# SAFEGUARDING IMAGING FOR ALL

## Australian Diagnostic Imaging Association

### BUDGET SUBMISSION 2015-2016

ADIA
australian diagnostic imaging association

ADIA represents medical imaging practices throughout Australia, both in the community and in hospitals. It promotes the ongoing development of quality accreditation standards and appropriate funding settings so that Australians can have affordable access to quality medical imaging services. This supports medical imaging's central role in the diagnosis, treatment and management of a broad range of conditions in every branch of medicine.

# President's Message

**Diagnostic imaging is a critical part of Australia's healthcare system. Every day tens of thousands of patients are diagnosed earlier and more accurately than ever before, resulting in faster and more effective treatment for an enormous range of medical conditions.**

This is why investment in diagnostic imaging at the front end of the patient journey is vital to ensuring better health outcomes for patients and savings for Government through reduced downstream health costs.

Contrary to general belief, technology is not the major cost in diagnostic imaging. The largest cost in providing a quality diagnostic imaging service is labour – primarily medical specialists (radiologists and nuclear medicine physicians) and allied health professionals (radiographers, sonographers and MRI technicians). It is important to remember that diagnostic imaging is a specialist medical service, just like cardiology and oncology etc., and most patients must be referred by their GP or specialist.

ADIA believes the decision not to proceed with the co-payment for diagnostic imaging was a wise one, as the co-payment coupled with the rebate cuts would have seen many patients face cost increases of hundreds of dollars, not the modest co-payment the Government wanted. However, the measure did spark a much needed debate about Medicare's long-term sustainability, principally the role of bulk billing and the barriers patients face when contributing to the cost of their diagnostic imaging.

In truth, diagnostic imaging funding has been very tightly constrained for many years. The Medicare Benefits Schedule has not kept pace with constant advances in technology because the Government has restricted access to essential diagnostic imaging services, particularly MRI. These funding constraints, as well as Medicare policies and systems, are currently inhibiting diagnostic imaging practices from delivering the best outcomes for patients and the Government.

These are complex issues but by working closely with the diagnostic imaging sector, the Government can implement appropriate policy and funding settings which will ensure the efficient use of tax dollars while making sure all patients who are referred for diagnostic imaging can access affordable, high quality services. Consider the following:

- Unlike almost all other Medicare services, diagnostic imaging rebates have not been indexed since 1998. This freeze is effectively a year-on-year cut to diagnostic imaging in real terms, and may result in diagnostic imaging becoming a commodity rather than a specialist medical service. This would be a devastating blow to the Australian healthcare system, resulting in limited access to radiologist advice and increasing government expenditure in the health sector. Current trends have resulted in rebates for common imaging procedures like a CT of the chest (to diagnose chest pain) falling by 35 per cent in real terms and an MRI of the head (used to diagnose brain tumours) falling by 46 per cent.

  With the cost of providing these services continuing to rise, combined with the freeze on diagnostic imaging rebates, patient gaps are increasing. The average gap was $92 in 2013-14 and is growing at 6.6 per cent each year. This seriously impacts access to essential services and is of far greater concern to patients than the proposed $7 co-payment. Often it is the most clinically complex services which are needed by our sickest patients who consequently attract the highest gaps. This is forcing some patients to choose between financial hardship or foregoing/delaying essential diagnosis and treatment.

  The current Medicare rules require diagnostic imaging patients - who are charged gaps of as little as $5 or $10 - to pay the full cost of the service and then claim the rebate from Medicare. This is a significant barrier for many patients because it requires them to access hundreds or even thousands of dollars at the time of service. It is important that this is addressed by enabling patients to pay a modest gap with the practice claiming the rebate directly. This is particularly important if the Government is not in a position to support ADIA's recommendation to recommence the indexation of diagnostic imaging rebates.

- The funding of public hospitals is fast becoming a chronic issue with regard to diagnostic imaging. Public hospitals are paid twice – through public hospital funding and Medicare rebates – to deliver Medicare-funded services to outpatients. This means doctors in public hospitals are being diverted from their core role of looking after inpatients. It also means Budget costs increase, with diagnostic imaging services delivered in public hospitals costing the taxpayer more than services provided by private practices.

  Following the Competition Policy Review, the Government has the opportunity to clarify the appropriate roles for the public and private sectors in delivering Medicare-funded diagnostic imaging to outpatients. If public hospitals maintain the ability to offer free bulk billed services in competition with private practices (which charge patient gaps) it is inevitable that many private practices will become unviable. The Government could also establish an effective competitive framework to support efficient provision of services by both the public and private sectors.

- Medicare regulations were designed to assure service quality by mandating appropriate examination practices. However these arrangements are not working properly because some providers are exploiting loopholes.

  The Government needs to implement the ADIA and Royal Australian and New Zealand College of Radiologists (RANZCR) -endorsed *Quality Framework for Diagnostic Imaging* so that referrers and patients can be confident that they are receiving quality diagnostic imaging. This is a cost neutral proposal and includes minimum radiologist attendance requirements for CT services to address concerns about radiation risk; criteria for Diagnostic Ultrasound services to ensure that services are delivered by medical specialists who hold minimum qualifications and practices that meet minimum equipment standards; and increases to Diagnostic Ultrasound fees to improve fee relativities which would reduce patient gaps.

- The process of referral has become much more complex as imaging options have expanded, and the role of imaging has broadened into treatment. To deal with concerns about inappropriate referral (including in the Department of Health's Review of Funding for Diagnostic Imaging Services), radiologists need to take on an expanded clinical role, and become more active in providing clinical advice on the appropriate referral pathway.

  Current funding settings mean that our health system is not taking advantage of radiologists' expertise in the use of medical imaging because unlike other medical specialists, their ability to claim a consultation fee is very restricted. The Government should work with ADIA and the RANZCR to consider opportunities where paying a consultation fee to radiologists would increase the appropriateness of imaging, and deliver a saving to the Budget.

  To address concerns regarding inappropriate imaging, ADIA recommends that arm's length referral become a pillar of appropriate referral. Currently there are gaps in the prohibited practices legislation that permit referral when the referrer has a pecuniary interest in the service provided, and ADIA recommends that these gaps be addressed.

- Addressing inefficient, overly burdensome regulation for diagnostic imaging will result in significant productivity gains. For example, capital sensitivity rules impose more burden than is necessary to achieve the Government's objective that diagnostic imaging is performed on quality equipment. Practices deal with considerable red tape when upgrading equipment so that it remains eligible for a full diagnostic imaging rebate; as well as when applying for rural and remote exemptions. Red tape around registration of provider numbers for radiologists can mean it takes months for paperwork to be completed – a massive burden for practices.

  Indeed, ADIA believes that the following recommendations regarding current policies in the diagnostic imaging sector can make a significant contribution to the Government's $1 billion red tape reduction target.

ADIA looks forward to collaborating with the Government to address barriers to achieving an efficient funding model for diagnostic imaging services. The issues are complex and many Australians are already struggling to access the diagnostic imaging services they need.

Dr Chris Wriedt

President

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# 01 Modest gaps for patients

**Patient gaps are becoming a primary hurdle in accessing necessary diagnostic imaging services, with the average gap growing by over 50 per cent in the last six years. Many families who cannot afford gaps such as $164 for an MRI are forced to forgo or delay essential diagnosis and treatment.**

## Average gaps by modality: 2007-08 to 2013-14

| | Ultrasound | CT | X-Ray | Nuclear Medicine | MRI | TOTAL |
|---|---|---|---|---|---|---|
| Average gap 2007-08 | $69.17 | $102.19 | $33.80 | $93.79 | $126.17 | **$61.09** |
| Average gap 2013-14 | $98.61 | $137.75 | $52.43 | $99.45 | $164.45 | **$92.00** |
| Growth from 2007-08 to 2013-14 | 42.6% ↑ | 34.8% ↑ | 55.1% ↑ | 6.0% ↑ | 30.3% ↑ | **50.6%** ↑ |

*Average patient contributions for out of hospital services. Source: Department of Health

Diagnostic imaging services covered by Medicare cost $3.4 billion in 2013-14, with over $500 million in patient contributions. This represents a patient contribution of 15 per cent, which is significantly higher than the patient contribution for visits to the GP. It must also be noted that Australians are paying the full cost of many MRI services as access to Medicare funded machines is restricted, as are the indications for which MRI is funded. For example, MRI of the breast is not eligible for a Medicare rebate. The issue that arises from this funding mix is a lack of equity. Only 24 per cent of diagnostic imaging patients contribute to the cost of their imaging and this is reflected in those patients paying very high gaps.

The failure of successive governments to index diagnostic imaging rebates since 1998 has also contributed significantly to the chronic rise in patient gaps. This freeze on indexation not only adversely impacts patients but makes it untenable for practices to keep up with the costs of a diagnostic imaging service while ensuring services remain affordable. Approximately 60 per cent of a diagnostic imaging service is labour – medical specialists (radiologists and nuclear medicine physicians) and allied health professionals (radiographers, sonographers, MRI technicians).

## The real story of diagnostic imaging fees: 1998 to 2014

| Service | 1998 fee | 2014 fee | Variation (16 years) | Fall in real value |
|---|---|---|---|---|
| 56301: CT – chest | $305.05 | $295.00 | $10.05 ↓ | 45% ↓ |
| 58103: X-Ray – spine | $58.95 | $55.10 | $3.85 ↓ | 46% ↓ |
| 63001: MRI – head | $475.00 | $403.20 | $71.80 ↓ | 51% ↓ |
| 55238: Ultrasound – vascular | $172.90 | $169.50 | $3.40 ↓ | 44% ↓ |

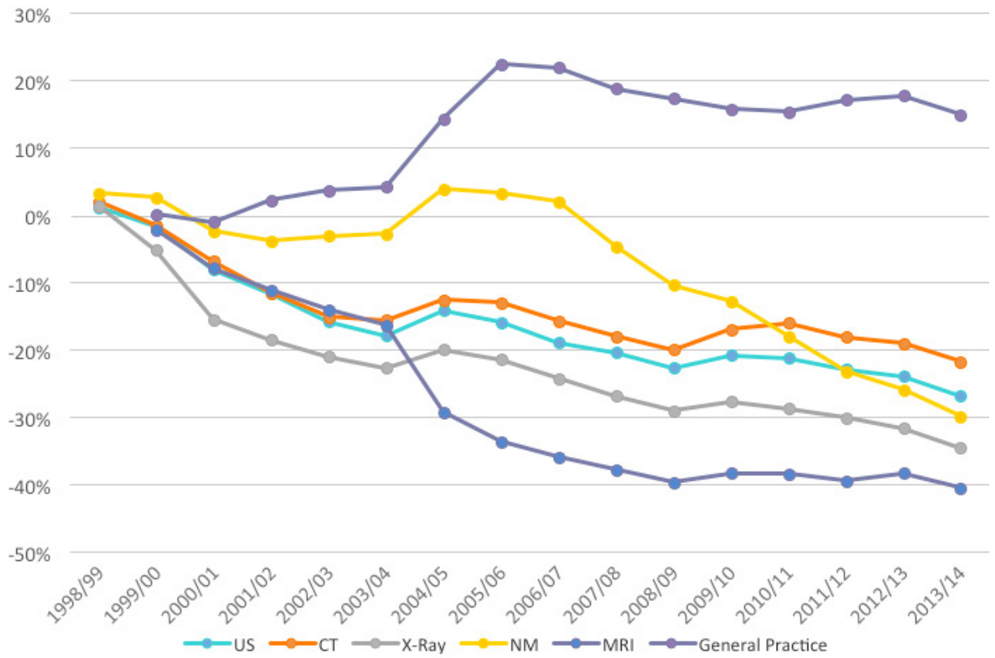
*Based on 100% of Schedule fees

Since indexation was stopped average rebates per service have declined by between 22 per cent (CT) and 40 per cent (MRI), compared to average rebates for GP services which increased by 15 per cent over the same period.

## Mammography

A mammogram provides detailed images of the internal structure of the breast. Mammograms are used as a screening tool to detect early breast cancer in women without symptoms and to detect and diagnose breast disease in women experiencing symptoms such as a lump, pain or nipple discharge. Mammography plays a central part in early detection of breast cancers because it can show changes in the breast before a patient or doctor can feel them. Early diagnosis of breast cancer saves lives.

CPI-adjusted average benefits per service – diagnostic imaging and general practice




Source: ADIA analysis of Medicare data provided by the Department of Health

Another issue for patients are the current bulk billing rules. These rules require that patients pay the total cost of a service upfront even if the gap charged is only $5 to $10. This is a serious impost for families because, unlike GP consultations which cost $50-100, the full cost of diagnostic imaging can run into hundreds or thousands of dollars. This requires many patients to choose between financial hardship and foregoing or delaying essential diagnosis. Even more troubling, it tends to be the most complex services requiring significant radiologist input which attract the highest gaps. These are the services that are crucial for our sickest patients.

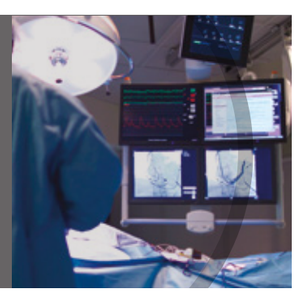
This is a severe barrier to accessing diagnostic imaging that can easily be addressed by the implementation of rules that would allow patients to pay only the gap upfront and permit practices to claim a rebate from Medicare directly. Furthermore, if the burden was shared by all patients who can afford to contribute to the cost of their diagnostic imaging, the gaps would not need to be as high.

### Recommendation

The Government should recommence indexation of diagnostic imaging rebates. Additionally, Medicare rules and systems should be amended to allow patients to pay just the gap upfront, and the practice to claim the rebate directly from Medicare. This will make it easier for practices to charge modest gaps for diagnostic imaging.

## Fluoroscopy

Fluoroscopy enables radiologists to view X-rays in real time on a television monitor. In most cases this involves the administration of a 'contrast' agent to outline the region of interest. The two most common fluoroscopic procedures are barium meal and barium enema. A barium meal is an examination of the upper part of the gastrointestinal tract, including the oesophagus, stomach and duodenum. A barium enema is an investigation of the large bowel.





# 02 An appropriate role for public hospitals

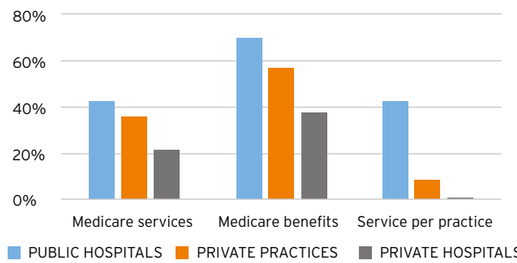
**Public hospitals are effectively being paid twice for the delivery of diagnostic imaging services to outpatients via hospital funding through the Australian Health Care Agreement as well as accessing Medicare rebates. This is an inefficient use of taxpayer dollars and creates an unfair advantage for public hospitals over private practices, resulting in a growing imbalance in the attendance of public hospitals for diagnostic imaging.**

Medicare-funded diagnostic imaging is designed as a level playing field, with services to outpatients being delivered by both private practices as well as public hospitals. To that end, the same Medicare rebate (85 per cent of the Schedule fee) applies to services provided in both settings. The current structure of the state and federal funding has allowed public hospitals to create an imbalance in this area, actively attracting outpatients with the prospect of 'free' services in an effort to claim Medicare rebates to supplement budget deficits.

To fund the provision of diagnostic imaging services to outpatients, public hospitals have put in place arrangements that will incentivise their doctors to undertake work which can be billed to Medicare. This means that doctors are being diverted from their core role of looking after inpatients – ADIA is aware of inpatients at major metropolitan public hospitals waiting as long as nine weeks for an MRI, as hospitals seek to attract more outpatients and more Medicare funding.

ADIA estimates that these services cost the Government at least $450 million in 2013-14, and this expenditure is growing at 9.2 per cent per year (compared to 7.6 per cent benefits growth in private practices), notwithstanding the costs involved in funding equipment, facilities and staff within public hospitals.

Public hospitals were the fastest growing provider type between 2004-05 and 2010-11




Source: ADIA analysis of Medicare data provided by the Department of Health

This not only costs taxpayers, it is also inefficient because the fleet of equipment in private practices generated through private investment across Australia is not being fully utilised.

### Recommendation

Government should use its response to the Competition Policy Review to clarify the appropriate roles for the public and private sectors in delivering Medicare-funded diagnostic imaging to outpatients. The Government should also establish an effective competitive framework to support efficient provision of services by both the public and private sectors.

## Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging uses a very powerful magnet and radio-frequency pulses to collect signals that are then processed by a computer to form an image of the body part. MRI gives a detailed view of the soft tissues of the body, such as muscles, ligaments, brain tissue, discs and blood vessels. MRI uses no radiation, and there are no known harmful side effects.

# 03 Improve the value and quality of diagnostic imaging by implementing the *Quality Framework*

**Medicare rules are designed to assure service quality and patient safety, however there are significant concerns that ADIA and RANZCR have recommended should be addressed with regard to ensuring a minimum service standard. With this in mind, ADIA and the RANZCR undertook significant work to develop the cost neutral *Quality Framework for Diagnostic Imaging* in response to the Diagnostic Imaging Review Reform Package (2011).**

The *Quality Framework* deals with ensuring that Diagnostic Ultrasound is more accessible and affordable to patients, and ensures that Diagnostic Ultrasound and CT services are delivered with appropriate clinical oversight.

Two elements of current diagnostic imaging practices need to be addressed in alignment with the *Quality Framework*:

- The criteria for a Diagnostic Ultrasound needs to be better defined with the advent of Point of Care Ultrasound, which is used both as an adjunct to a clinical examination or as part of procedurally guided techniques. Point of Care Ultrasound services currently attract the same rebates as Diagnostic Ultrasound services, which are comprehensive and include a written report to the referrer and the production of images.
- The growth in Point of Care Ultrasound is the main reason for Ultrasound growing by an average 8.0 per cent (service volume) and 9.8 per cent (expenditure) in the last five years (Aspex Consulting 2011). This compares to the growth in the total DIST, which is 5.5 per cent (service volume) and 8.1 per cent (expenditure).
- ADIA recommends that Point of Care Ultrasound is remunerated in a more appropriate way in other parts of the Medicare Benefits Schedule, while the criteria for Medicare-funded Diagnostic Ultrasound should be clarified so that only truly Diagnostic Ultrasound services are funded under the Diagnostic Imaging Services Table.

This would deliver savings that could be used to address the currently high patient gaps that patients are experiencing when they need to access a Diagnostic Ultrasound. The average patient gap of $98.61 is putting access to Diagnostic Ultrasound in jeopardy. To reduce these gaps, ADIA recommends that the savings from reduced overall Ultrasound expenditure under the Diagnostic Imaging Services Table are redirected to improve Medicare fees and fee relativities for targeted Ultrasound items in the General, Musculoskeletal, O&G and Urological subgroups (which have average fees almost 50 per cent lower than other subgroups).

### Recommendation

Point of Care Ultrasound should be renumerated in a more appropriate part of the Medicare Benefits Schedule and criteria for Medicare-funded Diagnostic Ultrasound should be amended so that only truly diagnostic Ultrasound services are funded under the Diagnostic Imaging Services Table. Furthermore, the savings from the reduced Ultrasound expenditure should be redirected to improve Medicare fees and fee relativities for targeted Ultrasound items.

- Current Medicare rules requiring CT services to be delivered under the supervision of a radiologist are not being enforced by the Department of Human Services due to a lack of clarity in drafting, and some CT practices in metropolitan areas are operating without either an onsite or visiting radiologist.

  It is critical that a radiologist is required to be onsite for a minimum number of hours per day when CT services are delivered, to provide the necessary clinical oversight of scheduled examinations, manage appropriate and safe administration of contrast, and to be available to attend to patients where clinically appropriate. Incorporating this requirement into practice accreditation standards would generate Budget savings by reducing the growth in unattended CT services.

### Recommendation

The Government should implement the *Quality Framework for Diagnostic Imaging*. The package of measures is Budget neutral, and it would give referrers and patients confidence about the quality of diagnostic imaging and reduce patient gaps in Diagnostic Ultrasound.



# 04 Improve the appropriateness of diagnostic imaging services

**Diagnostic imaging has changed dramatically over the last two decades, with a much wider range of imaging options available to referrers, and the role of imaging broadening into treatment. This has made the process of selecting the most appropriate imaging modality and technique much more complex, increasing the risk of inappropriate imaging. Indeed, the Diagnostic Imaging Review Reform Package in the 2011-12 Budget recognised that some diagnostic imaging referrals may be unnecessary or inappropriate, and included initiatives to improve 'appropriate requesting'.**

There are opportunities to address concerns about inappropriate imaging by expanding the clinical role of radiologists. Medicare is not currently taking advantage of this expertise because, unlike other medical specialists, radiologists are very restricted in their ability to claim a consultation fee for interaction with patients and referrers.

The Medicare funding model should recognise the expanding clinical role of radiologists as there are cost-effective opportunities to utilise radiologists' expertise to benefit patients and Government alike.

### Recommendation

The Government should work with ADIA and the RANZCR to consider opportunities where paying a consultation fee to radiologists would increase the appropriateness of imaging, and deliver a saving to the Budget.

Requiring all referrals to be at 'arm's length' would also reduce the volume of unnecessary imaging, protecting patients and generating savings for Government.

Prohibited practices legislation (the *Health Insurance Amendment (Inappropriate and Prohibited Practices and Other Measures) Act 2007*) was designed to prevent referrers from asking for or receiving benefits in exchange for requesting diagnostic imaging services. However, the legislation does not prohibit referrals where the referrer holds a pecuniary interest in the diagnostic imaging provider that delivers the service.

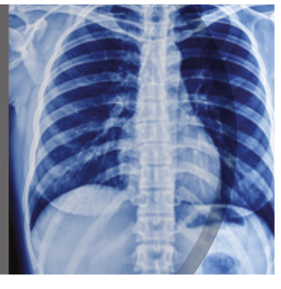
This gap in the law means that patients are at risk of unnecessary diagnostic imaging tests and the Government is exposed to paying for over-servicing, because some referrers have a direct or indirect financial incentive to increase the number of referrals they make. Studies from the United States have shown that physicians are as much as 200 per cent more likely to request diagnostic imaging within their own practice, than physicians referring to separate diagnostic imaging practices (Scott Gazelle et al. 2007).

### Recommendation

The Government should make arm's length referral a pillar of appropriate referral, by addressing gaps in prohibited practices legislation that permit referral when the referrer has a pecuniary interest in the service provided.

## General X-ray

An x-ray image shows the internal structures of the body including the bones and some of the soft tissues.  X-ray imaging still supports the quick and accurate diagnosis of many serious conditions including pneumonia, heart failure and lung cancer. Most commonly used for fractures and arthritic conditions, X-ray saves lives every day.



# 05 Address the regulatory burden

**Regulation is essential in diagnostic imaging to ensure that services meet appropriate quality standards and patients are kept safe. However, the balance is not always achieved between managing risk and imposing a regulatory burden on practices. Unnecessary regulatory requirements are hampering the productivity of the diagnostic imaging sector by forcing practices to devote resources to compliance, which would be better focused on patients:**

- **Capital sensitivity rules** impose more burden than is necessary to achieve the Government's objective that diagnostic imaging is performed on quality equipment. Practices deal with considerable red tape when upgrading equipment so that it remains eligible for a full diagnostic imaging rebate; as well as when applying for rural and remote exemptions. Good quality equipment is being discarded because the rebate is reduced by 50 per cent where the service is provided on equipment that is fully depreciated (less than 14,000 services were provided on fully depreciated machines in 2013-14 - less than 0.1 per cent of all services). This makes the service unviable, because equipment is only around 20 per cent of the cost of delivering a service (Access Economics study commissioned by ADIA). The Government's objective would be better served with minimum equipment standards enforced through practice accreditation.
- **Medicare provider numbers** are inefficient for radiologists, as they are required to have a separate provider number for every practice they report for within the organisation. This means that a radiologist working for a large practice group could require dozens of practice numbers, which involves a large quantity of paperwork when a radiologist commences or when practice details change. For example, if a practice group changes bank accounts, a form must be completed for every provider number. This could mean hundreds or thousands of forms across a practice group, particularly where radiologists report both on site and off site. In contrast, pathologists are given one provider number for all practices within their organisation. This policy should be expanded to radiologist provider numbers.
- **The Location Specific Practice Number (LPSN) register** requires practices to provide and update very detailed information about the equipment at each practice. For example, any change of Ultrasound probe greater than 7.5MHz must be reported to the Department of Human Services, even a change as minor as relocating a probe from one practice to another. Little use is made of this information. All changes must be reported on a form to be mailed or faxed, as electronic lodgement is not available. This is a significant compliance burden with questionable utility for the Government and patients. The purpose of the LSPN register should be clarified, and information collected only where it is needed to enforce Medicare rules.

There are many more examples of red tape and other administrative burdens that could be improved. ADIA would like to work with the Government to address inefficient regulatory requirements, which will increase productivity and free up resources within Government.

### Recommendation

The Government should consult with ADIA and other diagnostic imaging stakeholders to develop a list of inefficient regulatory requirements to be improved or repealed. This will contribute to the Government's $1 billion per year regulation reduction target.

## Radiology

Radiology procedures have become an essential tool in the diagnosis, treatment and post-treatment of a broad range of clinical conditions. Radiologists are medical specialists who work with a team of allied health professionals to capture and then interpret diagnostic quality images. The radiologist relates the image interpretation and diagnosis to the clinical context of the patient and provides a specialist medical opinion in a report to the referrer.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