Australian
Society of Anaesthetists

SUBMISSION

TO

FEDERAL PARLIAMENTARY INQUIRY

INTO

HEALTH FUNDING

BY

AUSTRALIAN SOCIETY OF ANAESTHETISTS

This submission by the Australian Society of Anaesthetists (ASA) concentrates on the delivery of anaesthesia services to the Australian community and aspects of health funding that impact on the maintenance of a high quality consumer-focused service delivered in an economically and clinically efficient way. It is the view of the ASA that reform and improvements in the funding of health services could provide improved outcomes for the community without incurring any significant increases in expenditure in health funding.

THE AUSTRALIAN SOCIETY OF ANAESTHETISTS

The Australian Society of Anaesthetists was established in 1934 and with 2,500 members currently represents 80% of medical practitioners (both specialist and general practitioner – GP) providing anaesthesia services in the private sector. Each year anaesthesia services are provided to approximately 1.6 million patients in the private sector with a similar number of patients in public hospitals totaling 3.2 million patients receiving anaesthesia services annually or 16% of the entire population. Whilst there are over 4,000 medical practitioners who provide anaesthesia services, 95% of services are provided by the approximately 2,000 specialist qualified anaesthetists.

IMPACT OF ANAESTHESIA SERVICES ON THE AUSTRALIAN PUBLIC

As stated above, approximately 3.2 million patients are anaesthetized in Australia every year. As a single specialty, anaesthesia impacts on a greater proportion of the Australian community than any other branch of hospital-based medicine. Improvements in the delivery of anaesthesia services therefore have the potential to result in widespread benefit to consumers of health services. Whilst the standard of anaesthesia in Australia is arguably equal to the highest in the world, the ASA firmly believes that significant improvements in health outcomes can still be achieved with suitably funded initiatives in anaesthesia practice.

ACHIEVING NEW FUNDING IN THE HEALTH SYSTEM

The ASA has been frequently frustrated in the past with aspects of health funding, both public and private, when attempting to initiate changes in anaesthesia practice which have been shown to produce improved health outcomes for the community. The following example will illustrate some of the deficiencies of the current system.

Anaesthesia Consultations

The Medicare Benefits Schedule (MBS) has no specific items (services for which a Medicare rebate is payable) for anaesthesia consultations. Whilst there are items for "specialist consultations" the rules of the MBS as applied by the Health Insurance Commission (HIC) result in these specialist consultation items being excluded from use by anaesthetists for about 95% of anaesthetist consultations. There is an item (MBS item 17603) in Medicare for "pre-anaesthesia examination..." which in the absence of access to any other items is used for the vast majority of anaesthetist consultations. Both the wording and the level of rebate (50% of a specialist consultation and 25% of a physician consultation) reflect that the service covered by the pre-anaesthetic examination MBS item is a simple, brief service of a non-specialist nature. This item has been utlised unchanged since the inception of Medicare more than 30 years ago despite a massive transformation of anaesthesia practice in that time.

Prior to Medicare, anaesthesia was often practiced by general practitioners who provided anaesthesia services on a part-time basis and without any specialist qualifications. 30 years later anaesthesia is now largely practiced by specialist anaesthetists who have undergone training through the Australian and New Zealand College of Anaesthetists (ANZCA) and with a steadily improving safety record making Australian anaesthesia equal to the best in the world.

Over the last 15 years there has been growing evidence, including from Australian data, that poor pre-operative assessment by anaesthetists is directly associated with poor outcomes following surgery, including death. The last three triennial reports into anaesthetic mortality and morbidity by the ANZCA have in fact demonstrated that poor pre-operative assessment is the most common factor leading to poor patient outcomes.

The ASA believes that by providing appropriate Medicare items for anaesthesia consultations (the ASA has suggested a time-based structure as already used for other specialists) best anaesthesia practice can be encouraged to achieve an even safer anaesthesia process for the 3.2 million Australians undergoing anaesthesia every year. A particular advantage from appropriate recognition of anaesthesia consultations in Medicare is the potential to increase the rate of surgical patients consulting with their anaesthetist prior to being admitted to hospital for their surgical procedure. Currently this practice only occurs for a very small number of surgical patients, partly because of the limited rebates provided to patients who receive this service. It is the firm belief of the ASA that with an appropriate level of rebate more anaesthetists would be in a position to offer this service to their patients. Many benefits have been shown to be delivered by this out-of-hospital service including reduced stay in hospital, reduced pre-operative pathology costs, reduced post-surgical complications and improved quality of pre-anaesthesia consultations. Apart from the above-mentioned health outcome benefits, the ASA has conservatively calculated the potential financial savings from such a change in practice to be in excess of $40 million per annum.

The ASA has been attempting over the last 15 years to have anaesthesia consultations recognised by both Medicare and private health insurers to provide appropriate incentive for best anaesthesia practice. Unfortunately, despite numerous submissions and innumerable meetings absolutely no change has been achieved to date. The Medicare process is clearly expenditure-directed with seemingly no allowance for either benefits in health outcomes or changes in medical practice that may have occurred over 30 years. Similarly we have had little success when discussing this issue with health funds partly because of legislative restrictions on private health fund involvement in out-of-hospital services (such as pre-hospital anaesthesia consultations).

With the evolution of the specialty, anaesthesia services have expanded into the post-operative period, particularly in the area of post-surgical pain management. As with pre-anaesthesia consultations, the ASA has not been able to have any new items introduced into Medicare to recognise the range of treatments and management techniques offered by anaesthetists to control the now acknowledged serious problem of post-operative pain.

The ASA believes that Medicare funding for services should be subject to review and a more outcome-based approach must be adopted and not one solely based on direct impact on health expenditure. In the case of pre-anaesthesia consultations, the ASA is able to show not only significant improvements in health outcomes but also significant cost savings to the broader health community but these benefits have not been able to be considered. The ASA also believes a more flexible approach to private health funding of initiatives should be adopted with provision to allow certain services intimately involved with in-hospital treatments (such as pre-anaesthesia consultations) to be deemed as part of the in-hospital episode of care. This would then allow the health funds to more fully embrace funding options for such services.

REDUCING BUREAUCRACY IN PUBLIC HOSPITALS

Public hospitals are currently unnecessarily weighed down by bureaucracy leading to much inefficiency and reduced clinical throughput. This has a direct impact on public access to health services and prolongs waiting periods for essential medical services. In some instances it also affects the standard of care provided to patients.

There are often many, many committees, frequently duplicating roles and producing dubious outcomes. The amount of paperwork and administrative work demanded of both nursing and medical staff seems to be increasing at an insurmountable rate taking these practitioners away from their primary care giving role.

There is a concern that Public hospital administration has increasingly and intentionally reduced the involvement of medical practitioners. Apart from the obvious feedback issues that this results in, this practice is also alienating a group that has a significant input into the actual consumption of resources. There needs to be a return to a more cooperative approach with appropriate representation of the medical profession at an administrative level.

As a start, there should be a return to Medical Boards running each hospital instead of non-medical Boards:

> These should be "honorary" appointments of doctors providing medical services at the hospital.
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> It would allow medical providers (who have a greater depth of knowledge of the hospital's medical requirements) to contribute to important decisions.
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> It would increase medical officers' commitment to a Public hospital, which can only have a positive flow-on effect for morale and the efficient treatment of patients.

A return to greater medical input to Public Hospital Boards of Management will significantly improve clinical decision making at Board level, including the allocation of scarce resources, and provide a more stream-lined decision-making process with health outcomes as at least part of the focus.

ANAESTHESIA FEES IN THE PRIVATE SECTOR

Rebates for anaesthesia services have been historically low compared to other specialists since the introduction of Medicare in 1975. In fact anaesthesia rebates are lower than for any other specialist group. With the introduction of private health fund schedules following legislative reform over the past 10 years, anaesthesia rebates have remained relatively low compared to all other specialties.

Data show that fees actually charged by anaesthetists are significantly above not only the MBS rebates but also above the health fund rebate schedules. In 2003 just under 30% of all anaesthesia services incurred a gap payment by the patient compared to 18% of all medical services and just 15% of surgical services. Reports suggest that for anaesthesia for major surgery 50% of anaesthesia services incur a patient gap payment.

Clearly an objective of the current Government is to eliminate substantially gap payments for medical services delivered in the private sector therefore making private health insurance more attractive to the public. In the area of anaesthesia services this has not been achieved because the level of rebates offered by the health funds to the approximately 2000 specialist anaesthetists providing services in the private sector does not match the value of the services provided.

The ASA believes that if these patient gaps are to be eliminated in anaesthesia services the funds will need to increase the rebates available to their members. Currently the ASA is prohibited from representing its members in negotiations with the health funds by the Trade Practices Act.

SUPPORT FOR PRIVATE SECTOR

The ASA strongly supports a strong private sector in the health industry as a crucial component of a comprehensive solution to providing universal health care to Australians. Increasingly the private sector is playing a major role in providing essential services to the public.

Whilst it was once thought that the majority of major surgery was only conducted in major teaching hospitals, that is no longer the case. With the development of intensive Care Units and Accident and Emergency Units in private hospitals there has been a significant transfer of major surgery to the private sector. This important function must be recognised and continued government support and funding for private hospitals and private health insurance must be maintained.

The continuing balance between the public and private health systems will remain dynamic but the current mix delivers the health care of the highest quality to the Australian public.