7 November 2008

Strategic Review of Future Funding for
Diagnostic Imaging and Pathology
Diagnostic Services Branch
Department of Health and Ageing
MDP 107
GPO Box 9848
CANBERRA ACT 2601

Dear Committee Members,

Strategic Review of Future Funding Arrangements for Diagnostic Imaging and Pathology Services

The Australian Diagnostic Imaging Association (ADIA) represents private diagnostic imaging (DI) practices in Australia. Membership comprises stand-alone practices, hospital-based practices, small practice groups and large practice groups. (Appendix 1). This submission relates exclusively to the funding of DI services across all these practice types.

ADIA refers the Interdepartmental Committee (the IDC) to the attached reports and papers in support of its findings and recommendations:

- A New Funding Framework for Funding Diagnostic Imaging Services in Australia (October 2008): Access Economics (Attachment 1) (In Confidence).
- The Value of Diagnostic Imaging (March 2008): Access Economics (Attachment 2 (*http://adia.aplinx.com/objectlibrary/156?filename=FINAL The Value of DI 12 Mar08.pdf*)
- Medicare Benefits Schedule Comparative Review of Radiology Rebates in 1998 & 2007: ADIA and RANZCR (Attachment 3 *(http://adia.aplinx.com/objectlibrary/155?filename=ADIA 0014 16pgs.pdf)*
- Diagnostic Imaging Services — Looking Forward: Four pillars of policy for diagnostic imaging services endorsed by ADIA, RANZCR, and ASA (Attachment 4).
- Investing in the Australian DI Sector (2007 Data): Independent Investment Analyst (Attachment 5). (In Confidence)
- ADIA Submission to the National Health and Hospitals Reform Commission (NHHRC) (May 2008) (Attachment 6) (*http://adia.aplinx.com/objectlibrary/170?filename=ADIA Submission to NHHRC May08.pdf*)
- Diagnostic Imaging/Spending Trends and the Increasing use of Appropriateness Criteria and Accreditation: Alvalere Healthcare LLC (July 2008) (Attachment 7).

ADIA has also developed a services and benefits forecasting model that adjusts for projected population changes and models the sustainability of funding for DI given intergenerational trends. This model has proven to be reliable and, with additional

development work by Access Economics, ADIA has been able to model the impact of various funding options over the next five years.

ADIA and its advisers request a meeting with the IDC at which Access Economics would overview its key findings, answer questions and discuss the pros and cons of various funding options.

This covering letter provides a summary of ADIA's views on the following issues:

- The current mix of funding arrangements for diagnostic imaging
- The impact of MOU funding on Government and Patients
- Workforce capacity constraints
- Practice efficiency and digitisation
- Future rebate options to underpin patient access to quality services
- ADIA's recommendations to the IDC

In short, diagnostic imaging services are an investment in the health care of patients and are critical in the early diagnosis of disease and for the treatment of many conditions without invasive surgery. Diagnostic imaging services save the Government money in many areas of health care. Access Economics concluded that –

> *"The analysis(of value of DI services) demonstrates the substantial contribution that DI makes to health outcomes in Australia – in priority health areas such as preventing injuries (fractures), musculoskeletal disease (knee derangement), cardiovascular disease (AAA), cancer (of the breast), neurological disease (MS) and digestive disease (appendicitis). Without these techniques, a less than optimal allocation of resources and health outcomes would be achieved."* (Attachment 2)

Meanwhile, diagnostic imaging services are critically underfunded and for patients to be able to access minimum standard quality services in Australia, Government needs to agree to a significant increase in the current level of patient rebates and to index those rebates annually. This increase would need to be coupled with further reform to ensure that quality services are in fact delivered. ADIA's recommendations are outlined in this letter and further detailed in the attached materials.

Mix of Funding Arrangements

In Australia, DI services to private patients are predominantly provided through Medicare by the private sector, with the public sector providing an estimated 13% of services. On the basis of LSPN data, there are around 520 private comprehensive DI practices in Australia (defined as a practice with X-ray, Ultrasound, CT and/or MRI or Nuclear Medicine) of which over half are ADIA members. There are 120 equivalent public sector sites providing comprehensive services to private patients through Medicare. The public sector is estimated to provide 35-40% of DI services when inpatient and public outpatient services are included.

Diagnostic imaging is generally funded as follows:

- For public inpatients – State/Territory and Federal government hospital funding through the Australian Health Care Agreements.
- For private inpatients – private health insurance, DVA, accident insurers, patient gap payments.

- For public outpatients –
  - State/Territory and Federal government hospital funding through the Australian Healthcare Agreements.
  - Medicare for MRI services only.
- For private patients –
  - Medicare for eligible services.
  - Patients for gap payments for non-bulk billed Medicare services.
  - DVA and third party insurers where they are responsible.
  - Patients for services not covered by Medicare or third party insurers.
  - Private health insurance is not applicable.

The current arrangements for State/Territory and Federal funding of DI services are of concern to private practices (described in Attachment 1). **ADIA strongly recommends that the Government enforce principles of competitive neutrality between public sector and private sector providers in respect of MBS-funded DI services for private patients.**

In all other respects, this submission relates to the funding of DI services for private patients through Medicare and does not comment on the adequacy or inadequacy of funding for the public sector. Levels of public sector funding could be contributing to the pressures within public hospitals to compete for private patient services and Medicare funding. ADIA assumes that State/Territory and Federal funding of DI services for public hospital patients will be subject to separate review.

MOU Funding

ADIA believes that the MOU arrangements for Medicare funding of DI services for the past 10 years have been good for government from a fiscal standpoint. However, they have provided the Government with a 'justification' for the ongoing underfunding of DI services such that patient access, patient affordability, patient care and the ongoing investment required to deliver quality DI services have all deteriorated to a concerning level. (Refer generally to the detailed assessment by Access Economics of the impact of the current funding arrangements in Attachment 1.)

From Government's Perspective:

- The MOUs delivered an efficiency gain to government of 30.6% over the past 8 years (3.4% p.a.). Between 1998 & 2006, average medical costs rose by 30% (THCI) and the weighted average rebates for DI fell by 0.6%.
- The MOUs provided that total growth in Medicare funding for DI was capped at around 5% per annum. This proved not to be a realistic cap in light of the underlying growth in the utilisation of DI services by referrers. For example, over the period of the recently expired MOU, GPs have increased their rate of ordering DI services from less than 14 services per 100 visits to over 15 services per 100 visits (an increase in the ordering rate of 10%)
- Notwithstanding this growth in the demand for DI services, over the period of the recently expired MOU, Government funding of DI declined as a percentage of overall Medicare outlays. DI accounted for 15.7% of Medicare funding in 2002/2003 and this declined year-on-year to 14% in 2007/2008. This decline in share of Medicare outlays reflects the inequity of the MOUs which did not allow for annual indexation of DI services or for the growing reliance world-wide on DI by doctors and patients for essential non-invasive medical diagnosis, prevention and treatment options.

- If funding for DI over the period of the recently expired MOU:
  - had remained constant as a percentage of Medicare expenditure, expenditure would have been around $2 billion in 2007/2008 – nearly $225 million higher (and by 2009/2010 it would have been around $500 million higher);
  - had been indexed to reflect actual increases in medical costs which have been rising in line with the THCI, expenditure would have been $269 million higher in 2007/2008 (and by 2009/2010 it would have been $316 million higher);
  - had been indexed by around 2% percent per annum in line with other Medicare rebates, expenditure would have been $185 million higher in 2007/2008 (and by 2009/2010 would have been $212 million higher).

From the Patient's Perspective:

- Inadequate funding has meant that service quality is not consistent and some patients are unable to access a quality service:
  - Some patients can access quality services at bulk-billed rates or can afford co-payments to private providers equipped with the latest technology and with radiologists on site supervising their care.
  - Other patients either cannot access quality services at bulk-billed rates or cannot afford co-payments. These patients experience varying levels of service depending upon the age and power of the equipment employed and the degree of professional supervision/engagement offered by their provider.
- Inadequate funding has meant that most patient rebates for DI services have actually remained static or have declined since 1997. Accordingly, patient co-payments have risen. The average co-payment per patient was 62% of the average Medicare rebate in the second half of 2007. This compares with 48% for GP services over the same period. Since then, the average co-payment has increased further.
- Bulk-billing rates vary widely across modalities and across States and regions. New practices often bulk-bill to attract business (83%) — however, this is not sustained, since the data reveals that large specialist comprehensive practices have the lowest rates of bulk-billing (37%). Costing analysis undertaken by Access Economics reveals that 100% bulk-billing of quality services is unsustainable at current rebate levels.
- The range of services offered by bulk-billing practices is also generally restricted. Appendix 2 provides an example of services not offered by typical bulk-billing practices.
- In respect of patient access to MRI services in Australia, current licensing and referral arrangements have constrained access to MRI to a level unreflective of clinical need and less than half the OECD average utilisation level.

Workforce Capacity

Health Professional Teams

DI services (including nuclear medicine) are delivered by teams of health professionals: radiologists and nuclear physicians, and technical staff including sonographers, radiographers and nurses. With the rapid introduction of more complex equipment, and constraints on funding, role delegation involving technical staff and nurses has become essential.

It is neither cost effective or time-efficient for a radiologist to run CT and MRI scanners, insert intravenous cannulae or to perform many ultrasound examinations. In each case the radiologist is responsible for the service, interprets the images in the context of the

patient's medical history and produces a medical report for the referring doctor. Increasingly however, through protocol and delegation, radiographers and sonographers are taking on increasing responsibilities in respect of the capture of diagnostic images and the care of patients. This is helping to make services more efficient and affordable.

To address the increasing complexity of DI services, there is also an increasing demand for sub-specialisation and this is occurring for all health professionals within the team. For example, within ultrasound, sonographers can sub-specialise in obstetric, vascular and musculo-skeletal ultrasound and within CT and MRI, there are other areas of sub-specialty.

Capacity

There are workforce constraints in respect of all of the health professionals in the diagnostic imaging team. As with most medical craft groups, there is a severe shortage of radiologists and this is compounded by an ongoing shortage of technical staff. This is causing wage inflation, particularly as pressure from the public sector increases.

Training

ADIA supports the Government's initiatives to introduce 280 additional specialist training places next year. ADIA is keen to support further initiatives to improve workforce numbers. ADIA is currently liaising with RANZCR, ASA and AIR and has sought recommendations from each of these groups to improve workforce capacity. In light of the pressures that workforce constraints place on business, individual members have themselves introduced training initiatives. For example, I-MED runs its own sonographer training school in Sydney and other ADIA members have led the way in the training of radiologists within the private sector.

Options for consideration by the IDC include:

- improved funding and terms of funding for private sector training of radiologists;
- funding for private sector training of radiographers and sonographers;
- formalisation of the training for 'radiographer aides'.

Practice Efficiency and Digitisation

Over the past 10 years most DI practices have invested in new equipment, digital imaging and business practices that make the delivery of DI services more efficient. Imaging equipment, which is now generally digitised, has become quicker, producing image sets which are larger and more complex. The new digital RIS/PAC systems have allowed radiologists to interpret and manipulate an increasing number of more complex and detailed image sets to produce far better patient outcomes.

However, the efficiency opportunities from the digitisation of DI practices cannot be fully realised during the transition phase from the analogue to the digital platforms. In respect of the provision of images to referrers, most practices that have invested in digital equipment are still required by some referring doctors, who only use the analogue technology, to either print the images to film or provide the images on portable media such as CD-ROMs. These same referrers have been vocal in their calls on Government to require DI practices to continue to provide images on film. Though this is necessary for patient care during the transition period, the cost is unreasonably being borne by DI practices. ADIA calls on the Government to meet this cost burden while referrers are transitioning to a digital platform.

There is also an opportunity for Government to gain efficiency and other benefits from the digitisation of DI practices. Though DI practices have invested in digital image capture, short term image storage, teleradiology and softcopy reporting, they have not generally invested in long term image storage and retrieval. The cost of storing and maintaining the huge volumes of data involved, and the cost of implementing secure portals for referring doctors to retrieve images is significant and the benefits of such investment will be realised by referrers, patients and Government rather than by DI practices. Patients will gain from having all of the relevant clinical information available to their treating doctor in all cases, including emergency treatment. Government will gain from better health outcomes, and a reduction in the number of medical and DI services due to the need for repeat imaging services when the images have been lost or are in the wrong format for the treating doctor. ADIA therefore recommends to Government that practices be paid a fee for long term archiving of patient images.

Future Rebate Options to Underpin Patient Access to Quality DI Services

1. If current trends in services growth continue unabated without any upward revision of DI rebates, Government outlays are projected to grow at 7% per annum on average over the next five years. This outcome would spell an end to patient access to quality private DI services because:
   - Current rebate levels are already below the cost of delivering a quality service;
   - There is minimal capacity to charge realistic gaps in the current environment;
   - There are currently only a small number of large specialist centres that have the capacity to charge realistic gaps;
   - Current "profits" (where they are made) are equal to or less than the value of patient gaps charged by the practice;
   - Current "profits" are well below an acceptable rate of return and well below the level required to sustain current minimum levels of necessary capital investment;
   - Current cost pressures due to workforce capacity pressures (coupled with the current exchange rate pressures impacting new capital investment and the likely pressure to bulk-bill an increasing proportion of patients) make it unrealistic to expect that practices with a commitment to quality service will continue to offer comprehensive services to their local communities.

2. ADIA has concluded that a stepped increase in the level of rebates is required due to the significant underfunding of the sector over many years. Future funding also needs to be indexed annually in line with Medicare. This has been modelled as follows (on the basis of current high trends in services growth rates):
   - annual indexation of rebates at 2% (the projected annual growth in the DoFD WCI-5 index) increases benefits growth to 8.5% per annum; and
   - a further one-off, flat increase of 10% across all modalities (on top of a $50 initial increase in MRI rebates) increases benefits growth to 11.6% per annum.

   This would represent a once-off increase in funding of $215 million in 2009/2010 (an average increase of $14 per service). From a sustainability perspective, this stepped increase in funding is necessary and affordable. It would represent a continuing reduction in the share of overall Medicare expenditure spent on diagnostic imaging. ADIA estimates that this level of funding would represent 12.7% of Medicare expenditure in 2009/2010 which would be a further reduction of 1.3 percentage points from the current level.

3. ADIA forecasts that growth in services could however be constrained through an ongoing commitment by Government to the following measures to deliver projected annual services growth of 3.5% (compared with 5.1% under a continuation of current incidence trends) and benefits growth of less than 9.6%:
   - introduction of CT licensing based on practice accreditation, radiologist supervision and minimum equipment standards;
   - improved enforcement of supervision rules generally but especially in respect of complex x-ray and ultrasound services;
   - introduction of minimum equipment standards to reflect clinical needs;
   - introduction of minimum standards to support and promote quality off-site reading and reporting;
   - constraints on non-arms-length referral;
   - methodical adjustment to the DIST to improve its alignment with cost and clinical value;
   - constraints on public hospitals providing private services by the imposition of competitive neutrality with private sector providers;
   - introduction of referrer decision support tools; and
   - introduction of a low-level, mandatory patient co-payment.

4. The rapid deterioration in current economic conditions might also have an impact on projected annual benefits growth. The forecast slowing of the national economy will probably restrain growth in services demand, at least over the first 2-3 years of the funding quinquennium. The magnitude of this effect is likely to be modest since demand for health care is only mildly responsive to changes in income. But in view of the sizeable forecast reduction in the rate of GDP growth over the next 1-2 years (at least 50%), this effect should not be discounted.

5. Industry analysis (based on 2007 data – Attachment 5) suggested that additional funding of at least $253 million from 2007/2008 per annum was required for the sector to reach a minimum acceptable return on invested capital. This analysis was undertaken on the basis of an underlying growth in benefits of 8%.

6. Appropriate funding of the private sector is particularly important as the downturn in the economy will stimulate a move away from private DI services back into the public sector. If the Government is to preserve timely access to DI services in public hospitals as patients transfer from the private sector, it should be keen to ensure the viability of private DI.

7. If the Government were to insist on benefits growth of, say, less than 7% per annum (which is the current average underlying growth rate without any rebate adjustment) then another way to square the industry's need for higher rebates to cover the cost of delivering quality services, with the Government's need to limit outlays growth, is to commit to the measures above to constrain growth and charge bulk-billed patients a mandatory minimum co-payment. This would make up the difference between the lower rebates and the higher cost of services. ADIA estimates indicate that a net co-payment of less than $3 per service would bridge the gap between the need for an increase in funding of 9.6% and a 7% benchmark. If however, Government did not commit to strategies to constrain growth, a net co-payment of around $5 per service would bridge the gap. An administration charge would of course need to be added to this net co-payment to produce a gross co-payment. The co-payment might also reinforce the constraint on services growth (and hence benefit outlays).

Recommendations:

1. Policy Framework:

Introduction of a policy framework for the ongoing funding of quality diagnostic imaging services for private patients in line with four pillars of policy recommended by ADIA, RANZCR and ASA:

- affordable access for all Australians;
- quality diagnostic imaging services;
- a skilled professional, and
- a viable practice environment.

2 Rebates:

- a one-off, flat increase of 10% across all modalities to make bulk billing viable;
- an annual application of Medicare indexation to all rebates for DI to make DI investment sustainable, and
- a $50 initial increase in MRI rebates to reduce the impact of the earlier excessive cut in MRI rebates.

3. Co-payment:

Consideration of a mandatory minimum patient co-payment for bulk-billed services of $3 plus an administration charge, if the above funding recommendations fall outside of acceptable budgetary parameters.

4. Scheduled Fees:

Develop a process and engage a panel to selectively re-balance the DIST to align rebates more closely to costs and clinical value.

5. Additional Fees:

Introduce additional fees for digital storage and retrieval.

6. Referral:

Reform referral arrangements to reduce the incidence of inappropriate referral, including:

- constraints on non-arms-length referral; and
- introduction of referrer decision support tools.

7. Licensing:

Reform licensing arrangements for MRI and CT based on practice accreditation, radiologist supervision and minimum equipment standards to improve access to MRI relative to CT and to replace current MRI licensing arrangements.

8. Standards:

- Equipment — incorporate minimum equipment requirements in DIST to reflect clinical needs and ensure service quality:
- Supervision – re-enforce and prescribe minimum standards of effective patient care and professional supervision to all DI services and, in particular, to support off-site reading and reporting

9. Competitive Neutrality:

Enforce principles of competitive neutrality between public sector and private sector providers in respect of MBS funded DI services.

10. Training:

Support additional training places for radiologists, sonographers and radiographers and other training options to support the increasing demand for DI services.

Over the last 10 years, there has been a technology revolution in DI that has made radiology examinations more essential in the management of all clinical episodes. In many instances, DI has replaced unreliable hands-on clinical diagnosis and high-cost investigative surgery.

The importance of DI to early diagnosis and non-invasive intervention is well recognised and the use of these procedures needs to be better recognised as a cost effective investment in enhanced patient outcomes.

ADIA members are currently charging gaps if they can, closing practices and reducing investment. The additional pressure these actions will place on public hospitals will be significant. ADIA has therefore adopted an "open book" approach to this review and commends our proposals to the IDC and the Government.

There is a shared risk moving forward. ADIA members request the Government to commit to management and funding of diagnostic imaging service at levels which support patient access to affordable and clinically appropriate services provided by qualified teams of health professionals with access to appropriate equipment.

Yours sincerely,

Dr. Ron Shnier
President
Australian Diagnostic Imaging Association