ADIA
australian diagnostic imaging association

Submission to the Senate Community Affairs Reference Committee:

The factors affecting the supply of health services and medical professionals in rural areas

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About ADIA and its members

- *ADIA represents private diagnostic imaging practices in Australia. They diagnose and treat 50,000 patients every day. ADIA members are both for-profit and charitable and operate practices in the community and in public and private hospitals in Australia.*

- *Private sector investment underpins diagnostic imaging in Australia.*

- *The private sector currently 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 metropolitan areas.*

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

- *It enables Australians access to highly qualified health professionals.*

- *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.*

1. Executive Summary and Recommendations

As with other medical services, rural diagnostic imaging practices are experiencing significant difficulties in recruiting and retaining radiologists. There is a historical and current shortage of radiologists willing to live and work in rural areas.

By way of 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.

Private practices have very good representation in regional areas – but not all of these employ a full time radiologist.

It is not commonly understood that a large number of diagnostic imaging services – often those required by the sickest patients – cannot be provided without radiologist involvement in the procedure. These include complex ultrasound procedures, musculoskeletal imaging, any diagnostic procedures which involve the use of contrast substances or fluoroscopy to identify pathologies, and interventional procedures (such as biopsy). Very importantly, it also includes diagnostic mammography (not to be confused with basic breast screening procedures for patients presenting without symptoms).

Even with more routine procedures, patients benefit greatly from having a radiologist on site (see Attachment).

When Australian radiologists cannot be recruited to rural practices, these practices have four options:

- They must either limit the diagnostic imaging services they can offer and rely on remote reporting of the images (teleradiology).
- They may use “fly in/fly out” rostered arrangements to bring radiologists into the practice on an occasional basis.

- They may simply close down their practices and relocate to an area where Australian radiologists can be recruited.

- They may recruit full-time radiologists from overseas.

The first two options are sub-optimal for patients in regional communities since they must either travel (sometimes long distances) or wait for a travelling radiologist to become available to receive the diagnostic services they need. The delays experienced by people who are in urgent need of accurate diagnosis may be critical.

The third option clearly has the worst possible impact on patients in need of diagnosis and treatment. Not only do they lose the private service altogether, but they are also likely to lose services from local hospitals, which frequently rely on private sector radiology practices to provide radiologists and the services not available in the hospital. (In some cases the local private practice provides all hospital diagnostic imaging services). In addition, the absence of a diagnostic imaging practice offering a wide range of services is frequently a disincentive for GPs or other medical specialists to set up their own practices in a regional location.

This leaves the recruitment of overseas trained radiologists as the preferred option, and this is where Federal Government policy rather than the availability of overseas trained radiologists or the unwillingness of the private sector to invest in rural practiced becomes the stumbling block.

State governments have their own Area of Need (AoN) criteria and processes for recruiting radiologists from overseas. These criteria are focussed on the actual needs and recruiting efforts of practices in particular rural communities. AoN rules and implementation do not avoid criticism; however the real problem lies with the Federal Government's District Workforce Shortage (DWS) program. DWS classification is required if an overseas radiologist is to be given a provider number for Medicare billable services (and, in a "chicken and egg" situation, DWS classification is necessary for AoN classification, just as AoN classification is necessary for DWS classification).

The DWS approach to determining workforce shortage is mechanistic and highly centralised. It relies on Medicare data to reveal whether there is a shortage assessed against a standardised formula.

The problem is, Medicare claims data cannot determine whether a service been has performed by an on-site radiologist or whether the images are taken by non-radiologist technicians and simply reported remotely.

Nor does Medicare data reveal whether radiologists with required sub-specialist expertise such as those identified at the beginning of this summary are available within a rural community.

The consequence is that many practices - who are prepared to invest very considerable time and expense to recruit overseas trained radiologists - get knocked back under the DWS program, and rural communities bear the consequences.

The absence of accurate data to support a pre-determined, centralised formula is not an excuse for poor public policy and community outcomes.

In the absence of a solution to the data problem, ADIA suggests that the DWS formula should simply be abandoned for the purposes of overseas trained radiology recruits and that state and territory AoN approval should suffice for the purposes of providing Medicare billing eligibility to overseas recruits. In this we have the support of the Royal Australian and New Zealand College of Radiologists (RANZCR).

The rural radiologist workforce is also an ageing workforce (the average age being 53) and ADIA also recommends that a retention program - similar to that which is available to rural GPs - should be made available to radiologists.

Recommendations

ADIA Recommendation 1:

That, due to the inability of the Medicare data underlying District Workforce Shortage calculations to determine the presence of radiologists in particular localities (and in the absence of any other government database which can supply this information), DWS status should automatically follow on from state and territory based Area on Need approval in all rural areas.

ADIA Recommendation 2:

That the desirability of mammography, interventional, musculoskeletal, MRI and other radiology specialties be recognised in the determination of Area of Need (AoN) status and flow on automatically to District Workforce Shortage approvals.

ADIA Recommendation 3:

That, regardless of changes to the calculation of District Workforce Shortage status, practices which have successfully applied for a Preliminary Assessment of DWS (PADWS) under the current system (which allows them to undertake the recruitment process) should be extended to 18 months before the PADWS approval expires in recognition of the time it takes to recruit a radiologist from overseas and for them to pass the necessary professional assessments required of the Australian Medical Board and the Royal Australian and New Zealand College of Radiologists.

ADIA Recommendation 4:

That the Government introduce a Rural Retention Program for radiologists similar to that which has been made available to GPs.

2. The Background

2.1 Regulatory and practical processes required to recruit an overseas trained radiologist to a rural practice

❖ Establishing Area of Need (AoN)

- Practices wishing to apply for Area of Need status in order to recruit from overseas need to apply to state governments.

- While the criteria and evidence for AoN status and the expiry periods for the classification vary from state to state, all states rely on local evidence to establish need and labour market testing. This will consist of evidence that the job has been advertised in Australia over a period of time in different appropriate media (often designated) and evidence of the reasons for the failure of the recruitment process.

- Approval from the relevant specialist college (RANZCR in the case of radiology) and sometimes other relevant local health bodies is also required.

- Practices need to be able to demonstrate the consequences of not filling the position.

- Practices will also need DWS classification from the Commonwealth.

❖ Basis for DWS classification

- District Workforce Shortage classifications are recalibrated on an annual basis for medical specialists (a quarterly basis for GPs).

- The latest Medicare billing statistics are used by the Department of Health and Ageing to determine DWS classifications. The statistics account for all active billing relating to a particular medical specialty within a local area.

- The number of full time equivalent (FTE) specialists practicing within an area is compared to the national average FTE. If there are less FTE specialists practicing within the area when compared to the national

average FTE for the specialty, the area is classified as a DWS for that specialty.

- A second ground for eligibility for DWS status is if there is an acute shortage of medical practitioners within the specialty across Australia.

- If a practice in an area which does not currently have DWS status wishes to recruit from overseas, or if there is a fear that the current status may expire, employers can apply to the Department of Health and Ageing for a Preliminary Assessment of DWS (PADWS). For specialists such as radiologists, a favourable PADWS determination is valid for a period of six months from the date of issue, but may be extended for an additional six months.

❖ **Assessment of qualifications**

Once a radiologist has been recruited, RANZCR must determine whether the recruit's qualifications and professional experience are comparable to those of an Australian-trained specialist.

2.2 Recruiting an overseas radiologist is not a cheap, easy or quick option

Typical costs of recruiting an overseas trained doctor:

Search phase:

- **Search for an Australian trained doctor – usually ongoing, but officially 3 months of advertising $4000 - $10,000.**
- **Apply for AON (valid 4 years NSW, 1 year QLD) and PADWS (valid 6 months with possibility of 6 month's extension).**
- **Advertise, or travel internationally, to attract a radiologist (up to 12 months and $5,000+)**
- **Fly prospective radiologist to Australia (with spouse usually) to view prospective location ($10,000+)**
- **Post acceptance, relocate radiologist and family to Australia ($20,000+) including travel, schooling, accommodation issues.**

Australian Regulation application stage:

- **Apply to Australian Medical Council and RANZCR - $5,000 - approx 4 weeks.**
- **Interview and assessment at RANZCR office in Sydney. $5,000 4-12 weeks.**
- **Application to Medical Board - $1,300 – 8- 10 weeks.**
- **Application to Dept Immigration– 6-8 weeks.**
- **Application to Medicare for provider number 4-5 weeks.**

Radiologist incurred costs:

- **Translation costs (variable)**
- **Notary public certification costs (variable)**

3 ISSUES

3.1 Inadequacy of Medicare data in calculating the shortage of radiologists in regional locations

- Where practices are unable to recruit radiologists (or a sufficient number or type of radiologist) they will often use a radiologist from another location to provide remote reporting via teleradiology. They may also use fly in/fly out or other temporary arrangements. Such arrangements may meet an immediate need, but there are many diagnostic imaging examinations which demand a radiologist either in attendance or available to be in attendance during an examination. This is particularly the case in sub-specialty areas, such as mammography or where interventional procedures are required to identify the presence of serious conditions such as cancer or aneurysms (for which delayed diagnosis can be fatal). Without a radiologist on site the practice can only offer a limited range of radiology services.

- The location of a reporting radiologist is not picked up in the Medicare statistics, which identify claims against LSPN (practice) numbers and provider (medical practitioner) numbers. It follows that LSPN (practice) statistics cannot be used to determine how many radiologists are practicing in particular localities. If practices are using teleradiology arrangements, the reporting radiologist will have a provider number for that practice, but will obviously not be on site.

- Furthermore, Medicare statistics do not reveal the presence of sub-specialists in radiology at all. Radiology practices require a range of sub-specialist radiologist skills to offer the diverse range of services required in a community. Not every radiologist covers every sub-specialty area of radiology. More than one radiologist is typically required to provide a comprehensive radiology service.

- In addition, the formula used to determine a workforce shortage – particularly how FTE is calculated – is not clear to ADIA. However, in the absence of reliable data to underpin the calculation, the assessment of radiologist workforce shortages is not possible.

ADIA Recommendation 1:

That, due to the inability of the Medicare data underlying District Workforce Shortage calculations to determine the presence of radiologists in particular localities (and in the absence of any other government database which can supply this information), DWS status should automatically follow on from state and territory based Area on Need approval in all rural areas.

3.2 Recognition of specialist skills among radiologists when determining Area of Need (AoN) and District Workforce Shortage (DWS)

- The submission of the Royal Australian College of General Practitioners (RACGP) to this Inquiry highlights that some general practitioners have specialist training and skills. The same is true of radiologists. These include but are not limited to MRI sub-specialists, mammography sub-specialists, interventional sub-specialists, musculoskeletal sub-specialists, and abdominal and chest sub-specialists.

- All of these specialities are readily available in metropolitan areas. If practices are willing to bring specialists and sub-specialists to rural communities then this should be promoted. Indeed, the presence of these radiology specialists may act as an inducement for other medical specialists to set up practices in rural areas.

- Again, since Medicare data cannot identify the presence of sub-specialists, AoN criteria and processes should be used.

ADIA Recommendation 2:

That the desirability of mammography, interventional, musculoskeletal, MRI and other radiology sub-specialties be recognised in the determination of Area of Need (AoN) status and flow on automatically to District Workforce Shortage approvals.

3.3 The need to extend Preliminary Assessment of a District Workforce Shortage (PADWS) for radiologists

- As noted above, a PADWS determination is valid for an initial period of six months. An extension to a PADWS determination for an additional period of six months may be considered by the Department of Health and Ageing upon application.

- ADIA members have informed us that it can take up to 18 months to recruit a radiologist from overseas and there have been instances where the recruitment process has been called to a halt due to the expiration of a PADWS and a failure to have it renewed.

ADIA Recommendation 3:

That, regardless of changes to the calculation of District Workforce Shortage status, practices which have successfully applied for a Preliminary Assessment of DWS (PADWS) under the current system (which allows them to undertake the recruitment process) should be given 18 months before the PADWS approval expires in recognition of the time it takes to recruit a radiologist from overseas and for them to pass the necessary professional assessments required of the Australian Medical Board and the Royal Australian and New Zealand College of Radiologists.

3.4 The need for a program for the retention of rural radiologists approaching retirement

- The undersupply of radiologists will worsen in rural areas as 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 has risen 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 their hours or retire.

- Indeed, the impending retirement of radiologists in rural practices and the failure to find replacements is one of the most common reasons for practices to seek permission to recruit from overseas.

ADIA Recommendation 4:

That the Government introduce a Rural Retention Program for radiologists similar to that which has been made available to GPs.

4. Conclusion

- The unwillingness of the private sector to invest in radiologists for rural diagnostic imaging practices which provide high levels of clinical input is not the problem.

- State-based Area of Need criteria – although they attract some criticism –are not generally the problem.

- The ability to recruit suitably qualified and experienced radiologists from overseas is not generally the problem.

- Opposition from the Australian Medical Board and the Royal Australian and New Zealand College of Radiologists is not the problem.

- Taking employment opportunities from Australian radiologists is not a problem. The evidence suggests that, generally speaking, they show no enthusiasm for rural employment and there is no reason to suppose that this situation will change.

- The method of calculating District Workforce Shortage (DWS) at the Federal level **is** a key hurdle to supplying radiologists to rural communities.

- The inability of Medicare data to recognise sub-specialities in radiology for the purposes of DWS is not a good reason to deprive rural communities of their skills.

- The time allowed to recruit overseas radiologists under PADWS is inadequate.

- There is a need to incentivise an ageing rural radiology workforce to delay retirement.

In short, 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 achieve this objective.

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