Medical Surgical Assistants Society of Australia

02 9567 7329
info@msasa.org.au
msasa.org.au

MSASA response to SAWG Draft Report.

7th[th] October 2022

The Medical Surgical Assistants Society of Australia (MSASA) Executive has reviewed the draft report of the Surgical Assistants Working Group (SAWG) Sub-committee of the Medicare Review Advisory Committee (MRAC), released on 26th August 2022.

1. The SAWG Sub-committee has found that there is no quantitative evidence of egregious billing by medical surgical assistants (MSAs), nor any reason to reduce Commonwealth Medicare Benefits Schedule (CMBS) patient rebates from 20% to 15% of the surgeon's rebate. We agree with the SAWG Sub-committee findings on this matter, in line with our submissions.

2. As stated previously we respect the right of surgeons to choose who assists them. We acknowledge that small numbers of nurse surgical assistants have been working in the private sector in Australia for many years.

3. However, we reject the notion that a nurse assistant is the equivalent of a medically qualified surgical assistant. Failure to understand the difference between these roles will have adverse impacts on patient safety.

4. Accordingly, we do not agree that nurse surgical assistants (NSAs) should receive the same remuneration as medical surgical assistants (MSAs) as this will lead to the presumption of equivalent medical knowledge, involving a detailed understanding of whole body systems, as is expected of a medically qualified surgical assistant.

5. If NSAs are included in the CMBS, the public will further assume they have equivalent medical knowledge. Hence, we oppose this proposition.

6. MSASA is aware of claims that NSAs are required because of a perceived shortage of MSAs in some areas. Our members are not aware of any efforts by affected hospitals to reach out to organisations such as MSASA for advice on supply of MSAs.

7. MSASA recommends that if the Federal Government is determined to directly rebate patients for the services of NSAs, then such funding should **NOT** be via the CMBS system, and the delineation between services delivered by medical practitioners and services delivered by nurses should be maintained in the interests of patient safety.

8. Any recommendation to include NSAs in the CMBS will lead to a justified avalanche of demands by allied health practitioners for equivalent access to CMBS rebates as well as putting significant pressure on the supply of high quality theatre nurses.

9. It is highly significant that the only workforce group lobbying for the proposed change are nurses. No surgeon group is lobbying for this change, nor any consumer or patient

advocacy group. It appears the SAWG Sub-committee is responding to the requests of a small interest group seeking an increase in remuneration, and/or a different model of remuneration for NSAs compared to other hospital and theatre nurses.

10. A short-term consequence of any agreement to the above proposal would likely be a move for all nurse theatre staff to be included on the CMBS, as no justification for their omission would exist.

11. Equity issues are raised to justify this action. Certainly there are differences in the way that doctors and nurses are currently remunerated in regard to surgical assisting, but this doesn't necessarily mean that the system is inequitable. MSAs should be rewarded, commensurate with their qualifications, skills and training, and the responsibilities they assume compared to other health professionals. The CMBS item numbers available to MSAs reflect this. Many nurses performing NSA duties are hospital employees and paid at appropriate award rates. Where surgeons wish to employ their own NSAs, we assume they are also paid at award rates.

12. The implications of providing access to the CMBS to any member of the nursing profession who completes as little as 116 hours of additional study are highly significant. We do not believe the members of the SAWG Subcommittee appreciate the depth of their duty to protect the CMBS from misuse. By allowing such access to a large non-medical group they will open the door to potentially over 500,000 non-medical health professionals who may understandably feel justified in seeking similar access.

13. The unintended consequences of the SAWG proposal are significant. Without controls such as proof of a shortage of MSAs, and then corresponding geographic limitations, there would be an unavoidable loss of training opportunities for both surgical trainees and junior medical staff. Both of these groups rely on private surgical assisting work as part of their surgical education.

    The proposal would also create a significant incentive for high quality theatre scrub nurses to leave their hospital employment in search of better remuneration and improved work conditions. This would exacerbate an existing shortage of high-quality theatre nursing staff.

14. **MSASA maintains that this solution is inappropriate, and by the SAWG Sub-committee's own admission will not address one of the primary problems, ie the alleged rural shortage of MSAs, which it uses to justify the change.**

MSASA concludes:

- The Draft Report assumes that there is a significant problem to be addressed, but it is based on a number of assumptions that are neither evidence-based nor quantified.

- As a result the proposal to provide NSAs with access to the same CMBS item numbers as MSAs is a simplistic solution to a questionable problem.

- It signals a lowering of the qualifications and training requirements for surgical assistants and wrongly equates, by association and implication, nursing training plus some additional study with a complete medical degree, consolidated by 12 months internship.

- Medical surgical assistants have an independent duty of care to the patients who come under their care during surgery. This is separate to that of the surgeon and hospital staff. This liability arises because of their qualifications and society's expectations of our doctors. Their remuneration is reflective of the responsibility they assume when caring for patients, even if this responsibility is shared with a surgeon. They must always carry appropriate indemnity insurance accordingly.

- This proposal assumes that a nurse can be called on and expected to provide the same procedural services and support as a medical practitioner, even a trained surgeon. This is a dangerous proposition. It fails to appreciate the cognitive input of the medical surgical assistant, which is often very important, especially in major surgery, or in times of crisis or emergency.

- MSASA notes for future reference that no patient safety impact study has been undertaken in regard to this proposal, and if it has been, it has not been made available to medical practitioners for comment or review.

- Academic excellence is a pre-requisite for entry into every Australian medical school for good reason. This underlines the importance universities place on the high cognitive capabilities expected of our medical doctors. It is dangerous to assume or advocate that competencies in regard to bodily interventions (including interventions undertaken by medical surgical assistants) can be acquired without the foundational knowledge of the **whole** body system. As former President of the Australian Medical Council Prof Richard Smallwood AO FRCP FRACP warned,

  "Competence, and hence performance, go beyond competencies. The tacit knowledge which directs higher order reflection and reasoning is a critical ingredient. A good physician is more than the sum of a set of discrete psychomotor skills and acquired facts. The AMC framework for competence-based education thus remains a broad one and not a list of narrowly defined, detailed individual elements of skill or knowledge."

  The new world of National Registration and Accreditation and Health Workforce Reform, *RACP News* Oct 2010.

- When this academic excellence is augmented with years of education in whole body systems, training and experience, it produces medical surgical assistants of the highest possible calibre. We doubt that there is any health system globally that has a better qualified private surgical assisting workforce than Australia, and this has contributed to the reputation Australia has achieved for world's best safe surgery. Undermining this model in any way is contrary to the welfare of patients and public confidence in Australian surgery.

- Any comparison of other first world countries use of non-medical surgical assistants should be considered in the context of overall health system rankings for health care **outcomes** and **equity.** In 2021, the US Commonwealth Fund Annual Report ranked Australia number 1 on

both of these measures, among 11 high income countries. The US system, so often thought to be a health care leader, ranked number 11 on the same measures.

- Any attempt to augment the private surgical assisting workforce with NSAs, or worse, attempt to replace MSAs with NSAs, will lower the minimum standards of the workforce.

- The recommendation fails to understand the practical structure and working relationships of surgical teams. A surgeon is more likely to heed the advice of a medically qualified colleague over the advice of a team member who is not medically qualified. This has implications for patient safety. In the airline industry one of the most common contributing factors in major accidents over the past 20 years has been a hierarchical difference between pilot and co-pilot. Airline companies are now focussing on ways to reduce that hierarchical difference, not enlarge it. Increasingly the health sector is looking to the airline industry for guidance on ways to improve patient safety.

- The Draft report recommends a solution to the purported problem, then admits the proposed solution will not address the primary problem identified as the reason for change.

- This recommendation is in response to lobbying from a small interest group – a subset of the nursing profession. By its own admission the number of nurse practitioners providing private surgical assisting services numbers less than 100. The access requests to the CMBS by this group are being used to justify a significant opening up of the CMBS to non-medical health professionals which will have to be **matched** by increases in Medicare funding and/or a cut to Medicare rebates at a time of increasing inflation and rocketing costs of living. Those other allied health professionals who are left out of this opening of the CMBS to non-medical health practitioners are more than capable of alerting the public to the perceived injustice and inequity of not including all allied healthcare.

- No private hospital groups seem to have been involved in discussions to date. Given they stand to bear the brunt of any exodus from theatre nurse roles to NSA roles, one would have expected to see their input. It appears the members of the SAWG Sub-committee are failing in their duty to properly inform and involve all likely affected stakeholders.

- If implemented, the proposal would exacerbate nurse workforce shortfalls. According to the Federal Secretary of the Australian Nursing and Midwifery Federation (ANMF) Annie Butler, “The number of vacant [nursing] positions being advertised currently has doubled since this time last year.” (ABC News, 13 Aug 2022)

- There are substantial liability issues with sub-contractor relationships in surgery. It is a minefield of complexity. The SAWG Sub-committee correctly identifies the risk of surgeons employing nurses and claiming rebates on their behalf. We believe this is a significant risk and is more likely to happen with nurses than it does with doctors due to the power imbalance or hierarchical difference.

In Summary

The proposal has not been subjected to an appropriate level of analysis that includes detailed investigations into patient safety impact implications. The report contains numerous sweeping statements and questionable assumptions, with little quantitative data to support them. The Sub-committee appears to have accepted the claims of the nursing groups lobbying for access to CMBS rebates at face value and without question.

We disagree with the premise that nurse surgical assistants are able to provide the same qualitative service as medical surgical assistants. They do not have the same training, skills or responsibilities as doctors and to grant the proposal is a presumption that they do, which will potentially impact adversely on patients.

We acknowledge that some nurses will continue to perform first surgical assistant duties, as they have done for many years. However we do not agree that they require access to CMBS rebates to continue to do this work. The current system does delineate between medical surgical assistants and nurse surgical assistants and maintains appropriate professional expectations of both groups.

This Sub-committee has proffered a solution that will appease the nurse lobby groups, but which by its own admission, fails to address the primary justification for change – namely an alleged (but not quantified) shortage of MSAs in rural settings. These issues should be addressed outside of a major structural change to the CMBS that will have significant unintended consequences at many levels - including the threat to junior doctor training and the likely exacerbation of a shortage of quality theatre nurses. It will also create an unquantified and unfunded additional drain on the CMBS.

Any expansion of access to the CMBS by non-medical persons will likely be keenly observed by the Allied Health Workforce. It will be seen as an opportunity to press for further access to the CMBS beyond the nurse practitioner workforce. Given that these pressures already exist in the system, this impact is likely to be immediate for a range of AHPRA-registered health professionals.

Finally, as per our previous submission, any move to deskill the surgical assistant, or increase their subservience, would encourage insurance companies to push for bundling of surgical fees for both surgeon and assistant, and likely anaesthetists as well. It would fit nicely with their US style “managed care” agenda, which is an ever-increasing threat to Australian private medicine and surgery. Hence, Australia’s balanced private- public hospital and healthcare model, which has produced world-class health and medical treatment for decades, risks being further pushed into corporate control, with funds driving the direction of private medical services in line with investor expectations.

Yours sincerely

Dr Nigel R Munday President MSASA 2022
On behalf of the executive of MSASA
Dr Eleanor Babcock (NSW)
Dr Allan Craft (Qld)
Dr Marty Blum (Vic)
Dr Peter Pedoulias (SA)
Dr Allan Craft (Qld)
Dr Deborah Pfeiffer (Qld)
Dr John Whishaw (Tas)