Editorial: Time to link compensation to best practice?

Governments are constantly reviewing how surgeons are compensated for the consultations and procedures they perform. However, the basis on which the current compensation is calculated is really based on 35 year-old data in Australia¹ and it is not that much better in New Zealand.² Certainly governments who contribute to the training of surgeons (typically 15+ years) should have a large say but the focus should remain on best practice rather than any other motivations.

Currently complex urological procedures such as partial versus radical nephrectomy do not reflect complexity nor best practice with an unintended incentive to actually remove the whole kidney rather than preserve nephrons. Also, urologists have largely moved to multi-disciplinary care models³ and streamlined services⁴ which has helped in cancer management but again is not broadly reflected in the health system compensation models. The concept has also not broadened beyond oncology where it could in many cases. Finally, one must acknowledge that urologists have in many instances adopted practices that are more time consuming such as transperineal prostate biopsy⁵ and complex laparoscopic surgery with no additional compensation with the focus again on better outcomes for patients.

The Urological Society of Australia and New Zealand (USANZ) strictly cannot discuss compensation but it certainly may discuss best practice.⁶ So where and how does this all fit together? Certainly, as a brand USANZ needs to be at the forefront of urological issues in our region if it is to stay relevant to its membership and to the public and keep other stakeholders accountable such as the Royal Australasian College of Surgeons. As urologists we should not only ask but demand that our voice remains heard at all government levels - by whatever is the appropriate channel but armed with the correct information and ideals to support our case.

The other aspect is to provide an incentive to do appropriate work efficiently and well with better patient outcomes. Again, many stakeholders are involved but teasing the issues is tricky with a domino effect always occurring (e.g. the Medicare Benefits Scheme in Australia is linked to private insurance rebates to surgeons- a freeze in one freezes all as has happened for the past five years). Also, the thorny area of penalising for complications needs to be navigated very carefully as such actions could drive surgeons away from operating on higher risk patients.

Perhaps around all of the issues is the lack of recognition that urologists and surgeons and indeed all medical practitioners represent small businesses. Hence compensation includes many other employees that are vital if optimal health services are to be delivered for patients. The sooner governments realise this then the debate may move beyond rebates to actually supporting a medical workforce that is crucial to the healthcare received in our region.

There has been an unprecedented focus on reimbursement of surgeons in the recent past but perhaps it is now time to turn the focus onto better patient outcomes⁷ but more importantly compensating and supporting best practice that leads to such outcomes.
Conflicts of Interest

None declared.

Nathan Lawrentschuk, MB BS PhD FRACS (urology)
BJUI USANZ Editor
Associate Professor
University of Melbourne
Department of Surgery, Austin Hospital and Peter MacCallum Cancer Centre, Melbourne, Australia
e-mail: lawrentschuk@gmail.com

References

5. Yaxley AJ, Yaxley JW, Thangasamy IA, Ballard E, Pokorny MR. Comparison between target magnetic resonance imaging (mri) in-gantry and cognitively directed transperineal or transrectal-guided prostate biopsies for prostate imaging-reporting and data system (pirads) 3-5 mri lesions. BJU Int. 2017;120 Suppl 3:43-50
Author/s: Lawrentschuk, N

Title: Time to link compensation to best practice?

Date: 2018-05-01


Persistent Link: http://hdl.handle.net/11343/284024