

# Chapter 5

## Funding and the Medicare Benefits Schedule

5.1 The Commonwealth Government funds diagnostic imaging services through the Medicare Benefits Schedule (MBS) and the National Health Reform Agreement (NHRA).<sup>1</sup>

5.2 The MBS is a Commonwealth Government funded subsidy scheme.<sup>2</sup> Under the MBS, subsidised professional services are allocated an item number. At the point of service delivery, if the conditions of the item number are met, the patient is entitled to a rebate.

5.3 The NHRA was a health funding arrangement signed by the Commonwealth Government and all state and territory governments in 2011.<sup>3</sup> The NHRA allows public patients in public hospitals to have their diagnostic imaging provided to them free of charge.<sup>4</sup>

5.4 This chapter will consider the challenges posed by attempting to provide financial assistance to the largest number of patients with costly health conditions against maintaining a sustainable system over the medium to long term. In particular, this chapter will consider: the number of services that are currently provided and the cost of providing those services; the benefits and challenges of managing MBS indexation; items that are currently standard practice but are not on the MBS; and the operation of special diagnostic imaging provisions of the MBS.

### Volume and cost of services

5.5 According to data provided by the Department, 394.3 million services were funded under the MBS in 2016–17 at a total cost of \$22 billion.<sup>5</sup> Of this total, diagnostic imaging services accounted for 25.7 million services (seven per cent) and \$3.4 billion in benefits (16 per cent).<sup>6</sup> A visual representation of these services and their cost appears in Figures 5.1 and 5.2.

---

1 Department of Health (Department), *Submission 18*, p. 5.

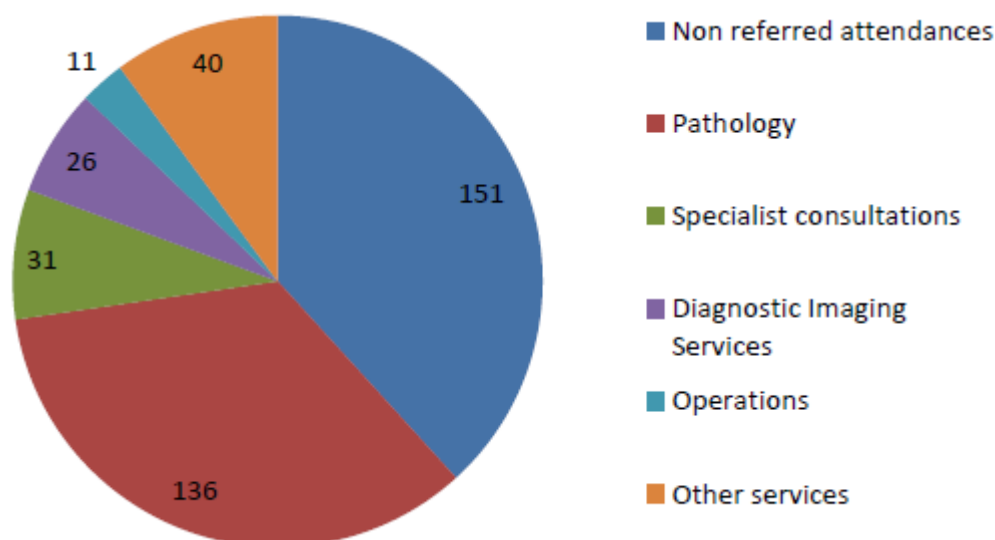
2 Department, *MBSOnline*, <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Home> (accessed 22 February 2018).

3 Administrator of the National Health Funding Pool, *National Health Reform Agreement summary*, <https://www.publichospitalfunding.gov.au/national-health-reform/agreement> (accessed 22 February 2018).

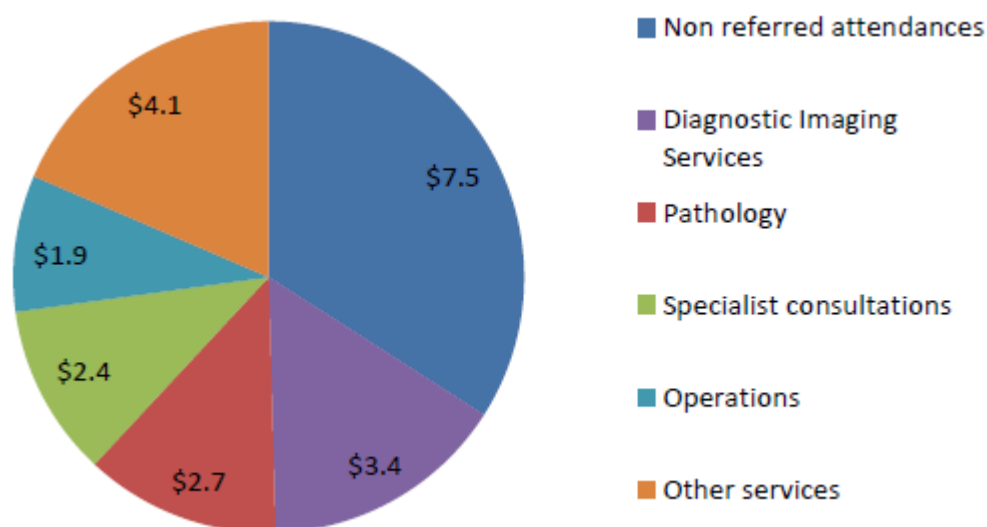
4 Administrator of the National Health Funding Pool, *National Health Reform Agreement*, [http://www.federalfinancialrelations.gov.au/content/npa/health/\\_archive/national-agreement.pdf](http://www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf) (accessed 22 February 2018).

5 Department, *Submission 18*, p. 17.

6 Department, *Submission 18*, p. 17.

**Figure 5.1: Number of MBS services by category (millions) 2016–17**

Source: Department, *Submission 18*, p. 17.

**Figure 5.2: MBS benefits by category (billions) 2016–17**

Source: Department, *Submission 18*, p. 17.

5.6 The funding for diagnostic imaging services is provided for by the *Health Insurance Act 1973* (Cth), and its associated regulations, the *Health Insurance Regulations 1975* and the *Health Insurance (Diagnostic Imaging Services Table) Regulation 2017* (DIST).<sup>7</sup> The *Health Insurance Act 1973* and the DIST provide for 'the conditions under which Medicare benefits are payable'.<sup>8</sup>

7 Each Medicare Benefits Schedule (MBS) service is allocated a schedule fee. Generally, this fee takes into account the expense incurred by a service provider to deliver a service, including capital costs of the equipment used. See, Department, *Submission 18*, p. 17.

8 Department, *Submission 18*, pp. 16–17.

### ***Re-indexation of diagnostic imaging services***

5.7 Whilst the diagnostic imaging component of the MBS is substantial, the cost to the MBS has been constrained by freezing the schedule fee for diagnostic imaging services.

5.8 Prior to 1998, decisions about MBS fee increases were made annually.<sup>9</sup> Between 1 July 1998 and 30 June 2008, diagnostic imaging expenditure was managed under Memoranda of Understanding (MoU) between the Commonwealth Government and the diagnostic imaging sector.<sup>10</sup> In April 2008, the government announced that the MoUs would be discontinued and 'MBS fees applicable at that time would apply'.<sup>11</sup>

5.9 The MBS schedule fee for diagnostic imaging services has remained the same since 2007.<sup>12</sup> Table 5.1 lists the dates of the last schedule fee increase for diagnostic imaging services.

**Table 5.1: Dates of last schedule fee increase for diagnostic imaging services**

<b>Group</b>	<b>Date of last schedule fee increase</b>
Ultrasound (except cardiac)	1 November 2004
Ultrasound—Cardiac	1 November 2007
CT	1 November 2004
Diagnostic radiology	1 November 2004
Nuclear medicine imaging	1 November 2006
MRI	1 July 2006

Source: Department, *Submission 18*, p. 21.

5.10 Professor Mark Khangure from the Australian Medical Association told the committee that the failure of MBS benefits to keep up with real costs means that practices have had to continually absorb costs or pass the costs on to patients:

Indexation for general practice items is a few years; indexation, or loss of, for imaging is virtually two decades. The total cost of equipment, of staff salaries, of running the practice itself, has gone up, with CPI [Consumer Price Index] alone well above, so there's a point in time where the practice

9 Department, *Submission 18*, p. 20.

10 Department, *Submission 18*, p. 20.

11 Department, *Submission 18*, p. 21.

12 Department, *Submission 18*, p. 19.

either folds up or it actually has to just say up-front to the patients: 'I'm sorry. You have to pay.'<sup>13</sup>

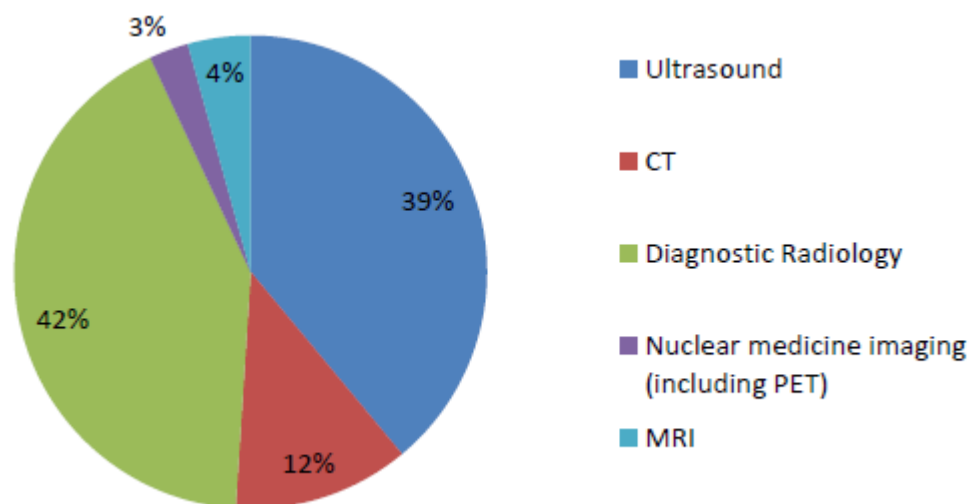
5.11 The WA Country Health Service also explained that current MBS revenue was not sufficient to cover the cost of public imaging services in rural Western Australia:

MBS rebates are a gross underrepresentation of the costs associated with providing an imaging service—particularly in regional areas, where costs are significantly higher. Almost every externally referred patient presenting for imaging in WA Country Health Service's imaging department costs the health service a sum of money, even after MBS revenue.<sup>14</sup>

5.12 In the 2017–18 Budget, the Commonwealth Government announced that some diagnostic imaging services would be re-indexed from 1 July 2020.<sup>15</sup> The Department advised the committee that this limited re-indexation would cost \$20.6 million in 2020 and would increase diagnostic imaging expenditure by \$700 million over ten years.<sup>16</sup> The committee heard from the Australian Diagnostic Imaging Association (ADIA) that the Government's 2016 election commitment to ensure that diagnostic imaging indexation resumes when the current GP rebate indexation freeze concludes is yet to be implemented.<sup>17</sup>

5.13 During 2016–17, patients claimed the following diagnostic imaging services as detailed in Figure 5.3.

**Figure 5.3—Percentage MBS services by modality 2016–17**



Source: Department, *Submission 18*, p. 5.

13 Professor Mark Khangure, Councillor, Australian Medical Association, *Committee Hansard*, 9 November 2017, pp. 3–4.

14 Mrs Marie Baxter, Executive Director of Nursing and Midwifery, WA Country Health Service, *Committee Hansard*, 9 November 2017, p. 30.

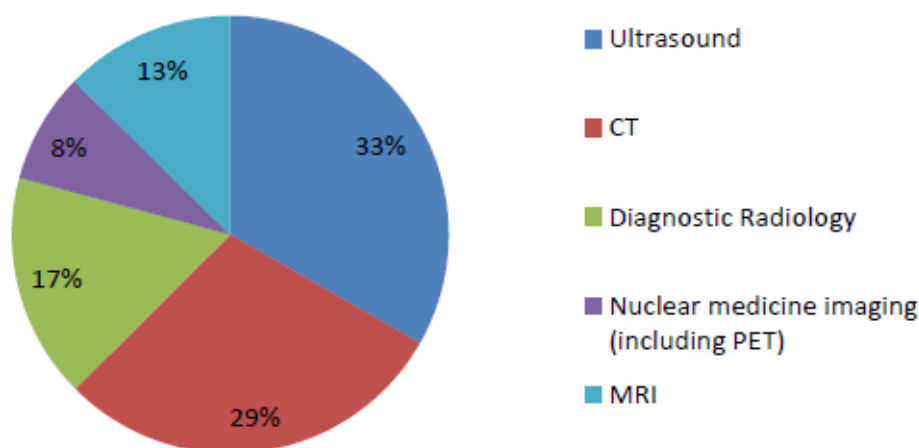
15 Commonwealth of Australia, *Budget Measures: Budget Paper No. 2 2017–18*, p. 108.

16 Department, *Submission 18*, p. 21.

17 Australian Diagnostic Imaging Association (ADIA), *Submission 17*, p. 5.

5.14 The Commonwealth Government paid over \$3.4 billion in patient rebates during the 2016–17 financial year.<sup>18</sup> Thirty-three per cent of this \$3.4 billion was provided as ultrasound rebates, followed by 29 per cent for CT, 17 per cent for diagnostic radiology, 13 per cent for MRI and eight per cent for nuclear medicine imaging.<sup>19</sup> A visual representation is included below in Figure 5.4.

**Figure 5.4—Percentage MBS benefits by modality 2016–17**



Source: Department, *Submission 18*, p. 18.

5.15 The Department has also identified that demand for diagnostic imaging services and the benefits paid (per capita) have grown in line with other MBS funded services.<sup>20</sup> Compounded annual growth has increased by three per cent for services and by five per cent for benefits paid.<sup>21</sup>

#### ***Bulk billing for diagnostic imaging services***

5.16 The rates of bulk billing for diagnostic imaging services differ depending on whether it is an out-of-hospital service or a service provided by, or on behalf of, a general practitioner (GP).<sup>22</sup> For out-of-hospital diagnostic imaging services, the general Medicare rate is 85 per cent of the MBS fee.<sup>23</sup> For GP services, the Medicare benefit is 100 per cent of the MBS fee.<sup>24</sup>

5.17 In 2016–17, 84 per cent of diagnostic services provided out of hospital were bulked billed. The Department submitted that the 'average out-of-pocket costs for out-of-hospital non bulk billed diagnostic imaging services in 2016-17 was just over \$97'<sup>25</sup> and '[o]ut-of-pocket costs have grown at an average annualised rate of four

18 Department, *Submission 18*, p. 5.

19 Department, *Submission 18*, p. 5.

20 Department, *Submission 18*, p. 18.

21 Department, *Submission 18*, p. 18.

22 Department, *Submission 18*, p. 21.

23 Department, *Submission 18*, p. 21.

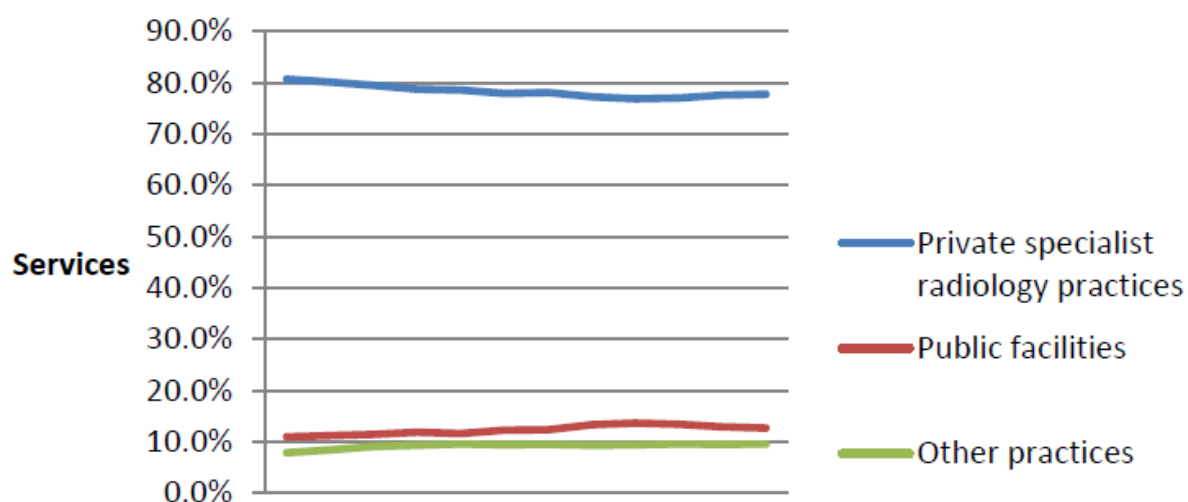
24 Department, *Submission 18*, p. 21.

25 Department, *Submission 18*, p. 7.

percent since 2004'.<sup>26</sup> The Department noted that this increase exceeded the average consumer price index increase of three per cent per annum.<sup>27</sup>

5.18 Seventy eight per cent of services claimed under the MBS in 2016–17 were provided by private specialist radiology practices, followed by public facilities (13 per cent), and other practices (10 per cent).<sup>28</sup>

**Figure 5.5—Percentage of MBS services claimed by practice type 2004–05 to 2015–16**



Source: Department, *Submission 18*, p. 34.

### ***Standard items not included on MBS***

5.19 Throughout the inquiry, submitters raised concerns that the number of diagnostic imaging tests listed on the MBS was too limited and did not include a number of tests which are now considered as standard.<sup>29</sup>

5.20 Items are only added to the MBS on the advice of the Medical Services Advisory Committee (MSAC). MSAC is an independent non-statutory committee largely made up of clinicians and academics to advise the Minister for Health about

26 Department, *Submission 18*, p. 7.

27 Department, *Submission 18*, p. 7.

28 Other practices include cardiology practices, GP clinics, vascular laboratories, obstetrics and gynaecological practices. See, Department, *Submission 18*, p. 7.

29 Cancer Voices Australia, *Submission 1*, p. 2; Prostate Cancer Foundation Australia, *Submission 15*, pp. 2–3; Rare Cancers Australia, *Submission 31*, [pp. 2–3]; Breast Cancer Network Australia (BCNA), *Submission 32*, p. 2.

the MBS.<sup>30</sup> According to the Department, MSAC assesses new technologies for comparative safety, clinical effectiveness and cost effectiveness.<sup>31</sup>

5.21 Breast Cancer Network Australia (BCNA) highlighted that, despite an MRI being required to confirm a breast cancer diagnosis, no MRI is currently available for many women.<sup>32</sup> Ms Spence from BCNA explained to the committee that a failure to rebate breast MRI caused a significant financial impost on those women:

We know they're paying anywhere from \$500 to \$1,500 out of pocket for that procedure. The fact that there's no rebate really does add to the fact that it's variable depending on where you're referred to.<sup>33</sup>

5.22 Prostate Cancer Foundation Australia expressed similar concerns for men who require multiparametric MRI or PET scanning. Associate Professor Anthony Lowe from Prostate Cancer Foundation Australia explained that multiparametric MRI is required for improved diagnostic accuracy and to prevent unnecessary prostate biopsies.<sup>34</sup> PET scanning also allows the specialist to tell if a cancer is recurring.<sup>35</sup> Associate Professor Lowe explained to the committee how PSMA PET scanning works:

The technique uses a radioactive tracer to attach to the cancer cell, and then it can be imaged in a PET CT scanner. As people say, it lights up the Christmas tree when you have cancer. You can see exactly where the cancer is. It's particularly important for men who've had primary treatment, whose PSAs reduce to an undetectable level so they feel they've been cured... After a number of years—possibly 10 years—their PSA starts to rise again, so we know that the cancer is recurring.<sup>36</sup>

5.23 However, these scans are not currently rebated on the MBS. Associate Professor Lowe explained that men who require scans to manage their prostate cancer can incur significant out-of-pocket costs:

On average, they are in the order of \$5,000 to \$10,000 for a man over the treatment period but there is currently no Medicare rebate either for

---

30 Department, *Frequently asked questions: What is MSAC?*, 20 July 2016, <http://www.msac.gov.au/internet/msac/publishing.nsf/Content/factsheet-04> (accessed 22 February 2018).

31 Department, *Submission 18*, p. 7; Department, *About MSAC*, 29 June 2016, <http://www.msac.gov.au/internet/msac/publishing.nsf/Content/about-msac> (accessed 22 February 2018).

32 Ms Danielle Spence, Director of Policy and Advocacy, BCNA, *Committee Hansard*, 13 December 2017, p. 18.

33 Ms Spence, *Committee Hansard*, 13 December 2018, p. 18.

34 Associate Professor Anthony Lowe, Chief Executive Officer, Prostate Cancer Foundation Australia, *Committee Hansard*, 13 December 2017, p. 18. See also Ms Emma Hornsey, *Submission 41*, [p. 1].

35 A/Prof Lowe, *Committee Hansard*, 13 December 2017, p. 19.

36 A/Prof Lowe, *Committee Hansard*, 13 December 2017, p. 19.

multiparametric MRI or for the PET scanning so men are out of pocket in the order of \$500 to \$600 per scan.<sup>37</sup>

5.24 Associate Professor Lowe and Ms Spence agreed that the cost of essential diagnostic imaging services not included on the MBS places additional financial stress on patients already suffering from a cancer diagnosis.<sup>38</sup> An individual told Rare Cancers Australia that 'it is embarrassing and stressful when you can't afford these things which your specialist teams need in order to help you.'<sup>39</sup>

5.25 As noted in chapter two, the limited assistance patient transport schemes provide is often not available if the procedure they are being transported for does not have an MBS item number attached to it.<sup>40</sup> Depending upon the person, whether the item is rebated or not may be the difference between the patient being able to have the scan or not.

5.26 Associate Professor Lowe told the committee that patients are often confused about why these essential tests do not attract an MBS rebate:

And that probably is the biggest inquiry we receive from men in our national office. They ask: why is it not rebated? Why do I have to pay this when my clinician is telling me it is essential for me to have this scan in order for them to be able to manage the situation?<sup>41</sup>

#### *Adding new items to the MBS*

5.27 The committee heard from the Urological Society of Australia and New Zealand (Urological Society) and BCNA that they have tried to have these scans added to the MBS.<sup>42</sup>

5.28 As noted above, new items are only added to the MBS on the advice of MSAC. Dr Peter Heathcote, President of the Urological Society told the committee that it had been seeking a rebate for multiparametric MRI for prostate cancer diagnosis and management for the past three and a half years and would soon be pursuing an application for the PSMA PET scanning.<sup>43</sup>

5.29 Similarly, BCNA told the committee that it had pursued a number of applications for breast MRI and genomic testing.<sup>44</sup> The genomic test, Oncotype DX, could have been prescribed to help an oncologist ascertain whether chemotherapy will

---

37 A/Prof Lowe, *Committee Hansard*, 13 December 2017, p. 19.

38 A/Prof Lowe, *Committee Hansard*, 13 December 2017, p. 20; Ms Spence, *Committee Hansard*, 13 December 2018, p. 18.

39 Rare Cancers Australia, *Submission 31*, [p. 3].

40 Rare Cancers Australia, *Submission 31*, [p. 2].

41 A/Prof Lowe, *Committee Hansard*, 13 December 2017, p. 19.

42 Dr Peter Heathcote, President, Urological Society of Australia and New Zealand, *Committee Hansard*, 13 December 2017, p. 20.

43 Dr Heathcote, *Committee Hansard*, 13 December 2017, p. 20.

44 Ms Spence, *Committee Hansard*, 13 December 2017, pp. 20–21.



help the patient. However, BCNA advised the committee that the application was unsuccessful:

...the MSAC decision, unfortunately, didn't approve Oncotype DX, even though it's standard care in most developed countries around the world. So, for women, if they want to access a genomic test it's \$4,500.<sup>45</sup>

5.30 BCNA explained that it had taken MSAC so long to process the application that the MSAC preferred (and cheaper) solution was no longer available:

Interestingly, the online tool that was cited... It's not available at the moment because everywhere around the world people are using Oncotype DX. So the test that MSAC referred to, where people can use this online algorithm, is not being used by oncologists at the moment because it's not available.<sup>46</sup>

5.31 Other submitters agreed that the application process and approval of new items on the MBS by MSAC was too slow.<sup>47</sup>

5.32 The Royal Australian and New Zealand College of Radiologists (RANZCR) told the committee that there were a number of useful scans that were still making their way through the MSAC process:

...there are several areas of the body for which imaging under MRI are very useful. They're not listed yet on the MBS and have been chugging very slowly through the MSAC process. Examples of that are cardiac MRI, liver MRI, breast MRI and prostate MRI...<sup>48</sup>

5.33 Submitters were sometimes unsure about why the approval had taken so long or why their application was refused.<sup>49</sup> Submitters highlighted that clinical best practice was evolving much faster than MSAC was able to consider the applications brought to it.<sup>50</sup> Ms Spence told the committee that MSAC's process need to be compressed:

I think we need to find a way to keep MSAC up to date with innovation because, by the time these rulings come out, often we've moved on to something that's standard practice overseas and that we're just now making the call on, and things have happened in between. As a consumer based organisation, we don't know whether that new evidence is part of the decision-making or whether it's just on the dossier that was presented in the

---

45 Ms Spence, *Committee Hansard*, 13 December 2017, pp. 20–21.

46 Ms Spence, *Committee Hansard*, 13 December 2017, p. 21.

47 Cancer Voices Australia, *Submission 1*, p. 2.

48 Mr Mark Nevin, Senior Executive Officer, Faculty of Clinical Radiology, Royal Australian and New Zealand College of Radiologists (RANZCR), *Committee Hansard*, 13 December 2017, p. 5.

49 Ms Spence, *Committee Hansard*, 13 December 2017, p. 21; Dr Heathcote, *Committee Hansard*, 13 December 2017, p. 21.

50 A/Prof Lowe, *Committee Hansard*, 13 December 2017, pp. 21–22; Ms Spence, *Committee Hansard*, 13 December 2017, p. 22.

beginning of that process, so it's hard to have that transparency around what influenced that decision. Was it just what was put forward three years ago, or is it taking into account the new evidence that's available?<sup>51</sup>

5.34 The Department told the committee that MSAC would next consider the applications for multiparametric MRI for prostate cancer, breast MRI, obstetric MRI and other diagnostic imaging applications at upcoming meetings in March and July 2018.<sup>52</sup>

#### *Reviewing items currently on the MBS*

5.35 In order to align clinical practice with the MBS, the MBS Review Taskforce is currently conducting a review of all 5700 items on the MBS.<sup>53</sup>

5.36 Since its establishment in 2015, the MBS Review Taskforce has provided the Minister for Health with a report on obsolete MBS items and two subsequent tranches of recommendations relating to diagnostic imaging: one into lower back pain and one into bone densitometry.<sup>54</sup>

5.37 The obsolete items report identified five MBS items for removal on the basis that their use did not accord with clinical best practice; recommended limiting the use of one item to a smaller clinical population and recommended further consideration of a seventh item.<sup>55</sup> Subsequent reports made four recommendations in relation to imaging for lower back pain and five recommendations in relation to unnecessary testing of bone densitometry.<sup>56</sup>

5.38 The MBS Review Taskforce will continue its work into 2018 with a view to examining co-claiming and capital sensitivity.<sup>57</sup>

---

51 Ms Spence, *Committee Hansard*, 13 December 2017, p. 22.

52 Department, *Submission 18*, p. 25.

53 Department, *Submission 18*, p. 23.

54 Department, *About the Medicare Benefits Schedule Review*, 14 February 2018, <http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSR-about> (accessed 22 February 2018).

55 Medicare Benefits Schedule Review Taskforce, *Obsolete MBS Items Report 2016*, pp. 1–3, [http://www.health.gov.au/internet/main/publishing.nsf/Content/6FB549C45F86EF9FCA257F5E001937B5/\\$File/Taskforce%20Summary%20-%20Obsolete.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/6FB549C45F86EF9FCA257F5E001937B5/$File/Taskforce%20Summary%20-%20Obsolete.pdf) (accessed 22 February 2018).

56 Medicare Benefits Schedule Review Taskforce—Diagnostic Imaging Clinical Committee, *Bone Densitometry Report: Taskforce Findings*, [http://www.health.gov.au/internet/main/publishing.nsf/Content/3E9F15BC250DDB89CA2580180018BD22/\\$File/Taskforce%20Summary%20-%20DI%20bone%20densitometry.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/3E9F15BC250DDB89CA2580180018BD22/$File/Taskforce%20Summary%20-%20DI%20bone%20densitometry.pdf) (access 22 February 2018); Medicare Benefits Schedule Review Taskforce—Diagnostic Imaging Clinical Committee, *Low Back Pain Report: Taskforce Findings*, [http://www.health.gov.au/internet/main/publishing.nsf/Content/E1FEC9FFE18698C0CA25801800184170/\\$File/MBS-Review-Taskforce-Recommendations-DI-Low-Back-Pain-Report.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/E1FEC9FFE18698C0CA25801800184170/$File/MBS-Review-Taskforce-Recommendations-DI-Low-Back-Pain-Report.pdf) (accessed 22 February 2018).

57 Medicare Benefits Schedule Review Taskforce, *Public Consultation Timeline 2017/18*, [http://www.health.gov.au/internet/main/publishing.nsf/Content/AEABC7BCD0C0A321CA257F5D00715DE1/\\$File/MBS%20Review%20Consultation%20Timeline%202017-18.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/AEABC7BCD0C0A321CA257F5D00715DE1/$File/MBS%20Review%20Consultation%20Timeline%202017-18.pdf) (accessed 22 February 2018).

---

**Committee view**

5.39 The committee understands that the government operates under fiscal constraints and that there is a need for the MBS to be sustainable over time. It also recognises that diagnostic imaging services currently account for a substantial portion of the MBS budget.

5.40 The committee acknowledges that freezing indexation of the diagnostic imaging service items on the MBS has required private providers and public health services to either absorb the difference between the cost of the service and the Medicare benefit, or pass costs on to patients.

5.41 The committee also acknowledges that, whilst it is a substantial investment to list an item on the MBS, patients are being forced to incur large out-of-pocket costs in order to have essential imaging services performed.

5.42 Whilst the committee understands that adding new items may be an increase in public expenditure, the committee considers that patients should be able to access medical services without placing themselves under significant financial stress.

5.43 The committee also considers that it would be advantageous if the speed of MSAC's processes could be increased to allow MSAC to consider all applications with up-to-date scientific evidence.

5.44 The MBS Review Taskforce appears to be consulting with stakeholders and completing its work diligently. The committee notes that the changes proposed to date have been largely focused on the identification of obsolete items, and there appears to be scope for broader review.

**Other MBS funding**

5.45 The Commonwealth Government uses the MBS to provide an economic incentive for providers to upgrade their equipment. This is called the capital sensitivity measure.

**Capital sensitivity measure**

5.46 The capital sensitivity measure aims to improve patient access to newer and better quality diagnostic imaging equipment by reducing the MBS fee once equipment reaches a certain age, thereby encouraging providers to upgrade or replace older equipment.<sup>58</sup>

5.47 All diagnostic imaging services listed on the MBS (with the exception of PET services) have two different MBS fees, schedule K items and schedule NK items. A schedule K diagnostic imaging service can be claimed if the service is performed on newer or upgraded equipment, whereas an NK schedule item is claimed on older equipment with the MBS fee reducing by approximately 50 per cent.<sup>59</sup>

---

58 Department, *Submission 18*, p. 26.

59 Department, *Submission 18*, p. 26.

5.48 The Department noted that the number of NK schedule items claimed is less than one per cent, indicating that the capital sensitivity measure is effective at ensuring diagnostic imaging equipment in metropolitan areas is upgraded.<sup>60</sup>

5.49 In accordance with the capital sensitivity measure, diagnostic imaging equipment must be replaced after 10–15 years (new effective life age), depending on the modality, or between 15 and 20 years (maximum extended life age) if the equipment has been upgraded prior to reaching its new effective life age.<sup>61</sup>

5.50 The Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) questioned the appropriateness of the life ages, noting that while the new effective life age and maximum extended life ages may have been appropriate previously, advancements in technology now occur at a much more rapid pace.<sup>62</sup>

5.51 ASMIRT submitted that diagnostic imaging equipment may now be obsolete or superseded within only five to eight years, far sooner than the current new effective life age.<sup>63</sup>

5.52 ASMIRT explained equipment should be upgraded more frequently because older equipment could lead to worse health outcomes for patients:

An ultrasound scanner that is 10 years old is less able to diagnose not only foetal abnormalities because the TV screen would have lost its brilliance or resolution, (a bit like your TV at home) but the electronics is so poor by today's standards the entire range of examination quality is poor.<sup>64</sup>

5.53 RANZCR told the committee that it believed that the current measure was adequate, but that it could be reviewed:

In terms of whether the times that have been set for CT, angiography equipment and MRI are appropriate or not, I think they're reasonable and cost achievable. Whether they should be less or not I think should be looked at by committees. It requires funding by the payer, essentially, which is the government, so that's a question that needs to be addressed...<sup>65</sup>

#### *Regional, rural and remote exemptions*

5.54 Practices in outer regional, remote and very remote areas are automatically exempt from the capital sensitivity measure and other inner regional practices may apply for exemptions in certain circumstances to ensure continued access to diagnostic imaging services in these locations, despite the use of older equipment.<sup>66</sup>

---

60 Department, *Submission 18*, p. 26.

61 Department, *Submission 18*, p. 39.

62 Australian Society of Medical Imaging and Radiation Therapy (ASMIRT), *Submission 24*, p. 7.

63 ASMIRT, *Submission 24*, p. 7.

64 ASMIRT, *Submission 24*, p. 7.

65 Dr Greg Slater, President, RANZCR, *Committee Hansard*, 13 December 2017, p. 7. See also ACT Health, *Submission 35*, p. 4.

66 Department, *Submission 18*, p. 27.

5.55 However, RANZCR expressed concern about whether allowing older equipment to be used in country areas was a disservice to regional, rural and remote residents:

Basically the old machines are being shipped out to the country. And I think you could argue that regional patients are being subjected to imaging on older equipment, which may not be in their best interests. So I think this should be reviewed. It may be inevitable, given the lower utilisation of machines in regional areas, but it's a subject of personal concern for me.<sup>67</sup>

5.56 The Department of Health Western Australia advised that diagnostic imaging services in regional centres were often conducted on older models which provide lower quality imaging services compared to technology available in Perth:

Where there are imaging services in regional WA, these do tend to be older models—for example, in Esperance, Kalgoorlie, Broome and Geraldton, where there is a 16-slice CT scanner. By contrast, Sir Charles Gairdner Hospital has a 320-slice scanner, and the new Fiona Stanley Hospital has two 256-slice scanners. The significance of this for the patient is that the quality of the images may be lower, the dose of the radiation required may be higher and the dose of the contrast agent that's required, which can have risks in terms of renal failure, may be higher. The older machines may also lend themselves less to hybrid technologies like CT/SPECT, necessitating trips to Perth.<sup>68</sup>

5.57 Rural service providers made it clear to the committee that the regional, rural and remote capital sensitivity exemptions were required to make imaging services in those locations viable.<sup>69</sup> The WA Country Health Service told the committee that if the rural capital sensitivity exemption was removed, it may struggle to continue to provide the same range of services:

The Commonwealth must maintain the current remoteness around capital sensitivity exemptions for medical imaging in order to maximise the availability of services to those regional patients. If removed, the costs associated with providing imaging may further increase, making it more expensive for [WA Country Health Service] due to more frequent equipment replacement and possibly resulting in the removal of some imaging services due to prohibitively expensive costs.<sup>70</sup>

5.58 Whilst equipment may only make up between 10 and 12 per cent of the cost of imaging, it can be a very substantial cost for rural communities.<sup>71</sup> Mr Aiden Cook from the Darling Downs Hospital and Health Service told the committee that whilst

---

67 Dr Slater, *Committee Hansard*, 13 December 2017, p. 8.

68 Dr Audrey Koay, Executive Director, Patient Safety and Clinical Quality, Department of Health, Western Australia, *Committee Hansard*, 9 November 2017, p. 29.

69 Mrs Baxter, *Committee Hansard*, 9 November 2017, p. 30.

70 Mrs Baxter, *Committee Hansard*, 9 November 2017, p. 30.

71 Ms Pattie Beerens, Chief Executive Officer, ADIA, *Committee Hansard*, 13 December 2017, p. 8.

upgrading rural equipment was required, some thought also needed to be given to the cost required to do so:

We have a need to upgrade regional machinery as much as anywhere, and it comes down to small hospitals and their ability to replace machinery at \$300,000 a pop. It's not easy. That's a lot of cakes that they need to come up with in some of these small places.<sup>72</sup>

5.59 ADIA told the committee that the capital sensitivity arrangements were being considered by the MBS Review Taskforce and may be the subject of an upcoming recommendation.<sup>73</sup>

### *Section 19(2) exemptions*

5.60 To support the availability of diagnostic imaging and defray the cost of purchasing new equipment in rural areas, the Council of Australian Governments introduced the Section 19(2) Exemptions Initiative to permit a list of rural sites to claim Medicare benefits for non-admitted, non-referred professional services (such as midwifery, nursing and dental services).<sup>74</sup>

5.61 Section 19(2) of the *Health Insurance Act 1973* provides that Medicare benefits are not payable where another payment is available to cover the service.

5.62 The WA Country Health Service noted that the exemption permits hospitals to retain Medicare benefits for providing professional services, including diagnostic imaging services to ensure that imaging can continue in rural areas:

This [exemption] allows the health service provider to charge Medicare for imaging procedures on patients referred through the hospital system and not just externally through GPs. The 19(2) exemption significantly improves the revenue stream to [WA Country Health Service] hospitals to ensure that we can maintain these needed imaging services.<sup>75</sup>

5.63 In addition to helping maintain the existing imaging services, the Darling Downs Hospital and Health Service noted that holding a section 19(2) exemption assisted smaller hospitals to accumulate revenue to purchase or upgrade its diagnostic imaging equipment:

...some of the smallish hospitals, particularly the 19(2) exemption sites, have a need to maintain some revenue out of those privately referred patients to enter the public hospital. The technology at the top end is quite expensive. In the pool of money available to replace equipment across Queensland, the pressure will come on to replace those high-value

---

72 Mr Aiden Cook, Director Medical Imaging, Darling Downs Hospital and Health Service, *Committee Hansard*, 13 December 2017, p. 16.

73 Ms Beerens, *Committee Hansard*, 13 December 2017, p. 8.

74 Department, *Council of Australian Governments (COAG) Improving Access to Primary Care in Rural and Remote Areas – COAG s19(2) Exemptions Initiative*, 18 July 2017, <http://www.health.gov.au/internet/main/publishing.nsf/Content/COAG+s19%282%29+Exemptions+Initiative> (accessed 7 February 2018).

75 Mrs Baxter, *Committee Hansard*, 9 November 2017, p. 30.

---

machines, and the low-value machines in general X-ray will probably have longer and longer life spans, and I think that a lot of these rural hospitals will start to run into difficulty.<sup>76</sup>

5.64 Currently, 19(2) exemption sites are determined based on population and geographic remoteness using the Modified Monash Model.<sup>77</sup>

5.65 The Queensland Nurses and Midwives' Union (QNMU) noted that two Queensland hospitals (Roma and Mareeba) have recently lost their section 19(2) exemptions.<sup>78</sup> The QNMU was concerned because, in addition to the lost revenue stream, the nurses and midwives operating the diagnostic imaging equipment in those hospitals have lost their ability to independently claim Medicare rebates.<sup>79</sup>

5.66 The QNMU submitted that the loss of the exemption led to a reversion to less innovative and efficient ways of working in the hospitals concerned.

5.67 The QNMU instead suggested that the social determinants of health or some other measure should be considered when deciding which areas ought to be eligible for section 19(2) exemptions to ensure that the overall number of hospitals eligible for section 19(2) exemptions was not reduced.<sup>80</sup>

#### ***Committee view***

5.68 The committee understands that medical technology evolves rapidly and that newer equipment will provide patients with a better quality of care and improved chance of accurate diagnosis. The committee considers that capital sensitivity measures could be reviewed for metropolitan centres and understands that this will be considered as part of the MBS Review.

5.69 While understanding the issues involved in regional, rural and remote areas, the committee is concerned about the impact on patient health of the current rural capital sensitivity exemptions and the section 19(2) exemptions to assist with the cost of services and equipment. While the committee expects that tighter capital sensitivity measures for metropolitan centres may permit modern equipment to be deployed to rural areas more frequently and at lower cost, the committee believes there needs to be consideration given to the possible poorer health outcomes of regional, rural and remote patients.

---

76 Mr Cook, *Committee Hansard*, 13 December 2017, p. 16.

77 The Modified Monash Model uses population size and distance to determine whether a particular location should be considered urban, inner or outer regional, rural or remote. Queensland Nurses and Midwives' Union (QNMU), *Submission 13*, p. 5.

78 QNMU, *Submission 13*, p. 5.

79 QNMU, *Submission 13*, p. 5; Mr Jamie Shepherd, Professional Officer, QNMU, answers to questions on notice, 13 December 2017 (received 18 January 2018).

80 QNMU, *Submission 13*, p. 5; Mr Shepherd, answers to questions on notice, 13 December 2017 (received 18 January 2018).

