

WEBINAR | COVID-19 PRIVATE HOSPITAL ARRANGEMENTS FOR PRIVATE SPECIALISTS | 8 APRIL, 7 PM

QUESTIONS

ARRANGEMENTS

- When will we see clarity on what is being offered?
 - Agreements are currently being finalised with private providers and it is estimated that by 20 April 2020 the five biggest private providers will have signed agreements in place. The individual Hospital and Health Services (HHS) will hold discussions with their local private providers on what the activity requirements are likely to be over the next couple of months. It will then be for the relevant providers to hold discussions with private specialists.
- Is it a problem that states/territories are going to conduct this partnership differently?
 - Efforts have been made to maintain consistency wherever possible, and you will have seen in the media some of the directions to align with the Victorian model which is broadly what has been progressed. We don't anticipate any issues due to slightly different approaches being taken.
- The AMAQ is our peak body in Queensland. Do you commit to work constructively with our Association to broker an appropriate agreement?
 - Queensland Health is committed to work constructively with all parties including the AMAQ. Noting that it is the responsibility of private providers to negotiate remuneration rates with private specialists
- How flexible is Queensland Health going to be if we find issues after the agreement is signed to change the agreement?
 - There is an ability to vary the agreements if required, however this will depend on how significant any issues may be, bearing in mind we need to maintain consistency across the contracts and also with the National Partnership Agreement (NPA) signed with the Commonwealth.
- How is the activity distributed among the providers?
 - This will be determined by each HHS depending on local demand, considering other factors such as capability and capacity of local providers and where the patient lives to allow people to be treated as close to home as possible.
- Will Queensland Health also cover the cost of the discharge process i.e. hospital in the home/TCP etc.
 - The first priority will be ensuring that patients receive the services they need, when and where they need them. Where possible we will seek to maintain consistency with existing models of care that cover the entire patient journey. If that means a provider is delivering services after discharge then this will form part of the activity payment, where agreed, between the HHS and the private provider. Alternatively, a patient may be referred back to a HHS for these services if that is appropriate clinically.

- Would it be beneficial to separate COVID-19 care to major public hospitals only to concentrate PPE, personnel and the pandemic, sparing private hospitals for urgent other care to attempt to prevent extra hospital centred outbreaks?
 - There are continuing conversations about how best to care for COVID-19 patients at each stage of the pandemic. However, each of the agreements which Queensland Health is signing with private providers will make provision for private facilities to treat both COVID and Non-COVID patients. The exact distribution of work will be determined locally.
- To improve the continuity of care from public to private and return, do you have plans to set up portals to the public hospital ieMR to enable review of patient history?
 - For many services there are existing systems and processes for exchange of clinical information when a patient is outsourced to the private sector. This does not currently involve a portal into the public hospital ieMR.
- Will patients be followed up in the public hospital or by the private provider?
 - This will depend on the service and the model of care that has been determined by the local HHS, however where possible we will be seeking to maintain consistency with existing models of care that cover the entire patient journey.
- We understand that Queensland Health is not guaranteeing the viability of rent or lease payments for Private Hospitals (which is different to other States) and that is prohibiting them from signing. Is that likely to change?
 - The scope of the viability payments to private providers is determined by a guideline from the Commonwealth government. Queensland Health has linked all its contracts with private providers to this guideline which will ensure consistency.
- Are there any current punitive measures if surgery is performed that is category 2 but non-urgent? i.e. is the Medicare item number being tracked for some of these surgeries?
 - Any tracking of Medicare item numbers would be an issue for discussion with the Commonwealth.
- How long do you foresee these collaborative agreements will be in place for?
 - That will depend on how the COVID19 pandemic develops and therefore how long the Commonwealth chooses to maintain the NPA.
- When will there be sufficient local data to accurately predict what capacity will be needed going forward?
 - This will continue to change depending on the number of COVID19 cases and modelling assumptions. Local HHSs will collaborate closely with local private providers regarding demand and capacity whilst these private provider agreements are in place.
- Has there been any mathematical modelling of the harmful effects of not allowing elective surgery? For example, how many bowel cancers are we missing by not performing screening colonoscopies?
 - There is no modelling that Queensland Health is aware of. Cases that are deemed as clinically urgent should continue to be undertaken.
- Are there sunset clauses, in the contracts with private operators, to avoid the defacto introduction of a United States style managed care system following the COVID 19 pandemic?
 - The agreements set out a clear process regarding the end date. They have been brought in to manage the response to the COVID-19 pandemic and it is not envisaged they will extend beyond what is required.

EMPLOYMENT

- Is the work allocated to individual surgeons by the private hospital operators or are they allocated by the public system?
 - The work will predominantly be allocated by private hospital operators
- Will the patients referred to a private hospital for elective surgery have a named referral to a doctor who has a public hospital appointment, or will the work be distributed evenly amongst private doctors willing to participate?
 - It could be either but will primarily be determined according to what is in the best interests of the patient.
- Will certain specialities go to particular hospitals i.e. will cardiac go to Wesley but not Mater? Will the private hospitals get work in all the range of specialist that they currently have?
 - The first priority will be ensuring that patients receive the services they need, when and where they need them. HHSs will allocate referrals depending on local demands and considering other factors such as capability and capacity of local providers and where the patients live to allow them to be treated as close to home as possible.
- What will be included in the scope of practice? Elective surgery? Medical inpatients? Obstetric services including birthing public patients in a private facility? Or elective caesarean sections moving from public to private? Mental health care to free up capacity within public mental health, and to what extent might private hospitals and the psychiatrists be asked to care for involuntary patients when the private hospital is usually not gazetted as a nominated facility under the MH Act?
 - The agreements are broad enough to cover a wide range of services. Work will be allocated within the clinical capability of the facility and within the scope of practice of the clinician based on their accreditation with the facility.
- How will VMOs and private specialists be employed? What flexibility will there be?
 - This will be up to private providers to agree with private specialists.
- Where do Medicare and private health funds fit in to the doctor-patient clinical contact funding for insured inpatients?
 - Insured patients may be seen and funded by private health funds as per normal practice, however this will need to be reported as revenue under the Agreements as an off set to the viability payments.
- Does the agreement include the provision of accommodation for private doctors if needed?
 - This is not in the guidelines for the private provider financial viability payment, however activity is funded on the National Efficient Price and therefore may be covered by that payment.
- Will anaesthetists who work with particular surgeons still be able to continue to work with them in longstanding relationships at the different hospitals, as well as participate in helping with public patients in a particular private hospital?
 - A guiding principle of the Agreements is that the private sector is available and responsive to local service demands as part of the COVID-19 response. In the majority of cases it is envisaged that this is unlikely to interrupt established working partnerships between surgeons and anaesthetists.
- Many of the hospital surveys state they are not interested in expression of interest from practitioners age over 60yrs. Are we more senior practitioners likely to be excluded?
 - The Agreements do not include any restrictions regarding the age of clinicians delivering services.

FEES

- Will Qld Health determine what the individual hospitals set the rate of pay or the hospital?
 - The private providers will agree this with private specialists.
- How is a private specialist to be remunerated when treating a public patient in a private hospital? Are episodes of care bundled to include all fees?
 - Activity payments for public patients in private facilities will be based on the National Efficient Price. Private specialist's rates will be agreed between the private hospital and the private specialist.
- How do I find out the national efficient price for a procedure?
 - The Independent Hospital Pricing Authority National Efficient Price Determination (NEP) is publicly available on their website at
 - <https://www.ihsa.gov.au/what-we-do/national-efficient-price-determination>
 - The NEP is published each year, with the April 2020 to June 2020 activity at <https://www.ihsa.gov.au/publications/national-efficient-price-determination-2019-20> and from July 2020 at <https://www.ihsa.gov.au/publications/national-efficient-price-determination-2020-21>
- The National Efficient Price is bundled. How do Doctors know what they will get paid by the Private Hospitals?
 - Private specialists' rates will be agreed between the private hospital and the private specialist.
- What is the NEP funding compared to Surgery Connect funding?
 - Surgery Connect rates are commercial in confidence and are not directly comparable as they bundle in other aspects of care such as follow up care that are separately classified and funded in the NEP.
- Is there a sunset clause? Will this be the new norm for surgery connect?
 - See above regarding the end date of the agreement. Once these Agreements end it is envisaged that Surgery Connect will resume.
- How will assistants and perioperative nurse surgical assistants be paid?
 - This will be determined by the private providers.
- Will only private doctors 'employed' for the purposes of performing surgery on public patients be able to do public patients? How does surgery connect fit into this if public doctors working in private only want to do their own public patients. What about anaesthetists who don't have their 'own' patients.
 - A guiding principle of the Agreements is that the private sector is available and responsive to local service demands as part of the COVID-19 response. This may include clinicians who do not normally work publicly delivering public services.
- Will Anaesthetists have to obtain their payment from the surgeon or from the hospital? Also, there has been some concern expressed that Anaesthetists may not be equitably remunerated that may limit our ability to engage in the collaborative arrangement. Is this being addressed at a Government or local level?
 - This will be determined by the private providers.

- If different hospitals have different rates of remuneration, will this lead to preferred hospitals by doctors?
 - We expect that private providers will be able to come to an agreement with private specialists that allows for services to be available and flexible during the COVID-19 response.

INDEMNITY – Responses previously sent on 9 April 2020

- Will the State provide indemnity to doctors who have to undertake work on public patients in private hospitals under the agreement? What safeguards are in place for sick pay should private specialists become ill looking after COVID-19 patients?
- How will the private facilities be able to cover indemnity and conditions that exist in VMO contracts (factoring costs)?

PPE

- Who will supply the PPE? Queensland Health or private hospitals?
 - There will be a collaborative effort regarding availability of PPE, however generally speaking Private Providers will be expected to source their own PPE for services they deliver.
- For a VMO visiting private hospitals, are the hospitals obliged to provide PPE in an appropriate manner or is it up to the private practice practitioner to attend to this issue?
 - This will be something for each private provider to work through with their clinicians to ensure PPE is available.

RECOVERY PHASE

- Do you anticipate non-Cat 1/urgent Cat2 elective surgery for private patients in private hospitals recommencing any time soon? If not have the Commonwealth given any idea when?
 - This will be an issue for the Commonwealth Government to address and is clearly one which will be kept under constant review.
- Could we start to do basic elective surgery in younger patients who are unlikely to require ICU and then ramp up?
 - Answers to these questions are still to be determined and will be shaped, in part, by decisions of the Commonwealth, the National Cabinet and Queensland Health as the situation progresses.
- Should the private system be allowed to function normally and only be called upon if the public system reaches capacity?
 - A collaborative approach is required to optimise service provision in response to the COVID-19 pandemic. However, if private activity can be undertaken without impacting the response this is acceptable.

- Day surgeries are very low risk of virus transmission and have no inpatient beds. Most of the equipment is only relevant for the specific surgery performed so, once PPE supplies are assured, when will private day surgeries be able to reopen?
 - This will depend on decisions of the Commonwealth regarding elective surgery.
- How do you envisage the private system returning to normal (and private practice being preserved) after this arrangement ends?
 - The arrangements outline a phased approach and a staged transition back to business as usual. As part of this transition there is also likely to be a backlog of both public and private elective work which will need to be undertaken as elective surgery restrictions are eased.