Queensland Audit Office

Right of private practice: Senior medical officer conduct

Report 13 : 2013–14

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February 2013

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

Dear Madam Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Right of private practice: Senior medical officer conduct.

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

Yours sincerely

Andrew Greaves
Auditor-General

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Summary

This is the second report relating to the performance audit of the right of private practice (RoPP) arrangements at Queensland's Hospital and Health Services (HHSs).

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

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

Our Report 1 for 2013–14 Right of private practice in Queensland public hospitals (Report 1) dealt with the first two lines of inquiry; this report deals with the third line of inquiry—the probity and propriety of senior medical officers (SMOs) participating in RoPP.

Participation in the right of private practice scheme

SMOs are offered a RoPP contract when they commence working for Queensland Health (which employs staff on behalf of HHSs).

In addition to their contractual commitment to treat public patients SMOs are permitted under their RoPP contracts to treat public patients electing private treatment ('private' patients) during their rostered hours, provided:

- treating private patients does not affect their continued obligations to treat public patients
- all private patients treated by the SMO on rostered time are seen at the SMO's approved hospital campuses
- all patient billing is undertaken by the HHS and revenues are allocated between the SMO and HHS as per the contract.

Each HHS provides facilities and administration to enable SMOs to treat these 'private' patients.

Under the standard RoPP arrangements, SMOs are able also to work outside their paid public employment; for example, they may own and operate their own 'private practice', provided they do so on their own time.

These contractual employment conditions create inherent conflicts of personal and public interest for an SMO: first, between their public patients and those electing private treatment, because hospitals and SMOs share in and may be motivated by the revenue generated; and, second, between the SMO's public employment and his or her private sector interests.

There is a heightened risk that SMOs may act improperly by putting their private interests ahead of the public interest. We received a number of allegations that this was occurring, including that SMOs were absent from their workplaces when rostered on; that they were manipulating their rosters to be paid overtime unnecessarily; and that they were treating their private sector patients on paid public time, a form of 'double dipping', which is not allowed under the *Health Insurance Act 1973* (HIA).

We investigated those SMOs who we considered to be in the category of highest risk for improper conduct. Their working arrangements, clinical specialty, the level of their billing, and extent of overtime claimed afforded them the greatest opportunity and incentive to manipulate the system for personal benefit.

Conclusions

We could neither wholly substantiate nor disprove the allegations we received of widespread absenteeism by SMOs. This is because the attendance monitoring systems at HHSs lack basic accountability and rely primarily on the integrity of SMOs.

Further, basic administrative processes relating to requesting and processing of SMO leave have failed; and the responsibilities and requirements of those employees operating within these processes are unclear, increasing the risk of inadvertent error or intentional misconduct.

This situation is exacerbated because allegations of misconduct are often based on a misapprehension by those making the allegation about what is permitted under the RoPP arrangements.

The present arrangements require greater transparency and more proactive management to restore and strengthen accountability.

Where SMOs work also in the private sector, the extent to which this affects their ability to deliver public services is largely invisible to hospital administrators. In some cases, by allowing SMOs to treat their private sector patients in the public hospital system, hospitals were forgoing revenue and subsiding the private businesses of these SMOs, who themselves were breaching the HIA. There is no clear rationale for such lack of transparency of SMOs' private interests, and it serves only to fuel suspicion and mistrust.

This relates also to the treatment outcomes for public patients: the evidence of which, both for elective surgery at selected HHSs (Report 1) and outpatients at the Royal Brisbane and Women's Hospital (RBWH), strongly indicates that public patients are being disadvantaged when compared to patients who elect to be treated privately.

Such adverse patient outcomes are contrary to the intent of the National Healthcare Agreement 2012. Of greater concern in this regard, if the workplace attendance patterns recorded by some SMOs accurately reflect their actual attendance, then it indicates SMOs and HHSs are not managing fatigue effectively, placing their patients at increased risk.

Key findings

Workplace attendance

Although we could neither substantiate, nor disprove allegations we received of widespread absenteeism by SMOs, we found seven of the 88 SMOs we investigated (almost eight per cent) appeared not to be at work during their rostered hours for more than 30 days.

Failure to submit or accurately process leave requests explained one-third of these absences. The controls surrounding the processing of leave forms are deficient; a subsequent review of four clinical units revealed 15.9 per cent of leave was either not submitted or processed.

The lack of an audit trail meant two-thirds of these apparent absences were not able to be acquitted. Some of these absences were explained by SMOs that we interviewed as arising from the fact that they were working under a 'give and take' arrangement, where SMOs make up missed time when they arrive late. Their clinical directors do not have any clear line of sight to know whether any lost time was made up and if so, whether the hours paid were comparable to the hours worked.

Allowing SMOs to structure their working week in a manner that suited them contributed in some cases to additional and unnecessary overtime. More efficient rostering would reduce overtime and better manage fatigue risks.

In relation to fatigue risk, we identified 115 SMOs (4.1 per cent of all SMOs as at 30 June 2013) during 2011–12 and 2012–13, who were working at levels regarded by the Australian Medical Association to be at 'Significant' or 'Higher' risk of fatigue for periods ranging between 20 and 91 weeks (see Appendix F for risk matrix). This is an indicator of workforce shortage issues in the face of clinical demand, but it also highlights the effect of poor rostering practices and lax administrative oversight.

For a number of SMOs reviewed, the rostered hours they are paid for and the work they actually perform did not align. There is no periodic, systematic review which would detect when such variances become significant and persist.

Treatment and billing practices

Tying the remuneration of SMOs and the revenues of HHSs to a patient election (to be treated privately) creates an inherent conflict of interest, resulting in the risk that private patients receive preferential treatment. The prima facie evidence from Report 1 was that this occurred with category 2 elective surgery patients at selected HHSs. We determined that this extends also to outpatients services at the private practice suites at RBWH (the Princess Alexandra Hospital was unable to provide us with data for this analysis).

Allegations of improper billing were able to be substantiated. Eight SMOs were treating private patients in public hospitals, but not declaring this income as they are contractually required to do. Four more SMOs were treating private patients in public hospitals without a right of private practice, with a proportion of this work done on paid time—effectively 'double-dipping'—which is a breach under the HIA.

Finally, we also identified system issues affecting two HHSs which resulted in them being collectively overfunded by $18.08 million by Queensland Health after they were paid for treating patients in emergency departments, when the patients were in fact treated in Acute Primary Care Clinics and had been already appropriately bulk-billed to Medicare.

Recommendations

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

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.**

Reference to comments

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

- Queensland Health
- Metro North Hospital and Health Service (HHS)
- Metro South HHS
- Children's Health Queensland HHS.

Relevant extracts of this report, with an opportunity to comment, were also provided to:

- Darling Downs HHS
- Wide Bay HHS
- Mackay HHS
- North West HHS
- Townsville HHS.

The views of these entities have been considered and are represented to the extent relevant and warranted in preparing this report.

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

The findings and information supporting this report warrant further consideration as to the potential for misconduct and accordingly, this report has been provided to the Crime and Misconduct Commission as required under section 38 of the *Crime and Misconduct Act 2001.*

1 Context

1.1 Background

In November 2012, allegations were widely reported in the media that a specialist working full time for Queensland Health 'secretly' earned an extra $2 million treating private patients while using public facilities.

The case of a senior medical officer (SMO) known as 'Dr X' had been quoted in the media as being included in a brief prepared for the Department of the Premier and Cabinet by the Crime and Misconduct Commission:

> *It is suspected that Dr X is contravening his contract conditions by not reporting his private earnings, thereby avoiding Queensland Health taking two-thirds of those earnings.*
>
> *By failing to comply with the conditions of his employment, Dr X becomes the sole beneficiary of his practice and deprives Queensland Health of substantial revenue.*

The brief contained a statement, quoted in the media, that there was a 'widespread culture of entitlement' among full time specialists.

On 12 November 2012, the Minister for Health wrote to the Auditor-General expressing concerns about questionable practices by some SMOs employed by Queensland Health. These matters related to right of private practice (RoPP) billing arrangements and challenges in ensuring oversight, visibility and transparency of the activities of SMOs.

The Auditor-General initiated a performance audit and tabled an interim report in Parliament on 11 July 2013. In Report 1 for 2013–14 Right of private practice in Queensland public hospitals (Report 1), we found a lack of effective central and managerial oversight of RoPP arrangements. We also found wide variability and levels of transparency in rostering practices, as well as a lack of transparency over the use of clinical support time.

In Report 1 we published the results of our survey of SMOs, where 71 per cent of surveyed respondents indicated that their induction to RoPP contractual obligations was inadequate and 69 per cent stated that ongoing support in relation to their contractual obligations was also inadequate. There was also a lack of clarity around billing, with 65 per cent advising that they did not receive adequate support in relation to what services are billable and when.

The matters addressed in Report 1 focused on systemic issues with the RoPP arrangements (currently subject to review and renegotiation). The audit continued, but shifted focus to the behaviour and practices of individual SMOs.

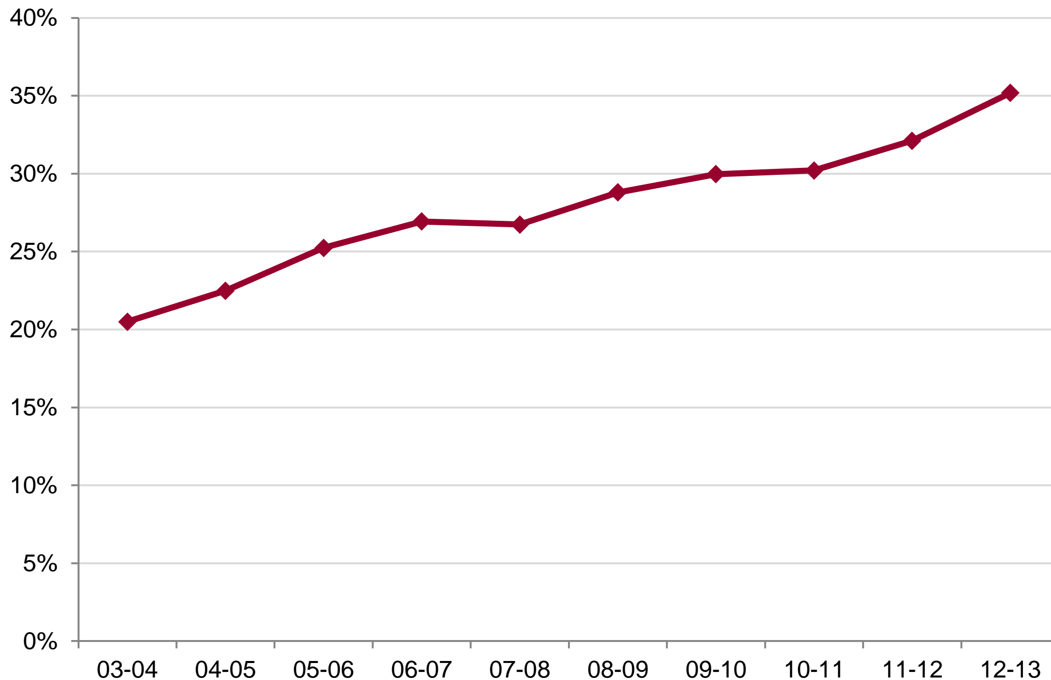
1.2 Basis of employment of SMOs

The 2 817 individual SMOs employed in the public hospital system as at 30 June 2013 are public servants, paid to treat public patients.

The current certified agreement—Medical Officers (Queensland Health) Certified Agreement (No. 3) 2012 (MOCA 3)—allows a full time SMO to work his or her contractual 80 hours over the course of the fortnight with shifts up to a maximum ten hours. In practice this has resulted in some SMOs working a full time load over eight days each fortnight. The remaining days are free for the SMO to use as each sees fit.

There is also a growing number of SMOs being employed on a part time basis. Figure 1A shows a steady increase between 2003–04 and 2012–13 in the proportion of SMOs employed part time.

Figure 1A
Part time SMOs as a proportion of total SMOs employed by Queensland Health 2003–04 to 2012–13



Source: QAO from Queensland Health payroll data

The majority of SMOs have the contractual right to treat public patients who elect to be treated privately at a public health facility, and, in exchange, either get paid an allowance or take a portion of the private fees charged.

SMOs are permitted to earn an income in private facilities outside their publicly rostered hours. Since 1 July 2013, RoPP contracts allow SMOs to earn income in public facilities outside their rostered hours. Such income is not part of the RoPP scheme, does not have to be declared to the Hospital and Health Service (HHS) and the HHS has no entitlement to any portion of it.

The ability to compress a full time working week into four days, combined with a rising number of part time employees, increases the opportunity for SMOs to participate in the private sector outside their rostered hours with Queensland Health.

1.3 Probity risks

The basis of employment for SMOs, where they can work across both public and private health systems, creates situations with inherent conflicts of interest and needs to be managed carefully. An incentive to maximise personal earnings may lead to an improper focus on treating private patients, where revenues accrue to each SMO.

The needs of a private patient also cannot simply be quarantined to rostered days off and weekends. Such conflicts could arise across a number of specialty areas, such as obstetrics where a natural birth of a private patient's baby cannot be scheduled to occur outside of publicly rostered hours. The same can be said for most surgical and inpatient-focused specialties where complications requiring attendance cannot always be quarantined to unrostered time.

RoPP policies (B48, B49 and B50) require that, should a conflict of interest arise with their full time public service employment, SMOs immediately detail the conflict in writing to their individual Director of Medical Services (DMS).

The definition of a conflict of interest under the RoPP policy has resulted in limited declarations being made. The RoPP policy defines a conflict as:

> *Conflict of interest refers to employees using a skill, knowledge or information derived directly from their employment with the public sector. It does not relate to a professional/specialist skill.*

Otherwise, SMOs are not required under their RoPP contracts, or generally by policies, to notify their clinical directors or their DMS of outside employment, unless it would elevate the risk of fatigue.

In contrast to Queensland, the New South Wales public health system has required mandatory declarations from staff specialists of their outside employment since 2006. The New South Wales industrial award requires that:

- full time staff specialists must seek the employer's written approval to engage in outside employment and their request for this approval must provide details of the proposed outside practice commitments including the location, employer (if any), working times, duration of work and any on call commitments
- part time staff specialists must notify the employer of any outside practice (including on-call commitments).

Since the audit commenced, we have received a number of representations from members of the public and medical practitioners, in both the public and private sectors, alleging SMO impropriety, stemming largely from this perceived conflict of interest.

The majority of the allegations made centred on SMOs not being present during their rostered hours (timesheet fraud). Other allegations included:

- manipulating rosters to result in overtime claims
- 'special deals' for some senior medical staff resulting in non-conforming RoPP arrangements with increased personal benefits
- manipulating waiting lists for personal financial benefit, including Surgery Connect
- incorrect billing to Medicare.

1.4 Audit objective, method and cost

The overall objective of this audit was to determine whether the RoPP arrangements in the public health system were achieving their intended public health outcomes in a financially sustainable manner.

Our analysis was limited to data held by the Queensland Health and at each HHS. We do not have access to data held by the Commonwealth agencies such as the Department of Human Services (Medicare Australia); or to data held by private hospitals. Medicare billing data would have provided more conclusive evidence as to where and when SMOs were undertaking work in the private sector or if they were failing to declare income to their HHS as contractually required.

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

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

This second report focuses on the third line of inquiry, using an audit approach that applied probity risk criteria to target SMOs at higher risk of impropriety.

To investigate allegations that SMOs were not present during their rostered hours, we developed risk criteria to identify those SMOs with greater opportunity and incentive to manipulate their contractual arrangements:

- in specialties which:
  - attracted higher value billable procedures
  - require SMOs to work across one or more hospital campuses
- in areas which provided access to greater patient volumes and potential anonymity in a hospital
- by providing services privately or in close proximity to private facilities.

Applying these criteria, we established that SMOs in selected specialties at larger metropolitan hospitals most closely matched all the risk criteria, as illustrated in Figure 1B.

Figure 1B
Extent of work attendance testing by hospital

Hospital	SMOs	Period analysed	Days in period analysed
Princess Alexandra Hospital (PAH)	26	17 April 2011 to 19 May 2013	764
Royal Brisbane and Women's Hospital (RBWH)	46	1 October 2012 to 29 May 2013	241
Royal Children's Hospital (RCH)	3	2 January 2011 to 29 May 2013	879
The Prince Charles Hospital (TPCH)	13	2 January 2011 to 29 May 2013	879

Source: QAO

The full data extract for RBWH was 2 January 2011 to 29 May 2013; however, there was 18 weeks of missing data due to the inability to obtain backup records for one of the two security systems in use. For the same reason, a further five interspersed days were missing during the period analysed in Figure 1B. We excluded the Townsville and Gold Coast (Southport) hospitals (audited in Report 1) from our work attendance testing, due to these facilities having limited car park security systems.

Figure 1C summarises the number of SMOs we investigated in response to the probity matters we identified.

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

The cost of the audit for both reports on the right of private practice in Queensland public hospitals was $1 496 000.

Figure 1C
Scope of testing performed

Probity risk	Audit test	No. SMOs selected	Basis for selection	Reference
Not at work when rostered	No campus footprint when rostered for payroll purposes	88	Specialties with higher value procedures, working across multiple locations, high patient volume, anonymity in hospitals, close proximity in private facilities	2.4.1
Manipulation of rosters to generate overtime	Frequency of overtime categories claimed	76	SMOs with frequent claims for extended hours overtime	2.4.2
	Late to work	88	Higher risk SMOs from Figure 1B	2.4.2
	Frequency of on-call arrangements	31	All SMOs receiving the on call allowance permanently	2.4.3
Special arrangements	SMO surgeons treating intermediate patients	34	SMO surgeons with patient data akin to that of VMOs' intermediate patients	3.3.1
	SMO anaesthetists treating intermediate patients	4	All SMO anaesthetists working at RBWH, PAH, TPCH and RCH providing services for VMO/SMO intermediate patients	3.3.1
	Option A SMOs also sharing in revenue generated	26	Initial data match between payroll allowance and billing records	3.4.3
Manipulating waiting lists for personal financial benefit	Value of Surgery Connect work compared to long waiting patients compared to clinical unit peers	43	SMOs who were paid high values directly by Surgery Connect to treat patients in private hospitals	3.3.2
	Private patient bias in private practice suites	55	All SMOs who billed in the private practice suites at RBWH in 2012–13	3.3.3
Incorrect billing to Medicare	Appropriateness of billing items based on an SMO's medical registration	30	SMOs with the highest amount of billings at APCC sites	3.4.1
	Surgeons present for services billed	45	SMO surgeons working at RBWH, PAH, TPCH and RCH with the highest amount of private patient billing	3.4.2

Source: QAO

2 Workplace attendance

In brief

Background

Senior medical officers (SMOs) are engaged to work for a defined number of hours, not for agreed upon levels of activities. There is no system being used to monitor hours or attendance and the degree of detail contained in clinical rosters varies widely. This environment has led to allegations of SMOs not being present for their rostered hours and manipulating rosters to result in unnecessary overtime claims.

Conclusions

The lack of a mandatory declaration about the extent to which an SMO also legitimately works outside the public system, combined with a lack of monitoring of time and attendance, fuels speculation around probity issues with publicly employed SMOs.

In this environment, SMOs self-manage their attendance on a ‘give and take’ basis which leaves the system open to abuse.

Key findings

- Seven of the 88 SMOs investigated (8.0 per cent) were rostered on but had no ‘footprint’ at their hospitals for more than 30 days each (over periods ranging between eight and 29 months). One-third of absences were explained by leave applications either not being lodged or processed in the payroll system.
- Leave is not being captured completely or processed accurately. In a targeted review of four clinical units, 15.9 per cent of leave was not reflected in the payroll system, but had been recorded 'locally' by clinical units.
- SMOs were incorrectly paid $500 000 in overtime while on leave, primarily due to planned overtime not being cancelled in the rostering system for payroll.
- 53 of the 88 SMOs (60.2 per cent) were late for work by more than an hour on 7.7 per cent of their rostered days (over periods ranging between eight and 29 months). For 178 of these days (20.3 per cent), the SMOs also claimed for overtime
- Although engaged for a number of hours, some SMOs treat their attendance as a ‘give and take’ arrangement; all hours may not be worked on one day in lieu of unclaimed overtime on another. There is no assurance framework to monitor that these arrangements are not being abused.
- 115 SMOs worked for periods between 20 and 91 weeks between 2011–12 and 2012–13 at risk levels considered to be 'significant' or 'higher' under the Australian Medical Association's guidelines for managing fatigue risk.

Recommendations

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

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.**

2.1 Background

Senior medical officers (SMOs) are engaged and paid to work for a number of rostered hours. The roster information is entered into the Queensland Health rostering system used for payroll when an SMO commences employment and as required by the clinical director. The system records the planned hours of work each day as a shift pattern, which is amended for variations such as overtime and leave. These are the hours for which an SMO is paid through the Queensland Health payroll system. SMOs do not complete timesheets.

Each clinical unit develops its own roster to manage clinical coverage for the delivery of the unit's services. This roster varies widely in the level of detail it contains. This roster is maintained independently from the roster used for payroll purposes.

In this chapter, we examine the probity risk that was central to most of the allegations we received—that SMOs were not present during their rostered hours. We also examined the allegation that SMOs were manipulating rosters to result in overtime claims.

2.2 Conclusions

The lack of transparency about where SMOs are required to be within their Hospital and Health Service (HHS), the extent to which they work outside the public hospital system and the informal arrangements of ‘give and take’ attendance, makes it almost impossible to detect or conclude unequivocally that absenteeism is occurring.

Allowing SMOs to structure their working week in a manner that suits them contributed in some cases to additional overtime. Significant opportunity exists to reduce overtime and to manage fatigue risk better through more efficient rostering.

The issue of apparent non-attendance during paid hours is clouded because controls around the processing of SMO leave have failed, meaning that SMOs were paid for working while they were on leave. Prima facie, this gave the appearance that many were rostered for work and being paid but were improperly absent from their workplaces; in fact, some had completed leave forms, but these had not been either correctly submitted or processed. In other cases, leave forms were not prepared. SMOs need to take responsibility for ensuring that they apply properly for their leave and that leave balances reflect their actual leave taken. Clinical directors and their supervisors need to take more responsibility for ensuring leave is being processed correctly for their units.

The current administrative approach has enabled SMOs to largely self-manage their hours on a ‘give and take’ basis. This has resulted in situations where paid rosters have not been adjusted to reflect changing work patterns and affords an SMO the ability to take leave without applying for it.

Some directors do not see it as their role to monitor and supervise SMOs within their units which means that, in an environment of ‘give and take’, there is scope for abuse. While hospital administrators believe more hours are provided than paid, they have no system to validate this belief.

2.3 Rosters and accountability for attendance

Rosters held by each clinical unit should be a key tool in managing the delivery of clinical services, as SMOs work across multiple locations within a hospital, such as outpatient clinics, surgical theatres, wards, clinical meetings and clinical support activities. Some SMOs also work at other hospitals within and/or outside their HHS.

Rosters are important in establishing attendance expectations and the nature of the work expected of the individual over the course of a fortnight to meet the needs of Queensland Health patients. In practice, the degree of detail contained within clinical rosters to achieve these objectives varies widely.

While some clinical units provide a high level of detail in their rosters—ward rounds, outpatient clinics, surgery, and administration—other clinical units did not have a consolidated roster. Instead, they maintained a listing only of outpatient clinic times, allocated weekly theatre times and an on call roster, with the balance of the week left to the discretion of the clinical director.

This results in a lack of transparency about where on the campus an SMO is during the day and the nature of the work undertaken during clinical support time. It weakens the ability of the system to hold an SMO accountable for workplace attendance.

While levels of activity by hospitals and clinical units are assessed across a range of key performance indicators (KPIs) such as National Emergency Access Target (NEAT) and the National Elective Surgery Target (NEST), they are not monitored at an individual SMO level. SMOs are assessed in the context of clinical outcomes; they do not have clearly defined KPIs or benchmarks related to levels of individual activity (such as the number of outpatients seen in a session) for them to deliver. In this vein, the extent to which an SMO is held accountable for his or her level of activity is determined by the director. Without any consistently applied outputs and activity-based performance measures—and a robust system to monitor both—the transparency of an SMO's expected activity through a roster becomes more critical.

There are no other systems or processes to corroborate actual hours worked against the roster, such as timesheets. The SMO manages actual work times and advises variations to rostered hours. Where the SMO performs duties at multiple locations throughout the hospital campus, or across two different campuses, there is limited visibility for a clinical director as to whether an SMO has delivered his or her paid hours.

Some SMOs we interviewed (including clinical directors) highlighted the complexity of rosters, given the number of interdependencies, and advised that the rosters were only amended to reflect substantial changes. One example we encountered was a roster last updated two years earlier.

This lack of regular revision to rosters has encouraged an attendance practice of 'give and take' to develop; where SMOs do not adhere to their rosters but, of their own accord, make up missed time when they arrive late.

2.4 SMO attendance patterns

We selected 88 of the 2 817 SMOs and investigated their patterns of attendance using data from security, patient billing and theatre management systems to ascertain whether the data corroborated that they were physically present during their rostered hours. An absent record in one of these particular systems would not in itself be conclusive evidence that the SMO was not at work when rostered; for example, an SMO can follow another employee through a secured door and a number of doors were not secured during normal rostered hours.

Using these data sources, we tested four scenarios that indicated potential probity issues for the periods when each selected SMO was rostered in the payroll system:

- no evidence of a campus 'footprint' on a rostered day, but paid for normal hours
- no evidence of a campus 'footprint' and claimed overtime
- arrived 'late' to work but paid for normal hours
- arrived 'late' to work but also claimed overtime.

2.4.1 No campus 'footprint'

Absent but paid for normal hours

We identified periods where SMOs were rostered but there was no other evidence to corroborate they were physically present at the workplace. We have factored into our analysis the documented occasions provided to us outlining where the SMO was off campus undertaking Queensland Health endorsed activities.

Figure 2A shows the number of SMOs and the number of days without a campus footprint we found at the four hospitals we tested. The length of the shift for a day without a campus footprint (missing days) varied between two and twelve hours.

Figure 2A
Rostered but no footprint

Hospital	Less than 10 days		10 to 30 days		More than 30 days		Total		Days in period analysed
	SMOs	Days	SMOs	Days	SMOs	Days	SMOs	Days	
PAH	8	25	11	194	5	338	24	557	764
RBWH	20	89	15	253	—	—	35	342	241
RCH	1	9	2	25	—	—	3	34	879
TPCH	3	16	1	13	2	115	6	144	879
Total	**32**	**139**	**29**	**485**	**7**	**453**	**68**	**1 077**	**—**

Note: The periods of time for which data was obtained for each hospital varies as shown in Figure 1B.

PAH—Princess Alexandra Hospital; RBWH—Royal Brisbane and Women's Hospital; RCH—Royal Children's Hospital; TPCH—The Prince Charles Hospital

Source: QAO

While RBWH had no absences greater than thirty days in Figure 2A, the period reviewed was less than one-third of its peer hospitals. If the patterns of exceptions continued, a number of SMOs would likely to be within the 'greater than 30 days' category.

For the seven SMOs (three directors or deputy directors) that were 'missing' for more than 30 days each, the individual number of missing days ranged between 42 and 158 days. Large proportions of these exceptions were blocks of consecutive days, rather than dispersed throughout the period, giving the appearance of leave.

Clinical units often have a leave register or track proposed leave on 'local' rosters they maintain outside the system used for payroll. After reviewing these 'local' leave registers and rosters held by the clinical unit, 154 days (one-third) were identified as blocks of time where these seven SMO were on leave, but leave forms either were:

- not completed and submitted for processing; or
- not captured and recorded by the payroll processing area.

We identified one example where the SMO had 39 days of leave during the 2012 calendar year for which the SMO did not submit leave applications. In this instance, the SMO asserted that any failure to submit leave forms would have been inadvertent.

To determine the extent of leave not being captured and accurately processed we tested selected months from 2012–13 for four clinical units (40 SMOs) across the three hospitals with the highest number of total 'missing' days (as shown in Figure 2A). We compared the leave shown on the clinical unit's leave register or roster with the leave forms held by the unit and the payroll system. Excluding the effect of unrecorded leave for the seven SMOs already identified, we found a further 109 days (15.9 per cent of the total leave recorded on the 'local' leave registers or rosters) that were not reflected in the payroll system. The 'missing' leave was a combination of forms not submitted and forms not accurately processed.

In one instance, an SMO had applied in advance for all leave proposed for the 2012 calendar year, totalling 53 days, with each period of leave approved and submitted on a separate form. None of these forms had been input by the payroll processing area.

Other types of leave up to three days' duration, such as sick leave (claimed on Attendance Variation and Allowance Claim forms—AVACs), if not captured in the system, would also contribute to missing days. We have not reviewed AVACs as part of our testing.

While this points to clear internal control breakdowns, the SMOs are also at fault in relation to their own unrecorded leave. The onus rests with the individual employees to ensure they submit their leave forms. An individual payslip shows the amount of leave that has been taken each day over the fortnightly pay period.

The preceding analysis was conducted for a relatively small number of SMOs. As the broader impact of this issue across the health system could be of much greater significance, it warrants a detailed investigation by Queensland Health into the quantum of this issue.

For the two-thirds of remaining days not explained by unprocessed planned leave, we were not able to resolve or make conclusions on the reasons for the lack of alignment between paid rosters and apparent actual working patterns. Undocumented legitimate absences from the campus, such as meetings off site and unplanned leave not applied for or processed (such as sick leave) may account for a portion of these absences. The generally weak oversight of attendance, and the absence of other controls to corroborate attendance, meant there was no 'audit trail' that could be examined.

Absent and also paid overtime

Under current industrial arrangements, SMOs can claim overtime for work performed outside of standard rostered hours. In Report 1 for 2012–13 Right of private practice in Queensland public hospitals (Report 1) we found that overtime claimed on Fridays was disproportionately large compared to the level of clinical activity undertaken on that day.

Figure 2B outlines the most common forms of overtime available to SMOs. It illustrates the total hours and amounts claimed in 2012–13 as well as the methods by which the overtime is approved. Overtime can either be planned for in advance on rosters or claimed retrospectively by SMOs submitting an AVAC form which is approved by directors.

Figure 2B
Overtime categories hours and payments
2012–13

Overtime categories	Type	Description	Approval process	Hours	$m
Unplanned—extended	Early start	Starting prior to rostered shift	Retrospective AVAC	5 250	1.19
	Working through lunch	Unable to take a lunch break		1 826	0.41
	Late leaving	Leaving later than rostered end of shift		56 404	12.77
Planned—extended	Planned	Rostered for either a shift extension or an additional shift	Pre-approved on entry of roster	46 886	10.62
Sub total—extended				**110 366**	**24.99**
Unplanned—call back/in	Recall	Required outside rostered hours	Retrospective AVAC	158 011	37.48
Total overtime claimed				**268 377**	**62.47**

Source: QAO extracted from Queensland Health's rostering system used for payroll

We tested the allegations that SMOs were constructing their own rosters—or attending work at certain times—to generate additional income through overtime claims.

We also identified 36 of the 88 selected SMOs (40.9 per cent) who were paid overtime for 265 total days but did not have a 'footprint' in the systems we interrogated. Figure 2C shows the number of SMOs and the total number of days we found at the four hospitals where data indicated they were not at work during the period they were paid overtime. The amount of overtime on a single day varied from fifteen minutes to over ten hours.

Figure 2C
Overtime but no footprint

Hospital	Less than 10 days		10 to 30 days		More than 30 days		Total		Days in period analysed
	SMOs	Days	SMOs	Days	SMOs	Days	SMOs	Days	
PAH	13	64	1	11	1	35	15	110	764
RBWH	10	30	1	16	—	—	11	46	241
RCH	2	13	—	—	—	—	2	13	879
TPCH	4	18	3	42	1	36	8	96	879
Total	**29**	**125**	**5**	**69**	**2**	**71**	**36**	**265**	**—**

Note: The periods of time for which data was obtained for each hospital varies as shown in Figure 1B.

Source: QAO

The overtime claimed by one SMO who was 'missing' for more than 30 days was predominantly planned overtime that occurred in a consistent pattern each fortnight. For most days where the SMO had no access footprint and was paid planned overtime, the SMO was on leave according to the clinical unit leave register. This leave was not recorded in the Queensland Health payroll system.

Other SMOs were paid planned overtime for periods where they also had leave recorded in the payroll system. This occurred because there is a lack of effective controls to stop overtime payments when staff members are on leave. Since the 2010 calendar year, Queensland Health has paid a combined $500 000 to SMOs in overtime payments when they were on some form of leave, the majority of which was planned overtime.

This issue is not confined to SMOs—it affects any Queensland Health employee claiming overtime. Queensland Health was aware of this issue prior to the audit commencing and, in early 2014, had implemented exception reporting to assist in preventing overtime payments during periods of leave.

2.4.2 Non-adherence to rostered times

We identified 53 of the selected 88 SMOs (60.2 per cent) who were 'late' for work by more than 60 minutes on 878 days (7.7 per cent of the days they were rostered) over periods ranging between eight and 29 months. Based upon their entry time to a boom-gated car park, these SMOs arrived at work more than one hour after their rostered start times in the rostering system used for payroll. We established a 60 minute threshold, as being late by an hour or more would cause disruptions to the efficient running of hospitals. For 178 of these days (20.3 per cent), the SMOs also claimed for overtime.

We have excluded the 1 564 days where the selected SMOs were late by less than 60 minutes.

We have adjusted for known Queensland Health commitments outside of their primary campuses and fatigue leave that explained the late starts.

Figure 2D
SMOs 'late' to work by more than 60 minutes

Hospital	Number of SMOs	Days late no overtime claimed	Days late overtime claimed	Total days late	Days in period analysed
PAH	11	321	88	409	764
RBWH	31	238	30	268	241
RCH	3	34	23	57	879
TPCH	8	107	37	144	879
Total	**53**	**700**	**178**	**878**	—

Notes:

1. The periods of time for which data was obtained for each hospital varies as shown in Figure 1B.

2. Not all requested rosters were received to ascertain hospital endorsed off-campus activity.

Source: QAO

Rostered hours not fully worked

Public hospitals must integrate numerous service areas; being on time is central to the efficient delivery of these services. Theatres or outpatient clinics not starting on time result in additional costs to the health system (such as overtime for staff) and increased waiting times for patients. In the absence of a time and attendance management system, hospital administrators are only made aware of patterns of lateness or absences of SMOs via a complaints process.

Where SMOs are late to work, one common explanation provided was that there was ‘give and take’ in the system and the lost time was made up by working later than their rostered finish time or working on another day. Such informal approaches are not easily monitored due to the lack of transparency of SMO's whereabouts, including their work commitments outside the public sector. Due to data limitations, particularly the absence of car park boom-gate exit data, we could not independently verify or otherwise substantiate the extent to which these practices occurred. We reviewed a small number of SMOs and noted that they had a campus footprint outside of paid hours (rostered or claimed overtime).

SMOs informed us that they completed administrative tasks away from the hospital campus, such as certain aspects of research, writing reports and unit management tasks. We were unable to test the veracity of these claims.

Hospital administrators advised us they were either comfortable with the reasons provided for why individuals were late, or that they have since taken corrective action, such as adjusting rosters to better reflect current work patterns. Most directors and hospital administrators we spoke to stated that more overtime is worked than claimed. While they were not able to substantiate this claim, we noted in 2012–13 that nearly 50 per cent of SMOs claimed only five per cent of all overtime paid.

In limited instances (less than five per cent of 88 selected SMOs), rostered hours for payroll did not reflect the hours SMOs regularly worked and currently there are no controls to ensure the two rosters align—one example is described in Case study 1.

Case study 1

Rostered hours for payroll not reflecting actual work patterns

An explanation provided by an SMO for why rostered hours in the payroll system did not align with the access footprint was due to being unaware of the rostered payroll start time.

This SMO rarely claimed overtime and advised us that the late starts would have been offset by not claiming overtime for work the SMO performed outside rostered hours.

The hospital and the SMO have agreed to adjust the roster. While flexibility in rostering is essential, this disconnect between the paid roster and the hours delivered weakens the accountability of an SMO to deliver his or her contracted hours.

Overtime claimed when late to work

In Report 1, we noted that the decrease in the working hours from 90 to 80 hours per fortnight and the introduction of the ability to deliver a full time load over ten-hour shifts may have enabled additional overtime for SMOs. The amendments to working hours were introduced to aid in the efficient and effective running of hospitals.

Under the Medical Officers (Queensland Health) Certified Agreement (No. 3) 2012 (MOCA 3) the employer makes the final determination as to how the 80-hour fortnight is implemented or worked, including the ability to refuse the working of a shift of ten or more ordinary hours if it may adversely affect service delivery or result in additional overtime.

In our discussions with SMOs and clinical directors, the determination on whether to work eight-hour shifts or ten-hour shifts has been made to largely suit the interests of SMOs and not necessarily the hospitals.

Planned overtime

Planned overtime comprised 25 per cent of the total overtime claimed on days the SMO was late to work.

As planned overtime is rostered in advance, it does not take into account days when SMOs may not begin work at their rostered start times and relies upon SMOs submitting AVACs to cancel or amend the overtime. We were advised these adjustments are not submitted where SMOs consider they have done more overtime than they have claimed in recent times, validating the 'give and take' approach to attendance.

Unplanned overtime

Unplanned overtime formed 75 per cent of overtime claimed on days SMOs were late to work, of which 74.5 per cent was extended hours overtime (the balance being recall overtime). Unplanned overtime is claimed by retrospectively submitting an AVAC form.

To explore the extent of unplanned overtime we considered all SMOs and further examined those with the highest frequency of unplanned overtime claims. Figure 2E is based on the top ten SMOs claiming unplanned overtime (in hours) across HHSs (presented in alphabetical order). It illustrates the percentage of distinct days that individuals have claimed at least one of the relevant classes of unplanned extended hours overtime compared to their number of rostered days between 1 July 2011 and 30 June 2013 (excluding leave).

Figure 2E
Significant unplanned extended overtime patterns by HHS
2011–12 and 2012–13 combined

HHS	SMO	Per cent of regular rostered days			Regular rostered days worked
		Early start	Working through lunch	Leaving late	
Children's Health Queensland	CHQ-001	44%	50%	67%	445
Darling Downs	DD-001	3%	41%	61%	475
Metro North	MN-001	83%	0%	87%	424
	MN-002	81%	45%	82%	449
	MN-003	0%	0%	88%	448
Metro South	MS-001	74%	10%	75%	449
	MS-002	42%	0%	92%	428
North West	NW-001	64%	0%	61%	435
	NW-002	5%	0%	97%	428
Townsville	TSV-001	1%	89%	96%	430

Source: QAO extracted from Queensland Health's rostering system used for payroll

While the Director of Medical Services (DMS) provided explanations for the large volumes of consistent unplanned overtime, a number of these practices are being reviewed. Where the unplanned overtime related to Option B SMOs, the DMS acknowledged the overtime claimed was in breach of RoPP policies and were taking action to correct work practices.

Consistent high volumes of overtime, prima facie, indicate workforce shortage issues in the face of clinical demand, but also raise the question of whether poor rostering and lax administrative oversight is a significant contributor. The consistent overtime worked by certain SMOs presents a fatigue risk which requires further consideration by HHSs.

We noted 115 SMOs 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* (the AMA code–see Appendix F for risk matrix), for periods ranging between 20 and 91 weeks over a 104-week period (2011–12 to 2012–13). Case study 2 illustrates an extreme example.

Case study 2

Extreme working hours

In Report 1, we identified an instance where an SMO claimed overtime of $709 360 in 2011–12 (the average overtime in 2011–12 was $31 457, which equates to a variance of $677 903). Approximately three quarters of the overtime claimed was for recall overtime (unplanned called back in). We explored this issue further with the HHS.

The HHS commissioned an investigation in September 2013 into overtime practices within the clinical unit involved. The investigation validated the attendance of the SMO. The SMO's explanation was they were trying to meet the hospital's service demands. Comparisons made to another similar-sized Queensland Health hospital indicated a shortage of SMOs in this clinical unit.

During the 2010 calendar year, the SMO worked a period of more than 180 days without having a day off, often requiring more than 110 hours in a week, averaging approximately 16 hrs per day.

Although the investigation did not find any wrongdoing on behalf of the SMO, the scope of the investigation did not extend to exploring the potential for negligence associated with working in a fatigued state.

For this SMO, during 2010–11 we noted that on 92 occasions they worked 17 hours or more in one day and for a further three occasions they worked 21 hours or more in one day. Staying awake for 17 hours has the same effect on performance as having a blood alcohol content of 0.05 per cent and 21 hours awake is equivalent to 0.1 per cent (Effects of fatigue, Workplace Health and Safety Queensland, 20 May 2013).

The recruitment of additional SMOs in subsequent years and changed work practices has reduced their overtime to $569 210 in 2012–13 (the average overtime claimed by SMOs for 2012–13 was $26 856). The HHS is considering the findings and recommendations of the investigator to further reduce overtime and fatigue risks within this clinical unit.

2.4.3 On call arrangements

We identified that 31 SMOs (less than one per cent of all SMOs) were permanently on call and were paid an allowance for this: that is, they were paid an allowance for every hour they were not rostered for work or on leave. Of the 31 permanently on call SMOs, 22 were based in south-east Queensland (see Appendix D for a map of HHSs).

Administrators stated that being on call presented a greater fatigue risk for some specialties than others; for example, some specialties may only be required to provide phone assistance whereas others require being recalled to the hospital.

Being permanently on call is identified by both the AMA code and the Queensland Health Fatigue Risk Management System (FRMS) as creating a severe fatigue risk. The FRMS recommends that staff should never be on call for more than four consecutive days.

Over 2011–12 and 2012–13, the 31 SMOs collectively received $2 830 155 in on call allowance payments. In three instances, the arrangements were approved by previous hospital administrators, but were not supported by the current hospital administrators and have since ceased. A further seven are being reviewed and are unlikely to continue. The remainder were supported by hospital administrators on the grounds of clinical need where there was only one SMO appropriately qualified to fulfil the role. Case study 3 illustrates one example of an SMO being permanently on call.

Case study 3

Permanently on call
One SMO was paid the on call allowance for each day except for recorded leave, amounting to approximately $300 000 between 2007–08 and 2012–13. These payments were not reflective of the on call requirements of this SMO who shared the on call responsbilities with their clinical unit peers. Through a lack of monitoring by the SMO, the clinical unit and the HHS, this matter remained undected until this audit. The HHS's preliminary investigation has indicated that this arrangement could have commenced as far back as April 2004.

3 Treatment and billing practices

In brief

Background

Under the right of private practice (RoPP) governing policies, participation in private practice must not compromise or adversely affect the treatment of public patients.

The National Health Reform Agreement (NHRA) and the National Healthcare Agreement 2012 (NHA) both require public hospitals to provide access to the same services for public patients as they do for patients electing private treatment.

At a minimum, to treat and bill a patient in a public hospital requires that:

- the patient has elected to be a private patient
- the senior medical officer (SMO) is exercising a RoPP
- the SMO has provided the service personally, or supervised the delivery of the service
- the SMO has a Medicare service provider number to bill Medicare.

Conclusions

The principles of the RoPP arrangement, and of the NHRA and NHA—that patients are to be afforded equitable access on the basis of clinical need—are not being followed.

Poor administration and a lack of oversight has resulted in Hospitals and Health Services (HHSs) subsidising SMOs' private businesses and allowed breaches of the *Health Insurance Act 1973* (HIA) to go unchallenged.

Inconsistent use of the emergency department information system to track a patient's journey has resulted in Queensland Health collectively overfunding two HHSs $18.08 million for services legitimately bulk-billed to Medicare.

Key findings

- Patients who elect private treatment in private practice suites at the Royal Brisbane and Women's Hospital receive their first outpatient consultation in time more consistently than public patients.
- Four SMOs without a right of private practice contract were treating their private sector patients on public time and billing in their own right. Eight other SMOs were treating private sector patients in a public hospital and retaining all the income contrary to their right of private practice contracts.
- Queensland Health has overfunded two emergency departments by $18.08 million for services provided in Acute Primary Care Clinics and legitimately bulk-billed to Medicare.

Recommendations

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

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.**

3.1 Background

The National Health Reform Agreement (NHRA) and the National Healthcare Agreement 2012 (NHA) both require public hospitals to provide access to the same services for public patients as they do for private patients.

The right of private practice (RoPP) policies (B48, B49 and B50), for both specialists and non-specialists, require the Director of Medical Services (DMS) in each Hospital and Health Service (HHS) to ensure that participation in private practice does not compromise or adversely affect the treatment of public patients.

In Report to Parliament 1 for 2013–14 Right of private practice in Queensland public hospitals (Report 1), we found that this was not occurring and there was no effective monitoring of the public versus private patient experience.

In this chapter, we examine further the risks that RoPP may be influencing the behaviour of senior medical officers (SMOs) through:

- the manipulation of waiting lists by preferencing private patients to obtain a financial benefit
- accessing special arrangements over and above the standard RoPP contracts
- engaging in inappropriate billing practices and potential ‘double dipping’.

3.2 Conclusions

There is prima facie evidence that private outpatients are receiving priority access to specialists by seeing them in the private practice suites at Royal Brisbane and Women's Hospital (RBWH). The financial incentive to treat private patients applies to both SMOs and hospitals and therefore the degree to which this private preference can be attributed to SMO behaviour is not clear. In the absence of monitoring whether patient outcomes have been equitable, there is no assurance that the principles under both the NHRA, NHA and RoPP policies are preserved.

Contributing to this inequity is the ability for a small number of SMOs (eight) to treat their own private sector patients in public hospitals—despite these special arrangements not conforming to the RoPP contracts in place at the time—and a further four were breaching the *Health Insurance Act 1973* (HIA) as they did not have RoPP contracts. These four SMOs were simultaneously paid by the public hospital and earning private sector income—effectively ‘double-dipping’. While all of these special arrangements were sanctioned at the time, the HHSs were unaware of the quantum of the subsidy they were providing these SMOs to run their private businesses. The majority of these arrangements have now ceased, freeing up theatres and other resources for public patients.

Queensland Health has collectively overpaid two HHSs $18.08 million for treating patients in emergency departments when the patients were in fact treated in Acute Primary Care Clinics (APCCs) and correctly bulk billed to Medicare. This outcome was the result of inconsistent use of the emergency department information system for APCC patients without subsequent adjustment to funding calculations. It was not due to individual SMO behaviour.

In other situations outside APCCs, we identified five Option A SMOs who were receiving their Option A allowance but were also granted the ability to share in the revenue they generated (similar to Option B SMOs) from treating private patients outside of their rostered hours. While the DMSs at their facilities endorsed the practice to meet emergent needs, the decisions deviated from the RoPP policies.

3.3 Treatment priorities

In Report 1, we examined the percentage of category 2 private patients who received elective surgery within the recommended time frames compared to public patients.

We made two key findings:

- that, prima facie, private patients were being seen in time more consistently than public patients
- the scheme was not attracting significant activity away from the private hospital sector.

3.3.1 Intermediate patients

In Report 1, we identified a class of patients known as an 'intermediate patient', being the private patients of a Visiting Medical Officer (VMO). These patients receive their consultation in the VMO's private rooms, but receive their surgery in the public hospital outside the VMO's contracted hours to Queensland Health. The patients are billed by the VMO in his or her own right and Queensland Health levies bed fees and/or accommodation fees.

Intermediate patients, whether treated by VMOs or SMOs, jump the public elective surgery waiting list and access subsidised treatment. As intermediate patients are often recorded as waiting less than 30 days for surgery, this will increase the proportion of private patients treated within the recommended time.

For this report, we reviewed the elective surgery data for public patients who elect to be treated privately and determined that eight SMOs (less than two per cent of all surgical SMOs) had intermediate arrangements akin to that of a VMO.

In addition to surgical SMOs with access to intermediate arrangements, we also identified four SMO anaesthetists (less than one per cent of all SMO anaesthetists) who were providing anaesthetic services for the intermediate patients of SMOs or VMOs on their own time and billing in their own right.

Most SMO intermediate arrangements had been in place for a number of years—one dating back as far as 1996. While these arrangements were sanctioned by hospital administrators at their commencement, including the SMOs' ability to retain the income generated from these services, there was limited written evidence authorising these arrangements. Where there was documentation, the authorisations were ineffective as Queensland Health's policy prohibits amending RoPP contracts. There was no evidence that these arrangements were subject to periodic review.

Significant factors resulting in the granting of intermediate arrangements to SMOs were the poorly worded RoPP contracts prior to 1 July 2013, varying interpretations across facilities and lack of definitive guidance by Queensland Health. The administration from one major metropolitan hospital took the view that the RoPP contracts prior to 1 July 2013 allowed SMOs to undertake intermediate sessions and retain the income, whereas another major metropolitan hospital believed that the contracts precluded SMOs retaining the income.

For the period 1 July 2013 to 30 June 2014, the Option A RoPP contracts have been amended to allow an SMO to retain the revenue from treating private patients in the public hospital outside of rostered hours. The Option B RoPP contracts are less clear regarding the need for the participating SMO to pay facility charges and administration fees when on un-rostered time.

SMO surgical intermediate patients

Figure 3A shows that SMO intermediate arrangements are confined to two HHSs.

Figure 3A
SMO surgical intermediate arrangements
1 July 2010 to 31 March 2013

HHS	SMOs	Intermediate patients	Patients treated on paid time
Metro North	4	461	279
Metro South	4	113	26
Total	**8**	**574**	**305**

Source: QAO

Prior to 1 July 2013, the RoPP contracts did not allow the SMO to retain all the revenue from intermediate patients.

Before this audit commenced, Metro North HHS had discontinued the intermediate arrangement of one SMO and agreed upon financial settlement of the benefit derived by the SMO undertaking these sessions in paid time. However Metro North HHS did not undertake a wider review to ascertain if these arrangements were more prevalent across the HHS. If it had, it would have identified the further three which we referred to them as part of this audit. At the time of writing, Metro North HHS had ceased all remaining SMO intermediate sessions and was still exploring the remedial action it intended to pursue.

Before this audit commenced, Metro South HHS had discontinued the intermediate arrangements for two SMOs and the other two arrangements were discontinued during the audit.

Over the three financial years ending 30 June 2013, we estimate Queensland Health and HHSs have subsidised the treatment of the SMO intermediate surgical patients by between $2.4 million and $2.6 million. While the overall lost revenue is small in terms of the HHSs' budgets, the individual benefit for the eight SMOs with access to such arrangements is far greater. Based on the number of patients treated over the 1 July 2010 to 31 March 2013 period, the subsidy per SMO ranged from $72 000 to $615 000.

Four of the eight SMOs in Figure 3A treated a portion of their own private sector patients on their paid public time. The hospitals in which these patients were treated did not bill the patients for their treatments. None of these SMOs had RoPP contracts in place nor did any receive the Option A allowance. For a full time SMO in the metropolitan hospitals, an Option A allowance is 50 per cent of their base salary which, for an SMO on the MO1–7 level, equates to approximately $89 500 per annum, which they have foregone.

These SMOs were ‘double dipping’ in that they were receiving a Queensland Health salary and treating and billing their own private sector patients at the same time.

The use of a RoPP contract has been the mechanism by which SMOs have been able to treat patients electing private treatment on paid time without breaching s19(2) of the HIA. The absence of a RoPP contract results in this section of the HIA being breached.

A further four SMOs who had treated private patients outside rostered hours had breached their RoPP contracts by retaining all the revenue and not assigning it (or paying facility changes and administration fees) to the HHS as contractually required.

Anaesthetists intermediate patients

For the surgical SMO intermediate arrangements, we considered also whether public anaesthetists were used and, if so, whether the revenue from these anaesthetic services was flowing to the public hospitals.

We noted that, across all VMO and SMO intermediate patients treated, public anaesthetists were used in 15 per cent of cases and private anaesthetists used in 85 per cent of cases (see Appendix B for the list of hospitals examined using data from the operating room management information systems). If public anaesthetists were used more frequently for intermediate lists, additional revenue could flow to the public health system. Hospital administrators have limited visibility over the use of anaesthetists for intermediate sessions; in part, due to the surgeon booking the theatre and being responsible for the provision of an anaesthetist. While a private patient may select an individual specialist for a surgery, the patient rarely selects an anaesthetist. The ability to increase the use of public anaesthetists would depend on their being sufficient capacity.

Between 1 January 2011 and 30 June 2013, we found four Option A SMO anaesthetists who were treating private sector patients in public hospitals on unrostered time and who were not assigning the income to the hospital as required under their RoPP contract. Over the same period, these four anaesthetists collectively billed $27 610 under their RoPP contracts; however, if their services on the intermediate lists were identified and billed by the hospitals, we estimate that the public hospitals would have generated a further $91 195.

3.3.2 Surgery Connect

One of the allegations we received and investigated was that the design of the Surgery Connect program created an incentive for SMOs not to treat longer waiting public patients, so they could instead treat them under Surgery Connect and be paid additional remuneration.

Surgery Connect was established to provide greater access to elective surgery for long waiting public patients. The budget for the 2012–13 year was $30.4 million, of which $1 million was allocated for contracting with individual SMOs or VMOs to undertake procedures in private hospitals.

To provide continuity of patient care, Surgery Connect prioritises surgery with the doctor who had the patient on his or her waiting list. Prior to Surgery Connect contracting with the SMO, there is no requirement for the individual to reach a defined level of treating patients in turn (that is, in the order they were added to the waiting list). There is also no requirement for the SMO to seek approval from, or declare the work to, the hospital. While Case study 4 highlights one extreme example, we did not find this to be a systemic issue.

Case study 4

Surgery Connect extreme example

One SMO received $132 259 in payments from the Surgery Connect program in the 2012–13 financial year for directly contracted procedures performed in private facilities. This was more than three times higher than the payment received by the next highest earner under Surgery Connect. This SMO treated 31 patients under the program, of which 18 patients came from the SMO's own elective surgery waitlist.

A peer comparison of long waiting elective surgery patients across the clinical unit revealed that the SMO had 64 long waiting patients, compared to the peer average of seven.

Further investigation is required to determine whether this situation arose from waiting list manipulation or was due to high demand for this particular SMO.

3.3.3 Outpatients

One primary means for the treatment of public patients to be adversely affected is for SMOs to focus their time and energies on private patients. Private patients in a public hospital are patients who either:

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

As Option B SMOs share directly in the revenue generated from seeing private patients, there is a risk that they may give priority to patients electing private treatment.

In Report 1, we found private outpatients were not given priority over public outpatients across all reporting hospitals in Queensland (excluding the Royal Brisbane and Women's Hospital (RBWH) and the Princess Alexandra Hospital (PAH)) for the period July 2012 to March 2013.

RBWH was unable to provide us with data in time for it to be analysed for inclusion in Report 1. PAH is still unable to provide us with data as its outpatient information management system is unable to extract data at the patient level for analysis. We have included our analysis of the RBWH data in this report.

RBWH outpatients

Outpatients attending their first appointment (that is, new patients) were seen at the RBWH private practice suites more consistently in time than public and bulk-billed patients.

Figure 3B shows the five specialties in the private practice suites that have treated the most new private patients. The figures for public and bulk-billed clinics include all new appointments, whether seen by SMOs, VMOs or registrars whereas the private practice suites are staffed only by SMOs. It shows the proportion of patients seen within the clinically recommended time in the private practice suites compared to public and bulk-billed clinics.

Figure 3B
Percentage of new outpatients seen in time by selected specialties at RBWH
1 July 2012 to 31 March 2013

Specialty	Per cent seen in clinically recommended time			Total new appointments	
	Public and bulk billed	Private practice suites	Variance	Public and bulk billed	Private practice suites
Gastroenterology	50%	70%	20%	3 739	559
Obstetrics and gynaecology	54%	74%	20%	4 173	444
Neurosurgery	25%	96%	71%	648	292
Rheumatology	36%	50%	14%	304	216
Orthopaedics	86%	92%	6%	4 483	170
Total listed clinics	**62%**	**75%**	**13%**	**13 347**	**1 681**
All clinics	**67%**	**77%**	**10%**	**35 774**	**2 280**

Source: QAO

Figure 3B demonstrates that patients who are prepared to pay the out of pocket expenses to see an SMO in the private practice suite receive priority access over public patients.

Hospital administrators confirmed that the private practice suites were created to maximise billable services and that patients meeting these out of pocket costs would expect they are afforded some advantages over public patients.

The NHA requires that patients have *'timely access to quality health services based on their needs, not ability to pay…'*. The RoPP policies require that participation in the scheme '*is in no way to compromise or adversely affect the treatment of public patients'*. Adequate monitoring of this aspect of clinical services has not occurred to ensure equitable access for public patients.

3.4 Billing practices

The NHA requires eligible public patients to be treated free of charge unless they elect to be private patients.

The basic requirements to bill a patient in a public hospital are:

- the patient has made an election to be a private patient
- the SMO is exercising a RoPP
- the SMO has provided the service personally, or supervised the delivery of the service
- the SMO has a Medicare service provider number to bill Medicare.

In Report 1, we found that there was weak revenue management, poor integration of systems to facilitate billing and processes were highly manual. Our survey of SMOs indicated that there was a lack of clarity around billing, specifically:

- 62 per cent of respondents had experienced situations where they were unsure as to whether services were billable; 26 per cent did not seek guidance on whether or not they could bill for the service
- 65 per cent said that they do not receive adequate support in relation to what services are billable and when.

This environment is conducive for inaccurate or incorrect billing to occur and is consistent with allegations we received around inappropriate billing to Medicare and potential 'double dipping'.

Given this, we investigated the following billing areas:

- billing in APCCs on the basis of a doctor's medical registration
- billing for elective surgery where the SMO was not present
- senior medical staff billing private patients outside their RoPP contracts.

In relation to these matters we found:

- low levels of under-billing in APCCs and double-counting of activity resulting in overfunding of two emergency departments
- a small number of instances where elective surgery was billed and the SMO was not present for the surgery
- five SMOs billing patients and sharing revenue outside their RoPP contracts.

3.4.1 Billing in Acute Primary Care Clinics

APCCs have evolved in Queensland over the last six years in a predominantly regional setting. The aim of an APCC is to relieve pressure from the emergency department by treating patients with less complex needs.

The NHRA requires that patients presenting to a public emergency department will be treated free of charge; however, where clinically appropriate, patients may be informed of other service providers such as APCCs.

The patients with less complex needs are given the choice of being treated in an APCC which is located near, but not part of, the emergency department. APCCs are staffed by hospital employees who bulk-bill Medicare for the services provided. All the SMOs working in APCCs were Option A doctors who are not entitled to a share of revenue generated. Appendix E provides a full list of APCCs.

Public hospital emergency departments are a publicly provided service funded by the state and Commonwealth under the NHRA which provides funding on the level of activity undertaken—no charges can be levied against Medicare.

We matched the data from each hospital's emergency department information system (EDIS) to the APCC billing data to determine if a patient was counted as being treated in an emergency department and billed for treatment in the APCC on the same day at approximately the same time.

We found that patients being treated in the APCCs in Mackay and Bundaberg are being funded twice: incorrectly by Queensland Health under the NHRA and correctly from Medicare.

This occurred due to the particular way EDIS is used at these sites to track a patient's journey. However no subsequent adjustment was made to the activity based funding calculations performed by Queensland Health to account for this. It was not due to individual SMO behaviour.

Over 2011–12 and 2012–13, this has resulted in $18.08 million in incorrect additional funding being provided from Queensland Health to these HHSs for emergency department services that were actually provided to 52 619 patients in the APCCs and validly billed to Medicare.

Billing incorrect item numbers

Mackay, Mt Isa and Bundaberg APCCs comprised 80 per cent of the 143 000 items billed in APCCs statewide between February 2010 and June 2013. We reviewed over 93 000 billed items from the 30 highest billers in these three APCCs and found that, collectively, APCCs had billed five per cent of items at a lower rate than eligible. The value of the items billed was $161 678. These situations occur when specialists use billing codes reserved for non-specialists.

3.4.2 Inappropriate billing for surgery

Medicare benefits are payable when an SMO performs a surgery or is training a registrar and provides them with 'direct supervision'. It would not be valid for an SMO to bill a private patient for surgery performed by an unsupervised registrar.

We compared surgeries billed by 45 Option B SMOs across four hospitals to their theatre management system to determine if the SMO was present. Of 2 680 items reviewed, fewer than 107 items (four per cent) were identified as having anomalies. Of the 32 items reviewed by HHSs, nine had errors, six were correct and the balance was inconclusive. These have been referred back to the relevant HHS for further examination of the extent of these issues.

3.4.3 Option A doctors billing as Option B doctors

Currently, SMOs are offered a right of private practice contract on being appointed to a senior medical officer role. HHSs are unable to vary the RoPP contract, ensuring every SMO is operating within one set of policies and guidelines.

SMOs who elect Option A receive an allowance in exchange for assigning all the revenue from their private practice to Queensland Health; those who elect Option B (or R) retain the revenue they generate and pay a facility charge and administration fee to Queensland Health. SMOs can only elect one option for each substantive position that they hold.

We undertook analysis to determine if there were SMOs who were receiving the Option A allowance (via payroll) who were also sharing in the revenue generated from seeing private patients—like an Option B SMO.

Over the period 1 July 2006 to 30 June 2013, we identified five SMOs who were receiving the Option A allowance and retaining a portion of the income they generated outside rostered hours from treating hospital patients electing private treatment. Hospitals collected facility charges and administration fees. These special arrangements varied in length and were granted to SMOs to meet emergent local needs such as additional services to meet demand.

Currently, these arrangements are not allowed; however, under the proposed reforms to the right of private practice arrangements, they would be permissible.

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Appendix E—List of APCCs 55

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Appendix A—Comments

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

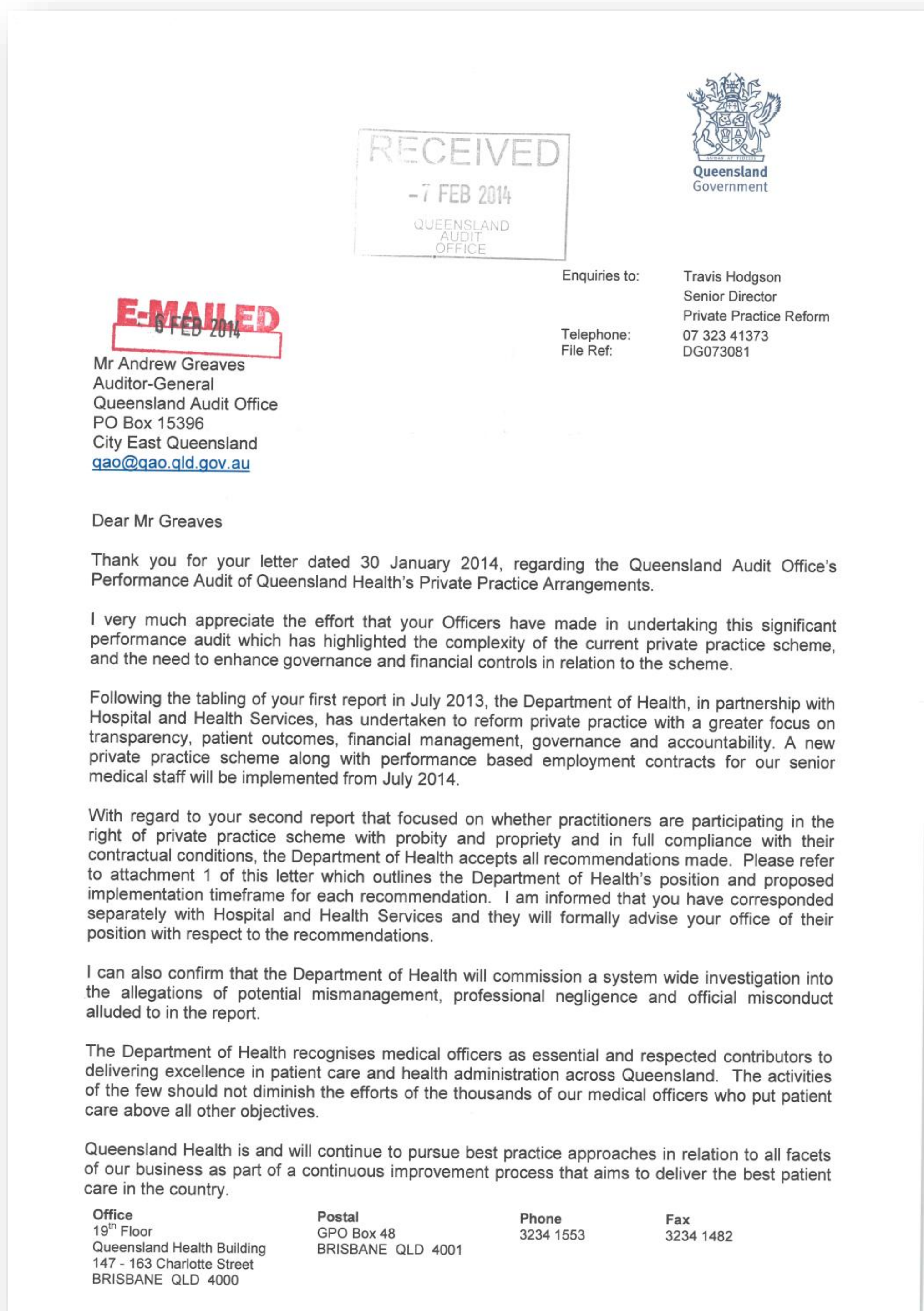
- Queensland Health
- Metro North Hospital and Health Service (HHS)
- Metro South HHS
- Children's Health Queensland HHS.

Relevant extracts of this report, with an opportunity to comment, were also provided to:

- Darling Downs HHS
- Wide Bay HHS
- Mackay HHS
- North West HHS
- Townsville HHS.

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

Comments received from Acting Director-General, Queensland Health on 6 February 2014



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Queensland Government

E-MAILED
6 FEB 2014

Enquiries to: Travis Hodgson
Senior Director
Private Practice Reform
Telephone: 07 323 41373
File Ref: DG073081

Mr Andrew Greaves
Auditor-General
Queensland Audit Office
PO Box 15396
City East Queensland
qao@qao.qld.gov.au

Dear Mr Greaves

Thank you for your letter dated 30 January 2014, regarding the Queensland Audit Office's Performance Audit of Queensland Health's Private Practice Arrangements.

I very much appreciate the effort that your Officers have made in undertaking this significant performance audit which has highlighted the complexity of the current private practice scheme, and the need to enhance governance and financial controls in relation to the scheme.

Following the tabling of your first report in July 2013, the Department of Health, in partnership with Hospital and Health Services, has undertaken to reform private practice with a greater focus on transparency, patient outcomes, financial management, governance and accountability. A new private practice scheme along with performance based employment contracts for our senior medical staff will be implemented from July 2014.

With regard to your second report that focused on whether practitioners are participating in the right of private practice scheme with probity and propriety and in full compliance with their contractual conditions, the Department of Health accepts all recommendations made. Please refer to attachment 1 of this letter which outlines the Department of Health's position and proposed implementation timeframe for each recommendation. I am informed that you have corresponded separately with Hospital and Health Services and they will formally advise your office of their position with respect to the recommendations.

I can also confirm that the Department of Health will commission a system wide investigation into the allegations of potential mismanagement, professional negligence and official misconduct alluded to in the report.

The Department of Health recognises medical officers as essential and respected contributors to delivering excellence in patient care and health administration across Queensland. The activities of the few should not diminish the efforts of the thousands of our medical officers who put patient care above all other objectives.

Queensland Health is and will continue to pursue best practice approaches in relation to all facets of our business as part of a continuous improvement process that aims to deliver the best patient care in the country.

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Comments received from Acting Director-General, Queensland Health on 6 February 2014

Should you require further information, Department of Health's contact is Mr Travis Hodgson, Senior Director, Private Practice Reform, System Support Services, on telephone 3234 1373

Yours sincerely

Dr Michael Cleary
Acting Director-General

Cc: Hospital and Health Service Chief Executives

Cc: The Hon Lawrence Springborg MP, Minister for Health

2

Responses to recommendations

Recommendation	Agree / Disagree	To be implemented by (month, year)	Additional Comments
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.	Agree	7 July 2014	The Department of Health has reviewed the New South Wales model for declaration of employment and have included a similar requirement into Schedule 1 "Duties", of the SMO and VMO individual employment contracts that will take effect from 7 July 2014. The Department of Health will partner with Hospital and Health Services (HHSs) to develop an awareness program for SMO's outlining conflict of interest obligations, as part of the broader learning management system. With regard to private practice, schedule 3 of the new employment contract requires that medical officers declare external private practice activities to the HHS Chief Executive. It is clear that conflicts 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. From July 2014, a written agreement (Licenced Private Practice agreement) will be the only instrument permitting this activity to occur. The Licenced Private Practice agreement template will require that resources, support services and infrastructure access are to be negotiated at the local level to address community, professional and service needs. These arrangements are to be conducted on a commercial basis .
2. Investigate the extent of unrecorded leave and undertake appropriate remedial action.	Agree	30 April 2014	The Department of Health with HHSs will investigate the extent of unrecorded leave and take immediate steps to rectify the situation. Significant work has been undertaken by the Department of Health Payroll Portfolio to provide line managers with access to the Work Brain roster system whereby they can view team rosters and better manage attendance, overtime and fatigue. This work is continuing across all HHSs.

Responses to recommendations

Recommendation	Agree / Disagree	To be implemented by (month, year)	Additional Comments
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.	Agree	30 April 2014	The Department of Health will fast track enhanced access to the rostering and time and attendance solution (Work Brain) for all HHSs. The Department of Health will increase monitoring of fatigue risk to ensure adequate mitigation measures are being implemented by HHSs.
4. Assess an SMO's performance based on an agreed level of clinical and non-clinical activity.	Agree	7 July 2014	Individual contracts for SMO's are being implemented and include key performance targets that relate to agreed levels 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	Agree	7 July 2014	Policy statements contained in the Private Practice Health Service Directive will include the following: **Patient centred:** private practice is conducted in a way that prioritises patients' on the basis of clinical need. **Efficiency and value:** private practice is conducted in a way that supports overall service sustainability and best use of public resources **Managed:** private practice is actively managed and monitored. **Simplicity and transparency:** obligations, performance criteria and fees for private practice are accessible, clear and consistent. Reporting functionality will be established in the Decision Support System so that HHSs are able to locally monitor.
6. Establish controls to maintain a consistent standard for collection and reporting of activity data for funding and statistical purposes.	Agree	30 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

Responses to recommendations

Recommendation	Agree / Disagree	To be implemented by (month, year)	Additional Comments
			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)*.

Comments received from Chair, Metro North Hospital and Health Service on 6 February 2014

Queensland Health

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MNB14/06

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

Dear Mr Greaves

I refer to your letters dated 20 and 29 January 2014 in which you outlined the basis of your performance audit on the right of private practice in Queensland Health public hospitals, a copy of which you provided to me under section 64 of the *Auditor-General Act 2009*. Thank you for providing me with the opportunity to comment on the report.

The clear message of the report is that the right of private practice system is open to potential abuse based on the findings and conclusions of the sample that the Queensland Audit Office obtained. It is further noted that samples are not always a true representation of reality and that care must be taken with interpretation and extrapolation from a sample, particularly those samples with small numbers. It was also clear from the report that there is scope for improvement in processes and controls. Whilst Metro North are of the view that the majority of Senior Medical Officers (SMOs) behave with professional integrity serving the public interest it is important that our systems are robust and enable effective monitoring, we are keen to review and improve our systems cognisant of the findings and recommendations provided in the report.

I appreciate the history of this performance audit, however it is unfortunate that this final report will be delivered during a critical stage of consultation and implementation of the Medical Officer Contract process. The vast majority of our SMOs are aware of their privileged position in our health system, these are the SMOs who are likely to be offended by the tone of this report especially as the data collection was constrained and the ability to demonstrate the full picture of commitment (or lack of it) was not possible. Specifically the section of "rostered hours not fully worked" due to constraints on data integrity or availability, data was only able to be collected for entry to the hospital site e.g. an SMO was late by more than 60 minutes. There was further data added to this picture of those SMOs who were late and who claimed overtime for that day as this data was available from the payroll system. What was not available to complete this analysis was the number of SMOs who arrived at work more than 60 minutes late and did not leave the hospital until more than 60 minutes past rostered time off and did not claim overtime.

Although I understand and agree that it is important to monitor time and attendance, it is also important that all parts of attendance are taken into consideration as well as recognising that in this instance we are dealing with senior professional staff who need to have some degree of flexibility in their attendance in order to maximise patient care. As there is likely to be a high proportion of our SMOs who work beyond their rostered commitment, we are concerned about the impact of these comments in the context of the contract discussions.

Please find enclosed the Metro North response to the recommendations provided within the report.

Yours sincerely

Dr Paul Alexander AO
Chair
Metro North Hospital and Health Board
5 / 2 / 2014

Responses to recommendations

Metro North Hospital and Health Service – Response to QAO Report 13 Recommendations

Recommendations: **It is recommended that Queensland Health and Hospital and Health Services:**	**Agree/Disagree**	**To be implemented by (month, year)**	**Additional Comments**
1) Strengthen the management of conflicts of interest for senior medical officers by a) Introducing a written mandatory declaration of outside employment for SMOs b) Requiring SMOs to provide updated information when situations change c) Better defining conflicts of interest in the context of public service SMOs undertaking secondary employment d) Strengthening the process for assessment of conflicts of interest e) Undertaking education and awareness training for SMOs in conflict of interest obligations	Agree	To be implemented as part of the Medical Officer Contract Implementation Project. Will be programmed into the development and implementation of the Performance Review component part of this project. Development of the PR component is scheduled for July – December 2014.	There is an opportunity to address this recommendation during the medical officer contract implementation process.
2) Investigate the extent of unrecorded leave and undertake appropriate remedial action	Agree	DATE TO BE ADVISED BY AUDIT	Incorporate into MNHHS internal audit program
3) Develop rosters for the efficient delivery of health services, including a) Aligning SMOs work patterns with rostered hours for payroll purposes b) Managing fatigue in accordance with Queensland Health guidelines	Agree in principal as long as consistent with Medical Officer Contracts		Agree in principal with need to review these issues but needs to be completed in light of the intent and content of the Medical Officer Contacts of employment. Will be Incorporated into the ongoing management framework around the Medical Officer Contract implementation process.
4) Assessing an SMOs performance based on an agreed level of clinical and non-clinical activity	Agree	First review due July 2014 with annual ongoing review as required in the contract	Will be achieved with the implementation of the Medical Officer Contracts.
5) Monitoring patient access to ensure that patients have fair and equitable access to services, regardless of their ability to pay	Agree	DATE TO BE ADVISED BY AUDIT	Incorporate into MNHHS internal audit program.
6) Establishing controls to maintain a consistent standard to collect and report activity data for funding and statistical purposes.	Agree	DATE TO BE ADVISED BY AUDIT	Incorporate into MNHHS internal audit program.

Comments received from Chair, Metro South Hospital and Health Service on 5 February 2014

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Queensland Government

Metro South Health

Enquiries to: Mr Terry White AO
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Our Ref: SOD:ac
Date: 3 February 2014

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

Dear Mr Greaves

Thank you for your correspondence of 29 January 2014 regarding the report "Performance audit on the right of private practice in Queensland Health public hospitals".

I do not wish to make any comments regarding the report. I have included with this letter my response to the recommendations, for your information.

I am aware that officers of Metro South Hospital and Health Service have had extensive dealings with two of your officers, Mr P Brahman, Assistant Auditor-General and Mr Damon Olive, Director, in the course of the conduct of the audit. Metro South Health officers would like to extend their thanks to Mr Brahman and Mr Olive for their ready availability, and open communication channels.

Yours sincerely

Mr Terry White AO
Chairman
Metro South Hospital and Health Board

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Responses to recommendations

Response to recommendations provided by Metro South Hospital and Health Service on x February 2014.

Recommendation	Agree/Disagree	To be implemented by(month, year)	Additional comments
1. Strengthen the management of conflicts of interest for senior medical officers: *introduce a written mandatory declaration of outside employment for SMOs *require SMOs to provide updated information when situations change *better define conflicts of interest in the context of public service senior medical officers undertaking secondary employment *strengthen the process for assessment of conflicts of interest *Undertake education and awareness training for SMOs in revised approaches	Agree	July 2014	Standard requirement included as part of Schedule 1 of the SMO contract
2. Investigate the extent of unrecorded leave and undertake appropriate remedial action	Agree		MSHHS understands this will involve Payroll leading this work. MSHHS will ensure processes for medical staff accessing leaving, including the

1

Responses to recommendations

			application for leave and notification to Payroll are documented and communicated to all senior medical staff and visiting medical staff.
3. Periodically review and monitor SMOs patterns of work: *to ensure they stay aligned with the rostered hours for payroll purposes *to manage fatigue in accordance with Queensland Health guidelines	Agree	July 2014 and ongoing	MSHHS will provide clarity of contracted hours and days of employment to senior medical officers and visiting medical officers as part of the medical contracts implementation. MSHHS continues to monitor fatigue at an individual and unit level through departmental directors on a daily basis.
4. Assessing an SMOs performance based on an agreed level of clinical and non-clinical activity	Agree	July 2014 and ongoing	Levels of clinical and non-clinical activity will be agreed with individual senior medical officers and visiting medical officers as part of the medical contracts implementation.
5. Monitor patient access to ensure that public patients have fair and equitable access to services	Agree	ongoing	MSHHS understands this recommendation pertains primarily to situation described at RBWH regarding private practice specialist outpatients. MSHHS will however, monitor its own practices for equity of access.
6. Establish controls to maintain a consistent standard for collection and reporting of activity data for funding and statistical purposes	N/A		MSHHS understands this recommendation pertains primarily to the HHS' referenced in the report which run APCCs.

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Appendix B—Audit details

Audit objective

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

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

Our Report 1 for 2013–14 Right of private practice in Queensland public hospitals (Report 1) dealt with the first two lines of inquiry; this report deals with the third line of inquiry—the probity and propriety of senior medical officers (SMOs) participating in RoPP.

Reason for the audit

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

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

Performance audit approach

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

The audit was conducted between November 2012 and January 2014 and examined the right of private practice arrangements statewide, with primary fieldwork completed at:

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

The audit consisted of:

- interviews with clinical, financial and administrative staff
- analysis of documents including Cabinet submissions, Director-General and Ministerial briefings, policies, plans, guidelines and manuals
- a survey of senior medical officers (see Appendix J in Report 1)
- extensive data analysis from the following sources:
  - payroll (via Queensland Health's Decision Support System (DSS))—statewide for all medical staff from the first pay period of 2003–04 to the last pay period in 2012–13
  - the rostering system for payroll (via Queensland Health's Workbrain system)—statewide for SMOs from 1 January 2011 to 30 June 2013
  - clinical activity (via Queensland Health's Hospital Based Corporate Information System (HBCIS))—statewide from 1 July 2000 to 30 June 2013 for inpatients; 1 July 2005 to 31 March 2013 for outpatients; and 1 July 2004 to 30 June 2013 for elective surgery
  - theatre management systems (via operating room management information systems) from 1 January 2011 to 30 June 2013 for the Princess Alexandra Hospital, the Royal Brisbane and Women's Hospital and The Prince Charles Hospital; and 21 November 2011 to 30 June 2013 for the Royal Children's Hospital
  - billing activity (via Queensland Health's system practiX)—statewide from 1 July 2002 to 30 June 2013 for all banked transactions
  - emergency department activity (via Queensland Health's Emergency Data Information System (EDIS))—statewide for the period 1 July 2011 to 30 June 2013
  - hospital security systems (via each hospital independent security system) from 17 April 2011 to 19 May 2013 for the Princess Alexandra Hospital; 1 October 2012 to 29 May 2013 for the Royal Brisbane and Women's Hospital; 2 January 2011 to 29 May 2013 for The Prince Charles Hospital; and 2 January 2011 to 29 May 2013 for the Royal Children's Hospital.

Appendix C—Glossary

Figure C1
Glossary

Term	Acronym	Definition
Attendance Variation and Allowance Claim form	AVAC	Used by staff to submit changes to the roster, such as leave and overtime
B48: Supplementary Benefit/Right to Private Practice Benefits Options—Senior Medical Officers—Specialists	B48	Human resources policy which defines the private practice arrangements available to specialist senior medical officers within Queensland Health and provides information on consequent obligations
B49: Supplementary Benefit/Right to Private Practice Benefits Options—Senior Medical Officers—Non-Specialists	B49	Human resources policy which defines the private practice arrangements available to non-specialist senior medical officers within Queensland Health and provides information on consequent obligations
B50: Supplementary Benefit/Right to Private Practice Benefits Options—Senior Medical Officers—Pathologists	B50	Human resources policy which defines the private practice arrangements available to pathologists within the Queensland Health Health Services Support Agency and provides information on consequent obligations
Bed fees	—	Bed fees are charged to private patients for their accommodation; fees are set by directive and closely follow guidelines issued by the Australian Government
Bulk billing	—	When a health provider bills Medicare directly for any medical or allied health service that the patient receives and accepts the Medicare benefit as full payment for the service provided
Clinical support time	—	Defined in Medical Officers Certified Agreement 3 as protected time during ordinary hours for duties that are not directly related to individual patient care; it includes administration, teaching, research and attendance at meetings
Department of Veterans' Affairs	DVA	Federal Department that pays medical benefits for eligible defence veterans and current personnel
Director of Medical Services	DMS	The senior clinician at the hospital or other hospital or other health facility situated in the HHS, or the person acting in that position from time to time, who is responsible for the hospital's clinical management on behalf of Queensland Health or the HHS, including the rights of private practice; where an Executive DMS role exists, it may assume the responsibilities listed throughout or delegated to the DMS
Decision Support System	DSS	Queensland Health's principle business intelligence and reporting tool, incorporating finance, payroll and medical information

Term	Acronym	Definition
Elective surgery	—	Surgery that, in the opinion of the treating doctor, is needed but can be delayed for at least 24 hours
Finance And Materials Management Information System	FAMMIS	Queensland Health information system that includes the finance, materials management and asset modules
Health Insurance Act 1973 (as amended)	HIA	Commonwealth legislation that provides for when a Medicare benefit is payable and to whom
Hospital and Health Service	HHS	A statutory body tasked with delivering hospital and other health services (including teaching and research) to Queenslanders
Hospital Based Corporate Information System	HBCIS	An integrated suite of 36 applications, each of which administers a hospital business function; it is a corporate patient administration system used by most Queensland Health facilities for inpatients and outpatients
Inpatient	—	A patient who undergoes a hospital's formal admission process to receive treatment and/or care; treatment and/or care is provided over a period of time and can occur in hospital and/or in the person's home (for hospital-in-the-home patients)
Intermediate patient	—	A private patient in a public hospital who is responsible for the full costs of his or her care and is treated by a doctor (usually a visiting medical officer) outside the doctor's publicly paid time
Medicare Australia / Medicare Benefits Scheme	Medicare	Australia's universal health insurance scheme; introduced in 1984, its objectives are: • to make health care affordable for all Australians • to give all Australians access to health care services with priority according to clinical need, and • to provide a high quality of care. Medicare provides access to: • free treatment as a public (Medicare) patient in a public hospital • free or subsidised treatment by practitioners such as doctors, including specialists, participating optometrists or dentists (specified services only). People who reside in Australia and: • hold Australian citizenship • have been issued with a permanent visa • hold New Zealand citizenship, or • have applied for a permanent visa (other requirements apply) are eligible to receive Medicare benefits.

Term	Acronym	Definition
Medicare principles	—	Defined in clause 20 of the current National Healthcare Agreement as: • states and territories will provide health and emergency services through the public hospital system, based on the following Medicare principles: - 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 - access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period - arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.
Medicare Benefits Schedule	MBS	A federal Department of Health and Ageing publication which lists the Medicare services subsidised by the Australian Government, it is updated regularly by the Department and is not a legal document
Medical Officers Certified Agreement	MOCA	Agreement outlining working conditions for medical officers employed by Queensland Health
National Healthcare Agreement 2012	NHA	Defines the outcomes and performance indicators and clarifies the roles and responsibilities that will guide the Commonwealth and states and territories in delivery of services across the health sector
National Health Reform Agreement	NHRA	This complements the NHA and sets out the architecture of the National Health Reform which will deliver major structural reforms to establish the foundations of Australia's future health system and provide for more sustainable funding arrangements
Non-specialist senior medical officer	Non-specialist SMO	A medical practitioner who is registered as a non-specialist with the Medical Board of Australia under the *Health Practitioner Registration National Law Act 2009* and who is employed as such
Outpatient	—	A patient who receives care from a recognised non-admitted patient service/clinic of a hospital
practiX	—	Primary system used by Queensland Health to bill private patients; some hospitals also use practiX to schedule outpatient appointments
Private patient	—	A patient of a public hospital that elects to be treated as a private patient
Private practice revenue	—	Revenue generated from the delivery of professional medical services by a senior medical officer exercising a right of private practice in a public hospital

Term	Acronym	Definition
Professional medical services	—	Medical services that are charged by a senior medical officer, generally using item numbers from the Medicare Benefits Schedule
Registrar	—	Doctor studying a medical specialty
Right of Private Practice	RoPP	Contractual arrangement offered by Queensland Health to senior medical officers, granting them the ability to charge patients who elect private treatment
Senior Medical Officer	SMO	Generic term covering job designations of medical superintendent, deputy medical superintendent, assistant medical superintendent, senior staff specialist, staff specialist, general practitioner and medical officer
Specialist	—	A person so designated as a registered specialist under the *Health Practitioner Regulation National Law Act 2009* who has undergone sufficient medical training and in a recognised specialty field as accredited by the relevant accreditation authority and as determined by the appropriate specialist college—for the purposes of this report, the term 'specialist' does not include general practitioners
Treated in turn	—	Patients are treated in the order they placed on a particular urgency category's waiting list
Urgency category one	Cat 1	A patient will be allocated to urgency category one if his or her health condition has the potential to deteriorate quickly to the point that it may become an emergency; recommended waiting time is no longer than 30 days
Urgency category two	Cat 2	A patient will be allocated to urgency category two if his or her health condition is causing some pain, dysfunction or disability but is unlikely to deteriorate quickly or become an emergency; recommended waiting time is no longer than 90 days
Urgency category three	Cat 3	A patient will be allocated to urgency category three if his or her health condition is causing minimal or no pain, dysfunction or disability, is unlikely to deteriorate quickly and does not have the potential to become an emergency; recommended waiting time is no longer than 365 days
Visiting Medical Officer	VMO	A visiting general practitioner or visiting specialist employed to work part time or sessional service who incurs ongoing costs for his or her external private practice

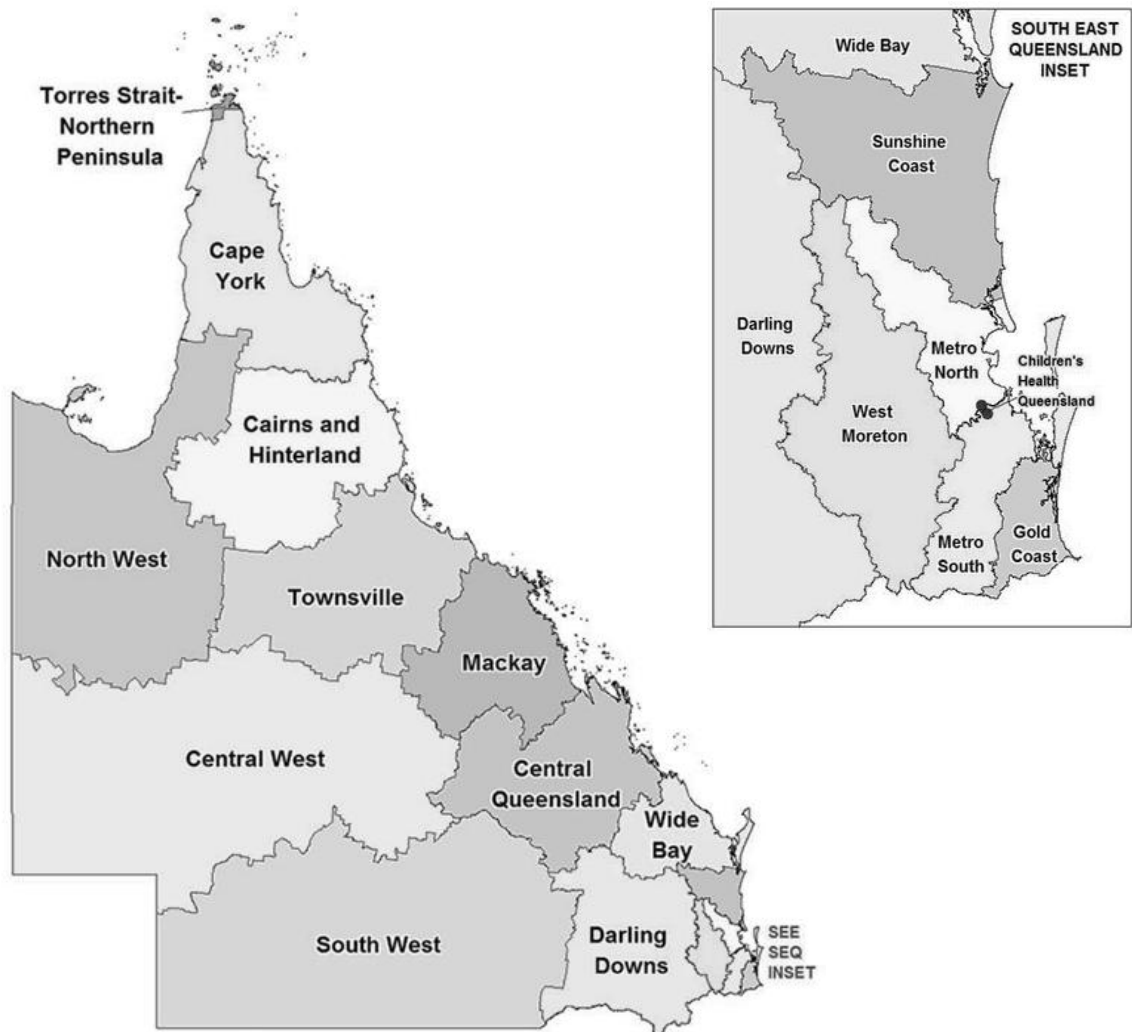
Source: QAO

Appendix D—Queensland HHS map

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

Figure D1
Queensland Hospital and Health Services

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



Source: Queensland Health

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

Appendix E—List of APCCs

Since 1 July 2012, the responsibility for establishing Acute Primary Care Clinics (APCCs) rests with Hospital and Health Services. Prior to this date, Queensland Health established APCCs. Over the testing period of February 2010 to June 2013, the following APCCs were operational:

Figure E1
Queensland Acute Primary Care Clinics

Hospital and Health Service	Hospital
Central Queensland	Rockhampton
Darling Downs	Kingaroy
Mackay	Bowen
	Mackay
	Proserpine
	Sarina
North West	Mt Isa
Wide Bay	Bundaberg

Source: QAO

Since 2011, the methods by which APCCs are established have been the subject of a determination by the Queensland Industrial Relations Commission (QIRC). The QIRC has mandated a consultation process with the aim of protecting private general practitioners' businesses, ensuring Queensland Health employees working in the APCC understanding their rights and obligations and ensuring other relevant stakeholders, including the unions, are involved in the development and establishment of APCCs. Since this determination was made, no APCCs have been established.

Appendix F—AMA code

Figure F1
Risk assessment guide

Lower risk	Significant risk	Higher risk
Fewer than 50 hours worked	50 to 70 hours worked	More than 70 hours worked
No more than 10 consecutive hours in any one period	Up to 14 consecutive hours in any one period	14 or more consecutive hours worked at least twice
Scheduled shift hours worked	Scheduled shift plus part of next shift worked	A full shift cycle worked of at least 24 hours
Three or more short breaks taken during shift	One or two short breaks taken during shift	No short breaks taken during shift
Little or no overtime	More than 10 hours overtime	More than 20 hours overtime
Rostered for on call fewer than three days in seven days	Rostered for on call duty three days or more in a seven-day period	Rostered on call continuously for more than a seven-day period
No night shift or extended hours into night shift	At least two night shifts or extended hours into night shift	At least three night shifts or extended hours into night shift
Minimum 10-hour breaks between work periods and two days free of work	Minimum 10-hour breaks between work periods and one day free of work	Less than minimum 10-hour break on at least two work periods and no full day free of work
Forward shift rotation and predictable cycle	Forward shift rotation but changed cycle	No stable direction or speed of rotation
No changes to roster without notice	Changes to roster through overtime and recalls worked	Roster changed so much because of overtime and recalls so as to be unpredictable
Maximum opportunity for sleep to be taken at night including two full nights of sleep	About two-thirds of sleep able to be taken at night including one full night of sleep	Less than half of sleep able to be taken at night and no opportunity for one full night of sleep

Source: AMA's National Code of Practice—Hours of Work, Shiftwork and Rostering for Hospital Doctors, January 2005

Auditor-General Reports to Parliament

Reports tabled in 2013–14

Number	Title	Date tabled in Legislative Assembly
1.	Right of private practice in Queensland public hospitals	July 2013
2.	Supply of specialist subject teachers in secondary schools	October 2013
3.	Follow up—Acquisition and public access to the Museum, Art Gallery and Library collections	October 2013
4.	Follow up—Management of offenders subject to supervision in the community	October 2013
5.	Traffic management systems	November 2013
6.	Results of audit: Internal control systems	November 2013
7.	Results of audit: Water sector entities 2012–13	November 2013
8.	Results of audit: Hospitals and Health Services entities 2012–13	November 2013
9.	Results of audit: Energy sector entities 2012–13	November 2013
10.	Contract management: renewal and transition	December 2013
11.	Results of audit: State public sector entities for 2012–13	December 2013
12.	Results of audit: Queensland state government financial statements 2012–13	December 2013
13.	Right of private practice: Senior medical officer conduct	February 2014

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