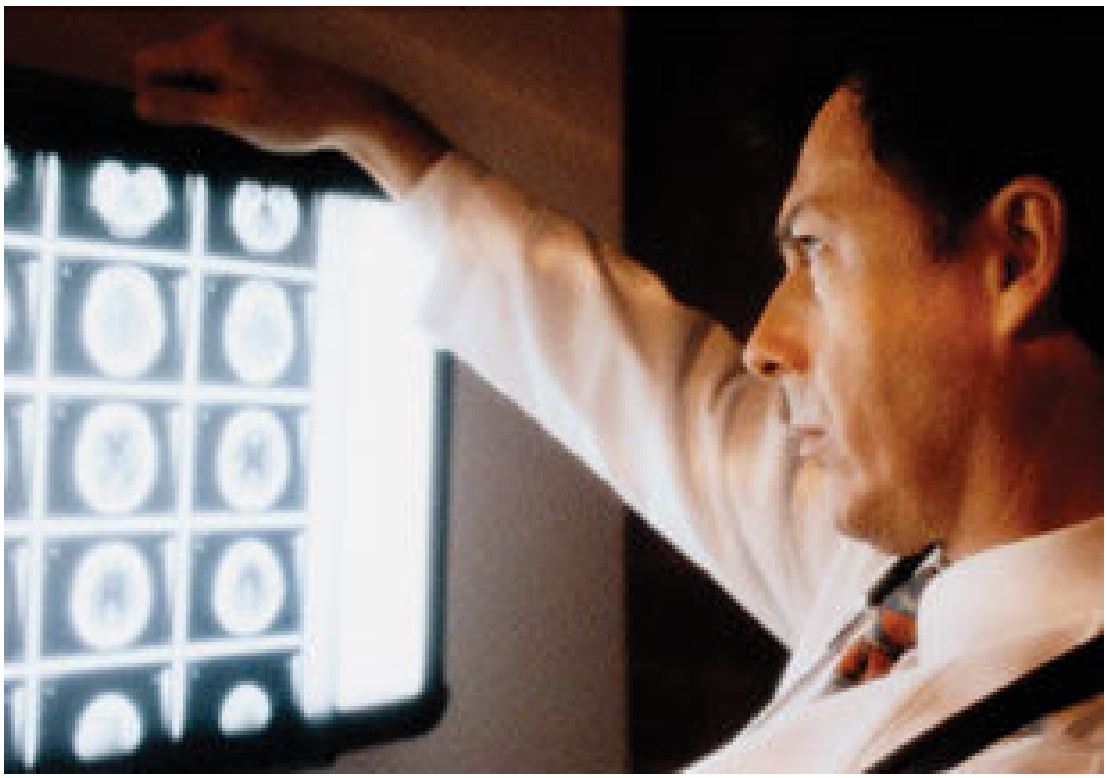
ADIA
australian diagnostic imaging association

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

FEDERAL BUDGET SUBMISSION 2011-12



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"Funding of diagnostic imaging in Australia – challenges and policy imperatives"
AE Report Nov.2010

B. Radiologist onsite Case Studies
"When a radiologist is on site patient outcomes improve" (20 pages)

Introduction: Early and Accurate Diagnosis Saves Lives

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.

These patients are seeking diagnosis of a vast range of diseases and injuries:

- *pregnant women needing access to ultrasound to ensure their pregnancies are progressing well (607 first pregnancy scans per day);*
- *women with a high risk of breast cancer who rely on the diagnosis (858 mammographies per day); and*
- *patients with cancer whose only hope of survival is dependent on early and accurate detection of their disease (788 CTs for lung cancer and 259 CTs for liver cancer per day).*

Every day, lives are saved and patients are treated for conditions which, if left undiagnosed for too long, may leave them with chronic, painful disabilities and a poor quality of life. Correct, early diagnosis and procedures, guided by imaging, save millions of taxpayer dollars by cutting hospitalisation times and reducing the burden on an already overwhelmed public hospital system.

Despite this, diagnostic imaging services are becoming increasingly unaffordable and the practices which try to provide quality services and services at the rebate level are becoming unviable. This distressing situation is the product of the failure by government to index diagnostic imaging Medicare rebates for over 12 years.

More and more patients are struggling to access affordable, quality diagnostic imaging services when and where they need them. Further:

- *Patient rebates have eroded (Section 3.).*
- *Patient rebates are now below cost (Section 3.2).*
- *The 10% bulk billing incentive (introduced in November 2009) that provided essential funding, particularly to bulk billing practices does not cover the shortfall (Section 3.2).*
- *Patient "gaps" are increasing – by 15% in 2010 (Section 3.3).*
- *The number of practices providing unsupervised CT services is increasing and will equal the number of quality comprehensive practices in metro areas in 2.5 years (Section 3.4).*

It is essential that patients (especially those that cannot afford to pay gaps) can access quality services from quality practices. These comprehensive radiology practices employ world-class staff and invest in training, digital infrastructure, state-of-the-art equipment and quality assurance - even in regional and remote areas. Their patients gain least from the bulk billing incentive funding. This must be reversed. Our patients must be able to rely on Medicare rebates that are indexed and properly funded. If this chronic underfunding is not addressed through indexation, comprehensive radiology practices will not be able to continue to offer quality, supervised services to Australians (Section 3.5).

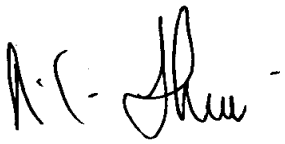
ADIA continues to actively engage with the Department of Health on the current Review of Funding of Diagnostic Imaging services. We also appreciate that the Federal Government must now commit precious budgetary resources to the recovery and reconstruction efforts following the flood crisis. However we remain concerned about the impact on patient care if government continues to overlook indexation of Medicare rebates for diagnostic imaging services.

Unlike other specialist medical services, patient rebates for diagnostic imaging services have not been indexed since 1997. In 1998 the rebate for an x-ray of the spine was $50.15. It is now $46.85.

With 60% of costs being healthcare workforce costs and another 20% of costs being premise rent, medical consumables and equipment maintenance – there can be no rationale for not indexing diagnostic imaging rebates even under the current budgetary restraints. It is a minimal right of patients to be sure the right test is being ordered, that a qualified radiologist is on site to ensure that correct and timely follow up treatment is being organized. All Australians have the right to ensure their health is not being compromised because of a lack of indexation and under funding of Medicare services.

This Budget submission offers a suite of policy solutions to remedy the ever increasing gap between patient rebates and the costs of providing diagnostic imaging services. ADIA supports the principle which underpins our country's health system - genuine universal healthcare. We commit this budget submission to the Government for consideration and look forward to working with Government on resolving these important policy challenges.

Yours sincerely



Dr Ron Shnier, ADIA President

1. Summary of Recommendations

ADIA Budget Recommendation 1 – Indexation:

That all diagnostic imaging Medicare rebates are indexed from 1 November 2011.

ADIA Budget Recommendation 2 – Rebates equal to 85% of cost:

That all Australians have access to affordable diagnostic imaging services with Medicare funding (patient rebates) equal to (at least) 85% of the average cost. This would be an average increase of $29 for privately billed services and $16 for bulk billed services. The extended Medicare safety net would continue to apply.

ADIA Budget Recommendation 3 – Quality supervised services:

That a Practice Incentive Program is introduced which builds on the current practice accreditation programs and provides additional funding for practices which provide a comprehensive range of diagnostic imaging modalities, on site radiologist supervision and timely care interventions and reporting. These radiology providers ensure patients receive, accurate and urgent diagnosis with essential specialist supervision - critical to good health outcomes. The Program should also be extended to provide funding for the infrastructure required to support the Government's commitment to the electronic health record.

ADIA Budget Recommendation 4 – Rebate increases for essential services that require significant professional input:

That Government increase the 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. Access to these services is becoming increasingly restricted because of the very high cost of providing these services.

ADIA Budget Recommendation 5 – Investment in rural and remote areas:

That Government, when considering specific investment decisions in respect to diagnostic imaging equipment in public hospitals (for example, in the context of grants made in the Health and Hospitals Fund Regional Priority rounds), take into account the impact on the sustainability of existing private diagnostic imaging services and the impact that the potential loss of such services would have on the community. This recommendation has no negative impact on the Health Budget and may produce savings to Government.

ADIA is willing to work with Government as part of an advisory panel to make recommendations in respect to the best sites for equipment taking into account the infrastructure that is already in place.

ADIA Budget Recommendation 6 – Other Priority Areas:

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

- The restriction on patient access to Medicare eligible MRI services.
- The restriction on GP referral to Medicare eligible MRI services.
- The need for competitive neutrality between the public and private providers of diagnostic imaging services, including the abolition of cost shifting.
- Inappropriate imaging due to referrers having a direct financial interest in diagnostic imaging practices (by way of joint venture or other arrangement).
- The increasing pressure on patient gaps due to the shortfall in patient rebates to cover the costs, including professional input, consumables, and equipment costs of providing quality diagnostic imaging services.

2. The Background

- Most diagnostic imaging services are required by patients while they are in the community and out of hospital.
- ADIA represents private radiology and diagnostic imaging practices located in communities and hospitals across Australia.
- The private sector provides over 85% of Medicare diagnostic imaging services in 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.
- 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 metro areas.
- Member practices and member groups offer a comprehensive range of medical and diagnostic imaging services to referrers and patients. The services offered by a comprehensive practice 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.
- 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 assist the patients and ensure that the images taken meet the needs of the reporting radiologist.

- All diagnostic imaging services provided by a comprehensive practice incorporate a specialist medical report of the medical diagnosis or opinion of a radiologist or a nuclear medicine physician based on the images.

- Where possible, comprehensive practices need to be supervised by a radiologist.

- Comprehensive practices are an exceptional model for providing patients with access to the diagnostic imaging services they require as they:
  - have imaging equipment that is usually selected with the needs of the local community, referring doctors and their patients in mind;
  - employ the radiologist (who may also be a proprietor), the health care team and practice staff required to ensure that patients have access to high quality, supervised services (approximately 60% of the cost);
  - invest in digital and other new technologies required to provide patients with the best tools for diagnosis and treatment;
  - have highly sophisticated modern computer networks, imaging and information systems and have expertise in these systems, and
  - offer a single investment in the equipment and infrastructure needed to provide a range of modalities (20% of the cost of providing a diagnostic imaging service).

- Referrers refer their patients for diagnostic imaging services when they seek a diagnosis of the presenting symptoms or measurement of the progress of a treatment or condition.

- Diagnostic imaging services are often used to "exclude" various possible conditions; for example, the referring doctor may believe that the patient has a minor ailment however needs to be sure because the symptoms are also consistent with a serious condition. Sometimes this leads to further investigation and a comprehensive practice makes this possible, convenient and ensures a better health outcome for the patient.

3. The Issues - Underfunding leads to patient care being compromised

Access Economics:
Quality of patient care is potentially compromised if practices cut costs in ways which undermine professional practice, including: - *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;* - *economising excessively on the input of professional radiologists and specialist labour input more broadly; and* - *postponing or even abandoning investment in updated or new equipment, hence failing to keep abreast of best clinical practice over time.*[1]

[1] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.3. Available on the ADIA website at http://www.adia.asn.au.

3.1 Patient rebates have eroded without indexation since 1997

Access Economics:
"There is growing concern over the inadequacy of Medicare funding for diagnostic imaging (DI) services in Australia. Apart from occasional adjustments for some individual services (both increases and reductions) and the introduction of the bulk-billing incentive in November 2009, Medicare Benefit Schedule (MBS) rebates for DI have remained unchanged over the past decade. Rebates have not been indexed despite strong growth in the cost of providing DI".[2]

- Unlike other specialist medical services, patient rebates for diagnostic imaging services have not been indexed since 1997.
- The cost of diagnostic imaging equipment, communications technology, consumables, real estate and, most importantly, labour have all increased significantly; meanwhile patient rebates have not.
- This has produced an ever increasing gap between the cost of providing services and patient rebates.
- The table below demonstrates the impact of rebate erosion for some common diagnostic imaging services. For example, the patient rebate for a privately billed CT scan of the chest has reduced over the past 12 years – by 31% in real terms. This has meant that over the past 5 years, patients have been required to contribute 43% more for these services by way of increased patient gaps.

Services *(examples)*	1998 Rebate	2010 Rebate	12 year impact *(CPI Adjusted)*
CT Scan Chest	$259.30	$250.75	31% ↓
X-Ray Spine	$50.15	$46.85	34% ↓
MRI Scan Head	$424.60	$342.75	43% ↓
Vascular Ultrasound	$147.00	$144.10	30% ↓

[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.

3.2 Patient rebates are below cost

Access Economics:

In 2007 an Access Economics study found that the average cost per Medicare-eligible DI service marginally exceeded the MBS rebate in 2005-06 (by around $1.40 per service). The study also found that unit costs exceeded average MBS revenue at around 50% of practice sites. Overall the study highlighted an emerging funding shortfall – DI services could not be bulk-billed without the practice sustaining a financial loss.[3]

The survey data (in 2010) reveals that, on average, unit costs associated with delivering Medicare-eligible DI services exceeded Medicare revenue by $33 per service in 2008-09 (Table 1.1). In addition, if private practices were to bulk-bill all Medicare services, Medicare rebates would not have covered service costs at 89% of sites. In other words, at current rebate levels, bulk-billing is not commercially viable for the great majority of DI practices.[4]

Table 1.1: Unit costs and average rebates for Medicare-eligible services[5]

	2008-09	2011-12 (projected)
MBS mean unit costs	$142	$162
Revenue – non bulk-billed services		
MBS unit rebate	$109	$109
Difference	-$33	-$53
Difference as % unit cost	-23%	-33%
% sites with unit revenue < unit cost	89%	N/A
Revenue – bulk-billed services^		
MBS unit rebate	$109	$122
Difference	-$33	-$40
Difference as % unit cost	-23%	-25%

^Includes the bulk-billing incentive from November 2009.

- If patient rebates are not increased :
  - By 2011-12, the average shortfall in Government funding of (non bulk billed) Medicare diagnostic imaging exams is estimated to be $53 (i.e. the rebate will be 33% below the cost of providing the average service).

[3] 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.

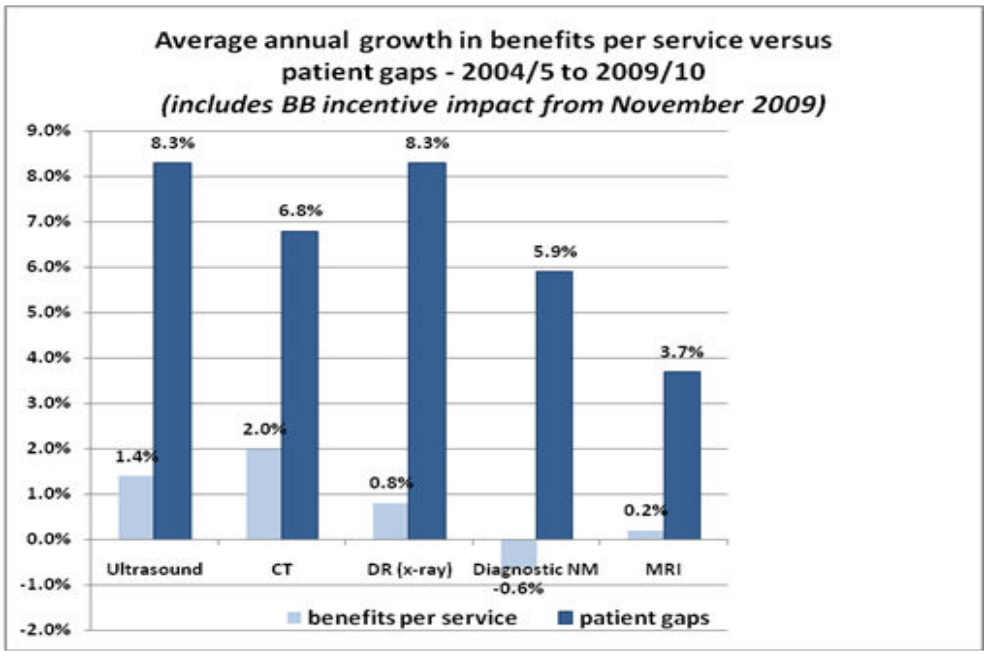
[4] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.2. Available on the ADIA website at http://www.adia.asn.au.

[5] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.3. Available on the ADIA website at http://www.adia.asn.au.

– While the bulk billing incentive has served to narrow this shortfall for some patients, the higher rebate for bulk billed services will also fall considerably short of covering costs in 2011-2012. Patient rebates for bulk billed services are projected to be 25% short in 2011-2012.

3.3 Services are becoming less affordable for patients

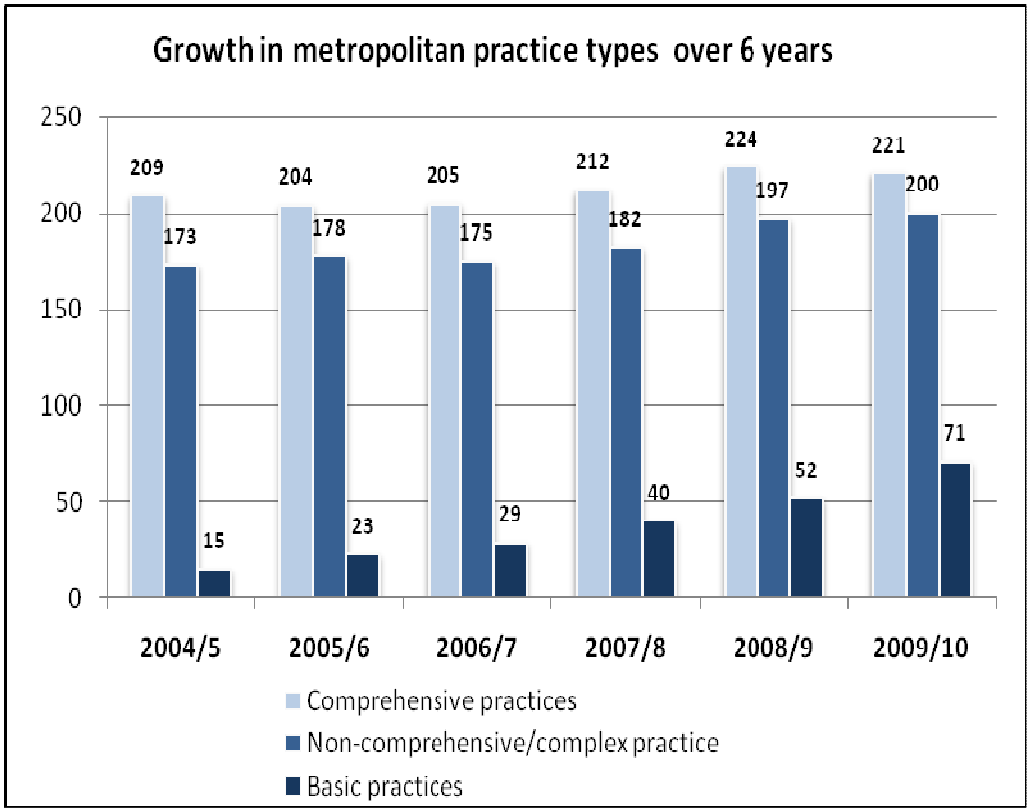
- With no indexation of patient rebates, practices are being forced to charge higher patient 'gaps'.
- In 2010, average patient gaps rose by 15% for diagnostic imaging services.
- Patient 'gap' payments are increasing at a much higher rate than patient rebates even with the recent injection of bulk billing incentive funding. The following graph shows this by modality. For example, its shows that between 2004/2005 and 2009/2010 patient gaps for ultrasound services have increased by 8.3% p.a. while patient rebates have increased by 1.4% p.a.



3.4 The erosion of quality, multi-modality practices and patient services due to underfunding

Access Economics:
The inability of practices to fund the high costs of operating a quality comprehensive practice has resulted in:- - *reduced bulk billing ;* - *increased patient gaps;* - *practice closures;* - *practices withdrawing from offering the full suite of imaging and professional services;* - *practices operating without full time supervision by a radiologist on site.*[6]

❖ Despite significant growth in the overall demand for diagnostic imaging services, the number of comprehensive practices in metropolitan areas has been static over the past 6 years. (See the chart below)

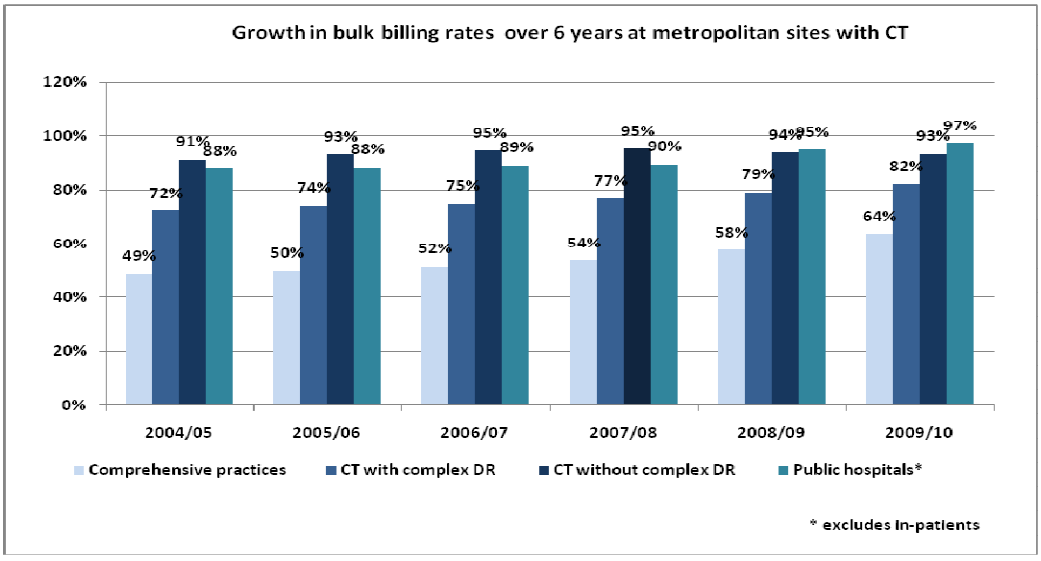


[6] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.3. Available on the ADIA website at http://www.adia.asn.au.

- The practice types which are growing most rapidly in metropolitan areas are those which offer CT, ultrasound and x-ray services and do not offer the complex, hands-on services such as interventional procedures, fluoroscopy or mammography services performed directly by the radiologist. Many of these practices are providing CT services without a radiologist on site. This could be compromising patient health outcomes. ADIA has provided a compendium of patient case studies (Attachment A) that underscore the importance of having a qualified radiologist on site. Specialist doctors ensure the right test is being ordered, the patient has been diagnosed properly, and the patient receives the right follow up treatment.

- The practice types which are growing most rapidly are benefitting most from the bulk billing incentive funding.

- The graph below demonstrates that the quality comprehensive practices significantly increased their rate of bulk billing in response to the new funding, i.e. from 54% in 2007/2008 to 64% in 2009/2010.



- If, however, the current trend towards unsupervised bulk billing practices continues, quality practices will continue to struggle and many patients will not have ready access to a supervised radiology practices.

- The only practice types which are increasing their share of services are the "basic practices" and "public hospital practices". Patients are being attracted to these practice types because they bulk bill most of their services. Meanwhile comprehensive practices need to charge gaps to fund the delivery of quality supervised services.

- In conclusion:
  - Underfunding is making it difficult for private practices to bulk bill diagnostic imaging services.
  - Quality practices will increase bulk billing if rebates are increased for quality services.
  - If current trends continue, in 2.5 years, there will be as many basic practices (with limited service offerings and low levels of professional input) as comprehensive practices.
  - The case studies in ADIA's compendium of case studies illustrate how essential it is for patients to access quality services and how dependent this is on having a radiologist on site for radiology services.

4. The Bottom Line

4.1 Indexation of DIST Fees and Patient Rebates

ADIA Budget Recommendation 1 - Indexation

That all diagnostic imaging Medicare rebates are indexed from 1 November 2011.

Access Economics:

There is a strong case for existing funding shortfalls to be met and for ongoing indexation – at a rate consistent with the growth in efficient service delivery costs. Indeed, the case for indexing rebates for DI services into the future seems difficult to deny given the extent of the anticipated funding shortfall in the sector[7].

- 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. Patient care will be compromised as practices reduce services, cut costs and increase gaps.

- Most specialist MBS fees are annually adjusted on 1 November by between 2% and 2.5%. Last year Medicare rebates were indexed by 2.4%. In contrast, rebates for diagnostic imaging services have not been indexed since 1997.

- The lack of indexation alone has seen diagnostic imaging rebates per service fall, in real terms, between 20% and 40%.[8]

- The cost to Government of Indexation is estimated to be as follows:

Forecast Indexation cost to Government	2011/12	2012/13	2013/14	2014/15	TOTAL
1.5% from Nov. 2011	$21m	$62m	$108m	$114m	$306m
2.0% from Nov. 2011	$28m	$83m	$144m	$153m	$409m

[7] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.4. Available on the ADIA website at http://www.adia.asn.au.

[8] Access Economics, **Funding of diagnostic imaging in Australia**; ***challenges and policy perspectives*** (November 2010), p.4. Available on the ADIA website at http://www.adia.asn.au/.

4.2 Increased patient rebates

ADIA Budget Recommendation 2 – Rebates equal to 85% of cost:

That all Australians have access to affordable diagnostic imaging services with Medicare funding (patient rebates) equal to (at least) 85% of the average cost. This would be an average increase of $29 for privately billed services and $16 for bulk billed services. The extended Medicare safety net would continue to apply.

- If patient rebates for diagnostic imaging services are not increased in 2011, the rebate plus the bulk billing incentive will only cover 75% of the actual cost of an average diagnostic imaging service. This means that practices will be unable to recover 25% of the cost of an average service. This will make it likely that patients will experience higher gaps and that they will increasingly find it difficult to access quality bulk billed services.

- The table below illustrates the impact of the *status quo* on patient access to quality services. It shows that, if patient rebates (both non-bulk billed and bulk billed) for diagnostic imaging services are not increased across the board in 2011-12:

  – patient rebates for bulk billed diagnostic imaging services will be $40 below the estimated average efficient cost of $162 per service;

  – patient rebates for privately billed diagnostic imaging services will be $53 below the estimated average efficient cost of $162 per service.

Impact of the status quo on patient rebates		
Cost of Service (based on 2011-12 projections)		**$162**
MBS Schedule Fee		**$109**
Patient Rebate	95% of MBS Fee for Bulk Billed Services (75% of cost)	**$122** **Shortfall $40**
Patient Rebate	85% of MBS Fee for non-Bulk Billed Services (67% of cost)	**$109** **Shortfall $53**

- The Table below sets out the increase required to ensure that patient rebates equate (on average) to 85% of the actual cost of delivering a diagnostic imaging service.

Rebate increase required to align diagnostic imaging funding with Medicare		
Cost of Service (based on 2011-12 projections)		**$162**
MBS Schedule Fee	Average increase of $53 per service	**$162**
Patient Rebate	85% of adjusted MBS Fee for all patients	**$138 Shortfall $23**

- ADIA recommends that patient rebates be increased to equal 85% of the average cost of delivering a diagnostic imaging service. This would be consistent with Medicare rebates being 85% of Medicare Schedule fees for other medical services which are maintained through an annual indexation adjustment.

4.3 Practice Incentive Payments to promote patient access to quality supervised practices

ADIA Budget Recommendation 3 – Quality supervised services:

That a Practice Incentive Program is introduced which builds on the current practice accreditation programs and provides additional funding for practices which provide a comprehensive range of diagnostic imaging modalities, on site radiologist supervision and timely care interventions and reporting. These radiology providers ensure patients receive, accurate and urgent diagnosis with essential specialist supervision - critical to good health outcomes. The Program should also be extended to provide funding for the infrastructure required to support the Government's commitment to the electronic health record.

- 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 the essential care and services.

- 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. The absence of a radiologist leads to situations where the wrong scan is performed, unnecessary repeat imaging is required, patients require further visits with their treating physician, and delays between diagnosis and treatment occur which can seriously compromise the effectiveness of treatment.

- 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.

- With these aims in mind, the eligibility criteria for access to the PIP funding would include:

  - modality availability (a minimum of CT, x-ray, ultrasound);
  - a minimum range of diagnostic imaging services that require clinical input;
  - digital imaging and archive infrastructure standards;
  - a radiologist or radiologists on site 35 hours per week.

4.4 Rebates for severely underfunded diagnostic imaging services need to be immediately adjusted

ADIA Budget Recommendation 4 – Rebate increases for essential services that require significant professional input:

That Government increase the 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. Access to these services is becoming increasingly restricted because of the very high cost of providing these services.

- While diagnostic imaging services are generally underfunded by Medicare, there are a number of items which stand out as being particularly underfunded. These tend to be complex, time consuming procedures with high levels of clinical input and sometimes specialist equipment or high consumables costs.

- They include services vital for the diagnosis of prominent chronic and fatal conditions. Examples include:

  - urological ultrasound for the diagnosis of kidney and other urinary tract diseases;
  - mammography for the diagnosis of breast cancer;
  - a range of diagnostic imaging techniques using contrast substances to allow the real time tracking of physiological processes in motion and used to guide surgery, and
  - interventional techniques, such as image guided biopsies, which allow definitive diagnosis of diseases such as cancer without much more invasive surgery.

- The rebates for these services bear no relationship at all to the costs of these procedures and, as a result, bulk billing rates are low (sometimes even for services offered by public hospitals) and many practices simply can't afford to keep offering these services.

4.5 Equitable funding to support a mix of public and private service options for patients

ADIA Budget Recommendation 5 – Investment in rural and remote areas:

That Government, when considering specific investment decisions in respect to diagnostic imaging equipment in public hospitals (for example, in the context of grants made in the Health and Hospitals Fund Regional Priority rounds), take into account the impact on the sustainability of existing private diagnostic imaging services and the impact that the potential loss of such services would have on the community. This recommendation has no negative impact on the Health Budget and may produce savings to Government.

ADIA is willing to work with Government as part of an advisory panel to make recommendations in respect to the best sites for equipment taking into account the infrastructure that is already in place.

- The private sector currently provides most diagnostic imaging services in both metropolitan Australia (86% of services) and regional Australia (80% of services). The private sector also provides many services for public hospitals.

- The ongoing sustainability of private diagnostic imaging practices in Australia is essential and needs to be maintained. The mix of funding for public and private services needs to be consistent with the principles of competitive neutrality.

- There is currently a lack of competitive neutrality in the funding of diagnostic imaging services. For example, public hospitals receive both grant funding for their capital equipment and the full Medicare rebates from the Federal Government.

- The lack of competitive neutrality is at risk of becoming a significant problem in non-metropolitan areas where private practices and quality patient services could be wiped out if new equipment is provided to public hospitals currently serviced by the public sector.

- If there is over-investment in public hospitals by way of new diagnostic imaging equipment in regional areas, affected private practices may be forced to close. There is already a trend emerging where the expansion of out-patient diagnostic imaging services in public hospitals is forcing local private practices to withdraw. If this is to become a pattern, the cost to government is estimated to be up to $4M for every 1% of private practice capacity taken up by the public sector.[9]

- The loss of private services cannot be compensated for by the public sector without major Government investment. If private practices, flexibly located to mirror community requirements close, then patients will encounter long waiting times for access to hospital services and may have to travel out of their region to access services no longer available in their local community.

[9] ADIA analysis

4.6 Ongoing Policy Reform

ADIA Budget Recommendation 6 – Other Priority Areas:

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

- The restriction on patient access to Medicare eligible MRI services.
- The restriction on GP referral to Medicare eligible MRI services.
- The need for competitive neutrality between the public and private providers of diagnostic imaging services, including the abolition of cost shifting.
- Inappropriate imaging due to referrers having a direct financial interest in diagnostic imaging practices (by way of joint venture or other arrangement).
- The increasing pressure on patient gaps due to the shortfall in patient rebates to cover the costs, including professional input, consumables, and equipment costs of providing quality diagnostic imaging services.

5. Conclusion

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

The only way to rectify this situation is for the Government to commit to indexation of patient Medicare rebates for diagnostic imaging services.

Even with last year's increase in funding for bulk billed services, the radiology sector is not adequately funded to offer quality bulk billed services.

Quality diagnosic imaging services save lives and save taxpayers' money.

Patients must be able to access affordable, timely and correct diagnosis through the most appropriate quality diagnostic imaging service. Without this, patients themselves are at risk.

We appreciate the difficult fiscal climate the Government finds its budget in but the Government can't ignore this worsening situation any longer. It must index the rebates for diagnostic imaging immediately. MBS fees are the same today as they were 14 years ago – this is just not sustainable. Radiology providers across the country are being pushed to the brink of collapse.

A well funded and sustainable diagnostic imaging service will minimise hospitalization time and guide less invasive medical procedures. Patients should be allowed to get the early and accurate diagnosis they need so as they can return to their normal lives and relieve the burden on an already overwhelmed public hospital system.

The Australian Diagnostic Imaging Association is committed to working with the Federal Government to ensure that funding is directed to essential quality 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.

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