BEYOND THE SCAN

MORE INFORMATION, BETTER CARE – HOW DIAGNOSTIC IMAGING **CAN DELIVER** A CLEARER PICTURE FOR PATIENTS.

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ADIA
australian diagnostic imaging association

Access to Diagnostic Imaging has never been more important in health care.

Diagnostic imaging (DI) is at the forefront of medical innovation, constantly evolving to improve the information we can uncover from the human body. This is improving outcomes for millions of patients.

Radiologist interpretation of the information from diagnostic images is enabling better and more targeted care, ensuring fewer patients are getting the wrong treatments.

But while DI continues to advance, the Medicare schedule is holding back much of this innovation from being accessed by patients. Australia is lagging behind the rest of the world in access to DI – and yet patients are referred at arm's length and the cost of each service is minimal when compared with the cost of surgery and other medical interventions.

21ST CENTURY MEDICINE, LAST CENTURY MEDICARE.

As the technology has advanced, DI has become central to the efficient, effective diagnosis and treatment of many more conditions.

However, while access to DI is now important for more Australians, **access to new services has been very slow**. In fact, of the 505 diagnostic imaging items added to the MBS over the past 10 years, only 22 were genuinely new services and these accounted for just 2.3% of total expenditure on DI services performed in 2014-15.

899 **DI items on the MBS (15.4% of total)**

389 **'red tape' DI items added since 2005 (0.04% of DI spend)**

22 **new DI services added since 2005 (2.3% of DI spend)**

More than 75% of DI items added to the MBS in the past decade are simply 'red tape' – duplicate services at lower rebate levels for imaging performed on old equipment.

PATIENTS HAVE THE RIGHT TO KNOW ABOUT THEIR HEALTH.

There is a growing list of DI services that are **not funded** by Medicare, despite representing contemporary practice, leaving patients significantly out of pocket. Australians are being told by their doctor "I recommend imaging however you will have to pay for it because it is not covered by Medicare or your private health insurance".

When DI services are funded by Medicare, after so many years without indexation, the average patient gap is $92. This means we already have a **two-speed health system** where some Australians cannot access the services they are referred for because they cannot afford them. This is a serious issue in radiology, despite services being **arm's length-referred** by the patient's doctor.

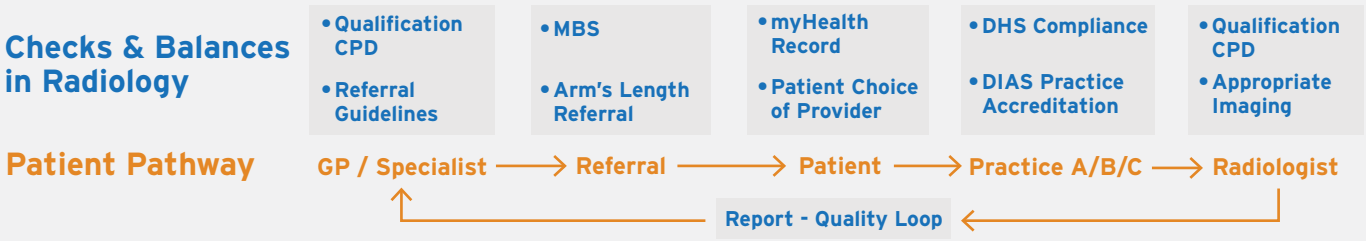
CASE STUDY: BREAST CANCER

Under the current Medicare schedule, patients **cannot**:

- get an MRI to stage their breast cancer
- get a PET image to help determine the right treatment
- get an MRI if they're in a high-risk group and over 50
- get an adequate rebate for a diagnostic mammogram
- get a rebate for a diagnostic breast ultrasound and an ultrasound-guided breast biopsy or fine needle aspiration on the same day without paying significant out of pocket costs

CLINICIAN USE OF QUALITY DI NEEDS TO BE SUPPORTED.

Medicare is a robust system with in-built checks and balances that are designed to ensure patients are only referred for the radiology they need.



At the heart of how Medicare supports patient access to radiology services is arm's length referral. This, coupled with well-accepted clinical guidelines, is key to appropriate referral. Referral guidelines have been published from time to time in easy-to-use formats and many radiology providers publish their own; however, more needs to be done. With clinician-endorsed referral guidelines in place and arm's length referral, patient access to radiology will be evidence-based and patient-focused in contrast with the approach adopted in the US system. These safeguards are core to the sustainability of Medicare and need to be enhanced.

We cannot allow the opposite to happen; the **MBS cannot become a rule book for doctors to follow**, codifying current clinical guidelines to tell them what they can refer for and when. Doctors are best placed to make the clinical judgements about what their patients need, and it costs Medicare more, not less, when our medical experts are hamstrung by hurdles, rules and administration that gets in the way of efficient and effective patient care.

Where is the benefit in a patient making repeat return visits to a clinic because they're dealing with a lack of information? What is the point of undergoing surgery if it is only going to treat part of the problem?

CASE STUDY: BACK PAIN

Under the current Medicare schedule, patients cannot get a referral for an MRI if their GP is particularly concerned about the cause of their symptoms despite Australian and international clinical guidelines recommending MRI as the most appropriate modality for a range of indications.

Even after the patient has rested for 4-6 weeks, the GP can still only suggest the patient see a specialist who is able to give a referral for an MRI under Medicare.

In another hurdle, Medicare-eligible MRI can only be accessed at a very limited number of MRI practices.

For example, under the current system, practices – particularly those in rural areas – are hamstrung because Medicare does not pay a rebate for many services when they are performed on the same day as other, clinically necessary services.

This lowers efficiency and increases costs. Patients decide to repeat long-distance trips or pay more to have both services performed on the same day.

THE REVIEW PROVIDES THE OPPORTUNITY TO MODERNISE.

Wholesale reform of Medicare is not required to resolve these problems – the structural features of Medicare are fundamentally sound, but its potential is not being realised. The Review is an opportunity to renew our focus on the patient.

Rather than trying to plug holes by adding more red tape, we need to **fine-tune policy settings** to put incentives in the right place to ensure that Medicare supports contemporary clinical practice and improves patient access to effective health services.

While outside the scope of the MBS Review, Medicare would be strengthened by

- embracing e-referral to streamline communication between clinicians,
- updating the prohibited practices legislation to close loop holes in arm's length referral, and
- promoting efficiency through productivity and competition based on quality.

By doing this, Government, doctors and patients will remain proud of how Medicare underpins Australia's healthcare system.

A strategic approach for a 21st Century Medicare

THE WAY FORWARD

- **Support ongoing development and use of clinical guidelines**
  - Avoid the temptation to replicate current day clinical guidelines in the MBS item descriptors.
  - Support clinicians to develop user friendly up-to-date referral guidelines which can be updated as clinical practice evolves. In turn the use of guidelines would increase as they become better known and accepted.
  - Provide referral data to referring clinicians and providers to support a well-functioning 'feedback loop'.
- **Update MBS items and rules**
  - Remove hurdles to patients accessing diagnostic imaging, such as rules that deny and reduce patient rebates for clinically appropriate complementary services performed on the same day.
  - Replace current professional supervision rules which are unenforceable with clear and enforceable rules that reflect clinically recommended practice.
  - Replace current out of date and ad-hoc minimum equipment regulations and align with a modern day web based system to manage the current paper-based LSPN system (Location Specific Practice Number).
  - Streamline Medicare provider numbers to reduce the administrative burden for practices and Government.
  - Target ultrasound funding to comprehensive diagnostic ultrasound in line with ADIA and RANZCR recommended Quality Framework.
  - Delete at least half the DI items on the MBS. Many apply to services performed on old equipment, others do not have a clear purpose, and a small number are obsolete services, which are not being used.
- **Collaborate on enforcement to improve compliance**
  - Rules need to be clear and professionally respected to support compliance. Where necessary, Guidelines need to be developed in consultation with ADIA and RANZCR.
  - Engage with ADIA and RANZCR to support active enforcement of clear and respected rules that promote quality practice and patient care.
- **Support access and choice for patients**
  - Review the level and type of evidence required by MSAC to expand the use of current diagnostic imaging technologies, to keep use in line with contemporary practice. Essential new DI services are not being added - only 22 genuinely new services have been listed in the last 10 years.
  - Enhance the online LSPN register to support patients seeking to access DI services – without this, patients remain confused as to where they can access the service they are referred for and where they need to go for their services to be eligible for a rebate.
  - Review the distinction between partial and full MRI-eligible units, to improve patient access to MRI services.
  - Permit patients to pay the gap only up front, index patient rebates and address equity by improving rebates on services that are unviable to bulk bill.
- **Promote a more efficient diagnostic imaging sector**
  - Increase productivity by adjusting funding settings to support competitive markets based on quality. This would encourage investment and innovation in lower-cost outpatient services.
- **Maintain a focus on the patient - Pilot Studies**
  - While the MBS review will encourage consumer and patient input, at its heart it is about the "rule book" and what changes should be made to it. ADIA recommends pilot studies focusing on patients with common conditions. What are the challenges that these patient face now in accessing radiology services and what needs to be changed to make Medicare work more effectively, and sustainably, for these patients? The learnings from these pilot studies could then be used to improve the treatment pathways for other patients. This approach would put the patient at the centre and ensure that changes are properly targeted.
- **Develop patient focused measures of success**
- **Reinvest savings from the Review into underfunded and unfunded diagnostic imaging services**

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