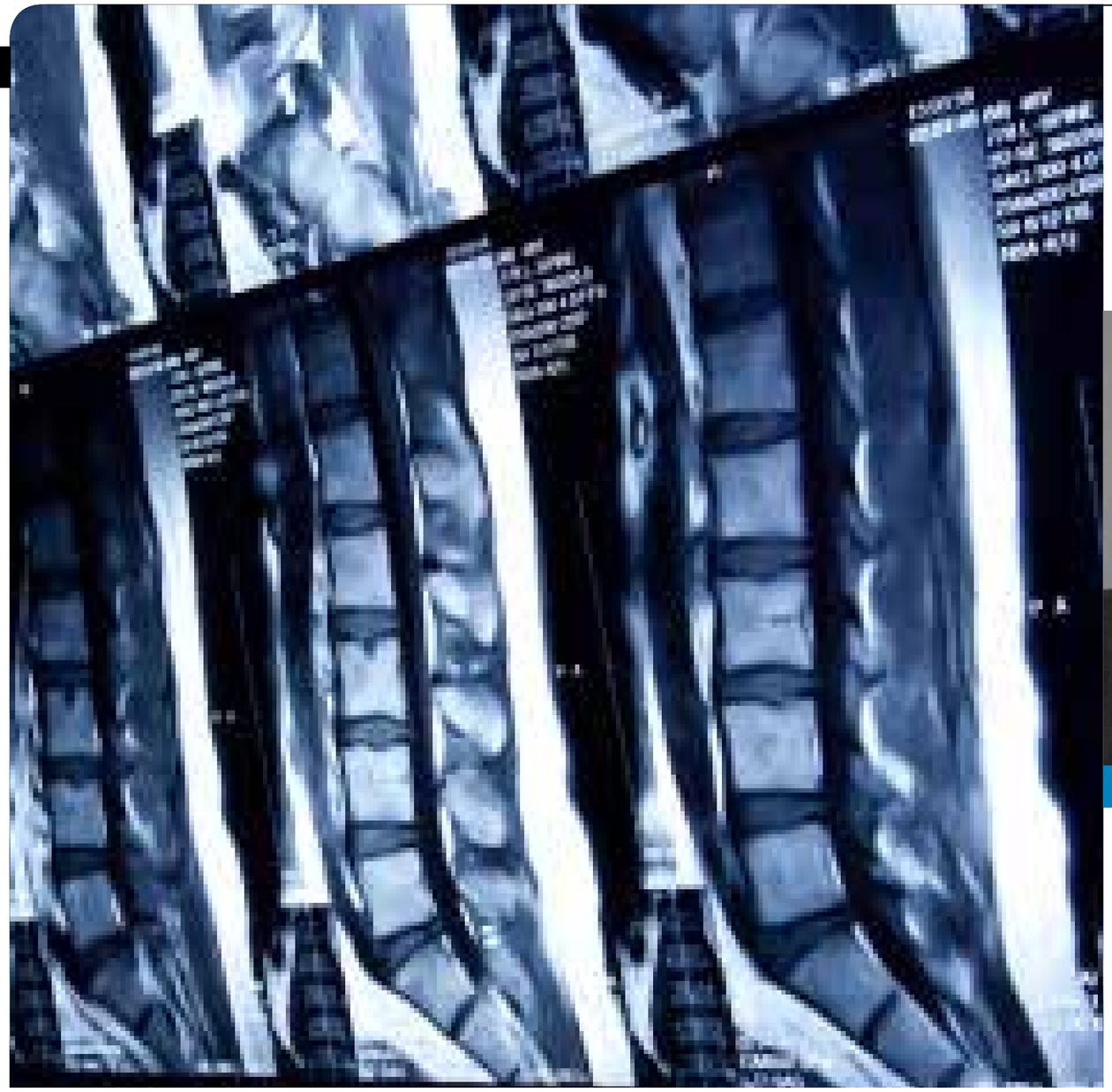
RADIOLOGY **SAVES LIVES**

2019-20 BUDGET SUBMISSION

SAFEGUARDING PRIMARY CARE BY MAKING QUALITY RADIOLOGY MORE AFFORDABLE

January 2019

australian diagnostic imaging association



ABOUT ADIA

ADIA works to ensure radiology remains accessible, affordable and safe for all Australians. As a member-led organisation, ADIA represents radiology practices nationwide.

ADIA
australian diagnostic imaging association

RADIOLOGY SAVES LIVES

PRESIDENT'S MESSAGE

Radiology – x-ray, ultrasound, CT, nuclear medicine, PET and MRI – is at the heart of modern medicine and key to managing a vast range of conditions, from the assessment of broken bones to the diagnosis, staging and monitoring of cancers.

GPs and specialists rely on accurate diagnosis to assess management options for their patients. As a reliable and efficient diagnostic tool, radiology is one of the most frequently accessed medical services in Australia with around 4 in 10 Australians referred for x-rays and scans each year.

However, while radiology continues to play a vital role in the provision of quality primary care, patients are finding it increasingly unaffordable to access. With the average gap reaching $100 in 2018, almost 300,000 Australians are foregoing radiology every year because of the cost.

In this Submission, ADIA is calling on the Government to address the following four priority issues in the 2019-20 Budget, so that all Australians have access to quality radiology services when they need them:

THE MEDICARE FREEZE

This is the number one issue affecting radiology patients. Despite the cost of providing services going up each year, Medicare rebates for radiology have been frozen for more than 20 years. This is pushing up gaps every year, with the average gaps now reaching $110 for ultrasound, $152 for CT and $182 for MRI. This imposes a substantial barrier for ordinary Australians to access the services they need.

THE MBS REVIEW

The Review is an opportunity to make sure that Medicare gives Australians access to the most appropriate services for their condition. However, the Government has focused on cutting access to clinically appropriate services like MRI of the knee to generate Budget savings, often contrary to clinical evidence and against the advice of expert clinicians.

THE MY HEALTH RECORD

To upload patient reports to the My Health Record, radiology practices will incur substantial upfront costs and ongoing costs of around $4 per service. These costs will flow to patients through increased gaps unless practices are remunerated to participate.

THE QUALITY FRAMEWORK

Access to an on-site radiologist is critical to quality radiology; however, professional supervision regulations for CT and contrast administration are not enforceable by Medicare. These regulations need to be strengthened to ensure that all radiology practices meet appropriate quality and safety standards.

Prior to the 2016 federal election, the Coalition Government committed to deliver a package of structural reforms to ensure Australians have affordable access to radiology. Chief among the Government's commitments was a promise to end the freeze on Medicare rebates for radiology at the same time as GPs, a promise that is still yet to be delivered.

With the 2019 election looming, the Government is running out of time to deliver on its promise and our patients are being forced to pay more and more – or miss out altogether – because of the Government's inaction.

Dr Siavash Es'haghi
ADIA President

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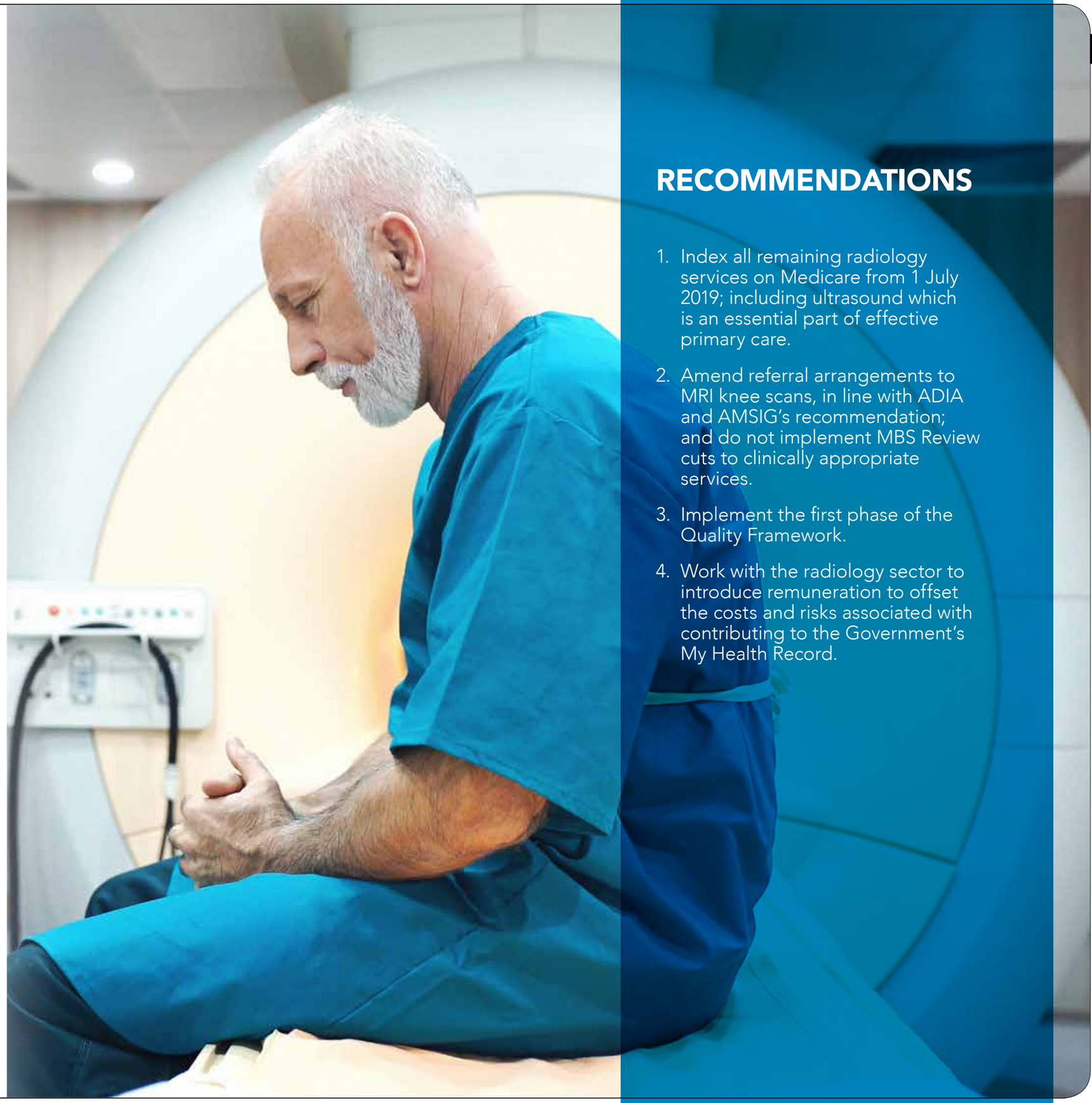


RECOMMENDATIONS

1. Index all remaining radiology services on Medicare from 1 July 2019; including ultrasound which is an essential part of effective primary care.
2. Amend referral arrangements to MRI knee scans, in line with ADIA and AMSIG's recommendation; and do not implement MBS Review cuts to clinically appropriate services.
3. Implement the first phase of the Quality Framework.
4. Work with the radiology sector to introduce remuneration to offset the costs and risks associated with contributing to the Government's My Health Record.

END THE MEDICARE FREEZE ON RADIOLOGY

The Medicare freeze is the number one barrier to affordable and accessible radiology for Australian patients. Prior to the 2016 election, the Coalition Government committed to ending the Medicare freeze for radiology services, but has not delivered on this promise.

Medicare rebates for radiology have not been indexed for more than 20 years, despite the increased costs associated with providing x-rays and scans. This means many services are now only accessible to patients who can afford to pay substantial gaps. The freeze has created a two-tiered health system based on the patient's ability to pay.

THE COST OF RADIOLOGY HAS BECOME THE BIGGEST BARRIER TO EFFECTIVE PRIMARY CARE

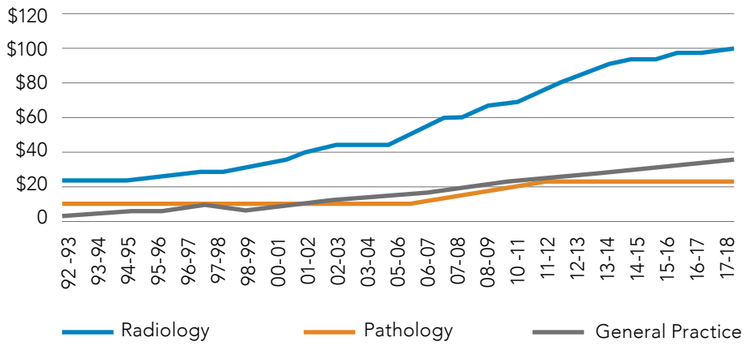
Radiology is an indispensable part of modern primary care. It is essential to the diagnosis, management and treatment of many common conditions, including the 35 most common cancers. One in every 10 patients who visit their GP will be referred for radiology, and yet it is significantly more difficult to access than other primary care services.

Radiology has the lowest bulk billing rate and highest gaps in primary care; gaps that are substantially higher than those for GP visits and pathology:

AFFORDABILITY OF PRIMARY CARE SERVICES 2017 -18[1]

	Radiology	Pathology	GP
Average Upfront Cost	$222	$45	$82
Average Gap	$100	$25	$37
Bulk Billing rate	78.0%	88.5%	84.7%

INCREASE IN AVERAGE GAP PAYMENTS FOR PRIMARY CARE SERVICES



[1]ADIA analysis of 2017-18 Medicare statistics.

PATIENT GAPS ARE INCREASING EVERY YEAR DUE TO THE FREEZE

In 2018, the average gap paid for radiology increased to almost $100 – a substantial increase on the average gap of $30 two decades ago.

AVERAGE GAP PAYMENT AND NUMBER OF SERVICES ATTRACTING A GAP PAYMENT, BY MODALITY, 2017-18[2]

Modality	Average gap	Number of services attracting gaps
Ultrasound	$110	2,755,000
CT	$152	618,768
X-Ray	$51	2,281,780
Nuclear Medicine	$105	94,902
MRI	$182	191,065
All services	**$100**	**5,941,072**

The significant increase in gap payments is preventing many Australians from accessing the services they need. Of the 9 million Australians who will be referred for radiology in 2019, approximately 300,000 patients will forego diagnosis of their condition because of the cost.[3] This is not acceptable for a world-class health system like Medicare.

The sickest Australians are those being hit the hardest by the Medicare freeze, because it tends to be complex radiology services (involving substantial clinical input by specialists) which attract the highest gaps. These patients will typically require more than one service throughout the management of their condition, each adding to the total cost of their diagnosis and treatment.

[2]ADIA analysis of Medicare data provided by the Department of Health
[3]ABS Patient Experiences survey 2016

TYPICAL COSTS OF RADIOLOGY SERVICES FOR THE DIAGNOSIS AND TREATMENT OF COMMON CANCERS

LUNG CANCER

Service	Upfront Cost	Gap
X-ray, chest	$69	$27
CT, chest and upper abdomen with contrast	$493	$157
PET, lung cancer staging	$1,131	$258
CT-guided fine needle aspiration	$547	$147
X-ray, chest	$69	$27
MRI, brain	$511	$169
Total	**$2,820**	**$785**

BOWEL CANCER

Service	Upfront Cost	Gap
CT, abdomen and pelvis with contrast	$597	$189
CT, chest, abdomen and pelvis with contrast	$660	$180
Bone study	$543	$135
MRI, pelvis	$527	$184
Total	**$2,327**	**$688**

Moreover, Medicare data shows that even pensioners and health care card holders are paying gaps for 1 in 10 radiology services.

[4]ADIA analysis of deidentified Medicare data provided by the Department of Health.

MEDICARE REBATES DO NOT COVER THE COST OF PROVIDING QUALITY RADIOLOGY SERVICES

An independent evaluation completed by Deloitte Access Economics in 2017 (commissioned by the Coalition Government and released under FOI), found an average $26 shortfall between the rebate for bulk billed radiology services and the cost of delivering the service. As costs increase, this shortfall will increase:

AVERAGE REVENUE AND COST FOR ALL BULK BILLED RADIOLOGY SERVICES[5]	
Revenue per service	$ 130
Cost per service	$ 156
Difference	$ - 26

A subsequent analysis of ultrasound rebates by Deloitte Access Economics in 2018 found the shortfall was particularly large for ultrasound services, averaging $53 per bulk billed service.

AVERAGE REVENUE AND COST FOR BULK BILLED ULTRASOUND SERVICES[6]	
Revenue per service	$ 107
Cost per service	$ 160
Difference	$ - 53

THE COST OF DELIVERING RADIOLOGY IS INCREASING EVERY YEAR

Over the past two decades, the costs associated with providing radiology have increased significantly yet Medicare rebates have not been increased to reflect this.

For example, in 1998 the Medicare rebate for a breast ultrasound was $86.70; in 2019, the rebate for the same service is $83.5. Meanwhile, the costs to provide this service (highly-trained professional staff including radiologists and sonographers; equipment; medical consumables; rent and electricity) increases each year.

[5]Deloitte Access Economics, Independent evaluation of the commercial environment of comprehensive diagnostic imaging practices, April 2017.
[6]Deloitte Access Economics, An analysis of ultrasound rebates, October 2018.

This is not an isolated example:

CHANGE IN MEDICARE REBATES BETWEEN 1998 AND 2019 FOR COMMON RADIOLOGY SERVICES[7]

Service	Medicare rebate 1998	Medicare rebate 2019	21 Year variation in Medicare rebate
Ultrasound - one breast	$86.70	$83.55	-$3.15
Ultrasound - pregnancy (22 weeks)	$86.70	$85.00	-$1.70
CT - brain	$171.25	$165.80	-$5.45
X-ray - foot, ankle, leg, knee or femur	$39.45	$36.90	-$2.55
MRI - brain	$424.60	$342.75	-$81.85

[7]Medicare Benefits Schedule: November 1998 and January 2019.
[8]ADIA analysis of 2017-18 Medicare statistics.

ENDING THE MEDICARE FREEZE IS THE BEST WAY TO REDUCE THE BURDEN ON PATIENTS

Radiology is a highly competitive market. Historic Medicare data shows that when rebates for radiology are increased, more services are bulk billed and the total gaps paid by patients stops increasing. Indexation also gives practices the certainty they need to invest in new clinics and services which would be unviable when rebates are frozen.

BULK BILLING RATES AND TOTAL GAPS PAID BY PATIENTS[8]

	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Bulk billing rate	63.2%	66.1%	69.5%	72.7%	73.9%	74.8%	76.0%	76.9%	77.3%	77.4%	78.0%
Gaps paid (mil)	$382.3	$399.5	$399.6	$405.4	$435.7	$456	$479.5	$491.8	$511.1	$528.3	$553.2

THE BUDGET IS THE GOVERNMENT'S LAST CHANCE TO DELIVER ON THEIR ELECTION COMMITMENT

The Coalition Government committed to addressing the Medicare freeze on radiology prior to the 2016 election, when it promised to "ensure diagnostic imaging indexation resumes when the current GP rebate indexation freeze concludes." However, the Government has broken this election promise. The freeze on GP services ended in July 2018, and only 59 of the 889 radiology items are scheduled to be unfrozen in 2020. The 2019-20 Budget marks the Government's final opportunity to deliver on this commitment.

RECOMMENDATIONS

To ensure that all Australians can access the radiology services they need, index all remaining radiology services on Medicare from 1 July 2019; including ultrasound which is an essential part of effective primary care.

ENSURE THAT MBS REVIEW CHANGES DO NOT COMPROMISE PATIENT CARE

ADIA supports the MBS Review, which was comissioned to ensure Medicare reflects contemporary clinical evidence and practice to improve the health outcomes for patients. However, it is important the Government does not prioritise Budget savings over clinical outcomes by implementing recommendations that will prevent patients from accessing the most appropriate services at the right time.

CUTS TO MRI KNEE SCANS WILL IMPOSE ADDITIONAL COSTS, DELAYS AND INCONVENIENCES FOR AUSTRALIANS OVER 50

In November 2018, the Government implemented the Review's recommendation to restrict GPs from referring patients over the age of 50 for an MRI of the knee, despite the lack of any clinical evidence to support this cut and strong opposition from expert stakeholders.

Australians over the age of 50 who suffer acute knee injuries are now required to see an orthopaedic surgeon to obtain a specialist referral for an MRI. This means that patients have to wait for an appointment with a surgeon (often weeks or months, particularly for Australians in regional and rural areas), and pay a substantial gap for the consultation – just to get a referral to be diagnosed. This increases costs for patients and the Government.

Patients who require immediate treatment are paying gaps of up to $500 to be diagnosed privately, and do not receive a rebate from Medicare.

While some patients over 50 are inappropriately referred for MRI, the introduction of an arbitrary cut-off based on age rather than clinical need is discriminatory. ADIA has proposed that referral eligibility is amended to require Australians over 50 to have an x-ray to rule out osteoarthritis, before being referred by their GP for MRI. This will address concerns about inappropriate referral, and is supported by the Australasian Musculoskeletal Imaging Group – the peak professional body for sub-specialists in musculoskeletal imaging.

THE MBS REVIEW RECOMMENDATION ON NUCLEAR CARDIOLOGY SERVICES WILL PREVENT SOME PATIENTS FROM ACCESSING THE MOST APPROPRIATE TEST

The MBS Review Taskforce has recommended that referrals for myocardial perfusion imaging (MPI) are restricted to patients meeting very limited criteria, with most patients with suspected coronary artery disease (CAD) to be referred for stress echo.

One of the major strengths of nuclear cardiology is its superiority over other modalities in quantitating the amount of ischaemia. This frequently will allow patients with only mild ischaemia to be managed medically, avoid coronary angiography and result in cost savings to Medicare. The recommendation does not align with clinical evidence and would prevent many higher-risk patients from being referred for the more appropriate MPI test. It is likely to markedly increase the number of patients requiring invasive coronary angiograms and fractional flow reserve procedures, because in moderate-to-high risk patients stress echo is less likely to provide a comprehensive assessment.

RECOMMENDATIONS

To ensure that all Australians can access the most appropriate radiology services, amend referral arrangements to MRI knee scans, in line with ADIA and AMSIG's recommendation; and do not implement MBS Review cuts to clinically appropriate services.

IMPLEMENT THE QUALITY FRAMEWORK

Clinical leadership of radiology services is a crucial pre-requisite to quality. An on-site radiologist does more than merely interpret and report examinations: among many clinical tasks they supervise and monitor studies, perform image-guided interventional procedures, and ensure that the requested service is appropriate to answer the clinical question posed by the referrer. This leadership role directly influences and improves patient care.

Radiologists also consult with referrers, which is a key indicator of quality practice. Patients benefit directly through improved appropriateness of imaging and more accurate reports. However, radiologists are not paid by Medicare for this service despite it being essential in many cases for patients to get the best care.

In its pre-election agreement with ADIA, the Government committed in writing to implement the first phase of the Royal Australian and New Zealand College of Radiologists' recommendations under the Quality Framework, which relate to clinical leadership of radiology services. The first stage of the Quality Framework will clarify professional supervision rules for CT services and contrast administration.

RECOMMENDATION

To safeguard quality radiology practice and ensure that patients have access to an on-site radiologist when clinically necessary, implement the first phase of the Quality Framework.

SUPPORT RADIOLOGY PRACTICES TO PARTICIPATE IN THE MY HEALTH RECORD

ADIA continues to support the inclusion of radiology reports in the My Health Record and is continuing to work with the Australian Digital Health to address roadblocks to participation by radiology practices.

While the process of uploading radiology reports to the My Health Record is mostly automated, the University of Queensland (2017)[9] identified substantial costs to practices involved with participating:

UPFRONT COSTS

These include administrative, procedural, change and implementation management processes, and training costs to incorporate the My Health Record into their practice.

Total Upfront Costs per practice

$15,000 - $45,000

\+ $100 per member of staff for non-technical costs, including training

ONGOING COSTS

These include data quality activities, training new staff members, maintenance of internal policies and procedures, technical management of the interface to the My Health Record, security certificates, and additional testing as part of patch upgrades for practice software.

Total Ongoing Costs per practice

$4 per radiology service

\+ $1,500 - $6750 per year

LIABILITY COSTS

By uploading reports to My Health Record, radiology providers will be exposed to increased liability relating to patient privacy and consent, and the integrity of all information uploaded to the Record. These costs have not been quantified.

Given the existing underfunding of radiology under Medicare, many practices will pass the costs of uploading reports on to patients through higher gaps, unless they are funded to offset these costs and risks. This does not represent good value for patients, as radiology reports are already available to most patients and GPs electronically, so the My Health Record does not represent a substantial improvement. Accordingly, many practices will choose not to participate in the My Health Record.

RECOMMENDATION

To ensure that the My Health Record works for patients and GPs, work with the radiology sector to introduce remuneration to offset the costs and risks associated with contributing to the Government's My Health Record.

[9]Smith, A. & Caffrey, L. (2017) Economic analysis of diagnostic imaging providers contributing diagnostic imaging reports to the My Health Record, Centre for Online Health: University of Queensland.

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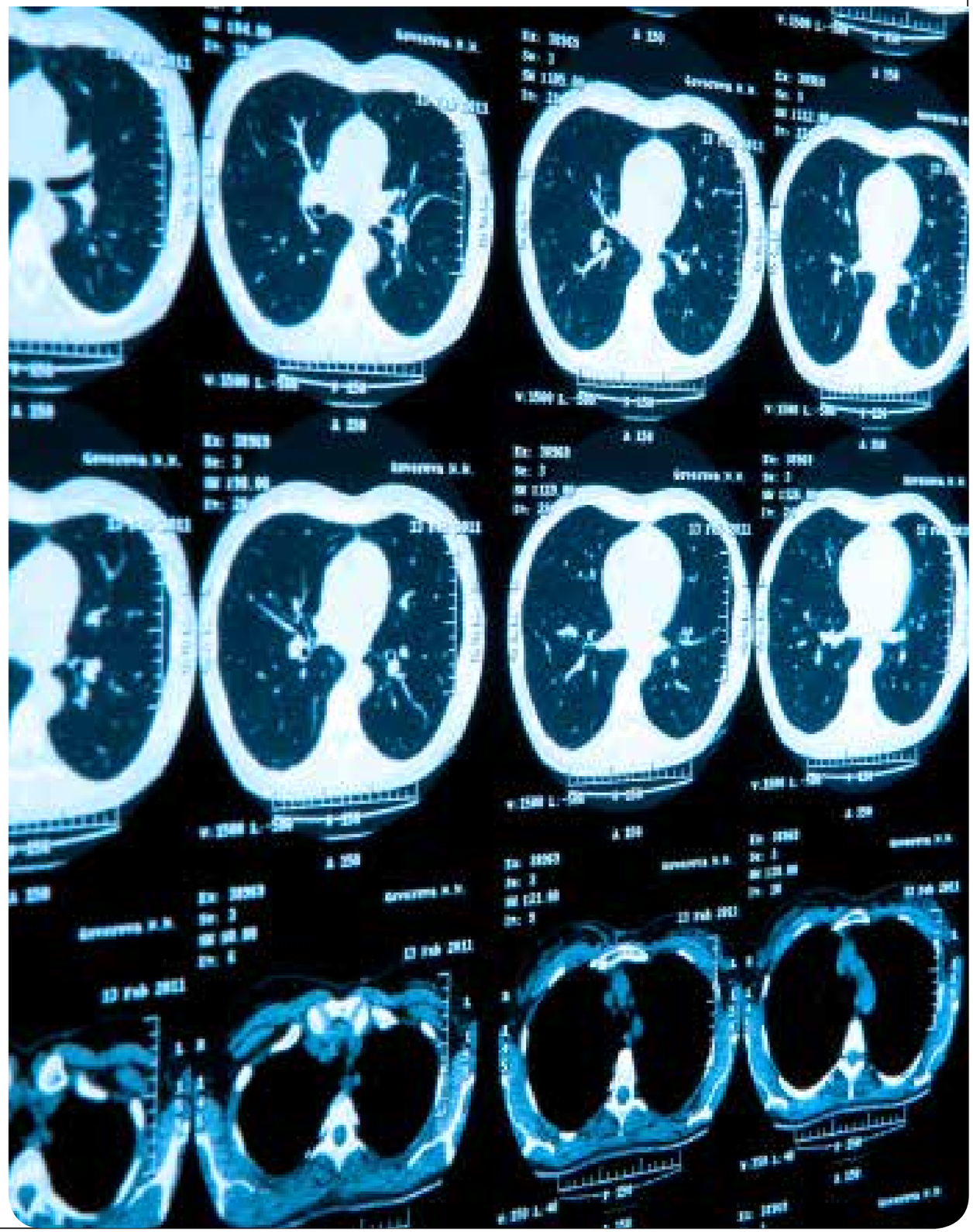

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