

Better Practice Guide

A Guide to Integrated Private General Practice

November 2023



Queensland Country Practice
Incorporating the National Rural Generalist Coordination Unit
Advancing rural health solutions



**Queensland
Government**

Version Control

Version	Date	Comments
1.0	22 February 2023	First release
1.1	3 November 2023	Updates to reflect 2023 federal budget announcements and new Queensland government certified agreements (including MOCA6). Editorial changes

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Better Practice Guide – A Guide to Integrated Private General Practice

Published by the State of Queensland (Queensland Health), 3 November 2023



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Disclaimer

This document is intended for the use of Hospital and Health Services and their officers in considering and developing service improvement options. Whilst all care has been taken in the consideration of and inclusion of references to relevant legal instruments, policies and guidelines, it does not replace the due diligence responsibilities of the relevant accountable officers in ensuring service changes meet all legal, policy and change management requirements and obligations. The workforce and income projections supplied are intended as a guide only.

A guide to Integrated Private General Practice

Introduction

This guide has been developed to support the design and implementation of integrated private general practice models that share local medical workforces to deliver both primary and secondary care in rural and remote communities. It is intended to inform business proposals where Hospital and Health Services (HHSs) become involved in the delivery of private general practice, or where necessary, operate and oversight a general practice until another private general practitioner is attracted to the community or as an ongoing service.

General practice models of care focus on maintaining patient wellbeing through preventative interventions, first response to accident and illness and whole of life care for patients with chronic conditions. General practice not only complements the clinical capabilities of rural hospitals, but actively reduces preventable presentations and avoidable hospitalisations.

Bringing general practice and hospital care together using an integrated workforce model is critical to delivering sustainable access to both primary and secondary care services in rural and remote areas due to the fragility of a small medical workforce. An integrated workforce model enables improved coordination of patient care, better allocation of resources to health care that delivers the greatest benefit and provides the necessary professional support and clinical variety that is more likely to attract and sustain a rural medical workforce.

Integrated workforce models involving granted private practice should not be pursued solely as an own source revenue opportunity. An accredited and well managed practice can not only provide a strong financial dividend but also help to strengthen the sustainability of smaller rural hospitals.

This guide brings together the requirements of applicable legislation and a number of important Queensland health policies and directives, and further elaborates on the arrangements prescribed in QH-HSD-044:2014 Private practice in the Queensland public health sector¹ as they apply to private general practice.

Whilst having a general applicability across Queensland, this guide is targeted towards regional, rural and remote centres where medical shortages are most acute, access to primary general practice is fragile or has failed and the opportunity to share and connect local health providers is greatest.

This better practice guide has been developed by Queensland Country Practice as the jurisdictional National Rural Generalist Coordination Unit in Queensland with the funding made available from the Australian Government Department of Health and Aged Care. Queensland Country Practice also acknowledges the contributions and assistance of practitioners and staff across Queensland Health.

¹ www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/private-practice-in-the-queensland-public-sector

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Part A: Framework for Integrated Private General Practice

More than a third of Queenslanders live in regional, rural and remote areas, who experience higher rates of hospitalisations, deaths and injury, and have poorer access to primary health care services, than people living in major cities².

Despite a range of government incentives and support packages designed to encourage rural practice, maldistribution of doctors continues to compromise access to primary health care for many rural communities. Recruitment and attraction challenges have impacted the availability and sustainability of services in our hospitals and pushed the viability of rural general practice to its limits. The lack of general practitioners in the bush is leading to reduced access to planned and preventative care for patients, increased preventable presentations in our hospitals, an increase in the cost of care, and a decline in patient wellbeing and quality of life.

1. Responsibility for Primary Care

The provision of primary health services in Australia is governed by a complex system of policies and funding arrangements between Commonwealth, State, and Territory governments. The National Health Reform Agreement (NHRA) 2020-2025³ outlines the responsibilities for the Commonwealth, State, and Territory jurisdictions.

The Commonwealth is largely responsible for funding and supporting GPs and primary health care services (including lead responsibility for Aboriginal and Torres Strait Islander Community Controlled Health Services), Medicare and the pharmaceutical benefits scheme, aged care services, veterans' health and regulating private health insurance. State and territory governments are mainly responsible for system management of public hospitals, oversight of Local Hospital Network performance, and public health services. Governments have a shared responsibility for funding public hospitals, exploring innovative models of care in the national funding model and closing the gap in Aboriginal and Torres Strait Islander health.

The split funding responsibilities of governments divides medical service in community primary care (general practice) and hospital secondary care sectors; into private and public sectors. The consequence of this division is acutely evident in smaller communities that lack economy of scale and have few general practices.

General practice plays a central role in the delivery of health care in the Australian Community⁴. A general practitioner is likely to be the first point of contact for personal health matters. The general practitioner takes a whole person approach to care, managing patient care over the period of their lifetime and coordinating the care of a patient with other health practitioners, specialists and local hospitals. General practitioners conduct a practice as a business, employing staff and contributing economically to the local community.

² The Health of Queenslanders 2022, Report of the Chief Health Officer Queensland

³ www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra

⁴ Adapted from RACGP What is a General Practice, www.racgp.org.au/education/students/a-career-in-general-practice/what-is-general-practice (accessed 6 October 2022)

Many communities have now experienced the closure of private general practice as doctors retire or move from these rural communities without practice succession. Low levels of interest in owning a practice and taking on the responsibilities of a business and employer, combined with limited business acumen, are significant barriers to achieving general practice succession in the rural sector, (and is also apparent in the corporatisation of general practice in large regional and metropolitan areas).

The impact of general practice decline (and in some cases the complete absence of general practice) creates a service, fiscal, and health crisis for the community as:

- People have no regular health checks or chronic disease management, and in many cases no regular doctor at all.
- Attending the secondary or hospital service is the only available option for people who become unwell. Episodic healthcare that is provided in a hospital emergency or outpatient department setting results in a general decline in overall health status within the community.
- Hospitals are geared to treating illness or accidents quite expertly, however primary care is the service that follows up on maintaining health and treating ongoing conditions.
- Very few people, if any, attend a hospital for a check-up as presentations are mainly for ill health. Patients may not be able to make appointments at the hospital and may be unwilling to wait to see a doctor, deferring attention to any growing health problems.
- Commonwealth funding into a community declines due to lower or absent Medicare billing. This defaults healthcare completely to the State and directly impacts the budgetary integrity of the HHSs for presentations that would normally be managed through general practice.
- The decline is cyclic in that declining general practice defaults in presentations to the hospital, whilst at the same time causing a decline in overall health status which in itself increases the need for medical care.

As a consequence of rural general practice closures, HHSs become the default provider of primary care with insufficient policy, guidance, expertise or capacity to do well in the private primary (general practice) sector. HHSs frequently have to expand emergency department and outpatient services to meet the episodic needs of patients and expand nurse-led community health services wherever possible.

Some HHS have established primary care clinics attached to the hospital to respond to the limited access to general practice services. Limited exemptions have been approved by the Commonwealth Health Minister that permit smaller hospitals to bulk-bill Medicare for some non-admitted presentations (see section 3.4 below). These policy departures were granted because these communities had little or no access to a general practitioner.

Medicare billing for primary health care is vastly different to the acute service funding of hospitals and private specialist care delivered in public hospitals. Hospital doctors and support staff may only have a broad understanding of the Medicare Benefits Schedule, its compliance rules and the supporting processes needed to efficiently and effectively bill for services provided. Incomplete and sub-optimal Medicare billing results in a loss of Commonwealth healthcare funding and shifting of cost to State hospital budgets for the delivery of primary care.

1.1 Primary health care agencies

Several support and enabling agencies play important roles in supporting the primary health care system.

Primary Health Networks

Primary Health Networks (PHNs) are independent organisations funded by the Australian government to coordinate primary health care in their region. There are seven PHNs in Queensland.

PHNs assess the needs of their community and commission health services so that people in their region can get coordinated health care where and when they need it⁵. They:

- commission health services to meet the needs of people in their regions and address gaps in primary health care.
- work closely with general practitioners (GPs) and other health professionals to build the capacity of the health workforce capacity to deliver high-quality care.
- integrate health services at the local level to create a better experience for people, encourage better use of health resources, and eliminate service duplication.

PHNs provide a valuable local support to HHSs to develop regional primary health strategies and support the integration of healthcare and development of integrated medical workforce models. PHNs are also strategic partners in practice quality development and improvement through practice support for accreditation and in undertaking data analysis for practices participating in quality improvement incentives.

Health Workforce Queensland

Health Workforce Queensland (HWQ)⁶ is a not-for-profit non-government rural workforce agency funded by the Australian government focused on making sure remote, rural, and Aboriginal and Torres Strait Island communities have access to highly skilled health professionals when and where they need them. In addition to supporting the recruitment of the rural and remote workforce, HWQ:

- participates in community development and practice support activities.
- contributes to strategies to increase sustainable primary health care business models.
- provides grants and scholarships to support career development initiatives.

⁵ Department of Health and Ageing website www.health.gov.au/initiatives-and-programs/phn/what-phns-are

⁶ www.healthworkforce.com.au

- facilitates professional development education and training.
- captures health workforce data for policy and planning purposes.

CheckUP Australia

CheckUP⁷ is a not-for-profit organisation dedicated to better health for people and communities who need it most, working with partner organisations and health providers to create healthier communities and reduce health inequities. CheckUP is the current holder of Australian government funding for specialist and other outreach services and provides a range of training, education and other resources and events to support the rural health workforce.

Royal Australian College of General Practitioners

The Royal Australian College of General Practitioners (RACGP)⁸ is a professional body for general practitioners in Australia. The RACGP is responsible for maintaining standards for quality clinical practice, designing and providing education and training, and undertakes research in Australian general practice⁹.

The RACGP develops resources and guidelines, advocates for GPs on issues that affect their practice, and develops standards that general practices use to ensure high quality healthcare.

Australian College of Rural and Remote Medicine

The Australian College of Rural and Remote Medicine (ACRRM)¹⁰ is accredited by the Australian Medical Council (AMC) for setting professional medical standards for training, assessment, certification and continuing professional development in the specialty of general practice.

ACRRM is dedicated to rural and remote medicine and plays an important role in supporting junior doctors and medical students considering a career in rural medicine.

ACRRM is committed to delivering sustainable, high-quality health services to rural and remote communities by providing quality education programs, innovative support and strong representation for doctors who serve those communities.

Rural Doctors Association of Queensland

The Rural Doctors Association of Queensland (RDAQ) was formed to improve the health of rural and remote Queenslanders and support rural doctors and their families¹¹. It offers a range of services to its members such as peer and mentoring support, education, professional development and conferences, as well as policy engagement and advocacy in rural healthcare.

⁷ www.checkup.org.au

⁸ www.racgp.org.au

⁹ en.wikipedia.org/wiki/Royal_Australian_College_of_General_Practitioners

¹⁰ www.acrrm.org.au

¹¹ www.rdaa.com.au

1.2 Rural generalism

In 2007, Queensland Health¹² pioneered a rural generalist training program to provide a specialist career pathway for registrars to become general practitioners with an advanced emergency, cognitive or procedural skill to support quality hospital care. The initiative was designed to provide a specific workforce pipeline for rural Queensland, sustaining the viability of both general practice and rural hospitals and servicing the healthcare needs of sparsely populated rural and remote communities.

By March 2023, the program had graduated more than 234 fellows with another 384 doctors training towards their rural generalist fellowship¹³. The program is making an important contribution to the recruitment of rural doctors achieving a retention rate of 65%. Of the 103 graduates who have held fellowship for >5years, 85% have practised in MMM4+ for 5 years or more.

In the 2020 Budget, the Australian Government established a national Rural Generalist program to support regional communities, building on the agreed definition of a Rural Generalist (*known as the Collingrove Agreement*)¹⁴:

‘a medical practitioner who is trained to meet the specific current and future healthcare needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team’

Rural generalists broaden the range of locally available medical services and help rural patients to access the right care, in the right place, at the right time, as close to home as possible. Growing the rural generalist workforce will reduce hospital admissions, reduce the use of locum services and limit the need for patient travel¹⁵.

The establishment of the national program, together with new incentives available to rural generalists, presents an opportunity to develop and implement sustainable integrated private general practice models across regional Queensland.

2. Integrated Private General Practice Arrangements

Communities are not well served by siloed and segregated medical services. In each rural hospital, an adequate headcount of doctors is required to maintain 24 hour, seven day a week emergency response cover which usually exceeds the overall medical requirement of the hospital/MPHS. These communities also require access to comprehensive primary health care delivered through general practice.

¹² Queensland Country Practice is a business unit within Darling Downs Health and works with all health services to support the sustainability of rural and remote medical practices and promote excellence through integrated medical practices and training, managing medical and allied health reliver programs and offering tailored service redesign expertise to health services.

¹³ 2023 QRGF Snapshot (current as at September 2023) <https://ruralgeneralist.qld.gov.au/about-us/>

¹⁴ www.racgp.org.au/the-racgp/faculties/rural/rural-generalist-fellowship/about-the-rural-generalist-fellowship/recognition-of-rural-generalist-medicine

¹⁵ Department of Health website <https://www.health.gov.au/initiatives-and-programs/national-rural-generalist-pathway>

Combining medical teams provides the best opportunity to more efficiently and effectively meet community needs, reduce the burden of disease, and assure the sustainability of required services.

Integrating healthcare has been a focus of national and jurisdictional policy development for more than two decades, striving to build collaborative planning, coordinated patient care and connecting care pathways between primary and secondary care. It can involve combining service capabilities through partnerships, contracts and sharing of resources.

Across Queensland, pockets of innovation have emerged with local hospitals and general practices collaborating to address the needs of both the general practice and hospital, using the same medical team with fractionated placements or granted private practice agreements. Integrated models of care can improve job satisfaction by balancing rosters, guarantee leave and professional development support and facilitate multidisciplinary team-based care arrangements.

The Productivity Commission found that while Australia's experience in integrated care is not extensive, it reflects international evidence that integrating the provision of GP and hospital services delivers better patient outcomes and at a lower cost. Hospitals need to be part of an integrated approach to care in order to achieve significant reductions in hospital utilisation and integration across GPs and the hospital sector is necessary to be cost effective¹⁶.

Many rural GPs currently collaborate with local hospitals and have admission rights for patients in their care. Some may require further upskilling to fully participate in an integrated hospital and practice model, though it is also acknowledged that not all rural GPs or hospital doctors will elect to participate in an integrated medical workforce.

2.1 Principles

Rural medical workforces are numerically small due to the smaller size of the communities they serve. The loss of even a single doctor can jeopardise the sustainability of local medical services as there is not a ready pipeline of trained medical practitioners seeking a rural lifestyle available to replace them.

To ensure sustainable secondary hospital services in rural and remote communities, there is an imperative that every doctor in primary care (general practice) is also engaged at the hospital; and that every doctor engaged at the hospital is also engaged in primary care (general practice).

This guide has been developed with reference to a set of principles supporting the design and operation of integrated private general practices:

- **Rural generalist model** – to optimise primary care delivery and sustain affordable medical services in a rural community, all medical practitioners should work in both primary practice and secondary care.
- **Joined up care** – medical practitioners should form a single integrated medical team that coordinates support with other health care providers to deliver healthcare for their patients.

¹⁶ Productivity Commission – 5 Year Productivity Review, Supporting Paper No. 5, Integrated Care, August 2017

- **Quality care** – healthcare should be delivered from an accredited practice, encourage specialist registration of all medical practitioners and ideally become an accredited training practice for students and registrars.
- **Patient centred** – comprehensive, planned and ongoing patient care with an opportunity to securely share patient information.
- **Value for money** – evidence shows that access to comprehensive primary health care improves patient outcomes and reduces preventable hospitalisations.
- **Culturally applicable** – service models can be developed collaboratively with Indigenous health organisations and communities.

The redesign of local medical services into sustainable workforce models can be achieved through the following key enablers:

- **Consultation** and engagement with health practitioners, other practices and service providers and community stakeholders.
- Identifying **community needs** for primary care and emergency care needs.
- Enhancing the **vocational aspirations** of the workforce including medical Rural Generalists, nurses and allied health professionals.
- Ensuring safety and quality through adoption of **accreditation** standards for general practices set by the Royal Australian College of General Practitioners (RACGP); and teaching accreditation for Australian General Practice Training (AGPT) and independent pathway registrars by both GP Colleges.
- Accessing and optimising available Commonwealth **funding sources** for primary care from Medicare billing, practice incentives, COAG 19(2) exemptions, PHNs, and available GP and Regional Infrastructure grants.

2.2 Objectives

An integrated general private practice model will aim to:

- promote patient-centred care, strengthening preventative and planned health care to deliver better health and quality of life outcomes;
- increase access to multidisciplinary/team-based care and better connect primary and secondary services;
- optimise and sustain the local health workforce for both general practice and hospital services; and
- maintain and increase Australian government funding for primary healthcare in rural and remote communities.

Integrated models of general practice make the best use of the local medical and health workforce and deliver care that provides the greatest value to patient safety and wellbeing. The benefits of integrating hospitals and general practices include:

- Continuing access to planned and preventative care in the community.
- Higher rates of immunisation.
- Early detection, treatment and ongoing care of health issues.
- Reduced presentations at the emergency department.
- Fewer preventable hospitalisations.
- Lower acuity of presentations arising from chronic conditions.
- Longer life and better quality of life.
- Better coordination of care between health professionals and specialist care.
- Continuity of care where doctors see patients in both the general practice and in the hospital.
- Enhanced patient safety when patient records are shared between the practice and the hospital.

At the business level:

- Expensive medical resources can be better allocated to optimise patient care.
- Increased patient Medicare benefits defray practice costs and contribute to medical salaries.
- More doctors available to share the on-call roster and reduce fatigue.
- Opportunities to expand the use of local hospitals for step-down care.
- Improved workforce retention.
- Reductions in patient transport and retrieval costs.

2.3 Models of integrated practice

Models of integrated care exist on a continuum of collaboration. The objectives of integrated care could be met by simply improving the extent, frequency and scope of engagement amongst clinical leaders and by collaborating on patient care pathways and documented procedures. Alternatively, integrated care could provide an opportunity to establish partnership arrangements and sharing the medical workforce with a local general practice(s) for mutual benefit.

Where general practices have already closed, the integrated care solution may involve hosting the provision of general practice by HHS employed doctors using granted private practice rights in line with Queensland Health employment policies.

These models of care integration are summarised in figure 1.

Figure 1: Four broad models of integrated general practice

<p>Private General Practice operated by a Medical Practitioner Private Practice (MPPP) or Rural Generalist MPPP</p>	<ul style="list-style-type: none"> • A practice building is owned or leased by the MPPP or made available by the HHS or another organisation • HHS makes other facilities available to access QH enterprise systems • The practice is owned and operated by a MPPP • Patient records are in the custody of the MPPP • Staff are employed by the MPPP • Other MPPPs make private practice arrangements with the MPPP operating the practice • MPPPs are employed by the health service on a retainer model and have hospital duties set out in the Award¹⁷
<p>Private General Practice partnering local hospital/multi purpose health service (MPHS)</p>	<ul style="list-style-type: none"> • The practice building is owned or leased by the general practice • The practice is owned and operated by the general practice • Patient records are in the custody of the general practice • Staff are employed by the general practice • General practitioners are rostered in the hospital as a VMO or as a fractionated SMO (part-time employment)
<p>HHS employed Rural Generalists working in privately owned general practice (or Aboriginal Community Controlled Health Service)</p>	<ul style="list-style-type: none"> • The practice building is owned or leased by the general practice • The practice is owned and operated by the general practice • Patient records are in the custody of the general practice • Staff are employed by the general practice • Rural generalists conduct their private practice in the general practice using Granted Private Practice Agreement (assigned or retained) or external practice arrangements (outside employment) • Rural generalists work in combined hospital and practice rosters • General practitioners may or may not work in the hospital as a VMO or fractionated SMO
<p>HHS employed Rural Generalists working in a HHS operated general practice</p>	<ul style="list-style-type: none"> • The practice building and related ICT facilities is provided by the health service • The practice is operated by the health service • Patient records are in the custody of the health service • Staff are employed by the health service • Rural generalists conduct private practice in a general practice using Granted Private Practice Agreement (assigned or retained) or Licenced practice arrangements (in the doctor's own time) • Rural generalists work in combined hospital and practice rosters

¹⁷ Clauses 14.2 and 14.3 of the Medical Officers (Queensland Health) Award – State 2015

Fully integrated practice models may include the sharing of patient medical records so that health practitioners can access a patient's full medical history in both the practice and the hospital.

2.4 Integrated practice planning considerations

Integrated care models are best developed when there is time to plan, consult, design, authorise and establish the most appropriate solution. Unfortunately, the unplanned departure of a practice principal or sudden closure of a general practice can bring about more urgent attention to primary care delivery.

A number of lead indicators exist that may suggest its timely to scope the development of an integrated private practice model, such as:

- The principal of the general practice (or MPPP) is nearing retirement or is seeking to leave the community.
- General practice hours are irregular, patients have a long wait to see a doctor or the practice frequently cancels its appointments.
- Low acuity hospital presentations to the emergency department are rising, especially during normal business hours.
- There are high rates of chronic disease presentations and other preventable hospitalisations.
- The hospital has a medical on-call roster of one-in-three or less.
- The hospital's medical establishment is greater than usually needed for the hospital to maintain after hours and procedural on call rosters.
- Expenditure on locum doctors is rising.

3. Private Practice Arrangements in Queensland Health

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

In rural health, private practice can be used to unlock Medicare benefits that are available to finance primary health care delivery in a community and fund the medical workforce.

3.1 Private practice Health Service Directive

Health Service Directive QH-HSD-044:2014 “Private practice in the Queensland public sector” sets out the mandatory requirements for HHS that support medical practitioners to engage in private practice arrangements. These include:

- Using standard granted private practice agreement (GPPA) templates or granted private practice schedule templates for Visiting Medical Officers.
- Documenting Licensed Private Practice arrangements, where a medical officer provides private practice within a HHS facility beyond their hours of employment and GPPA.
- Reviewing the performance of private practice activities annually.
- Ensuring fees are charged for private practice services in accordance with the Queensland Health Fees and Charges Register.
- Complying with the Private Practice in the Queensland Public Health Sector Framework¹⁸.
- Ensuring all clinicians and support staff have access to training and education material appropriate to their roles and responsibilities regarding private practice.
- Establishing a local private practice governance committee (or a committee with adequate terms of reference) to oversee the administration and sustainability of private practice arrangements operating within the service.

The supporting guideline *Private practice in the Queensland public health sector framework*¹⁹ further expands on the mandatory requirements, and whilst they largely deal with private practice conducted from within a hospital, they also apply in large part to general private practice activities.

3.2 Private practice governance committees

Each HHS is required to establish a local private practice governance committee (or a committee with adequate terms of reference) to oversee the administration and sustainability of private practice arrangements operating within their service²⁰.

The private practice governance committee should include members with an understanding of general practice as well as business and financial skills. The committee should report regularly against its functions to the HHS Chief Executive (or as otherwise determined in the HHS governance structure). The committee must ensure:

- Appropriate systems and controls are developed and monitored (documented) to ensure private arrangements are compliant with Medicare legislation, Queensland Health policies and (where applicable) any Partnership Agreement.

¹⁸ <https://www.publications.qld.gov.au/dataset/afd5ae59-60ce-4ef8-b59d-f84137aa4962/resource/3fab45ba-ed8e-4bb0-8722-ef3d4f85d428/download/private-practice-framework-2019.pdf>

¹⁹ <https://qheps.health.qld.gov.au/finance/revenue/guidelines>

²⁰ QH-HSD-044:2014: Private practice in the Queensland public sector, updated September 2020

- Internal controls are in place to ensure practice assets are protected, Medicare billings are accurate and complete and human resource management practices are properly applied.
- Practice revenue is monitored against target and the extent to which practice cost recovery is achieved.
- The accountable officer responsible for agreements with medical practitioners reviews their practice performance annually.
- Arrangements are made to manage any conflict of interest arising where an employed medical officer is also a partnering private practice principal, particularly with respect to rostering responsibilities and managing recalls.

3.3 Granted private practice agreements

Senior Medical Officers (SMO) are to be provided with a standard template Granted Private Practice Agreement (GPPA) on commencement to participate in private practice activities²¹. An attraction and retention incentive is provided to SMOs conducting private practice.

The effect of the agreement is that doctors may be released from their duties to engage in their own private practice. The amount of private practice time is negotiated with the HHS.

The SMO agrees to facilitate patient choice of private care and to appoint the HHS as their billing agent. The HHS in return must provide reasonable administrative and clinical support and provide the SMO with timely and accurate information on the practitioners practice activities²².

The SMO can elect one of two options under the GPPA (and may alter this election annually):

- Assigned – this option assigns 100% of the billable earnings to the HHS. The HHS incurs all costs associated with practice management and administering billing.
- Retained – this option entitles the SMO to keep billable earnings, less a service fee applied by the HHS associated with providing practice management services. The service fee for general private practice is negotiated with the HHS. If this option is elected, the attraction and retention incentive is decreased.

Regardless of which option is elected, all proceeds derived from granted private practice must be received by the HHS in the first instance (unless otherwise provided in a Partnership Agreement with a general practice or another health care provider).

²¹ Clause 11.31, Medical Officers' (Queensland Health) Certified Agreement (No.5) 2018

²² Clause 11.32, Medical Officers' (Queensland Health) Certified Agreement (No.5) 2018

3.4 Access to Medicare

The *Health Insurance Act 1973 (Cth)* provides for the payment of a benefit to an eligible person who has incurred a medical expense for a professional service. The eligible services and benefits payable are set out in the Medicare Benefits Schedule.

The legislation is designed to avoid 'double dipping' by restricting the payment of a Medicare benefit for services provided by an organisation (such as a hospital) or by a medical practitioner employed by them, where it is *already funded to provide the service* (including where the professional service is compensable)²³. The responsible Minister may grant exemptions to this (see below).

An exemption is not required for HHS medical practitioners exercising their granted private practice rights. Professional services provided by a salaried health practitioner pursuant to their private practice is rendered under a contract between the patient and the practitioner and *not by, for, on behalf of, or under an agreement with, the government or a HHS* that has granted the private practice²⁴.

Clause 8 of the Addendum to the National Health Reform 2020-2025²⁵ provides that patients should be able to access services historically provided in a hospital free of charge. To avoid any doubt, private general practice services undertaken in a HHS facility (co-located in a hospital or a HHS managed facility in the community) must be clearly signed to show the general practice services are private and not part of the hospital's activities. Importantly, patients must not be directed from an emergency department to the private practice (except as a private patient alternative).

3.5 Public patient billing exemptions

In 2006-07 the former Council of Australian Governments (COAG) introduced an initiative to improve access to primary care for people living in rural and remote areas of Australia. The initiative enabled state and NT government services to access MBS funding through an exemption permitted under Section 19(2) of the *Health Insurance Act 1973* at approved sites. The approved sites in rural and remote communities would have limited access to primary health care services and experience primary health care workforce shortages.

The initiative enabled Medicare to be billed for a range of non-admitted services provided by doctors, nurse practitioners, dentists and allied health practitioners. In effect, the exemption is authorising billing for public practice, not private practice. The exemption is conditional on 70% of the revenue being invested in new services and improvements to approved eligible sites and outreach services²⁶.

²³ Section 17, *Health Insurance Act 1973*

²⁴ *Private Practice in the Queensland public health sector framework*, Department of Health, March 2019 p.12

²⁵ https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHRA_2020-25_Addendum_consolidated.pdf

²⁶ COAG s19(2) Exemptions Initiative - Memorandum of Understanding – 2022–2025 Schedule B – Operational Plan

Under the 2022–25 eligibility criteria, sites must be located in areas classified under the Modified Monash Model²⁷ as MMM 5 (small rural towns), MMM 6 (remote communities) or MMM 7 (very remote communities).

Many rural hospitals have pursued these arrangements as own source revenue strategies to finance ‘additional’ primary care activity in areas with little or no access to general practice care. A few established primary care clinics within the hospital to target the management of chronic disease.

The Section 19(2) COAG initiative followed an earlier initiative, the Rural and Remote Medicare Benefits Scheme, through which the Commonwealth Minister exempted medical officers employed by Queensland Health, Aboriginal Community Controlled Health Organisations and the Royal Flying Doctor Service permitting them to bill Medicare for services provided to designated communities with large Aboriginal and Torres Strait Islander populations. Expenditure on the MBS and PBS in these communities was well below national averages highlighting diminished access to primary health care. The ability to access Medicare enabled these organisations to increase the primary health care workforce. The scheme is conditional on benefits claimed in a community being used for improved services in that community.

Hospitals billing Medicare for eligible public patient services under the Section 19(2) Exemptions must bulk bill for the professional services provided and cannot charge additional charges or co-payments on public patients.

3.6 Pharmaceutical benefits

The Pharmaceutical Benefits Scheme (PBS)²⁸ provides timely, reliable, and affordable access to necessary medicines to all Australians. The PBS is part of the Australian Government’s broader National Medicines Policy to promote optimal health outcomes and economic objectives for the Australian community.

The PBS Schedule²⁹ lists medicines that can be prescribed to eligible patients at government subsidised prices. The scheme is administered by Services Australia under the provisions of the *National Health Act 1953*³⁰ and the *National Health (Pharmaceutical Benefits) Regulations 2017*³¹.

The Repatriation Pharmaceutical Benefits Scheme (RPBS) is a further list of medicines available to veterans and war widows/widowers that are subsidised by the Department of Veterans’ Affairs (DVA).

A practitioner with a Medicare provider number will only require a single unique 7-digit prescriber number, which is not location specific.

Prescribers must ensure medicines are prescribed in accordance with the Schedule, which may detail criteria the patient must satisfy to be eligible to obtain the subsidised medication.

²⁷ Department of Health and Aged Care website (accessed 21 October 2022) www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm

²⁸ Department of Health and Aged Care www.pbs.gov.au/pbs/home

²⁹ PBS Online www.pbs.gov.au/browse/medicine-listing

³⁰ National Health Act 1953 www.legislation.gov.au/Details/C2023C00143

³¹ National Health (Pharmaceutical Benefits) Regulations 2017 www.legislation.gov.au/Details/F2023C00545

Prescribers have a responsibility to ensure the integrity of the PBS. Services Australia views fraud as dishonestly obtaining a benefit by deception, such as writing a script where the patient does not meet the eligibility criteria or providing false information to obtain an authority approval.

3.7 Other considerations

Private practice patient fees

Hospital and Health Services must approve the fees to be charged by medical practitioners undertaking granted private practice (unless the services are bulk-billed) and ensure service fees for granted private practice retention arrangements are levied in accordance with Queensland Health Fees and Charges Register^{32, 33}. Medical practitioners conducting Licensed private practice outside of their ordinary working hours and those undertaking outside employment in their own time may determine their own practice fees.

Private general practices set their fees to cover their operational costs, provide the medical practitioners with an income and make a fair return on their investment in practice infrastructure. Whilst practice fees are commonly set above the Medicare scheduled fee, resulting in a patient out-of-pocket cost, most rural and remote practices continue to bulk-bill most of their patients who would otherwise be unable to pay for these services.

A HHS will need to negotiate a service fee when establishing a partnership arrangement with an independent private practice or ACCHO to cover their practice costs (staffing, rent, equipment, consumables etc) and administering the medical practitioner's billing.

Competition policy

The *Competition and Consumer Act 2010 (Cth)*³⁴ may apply to any government authority carrying on a business or conducting commercial activities that are beyond or outside of their usual or traditional governmental or welfare functions (such as providing free public health care and hospitals). Where a commercial activity is provided, the authority must ensure no unlawful conduct occurs that may lessen competition, fix prices, or mislead customers and suppliers.

Individual medical practitioners conduct private practice and create the entitlement to a fee (whether a patient charge or a bulk-billed benefit). A HHS may provide a practice management service to enable or sustain general practice, including the maintenance of practice software, employing practice staff and supplying equipment and medical supplies.

HHSs must ensure that their activities and those of their medical practitioners do not compete with or adversely impact any existing independent private practices in their community.

³² QH-HSD-045:2016 Fees and charges for healthcare services

³³ qheps.health.qld.gov.au/csd/business/finance/revenue/fees/past

³⁴ www.legislation.gov.au/Details/C2011C00003

Taxation

Medical officers and the HHS must ensure compliance with their taxation responsibilities.

For the purposes of the *Income Tax Assessment Act (ITAA) 1997*³⁵:

- Private practice revenue derived by a salaried medical officer or visiting medical officer (VMO) undertaking granted private practice is ordinary income assessable under subsection 6-5(2) of the *ITAA 1997* and must be included in their tax return (net of any GST applicable).
- Contracted VMO earnings directed to a nominated medical agency or partnership are also considered ordinary income of the clinician providing personal services to patients.
- Earnings retained by a clinician is not salary and wages as defined in the *ITAA* and is not subject to PAYG tax withholding by the HHS. However, the clinician may be subject to instalment payments under the PAYG instalment system for 'business' income.
- A deduction is allowable under paragraph 8-1(1)(a) for private practice revenue assigned to the HHS under the assignment option.
- A deduction is also allowable for the service (or facility) fee retained by the HHS under the retention option.
- The HHS is responsible for providing relevant information required by medical officers for taxation purposes including income, retention of fees or service fees or service retention amounts, and the GST included in these amounts.
- All employees and contractors should seek individual tax advice from a suitably qualified financial advisor or tax agent to determine how these arrangements impact their individual circumstances.

For the purposes of the *A New Tax System (Goods and Services Tax) Act 1999*³⁶:

- Medical services that are eligible for a Medicare rebate or are generally accepted in the medical profession as being necessary treatment for a patient are GST-free.
- Goods and services tax is payable on other medical services, such as a medical report, and on service (facility) retention amounts or fees payable under the retained option.
- The HHS must remit GST collected from the billing of patients for any taxable supplies to medical officers that have elected the retention option under their granted private practice agreement. The clinician must include those receipts in their Business Activity Statement and forward the GST received to the Australian Taxation Office.
- Medical officers must ensure all information provided to the HHS is accurate and to act in a manner which avoids the creation of a shared debt (see Medicare compliance) or reduces exposure to administrative penalties that may be imposed for incorrect Medicare billing.

³⁵ Income Tax Assessment Act (ITAA) 1997 www.legislation.gov.au/Details/C2023C00094

³⁶ A New Tax System (Goods and Services Tax) Act 1999 www.legislation.gov.au/Details/C2014C00008

*Fringe Benefits Tax Assessment Act 1986*³⁷ (FBT)

- Eligibility for the FBT exemption cap will generally be unaffected in an integrated practice model as long as the HHS maintains responsibility for the employment, remuneration, management, control and direction of the medical officer while undertaking all of their duties under granted private practice^{38,39}. These arrangements should be documented in a service agreement where private practice is undertaken at an independent general practice. HHSs should contact the Department of Health's Taxation Services team (FBT@health.qld.gov.au) for further advice if arrangements depart from those outlined in this Guide.

Indemnity

Liability for civil claims is to be accepted for salaried medical practitioners when notification of a potential claim is made to Queensland Health and an undertaking is given by the medical practitioner that they acted in good faith and without gross negligence⁴⁰.

Due to the specialised nature and circumstance of work in the public health sector, Queensland has a separate indemnity policy covering medical practitioners - Indemnity for Queensland Health Medical Practitioners – Human Resources Policy I2⁴¹.

Indemnity is provided for claims against medical practitioners who have been engaged to perform duties and functions under the direction of a HHS and who engage within their qualified scope of practice. This specifically includes activities performed under granted private practice arrangements by salaried medical officers and for a MPPP private practice procedural work. The policy extends application to rural general practitioners (i.e. non-employee visiting medical practitioners) who have been granted an indemnity undertaking by a HHS for private procedural work and have entered into an indemnity cover agreement that includes participating in on call rosters.

However, indemnity is not provided for licenced private practice (being services undertaken outside of the practitioner's hours of employment), regardless of whether the services are provided in a HHS facility. Medical practitioners providing services outside of their granted private practice arrangements must avail themselves of all necessary insurances and medical defence coverage.

It is recommended that medical practitioners seek their own independent advice on whether additional medical defence insurance would be beneficial. These commercial policies may extend coverage on matters excluded under the Queensland Health policy (for example, if facing litigation for a fraud accusation or for gross negligence) and can provide a doctor with access to support and legal advice for regulatory and coronial investigations.

Medical practitioners are required to notify the HHS as soon as they become aware of a claim or potential claim. The practitioner must submit a notification and undertaking for a grant of indemnity to the decision maker and supply all relevant information. Incorrect or misleading information could lead to subsequent withdrawal of indemnity.

³⁷ Fringe Benefits Tax Assessment Act 1986 www.legislation.gov.au/Details/C2014C00048

³⁸ Finance Practice Statement – Public Hospital FBT Exemption Cap & Salary Packaging Arrangements, Queensland Health.

³⁹ Finance Practice Statement – Rotations/Placements/Secondments and Salary Packaging, Queensland Health

⁴⁰ Section 26C of the Public Service Act 2008

⁴¹ qheps.health.qld.gov.au/hr/policies-agreements-directives/policy-index/i-other/indemnity-medical-practitioners

Where indemnity or legal assistance is granted, the HHS is obliged to pay for all reasonable costs including legal professional costs and any awarded damages against the indemnified medical practitioner. Such costs are underwritten by the Queensland Government Insurance Fund.

The Department of Health further provides assurance that medical practitioners claiming Medicare rebates through approved private practice arrangements during the course of their hours of work will not suffer any financial detriment as a result of complying with Queensland Health policy or guidelines relating to private practice where HHSs are a financial beneficiary to those claims.

Compliance with policies and the Code of Conduct

The Queensland Public Service Code of Conduct⁴² applies to all staff employed by the HHS including employed VMOs. The Code continues to apply when conducting private practice. Where private practice is conducted in an independent general practice, the medical officer should comply with the general practice's policies and directions to the extent they do not conflict with the Code of Conduct.

VMOs engaged as independent contractors to work in the HHS have a requirement in their contract to ensure compliance with any laws, directions, policies, rules, by-laws, practices and procedures in effect from time to time in the HHS. HHS should ensure VMOs are provided access to information regarding these matters and the Queensland Public Service Code of Conduct.

4. Medical Workforce Engagement Options

Rural GPs in many regional towns across Australia deliver the majority of medical care to hospital emergency departments and inpatient wards as Visiting Medical Officers (VMO) and maintain the medical on-call roster. The variety of practice together with better continuity of patient care is highly valued.

In Queensland, however, many of the doctors working in rural hospitals are employed by the HHS.

- Where hospital demands for medical care have been relatively low and less acute, and experienced Rural and Isolated Practice Registered Nurses (RIPRN) have been rostered after hours, a MPPP model with one or two doctors has been established.
- Where demand is higher, especially after hours, or where recruitment for an MPPP has failed, hospitals have employed three or four senior medical officers to provide hospital services and conduct private practice arrangements when not required for public duties.
- In some situations, hospitals have engaged a fractionated SMO model in which medical practitioners work part time in the hospital and the remaining time at an independent private general practice.

⁴² Code of Conduct for the Queensland Public Service, Queensland Public Service Commission, 2010
www.forgov.qld.gov.au/employment-policy-career-and-wellbeing/public-service-values-and-conduct/public-service-code-of-conduct

A recent survey undertaken by Health Workforce Queensland has identified that a number of private general practitioners are interested in working at the local hospital and there are also a number of hospital Rural Generalists willing to work in general practice. However, high workloads, a feeling of not being wanted, and upskilling requirements present obstacles to private general practitioners in engaging in a shared medical workforce arrangement.

With serious distribution shortages in rural and remote areas, the development of shared workforce arrangements has become more practical and almost a necessity in some regions. Sharing the medical workforce can be readily achieved by engaging local GPs to work in our hospitals, facilitating hospital rural generalists to engage in private practice, or both.

Whilst this better practice guide focuses on the medical workforce, it is important to acknowledge the benefits of a team-based practice workforce and the valuable roles undertaken when nurses, midwives and allied health staff work to their full scope of practice.

Nurse Practitioners in particular make an important contribution to the delivery of general practice care to patients in collaboration with medical practitioners.

- Section 95 of the Health Practitioner Regulation National Law Act 2009⁴³ permits the Nursing and Midwifery Board of Australia to endorse the registration of a nurse as being qualified to practise as a nurse practitioner, indicating the person has the additional education, training and competence required to assume additional roles, functions, responsibilities, and decision-making activities beyond those within the ordinary scope of a registered nurse.
- Eligible nurse practitioners are able to treat their own patients, in collaboration with medical practitioners and are not limited to providing care on behalf of medical practitioners.
- Collaborative arrangements (a written agreement between the Nurse Practitioner and one or more medical practitioners which provides for consultation, referral or the transfer of a patient's care) must be in place at the time the eligible nurse practitioner provides a Medicare service.

4.1 Engaging rural GPs in hospitals

A Rural GP may be engaged as either a sessional or casual VMO, as a Senior Medical Officer (SMO) on a permanent, part-time or casual basis, or as a Medical Practitioner Private Practice.

Visiting Medical Officers

VMOs supplement the full-time medical specialist services available in our hospitals and can be engaged as either employees or as independent contractors, on a regular or casual basis, or for short periods or continuing arrangements. A VMO must be conducting a private practice as the remuneration provisions include compensation for the maintenance costs of their private practice during periods of employment with the hospital.

- VMO employees are engaged under a framework agreement (contract) in line with *Health Employment Directive No. 05/18*⁴⁴. The Terms and Conditions of employment for VMOs are

⁴³ www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-045

⁴⁴ www.health.qld.gov.au/_data/assets/pdf_file/0026/816029/hed-0518.pdf

determined by the Director-General in accordance with section 45(g) of the *Hospital and Health Boards Act 2011*⁴⁵.

- A VMO employee's contract may include provisions to participate in on-call rosters.
- Health Service Chief Executive approval is required where VMO sessions exceed 15 hours per week. Sessions cannot exceed 64 hours (on average) per fortnight (*HR policy B20 - Visiting Medical Officer – Engagement, entitlements and duties*⁴⁶).
- A VMO can also be engaged as an independent contractor through a medical practice company or partnership using the standard Queensland Health VMO contract. VMOs cannot be contracted as a sole trader (*HR policy B21 Visiting Medical Officer – engagement options*⁴⁷).

Senior Medical Officers

- SMOs are engaged under the *Medical Officers (Queensland Health) Award – State 2015 and Medical Officers (Queensland Health) Certified Agreement (No 6) (MOCA6)*⁴⁸.
- The establishment, recruitment and appointment provisions of *HR Policy B1 Recruitment and Selection*⁴⁹ apply.

All Rural GPs will require credentialing to an appropriate Scope of Clinical Practice prior to undertaking any clinical activity within a facility (*Health Service Directive: Credentialing and defining the scope of clinical practice QH-HSD-034:2014*⁵⁰)

Arrangements should be made to support Rural GPs to update their emergency training and obtain or maintain an AST required by the facility (where possible).

Medical Practitioner Private Practice

Medical Practitioners Private Practice (MPPP), (previously known as Medical Superintendents with Right of Private Practice) and Medical Officers Private Practice, have worked in Queensland for over fifty years ensuring rural hospitals had access to medical care whilst the community benefited from access to general practice.

An MPPP is a medical practitioner appointed to perform administrative and clinical duties at the hospital or MPHS when not otherwise engaged in their own independent private practice of medicine. These hospital duties include a minimum attendance at the hospital weekdays and on weekends, availability on call when not present in the hospital and to be recalled for emergency care when required. The HHS often provides a practice facility for the MPPP to engage in their general practice.

⁴⁵ www.legislation.qld.gov.au/view/pdf/inforce/current/act-2011-032

⁴⁶ www.health.qld.gov.au/_data/assets/pdf_file/0035/395666/qh-pol-256.pdf

⁴⁷ www.health.qld.gov.au/_data/assets/pdf_file/0036/395937/qh-pol-254.pdf

⁴⁸ https://www.qirc.qld.gov.au/sites/default/files/2023-06/2023_cb53.pdf

⁴⁹ www.health.qld.gov.au/_data/assets/pdf_file/0034/635893/qh-pol-212.pdf

⁵⁰ www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/credentialing-and-defining-the-scope-of-clinical-practice

The MPPP model has been favoured by rural hospital management due to the lower cost of the retainer model, the absence or limited exposure to recall costs⁵¹, and the ability to leave primary care responsibilities to the MPPP. A significant proportion of MPPP roles have been occupied by overseas trained doctors seeking Australian registration and vocational recognition, which have aided districts of workforce shortage.

The number of MPPP establishments across Queensland has fallen in recent years. Declining rural populations, frozen Medicare benefits and dissatisfaction with after-hours and on-call rosters has made the running a private general practice difficult. Increasing attendances at local hospitals will further remove the MPPP from their private practice, impacting on community-based health care and resulting in a loss of income for the MPPP (whilst their idle practice continues to incur running costs).

Australian graduates appear to preference the senior medical officer employment arrangement as a rural generalist which offers a more manageable work-life balance, especially for doctors planning to start or expand their family. Recent changes to employment conditions for MPPPs has established part-time employment options and enables those Rural Generalist MPPPs working in MM3-7 regions to progress their careers to Level 27.

Notwithstanding, the MPPP remains a meritorious employment model that can reward both the medical practitioner and rural hospital if demands are balanced and the HHS provides the necessary support and incentivisation for the practice, which may include providing practice management services for the MPPP (employing practice staff, supplying equipment and practice software etc).

4.2 Involving hospital doctors in general practice

Hospital SMOs with a general practice fellowship can undertake private general practice arrangements in an existing privately operated general practice or in their own right in a general practice facility administered by a HHS.

- SMOs must elect to participate in private practice arrangements under granted private practice provisions in MOCA6. Electing to do so increases the standard allowances paid to the SMO.
- The SMO must sign the Granted Private Practice Agreement⁵².
- Earnings are either assigned to the health service, or less commonly for general practice, may be retained.
- Where earnings are retained by the SMO, the health service may deduct a service fee and will reduce the doctor's attraction and retention allowance. Retaining earnings can incentivise a doctor's productivity and the practice's efforts to ensure complete and accurate Medicare billing.

⁵¹ An MPPP called to duty during their private practice hours may be entitled to recall rates for the time spent at the hospital – Clause 12.5 of the Medical Officer's (Queensland Health) Certified Agreement No 6.

⁵² qheps.health.qld.gov.au/__data/assets/pdf_file/0024/614085/gppa.pdf

- A health service must establish a written agreement where the granted private practice is conducted within an existing practice. The agreement will cover the private practice hours offered, practice costs levied on earnings, arrangements for remitting earnings and reporting/accountability arrangements.
- Where the health service hosts and administers the general practice, it should document the arrangements offered to SMOs conducting granted private practice.
- Alternatively, an SMO may undertake private practice outside of their usual working hours (Licenced private practice). This practice must be approved if it is conducted on the health services premises or disclosed where it is performed off-site.

As part of a comprehensive approach to change management, Health services should engage with their medical workforce at an early stage when considering plans to establish integrated private practices or extend granted private practice arrangements and clearly outline the expected benefits and impacts to current roles and the medical roster.

A careful analysis of the engagement models and how they respond to the interests and preferences of the potential workforce is essential in sustaining or restoring adequate resourcing to general practice whilst retaining emergency responsiveness and acute care in the hospital.

Figure 2 below summarises a number of ways in which the medical workforce in a small community can be engaged to deliver both primary care and support acute hospital care.

Figure 2: Comparison of medical employment options

	Terms of employment	Public care duties	Private Practice
Senior Medical Officer (General Practice or Rural Generalist)	<ul style="list-style-type: none"> • Medical Officers (Queensland Health) Award – State 2015 • Medical Officer (Queensland Health) Certified Agreement (No.6) 2022 (MOCA 6) • Private Practice in the Queensland Public Health Sector (QH HSD No. 044:2014) 	<ul style="list-style-type: none"> • Provide public medical service for 80 ‘ordinary’ hours per fortnight (or part thereof if a part time engagement is offered). • Minimum engagement is 4 continuous ordinary hours • Ordinary hours of duty are performed between 07:00 and 18:00 Monday to Friday unless an extended 	<ul style="list-style-type: none"> • Medical Officers may be granted private practice rights within their ordinary hours of duty. • By agreement, private practice earnings may be retained or be assigned to the health service. • Attraction and retention allowances will vary depending on the nomination by the SMO (assigned or retained).

	Terms of employment	Public care duties	Private Practice
		<ul style="list-style-type: none"> shift roster has been agreed. Loadings to the base rate of pay apply to work done out of ordinary hours, overtime and recall. Public practice is provided to patients electing public care, including those eligible to be billed to Medicare under COAG 19(2) exemptions. 	<ul style="list-style-type: none"> A medical officer may perform private practice within a hospital outside of their ordinary hours of duty using Licenced private practice agreement. Where practice earnings are retained, a facility fee will be deducted by the health service that operates the primary care practice. Medical officers should disclose any private practice arrangements undertaken in their own time.
Senior Medical Officer – Medical Practitioner Private Practice (MPPP) / Rural Generalist MPPP		<ul style="list-style-type: none"> Medical officer is ‘retained’ by health services for public practice duty. Section 14 of the Award prescribes limited duties including daily outpatient session and inpatient rounds Monday to Friday, inpatient visits on weekends as needed and 24 hour shared on-call roster. No additional payments are made for on-call or recall. Provide duties 20 days in every 28 day cycle. Hospital may bill public non-admitted patients to Medicare under COAG 19(2) exemptions. 	<ul style="list-style-type: none"> Private practice arrangements for MPPPs are negotiated at the local level through an exchange of letters or written agreement. MPPP may be granted use of a HHS facility to conduct the private practice. MPPP retain their practice earnings, less a facility fee where the health service operates the primary care practice.
Visiting Medical Officer (VMO) contracted as an employee	<ul style="list-style-type: none"> VMO Employment Framework Health Employment Directive (HED No. 05/18). HR Policy B20. Visiting medical officer – Engagement, entitlements and duties. Private Practice in the Queensland Public Health Sector (QH HSD No. 044:2014). 	<ul style="list-style-type: none"> Contracted for public duties as needed. Can be engaged on a part-time or casual basis. Total engagement hours above 15 hours/week must be approved. Total sessional attendances must not exceed (on average) 32 hours/ week. Additional duty and recall allowances payable. VMO must provide 	<ul style="list-style-type: none"> VMOs will usually conduct private practice outside of their duties with the hospital. VMOs may enter into a Grant of Private Practice during their contracted hours of duty with earnings either retained or assigned to the health service. Private practice performed within an eligible hospital must be bulk-billed to Medicare under COAG 19(2) exemptions.

	Terms of employment	Public care duties	Private Practice
		telephone advice at no charge. <ul style="list-style-type: none"> Duties can include participation on 24 hr on-call roster. 	<ul style="list-style-type: none"> Private practice arrangements outside of the hospital are negotiated through a written agreement.
Visiting Medical Officer contracted as an independent contractor (as a medical practice company or a partnership)	<ul style="list-style-type: none"> HR Policy B21. Visiting medical officer – engagement options HR Policy B19. Visiting medical officer contractor – Advanced practice status for rural maternity. Private Practice in the Queensland Public Health Sector (QH HSD No. 044:2014). 	<ul style="list-style-type: none"> Contracted for public duties as needed. Can be contracted to be available for 24 hour on-call. Standard VMO contract. 	<ul style="list-style-type: none"> VMOs conduct private practice outside of their contracted agreements

Part B: Implementing an Integrated Private General Practice

The following part provides further information to assist a HHS to consider localised integrated solutions, develop a proposal for an integrated service and necessary steps required to implement a model.

5. Private Practice Governance

5.1 Integrated private practice committees

An Integrated Private Practice Committee may be formed (integrated with or in addition to the Private Practice Committee) to focus attention on the design, establishment and operation of an integrated general practice model.

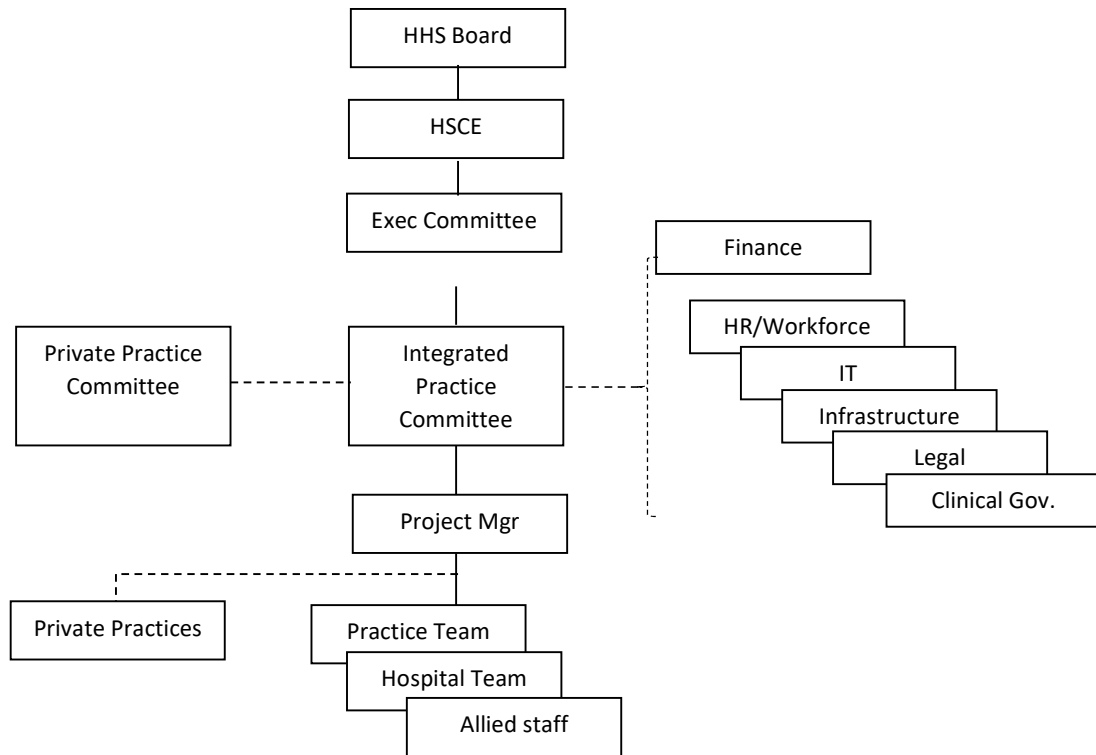
The Committee would comprise HHS decision makers and key stakeholders to plan and direct the establishment and ongoing operation of integrated general practice arrangements. Where a collaborative model is being implemented, the committee will include representatives of existing general practice(s) and/or local Aboriginal Community Controlled Health Organisations.

The committee forms part of HHS governance, so its functions and scope of decision making will need to reflect the model of integrated care being contemplated.

- Where the model involves collaborating with an existing general practice(s), the committee would focus on compliance and performance of the HHS obligations under the Partnership Agreement entered into. This might include medical workforce recruitment, AST and skills maintenance, joint primary care planning, practice performance monitoring and ensuring a culture of collaboration and cooperation between the practice and the hospital.
- Where the model involves the HHS establishing a clinic and providing practice management services, the committee will have a specific project governance responsibility, endorse the model of care based on best practice and safety and quality considerations, ensure legislative and policy compliance and oversight service planning, performance monitoring, workforce management and fostering of a collaborative culture.

The committee may also seek to involve the HHS regional clinical leads (including allied health) together with location specific Medical Superintendents and Directors of Nursing. The committee may include observers /advisers from the HHS finance, HR/workforce, IT, Infrastructure, Legal and clinical governance units, attending as needed (see sample structure in figure 3).

Figure 3: Example organisational structure for integrated private practice committee



Performance Indicators

Performance indicators to monitor the extent to which the practice is meeting the objectives of collaboration and integration may include:

Patient outcomes

- Improvements in one or more of the PIP Quality Improvement measures (i.e. the proportion of diabetes patients with a current HbA1c result).
- Reduction in preventable presentations in the hospital.
- Reduction in avoidable hospitalisations related to preventable chronic health conditions.
- Immunisation coverage for children under 5, First Nations patients etc.

Practice model

- Increase in the proportion of planned care consultations (health assessments, GP health management plans and reviews, mental health treatment plans and reviews etc) to standard consultations.

- Reduction in patients with chronic conditions that do not have a diagnosis recorded (or select other Practice Incentive Program Quality Indicators).
- Reduction in patient transfers from aged care services (where the practice provides outreach care to an aged facility).

Workforce

- Increase in average tenure of the medical workforce (excluding locum).
- Reduction in locum fulltime equivalent each quarter.

Financial

- Increase in Medicare earnings (variation to target, percentage of potential revenue).
- Percentage of practice costs recovered from private practice earnings.
- Reduction in aeromedical retrieval and PTS costs related to chronic conditions.
- Increased revenue associated with after-hours care.

5.2 Authorising integrated private practice proposals

Each HHS will have established systems for good governance and have documented plans, procedures and authorisations that support decision making and performance accountability.

Ideally, proposals should be submitted in concept first to obtain executive endorsement to expend further resources in developing a detailed business case, consult on the options to be considered with internal and external stakeholders and develop the detailed earnings and practice costings (including medical workforce). Considerations would include:

- Aligning private practice proposals with the organisation's strategic, operational and business plans.
- Ensuring investigations into developing practice partnerships or other integrated models of general practice should be assessed and reviewed through the health service's usual committees and approval pathways.
- Taking into account community and stakeholder consultation and feedback.
- Establishing a senior Project Sponsor to oversight the development of integrated private practice options and commissioning of new services.
- If approved, briefing the health service's private practice committee.
- Developing project plans to prepare for, establish and commission the integrated private practice. This would include financial projections, workforce and recruitment requirements and completing a risk assessment.
- Seeking legal advice in cases involving the development of partnership agreements or where a general practice's assets are being acquired by the HHS.

- Documenting the roles and accountabilities, mutual obligations, and specific undertakings of the parties, include a process for joint review and governance, in any proposed partnership agreement.
- Including a change management plan and strategies for ongoing communication and engagement with stakeholders.

5.3 Change management

A key factor in the successful adoption of integrated private practice models is developing a shared understanding of the value and benefits to the community of the collaboration. Many HHS staff will be unfamiliar with general practice operations and staff may be cautious about billing patients for health services. Similarly, practice staff may be unfamiliar with hospital routines, governance processes and care priorities.

Primary care is fragile in rural and remote areas, and despite targeted funding and support from the Australian government and Primary Health Networks, general practices have closed due to the departure of general practitioners and due to business viability. In these situations, there is a compelling case for HHS to collaborate, support and/or maintain access to primary care services and avoid patients seeking primary care through hospital emergency departments.

There is strong evidence to show that patients receiving comprehensive planned and preventative primary healthcare in the community have better health outcomes and have a lower impact on our hospitals.

Unlike state hospital services, primary health care is largely delivered by private providers (including many allied health services) with a business model reliant on Medicare benefits and patient fees. Medicare rebates do not cover the cost of providing a medical practice alone, resulting in most general practices charging fees above the Medicare schedule by necessity. Note that patients' out of pocket costs can be minimised by attending a bulk billing practice or when the family group has reached the Medicare Safety Net⁵³.

The levying of patient fees by State entities providing services on behalf of the Commonwealth is not new. Residents pay fees for residential aged care and home care packages whilst clients also pay for support services provided through the National Disability Insurance Scheme.

HHS will need to prepare for private practice changes, manage the change process and take steps to reinforce the change through effective governance, consultation and planning.

HHS change planning may include:

- An executive being assigned responsibility for primary health care.
- HHS policies and procedures reflecting a shared responsibility to ensure access is available to effective, comprehensive primary health care.
- Staff having access to information about integrated private practice arrangements, including the important reason for Medicare billing.

⁵³ www.servicesaustralia.gov.au/what-are-medicare-safety-nets-thresholds?context=22001

- Orientating practice staff with hospital functions, processes and requirements.
- Including both local hospital and general practice staff in the planning and implementation of integrated private practice models.
- Reviewing role descriptions to reflect public-private partnerships.

Whilst a business case for change may not be necessary to implement an integrated practice model, as existing industrial arrangements are in place for granted private practice, it is recommended unions are informed of developments and planning for the local workforce.

The change management plan should also include actions to engage with the local community. This is particularly important where the succession of the private general practice has failed and primary care transfers to a HHS operated general practice. The HHS needs to maintain the community's confidence following the departure of a trusted general practitioner principal.

This can occur through the local Community Advisory Network (or similar), or alternatively, through the local Council which may also seek to convene a community meeting. HHS should consider:

- Being pro-active and setting the agenda for community engagement.
- Providing the background to the local situation and explaining federal and state healthcare responsibilities.
- Outlining the planned approach and model and listening to community feedback and concerns.
- Providing regular updates, particularly arrangements for continuing care and replacement practitioners.

The outgoing general practice principal is responsible for managing employee separations and communicating to patients the arrangements made for transferring their medical records and ongoing care.

6. Working with Independent General Practices

It may be necessary to engage with one or more existing general practices to develop interest in further collaboration, building an integrated local medical workforce team, or in some cases, planning for the succession of a general practice to a new structure where a practice principal is contemplating retirement.

The strength of the relationships between the general practitioners and local health service management and clinicians will guide the engagement strategy. Care should be taken to enquire into, understand and consider responses to past concerns raised by the general practitioners.

Consideration should be given to the following steps in developing the engagement plan:

- Formally open dialogue through a HSCE (or Board Chair) letter.
- Meet at a time and place suited to the GP(s), potentially after business hours.
- Be open, honest and respectful, share studies or reports prepared by the health service.
- Discuss the challenges facing the community and share data or survey results.
- Seek input, advice and views from the GPs (and colleagues, as appropriate).
- Seek to understand the change impact on the GP business model and explore partnerships that do not compete with their business interests or viability.
- Do not over expect or assume commitments or decisions will be made quickly.
- Start by building confidence. Steps and actions that both could take towards improving cooperation, keeping best patient care as the vision.
- Meet regularly to maintain the momentum and continue to share data and information.
- Consult on the drafting of relevant agreements (aggregation of practices, integrated practice or asset acquisition agreement) and demonstrate how GP's views have been taken into account.
- Prepare a plan for practice staff and have information available on future employment arrangements where an aggregated practice or Queensland Health operated practice is proposed.
- Consider interim or transitional plans that could stage the introduction of changes.
- Jointly engage independent and experienced private practice valuers where practice consolidation or the acquisition of assets is proposed.
- Jointly communicate to the community and to practice patients.
- Set a date for the commencement of change.
- Acknowledge and locally recognise a departing practice principal and their contribution to the community (as appropriate).

6.1 Agreements with existing general practices

Partnering with an existing, established general practice in the community can often be the most successful form of delivering improved primary health care and strengthening the sustainability of private practice. It is a proven model frequently found in group practices across Australia which enable doctors to practice without making a capital investment and leverages a shared practice management team to efficiently operate the business on the doctor's behalf.

These arrangements can be established by the HHS as a contracted medical labour arrangement in which the health service will provide rural generalists for an agreed number of sessions each week (allowing for changes in the medical workforce) or can be made on a case-by-case arrangement with individual rural generalists.

These arrangements will require a written commercial agreement with the independent general practice to set out the terms under which the medical practitioners will be provided to align with the requirements of the Queensland public sector private practice framework. The provisions of the commercial agreement would include:

- The number of sessions to be provided and the periods in which they are to be performed (should ideally be a best endeavours clause or include a condition relating to hospital recall).
- The minimum qualifications held by the contracted medical practitioners.
- The importance of medical practitioners reviewing their daily private practice billings to ensure Medicare compliance.
- The responsibility of medical practitioners to comply with practice policies and directions (subject to any legislative or Queensland Public Service Code of Conduct requirements).
- Clear roles and responsibilities of the independent general practice in providing practice management services and those of the HHS relating to clinical and performance management.
- The frequency of remittance of billings. Assigned billings must be remitted intact to the health service at least fortnightly.
- The facility (or service) fee to be applied to practice billings and the frequency in which this is paid to the independent general practice (this may be completed using a recipient created tax invoice).
- Arrangements for ongoing consultation, planning and review of health measures.
- Ownership of patient medical records and access to these records for regulatory purposes.
- Dispute handling and termination provisions, including transitional arrangements if needed.

6.2 Working with Aboriginal Community Controlled Health Services

Queensland Health is committed to achieving health equity for Aboriginal people and Torres Strait Islander people⁵⁴. Each HHS will have a health equity strategy to achieve health equity and work with Aboriginal people, Torres Strait Islander people and Aboriginal and Torres Strait Islander communities and organisations to design, deliver, monitor, and review health services and improve the integration of health service delivery between the HHS and the service-delivery stakeholder⁵⁵.

There are more than 30⁵⁶ health services operated by Aboriginal Community Controlled Health Organisations (ACCHO) working to improve health outcomes across Queensland. Many of these services employ general practitioners along with a range of other healthcare disciplines to provide comprehensive primary health care to Aboriginal and Torres Strait Islander communities.

ACCHOs receive most of their funding support from the Australian government and are expected to bulk bill Medicare for general practice services. Health assessments and care plans are undertaken together with Aboriginal and Torres Strait Islander health workers and practitioners to deliver a culturally safe and comprehensive primary health care service.

In Queensland, there are a number of locations where HHS and ACCHOs have developed collaborations that share facilities and workforce to deliver culturally safe and effective health care program. Some of these include hospital rural generalists practicing in health clinics operated by ACCHOs.

Integrated workforce models in collaboration with ACCHOs recognise the strengths of each organisation and avoids the duplication of effort and confusion about health services in local communities and make best use of scarce resources to improve health outcomes. These collaborations should:

- Be documented in a partnership agreement that has been developed following extensive consultation and clearly sets out the vision and purpose of the collaboration, the contributions and obligations of both parties, provisions for joint governance and review of services, and clear measures and targets that can be shared with the local community.
- Have the full and continuing support of the Board and leadership teams of both the HHS and the ACCHO.
- Be supported with ongoing community consultation and feedback.
- Invest in change and transformation management over the longer term, including cultural capability training for staff.

The Queensland government is developing a new Aboriginal and Torres Strait Islander health workforce strategy in partnership with the ACCHO sector. The strategy will complement efforts to achieve health equity and the underrepresentation of First Nations peoples working in the health system. This will require investment from both levels of government in the workforce education pipeline.

⁵⁴ Section 13 Guiding principles, *Hospital and Health Boards Act 2011*

⁵⁵ Regulation 13A Prescribed requirements for health equity strategies, *Hospital and Health Boards Regulation 2012*

⁵⁶ Queensland Aboriginal and Islander Health Council website (accessed 31 October 2022) www.qaihc.com.au/about/our-members

7. HHS Operated Private General Practices

Unless other arrangements are made, a hospital medical practitioner undertaking granted private practice authorises the HHS (or an entity appointed by the HHS) as their billing agent to raise appropriate fees under the medical practitioner's Medicare provider number (where eligible).

- The HHS must provide the senior medical officer reasonable support, such as administration and clinical support staff, to ensure the effective delivery of private patient care at the hospital/facility.
- The HHS will collect and retain all billings unless revenue retention has been elected under the granted private practice agreement, in which case the HHS will retain a service (facility) fee and remit the balance to the medical practitioner.

The suitability of the private practice facilities and the extent of administrative and clinical support required can be negotiated with each medical practitioner, having regard to the requirement to avoid competition with existing general practices or adversely impacting on their operations.

Investing in private practice infrastructure has been identified as a key barrier for general practitioners seeking to live and work in rural communities. General practitioners may be willing to establish their careers in rural communities and conduct private practice but are not willing to invest large sums of their own resources to buy or establish a rural practice for which they may not realise a return.

In 2014, the AMA endorsed a position paper (revised in 2019) outlining a model for a walk-in walk-out approach that would enable rural GPs and rural generalists to focus on their clinical work and leave the operation and investment in a practice to a third party⁵⁷. The Easy Entry, Gracious Exit approach aims to remove barriers to recruitment and increase the chances of doctors remaining in rural and remote communities due to their experience of support, reasonable financial arrangements and interesting medicine.

The model outlines ways in which a Council, not-for-profit or a government entity could assume responsibility for owning practice infrastructure, employing the staff, leasing facilities and housing, maintain the practice systems and negotiate VMO contracts with the doctors to work in local hospitals. Each doctor would continue to be responsible for their own medical liability insurance. The model assures the continuity of the practice infrastructure and practice management skills independent of the continuity of the medical practitioner.

Where an independent general practice has closed without succession, a HHS may need to consider establishing a private practice or expanding primary care services to ensure the community has access to primary care. These facilities may be on site, within the hospital, or be undertaken in a leased or owned building in a community location. It may even be possible to deliver the service from the same location of the former independent private practice.

⁵⁷ Easy Entry, Gracious Exit Model for Provision of Medical Services in Small Rural and Remote Towns – 2014, Australian Medical Association, https://ama.com.au/sites/default/files/documents/Entry_Gracious_Exit_Model_for_Provision_of_Medical_Services_in_Small_Rural_and_Remote_Towns_2019_1.pdf. [Accessed 21 September 2023]

A HHS could provide capital funding for the practice building (if a lease is not available) and finance the practice fit-out and purchase of major equipment items, either through the health services Minor Capital Works program or through new project funding from the Department.

- The investment would need to compete with other capital demands across the health service and may not be prioritised by local executive management.
- Applications can be made to the Department of Health under the Sustaining Capital Program (SCP), though again, funds from this program are largely targeted toward replacement or emergent rectification works.

An investment by the HHS in practice facilities and costs associated with ongoing maintenance should be considered by the HHS in negotiating the service fee for administering granted private practice arrangements for practitioners who have elected the retained option in their granted private practice agreement (see section 3.3).

7.1 Key components of operating primary care practices

Primary care is a different service model to the provision of acute secondary services. The acute care model of service responds to patients presenting to hospital when they are unwell, results in people only receiving care when they are sick as opposed to providing ongoing care in the community that keeps them well and out of hospital.

Primary health care is often the first contact an individual with a health concern has with the health system. Primary health care includes health promotion, prevention, early intervention, treatment of acute conditions, and management of chronic conditions. Primary health care services are delivered in settings such as general practices, community health centres, allied health practices, and via communication technologies such as telehealth and video consultations.

There are five broad areas of primary care operations in a general practice business which together contribute to achieving clinical and financial outcomes. These are underpinned by the general practice standards that promote patient safety and quality care through gap analysis and continuous improvement (see figure 4).

- Practice governance and leadership

The culture, systems, processes, resources, people, management skills and reputation of a practice all contribute to the practice's capability and success. Even though patients do not notice some of these elements, they are obvious to the doctors and staff working in the practice.

Clinical leadership plays a vital role in maintaining the vision of an integrated practice, sustaining the practice's focus on quality and safety in clinical practice, and underpins the practice's stability and longevity. Competent leadership will also aid in attracting other doctors and healthcare staff.

- Practice workforce

A professional and experienced practice manager provides necessary business acumen, expert knowledge of Medicare requirements and facilitates optimal rostering and appointment planning. The role should be suitably described and remunerated with access to ongoing training and development.

Practice nurses (and Aboriginal and Torres Strait Islander health workers and practitioners) should be actively engaged in the practice. These nurses extend planned and preventative care, can complete part of any health assessment or GP management plan (and where trained, part of a GP Mental Health Treatment Plan) for the doctor’s review, can deliver immunisation and wound care services, and can support minor procedures in the practice. Incentive funding is available to accredited practices employing practice nurses, allied health professionals and Aboriginal and Torres Strait Islander health practitioners and workers.

Action should be taken to connect with allied health services, including from the hospital if private allied health services are not available. Some services qualify for Medicare rebates. Some private services could be provided by health service staff under licensed arrangements.

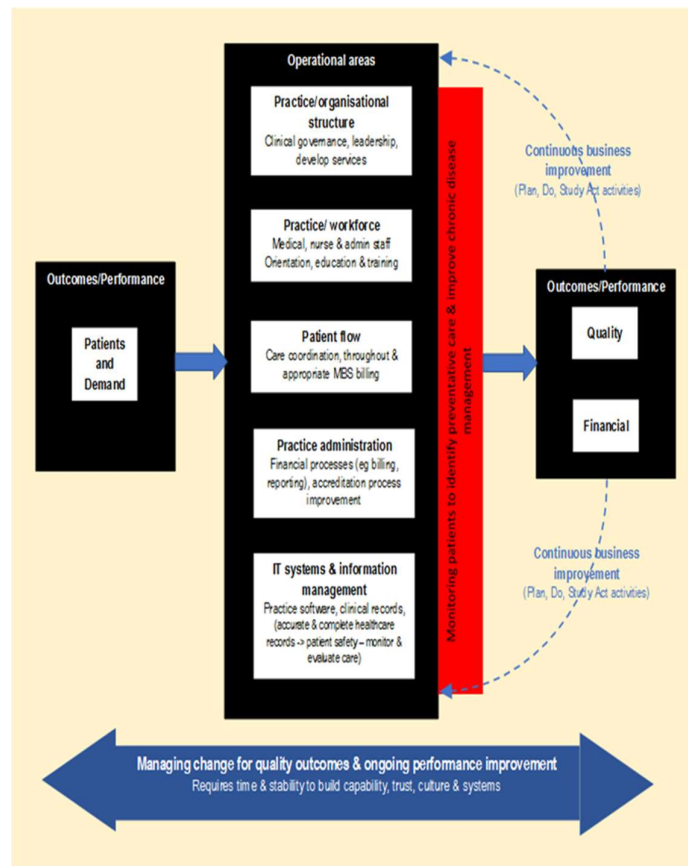
- Patient flow

Effective general practice has a systematic approach to planned and coordinated patient care. With thin margins in general practice, it is vital that practices focus on their patient flows and appointment scheduling to ensure the viability of the practice.

Practices should triage patient enquiries, allocate suitable consultation times, review recall lists and reminders, and monitor patients with historically poor attendance patterns – failure to attend is detrimental to both patient care and practice viability.

Systems should be in place to monitor diagnostic and pathology results and reports from specialists and the consequent need to book patients to see their practitioner.

Figure 4: General practice continuous improvement model



Clinical audit tools can enable staff to proactively identify patients who may benefit from health care assessments, GP management plans or mental health treatment plans. Planned care can significantly improve patient wellbeing, reduce the cost of the health system and attracts higher Medicare benefits.

- Practice administration

Practice administration covers its recruitment and induction processes, financial practices (pricing, billing and reporting), service and supplier arrangements, accreditation maintenance processes, workplace health and safety management and other routine processes. These should all be documented in the practice's policy and procedures manual.

The practice should also invest in its knowledge and understanding of the Medicare system, keep abreast and action changes to the schedule, and review the adherence with MBS items.

- IT systems and information management

Effective general practice is enabled by its specialised practice management software to efficiently maintain patient records, prescribe, order pathology, arrange referrals, generate follow-ups, recall patients and enable practice billing.

Clinical audit tools such as Pen Clinical Audit Tool (PenCAT)⁵⁸ or Primary Sense⁵⁹ enables the practice to monitor and track its performance against a range of clinical indicators and target health care initiatives to its patient population.

Ideally, the practice should consider being accredited as a training practice for GP registrars. GP registrar training in rural practices is essential to the rural GP pipeline and contributes to a 'grow-your-own' medical workforce if the training experience is well managed. With experience, registrars can productively contribute to the practice whilst learning. Supervision and Practice costs are well funded to defray forgone practice earnings.

An integrated practice model requires executive support and ongoing commitment. Until recently, many hospital employees have not considered primary care as being part of the HHS role and of the billing of patients through Medicare contrary to the free public health care system. Successful implementation will require attention to change management and include hospital staff in the design and development of the integrated practice. Hospital staff should be supported with information to understand the value of strong primary health care and how the integration with the hospital benefits the community.

Rights to healthcare

The Australian Charter of Healthcare Rights⁶⁰ was developed by the Australian Commission on Safety and Quality in Health Care, setting out a framework for healthcare rights for all people accessing any health service in Australia.

⁵⁸ www.pencs.com.au/category/cat4/

⁵⁹ gcphn.org.au/practice-support/primary-sense

⁶⁰ Australian Commission on Safety and Quality in Health Care www.safetyandquality.gov.au/consumers/working-your-healthcare-provider/australian-charter-healthcare-rights

The Charter provides that people have a right to access healthcare services and receive treatment that meets their needs, is safe and of high quality, and treats people with dignity and respect and have their culture, identity beliefs and choices recognised. Patients also have the right to be fully informed of any treatment proposed, be involved in care decision making and be assured their records and information will be treated with privacy and confidentiality.

Health professionals also have individual obligations to observe codes of conduct and behaviour that further expand on the application of the Charter in practical ways for every-day care (for example, the *Australian Medical Council's Good Medical Practice: A Code of Conduct for Doctors in Australia*⁶¹).

Cultural diversity and safety

The RACGP Standards for General Practice highlight the importance of designing and delivering services that consider the cultural and linguistic needs of practice patients.

- The practice needs to understand the demographics and cultural backgrounds of the patient population so that it can provide the most appropriate care.
- The practice should provide respectful and culturally appropriate care that is based on cultural awareness and sensitivity, which begins with learning about other cultures and cultural beliefs.
- Patients have a right to culturally appropriate care that may mean a preference of clinician gender, the role played by the patient's family, the impact of culture on a patient's health beliefs and having regard to historic traumatic events.
- The practice provides access to cultural awareness and cultural safety training for the practice team.
- The practice must ensure patients have access to resources and information that is culturally appropriate, translated and be in plain English. The practice should have access to translators.
- The practice employs Aboriginal people, Torres Strait Islander people in the practice or on the clinical team.

⁶¹ Australian Medical Council Ltd www.amc.org.au/wp-content/uploads/about/good_medical_practice/2009-07_Final_Code.pdf

7.2 Practice accreditation

As HHSs become more involved in the delivery of primary care services as a result of private general practice closures, it is important that these services are delivered to the same quality and safety assurance framework used for general practice.

All public health services and programs undertaken by a HHS must be accredited to the standards required by the Department⁶². The Department has specified that a general practice must be accredited in accordance with the current edition of the Royal Australian College of General Practitioner's accreditation standards and in line with the National General Practice Accreditation Scheme⁶³.

The Standards have been developed to protect patients from harm by improving the quality and safety of services provided in the primary care setting. Accreditation is a tool to measure and improve the performance and outcomes of services and identify any potential gaps in existing systems and processes. Accreditation can give practice patients confidence to the service maintains high standards of care and safety. General practice accreditation is voluntary but is a prerequisite for accessing important Medicare incentive programs.

For practices to be accredited against the Standards, they must be formally assessed by an accrediting agency approved under the National General Practice Accreditation Scheme.

Before a practice or health service is eligible to be accredited against the Standards, it needs to meet three core criteria.

1. The practice or health service operates within the model of general practice as described by the RACGP⁶⁴.
2. Services are predominantly of a general practice nature.
3. The practice or health service can meet all mandatory indicators in the Standards.

Accreditation demands a level of resourcing effort to establish the required policies, systems and practices and provide ongoing oversight to ensure consistent and continuous application of the Standards. The practice will also incur annual fees and periodic inspection costs.

Practices and health services looking to become accredited should be providing at least three doctor sessions a week delivering more than a total of 3,000 patient care episodes a year. HHS may explore including weekly clinics to surrounding communities within a single practice (a "base" practice with one or more "branches"), providing they use the same practice procedures and services are provided by the same group of doctors. Medicare billable services at the branch practice are included in the base practice's calculations for incentive payments.

⁶² www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety

⁶³ www.health.qld.gov.au/system-governance/policies-standards/health-service-directives/patient-safety/accreditation

⁶⁴ RACGP, What is General Practice? <https://www.racgp.org.au/becomingagp/what-is-a-gp/what-is-general-practice>

7.3 Culturally safe and effective services for Aboriginal and Torres Strait Islander patients

Primary health care services provided through a practice should aim to be accessible, effective and valued by Aboriginal and Torres Strait Islander people, requiring attention to how the practice presents to the community, how its staff engages with their Indigenous patients and how clinicians deliver their care.

The NACCHO⁶⁵ RACGP Good practice tables⁶⁶ provides a checklist for practices to understand where they sit on the continuum of culturally responsive primary health care and to build improvements in line with the RACGP Standards for General Practice⁶⁷. Some of the key elements to maintaining a culturally safe and responsive practice include:

- Understanding the local culture and customs by engaging with community leaders and elders – know the name of country and acknowledge country in the practice’s reception.
- Create a welcoming place using posters, flags and artworks that have meaning for local Aboriginal and Torres Strait Islander people; and celebrate culturally significant events.
- Ensure all staff undertake face to face cultural practice training (mandatory training for all Queensland Health Staff) and make commitments about how they will contribute to a safe and culturally effective service.
- Involve Aboriginal and Torres Strait Islander patients in the design and delivery of services, listen and understand the feedback provided.
- Practice staff are aware and trained in the importance of identifying and recording Aboriginal and Torres Strait Islander status in the patient record and patients have information displayed to explain how and why their Indigenous status is recorded.
- Aboriginal and/or Torres Strait Islander practitioners and health workers are engaged in the practice.
- The practice clinical team is aware of and uses the NACCHO/RACGP National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people⁶⁸ and other clinical pathways designed to support Indigenous patient healthcare.
- Patients are provided with appropriate information and support to consent to undertake an MBS Aboriginal and Torres Strait Islander annual health check⁶⁹.
- The practice is registered for the Practice Incentive Program and is able to inform and support Aboriginal and Torres Strait Islander patients to register with the practice for the Indigenous Health Incentive⁷⁰ and the Closing the Gap (CTG) Pharmaceutical Benefits Scheme (PBS) Co-payment Program⁷¹

⁶⁵ National Aboriginal Community Controlled Health Organisation www.naccho.org.au/

⁶⁶ www.racgp.org.au/cultural-safety

⁶⁷ <https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition/standards-for-general-practices-5th-ed-1>

⁶⁸ www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/national-guide

⁶⁹ www.health.gov.au/health-topics/aboriginal-and-torres-strait-islander-health/primary-care/annual-health-checks

⁷⁰ www.health.gov.au/initiatives-and-programs/practice-incentives-program-indigenous-health-incentive

⁷¹ www.pbs.gov.au/info/publication/factsheets/closing-the-gap-pbs-co-payment-measure

Acronyms

Acronym	Explanation
ACCHO	Aboriginal Community Controlled Health Organisation
ACRRM	Australian College of Rural and Remote Medicine
COAG	Council of Australian Governments
DVA	Department of Veterans' Affairs
GP	General Practitioner/ general practice
GPPA	Granted Private Practice Agreement
HHB	Hospital and Health Board
HHS	Hospital and Health Service(s)
HWQ	Health Workforce Queensland
ICT	Information and communications technology
MBS	Medicare Benefits Schedule
MMM	Modified Monash Model
MOCA	Medical Officers Certified Agreement
MPHS	Multi Purpose Health Service
MPPP	Medical Practitioner Private Practice
NHRA	National Health Reform Agreement
PHN	Primary Health Network
RACGP	Royal Australian College of General Practitioners
RDAQ	Rural Doctors Association Queensland
SMO	Senior Medical Officer
VMO	Visiting Medical Officer