Private Healthcare Australia
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Surgical assistants working group - response to Issues Paper

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14 million Australians.

Surgical assistance

Private Healthcare Australia values the work of surgical assistants, who along with surgeons, anaesthetists, nurses and other theatre staff, form part of a patient's surgery team.

The surgical assistant is generally a medical practitioner, generally a doctor who is skilled at surgery and in many cases is on the path to becoming a surgeon (or a general practitioner with surgical skills).

The Surgical Assistant Working Group (SAWG) has examined two issues:

- Surgical assistant billing arrangements, and
- Access to surgical assistant MBS items for non-medical surgical assistants.

In both areas, the Working Group has failed to adequately examine the issues from the consumer perspective, and thus the conclusions may be flawed. PHA recommends a re-examination of these issues, considering the points below.

Surgical assistant billing arrangements

The two issues identified by the Taskforce's Principles and Rules Committee are valid and important to the consumer:

- Separate billing of the patient by the surgeon and surgical assistant, and the surgeon's frequent lack of visibility of their assistant's billing practices.
- Wide variability in the amount of out-of-pocket costs charged by surgical assistants, including some assistants charging a higher fee than the surgeon, and large differences between the lowest, average and highest fees charged by surgical assistants as a cohort.

That the SAWG considered that no changes to billing arrangements was necessary as there were no significant data indicating instances where surgical assistants are charging a fee in excess of the primary surgeon is a ludicrous benchmark to use.

The SAWG should consider this issue from a consumer perspective. The core data points to consider is how many surgical assistants change at or below the MBS fee, and how many charge patients out of pocket costs. These data are available from the department's Medicare statistics and HCP1 databases, and it is disappointing that the SAWG chose not to consider or report these data.

The data held by PHA suggest that around 15% of patients are charged an out-of-pocket cost by their surgical assistant after MBS and health fund rebates, and over 95% of services are charged above the MBS fee. Both benchmarks are significantly higher than the average for medical services.

The separate billing by surgical assistants is problematic for consumers, and in many cases, consumers are completely unaware that they will be receiving a bill for a surgical assistant. Hidden out of pocket costs from surgical assistants are one of the more common areas of complaint from private health insurance fund members.

The wide variability of fees means that out of pocket costs are often very high, as surgical assistants are among the least likely professionals to seek informed financial consent.

PHA has recently released a policy paper on surprise billing which is designed to prevent unknown out of pocket costs, by ensuring a patient is not liable for out-of-pocket costs where a doctor has failed to provide informed financial consent (attached).

The assertion by the SAWG that consumers are currently paying out of pocket costs for the services of non-medical surgical assistants is not supported by any evidence. This issue has not been reported to health funds, and nor do funds have evidence of widespread attempts to claim benefits. It is more likely that non-medical personnel who do assist in surgery are not billing patients, and very likely that the lack of remuneration means non-medical personnel are not asked to assist in surgery. The suggestion from the SAWG that "nurses are providing up to 50% of surgical assisting and bill separately from the surgeon" is reported without supporting evidence and does not bear scrutiny.

Private health insurance pays both medical benefits and hospital benefits, often under contracted arrangements. For hospital benefits, the costs of non-medical staff are covered by contracting arrangements. If a non-medical surgical assistant is charging patients separately (and there is no evidence that this is the case) that is likely to clash with the terms of the contract with the hospital.

PHA recommends that the Medicare Review Taskforce reject the SAWG advice as presented and ask the SAWG to collect the evidence, consider the billing issues from a consumer perspective and then report back.

Access to surgical assistant MBS items for non-medical surgical assistants

PHA makes no comment on the ability of non-medical personnel to assist with surgery – this is a task for the learned medical colleges. The colleges will need to consider quality, access and training issues, along with the potential for medical trainees to be displaced by non-medical surgical assistants.

PHA asks that the government consider the breadth of personnel who may be present in an operating theatre (including surgeons, anaesthetists, other doctors, nurses, support personnel and, often, medical device sales representatives) and on what basis the surgeon determines who is assisting with surgery and who is undertaking other important roles.

The SAWG report does not go to the qualifications needed to provide surgical assistance, and in the absence of such criteria, it appears that any person who happens to be in the operating theatre could potentially be deemed a surgical assistant (despite these staff already paid for through hospital contracting arrangements). Allowing any person in the team to be deemed the surgical assistant could lead to the position where every surgery has a nominated person who would be allowed to bill the patient through Medicare, regardless of the individual's qualification or the patient's need.

The claim that non-medical surgical assistants would reduce the out-of-pocket costs to patients is predicated on the baseless claim that charging by these assistants is common practice, when there is no evidence to suggest this is the case. The most likely scenario is a significant increase in out-of-pocket costs to consumers along with increased costs to the taxpayer, to the health system, and to over 14 million Australians with private health insurance – with no assurance of quality, training and benefit to the patient or the community.

PHA does not recommend that non-medical personnel be granted access to MBS billing for surgical assistance based on this analysis. There may be a case for well qualified personnel to provide surgical assistance, but this would need to be accompanied by a more thorough examination of qualifications and training; and economic modelling based on real data rather than assertions not supported by the evidence.