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Medicare Benefits Schedule Review Taskforce
Chair, MBS Principles and Rules Committee
Email: mbsreviews@health.gov.au

Dear Professor Grigg

MBS Review—Proposed changes to remuneration arrangements for surgical assistants

Thank you for your letter dated 4 September advising of proposed changes to remuneration arrangements for surgical assistants. We appreciate the opportunity to provide comments on these very significant proposed reforms.

Whilst the AMA appreciates the MBS Review Taskforce Principles and Rules Committee's (PRC) concerns regarding transparent billing practices and wide variability in out-of-pocket (OOP) costs; we adamantly reject the proposed recommendations and strongly urge the Taskforce to not progress with these recommendations.

There is strong opposition to the recommendations by our members and the justification is detailed below for your consideration.

They are independent practitioners – they should remain so

Medical surgical assistants work closely with the principal surgeon as a skilled second pair of hands before, during and after surgery, to maximise safety and efficiency. Medical surgical assistants are an integral part of the surgical team and have made a significant contribution to the high standards of surgery patients now enjoy. Surgical interventions are increasingly complex, and even routine procedures can involve considerable risk.

Although medical surgical assistants work under the leadership of the primary surgeon as part of a multi-disciplinary surgical team, they are independent practitioners, not unlike anaesthetists, and should remain so. For the surgeon to bill on behalf of, and then reimburse the assistant surgeon will add a level of additional administrative and contractual complexity. There may also be significant tax implications involved, with the potential for some arrangements to be viewed as an employer/employee relationship.

These recommendations set a dangerous precedence for a bundled payment for all doctors involved. The system must respect doctors' right to practice independently and make their own decisions regarding fees on a patient-by-patient basis. Not only should the independence of career surgical assistants be protected, but also assisting in the private sector is an essential component of training for many registrars and must be fully supported and funded.

The relationship - power imbalance

Given the hierarchy of surgeon and assistant, this proposal has the potential to further exacerbate this and potentially undermine a professional training pathway for future primary surgeons.

Changing the financial transaction around payment changes the interrelationship between the surgeon and assistant surgeon that affect the assistant's actions (potentially being unable to put forward independent clinical opinion, even as a suggestion, if this differs from the primary surgeons given how beholden their livelihood is to the surgeon's discretion) that may have consequences for the patient, as well as the inconsistency for assistants in payment practices and the impact on their wellbeing and livelihood.

Independent billing supports quality patient care by maintaining and supporting a financial and employment separation between surgeon and assistant. This will facilitate a surgical assistant's ability to practice professionally and independently according to good medical practice and in the patient's interest.

Role of surgical assistants in training – negative impact

The AMA also has concerns around the effect upon trainees that would result from adoption of the proposed recommendations. Many doctors in training undertake surgical assistant roles in order to enhance their prospects of selection on to the surgical training program, as well as access the types of clinical experience in the private sector during vocational training, that are often quite limited in a public setting. These leaves them in a very vulnerable position in terms of negotiating an appropriate fee for their work.

Risk of de-skilling GPs in rural and remote areas

With fewer specialists available, rural GPs are often required to provide a wider scope of practice than in metropolitan areas. GP proceduralists, or generalists, working across rural and remote Australia are vital to rural patients access to local surgical services. Most rural GPs work as private practitioners, with many providing services at their local hospital as Visiting Medical Officers. Proceduralist GPs with surgical skills help ensure that rural residents have timely access to a range of general surgical procedures.

These proceduralist GPs, not only provide surgical assistance to visiting surgeons, they may also provide the post-operative care required after a procedure.

Requiring independently practicing GPs to have the payment for their service dependent on coming to a mutually agreeable financial agreement with a multitude of primary surgeons who, in many cases may be working in a fly-in, fly-out arrangement, will be administratively burdensome for both parties. The potential for disputes with such an arrangement could see decreased willingness in practitioners' willingness to use or be surgical assistants and reduce overall access to care in rural settings.

With rural workforce data showing there has already been a significant decline in GP proceduralists, any measure that threatens their capacity to utilize and maintain their skills, jeopardises rural residents' equitable and timely access to surgical services and to quality care.

Proposed derived fee – baseless assumptions

The MBS Review Taskforce's proposal for the surgical assistant's derived fee/s to be reduced from 20 per cent to 15 per cent of the surgical MBS item is based on the assertion that: *"Historically, MBS fees for surgical items have been taken to comprise 75 percent for the surgery (the 'operative' component) and 25 per cent for 'aftercare'…";* that surgical assistants are not involved in aftercare; and therefore should only receive a derived MBS fee of 20 per cent of the 75 per cent. I've received feedback from AMA members that surgical assistants do in fact provide aftercare as part of their assistance at operations and they disagree with the rationale for the reduction in the derived fee.

Furthermore, the current significant gap between MBS rebate and real costs of providing medical services— and therefore increasing patients' out of pocket costs, will only be worsened by cutting funding to medically qualified surgical assistants. The recommendations will also be strongly opposed if based on outdated or incorrect assumptions.

Private Health Insurance and Out of Pockets Reforms underway

Informed financial consent and increasing patients' out of pocket costs are complex and multifaceted issues. It involves, but is not limited to, no and known gap agreements, contracts between hospitals and insurers, varying benefit schedules, and increasingly complex insurance policies.

The Private Health Ministerial Advisory Committee (PHMAC) and the Ministerial Advisory Committee (MAC) on Out-Of-Pocket Costs have been established specifically to oversee private health insurance reforms, Informed Financial Consent (IFC) and OOP costs.

This issue is therefore not the remit of the MBS Review Taskforce – which is to "align the MBS with contemporary clinical evidence and practice and improve health outcomes for patients". In addition to inappropriate, it could possibly be detrimental for separate committees to implement separate reforms to address IFC and OOP costs.

Furthermore, MBS items form the basis of the rebate system used by all private health insurers and are written into the private health insurance legislation and regulations. Significant changes to MBS items, such as those proposed for surgical assistants, have the ability to disrupt the entire payment schedules for private health insurance rebates.

Not only will each private health insurer have to adjust their information systems and billing practices to take into account of the proposed changes to the assistant surgeon MBS items, this is such a fundamental structural change to MBS that every insurer will also be required to adjust their no and known gap policies.

This is a major structural reform of PHI – which no doubt would be implemented in 2019, exactly when the other major structural reforms of private health insurance are due to come into effect. The MBS Review's proposed changes to surgical assistants' remuneration are entirely out of sync and detracts from other major Government reviews relating to ICF, OOP and private health insurance.

Alternative mechanisms to address concerns

The AMA strongly supports provision of IFC. IFC works best when medical practitioners, hospitals and health insurers work together to provide information to patients about the costs associated with treatment, and the private health insurance benefits payable, prior to treatment. The proposed new arrangements in which the primary surgeon pays the assistant directly for their services will not solve the problem of IFC and OOP costs. As mentioned, there are many factors that contribute to the out of pocket costs for patients and the MAC on Out-of-Pocket Costs are pursuing strategies to reduce OOP expenses and improve IFC. The proposed MBS Review Taskforce PRC's recommendations only serve to create more problems than solutions.

However, strong IFC can help patients understand the cost of their surgery. The AMA has made numerous submissions to the Government and the Parliament on this issue, as well as continuing to work with the profession and consumers to address these concerns. This includes but is not limited to the suite of information available on our website.

No data provided on the problem

The increasing year-on-year cost of providing medical care, has not been matched with annual indexation to MBS fees. This has contributed to the growing OOP expenses for patients. The recent slow thaw for some sections of the MBS falls short of redressing the years of funding neglect. While the AMA continues to advocate for much needed increases in public funding for medical services to address the growing OOP costs, it's unclear how a 'bundling arrangement' would solve this issue. Furthermore, without being provided with a list of the items in question by the MBS Review Taskforce, and what the proposed new items would include, it is impossible to determine.

An additional argument for rejecting the MBS Review Taskforce's proposal for new remuneration arrangements for surgical assistants is that, based on data from the Australian Prudential Regulation Authority (APRA), the no and known gap rate for the 2017-18 financial year was 92 percent and an average known gap fee of $94, for assistance at operations MBS items 51300 to 51318[1]. Additionally, the Medical Surgical Assistants Society of Australia (MSASA) has advised the AMA that the two main MBS item numbers are 51300 and 51303; and they have obtained data from a major national billing service which indicates that no gap rates are 93 per cent and combined no and known gap rates are in excess of 99 per cent for these items, in the last financial year, against a volume of 450,000 services.

I understand that a small number of practitioners are alleged to be charging egregious fees, but in comparison to the hundreds of other practitioners who provide half a million fair priced and necessary services annually, a complete restructure appears inappropriate. Additionally, it is impossible for the AMA to comment on the scale of the concerns identified by the MBS Review Taskforce in the absence of being provided any data on the MBS items, their relationship with insurance coverage, and finally, the potential OOP cost to the patient.

[1] Private Health Insurance Medical Services June 2018 (released 16 August 2018), APRA, https://www.apra.gov.au/publications/private-health-insurance-medical-services - accessed 18/9/18

Conclusion

The arguments provided in this submission provide strong evidence of the potential for unintended and possibly perverse consequences, of the MBS Review Taskforce PRC's proposed changes to remuneration arrangements for surgical assistants.

Consequently, the AMA adamantly rejects the proposed recommendations.

In the absence of any data being provided, it appears that the problems that the MBS Review Taskforce PRC has identified with surgical assistants are isolated to a very small number of practitioners, and these sweeping proposed changes to the remuneration arrangements are wildly inappropriate and unacceptable, not to mention via the wrong mechanism.

The AMA remains happy to discuss issues regarding OOP costs and the PHI via the relevant committee. In the meantime, the AMA strongly urges the Taskforce to not progress with these recommendations.

Yours sincerely

Dr Tony Bartone
President