Private Practice Arrangements in Health Services

Victorian Auditor-General's Report | October 2008 | 2008-09:4

VICTORIA

Victorian
Auditor-General

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Ordered to be printed

VICTORIAN
GOVERNMENT PRINTER
October 2008

PP No 131, Session 2006-08

ISBN 1 921060 82 4

VAGO

Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my performance report on *Private Practice Arrangements in Health Services.*

Yours faithfully

D D R PEARSON
Auditor-General

29 October 2008

Foreword

Health services provide medical care to Victorians within well established accountability and compliance frameworks. This audit examined a health service's compliance with two such frameworks, the Australian Health Care Agreement and the *Health Insurance Act 1973*, in granting medical specialists rights of private practice.

Health services grant private practice rights to medical specialists, to allow them to attend to private patients, as individual service providers. These arrangements provide Victorians with ready access to the broadest possible range of public health services and assist health services to retain skilled staff.

The health service examined had developed systems and controls to enable medical specialists to treat both public and private patients in accordance with the Australian Health Care Agreement. However, there was less certainty around compliance with the *Health Insurance Act 1973*; particularly when salaried medical specialists exercised their private practice rights during their 'paid public time'.

There was also a lack of transparency surrounding the costs the health service incurred in supporting private practice arrangements. Understanding the costs incurred in supporting private outpatient clinics would better inform health services' decisions to enter into these arrangements, while also serving to demonstrate probity in the use of public resources.

I believe these findings and recommendations are relevant across Victorian health services generally. They require attention so the highest standards of accountability in the spending of public funds continue to be assured.

D D R PEARSON
Auditor-General

29 October 2008

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1 Executive summary

1.1 Introduction

1.1.1 Health service funding

Funding for public health services is provided primarily through the Department of Human Services (DHS), on behalf of the Victorian Government. This funding comes from both the Commonwealth Government via the Australian Health Care Agreement (AHCA), and the Victorian Government. Commonwealth funds are also accessed by individual medical specialists through the Medicare system for private patients.

The primary objective of the AHCA is **to secure access for the community to public hospital services** based on the following 'Medicare principles':

(a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals

(b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period

(c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

There are seven other AHCA objectives, the first of which is 'to improve transparency of the Commonwealth's and Victoria's financial contributions to public hospital services'.

1.1.2 Public outpatient services

In the Victorian health system there are 18 public health services that provide public patients with access to free outpatient services. These outpatient services are an important area of medical care and include medical assessments, management of chronic conditions, pre-admission consultations, diagnostic tests, and care, following discharge from hospital.

DHS distributes funding for public outpatient services to health services primarily through the Victorian Ambulatory Classification System (VACS). In 2006–07 the total outpatient budget, excluding funds associated with the Department of Veterans Affairs, but including block funding, was $400 million, or 8.7 per cent of total hospital expenditure in Victoria.

1.1.3 Private practice arrangements

An increasing number of public health services have chosen to offer outpatient services to private patients through private practice arrangements. Under these arrangements, a health service allows a medical specialist to provide services as an individual, rather than as a health service employee. Services to private patients are provided within a public hospital's outpatients' department, with the health service typically providing booking services and administrative and nursing staff.

A Medicare benefit is payable by the Commonwealth Government where the medical service is provided in a private capacity. In these cases, patients are referred to a named specialist, elect to be responsible for the cost of the treatment, and assign the Medicare benefit to the named specialist to meet the cost of the treatment. The named specialist then claims the benefit through the Medicare Benefits Schedule (MBS) system.

1.2 Findings

1.2.1 Private practice arrangements

Allowing specialists employed for the treatment of public patients to exercise a right of private practice, using public health services' facilities, serves the following purposes:

- it helps health services attract and retain skilled medical officers who could offer quality services to public patients
- it provides patients with a choice of public or private medical services.

Private practice remuneration arrangements can be classified into three broad types: a 100% retention model, a 100% donation model and a shared model. The details of specific private practice arrangements are subject to negotiation between the specialist and the health service, and therefore vary from case to case.

The level of benefit that the health service derives from private practice arrangements depends on which of the three models of private practice arrangement is used. We found private practice arrangements offer improved value for health services.

Nevertheless, there is a significant lack of transparency in regard to:

- the value of public resources being used to support the treatment of private patients in health services' outpatient clinics
- the benefits that health services derive from these arrangements.

The lack of transparency means that, while there are benefits from supporting private practice arrangements, health services are not able to enter the arrangements on an appropriately commercial basis. Assurance cannot be provided that all private practice arrangements are cost effective for the people of Victoria.

A more rigorous methodology should be developed to determine the level of net benefit each private practice arrangement offers the health service. This methodology should be used to underpin more thorough public disclosure of aggregate net benefits.

In some other Australian jurisdictions, private practice arrangements are 'capped' to limit the amount of MBS billed revenue a specialist can receive annually. This serves to limit any incentives for specialists to treat all private patients during the time they are being paid by the hospital. The absence of a cap does not suggest misuse of private practice arrangements. However, DHS and Victoria's public health services could review these interstate arrangements and consider the merits of including similar capping arrangements in future private practice agreements.

The audit did not identify instances of non-compliance with the AHCA. The health service reviewed had implemented processes to ensure compliance with its obligations under the AHCA, and the transactions examined complied with these processes. The health service provided a range of services typical of those found in large metropolitan health services.

VAGO nevertheless identified a lack of clarity and guidance on whether MBS billing for private patients treated during the hours a specialist was contracted to work under the terms and conditions of employment (i.e. during 'paid public time') was consistent with section 19(2) of the *Health Insurance Act 1973*. While there are clear provisions for private practice arrangements to be entered into, legal advice to date has been based on the premise that medical specialists are not conducting private practice during the hours of employment at health services.

Public accountability considerations warrant that systems and processes provide unequivocal assurance that legal arrangements with medical specialist are not in breach of the *Health Insurance Act 1973.*

1.3 Recommendations

The Department of Human Services should:

- seek definitive legal advice to determine whether the opinion it received from the Commonwealth—that private practice arrangements were not in breach of section 19(2) of the *Health Insurance Act 1973*—also applies when services are billed to MBS during 'paid public time', and provide guidance to health services on the matter **(Recommendation 3.1)**.
- refresh its MBS billing resource kit to provide health services with:
  - a framework to determine the total value of resources used and benefits gained in supporting private outpatient sessions
  - guidelines that assist with the formulation of fee structures for use in the facility agreements that reflect the value of the resources used **(Recommendation 3.2)**.

In future private practice agreements offered to employed specialists, health services should adopt a preferred position to act as the MBS billing agent, to improve access to data and increase transparency around financial transactions, so that they are better able to demonstrate accountability and probity in the use of public resources **(Recommendation 3.3)**.

RESPONSE provided by Secretary, Department of Human Services

Recommendation 3.1

Not accepted

Long-standing advice to the Department of Human Services from the Australian Government's Department of Health and Ageing says that '... professional services rendered by a practitioner pursuant to his or her right of private practice would be rendered under a contract between practitioner and the patient, and not by, for, on behalf of or under an agreement with the government or statutory authority that has conferred or agreed the right of private practice. That is, the provision of the service is not caught by subsection 19(2) [of the Health Insurance Act 1973].

This advice anticipates that medical practitioners and health services may enter into arrangements that provide an opportunity to conduct private practice, and that these arrangements are compliant with the Health Insurance Act 1973.

The interpretation of the Health Insurance Act that underpins this advice is widely accepted within the public health sector and supports rights of private practice in public hospitals.

RESPONSE provided by the Secretary, Department of Human Services – continued

Compliance with the Health Insurance Act is the responsibility of the Australian Government. As such, advice from the Australian Government confirming the rights of private practice are consistent with the Act has been considered definitive.

Therefore, the Department of Human Services disagrees with the conclusion in the report that 'it is possible that some health services have entered into arrangements with medical specialists that are in breach of the Health Insurance Act 1973'.

FURTHER comment by the Auditor-General

The long-standing advice from the Department of Health and Ageing (DOHA), referred to in relation to Recommendation 3.1, upon which DHS is relying, is neither definitive nor sufficient. It is general advice regarding private practice arrangements, and it does not specify the questions DHS put to DOHA to obtain the advice. In particular, the DOHA advice does not specifically address the issue of salaried medical specialists exercising rights of private practice during 'paid public time'.

That 'medical practitioners and health services may enter into arrangements that provide an opportunity to conduct private practice' does not mean that all arrangements subsequently made, are compliant.

RESPONSE provided by the Secretary, Department of Human Services – continued

Recommendation 3.2

Accepted

The Department of Human Services agrees that private practice arrangements offer improved value for health services, and should be cost effective. The department will update its 'Specialist clinics in public hospitals' resource kit to assist health services to describe this value consistently and transparently.

Recommendation 3.3

This recommendation is addressed to health services. The Department of Human Services encourages the practice that health services act as billing agents for salaried medical specialists.

2 Background

2.1 The Victorian health system

The Victorian health system includes the Department of Human Services (DHS), health services, community health centres and a number of other service agencies and entities, such as Ambulance Victoria.

Public health services provide access to free medical care for people electing to be treated as a public patient. Each health service is managed by a chief executive officer, and has an independent board appointed by the Governor-in-Council.

DHS plans, funds and delivers health, community and housing services.[1]

The Commonwealth Government contributes funds to Victoria for use in health services under the terms and conditions of the Australian Health Care Agreement (AHCA).

2.1.1 Australian Health Care Agreement 2003–2008

The AHCA is an agreement between the Commonwealth Government and the states and territories of Australia. It is the mechanism through which Commonwealth funding is provided to Victoria for the purposes of funding public health services. It is one of the Commonwealth's specific purpose payments, meaning that Commonwealth funding is 'tied' to a particular use and subject to a range of conditions. Under the terms of the AHCA, Victoria needs to meet a range of requirements, including the provision of data and information to the Commonwealth Government.

The current agreement is for the period 2003–2008. It was due to expire on 30 June 2008 however, it has been extended until 31 December 2008, at which time it is expected that a national health care agreement will take effect.

Part 2 of the AHCA outlines its principles and objectives. The primary objective of the AHCA is **to secure access for the community to public hospital services** based on the 'Medicare principles':

(a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals[2]

[1] DHS website.

[2] Health and emergency services of a kind or kinds that are currently, or were historically provided by hospitals means public hospital services as defined in this agreement.

(b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period
(c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

There are seven further AHCA objectives, the first of which is 'to improve transparency of the Commonwealth's and Victoria's financial contributions to public hospital services'.[3]

To comply with the terms of the agreement, Victoria must be able to certify that the funding received under the agreement is expended on the provision of 'public health services' (as defined in the agreement).

Part 3 of the AHCA outlines the responsibilities of the parties to the agreement. This includes clause 10(a), which states that Victoria is responsible for ensuring that public hospital services are provided in accordance with the AHCA.

2.1.2 *Health Services Act 1988*

Health services are created under the *Health Services Act 1988* for the 'carrying on of hospitals and other health care agencies and related matters'.[4] There are 18 public health services in Victoria[5], located across the state.

Under the *Health Services Act 1988*, public health services are given the status of autonomous corporate bodies. Despite this autonomy, hospitals are required to manage their activities in accordance with broad policy directives provided by the government. Section 17A of the Act empowers the Secretary, Department of Human Services to provide grants, payments, subsidies or other financial assistance to health services on the terms and conditions that the Secretary considers appropriate. Section 42 of the Act requires hospitals to comply with directions issued by the Secretary.

The requirement for Victorian public health services to comply with the principles of the AHCA stems from a number of sources. Section 17AA of the *Health Services Act 1988* provides*:*

'The principles contained in any agreement in force from time to time between the Commonwealth and Victoria with respect to the provision of public hospital services are established as guidelines for the delivery of public hospital services in Victoria.'

[3] Australia Health Care Agreement, Part 2 clause 8(a).

[4] *Health Services Act 1988.*

[5] Schedule 5 *Health Services Act 1988.*

Further, 'Victoria—public hospitals and mental health services: policy and funding guidelines 2008–09—general conditions of funding', spells out the requirements placed on health services in order to comply with the AHCA. The conditions state:

'The requirement [of health services] to meet [the Medicare] principles is absolute. There are additional obligations on Victoria that are linked to the Medicare principles.

The following is a summary of some of the additional obligations:

- *The range of services available to public patients should be no less than was available on 1 July 1998.*
- *All public hospital services available to private patients should be accessible on a public patient basis, where there is demonstrated clinical need.*
- *Eligible veterans retain the right to be treated as public patients when accessing public hospitals, notwithstanding the agreement between Victoria and the Repatriation Commission.*
- *All eligible patients must elect to receive admitted public hospital services as a public or private patient. This is to be exercised in writing in accordance with the national standards for public hospital admitted patient election process.*
- *Eligible patients presenting to public hospital emergency departments will be treated as public patients unless a third party has entered into an arrangement with the hospital or Victoria to pay for such services, such as the Transport Accident Commission (TAC), WorkSafe Victoria, or the Department of Veterans' Affairs (DVA).*
- *Pre-admission and post discharge care should be provided free of charge as a public hospital service for those patients who have elected to be public patients.*
- *Public hospitals must ensure that all relevant staff understand and comply with the obligations agreed to under the AHCA. Failure to do so could result in Victoria incurring significant penalties for not meeting one or more of the compliance requirements over consecutive years.*
- *The agreement provides that in those hospitals that rely on general practitioners for the provision of medical services (normally small rural hospitals), eligible patients may obtain non-admitted patient services as private patients where they request treatment by their own general practitioner, either as part of continuing care or by prior arrangement with the doctor.'*

DHS has issued Hospital Circular 33/2003 advising that public hospitals must comply with the Medicare principles and the related requirements of the 2003–2008 AHCA. It further provided:

'Public hospitals must ensure that all relevant staff understand and comply with the Medicare principles and the other requirements of the AHCA. They must ensure that any complaints relating to potential breaches of the Medicare principles or the AHCA are managed at senior levels. Public health services, public hospitals and multi-purpose services should consult with the Department of Human Services before taking action that might be construed as a breach of the Medicare principles or the AHCA.'

These requirements were reiterated in Hospital Circular 34/2004.

A cornerstone of public sector accountability is being able to demonstrate value for money and fair and equitable use of available resources for public benefit. Accordingly health services should have a transparent accountability framework in place. Under such a framework, DHS would be expected to be responsible for:

- providing both sector-wide and individual, entity specific directions and guidelines to public hospitals
- monitoring the effectiveness of those directions in operation.

2.1.3 Statements of priorities

The Minister for Health and the chair of each of the health services enter into an annual agreement—the statement of priorities (SoP)—which is required under section 65ZFA of the Health Services Act 1988. The SoPs for each health service have replaced the former annual health service agreements and are the key accountability agreements between the government and individual health services. The SoP outlines the annual funding allocation for the health service and establishes performance targets. It specifically requires the health service to comply with:

- all laws applicable to it
- the requirements of the AHCA
- all applicable requirements or terms and conditions of funding specified in the policy and funding guidelines
- all applicable policies and guidelines issued by DHS from time to time and notified to the health service.

2.2 Outpatient services

Outpatient services are those services provided to patients not admitted into a hospital bed. There are a large number of specialties covered by outpatient services, including cardiology, neurology, oncology, allied health and diagnostic services.

Public hospital-based outpatient services are a core part of the acute healthcare system. Along with emergency departments, they act as a major pathway for people to access inpatient care, including elective surgery. Outpatient services also perform an important preventative role through the early diagnosis and management of medical conditions, potentially reducing the demand for inpatient services.

Outpatient services are one of the more common ways for people to come into contact with public hospitals, and they provide access to inpatient care. They provide access to free specialist services, which include medical assessments, management of chronic conditions, consultations prior to admission to hospital, diagnostic tests, and medical care following discharge from hospital. In addition, outpatient services are an important training ground for medical students, residents and registrars.

2.2.1 Funding of outpatient services in public hospitals

Specialist outpatient services are funded by the Victorian and the Commonwealth Governments.

The Victorian Government distributes funds for the provision of health services, including a range of specialist medical outpatient clinics, primarily through the Victorian Ambulatory Classification System (VACS). Two other types of grants are paid by the Victorian Government to health services for non-admitted services outside VACS: one grant for emergency departments, and the second for other non-admitted services, including specialist outpatient services.

The Commonwealth funds the provision of specialist medical care where the service is provided in a private capacity. In these cases, patients elect to see a specific specialist, who then recovers the cost of the consultation through the Medicare Benefits Schedule (MBS) system.

In recent years there has been a trend for an increasing number of public hospital outpatient clinics to provide private services. Many of the MBS billed clinics are now located within public hospital outpatient departments.

For a hospital to meet the requirements of the AHCA—in particular the Medicare principles—it must ensure that 'all public hospital services available to private patients should be accessible on a public patient basis, where there is demonstrated clinical need'.

The AHCA requires that eligible patients receiving care in outpatient departments at public hospitals must be treated 'free of charge'—the hospital cannot charge either the patient or the MBS for the treatment—except where:

- there is a third-party arrangement with the hospital or Victoria to pay for such services (such as an employer or insurer)
- the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient (see section 2.2.3 below).

Public hospitals must ensure that patients are given the choice to access, as public patients, any outpatient services provided by the hospital. Hospitals must also ensure that patients are not required to have a private referral as a prerequisite to accessing these outpatient services, and that services available to private patients should be accessible to public patients where there is a demonstrated clinical need.

2.2.2 Victorian ambulatory classification system

Services at outpatient clinics are provided free of charge to public patients. Some of the funding for these services is provided through the Victorian Ambulatory Classification and Funding System (VACS). Introduced in 1997, VACS is an output-based funding system for outpatients that parallels the use of the output-based casemix funding arrangements for inpatients.

VACS is a classification system based on 35 weighted medical and surgical clinical specialties and 11 unweighted allied health specialties.

There are four components of the VACS funding:

1. base grant for fixed or non-variable activities
2. variable grants for medical and surgical encounters and allied health occasions of services
3. teaching grant for teaching and training
4. specified grants for services that are relatively specialised and cannot be readily classified into the normal categories of outpatients.

Health services are funded up to particular targets, with targets being set separately for medical and surgical services, and for allied health services. The VACS targets are based on the number of weighted encounters and occasions of service within outpatient clinics. Hospitals advise DHS of proposed new outpatient clinics throughout the year, which are submitted annually to the VACS Clinical Panel for approval.

In 2006–07 the total outpatient budget for Victoria, excluding those associated with the Department of Veterans Affairs, but including block funding, was $400 million, or 8.7 per cent of the total hospital expenditure in Victoria.

DHS undertook a review of the VACS in 2007–08, as part of its Outpatient Improvement and Innovation Strategy and is currently considering the following changes:

- VACS activity targets will be set and administered at the health service level
- endorsed nurse practitioners will be entitled to claim medical/surgical VACS payments
- reporting of private (MBS billed) outpatient activity to enable future allocation of the VACS teaching grant on a total activity basis.

During 2008–09 further work will be undertaken to:

- develop funding weights that span medical/surgical and allied health categories
- develop options for conversion of the base grant to variable funding
- continue transition to variable funding of eligible specified grants
- consider the establishment of reform and innovation funds on a recurrent basis
- establish projects to undertake and evaluate early assessment and linkage (EAL) clinic trials.

In 2008–09 encounters (visits to a clinic generally involving a specialist) are funded at $167 and allied health occasions of service (visits to a clinic not involving a specialist) at $59.

Further details on the VACS and the outcomes of the review are outlined at www.health.vic.gov.au/vacs.

2.2.3 MBS billed specialist medical services

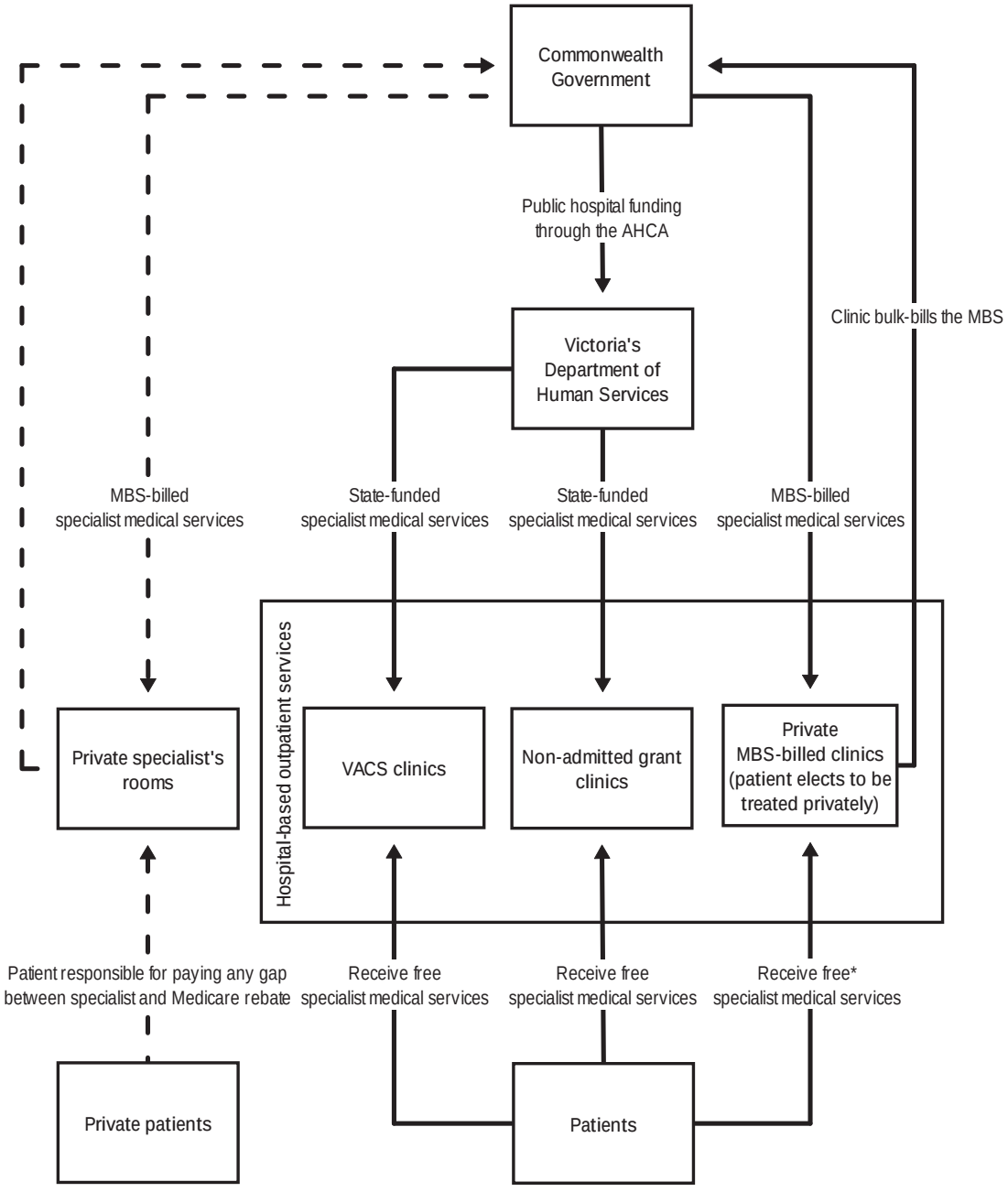
In some health services, medical specialists may lease space within the hospital premises to run private specialist services. Commonly termed the 100% retention model, these services are usually physically separate from the health service's outpatient department. They use no other hospital resources (such as staff and administration) and conduct their business 'at arm's length' from the health service.

All specialists providing services to private patients, whether within hospital grounds or at another location, bill the MBS for the services they provide. These services are illustrated on the left of Figure 2A.

A health service may permit its employed medical specialists to exercise a right of private practice, using public hospital facilities and resources. Private practice arrangements occur when a health service allows a medical specialist to provide services as an individual, rather than as a health service employee. These services to private patients are provided within a public hospital's outpatient department, with the health service typically providing booking services, and administrative and nursing staff. However, the specialists bill the MBS for the services they provide to private patients.

Prima facie, the practices of private specialists in MBS billed clinics do not fall within the scope of the Victorian Auditor-General's Office audit mandate under the *Audit Act 1994*. However, VAGO may examine the legal and financial aspects of those arrangements, where health services have allowed their employed specialists to exercise rights of private practice using the hospital's facilities or during their employment. This audit looked at payments to specialists by the hospitals under private practice arrangements, and, in entering such arrangements, the health service's compliance with the requirements of relevant legislation.

Figure 2A
Commonwealth and state funding responsibilities for specialist medical services



*Patient is responsible for paying any gap between specialist and Medicare rebate

Source: Victorian Auditor-General's Office, 2008.

2.3 Audit objective and scope

This audit examined the payment arrangements for specialists employed by a health service exercising private practice rights in outpatients' clinics and whether they were consistent with relevant requirements. It examined the arrangements at one public health service, which provides services typical of those offered in other public health services. As private practice arrangements are widely used in Victoria, the findings and recommendations of this audit should be considered by all public health services.

The audit examined whether the private practice arrangements at the health service comply with legislation and policy.

This audit was performed in accordance with Australian Auditing Standards applicable to performance audits, and included tests and procedures sufficient to allow for audit conclusions to be reached. The total cost was $128 000. This cost includes staff time, overheads and printing.

3 Private practice arrangements

At a glance

Background

Victorian public health services may grant medical specialists, as part of their employment contracts, a right of private practice to attend to private patients.

There are three typical models of private practice arrangements, with differing levels of support provided by, and financial benefits for, health services.

Key findings

- The introduction of private practice arrangements has assisted in the recruitment and retention of medical specialists into the public health system. However, there is insufficient transparency regarding the resources used and the benefit obtained through these arrangements.
- The current 'facility fee' rate of $110 per session at the audited health service does not cover actual costs.
- The audited health service had established processes for ensuring compliance with the Australian Health Care Agreement.

Key recommendations

The Department of Human Services should:

- seek definitive legal advice to determine whether the opinion it received from the Commonwealth—that private practice agreements were not in breach of section 19(2) of the *Health Insurance Act 1973*—also applies when services are billed to MBS during 'paid public time', and provide guidance to health services on the matter **(Recommendation 3.1)**.
- refresh its MBS billing resource kit to provide health services with:
  - a framework to determine the total value of resources used and benefits gained in supporting private outpatient sessions
  - guidelines that assist with the formulation of fee structures for use in the facility agreements that reflect the value of the resources used **(Recommendation 3.2).**

In future private practice agreements offered to employed specialists, health services should adopt a preferred position to act as the MBS billing agent, to improve access to data and increase transparency around financial transactions, so they are better able to demonstrate accountability and probity in the use of public resources **(Recommendation 3.3)**.

3.1 Private practice arrangements

Full-time and visiting medical specialists working in Victorian public hospitals may be allowed to also attend their private patients, including in ward sessions, surgery and clinics. This right of private practice may be granted to specialists as part of their employment contract.

Private practice arrangements are used in all Australian states and territories. Allowing the specialists it employs to treat public patients and exercise a right of private practice using the hospital's facilities serves, the following purposes for the health service:

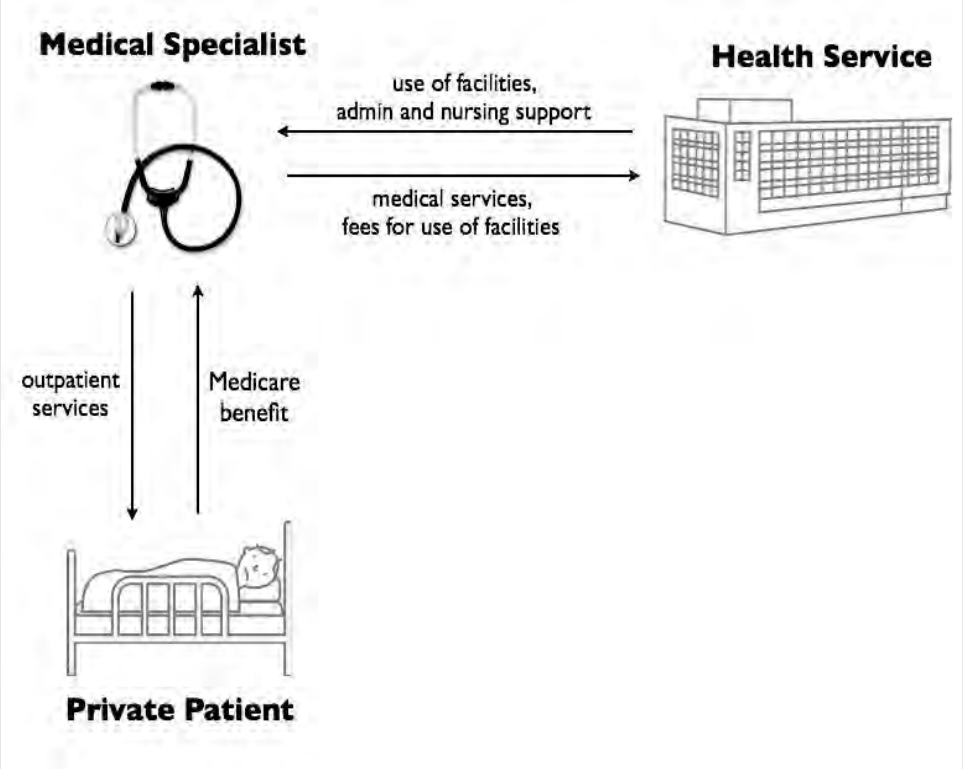
- it assists in the recruitment and retention of skilled medical officers who can offer quality services to public patients
- it provides patients with a choice in the services they access.

3.1.1 Remuneration models

Agreements establishing private practice arrangements used in Victorian health services generally align with one of three remuneration models—100% retention model, 100% donation model and shared model. These models are summarised in the following figures.

Figure 3A
Model 1 – 100% retention model

Under the 100% retention model, which is sometimes referred to as a 'facility agreement', a medical specialist retains all income derived through his or her MBS billing of private outpatients. There is usually an agreement between the specialist and the health service that provides the health service with a facility fee in exchange for giving the specialist access to staff, facilities and equipment at the health service. This fee is generally a flat rate charged per session.



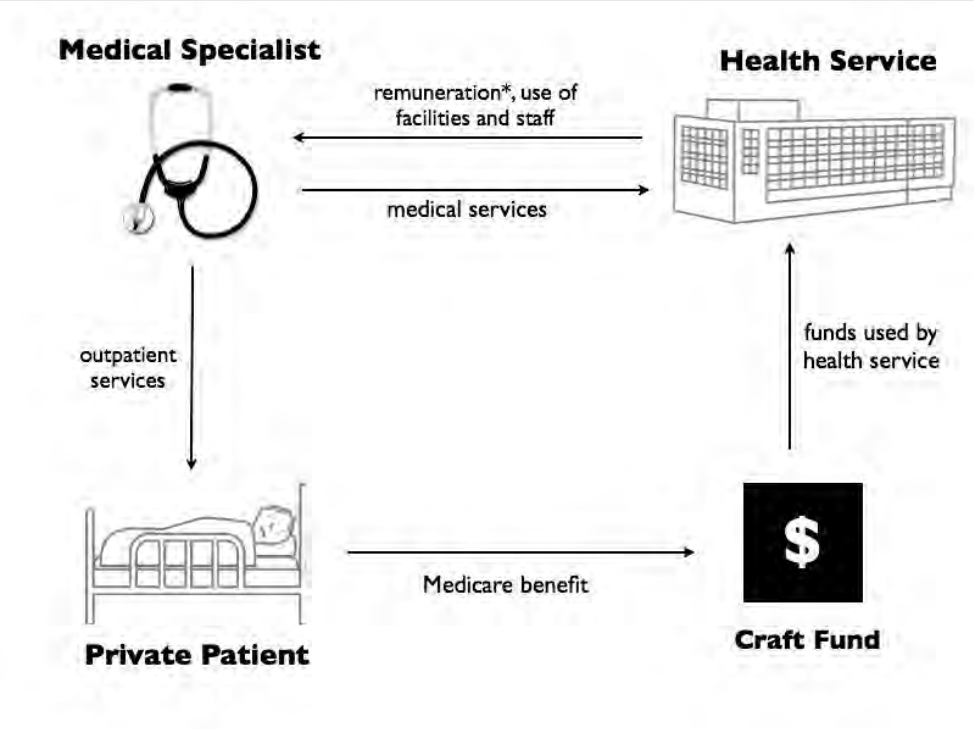
Source: Victorian Auditor-General's Office, 2008.

Figure 3B
Model 2 – 100% donation model

Under the 100% donation model, all funds generated through MBS billing of private patients are 'donated' to the health service. In exchange, the health service gives the specialist free access to the staff, facilities and equipment to support the treatment of private patients, as well as a negotiated additional salary (or sessional rate) to compensate for the foregone MBS income. Under this model, the specialist has access to medical indemnity insurance through the Victorian Managed Insurance Authority. It is common for the specialist to authorise the health service to act as an agent for the purposes of billing the services to the MBS, which also enables patients' MBS billed clinic records to be integrated with their hospital records.

Medicare benefits donated to the health service under this model are held in a special purpose fund according to the specialist's craft group. Funds in these 'craft accounts' are used by the health service at the discretion of management, although the individual specialist may negotiate particular types of expenditure allowed from the account.

This model is more common with specialists employed by the health service on a full-time basis.



**Note:* remuneration includes salary for permanent medical officers, or sessional or fee-for-service payments to visiting medical officers, plus an allowance (or 'additional salary') paid in consideration of the MBS benefits being retained by health service.

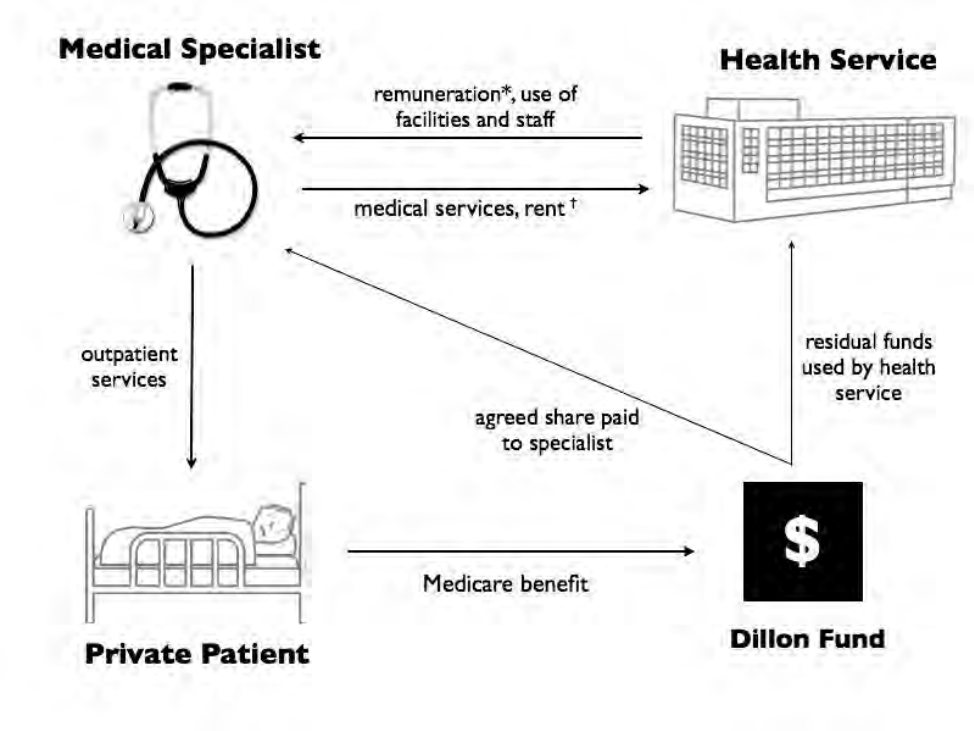
Source: Victorian Auditor-General's Office, 2008.

Figure 3C
Model 3 – shared model

The more common remuneration model involves an agreement to share the revenue derived from MBS billed services between the specialist and the health service. The health service provides administrative support, including appointment bookings, staff, facilities and equipment in return for a percentage of the Medicare benefit assigned by the patient.

Commonly, the health service is authorised to act as agent in claiming Medicare benefits, which it then places in a special purpose fund, known as a 'Dillon account'. A separate Dillon fund is maintained for each specialist. Fund proceeds are regularly distributed to the specialist according to the agreed sharing arrangements, with the residual available to the health service.

This model is more common for specialists employed by the health service as visiting medical officers (VMOs) but is used by some full-time specialists.



Note: * remuneration includes salary for permanent medical officers, or sessional or fee-for-service payments to visiting medical officers

Note: † A separate rental payment for use of facilities may or may not be included in the contractual arrangements under this model

Source: Victorian Auditor-General's Office, 2008.

These remuneration models are typical of arrangements used across Victoria and other states. Particular arrangements are subject to negotiation between the specialist and the health service and may, therefore, differ in some details from the above descriptions.

DHS has recommended that public health services use the 100% donation model, but its resource kit for MBS billed services notes that decisions about specific remuneration models must occur at the level of the individual public hospital or health service. DHS advises public health services that they should seek their own legal, financial and industrial advice on the impacts of particular remuneration models and also consider their ability to recruit and retain a skilled specialist medical workforce.

The audited health service employed 120 medical specialists with rights of private practice. Almost half of the private practice arrangements aligned with the 100% retention model, also known as the facility agreement. About one quarter used the DHS-recommended 100% donation model, and the remainder used the shared model—a handful of which also included payment of a facility fee per session.

3.1.2 Contractual arrangements

The contractual arrangements with individual specialists to effect these private practice arrangements involve:

- an employment contract, which includes the granting of the right of private practice
- a private practice agreement, which sets out sharing arrangements and nomination of special purpose fund
- special purpose fund agreement, which sets out how the fund may be used.

At the health service examined, the employment contracts for individual specialists incorporated the more detailed terms and conditions of an agreement reached between the health service and the Australian Medical Association (Victoria) and the Australian Salaried Medical Officers Federation. This ‘Hospital Specialists Agreement’ sets out minimum rates of pay for specialists employed by the health service, based on classification and period of service.

For salaried full-time medical specialists, the agreement specifies a lower minimum salary for those granted a right of private practice, reflecting the ability for these specialists to earn additional income through private practice. For visiting medical officers, the calculation of hours for which they are paid a minimum sessional rate, specifically excludes time spent providing services to private inpatients, but includes time spent providing services to private outpatients.

3.2 Value for money

We examined whether the practice of using public resources in private outpatient clinic sessions represented value for the state.

Within the context of increasing demand for public hospital services, especially in areas of high population growth, budget constraints, increasing difficulties in attracting necessary medical specialists, health services have had to become more innovative in how they deliver quality public health services more effectively and efficiently.

The ability to negotiate private practice arrangements has emerged as an integral part of the overall employment package for specialist medical staff. The introduction of the private practice arrangements has assisted in the recruitment and retention of medical specialists into the public health system, which is a logical step towards improving public health services.

Health services are able to use the income derived from these arrangements according to the terms of the special purpose fund agreements. These agreements generally provide the health service a wide discretion to use funds in areas, such as training and research, equipment, and staff.

These arrangements also provide value to patients. Co-location of MBS billed clinics with public hospitals can:

- assist public health services attract and retain skilled medical officers who could offer quality services to public patients
- provide patients with a choice of either public or private medical services.

Following the 2006 Health Options Review, the government endorsed a reform program that included an initiative for further privatisation of outpatient services, to access Commonwealth MBS funding. A key priority identified by DHS[1] in the area of outpatient reform is 'support the implementation of *Specialist clinics in public hospitals: a resource kit for MBS billed services*'. Where outpatient services funding models take account of actual or potential MBS billing revenue, DHS should be better informed of the value of public resources used in supporting the treatment of private patients in public outpatient clinics.

Measuring benefits of private practice arrangements

The financial benefits to the health services from each of the remuneration models depend on the specific arrangements negotiated with the specialists—in particular, any additional salary paid to the specialist under the donation model, the agreed sharing arrangements under the shared model, and the fee charged for use of facilities. At the health service examined:

- there was no framework for determining which remuneration model was best suited to each specialist's arrangements
- there was no evidence that the 'fee' paid by the medical specialists as part of the facility agreements for the use of facilities, staff and other services reflected the real value of public resources being used
- there was no allocation methodology used under the 'shared model' to determine an appropriate percentage share between the health service and specialist—all specialists received the same proportional allocation with no adjustment for individual circumstances.

[1] DHS *Policy and funding guidelines, 2008-09*.

In 2007, as part of its ongoing internal audit processes, the health service reviewed its private practice arrangements. It found that the business processes and controls surrounding the private practice arrangements were adequate, with a focus on compliance with the legislation and better practice. Six risk areas that warranted further action were identified:

1. lack of internal guidelines regarding private practice requirements
2. lack of analysis to determine appropriate facility fees
3. several billing discrepancies (instances where billing that should have been charged was not)
4. some special purpose fund agreements had expired and had not been renewed
5. lack of relevant taxation information in the special purpose fund policy
6. lack of a master file of all private practice agreements.

The health service had agreed to address the risks identified by the end of 2007 and early 2008. We found that these actions had been completed. The implementation of actions from the review were appropriately overseen by the internal audit committee, which has established a monitoring and reporting framework for tracking the progress of action implementation for such reviews.

For ‘facility agreements’, where the medical specialists conduct their private practice completely separately from the services they provide to the hospital, the fee charged for the use of facilities should reflect the commercial value of the resources used. We found that while DHS has an expectation that commercial arrangements would be in place, there was no guidance for health services on this matter, or monitoring of these arrangements by DHS. Given the resources used include premises, equipment, nursing and administrative staff, a fee of $110 per session is most unlikely to reflect the true value. While a discounted or ‘below cost’ fee could be justified in some circumstances as part of collateral arrangements with a specialist, the health service was unable to provide us with any substantiation that its fee structure reflected economic value to the state. While the health service advised it had compared its fees with those charged by other health services, it was not established the fees reflected commercial value.

Under the donation and shared models, the use of private practice arrangements relied on the assumption that treatment of private patients on ‘public time’ only represents a small component of all services performed during their employment. This is *ex ante* a reasonable assumption. The employment contracts at the health service state that the specialist is employed to primarily deliver services to public patients. The standard private practice agreements also include a clause that the specialist agrees to conduct any private practice in a manner that will not interfere with the specialist’s duties and responsibilities as a full-time employee of the hospital, which is an overriding obligation. The employed specialists are also required to meet duty rosters for outpatient sessions and theatre lists.

In 2007–08 the total revenue accruing to the health service from charging facility fees and sharing of MBS benefits under the various private practice arrangements was almost $1 million.

The health service did not have a methodology in place for measuring the value of resources it provided in supporting these private practice arrangements. While the health service had sufficient mechanisms for recording the time specialists were treating private patients, there was no mechanism to measure how much of these private treatments occurred during the hours for which the specialist was paid by the health service under their employment contract (i.e. during 'public time'). The health service is, therefore, unable to effectively assess whether the overall remuneration of individual specialists reflects value for money.

3.3 Compliance

3.3.1 Compliance with the Australian Health Care Agreement

The Australian Health Care Agreement (AHCA) requires that funding provided to Victoria under the agreement be expended on 'public hospital services'. This is not defined as a technical or legal term. The Commonwealth has been aware of private practice arrangements being used by public hospitals across Australian states and territories for many years and has included references to these arrangements in its guidance material. It is understood that hospitals attracting specialists to the public health system by entering private practice arrangements is an ancillary part of their function to provide public hospital services.

Victorian health services must comply with the *Health Services Act 1988*, funding agreements with DHS, the statement of priorities agreed with the Minister for Health, and other directions and guidelines issued by the Minister or Secretary of DHS. Through these mechanisms, health services are also required to comply with the Medicare principles and other obligations in the AHCA (see Part 2).

The health service had implemented a range of processes to comply with the AHCA obligations. There were checks in place to verify that patients electing to be treated as private patients had the necessary referrals and had properly made that election. The health service had high-level controls in place to ensure that all outpatients' services provided by its specialists were available to public patients.

Where the health service acted as MBS billing agent for the specialist, compliance with AHCA obligations was appropriately checked by the health service before lodging the MBS claim and also before disbursing any income to the specialist. The health service had relied on guidance contained in the DHS resource kit in establishing these compliance measures.

The sample of MBS billing reviewed by VAGO was found to meet the established requirements satisfactorily.

3.3.2 Compliance with other requirements

The *Health Services Act 1988* gives health services all necessary powers to enable the hospital to carry out its objects, and do all things it is required, or permitted to do under the Act. Other documentation does not prevent a health service entering private practice arrangements with its full-time or visiting medical officers, or providing use of the hospital's facilities and staff to support the treatment of private patient outpatient departments. Indeed, DHS has issued guidance material to health services to assist them in establishing and running MBS billed clinics and entering into private practice agreements. Hospitals advise DHS of proposed new outpatient clinics throughout the year, which are submitted annually to the VACS Clinical Panel for approval.

As previously noted, salaried full-time specialists and visiting medical officers (VMOs) paid on a sessional basis sometimes attend to private patients during the time that they are being paid by the health service (i.e. on public time). This is consistent with their employment contracts, which specifically grant the right of private practice both within and outside normal working hours.

The question, however, arises as to the compliance of this practice with the *Health Insurance Act 1973*, and in particular section 19(2) which provides:

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

While compliance of section 19(2) is primarily a matter between the specialist and the Commonwealth, by being both employer and billing agent for the specialist, the health service is in a position to identify where MBS billing is not in compliance with the Act. Compliance with the Act is also pertinent for DHS, as it has issued guidance material to health services on the use of private practice arrangements, including statements that the arrangements are consistent with the Act.

Written advice from the then Health Insurance Commission (now Medicare Australia) indicates that section 19(2) is not violated merely because billing of private patients occurs under the exercise of a right of private practice granted under a specialist's employment contract. This is because the employment contract grants permission to attend—and therefore bill—private patients, but does not, outside of the services of employment, create any contractual or other agreement obliging the specialist to render any particular service to any particular private patients.

Where a specialist attends a private patient, during the time they are required to provide services to the health service under their employment contract (i.e. during public time), these services could be construed as being rendered 'under an agreement with' the health service, which would be in breach of section 19(2). The written advice from the Health Insurance Commission, and guidance provided by DHS to health services did not explicitly address MBS billing during public time.

One interpretation is that every service performed by a specialist during their contracted hours of employment is a service rendered under agreement with the health service, and would therefore be captured by section 19(2). Alternatively, the remuneration paid to specialists could be seen to secure their availability at the hospital for a specified number of hours without requiring any particular medical services to be provided.

Ultimately, compliance will depend on what the specialist is specifically employed to do under the terms of their employment contract. A sample of employment contracts reviewed did not provide sufficient clarity on the obligations of employment. While the contracts specified that a specialist is employed for a certain number of hours per week, the performance of any particular medical service is at the discretion of management, primarily through the roster system for clinics and theatre lists. It is unclear if treating private patients within the paid hours of employment, but after all other duties assigned to the specialist during their employment have been completed, is sufficient to be regarded as a service rendered under an agreement with the health service.

Neither DHS nor the health service has obtained explicit legal advice on this specific matter; instead they have presumed that previous advice extends to the situation where private practice occurs during public time. Guidance material issued by the Commonwealth and Victorian Governments is unclear or silent on the situation where private patients are seen during public time.

The lack of legal certainty does not relate to the situation where medical specialists perform services for the public hospitals under a fee-for-service arrangement. Obtaining a fee for performing a particular and specific medical service on a particular patient for the hospital, and then claiming a Medicare benefit for the same service, would be a clear breach of section 19(2). We saw no evidence that this had occurred.

The health service undertakes regular internal audits of all fee-for-service payments to verify that the payments made by the health service relate to public patients.

3.4 Conclusions

Overall, we are satisfied that the private practice arrangements offer benefits for the health services. Private practice arrangements are entered into for the purpose of attracting and retaining skilled medical specialists, and realising efficiencies in the use of facilities and equipment, thereby, enhancing the health services available to the public by the hospital. The increased use of such arrangements across all states and territories would suggest they are a way to cost-effectively deliver quality public hospital services.

Nevertheless, there is a lack of transparency in the value of public resources being used to support the treatment of private patients in outpatient clinics, and the value of benefits to the health service derived from these arrangements.

A more rigorous methodology should be developed to determine the level of net benefit each private practice arrangement is likely to offer to the health service. This methodology would be more robust if health services captured and analysed data on the level of private outpatient services performed by employed specialists.

DHS reviewed VACS in 2007–08. As a result, from 2008–09 it is likely that there will be reporting of private (MBS billed) outpatient activity to enable future allocation of VACS teaching grants on a total activity basis. Collecting and publishing this and related data will generate wider benefits, as health services and other interested parties will be able to better gauge the impact of private practice arrangements, and the costs and benefits of these arrangements would be made more transparent. DHS should ensure that data are captured on a consistent basis, which would be aided by health services acting as billing agents for all MBS claims made by its specialists.

In some Australian jurisdictions, private practice agreements have ‘capped’ the amount of MBS billed revenue a specialist can receive annually. This serves to limit any incentives for specialists to treat all private patients during the time they are being paid by the hospital. The absence of a cap does not suggest misuse of private practice arrangements. However, DHS and Victoria’s health services could review these interstate arrangements and consider the merits of including similar capping arrangements in future private practice agreements.

The private practice arrangements and procedures at the examined health service were in compliance with the obligations of the AHCA. Guidance material provided to health services by DHS was found to be useful in making the health service aware of their obligations under the AHCA.

However, there was an absence of definitive legal advice and guidance to health services that deals explicitly with whether employed specialists attending to private patients and billing the MBS during public time is consistent with the *Health Insurance Act 1973*.

In this context of a lack of transparency and legal certainty, it is possible that some health services have entered into arrangements with medical specialists that are in breach of the *Health Insurance Act 1973*.

Recommendations

The Department of Human Services should:

3.1 Seek definitive legal advice to determine whether the opinion it received from the Commonwealth—that private practice arrangements were not in breach of section 19(2) of the *Health Insurance Act 1973*—also applies when services are billed to MBS during 'paid public time', and provide guidance to health services on the matter.

3.2 Refresh its MBS-billing resource kit to provide health services with:

- a framework to determine the total value of resources used and benefits gained in supporting private outpatient sessions
- guidelines that assist with the formulation of fee structures for use in the facility agreements that reflect the value of the resources used.

3.3 In future private practice agreements offered to employed specialists, health services should adopt a preferred position to act as the MBS-billing agent, to improve access to data and increase transparency around financial transactions, so they are better able to demonstrate accountability and probity in the use of public resources.

Appendix A. Glossary

Australian Health Care Agreement

AHCA is an agreement between the Commonwealth Government and the states and territories of Australia on the provision and funding of public hospital services to the community. It is a multi-lateral agreement that requires all states and territories to agree to the terms before each of state enters into an individual agreement with the Commonwealth.

Department of Human Services (DHS)

DHS is the Victorian Government department responsible for planning, funding and delivering health, community and housing services in Victoria.

Health service

A health service is an entity created under the *Health Services Act 1988* (Vic) for the carrying on of hospitals and other health care agencies.

Medicare benefits schedule (MBS)

The MBS is a listing of the Medicare services subsidised by the Australian Government. The MBS is part of the wider Medicare benefits scheme managed by the Commonwealth Department of Health and Ageing and administered by Medicare Australia.

MBS-billed service

MBS-billed services are medical services provided to a patient who elects to be seen as a private patient.

Medicare Australia

Medicare Australia is a prescribed agency under the *Financial Management and Accountability Act 1997* (C'wealth) and is a statutory agency under the *Public Service Act 1999* (C'wealth), within the Commonwealth Department of Human Services. Before 1 October 2005, Medicare Australia was known as the Health Insurance Commission.

Medicare benefit

A Medicare benefit is an entitlement payable to patients to meet medical expenses, other than patients that elect to be treated as a public patient in a public hospital. Under bulk-billing arrangements, the entitlement to receive a Medicare benefit is assigned to the specialist to cover medical costs, with the specialist responsible for billing the MBS.

Outpatient

Outpatients are any patients not admitted into a hospital bed. Outpatient services may include day surgery, diagnostic services, oncology and neurology.

Private patient

A private patient is a patient that has been referred to a specific specialist and elects to be responsible for meeting the costs of the medical services. In most cases, the costs are effectively met by the Medicare benefit and private health insurance.

Public patient

A public patient is a patient that elects to receive medical treatment free of charge in a public hospital.

Public time

Public time refers to the hours for which a medical specialist is paid under an employment contract with a health service.

Victorian Ambulatory Classification System (VACS)

VACS is an output-based funding system for outpatient services provided by public hospitals. It is administered by the Department of Human Services.

Visiting medical officer (VMO)

A VMO is a medical practitioner appointed by a hospital board to provide medical services for hospital (public) patients on an honorary, sessionally paid, or fee-for-service basis.

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