

# Private practice in the Queensland public health sector framework

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

June 2024

## Private practice in the Queensland public health sector framework

Approved – Director-General 06/09/2024



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Beyond the framework, the *Private Practice Guidelines (online resource)* provides additional best-practice guidance to improve private practice in public health facilities.

## Purpose of this framework

The purpose of this framework is to ensure private practice activities in the Queensland public health sector are sustainable and support patient choice, workforce attraction and retention.

As a supporting document to the Health Service Directive – Private practice in the Queensland public health sector, this document is a mandatory policy instrument and applies to Hospital and Health Services (HHSs).

As a supporting document to the Department of Health Policy – Private practice in the Queensland public health sector, this document is a mandatory policy instrument and applies to Department of Health divisions (e.g. Queensland Public Health and Scientific Services (QPHaSS)).

This framework should be read in conjunction with, and applied in a manner consistent with, the legislative instruments, industrial instruments, contractual agreements, and policy directives that it references.

# Introduction

Arrangements for Queensland Health clinicians to participate in private practice have been in operation since 1986. Private practice in the Queensland public health sector facilitates patient choice, helps to attract, and retain a highly skilled clinical workforce and enhances the overall sustainability of the public health system.

Private practice arrangements have historically aimed to address five key objectives:

- Remunerate medical staff at a level commensurate with other States and Territories.
- Provide a means to address public sector workforce shortages, particularly in diagnostic specialties by allowing individuals to retain a portion of their billings.
- Facilitate private patient choice in the public health sector, consistent with the National Health Reform Agreement and successive National Healthcare Agreement obligations.
- Optimise third party funding sources (Medicare Benefits, Private Health Insurance etc.) for reinvestment into improving healthcare services.
- Optimise the efficient utilisation of public health sector infrastructure.

For the purpose of this document, private practice relates to the treatment of a person who could receive treatment free of charge under the *National Health Reform Agreement* (as amended or replaced) but who has elected to be treated privately in the public system, or a person who agrees to be a fee-paying patient of the medical officer and makes this election on the basis of informed financial consent.

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

### 1. Regulation

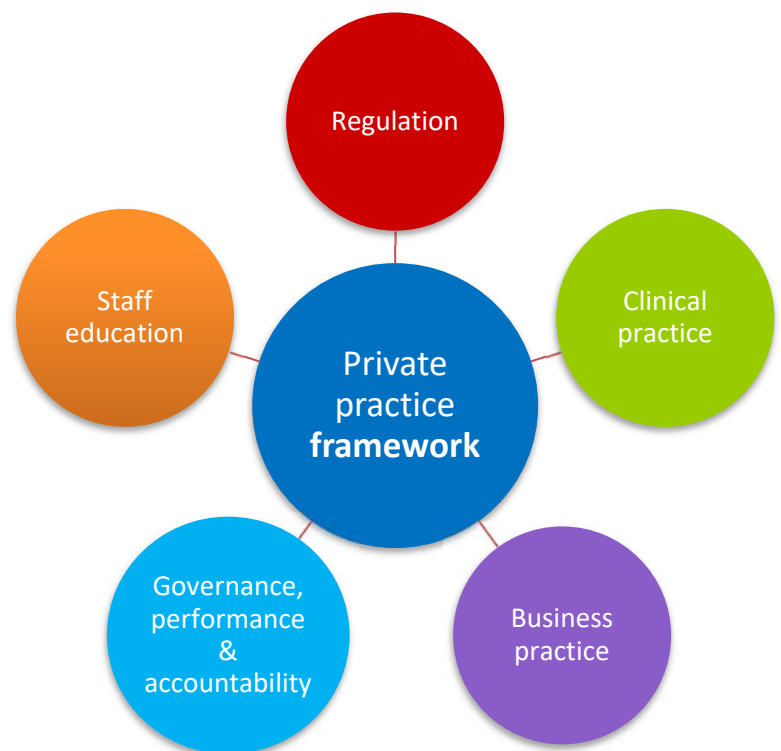
Private practice is provided in accordance with relevant legislation, regulation and policy.

### 2. Clinical practice

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

### 3. Business practice

Private practice supports the business requirements of HHSs and Department of Health divisions in achieving efficient and cost-effective delivery of health services.



#### **4. Governance, performance and accountability**

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

#### **5. Staff education**

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

## **Implementing the framework**

HHSs and Department of Health divisions will use this framework to support private patient service delivery.

Appendix 1 provides a matrix with specific areas of potential improvement for each of the framework components.

## Regulation

Private practice is provided in accordance with relevant legislation, regulation and policy. HHSs and Department of Health divisions are to:

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

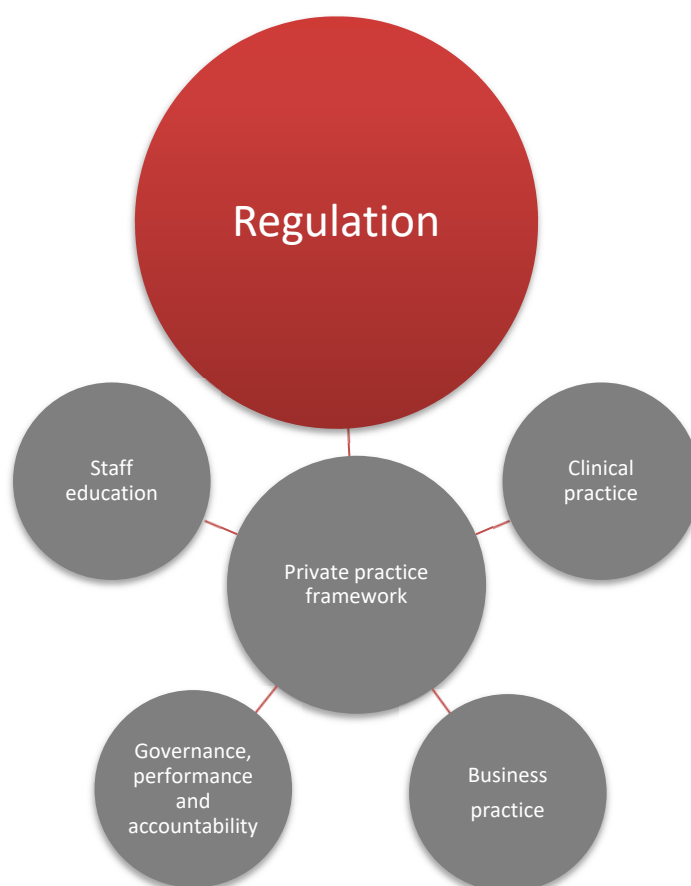
### Overview—regulation requirements

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

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

The following principles underpin the regulation component of the framework:

- HHSs, Department of Health divisions and individuals will provide Medicare Benefits Schedule billed services in compliance with the *Health Insurance Act 1973*.
- A professional service provided by a clinician engaging in private practice is rendered under a contract between the clinician and the patient.
- Where support staff are involved in providing a service, the treating clinician is responsible for meeting the supervision requirements and must also attend to the patient where there is a requirement to do so (e.g. Medicare benefits for consultation items).
- Clinicians are obliged to fulfil the terms and conditions of their granted private practice agreement.





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

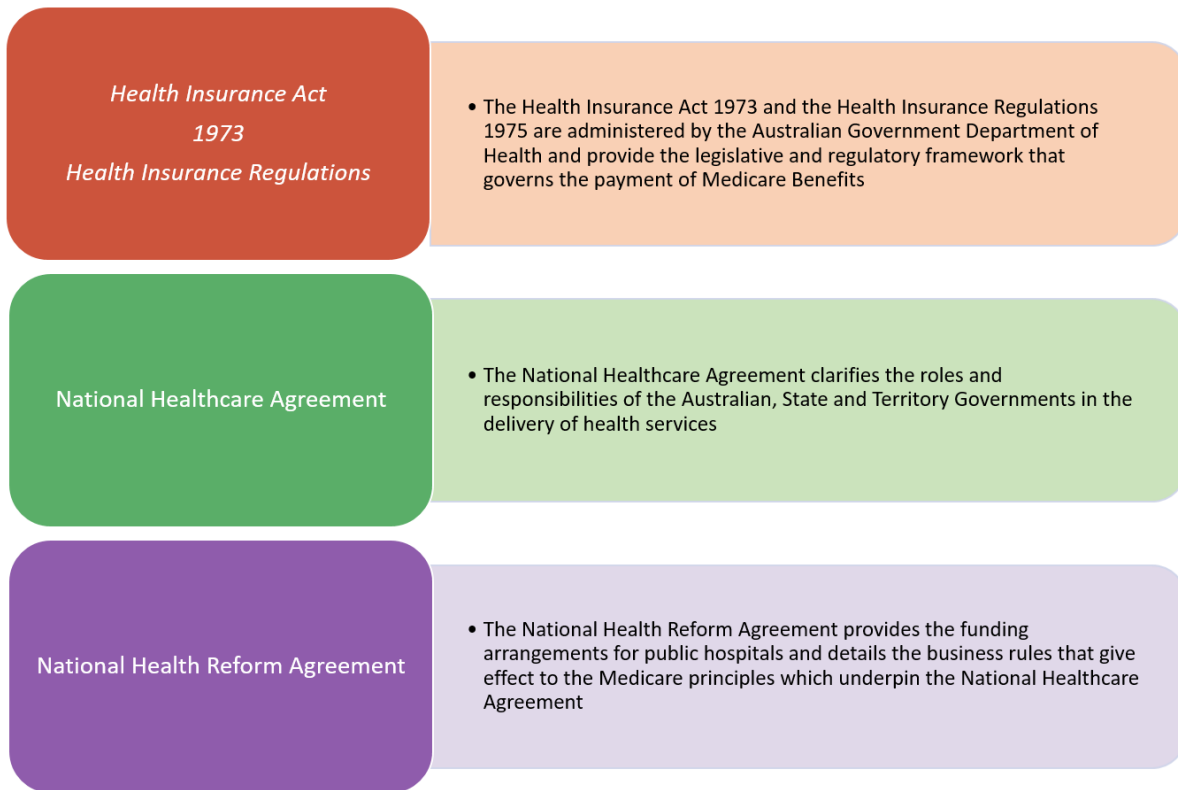
- *Private Practice in the Queensland public health sector framework (this document)*
- *Private Practice in the Queensland public health sector - Health Service Directive*
- *Queensland public health sector – Private Practice Guidelines (online resource)*
- *Private Practice in the Queensland public health sector -Department of Health Policy (applies to Department of Health division's only)*
- *Private Practice in the Queensland public health sector – Department of Health Standard (applies to Department of Health division's only)*

Individuals will benefit most from reading the framework in conjunction with the *Private Practice Guidelines* which provides additional information for practice managers, clinicians and support staff on referral and billing practices.

Other key documents relevant to private practice activities:

- *Fees and charges for healthcare Services - Health Service Directive*
- *Queensland Health Fees and Charges Register*
- *The Medical Officers' (Queensland Health) Certified Agreement (MOCA)*

To support the regulation component of the framework, it is important to understand key Australian Government regulation/s and legislation, including:



## Health Insurance Act 1973

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

## Restrictions on claiming and ministerial directives

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

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

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

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

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

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

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

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

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

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

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

## Medicare Benefits Schedule

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

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

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

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

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

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

### **GN.1.3 Medicare benefits and billing practices**

#### **Key information on Medicare benefits and billing practices**

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

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

Source: s.GN.1.3 Medicare Schedule Benefits Book

Section GN.2.4 provides key information on provider eligibility for Medicare.

### **GN.2.4 Provider eligibility for Medicare**

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

- (a) a recognised specialist, consultant physician or general practitioner
- (b) in an approved placement under section 3GA of the *Health Insurance Act 1973*
- (c) a temporary resident doctor with an exemption under section 19AB of the *Health Insurance Act 1973* and working in accord with that exemption.

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

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

**Note:** It is an offence under Section 19CC of the *Health Insurance Act 1973* to provide a service without first informing a patient where a Medicare benefit is not payable for that service (i.e. the service is not listed in the Medicare Benefits Schedule S). Source: s.GN.2.4 Medicare Schedule Benefits Book

## **National Health Reform Act 2011**

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

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

The *National Health Reform Act 2011* is relevant to private practice insofar as it governs the establishment and functioning of national bodies associated with health reform. It does not prescribe specific rules relating to private practice; however, the Independent Hospital

Pricing Authority sets the National Efficient Price for private patients treated in the public health sector.

## Intergovernmental agreements

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

The National Healthcare Agreement clarifies the roles and responsibilities that guide the Commonwealth and states and territories in the delivery of health services.

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

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

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

Relevant clauses include:

- G14 Requires all admitted patients to make a written election to receive admitted patient care as either a public or private patient. It states, 'election by eligible patients to receive admitted public hospital services as a public or private patient will be exercised in writing before, at the time of, or as soon as possible after admission and must be made in accordance with the minimum standards set out in this agreement' (p.83).
- G15 Provides that 'private patients have a choice of doctor, and all patients will make an election based on informed financial consent' (p.83).
- G16 Indicates that 'where care is directly related to an episode of admitted patient care, it should be provided free of charge as a public hospital service where the patient chooses to be treated as a public patient, regardless of whether it is provided at the hospital or in private rooms' (p. 83).
- G17 Specifies that 'services provided to public patients should not generate charges against the Commonwealth MBS:
  - a. except where there is a third-party payment arrangement with the hospital or the State, emergency department patients cannot be referred to an outpatient department to receive services from a medical specialist exercising a right of private practice under the terms of employment or a contract with a hospital which provides public hospital services.
  - b. referral pathways must not be controlled so as to deny access to free public hospital services; and
  - c. referral pathways must not be controlled so that a referral to a named specialist is a prerequisite for access to outpatient services' (p.83 & 84).

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

However:

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

b.ii) hospital employees will not direct patients or their legal guardians towards a particular choice' (pp.58-984).

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

a .l) there is a third-party payment arrangement with the hospital or the state or territory to pay for such services; or

b. ii) the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient' (p.8459).

G20 States that 'where a patient chooses to be treated as a public patient, components of the public hospital service (such as pathology and diagnostic imaging procedures) will be regarded as a part of the patient's treatment and will be provided free of charge' (p.84).

G30g Stipulates 'a statement that patient election status after admission can only be changed in the event of unforeseen circumstances. Examples of unforeseen circumstances include, but are not limited to the following:

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

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

iii) patients whose social circumstances change while in hospital (for example, loss of job)' (p.86).

Source: Schedule G – Business Rules. National Health Reform Agreement

## Private Health Insurance Act 2007

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

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

## Health Practitioner Registration National Law Act 2009

The *Health Practitioner Registration National Law Act 2009* (Qld) (National Law)

regulates practitioner registration and compliance. Registration of health practitioners is provided for in Part 7 and performance and conduct matters are set out in Part 8. Medical registration is a prerequisite for obtaining a Medicare provider number.

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

Goods and services tax (GST) is payable on taxable supplies and taxable importations. Therefore, GST is payable on medical reports (unless a Medicare benefit is payable for the report or the report is an ordinary and natural part of the performance of a GST-free medical service), service retention amounts and any service fees payable by a clinician engaging in the revenue retention private practice arrangement.

## **Income Tax Assessment Act 1997**

Private practice-related remuneration is assessable income (s.6-5) to the Medical Officer signing the agreement. Allowable deductions (s.8-1(1)) may include the amount of billings assigned to a HHS or Department of Health division. Clinicians should obtain independent taxation advice about the impact of private practice on their income.

The HHS or Department of Health division (as applicable) is responsible for providing relevant information required by clinicians for taxation purposes including income, retention of fees or service fees or service retention amounts and the GST included in these amounts.

## **Competition and Consumer Act 2010**

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

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

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

## **Hospital and Health Boards Act 2011**

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

- employing staff in the Department of Health or HHSs other than a prescribed HHS.
- managing statewide industrial relations, including the negotiation of certified agreements and making applications to make or vary awards.



- establishing the terms and conditions of employment for health service employees (s.45(e)-(g)).

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

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

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

- s.51A(1) – the Director-General may issue health employment directives about the conditions of employment for health service employees.

## Financial legislation and related instruments

The *Financial Accountability Act 2009* (Qld) and related regulatory regime including the Financial Accountability Regulation 2019 (Qld), Financial Performance and Management Standard 2019 and the local Financial Management Practice Manual govern many aspects of the private practice schemes.

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

HHSs and Department of Health divisions must comply with the Queensland Health Fees and Charges Register, and the Health Service Directive - Fees and Charges for Health Care Services. The Fees and Charges Health Service Directive is to ensure consistent application of fees and charges for health care services across the public health system in Queensland and to achieve commercially viable cost recovery for fee paying patient services. The Queensland Health Fees and Charges Register is established under the directive and outlines the fees and charges applicable for fee paying patient services, and fees relating to the granted private practice revenue retention arrangement.

*Note: The Queensland Health Fees and Charges Register does not apply to Licensed Private Practice arrangements for individual medical officers. HHSs and Department of Health divisions will ensure appropriate fees and charges, determined at the local level, are levied on Licensed Private Practice arrangements for individual medical officers.*

## Other key internal documents

### Indemnity for private patient services

Due to the specialised nature and circumstance of work in the public health sector, Queensland has separate indemnity policies to cover medical practitioner and health service employees. The policy relevant to medical practitioners is Indemnity for Queensland Health Medical Practitioners – Human Resources Policy I2.

Indemnity is provided for claims against medical practitioners who have been engaged to perform duties and functions under the direction of a HHS or a Department of Health division and who engage within their qualified scope of practice.

Indemnity may be granted in relation to civil proceedings, inquiries, or investigations such as registration boards. Medical practitioners are not entitled to an indemnity for conduct that constitutes wilful neglect as outlined in Human Resources Policy I2.

Where indemnity or legal assistance is granted, the Department of Health division, or the relevant HHS is obliged to pay for all reasonable costs including legal professional costs and any awarded damages against the indemnified medical practitioner.

The Department of Health provides assurance that medical practitioners claiming Medicare benefits through approved private practice arrangements during the course of their hours of work will not suffer any financial detriment as a result of complying with Queensland Health policy or guidelines relating to private practice where HHSs or the Department of Health are a financial beneficiary to those claims. In the event that billings are required to be refunded to a third party (i.e. patient, Medicare, health fund) due to incorrect claiming, HHSs or the Department of Health would be responsible for refunding its portion of retained billings that were incorrectly claimed.

### Credentialing and defining the scope of clinical practice for medical practitioners

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

### Code of Conduct for the Queensland Public Service

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

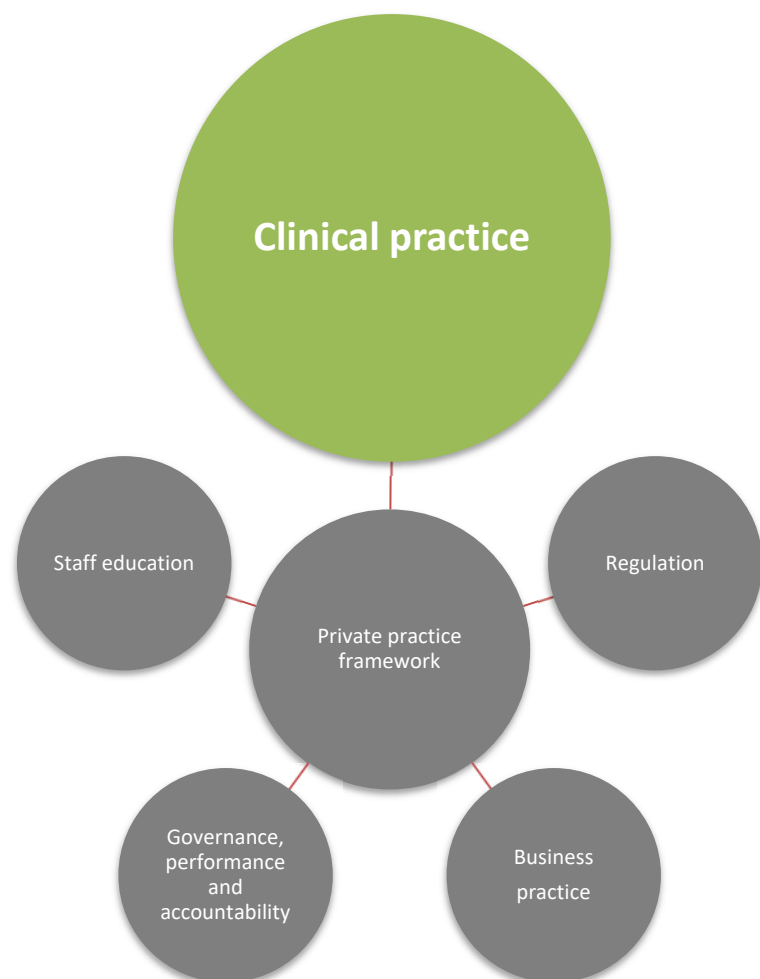
## Clinical practice

Private practice supports evidence-based practice with a focus on achieving positive clinical outcomes. HHSs and Department of Health divisions are to:

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

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

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



## Business practice

Private practice supports the business requirements of HHSs and Department of Health divisions in achieving efficient and cost-effective delivery of health services. HHSs and Department of Health divisions are to:

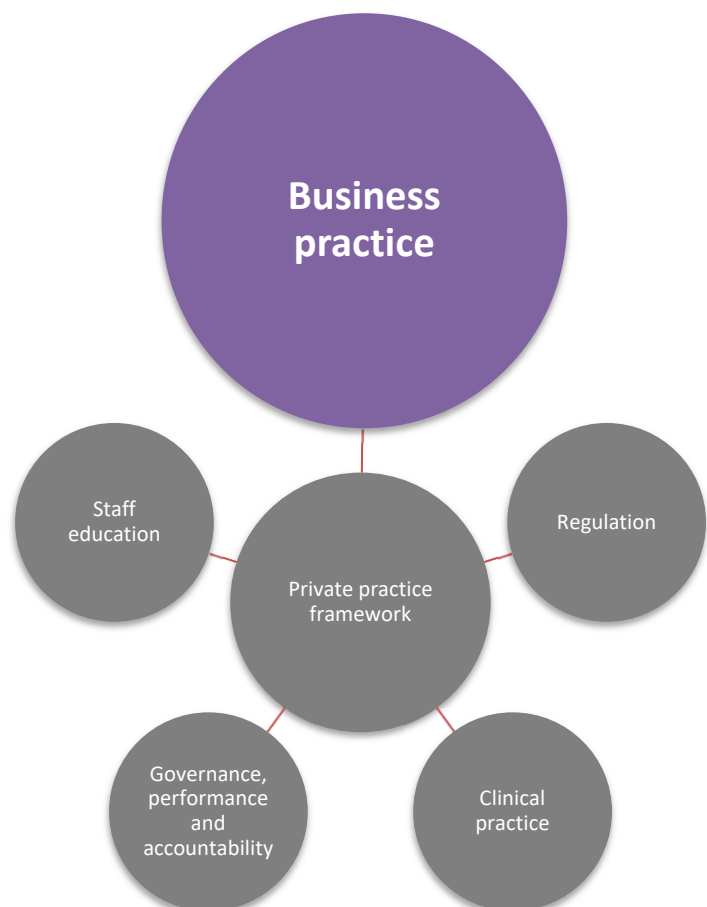
- Ensure all appropriate revenue sources are considered and optimised for the sustainable delivery of quality healthcare services to their community.
- Levy appropriate fees and charges to clinicians and patients to ensure private practice is not delivered to the financial detriment of public sector health services.

## Granted private practice business principles

Senior medical officers are granted rights to conduct private practice at their place of work alongside their public patient duties, consistent with the terms and conditions of the senior medical officers granted private practice agreement with their employer. Visiting medical officers can be granted rights to conduct private practice at their place of work alongside their public patient duties, consistent with schedule 3 of their employment contract. These forms of private practice are referred to as granted private practice.

HHSs and Department of Health divisions should use private practice to optimise:

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



## General business rules - granted private practice

The following business rules apply to granted private practice arrangements:

- Private practice arrangements for senior medical officers are provided under the standard granted private practice agreement template.
- In completing the granted private practice agreement (standard template issued by Queensland Health), senior medical officers are required to nominate which private practice arrangement they wish to partake (revenue assignment or revenue retention).
- For a granted private practice agreement to become effective, the agreement must be signed by both the senior medical officer and the employer's approved delegate.
- A senior medical officers' attraction and retention incentive allowances will be reduced in accordance with the Medical Officers' (Queensland Health) Certified Agreement (MOCA) and the granted private practice agreement where a senior medical officer:
  - no longer wishes to engage in granted private practice (had a granted private practice agreement and decided to opt out), or
  - has their granted private practice terminated, or
  - participates in an approved granted private practice revenue retention arrangement.
- Senior medical officers can nominate to change options on a financial year basis, or at another time upon mutual agreement with their employer.
- Patients have a choice to be treated as a public or private patient in a public health facility, and health services are obliged to honour this choice.
- Private patients have a choice of doctor (where available) and all patients will make an election based on informed financial consent. In cases where a private patient receives care from a team of specialists, the patient is to be informed of this.
- Senior medical officers are required to attend to private patients that are referred appropriately either as inpatients or outpatients during hours of work and perform professional services such as procedures, consultations and diagnostic examinations on the basis of clinical need.
- Where a patient elects to be treated as a private patient under a senior medical officer's care, the senior medical officer authorises the employer and/or an entity appointed by the employer as their billing agent to raise appropriate fees under the senior medical officer's Medicare provider number (where eligible).
- HHSs and Department of Health divisions must provide reasonable support (e.g. administration and clinical support staff) to ensure the effective delivery of private patient care at the hospital/facility.
- HHSs and Department of Health divisions must provide senior medical officers with monthly reports of billing activities (detailing billings, fees paid, GST and service retention amounts) against the senior medical officer's Medicare provider number, within 14 days of the month ending to assist the senior medical officer with reporting obligations (e.g. taxation reporting).
- HHSs and Department of Health divisions must provide clear and prompt communication to the senior medical officer when informed financial consent has been provided by a patient wishing to be treated privately under their care.

- HHSs and Department of Health divisions should develop a business plan for the management of private practice to manage achievement of objectives in accordance with specific local requirements and general business requirements, including:
  - Where acting as the agent of clinicians conducting private practice, administering that role in a simple, efficient and professional manner.
  - Developing processes for recovering outstanding debt.
  - Undertaking regular analysis of private practice activities to determine if these activities are being delivered in a sustainable manner and notifying the accountable officer where there is material risk of this being achieved.

**Note: The terms applicable for employee Visiting Medical Officers engaging in granted private practice are detailed within Schedule 3 of their employment contract.**

## Granted private practice options

Revenue assignment	Revenue retention
<ul style="list-style-type: none"> <li>• This arrangement provides full access to the Attraction and Retention allowances available under MOCA, for example 50% of base salary for a metro specialist, and the senior medical officer assigns 100% of private patient billings to the HHS / Department of Health division.</li> </ul>	<ul style="list-style-type: none"> <li>• For senior medical officers, this arrangement provides partial access to the Attraction and Retention allowance (on average 25% of base salary).</li> <li>• participants of this arrangement retain professional services revenue, after the payment of service fees, GST and any service retention amount</li> <li>• an earnings ceiling applies to this arrangement</li> </ul>

## Hours of work - granted private practice (Senior Medical Officers)

- Granted private practice operates during a senior medical officer's hours of work.
- Consistent with the granted private practice agreement, hours of work means the hours during which the senior medical officer is employed by the HHS / Department of Health division whether full time or part-time, and includes, normal rostered hours, extended hours, on-call, recall and overtime.
- Consistent with clause 3.3 of the granted private practice agreement, senior medical officers may participate in other private practice arrangements (i.e. licensed private practice, external private practice etc.), including when on call, but must disclose these arrangements in writing to the HHS / Department of Health division.
- Consistent with clause 3.4 of the granted private practice agreement, except where clinical priorities require otherwise, where any conflict arises between the senior medical officer's duties to their private patients (i.e. under a licensed private practice arrangement, external private practice etc.) and the senior medical officer's duties to

the HHS / Department of Health division, the duties to the HHS / Department of Health division will prevail.

- It is accepted that some senior medical officers have licensed private practice arrangements with their employer and that in some cases they may be recalled to treat a public patient or a granted private practice patient, and upon returning to the facility may also treat a patient under their licensed private practice arrangement. In this event, recall is only claimable for the duration of duties undertaken for the HHS / Department of Health division and time spent attending to licensed private practice patients is not to count towards recall duration.
- Recall is not to be claimed exclusively for attending to a licensed private practice patient.
- It is also accepted that there may be occasions due to clinical priorities that require a senior medical officer to extend their ordinary hours of work and perform overtime. In this event, in accordance with MOCA, overtime is only claimable for the duration of duties undertaken for the HHS / Department of Health division and is not to count towards time spent treating licensed private practice patients.
- Overtime is not to be claimed exclusively for attending to a licensed private practice patient.

## Billing

- HHSs and Department of Health divisions will take on the functions of billing, collection and distribution of granted private practice revenue. Strict process monitoring mechanisms are to be implemented.
- Where a clinician is engaged under the revenue assignment arrangement, HHSs and Department of Health divisions, as the billing agent acting on behalf of the clinician, retain 100 per cent of all revenue through the tax invoice method.
- Where a clinician is engaged under the revenue retention arrangement, HHSs and Department of Health divisions, as the billing agent acting on behalf of the clinician, raise service fees in accordance with the Queensland Health fees and charges register. Service fees and Service Retention Amounts are to be deducted from gross revenue as detailed within the tax invoice. GST collected from billing of patients for Taxable Supplies under this method will be paid to the clinician. The clinician must include all private practice revenue in their Business Activity Statement and any GST received must be taken into account in the clinician's Business Activity Statement.
- Clinicians must ensure that all information provided to the billing agency, including the information provided under is accurate and to act in a manner which:
  - will not give rise to circumstances which would allow a Shared Debt Determination to be made;
  - would reduce administrative penalties in accordance with s 129AEB(3) of the *Health Insurance Act 1973*; and
  - would not increase administrative penalties as provided for in s 129AEB(4) of the *Health Insurance Act 1973*.

## Fees and charges

- Unless otherwise agreed with the HHS or Department of Health division, the maximum fee charged by a clinician for professional services will be an amount which achieves a no-gap result for the private patient.
- Where fees for professional services result in out of pocket expenses to the patient, this may only occur if the patient has provided informed financial consent.
- Service fees and other fees and charges to be levied by a HHS or Department of Health division are detailed in the Queensland Health fees and charges register.

## Service fees for revenue retention arrangement

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

Service fees have been set based on the following principles:

Clinical Area / Item Category	Medical Specialist	Clinical & Other Supplies	Practice Staff / Resources	Infrastructure	Minor Capital	Major Capital
Pathology						
Medical Imaging						
Radiation Oncology						
Nuclear Medicine						
Diagnostic Procedures						
Surgical Procedures						
Svcs not contained in the MBS						
Misc. Svcs						
Therapeutic Procedures (Exc Rad Onc)						
Professional Attendances						

Note - Service fees and the annual earnings ceiling (threshold) will be set annually and gazetted in the DoH Fees and Charges Register.

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



**Examples of cost drivers within the abovementioned item categories include:**

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

## Disbursement of service fees

Service fees received by the HHS or Department of Health division are able to be credited to either an operating account or trust account, at the chief executive's discretion. The return of service fees to the actual division/service line generating that revenue is a decision for the HHS or Department of Health division. Returning revenue to the division/service line generating the revenue is however considered best practice as it ensures transparency and incentivises participation. The GST component of the service fees must be taken into account in Queensland Health's Business Activity Statement.

## Group practice - revenue retention arrangement

- A HHS or Department of Health division may allow an individual that engages in the revenue retention arrangement to become a member of a group arrangement (e.g. radiology group practice).
- If an individual enters into a group arrangement with his/her colleagues, net earnings will be subject to the combined threshold level of all group participants.
- Group threshold levels for revenue retention group arrangements may vary over a financial year forcing the group threshold amount to be recalculated.

Examples:

- a clinician joins a group arrangement during the financial year and the members have already reached the group threshold amount, after recalculating the new group threshold amount the new clinician will have reached the threshold ceiling and only receives \$1 in every \$3.
- clinicians who change their employment status (e.g. FTE percentage) or leave a group arrangement during a financial year could impact on the overall group threshold amount. This may result in members of the group arrangement having to pay back income after the group threshold amount has been recalculated.
- Private practice income from fees and charges billed under the clinician's provider number for private patient activities is regarded as assessable ordinary income of the clinician under s.6–5 of the *Income Tax Assessment Act 1997*, and the gross amount billed under the clinician's Medicare provider number should be disclosed as such in the clinician's tax return. Where clinicians participate in group arrangements, the clinician may be able to claim an offsetting deduction in their income tax return for payments made over to the partnership but this is dependent on the group's membership arrangements. Clinicians should seek independent tax advice on this matter.

- At a minimum, HHSs and Department of Health divisions shall provide to clinicians entering into a group revenue retention arrangement:
  - monthly payment into the group’s nominated bank account(s)
  - timely information identifying medical fees billed and disbursed, service fees and service retention amounts deducted (including GST) to enable the clinician to prepare their individual income tax return.
- Group arrangements are to be developed and managed locally.

## Earnings ceiling (threshold)

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

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

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

- Where clinicians are part of a group, it is the group members' individual threshold levels summed, less the group members' individual Service Fees (excluding GST) summed that become the group threshold level. Where this calculation results in an amount that exceeds the published earning ceiling then only \$1 in every \$3 (after payment of service fees) is available to be retained by the clinician from that point forward for the remainder of the financial year, with the balance being credited to the employing HHS or Department of Health division.
- Revenue retained by HHSs and Department of Health divisions may be disbursed to specific purpose accounts (e.g. Study, Education and Research Trust Account (SERTA)) or operating accounts at the discretion of the HHS or Department of Health division chief executive.

## Incentive payments

- Incentive payments as advised by the Australian Government Department of Health and Services Australia (Medicare) are to be considered on an individual incentive scheme basis by the Private Practice Governance Board.
- Any fees determined by the Private Practice Governance Board will be managed through the Queensland Health Fees and Charges Register.

## Shared Debt Determinations

On 1 July 2018, the Commonwealth Government made changes to the *Health Insurance Act 1973*, which included the introduction of the 'Shared Debt Recovery Scheme' which will form part of the Medicare audit process. The Shared Debt Recovery Scheme takes effect on the 1 July 2019.

The Shared Debt Recovery Scheme may apply when, as a result of a Medicare compliance audit, Medicare determines that there has been a 'false or misleading statement' (section 129AC(1) of the *Health Insurance Act 1973*).

In this circumstance, if contractual or other arrangements exist between the health practitioner (Medical Officer) who is the subject of the audit and an employer or organisation to render Medicare services, both may be held responsible for the repayment of a portion of the debt. This is known as a Shared Debt Determination.

Any Shared Debt Determinations made against a Medical Officer (primary debtor) and a HHS or Department of Health division (secondary debtor) will be treated as follows:

1. If a Shared Debt Determination is made in respect of professional services in relation to the Medical Officer's Granted Private Practice for which the Medical Officer has nominated the Revenue Assignment disbursement model, the Employer must reimburse the Medical Officer the amount paid by the Medical Officer under the Shared Debt Determination.
2. If a Shared Debt Determination is made in respect of professional services in relation to the Medical Officer's Granted Private Practice for which the Medical Officer has nominated the Revenue Retention disbursement model and
  - a. the Employer has paid an amount under the Shared Debt Determination exclusive of any administrative penalty, which is less than the amount, including any Service Fees, retained by the Employer under the Granted Private Practice Agreement in respect of the professional service to which the Shared Debt Determination relates, the Employer must reimburse the Medical Officer an amount equal to the difference between the amount retained by the Employer and the amount paid by the Employer;
  - b. the Medical Officer has paid an amount under the Shared Debt Determination exclusive of any administrative penalty, which is less than the amount retained by the Medical Officer under the Granted Private Practice Agreement in respect of the professional service to which the Shared Debt Determination relates, the Medical Officer must reimburse the Employer an amount equal to the difference between the retained amount by the Medical Officer and the amount paid by the Medical Officer.

*Note:*

- *Refer to clause 7 "Shared Debt Determinations" of the Senior Medical Officer's Granted Private Practice Agreement.*
- *Administrative penalties are not dealt with by the 'Private practice in the Queensland public health sector framework'. Refer to the '12 Indemnity for Queensland Health Medical Practitioners policy'.*

## Taxation

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

Regardless of whether a clinician is engaged under the revenue assignment or retention arrangement, private practice income from fees and charges billed under the clinician's provider number for private patient activities is regarded as assessable ordinary income of the clinician under s.6–5 of the *Income Tax Assessment Act 1997*, and the gross amount billed under the clinician's Medicare provider number should be disclosed as such in the clinician's tax return.

It is a requirement that HHSs and Department of Health divisions provide clinicians with monthly and annual earnings statements, identifying services billed and receipted, charges levied and any GST to enable the clinician to meet his or her Australian Taxation Office reporting obligations.

Note that the information provided below is generic in nature and is provided only as a guide and it is recommended that all medical officers engaging in private practice should seek individual tax advice.

### Taxation — revenue assignment arrangement

- Under this arrangement, the clinician provides the HHS or Department of Health division with the right to render accounts in the clinician's name (or HHS / Department of Health division name, acting as the clinician's agent) and collect all fees payable by private patients which are then assigned to the HHS or Department of Health division.
- For income tax purposes, revenue generated by a clinician is assessable income of the clinician under s.6–5 of the *Income Tax Assessment Act 1997* and the amounts assigned to the HHS or Department of Health division represent a loss or outgoing incurred in gaining or producing the clinician's assessable income and are allowable deductions under s.8–1 of the *Income Tax Assessment Act 1997*. The income and expenses should be disclosed separately in the clinician's tax return.

### Taxation – revenue retention arrangement

- Under the revenue retention arrangement, the HHS or Department of Health division grants a clinician the right to provide medical services to private patients alongside public employment duties. In return the clinician provides the employer with the right to render accounts in the clinician's name (or HHS/Department of Health name, acting as the clinician's agent) and collect all fees payable. From this revenue, clinicians are entitled to the net amount remaining after deductions of GST, Service Fees and the Service Retention Amount.
- For income tax purposes, revenue generated by a clinician is assessable income of the clinician under s.6–5 of the *Income Tax Assessment Act 1997* and the Service Fees and the Service Retention Amount represent a loss or outgoing incurred in gaining or producing the clinician's assessable income and are allowable deductions under s. 8–1 of the *Income Tax Assessment Act 1997*. The income and expenses should be disclosed separately in the clinician's tax return.

- For GST purposes, the clinician must include all private practice revenue in their Business Activity Statement and any GST received must be taken into account in the clinician's Business Activity Statement.
- The fees retained by the clinician are not salary and wages as defined in the *Income Tax Assessment Act 1997*. As a consequence of this, the income paid to the clinician arising out of private practice is not subject to the deduction of PAYG tax withholding. Private practice income is derived as ordinary 'business' income and therefore is assessable income under section 6-5 of the *Income Tax Assessment Act 1997*.

## Licensed private practice

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

*Note: The Queensland Health Fees and Charges Register does not apply to Licensed Private Practice arrangements for individual medical officers. HHSs and Department of Health divisions will ensure appropriate fees and charges, determined at the local level, are levied on Licensed Private Practice arrangements for individual medical officers.*

## Medical Superintendent with Private Practice (MSPP) and Medical Officer with Private Practice (MOPP)

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

### Private Practice – Junior Medical Officers

Under normal circumstances junior medical officers do not have access to private practice arrangements in the Queensland public health service.

However, junior medical officers undertaking private practice under the auspices of the Queensland Country jDocs program is a notable exception. The first critical enabler of this private practice by junior medical officers is the s3GA (see below) approved status of Queensland Country jDocs, by which these non-vocationally qualified doctors have access to a Medicare Provider Number.

The “Private practice in the Queensland public health sector framework” (this document) relates to “...the treatment of a person who could receive treatment free of charge under the National Health Reform Agreement 2011 ... but who has elected to be treated privately in the public system, or a person who agrees to be a fee-payment patient of the medical officer and makes this election on the basis of informed financial consent”.

The private practice of junior medical officers deployed under the auspices of Queensland Country jDocs, given that it is within the private practice of private practitioner’s program, falls outside the private practice framework definition – its second critical enabler.

### Queensland Country jDocs program (Private Practice)

Under the Queensland Country jDocs program, junior medical officers may be required to undertake private practice activities as part of a rural generalist term placement. Private practice for these non-vocationally qualified junior medical officers is possible because Queensland Country jDocs incorporates the *Queensland Country Relieving Doctors Program*, a workforce program approved under s3GA of the *Health Insurance Act 1973 (Cth)* (HIA) and listed in Schedule 5 of the *Health Insurance Regulations*.

For this type of private practice arrangement under the jDocs program to be possible, the *junior medical officer* must comply with the following criteria:

- be assigned to serve in private practice as a Principal House Officer within Hospital and Health Service (HHS) employment in a rural placement
- have a Medicare provider number capable of billing Medicare Benefits Schedule item numbers, or
- be able to get access to a billing Medicare provider number under Sections s19AA and s3GA of the HIA.
- not undertake private practice arrangements in the Queensland Health public health service

- be undertaking supervised private practice arrangements in a medical practice operated by a Medical Superintendent with Private Practice (MSPP) or Medical Officer with Private Practice (MOPP) as part of their rural placement, or
- be undertaking supervised private practice arrangements in a medical practice independent of the public operations of the HHS but as part of their rural placement within HHS employment
- have agreed to assign all medical fees generated from private practice activities to the HHS
- have entered into a private practice agreement with the HHS via an exchange of letters or agreement.

## Taxation - Junior Medical Officer in jDocs program

Junior medical officers undertaking private practice arrangements as part of their supervised rural placement will need to include this revenue (the Medicare billings) as part of their assessable income in their tax return as per s.6-5(1) of *the Income Tax Assessment Act 1997 (Cth)*. These are subject to the same taxation requirements as senior medical officers or visiting medical officers who undertake a granted private practice revenue assignment arrangement.

Junior medical officers who have agreed to assign all medical fees generated under their billing provider number as part of their supervised rural placement will receive a 'statement of income generated' from the HHS managing the rural placement.

Revenue generated by a junior medical officer that is assigned to a HHS, may represent a loss or outgoing incurred in gaining or producing the clinician's assessable income and be an allowable deduction under s.8-1 of *the Income Tax Assessment Act 1997 (Cth)*.

Where the fees are remitted to the HHS, these expenses can be disclosed separately as an allowable deduction in the junior medical officer's tax return.

All employees and contractors should seek individual tax advice from a suitably qualified financial advisor or tax agent to determine how these arrangements impact their individual circumstances.

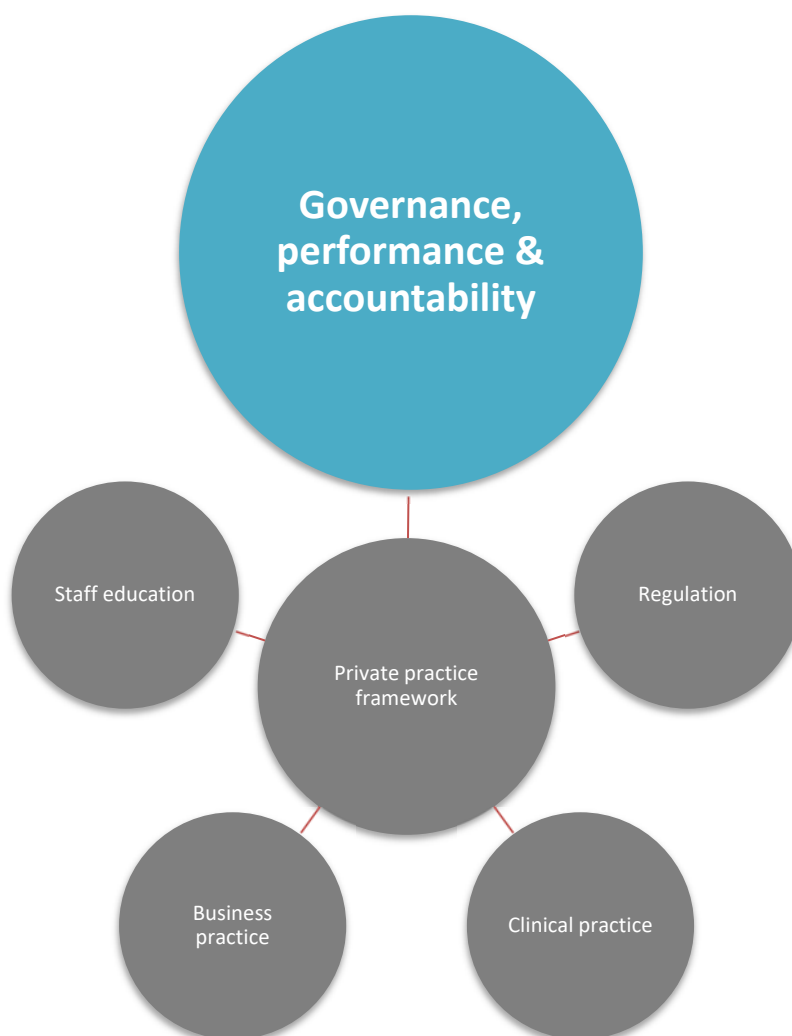
## Governance, performance and accountability

Private practice is effectively managed and monitored to achieve key deliverables and desired outcomes. HHSs and Department of Health divisions are to:

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

### Governance approach

- An accountable officer will be assigned by the HHS or Department of Health division chief executive the responsibility to oversee private practice activities.
- HHSs and Department of Health divisions will establish a private practice governance committee (or delegate an alternative committee) to oversee the administration of private practice arrangements operating within their jurisdiction and ensure it performs the following functions:
  - provides clear governance and direction for private practice arrangements through ensuring activities comply with statewide and local directives and policies
  - Monitors performance criteria to ensure private practice arrangements achieve their desired outcomes in a sustainable manner.

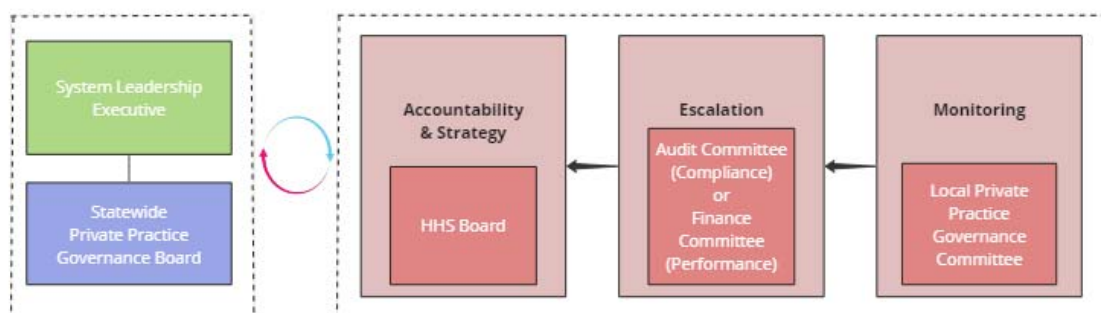




The below diagram demonstrates the governance relationship between HHSs and the Department of Health.

## Statewide Coordination

## Local Hospital and Health Service/Division Governance and Monitoring



### State-wide responsibilities

- Custodian for all system wide policy and regulatory instruments
- Lead the implementation and monitoring of parties' obligations in accordance with the Medical Officers Certified Agreement as it relates to private practice.
- Provide coordinated, reputable operational support and advisory on private practice matters relating to governance, assurance and compliance
- Establish and monitor performance criteria to ensure system wide compliance with applicable Health Service and Employment Directives
- Establish and monitor performance criteria to ensure system wide "value for money" for private practice activities
- Lead system wide private practice capability development initiatives

### Local responsibilities

- Comply with state-wide policies and directives
- Develop and implement local operational policy
- Comply with regulatory requirements
- Negotiate private practice agreements and make clear associated local performance measures
- Ensure efficient operation of private practice across the health service
- Maintain robust private practice governance and internal controls
- Implement effective strategies to optimise own source revenue
- Monitor performance criteria to ensure compliance with applicable Health Service and Employment Directives

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

### Statewide private practice governance board

The purpose of the private practice governance board is to work as an authoritative governance body providing oversight of the administration of private practice arrangements operating across HHSs and Department of Health divisions 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 are operating in accordance with applicable Health Service and Employment Directives.

- take remedial action where required and/or escalate the matter where appropriate (i.e. performance management team.)

## Local private practice governance committee

HHSs and Department of Health divisions are responsible for the successful operation of private practice at the local level, and will implement a robust governance framework and oversight committee chaired by an accountable officer to ensure the following:

- compliance with statewide policies and directives
- local operational policy is developed and implemented
- objectives of private practice activities and outcomes are clearly defined and regularly measured against key performance indicators and remedial action is taken where appropriate
- robust governance and internal controls are maintained
- establish and monitor performance criteria to ensure the private practice arrangements achieve their desired outcomes in a sustainable manner
- initiate remedial action where required and/or escalate the matter where appropriate (local audit committee, jurisdictional board, statewide private practice governance board etc.)

## Governance process

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

## Internal controls

Internal controls will be in place to ensure:

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

The system of internal controls will:

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

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

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

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

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

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

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

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



## Staff education

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

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

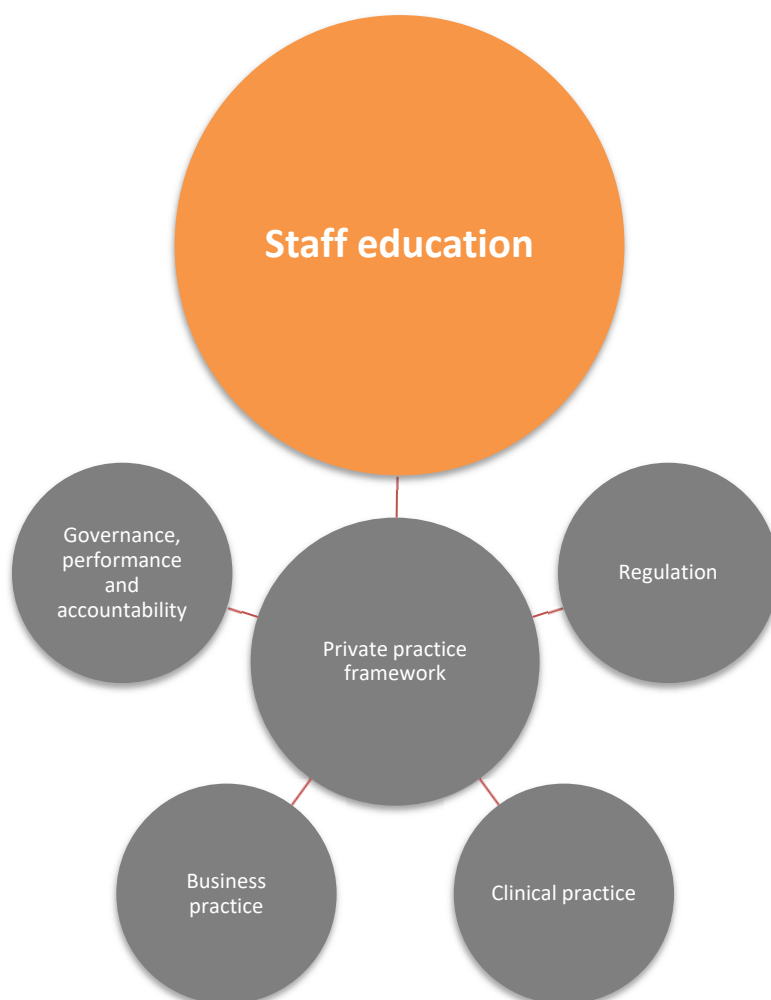
This section of the framework specifies the education and training standards in which private practice is conducted within the public health sector.

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

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

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

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



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

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

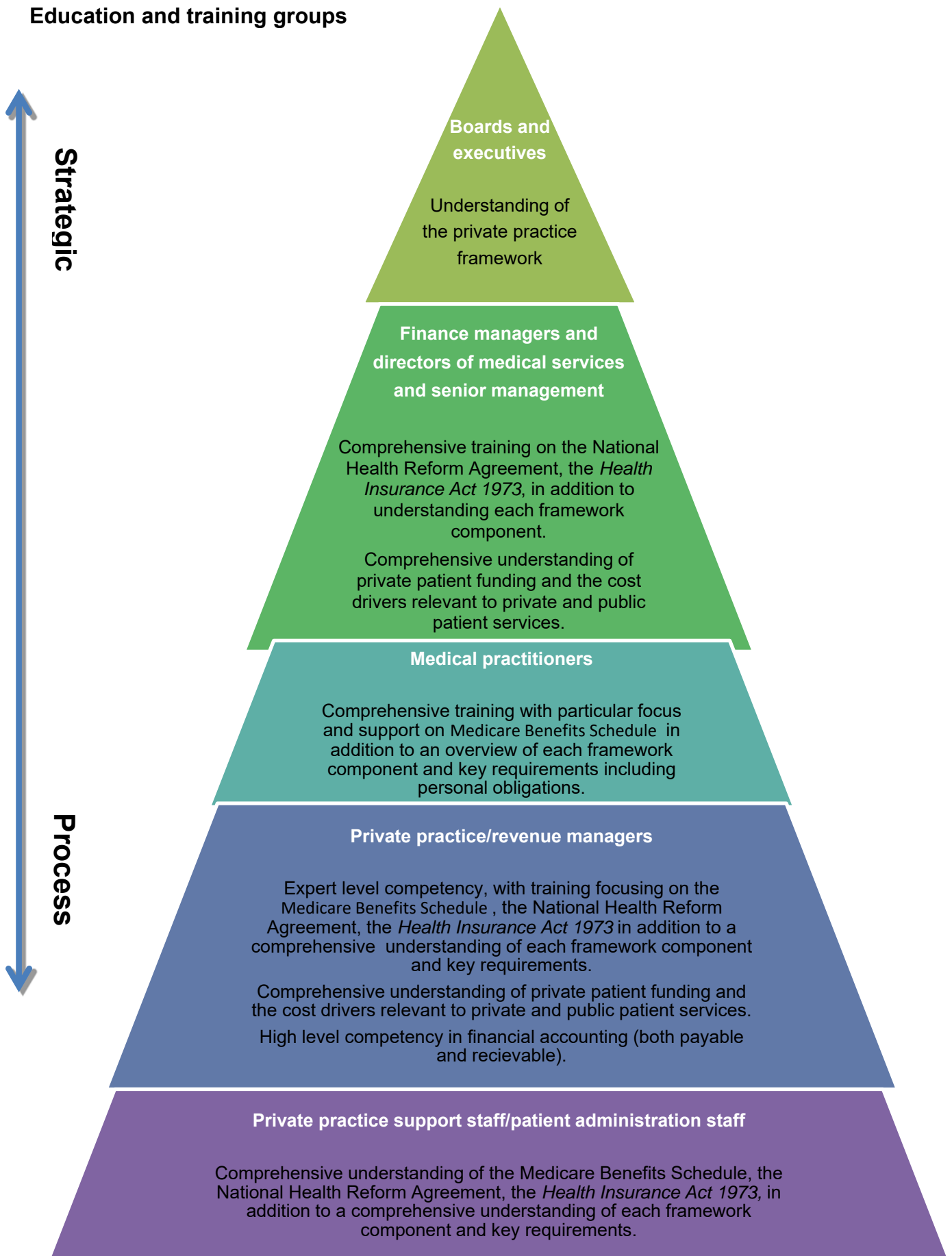
- providing educational tools and training to facilitate compliance, and support clinicians and support staff in the effective delivery of private patient services
- developing and maintaining high quality teaching and learning resources for all staff involved in private practice activities.

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

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

Locally tailored training packages should be developed and delivered to staffing groups as suggested in the diagram on the following page.

## Education and training groups



## Definitions

Term	Definition
Activity based funding	A model for funding public hospital services provided to individual patients using national classifications, cost weights and efficient prices developed by the Independent Hospital Pricing Authority.
Administrative Penalty	Means a penalty under sections 129AEA and 129AEB of the <i>Health Insurance Act 1973</i> .
Clinician	An individual who provides diagnosis, or treatment, as a professional: <ol style="list-style-type: none"> <li>a) medical practitioner</li> <li>b) nurse</li> <li>c) allied health practitioner; or,</li> <li>d) Health practitioner not covered by paragraph a), b) or c) (<i>National Health Reform Act 2011</i>).</li> </ol>
Department of Health	The Department of Health includes: <ul style="list-style-type: none"> <li>• Clinical Excellence Queensland</li> <li>• Clinical Planning &amp; Service Strategy</li> <li>• Corporate Services Division</li> <li>• eHealth Queensland</li> <li>• First Nations Health Office</li> <li>• Health Infrastructure Queensland</li> <li>• Healthcare Purchasing &amp; System Performance Division</li> <li>• Office of the Chief Health Officer</li> <li>• Office of the Director-General</li> <li>• Queensland Public Health and Scientific Services</li> <li>• Strategy, Policy and Reform Division</li> <li>• any successor agency of those listed above however so named.</li> </ul>
Granted private practice	A limited right to provide professional services to private patients on the terms of a Senior Medical Officer's Granted Private Practice Agreement or on the terms of Schedule 3 of a Visiting Medical Officer's Employment Contract.
Hospital and Health Service (HHS)	A statutory body established under the <i>Hospital and Health Boards Act 2011</i> responsible for the provision of public sector health services for a geographical area, which includes one or more health facilities.
Independent Hospital Pricing Authority (IHPA)	The authority established by the Commonwealth legislation in accordance with clause B1 to perform the functions set out in clauses B3 to B8. ( <i>National Health Reform Act 2011</i> ).
Licensed private practice	An arrangement granted by the HHS or Department of Health division for an individual to undertake private patient activities at a public health facility during unpaid time.
Medical officer/practitioner	A medical practitioner who is registered with the Medical Board of Australia under the <i>Health Practitioner Registration National Law Act 2009</i> .
Medical services	Any of the medical services set out in Schedule 1 of the <i>Health Insurance Act 1973</i> .
Medicare Benefits Schedule (MBS)	The Commonwealth government's scheme to provide medical benefits to Australians established under part II, IIA, IIB and IIC of the <i>Health Insurance Act 1973</i> together with relevant regulations made under the act.
Medicare principles	The principles set out in Clause 4 of the <i>National Health Reform Agreement</i> .
National efficient price	The base price(s) which will be determined by the IHPA and applied to those services funded on the basis of activity for

Term	Definition
	<p>the purpose of determining the amount of Commonwealth funding to be provided to public health services. The IHPA may determine that there are different base prices for discrete categories of treatment, for example admitted care, sub-acute care, non-admitted emergency department care and outpatient care.</p> <p>In the event that there are multiple national efficient prices, the IHPA will determine which national efficient price applies.</p>
Pharmaceutical Benefits Scheme (PBS)	The Commonwealth government's scheme to provide subsidised pharmaceuticals to Australians established under part VII of the <i>National Health Act 1953</i> together with the <i>National Health (Pharmaceutical Benefits) Regulation 1960</i> made under the National Health Act.
Private patient	A person who could receive treatment free of charge under the <i>National Health Reform Agreement 2011</i> but who has elected to be treated privately in the public system, or a person who agrees to be a fee-paying patient of the medical officer and makes this election on the basis of informed financial consent.
Private practice (retention arrangement)	Private practice performed during employed time where the clinician retains billings after paying applicable Service fees.
Private practice (assignment arrangement)	Private practice performed during employed time where the clinician assigns all billings to the HHS or Department of Health division.
Private practice	<p>Any contractual arrangement between the Department of Health or a HHS and clinical staff with these features:</p> <ul style="list-style-type: none"> <li>• The medical treatment of a patient who has elected to be a private patient in respect to informed financial consent</li> <li>• Clinical staff treating the private patient uses their Medicare Provider Number to facilitate billing where applicable</li> </ul>
Public patient	In relation to a hospital, means a person in respect of whom the hospital provides comprehensive care, including all necessary medical, nursing and diagnostic services and, if they are available at the hospital, dental and paramedical services, by means of its own staff or by other agreed arrangements ( <i>Health Insurance Act 1973</i> ).
Queensland Country jDocs program	The new operational name of the Queensland Country Relieving Doctors Program.
Queensland Country Relieving Doctors Program	The generic program name by which Queensland Country Relieving Doctors (previously) and Queensland Country jDocs currently is granted approval under Section 3GA of the Health Insurance Act 1973 as an Approved Placement Program.
Queensland Health	The accumulative body of the Department of Health, support agencies and HHSs.
Scope of clinical practice	The extent of an individual practitioner's approved clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the organisation to support the practitioner's scope of clinical practice.
Service fees	The fees applicable to granted private practice retention arrangement participants, as specified in the Queensland Health Fees and Charges Register. GST applies to Service Fees.



Term	Definition
Service Retention Amount	The amount retained by HHSs and Department of Health divisions from granted private practice revenue retention arrangement participants after they have reached the earnings ceiling threshold. GST applies to the Service Retention Amount (SRA).
Shared Debt Determination	Is a written determination under s.129ACA of the <i>Health Insurance Act 1973</i>

## Appendix 1: Framework implementation

The supporting activities below are provided as suggestions to enable achievement of the high level deliverables. HHSs and Department of Health divisions may develop and implement local initiatives and processes to meet deliverables.

Regulation	Clinical practice	Business practice	Governance, performance and accountability	Staff education
<b>High level deliverables</b>				
<ul style="list-style-type: none"> <li>Compliance with all regulatory obligations, including relevant policies, directives, standards and areas such as patient rights and financial accounting standards.</li> </ul>	<ul style="list-style-type: none"> <li>Clinical practice is conducted in a way that enhances public practice as the primary mode of care.</li> </ul>	<ul style="list-style-type: none"> <li>Private practice is used in line with strategic business objectives of the employing facility.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate and effective governance of private practice is established and sustained. Improvements are measured against key performance indicators.</li> </ul>	<ul style="list-style-type: none"> <li>All staff involved in private practice are to participate in appropriate education activities and private practice managers are adequately trained and qualified.</li> </ul>
<b>Supporting activities</b>				
<ul style="list-style-type: none"> <li>Identify and articulate regulatory requirements to all staff involved in private practice.</li> </ul>	<ul style="list-style-type: none"> <li>Promote private practice as a tool to support and enhance overall clinical services.</li> </ul>	<ul style="list-style-type: none"> <li>Investigate funding sources to determine best value (i.e. private versus public funding).</li> </ul>	<ul style="list-style-type: none"> <li>Establish an accountable executive officer to oversee private practice.</li> </ul>	<ul style="list-style-type: none"> <li>Develop standards and tools for education and training relevant to staff groups</li> </ul>
	<ul style="list-style-type: none"> <li>Patient safety and quality patient care is prioritised without regard to private or public patient election status.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor funding source data to develop a strategic business approach.</li> </ul>	<ul style="list-style-type: none"> <li>Clinician performance is reviewed annually against a set of agreed performance indicators.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor education uptake and set education key performance indicators.</li> </ul>
		<ul style="list-style-type: none"> <li>Appropriate service fees (including GST) are levied against individuals engaging in private practice.</li> </ul>	<ul style="list-style-type: none"> <li>Collect private practice data, set key performance indicators and measure against the objectives.</li> </ul>	<ul style="list-style-type: none"> <li>Educational activities are evaluated and evidence-based updates conducted as appropriate.</li> </ul>
		<ul style="list-style-type: none"> <li>Clinicians are appropriately contracted to provide private practice.</li> </ul>	<ul style="list-style-type: none"> <li>Investigate opportunities to streamline processes to realise efficiencies.</li> </ul>	<ul style="list-style-type: none"> <li>Contractual obligations should be clearly understood by all involved parties at the time of agreement.</li> </ul>

## Document revision and approval history

Version No	Developed/modified by	Approved by	Date
1.0	Private Practice Reform Program	Chair - Private Practice Governance Board	22 January 2014
2.0	Private Practice Reform Program - (updated to align with corporate style guide and amended 'disbursement of fees section.	Chair - Private Practice Governance Board	27 February 2014
3.0	Private Practice Reform Program – update the Service fees for revenue retention arrangement table.	Chair – Private Practice Governance Board	28 March 2014
4.0	Private Practice Reform Program – update terminology of MSPP/MOPP and insert section for management of incentive payments	Program Senior Director – Private Practice Reform	17 April 2014
5.0	Private Practice Reform Program – update licensed private practice to allow HHSs to negotiate specific agreements / templates.	Program Senior Director – Private Practice Reform	22 May 2014
6.0	Private Practice Reform Program – Final style guide, amend MSPP/MOPP section with added link for example template.	Program Senior Director – Private Practice Reform	29 May 2014
7.0	General update of the Private Practice Framework (including: Taxation and GST).	Chair – Private Practice Governance Board	30 April 2015
8.0	Medical Officers' Certified Agreement Project (updated to align with MOCA + general update).	Chair – Private Practice Governance Board	03 September 2015
9.0	General update of the Private Practice Framework and information added regarding the Queensland Country jDocs program	Private Practice Governance Board	11 November 2016
10.	General update of the Private Practice Framework and inclusion of the 'Share Debt Determinations' information.	Private Practice Governance Board	14 March 2019
11.	General update to the Private Practice Framework that include document references, Taxation, GST and diagrams.	Private Practice Governance Board	TBC

