



Diagnostic Imaging Review
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Review of Funding Arrangements for Diagnostic Imaging Services

Introduction

The AMA has a wide range of members: those who own diagnostic imaging companies; those who provide diagnostic imaging services and those who request diagnostic imaging services. Accordingly, our submission seeks to address the issues around Government subsidy of diagnostic imaging services from the perspective of all our members and their patients.

The AMA appreciates that the Government is keen to manage future health outlays. However, from a health policy perspective, it is short sighted to manage total health outlays by taking a siloed approach in managing discrete elements of health funding.

Diagnostic services are key clinical tools in assessing, diagnosing and treating disease early. If new funding arrangements are implemented purely to force the cheapest “price” for diagnostic imaging, there is a risk that many diagnostic imaging providers will find it difficult to remain viable. A reduction in the number of diagnostic imaging providers, or the range of services they offer, will consequently impact on access and affordability for patients.

If patient access, affordability, safety and quality of care are affected by changed funding arrangements, costs to the health system will simply be transferred, and added, to other parts of the health system. Hospital admissions will not be avoided, and the Government will ultimately pay for more expensive treatment of late stage disease.

Inevitably in health financing if you make changes to one part of the system there are unintended consequences elsewhere in the system.

It is in this context that we caution the Department in conducting a review of funding for diagnostic imaging without first fully understanding how the Australian people and the health care system is served by the diagnostic imaging sector and the current financing arrangements. Secondly, the review discussion paper has failed to ask the most important question of all: whether (and if so how) changes in the current funding arrangements for diagnostic imaging might improve the overall effectiveness of the health system.

Fee for service arrangements have over the years encouraged and enabled an efficient, competitive market of high quality diagnostic imaging providers to respond to local demand in most areas of Australia. The cost of services is shared between government, third party insurers and patients – all of whom have some influence on the “price” sought by the provider. The amount of Government assistance to patients is a matter for Governments and patients. But, any new arrangements for the way in which the Government pays its subsidies to patients should not have the effect of reducing the number or scope of providers and therefore limit access to these services.

In making a submission to the review, the AMA highlights:

- the clinical importance of diagnostic imaging in patient care;
- the need for the review to include an analysis of the diagnostic imaging sector and how it has changed as a result of historical changes to funding arrangements;
- the need to identify the problems that changed funding arrangements seek to correct; and
- the principles for funding diagnostic imaging services in Australia.

The importance of diagnostic imaging in patient care

It is not possible to conduct a review of funding arrangements for diagnostic imaging services without first fully understanding the importance of diagnostic imaging in patient care and the reasons why there is a demand for diagnostic imaging services.

Contrary to the statement in the discussion paper that the “review will not focus on issues around the requesting of and demand for services”, the level of demand for diagnostic imaging services, and the role diagnostic imaging plays in managing patient care, is a critical factor for Governments in deciding how much it will spend on health and how it will manage health expenditure.

Diagnostic imaging is a vital element of best practice patient care. It provides crucial information to enable doctors to assess and diagnose a patient’s condition and to determine the best approach for treatment. Early diagnosis provides cost effective treatment and significantly improves patient outcomes.

Once a treatment plan is implemented, many medical conditions require follow-up imaging to determine when treatment has successfully alleviated the condition, for example, the healing of a fracture or the curing of cancer.

Further, many minimally invasive procedures require an associated diagnostic imaging service in order to carry out the procedure. Minimally invasive surgery reduces the length of hospital stay and improves patient recovery and outcomes.

Diagnostic imaging services provided by the treating doctor, such as specialist obstetricians, gynaecologists and cardiologists ensures patients receive timely, convenient, comprehensive and integrated care.

Diagnostic imaging is integral to cost-effective treatment as well as ongoing patient management. This is the reality of delivering clinically appropriate and cost effective health care.

Patient management and safety and quality of care are optimal when there is clinically appropriate access to the right diagnostic service at the right time. Treating doctor and patient access to the full spectrum of diagnostic imaging services must not be compromised by short sighted changes to funding arrangements designed only to reduce outlays on diagnostic imaging services.

The review process

The task of the review is to advise the Minister on the options for future funding of diagnostic imaging services to ensure the Government is paying the right amount to support access. However, the AMA is not confident that the review will identify valid options because the objectives of the review have not been clearly articulated. Nor has there been any analysis about whether, under the current funding arrangements, the Government is paying the wrong amount for diagnostic imaging services, and if so, why the current arrangements are not suitable. Without this analysis, it will be impossible to assess whether alternative funding arrangements will improve the overall effectiveness of the health system. Indeed, it may well be that the government's objectives for the health system will be well served by increasing the aggregate expenditure on diagnostic services. But we won't know this unless the question is asked.

Further, to fully understand what impact different funding arrangements might have on access to and affordability of services, it is necessary to analyse what impact the current financing arrangements and the structure of the diagnostic imaging sector have on servicing the Australian people now. The review should elicit information about the nature and structure of the diagnostic imaging sector today: the types of providers; the range of services offered by the different types of providers; their geographical spread; and what those services currently cost overall.

The discussion paper has not identified that there are any gaps in patient access to services or the affordability of services. There is no analysis of what impact the previous funding arrangements under the Memorandum of Understanding have had on the structure and diversity of the sector. Consequently, it is not possible to even speculate how different funding arrangements might address particular problems with patient access to quality diagnostic imaging services when the problems have not actually been identified.

The AMA believes this analysis should be done as part of the review.

The AMA offers the following principles against which the existing arrangements and proposed options should be tested:

- access to diagnostic imaging services should continue to be based on clinical need;
- safety, quality, access and affordability should remain paramount;
- sustainability of the industry should be maintained which in turn will support the provision of services right across the country, including in regional and remote areas; and

- any changes should facilitate patient care and convenience.

These principles require service delivery arrangements that do not:

- cap expenditure;
- restrict access;
- limit the number of eligible providers; and
- limit the number of eligible machines.

Safety and quality

The Department's discussion paper suggests that there could be areas where the Medicare rules may be making poor use of radiologists' time, and questions whether it is necessary for a radiologist to personally supervise certain Medicare-eligible services in order to ensure safety and quality. This reflects a misunderstanding of the role of radiologists and their relationship with technicians and treating doctors.

Radiologists supervise support staff such as sonographers, radiographers and nurses, not just to ensure quality and accuracy, but also to provide a pivotal role in guiding clinical care and best outcomes for patients. Interpretation of images by radiologists is an integral part of any diagnostic imaging service.

Radiologists also maintain long-standing relationships with treating doctors to ensure that high quality medical care is provided to patients informed by expert medical opinion. Radiologists and treating doctors regularly confer on the interpretation of results of diagnostic tests ordered by the treating doctor. This interaction ensures optimal patient care and facilitates quality diagnostic referrals. This professional engagement does not attract a Medicare rebate for either doctor.

Consequently, it is clinically inappropriate to suggest that there are circumstances where a report should not be provided. The AMA cannot support any proposal to split fees for image capture and reporting. Administratively, there is little to be gained by splitting fees.

Quality use of diagnostic imaging

The AMA would support measures to improve the knowledge base about best practice diagnostic imaging for providers and requestors. It is appropriate that the work of the *Diagnostic Imaging Pathways* be built upon to evaluate clinical pathways associated with diagnostic imaging and to develop best practice guidelines. The National Prescribing Service has received funding in the 2009-10 Budget to support quality diagnostic imaging requesting and we look forward to the results of this work.

Access and affordability

Access to medical services for many people is dependent upon affordability. The Government has for many years used a blunt instrument to limit its MBS outlays for diagnostic imaging services by not indexing MBS rebates during the period of the Memorandum of Understanding. Despite this, diagnostic imaging providers have managed to maintain high levels of bulk billing. However, where services have been patient billed, patient out of pocket costs have steadily increased and it is those

patients who have been short-changed by the Government's strategy of zero indexation.

The risk of Government changes to the funding arrangements for patients is that it will effectively transfer a greater portion of the costs for diagnostic imaging services to more patients. Further, if funding arrangements, such as tendering processes, result in only a few large organisations providing Medicare funded services, reduced competition could have the effect of a departure from relatively high bulk billing rates and/or diagnostic imaging services may no longer be available locally.

If that is the case, then there is an increased risk that more patients won't access services when they need them. For example, patients requiring multiple ultrasounds during a pregnancy and who cannot afford the multiple out-of-pocket payments, simply do not have the tests. In some regions, patients do not have the safety net of attending a public hospital service. As mentioned previously, poorly managed conditions and/or treating late stage disease leads to increased downstream costs for the health system.

The Australian fee for service model for diagnostic imaging services has reached a delicate balance that has developed over many years. For example, under the fee for service arrangements, providers cross-subsidise between services – the true cost of very complex and costly services that are not performed very often is not passed directly onto those patients using those services. Providers are able, to some degree, to offset these more expensive, less frequent imaging services with lower cost, but higher volume services. This allows providers to offer a wider range of diagnostic imaging services in a local area.

The current fee for service environment provides the best balance of incentives to encourage quality services and competition.

It is the level of the Government rebate that impacts on patient access and affordability. Any new funding arrangements must ensure the gap between MBS rebates and the real cost of providing these services does not grow. It is vital that those less well off and in areas of social disadvantage remain able to access the mainstream health system.

Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET)
Patient access to MRI and PET examinations should be based on clinical need not on geographic availability dependent on arbitrary decisions by the Government on the number and locations of machines.

Current restrictions fly in the face of strong evidence that an MRI or a PET examination is the best diagnostic test for many conditions, for example, an MRI examination is more appropriate for spine issues than a CT scan while a PET scan is often the best test for lymphoma. Changing imaging referral patterns based on evidence will save money as well as improve patient care.

MRI examinations also have a safety advantage over CT scans which expose patients to high levels of ionising radiation. For example, MRI of the bowel is an important advance for patients with inflammatory bowel disease, such as Crohn's disease. These

patients are usually quite young and often need multiple episodes of imaging. They are currently mostly imaged with CT resulting in a significant cumulative radiation dose.

The AMA considers that all MRI machines that meet standards set by the Royal Australian and New Zealand College of Radiologists should be licensed for MBS purposes. If Australian health care is to reap the downstream benefits that timely access to diagnostic imaging delivers, it must ensure there is adequate supply to meet demand.

Sustainability of services

A decade of inadequate MBS fees is beginning to reduce the commercial viability of some diagnostic imaging providers.

The AMA notes that the public system does not have sufficient capacity to meet the demand that would be created by a diminished private imaging sector. Therefore it is very important to ensure the funding arrangements do not undermine the viability and sustainability of private diagnostic imaging providers.

While MBS fees have remained stagnant, all the costs associated with providing services have increased, e.g. salaries, equipment, consumables and rent. There have been efficiency gains from new technologies. Offering the full spectrum of services allows practices to cross subsidise the earnings from certain services to other more expensive services in order to reduce patient out of pockets costs for the latter. At the same time, the complexity of many services has increased substantially and requires more time from radiologists and technologists.

If new funding arrangements threaten the sustainability of practices, there is a risk of flow on consequences for thousands of jobs: directly, on radiologists, radiographers, sonographers, office staff and administrators; and indirectly on people working for suppliers and their subsidiaries.

The viability of services in small centres is particularly vulnerable to funding changes. As has already been recognised by the Government in its National Health and Hospitals Network policy, additional financial support is necessary for services located in rural and remote areas in the form of special grants or additional loadings.

Over the last ten years or so we have seen the closure of many General Practice based radiology practices because it became less viable to provide those services. Plain x-ray based practices which existed in larger general practices resulted in savings to the health system by allowing GPs to diagnose and treat a multitude of minor conditions within their surgeries. For example, chest x-rays confirmed or excluded pneumonia and extremity x-ray allowed minor fractures to be managed in the community. Many unnecessary presentations to emergency departments were avoided.

Capital costs

The AMA understands that the Department considers that Medicare rebates are somehow over paying capital costs. It is not clear how the Department could reach this conclusion, particularly as MBS fees for diagnostic imaging have not been indexed in over a decade.

The AMA recommends that the Department take advice from the diagnostic imaging providers on this issue. However, we would point out that the frequency with which diagnostic imaging practices replace older machines with new machines depends on a number of factors including costs, quality, patient care, and previous investment. These factors interact with each other in complex ways, impacting on a provider's decision whether and when to replace a machine. In addition, the costs of some machines are cross-subsidised by others in the same way as some services are; cheaper, older machines that are used more frequently subsidise the cost of more expensive, modern machines used less frequently. Consequently it will be difficult to draw a uniform industry position on the cost of capital.

Introducing the payment of rebates on the basis of specific depreciation time limits is not supported because of the potential perverse incentives it could encourage. For example, too short a depreciation period might disadvantage a diagnostic imaging provider who invests in a top-of-the-line machine that can produce good quality images for a long period with periodic upgrades, and instead encourage a provider to purchase a cheaper quality machine that produces poorer quality images but that can be replaced more often.

There is a risk that sellers of machines would change their behaviour to match funding changes. For example, servicing of machines might cease after depreciation time limits, thereby forcing imaging providers to buy new ones unnecessarily.

The accreditation arrangements for diagnostic imaging as a requirement for Medicare benefits ensure the entire diagnostic imaging service, including the imaging equipment, complies with the highest standards. Given that compliance with accreditation requirements comes with an administrative and financial cost to the imaging provider, it is reasonable to conclude that these costs can be partly attributed to any capital component within the MBS fee.

Licensing machines

Another mechanism used by Government to cap expenditure is to limit the number of machines which are eligible for rebates. This policy only serves to limit patient access to imaging. Patient access to MRI examinations should be based on clinical need, not on geographic availability depending on arbitrary decisions by Government on the number and locations of machines.

The AMA notes that many licensed machines are currently at capacity, and many non rebated services referred by GPs are currently performed on unlicensed machines – these would become unviable if GP referrals moved to licensed machines.

All MRI machines that meet the relevant Royal Australian and New Zealand College of Radiologists specification should be licensed for Medicare benefits purposes. If the

government is to reap the downstream benefits that timely access to diagnostic imaging delivers, it must ensure there is adequate supply to meet demand.

Increasing MBS fees would not only enhance sustainability overall, but also support practices to pay for adequately trained and skilled staff, and to deliver high quality imaging services. It would help encourage new entrants to the market, who can be deterred by the high cost of equipment and other set-up requirements, and therefore increase competition – one of the Government’s objectives.

Enhanced patient care and convenience

Imaging services provided by treating doctors, such as obstetric and gynaecological ultrasound and cardiac imaging currently have MBS fees that are considerably lower than the same service provided in a diagnostic imaging practice, although the capital and recurrent costs are relatively similar. Consequently, rebates for these services result in high patient out of pockets costs. Reading and interpretation of the result of the imaging service by the treating doctor are integral to the provision of the imaging service and not part of any patient consultation. Imaging services provided by treating doctors offers patients timely and comprehensive care and are cost effective to the health system. Treating doctors will refer the patient when a more specialised opinion is needed.

GP MRI

In the 2008-09 Federal Budget the Government recognised the benefits to patients of GP MRI referral by confirming a previous funding provision for GP referred MRI of \$13.1 million over four years. The Minister for Health and Ageing is unnecessarily delaying implementation of this policy initiative. There are many overseas experiences that the Australian Government can follow in respect of GP MRI ordering for improved clinical outcomes.

It is worth noting that limiting referrals to diagnostic imaging often creates additional expenditure to the health care system. GP referred MRI will assist patients to have more timely access to care and reduce downstream expenditure. Under current MRI arrangements, patients must first see their GP for a referral to another specialist. Depending on the location, the patient may then need to wait some months before they can see the specialist. It is likely that they will then have to wait for a further period before they can access an MRI scan. In the meantime, the GP may order a CT scan so he or she can manage the patient’s condition until the patient sees the specialist.

Allowing GP referred MRI scans would significantly improve this process and be consistent with the Minister’s preventative health and health management objectives. In cases where the GP could manage the patient’s condition effectively, they would be able to initiate treatment earlier. If specialist referral were necessary, then the patient would already have their MRI scan available when they have their first specialist appointment, thus making better use of the consultation.

Alternative funding arrangements

The Department has not provided any evidence to demonstrate that alternative funding arrangements would work better than the fee-for-service model, or that any alternative arrangements would improve patient care and affordability.

The Department's own commissioned literature review on funding arrangements for diagnostic imaging services in a sample of OECD countries notes that: 'it is extremely unlikely that a single representative model of incentives or business efficiency could ever be developed to be fit-for-purpose in health sectors in different countries. Interventions will have a range of repercussions which may not always be fully understood when the intervention is made'.¹

Further, the cross subsidisation of services mentioned above is unlikely in the alternative funding models canvassed in the discussion paper.

Performance-based payments and benchmarks

The AMA opposes the introduction of any type of performance-based incentive payments. The Department's assumption in the discussion paper that diagnostic imaging could be 'improved' through quicker turnaround is not supported by any evidence. The current fee for service model already encourages providers to maximise throughput. The Department has not provided any evidence that patients are waiting too long for diagnostic imaging services or their results.

The AMA also opposes any move by the Government to introduce performance benchmarks that create caps, limitations or restrictions. For example, the Sydney South West Area Health Service imposed a performance requirement on BreastScreen that no more than 5% of breast screens should be recalled for further testing. This led to a missed diagnosis of breast cancer in a woman because her screen was not recalled despite a change from an earlier screen, and the NSW Government paid the woman \$400,000 in compensation.

Extending the ordering of diagnostic imaging outside the medical profession

The extension of Medicare rebates to diagnostic imaging services requested by nurse practitioners and midwives is one health policy that will add to Medicare expenditure.

In the United Kingdom, nurses practising in extended roles in the primary care setting use more tests and investigations than general practitioners². If Australia is to avoid the additional cost of these unnecessary services it is critical that nurse practitioners and midwives work in a collaborative care model with medical practitioners.

Conclusion

From a clinical perspective, diagnostic imaging and other diagnostic tests are the greatest weapon against disease and cost blowouts to other parts of the health system. The funding arrangements for these services must not impact on access and affordability for these services. Patients and their doctors must have access to

¹ http://health.gov.au/internet/main/publishing.nsf/Content/MBRTG-DI_Publications, pg. 14

² *Advanced nurse roles in UK primary care*. Sibbald, Laurant, Reeves. MJA 2006;185 (1):10-12.

clinically relevant information to ensure disease is assessed, diagnosed and treated early and effectively.

Government funding of diagnostic imaging services must correct the gap between MBS rebates and the real cost of providing these services. It is vital that the less well off and those in areas of social disadvantage remain able to access the mainstream health system. They should not be disenfranchised from health care because of high out of pocket costs for pathology. Funding arrangements should encourage a sufficient number of providers:

- so that patients have timely access to services;
- to ensure there is sufficient geographic spread of services; and
- to create a competitive market.

The fee for service arrangement has delivered these outcomes for the Australian people and should continue to be supported by the Medicare benefits arrangements.

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