

**AVAILABILITY AND ACCESSIBILITY OF DIAGNOSTIC IMAGING
EQUIPMENT AROUND AUSTRALIA**
ADIA SUBMISSION



October 2017

ADIA is grateful for the opportunity to provide a submission to the Senate Community Affairs References Committee on the availability and accessibility of diagnostic imaging equipment around Australia, and would welcome the opportunity to participate in a public hearing.

About ADIA

ADIA represents radiology practices throughout Australia, both in the community and in hospitals. It promotes the ongoing development of quality accreditation standards and appropriate funding settings so that Australians can have affordable access to quality radiology services. This supports radiology’s central role in the diagnosis, treatment and management of a broad range of conditions in every branch of medicine.

Introduction and recommendations

The most important issue facing Australia’s nine million radiology patients is out of pocket costs, caused by systemic underfunding due to the ongoing freeze on Medicare rebates. The evidence is that patient costs can only be reduced through increased government funding, as shown by the fall in total patient gaps when the bulk billing incentive was introduced:

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
Gaps paid (\$m)	251.7	286.7	299.5	310.4	303.2	299.6	317.7	328.9	344.7	350.2
Growth	11.5%	13.9%	4.5%	3.6%	-2.3%	-1.2%	6.0%	3.5%	4.8%	1.6%

BBI introduced
November 2009

Out of pocket costs are steadily increasing every year to cover the rising cost of providing radiology, and now average almost \$100. These are the highest out of pocket costs among the primary care services, and cause almost 300,000 patients every year to miss out on being diagnosed.

Upfront costs, gaps and bulk billing rates for primary care services, 2015-16

	Radiology	General practice	Pathology
Average upfront cost	\$217	\$78	\$50
Average gap	\$97	\$33	\$25
Bulk billing rate	77%	84%	88%

Source: ADIA analysis of 2015-16 Medicare statistics

Radiology is a key part of primary care because it enables early diagnosis of patient conditions. Early diagnosis means that patients can be treated more effectively and less expensively – for themselves and our health system. It also reduces the burden on our public hospitals by preventing hospital admissions which occur when patients need more complex treatment.

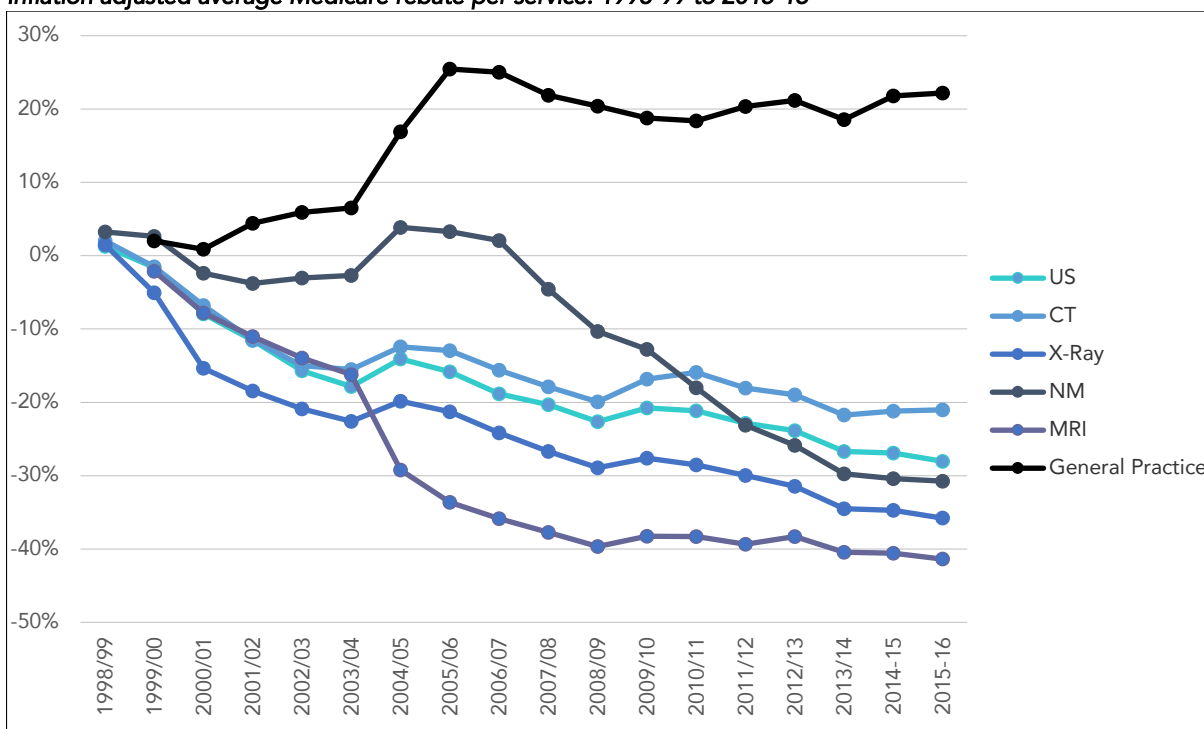
To improve access to radiology for Australians, ADIA recommends that the Government:

- deliver on the suite of 2016 election commitments to improve safe and affordable access to radiology services;
- keep its promise to make radiology more affordable by reinstating indexation of all radiology services in line with GP services on 1 July 2018;
- immediately implement the first phase of the Quality Framework, to ensure that patients are protected by quality standards and retain access to radiologist-supervised and radiologist-administered services;
- review the barriers to attracting radiologists to regional, rural and remote areas, and support rural training and workforce initiatives of the Royal Australian and New Zealand College of Radiologists to increase the number of radiologists working outside metropolitan areas. The review should include provision for employing overseas trained radiologists as a backup, so that local communities can benefit from an on-site radiologist. This includes changing the method by which the Department of Health calculates districts of workforce shortage for radiology services;
- review the process and criteria that MSAC uses to determine its recommendations to the Government for radiology services, to stop patients missing out on clinically appropriate services recommended by their doctor;
- develop clearer criteria for issuing new MRI licences and relocating existing MRI licences, and reduce complexity for patients and providers associated with 'full', 'partial' and unfunded machines.

Out of pocket costs in radiology are the highest in primary care

1. Access to primary health care is crucial to every Australian. However, radiology has become the biggest barrier to primary care – with the highest upfront costs, the highest patient gaps and the lowest bulk billing rate. This needs to be addressed in light of the Government’s commitment to guaranteeing Medicare.
2. Medicare rebates for radiology have been frozen since 1998, and in many cases have gone backwards. In that time, average rebates per radiology service have fallen by between 21 percent (CT) and 41 percent (MRI) in real terms, compared with average rebates for GP services which have increased by 22 percent over the same period.

Inflation adjusted average Medicare rebate per service: 1998-99 to 2015-16



Source: ADIA analysis of statistics provided by the Department of Health; ABS data

Getting diagnosed is becoming more expensive because rebates are frozen

3. Due to the freeze, patient gaps for radiology almost doubled in the last decade:

Patient gaps for radiology, 2005-06 to 2015-16

	2005-06	2015-16	Increase
Average patient gap	\$51.54	\$97.34	89%

Source: 2015-16 Medicare statistics

4. ADIA estimates that patient gaps will double again over the next decade, unless indexation is reinstated so that patient rebates increase in line with costs.

5. Common patient conditions often require more than one radiology service for diagnosis, treatment and monitoring, meaning that patients pay thousands of dollars upfront and are left hundreds of dollars out of pocket. Average upfront costs and gaps for some typical patient conditions are shown below:

Costs of radiology services for diagnosis and treatment

Condition	Service	Upfront cost	Patient gap
Lung cancer	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
Breast cancer	Diagnostic mammogram	\$212	\$85
	Ultrasound, breast	\$187	\$94
	Ultrasound-guided biopsy or fine needle aspiration	\$178	\$85
	Lymphoscintigraphy	\$478	\$183
	MRI, breast cancer staging and planning	\$600*	\$600*
	Total	\$1,655	\$1,047
Bowel cancer	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
Multiple sclerosis	MRI, brain and whole spine with contrast	\$639	\$220
	Total	\$639	\$220
Pancreatitis (chronic)	Ultrasound, abdomen	\$174	\$80
	CT, upper abdomen with contrast	\$489	\$183
	MRI, pancreas and biliary tree	\$526	\$183
	Total	\$1,189	\$446

Source: ADIA analysis of deidentified Medicare patient data released by the Department of Health

*Not funded by Medicare

6. With upfront and out of pocket costs so high, early diagnosis is becoming unaffordable for many Australians. ABS data shows that almost 300,000 Australians are forgoing radiology each year due to cost pressures.¹

¹ ABS (2016), *Patient Experiences in Australia 2015-16*

The Government has not delivered on its election commitment to deliver affordable access to radiology

7. The Government recognised the importance of radiology to Australian patients prior to the 2016 election, when it made a series of commitments to improve safe and affordable access to radiology services.² These commitments included ending the 19-year freeze on patient rebates for radiology when the GP freeze ends.
8. The draft final report of an independent evaluation commissioned by the Government (April 2017) and published under FOI in September 2017, supports the commitments that the Government made before the election.³ This independent evaluation should be finalised and the recommendations acted upon by the Government.
9. The independent evaluation, conducted by Deloitte Access Economics, found that patient rebates for non-bulk billed services were \$39 below cost, and \$25 below cost for bulk billed services. The sector-wide funding shortfall comes to more than \$700 million per year.
 - Deloitte recommended that indexation of Medicare rebates for radiology services – frozen since 1998 – should be “reinstated in recognition of ongoing cost increases”.
10. Current indications are that the Government does not intend to honour its commitment to reinstate indexation of radiology in line with GP services. In the 2017-18 Budget, the Government announced that the GP freeze will end on 1 July 2018, but radiology rebates will remain frozen. To honour its election commitment, the Government needs to end the radiology freeze on 1 July 2018.

Recommendation 1

The Government should keep its promise to make radiology more affordable by reinstating indexation of all radiology services in line with GP services on 1 July 2018.

The best measure of availability is access to services, rather than equipment

11. Several critical radiology services require in-person clinical input by a radiologist, such as diagnostic mammography and image-guided interventional procedures. These services are not available in practices which are not attended by a radiologist, even when the equipment is available.
12. Before the election, the Government committed to implement the first phase of the RANZCR-recommended Quality Framework, which clarifies professional supervision rules for comprehensive radiology practices which offer CT. The Quality Framework supports patient access to quality radiology by requiring that CT services are supervised by a radiologist.

Recommendation 2

The Government should immediately implement the first phase of the Quality Framework, to ensure that patients are protected by quality standards and retain access to radiologist-supervised and radiologist-administered services.

² <https://www.liberal.org.au/latest-news/2016/06/05/coalition-plan-access-affordable-diagnostic-imaging-all-australians>

³ <http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-304-1617>

Practices have difficulty attracting radiologists to regional, rural and remote areas

13. When a radiologist is not available to work on-site at a radiology practice, services are limited. Nevertheless, the model that makes a limited range of unsupervised radiology services available in regional, rural and remote areas is sound; with radiologists interpreting and reporting examinations, providing clinical input and supervising technical staff in real time via internet-based image networks. However, this is not a full substitute for a comprehensive practice with an on-site radiologist, as the range of services is limited and equipment cannot be used to its full potential without in-person input by a radiologist.
 - Patients in communities without a radiologist need to travel (sometimes for long distances) for services which require a radiologist on-site.
14. ADIA strongly supports RANZCR's rural training and workforce initiatives, which will cause more radiologists to be available to live and work in rural communities.
15. Many practice groups providing radiology services outside metropolitan areas have difficulty attracting radiologists, even when offering lucrative remuneration packages, and need to employ overseas-trained radiologists. However, there are several barriers to bringing these doctors to work in underserved communities:
 - The Department of Health's method of calculating districts of workforce shortage is misleading when it is applied to radiology services. For example, Mosman (NSW) is classified as a district of workforce shortage, while Yeppoon (Queensland) is not
 - Very onerous requirements by state health departments to designate a location as an area of need
 - Excessive credentialing requirements for registration as a specialist medical practitioner

Recommendation 3

The Government should review the barriers to attracting radiologists to regional, rural and remote areas, and support rural training and workforce initiatives of the Royal Australian and New Zealand College of Radiologists to increase the number of radiologists working outside metropolitan areas. The review should include provision for employing overseas trained radiologists as a backup, so that local communities can benefit from an on-site radiologist. This should include changing the method by which the Department of Health calculates districts of workforce shortage for radiology services.

Availability of radiology equipment is generally good across Australia

16. Previous ADIA analysis has found that most population centres of 10,000 people or more are well serviced, with access to x-ray, ultrasound and CT.

MRI

17. The Diagnostic Imaging Reform Package was announced by the previous government in the 2011-12 Budget, and included an increase in the number of Medicare-eligible MRI machines (licences). The Package ultimately increased the number of MRI licences from 125 to 349.

18. The Package also included Medicare listing of four GP-referred MRI services for adults, and six GP-referred MRI services for children.
19. When assessing the impact of the Package, it is important to distinguish between the expansion in licences and the new listings:
- The expansion in the number of licences did not significantly increase access to services, with existing MRI items on Medicare increasing from 24.1 services per 1,000 population (2010-11) to 27.2 services (2015-16) – an increase of 13%. In comparison, CT services increased from 91.2 to 115.3 services per 1,000 population, an increase of 26%.
 - The introduction of Medicare funding for a limited number of GP-referred services had the most substantial impact on MRI volumes. This resulted in an additional 15.2 MRI services per 1,000 population between 2010-11 and 2015-16.
 - While the availability of Medicare-funded MRI has increased substantially due to the expansion of MRI licences, Medicare data does not suggest that expanding the number of licences makes MRI services more affordable. Average patient gaps have increased by almost 30 per cent since the expansion was announced. This is consistent with the discussion above and the evidence that patient out of pocket costs reflect government underfunding, and can only be reversed with an injection of funding.

MRI under Medicare, 2010-11 to 2015-16

	2010-11	2015-16
Number of MRI licences ⁴	125	351*
MRI services	538,058	1,025,566
Services per MRI licence	4,304	2,922
Services per 1,000 population	24.1	42.4
Services per 1,000 population (excluding GP-referred)**	24.1	27.2
Average patient gap	\$143	\$184

Source: ADIA analysis of 2015-16 Medicare statistics

*Two new licences were issued in the 2016-17 year

**The number of CT services per 1,000 population increased from 91.2 to 115.3 with the three CT services listed during this period excluded between 2010-11 and 2015-16.

20. It is now timely to look at the next phase of policy development for MRI access under Medicare. This should include clear criteria and transparent processes for allocating new MRI licences and relocating existing licences, and consideration of how to address the confusion for patients which arises from the distinction between ‘partial’, ‘full’ and unfunded MRI machines.

Out of pocket costs for radiology services not funded by the Commonwealth are very high

21. High out of pocket costs put unfunded radiology services out of reach for most Australians. Private health insurance rarely covers these costs, because insurers only subsidise Medicare-eligible services that are provided to inpatients. In addition, public hospitals do not provide these services to outpatients – there is no safety net for patients who cannot afford private fees.

⁴ ANAO (2014), *Performance Audit Report 2014-15 No.12: Diagnostic Imaging Reforms*, page 75

Medicare has not kept pace with advances in radiology

22. The process of applying to MSAC for Medicare funding takes several years and imposes very high hurdles for a service to be listed on Medicare.

- Despite radiology being a field of rapid medical innovation, only 24 new radiology services have been listed on Medicare since 2005.

23. As a result, many 'standard of care' radiology services are not listed. These are services which are being referred for by specialists at arm's length (i.e. they have no financial incentive to refer for the service) in significant volumes. These services cost patients many hundreds (and sometimes thousands) of dollars in private fees, and include:

- mpMRI prostate diagnostic scans and MR-guided prostate biopsies
- PSMA PET/CT scan for prostate cancer
- MRI scan for evaluation and treatment planning for breast cancer
- FDG PET scan for pancreatic cancer
- CT coronary artery calcium scoring

Recommendation 4

To stop patients missing out on clinically appropriate services recommended by their doctor, the Government should review the process and criteria that MSAC uses to determine its recommendations to the Government for radiology services. The guiding principle should be that services referred for by specialists at arm's length in significant volumes (i.e. services that have become 'standard of care') should be listed on Medicare and available to all Australians.

Medicare rules also limit patient access to Medicare-funded services

24. Some Medicare rules have been specifically designed to limit patient access to Medicare rebates, and result in higher out of pocket costs for patients. For example:

- The same day rule for ultrasound. Medicare does not fund multiple ultrasound services on the same day, so where a diagnostic breast ultrasound indicates the need for an ultrasound-guided biopsy or fine needle aspiration, this is not funded if performed on the same day. This can cause considerable distress where a patient is given the choice of paying a large out of pocket cost or returning the next day.
- Biopsies and injections cannot be co-claimed with an ultrasound procedure item. This means that patients pay out of pocket costs associated with the injection or biopsy.
- X-rays of multiple spine regions referred by a chiropractor will be removed from Medicare from 1 November 2017. Patients will pay private fees for these services.

25. MRI services provided on unlicensed MRI machines (or most specialist-referred services provided on partially licensed machines) are ineligible for Medicare rebates.

There is no process or pathway for granting new MRI licences

26. Radiology practices with an unlicensed MRI unit that request a licence are currently advised by the Minister for Health that there is no application process available, and therefore no mechanism for granting new licences.
27. Should the Government choose to issue new licences, it is important that these are allocated to MRI units where local community need has been demonstrated, through a robust and transparent assessment process. The Government should also address patient confusion which arises from the system of 'full', 'partial' and unfunded machines.

Recommendation 5

Ahead of issuing new MRI licences, the Government should develop criteria to assess applications based on need; and consider how to address the confusion for patients associated with the separate 'full', 'partial' and unfunded machines.

The criteria for relocating licences are vague

28. The Department of Health has previously circulated criteria it uses to assess applications for permanent relocation of existing MRI licences. Those criteria do not appear to have been followed in decisions to relocate licences and are not robust.
29. The Department's process for assessing applications should be transparent, with affected stakeholders (including competing MRI providers in the location where the applicant seeks to move the licence) given the opportunity to comment on the proposed relocation.
 - Radiology providers make significant investments in equipment, staff and facilities to provide MRI, so relocation criteria and processes need to be transparent.

Recommendation 6

The Government should develop a robust and transparent process for assessing applications to relocate MRI licences.