Dear Professor Grigg,

RE: MBS Review Consultation: Discussion on current arrangements for surgical assistants

Thank you for the opportunity to respond to this review which was brought to RACS’s attention by various groups some time ago. The MBS Taskforce was contacted by the RACS Manager of Policy and Standards. I have been assured by the MBS Review Branch that they have updated their email database to ensure that RACS will receive advance notice in future for a submission as a relevant stakeholder. Since then an official invitation to respond has been provided to RACS with an extended deadline.

In principle RACS opposes any form of the bundling of fees and supports billing independence.

Medical surgical assistants are greatly valued by our surgeons who utilises their skills and experience, especially in rural and remote areas. The Medical Surgical Assistants Society of Australia (MSASA) has made a compelling argument to RACS. They have argued against the bundling of patient rebates for surgical assistants and have research to show that “the overwhelming majority of MSA accounts are either no gap (93%) or ‘no and known gap’ (99.69%)… from private billing agency accounts of 450,000 services provided under group T9 by several thousand assisting doctors over the last 10 years.”

The following Four Principles being examined by the MBS Review are as follows;

1. Informed financial consent on the part of the patient is a fundamental principle underpinning the provision of MBS services.
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.
3. The primary surgeon should have control over the patient’s out-of-pocket costs for the primary and assistant (if any) surgical services.
4. When using a designated assistant for a procedure, the primary surgeon should take responsibility for the remuneration of the assistant.
RACS has sent out a communique to our partner specialty surgical societies and associations for more feedback which we have since received to assist with our submission. The matter was discussed during a recent Board of Council meeting. Early discussions with many of our Fellows, the Australian Medical Association (AMA), the Medical Surgical Assistants Society of Australia (MSASA), the Australian Association of Nurse Surgical Assistants (AANSA) and other stakeholder groups would suggest that there is support for Principles 1 & 2 but not 3 & 4. This is in line with RACS' final position on the matter.

*RACS supports Principles 1 and 2 but rejects Principles 3 and 4. While IFC is supported, the belief that surgeons should determine the overall charges inclusive of any potential out-of-pocket costs is not. The reason being that it will equate to a huge extra administrative burden for our Fellows. RACS also disagrees with the recommendation to reduce the assisting fee from 20% to 15% of the schedule fee.*

**RACS' PREVIOUS POSITION**

*RACS published an earlier submission* to the MBS Review in November 2015 which stated the following position:

We encourage review of surgical assistant fees, including procedures that generate an assistant's fee, and *discourage the bundling of surgical assistant, anaesthetist and surgery items* on the schedule because it will inevitably result in greater out of pocket expenses for the patient, and could introduce a perverse incentive to minimise use of assistants where an operation should not be done without an assistant. (p.3)

Our position has not changed.

**ANALYSIS OF KEY ISSUES**

**Reducing the Assisting Fee to 15% of the Schedule Fee**

After consultation with our specialty surgical societies and associations RACS received the following feedback. The Australian and New Zealand Association of Urological Surgeons (ANZAUS), Australian and New Zealand Society for Vascular Surgery (ANZSVS) and General Surgeons Australia (GSA) advised RACS that they disagreed with reducing the assisting fee from 20% to 15% of the schedule fee. The reasons being are that regional areas will be negatively impacted, and with the MBS fees remaining stagnant due to the MBS indexation freeze it will subsequently lead to increases in gaps as opposed to the intended outcome of eliminating “bill shock.”

**Average Growth Rate**

On p.1 of the Consultation Paper, reference was made that the “compound average growth rate for Group T9 is 1.97% over the last five financial years to 2016/17.” The MBS Principles and Rules Committee (PRC) of the Taskforce argued that separate billing, lack of transparency and the wide variability of costs have amounted to this growth rate. However, a *new report* from the Australian Institute of Health and Welfare (AIHW) has shown that “between 2012–13 and 2016–17, the number of hospitalisations rose by an average of 4.3% each year for public hospitals and 3.6% each year for private hospitals.” This steady growth of hospital entry has been ignored in the Consultation Paper as a reality of our healthcare environment.
Variability in Assistant Billing and Out-Of-Pocket Costs (OOP)

In RACS’ experience with surgical variance reports, some outliers are present. While at times fees may be deemed as potentially excessive, RACS always supports the value of risk adjustment measures to be applied where there may be other reasons that influence costs such as the complexity of a procedure and geography. Table 2 (p.2) of the Consultation Paper provides clear examples of questionable outliers between 2016 and 2017. However, the table also shows that the average assistant’s fees is considerably low (i.e. Complex Caesarean section; surgeon’s fee is $2,118, assistant’s fee $9,250, average assistant’s $258). Why is there the current level of high scrutiny being imposed upon surgical assistants when the great majority by the PRC’s estimates appear to be providing a reasonable out-of-pocket cost?

RACS has already stated in our position paper that extortionate or manifestly excessive fees are exploitative, unethical and in breach of our Code of Conduct. Furthermore, matters concerning Private Health Insurance and OOP reforms are already being dealt with by the Private Health Ministerial Advisory Committee (PHMAC) with RACS immediate past President Mr Philip Truskett AM as a member and the Ministerial Advisory (MAC) on Out-Of-Pocket Costs which I am a member of.

Principles and Rules Committee Proposals

RACS is of the firm belief that the voluntary implementation of Informed Financial Consent policies and practices in Australia will assist patients with cost transparency. Understanding what has been billed for a particular procedure will provide patients with the opportunity to question or negotiate their terms and conditions. RACS has been on the front foot having already established an IFC position paper and we are currently examining other pathways for clearer patient information.

Perioperative Nurse Surgical Assistants & Nurse Practitioners

RACS wrote a letter on the 27 September 2017 to the AANSA through our Chair of Professional Development and Standards Board Mr Richard Perry FRACS indicating our support in the advocacy for the remuneration of Perioperative Nurse Surgical Assistants (PNSA) via the MBS Schedule within the MBS definition of ‘T.9.1. Assistance at Operations - (Items 51300 TO 51318). Feedback and research from our Fellows indicated that PNSA’s are largely being used in settings where assistants may otherwise be unavailable or where it may be difficult to achieve continuity of care. We do emphasise however, that the use of PNSA’s should in no way impede the ability of our surgical trainees in gaining access to training in the operating theatre.

The following caveats for PNSAs have been endorsed by RACS as minimum entry requirements. These include; the appropriate qualifications (i.e. PNSA course offered by La Trobe University), credentialed continuity at each hospital they work at, access to a surgeon mentor and access to the appropriate indemnity insurance. Formalised oversight and participation in ongoing CPD for PNSA’s that is competency based and within their scope of practice is essential with RACS willing to review the CPD framework for PNSA’s and provide advice as appropriate. Nurse Practitioners who are adequately educated and skilled should be allowed access to appropriate MBS remuneration. Patient’s exposure to out-of-pocket expenses may increase if the MBS does not appropriately remunerate Nurse Practitioners for surgical assistance, especially in a rural setting.
CONCLUDING THOUGHTS

RACS understands the importance of the MBS Review as a whole and affirms its key goals to deliver better patient outcomes as a result of a thorough scientific and economic assessment of the MBS items and associated rules. However, any measure which may result in assistants being put in a position to negotiate an employment contracts scenario with their surgeons has received some considerable backlash from our Fellows and other key stakeholders. RACS would encourage the PRC to please reconsider their position concerning Principles 3 and 4, and instead allow the Private Health Ministerial Advisory Committee (PHMAC) and the Ministerial Advisory (MAC) on Out-Of-Pocket Costs to tackle the all-important question concerning IFC and how transparency can be better delivered and presented to our patients.

Yours sincerely,

Mr John Batten
President

C.c.: Mr Richard Perry - RACS, Chair Professional Development and Standards Board
Ms Mary Harney - RACS, CEO
Mr John Biviano - RACS, Deputy CEO