



Australian Government
Department of Health and Ageing

DETAILED REVIEW OF FUNDING FOR DIAGNOSTIC IMAGING SERVICES

DISCUSSION PAPER

This paper has been prepared by the Department of Health and Ageing as a basis for consultation with diagnostic imaging stakeholders. These consultations will inform the development of advice to the Minister for Health and Ageing, the Hon Nicola Roxon MP, regarding options for future funding of diagnostic imaging services.

This discussion paper has been developed to guide consultation and discussion by providing an overview of some of the issues identified in respect of the current funding arrangements and to help identify possible alternative options for consideration. These options have not been endorsed by the Department of Health and Ageing, the Minister or the Australian Government.

Any queries in relation to the contents of this discussion paper can be directed via email to the Medical Benefits Reviews Task Group at MBRTG@health.gov.au

Medical Benefits Reviews Task Group
Department of Health and Ageing
January 2010

DETAILED REVIEW OF FUNDING FOR DIAGNOSTIC IMAGING SERVICES

BACKGROUND

1. The Government has requested a detailed review of funding arrangements for diagnostic imaging, to ensure that the Government is paying the right amount in the right way to support access for patients to quality diagnostic imaging services.
2. This review will focus on diagnostic imaging services currently funded through the Medicare Benefits Schedule (MBS), including x-ray, ultrasound, computed tomography, magnetic resonance imaging (MRI), nuclear medicine imaging and positron emission tomography (PET). The review will not focus on issues around the requesting of and demand for diagnostic imaging services, except where this is relevant to considering how services are funded.
3. The review is taking place in the broader context of reviewing the MBS. It will align with other review and reform agendas including the MBS Quality Framework, the Review of Health Technology Assessment, the Primary Care Strategy and the National Health and Hospital Reform Commission.
4. The review of funding for diagnostic imaging services has four key tasks:
 - To establish appropriate fee relativities for MBS items across and within different diagnostic imaging modalities;
 - To develop alternatives to fee-for-service and establish whether there are areas of diagnostic imaging that would be more appropriately funded through a different mechanism;
 - To review current funding arrangements for MRI, particularly restrictions around Medicare eligible/ineligible units; and
 - To review current funding arrangements for PET, particularly around what capital arrangements should apply.
5. In addition, within these four key tasks the review will consider the long-term viability of diagnostic imaging services in rural, regional and outer-metropolitan areas.
6. The review will take place against the background of the Government's broader agenda to ensure that spending on health is sustainable, affordable and provides maximum benefit to the greatest number of people, which will involve continued emphasis on savings and efficiencies.
7. This discussion paper is broken into the four key tasks outlined above with a series of questions the Department of Health and Ageing (DoHA) seeks to answer under each. These questions are aimed at stimulating discussion and providing direction on the information and evidence required in order to generate appropriate options for the future funding of diagnostic imaging.
8. Following consultation with stakeholders and careful analysis, DoHA will provide the Minister for Health and Ageing with options for consideration by Government. It is expected

that the Government's decisions in response to the review will be reflected in the 2011-12 budget.

9. The full Terms of Reference are attached.

Consultations

10. The Government is aware that information about cost structures of providing different types of diagnostic imaging services, general and specific industry structures, and the clinical requirements of different patient groups, is not captured through existing Medicare data and must be obtained from other sources.

11. The Department will undertake an extensive consultation process with a wide range of stakeholders, through formal committees, written discussion papers and submissions, forums and bilateral meetings.

12. These consultations will be largely seeking to gather information about how current arrangements operate in practice and to invite stakeholders to propose options for the future.

13. A Diagnostic Imaging Review Consultation Committee will be established. This committee will comprise representatives of the following groups:

- Australian Diagnostic Imaging Association (ADIA);
- Royal Australian and New Zealand College of Radiologists (RANZCR);
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG);
- Cardiac Society of Australia and New Zealand (CSANZ);
- Australia and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM);
- Consumers Health Forum (CHF);
- Australian Medical Association (AMA);
- Australian Institute of Radiography (AIR);
- Australian Sonographers Association (ASA);
- Australasian Society for Ultrasound in Medicine (ASUM); and
- Department of Health and Ageing (both the Diagnostic Imaging Review team and Diagnostic Services Branch).

Written Submissions

14. Stakeholders are invited to provide written submissions by **30 April 2010**. Submissions received will be made publicly available unless confidentiality is specifically requested and justified. Stakeholders are welcome to address all, or selected, issues raised in this discussion paper. Submissions made to the 2008 strategic review of diagnostic imaging will be taken into consideration. Submissions should be addressed to:

- Diagnostic Imaging Review
Medical Benefits Reviews Task Group
Department of Health and Ageing
MDP 153
GPO Box 9848
CANBERRA ACT 2601

15. For further information regarding this discussion paper or to arrange a bilateral meeting to discuss any aspect of the review please contact the Medical Benefits Reviews Task Group at: MBRTG@health.gov.au

Further Consultations

16. A second discussion paper, to be released in mid-2010, will outline the results of this information gathering and analysis phase and will identify a range of possible options. Stakeholders will be provided with an opportunity to comment on these options at that time.

Website

17. <http://www.health.gov.au/MBRTG> has been developed to provide background information on the review, provide updates on progress, and provide access to consultant reports commissioned for the review, where appropriate.

1. FEE RELATIVITIES ACROSS DIAGNOSTIC IMAGING MODALITIES

Background

18. Since 1998 there have been several Memoranda of Understandings (MoUs) agreed between the Government and the diagnostic imaging sector. These agreements involved seeking to achieve a fixed target rate of expenditure growth by changing rebates where service volumes fell outside agreed thresholds. The last MoU expired at the end of June 2009 and the Government decided that it will no longer use MoUs for managing diagnostic imaging expenditure.

19. Across the life of the MoUs there has also been a variety of both positive and negative impacts on the costs and clinical value associated with providing different diagnostic imaging services such as advances in technology and workforce capacity constraints.

20. As a result current MBS rebates for diagnostic imaging services may no longer be aligned with the cost and clinical value of individual services.

21. It has been suggested that the issue of cross-subsidisation between modalities and patients, has arisen as a result of rebates not reflecting actual service costs.

22. For example advice from within the sector is that Computed Tomography (CT) is over-remunerated relative to other modalities and is used to cross-subsidise less profitable services.

23. The Diagnostic Imaging Review will consider whether current fee relativities should be changed to better reflect costs and clinical value, both between and within different modalities of imaging to ensure that relativities between MBS rebates do not create incentives to provide (or not provide) particular services, as these decisions should be driven by patient needs and clinical judgement, not remuneration.

24. In establishing the appropriateness of current fee relativities the following information is sought.

Common core requirements and costs to maintain high quality services

25. What are the common minimum requirements and associated costs to provide high quality diagnostic imaging services, in terms of workforce, capital infrastructure, accreditation requirements, consumables, information technology etc and how does this differ within and between diagnostic imaging modalities:

- What resources are common to all imaging modalities?
- What resource needs are significantly different between different modalities?
- What are the elements that contribute to the cost of providing each service?
- Do services claimed against a particular MBS item generally involve similar costs, or are there circumstances where the costs would vary?
- Are there particular medical specialists who need or expect a different approach to diagnostic imaging services for their patients?
- Have technological advances affected the costs of providing services? If so how?

- How many reports can a single FTE radiologist provide for each modality per day?
 - How much time does a radiologist spend on average reporting and providing clinical guidance under each modality?
- What is the role of radiographers/sonographers in the provision of services within the different modalities?
 - Are there services wholly provided by radiographers/sonographers?
- How many services can be provided in a day for different imaging modalities?
 - Is this affected significantly by the age of the machine, the practice IT system, the experience of the radiography/sonographer, other factors?
 - Is this different depending on the kind of patients or the practitioner who requested the imaging?
- Are there any aspects of current MBS items or rules that could be improved to better accommodate the specific nature of these services?
- To what extent are there economies of scale for different modalities of imaging?
- Are there factors that are outside the diagnostic imaging provider's control that affect the cost of providing different diagnostic imaging services?

26. What differences are there in how services are provided, and the costs involved, in rural, regional and outer-metropolitan areas?

- What is the impact of geographical location on the costs associated with providing diagnostic imaging services in rural, regional and outer-metropolitan areas?
- Does geographical location impact on the ability to operate certain diagnostic imaging equipment at an 'efficient volume' as a result of population and requesting doctor constraints?
- Are requesting doctors influenced by the availability of equipment?

27. What differences are there in how services are provided, and the costs involved, between comprehensive diagnostic imaging practices and other practices that provide limited diagnostic imaging?

- Does operating a comprehensive practice affect cross-subsidisation between profitable and non-profitable modalities in order for all modalities to remain viable?
- Are there significant efficiencies gained in operating a comprehensive practice e.g. in staffing, IT requirements and facility costs, as opposed to smaller practices?
- How do comprehensive practices impact on patient access to quality diagnostic imaging services and the cost of services for patients?

Do the current MBS fees adequately reflect the costs of providing different kinds of diagnostic imaging services?

28. Where there are identified differences in service requirements and costs between and within modalities are current fee relativities reflecting this?

- Are current relativities in fees between different services appropriate?
- If you consider some current fee relativities are not appropriate:
 - What are the consequences of this?
 - What evidence is there to support a change to relativities?

- How could fee relativities be adjusted to better reflect changes in costs over time?
 - How have the costs of each element changed over the past 5-10 years?
 - How are these costs likely to change in the future?
- What factors should be considered in deciding on appropriate MBS fees for diagnostic imaging services?
 - What evidence is available about how different diagnostic imaging services contribute to better health outcomes?
 - Are there diagnostic imaging services that have limited usefulness in informing a clinical decision for the requesting doctor?
- Are there aspects of current funding arrangements that lead to distorted incentives, unintended consequences or poor outcomes for patients? E.g. recently there has been significant media coverage about the apparent overuse of CT in Australia and the risks associated with this.
 - Do you think that CT or any other modality is currently being overused in Australia? If so what is the main cause of this?
 - Do the current funding arrangements have an influence on the usage of certain modalities such as CT?
 - How could the current arrangements be changed to ensure more appropriate use of all modalities?
 - Is there a need to tighten restrictions on access to some modalities such as CT? If so how could this be achieved?
- Are there any areas where current arrangements unnecessarily add to costs or make poor use of the time of radiologists or other skilled staff?
- Are the current arrangements sustainable over the medium to longer term, for Government, for patients and for diagnostic imaging providers?
 - What factors are driving increased rates of diagnostic imaging servicing?
 - To what extent are these influenced by current funding arrangements?
- Do current arrangements support long-term viability of diagnostic imaging services? If not, what are the options for addressing this?
- How well do current funding arrangements support patient access to diagnostic imaging services and contribute to improved health outcomes?
- Are there any patient groups who are not well served by current arrangements? What options might improve this?

Patient access and viability in rural, regional and outer-metropolitan areas

29. What issues exist with the current arrangements that are specific to services provided in rural, regional and outer-metropolitan areas?

- How do the current arrangements impact on patient access and referrer patterns in rural, regional and outer-metropolitan areas?
- How do the current arrangements impact on the viability of diagnostic imaging practices in rural, regional and outer-metropolitan areas?

2. ALTERNATIVE/BETTER TAILORED FUNDING ARRANGEMENTS

Background:

30. The last MoU expired at the end of June 2008 and the Government decided that it will no longer use MoUs for managing diagnostic imaging expenditure. Instead, it has requested a detailed review of funding arrangements, to ensure that the Government is paying the right amount to continue to support access for patients to quality diagnostic imaging services.

31. As a result of the MoU arrangements, diagnostic imaging fees have not increased annually based on indexation like most other areas of the MBS. The impact of this and cost consequences of applying indexation-based increases to diagnostic imaging fees will be considered in the review.

32. The MBS system is long-established, well-understood, and efficiently administered. Under the MBS, the Commonwealth is a monopsony purchaser, fixing a floor price for services and assisting some patients to pay prices they might otherwise not be able to afford. The MBS pays fixed rebates to all providers who can meet minimum requirements and there is little competition on price.

33. The review will consider approaches to funding other than fee-for-service under Medicare and seek to identify any specific areas of diagnostic imaging that might be more appropriately supported through a different financing arrangement.

34. The review will need to consider general issues such as:

- What alternatives to fee-for-service under Medicare could potentially be appropriate for some kinds of diagnostic imaging?
- Are there any specific areas of diagnostic imaging that might be more appropriately supported through a different financing arrangement?
 - What would be the advantages, disadvantages and risks of adopting different financing arrangements?
- How could alternative approaches to financing be implemented, while maintaining access to high quality diagnostic imaging services?
 - What transitional arrangements would need to apply?
 - What would be the effects of having some segments of diagnostic imaging subject to fee for service and others subject to different funding arrangements?
- What effect would different funding arrangements have on patient access to quality diagnostic imaging services?
 - These could include risks related to: quality and continuity of services; integration with other health services; patient access; costs to Government; etc.
- What effect would different funding arrangements have on long-term viability of diagnostic imaging services in rural, regional and outer-metropolitan areas?

Options for Discussion

35. There may be a number of alternative options that could be considered for the funding of diagnostic imaging services. The options suggested in this paper are to stimulate discussion and to encourage stakeholders to propose additional options for the future.

Funding for Capital Equipment

36. In general, the MBS includes any relevant capital costs in the rebate for each item, although over time the relative share of capital and other costs has become quite opaque. In any area with significant capital costs, this can create distortions. MBS items are not adjusted to reflect whether capital investment has recently occurred or whether equipment is fully depreciated. As a result, the cost of capital may be over-compensated, if fully depreciated equipment remains in service generating the same level of income. Conversely, if over time equipment prices fall or new technology enables services to be provided more efficiently, then newer equipment may be over-compensated by fixed MBS rebates.

37. The review will consider the following questions in relation to capital equipment:

- How significant is capital expenditure for different diagnostic imaging modalities?
- What alternative means could the Government use to assist the funding of capital equipment?
- If capital equipment were funded through different mechanisms, what implications would this have for current funding arrangements?
- Would this encourage upgrade/access to more equipment in rural, regional and outer-metropolitan areas?

Tendering

38. Tendering would involve setting out the expected number, kind and quality standards for particular categories of services and inviting competitive bids from providers.

39. There are a number of approaches that could be considered:

1. Single supplier arrangements;
2. Specialised supplier arrangements;
3. Multiple supplier arrangements.

Single supplier arrangements

40. The successful bidder would generally have a monopoly over the supply of the specified services for a fixed period.

Specialised supplier arrangements

41. Another approach would be to tender for more specialised, complex services which may provide an opportunity for smaller niche providers to be competitive in the market place.

Multiple supplier arrangements

42. To avoid a monopoly arrangement, open tendering could be undertaken whereby any tenderer who met mandatory criteria, including pricing criteria, could be a successful tenderer. Alternatively, the two or three tenderers with the lowest bids could be awarded the tender, either at the price bid, or at a price set by reference to the other successful tenders (for example, the tender could be awarded to the two lowest bidders, at the price proposed by the

second lowest bid). Pricing criteria would consider competitive neutrality in order to level the playing field between public/private providers, as well as large corporations and independent radiologists.

43. The review will consider:

- Which segments of diagnostic imaging services (if any) may be feasible to tender?
- What would be the advantages, disadvantages and risks of tendering different segments?
- How would the transition to new arrangements be handled?

Episodic or bundled payments

44. One of the recommendations of the Final Report of The National Health and Hospitals Reform Commission “*A Healthier Future for All Australians*” is the development of episodic payments for primary care. Essentially this would bundle together the cost of packages of primary health care for enrolled individuals over a course of care or period of time. This would not be appropriate for all classes of patients but diagnostic imaging may be a medical discipline included within the defined episode of care.

45. The review will consider:

- What types of episodes of care involving diagnostic imaging might suit this model?

Splitting Fees for Image Capture and Storage

46. Currently MBS rules state that a benefit is payable for the preparation of the radiologist’s report, rather than the image capture (except for self-referred services). Splitting fees for image capture and storage, from fees for interpreting and reporting on an image may allow incentives to be introduced for making more extensive use of digital options for image capture, storage and viewing and potentially reduce the need for all images to be viewed by a radiologist, where the requesting practitioner is capable of interpreting the image themselves.

47. The review will consider:

- Is it feasible to separate fees on this basis?
- What modalities of diagnostic imaging could this model be applied to?
- How would this model impact on the roles of radiologists, radiographers and sonographers?
- How could fees be appropriately split? What percentage of fees should be attributed to image capture versus reporting?

Component Payment

48. Similar to the MBS relative value guide (RVG) arrangements for anaesthetists, a component payment model could be considered for diagnostic imaging. Under anaesthesia arrangements, relative payments are made for components of:

- Initiation of management of anaesthesia (fee according to service and category of service);
- Time taken (unit-based element); and
- Modifying units based on complication factors (physical status, emergency, age etc.).

49. Similarly, under diagnostic imaging arrangements, relative payments could be made for components such as:

- Complexity of service and reporting (higher payment for time consuming complex imaging procedures to lower payment for quicker less complex services);
- Capital/equipment; and
- Professional intervention (which could include training and supervision).

Performance-Based Payments

50. In addition to fee-for-service payments, it may be possible for diagnostic imaging services to attract performance-based incentive payments. Elements of diagnostic imaging services such as the timeliness of images and reports returned to the requester may be used for this type of incentive model. Issues that would need further consideration would include:

- How would 'appropriate' turn-around times for diagnostic images and reports be determined for each modality?
- What other elements of diagnostic imaging could be improved with incentive payments?
- How would benchmarks be established?
- How would payments be made and how frequently?
- How would data be collected to measure performance?
- Should clinical indicators be established?
- Would the administrative burden of managing this type of arrangement outweigh benefits?

Efficient use of workforce

51. The range of tasks involved in delivering quality diagnostic imaging services is hugely varied. From the time a request is received through to when a report is written there are a number of areas where the experience and expertise of a radiologist, radiographer, sonographer or other support staff is utilised.

52. Establishing the best use of clinical expertise across all staff directly involved in the provision of diagnostic imaging services, and then using this as a basis for ensuring staff are working in the most efficient and effective way may provide another avenue upon which fees could be based.

53. The review will consider:

- What are the key roles of radiologists? Would any of these roles be more appropriately performed by other staff such as radiographers? Have any of these roles become obsolete?
- What are the key roles currently being performed by radiographers/sonographers?
- What are the remaining roles performed by other support staff?
- Are there additional tasks that could be performed to improve quality and patient outcomes that are not being performed currently because of role distribution?
- How could fee arrangements be altered to encourage appropriate and efficient use of all staff?

54. There has been some suggestion that currently radiologists may be performing roles that do not make best use of their training and expertise and that in turn radiographers may be underutilised.

- Are there examples of where legislative restrictions place additional unnecessary requirements on radiologists?

Greater Radiologists Involvement in the Diagnosis Process

55. If some of a radiologist's time was freed up because of improved role distribution an additional form of payment could also be considered to encourage greater involvement by radiologists in the clinical diagnosis of patients. A fee could be included on the MBS to allow the radiologist to be consulted by the referring doctor on the most appropriate imaging for a particular condition. Alternatively, a request from a medical practitioner could simply ask for the most appropriate imaging for a suspected illness/disease, leaving the radiologist to determine what the appropriate imaging would be. This may allow the expertise of radiologists to be better utilised, and the correct imaging to be undertaken with potentially better outcomes for the patient. It may also result in more appropriate and potentially safer imaging being undertaken. Rules and restrictions on imaging would need to be in place to ensure over-servicing would not occur.

56. The review will consider:

- Is it feasible to involve radiologists more in the clinical diagnosis process? What are the costs or other implications of doing so?
- What impact would this approach have on requesting medical practitioners and would it meet their needs in terms of patient care?

3. MAGNETIC RESONANCE IMAGING FUNDING ARRANGEMENTS

Background:

57. As well as considering MRI under Sections One and Two above, the review will look specifically at arrangements for funding MRI, particularly restrictions around Medicare eligible/ineligible units, given the impact of the current arrangements on competition, regulatory burden and patient access. MRI services are required to be provided on 'eligible equipment' as defined in the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2009*, and as a result, some MRI units are Medicare-eligible, while others are Medicare-ineligible. The review will consider the effects of these funding arrangements for MRI and how they could be improved.

Effect of Current Arrangements

58. What are the effects of current arrangements on competition between providers, on regulatory burden for businesses and on patient access to MRI services?

- Does operating a Medicare-eligible MRI unit as part of a diagnostic imaging practice impact on:
 - The number of services performed using other diagnostic imaging modalities i.e. total patient throughput?
 - The number of repeat requestors using the practice for other diagnostic imaging services?
 - The attraction and retention of qualified staff including radiologists and radiographers?
 - Ability to compete in locations serviced by one or more other diagnostic imaging providers.
- What, if any, additional regulatory burden is placed on a diagnostic imaging practice operating a Medicare-eligible MRI unit?
 - Is there a cost associated with meeting this additional regulatory burden?
- Do the current arrangements provide for equitable and appropriate access for patients to MRI?
 - What are the current average waiting times for access to Medicare-eligible MRI services in metropolitan, outer-metropolitan and rural and regional areas?
 - Are there patient groups that currently do not have sufficient access to Medicare-eligible MRI services? Why?
 - Are there patients who are currently overserved? Why?
 - What role do Medicare-ineligible MRI units play in the supply of MRI services to patients?
- How do the current arrangements impact on the viability of diagnostic imaging practices operating MRI services, both Medicare-eligible and Medicare-ineligible, in rural, regional and outer-metropolitan areas?
 - Do they affect the viability of other imaging modalities?

Impact of Technology

59. How is MRI technology evolving and what are the implications of this for funding arrangements?

Effect of Current Arrangements on Other Diagnostic Imaging Modalities

60. How does the availability of Medicare-eligible MRI services affect the need for other diagnostic imaging services?

- In what instances can MRI replace the need for the use of other diagnostic imaging modalities?
- How often do patients accessing MRI also require additional access to other diagnostic imaging modalities?
- Is MRI most efficient and effective when operated as part of a comprehensive diagnostic imaging practice? Why? Why not?

Option for Future Funding of MRI

61. What are the options for improving funding arrangements for MRI? The options suggested in this paper are to stimulate discussion and to encourage stakeholders to propose additional options for the future.

Open Access

62. Under open access, Medicare benefits would become available to scans performed on any MRI unit that operates in line with standard MRI requirements outlined in legislation. These requirements would be the same for all MRI units, unlike the current situation where Medicare-eligible units operate under a series of different arrangements. The number of MRI units able to attract Medicare benefits would not be restricted, and MRI arrangements under Medicare would therefore be more like the arrangements for other diagnostic imaging modalities.

- What would be the effect on the viability of existing Medicare-eligible and Medicare-ineligible MRI units under open access?
- What would be the effect on competition?
- What effect would open access have on patient access to MRI services, particularly in rural, regional and outer-metropolitan areas?
- How could the transition to an open access arrangement be handled?

Alignment of current Medicare-eligibility arrangements

63. Currently Medicare-eligible MRI units operate under a series of different arrangements; some outlined explicitly in legislation others in individual agreements between the Government and providers. This has resulted in MRI units having to meet different core requirements in order to access Medicare benefits for services provided, e.g. patient charges, hours of operation. Bringing all current Medicare-eligible MRI units under the same set of core requirements and specifying these in legislation would provide a consistent and transparent system for all Medicare-eligible units to operate within.

- What are some of the key requirements that all Medicare-eligible MRI units should have to meet?

- What effect would aligning Medicare-eligibility arrangements have on patient access to MRI services, particularly in rural, regional and outer-metropolitan areas?
- What effect would aligning Medicare-eligibility arrangements have on affordability of MRI services, particularly in rural, regional and outer-metropolitan areas?

Possible Implications of Changing Current Arrangements

64. What are the risks of changing the current arrangements?
- What would be the advantages, disadvantages and risks of changing the current arrangements?
 - How would any changes to the current arrangement affect the viability of existing Medicare-eligible services particularly in rural, regional and non-metropolitan areas?
 - How would any changes to the current arrangement affect the affordability of existing Medicare-eligible services particularly in rural, regional and non-metropolitan areas?
 - How would any changes to the current arrangement affect the affordability and viability of other diagnostic imaging modalities?
65. How could different funding arrangements be implemented, while maintaining access to high quality MRI services?
- What implementation process would be required to maintain high quality services now and in the future?
 - What quality assurance mechanisms could be put in place to ensure that quality is not jeopardised in the transition into any new funding arrangements?

Issues Surrounding Current Requesting Arrangements

66. Currently Medicare-eligible MRI scans can only be requested by specialists or consultant physicians, whilst GPs can still request an MRI scan it will not attract a Medicare-benefit.
67. What is the impact of the current requesting arrangements for Medicare-eligible MRI?
- What is the impact of the current arrangements on the volume of MRI services and how does this affect the cost/efficiency of providing an MRI service?
 - Is this impact different in rural, regional and outer-metropolitan areas?
68. What would be the impact of the introduction of GP requesting for Medicare-eligible MRI?
- If the Government considered GP requesting of Medicare-eligible MRI what services should be allowed to be requested by GPs? What evidence exists to support this?
 - If requesting rights for Medicare-eligible MRI were extended to GPs, would the services generated replace other diagnostic imaging services, e.g. CT items?
 - Would additional clinical support be required for GPs to ensure appropriate referral? If so what form could this take?

4. POSITRON EMISSION TOMOGRAPHY FUNDING ARRANGEMENTS

69. As well as considering PET under Sections one and two above, the review will look specifically at arrangements for the funding of PET services, including the level of capital funding, and the impact of the current arrangements on the provision of PET services. Medicare funded PET services have all been recommended for public funding through an assessment by the Medical Services Advisory Committee (MSAC). MSAC advises the Minister for Health and Ageing on the strength of evidence pertaining to new and emerging medical technologies and procedures in relation to their safety, effectiveness and cost effectiveness, and under what circumstances public funding should be supported for these services.

70. The issue of capital funding is particularly relevant for PET services where, unlike other diagnostic imaging modalities, MBS rebates do not currently contain a capital component. As all PET items will soon be contained within the *Health Insurance (Diagnostic Imaging Services Table) Regulations 2009*, (making them consistent with other diagnostic imaging modalities), it is important to consider whether, and how, a capital component should be calculated.

Effect of Current Arrangements

71. What are the effects of current arrangements on competition between providers, service provision and on patient access to PET services?

- Does the operation of PET equipment by credentialed specialists provided at a comprehensive facility impact on:
 - The number of services performed using other diagnostic imaging modalities i.e. total patient throughput?
 - The number of repeat requestors using the practice for other diagnostic imaging services?
 - The attraction and retention of qualified staff?
 - Ability to compete in locations serviced by one or more other diagnostic imaging providers.
- What, if any additional regulatory burden is placed on a diagnostic imaging practice providing PET services?
 - Is there a cost associated with meeting any additional regulatory burden?
- Do the current arrangements provide for equitable and appropriate access for patients to PET?
 - What are the current average waiting times for access to Medicare-eligible PET services in metropolitan, outer-metropolitan and rural and regional areas?
 - Are there patient groups that currently do not have sufficient access to PET services? Why?
 - Are there patients who are currently over-serviced? Why?
- How do the current arrangements impact on the viability of diagnostic imaging practices operating PET services in rural, regional and outer-metropolitan areas?

- Do they affect the viability of other imaging modalities?

Impact of Technology

72. How is PET technology evolving and what are the implications of this for funding arrangements?

Capital Funding for PET Services

73. What capital arrangements should apply for PET?

Possible Implications of Changing Current Arrangements

74. What are the risks of changing the current arrangements?

- What would be the advantages, disadvantages and risks of changing the current arrangements?
- How would any changes to the current arrangement affect the viability of existing Medicare-eligible services particularly in rural, regional and non-metropolitan areas?
- How would any changes to the current arrangement affect the affordability of existing Medicare-eligible services particularly in rural, regional and non-metropolitan areas?
- How would any changes to the current arrangement affect the affordability and viability of other diagnostic imaging modalities?

The Department welcomes comment on any of the suggestions included in this paper. In addition, stakeholders are encouraged to provide additional information or options for consideration.

**Medical Benefits Reviews Task Group
Department of Health and Ageing
January 2010**