A Message from ADIA President

This edition's foreword statement is from *Dr Sue Ulreich*, President of The Australian Diagnostic Imaging Association.

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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.

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.

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.

ADIA
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