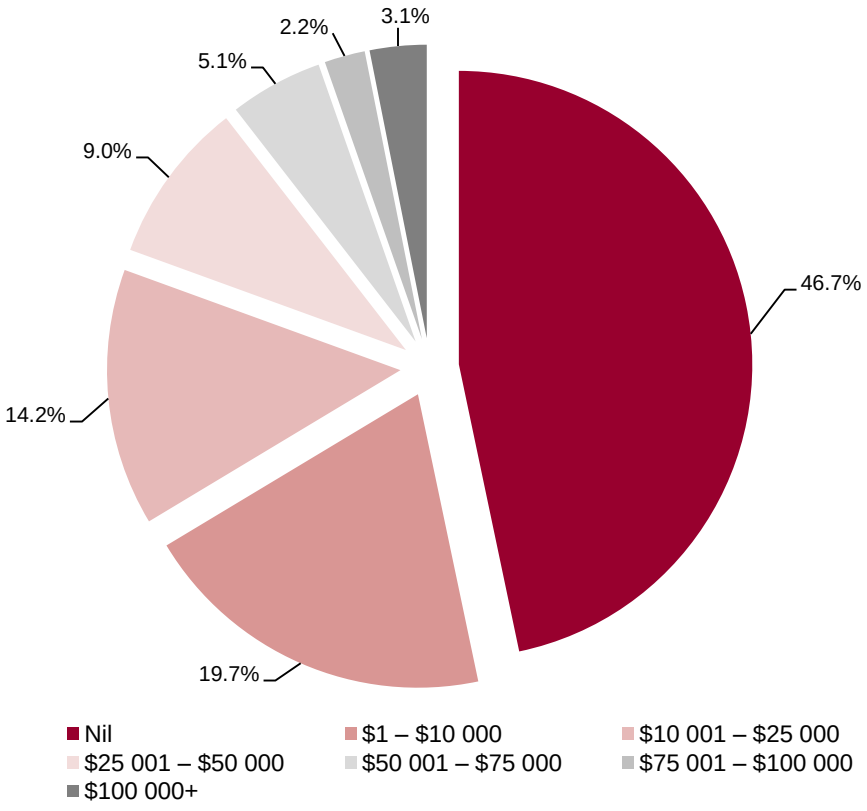
The implementation of adequate financial systems and processes, together with appropriate monitoring by management, are critical to revenue maximisation. We examined Queensland Health's approach to managing revenue and whether these inflows are adequate to cover the direct and indirect costs of the RoPP scheme.

4.3.1 Option A revenues

At the time of its commencement in 1992, it was envisaged that Option A would be cost neutral, meaning SMOs would have then needed to bill at least $15 364 to offset the cost of their allowance. Twenty years later, Option A SMOs generate on average $26 886 in revenue, where, to be cost neutral, they would need to bill $91 674.

Figure 4A shows that, for 2011–12, almost half of all Option A SMOs (1 210 individuals) generated no revenue under their contracts. Approximately 20 per cent (504 individuals) generated less than $10 000.

Figure 4A
Distribution of total amounts billed by individual SMOs in Option A 2011–12

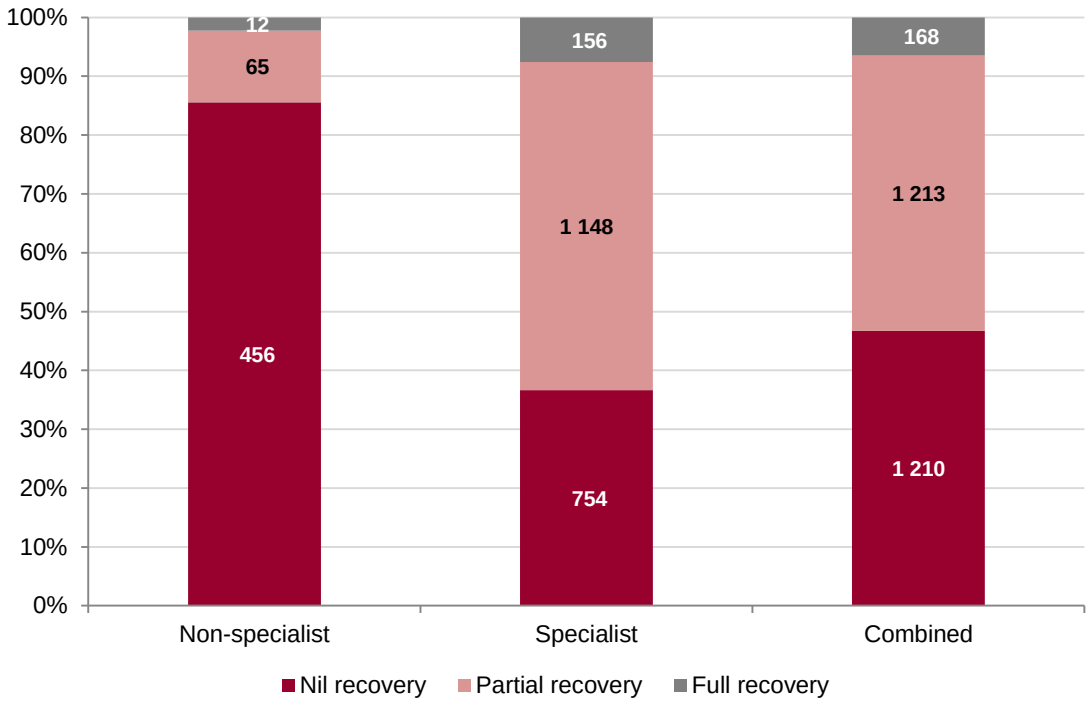


Source: QAO using data extracted from Queensland Health billing and payroll systems

Figure 4B splits individual Option A SMOs into two cohorts—specialists and non-specialists—and charts their allowance recovery rates. It illustrates that 85.5 per cent (456 SMOs) of non-specialists—to whom the scheme was extended in 2006—are not generating any revenue, compared to 36.6 per cent (754 SMOs) of specialists.

Only 6.5 per cent of Option A SMOs (168 individuals) generated sufficient revenue to offset their allowances.

Figure 4B
Option A allowance recovery: specialist vs non-specialist SMOs
2011–12

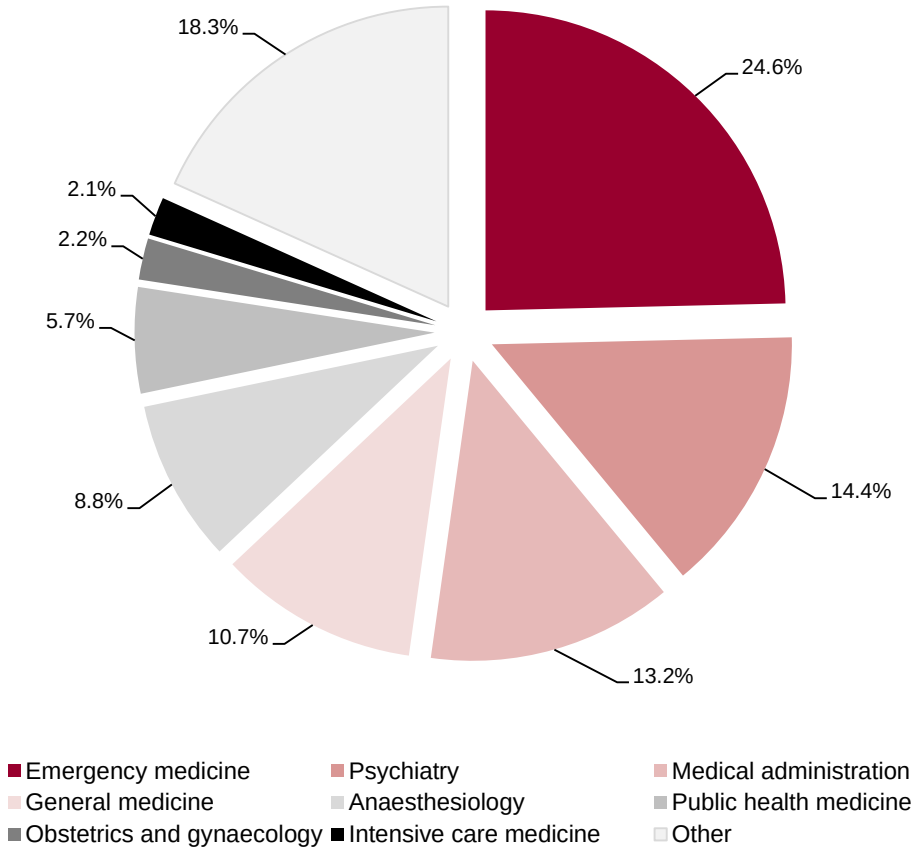


Source: QAO using data extracted from Queensland Health billing and payroll systems

The ability of some disciplines to generate revenue in a public hospital setting is limited—for example, patients presenting to emergency departments are treated free of charge until such time as they are admitted to hospital and elect to be treated privately.

Figure 4C shows the distribution of the 46.7 per cent (1 210 individuals) of SMOs who generated no revenue during 2011–12.

Figure 4C
Distribution by discipline of Option A SMOs who generated no revenue 2011–12



Note: 'Other' comprises all other disciplines

Source: QAO using data extracted from Queensland Health billing and payroll systems

Expectations of Option A SMOs

The expectation for Option A SMOs to recover their allowances through revenue generation was eroded in the early 2000s by amendment of the contractual requirements for SMOs to use 'their best endeavours' to identify potential private patients under their care and advise them of their option to be treated privately. This wording is ambiguous in terms of a performance expectation, further perpetuating the view that the allowance was not closely tied to achieving revenue targets.

SMO understanding and attitudes

Poor engagement by Queensland Health and administrators has resulted in a culture of apathy and a lack of understanding of the scheme by some SMOs. There is indifference towards generating revenue as this is not linked to receiving allowances. There is a lack of knowledge of when services are billable. In rarer cases, SMOs actively disengage from undertaking private practice due to a personal view that all services provided in public hospital settings should be free of charge.

Right of private practice contracts and policy documents place the onus on SMOs to be familiar with the scheme and the billing process. Respondents to our survey indicated that 50 per cent of Options B and R SMOs, and 75 per cent of Option A SMOs, felt they did not receive an adequate induction on their contractual obligations; while 64 per cent and 82 per cent respectively felt they did not receive an adequate introduction into what services are billable.

In our survey, we asked if SMOs experienced situations where they were unsure if a service was billable or not: 62 per cent stated that they had. Of this cohort, 26 per cent did not seek guidance about whether or not the service was billable.

The primary reason given for not seeking guidance—nominated by 29 per cent of respondents—was that SMOs were unclear on where to seek such guidance. In this respect, 69 per cent of all respondents said they do not receive adequate ongoing support in relation to their contract, and 65 per cent said they do not receive adequate support in relation to what services are billable and when.

The training and guidance that is provided for SMOs fails to address adequately the practical issues that each specialty faces. Only in recent reporting periods has Queensland Health sought to provide guidance directly to SMOs. The primary means has been through documents such as the April 2011 guide titled '*Billing for specialist clinics in Queensland public hospitals'*. Only one of the four HHSs that we visited, Metro North, had developed management-approved local guidelines: these were issued in October 2012. More expansive explanatory guidance, '*A guide to private practice in Queensland public hospitals'*, was issued to all SMOs for the first time in early 2013.

Our discussions with SMOs revealed that many are hesitant to participate actively, due to their concerns around the legality of billing private practice services to Medicare. SMOs are legally responsible for all services billed against their individual Medicare Service Provider Number(s). The fact that SMOs have not received adequate induction or ongoing support into what services are billable contributes to these concerns.

The high degree of confusion amongst SMOs about the scheme, which has persisted for a number of years, emanates also in part from conflicting messages from Queensland Health over time.

Since the early 2000s and epitomised in 2006, SMOs contend that the 'message' they received from Queensland Health was that RoPP, particularly Option A, is effectively a pay rise. Our survey to participating SMOs supports this view, with 73 per cent of Option A respondents indicating their view that the allowance is not contingent upon achieving a level of billing activity.

The confusion and indifference felt by SMOs has been fed by the lack of transparency around their contractual obligations. While the original intent of RoPP was active participation, dilution of contractual obligations and providing the Option A allowance to SMOs with limited or no ability to generate revenue has reinforced the cultural message that the Option A allowance is only a pay increase.

4.3.2 Billing practices

Since 2009, Queensland Health has directed more effort and attention to increasing private practice revenues across HHSs. However, this effort has not been matched with a similar investment in automation and integration of systems that would facilitate better management of private practice billing.

The clinical and billing systems are not integrated which means they cannot be used to cross check between each other to ensure that billing is complete and accurate. Systems do not exist to bill inpatients at the time they are discharged, meaning that extra effort and time is needed to bill. Outpatient billing evidence is not retained to substantiate the patient's election to be bulk billed. Our survey found that 65 per cent of SMOs did not consider the current billing practices to be efficient.

Limited system integration results in significant manual effort and post transaction processing controls so that administration officers can bill accurately and completely. For example, the clinical systems used for diagnostic imaging and cancer care do not have integrated billing modules or interfaces with the private practice billing system. As such, services provided have to be identified from the clinical system and manually entered into the billing system for invoicing. This results in double-handling that is prone to human error. In 2011–12, over 307 000 diagnostic imaging transactions had to be re-entered manually.

Manual reconciliations and exception reports are generated and reviewed in an attempt to identify whether invoices have been raised for all billable services. Verification of invoices raised in the separate billing system also requires extensive manual review of information contained in separate clinical systems and patient charts.

Furthermore, there has been a lack of central guidance on the most effective design and methods of implementing billing controls in each facility. Queensland Health undertook reviews of selected HHSs during the 2011–12 and 2012–13 financial years which provided recommendations to improve local processes within the existing environment. However, the scheme would have benefited from earlier intervention of this nature and potentially avoided clinical units needing to develop their own localised methods to ensure that billing is accurate and complete.

Inpatient billing

The public hospital system must assume patients will be treated as a public patient until the patient elects to be treated privately. Once a patient elects to be treated privately, the entire episode of care from the time of admission is able to be billed. In the absence of integrated information systems, changes in patient status from public to private need to be captured retrospectively for billing by administrative staff. This is a highly manual process.

Queensland Health undertakes 'chart audits' for billing inpatients: this process is the primary means of collating all data to raise an invoice for the private practice services provided. The chart audits are needed because systems to bill patients at the time of their discharge do not exist and SMOs fail to provide billing details on a timely basis to administrative staff. SMOs are contractually obligated to provide all relevant billing details by the end of each week; however, the failure by SMOs to provide this information means administrative personnel are required to identify billable items from the chart audits.

This creates an additional process to reconfirm the billable items with the treating SMO, which in turn adds to the length of time required to finalise a chart for billing purposes. HHSs advise other factors affect the timely completion of chart audits, namely:

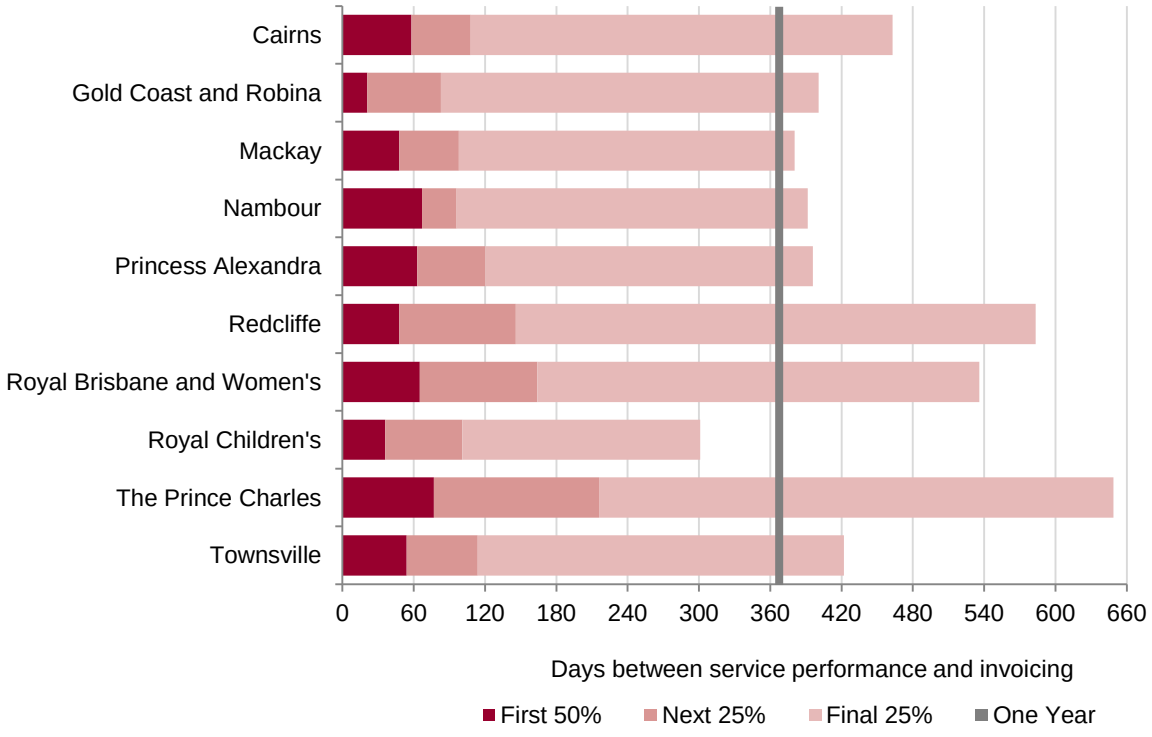
- the need for clinical coding to be completed for compliance reporting
- timeliness of medical record delivery
- manually cumbersome processes to decipher clinical notes
- searches of multiple information systems.

Claims for payment by Queensland Health for private inpatients can be made up to a maximum of two years from the date the service was provided. A number of facilities have long-outstanding chart audits for billing inpatients. For example, as at February 2013, Princess Alexandra Hospital had 3 244 outstanding chart audits—some of which date back as far as May 2011—and the Royal Brisbane and Women's Hospital had 1 776 outstanding chart audits, some of which date back as far as September 2012.

We analysed the billing data for the top ten billing facilities to assess whether the high level of outstanding chart audits had an impact on the timeliness of raising invoices.

Figure 4D shows that it takes 60 days on average to invoice 50 per cent of all private inpatients; up to 216 days to complete the next 25 per cent of inpatient invoices; and, in one facility, up to 649 days to complete invoicing of all private inpatients.

Figure 4D
Inpatient billing by facility
Time lag in days between service performance and invoicing
2011–12



Source: QAO using data extracted from Queensland Health billing system

Retention of Medicare assignment forms

In 2009, Queensland Health issued advice to all health districts that drew attention to Medicare's changed stance on 'bulk billing', particularly the retention of the Medicare assignment form. This is the form signed by a patient as evidence that he or she has agreed to assign the Medicare rebate to the treating SMO.

Medicare changed the documentary evidence requirements to allow the destruction of the assignment form. Queensland Health subsequently determined that this could occur shortly after receipt of funds and advised facilities accordingly. Queensland Health did not seek approval from the State Archivist prior to making the decision to allow destruction of these assignment forms.

In the absence of any other relevant documentation, the assignment form is the only evidence that an outpatient has elected to be treated as a private patient. These documents therefore are critical to support the validity of all outpatient revenue that is billed.

4.3.3 Potential for revenue uplift

Given the lack of system integration, ineffective monitoring and review, variable administrative practices and lack of active involvement from SMOs in maximising billing opportunities, we undertook analysis to identify opportunities to improve billing and collections. Our list is not exhaustive and our estimates are conservative. The intention of this exercise was to demonstrate the potential amounts of revenue foregone within the current environment.

We tested our assumptions using Queensland Health's 2011–12 data and identified several areas with the potential to increase revenue by $22.76 million. To capitalise on these revenue opportunities, senior medical officers and administrative staff will need to work collaboratively. Inherent to generating this revenue is the need for accurate, timely and complete source documentation to identify billable services—this will require that SMOs adhere to their contractual responsibilities.

Figure 4E
Potential revenue uplift
2011–12

Category	Potential revenue uplift $ m
Inpatient bedside consultations	4.78
Admission through the emergency department	0.37
Diagnostic imaging	2.41
Pathology	12.41
Procedures without a facility charge and administration fee	0.39
Reviewing the facility and administration fees	2.40
Total	**22.76**

Source: QAO using data extracted from Queensland Health billing system, emergency department information system, various radiology information systems, pathology system, payroll system and clinical system

The Queensland Health Revenue Strategy and Support Unit has established a 2013–14 target to generate an additional $17.73 million in revenue from outpatient billing.

Inpatient bedside consultations

SMOs can bill for a bedside consultation for a private inpatient; this requires the SMO to record the consultation on the patient chart or notify administrative staff at the end of a ward round that a consultation has occurred.

To identify the level of billing for these consultations, we compared the number of overnight bed days for privately insured and Department of Veterans' Affairs (DVA) inpatients to the number of consultations billed by SMOs. We calculated the ratio of bed days to the number of billed consultations to determine an average rate. Our analysis excludes same day patients and patients receiving surgical procedures, which includes post-operative care and thus would not be billed as separate consultations.

Figure 4F shows wide ranging practices across the facilities that we visited, contrasted with Mackay Base Hospital, which billed more consultations per overnight bed day.

Figure 4F
Average bed days per billable consultation
2011–12

Facility	Average bed days per billable consultation
Mackay Base Hospital	1.88
Townsville Base Hospital	4.41
Royal Brisbane and Women's Hospital	5.60
Princess Alexandra Hospital	11.10
Gold Coast and Robina Hospitals	24.80

Note: Excludes consultations that were not billed such as those undertaken by registrars or VMOs, or consultations performed by SMOs that were not recorded for billing

Source: QAO using Queensland Health clinical and billing systems

The composition of the medical workforce (such as a higher proportion of VMOs who do not have a right of private practice contract) and the varying case-mix will affect the ability to bill inpatient consultations. In addition, the backlog of chart audits and delays in invoicing inpatients will affect the data presented in Figure 4F.

Figure 4G illustrates the potential revenue uplift should a higher rate of inpatient consultations be performed and billed across all facilities.

Figure 4G
Potential revenue uplift: bedside consultations
2011–12

Inpatients' billable bedside consultations	Potential revenue $ m
Average every two days	4.78
Average every three days	2.51
Average every four days	1.37

Source: QAO using data extracted from Queensland Health clinical, billing and payroll systems

Admission through the emergency department

Emergency department SMOs are paid an 'extended hours benefit', in addition to the Option A allowance, where their rostered ordinary hours coverage is at least from 8:00am until 10:00pm Monday to Friday and includes weekend coverage. These SMOs have limited capacity to provide private services as all patients presenting to emergency departments are treated free of charge until such time as they are admitted to hospital and elect to be treated privately.

Patients may be admitted under an emergency department SMO to an emergency medical unit or short stay ward. One health district received advice in 2012 from the federal Department of Human Services that consultations can be billed by emergency department SMOs after deciding to admit the patient and the patient elects to be treated privately.

To determine the extent of billing performed by emergency department SMOs, we analysed data on privately insured or DVA patients from the Emergency Department Information System (EDIS) that were admitted through the emergency department and were not discharged in EDIS within six hours of admission. This analysis was performed across all public hospitals for the period January to May 2012.

Applying the relevant rates from the Medicare Benefits Schedule (MBS) to the number of patients identified in our analysis, we have estimated a potential revenue uplift of $0.15 million. Extrapolated over twelve months, the value of this potential revenue uplift is $0.37 million.

Diagnostic imaging

Due to the lack of integrated information systems and the highly manual process for raising invoices for diagnostic imaging services, the risk arises that not all billable services will be captured. We examined the potential for unbilled services across six patient scenarios, using data from the radiology information systems of the four hospitals we visited plus Nambour General Hospital.

We analysed this data with the billing, clinical and emergency department information systems for the period January to May 2012 and extrapolated these results for a full financial year. Some of our scenarios are more likely to result in a billable service than others and we have therefore discounted the potential revenue using the percentage estimates in Figure 4H. For example some radiology services are unable to be billed where:

- they have been performed by registrars or VMOs
- inpatients presented to an emergency department on the day they were admitted, due to services linked to an emergency department being provided free of charge.

Figure 4H shows the potential revenue uplift that could be achieved for diagnostic imaging. One of the six scenarios yielded a result of less than $70 000 when extrapolated over a year and has been excluded.

Figure 4H
Potential diagnostic imaging uplift
2011–12

Scenarios	Extrapolated over a year $ m	Percentage estimate	Potential revenue $ m
Patient received a private consultation 30 days before the imaging service	1.35	50%	0.68
Private health insurance or DVA inpatient received imaging service(s), excluding the first and last days of stay	1.38	50%	0.69
Radiology imaging system examination with no matching record in: • emergency department • inpatient services • outpatient clinics within the last 30 days	1.39	30%	0.42
Private health insurance or DVA inpatient with an imaging service on the first or last day of stay and not linked to the emergency department	0.81	30%	0.24
Private health insurance or DVA inpatient with an imaging service on the first day of stay and an emergency department presentation on the same day	1.89	20%	0.38
Total			**2.41**

Source: QAO using data extracted from Queensland Health billing system, emergency department information system, various radiology information systems and clinical system

Pathology

Due to the lack of integrated information systems, the risk arises that not all billable services will be captured. The ability to bill private patients is also affected by the patient being identified correctly as a private patient on the request form and the requesting SMO having a valid Medicare service provider number. We examined the potential for unbilled services across four patient scenarios, using data from the statewide pathology information system.

We analysed this data with the billing, clinical and emergency department information systems for the period January to May 2012 and extrapolated for a full financial year. Figure 4I shows the potential revenue uplift that could be achieved. Some of our scenarios are more likely to result in a billable service than others and we have therefore discounted the potential revenue using the percentage estimates in Figure 4I. One of the four scenarios yielded a result of less than $20 000 when extrapolated over a year and has been excluded.

Figure 4I
Potential pathology uplift
2011–12

Scenarios	Extrapolated over a year $ m	Percentage estimate	Potential revenue $ m
A patient received a private consultation 30 days before the pathology service	14.86	50%	7.43
A private or DVA inpatient received a pathology service, excluding the first and last days of their stay	8.96	50%	4.48
Private or DVA inpatient with a pathology service on the first day of stay admitted through the emergency department	2.53	20%	0.50
Total			**12.41**

Source: QAO using data extracted from Queensland Health billing system, emergency department information system, pathology information system and the clinical system

Procedures without a facility charge and administration fee

The schedule of facility charges and administration fees charged by Queensland Health for Options B and R SMOs is contained within the B48 policy. The fees and charges are established as a percentage of the relevant MBS item numbers. This schedule was last revised before 2001, meaning that changes in the MBS, such as the inclusion of new items, have not been reflected.

For the 2011–12 financial year, we identified $1.13 million in billings for which no facility charges and administration fees were levied on Options B and R SMOs; and $4.86 million for the period 1 July 2002 to 31 December 2012.

We have calculated a potential revenue uplift of:

- $0.39 million in the 2011–12 financial year
- $1.45 million from 1 July 2002 to 31 December 2012.

Reviewing the facility charges and administration fees

The rates of facility charges and administration fees have not been revised since the rates were set prior to 2001 and Queensland Health was unable to demonstrate whether the current fees and charges are achieving their original aims. The implementation taskforce in 1986 identified the need for ongoing monitoring of the facility charges.

A review of facility charges and administration fees was undertaken in 2001 and recommended new rates. However, these were not adopted by Queensland Health; we were not provided with documentation detailing the reason(s) why.

Queensland Health commissioned a further review by an external consulting firm in 2010. It found:

> *The facility [charges] and administration [fees] are unable to be reconciled to a pre-existing methodology and appeared haphazard in design and application. Additionally there are items in the [B48 policy] that are end dated in the MBS and therefore the facility [charges] and administration [fees] attached to those procedures are no longer relevant.*
>
> *There is a lack of an established governance and management structure of the RoPP arrangements. Given the level of co-contribution by Queensland Health, the fundamentals of the RoPP arrangements should be reviewed regularly to reflect accuracy and market relevance.*

As the facility charges and administration fees are 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. Queensland Health has not determined whether these proportionate increases are sufficient to recover their intended costs.

In the absence of any revision to the existing fees, we have referenced the June 2001 proposed rates for facility charges and administration fees to determine the potential uplift in revenue.

Adopting these rates would have resulted in an additional:

- $2.40 million in the 2011–12 financial year
- $11.01 million for the period 1 July 2002 to 31 December 2012.

This excludes the impact of the Option R subsidy and items without a facility charge and administration fee.

Outpatient bulk billing

Queensland Health has identified that the 2012–13 average rate of bulk billing across Queensland public hospitals is 32 per cent of potentially billable patients.

If the ability to bulk bill was available at all outpatient clinics and HHSs billed 50 per cent of all privately identified patients, Queensland Health estimates an additional $17.73 million could be generated (based on the 2011–12 activity levels). This would require HHSs to ensure that doctors with a right of private practice attend sufficient clinics to achieve a 50 per cent target. Queensland Health has built this target into their budget and the budgets of HHSs.

We have not calculated the cost to:

- implement bulk billing (or mixed) clinics at the 37 facilities with the potential to bill that are not billing currently
- to increase the number of bulk billing (or mixed) clinics at the facilities that are currently billing.

We have not included this potential uplift in our calculations as this has already been identified by Queensland Health.

4.4 Expenditure management and control

Revenues generated from the RoPP scheme are disbursed three ways: to Queensland Health; to SMOs; and into study, education and research trust accounts (SERTA and SERTF). Funds held within SERTA and SERTF may be applied only for specified purposes.

We examined whether adequate systems and processes are in place to ensure these disbursements are accurate and in accordance with policy and contractual conditions.

The policies governing right of private practice contain specific provisions on the payment of overtime for SMOs. In 2011–12, the average overtime paid to an SMO amounted to 18.7 per cent of his or her base pay.

We also examined management's monitoring of overtime, compliance with the right of private practice policies and the relationship between the amounts of overtime paid to roster management.

4.4.1 Disbursement of revenue generated

Private practice revenue is receipted into a separate private practice bank account at each facility before being disbursed monthly in the proportions detailed in policy and contractual obligations to:

- Queensland Health
- SMOs participating in Options B, R and P
- study, education and research trust accounts (SERTA and SERTF).

Determining the split of these funds is a complicated process. We identified a number of control and process issues which increase the risk of error and increase the administrative burden, including:

- each facility has its own customised monthly spreadsheets to calculate the split of payments—the extent of data integrity controls in the spreadsheets vary significantly
- there are contradictions between the policy and contracts on when to apply GST in calculating the Options B and R SERTA threshold—the contract states that GST is not to be included in calculating the earnings cap whereas the policy document states that GST is to be included in calculating the earnings cap
- Options B and R SMOs are entitled to a share of the interest earned on the funds held in the private practice bank account prior to the monthly disbursement process—the interest split calculations are made difficult with Option A and B receipts being deposited into the same bank account
- SMOs can work at multiple facilities, each with its own billing database and doctor identifier; to track if and when an SMO reaches the SERTA threshold, administrative staff must request billing information from any facility at which their SMOs have worked during the month as the billing databases are not linked or centrally monitored for this purpose
- private partnership arrangements between SMOs participating in Options B or R require an additional level of administrative effort due to the changes in membership.

There is no prescribed method, common policy or standard procedure to recognise and pay Options B and R SMOs. Some facilities pay their SMOs directly from the private practice bank account via electronic funds transfer or manual cheque without recording details of the payment in the general ledger; others establish accounts payable vendors for SMOs but do not record these payments through the income statement. This hinders effective oversight of the scheme as the quantum of payments will not appear on management reports generated from the general ledger.

4.4.2 Disbursements into SERTA and SERTF funds

Individual facilities maintain SERTA and SERTF that are funded from the net billings of SMOs participating in Options B, R and P. Each facility is required to establish an advisory committee, whose members include participating SMOs, to assess all expenditure applications.

Outlays from both SERTA and SERTF are restricted to:

- grants for study, research and educational purposes for employees within the facility
- funding for equipment or other property for operational, research and educational purposes that may not be within the normal budgeting capacity of the HHS
- funding to employ staff in research or education.

Figure 4J shows that, since 2003–04, the balance of the funds has grown by 377.1 per cent to $45.8 million. The balance allowed to accumulate in these funds is not capped.

Figure 4J
SERTA or SERTF balances per facility ($ million)
2003–04 to March 2013

Facility	03-04	04-05	05-06	06-07	07-08	08-09	09-10	10-11	11-12	12-13
Princess Alexandra Hospital	4.0	5.3	7.2	7.9	9.9	11.9	14.1	15.7	18.3	19.7
Royal Brisbane and Women's Hospital	1.6	2.6	3.9	5.4	6.8	7.8	8.0	7.7	7.0	6.0
Townsville Hospital	1.1	1.0	1.0	1.4	1.8	2.5	2.8	3.2	4.4	5.4
Pathology Queensland	0.8	0.8	0.8	1.0	1.4	1.8	1.8	2.2	3.5	4.8
Royal Children's Hospital	0.0	0.0	0.0	0.1	0.4	0.6	1.0	1.4	1.8	2.0
Toowoomba Hospital	0.8	0.8	0.8	0.9	0.9	0.9	0.9	0.9	1.4	1.9
Nambour Hospital	0.4	0.4	0.4	0.7	1.0	1.1	0.8	0.9	1.3	1.4
Gold Coast Hospital	0.1	0.0	0.1	0.1	0.1	0.1	0.1	0.2	1.0	1.3
Redcliffe Hospital	0.1	0.1	0.2	0.3	0.5	0.7	1.0	1.1	1.1	0.9
The Prince Charles Hospital	0.5	0.6	0.7	0.9	0.6	0.5	0.5	0.2	0.7	0.7
All others	0.2	0.3	0.4	0.4	0.7	1.0	1.3	1.5	1.7	1.7
Total	**9.6**	**11.9**	**15.5**	**19.1**	**24.1**	**28.9**	**32.3**	**35.0**	**42.2**	**45.8**

Source: QAO using data extracted from Queensland Health general ledger

The growth in balances has been driven largely by the growth in private practice revenue, combined with:

- a failure to revise facility charges and administration fees since before 2001
- the introduction of the Option R subsidy for radiologists since 2006
- the unchanged status of Options B and R earnings caps since 1 January 2011.

These have meant that relatively more revenue is attributed to SMOs and to SERTA or SERTF than to HHSs, leading to increased numbers of SMOs exceeding their revenue thresholds as billing activity has increased.

The increased inflows have not been matched by increased outflows. This has been driven by:

- a lack of active promotion of available funds to all staff at the facility
- facility-specific business rules restricting the quantity and value of applications an individual can make to the funds in any one year.

4.4.3 Overtime payments to SMOs

A full time SMO is employed over an 80 hour fortnightly roster to provide medical services with demand for 24 hour care. This can necessitate the working of two types of overtime for which SMOs can be compensated:

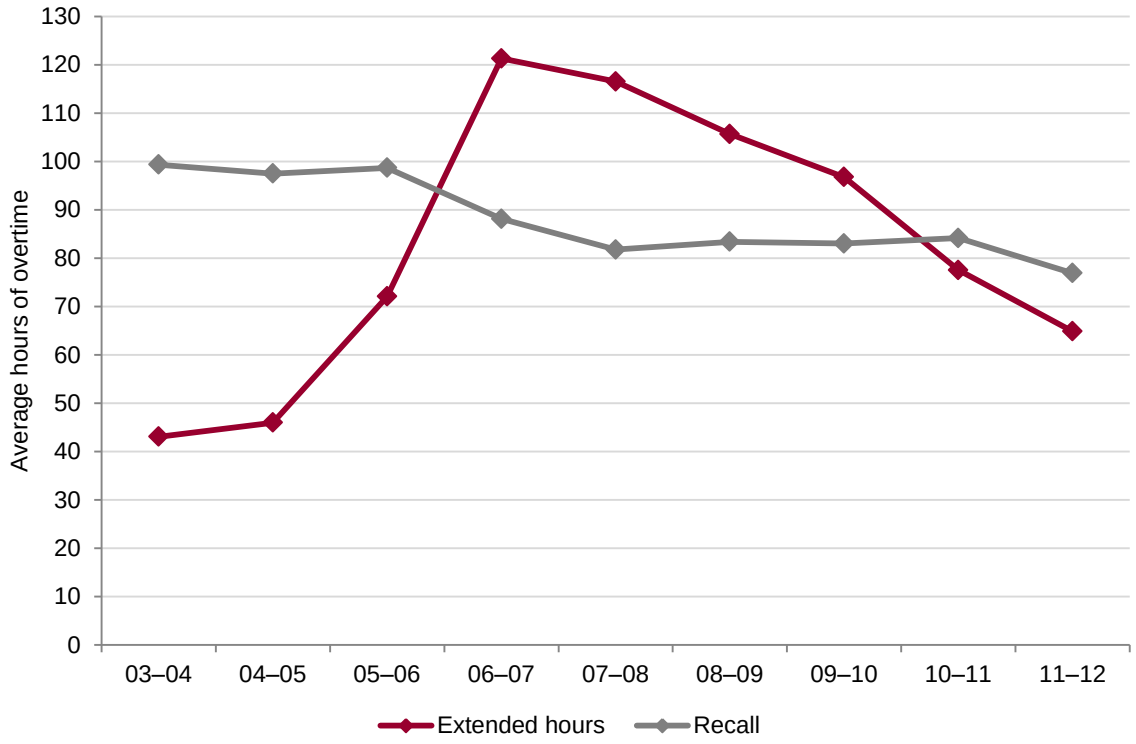
- extended hours—paid when the SMO is required to start earlier or finish later than his or her standard hours
- recall—paid when the SMO is recalled to duty 'out of hours'.

Between 2004–05 and 2011–12, the number of full time equivalent SMOs has grown by 1 182 (107.0 per cent). Acute hospital activity, measured by outpatient occasions of service and inpatient episodes of care, has increased by 26.4 per cent over the same period. In this context, it could be expected that the average amount of overtime required of SMOs would have decreased.

Contrary to this expectation, the average extended hours overtime has not decreased significantly as the number of SMOs has increased. The increase in SMOs had an early positive impact in reducing recall hours between 2005–06 and 2007–08; however, this trend has not continued.

Figure 4K shows the average number of overtime hours claimed by SMOs since 2003–04, split into extended hours and recall hours per full time equivalent. This shows a significant increase in extended hours overtime from 2004–05 to 2006–07 (163.8 per cent). While the level of extended hours overtime reduced in subsequent years, there was an overall increase of 41.3 per cent from 2004–05 to 2011–12. Over the same period, the average number of recall hours has decreased by 21.1 per cent.

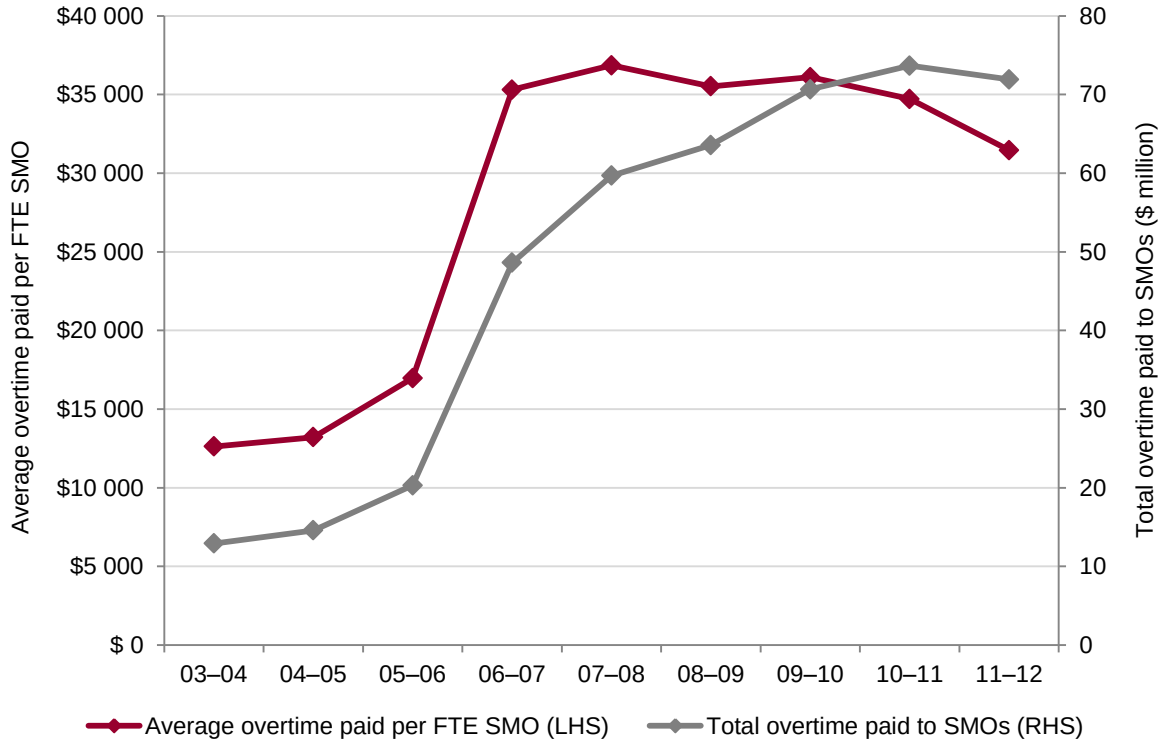
Figure 4K
Average hours of overtime claimed per full time equivalent SMO
2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

Figure 4L shows the average amount of combined extended hours and recall overtime paid per full time equivalent SMO and the total amount of overtime paid to SMOs since 2003–04.

Figure 4L
Average overtime paid per full time equivalent SMO vs total overtime paid to SMOs 2003–04 to 2011–12



Source: QAO using data extracted from Queensland Health payroll system

Between 2004–05 and 2011–12, the average overtime paid per full time equivalent SMO has grown by 138.1 per cent. In 2011–12, this equated to 18.7 per cent of an SMO's base pay. As part of the scheme changes in 2006, the value of overtime increased when the Option A allowance was included in the hourly rate for the calculation of overtime payments for all SMOs, regardless of their option.

In one extreme case, an SMO claimed overtime of $709 360 in 2011–12. This represents $677 903 more than the average overtime per full time equivalent of $31 457.

Option B and R overtime

Policy B48, governing Option B and R contractual arrangements, prohibits SMOs from attributing significant periods of private practice towards the calculation of extended hours overtime on any one day. This is due to the SMOs directly benefiting—by receiving a portion of the revenue—from treating private patients.

While ‘significant periods of private practice’ is referred to as measurable blocks of time, Queensland Health does not quantify this term, nor does it have an effective management mechanism to enforce this requirement.

In the absence of a measure of what constitutes 'significant periods of private practice', we developed a proxy measure based on the number of items billed and the dollar value of billings on a daily basis. To establish whether the B48 policy requirement may have been breached, we then modelled two scenarios using our proxy measures on a per day basis:

- billed at least 10 items or more than $1 000—low range
- billed at least 20 items or more than $4 000—high range.

These ranges were based on consultations as an indicator of the extent of services provided—consultations are the item billed most frequently by SMOs. For the sake of our analysis, we determined that seeing 10 patients would constitute a 'significant' period of time. The average consultation billed in the Queensland Health billing system is approximately $100; therefore, $1 000 was used as the indicator for the amount billed.

We matched these two scenarios to days when Option B and R SMOs claimed extended hours overtime and, to exclude isolated instances, included only those SMOs with 20 or more days in the year where the scenario applied. This equates to (approximately) once per fortnight when recreation leave (4 weeks), professional development leave (3.6 weeks) and public holidays (2.1 weeks) are taken into account.

The first scenario identified 39 specialists in 2011–12 who collectively claimed $1.44 million in extended hours overtime. The second scenario identified 18 specialists who collectively claimed $0.66 million in extended hours overtime.

Figure 4M illustrates our findings for 2010–11 and 2011–12 by HHS. In the absence of other methods to measure what is 'significant', our criteria indicate that the B48 policy requirement may have been breached.

Figure 4M
Extended hours overtime claimed by Option B and R SMOs per HHS 2010–11 and 2011–12

Hospital and Health Service	2011–12 $		2010–11 $	
	>10 items or $1 000 billed	>20 items or $4 000 billed	>10 items or $1 000 billed	>20 items or $4 000 billed
Children's Health Queensland	54 000	27 588	81 456	35 749
Darling Downs	156 494	153 572	—	—
Gold Coast	52 481	—	44 585	—
Metro South	247 943	27 853	212 980	57 002
Metro North	852 289	435 225	921 734	554 829
Townsville	77 169	12 627	238 537	127 835
Total	**1 440 376**	**656 865**	**1 499 292**	**775 415**

Source: QAO using data extracted from Queensland Health billing and payroll systems

Roster management

HHSs use rosters to manage the workload of their SMOs. Queensland Health and the HHSs do not require the medical workforce to submit timesheets. An Attendance Variation and Claim form (AVAC) must be submitted and approved where a variation to the roster occurs (such as overtime).

The current rostering practices vary significantly in the level of detail recorded across facilities and specialties. Some rosters detail hour by hour activity across categories such as clinics, theatre, ward rounds and teaching. Others only show the span of hours SMOs are required to attend hospitals and their on-call requirements. The rosters for a variety of specialties at the facilities we visited allocated blocks of time in a working day to periods referred to as 'clinical support time'.

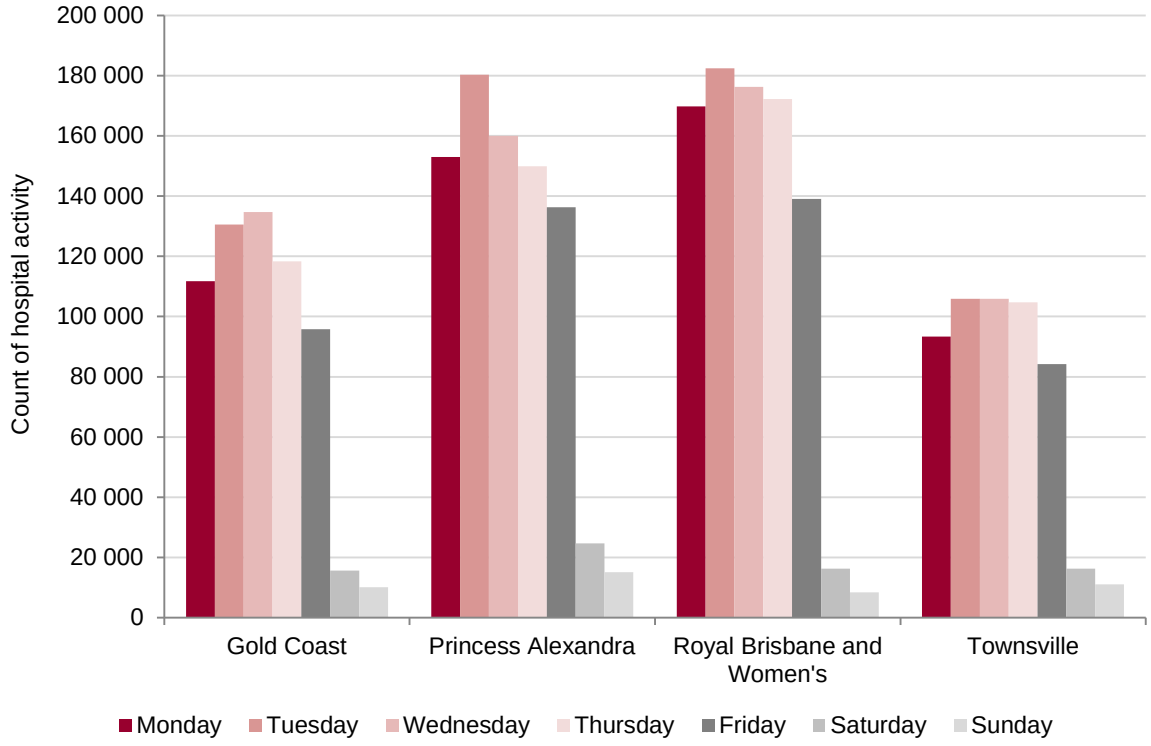
Doctors' clinical time—for example, surgery and outpatient clinics—is more transparent than their clinical support time, which encompasses activity such as teaching, research and administration. The management of clinical support time is at the discretion of the specialty director and there is a wide variation in the degree of oversight of this time.

The Medical Officers' (Queensland Health) Certified Agreement (No. 3) 2012 (MOCA 3) outlined minimum clinical support provisions and that this time is to be determined in consultation with the specialty director. We note that some directors of specialties are quite specific on what clinical support activities are to be delivered and include activities such as reviewing journal articles, update of clinical procedure manuals and delivery of teaching sessions.

All of the facilities we visited provide for SMOs to complete their full time workload of 80 hours a fortnight over an eight day period (typically 10 hour days and four days a week). At the hospitals we visited, we analysed 2011–12 hospital activity (outpatient occasions of service, inpatient admissions and elective surgery) to better understand whether activity was distributed equally across the working week.

Figure 4N shows that Mondays and Fridays have appreciably lower levels of activity than those undertaken midweek. There are valid clinical reasons for this, such as undertaking complex elective surgery earlier in the week to take account of intensive care needs. However, we are unable to determine the extent other factors, such as unplanned clinical demand across the week, contribute to this pattern of activity.

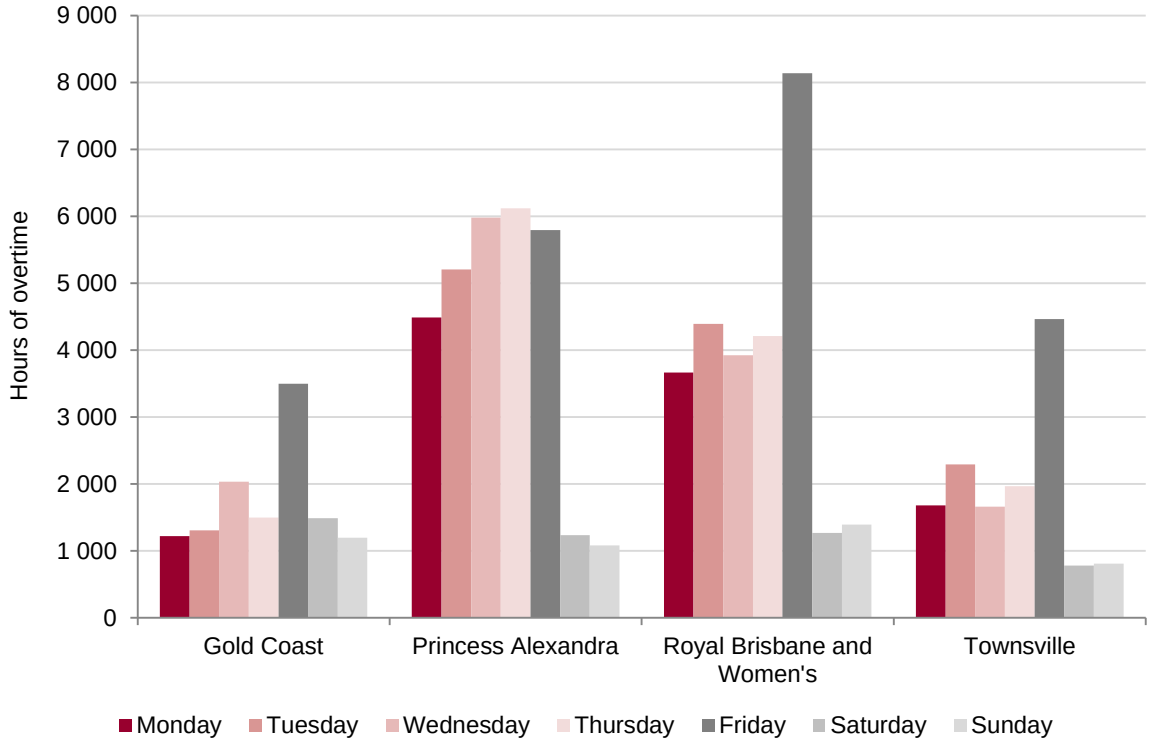
Figure 4N
Hospital activity levels by weekday
2011–12



Source: QAO using data extracted from Queensland Health clinical system

We then analysed extended hours overtime claimed by SMOs by day of the week with the expectation that this would correlate to the periods of increased hospital activity. Figure 4O shows that, in the four hospitals we visited, overtime claimed on Fridays is disproportionally large compared to the relative proportion of clinical activity undertaken on that day.

Figure 4O
SMO extended hours overtime by day of the week
2011–12



Source: QAO using data extracted from Queensland Health payroll system

In three of the four hospitals, the level of extended hours overtime claimed on Fridays is higher than any other day. We identified that this behaviour was not evident prior to 2006; this change correlates to two terms introduced in MOCA 1 in 2006:

- transition from a 90 hour fortnight to a 40 hour week for SMOs (changed subsequently to an 80 hour fortnight in MOCA 3)
- the ability for SMOs to complete these hours over four days per week through 10 hour shifts.

Our discussions with clinical directors and review of current rostering arrangements revealed that a number of specialties have 'rostered' overtime each week or fortnight, particularly on Fridays. This was most evident where SMOs predominately worked four days a week with 10 hour shifts. When viewed in light of this data, the two terms introduced in MOCA 1 may have had the unintended consequence of enabling more overtime for SMOs.

4.5 Recommendations

All recommendations need to be considered in light of the final model of activity based funding under the National Health Reform Agreement.

It is recommended that Queensland Health and the Hospital and Health Services:

5. **make immediate attempts to recover foregone revenue, if cost effective, and investigate further revenue uplift opportunities**
6. **develop a strategy and engage with private practice participants, medical administrators and support staff to communicate a consistent message aligned with the objectives of the redesigned scheme, including contractual obligations**
7. **redesign end to end business processes and systems to support enhanced revenue and expenditure management including rostering and overtime**
8. **review the objectives and the principles governing the use of the study, education and research funds (SERTA and SERTF) to ensure maximum benefits are derived for the state.**

Appendices

Appendix A—Agency comments

Auditor-General Act 2009 (Section 64)—Comments received

Introduction

In accordance with section 64 of the *Auditor-General Act 2009,* a copy of this report was provided to the following entities with a request for comment:

- Queensland Health
- Metro North Hospital and Health Service (HHS)
- Metro South HHS
- Townsville HHS
- Gold Coast HHS.

In accordance with section 64 of *the Auditor-General Act 2009*, relevant extracts of this report were provided to the following entities with an invitation to comment:

- Cairns and Hinterland HHS
- Children's Health Queensland HHS
- Darling Downs HHS
- Mackay HHS
- Sunshine Coast HHS
- Wide Bay HHS.

Responsibility for the accuracy, fairness and balance of the comments rests with the head of these agencies.

Comments received

Response provided by the Director-General, Queensland Health on 28 June 2013.

RECEIVED
02 JUL 2013
QUEENSLAND AUDIT OFFICE

Queensland Government

Queensland **Health**

Enquiries to: Dr Michael Cleary
Deputy Director-General
Health Service and Clinical Innovation
Telephone: 3405 6181
File Ref: DG071051

E-MAILED
28 JUN 2013

Mr Andrew Greaves
Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002

By email: andrew.greaves@qao.qld.gov.au

Dear Mr Greaves Andrew

I refer to your letter dated 6 June 2013, regarding the Queensland Audit Office's (QAO) proposed report on the performance audit of the right of private practice in Queensland public hospitals, which will be tabled in Parliament in early July.

I thank you for the opportunity to provide the enclosed response to the proposed report. Queensland Health's response consolidates comments from the Department of Health and Hospital and Health Services, and includes general comments as well as the QAO template commenting on each of the recommendations.

Should your officers require further information, Queensland Health's contact is Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation, on telephone 3405 6181.

Yours sincerely

Dr Tony O'Connell
Director-General

Encl. 2

Office
19th Floor
Queensland Health Building
147 - 163 Charlotte Street
BRISBANE QLD 4000

Postal
GPO Box 48
BRISBANE QLD 4001

Phone
3234 1553

Fax
3234 1482

Comments received

Response provided by the Director-General, Queensland Health on 28 June 2013.

Right of Private Practice in Queensland Health public hospitals

Response to the Performance Audit Report

Response to the performance audit report provided by Director-General, Department of Health on 27 June 2013.

The right of private practice for medical practitioners within the Queensland public sector health services is extremely complex. Undertaking a performance audit of such a complex system is commendable both in terms of the scope and the depth of the review. The audit has provided independent, credible and comprehensive evidence for the redesign of the right of private practice for medical staff who work within the public sector. Work already underway within the Department of Health has been enhanced so that it aligns with the recommendations of the audit. These changes will include the redesign of the right of private practice in the Queensland public sector health services: a redesign that will transform the private practice arrangements for medical staff within the Queensland public health sector.

The recommendations of the audit report are accepted by the Queensland Department of Health.

The current forms of right of private practice are the result of 27 years of progressive variation to a system of practice. The original arrangement for the right of private practice in 1986 was designed to enhance clinical practice within the public healthcare system.

It is evident from this performance audit that the various revisions of the scheme attempted to align two competing policies; redressing medical workforce shortages and optimising private practice arrangements.

A major variation in the private practice arrangement was instituted in 1992. This change attempted to redress the senior medical officer recruitment and retention challenge as evidenced by the 20% vacancy rate reported at the time. The principal policy driver at that time was to establish a new revenue stream from private practice conducted by doctors not already exercising a right of private practice. The audit report correctly concludes: "there is no evidence of adequate rigour in the design of the scheme or in subsequent analysis of the impact of further changes". The 1992 proposal contains an internal inconsistency between revenue and retention objectives, which assumed the proposed scheme had the financial capacity to shoulder the full burden of a remuneration package redressing the recruitment and retention challenge. This was not an achievable policy direction.

It is noteworthy that the Industrial relations *Circular IR 38/93*, states:

> *The Government approved the introduction of the arrangements to help ensure the recruitment and retention of full time medical specialists into the public health system. This is an important aspect of the overall strategy to improve health services throughout Queensland.*

However, in the very next paragraph this document states:

> *Option A is designed to be self funding with all monies being kept by the Hospital to cover the payment of the allowance and any other costs related to the scheme.*

Comments received

Response provided by the Director-General, Queensland Health on 28 June 2013.

Almost by definition these policy objectives were conflicted, particularly in the context of a relatively low private insurance rate at that time. This internal inconsistency established an irreconcilable tension in operation of "Option A" private practice arrangement from 1992 to the present.

The major enhancements to the "Option A" private practice arrangement provided a supplementary benefit for senior medical staff in 1995 and 2006. This added to the tension and aggravated the burden of a competitive senior medical officer remuneration package.

It might reasonably be concluded, as the audit reports, that the scheme has resulted in a cost burden on the public health system over the last decade. This is a reasonable conclusion only if the original premise of cost-neutrality is reasonable given this policy also sought to enhance the recruitment and retention of the senior medical workforce.

Since 1986 arrangements that underpin the provision of public sector health services have significantly changed in terms of organisation and funding. Within this context, access to private practice still offers significant business and service advantages to Hospital and Health Services. A redesigned arrangement of private practice will ensure these potential benefits are realised by Hospital and Health Services. In this context, the Department of Health will develop, in consultation with stakeholders, new employment arrangements for senior medical officers that will address the recommendations of this performance audit.

Responses to recommendations

Responses to recommendations provided by the Director-General, Queensland Health on 28 June 2013.

Right of Private Practice in Queensland Health public hospitals

Responses to recommendations

Response to recommendations provided by Director General, Department of Health on 27 June 2013.

Recommendation	Agree / Disagree	Timeframe for Implementation	Additional Comments
1. Redesign private practice arrangements to incentivise practitioners so the scheme is financially sustainable.	Agree	• Concept design of redesigned private practice arrangements in the Queensland public sector health services completed – 31 May 2013 • Approval of the concept design – July 2013 • Detailing of: a. fees, b. policy & standard and calibrating and retrospective, operational testing of the model of private practice for Senior Medical Officers and Visiting Medical Officers completed – 30 September 2013 • Consultation, refining & completion of state implementation planning – 31 December 2013 • Implementation of pilot of employed VMO "release" into private practice – January 2014 • Completion of HHS implementation planning – 31 March 2014 • Implementation commenced – 1 July 2014 • Implementation completed – 31 December 2014	The Department of Health (DoH) and Hospital and Health Services (HHSs) accept this recommendation. A taskforce commissioned by the Director-General, DoH, in November 2012 to reform "right of private practice" has completed redesign of private practice in concept. The response to this recommendation and others which follow is based in large part upon the work completed, with significant elements beyond concept design now in progress. The completed concept design wholly transforms private practice within the Queensland public sector health services. It: • encompasses all private practice • establishes an objective of State benefit, particularly for public medical services • integrates thoroughly and dependently with redesigned medical officer engagement by the State in a manner which appropriately places key responsibility for workforce recruitment and retention in the remuneration package • confers the "right of private practice" in public facilities by a standard principle of "release" of an employed practitioner or "license" of a private practitioner • establishes operational conformity to relevant government policy and commercial standards • conforms transparently to the regulatory framework of Commonwealth and State legislation and agreements • conforms to principles assuring patient safety and priority of clinical practice • conforms to business principles gaining maximum advantage for the business objectives of HHS in fulfilling Service Agreements • conforms to standards of excellence in governance and performance accountability in both state operation and health service operation • depends upon a comprehensive educational framework, to assure appropriate orientating and/or training of all relevant staff regarding private practice
2. Establish clear targets for the optimal medical workforce in the context of desired clinical, patient access and financial	Agree	Implementation completed by 1 July 2014 to align with commencement of new funding arrangements under the National Health Reform Agreement	The DoH and HHSs accept this recommendation. This is largely a HHS activity, linked to (documented) workforce planning and employment strategy of each HHS. As indicated in the recommendation, optimal medical workforce targets will necessarily be

*Page **1** of **5***

Responses to recommendations

Responses to recommendations provided by the Director-General, Queensland Health on 28 June 2013.

Recommendation	Agree / Disagree	Timeframe for Implementation	Additional Comments
outcomes.		and new contract of employment arrangements	subject to: • strategic goals of HHSs relating to clinical service and service access • clinical practice standards • funding framework under the National Health Reform Agreement (NHRA) Targets will also be subject to: • consideration of safe hours and sustainable rosters which at times dictates a critical minimal number of practitioners • redesigned private practice arrangements • redesigned contract employment arrangements • alternate service / workforce capacity in private sector health services
3. **Develop an appropriate governance framework for private practice arrangements, which includes:** • **An oversight body comprising members with sufficient skill, authority and responsibility state-wide,** • **Board oversight with appropriate delegation of responsibilities at the facility level to monitor and enforce contractual obligations**	**Agree**	Completed by 1 July 2014 to align with implementation of recommendation 1. above.	The DoH and HHSs accept this recommendation. The completed concept design of redesigned private practice arrangements wholly transforms governance arrangements. The redesigned arrangements are built upon five interdependent frameworks: a. Clinical b. Regulatory c. Business d. Governance & Performance e. Education. The Governance and Performance Framework establishes: • a body constituted of members with the skill, authority and responsibility for state-level governance of policy and strategy for private practice within the public sector health services to industry-benchmarked standards of excellence with performance targets and measures • operational governance by each HHS Board to a standard of excellence with appropriate delegation of responsibilities at facility level to manage private practice within the specified frameworks to assure achievement of Board business objectives with performance targets and measures, and reported as agreed to the state governance body.
4. **Develop for all administrative, clinical and billing systems supporting private practice:** • **Standards to ensure the quality of data captured is meaningful and**	**Agree in principle, subject to detailed scoping and costing.**	• Completion of Phase 1: a detailed scoping and costing study – 31 December 2013 • Completion of Phase 2: implementation planning – 31 June 2014 • Commencement of	The DoH and HHSs accept this recommendation. Implementation planning (DoH and HHS) for the redesign of private practice arrangements in public sector health services will necessarily address, amongst other things: • specification of standards to assure the quality of data collected in terms of relevance and reliability • specification and design of the integration

*Page **2** of **5***

Responses to recommendations

Responses to recommendations provided by the Director-General, Queensland Health on 28 June 2013.

Recommendation	Agree / Disagree	Timeframe for Implementation	Additional Comments
relevant • **Integration to realise efficiencies and enable monitoring of clinical and non-clinical (including financial) activity** • **A single common doctor identifier**		Phase 3: implementation (subject to Phase 1) from 1 July 2014	of information systems (clinical and non-clinical, including financial) to assure efficiency and effective management of the scheme against performance targets • specification of a single, common doctor identifier for application across all relevant information systems. A Phase 1 detailed scoping study will identify the size and complexity of the task of integration of information systems, followed by an analysis of options and costings in collaboration with HHSs. Phase 2 implementation planning will specify the implementation project and funding. Phase 3 implementation will necessarily depend upon the outcomes of Phase 1.
5. **Make immediate attempts to recover foregone revenue, if cost effective, and investigate further revenue uplift opportunities.**	**Agree**	Implementation completed by 31 December 2013.	The DoH and HHSs accept this recommendation. Given the autonomous self-governing structure of HHSs, each HHS will independently determine what recovery actions are taken. The DoH Revenue Strategy and Support Unit (RSSU) will coordinate a recovery plan for high value items (procedures, high cost devices and high value professional services) and form a project team inviting representation from all HHSs to focus on implementation. The project team will also develop tools to undertake retrospective auditing of private practice accounts, capturing missed revenue. In relation to uplift strategies, the DoH already undertakes annual comprehensive reviews on uplift potential, which inform the following year's Own Source Revenue Stretch Targets. Established in 2010, an area of work that assists the DoH and HHSs to identify foregone revenue is the Own Source Revenue Profile Review process. Through these profiles, performance is reviewed with a view to: • optimise own source funding opportunities as a means to maximising HHS operational efficiency • identify opportunities to improve the quality and scope of support services provided by facility revenue staff • improve adequacy and optimal utilisation of resources • identify opportunities to improve Own Source Revenue systems, processes and controls • reduce outstanding debt

*Page **3** of **5***

Responses to recommendations

Responses to recommendations provided by the Director-General, Queensland Health on 28 June 2013.

Recommendation	Agree / Disagree	Timeframe for Implementation	Additional Comments
6. **Develop a strategy and engage with private practice participants, medical administrators and support staff to communicate a consistent message aligned with the objectives of the redesigned scheme, including contractual obligations.**	Agree	Implementation to align with implementation of recommendation 1. above, commencing January 2014 through July 2014 and ongoing.	The DoH and HHSs accept this recommendation. The completed concept design of redesigned private practice arrangements wholly transforms the preparedness of health service employees for private practice in public sector health services. An Educational Framework complements each of the frameworks listed in the comments on recommendation 3 above and: • fosters and supports a collegiate environment for employees to participate in private medical practice through the terms of their engagement • ensures employees have a working knowledge of the Australian Healthcare System, National Healthcare Funding Model and each framework underpinning private practice in public sector health services • ensures private practice staff have certified competence to achieve the objectives (clinical and business) of private practice in public sector health services • promotes targeted training and educational resources to provide: o General Staff Orientation – Overview o Clinical Support Staff – Overview o Billing and Private Practice Support Staff – Advanced Training with particular focus and support on Medical Benefits Schedule (MBS) in addition to an overview of each framework and key requirements o Participating Medical Officers – Advanced Training with particular focus and support on MBS in addition to an overview of each framework and key requirements o Medical Administration and Clinical Managers – Advanced Training with particular focus and support on MBS in addition to an overview of each framework and key requirements o Management - Overview of each framework and key requirements o Practice Managers – Extensive Training with particular focus and support on the MBS, the National Health Reform Agreement, the *Health Insurance Act 1973* (Cth) in addition to a comprehensive understanding of each framework and key requirements. The Educational Framework is necessarily supported by detailed consultation and communication with all relevant stakeholder groups internal and external to public sector health services.

*Page **4** of **5***

Responses to recommendations

Responses to recommendations provided by the Director-General, Queensland Health on 28 June 2013.

Recommendation	Agree / Disagree	Timeframe for Implementation	Additional Comments
7. **Redesign end to end business processes and systems to support enhanced revenue and expenditure management including rostering and overtime.**	Agree	Completion of design – 31 December 2013 Implementation from January 2014 to align with implementation of recommendation 1. above.	The DoH and HHSs accept this recommendation. It is important to note that given the autonomous self-governing structure of HHSs, each HHS will need to independently determine what actions are taken. The DoH Revenue Strategy and Support Unit (RSSU) will enhance the Practice Management Advisory Group with representation from all HHSs to focus on business process redesign in relation to revenue uplift opportunities, extending to cover practice management "best practice" models. Protocols and subsequent process maps will be redesigned by clinical and clinical support staff and published on the intranet for HHSs to consider. Accepting this recommendation is integral to recommendations 4 and 5. With respect to system integration and standardisation, the Own Source Revenue Project Board will explore opportunities for billing system consolidation and improvement. Milestones: 31 December 2013 – design stage complete 30 June 2014 – implementation progressed
8. **Review the objectives and the principles governing the use of study, education and research funds (SERTA/SERTF) to ensure maximum benefits are derived for the State.**	Agree	Completion of HHS review of current fund and application of current accumulation – 31 December 2013. Implementation of new trust fund arrangements from 1 July 2014 to align with implementation of recommendation 1. above.	The DoH and HHSs accept this recommendation. The completed concept design of the redesigned private practice arrangements wholly transforms the relationship between private practice and SERTA/SERTF. While redesigned private practice arrangements will preserve application of existing SERTA/SERTF funds at the discretion of the HHSs, HHSs will review current fund status and operation and ensure early, beneficial application of current accumulation. The redesigned private practice arrangements will not preserve a revenue stream into the existing SERTA/SERTF by policy, but rather: • HHS trust funds will be established under a Treasurer's approval in terms of the *Statutory Bodies Financial Arrangements Act 1982*. • Each HHS will have capacity to establish trust funds to serve study, education, research and clinical purposes. They may receive donations into the funds (including from private practice participants) and may determine (in consultation with private practice participants) a proportion of private practice fees to be received by the funds.

*Page **5** of **5***

Appendix B—Glossary of terms

Term	Acronym	Definition
Attendance Variation and Allowance Claim form	AVAC	Used by staff to submit changes to their roster, such as leave and overtime
AUSLAB	—	All in one IT system used by Pathology Queensland to record occasions of service and bill public hospitals, private patients and health insurance funds
Australian Refined Diagnosis Related Group	AR–DRG	An Australian admitted patient classification system which provides a clinically meaningful way of relating the number and type of patients treated in a hospital to the resources required by the hospital
B48: Supplementary Benefit / Right to Private Practice Benefits Options— Senior Medical Officers—Specialists	B48	Human resources policy effective from September 2012 which defines the private practice arrangements available to specialist senior medical officers within Queensland Health and provides information on consequent obligations
B49: Supplementary Benefit / Right to Private Practice Benefits Options—Senior Medical Officers—Non-Specialists	B49	Human resources policy effective from September 2012 which defines the private practice arrangements available to non-specialist senior medical officers within Queensland Health and provides information on consequent obligations
B50: Supplementary Benefit / Right to Private Practice Benefits Options—Senior Medical Officers—Pathologists	B50	Human resources policy effective from September 2012 which defines the private practice arrangements available to pathologists within the Queensland Health Health Services Suport Agency and provides information on consequent obligations
Bed fees	—	Bed fees are charged to private patients for their accommodation; fees are set by directive and closely follow guidelines issued by the Australian Government
Bulk billing	—	When a health provider bills Medicare directly for any medical or allied health service that the patient receives and accepts the Medicare benefit as full payment for the service provided
Clinical support time	—	Defined in MOCA 3 as protected time during ordinary hours for duties that are not directly related to individual patient care—it includes administration, teaching, research and attendance at meetings
Department of Veterans' Affairs	DVA	Federal Department that pays medical benefits for eligible defence veterans and current personnel
Directors of Medical Services and Medical Superintendents	DMS	The senior clinician at a hospital or other health facility situated in a HHS, or the person acting in that position from time to time, who is responsible for the hospital's clinical management on behalf of Queensland Health or the HHS, including the rights of private practice—where an Executive DMS role exists, that role may assume the responsibilities delegated to the DMS
Decision Support System	DSS	Queensland Health's principal business intelligence and reporting tool, incorporating finance, payroll and medical information
EDIS—Emergency Department Information System	EDIS	Captures clinical information from patients seen through the emergency department; a stand-alone system that can only receive demographic information from HBCIS

Term	Acronym	Definition
Elective surgery	—	Surgery that, in the opinion of the treating doctor, is needed but can be delayed for at least 24 hours
Episode of care	—	The period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type
Extended hours overtime	—	Paid when a senior medical officer is required to start earlier or finish later than his or her standard hours
Finance And Materials Management Information System	FAMMIS	Queensland Health information system that includes the finance, materials management and asset modules
Front End Deductible	FED	An amount of money a patient agrees to pay for a hospital stay before private health fund benefits are payable
Health Insurance Act 1973	HIA	Commonwealth legislation that provides for when a Medicare benefit is payable and to whom
Health Service Support Agency	HSSA	Queensland Health business unit that delivers public forensic, scientific, diagnostic, therapeutic and clinical support services in Queensland
Hospital and Health Boards Act 2011	HHB	State legislation that recognises and gives effect to the principles and objectives of the national health system agreed by the Commonwealth, states and territories
Hospital and Health Service	HHS	A statutory body tasked with delivering hospital and other health services (including teaching and research) as stated in their service agreement
Hospital Based Corporate Information System	HBCIS	An integrated suite of 36 applications, each of which administers a hospital business function, HBCIS is a corporate patient administration system used by most Queensland Health facilities for inpatients and outpatients
Inpatient	—	A patient who undergoes a hospital's formal admission process to receive treatment and/or care—treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients)
Intermediate patient	—	A private patient in a public hospital who is responsible for the full costs of his or her care and who is treated by a doctor (usually a VMO) outside the doctor’s publicly paid time

Term	Acronym	Definition
Medicare Australia / Medicare Benefits Scheme	Medicare	Australia's universal health insurance scheme that was introduced in 1984, its objectives are: • to make health care affordable for all Australians • to give all Australians access to health care services with priority according to clinical need • to provide a high quality of care Medicare provides access to: • free treatment as a public (Medicare) patient in a public hospital • free or subsidised treatment by practitioners such as doctors, including specialists, participating optometrists or dentists (specified services only) People who reside in Australia and: • hold Australian citizenship • have been issued with a permanent visa • hold New Zealand citizenship or • have applied for a permanent visa (other requirements apply) are eligible to receive Medicare benefits
Medicare principles	—	Defined in clause 20 of the National Healthcare Agreement 2012 as: States and Territories will provide health and emergency services through the public hospital system, based on the following Medicare principles: a) 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; b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.
Medicare Benefits Schedule	MBS	A federal Department of Health and Ageing publication which lists the Medicare services subsidised by the Australian government, the MBS is updated regularly by the department and is not a legal document
Medical Officers (Queensland Health) Certified Agreement	MOCA	Industrial agreement outlining working conditions for medical officers employed by Queensland Health
National Healthcare Agreement 2012	NHA	Defines the outcomes and performance indicators and clarifies the roles and responsibilities that will guide the Commonwealth and states and territories in delivery of services across the health sector
National Health Reform Agreement 2011	NHRA	Complements the National Healthcare Agreement and sets out the architecture of the National Health Reform, which will deliver major structural reforms to establish the foundations of Australia's future health system and intends to provide for more sustainable funding arrangements

Term	Acronym	Definition
Non-specialist senior medical officer	Non-specialist SMO	A medical practitioner who is registered as a non-specialist with the Medical Board of Australia under the *Health Practitioner Regulation National Law Act 2009* and who is employed as such
Occasion of service	OOS	Occasions of examination, consultation, treatment or other service provided to a patient in a medical, surgical or diagnostic unit of a health service—each diagnostic test or simultaneous set of related diagnostic tests for the one patient referred to a hospital pathology department consists of one occasion of service
Outpatient	—	A patient who receives care from a recognised non-admitted patient service or clinic of a hospital
Outpatient Scheduling Information Management	OSIM	Information technology system used by some hospitals to schedule outpatient appointments
Pathologist	—	A doctor who specialises in the anatomical and chemical changes occurring with diseases
Pharmaceutical Benefits Scheme	PBS	A Federal Government scheme to subsidise the cost of medicine for most medical conditions—the PBS Schedule lists all of the medicines available to be dispensed to patients at a government-subsidised price
practiX	—	Primary system used by Queensland Health to bill private patients; some hospitals also use practiX to schedule outpatient appointments
Private patient	—	Includes a patient of a public hospital that elects to be treated as a private patient
Private practice revenue	—	Revenue generated from the delivery of professional medical services by a senior medical officer exercising a right of private practice in a public hospital
Professional medical services	—	Medical services that are provided by a senior medical officer
Radiologist	—	A doctor trained in radiology interpretation and its use in the diagnosis of diseases and injuries
Recall overtime	Recall	Paid when the senior medical officer is recalled to duty ‘out of hours'
Registrar	—	Doctor studying a medical specialty
Right of Private Practice	RoPP	Contractual arrangement offered by Queensland Health to senior medical officers, granting them the ability to charge patients who elect private treatment in a public hospital
Senior Medical Officer	SMO	Generic term covering the following job designations: a Medical Superintendent, Deputy Medical Superintendent, Assistant Medical Superintendent, Senior Staff Specialist, Staff Specialist, General Practitioner and Medical Officer

Term	Acronym	Definition
Specialist	—	A person so designated as a registered specialist under the *Health Practitioner Regulation National Law Act 2009* who has undergone sufficient medical training and in a recognised specialty field as accredited by the relevant accreditation authority and as determined by the appropriate specialist college—for the purposes of this report, the term 'specialist' does not include general practitioners
Study, Education and Research Trust Account / Fund	SERTA / SERTF	Monies generated from private practice arrangements which have the purpose of providing grants or funding for: • study, research, conference and educational purposes for employees • equipment or other property for operational, research and educational purposes that may not be within normal budgeting capacity • employment of staff who are engaged in research or education
Treated in turn	—	Patients are treated in the order they are placed on a particular urgency category's wait list
Urgency category one	Cat 1	A patient will be allocated to category one if his or her health condition has the potential to deteriorate quickly to the point that it may become an emergency; recommended waiting time is no longer than 30 days
Urgency category two	Cat 2	A patient will be allocated to category two if his or her health condition is causing some pain, dysfunction or disability but is unlikely to deteriorate quickly or become an emergency; recommended waiting time is no longer than 90 days
Urgency category three	Cat 3	A patient will be allocated to category three if his or her health condition is causing them minimal or no pain, dysfunction or disability, is unlikely to deteriorate quickly and does not have the potential to become an emergency; recommended waiting time is no longer than 365 days
Visiting Medical Officer	VMO	A general practitioner or specialist who is employed to work part time or sessional services (visiting a hospital or health facility) and who incurs ongoing costs for his or her external private practice

Appendix C—Audit methodology

Audit objective

The objective of the audit was to determine whether the right of private practice (RoPP) arrangements in the public health system were achieving their intended public health outcomes in a financially sustainable manner. In conducting the audit, we pursued three lines of inquiry to determine if:

- the intended health and financial benefits of the scheme are being realised
- the scheme is being administered efficiently
- practitioners are participating in the scheme with probity and propriety and in full compliance with their contractual conditions.

Reason for the audit

On 12 November 2012, the Minister for Health wrote to the Auditor-General expressing concerns about questionable practices by some senior medical officers (SMOs) in Queensland Health that were raised by the Crime and Misconduct Commission. These matters related to private practice billing arrangements and challenges in ensuring oversight, visibility and transparency of the activities of senior medical officers.

After considering these matters were of significant public interest, the Auditor-General agreed on 13 November 2012 to commence investigating the concerns raised with a view to proceeding to an audit. On 5 December 2012, the Auditor-General wrote to the Minister for Health, the Chairs of the seventeen Hospital and Health Service Boards, and the President of the Australian Medical Association (AMA) Queensland confirming that an audit would be undertaken.

Performance audit approach

The audit was conducted in accordance with the Auditor-General of Queensland Auditing Standards, which incorporate the requirements of standards issued by the Australian Auditing and Assurance Standards Board.

The audit was conducted between November 2012 and June 2013 and examined the right of private practice arrangements statewide, with primary fieldwork completed at:

- Queensland Health
- Metro North HHS
- Metro South HHS
- Gold Coast HHS
- Townsville HHS.

The audit consisted of:

- interviews with clinical, financial and administrative staff
- analyses of documents including Cabinet submissions, Director-General and Ministerial briefings, policies, plans, guidelines and manuals
- a survey of senior medical officers (see Appendix J)
- extensive data analysis incorporating data from the following sources:
  - payroll (via Queensland Health's Decision Support System (DSS))—statewide for all medical staff from the first pay period of the 2003–04 financial year to the last pay period in the 2012 calendar year
  - clinical activity (via Queensland Health's Hospital Based Corporate Information System (HBCIS))—statewide from:
    - 1 July 2000 to 31 December 2012 for inpatients
    - 1 July 2005 to 31 March 2013 for outpatients
    - 1 July 2004 to 31 December 2012 for elective surgery
  - billing activity (via Queensland Health's system practiX)—statewide from 1 July 2002 to 31 December 2012 for all banked transactions
  - pathology activity (via Pathology Queensland's system AUSLAB)—statewide for the period 1 January 2012 to 31 December 2012
  - emergency department activity (via Queensland Health's Emergency Data Information System (EDIS))—statewide for the period 1 January 2012 to 28 February 2013
  - radiology examinations (via Queensland Radiology Information Systems):
    - Princess Alexandra Hospital, Royal Brisbane and Women's Hospital, Townsville Hospital and Nambour Hospital for the period 1 January 2011 to 31 March 2013
    - 1 January 2011 to 31 December 2012 for Gold Coast Hospital
  - financial records (via Queensland Health's Finance And Materials Management Information System (FAMMIS))—statewide for the period 1 July 2000 to 31 March 2013.

Primary systems used

We used three primary systems to perform our data analysis of the scheme – the billing (practiX), payroll (SAP-HR / Lattice) and clinical (HBCIS) systems. The remaining clinical systems were primarily used to determine the potential revenue uplift.

practiX is Queensland Health's primary system used to bill medical services provided to private patients. It contains:

- basic patient details (including patient number and inpatient / outpatient flag)
- individual services billed (including service dates, item numbers from the MBS, amount billed, facility charges and administration fees, amount payable to the SMO (for Options B and R) and debtor name)
- doctor details (including doctor ID, doctor name and private practice option (A or B))
- location details.

At the time of our audit, there were 25 instances of practiX, each operating its own standalone database. This covered 72 out of a total 82 public hospitals using practiX, including the four facilities that we visited. The remaining locations, primarily in rural and remote settings, represent less than one per cent of the full time equivalent SMO workforce and use other systems which are not integrated with practiX.

SAP-HR is Queensland Health's current payroll system for all employees and replaced the Lattice system in March 2010. It contains:

- employee details (including employee ID, employee name, position held, location, standard hours)
- payment details (including paypoint, base salary, allowances and overtime)
- leave and overtime records (including the day that leave or overtime was claimed, hours claimed and amount paid).

HBCIS is Queensland Health's enterprise clinical system used for patient administration, capturing and managing both admitted and non-admitted patients. It contains:

- patient demographic information and medical record tracking (including facility-unique medical record numbers for each patient)
- details of admissions and discharges (including dates and locations)
- referral and waiting list management for both specialist outpatients and elective surgery
- elective admissions and procedures management.

Some small rural and remote facilities do not use the HBCIS system.

While we obtained patient level data, we obtained no patient details other than the patient identification number and Aboriginal or Torres Strait Island identification status.

We found that these systems were not well integrated and therefore we were required to perform our own manual data integration in order to conduct our audit of the right of private practice scheme.

Data integration and analysis

The billing, payroll and clinical systems contain 'doctor IDs' that are unique to each system. This is shown in Figure C1 below:

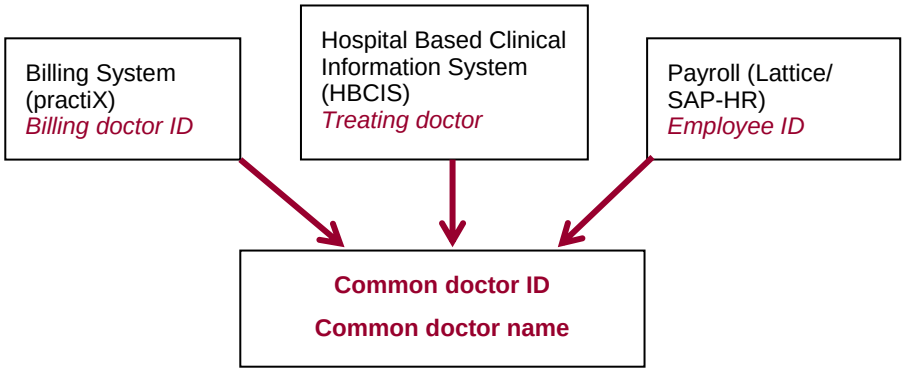
Figure C1
Comparison of billing, payroll and clinical system 'doctor IDs'

System	Field name(s)	Description
Billing	Billing doctor ID Billing doctor name	• Free-text fields, maximum three characters for billing doctor ID • Unique to each practiX database, therefore different databases can use the same billing doctor ID and one doctor can have different billing doctor IDs across each database • One doctor can have multiple billing doctor IDs and billing doctor names in the one practiX database
Payroll	Employee ID First name, middle name, surname	• Unique to each employee • Sequential, fixed length employee ID of eight numbers
Clinical	Treating doctor	• Hospital code use to describe the individual doctor chiefly responsible for treating the patient • Collected for hospital use only • No fixed length • Unique to each facility, therefore different facilities can use the same treating doctor ID and one doctor can have different treating doctor IDs across each facility

Source: QAO

In order to link these systems to undertake our analysis, we created a table of unique doctor IDs and names using probability matching as shown in Figure C2 below:

Figure C2
Method for matching 'doctor ID' between systems



Source: QAO

The characters in the 'doctor ID' fields from each system were compared and a 93 per cent correlation was initially deemed to be a 'match'. After this was performed, several iterations of manual checks were conducted, such as correcting duplicate matches for doctors who had the same first name and surname, to ensure that the reference table was of sufficient quality for analysis. We estimate the accuracy of this match between the three systems to be better than 90 per cent, with matches between the billing and payroll systems better than 95 per cent.

In order to allocate a doctor to a discipline or specialty group, we obtained a reference table from Queensland Health which mapped facility-specific position titles to one of 52 categories. We performed limited verification of the reference table by checking the list of doctors allocated to some specialties to a list of doctors whom we knew worked in those specialties, based on our interviews conducted at the facilities we visited. Additionally, we made limited amendments to the reference table where it was clear from the position description that the allocation was incorrect.

The right of private practice scheme provides four different options for SMOs: A, B, P and R. There is no central register containing the option SMOs have elected for each contracted period; therefore, we were required to use some assumptions to assign one option to an SMO for each financial year (the contracted period). The process used was:

- identify the pay periods in which the SMO received an Option A or P allowance
- count the number of pay periods in a financial year that the SMO received each of the allowances
- count the total number of pay periods in a financial year that the SMO was paid
- if the SMO received the Options A or P allowance in more than half the total pay periods that the SMO was paid in a financial year, the SMO was allocated to Options A or P
  - where the SMO received both allowances in equal measure (in the case of an employee holding two or more positions), he or she was allocated to Option P
- If the SMO received allowances in half, or less than half, the total pay periods that the SMO was paid in a financial year, he or she was allocated to Option B
  - where the SMO had an allocated specialty indicating he or she was a radiologist, he or she was allocated to Option R.

Illustrative examples of this process are shown in Figure C3.

Figure C3
Illustrative examples of allocating private practice options to SMOs

Financial year	Total pay periods	Pay periods with Option A allowance	Pay periods with Option P allowance	Specialty	Option assigned
2011–12	26	26	0	Cardiology	A
2011–12	26	26	26	Haematology	P
2011–12	13	13	3	Haematology	A
2011–12	26	0	0	Cardiology	B
2011–12	26	13	0	Cardiology	B
2011–12	26	5	0	Radiology	R
2011–12	26	14	0	Radiology	A

Source: QAO

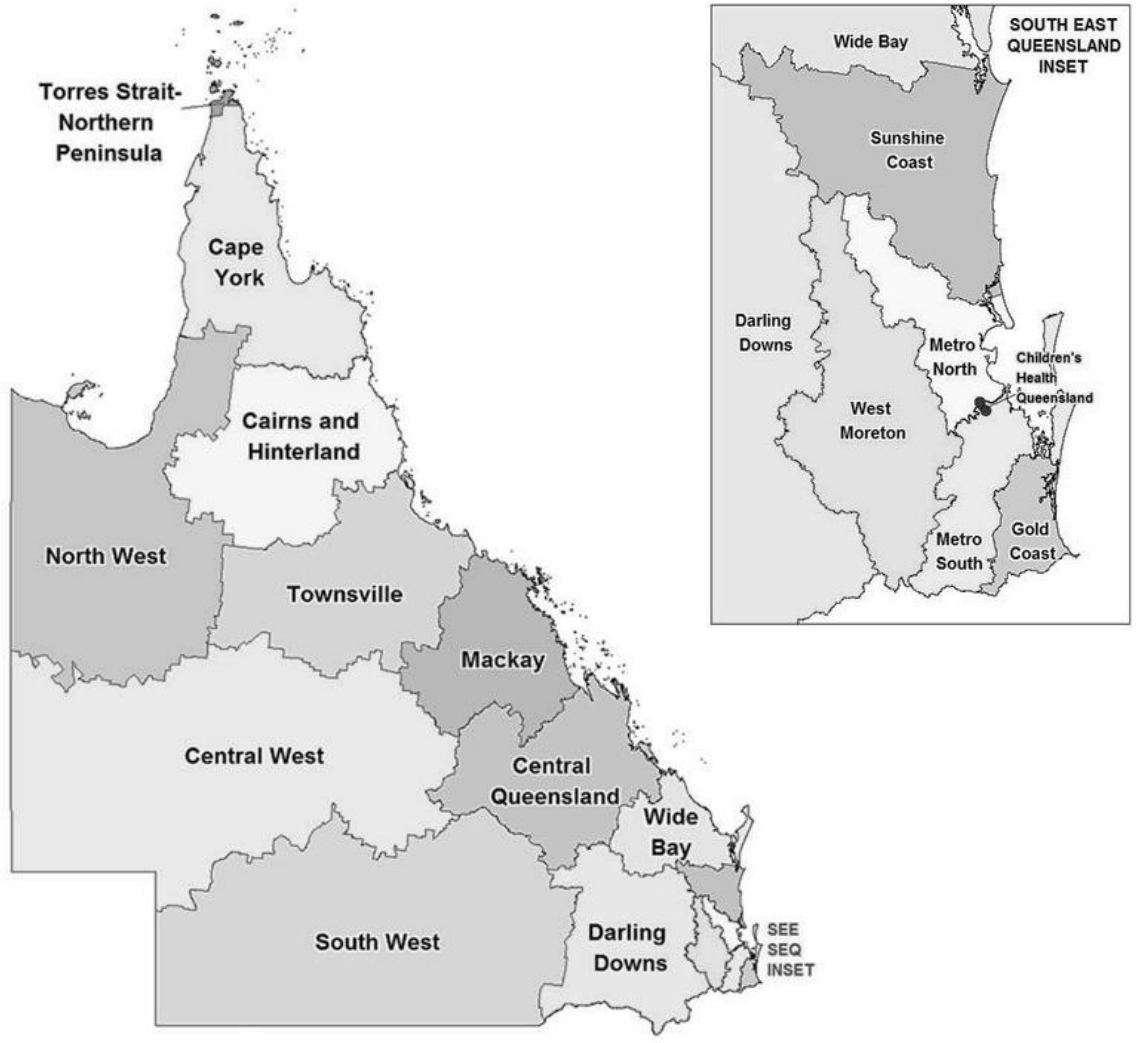
Once we had these matched datasets, we were able to analyse SMO activity across the payroll, billing and clinical systems.

Appendix D—Queensland HHSs map

Under the National Health Reform Agreement, the delivery of health services is the responsibility of the Hospital and Health Service Boards, performed under a service agreement with Queensland Health. The Boards administer the 17 HHSs shown in Figure D1.

Figure D1
Queensland Hospital and Health Services

SEQ	Outside SEQ	
Children's Health Queensland	Cairns and Hinterland	North West
Gold Coast	Cape York	South West
Metro North	Central Queensland	Torres Strait—Northern Peninsula
Metro South	Central West	Townsville
Sunshine Coast	Darling Downs	Wide Bay
West Moreton	Mackay	



Source: Queensland Health

The Queensland Government also provides grant funding to the group of Mater Public Hospitals in Brisbane. These facilities are not governed by a Hospital and Health Service Board.

Appendix E—Section 19(2) exempt sites

The *Health Insurance Act 1973* (Cth) (HIA) establishes where a Medicare benefit is payable. Section 19(2) states that:

> *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:*
>
> *…*
>
> *(b) a state*
>
> *…*

An exemption under s19(2) of the HIA allows Medicare benefits to be claimed for state-remunerated health care services. The revenue raised under these initiatives is to be used for primary health care enhancements at the sites in which the Medicare benefit is generated.

The Council of Australian Governments agreed with the then Federal Minister for Health and Ageing that health services provided in approved sites (for non-admitted and non-referred patients of medical practitioners, including senior medical officers) can be claimed against the Medicare Benefits Schedule. This initiative is called *Improving Access to Primary Care Services in Rural and Remote Areas (s19(2) exemptions)* or COAG s19(2). To be approved, the site must be in a rural or remote area with a workforce shortage and a population of less than 7 000. Under this section, an exemption has been given to sites in seven HHSs.

Separately, Queensland has reached an agreement with the then Federal Minister for Health and Ageing for sites in rural and remote communities to receive Medicare benefits for services provided by Queensland Health employees (including services delivered by the Rural Flying Doctor Service on behalf of Queensland Health); sites in nine HHSs have been granted this exemption. Queensland Health refers to this as the *Rural and Remote Medicare Benefit Schedule* (RRMBS) initiative.

The sites granted an exemption—as at the time of writing this report—are listed in Figure E1.

Our report excludes revenue generated in exempted sites as billing is not contingent on the senior medical officer being granted a right of private practice.

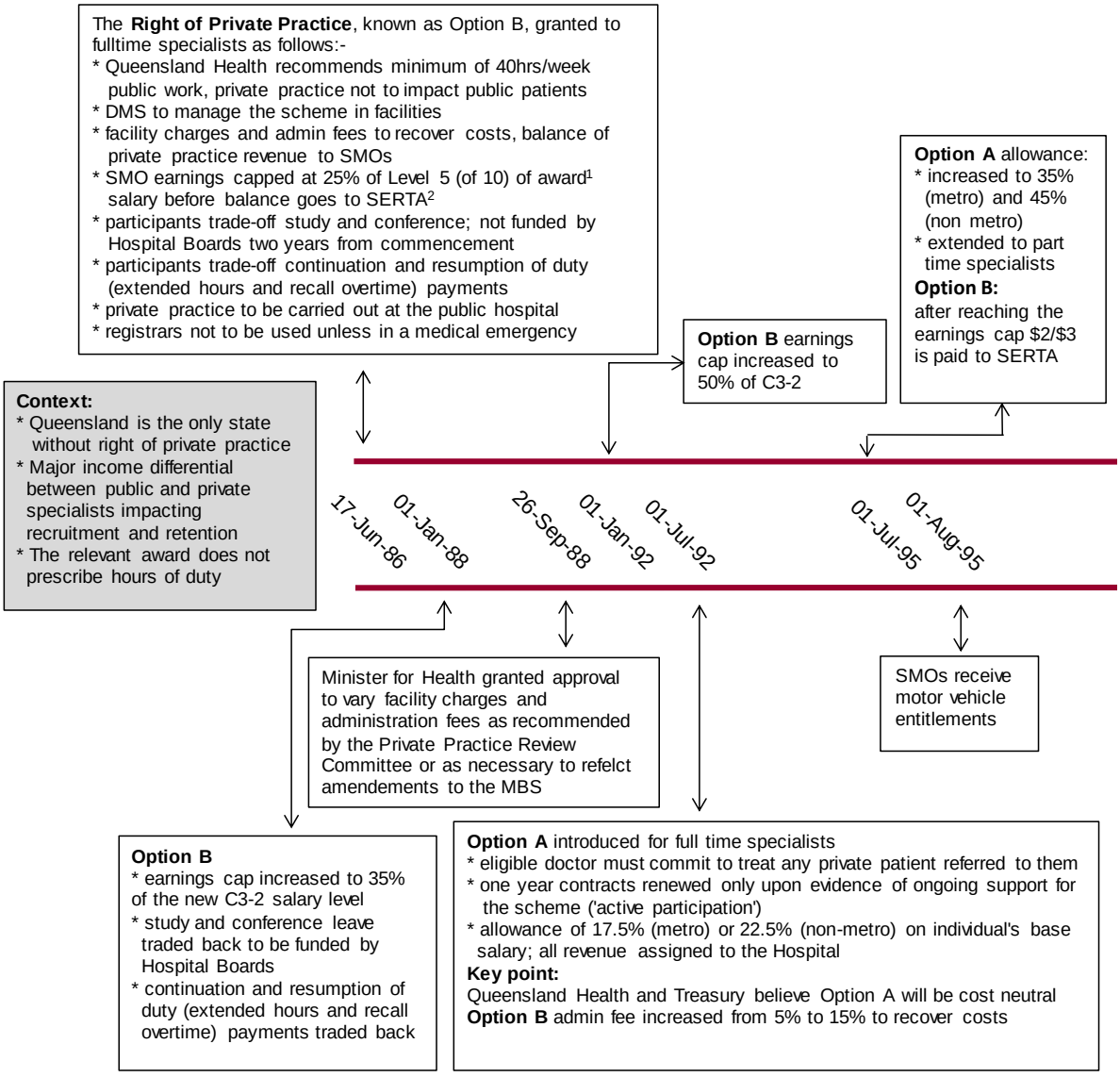
Figure E1
Section 19(2) exempt sites by HHS

HHS	COAG s19(2)[1]	RRMBS[2]		
Cairns & Hinterland	• Babinda • Cardwell • Dimbulah • Mareeba • Tully	• Dareel Landing • Jumbun • Wujal Wujal • Yarrabah		
Cape York		• Aurukun[4] • Coen[4] • Cooktown • Hope Vale	• Kowanyama[4] • Laura • Lockhart River[4] • Mapoon	• Napranum[4] • Pormpuraaw[4] • Weipa[4]
Central Queensland		• Woorabinda		
Central West	• Longreach			
Darling Downs	• Chinchilla • Miles • Millmerran • Oakey	• Cherbourg • Goondiwindi		
Mackay	• Collinsville			
Metro South	• Inala[3]	• Stradbroke Island		
North West		• Burketown • Camooweal • Cloncurry • Dajarra	• Doomadgee • Gregory Downs • Gunpowder • Julia Creek	• Karumba • Mornington Island • Normanton
South West	• Dirranbandi • Mitchell	• Charleville • Cunnamulla		
Townsville		• Ayr • Camu	• Home Hill • Palm Island	
Torres Strait—Northern Peninsula		• Badu Island • Bamaga • Boigu Island • Coconut Island • Darnley Island • Dauan Island • Horn Island	• Injinoo • Kubin • Mabuiag Island • Mer Island • New Mapoon • Saibai Island • Seisa	• Sibawanal Ngurpai Meta • St Pauls • Thursday Island • Umagico • Warraber Island • Yam Island • Yorke Island
Wide Bay	• Eidsvold • Monto • Mundubbera			

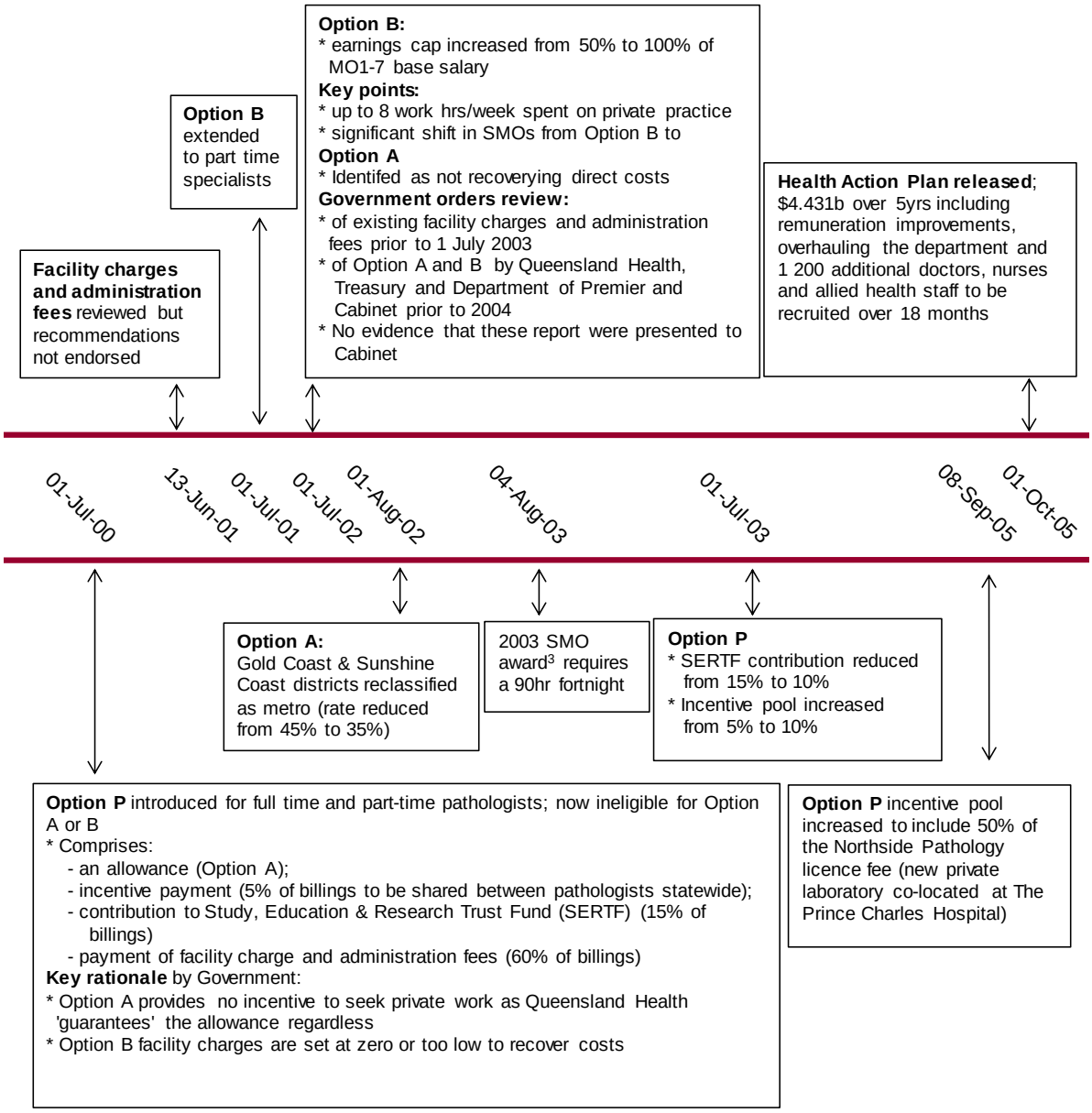
Notes:
1. Signed direction by the delegate of the Minster for Health and Ageing dated 29 September 2011
2. Signed direction by the delegate of the Minster for Health and Ageing dated 13 June 2011
3. Signed direction by the delegate of the Minster for Health and Ageing dated 26 June 2009
4. Delivered by the Royal Flying Doctor Service under contract to Queensland Health

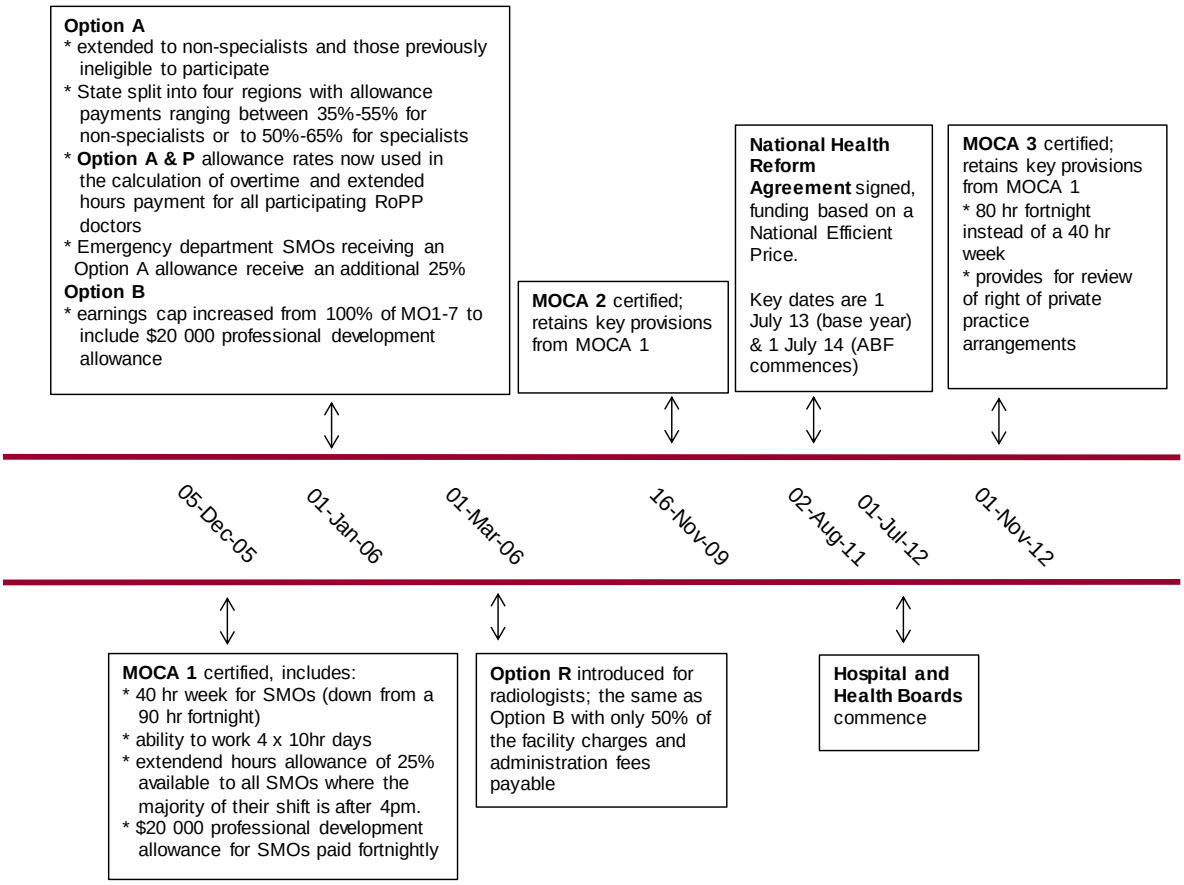
Source: Queensland Health

Appendix F—Timeline of the right of private practice



1. Award for senior medical staff - public hospitals, Queensland and the Queensland Radium Institute
2. Study, Education and Research Trust Account (SERTA)
3. District Health Services - Sneior Medical Officers and Resident Medical Officers Award - State 2003


Option B:
* earnings cap increased from 50% to 100% of MO1-7 base salary
Key points:
* up to 8 work hrs/week spent on private practice
* significant shift in SMOs from Option B to **Option A**
* Identifed as not recoverying direct costs
Government orders review:
* of existing facility charges and administration fees prior to 1 July 2003
* of Option A and B by Queensland Health, Treasury and Department of Premier and Cabinet prior to 2004
* No evidence that these report were presented to Cabinet
Option B extended to part time specialists
Facility charges and administration fees reviewed but recommendations not endorsed
Health Action Plan released; $4.431b over 5yrs including remuneration improvements, overhauling the department and 1 200 additional doctors, nurses and allied health staff to be recruited over 18 months
01-Jul-00
13-Jun-01
01-Jul-01
01-Jul-02
01-Aug-02
04-Aug-03
01-Jul-03
08-Sep-05
01-Oct-05
Option A: Gold Coast & Sunshine Coast districts reclassified as metro (rate reduced from 45% to 35%)
2003 SMO award[3] requires a 90hr fortnight
Option P
* SERTF contribution reduced from 15% to 10%
* Incentive pool increased from 5% to 10%
Option P introduced for full time and part-time pathologists; now ineligible for Option A or B
* Comprises:
- an allowance (Option A);
- incentive payment (5% of billings to be shared between pathologists statewide);
- contribution to Study, Education & Research Trust Fund (SERTF) (15% of billings)
- payment of facility charge and administration fees (60% of billings)
Key rationale by Government:
* Option A provides no incentive to seek private work as Queensland Health 'guarantees' the allowance regardless
* Option B facility charges are set at zero or too low to recover costs
Option P incentive pool increased to include 50% of the Northside Pathology licence fee (new private laboratory co-located at The Prince Charles Hospital)

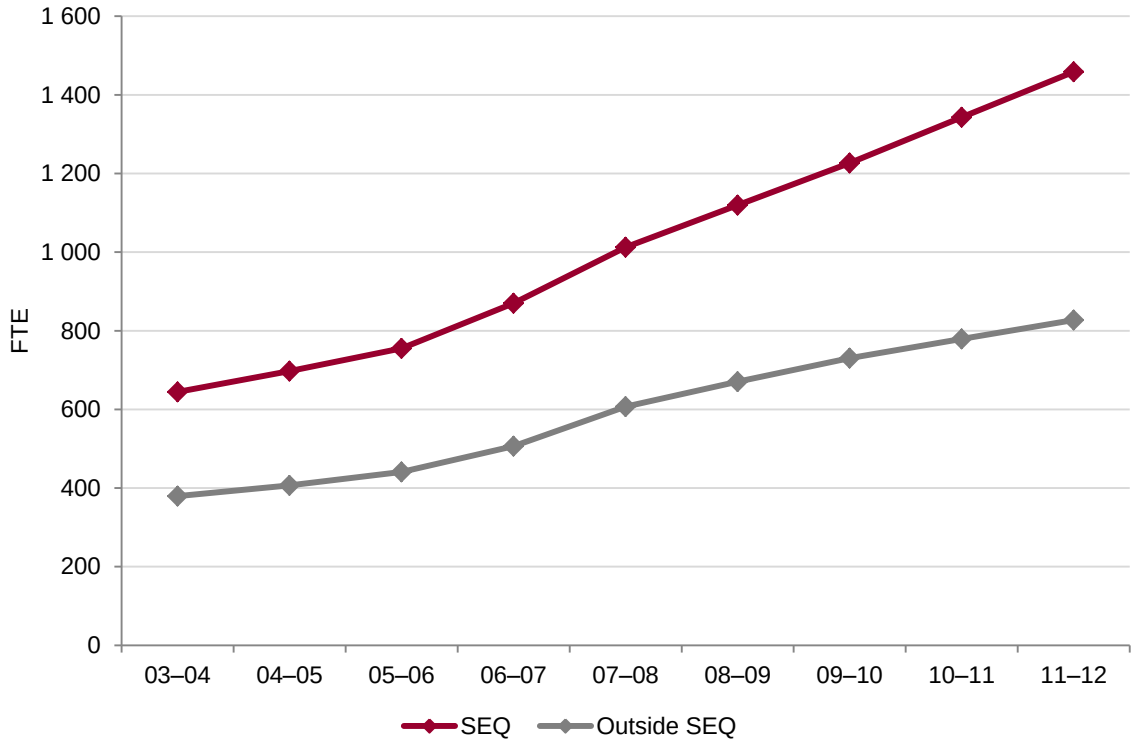

Option A
* extended to non-specialists and those previously ineligible to participate
* State split into four regions with allowance payments ranging between 35%-55% for non-specialists or to 50%-65% for specialists
* **Option A & P** allowance rates now used in the calculation of overtime and extended hours payment for all participating RoPP doctors
* Emergency department SMOs receiving an Option A allowance receive an additional 25%
Option B
* earnings cap increased from 100% of MO1-7 to include $20 000 professional development allowance
MOCA 2 certified; retains key provisions from MOCA 1
National Health Reform Agreement signed, funding based on a National Efficient Price.
Key dates are 1 July 13 (base year) & 1 July 14 (ABF commences)
MOCA 3 certified; retains key provisions from MOCA 1
* 80 hr fortnight instead of a 40 hr week
* provides for review of right of private practice arrangements
05-Dec-05
01-Jan-06
01-Mar-06
16-Nov-09
02-Aug-11
01-Jul-12
01-Nov-12
MOCA 1 certified, includes:
* 40 hr week for SMOs (down from a 90 hr fortnight)
* ability to work 4 x 10hr days
* extendend hours allowance of 25% available to all SMOs where the majority of their shift is after 4pm.
* $20 000 professional development allowance for SMOs paid fortnightly
Option R introduced for radiologists; the same as Option B with only 50% of the facility charges and administration fees payable
Hospital and Health Boards commence

Source: QAO

Appendix G—Regional vs metropolitan growth

As Figure G1 illustrates, regional SMO numbers have increased by 218.0 per cent, while in south-east Queensland, the increase was 226.4 per cent, over the period 2003–04 to 2011–12.

Figure G1
Growth in SMOs—south-east Queensland vs rest of Queensland (full time equivalent) 2003–04 to 2011–12

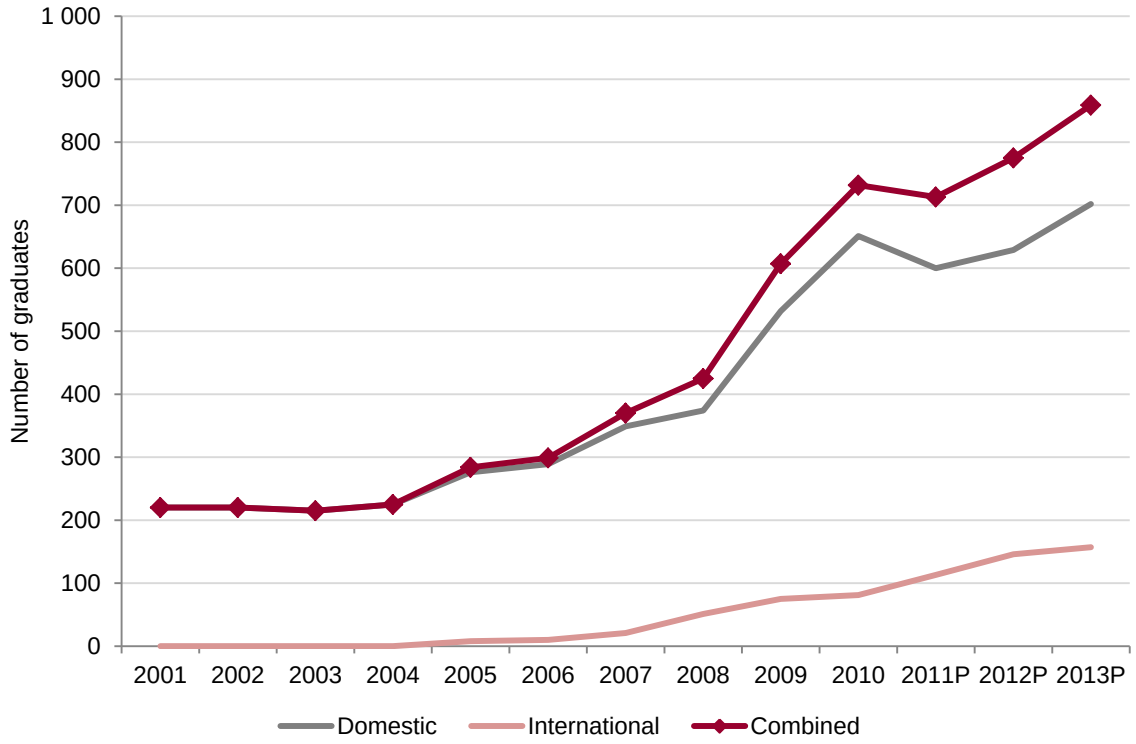


Source: QAO using data extracted from Queensland Health payroll system

Appendix H—Growth in medical graduates

Queensland domestic and international graduate numbers have increased at a rapid rate over the past 10 years and will support the growth in the SMO workforce for many years to come. It takes between six and seven years from graduating to becoming a specialist (five years for general practitioners). The growth represents an increase in medical graduates of 252.3 per cent from 2001 to 2012.

Figure H1
Queensland domestic and international graduate numbers
2001 to 2013 calendar years



P = projected

Source: Medical Training Review Panel Fifteenth Report February 2012 (pg32)

There are four medical schools in Queensland:

- Bond University
- Griffith University
- James Cook University
- The University of Queensland.

Appendix I—Elective surgery public vs private

Figures I1 and I2 are an extension of Figure 2M. They show the percentage and number of elective surgery patients that were seen within the clinically recommended time for categories 1 and 3, split between public and private patients. We do not consider the variations to be statistically significant.

Figure I1
Category 1 elective surgery patients seen by SMOs within the clinically recommended time 2010–11 and 2011–12 (combined)

Hospital and Health Service	Category 1 (within 30 days)			
	Public		Private	
	Per cent seen in time	Total patients	Per cent seen in time	Total patients
Children's Health Queensland	97%	947	99%	201
Metro North	92%	10 881	95%	857
Metro South	89%	8 778	92%	271
Sunshine Coast	82%	3 539	92%	112
Townsville	85%	2 735	94%	114
Listed HHS	**89%**	**26 880**	**95%**	**1 555**
Statewide patients (SMOs)[1]	**89%**	**41 667**	**93%**	**2 275**
Statewide patients (all)[2]	**86%**	**82 177**	**93%**	**3 735**

1. Statewide (SMOs) includes all category 1 elective surgery performed during 2010–11 and 2011–12 including HHSs not listed.
2. Statewide (all) includes all surgeries performed, including those by registrars and VMOs and in HHSs not listed.

Source: QAO using data extracted from Queensland Health clinical and payroll systems

Figure I2
Category 3 elective surgery patients seen by SMOs within the clinically recommended time 2010–11 and 2011–12 (combined)

Hospital and Health Service	Category 3 (within 365 days)			
	Public		Private	
	Per cent seen in time	Total patients	Per cent seen in time	Total patients
Children's Health Queensland	94%	236	100%	32
Metro North	92%	1 629	94%	106
Metro South	96%	2 696	100%	58
Sunshine Coast	98%	1 012	100%	19
Townsville	88%	1 193	89%	28
Listed HHS	**94%**	**6 766**	**96%**	**243**
Statewide patients (SMOs)[1]	**94%**	**11 602**	**98%**	**355**
Statewide patients (all)[2]	**89%**	**26 757**	**99%**	**2 657**

1. Statewide (SMOs) includes all category 3 elective surgery performed during 2010–11 and 2011–12 including HHSs not listed.
2. Statewide (all) includes all surgeries performed, including those by registrars and VMOs and in HHSs not listed.

Source: QAO using data extracted from Queensland Health clinical and payroll systems

Appendix J—SMO questionnaire

We stratified the entire population of 2 809 Queensland Health SMOs into Options A, B, P and R, to ensure a representative sample, before randomly selecting 471 SMOs to survey. We asked them to complete an anonymous survey on their perspective about the operation of elements of the right of private practice scheme in Queensland public hospitals. We received 86 completed responses by the close of the survey.

Figure J1
Responses to QAO survey by Queensland Health senior medical officers

Option	Individuals	Percentage of total population	Random sample size	Percentage of sample size	Respondents	Response rate
A	2 395	85.2%	410	87.1%	71	17.3%
B	230	8.2%	30	6.4%	11	36.7%
P	92	3.3%	12	2.5%	1	8.3%
R	92	3.3%	19	4.0%	3	15.8%
Total	**2 809**	**100.0%**	**471**	**100.0%**	**86**	**18.3%**

Survey results

We have presented the results of the survey below, split into each private practice option that was nominated in question 18 of the survey. Mandatory questions are marked with a '*'.

1. Was the level of induction you received in relation to your contractual obligations under the Right of Private Practice arrangements adequate?*

Option	Yes	No	Yes %	No %
A	18	53	25%	75%
B	5	6	45%	55%
P	-	1	0%	100%
R	2	1	67%	33%
Total	**25**	**61**	**29%**	**71%**

2. Was the level of induction you received in relation to what services are billable (e.g. to Medicare or private health insurance funds) adequate?*

Option	Yes	No	Yes %	No %
A	13	58	18%	82%
B	4	7	36%	64%
P	-	1	0%	100%
R	1	2	33%	67%
Total	**18**	**68**	**21%**	**79%**

3. Is the level of ongoing support you receive in relation to your contractual obligations under the Right of Private Practice arrangements adequate?*

Option	Yes	No	Yes %	No %
A	21	50	30%	70%
B	5	6	45%	55%
P	-	1	0%	100%
R	1	2	33%	67%
Total	**27**	**59**	**31%**	**69%**

4. Is the level of ongoing support you receive in relation to what services are billable (e.g. to Medicare or private health insurance funds) adequate?*

Option	Yes	No	Yes %	No %
A	24	47	34%	66%
B	5	6	45%	55%
P	-	1	0%	100%
R	1	2	33%	67%
Total	**30**	**56**	**35%**	**65%**

5. Have you experienced the situation(s) where you were unsure whether a particular service / procedure was billable or not?*

Option	Yes	No	Yes %	No %
A	44	27	62%	38%
B	7	4	64%	36%
P	-	1	0%	100%
R	2	1	67%	33%
Total	**53**	**33**	**62%**	**38%**

6. Did you seek guidance to determine the eligibility or otherwise to bill for such a service(s)?*

Option	Yes[1]	No[2]	No Ans	Yes %	No %	No Ans %
A	24	21	26	34%	30%	37%
B	6	1	4	55%	9%	36%
P	-	-	1	0%	0%	100%
R	2	-	1	67%	0%	33%
Total	**32**	**22**	**32**	**37%**	**26%**	**37%**

1. Go to question 8

2. Go to question 7

7. What was the primary reason for not seeking guidance about the eligibility to bill?

Option	(a)	(b)	(c)	(d)	(a) + (c)	(a) + (b)	(a) + (d)	(a) + (b) + (c)	No Ans
A	7	4	3	5	1	1	1	1	48
B	-	-	1	-	-	-	-	-	10
P	-	-	-	-	-	-	-	-	1
R	-	-	-	-	-	-	-	-	3
Total	**7**	**4**	**4**	**5**	**1**	**1**	**1**	**1**	**62**

(a) Unclear where to seek guidance

(b) Value of service didn't warrant time to clarify

(c) Key staff were not available to assist

(d) Other

8. Are you provided with the proposed billing items for a particular patient prior to the invoice being raised?*

Option	Yes	No	Yes %	No %
A	33	38	46%	54%
B	8	3	73%	27%
P	-	1	0%	100%
R	1	2	33%	67%
Total	**42**	**44**	**49%**	**51%**

9. Do you receive a statement outlining the billing performed by the Hospital and Health Service (HHS) using your Medicare service provider number(s)?*

Option	Yes	No[1]	Yes %	No %
A	33	38	46%	54%
B	8	3	73%	27%
P	-	1	0%	100%
R	1	2	33%	67%
Total	**42**	**44**	**49%**	**51%**

1. Go to question 14

10. How often are these statements provided?

Option	(a)	(b)	(c)	(d)	(e)	No Ans
A	16	15	4	3	4	29
B	7	-	-	-	-	4
P	-	-	-	-	-	1
R	3	-	-	-	-	-
Total	**26**	**15**	**4**	**3**	**4**	**34**

(a) Monthly

(b) Quarterly

(c) Every six months

(d) Annually

(e) Less often than annually

11. Is your statement itemised (e.g. item numbers billed per patient)?

Option	Yes	No[1]	No Ans	Yes %	No %[1]	No Ans %
A	14	27	30	20%	38%	42%
B	5	3	3	45%	27%	27%
P	-	-	1	0%	0%	100%
R	2	1	-	67%	33%	0%
Total	**21**	**31**	**34**	**24%**	**36%**	**40%**

1. Go to question 13

12. Have you noted errors in relations to the statements provided?

Option	Yes	No[1]	No Ans	Yes %	No %[1]	No Ans %
A	10	17	44	14%	24%	62%
B	3	4	4	27%	36%	36%
P	-	-	1	0%	0%	100%
R	-	3	-	0%	100%	0%
Total	**13**	**24**	**49**	**15%**	**28%**	**57%**

1. Go to question 14

13. What is the average rate of error on your statements?

Option	<5%	5-10%	10-25%	>50%	No Ans
A	14	3	6	1	47
B	3	2	1	-	5
P	-	-	-	-	1
R	2	-	-	-	1
Total	**19**	**5**	**7**	**1**	**54**

14. Do you consider the current billing processes to be efficient?*

Option	Yes	No	Yes %	No %
A	24	47	34%	66%
B	4	7	36%	64%
P	-	1	0%	100%
R	2	1	67%	33%
Total	**30**	**56**	**35%**	**65%**

15. If you would like to comment on any potential improvements to billing processes, please provide your response here.

    [free form text box; answers not reproduced to protect confidentiality]

16. Do you consider the receipt of the Option A Allowance is contingent upon achieving a level of billable activity?*

Option	Yes	No	Yes %	No %
A	19	52	27%	73%
B	6	5	55%	45%
P	-	1	0%	100%
R	-	3	0%	100%
Total	**25**	**61**	**29%**	**71%**

17. If you would like to provide comment on the receipt of the Option A allowance, please provide your response here.

    [free form text box; answers not reproduced to protect confidentiality]

18. Please nominate your current Right of Private Practice Option*

Option	Respondents
A	71
B	11
P	1
R	3
Total	**86**

Source: QAO

Auditor-General Reports to Parliament

Tabled in 2013–14

Report number	Title of report	Date tabled in Legislative Assembly
1	Right of private practice in Queensland public hospitals	July 2013

Reports to Parliament are available at www.qao.qld.gov.au