The Royal Australian and New Zealand College of Radiologists®

Submission to the Senate Inquiry into out-of-pocket costs in Australian healthcare

Introduction

The Royal Australian and New Zealand College of Radiologists (RANZCR) is the peak body advancing patient care and quality standards in the clinical radiology and radiation oncology sectors.

RANZCR represents over 3,500 members in Australia and New Zealand.

We are working to drive the appropriate, proper and safe use of radiological and radiation oncological medical services. This includes supporting the training, assessment and accreditation of trainees, the maintenance of quality and standards in both specialties, and workforce mapping to ensure we have the staff to support the sectors in the future.

Clinical radiology relates to the diagnosis or treatment of a patient through the use of medical imaging. Diagnostic imaging (DI) uses plain X-ray radiology, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound and nuclear medicine imaging techniques to obtain images that are interpreted to aid in the diagnosis of illness and injury. Interventional radiologists treat as well as diagnose disease using imaging equipment.

Radiation oncology (RO) is a medical specialty that involves the controlled use of radiation to treat cancer either for cure, or to reduce pain and other symptoms caused by cancer. Radiation treatment remains a powerful weapon against cancer in its many manifestations, resulting in increased cancer cures and lessening the suffering for patients and their families.

At all times, RANZCR seeks to promote the best standards of practice for patient care and ensure that all Australians have access to quality care in the radiology and radiation oncology sectors.

Clinical leadership from the College President, A/Prof Chris Milross, and the Dean of the Faculty of the Clinical Radiology, Dr Greg Slater, has been important in the preparation of this submission.

In preparing this submission, RANZCR has relied on Medicare statistics, some of which are unpublished data provided to RANZCR by the Department of Health.

Context of diagnostic imaging

Diagnostic imaging is a critical component of the health care system. It is the best practical way to diagnose, monitor treatment and detect progression or relapse of many important and common diseases in a minimally invasive and anatomically precise manner.

Any consideration of trends in out-of-pocket costs for DI needs to have regard for the impacts of a range of policy and regulatory distortions related to the funding of these services. These include:

- Capped MBS funding agreements for DI services from 1998-2008;
- Shared funding arrangements between the Federal and State/Territory Governments;
- Cost shifting to the Medicare by state/territory governments which, in combination with the capped funding arrangements, resulted in a freeze on MBS rebates for DI services that has been continuous since 1998;
- Under current Medicare Benefits Schedule (MBS) arrangements, DI is predominantly an arm's length referred service with radiologists having little role in the clinical decision making process as to which imaging is required. The arrangements do however allow non-radiologist specialists who perform imaging in their offices, especially ultrasound, to self-determine the need for imaging services on equipment they have a financial interest in;
- MBS funding and licensing arrangements for MRI have created a range of inequities for both DI providers and patients. MRI rebates were arbitrarily reduced in 2004 by 15% to fund a further expansion of MRI licensing. Different operating arrangements were applied across providers as new licenses were issued: some were required to bulk bill patients; some had agreements to charge some patients a small patient contribution; and others had no billing restrictions;
- Introduction of a 95% bulk-billing incentive for DI services in November 2009;
- A phased extension of capital sensitivity arrangements from 1 July 2011 whereby, with a few exemptions, DI rebates are reduced by 50% for services provided on equipment deemed to be beyond its effective life, or in the case of upgraded equipment deemed to be beyond its maximum extended life;
- Standardising of the billing arrangements for the licensed MRI units and an increase in the bulk billing incentive from 95% to 100% for MRI from 1 May 2012; and

- Further, expansion of MRI licensing arrangements and extension of patient access through GP referral for certain clinical indications for children under 16 from November 2011 and for adults from November 2012- before this, patient access to MBS funded MRI was by specialist referral.

The DI sector has some unique practice input costs including high capital and fit-out costs and the involvement of a range of health professionals including radiologists, radiographers and sonographers in the provision of services. Further, rebates are the same regardless of the input costs that might apply across different practice settings, e.g. comprehensive practices, office based, or public sector.

Despite the distortions caused by the DI funding arrangements over a long period, substantial productivity and efficiency gains have been delivered to the government by the private sector enabling out-of-pocket costs for DI services to be largely contained.

Imaging providers have invested in the most sophisticated data management systems in the country, largely driven by the need to manage increasing workloads. At the same time advances in imaging technologies and algorithms of practice are creating further cost pressures. It has not been recognised by governments that the platforms and connectivity installed by DI practices are already sustaining the system at a lower cost, higher cost effectiveness and greater efficiency.

RANZCR acknowledges the Government aims to ensure that the total future health care spending is sustainable and that in the context of the ageing Australian population it will be necessary for the Government to manage the increasing demand for DI services as part of the overall effort to contain health spending within affordable limits. On the other hand, the DI sector needs a stable and predictable fiscal environment to maintain investment and deliver high quality imaging services.

RANZCR is concerned that policy for the future funding and delivery of quality DI services needs to be determined not primarily by an imperative to cut spending, but strategically and recognising DI's increasing role in modern medical management.

It is RANZCR's view that one of the major challenges in addressing imaging growth is to ensure that imaging is appropriate and clinically accountable. It is generally acknowledged that a proportion of imaging referrals are clinically inappropriate or unnecessary and RANZCR has

been calling for some time for reform of the diagnostic imaging sector including a greater, more recognised and more collaborative role for radiologists in clinical decision making and patient management.

A detailed Government Review of Funding for Diagnostic Imaging (DI Review) was carried out in 2010, aimed at ensuring the Government was paying the right amount to support access for patients to quality DI services.

In response to the DI Review, the Government outlined a DI Reform Package in the 2011 Budget to be implemented over a five year period, aimed at improving the quality and value of DI services. The key elements of the reform package included:

- Addressing fee relativities and incentives;
- Ensuring appropriate requesting of DI;
- Enhancing the role of radiologists in appropriate imaging;
- Enhancing the DI Accreditation scheme;
- Expanding patient access to MRI; and
- Increasing access to MRI for primary care patients.

RANZCR has been working with the Department of Health and other stakeholders since that time to progress the implementation of a quality framework to underpin sustainable, quality medical imaging.

The quality framework proposes an onsite radiologist in a multi-modality service that includes at least X-ray, ultrasound and CT with the objective of enabling more direct clinical oversight of imaging services, particularly in relation to the appropriateness of an imaging request and the care of the patient. The proposal also aims to facilitate improved communication between referring practitioners and radiologists to ensure optimum patient care and health outcomes.

The 2014 Budget measures, as they affect DI services in particular, are a blunt instrument aimed at reducing outlays for these services. They may actually lead to unintended consequences downstream in terms of their potential to deter patients from having clinically indicated diagnostic procedures and to put downward pressure on the quality of service delivery. As diagnostic imaging provides the potential to detect disease at its most treatable, reducing expenditure at the diagnostic stage has the potential to create a greater cost burden elsewhere in the health system.

It is RANZCR's view that the budget measures serve to highlight the importance and the urgency of introducing the proposed quality framework.

Specific Response to the Inquiry Terms of Reference

a. the current and future trends in out-of-pocket expenditure by Australian health consumers;

RANZCR's comments in this section relate to the current and future trends in patient out of pocket expenditure prior to the 2014 budget measures, which have the potential to impact on the future trends in patient out-of-pocket expenditures for DI and RO services. These are discussed in the following sections.

Diagnostic Imaging

Approximately 92% of DI services in 2012/13 were provided out-of-hospital and approximately 14% were provided by the public sector.

Competitive pressures, including from public hospitals, have seen bulk billing rates for out-of-hospital DI services increase steadily over the past few years to a record high of 81% across all DI services in 2012/13 (up from 71% in 2008/09). The introduction of the Government's bulk billing incentives in 2009 did not alter the trend but have served to maintain the high level of bulk billing for DI services.

There is some variability in the bulk billing rates across the different modalities. Overall, however, for some 80% of services, patients are paying nothing for their imaging services.

Average patient out-of-pocket expenses for patient-billed services have been increasing, with the average payment (after reimbursement under the Medicare Safety Net arrangements) for out-of hospital patient-billed services around $88. It should be noted that payments under the Medicare safety net arrangements represent a small proportion (less than 1.5%) of total DI outlays, in the main due to the fact that DI procedures are usually conducted early in a patient's episode of care. The impact of the Medicare safety net reduces patient out-of pockets by an average of $8.

The focus on bulk billing rates as a measure of the appropriateness of MBS rebate levels has pushed patients towards an expectation that they do not have to pay for services and encouraged referring practitioners to see the benefit of requesting a “free” test rather than use more traditional, but more time consuming, clinical management.

At the same time, some patients are willing to pay a contribution for services they value. There are now a large number of MRI units where patients are not entitled to MBS rebates for their scans, but patients are willing to pay out-of-pocket expenses for their scans. In the case of Ultrasound, which has lower bulk billing rates than most other services, largely reflects the higher costs of providing the services (wages for sonographers are typically higher than other medical imaging technologists, and higher equipment costs for specialist ultrasound) and the historically low rebate level.

2012/13 Bulk Billing Rates – Out-of-Hospital DI Services

Modality	% Bulk Billed
Ultrasound	
General	74.1
Cardiac	67.2
Vascular	80.5
Urological	46.4
O & G	60.3
MSK	77.9
Total Ultrasound	71.2
Computed Tomography	86.7
Diagnostic Radiology	88.1
Nuclear Medicine	88.7
MRI	75.4
Total DI	81.1

Source: Unpublished Medicare data, Dept. of Health

Radiation Oncology

Less than 3% of RO services are provided in hospital. An estimated 61% of out-of-hospital RO services are provided by the public sector.

As with DI services, there is some variability in the bulk billing rates for RO services across the different types of services provided. The overall rate has been increasing slowly (from 33% in 2008 to 58% in 2012). It should be noted however that all services provided by the public sector are billed at or below the schedule fee, including bulk billed services. Bulk billing in the private sector is less than 25% and less than 50% are billed at or below the schedule fee.

In 2012 the average out-of-pocket cost per patient-billed RO service (after reimbursement under the Medicare Safety Net arrangements) was approximately $55 in the private sector and approximately $10 in the public sector. Payments under the Medicare Safety Net arrangements accounted for approximately 10% of MBS outlays for RO services in 2012, reflecting the greater utilisation of MBS services by patients undergoing treatment for cancer.

b. the impact of co-payments on:

i. consumers' ability to access health care, and

Diagnostic Imaging

Those patients who currently pay out-of-pocket costs for DI services - approximately 20% of out-of-hospital services are patient-billed - are subsidising those whose services are currently bulk billed. Under the proposed budget measures, these patients will receive $5 less from Medicare for their DI services.

The patients expected to be most impacted by the proposed budget measures in terms of access to DI services will be:

- Concession card holders and children under 16 who will be required to pay the $7 co-payment for any DI service incurred in getting to the capped maximum of 10 GP, DI and Pathology services in a calendar year; and
- Those general patients who are currently bulk billed and are not concessional patients who potentially face a co-payment for DI services that is substantially higher than the $7 announced by the Government.

RANZCR understands that some 47% of DI services in 2012/13 were provided to concession card holders, although there was some variability across the states/territories and across the different imaging services. This is consistent with RANZCR's June 2013 estimate of approximately 10.2M (or 45% of the population) concession card holders and children under 16[1].

Patient access to DI services may therefore be differentially affected by socio-economic factors and the capacity of providers in such areas to respond to the rebate reductions and removal of bulk billing incentives.

It is not clear how the package of related measures will impact patients in practice. A number of the specific details are yet to be determined, for example whether the $7 co-payment will be levied per visit or per DI item claimed if more than one item is provided or whether patients

[1] Derived from ABS population data and statistics regarding concession card holders from the FACSIA 2012-13 annual report.

who are charged out-of-pocket costs above the proposed $7 co-payment will be required to pay the full fee up front and claim the rebate from Medicare. Requiring patients to pay the full fee up-front may create a significant cost barrier to access care, ranging from $45 dollars for a simple chest x-ray to $380 for an MRI screen of the head.

It is important that patients are not deterred from having clinically indicated diagnostic procedures by the requirement to pay substantial costs up front for DI services.

Radiation Oncology

Radiation oncology patients require a number of DI services as part of their treatment program. Depending on their concessional/general patient status these patients will be impacted by the budget measures affecting DI services.

It is less likely that general patients will be deterred from having these procedures by any new requirement to pay additional out-of-pocket costs as they are more likely to benefit from the lower threshold that will apply under the proposed new safety net arrangements.

The budget measures related to the changes in the safety net and the limit of 150% of the schedule fee may affect some of the higher cost RO items, especially with the removal of the maximum gap arrangements. Stereotactic radiosurgery is one service where some patients who have previously paid out-of-pocket expenses well in excess of 150% of the schedule fee will face a significant increase in their contribution to the cost of the services. The volume of these services is currently low (330 in 2012).

ii. health outcomes and costs;

Diagnostic Imaging

The Budget proposals highlight the importance of progressing the proposed quality framework to underpin sustainable, quality medical imaging that is so important to the health outcomes of patients.

As outlined above, the proposed co-payment and related measures, have the potential to deter patients from having clinically appropriate imaging services, which will have implications for the patients' health outcomes and for healthcare costs in the long term.

A survey conducted by the ABS[2] in 2009 found that 2% of people aged 15 years or over delayed having, or did not have an imaging test in the past year because of the cost. Slightly more women than men found cost a barrier to imaging tests. This survey was conducted prior to the introduction of the bulk billing incentives in November 2009 and as such lends support to the College's concerns about cost being a barrier to access to imaging services for some patients.

The proposed budget measures also have the potential to put downward pressure on the quality of service delivery as imaging providers seek to meet the demand for services in an environment of lower rebates and a further two years without any fee indexation to offset increasing service delivery costs. This will discourage further investment in capital replacement when the sector is already facing 50% rebate reductions for services provided on equipment that has exceeded its effective life.

The proposed budget measures are also likely to put further resource pressure on practices to provide patients with details of out-of-pocket expenses and to manage the changes in billing arrangements that will result from the co-payment arrangements.

Conclusion

It is clear that there are a number of pressures impacting out-of-pocket costs for Australian healthcare consumers.

The proposed co-payment measure has the potential to significantly increase costs for diagnostic imaging services in a manner that may restrict access and quality of care. As outlined above, the proposed budget measures are a blunt instrument aimed at reducing outlays where a more sophisticated approach is required. The proposed measures may actually lead to unintended consequences downstream in terms of their potential to deter patients from having clinically indicated diagnostic procedures. As diagnostic imaging provides the potential to detect disease at its most treatable, reducing expenditure at the diagnostic stage has the potential to create a greater cost burden elsewhere in the health system.

[2] 4839.0.55.001 – Health Services: Patient Experiences in Australia, 2009. Latest Issue Released 30/7/2010.

RANZCR has been calling for some time for reform of the DI sector to maintain standards of quality and care. The quality framework proposes an onsite radiologist in a multi-modality service that includes at least X-ray, ultrasound and CT with the objective of enabling more direct clinical oversight of imaging services, particularly in relation to the appropriateness of an imaging request and the care of the patient. The proposal also aims to facilitate improved communication between referring practitioners and radiologists to ensure optimum patient care and health outcomes.

The Budget proposals highlight the importance and urgency of progressing this quality framework.

Further enquiries regarding this submission may be made to Ms Natalia Vukolova, CEO

Yours sincerely,

Natalia Vukolova
Chief Executive Officer