ADIA
australian diagnostic imaging association

WHAT PATIENTS NEED: ACCESSIBLE, ACCURATE, AFFORDABLE AND EARLY DIAGNOSIS THROUGH QUALITY DIAGNOSTIC IMAGING

FEDERAL BUDGET SUBMISSION 2012-13

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Introduction: Early and accurate diagnosis and image-guided treatment saves lives, suffering and healthcare costs

Across Australia, 50,000 patients each day seek to have their conditions diagnosed or treated using x-ray, ultrasound, CT, MRI, mammography and nuclear medicine.

Most people are aware that diagnostic imaging is essential to identify the presence and extent of disease and injury. But few are aware of the advances made in diagnostic imaging in recent years and the extent to which these contribute to treatment, minimisation of disabilities, avoidance of surgery, effectiveness of surgery, and the saving of healthcare costs – particularly with respect to hospital expenditure, publicly funded healthcare facilities and other disability funding.

Despite the benefits they provide, private diagnostic imaging services (which currently account for 85% of Medicare diagnostic imaging services in Australia) are becoming increasingly unaffordable, and many practices which try to provide quality services at the rebate level are becoming unviable.

More and more patients, especially the sickest patients, are struggling to access affordable, diagnostic imaging services when and where they need them. This is largely because:

- *After 14 years of non-indexation of Medicare rebates for diagnostic imaging, the value of patient rebates has eroded and rebates are now substantially below the costs of providing many services.*

- *Patient co-payments for non-bulk billed services are increasing by more than CPI and this is particularly evident for more complex services which patients struggle to afford.*

- *The 10% bulk billing incentive (introduced in November 2009) that provided essential funding, particularly to bulk billing practices, does not cover the cost shortfall, and bulk billing practices are under pressure to reduce the spectrum of services offered and to avoid the more complex and high cost services.*

- *The incentive to invest in new technology and clinically advanced services with a high level of clinical input is abating.*

- *Two tiers of practice of are emerging: comprehensive practices offering a spectrum of services with a high level of clinical input on the one hand, and more basic*

practices offering services which can be more easily bulk billed on the other. It is this second category of practice which is growing.

To further complicate the situation, public hospitals are increasingly using bulk billed outpatient diagnostic imaging services to compete with the private sector. They can compete more effectively on price because many of their costs are already covered by government grants. Their access to the enhanced bulk billing incentive provides an additional source of revenue. While such competition may seem to offer short-term gains to both patients and the public hospital system, the medium to long term consequences will be negative as a shift in service provision from the private to the public sector occurs and pressure mounts on an already overburdened public system.

While the problems identified above are system-wide, they are especially acute in regional areas. In addition, regional areas have their own special problems which include an acute shortage of professional staff and the ageing of the current radiology workforce.

This Budget submission offers a suite of policy solutions to remedy the decline in the access, affordability and clinical advancement of the diagnostic imaging sector in Australia.

We commit this Federal Budget submission to the Government for consideration and look forward to working with Government on resolving these important policy challenges.

Dr Sue Ulreich
President
Australian Diagnostic Imaging Association (ADIA)

1 Summary of Recommendations

To ensure that patient rebates can cover the increasing cost of providing diagnostic imaging services:

ADIA Recommendation 1:

That all diagnostic imaging Medicare rebates are indexed from 1 November 2012.

To underpin bulk billing for concession card holders:

ADIA Recommendation 2:

That, if the Government feels unable to index rebates in the next Budget due to fiscal constraints, it should at the very least increase diagnostic imaging rebates to 100% of the scheduled Medicare fee (consistent with the introduction of 100% of the scheduled fee for bulk billed MRI services in May 2012) for the patients least able to make co-payments – i.e. concession card holders.

To retain and promote patient access to specialist care and clinically indicated imaging services:

ADIA Recommendation 3:

That a Practice Incentive Program be introduced which builds on current practice accreditation programs and provides additional funding and indexation for practices which offer a wide spectrum of diagnostic imaging modalities and services, on-site radiologist supervision, timely care interventions and reporting, minimum radiation dose and active decision support for referrers. These radiology providers ensure patients receive accurate and urgent diagnosis with high levels of essential specialist clinical input.

To promote rational and efficient investment in diagnostic imaging by the public and private sector:

ADIA Recommendation 4:

That the Government should discourage the movement of diagnostic imaging services from the private to the public sector by:

- Incorporating the principle of competitive neutrality between the public and private sectors into the overarching principles for the National Health Reform Agreement Pricing Framework.
- Funding the provision of public hospital outpatient services exclusively through public hospital activity based pricing (ABF), thus prohibiting the current practice of double dipping into both Medicare and government grant funding for the provision of the same service.
- Ensuring that provision of public outpatient services is restricted to cases where there is a genuine gap in local diagnostic service provision.

To underpin ongoing access for those in regional and remote Australia:

ADIA Recommendation 5:

- That the Government introduce indexation of rebates for rural services.
- That the Government introduce a Rural Retention Program for radiologists
- ADIA is also requesting a revision of District Workforce Shortage (DWS) criteria for all regional areas. The current calculation of radiologist shortages fails to recognise that Medicare services are often remotely reported

To address policy and funding gaps that negatively impact the diagnostic imaging sector and patients:

ADIA Recommendation 6:

That Government pursues improved funding arrangements in respect to the following priority areas:

- Increases in rebates for significantly underfunded MBS items. These services are characterised by high levels of complexity and a requirement for clinical input throughout the imaging process.

- Improvements to the enforcement of the Prohibited Practices provisions of the *Health Insurance Act (1973)* to prevent inappropriate imaging due to referrers having a direct financial interest in diagnostic imaging practices (by way of joint venture or other arrangement).

- Funding support to private practices for image storage and other cost impositions required by the introduction of the Personally Controlled Electronic Health Record (PCEHR) system which are over and above the existing high levels of investment in e-Health in the private diagnostic imaging sector.

2 The Background

2.1 Diagnostic Imaging: Reducing health costs by improving health outcomes

It is not always well understood just how central diagnostic imaging is to both the health of Australians and the containment of health costs.

There are many, many instances where early and appropriate diagnostic imaging is the pathway to patient health outcomes which avoid or reduce disability and suffering, save mounting healthcare costs and preserve the productivity of people suffering from potentially incapacitating conditions.

Early and accurate diagnosis minimises the impact of chronic disease, keeps people out of hospital and aged care facilities, and facilitates interventional procedures which can either assist to maximise the efficiency and effectiveness of surgery or remove the need for invasive surgery altogether. In addition, a new generation of diagnostic services offer pathways to treating previously untreatable diseases.

Take, for example, three of the top five diseases in Australia in terms of the burden of illness (i.e. morbidity, mortality and direct health care costs).

Cardiovascular disease: Cardiovascular disease or CVD (which includes coronary heart disease, stroke, heart failure, rheumatic heart disease and high blood pressure) is the leading cause of death in Australia and the second leading cause of disease burden. It is estimated to have accounted for 16% of Australia's overall disease burden in 2010 when both mortality and disability are taken into account**.** It is also the most expensive disease group in Australia in terms of direct health-care expenditure ($5.94b or 11% of overall recurrent health system expenditure in 2004-5).

CVD advances in diagnostic imaging improve early diagnosis and can remove the need for highly invasive surgery

- Coronary angiography provides an image of the heart's arteries which identifies in detail where arteries are narrowed or blocked. A catheter is inserted into an artery, usually in the groin, and guided to the heart. A special dye is injected through the catheter into the arteries before images are taken. ***This is an important diagnostic test that medical professionals use to plan treatment options.***

- Through CT Coronary Angiography (CTCA) it is possible to take images of the beating heart that will provide information about the heart muscle, heart valves and the coronary arteries. The coronary arteries supply the blood to the heart muscle and it is the disease of these vessels that is responsible for most heart attacks. ***CTCA is a very good predictor of the likelihood of heart attack.***

- Image guided interventional techniques are also used in the treatment of CVD. For example, "coiling" involves removing potentially lethal pathologies (such as aneurisms) through the insertion of tubes filled with tiny platinum coils into a vein. The insertion is guided via imaging to the site of the aneurysm. The coil blocks blood flow and prevents rupture. Where the blockage is located in the brain, endovascular coiling removes the requirement for removing a section of the skull and the spreading of brain tissue. ***This procedure significantly reduces both hospital and recovery time and the risk of poor outcomes.***

Cancer: In 2010, 43,000 people died of cancer and cancer contributed more than $3.8b in direct health system costs. Of the three most prevalent cancers (excluding melanoma), prostate cancer is the most common (19,400 cases a year), followed by bowel cancer (14,000 new cases a year) and breast cancer (12,700 new cases a year). For these conditions early diagnosis is key to both retaining a normal quality of life and to survival. Diagnostic imaging is not only a pathway to early diagnosis, but it offers less invasive avenues to diagnosis and treatment than have historically been available.

- ❖ 90% of people with bowel or colon cancer will still be alive after 5 years if it is caught early enough. Pathology screening tests can identify the possibility of the presence of cancer, but it must be confirmed through diagnostic imaging.

Advances in diagnostic imaging of the bowel or colon are making the detection of cancer less invasive and less costly

- The traditional procedure for the detection of bowel or colon cancer is an x-ray involving a barium enema or, more frequently these days, a colonoscopy. A colonoscope - which is a flexible tube with lenses and a tiny TV camera at the end - is inserted into the rectum and images are transmitted to a video screen. It is a lengthy procedure and the patient is under general anaesthetic.

- Colonoscopies are gradually being replaced by virtual colonoscopies using CT or MRI. These do not involve the insertion of a colonoscope or sedation. It takes less time. There is no risk of perforation of the bowel. It provides a more comprehensive examination, and it has the advantage of revealing diseases or abnormalities outside the colon. The cost of providing this service is less than $500 compared to a traditional colonoscopy which can costs thousands of dollars.

❖ If prostate cancer is diagnosed before it has spread beyond the prostate, nearly all patients will be alive after 5 years, with 10 and 15 year survival rates being 93% and 77% respectively. If the cancer has spread, treatment pathways can be complex and costly. Diagnostic imaging is not only playing an increasing role in the early identification of prostate cancer, but it may reduce the requirement for unnecessary treatment of the condition.

Diagnostic imaging is providing less invasive and more detailed images in the identification and treatment of prostate cancer

- Currently, trans-rectal ultrasound-guided biopsy (TRUS-Bx) is the common tool for diagnosis. This relies on random sampling of the prostate and there is a need for a number of core biopsies to be taken.

- In recent advances, special MRI technology is used to identify cancerous cells with much more specificity and sensitivity. It can help discern between patients with insignificant disease and patients in need of treatment. The technology may also alleviate the need for biopsies to be taken for accurate diagnosis, or at least significantly lower the number of biopsy cores needed. Currently no rebate is provided for an MRI of the prostate and cancer patients face the full out-of-pocket cost for this 'gold standard' procedure

❖ If breast cancer is limited to the breast, then 98% of patients will meet the 5+ years mortality rate.

Diagnostic imaging advances in the early identification and treatment of breast cancer

- Diagnostic mammography (not to be confused with basic breast screening procedures for patients presenting without symptoms) has recently taken an important step forward through 3D tomosynthesis breast imaging. This allows the radiologist to detect cancers that are not visible on conventional 2D mammography and allows the identification of very early stage breast cancers.

- If something is found, radiologists can also perform a minimally invasive biopsy, often on the same day. This involves the guided insertion of needles, as opposed to more costly surgical biopsies which involve more trauma (cutting) to the breast, hospitalisation and anaesthesia. The radiologist can also inject a solution containing carbon to mark or track the biopsy site, allowing surgeons to make very precise, image guided identification of the cancer site/s to be removed, taking away the need for an additional procedure before surgery. Very small cancers can actually be removed via a needle biopsy.

Neurological Disorders: Diagnostic imaging is also playing an increasing role in the diagnosis and treatment of mental diseases. For example, neurological disorders, particularly dementia, impose massive costs in terms of their impact on patients, their families and the health system; and this cost is growing rapidly with the ageing of the population. In 2008–09, over half (53%) of the permanent residents living in Australian Government subsidised aged care facilities were diagnosed with dementia. Alzheimer's disease was the most common type of diagnosed dementia, affecting 76% of residents with dementia. Almost 56% of residents with dementia had high needs for assistance in the behavioural care domain. It has been estimated that, without significant advances in the treatment of Alzheimer's, the costs associated with the disease could absorb 3% of GDP by 2050.

Diagnostic imaging in the early identification and staging of Alzheimer's disease

- Diagnostic imaging is contributing to the early (pre-dementia) detection of Alzheimer's disease (1500 new cases a week and growing). Diagnosis of the phases of Alzheimer's is assisting pharmaceutical companies to develop medicines which will ***substantially retard the progress of the disease***.

The examples canvassed above are far from exhaustive. Indeed, diagnostic imaging is central to the diagnosis and treatment of other National Health Priority Areas such as arthritis and musculoskeletal conditions and injuries

2.2 Private sector investment underpins diagnostic imaging in Australia

It provides the vast majority of diagnostic imaging services nationally

The private sector currently provides over 85% of Medicare diagnostic imaging services in Australia.

It operates most comprehensive practices throughout Australia

There are around 700 comprehensive practices located within 30km of 92% of Australia's population. Six hundred of these are owned and operated by the private sector.

It operates most comprehensive practices in rural and remote areas

The private sector also underpins patient access to services in rural and remote Australia – it owns and operates 80% of the comprehensive practices outside of metropolitan areas.

It directly supports public hospitals

The private sector often also provides radiology services (professional staff and sometimes equipment) to public hospitals.

It provides a breadth of services

Practices offer a wide range of medical and diagnostic imaging services to referrers and patients. The services offered by comprehensive practices encompass the following diagnostic imaging modalities:

- General x-ray
- Fluoroscopy;
- Mammography;
- DEXA (Bone Densitometry) scans;
- Ultrasound services;
- Multi-slice Computed Tomography (CT) scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear Medicine; and
- Position Emission Tomography (PET) services.

(Conditions for which these different technologies are used in diagnosis and treatment are described in ***Attachment A***.)

It enables Australians access to highly qualified health professionals

Comprehensive practices employ a team of health professionals with expertise in the various diagnostic imaging modalities; including radiographers, sonographers, nurses and nuclear medicine technicians. They are well equipped to offer patients access to the latest advances in diagnostic imaging as well as to the more routine services required by patients.

It invests in new technology

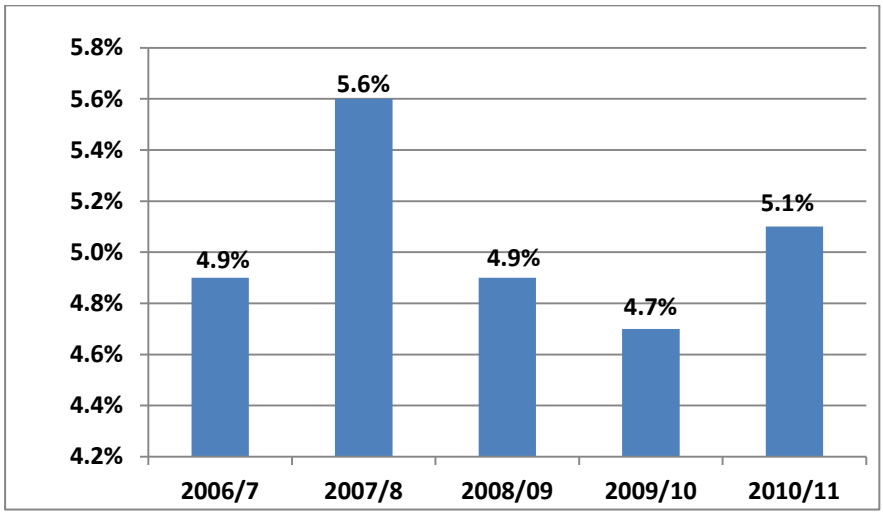
The private sector has led the way with investment in new services and new modalities long before there was any government funding for these services in many geographic locations. In recent years the private sector has reinvested the equivalent of 16% of Medicare diagnostic imaging funding per annum into our health infrastructure.

3 ISSUES

3.1 The erosion of patient rebates for Medicare services

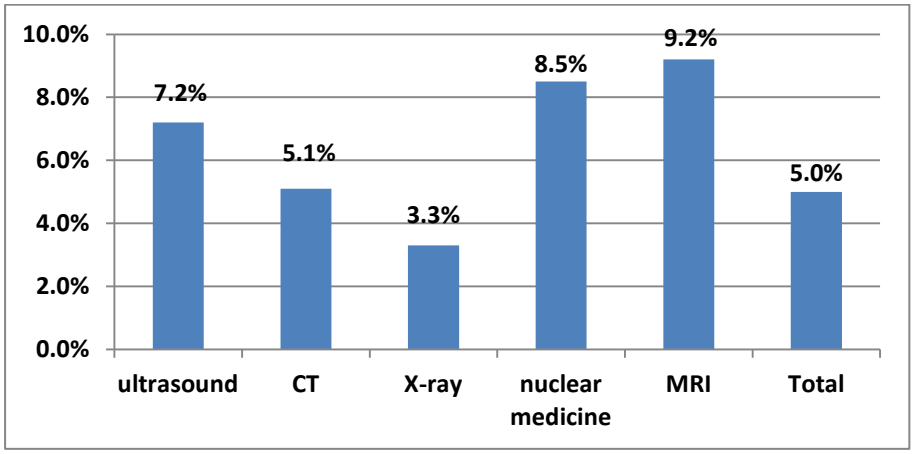
Growth in the demand for diagnostic imaging services has steadied in Australia over the past 5 years (averaging about 5%). Indeed this has been a worldwide phenomenon.

Chart 1: Total annual growth of Medicare billed DI services



However the demand for services involving newer technologies and higher levels of clinical involvement is increasing. At a modality level, growth in the oldest technology – general x-ray – is flattening out, while demand for ultrasound, CT, MRI and nuclear medicine services is growing.

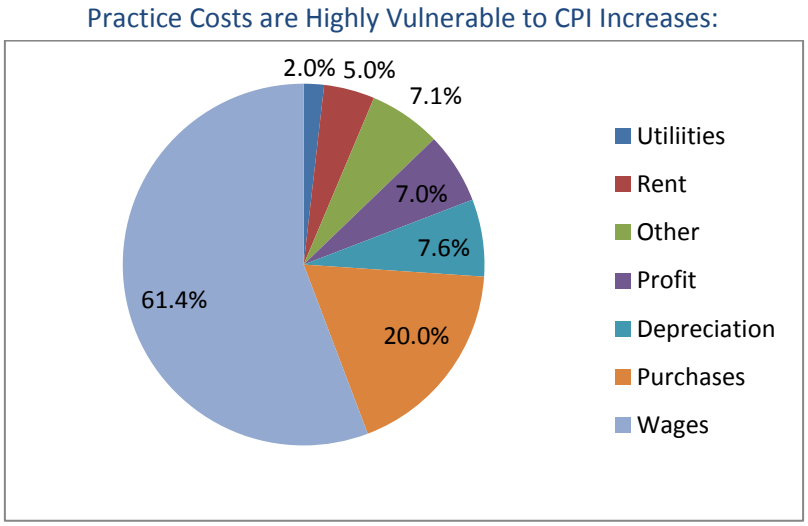
Chart 2: Average annual service growth over the past 5 years by modality



The cost of providing diagnostic imaging services has however also been increasing, largely in line with staff and professional costs. The other input costs have also been increasing, including the costs of imaging equipment, communications technology, rent, and consumables. Image transmission and image storage costs have grown rapidly as improved technology has increased the number of slices (images) per examination. Transmission and image storage requirements are likely to cost practices even more with the introduction of Personally Controlled Electronic Health Records (PCEHR). Diagnostic imaging also has high energy requirements and the introduction of the carbon tax in 2012 will add to those costs.

However, of all these costs, wages constitute the highest proportion - 60% in an average practice- and are most sensitive to CPI increases. Staff costs are comprised of: radiologist costs (21% of total costs); radiographer, sonographer and other technician costs (23%); and non-medical staff (13%).[1] Professional costs in practices which offer services with a high level of clinical input will obviously be much higher.

Chart 3: Average distribution of practice income



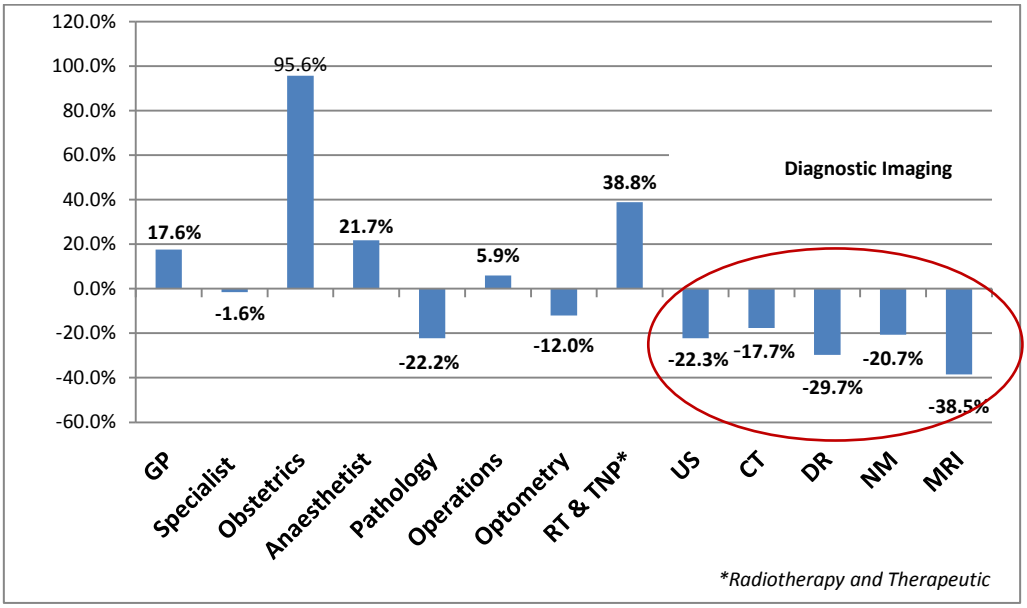
Department of Health Ageing, November 2010

Diagnostic imaging has been left behind other specialist medical services, with no indexation of rebates since 1998

The reason there is such a discrepancy between the costs of providing diagnostic imaging services and Medicare rebates for these services is that, unlike nearly all other specialist medical services, diagnostic imaging patient rebates have not been indexed since 1998. This is an outcome of capped MoU funding arrangements between 1998 and 2008. When the MoU expired, indexation was not restored to the diagnostic imaging component of Medicare and this has led to an ever increasing gap between practice costs and patient rebates for diagnostic imaging services.

[1] Access Economics, 2008, The Costs of Diagnostic Imaging for Services Covered by the Radiology MoU

Chart 4: CPI adjusted % benefits change in services – 1998/9 to 2010/11



The table below demonstrates the CPI adjusted impact of non-indexation for some common diagnostic imaging services and the flow on effect to patient contributions.

Chart 5: Decline in the value of DI Medicare rebates between 1998 and 2010 – some examples

Government Contribution					Patient Contribution	
Service	1998 Rebate	2010 Rebate	Variation over 12 years	CPI Adj	Average increase over 5 years (2005-2010)	
CT scan chest	$259.30	$250.75	3% ↓	34% ↓	43% ↑	CT Services
X-ray spine	$50.15	$46.85	7% ↓	37%% ↓	62% ↑	X-ray services
MRI head scan	$424.60	$342.75	19% ↓	45% ↓	25% ↑	MRI services
Vascular ultrasound	$147.00	$144.10	2% ↓	33% ↓	66% ↑	Ultrasound services

3.2 Challenges arising from the bulk billing incentive rebate

In November 2009 the Government introduced a 10% bulk billing rebate incentive for services that are bulk billed. Through this measure essential funding was injected into the sector and to practices that bulk billed a high percentage of their services. Unfortunately this incentive is not indexed and increased costs have eroded its effectiveness Analysis from Access Economics' most recent cost survey projects that in 2011-12 average rebates for non-bulk billed services will be $53.00 or 33% below average unit costs, and average rebates for bulk billed services (including the incentive) will be $40.00 or 25% below average unit costs.[2]

Nevertheless, the private diagnostic imaging sector is highly price competitive and many practices continue to bulk bill a high percentage of services. This in turn puts pressure on other diagnostic imaging providers to bulk bill. While, on the face of it, this may seem like a benefit from a healthcare perspective, it has some perverse outcomes. Given the revenue to cost shortfall, private practices which choose to bulk bill in the face of rising costs must continue to cut costs and achieve high service turnover. Among the ways practices can cut costs are:

- Narrowing the spectrum of services available to patients at a given practice, hence limiting the access of some patients to the most clinically appropriate services.

- Since labour is the highest cost factor for practices, economising on the input of specialist radiologists and other health professionals.

Even bulk billing practices can't afford to bulk bill some services. Furthermore, practices that advertise as "bulk billing" will often limit the range of services offered or charge gaps for the more complex and time consuming services involving higher levels of professional input and costly consumables (such as prosthetics, contrast substances and injections) – even to concession card holders. Rather they will offer more routine diagnostic imaging services at bulk billing rates and not the more complex services required by the really ill. This means that they are unlikely to provide the type of services referred to in the first section of this submission – ***often those which produce the most savings to the health system as a whole.***

[2] Access Economics, Funding of diagnostic imaging in Australia; challenges and policy perspectives (November 2010), p.1. Available on the ADIA website at http://www.adia.asn.au

A typical list of services not offered at the bulk billing rate by "bulk billing" practices is at ***Attachment B***. Again, it is notable that ***services requiring a higher level of professional involvement and sub-specialist training – diagnostic mammographies, injection of contrast substances, the need for sedation – are those needed by the really ill and which require a patient co-payment.***

3.3 Declining patient access to supervised diagnostic imaging services

The range and quality of services available to patients is beginning to decline

Many patients will not have ready access to professionally supervised radiology practices or to a range of necessary diagnostic treatment if current trends continue. This includes time consuming and clinically intensive examinations (such as mammography and standard interventional procedures, let alone the new breakthrough technologies such as those mentioned at the beginning of this submission). Nor will there be as large a pool of specialist private sector radiologists for public hospitals to draw upon when they lack expertise and equipment in-house.

Distinctive tiers of practice are emerging

ADIA has analysed Medicare practice data with a view to identifying the changing mix of practice types and services available to patients. On the basis of that data, we have categorised practices in terms of the services they offer (both in terms of modalities and of the clinical significance of those services). The categories are identified in the table below.

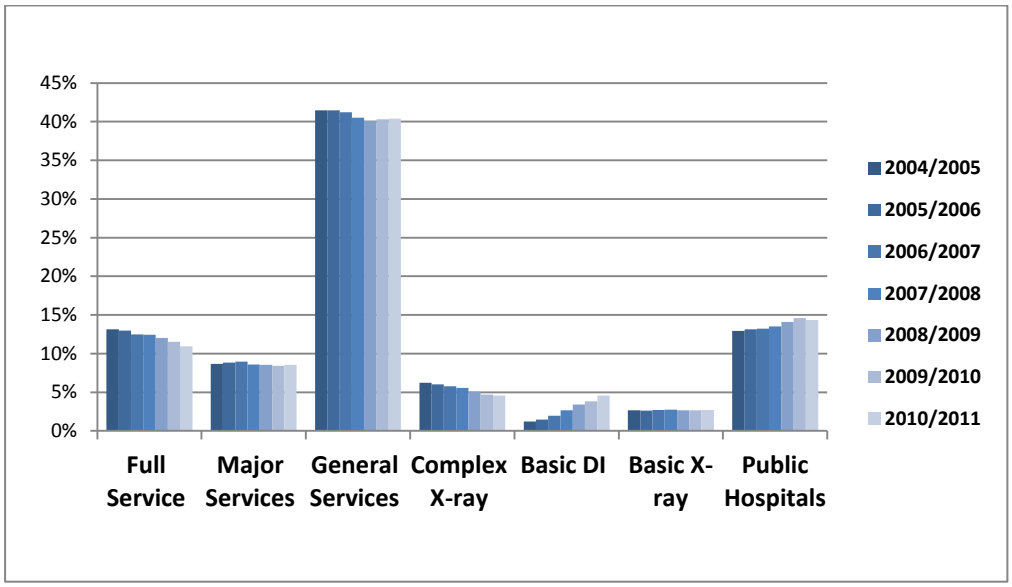
Chart 6: Diagnostic Imaging Practice Types

Full service diagnostic imaging practice	DI practices with complex services. All services including ultrasound, CT, MRI and all complex x-ray services (including breasts, angiography, fluoroscopic examination and reporting, and interventional techniques) May also provide nuclear medicine. Services require radiologists to be available for involvement in the procedures.
Major service diagnostic imaging practice	X-ray, ultrasound, CT, MRI and some complex x-ray services (may also offer nuclear medicine diagnostic servies). Services require radiologists to be available for involvement in procedures.
General service diagnostic imaging practice	CT, ultrasound, routine x-ray and sometimes complex x-ray services. Some will have MRI. Require radiologist involvement in some services.
Basic diagnostic imaging practices. These practices are unlikely to have a radiologist on site.	CT, ultrasound, routine x-ray.
Complex X-ray practice	X-ray and ultrasound including some complex x-ray services such as angiography, diagnostic breast imaging, fluoroscopic examination and reporting and/or interventional techniques. Some services require radiologist involvement.
Basic X-ray	Routine x-ray which does not require professional supervision or real time involvement in the examination. May also offer ultrasound services.
Public hospital outpatient services	Services mix offered will vary from hospital to hospital.

There has been an increase of practices offering a limited spectrum of services throughout the sector and, in some cases, the closure of practices which offer comprehensive services.

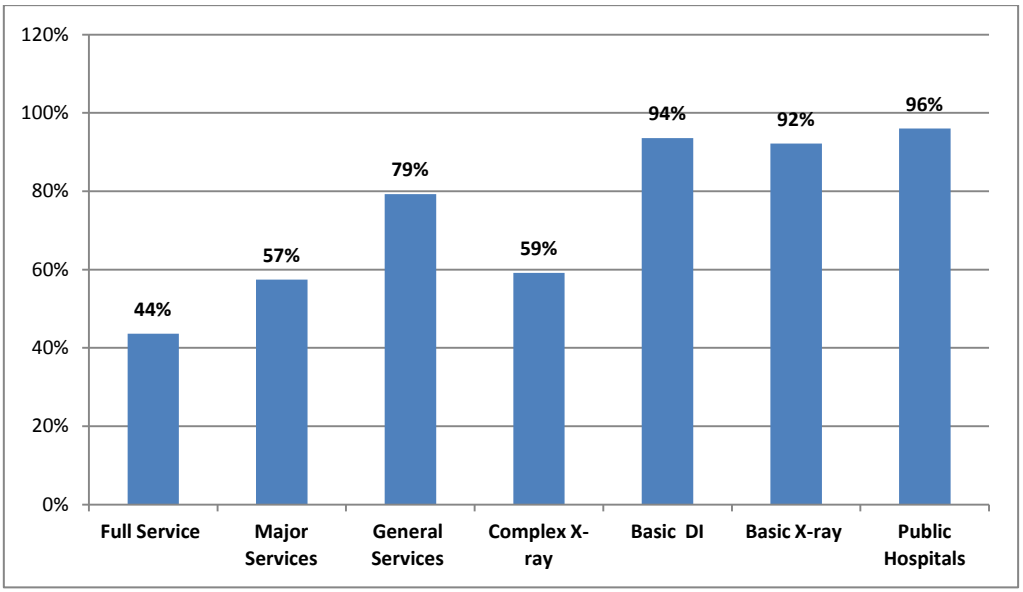
As the chart below demonstrates, the growth over the past seven years has been in the basic or limited practice types and public hospital outpatient services. Practices which offer a range of services and higher levels of clinical input (and are also most likely to offer after hours services at some cost to themselves) are stagnating or declining in number and experiencing declining growth

Chart 7: Percentage shares of total MBS fees by practice type over 7 years



The basic diagnostic imaging practices and the basic x-ray practices are least likely to have a radiologist on site, least likely to offer after hours services, most likely to bulk bill and most likely to receive a high share of the bulk billing incentive funding. Similarly, the public hospitals are attracting a growing share of services due to their bulk billing practices.

Chart 8: Bulk billing rates by practice type – 2010-11



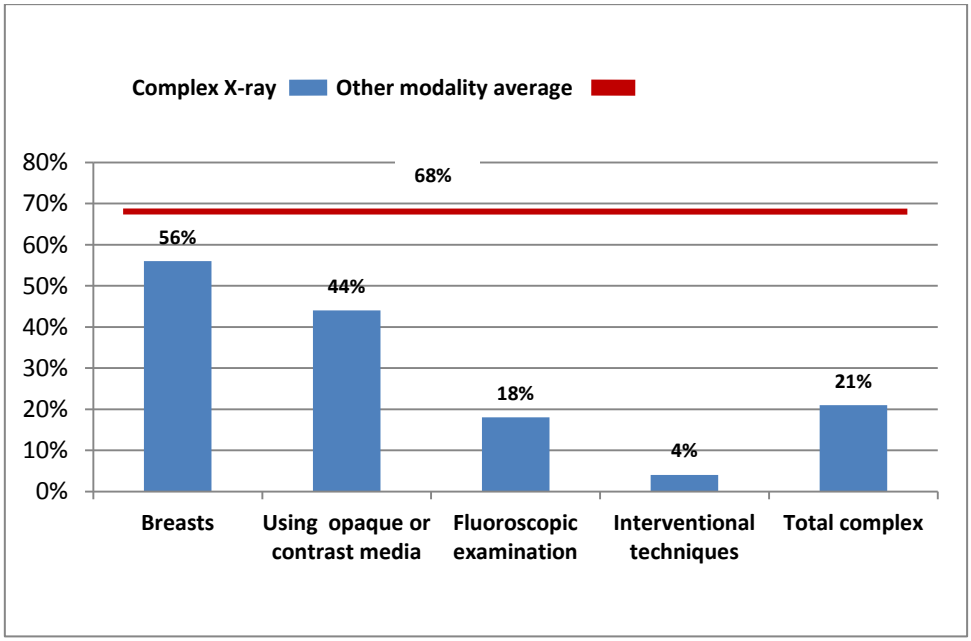
Moreover, if this trend continues, there will soon be as many basic practices (with limited service offerings and lower levels of professional input) as there are full service practices, and a concomitant decline in practices offering a spectrum of services.

Patient co-payments are rising for non-bulk billed services

The second major outcome of the failure to index diagnostic imaging rebates is that patient gap payments for services which are not bulk billed will continue to rise. The Department of Health and Ageing have noted a 7% increase in average gap payments for non-bulk billed services between 2008-09 and 2009-10.[3] Gap payments for many cost-intensive services is well in excess of this average.

Take for example complex x-ray examinations. As the chart below illustrates: the bulk billing rates for complex x-ray examinations are significantly below the average bulk billing rates for other diagnostic imaging services, and the level of bulk billing decreases with the complexity of the procedure

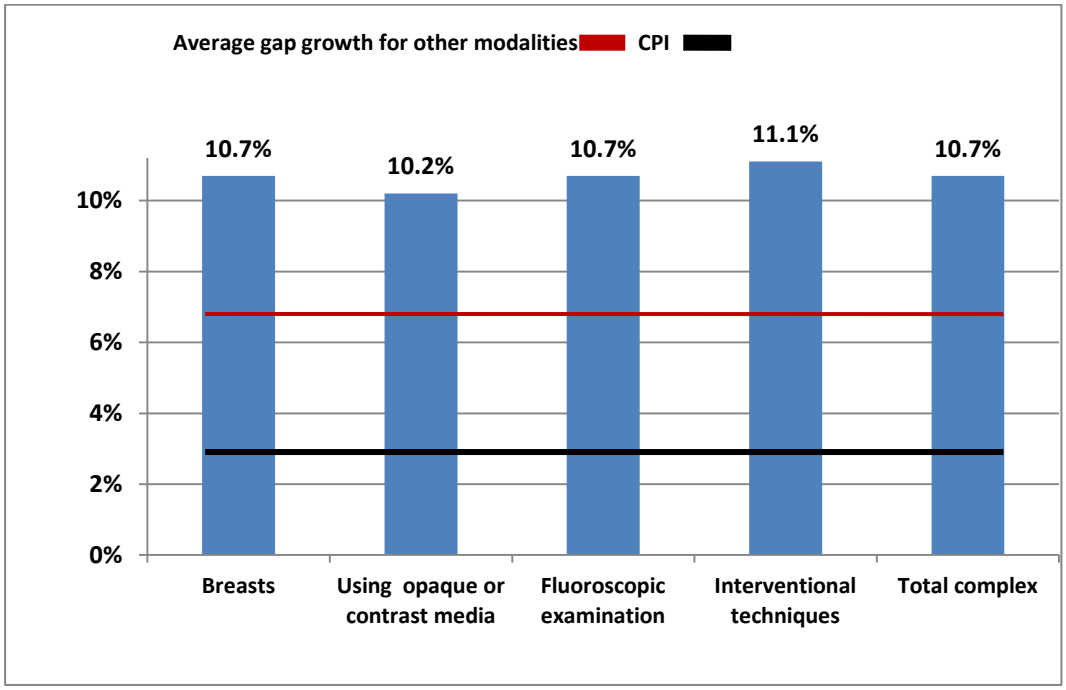
Chart 9: Bulk billing rates (2011) for complex x-ray services versus total other modality average bulk billing rates



[3] Unpublished Medicare data from the Department of Health and Ageing.

Conversely, gaps payments are higher than average payments for other modalities, although the growth in the average gap payments in all modalities is significantly above CPI.

Chart 10: Average annual growth in patient gap payments for complex x-ray services since 2004/05 versus average diagnostic imaging gaps for other modalities



Declining incentives for private investment in more advanced services

A third outcome of the accumulating imbalance between rebates and costs is that it erects a road block to investment in the more advanced diagnostic imaging services which are becoming available. A past study commissioned by ADIA found that the diagnostic imaging sector invested approximately $470M p.a. in new equipment. Of this, nearly 65% ($305m) was private sector investment. This represents a level of reinvestment into our health infrastructure equal to 16% of Medicare diagnostic imaging funding per annum. The consistent decline in the value of rebates is hardly an inducement to continue this level of investment and reinvestment

3.4 The shift in diagnostic imaging services from the private to the public sector

A complicating feature which is further undermining investment in quality private sector diagnostic imaging practices, and which will add to Government health costs, is the gradual shift in outpatient services from the private to the public sector.

Increasingly, private practices are experiencing strong competition from public providers of outpatient diagnostic imaging services. Over recent years we have seen public hospital providers actively promote bulk billing to GPs in the community. This has often been in direct competition with local private practices.

A viable mixed system can underpin access by all communities across Australia to a full suite of essential diagnostic imaging services. In many rural communities the local radiologist reports the services for inpatients and outpatients in both the public hospital and the local private practice. In other communities the private practice provides a comprehensive service for the public hospital. The models vary to meet the needs of the community. These arrangements should be fostered and new public investment in the sector should be directed at filling gaps; not at undermining these arrangements with new investment funding from the public sector.

It is important to ensure that the public sector is not undermining quality, efficient, supervised private practices that offer the community essential services such as mammography and supervised ultrasound. ADIA has anecdotal evidence of instances where public hospitals have become so overcommitted to outpatient services that they are asking private providers to take on their inpatients. There have been other instances where private providers have closed their doors in the face of public sector competition and withdrawn specialist services from the community that the public hospital does not provide.

The market distortions that we are witnessing in the diagnostic imaging sector are being driven by a number of factors. In many instances the lack of indexation of Medicare rebates makes bulk billing of quality private services in competition with the public sector unviable. Public hospitals benefit from more favourable cost structures due to exemptions from certain taxes and from public funding of some of their costs and equipment. In addition they are able to claim the highest level of Medicare rebate for their services – i.e. the 10% bulk billing incentive. In locations where public outpatient services are aggressively competing for market share, private providers which are already struggling to balance costs and revenue are losing patients to the public providers.

A recent development which may drive further proliferation of public outpatient services is the National Health Reform Agreement which will expand Local Hospital Networks (LHNs) throughout Australia, and which encourages them to provide outpatient services to fill "gaps" in community services. The Agreement also allows for the retention of the revenues raised. The opportunity to treat Medicare as an additional source of revenue could further incentivise these new LHNs to offer outpatient services even where service gaps do not

exist. The consequences of a significant shift of diagnostic imaging services from the private to the public sector are likely to be:

- The continuing erosion of private comprehensive practices offering a wide range of services and high levels of investment in equipment and clinical expertise.

- Increased pressure on a public hospital system already struggling to meet the needs of an ageing population, resulting in long waiting lists, the pressures of high patient turnover, and the delays and inevitable mistakes that occur in diagnosis under these conditions.

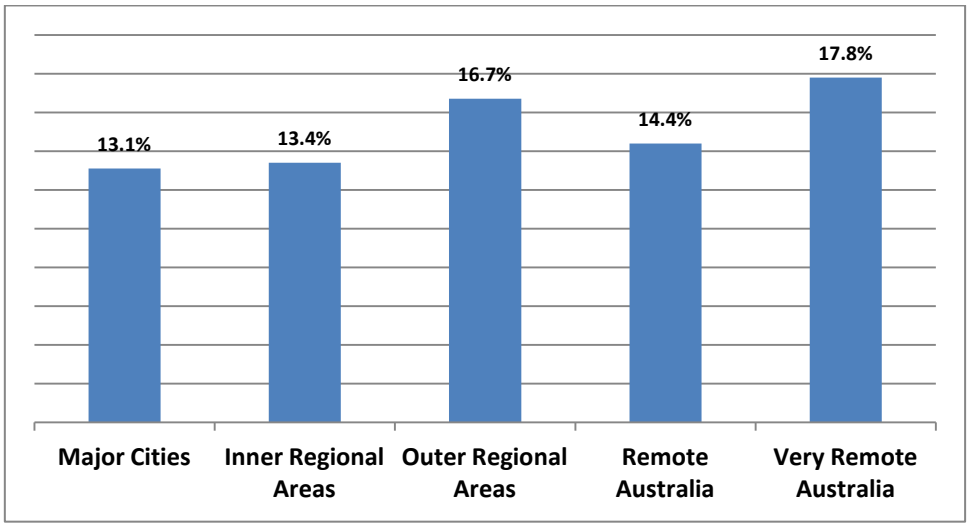
- If private practices close, particularly in regional areas, there will often be a flow-on loss to both the public sector and the community of specialist radiologists.

3.5 Risks to diagnostic imaging services in regional Australia

The challenges confronting the private diagnostic imaging sector canvassed above are common throughout Australia but are particularly acute in regional areas.

Regional and remote diagnostic imaging services have smaller catchments and need to pay higher communications and consumables cost than their city counterparts. It is therefore not surprising that patient gap payments are highest in these areas. When patient gap payments are looked at on a geographic basis, the largest increases in payments since 2004 (those in the top 25% of gap payments) have been experienced by regional and remote populations.

Chart 11: The largest increases in gap payments (the top 25%) by geographical area



In addition, regional areas of Australia have their own unique problems. One of the most pressing is the growing shortage of radiologists. Data provided by the Royal Australian and New Zealand College of Radiologists (RANZCR)[4] indicates an imbalance between access to radiologists in metropolitan areas (ASGC-RA1) and other ASGC RA classifications. For example:

- 87% of the radiologist workforce in NSW resides in RA1 compared to 73% of the NSW population.
- 88% of the radiologist workforce in Victoria resides in RA1 compared to 75% of the Victorian population.
- 81% of Queensland radiologists reside in RA1 compared to 60% of the Queensland population.

To add to the pressure of undersupply of radiologists, the rural radiologist workforce is ageing. The average age of radiologists across Australia has climbed to over 50 years, despite growth in graduate numbers. In regional and rural areas the average age rises to over 53 years, indicating that those areas already most in need will come under increased pressure in years to come, as an older workforce seeks to reduce hours or retire.

[4] RANZCR submission to Skills Australia's Skilled Occupation List (SOL), 2011

4. The Bottom Line

4.1 Indexation of DIST Fees and Patient Rebates

It is absolutely essential that diagnostic imaging rebates are indexed in the future. Otherwise:

- The pattern of rebates diminishing as a percentage of costs and the consequences for affordability and accessibility of quality diagnostic imaging services will continue.
- Investment in more efficient, safer and clinically superior equipment which also reduces the more expensive health costs elsewhere in the system will be constrained.
- Any other favorable adjustment to rebates, such as access to Medicare eligible MRI announced in the last Budget, will be quickly eaten away.
- The effectiveness of the bulk billing incentive funding will erode and gap payments will continue to grow.

ADIA Recommendation 1:

That all diagnostic imaging Medicare rebates are indexed from 1 November 2012.

ADIA Recommendation 2:

That, if the Government feels unable to index rebates in the next Budget due to fiscal constraints, it should at the very least increase diagnostic imaging rebates to 100% of the scheduled Medicare fee (consistent with the introduction of 100% of the scheduled fee for bulk billed MRI services in May 2012) for the patients least able to make co-payments – i.e. concession card holders.

The cost to Government of indexation is estimated to be:

Table 3: Indexation Costs - Forward Estimates

	2012/13	2013/14	2014/15	Total
Indexation impacts	$160m	$228m	$240m	$628m

4.2 Preserving quality comprehensive practices

ADIA specifically recommends that additional funding be paid directly to practices that provide a broad range of diagnostic imaging services and a high level of radiologist clinical input into patient services. The underfunding of diagnostic imaging services has resulted in an alarming growth in practices which do not offer direct clinical input by radiologists.

The loss of a broad mix of diagnostic imaging services will have a direct impact on patient access to essential care and services and will lead to fragmentation that further reduces the efficiency of the sector.

It is important that there is a radiologist available to confer with referrers and patients, to determine that the right scan has been ordered, to perform interventional procedures such as biopsies and guided injections, and to intervene in urgent cases.

This targeted approach could take the form of Practice Incentive Program (PIP) funding. This would be akin to the funding made available to general practitioners. The General Practitioner Practice Incentive Program delivers financial incentives to practices that provide comprehensive, quality care in the form of longer consultations, provision of afterhours care, better prescribing and a range of targeted interventions in relation to patients with particular health concerns.

ADIA recommends a similar program for diagnostic imaging practices. It could be tailored to promote convenient patient access to efficient, supervised, diagnostic imaging practices which provide a range of modalities and services and a high level of clinical input.

ADIA Recommendation 3:

That a Practice Incentive Program be introduced which builds on current practice accreditation programs and provides additional funding and indexation for practices which offer a wide spectrum of diagnostic imaging modalities and services, on-site radiologist supervision, timely care interventions and reporting, minimum radiation dose and active decision support for referrers. These radiology providers ensure patients receive accurate and urgent diagnosis with high levels of essential specialist clinical input.

4.3 Preserving the private/public mix in the provision of services

Although ADIA supports a mixed system, it is calling on governments to recognise that such competition should be on a competitively neutral basis in accordance with National Competition Policy and in the interests of preserving the efficient allocation of health resources and ongoing private investment to meet patient needs.

ADIA Recommendation 4:

That the Government should discourage the movement of diagnostic imaging services from the private to the public sector by:

- Incorporating the principle of competitive neutrality between the public and private sectors into the overarching principles for the National Health Reform Agreement Pricing Framework.
- Funding the provision of public hospital outpatient services exclusively through public hospital activity based pricing (ABF), thus prohibiting the current practice of double dipping into both Medicare and government grant funding for the provision of the same service.
- Ensuring that provision of public outpatient services is restricted to cases where there is a genuine gap in local diagnostic service provision.

4.4 Preserving diagnostic imaging services in regional Australia

The unsustainability of bulk billing practices in regional areas and the high gap payments required of rural patients means that the indexation of rebates is critical for the early diagnosis of disease in regional and rural areas.

Action is needed to address radiologist workforce shortages in regional areas arising from the ageing of the workforce

The Federal Government has established a Rural Retention Program which aims to recognise and retain long-serving general practitioners (GPs) in rural and remote communities experiencing significant difficulties in retaining GPs.

ADIA Recommendation 5:

- That the Government introduce indexation of rebates for rural services.
- That the Government introduce a Rural Retention Program for radiologists
- ADIA is also requesting a revision of District Workforce Shortage (DWS) criteria for all regional areas. The current calculation of radiologist shortages fails to recognise that Medicare services are often remotely reported

4.5 Ongoing Policy Reform

ADIA Recommendation 6:

That Government pursues improved funding arrangements in respect to the following priority areas:

- Increases in rebates for significantly underfunded MBS items. These services are characterised by high levels of complexity and a requirement for clinical input throughout the imaging process.

- Improvements to the enforcement of the Prohibited Practices provisions of the *Health Insurance Act (1973)* to prevent inappropriate imaging due to referrers having a direct financial interest in diagnostic imaging practices (by way of joint venture or other arrangement).

- Funding support to private practices for image storage and other cost impositions required by the introduction of the Personally Controlled Electronic Health Record (PCEHR) system which are over and above the existing high levels of investment in e-Health in the private diagnostic imaging sector.

5 Conclusions

Patients are at risk of not being diagnosed and treated for serious conditions because they can no longer afford, or have access to, quality diagnostic imaging services.

The only way to provide a sustainable solution is for the Government to commit to indexation of patient Medicare rebates for diagnostic imaging services.

Bulk billed services and bulk billing will become less sustainable as the lack of indexation erodes the value of the incentive rebate.

We appreciate the difficult fiscal climate currently confronting the Government. However, much like a disease, the longer the problems are left untreated the more the situation disintegrates and the more difficult and expensive they become to redress. Rebates for MBS fees are the same today as they were 14 years ago – this is just not sustainable. Many private radiology providers across the country are being pushed either to the brink of collapse or a reduction in the range and clinical currency of service provision.

Trends which shift the provision of services from the private to the public sector impose unnecessary costs on government and pressure on already overburdened public services.

In the interests of providing acceptable levels of universal healthcare to all Australians, there is a need to address the decline of the radiology workforce in regional areas.

The Australian Diagnostic Imaging Association is committed to working with the Federal Government to ensure that: funding is directed to clinically necessary diagnostic imaging services; patients who cannot afford services can access quality bulk billed services and patient gaps remain low.

If you require further information, please do not hesitate to contact Ms Pattie Beerens, Chief Executive Officer of ADIA on (03) 9867 5070.