



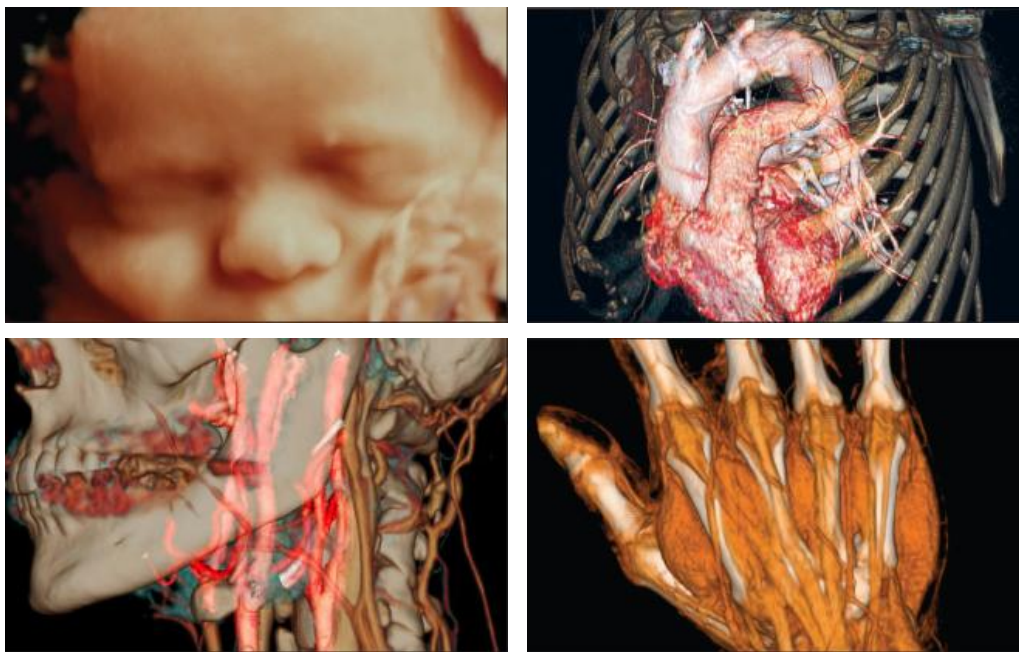
Budget Submission 2013

Australian Diagnostic Imaging Association

A framework to improve patient access to quality medical imaging services in Australia.







ADIA represents medical imaging practices throughout Australia, both in the community and in hospitals, and promotes ongoing development of quality practice standards so doctors and their patients can have certainty of quality, access and delivery of medical imaging services.



The President's Message

ADIA promotes patient access to quality medical imaging in Australia and is proud of how patients and taxpayers continue to benefit from advances in medical imaging.

Australia's network of comprehensive radiology practices continue to invest in the latest software and equipment, to train staff in low dose techniques and other advances and, to bulk bill many patients that are unable to meet the growing out of pocket costs associated with medical imaging. In 2010-11 gaps grew by 9.6% and Australian patients paid \$400 million in gap fees.

Meanwhile there is an increasing reliance on medical imaging to diagnose and treat patients. This is partly due to the ageing of the population and partly due to advances in the diagnostic capacity of the imaging modalities.

For example, over the past decade, the 12 week pregnancy ultrasound has become more critical due to medical advances. Ultrasound technology now enables better visualisation of structural abnormalities and 'soft' markers of chromosomal abnormalities at this early stage. The ultrasound still involves measurement of the fetus but also a review of the whole pregnancy – the amount of amniotic fluid, the position and appearance of the placenta, the anatomy of the foetus and excludes ectopic or molar pregnancies. If there are no abnormalities detected this service - usually performed by a Sonologist or Sonographer under the supervision of a radiologist - takes approximately 30 minutes. The report then takes a little more time to complete.

This illustration also highlights the ongoing importance of ensuring that all medical imaging services are performed with appropriate clinical oversight. Like the 12 week ultrasound, most medical imaging services have become more rather than less complex, in that the scope for diagnosis and treatment has broadened with advances in technology.

In contrast, patient rebates for medical imaging services have remained static. The rebate for a 12 week pregnancy ultrasound has remained at \$59.50 since 2000 when the fees for pregnancy ultrasound services were restructured. Most other rebates have been static since 1998 and have not even been indexed to reflect CPI increases since that time.

Meanwhile, the overall cost to Medicare of medical imaging as a specialty continues to rise and increased by 10.1% in 2011-12. This was largely due to a 10.5% increase in ultrasound examinations – mainly in cardiac, musculoskeletal and point of care ultrasound. The negative growth in CT services was reversed in 2011-12 and patients benefited from increasing access to MRI. Only 0.3% of the growth was due to a change in the average benefit paid per service.

So while the cost to government is growing due largely to utilisation, the currency of rebates to patients is not. Without indexation, patient rebates reduce each year in real terms and patient gaps increase. To keep medical imaging rebates frozen is therefore not sustainable, particularly given that more than 60% of the cost of medical imaging services relates to staff. There is no case to justify the ongoing exclusion of medical imaging from the annual round of increases applied to other Medicare rebates. Why is it that Medicare fees for ultrasounds of the eyes (Items 11242 and 11243) are indexed whilst other diagnostic ultrasounds are not? Fees for acupuncture (Group A7), contact lens attendances (Group A9) and optometrical services (Group A10) are indexed each year. A whole category of diagnostic procedures and investigations (Group 10) is indexed and includes allergy testing, sleep apnoea investigation and bone densitometry. The fees for all of these services are increased each year while, due to arrangements that



existed under MOUs that expired more than 5 years ago, the fees for diagnostic imaging services under Category 5 are not indexed and are frozen in time. This needs to be addressed as a matter of urgency to underpin patient access to quality services.

In this Budget Submission, ADIA makes a mix of policy and funding recommendations which together would improve fee relativities and incentives within the current diagnostic imaging fee schedule:

1. ADIA strongly supports the Quality Framework (Schedule One) recommended jointly with The Royal Australian and New Zealand College of Radiologists (RANZCR) as an essential first step. It addresses the need for ultrasound to be performed by qualified practitioners, for adequate medical supervision of medical imaging practices that provide CT services and for standards to be developed to ensure that remotely reported services provided to patients in rural areas are underpinned by minimum standards;
2. ADIA calls for equitable treatment of Category 5 - Diagnostic Imaging Services of the Medicare Benefits Schedule so that patient rebates for these services are indexed (by a rate less than inflation) in line with other Medicare funded medical services, as well as targeted funding increases for essential medical imaging services to ensure that patient rebates continue to support patient access;
3. ADIA supports efficient and transparent pricing of Medicare funded diagnostic imaging services provided to outpatients in public hospitals and improved prohibited practices arrangements to ensure referrers remain independent of providers of Medicare services; and
4. ADIA outlines an incentive funding program to promote essential investment in patient and referrer access to digitally stored images.

We are grateful for the ongoing interest and support from many consumer health bodies in our efforts to protect and improve the quality, accessibility and affordability of medical imaging in Australia. In their own Federal Budget Submission, the Consumers' Health Forum highlighted the need to address increasing out of pocket costs within the sector, noting that consumers "faced financial barriers to accessing diagnostic testing" (page 3).

Without funding increases coupled with a quality framework, barriers to accessing the existing and emerging benefits of medical imaging will rise, and inefficiencies in the current funding arrangements will persist. However, as detailed in this submission, ADIA believes that headway can be made in meeting the significant funding and policy challenges of the sector within current budget constraints.

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



Dr Sue Ulreich

President

Australian Diagnostic Imaging Association (ADIA)





Summary:

How Government Objectives for Diagnostic Imaging are met by ADIA Recommendations

Challenge:	Recommendation:
1. <i>"Patients' access to affordable and convenient diagnostic imaging services be maintained":</i>	
<ul style="list-style-type: none"> • Patient gaps are increasing at a faster rate than bulk billing • Bulk billing is highest in low service practices • The services that attract rebates equal to less than half their cost are not being maintained • Services for the seriously ill are underfunded • Australians are lagging in their access to advances in medical imaging 	<ul style="list-style-type: none"> → Indexation → Incentive Program to promote investment into quality initiatives → Targeted patient rebate increases → Quality Framework → Incentive Program to promote investment into quality initiatives → Targeted patient rebate increases → Indexation → Review of barriers to accessing advances in medical imaging
2. <i>"Patients in rural and remote areas have continued access to quality diagnostic imaging services":</i>	
<ul style="list-style-type: none"> • Gaps are growing fastest in rural areas • Rural and regional patients are not protected by practice accreditation in respect to remotely reported services 	<ul style="list-style-type: none"> → Indexation of rebates for rural service → Quality Framework
3. <i>"Each diagnostic imaging service reflects best clinical practice, is performed by an appropriately qualified practitioner and is provided within a facility which meets all necessary accreditation standards, minimising exposure to unnecessary radiation":</i>	
<ul style="list-style-type: none"> • Clinical best practice is suffering as a result of financial constraints • Referrers observe that quality varies from practice to practice 	<ul style="list-style-type: none"> → Indexation → Quality Framework → Incentive Program to promote investment into quality initiatives
4. <i>"Requesting practitioners and imaging services communicate effectively to ensure that patients receive appropriate imaging":</i>	
<ul style="list-style-type: none"> • Medicare is not actively enforcing current professional supervision rules due to lack of specificity 	<ul style="list-style-type: none"> → Quality Framework → Incentive Program to promote investment into quality initiatives
5. <i>"Ongoing Government expenditure for diagnostic imaging services is sustainable":</i>	
<p>Outlay inefficiencies are occurring due to:</p> <ul style="list-style-type: none"> • Growth in limited service practice types • Growth in public sector outpatient imaging • Growth in point-of-care ultrasound 	<ul style="list-style-type: none"> → Quality Framework → Incentive Program to promote investment into quality initiatives → Competitive neutrality for public & private sectors → Prohibited practices reform
6. <i>"The diagnostic imaging sector is sustainable":</i>	
<ul style="list-style-type: none"> • The sustainability of comprehensive practices is seriously at risk 	<ul style="list-style-type: none"> → Indexation → Incentive Program to promote investment into quality initiatives → Competitive neutrality for public & private sectors



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ADIA 2013 Budget Submission

1. Background

After 14 years without indexation, patient rebates for diagnostic imaging services do not reflect the cost of service delivery. In contrast, each year in November, patient rebates for most other Medicare services i.e. other than diagnostic imaging, are increased by around 1-1.5% (i.e. by less than the rate of CPI). This anomaly exists because fee adjustments for diagnostic imaging rebates were managed within MOUs with the Government between 1998 and 2006 and when the MOUs concluded in 2006, no move was made to reinstate annual adjustments for diagnostic imaging.

As a result, a black hole has opened up and is becoming more and more challenging to fill. The MOUs delivered an efficiency gain for the Government of 30.6% over 8 years (3.4% per annum) while average rebates for diagnostic imaging fell by 0.6%. Therefore patient rebates for diagnostic imaging services are now about the same as they were in 1998.

The Government has been reviewing the diagnostic imaging sector since the MOUs expired in 2006:

- A Strategic Review of Future Funding Arrangements for Diagnostic Imaging (2008)
- A Review of the Funding for Diagnostic Imaging (2011)

These reviews have sought to ensure the Government is paying the right amount in the right way to support patient access to quality diagnostic imaging services. The Review of Funding for Diagnostic Imaging Services (2011) established objectives for diagnostic imaging.

The Government's key objectives for diagnostic imaging funded through the Medicare Benefits Schedule are that:

1. *Patients' access to affordable and convenient diagnostic imaging services be maintained;*
 2. *Patients in rural and remote areas have continued access to quality diagnostic imaging services;*
 3. *Each diagnostic imaging service reflects best clinical practice, is performed by an appropriately qualified practitioner and is provided within a facility which meets all necessary accreditation standards, minimising exposure to unnecessary radiation;*
 4. *Requesting practitioners and imaging services communicate effectively to ensure that patients receive appropriate imaging;*
 5. *Ongoing Government expenditure for diagnostic imaging services is sustainable; and*
 6. *The diagnostic imaging sector is sustainable.*
-

Source: Medical Benefits Review Task Group, Diagnostic Imaging Review Team, Department of Health and Ageing, 2011.

Meanwhile, medical imaging is transforming medicine. Already the role of the Radiologist has repositioned solely from a diagnostician and into treatment and management of disease. Medical imaging today is used in almost all areas of medicine. Each year, advances in medical imaging help us visualize diseases in a yet unseen fashion and by that open up new clinical possibilities of detection, more accurate diagnosis and more targeted therapy at lower dose levels. The specialty has already proven its enormous potential for preserving quality of life through early detection, and for reducing hospital costs by averting admissions and shortening hospital stays.

However, there are a range of persistent and emerging trends shaping the diagnostic imaging sector, effectively taking the emphasis of funding further away from Government's objectives. For every year that nothing is done to address them, the challenge for Government only becomes greater.

Within this submission, ADIA details these trends and the impact they are having on the sector, along with a fiscally conservative set of recommendations to address them. The discussion looks at the issues in the context of Government's six objectives for the funding of diagnostic imaging.

2. Current Challenges

2.1. Government Objective One

That patients' access to affordable and convenient diagnostic imaging services be maintained.

The introduction of the bulk billing incentive in 2009 has had the desired effect of increasing the percentage of diagnostic imaging services bulk billed.

There have however been trade-offs and some of these need to be addressed.

Patient gaps are increasing at a faster rate than bulk billing

The average gap paid by a patient is growing at an alarming rate. In fact, the concomitant growth in gap payments and bulk billing suggests that larger gaps for some services are being used to fund bulk billing for others.

In 2010-11 gaps grew by 9.6% and Australian patients paid \$400 million in gap fees.

Table 1: Patient Co-payments are increasing to fund Bulk Billing (2010- 11):

Modality	Growth in Bulk Billing rate 2010/11	Growth in Average Patient Co-payment per service 2010/11
Ultrasound	7.1%	11.2%
CT	4.0%	7.7%
X-ray	3.7%	8.5%
MRI	7.3%	5.5%
Total	4.8%	9.6%

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

Bulk billing is highest in low service practices

The overall rate of bulk billing was 73% in 2010/11. 68% of services were provided in stand-alone private practices which bulk billed 78% of services. In isolation this performance bodes well for patients however, when the data is further analysed, it reveals that the average rate of bulk billing for full service providers was only 45% whilst the average rate for basic practices, which did not have a radiologist in

attendance, is estimated by ADIA to be 93%. Since the introduction of the bulk billing incentive, investment has been directed to limited service practices which, in turn, has led to a further deterioration in the viability of comprehensive practices.

The services that attract rebates equal to less than half their cost are not being maintained

Many of the services that are significantly underfunded cannot viably be bulk billed by any practice, regardless of their efficiency or throughput. Practices adopting a bulk billing model, as encouraged by Government incentives, often make exceptions for these services and charge significant gaps.

Furthermore, it is not just the service itself that becomes difficult for patients to afford and access. Loss generating services are a financial burden to the sub-specialty to which they belong. When several item numbers from one sub-specialty are loss making in every instance, then access to that entire sub-specialty is put at risk. New practices are reluctant to invest in equipment for an unviable sub-specialty. Old equipment does not get updated, and while an alternative may exist for one procedure, this will not be the case for every procedure or every patient. As a result, the underfunding of a service can have an unforeseen impact on a diverse range of patients and practitioners. A range of underfunded sub-specialties and their impact on patient access are described in **Schedule Two** (refer page 30).

"When we first started our practice more than 10 years ago, we were fully bulk billing. Since then, we have needed to build up a non-bulk billed list of procedures/examinations. The list is growing and the gap fee is gradually increasing also. We are passionate about providing an affordable and convenient diagnostic imaging service, however, we can't continue in this manner, the funding inadequacy has already changed the way we practice. By January 2013, we will only offer Fluoroscopy in one practice because of its lack of viability. This means that patients needing a hysterosalpingogram (to determine patency of the fallopian tubes when couples are having difficulty in conceiving) will have to travel from one side of town, St Albans to Hawthorn. Currently we have two working units but the unit at St Albans is more than 10 years old. It is not financially viable to buy a new unit."

Dr Paul Lau - Radiologist and Practice Owner, Future Medical Imaging Group.

Services for the seriously ill are underfunded

The sickest patients often require the clinically complex services that are most impacted by underfunding.

Clinically complex services, by their very nature require greater involvement by radiologists, sonologists and/or other highly trained health professionals over other more routine procedures. For the last 14 years, these services have been disproportionately impacted by annual increases in the cost of wages at a rate significantly above CPI - all the while Medicare rebates have remained stagnant. The result is that the cost of delivering these services today bears little relevance to the scheduled fee once designed to underpin patient access.

The most concerning aspect of the underfunding of clinical complexity is that it is most often our sickest patients who need this care. Due to the seriousness of their illness or symptoms, it is our country's sickest patients who are most likely to undergo medical imaging services that require a high degree of clinical input. Such procedures include but are not limited to:

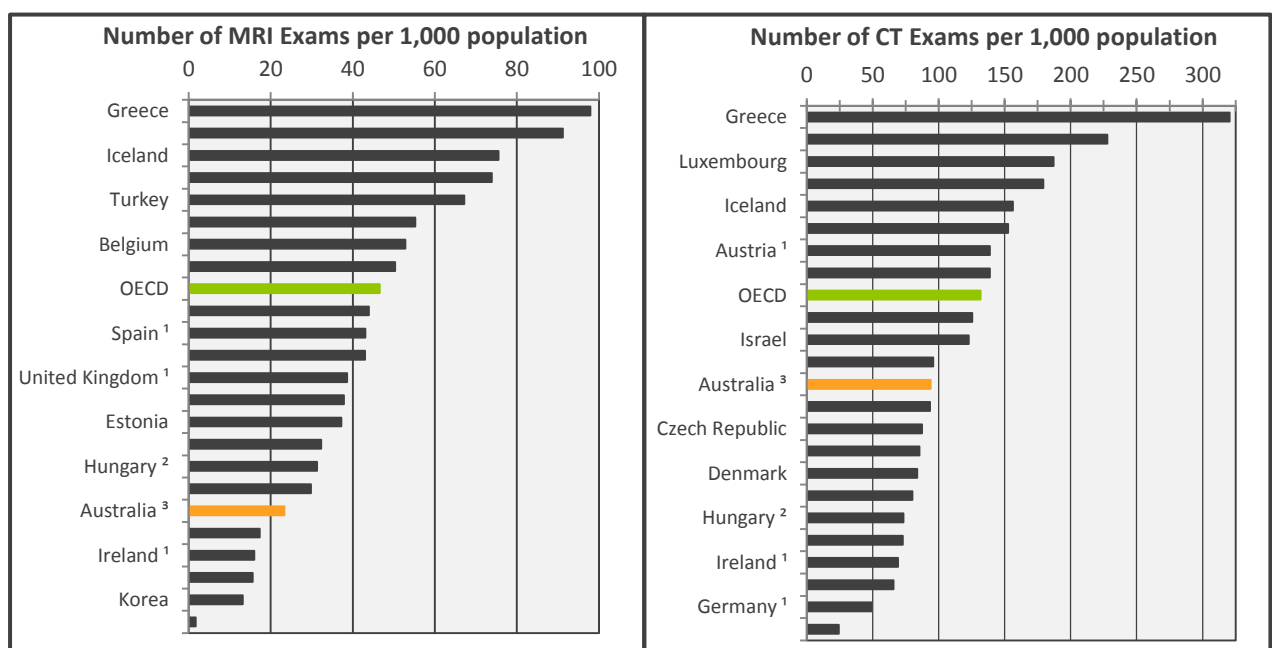
- a biopsy of the prostate to confirm a prostate cancer diagnosis and plan a treatment path;
- a mammogram – a service performed on symptomatic patients to investigate in detail suspect breast tissue, lump or cyst;
- an injection of pain relieving medication into a joint under the guidance of fluoroscopic imaging, often the only treatment available to chronic pain sufferers as a result of arthritis.

Due to their urgent and ongoing need for medical care, these patient groups are vulnerable to the financial burden that results from the serious underfunding of clinically complex procedures. The patients needing these services face gaps that can be financially crippling or worse still, they may have to refuse treatment or delay a diagnosis. So while patient access to these services is critical, it is at risk due to underfunding.

Australians are lagging behind the rest of the world in their access to advances in medical imaging

Current government funding of medical imaging has not kept pace with advances in medical imaging. As a result it has restricted private providers' investment in advanced technology and techniques and we as a nation are now far more limited in our access to newer modalities including MRI and CT compared to the OECD average. For chronic disease sufferers in particular this has resulted in diminished access to advanced techniques and increased financial burden as outlined above.

Chart 1. Utilisation of MRI and CT by OECD Nation (Source: OECD data 2011)



Essentially, emerging advances within a number of modalities are not being made available to patients due to structural barriers to accessing funding for new services. In addition to the underfunding of many items, these barriers include:

- *Facility and equipment 'licensing' restrictions for eligibility for MBS rebates for MRI and PET services*

Restrictions around eligibility for Medicare funded PET and MRI service provision means that these advanced imaging techniques have not been widely adopted in Australia, when compared to other modalities. These restrictions are generally not based on clinical grounds and for chronic disease sufferers can result in the use of less appropriate medical imaging due to the access block created, excessive out of pocket expense and longer waiting periods for diagnosis and treatment.

- *MBS item number restrictions*

Extensive restrictions apply to newly recognised medical imaging techniques and modalities, including thresholds for maximum rebateable examinations in any one year (MRI) and indicators for use (Cardiac CT, CT Colonoscopy, Bone Mineral Densitometry [BMD], PET and MRI).

These restrictions often prejudice those people requiring the most access to medical imaging, i.e. the chronically and seriously ill. For example, restrictions on BMD and CT prevent the vast majority of Australians from having access to non-invasive early detection and screening for osteoporosis, colorectal cancer and coronary disease, which is key to minimising the prevalence and severity of these disease states.

- *Lack of recognition of Radiologist professional services as referred specialist consultations*

Some highly labour intensive services – particularly in the newer sub-speciality of Interventional Radiology – are considerably underfunded due to the failure of the Department of Health and Ageing to acknowledge Interventional Radiology as a referred medical specialist attendance.

- *Lack of access to the 'Prosthesis Rebate' scheme*

This scheme which is available to Hospitals and Day Surgeries, as well as to the surgeons working within them, is not extended to outpatient services. As a result, significant out-of-pocket expenses in the realm of hundreds of dollars need to be borne by patients unless they are admitted to hospital. This issue particularly affects cancer sufferers requiring vascular access for vital chemotherapy.

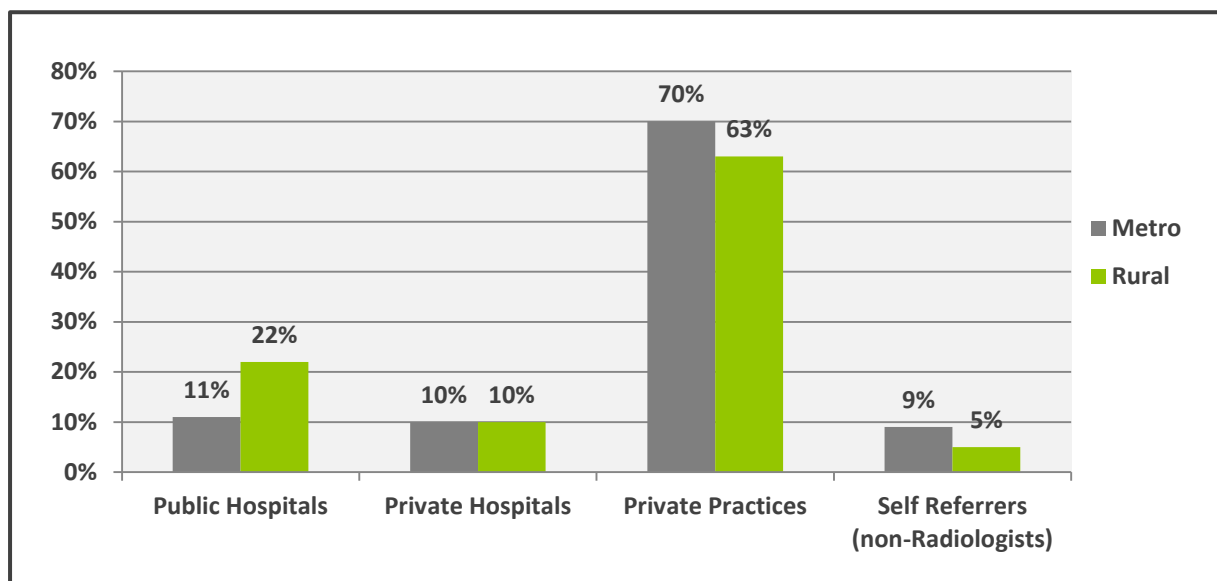
- *Lack of an efficient avenue for listing new procedures to the Medicare Benefits Schedule*

2.2. Government Objective Two

Patients in rural and remote areas have continued access to quality diagnostic imaging services.

The vast majority of diagnostic imaging services are currently provided by the private sector, mostly in community based practices provided in rural and regional areas.

Chart 2. Percentage share of MBS services by practice type in metropolitan and rural Australia 2010-11



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

However, the challenges confronting the private diagnostic imaging sector are particularly acute in regional areas. Regional and remote diagnostic imaging services have smaller catchments and need to pay higher communications and consumables costs than their city counterparts.

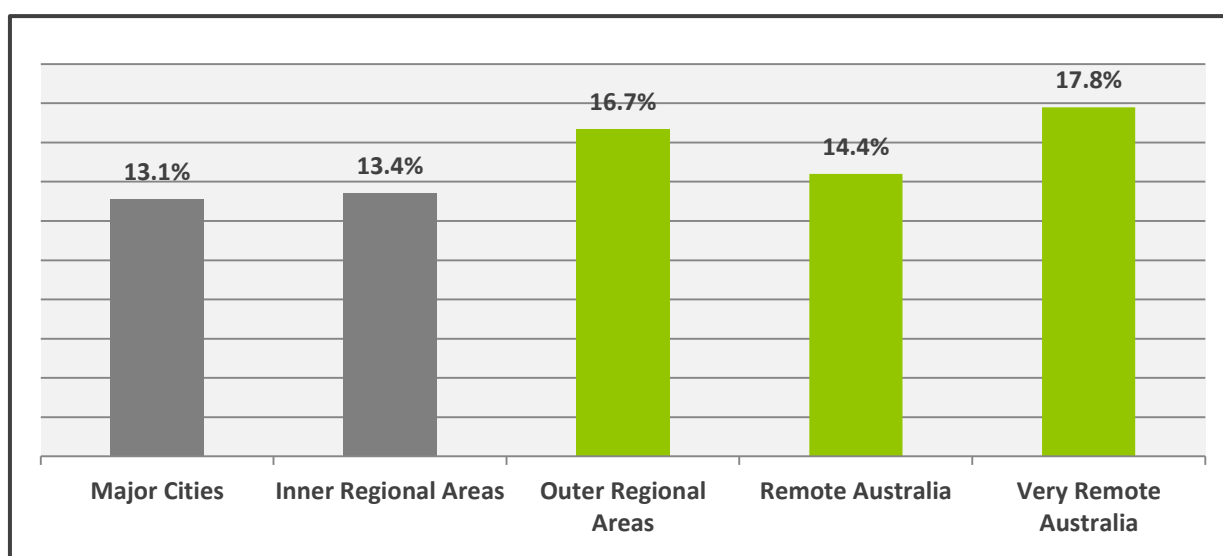
"After 7 years in this role, I have seen a deterioration in the availability of services in rural areas. Breast imaging and procedural services have already been rationalised by our organisation so there is now a reduced geographic spread of these services and an increased centralisation to major regional centres."

Mark Simpson - General Manager, Regional Imaging.

Gaps are growing faster in regional Australia

It is therefore not surprising that patient gap payments are highest in these areas. When patient gap payments are viewed 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 (*refer Chart 3*).

Chart 3. Highest average growth in patient co-payments (the top 25%) by geographical area, 2004-2011



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

Rural and regional patients that rely on remotely reported imaging services need to be safeguarded

As patients in rural areas gain increasing access to more advanced medical imaging services, they need to be safeguarded by mandatory minimum quality standards for remote supervision and reporting.

While teleradiology has improved access to radiology specialists and subspecialists in many remote towns, there are currently no minimum standards for quality reporting via teleradiology. ADIA and RANZCR have recommended that this be addressed through the Quality Framework Proposal set out in **Schedule One** (refer page 27).

2.3. Government Objective Three

Each diagnostic imaging service reflects best clinical practice, is performed by an appropriately qualified practitioner and is provided within a facility which meets all necessary accreditation standards, minimising exposure to unnecessary radiation.

The funding freeze is intensifying cost pressures across the industry year after year. Meanwhile the Government has limited capacity to protect patients from poor quality imaging that may arise as imaging practices search for new ways to find savings in order to remain viable.

Clinical best practice is suffering as a result of financial constraints

The provision of quality medical imaging services requires the professional input of a supervising radiologist and the support of highly trained health professionals alongside modern equipment. The input of highly trained medical specialists (Radiologists and Sonologists) and health professionals (Radiographers, Sonographers, Nuclear Medicine Technicians, etc) is key to the quality of medical imaging services.

- *Investment in staff ratios and clinical input is declining*
Labour costs represent approximately 60% of service costs. With the ongoing indexation freeze, medical imaging practices are forced to increase patient gaps, to reduce non income generating expenditure and/or to economise on 'lumpy' staff and equipment costs
- *More practices are operating without a radiologist*
ADIA estimates that at least 64 comprehensive practices in metropolitan areas across Australia (2010-2011) were offering CT without a radiologist attending the site and the number of these practices is growing rapidly.

"I have seen unsupervised practices take the work from supervised practices causing the radiologist in the town to leave – this seems to be occurring more in regional areas. The impact on local patients is significant including reduced access to services requiring on-site radiologists (i.e. biopsies etc.) and/or increased travel time to services in other towns or no access at all."

Mark Simpson, GM Regional Imaging

- *Investment in new equipment is declining*
Capital, equipment and maintenance are also large component of costs, representing up to 20% of service costs. The investment into low-dose CT and other new equipment can only come about if practices can adequately recover the costs of this investment.



- *Two tiers of service quality are emerging in medical imaging*

The growth in bulk billing rates since the introduction of the bulk billing incentive in 2009 has led to investment being directed into lower cost practice types which are growing at a considerably faster rate than full service practices (*refer chart 4*) and it is evident that at least two tiers of service quality have emerged:

Low cost practices which combine lower cost structures with high turnover, lower levels of clinical input and supervision and a restricted range of more routine services.

Comprehensive supervised practices offering a range of services on a range of equipment. These practices need to recover the higher costs of professional input to remain viable. These practices are under more pressure than ever because of the loss of patients seeking lower cost services and the lower level of funding paid when a gap is charged.

Figure 1. The emergence of two tiers of quality

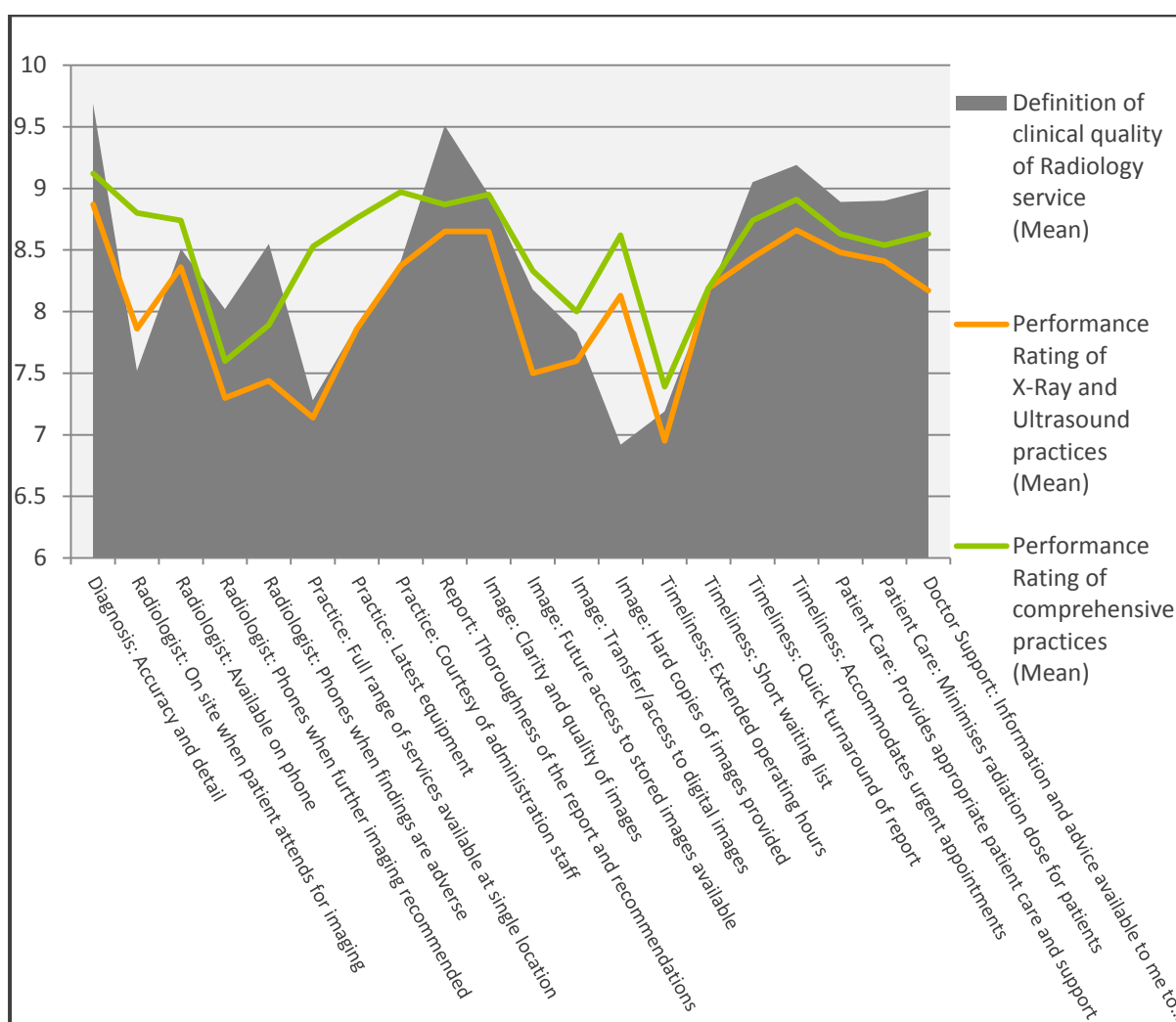
Supervised high quality comprehensive practices 	Unsupervised lower cost limited service practices 
✓ Active clinical input and onsite supervision	✗ Reducing clinical input
✓ Comprehensive service and modality options	✗ Narrowing service range
✓ More complex services and high risk patients	✗ High through-put of low clinical value services
✓ Higher proportion of specialist referred services	✗ Higher proportion of GP referred services
✓ Charge gap fees to sustain diversity and quality of service	✗ Bulk bill higher proportion of services and therefore receive more Government funding per service
<p><i>(NB rebates for services that are not bulk billed are lower than for services that are bulk billed. This means that the same service may be bulk billed in one practice that offers minimum levels of clinical input and subject to a patient gap in another due to the high level of clinical input provided. In the latter case, the Government pays less.)</i></p>	

Referrers observe that quality varies from practice to practice

In 2012, specialist research and analytics group, Press Ganey were engaged by ADIA to conduct a survey of referrers to explore the perceptions of clinical quality in diagnostic imaging. Over 200 referrers responded to the survey, mostly from suburban practices (59%) with 10+ years' experience (76%).

It found that referring doctors observed a clear difference in the quality of care being provided by different practice models. The results confirmed that “comprehensive” practices outperformed “ultrasound/x-ray only” practices on almost all dimensions assessed. Referrers reported that they receive considerably less support, guidance and professional input from “ultrasound/x-ray only” practices than they do from “comprehensive” practices. 77% of respondents found that quality varied from practice to practice.

Chart 4. Performance rating against quality expectations by practice type



Source: Press Ganey 2012, Doctor perceptions of radiology services in Australia.

2.4. Government Objective Four

Requesting practitioners and imaging services communicate effectively to ensure that patients receive appropriate imaging.

In order for an adequate degree of communication between referrer and medical imaging practice to occur, a radiologist needs to be available in real time to review patient cases, to liaise with the imaging team and to communicate with referring physicians.

Medicare is not actively enforcing current professional supervision rules due to lack of specificity

Professional supervision is critical and needs to be enforced. In contrast, Medicare is not actively enforcing the current professional supervision requirements due to their lack of specificity. This has promoted unrestrained growth in practices that are not attended by a radiologist.

The Press Ganey referrer survey found that referrers expect a high degree of input from the radiologist in the practice. Referrers valued most highly (with a rating greater than 8.5/10) -

- *Professional input:* Accuracy of diagnosis; image clarity and quality; availability of radiologist on the phone; Radiologist phones if findings adverse; the thoroughness of the report and recommendations; and the availability of information and advice to help refer for the correct procedure;
- *Patient care:* dose minimization and general patient support; and
- *Timeliness:* of the report and in accommodating urgent requests.

2.5. Government Objective Five

Ongoing Government expenditure for diagnostic imaging services is sustainable.

More and more medical imaging is being used to diagnose or treat patient conditions and this is reflected in the growth in diagnostic imaging outlays experienced by Government.

Despite its increased use, the overall savings to the health system driven by advances in medical imaging are clearly evident.

In 2008, Access Economics conducted an analysis into the value of diagnostic imaging. The analysis demonstrated the “substantial contribution that DI makes to health outcomes in Australia – in priority health areas such as preventing injuries (fractures), musculoskeletal disease, cardiovascular disease, cancer of the breast, neurological disease and digestive disease.”¹

Medical imaging intervention provides dual benefits to the population - health costs are reduced and health outcomes improved. This is achieved through earlier diagnosis of many conditions which in turn usually leads to patients undergoing less invasive treatment options. Investigative and exploratory surgery has largely become redundant with advances in medical imaging and many surgical procedures are now less invasive as they are performed under image guidance.

Never-the-less, as funding is limited it must be directed to the most vital and valuable services as well as to the most disadvantaged patients.

In this context, ADIA is concerned about the following trends:

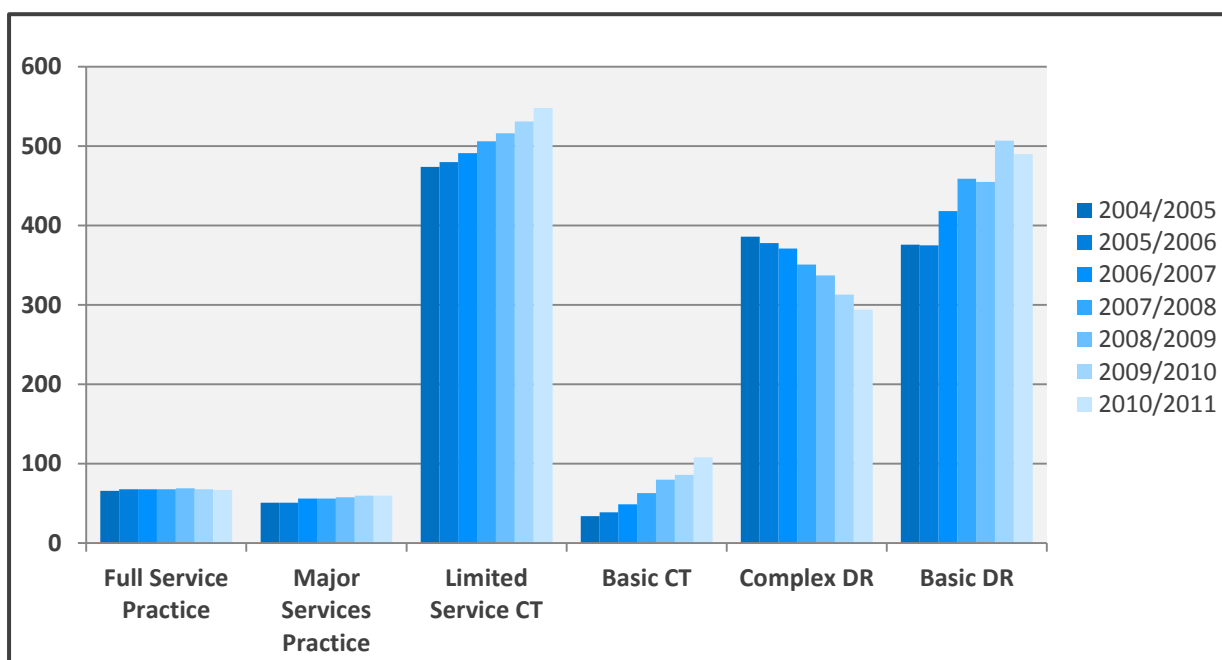
- Increasing investment into low cost practices and high volume-low costs services which in turn lead to efficiency challenges for the existing network of quality supervised comprehensive practices;
- Negative incentive to offer a quality comprehensive practice that invests in staff, technology and clinical input;
- Declining levels of onsite radiologist supervision;
- Declining access to some essential medical imaging services;
- Increasing public sector competition for outpatient services due in part to a lack of competitive neutrality;
- Increasing rates of point of care ultrasound services.

¹ Access Economics, 2008, The value of diagnostic imaging, Page ii.

Growth in limited service practice types

Continued growth in limited service practice types will lead to reduced access and higher gaps for many services. It will lead to an increasing percentage of Government funding being directed toward low-clinical value procedures and leave those patients with more pressing health care needs with a higher cost burden.

Chart 5. Growth in limited and basic service practice types over 7 years



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

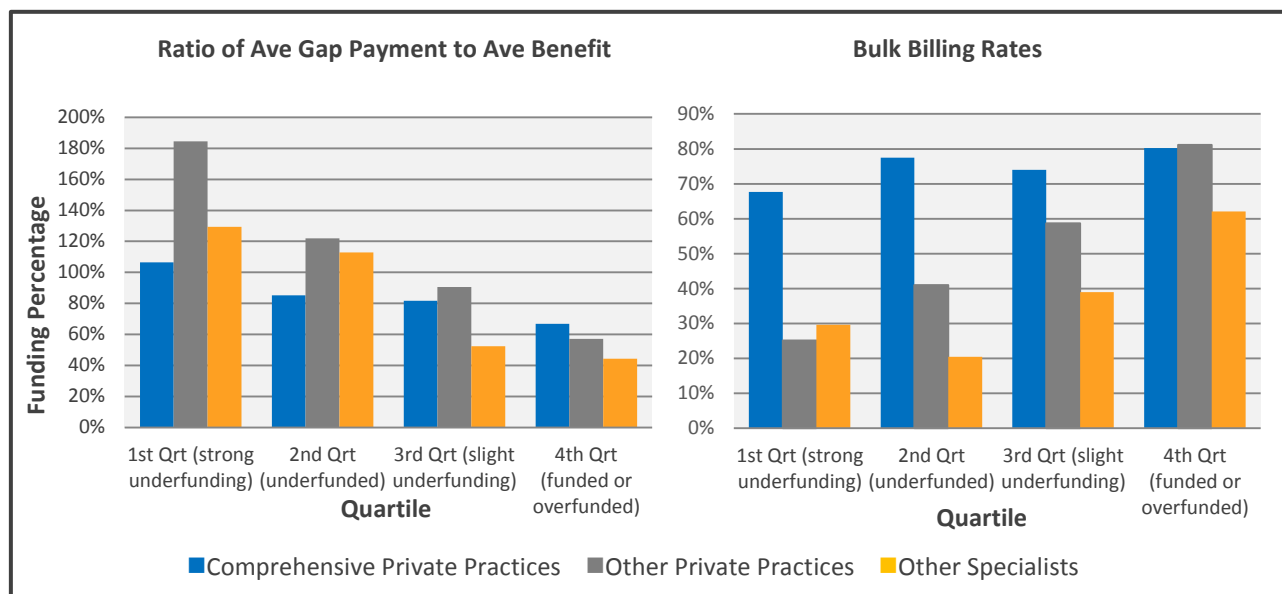
The longer this trend continues unmanaged, the greater the threat to Australia's network of full service (comprehensive) practices that endeavour to offer the full range of services – even the loss making services.

And it is the comprehensive practices that are keeping diagnostic imaging services affordable. The chart below (Chart 6) highlights bulk billing behaviour in respect to ultrasound service by provider type.

Comprehensive private practices are often the only site in a geographical catchment area equipped to provide a full range of procedures and the loss making services are largely provided by these practices—i.e. by the practices with a strong investment in and commitment to clinical care. Their ability to continue to do this is however eroding because of the long term lack of indexation and because the loss of volume to limited service practices.

The following chart demonstrates divergent bulk billing behaviours within the private sector based on the degree of underfunding of ultrasound items.

Chart 6. Ultrasound billing behaviour by practice type and funding level

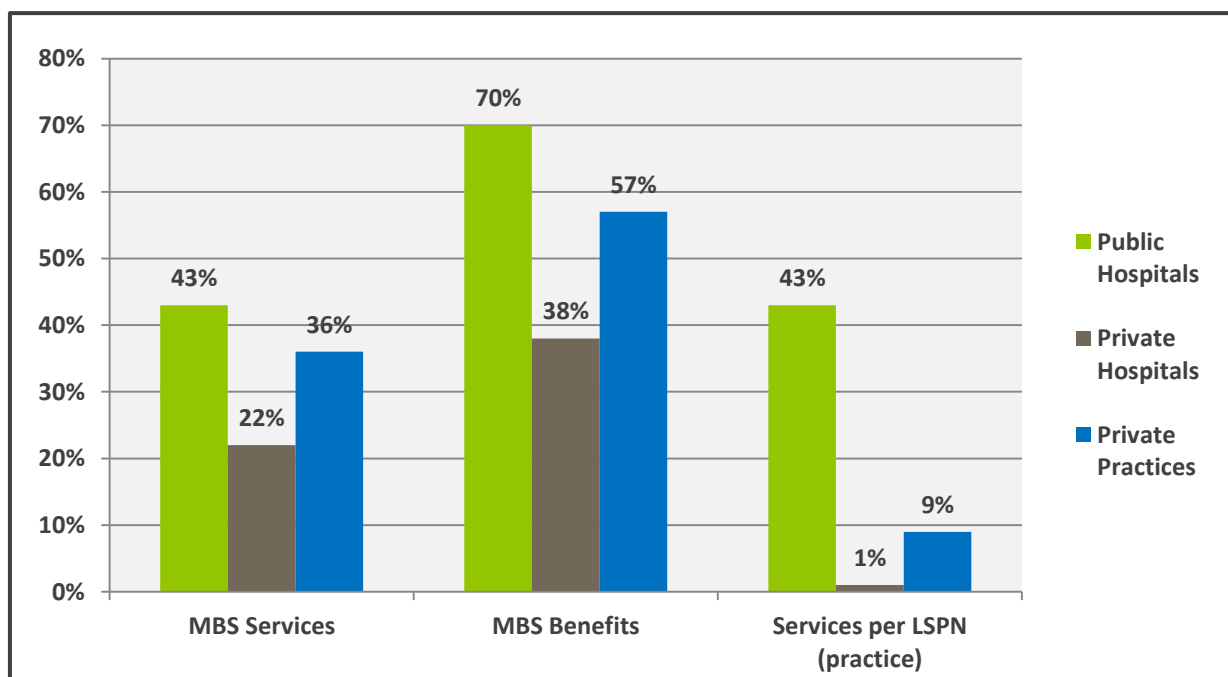


Source: ADIA analysis of Medicare data provided by the Department of Health and Ageing.

Growth in public sector outpatient imaging

Public hospitals have traditionally provided a range of outpatient diagnostic imaging services to patients. Increasingly however, they are competing aggressively with private practices to access a larger share of Medicare funds to top up revenues. The public sector share of Medicare benefits for diagnostic imaging is close to 15% and has been growing on average by 9% per year over the last 7 years making it the fastest growing practice type in the sector. This is in stark contrast to the flat growth experienced by private practices over the same period.

Chart 7. Total percentage growth in share of Medicare funding between 2004-05 and 2010-11:
Public versus private sector



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

This presents a challenging competitive environment for private practices because public hospitals are entitled to concessional treatment - for example, exemptions from payroll tax and local government rates; concessional fringe benefits tax arrangements; and the ability to secure credit under favourable public sector borrowing arrangements. Public hospitals can also use their status as charities to offer packages to Radiologists and medical staff that are more attractive than those available in the private sector at a significantly lower employer cost. They also access direct public funding for costs including: wages, imaging equipment, communications technology, rent, consumables, energy, image transmission and storage costs.

Meanwhile, these costs are also built into the Medicare Fee Schedule. So when public hospitals bill Medicare they are being paid twice for the provision of the same service.

In its 2012 submission to the Independent Hospital Pricing Authority (IHPA) on its Draft Pricing Framework, the Royal Australian and New Zealand College of Radiologists (RANZCR) - which represents both public and private sector radiology - commented that efforts by public hospital administrators to obtain additional revenue by shifting costs to Medicare has:

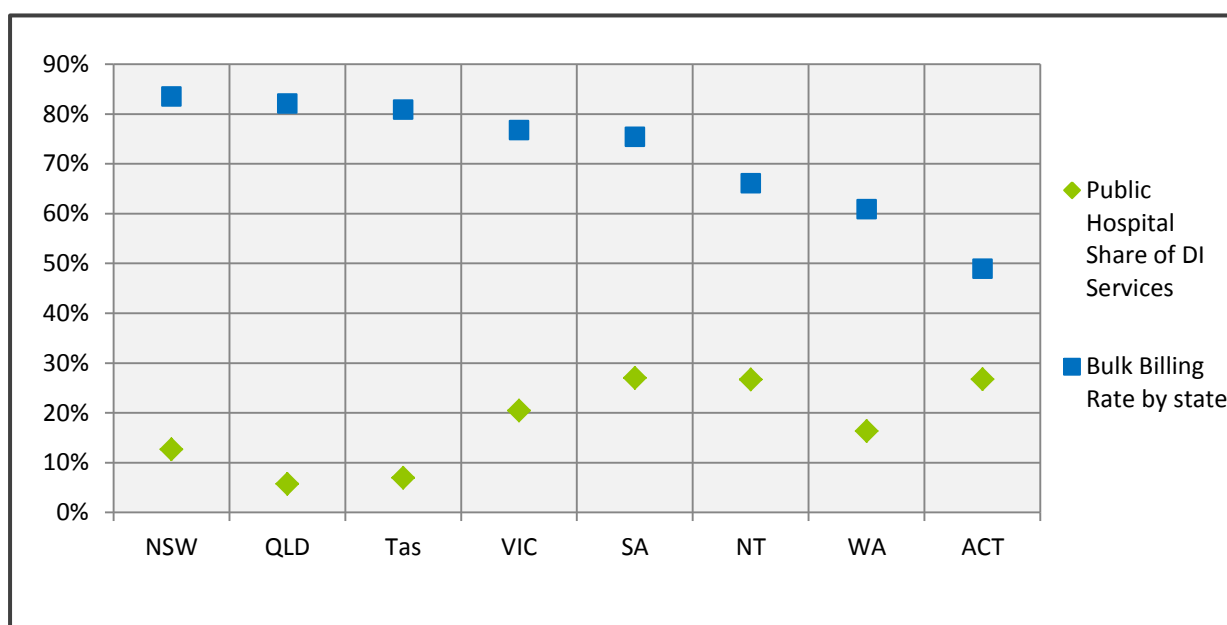
- *Created a two tier public system through the perverse incentive to prioritise Medicare eligible patients over those who are not eligible for Medicare;*
- *Been detrimental to their academic teaching role;*
- *Severely limited capacity to provide adequate training positions;*

- Impacted negatively on the quality of services to patients accessing their services, particularly public patients who are not eligible for Medicare rebates;
- Detrimently impacted the viability of many private providers operating in the same community to maintain a high quality service, or in some cases any service, when confronted with an expansion of bulk billing capacity by public hospitals who have a dual source of funding for equipment and other competitive advantages compared to private sector practices; and
- Increased the level and complexity of administrative and billing processes in radiology departments and exposed individual public hospital radiologists to the risk of being in breach of Medicare billing regulations.

In its submission RANZCR also noted that, of the Medicare billed diagnostic imaging services provided in public facilities in 2010-11, less than 20% were provided to inpatients.

Finally, there is concerning evidence that the higher the share of public hospital imaging services in a state, the lower the average bulk billing rate in that state (refer to chart 8 below). Effectively, as the public hospital outpatient share of imaging services increases, private medical imaging practices lose critical volumes. Combined with the lack of indexation, this forces them to charge gaps for a higher number of patients to remain viable. Given private practices provide 86.5% of services in the sector, the overall decline in bulk billing is felt across the industry as a whole.

Chart 8. State by state bulk billing rates and public hospital share of diagnostic imaging



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

Due to these structural issues, increasing growth in this sector represents increasing inefficiency and waste in health budget outlays as the lack of competitive neutrality between the public and private sectors effectively means that taxpayers are paying more when the service is provided by the public hospital.

If left unchecked, the sector will continue to fragment leading to further underutilisation of existing facilities and concerning inefficiencies in Government outlays.

Growth in Point-of-Care Ultrasound

Ultrasound is the largest diagnostic imaging modality, representing 35% of total diagnostic imaging services in 2010/11, and the fastest growing (experiencing 6.6% service growth and 9.3% growth in benefits in 2010/11). The bulk billing rate is the lowest for ultrasound and patient gaps are highest.

The bulk billing rate is lowest for urological ultrasound (22%), O&G Ultrasound (29%) and general ultrasound (49%). This is largely due to the low average rebates paid for these services.

The Aspex Consulting report to DoHA in 2011 concluded that ultrasound procedures are being performed by clinicians without recognised qualifications and that the criteria for access to Medicare funding for ultrasound services is very loose and open to being “creamed”². Aspex forecasts that outlays on ultrasound (\$2,287 million in 2010/2011) would increase by more than \$700 million per annum over 3 years due to increasing use of ultrasound by a broad range of specialists.

Government therefore needs to be vigilant in realising the savings made possible from early detection and non-invasive intervention of medical imaging so as newer procedures can be made available via Medicare.

² Aspex Consulting 2011, Study of ultrasound use by (non-radiology) medical specialists.



2.6. Government Objective Six

The diagnostic imaging sector is sustainable.

In order for the sector to remain sustainable, it must continue to invest in the profession, in staff training and in the emerging capabilities of medical imaging. This is essential if Australians want early diagnosis and treatment options to keep them well and out of hospital.

Private comprehensive practices provide 85% of all Medicare funded medical imaging services delivered in a comprehensive practice.

The sustainability of comprehensive practices is seriously at risk

This is driven by:

- the volume growth per practice has been an average of 1% per annum;
- the real value of rebates has declined year after year by the rate of inflation;
- the productivity burden due to the increase in image load and higher levels of scrutiny of large data sets produced by advanced imaging modalities constrains efficiency opportunities (for example, a CT of the chest, abdomen and pelvis has increased from an average of 60 slices in 1998 to 1,000 slices [or images] in 2013);
- staff costs, which represent about 60% of all practice costs increase by more than the rate of inflation each year;
- rental costs, IT costs and maintenance costs have been subject to further significant increases;
- competition based on differential levels of clinical input and service offering; and
- the volume and efficiency loss due to public hospitals competing for outpatient services.

3. ADIA Recommendations:

In this Budget Submission, ADIA makes a mix of policy and funding recommendations which would improve fee relativities and incentives within the current diagnostic imaging fee schedule and, together could be budget neutral:

3.1. A Quality Framework for Diagnostic Imaging

ADIA strongly supports the Quality Framework (**Schedule One** [refer page 27]) recommended jointly with The Royal Australian and New Zealand College of Radiologists (RANZCR) as an essential first step. It addresses aspects of quality practice and paves the way to improving patient access to affordable high clinical input services and to the latest advances in quality. Specifically:

- Patient access to CT services in radiologist supervised comprehensive practices offering a minimum range of imaging modalities;
- Patient access to radiologist supervised diagnostic mammography and MSK ultrasound services;
- Quality protocols to preserve the clinical chain of responsibility from the beginning to the end of the service for all remote reporting of images – including in rural areas where special rules will apply to ensure that limited access to radiologist specialists is not a barrier to patient access in these areas;
- All Medicare funded diagnostic ultrasound services to be performed by practitioners with accepted minimum professional qualifications.

“One of the key advantages of those practices with a Radiologist directly on site is to ensure the full range of examinations is performed. It is important to maintain the integrity of these services as without the direct on site attendance by a radiologist many important examinations are not performed. This includes interventional examinations such as biopsies and injections, fluoroscopy such as barium studies and real time dynamic examinations such as many musculoskeletal ultrasound services. While the addition of a non-supervised practice into an already serviced region may have the appearance of improving access it can, and in some cases has, lead to an eventual reduction in access to these important examinations.”

Matthew Swain – General Manager, South East Radiology

3.2. Indexation and targeted patient rebate increases to ensure that patient rebates continue to support patient access

ADIA calls for equitable treatment of Category 5, Diagnostic Imaging Services, so that patient rebates for these services are indexed in line with other Medicare funded medical services.

It is essential that diagnostic imaging rebates are indexed. 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 favourable adjustment to rebates to promote bulk billing will erode and gap payments will continue to grow.

ADIA recommends that all diagnostic imaging Medicare rebates are indexed from 1 November 2013.

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 for bulk billed services 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.

ADIA also proposes targeted funding increases for essential medical imaging services that patients are most at risk of not being able to access or afford— where patients are most at risk due to current underfunding.

In the first instance, ADIA recommends fee adjustments for diagnostic imaging services that involve the attendance of the radiologist. Unlike other specialists, Radiologists are generally not permitted to charge a separate consultation fee for these services which are increasingly not available to patients that cannot afford to pay significant out of pocket expenses. Many of these services are required to diagnose serious conditions.

3.3. Efficient and transparent pricing of Medicare funded diagnostic imaging services provided to outpatients in public hospitals

ADIA strongly supports a mix of public and private providers of diagnostic imaging services in Australia and is calling on the Government to recognise that the viability of a mixed provider system relies on there being competitively neutral funding arrangements in place in accordance with National Competition Policy. It is unreasonable (and more costly for the taxpayer) to expect private providers to operate in competition with public hospital outpatient services which are funded through a mix of State Government investment in staff and equipment and Federal Medicare funding. This is especially challenging for private providers when Medicare funding is not indexed.

ADIA estimates that each 1% gain in market share by public hospitals is costing the taxpayer \$50 million in additional funding per annum. If private sector efficiency was incorporated into the public sector, the saving to the taxpayer would be up to \$1.2 billion per annum. With this funding, the MBS could fund patient access to all services at an efficient price (including MRI and PET) and gaps could be kept to a minimum.

ADIA recommends that the Government 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;
- Ensuring that provision of public outpatient services is restricted to cases where there is a genuine gap in local diagnostic service provision; and
- Adjusting the Medicare rebate for public outpatient services downward to reflect the fact that a portion of the cost of their services has already been paid for from the public purse.

Alternatively the Government could fund 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.

3.4. Review of barriers in the funding structure that are inhibiting access to advances in medical imaging

ADIA proposes that Government review the structure of funding for medical imaging. This review is urgently required in order to afford Australians access to medical imaging advances that are transforming medicine around the world, and to technology that can improve the wellbeing and prognosis of seriously ill patients and those suffering with chronic conditions.

Alongside targeted funding increases (recommendation 3.2), key areas requiring review are:

- Facility and equipment 'licensing' restrictions over the eligibility for MBS rebates for MRI and PET services;
- MBS Item number restrictions, including thresholds for maximum rebateable examinations in any one year and indicators for use;
- Lack of recognition of Radiologists' professional services as referred specialist consultations;
- Lack of eligibility to access the Prosthesis Rebate Scheme in an outpatient or Medicare setting;
- Lack of an efficient avenue for listing new procedures to the Medicare Benefits Schedule.

3.5. 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 recommends that the Government:

- Index rebates for rural services;
- Introduce a Rural Retention Program for radiologists; and
- Revise the 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.

3.6. Quality Incentive Program

ADIA recommends an incentive funding program to promote investment in quality practice and quality improvements which are at risk in the face of current cost and margin pressures.

ADIA supports the further development of minimum standards within the mandatory Diagnostic Imaging Accreditation Scheme (DIAS) to address the needs of referrers and patients. This Program is however in the early stages of development and new standards are likely to be introduced slowly to accommodate the broad range of practices that need to comply.

ADIA therefore recommends that new standards be transitioned with an incentive program. This approach would operate to balance the Government's current measures to promote bulk billing and would help ensure that patients that are bulk billed are able to access practices that invest in maintaining or meeting these standards.

To achieve this, ADIA is seeking:

- Funding to work collaboratively with RANZCR and other stakeholders on the development of practice standards for the following priority areas (full details are attached in **Schedule 3** [refer page 34]):
 - Incentive for the Storage of Images;
 - Hyperlink to Patient Images on Reports;

- Compliance with Quality Image Standards;
 - Incentives for practices that participate in the ARPANZA radiation dose monitoring program; and
 - Incentives for practices with a Radiologist on site.
- Incentive funding for imaging practices to promote compliance with these standards. It is proposed that this funding would continue for a period of 3-5 years, prior to the standards becoming mandatory under the DIAS.

This initiative would see patient outcomes improve:

- due to a measureable approach to dose minimisation;
- as treating practitioners would more readily be able to compare historical images; and
- due to the increased availability of a radiologist on site in practices. (For detailed supporting information and case studies on the benefits of having a radiologist on site, please refer to the following published report on the ADIA website: “When a Radiologist is onsite, health outcomes are improved”, accessible via: <http://www.adia.asn.au/sites/default/files/February%202011%20-%20When%20a%20%20radiologist%20is%20onsite%20health%20outcomes%20are%20improved.pdf> .)

Savings would also be found as a result of the uptake of these standards by imaging practices, which would offset the cost of the proposed transitional Quality Incentive Program. Savings are expected in the following forms:

- Reduction in repeat imaging as previous patient studies will be more readily retrievable; and
- Reduction in repeat or extended GP or specialist consultations due to delays in sourcing patient imaging.

3.7. Prohibited Practices Reform

ADIA has been a long term advocate of “arm’s length referral” because it is important to patients and to the Government that all Medicare funded imaging service is necessary and affordable.

ADIA therefore recommends that the Government promote arm’s length referral by making improvements to 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).

4. Conclusion

Against a background of flagging viability, the private medical imaging sector has continued to provide patients access to services in the interests of patient care and professionalism. The health of Australians is highly dependent on the services provided by comprehensive private practices – they diagnose and treat 85% of all Medicare patients that attend a comprehensive practice (48,500 patients every day); they underpin the quality and breadth of medical imaging service delivery in Australia; and they actively invest in new equipment, medical advances and professional development to a global standard.

However the future of patient access to affordable quality medical imaging in Australia remains uncertain. In this submission ADIA has emphasised the need for an ongoing commitment to improving the funding and policy arrangements for diagnostic imaging services. ADIA has detailed a fiscally responsible mix of policy and funding recommendations in this Budget Submission, that if adopted will go some way to redress imbalances in the sector, to ensure value for money from government outlays, and to ensure Australians' ability to access quality medical imaging is genuinely maintained.

ADIA is committed to continuing its work with DoHA on the Diagnostic Imaging Review Reform Package announced in 2011 and recognises the current funding constraints.

If new funding is limited, then we must ensure that current funding is properly targeted and that the priorities are right.

ADIA urges Government to take urgent action to bring the emphasis of funding back into alignment with its objectives, as for every year that meaningful change in the sector is overlooked, the greater the challenge to Government, to providers of quality imaging services, to patients and ultimately taxpayers.



Schedule One: A Quality Framework for Diagnostic Imaging



The Royal Australian and New Zealand
College of Radiologists*



The DI Reform Package: A Quality Framework to underpin sustainable, quality Medical Imaging

In May 2011 the Government announced it would implement the Diagnostic Imaging Review Reform Package over a five-year timeframe commencing from 1 July 2011 until 30 June 2016, to improve the quality and value of diagnostic imaging services. The Government's Reform Package is to be underpinned by a Quality Framework.

Guiding Principles

The Guiding Principles for the Quality Framework are:

- patients' access to affordable and convenient diagnostic imaging services;
- patients in rural and remote areas have continued access to quality diagnostic imaging services;
- requesting practitioners and imaging services communicate effectively to ensure that patients receive appropriate imaging; and
- each diagnostic imaging scan reflects best clinical practice, is performed by an appropriately qualified practitioner and is provided within a facility which meets all necessary accreditation standards, minimising exposure to unnecessary radiation.

ADIA and the RANZCR have developed proposals to address the priority issues.

1. Patients will always access Medicare funded CT services in radiologist supervised practices offering a minimum range of imaging modalities.
 - An onsite radiologist in a multi-modality service that includes at least X-ray, ultrasound and CT will enable more direct clinical oversight of imaging services, particularly in relation to the appropriateness of an imaging request and the care of the patient.
 - There will be a radiologist on site for a minimum number of hours per day to provide the necessary clinical oversight of scheduled examinations, manage appropriate and safe administration of contrast, perform imaging-guided interventional procedures and be available to attend patients when clinically indicated to ensure that services are appropriate, safe and of a high quality.
 - This measure will facilitate improved communication between referrers and radiologists, and will highlight to referrers and patients that CT should only be used where clinically indicated and with the lowest possible radiation dose, and make a definitive response to increasing awareness and concern in the community around radiation risk associated with CT.
 - This will address concerns that have been raised with regard to CT services where there is either no, or minimal onsite supervision by a radiologist.



- It will establish a platform for further reform strategies to address appropriateness in imaging by:
 - Ensuring there is a minimum cluster of alternative imaging modalities available to the radiologist when he/she receives a request to provide a service that may not be the right test for the patient's clinical indication; and
 - Ensuring there is a radiologist on site, who is available to personally attend a patient when this is required, to determine that the imaging performed is appropriate to patients' clinical needs.
- The measure will ensure that referrers and patients will have greater access to supervised ultrasound services.
- Advances in imaging technology are reducing the amount of time it takes to scan the patient, however the wider application of more complex imaging techniques substantially increases the radiologist's involvement in the patient's examination and in the interpretation of the images. This makes the availability of the radiologist/s onsite even more essential.

2. Patients will have access to radiologist supervised Diagnostic Mammography and MSK Ultrasound Services

- Diagnostic mammography services are for the follow-up and assessment of symptomatic women and they require 'hands on' clinical expertise during acquisition of imaging data.
- Mammography patients will have a radiologist available on site to attend and examine the patient when this is required, and when adjunct breast ultrasound is performed in conjunction with mammography.
- When the mammography and breast ultrasound service indicates the need for breast biopsy to confirm whether breast pathology is cancerous, having the radiologist onsite will enable more efficient and timely patient management and assessment.
- Musculoskeletal Ultrasound examinations will only be performed when a radiologist is on site and the out-dated mandatory personal attendance rule that currently applies will be removed.

3. All remote reporting of images will meet quality protocols to preserve the clinical chain of responsibility from the beginning to the end of the service.

- This will ensure that remote reporting of images by specialist radiologists maintains access to diagnostic imaging services and increases access to sub specialist expertise, especially in rural and remote communities.
- The supervising radiologist will be responsible for the entire medical imaging procedure for each patient; including appropriateness, radiation safety, radiation dose and the clinical quality of all aspects of the procedure.
- Remote reporting of images will meet standards which preserve the clinical chain of responsibility. The standards will address common quality protocols and the need for shared or fully compatible communications and storage systems.
- Where rural/remote exemptions need to apply to onsite radiologist supervision, remote reporting rules will expand to require real time access to supervising radiologists in order to recognise the workforce constraints in these areas.

4. All Medicare funded diagnostic ultrasound services will be performed by practitioners with accepted minimum professional qualifications.

- The proposal sets out minimum qualifications for those medical specialists and health professionals who provide diagnostic ultrasound services.
- It ensures that all providers of diagnostic ultrasound services will be appropriately trained and qualified to provide these services, and meet continuing education requirements.
- It will mean that only truly diagnostic ultrasound services will be reimbursable under the Diagnostic Imaging Services Table of the MBS, and that all diagnostic ultrasound services, including point of care ultrasound services, will meet minimum standards of care.

Why these initial proposals are so important for patients

- The current Government mandated professional supervision requirements are not being enforced by Medicare due to their lack of specificity.
- Unsupervised multi-modality medical imaging practices are of concern to patients, the radiology profession and to medical imaging practices committed to the provision of quality medical imaging services that require on-site medical attendance and appropriate use of these services.
- Medical imaging has advanced beyond diagnosis and into medical assessment and treatment, and non-surgical interventional procedures; therefore it is important that patients are able to access these advanced services in supervised, quality, multi-modality, practices.
- As patients in rural areas gain increasing access to more advanced medical imaging services, they need to be safeguarded by a Quality Framework for remote supervision and reporting.
- The proposed changes will ensure that Medicare funding is better directed to efficient, appropriate and quality imaging services for patients.
- Patient rebates have not been indexed for 14 years and these initial proposals are intended to address some of the impacts that this has had on the provision of quality diagnostic imaging services.
- There will need to be fee adjustments within Medicare to ensure that patients can afford radiology services that involve attendance by a radiologist. These services are increasingly not available to patients that cannot afford to pay significant out of pocket expenses. It is envisaged that the required adjustments can be made within a cost neutral framework.

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Schedule Two: Sub-specialties impacted by underfunding

Fluoroscopy

What is involved? All fluoroscopy based procedures are labour intensive services. Fluoroscopy uses a continuous or pulsed x-ray beam to create a sequence of images that are projected onto a monitor. When used with an injected or ingested contrast material, which clearly defines the area being examined by making it appear dark, it is possible for the Radiologist to view joints or internal organs in motion. These services require continuous Radiologist and Radiographer time during the examination as well as reporting time by the Radiologist after the examination

What are the current Medicare fees? The little to no recognition of labour costs and essential equipment replacement costs in rebate calculations is highlighted by a comparison between 1998 rebates and those paid in 2012. Rebates for fluoroscopy procedures such as barium swallows have actually decreased over this 14 years period despite the labour intensive nature of these services and increase in labour costs.

A barium swallow procedure attracted a rebate of **\$96.15** in 1998, while the rebate in 2013 is just **\$89.95**. This represents a decrease of \$6.20. Meanwhile, during this twelve year period, imaging and processing equipment would have needed to be replaced to achieve assumed efficiencies and keep up with digital standards; teleradiology equipment and infrastructure would have had to be procured installed and maintained; and salaries and wages would have been indexed 14 times!

What are the implications? As a result, fluoroscopy procedures are generally not performed at all in private settings. Over time, as the sub-specialty has become less and less financially viable, some fluoroscopic imaging procedures have been replaced with newer modality imaging services such as CT. However, there is not an alternative for every fluoroscopy item or for every patient. In fact, fluoroscopic imaging is an essential tool for the assessment of paediatric patients, particularly infants suffering from reflux and renal dysfunction. For many ill children, there are little to no non-invasive alternatives. Paediatricians and parents are highly reliant on the provision of these services in order to avoid hospital stays and image intensifier guided alternative imaging in theatre, however the extremely low Medicare funding for these services is creating an obstacle to ongoing investment in the sub-specialty and therefore patient access.

Mammography

What is involved? High quality breast imaging is a labour intensive examination undertaken by specialised professional staff and Radiologists. Unlike screening tests, diagnostic mammography and localisation procedures must be tailored to the individual and the imaging sequence must address the specific anatomical and pathological findings revealed during the actual procedure. This involves imaging and review several times throughout a single service by a Radiologist. High quality breast imaging and intervention also requires the latest imaging technology and ancillary equipment.

What is the current Medicare fee? The current Scheduled Fee for a mammogram of one breast is **\$54.00**. The rebate is therefore either 85 or 95% of this amount. The procedure requires 30 minutes (minimum) of hands on specialist Radiologist time. It is a doctor-referred service that requires significant investment in labour and equipment. In contrast, the scheduled fee for a standard GP referred specialist consultation is **\$142.65**!

What are the implications? Due to the cost-intensive nature of mammography and the extremely low Medicare funding available for these services, many imaging practices either no longer offer the services or provide them at a high out-of-pocket cost to the patient. Moreover, most women with breast cancer will have undergone not only a mammogram, but breast ultrasound and image guided biopsy to detect and diagnose their cancer and after treatment, further follow up imaging. This can cost women hundreds of dollars in the initial diagnosis and ongoing yearly imaging follow-up, due to the inadequacy of Medicare rebates.

Interventional Radiology

What is involved? Interventional Radiology utilises minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system. Using X-rays, CT, ultrasound, MRI, and other imaging modalities, interventional radiologists obtain images which are used to direct interventional instruments throughout the body. These procedures are usually performed using needles and narrow tubes (catheters), rather than by making large incisions into the body as in traditional surgery. Many conditions that once required surgery can now be treated non-surgically by interventional radiologists. By minimising the physical trauma to the patient, peripheral interventions can reduce infection rates and recovery time, as well as shorten hospital stays

What are the current Medicare fees? Many interventional radiology procedures are considerably underfunded and some are not funded at all due to the combination of:

- the retraction of minor surgical item numbers from the MBS in 2009 on the basis that ‘benefits payable being under existing attendance items’;
- the fact that Medicare does not acknowledge and provide a fee for Interventional Radiology as a referred medical specialist attendance, as distinct from a requested Medical Imaging examination;
- The lack of access to the ‘Prosthesis Rebate’ scheme. This scheme which is available to Hospitals and Day Surgeries, as well as to the surgeons working within them, is not extended to independently-operated medical imaging practices or to outpatient services. As a result, significant out-of-pocket expenses in the realm of hundreds of dollars need to be borne by patients requiring vascular access for therapy unless they are admitted to hospital;
- The difficulty in getting new interventional procedures listed in the Diagnostic Imaging Services Table.

What are the implications? The gap payments for interventional examinations, such as vascular access procedures, are significant due to the high cost of the medical consumables required, which are not rebatable for Medical Imaging providers and the time-intensive nature of the procedures. MRI guided interventional techniques do not attract Medicare rebates at all and as a consequence the full cost is worn by the patient. Underfunding for interventional procedures and associated out-of-pocket expenses act as a major barrier for patients to access private providers on the basis of affordability. This results in greater waiting periods for diagnosis and treatment and therefore poorer outcomes.

Obstetric Ultrasound

What does it involve? Obstetric Ultrasound involves the review of both foetus and mother at different stages of pregnancy. These procedures not only assess viability and morphology of the foetus but also assess the condition of the uterus, amniotic fluid and placenta.

Obstetric ultrasound requires specific measurements, data and images to be captured however there is no way of ensuring optimal positioning of the foetus. For example a sonographer / sonologist must assess all vital organs or indicators (gestational age dependant) and may be faced with a moving foetus or a foetus positioned such that required body parts or organs are obscured. Technique and knowledge are vital to successful completion of a true diagnostic test in these cases.

A high level of skill is also required to avoid missed or misdiagnosis. The indicators of some very serious syndromes and abnormalities are subtle and may require immediate intervention. Other conditions diagnosed pre-birth must be operated on as soon as the baby is born. Ultrasound allows for management of the patient before birth.

What are the Medicare fees? Despite its complexity, the scheduled fee for a 60 minute Obstetric ultrasound with known pregnancy and potential complications (eg 55710) is just **\$35** compared to a general 30 minute abdominal ultrasound (55036) at **\$111.30** and a standard GP referred specialist consultation at **\$142.65**

This is a significantly underfunded category of ultrasound, made up of 16 items with an average Scheduled Fee of **\$78**. This compares poorly to **\$140** for the average vascular ultrasound, **\$205** for the average cardiology ultrasound and **\$101** for a general ultrasound.

What are the implications? Families hoping to have their pregnancy managed through the private system face gap payments in the order of hundreds of dollars.

Schedule Three: A Quality Incentive Program to support the transition to mandatory standards

The quality improvements and initiatives that have been identified as needing Minimum Standards are as follows:

a) Incentive for the Storage of Images

Now that images are captured digitally, there is an expectation that they are available for retrieval by referrers and patients when requested. Unfortunately, storage is complex and costly. There are issues with the size of the images stored, the number of images stored in the case of multi slice modalities, access to the images and the length of time the images need to be stored.

Pursuant to ADIA's Code of Practice for Diagnostic Imaging Services - *Provision of Digital Diagnostic Images (September 2009)* (<http://www.adia.asn.au>) - ADIA Practices, having made the transition to digital imaging, have committed to a minimum storage period of six (6) months. This again has been voluntary and only covers ADIA practices.

The investment required to be able to offer image retrieval is significant. All of the practices in the group need to be electronically networked and connected to a central data base and storage facility. Software needs to be in place to manage the data retrieval and privacy overlays.

Five years on, the expectation of referrers and patients is that images are stored and available for longer periods and that they should be available if required at a later date – to avoid repeat imaging or for comparison with newer images.

b) Hyperlink to Patient Images on Reports

Many referrers, especially GPs who manage patient files electronically, find access to digital images easiest when they are provided an electronic hyperlink in the report. Referrers can file the report in the patient's electronic file and access them at any time including when the patient presents for a consultation. A hyperlink makes it easy to send the images to a specialist and leads to a reduction in lost images and repeat imaging. The provision of this service would also prepare the sector for electronic patient records.

This service is dependent on practices having the systems and processes in place to store images (above), the cost of which is prohibitive for many providers. It involves electronically linking reports with images and the development of encrypted links with referrers that are password protected. It is estimated that 45 person days is required to develop each provider link, with an additional 15 days required for development, testing and implementation.

c) Incentive to meet Quality Image Standards

Since 2009, ADIA has supported the initiative of the Royal Australasian College of Surgeons (RACS) to develop recommendations on the delivery of, access to and viewing of diagnostic quality digital

images for clinicians. RACS is now calling for these recommendations to become the basis for Australian Standards. These standards need further development and broader stakeholder input to meet the needs of all referrer groups. Pursuant to ADIA's Code of Practice for Diagnostic Imaging Services - Provision of Digital Diagnostic Images (September 2009) (<http://www.adia.asn.au>) - ADIA Practices, are required to meet the image quality needs of referrers. This again has been voluntary and only covers ADIA practices.

d) Incentives for practices that participate in the ARPANZA radiation dose monitoring program

The Australian National Diagnostic Reference Level Survey (www.arpanza.gov.au/services/NDRL/index.cfm) seeks to gather individual practice data that will be collated and used to establish National Diagnostic Reference Levels for common diagnostic imaging procedures. The objective of developing DRLs is to establish a measure of indicative doses for current diagnostic imaging practice in Australia, allowing individual practices to compare their doses against those of their peers.

The objective of a diagnostic reference level is to help avoid excessive radiation dose to the patient that does not contribute additional clinical information value to the medical imaging task. Typically, diagnostic reference levels are used as investigation levels (i.e. as a quality assurance tool) and are advisory.

Practice Reference Levels can be used by practices to establish a reference dose for their common imaging protocols that can be used for internal and external comparison.

To participate, practices need staff to determine which surveys they would like to complete (i.e. which procedures and which age cohort), to collect the data (20 patients per survey are required) and then record and log the data. When the data is returned the data would be analysed and protocols reviewed.

The dose report will give practices feedback on where their doses fit in relation to their peers – their response to the report is up to them.

This initiative represents a further burden on practices that are reducing their staffing levels so they can keep their services affordable. It is also likely that without an incentive program, uptake will be slow and it will be the practices already committed to low dose initiatives that will participate.

e) Incentives for practices with a Radiologist on site

ADIA recommends the introduction of enforceable supervision rules in line with the Quality Framework set out in **Schedule One** (refer page 27).

In the interim, 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 the below Practice Incentive Program (PIP). The program would 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.

Practice Incentive Program:

- *Description:*

The program will build on current practice accreditation programs and will encourage practices to provide a diverse range of modalities and clinical services (including clinically complex services) with onsite radiologist supervision, timely care interventions and reporting, active decision support for referrers, and evidence-based protocols to minimise radiation exposure for patients.

- *Aims:*

To promote convenient patient access to efficient, supervised, comprehensive DI practices which offer patients high levels of clinical input, high levels of communication between referrers and radiologists, and high levels of safety for patients.

- *Eligibility Requirements:*

1. Modality availability (CT, x-ray and ultrasound at a minimum).
2. Service availability (a minimum range of DI services that require specialist clinical input and personal radiologist attendance on the patient.)
3. Radiologist in attendance on site. For rural practices, this requirement will be modified to promote real time supervision via telehealth while the patient is in attendance at the rural practice.
4. Active decision-support offered to referrers to promote referral for the most appropriate diagnostic imaging service.
5. Digital imaging and archive infrastructure compliance (DIAP Program standards).

6. An agreement to monitor radiation exposure and reduce it to minimum practical levels on a patient by patient basis consistent with the specialist's requirements for image clarity and comprehensiveness.
- *Incentive:*
A set fee per annum for each radiologist on site (full-time equivalent) subject to minimum case load thresholds per radiologist.
 - *Indexation of eligible patient services:*
Loadings could be added for additional services such as fluoroscopy and after hours' attendances.
 - *Accreditation:*
Practices to be accredited by existing accrediting bodies (including QIP and NATA) under a new practice accreditation module of the DI Practice Accreditation Program.
 - *Compliance:*
Accreditation agency responsible for monitoring compliance by practices.





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