Australian
Private Hospitals
Association

MBS Review – Surgical Assistants

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Introduction

The Australian Private Hospitals Association (APHA) is appreciative of the opportunity to make a submission to the Medical Benefits Schedule (MBS) Review in response to draft recommendations in relation to surgical assistants.

By way of context, the APHA Board has a firm position in relation to out-of-pocket costs:

- APHA acknowledges charging of out-of-pocket charges to patients impacts the affordability of access to healthcare. Out-of-pocket costs also influence consumer perceptions of the value of private health care and private health insurance.

- APHA notes that, when care is covered by private health insurance, out-of-pocket costs charged by private hospitals themselves for services provided by them are usually limited to private health insurance excesses and co-payments.

- Medical fees, however, are a matter for patients and their treating doctors. Medical out-of-pocket costs (including those charged by the surgeon, consulting physicians and/or anaesthetist and/or diagnostic providers) can be significant.

- APHA unequivocally endorses transparency in relation to medical fees and out-of-pocket charges including the provision of written information to consumers prior to treatment.

Consequently, the APHA is supportive of reforms which genuinely improve transparency for consumers and enable informed financial consent. While supporting in part the underlying principles identified by the MBS Review, the APHA is concerned the proposed recommendations will not adequately address the problem identified, and furthermore, they carry significant risk of unintended consequences.

The APHA recommends the problem(s) to be resolved by this reform process are more clearly identified so that a solution can be sought that is both proportionate and effective.

The APHA notes specifically the proposed recommendations fail to take account of three important contextual factors:

- A significant number of surgical assistants are employed by private hospitals either as “vocational surgical registrars” (participants in the Royal Australasian College of Surgeons (RACS) training program) or “service surgical registrar” (doctors waiting to get into the RACS program). In approved circumstances, services provided by these employees to private patients are eligible for an MBS rebate.
- Surgical assistants providing MBS eligible services are almost always also reimbursed through private health insurance and may also participate in known-gap and no-gap agreements with private health insurers.
- Medical practitioners qualified to fulfil surgical assistant roles can frequently be in short supply particularly when hospitals require rosters for emergency and out-of-

hours surgery. Currently around 40 private hospitals provide emergency department services and many operate on an extended hours or 24/7 basis.

This response will address each of the draft principles and recommendations provided by the MBS Review for consultation purposes. It will then discuss the following risks and potiential unintended consequences:

- Loss of training opportunities
- Legal ambiguities relating to employment arrangements
- Unavailability of medical surgical assistants
- Private hospital costs.

Underlying principles

The MBS Review has sought comment on four principles. These principles and APHA's proposed response are outlined below:

1. Informed financial consent on the part of the patient is a fundamental principle underpinning the provision of MBS services.

   APHA supports this principle.

2. The cost to patients of a particular surgical service subsidised through the MBS should not vary significantly when services are provided under similar circumstances.

   APHA supports this principle.

3. The primary surgeon should have control over the patient's out-of-pocket costs for the primary and assistant (if any) surgical services.

   APHA supports this principle to the extent it would improve transparency and informed financial consent for consumers with respect to medical out-of-pockets, pending resolution of measures to avoid unintended consequences.

4. When using a designated assistant for a procedure, the primary surgeon should take responsibility for the remuneration of the assistant.

   APHA supports this principle to the extent it would improve transparency and informed financial consent for consumers with respect to medical out-of-pockets, pending resolution of measures to avoid unintended consequences.

APHA notes, however, these principles are not sufficient to fully address the issues of transparency and informed financial consent for patients undergoing surgical procedures as MBS eligible private patients.

APHA has identified the risk of several unintended consequences which would need to be addressed before full support could be given for principles three and four. These matters are discussed further at page 6.

Draft recommendations

The MBS Review has sought comment on two recommendations:

1. That current arrangements under which surgical assistants bill patients separately from the primary surgeon, and have access to MBS items for their specific services, be discontinued.

2. That new arrangements be introduced under which the primary surgeon pays the assistant directly for their services.

APHA's support for these recommendations is conditional upon measures to mitigate the risk of unintended consequences and the establishment of appropriate monitoring mechanisms.

APHA recommends further consideration be given to defining the problem(s) to be solved by reform in this area and ensuring the policy response is both accurately applied and proportional to the issue(s) identified. APHA notes:

- These recommendations are not sufficient to fully address the issues of transparency and informed financial consent for patients undergoing surgical procedures as MBS eligible private patients.
- These recommendations represent a significant change to the MBS impacting almost 500,000 services annually.
- The instance of egregious out-of-pocket charging by surgical assistants, while of concern, has not been quantified in the information provided to the APHA.

APHA also notes the Ministerial Advisory Committee on Out-of-Pocket Costs will shortly provide its advice to government and this advice might substantially change the context in which the issue of out-of-pocket charges for surgical assistants should be addressed

Issues on which advice has been sought

1. How to ensure patients' access informed financial consent (IFC) and suggestions to improve current IFC processes.

Surgeons are currently subject to IFC requirements. The proposal is a step towards simplifying the process although additional measures would be required to ensure consumers were also made aware other charges might apply and to provide consumers with timely and comprehensive information as to what these other charges might be.

The proposal might reduce egregious out-of-pocket costs by placing the primary surgeon in the position of negotiating a fee and then taking responsibility for passing that fee and any associated out-of-pocket costs onto the consumer. However, the scale of this problem has not been quantified in the information provided to APHA and it is by no means certain this change would have the effect intended without, at the same time, producing a number of unintended consequences including increased out-of-pocket costs to cover added administrative overheads.

One additional issue which would need to be explored by the MBS Review is how the proposed arrangement would work in instances where either or both surgeons were a participant in a no-gap or known-gap agreement with the health insurer.

2. Ways to minimise potential conflicts of interest when referring doctors become the surgical assistants for their patients.

Potential conflicts of interest exist under current arrangements and can only be mitigated by disclosure requirements on the part of both the referrer and the principal surgeon. This issue is made all the more complex by the possibility the primary surgeon might not necessarily deem it appropriate to pass the full rebate on to the surgical assistant.

Avoidance of unintended consequences

Loss of training opportunities
Currently, it is possible for MBS eligible private patients to receive an MBS rebate when treated by a trainee registrar performing the role of "first assistant". Under the proposed new arrangements, the trainee registrar would need to negotiate a fee with their supervising surgeon. The proposed changes could result in a loss of training opportunities if:

- Surgeons were less willing to provide supervision in the private sector because of the additional administrative costs involved.
- Hospitals were unable to afford the costs of providing training positions.

APHA estimates there were 38 FTE RACS training positions in the private hospital sector in in 2014-15. This is likely to be a conservative estimate because it is difficult to fully capture the extent to which trainees gain exposure to the private sector outside the provision of opportunities through the Commonwealth-funded Specialist Training Program.

In addition, the role of surgical assistant is also frequently undertaken by "service surgical registrars" (junior doctors waiting to get into the RACS program) allowing them access to valuable experience. Surgical assistance provides a valuable training and employment opportunity for these junior doctors.

The extent to which registrars currently bill the MBS as surgical assistants is not revealed in published data. However, it should be noted Commonwealth funding does not meet the full cost of employing and training a vocational registrar and consequently, MBS billing has provided a valuable mechanism for covering this cost. Hospital benefits paid by private health insurers do not include the cost of medical services, it is therefore essential junior doctors are able to claim against the MBS when performing recognised medical services.

The opportunity for surgical registrars to undertake surgical assistant roles in theatre is an essential part of their training. The private hospital sector plays a crucial role in providing such opportunities because of the high volume of surgeries performed in the private sector and the differences in case-mix found in public and private hospitals. Without access to training opportunities in the private sector, surgical registrars lack exposure to procedures less commonly performed in the public sector.

APHA recommends, if adopted, the implementation of these proposals should be monitored to ensure there is no impact on the availability of training opportunities in the private sector.

Legal ambiguities relating to employment arrangements
The proposal raises a number of unanswered questions as to whether the proposed arrangement would constitute an employment relationship between the surgeon and surgical assistant and what this might mean if the surgical assistant were also an employee of the private (or public) hospital.

A significant number of surgical assistants are employed by private hospitals either as "vocational surgical registrars" (participants in the RACS training program) of "service surgical registrar" (doctors waiting to get into the RACS program). It is also common practice for vocational registrars to be seconded from the public sector when they are send to a private hospital for a training rotation. In approved circumstances services provided by these doctors to private patients are eligible for an MBS rebate.

APHA recommends the MBS Review seek clarification on these points before proceeding further as there could be significant implications.

Unavailability of independent surgical assistants

The MBS Review consultation paper specifies surgical assistants would be medically qualified and their provider number would be required as part of the claim. The consultation also recommends MBS rebates be set on the basis of the assistant's fee being derived as 15 percent of the surgical items (20 percent of the 'operative' 75 percent component of the relevant surgical item). Currently the most commonly used surgical assistance MBS item (51303) is a derived fee of 20 percent of the primary surgery items. This recommendation would effectively reduce the MBS rebate paid (indirectly via the primary surgeon) to surgical assistants by 25 percent.

If this reform were to result in independent surgical assistants being less available (either because surgeons do not want to pay them or accept the administrative overheads of such arrangements or assistants do not want to accept those terms) it would have the following consequences:

- Increased pressure from surgeons on private hospitals to provide salaried assistants (either medical or non-medical)
- Safety and quality risks if surgeons proceeded without assistance or with a lower level of assistance
- Reduced availability of some procedures in the private sector
- Movement of private patient procedures into the public sector.

The proposal for an assistant rebate based on 15 percent of the primary surgical fee should be reviewed so it provides adequate incentive to ensure:

- Medical assistants will be available for emergency operating lists
- Medical assistants will be available for procedures where the absence of an assistant would give rise to safety risks
- Medical assistants will be available in markets where general practitioners take time away from their practices to provide this service
- The consequent reduction in MBS rebates will not result in increased costs for hospitals employing assistant surgeons
- The consequent reduction in MBS rebates will not result in an increase in out-of-pocket charges to consumers.

Even under current arrangements some hospitals experience difficulties in recruiting sufficient medical surgical assistants especially when filling emergency on-call and out-of-hours rosters. Medical surgical assistants are drawn from a variety of backgrounds, many are general practitioners who may decide the new arrangements are no longer attractive when compared to other practice options. A significant number are medical practitioners who do not want to work full-time, but for whom a reduced fee may not be viable.

Private hospital costs

The MBS Review consultation paper specifies MBS funding would not be used to fund services "which are covered by hospital funding". This is a core principle frequently stated in MBS Review reports. Consistent with this point, it is important the proposed reforms should not increase costs for private hospitals.

APHA does not regard it as acceptable for hospitals to be expected to compensate surgical assistants for lost income as a result of any reduction in MBS rebates for surgical assistants or changed arrangements requiring surgical assistants to negotiate a fee with the primary surgeon.

As indicated above the proposed recommendations carry a risk some surgeons might put pressure on private hospitals to provide additional administrative services to enable reimbursement arrangements between surgeons and surgical assistants. These recommendations also risk some surgeons will put increased pressure on private hospitals to provide and pay for surgical assistants, either medical or non-medical.

A shift in costs from the MBS to private hospitals is not sustainable. Private health insurers do not reimburse hospitals for medical costs. On the contrary, they demand private hospitals constantly strive to provide services as efficiently as possible in order to reduce upwards pressure of private health insurance premiums.

Private Hospitals in Australia

The private hospital sector makes a significant contribution to health care in Australia, providing a large number of services and taking the pressure off the already stretched public hospital system.

The private hospital sector treats:

- 4.43 million hospitalisations a year.

In 2016–17 it delivered:

- 60 percent of all surgery
- 73 percent of eye procedures
- Almost half of all heart procedures
- 73 percent of procedures on the brain, spine and nerves.

Australian private hospitals by the numbers:

- Almost half (49 percent) of all Australian hospitals are private
- 657 private hospitals made up of:
    - 300 overnight hospitals
    - 357 day hospitals
- That amounts to: 34,339 beds and chairs (31,029 in overnight hospitals and 3,310 in free-standing day surgeries)
- Employs more than 69,000 full-time equivalent staff.

The Australian Private Hospitals Association

The Australian Private Hospitals Association (APHA) is the peak industry body representing the private hospital and day surgery sector. About 70 percent of overnight hospitals and half of all day surgeries in Australia are APHA members.