AMA QUEENSLAND

PRINCIPLES

WORK UNDERTAKEN BY NON-GP PRIVATE SPECIALISTS UNDER THE COVID19 PUBLIC-PRIVATE PARTNERSHIP

1. The arrangements provided for under the COVID-19 public-private partnership must be time limited (e.g. 3 months). This arrangement is designed to specifically address COVID-19 and should not be viewed as a pathway to managed care, price control or greater contracting of medical practitioners in the private sector by health insurance funds or private hospital organisations.

2. Work conducted under the public-private partnership does not assume priority over the usual work of the medical practitioner – decisions of treatment priority are always to be made based on clinical need and solely at the treating medical practitioner's discretion.

3. There is no limitation on the medical practitioner undertaking their usual work through their private practice.

4. Private hospitals are to advocate and work strenuously towards a safe and appropriate return of normal operations to the private healthcare system as quickly as possible.

5. The private hospital will ensure that the resources required to support the VMO will be available, including but not limited to, personal protective equipment (PPE) and appropriate staffing. PPE is required for all staff caring for severely ill COVID patients or when conducting an aerosolising procedure on any COVID patient or a patient at high-risk as defined by current Commonwealth/State guidelines. The private hospital will develop clinical guidelines in consultation with their VMOs and consistent with current State and Commonwealth recommendations, to ensure otherwise at-risk, suspect patients or those with an acute respiratory illness are appropriately screened and if possible, cleared of COVID so the majority of routine clinical care can continue as usual within the private hospital.

6. Credentialing will be dealt with expeditiously and fairly.

7. Medical practitioners enter into the arrangement freely and without recrimination if they decline.

8. All medical practitioners working in private hospitals under this scheme will be extended full indemnity by the Queensland Government if required, as if they were employed within the public hospital system. This arrangement will apply if they do not hold private medical indemnity insurance or their current medical indemnity provider does not provide sufficient cover.

9. Scope of practice will be defined as the VMOs usual scope of practice.

10. Rostered shifts and fee-for-service work must be shared equally and align with current safe work standards. A craft group lead is to be appointed by the craft group in each hospital to facilitate a transparent and equitable distribution and be accountable for fair task allocation.

11. The two principle remuneration methods are envisagedto be fee-for-service or fixed salary.

    a) Fee-for-service work should be paid at a price directly linked to the AMA fee schedule. In the case of anaesthetics the full RVG should be applied as usual and in the management of COVID-19 and high-risk patients a second anaesthetist be present and fully remunerated, as per clinical guidelines.

    b) If paid on an hourly-basis or on call this should be at least consistent with the VMO rates as defined in the current Queensland VMO agreement. For those VMOs rostered on-call and required to remain on-site during the on-call period, an appropriate on-call rate should be paid. Additional call back rates should be paid for services provided.

12. Up to 21 days COVID-19 pandemic leave should be extended to all VMOs who are directed into isolation or treatment due to know exposure to COVID-19 at a facility where they are providing patient services under a VMO Contract. This cost should not be borne by the VMO or individual medical practitioner.