Auditor-General Reports: Private practice arrangements in Queensland public hospitals

Report No. 62
Health and Community Services Committee
December 2014
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# Contents

Abbreviations and glossary vii
Chair’s foreword viii
Committee recommendations ix

## 1 Introduction
1.1 Role of the committee 1
1.2 Committee process and structure of this report 1
1.3 Role of the Auditor-General 2
1.4 Overview of the audit 2

## 2 Auditor-General’s conclusions, findings and recommendations
2.1 The right of private practice scheme 3
2.2 Auditor-General’s conclusions and findings

- 2.2.1 Future design of private practice arrangements 3
- 2.2.2 Confusion about objectives of the right of private practice scheme 4
- 2.2.3 Recruitment and retention of senior medical officers 4
- 2.2.4 Design of the right of private practice scheme 4
- 2.2.5 Oversight of the right of private practice scheme 5
- 2.2.6 Cost neutrality 5
- 2.2.7 Senior medical officers’ workplace attendance 6
- 2.2.8 Patients 6
- 2.2.9 Billing practices 6
2.3 Auditor-General’s recommendations 6

## 3 Private practice arrangements
3.1 Auditor-General’s recommendations about future arrangements 8
3.2 Redesign of arrangements

- 3.2.1 Introduction 8
- 3.2.2 Documents about the revised private practice arrangements 8
- 3.2.3 Granted private practice 8
- 3.2.4 Licensed private practice 9
- 3.2.5 Committee comment 9
- 3.2.6 Communication with medical officers and staff 9
- 3.2.7 Departmental communications about private practice arrangements 10
- 3.2.8 Senior medical officer employment contracts 11
- 3.2.9 Governance arrangements 11
- 3.2.10 Importance of clear objectives 12

## 4 Medical workforce targets
4.1 Auditor-General’s findings and recommendation 15
4.2 Department’s response to Auditor-General’s recommendation 15
4.3 Implementation 15
4.4 Committee comment 15

## 5 Systems to support private practice – administrative, billing and clinical systems
5.1 Auditor-General’s recommendations 16
Auditor-General Reports: Private practice arrangements in Queensland public hospitals

Abbreviations and glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBU</td>
<td>commercial business unit (of Department of Health)</td>
</tr>
<tr>
<td>the committee</td>
<td>Health and Community Services Committee</td>
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<tr>
<td>the department</td>
<td>Department of Health</td>
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<tr>
<td>HHB</td>
<td>Hospital and Health Board</td>
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<tr>
<td>HHS</td>
<td>Hospital and Health Service</td>
</tr>
<tr>
<td>the Minister</td>
<td>Hon. Lawrence Springborg MP, Minister for Health</td>
</tr>
<tr>
<td>Option A</td>
<td>‘Assignment’ model introduced in 1992. Primary objective: to capture revenue from private patients in a cost neutral manner; secondary objective was to assist in recruitment and retention of full time staff. On top of base salaries, participating SMOs are paid an allowance in exchange for assigning all revenue from private practice to the hospital.1</td>
</tr>
<tr>
<td>Option B</td>
<td>Original scheme, which became known as Option B once Option A was introduced in 1992. Primary objective: to aid in recruiting and retaining full time specialists by increasing their remuneration at no net cost to the State. On top of base salaries, SMOs retained the net revenue (up to an earnings cap) from private practice billings after deducting facility charges and administration fees paid to the hospital.2</td>
</tr>
<tr>
<td>Option P</td>
<td>Introduced in 2000, for pathologists. Primary objectives: provide a fairer distribution of benefits to all pathologists, incentivise pathologists to identify private patients and improve turnaround times. The Option A allowance is retained and pathologists receive an incentive payment based on statewide pathology private practice billing.3</td>
</tr>
<tr>
<td>Option R</td>
<td>Introduced in 2006, for radiologists. Modified Option B, with 50 per cent lower facility charges and administration fees.4</td>
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<tr>
<td>QAO</td>
<td>Queensland Audit Office</td>
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<tr>
<td>Report 1</td>
<td>QAO, Right of private practice in Queensland public hospitals, Report 1: 2013-14</td>
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<tr>
<td>RoPP</td>
<td>(former) Right of Private Practice</td>
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<tr>
<td>SMO</td>
<td>Senior Medical Officer</td>
</tr>
</tbody>
</table>

2 QAO, Report 1, p.44  
3 QAO, Report 1, p.44  
4 QAO, Report 1, p.44
Chair’s foreword

This report summarises the committee’s inquiry to review the implementation by the Department of Health and Hospital and Health Services of the Auditor-General’s recommendations in two reports: Right of private practice in Queensland public hospitals and Right of private practice: Senior medical officer conduct.

The committee’s focus was on the extent to which the Auditor-General’s recommendations have been implemented.

The Department of Health and Hospital and Health Services have undertaken considerable work to redesign the previous right of private practice schemes since the Auditor-General’s performance audit began. The new private arrangements commenced only a few months ago in August 2014, and the committee has therefore considered the various documents that underpin the new arrangements, rather than how it is working in practice.

I commend the report to the house.

Trevor Ruthenberg MP
Chair
Committee recommendations

** Recommendation 1 14**

That the Minister for Health ensure that the department:

- clearly specify the primary objectives and desired outcomes of the private practice arrangements to facilitate effective monitoring and governance of the arrangements
- incorporate the objectives in relevant documents about private practice arrangements
- clarify the respective roles of the Private Practice Governance Board and Hospital and Health Service private practice governance committees in relation to defining objectives for private practice, and in defining performance criteria to measure whether objectives are being achieved.

** Recommendation 2 17**

The committee recommends that a future committee of the Legislative Assembly inquire into Queensland Health’s implementation of its *ICT Strategic Roadmap* and related strategies, plans and initiatives, including systems to support private practice in the public health sector and related information systems.

** Recommendation 3 23**

The committee recommends that a future committee of the Legislative Assembly consider inquiring into the implementation of the Auditor-General’s recommendation about fatigue management, including policy and practice in the Department of Health and Hospital and Health Services to manage the risk of medical officer fatigue.
1 Introduction

1.1 Role of the committee

The Health and Community Services Committee (the committee) was established by resolution of the Legislative Assembly on 18 May 2012, and consists of government and non-government members. The committee’s areas of portfolio responsibility are: Health; Communities, Child Safety and Disability Services; National Parks, Recreation, Sport and Racing; and Aboriginal and Torres Strait Islander and Multicultural Affairs.5

Section 94 of the Parliament of Queensland Act 2001 provides that the committee is responsible for the assessment of the integrity, economy, efficiency and effectiveness of government financial management by examining government financial documents and considering the annual and other reports of the Auditor-General.6

1.2 Committee process and structure of this report

The Auditor-General’s performance audit resulted in two reports


The Auditor-General and officials from the Queensland Audit Office (QAO) briefed the committee on both reports on 5 March 2014. On that date, the committee resolved to conduct an inquiry into the implementation of the recommendations contained in the two reports. The committee sought and considered information from the Department of Health (the department) and from Hospital and Health Services (HHSs) about the implementation of the recommendations in both reports.

This report summarises the Auditor-General’s main findings and recommendations, and the information provided by the department and HHSs to assess the extent to which the Auditor-General’s recommendations have been implemented. The report is structured around groups of recommendations, as follows:

<table>
<thead>
<tr>
<th>Chapters – implementation of Auditor-General’s recommendations</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3: Private practice arrangements</td>
<td>Rec. 1, 3 and 6</td>
</tr>
<tr>
<td>4: Medical workforce targets</td>
<td>Rec. 2</td>
</tr>
<tr>
<td>5: Systems to support private practice</td>
<td>Rec. 4</td>
</tr>
<tr>
<td>6: Business process and system design</td>
<td>Rec. 7</td>
</tr>
<tr>
<td>7: Work hours, rosters and medical officers leave</td>
<td>Rec. 2, 3 and 4</td>
</tr>
<tr>
<td>8: SMOs – conflicts of interest and performance assessment</td>
<td>Rec. 1</td>
</tr>
<tr>
<td>9: Data standards</td>
<td>Rec 6</td>
</tr>
<tr>
<td>10: Recovery of foregone revenue</td>
<td>Rec 5</td>
</tr>
<tr>
<td>11: Patient access to services</td>
<td>Rec 5</td>
</tr>
<tr>
<td>12: Study and professional funds</td>
<td>Rec 8</td>
</tr>
</tbody>
</table>

1.3 **Role of the Auditor-General**

The Auditor-General’s role and functions are provided for in the *Auditor-General Act 2009*. The Auditor-General’s functions include conducting performance audits of public sector entities. A performance audit evaluates whether an agency or government program is achieving its objectives effectively, economically and efficiently, and is compliant with relevant legislation. It does not consider the merits of government policy; rather, it focusses on how that policy is implemented.

The Auditor-General may prepare a report on any audit conducted under the *Auditor-General Act 2009* and table it in the Legislative Assembly. The Standing Rules and Orders of the Legislative Assembly require that the Committee of the Legislative Assembly refer an Auditor-General report to the relevant portfolio committee/s, as soon as practicable after it has been tabled.

1.4 **Overview of the audit**

In November 2012 allegations were reported in the media that a specialist working for Queensland Health ‘secretly’ earned an extra $2 million treating private patients while using public facilities. The Minister for Health wrote to the Auditor-General in November 2012 expressing concerns about questionable practices by some senior medical officers (SMOs) employed by Queensland Health. Those practices related to right of private practice billing arrangements and the challenges in ensuring oversight, visibility and transparency of SMO practices.

The Auditor-General initiated a performance audit and tabled the interim report (Report 1) in July 2013 and Report 2 in February 2014. The performance audit considered whether the arrangements were achieving the intended health outcomes and were financially sustainable. In conducting the audit, the QAO 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.


The audit was undertaken in accordance with *Auditor-General of Queensland Auditing Standards*, which incorporate Australian auditing and assurance standards.

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8 Legislative Assembly of Queensland, *Standing Rules and Orders of the Legislative Assembly*, SO 194B
2 Auditor-General’s conclusions, findings and recommendations

2.1 The right of private practice scheme

The right of private practice scheme enabled SMOs employed in the public health system to also treat patients who come into the public system and choose to be treated as private patients. Funds from fees charged for those services flow into the public health system.

The right of private practice scheme was first introduced in 1986. It had two objectives:

- to capture private patient revenue in a cost neutral manner, and
- to improve the rate of recruitment and retention of SMOs in order to improve patient access to specialist medical services in the public health system.

All of the categories under the right of private practice scheme and their objectives are listed in the Abbreviations and Glossary on page vi. At the time of the Auditor-General’s performance audit there were two main variants of the right of private practice scheme:

- the SMO received a private practice allowance as well as base salary, and the SMO assigned all private practice revenue they generated to the HHS facility where they worked. The HHS absorbed the direct and indirect costs associated with the service, such as the cost of billing and revenue collection.
  
  This arrangement was offered from 1992. It was referred to as ‘Option A’ or the ‘assignment’ model, and applied to 86.1 per cent of SMOs participating in the right of private practice at the time of the performance audit.

- the SMO retained a proportion of the private fees they earned, and paid the balance into a trust account for the HHS facility to apply to research by staff and education of staff at the facility. The HHS recovered a facility charge and administration fee from participating SMOs to defray overhead costs.
  
  This arrangement was offered from 1986. At the time of the performance audit it applied to only 9 per cent of participating SMOs and was called ‘Option B’ or the ‘retention and revenue sharing’ model. A variant which applied only to radiologists was called ‘Option R’.

2.2 Auditor-General’s conclusions and findings

2.2.1 Future design of private practice arrangements

The performance audit identified multiple issues with the right of private practice scheme, confusion about its purpose, and that it had not been financially sustainable. The Auditor-General recommended that private practice arrangements be redesigned to incentivise practitioners so the scheme is financially sustainable. The redesigned scheme is summarised in chapter 3, along with discussion of some of the issues raised by the department and HHSs about implementation of the revised scheme.

At the time of the Auditor-General’s first report in mid-2013, elements of the funding reforms under the National Health Reform Agreement were still in development. From 2014-15, States would receive funding indexation and growth payments for eligible services based on National Efficient Prices (NEP), developed by the Independent Hospital Pricing Authority. The Auditor-General noted that the new NEP was being refined, and that if Queensland payments to SMOs resulted in costs that are higher than the NEP, the State must fund the difference. Report 1 noted that recommendations therefore needed to be considered in light of the final model of activity based funding under the National Health Reform Agreement.
2.2.2 Confusion about objectives of the right of private practice scheme

The right of private practice scheme was not well understood by SMOs. The Auditor-General surveyed SMOs and found that 62 per cent had experienced situations where they were unsure if a service was billable or not. A high proportion (64 per cent of Options B and R SMOs and 82 per cent of Option A SMOs) felt they did not receive an adequate introduction into what services are billable. A high proportion also felt they did not receive adequate induction on their contractual obligations.

The Auditor-General found that the training and guidance that is provided for SMOs “fails to address adequately the practical issues that each specialty faces”. Uncertainty about contractual obligations and billing under right of private practice arrangements led to SMO hesitation about participation in the scheme due to concerns about the legality of billing.

The Auditor-General found there was a: ...

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

... confusion and indifference felt by SMOs had 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 not ability to generate revenue has reinforced the cultural message that the Option A allowance is only a pay increase.10

The Auditor-General recommended that the scheme be redesigned, and Queensland Health’s implementation is described in chapter 3.

2.2.3 Recruitment and retention of senior medical officers

The right of private practice scheme was introduced to assist in recruitment of SMOs in a cost neutral manner. The Auditor-General found that there had been a sustained growth in SMOs working in Queensland public hospitals, which was evidence that the scheme has aided in recruitment.11 There were 1,262 more full time equivalent SMOs at the end of June 2012 than in 2003-04, a 123.3 per cent increase from 1,024 to 2,286 SMOs.12 Other factors that may have contributed to the increase in SMOs included improved retention rates, changes to industrial conditions including hours of work and allowances, growth in health budgets, and population increase.

The Auditor-General noted that the absence of a target for the number of SMOs needed in Queensland public hospitals meant that it is not possible to determine whether the recruitment of SMOs is more or less than required, or if Queensland Health had the right number.13 Accordingly the Auditor-General recommended that clear medical workforce targets be established. Chapter 4 of this report outlines Queensland Health’s implementation of the recommendation.

2.2.4 Design of the right of private practice scheme

A theme in the Auditor-General’s report was a lack of adequate rigour in the design, management and oversight of the right of private practice scheme. Key findings on those issues were:

- the scheme design does not reflect its original objectives
- the introduction of various right of private practice options, increased payments to SMOs without commensurate financial return and extension of the scheme has eroded financial sustainability
- governance arrangements are lacking, with limited scheme oversight

10 QAO, Report 1, p.60
11 QAO, Report 1, p.24
12 QAO, Report 1, p.24
13 QAO, Report 1, p.24
The Auditor-General examined how well informed decision makers were about the initial design and subsequent changes to the right of private practice scheme. Report 1 concluded that “[t]here is no evidence of adequate rigour in the design of the scheme or in subsequent analysis of the impact of further changes”. There was an apparent absence of program planning, financial analysis or evaluation.

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.

2.2.5 Oversight of the right of private practice scheme

The Auditor-General found that oversight of the right of private practice scheme was ineffective. From the scheme’s inception in 1986 until 2009, Queensland Health was not able to provide any evidence of oversight of the scheme.

A committee formed in 2009 operated to optimise revenue opportunities but did not constitute a governance body. Directors of medical services and medical superintendents had been given a broad remit to manage the right of private practice scheme, but received conflicting messages about the scheme aims. In addition, Report 1 said that senior staff did not have adequate support from Queensland Health or the management information required to ensure compliance with the scheme, for example the data in billing and payroll systems has not been matched at the necessary level of detail.

The Auditor-General recommended that improved governance arrangements be put in place and that administrative, clinical and billing systems be integrated and have standards to enable meaningful and relevant data capture. Progress in the implementation of those recommendations is discussed in chapters 3 (governance) and 5 (system integration).

2.2.6 Cost neutrality

Report 1 concluded that the right of private practice scheme was not cost neutral and had resulted in a substantial revenue shortfall. The most commonly used right of private practice scheme (Option A, see 2.1 above) generated cumulative deficits of $725.69 million over the nine years to June 2012. The report stated that “from inception Option A has failed to be self-sufficient”.

Overall the Auditor-General concluded that the right of private practice scheme cost $804.24 million of the nine years to June 2012. This consists of the $752.47 million difference between the payments to SMOs and Queensland Health’s share of the revenues earned, and $51.77 million in unrecovered administrative support costs.

Confusion and lack of clarity about the right of private practice scheme, and a ‘message’ that the right of private practice Option A allowance was a salary supplement contributed to the cost of the right of private practice arrangements. As well as recommending redesign of the scheme, the

14 QAO, Report 1, p.43
15 QAO, Report 1, p.45
16 QAO, Report 2, p.4
17 QAO, Report 1, p.49
18 QAO, Report 1, pp.49-50
19 QAO, Report 1, p.2
20 QAO, Report 1, p.3
Auditor-General recommended that attempts be made to recover foregone revenue. Queensland Health’s response to this recommendation is discussed in chapter 10 of this report.

2.2.7 Senior medical officers’ workplace attendance

The performance audit was not able to substantiate or disprove allegations of widespread absenteeism by SMOs. The audit found the systems in place at HHSs to monitor attendance “lack basic accountability”, administration relating to “requesting and processing SMO leave have failed”, and allowing SMOs to structure their working week contributed to additional overtime. In some instances, additional overtime resulted in SMOs working at levels regarded to be a ‘significant’ or ‘higher’ risk of fatigue.

Queensland Health’s response to recommendations about leave matters and fatigue management are summarised in chapter 0.

2.2.8 Patients

Patients who arrive at a public hospital are asked whether they elect to be treated as a private patient. Report 2 found that tying SMO remuneration to this patient election created an inherent conflict of interest, and resulted in the risk that private patients receive preferential treatment. The Auditor-General found that, at some HHSs, some elective surgery patients who elected to be treated privately received preferential treatment.

The Auditor-General recommended that patient access be monitored to ensure that patients have fair and equitable access to services, regardless of their ability to pay. Queensland Health’s response to this recommendation is described in chapter 11.

2.2.9 Billing practices

Two HHSs were found to have been overfunded after they were paid for treating patients in emergency departments when in fact the patients were treated in nearby Acute Primary Care Clinics which had bulk-billed to Medicare.

Allegations of improper billing by a 12 SMOs were substantiated by the Auditor-General. The audit found that eight SMOs who treated private patients in public hospitals did not declare income as required by contracts; and four SMOs treated private patients in a public hospital but did not have a right of private practice, and in some instances this work was on paid time. Those matters were referred to the Crime and Corruption Commission and the outcome is summarised in chapter 13.

2.3 Auditor-General’s recommendations

The full text of recommendations made in both Auditor-General reports is contained in Appendix 1.

The recommendations in Report 1 were directed at the department and HHSs and focused on system issues about the design and operation of the right of private practice schemes. In summary the recommendations concerned:

- redesign of private practice arrangements so the scheme is financially sustainable
- establishment of medical workforce targets
- development of governance arrangements for private practice arrangements
• development of standards and integration of administrative, clinical and billing systems supporting private practice to ensure the quality of data captured and to realise efficiencies and enable monitoring of activity
• recovery of foregone revenue
• development of a strategy to engage with participants, medical administrators and support staff to communicate a consistent message about the scheme
• redesign of business processes and systems to support enhanced revenue and expenditure management, including rostering and overtime
• review of the objectives of the study, education and research funds (created from ‘Option B’ of the scheme).

The recommendations in Report 2 focused on the probity of SMOs’ participation in the right of private practice scheme. In summary the recommendations concerned:

• strengthening the management of conflicts of interest for SMOs
• investigating the extent of unrecorded leave and undertaking remedial action
• developing rosters for the efficient delivery of health services, including aligning work patterns with rostered hours
• assessment of SMO performance based on agreed levels of activity
• monitoring of patient access to ensure fairness and equity, regardless of ability to pay
• establishment of controls to maintain a consistent standard for collection and reporting of data for funding and statistical purposes.
3 Private practice arrangements

3.1 Auditor-General’s recommendations about future arrangements

The Auditor-General’s main recommendation about future private practice arrangements was that the scheme be redesigned. As the Auditor-General noted, the recommendations needed to be considered in light of the final model of activity based funding introduced under the National Health Reform Agreement, which changed the way that private practice activity is funded in the public health system.

This chapter describes the re-design of private practice arrangements, and discusses Queensland Health’s implementation of the following recommendations, as part of the redesigned scheme:

- redesign private practice arrangements to incentivise practitioners so the scheme is financially sustainable (recommendation 1, Report 1)
- develop an appropriate governance framework (recommendation 3, Report 1)
- 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 and contractual arrangements (recommendation 6, Report 1).

3.2 Redesign of arrangements

3.2.1 Introduction

The right of private practice scheme ceased on 4 August 2014, and was replaced by new private practice arrangements. For most SMOs, the new arrangement is ‘granted private practice’ which is granted by the HHS or the department as part of the SMO contract of employment. There is also a ‘licensed private practice’ arrangement which is described in section 3.2.4 below.

3.2.2 Documents about the revised private practice arrangements

The department provided the committee with documents about the revised private practice arrangements, which are listed below and published on the committee’s webpage, along with a Health Service Directive about private practice arrangements.

- System Support Services Division, Action Plans for implementation of Report 1 and Report 2 (at 27 August)
- Private practice in the Queensland public health sector framework (May 2014)
- Private practice in the Queensland public health sector guideline (February 2014)
- Private practice: New private practice arrangements for senior medical staff, Summary factsheet (no date)
- Senior Medical Officer Contract of Employment, Core Contract and Schedule 3 – Private Practice
- SMO/VMO contract grievance/dispute resolution procedure (no date)
- Terms of Reference & Business Rules: Private Practice Governance Board (PPGB), (draft, 11 August 2014)
- Health Service Directive – Private Practice in the Queensland Public Health Sector (effective 28 August 2014)

3.2.3 Granted private practice

The former right of private practice ceased on 4 August 2014 and was replaced by a grant of private practice. The SMO Contract of Employment specifies that the employing entity will nominate whether the SMO is granted permission to participate in private practice during hours of work in the public hospital system. Granted private practice is the delivery of professional services to a person who has elected to be treated as a private patient.
3.2.3.1 *Types of granted private practice*

There are two variants of the granted private practice arrangement:

- **assignment** – (applies to approximately 90 percent of SMOs) all revenue is assigned to the HHS or Commercial Business Unit (CBU) of the department; this replaces the former ‘Option A’ and ‘Option P’ arrangements
- **retention** – (applies to approximately 10 percent of SMOs) clinicians retain billings after payment of relevant fees; this replaces the former ‘Option B’ and ‘Option R’ arrangements.\(^{27}\)

The monetary value of the former ‘Option A’ has been incorporated into the remuneration framework which includes a ‘Tier 3’ allowance of 25 per cent of base salary (up to 25 per cent for new SMOs), which will be linked to productivity and performance.

A medical officer appoints the employer (or their agent) to render accounts and collect fees, and agrees to pay a service fee for assistance and services the employer considers appropriate to enable the medical officer to exercise granted private practice. The contract of employment specifies that the maximum fee charged will be an amount which achieves a no-gap result for the private patient.

3.2.3.2 *Service fees*

Information provided by the department indicates that there were formerly 83 facility and administration fees. They have been replaced with a service fee aligned to nine Medicare benefit sub categories. The new service fees will be phased in over a two year period.\(^{28}\)

3.2.4 *Licensed private practice*

Licensed private practice includes private practice by a clinician outside work hours (if the clinician is an employee of the HHS or CBU), in the course of a university or honorary appointment, and in circumstances where the clinician is not an employee or appointee of the HHS or CBU. The private practice is undertaken at a public health facility during unpaid time.

Licensed private practice is subject to a written agreement between the clinician and HHS or CBU. The HHS acts as billing agent for services provided by the HHS such as patient accommodation, consumables and prosthetics, and the clinician can elect to use the HHS as the billing agent for their professional services. Clinicians need to make their own professional indemnity arrangements for licensed private practice.\(^{29}\)

3.2.5 *Committee comment*

The committee notes the substantial effort that has gone into redesigning arrangements for private practice in public health services in response to the Auditor-General’s performance audit.

3.2.6 *Communication with medical officers and staff*

3.2.6.1 *Context*

The Auditor-General found that there was considerable confusion about the objectives of the former right of private practice scheme (see 2.2.2 above) and recommended development of a communication strategy and engagement with SMOs and others involved in private practice arrangements.

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\(^{28}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 6

The Health Service Directive, *Private practice in the Queensland public health sector*, requires HHSs to “[e]nsure all clinicians and support staff complete training and other education and training activities appropriate to their roles and responsibilities regarding private practice”. That training and education appears to be the main communication about the new arrangements.

### 3.2.7 Departmental communications about private practice arrangements

The department advised that a suite of communication materials was developed, including fact sheets, questions and answers, and web content, to support implementation of the program. The materials included two online modules ‘Introduction to private practice for all staff’, and ‘Introduction to practiX: bulk billing outpatient services’.

Detailed information about the private practice arrangements and related SMO conditions of employment is contained in a series of documents produced by the department and provided to the committee. Those documents are listed in section 3.2.2 and published on the committee’s webpage at [http://www.parliament.qld.gov.au/work-of-committees/committees/HCSC](http://www.parliament.qld.gov.au/work-of-committees/committees/HCSC).

The department also advised that summary presentations about the private practice framework and guidelines (listed in 3.2.2) have been produced. The summary presentations are intended to ensure that the medical workforce is aware of their contractual obligations and responsibilities under the new private practice model, and that all stakeholders and staff involved in the private practice scheme have clear guidance about it, including the alignment of private practice activities with the new funding model.

#### 3.2.7.1 Committee comment

The committee notes the detailed documents about the revised private practice arrangements have been produced by the department.

The committee is pleased to see that detailed information about the revised private practice arrangements has been published to provide guidance for SMOs and relevant staff. As noted previously, the Auditor-General found there was confusion about the earlier arrangements. The committee considers it important that information about private practice arrangements is regularly updated and refined, and notes that the private practice framework specifies the education and training standards for staff and board members about the conduct of private practice in the public sector.

In particular the committee noted that the guideline ‘Private practice in the Queensland public health sector guideline’ provides useful summaries of, and links to further information about relevant parts of national health agreements, the Medicare Benefits Schedule, and the *Health Insurance Act 1973*. In addition it provides summary information about indemnity, and arrangements in relation to various categories of patients (e.g. veterans and those who seek treatment in relation to workplace injuries or motor vehicle accidents).

The committee notes that the role of the Private Practice Management Advisory Network (see below) includes development of resources and tools, and encourages the department to ensure that communication materials are updated regularly.

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32 Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 4, p.31
3.2.8  **Senior medical officer employment contracts**

A number of the Auditor-General’s recommendations were implemented through SMO employment contracts, which came into effect in August 2014. The department advised the committee in early June 2014 that a schedule for SMO contracts had been prepared.\(^{33}\) Schedule 3 of the SMO contract of employment sets out arrangements for an SMO to participate in private practice in a public health facility.

3.2.9  **Governance arrangements**

The Auditor-General found significant deficiencies in governance of the former right of private practice scheme. The department has established a framework for governance at statewide and HHS levels.

3.2.9.1  **Statewide**

A Private Practice Governance Board (PPGB) has been established to:

> provide oversight of the administration of private practice arrangements operating across HHS/CBU as follows:

- provide overarching governance and statewide strategic direction for private practice arrangements and associated frameworks, policies, directives and guidelines
- establish and monitor performance criteria to ensure the private practice arrangements achieve their desired outcomes in a financially sustainable manner
- taking remedial action where required and/or escalate the matter where appropriate (Executive Management Team, Performance Management Executive Group etc.).\(^ {34}\)

The draft terms of reference for the PPGB provided by the department specify that it is chaired by the Deputy Director General, System Support Services of the department. The members include the Chief Finance Officer, Chief Human Resources Officer, Chief Legal Officer, Principal Medical Officer, the Chair of the Directors of Medical Services Advisory Committee, and two HHS chief executives.\(^ {35}\)

A Private Practice Management Advisory Network (PPMAN) was proposed\(^ {36}\) as a multidisciplinary group with the following roles:

- collaboratively develop resources and tools (e.g. protocols, procedures, guides, reports) that support the optimisation of the private practice scheme
- provide a platform for knowledge transfer between HHSs and CBUs, and the private sector on professional practice management
- promote a culture across Queensland Health recognising the benefits of private practice options and own source revenue.\(^ {37}\)

3.2.9.2  **Hospital and Health Services**

A Health Service Directive requires each HHS to establish a private practice governance committee to oversee the administration and financial sustainability of private practice arrangements.\(^ {38}\) The

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\(^{35}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 3

\(^{36}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 1

\(^{37}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 6, p.5

\(^{38}\) Queensland Health, *Private Practice in the Queensland Public Health Sector*, Health Service Directive
The **Private practice in the Queensland public health system framework** states that HHSs and CBUs are responsible for the successful operation of private practice at the local level, and will implement a robust governance framework and governance committee to ensure:

- compliance with statewide policies and directives
- local operational policy is developed and implemented
- objectives of private practice activities and outcomes are clearly defined and regularly measured against key performance indicators and remedial action is taken where appropriate
- robust governance and internal controls are maintained
- remedial action where required and/or escalate the matter where appropriate (local audit committee, jurisdictional board, statewide Private Practice Governance Committee etc).39

The respective roles of the statewide and local (HHS) bodies is summarised in Figure 1 below.

**Figure 1 – Governance relationship between Hospital and Health Services and the Department of Health**

Example terms of reference were developed for HHSs to use when setting up local private practice governance boards.41

### 3.2.10 Importance of clear objectives

In a recent report the Auditor-General stated that objectives are meant to express clearly what achievements are wanted, be focused on the end result or outcome, and be measureable and understandable.42

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39 Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 1
40 Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 4, p.28
41 Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 1
Without a clear statement of the purpose or objectives, it is difficult to develop meaningful performance measures that will enable decision makers and stakeholders to know whether the program is achieving the desired outcomes, and whether modifications are required.

The documents provided by the department give detailed and useful information about various aspects of the revised private practice arrangements, including governance arrangements. However, the purpose, objective or outcomes sought are not as explicit as the committee considers desirable.

3.2.10.1 Statements about the objectives of private practice arrangements

The committee noted the following statements in the private practice documents it examined that point to possible objectives of the revised arrangements.

The *Private practice in the Queensland public health sector framework* states:

*Private practice in the Queensland public health sector facilitates patient choice, helps to retain a highly skilled workforce and enhances the overall financial sustainability of the public health system.*

*Effective operation of private practice will achieve the following outcomes:*

- quality patient services
- attracting and retaining a quality workforce
- financial sustainability
- optimal resource use (fixed assets and human capital).\(^{43}\)

and ...

*Private practice is effectively managed and monitored to achieve key deliverables and desired outcomes in a financially sustainable manner.*\(^{44}\)

In addition the *Private practice in the Queensland public health sector framework* states:

- *Private practice is conducted in a way that enhances public practice as the primary mode of care*
- *Promote private practice as a mechanism to support public practice*
- *Patient safety and quality patient care is prioritised above private or public patient election status.*\(^{45}\)

The Health Service Directive about private practice states:

*Private practice activities undertaken during employed time in the Queensland public health sector are financially sustainable and support patient choice and workforce retention.*\(^{46}\)

The committee considers that it would be desirable to more clearly and succinctly specify the primary objectives of the private practice arrangements. Clearly specified objectives would facilitate effective governance of the revised private practice arrangements. The committee therefore recommends that the Minister ensure that clear objectives for the private practice arrangements are developed and incorporated into relevant documents about the private practice arrangements.

As noted above, both the PPGB and the local governance committees at HHSS and CBUs have roles in the monitoring of performance indicators. The statewide PPGB is required to “establish and monitor performance criteria to ensure that the desired outcomes are achieved”. Local governance committees are required to ensure that “objectives of private practice activities and outcomes are clearly defined and regularly measured against key performance indicators”. The committee notes

\(^{43}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 4, p.5

\(^{44}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 4, p.5

\(^{45}\) Mr Ian Maynard, Queensland Health, *Correspondence*, 16 August 2014, Attachment 4, p.17

\(^{46}\) Queensland Health, *Private Practice in the Queensland Public Health Sector*, Health Service Directive
that the PPGB role is limited to establishing and monitoring performance criteria (generally to measure whether objectives are being achieved), and arguably the HHS governance committees role is much broader, to define the objectives of the private practice arrangements.

The committee recommends that the terms of reference for the Private Practice Governance Board and guidance material for terms of reference for HHS governance committees are reviewed to ensure clarity in their respective roles in defining the objectives of the private practice arrangements.

**Recommendation 1**

That the Minister for Health ensure that the Department of Health:

- clearly specify the primary objectives and desired outcomes of the private practice arrangements to facilitate effective monitoring and governance of the arrangements
- incorporate the objectives in relevant documents about private practice arrangements
- clarify the respective roles of the Private Practice Governance Board and Hospital and Health Service private practice governance committees in relation to defining objectives for private practice, and in defining performance criteria to measure whether objectives are being achieved.
4 Medical workforce targets

4.1 Auditor-General's findings and recommendation
The Auditor-General’s Report 1 recommended that the department of HHSs establish clear targets for the optimal medical workforce in the context of desired clinical, patient access and financial outcomes (recommendation 2).

The Auditor-General commented that the right of private practice had 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”. 47

4.2 Department’s response to Auditor-General’s recommendation
Queensland Health initially advised the Auditor-General that the recommendation would be implemented by July 2014 to align with commencement of new funding arrangements under the National Health Reform Agreement and new employment contract arrangements.

Setting targets for the optimal medical workforce was described as “largely a HHS activity, linked to (documented) workforce planning and employment strategy of each HHS”. 48

4.3 Implementation
In June 2014 the director general confirmed that determination of staffing numbers was for HHSs to determine in workforce strategic plans. 49 The department’s advice in September 2014 also noted that HHSs determination of adequate staffing numbers in local workforce strategic plans would be aligned to MOHRI targets. 50

It was apparent from responses to the committee’s August 2014 request to Hospital and Health Boards (HHBs) for an update on implementation of the Auditor-General’s recommendations, that workforce planning is a work in progress in HHSs. For example, the Children’s Health Queensland (CHQ) board advised that CHQ is undertaking a full workforce redesign and recruitment to map to the needs of the Lady Cilento Children’s Hospital. 51

4.4 Committee comment
The committee recognises that workforce planning activity is an ongoing process for HHSs, and supports HHS in continuous planning that takes account of expected capacity and needs.

47 QAO, Report 1, p.24
48 Mr Tony O’Connell, Director-General, Queensland Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, Appendix A, p.85
49 Queensland Health, Correspondence, 3 June 2014, Attachment
51 Ms Susan Johnson, Chair, CHQ HHB, Correspondence, 5 September 2014 (Note: MOHRI targets are ‘Minimum Obligatory Human Resource Information’ data required by the Public Service Commission)
5 Systems to support private practice – administrative, billing and clinical systems

5.1 Auditor-General’s recommendations
The Auditor-General recommended (recommendation 4 in Report 1) that the department and HHS:

... 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.  

5.2 Department’s response to Auditor-General’s recommendation
The department advised the Auditor-General in June 2013 that the department and HHSs accepted recommendation 4 in principle, subject to detailed scoping and costing.

The department stated that a “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”. The second phase, to be completed in June 2014, would plan implementation and specify the project and funding. Implementation would commence in July 2014, subject to the initial scoping study.  

5.3 Implementation

5.3.1 Scoping study
The committee did not receive clear information about whether the scoping study for integration of information systems was commenced, and if so, the options and costings that it may have identified. The committee is aware of significant changes in the department’s approach to information technology with the publication of the Queensland Health ICT Strategic Roadmap in July 2014 (see 5.4 below) which may have affected progress of the scoping study.

5.3.2 Other action
The department advised the committee in May and September 2014 that a number of planned actions were completed. Those actions were: ‘document standards’; ‘recommend data integration where possible’; and ‘compile a single common identifier across Payroll and Practix billing systems’.  

5.3.3 Integration of administrative, clinical and billing systems supporting private practice
In May 2014, the department advised the committee that the Corporate Solutions Portfolio (CSP) of the department was:

... considering the next stage of the information technology advancement with respect to administrative, clinical and billing systems supporting private practice.  

In September 2014 the department advised that the CSP, which was considering the next stage of information technology advancement to implement the Auditor-General’s recommendation, was

52 QAO, Report 1, p.6
53 Dr Tony O’Connell, Department of Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, p.87
55 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment, p.2
closed during 2014. The department’s September advice described the current billing system as an outstanding issue of the Private Practice Reform Project, and:

Stakeholders have expressed concern with the current billing solutions which are resource intensive and require manual intervention to collect all sources of revenue. The unexpected early closure of CSP means that a billing solution is not on the current work plan. This may result in missed revenue opportunities and continued inefficiency.\textsuperscript{56}

It appears that recommendation 4 in Report 1 has been only partially implemented. The outstanding issue is the integration of information technology systems that support private practice.

5.4 Committee comment

From the information provided by the department it appears that part of the Auditor-General’s recommendation 4 has been implemented: that is, a single common doctor identifier and documentation of standards for data capture. However it appears that the recommended integration of information technology systems that support private practice in the public health system has not occurred.

Queensland Health’s information technology strategy has been under review. The Queensland Health ICT Strategic Roadmap\textsuperscript{57} was announced in July 2014, resulting from a review undertaken by a consultant. The ICT Strategic Roadmap includes the development of a new ICT Strategic Framework, new governance arrangements for ICT and greater devolution to HHSs.

The committee acknowledges that some ICT improvements and projects may have been delayed while higher level strategies and plans are developed. The committee considers that short term delays are acceptable if they lead to well designed, integrated ICT systems that improve efficiency and support patient care. Insufficient information is available at this time to assess the efficacy of the proposed strategic changes to ICT, and the committee considers that ICT development in QH warrants further monitoring and scrutiny. It therefore recommends that a committee of a future Parliament inquire into Queensland Health’s implementation of the ICT Strategic Roadmap and related strategies, plans and initiatives.

Recommendation 2

The committee recommends that a future committee of the Legislative Assembly inquire into Queensland Health’s implementation of its ICT Strategic Roadmap and related strategies, plans and initiatives, including systems to support private practice in the public health sector and related information systems.


6 Business process and system redesign

6.1 Auditor-General’s recommendation
In Report 1 the Auditor-General recommended (recommendation 7) that the department and HHSs:

... redesign end to end business processes and systems to support enhanced revenue and expenditure management including rostering and overtime.58

6.2 Department’s response to Auditor-General’s recommendation
The department’s initial response to the Auditor-General’s recommendation about process and system redesign noted that each HHS would determine what actions are taken. The department advised the Auditor-General that an advisory group with representation from all HHSs will

... 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.

With respect to system integration and standardisation, the Own Source Revenue Project Board will explore opportunities for billing system consolidation and improvement.59

6.3 Implementation
Progress by the department and HHSs toward an improved rostering system is described in Chapter 7 in relation to the Auditor-General’s recommendation about improvement of rostering. In the committee’s view work to implement the Auditor-General’s recommendation in relation to rostering has not been completed.

The department reported in May 2014 that its plan was to review end to end processes in priority areas and do a high level review of IT systems supporting billing. The department advised that end to end processes were being mapped. It noted that the Queensland Health IT strategy was under review, and will be a key factor in aiding long term solutions to the billing systems and process issues.60

In September the department advised the committee that implementation of the Auditor-General’s recommendation was not completed.

The necessary information technology (IT) enhancements required to complete this action are subject to the ongoing review and redesign of Queensland Health’s information and communications technology (ICT) systems. As we progress with the development of a state-wide ICT strategic plan, these issues will be incorporated in the specifications of the system replacement strategy.61

6.4 Committee comment
The committee notes that further work is required by Queensland Health to implement the Auditor-General’s recommendation in relation to rostering, and the department’s advice that these issues will be incorporated in ICT strategic plans.

The committee’s comments and recommendation in Chapter 5 for a future parliamentary committee

58 QAO, Report 1, p.6
59 Dr Tony O’Connell, Department of Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, p.89
60 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment, p.2
to monitor Queensland Health’s implementation of the new *ICT Strategic Roadmap* and related plans are relevant to the matters discussed in this chapter.
7 Work hours, rosters and medical officers leave

7.1 Auditor-General's recommendations

A number of issues were raised in the Auditor-General’s Report 2 about SMO working hours, including the possible impact on patient safety, rosters, systems for recording leave, possible unrecorded leave and SMO performance assessment. The Auditor-General’s recommendations on those matters were that the department and HHSs:

... investigate the extent of unrecorded leave and undertake appropriate remedial action\(^{62}\)

... develop rosters for the efficient delivery of health services, including:
- aligning SMOs’ work patterns with rostered hours for payroll purposes
- managing fatigue in accordance with Queensland Health guidelines \(^{63}\)

7.2 Unrecorded leave

7.2.1 Queensland Health response to the Auditor-General’s recommendation

In February 2014, the department advised the Auditor-General that it would work with HHSs to investigate the extent of unrecorded leave and take immediate steps to rectify the situation.

7.2.2 Implementation

The department and HHSs implemented a statewide audit to determine the extent of unrecorded leave. The department advised the committee in September 2014 that, in May 2014, fieldwork was well advanced in the department and that all but one HHS had indicated their intention to undertake a review of unrecorded leave.\(^{64}\)

The department did not provide the committee with any additional information on this matter in its 1 September 2014 response to the committee’s request for an update on implementation of the Auditor-General’s recommendations.

Some HHBs and HHSs provided information to the committee in September and October 2014 about their investigation of unrecorded leave. Four of these advised the committee that audits of leave were undertaken; two of those audits did not reveal any issues about unrecorded leave.\(^{65}\) A third HHS advised that, as a result of its audit, leave management procedures and training were being developed.\(^{66}\) Another HHS advised that forensic investigations have occurred, based on the audit findings.\(^{67}\) One HHS advised that an audit of leave was nearing completion.\(^{68}\)

The Board of Children’s Health Queensland advised the committee that a detailed leave management audit was included in its internal audit plan for 2014-15, and noted a limitation in audits due to current systems:

... the ability to undertake comprehensive leave audits is somewhat limited by the current human resource and payroll systems which do not provide a ‘time in attendance’ system. While leave audits are undertaken, any prospective approach to this is restricted to manual work arounds or proxies such as car park or access records.\(^{69}\)

62 QAO, Report 2, Recommendation 2, p.4
63 QAO, Report 2, Recommendation 3, p.4
64 Dr Michael Cleary, Queensland Health, Correspondence, 1 September 2014, p.3
65 Mr Ed Warren, Chair, Central West HHB, Correspondence, 8 September 2014; Mr Kevin Hegarty, Health Service Chief Executive, Sunshine Coast HHS, Correspondence, 12 September 2014
66 Ms Lesley Dwyer, Health Service Chief Executive, West Moreton HHS, Correspondence, 3 September 2014
67 Ms Debbie Carroll, Acting Chief Operating Officer, Wide Bay HHS, Correspondence, 22 October 2014, p.2
68 Dr Jill Newland, Health Service Chief Executive, Torres and Cape HHS; Correspondence, 12 September 2014, p.2
69 Ms Susan Johnston, CHQ HHB, Correspondence, 5 September 2014, p.1 and attachment
7.2.3  **Committee comment**

The committee notes the limitations on routine and comprehensive leave audits that arise from current software systems. The committee has recommended in chapter 5 that a committee of a future parliament inquire into implementation of the Queensland Health ICT Strategic Roadmap and related plans. One issue for examination could be the implementation of improved, integrated systems for rostering, financial management and support of private practice, as recommended by the Auditor-General.

7.3  **Medical officer rosters, fatigue and patient safety**

7.3.1  **Department’s response to Auditor-General’s recommendation**

The Auditor-General reported that some SMOs had

... worked at levels that were at significant or higher risk, according to the Australian Medical Association’s (AMA) National code of Practice Hours of Work, Shiftwork and Rostering for Hospital Doctors ..., for periods ranging between 20 and 91 weeks over a 104-week period (2011-12 to 2012-13).\(^{70}\)

Other fatigue risks were found by the Auditor-General, for example 31 SMOs were permanently on call. Permanent on-call arrangements are identified as a severe fatigue risk by both the AMA Code and the Queensland Health Fatigue Risk Management System.\(^{71}\)

In response to the Auditor-General’s recommendation about rosters, alignment with payroll systems and management of fatigue, the department’s initial response to the Auditor-General was that significant work had been undertaken to provide line managers with access to the Workbrain roster system “whereby they can view team rosters and better manage attendance, overtime and fatigue”.\(^{72}\)

Metro North HHS Board, Central West HHS Board, and Sunshine Coast HHS advised that current fatigue risk management policy and procedures are in place.\(^{73}\)

7.4  **Implementation**

7.4.1  **Rostering**

A departmental project worked to provide roster managers with access to Workbrain, “which provides immediate alerts of compliance issues, include fatigue penalty, at the time of roster creation (rather than waiting for a future payroll report input and report running at a later point)”. The department reported that in April 2014 just over 900 roster managers had access to Workbrain.\(^{74}\)

One HHS commented that the “system would be better served through investment in an effective roster build model as a front-end to the SAP and Workbrain systems”.\(^{75}\)

The implementation of improved rostering was still underway when the department updated the committee on implementation in September 2014. A reference group with members from all HHSs and the department was established in June 2014 to inform and endorse the future use of the Integrated Workforce Management (IWFM) solution. Onsite engagement with selected HHSs was

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70 QAO, Report 2, p.20
71 QAO, Report 2, p.20
72 Dr Michael Cleary, Queensland Health, Correspondence to Auditor-General, 6 February 2014, reproduced in QAO, Report 2, p.38
73 Dr Paul Alexander AO, Chair, Metro North HHB, Correspondence, 4 September 2014; Mr Kevin Hegarty, Sunshine Coast HHS, Correspondence, 12 September 2014; Mr Ed Warren, Central West HHB, Correspondence, 8 September 2014
74 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment, p.5
75 Mr Kevin Hegarty, Sunshine Coast HHS, Correspondence, 12 September 2014
planned to ensure the IWFM is driven by business needs and aligns with requirements. The committee was not informed of an expected time for full implementation of the proposed system.

One action reported by the department as completed was to include in SMO contracts the ability for HHSs to introduce shift work instead of overtime payments during core hours. This appears in the Core Contract for SMOs and enables the introduction of shift work, extended rosters, and variation of rosters or shifts in consultation with the medical officer, and with reasonable notice of changes.

7.4.2 Fatigue management policy and implementation

The department advised the committee in May 2014 that fatigue management policies had been updated and consolidated, and “a working group is being set up to consider the next steps in the future management of fatigue risk within Queensland Health”.

The August 2014 SMO contract of employment states that hours of work, whether worked or on call, will be monitored in accordance with the fatigue provisions of the contract. The contract states that the employing entity (either the department or a HHS) is:

... required to have an open and transparent fatigue management strategy in place for Medical Officers. Any fatigue-related matters will be managed in cooperation between the Medical Officer and their relevant manager to ensure the health and safety of both patients and the Medical Officer. Excessive on call hours and hours of work are to be managed in accordance with best practice fatigue management, the Department’s Policy I1 Medical Fatigue Risk Management System, as amended from time to time and the Service’s fatigue management strategy.

The department updated its human resources policy on fatigue risk management in June 2014. A Queensland Health ‘Implementation Standard for Health Practitioner Fatigue Risk Management’ was approved in January 2014 and was due for review in October 2014. The Implementation Standard requires HHS chief executives and divisional heads to ensure that a health practitioner fatigue risk management system is developed, documented, maintained and reviewed, and that health practitioners receive training about the effects of fatigue and fatigue related risk.

7.4.3 Committee comment

The committee acknowledges the commitment of medical and other health staff who work long hours to provide care and treatment for patients, and the complexities of balancing the need for health care with reasonable working hours. The committee also considers that appropriate management of fatigue risks is essential to patient safety, and notes that each employing entity (either the department or HHSs) are required to have an open and transparent fatigue management strategy in place. The committee understands that HHSs are still in the process of developing fatigue risk management strategies and procedures.

76 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment, p.5
78 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment, p.5
79 Mr Ian Maynard, Queensland Health, Correspondence, 16 August 2014, Attachment 2.1, items 5 and 18 of Core Contract
Recommendation 3

The committee recommends that a future committee of the Legislative Assembly consider inquiring into the implementation of the Auditor-General’s recommendation about fatigue management, including policy and practice in the Department of Health and Hospital and Health Services to manage the risk of medical officer fatigue.
8 Senior Medical Officers – conflicts of interest and performance assessment

8.1 Conflicts of interest

8.1.1 Auditor-General’s recommendation

The Auditor-General recommended that the management of conflicts of interest for SMOs should be strengthened. Declarations of outside employment should be required; conflicts should be better defined in the context of SMOs undertaking secondary employment; and education and awareness training for SMOs in their conflict of interest obligations was recommended.

8.1.2 Queensland Health response to recommendation

The department advised the Auditor-General in February 2014 that the SMO contract of employment would include a requirement for SMOs to declare private practice activities. The department planned to partner with HHSs to develop an awareness program for SMOS outlining conflict of interest obligations, as part of the broader learning management system.

The department noted that conflicts of interest have arisen where a medical officer is granted the ability to treat their own private patients (i.e. from private rooms external to the hospital), at the public hospital. The department advised that from July 2014 a template Licenced Private Practice agreement would be the only instrument permitting this activity to occur.

8.1.3 Implementation

The department advised that it had implemented the Auditor-General’s recommendation through a range of measures including:

- the SMO Contract of Employment requires SMOs to disclose external employment and private practice arrangements in writing
- the Terms and conditions of employment – contracts, require SMOs to disclose conflicts of interest in writing
- training resources on fraud awareness and ethics are available on-line
- a conflict of interest awareness program for HHSs was in development, and employee and manager guidelines were to be available on-line
- an example Licenced Private Practice contract for SMOs to have intermediate patient access to public health facilities is available for HHS use.

8.1.4 Committee comment

The committee notes that reasonable steps have been taken to implement the Auditor-General’s recommendation.

8.2 Performance assessment

8.2.1 Auditor-General’s recommendation

The Auditor-General recommended (number 4 in Report 2) that the department and HHSs “assess an SMO’s performance based on an agreed level of clinical and non-clinical activity”.

8.2.2 Queensland Health response to the Auditor-General’s recommendation

In its response to the Auditor-General’s recommendation about assessment of SMO performance on agreed activity levels, the department advised the Auditor-General in February 2014 that individual

82 QAO, Report 2, p.4
contracts for SMOs would include key performance targets that relate to agreed levels of clinical and non-clinical activity.83

8.2.3 Implementation

The department advised that performance assessment for SMOs was implemented through the development of a ‘Capability Development Toolkit’ which was provided to HHSs. The Toolkit incorporates a range of plans and tools to support the implementation of performance management. In addition the department advised that agreed levels of performance were to be included in SMO contracts.84

The August 2014 SMO employment contract includes details of conditions and space in various schedules of the contract for descriptions of duties, employment details and key performance indicators.

The department provided the committee with a copy of the Health Employment Directive No. 7/14 ‘Senior Medical Officers – Employment Framework’ and its attachments, which provide detailed information about remuneration and terms and conditions of employment. The terms and conditions of employment include a requirement for SMOs to participate in regular performance reviews, including assessment against performance criteria. The productivity and performance payment is up to 25 per cent of base salary.85

The KPIs will be developed at the HHS level in agreement with the SMO and will be reviewed by the HHS from time to time.86

The SMO contract of employment states that review of agreed KPIs for 2015-16 will be measured and the outcomes may impact on remuneration for the 2016-17 financial year.87

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83 Dr Michael Cleary, Queensland Health, Correspondence to Auditor-General, 6 February 2014, reproduced in QAO, Report 2, Appendix A, p.39
84 Dr Michael Cleary, Correspondence, 1 September 2014, Attachment 2, p.11
87 Mr Ian Maynard, Queensland Health, Correspondence, 16 August 2014, Attachment 2.1
9 Data standards

9.1 Auditor-General’s recommendation

The Auditor-General recommended that controls be established to maintain a consistent standard for collection and reporting of activity data for funding and statistical purposes.88

This recommendation arose from anomalies the Auditor-General identified in emergency departments in facilities which also have an Acute Primary Care Clinic (APCC). The anomalies arose due to incorrect computer classification in the emergency department.

The aim of an APCC is to provide care to patients with less complex needs who present to an emergency department and instead choose to attend the nearby APCC. An APCC is staffed by HHS staff who bulk-bill Medicare for the services provided.

9.2 Department’s response to Auditor-General’s recommendation

The department advised the Auditor-General in February 2014 that it would complete implementation of the recommendation by April 2014:

With regard to the report’s findings relating to the classification of patients that present to hospital emergency departments and then subsequently present to an Acute Primary Care Clinic at the same facility – the Department of Health agrees that these cases have been incorrectly classified as emergency service events. The Department of Health will develop a new data element to identify instances where patients present to the emergency department but choose to access an alternate care pathway at a facility.

The Department of Health will ensure source data is amended. As highlighted in your report, the Department of Health agrees that the Acute Primary Care Clinics reviewed have not breached any section of the Health Insurance Act 1973 (Cth).89

9.3 Implementation

The department advised the committee in September 2014 that one HHS closed its APCC in March 2014. A data definition for patients who initially presented to the emergency department but ‘did not wait’ was provided to the other HHS which had classified patient attendance incorrectly. It was then provided to all HHSs. The department was still working with one HHS in August to ensure that data was adjusted to the ‘did not wait’ category before the end of September 2014 when final activity data was due to the National Funding Administrator.90

9.4 Committee comment

The committee notes that this issue appeared to be close to resolution when the department reported in early September 2014.

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88 QAO, Report 2, Recommendation 6, p.4
89 Dr Michael Cleary, Queensland Health, Correspondence to Auditor-General, 6 February 2014, reproduced in QAO, Report 2, pp.39-40
90 Dr Michael Cleary, Queensland Health, Correspondence, 1 September 2014, Attachment 1, p.13
10 Recovery of foregone revenue

10.1 Auditor-General’s findings and recommendation

The Auditor-General’s Report 1 found that Queensland Health paid allowances to SMOs as part of the private practice arrangements, with little or no ability to recover those costs. Under ‘Option A’, which was originally intended to be cost neutral, SMOs were paid an allowance. All private practice income was paid to the HHS. Patient fees could not exceed the schedule fee in the Medicare Benefits Schedule.

The revenue generated from private practice by SMOs who received an allowance was insufficient to cover the allowances paid to SMOs. The Auditor-General found that almost half of the SMOs (46.7 per cent) did not generate any private practice revenue in 2011-12. Meanwhile the private practice allowance had come to be perceived as a routine allowance for SMOs. Some SMOs, for example specialists in emergency medicine, medical administration and anaesthetics had limited or no ability to generate private practice revenue.

The Auditor-General recommended that the department and HHS “make immediate attempts to recover foregone revenue, if cost effective, and investigate further revenue uplift opportunities”.

10.2 Queensland Health’s response to Auditor-General’s recommendation

10.2.1 Recovery of foregone revenue

The department advised the Auditor-General in June 2013 that recovery of foregone revenue would be implemented by December 2013. Each HHS would determine the recovery actions it would take. The department would coordinate a recovery plan for high value items, and form a project team which would develop tools to undertake retrospective auditing of private practice accounts to capture missed revenue.

10.2.2 Investigation of revenue uplift opportunities

The department’s advice to the Auditor-General in June 2013 was that it “already undertakes annual comprehensive reviews on uplift potential, which inform the following years Own Source Review Stretch Targets.”

10.3 Implementation

10.3.1 Department of Health

The department advised in May 2014 that it sought to recover private patient revenue lost for the past two years. Data would be provided to HHSs for validation and billing. The department noted that significant manual reconciliation may be required by HHSs to verify if invoices had been raised for the identified items.

The department informed the committee in May 2014 that $10.8 million had been recovered in relation to previous financial years. It reported that it was on track to increase private patient billings in the financial year 2013-14 by $21 million compared to 2012-13.

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91 QAO, Report 1, p.55
92 QAO, Report 1, p.59
93 QAO, Report 1, Recommendation 5, p.6
94 Mr Tony O’Connell, Queensland Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, p.87
95 Mr Ian Maynard, Queensland Health, Correspondence, 29 May 2014, Attachment
10.3.2 Hospital and Health Services

One HHS advised that it had substantially completed work to recover revenue and would conduct a manual review of potential missed billing in September 2014. Another HHS advised that it had an ongoing process of review to ensure that unbilled items are recovered, and one advised that a project to recover revenue was underway. Yet another advised that it had completed recovery of foregone revenue.

10.3.3 Committee comment

The committee notes that the Auditor-General’s recommendation about recovery of foregone revenue was for recovery action, if it was cost effective. Further, the committee notes that the department’s advice was to attempt revenue recovery of foregone revenue for the past two years, and that significant manual reconciliation by HHS may be required.

The committee is satisfied that reasonable efforts have been implemented to recover foregone revenue.

96 Ms Susan Johnson, CHQ HHB, Correspondence, 5 September 2014
97 Dr Peter Bristow, Health Service Chief Executive, Darling Downs HHS, on behalf of Mr Horan, Chair, Darling Downs HHB, Correspondence, 9 September 2014
98 Ms Lesley Dwyer, West Moreton HHS, Correspondence, 3 September 2014
99 Dr Paul Alexander AO, Metro North HHB, Correspondence, 4 September 2014
11 Patient access to services

11.1 Auditor-General’s findings and recommendation

The National Health Reform Agreement and the National Healthcare Agreement 2012 require public hospitals to provide access to the same services for public patients as they do for private patients. The Auditor-General examined whether the right of private practice scheme resulted in any adverse effect on patients.

Report 1 noted that the business cases supporting introduction and evolution of the right of private practice scheme included the principle that public patients should not be adversely affected. Report 2 noted that there was no effective monitoring of public versus private patient experience. The Auditor-General recommended that the department and HHSs “monitor patient access to ensure that patients have fair and equitable access to services, regardless of their ability to pay”. 100

11.2 Queensland Health’s response to Auditor-General’s recommendation

The department advised the Auditor-General in February 2014 that the proposed Health Service Directive would include requirements about the way that private practice would be provided, including that private practice would be “actively managed and monitored”. 101

11.3 Implementation

The department advised the committee that statements on patient access to services were included in policy documents about the private practice arrangements, and that a decision support system cube to enable local monitoring of private activity was completed. 102 It is not clear whether the decision support system has been implemented in HHSs.

The Health Service Directive includes principles that private practice is “actively managed and monitored by Hospital and Health Services” and is “conducted in a way that prioritises patient’s needs”. 103

The Private practice in telehealth Queensland public health sector framework states that private practice is to be conducted in a manner that, among other things, is consistent with the National Health Reform Agreement and enhances “access to patient care and clinical outcomes without discrimination on ability to pay (i.e. private patient services must support access to care and the quality treatment provided in the public sector regardless of a patient’s ability to pay)”. 104

11.4 Committee comment

The committee notes that the combined effect of the Health Service Directive, the private practice framework and decision support systems that provide meaningful management information should enable monitoring of patient access to ensure that public patients have fair and equitable access to services, regardless of their ability to pay. However, the committee does not have sufficient information about the implementation of management information systems to know whether monitoring will be adequate.

100  QAO, Report 2, Recommendation 5, p.6
101  QAO, Report 2, Appendix A, p.39
102  Dr Michael Cleary, Queensland Health, Correspondence, 1 September 2014, Attachment 2
103  Queensland Health, Private Practice in the Queensland Public Health Sector, Health Service Directive
104  Mr Ian Maynard, Queensland Health, Correspondence, 16 August 2014, Attachment 4, p.17
12 Study and professional funds

12.1 Auditor-General’s recommendation

The Auditor-General recommended that the department and HHSs “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”.105

12.2 Department’s response to Auditor-General’s recommendation

In a response to the Auditor-General’s draft report on 28 June 2013, the director-general of the Department advised that completion of a HHS review of the current fund and application of the current accumulation was planned by the end of 2013, and new trust fund arrangements would be implemented by 1 July 2014 in conjunction with the redesigned private practice arrangements. The director-general advised that the relationship between private practice and SERTA and SERTF would be transformed.106

The redesigned private practice arrangement would not preserve a relationship between private practice and the funds. Instead, each HHS would have the capacity to establish trust funds to serve study, education, research and clinical purposes. The funds could receive donations, including from private practice participants, and may determine proportion of private practice fees to be received by the funds. Trust funds would be “established under the Treasurer’s approval in terms of the Statutory Bodies Financial Arrangements Act 1982”.107

12.3 Implementation

The department advised the committee that the recommendation had been fully implemented by January 2014. The disbursement of funds had been reviewed and clear guidance had been provided to HHSs about trust funds.108

A report provided to the committee in August 2014 stated that the Private practice in the Queensland public health sector framework (May 2014) had “eliminated the mandatory requirement to have revenue disbursed to trust accounts for study, education and research”.109

105 QAO, Report 1, Recommendation 8, p.6
106 Dr Tony O’Connell, Queensland Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, p.89
107 Dr Tony O’Connell, Queensland Health, Correspondence to Auditor-General, 28 June 2013, reproduced in QAO, Report 1, p.89
108 Queensland Health, Correspondence, 3 June 2014, Attachment, p.2
109 Mr Ian Maynard, Queensland Health, Correspondence, 16 August 2014, Attachment 1
13 Alleged improper conduct

13.1 Auditor-General’s finding
Concerns about the way that some SMOs participated in the right of private practice scheme preceded the performance audit undertaken by the QAO. Report 1 of the performance audit highlighted systemic issues that had contributed to problems with the scheme. Report 2 focused on the probity of SMOs participation in particular in relation to billing.

As noted in Chapter 2, Report 2 found that some allegations of improper billing by twelve SMOs were substantiated. Eight SMOs had not declared income from treating private patients in public hospitals as required by contracts. Four SMOs had treated private patients in a public hospital but did not have a right of private practice. In some instances the treatment of private patients was on paid time. 110

13.2 Department’s response to Auditor-General’s findings
The department advised the Auditor-General in February 2014 that it would “commission a system wide investigation into the allegations of potential mismanagement, professional negligence and official misconduct alluded to in the report”.111

13.3 Referral and report by the Crime and Corruption Commission

13.3.1 Referral
The QAO referred concerns about possible official misconduct by twelve SMOs to the Crime and Corruption Commission (CCC).

13.3.2 Assessment report
The CCC engaged the Hon. S. Jones AO QC to assess the allegations and advise whether investigation by the CCC was warranted.112 The CCC reported in September 2014. It accepted the advice of the Hon. S. Jones, which noted that there was limited evidence and stated in part:

Since the specialists’ conduct was founded on informal contractual arrangements under supervision of hospital administrators, there was no evidence that the practices of the specialists were dishonest or done so as to deliberately deceive the hospital administrators. 113

The advice concluded that the referral from QAO:

... identified serious issues of lack of accountability within the public health systems, and that most of the shortfall was due to systemic deficiencies and lack of oversight by administration. 114

The CCC report accepted the Hon. S. Jones’ conclusion:

... that while the material in some instances did expose conduct which justified the concerns raised by QAO, there was insufficient cogent evidence to warrant investigation by the CCC, particularly given the absence of any other adverse conduct. 115

110 QAO, Report 2, p.3
111 Dr Michael Cleary, Queensland Health, Correspondence to Auditor-General, 6 February 2014, reproduced in QAO, Report 2, p.36
113 Crime and Corruption Commission, Conduct of Senior Medical Officers, p.6
114 Crime and Corruption Commission, Conduct of Senior Medical Officers, p.7
115 Crime and Corruption Commission, Conduct of Senior Medical Officers, p.7
The CCC referred information in relation to two medical practitioners to the relevant HHSs, and took no further action with respect to the remaining practitioners.

13.3.3 Committee view
In light of the examination of the possibility of official misconduct by the CCC, and its decision not to proceed to investigate the matter, the committee makes no comment on these matters.
Appendices

Appendix 1 – Auditor-General’s recommendations

Right of private practice in Queensland public hospitals (Report 1)

All recommendations need to be considered in light of the final model of activity based funder 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 to ensure maximum benefits are derived for the state.

Right of private practice: Senior medical officer conduct (Report 2)

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

1. strengthen the management of conflicts of interest for senior medical officers by:
   - introducing a written mandatory declaration of outside employment for SMOs
   - requiring SMOs to provide updated information when situations change
   - better defining conflicts of interest in the context of public service SMOs undertaking secondary employment
   - strengthening the process for assessment of conflicts of interest
   - undertaking education and awareness training for SMOs in conflict of interest obligations
2. investigate the extent of unrecorded leave and undertake appropriate remedial action
3. develop rosters for the efficient delivery of health services, including:
   - aligning SMOs’ work patterns with rostered hours for payroll purposes
   - managing fatigue in accordance with Queensland Health guidelines
4. assess an SMO’s performance based on an agreed level of clinical and non-clinical activity
5. monitor patient access to ensure that patients have fair and equitable access to services, regardless of their ability to pay
6. establish controls to maintain a consistent standard to collect and report activity data for funding and statistical purposes.
Appendix 2 – Bibliography


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Attachment 2, Senior Medical Officers – Employment Framework, Health Employment Directive no. 7/14,


Attachment 2.2, ‘Senior medical officers: Terms and conditions of employment – contracts’, Attachment 2 to Senior Medical Officers – Employment Framework,


Attachment 3, Terms of Reference & Business Rules: Private Practice Governance Board (PPGB), draft at 11 August 2014,

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Attachment 5, Private practice in the Queensland public health sector guideline,

Attachment 6, Private practice: New private practice arrangements for senior medical staff, Summary factsheet, (no date),


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