Chapter 6

Recommendations and conclusions

6.1 The committee recognises that diagnostic imaging plays a vital part in assisting health practitioners to diagnose and assess many medical conditions.

6.2 Throughout the course of this inquiry, submitters raised concerns with the committee about the licensing of Magnetic Resonance Imaging (MRI) machines, availability and accessibility of diagnostic imaging (especially as it relates to regional, rural and remote Australians) and the future of the diagnostic imaging workforce.

Magnetic Resonance Imaging licensing

6.3 In chapter three the committee considered the licensing of MRI machines. Unlike other diagnostic imaging modalities, MRI is subject to a licensing system that grants Medicare Benefits Schedule (MBS) eligibility to a specific provider, in a specified location for a specific machine. However, the committee also received evidence that MRI licences may be transferred in some instances.[1]

6.4 Currently, there are fully licensed machines, which can provide Medicare rebates on all of the diagnostic imaging items listed on the MBS, partially licensed machines, which can provide Medicare rebates on a subset of items on the MBS, and unlicensed machines, which attract no Medicare rebate and require all scans to be paid for by patients out of their own pockets.

6.5 The distinction between these machines is historic. Machines that were operating at the time that licences were first granted received full licences and those that commenced operation later received either a full or partial licence. Submitters told the committee that there is currently no pathway to apply for a licence. As a result, some places which have experienced substantial population growth, such as Perth, have been unable to obtain additional licences to ensure that patients have access to affordable diagnostic imaging.

6.6 The committee heard that under current licensing arrangements general practitioners are only able to refer patients to partially licensed machines, while specialists are able to refer patients to fully licensed machines. The committee received evidence that these different referral pathways are confusing, inconvenient and potentially lead to poorer outcomes for patients.

6.7 The committee also received evidence that many practitioners, in an attempt to save patients' money, order computed tomography (CT) scans instead of MRI scans because patients would be eligible for a rebate on a CT scan. However, because MRI is clinically superior for some conditions, patients are often required to undergo a CT and then an MRI scan to ascertain the necessary diagnostic information. Submitters

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1 Mrs Lenka Psar-McCabe, Chief Executive Officer, Perth Radiological Clinic, *Committee Hansard*, 9 November 2017, p. 26; Mr Dean Lewsam, Chief Executive, Healthcare Imaging Services, Primary Health Care Limited, *Committee Hansard*, 13 December 2017, p. 31.

told the committee that there may be some cost substitution in a deregulated MRI market because medical practitioners may elect to send patients for the more clinically appropriate MRI scan first, rather than requiring patients to undergo a CT and then an MRI scan.

6.8 Some submitters suggested that the system of referral should be entirely deregulated and that medical practitioners ought to be able to direct patients to the most convenient or newest machine in the vicinity to prevent unnecessary travel and cost for patients. Others suggested that deregulating the MRI licensing system would lead to a considerable increase in expenditure for the Commonwealth Government but may only provide marginal benefits to a vast majority of patients.

6.9 The committee considers that there should be a process or pathway for providers to be able to apply to the Department of Health (Department) to be granted a full or partial licence. A number of witnesses and submitters suggested that an application process should be introduced which takes into account current population data, clinical need and the need to improve patient outcomes. One possible suggestion was to model the application process on the Department's Radiation Oncology Health Program Grant scheme. The committee considers that it is important that a transparent process is created to award MRI licences.

6.10 The committee notes that the Department has provided advice to the Minister for Health about reforming the MRI licensing system. The committee expects that this will be progressed as a matter of urgency.

Recommendation 1

6.11 The committee recommends that the Commonwealth Government immediately implement an application process with clear, objective and transparent assessment criteria to permit hospitals and radiology practices to apply for licences for Magnetic Resonance Imaging machines.

Recommendation 2

6.12 The committee recommends that the Medicare Benefits Schedule Review Taskforce review the Magnetic Resonance Imaging referral pathway and rebates, including consideration of options to allow specialists and general practitioners to refer patients to both fully licensed and partially licensed machines.

6.13 The committee considers that, in the longer term, the Minister for Health should review the future of the licensing system.

Access to diagnostic imaging services

6.14 Throughout the course of this inquiry, the committee heard from submitters who experienced barriers to accessing diagnostic imaging services. These barriers are partly a function of the current distribution of diagnostic imaging machines and also a function of a lack of skilled specialists being available in those areas.

6.15 The committee was very concerned by evidence it received that people with physical disabilities may be unable to obtain diagnostic imaging because they cannot

access the facilities. The committee considers that all health services ought to be physically accessible to all people, including those with a physical disability.

6.16 The committee notes that obligations already exist to ensure that people with disabilities are able to access health care facilities. The committee considers that access obligations ought to extend to the services inside the building as well. The committee heard that in some cases it may only require a sling or a hoist to make diagnostic imaging services accessible. The committee notes that in other sectors service providers, such as swimming pool operators, are already required to accommodate access for persons with physical disabilities under the National Construction Code.[2] The committee calls on all health care providers to ensure that their premises and services are accessible to all people who may require them, including those with disability.

Recommendation 3

6.17 The committee recommends that the Department of Health consider how to make diagnostic imaging services fully accessible to people with physical disability.

6.18 The most common form of disadvantage that was brought to the committee's attention during this inquiry related to geographic access. The committee understands that regional, rural and remote Australians experience poorer health outcomes than their urban counterparts and that a lack of access to high quality diagnostic imaging services contributes to that disparity.

6.19 The committee considered evidence in chapter two that regional, rural and remote Australians often have to travel considerable distances in order to receive diagnostic imaging services. To defray the cost of obtaining these scans, state and territory governments often subsidise the cost of traveling to obtain the scan. However, submitters told the committee that the current subsidies provided by state and territory governments are inadequate to cover the costs of transport and accommodation.

6.20 The committee also heard that Aboriginal and Torres Strait Islander peoples often culturally require an escort to leave their community. Current patient transport subsidy services often do not cover costs associated with this. The committee accepts that it is not feasible to provide all diagnostic imaging services in all communities, but the committee considers that regional, rural and remote Australians should not be disadvantaged because of where they live. The committee considers that in order to provide equitable access for all Australians, state and territory governments should review the subsidies that are currently available.

2 Australian Construction Codes Board, *National Construction Code 2016—Volume One Amendment 1*, February 2016, pp. 219–222.

Recommendation 4

6.21 The committee recommends that state and territory governments review the adequacy of patient transport subsidies that are currently available with a specific view to ensuring access to diagnostic imaging.

6.22 The committee heard from the Australian Medical Association that the multiple services rule means that regional, rural and remote Australians must travel to the city on multiple occasions or face extended stays away from home if they wish to receive Medicare benefits for multiple procedures. The implementation of the multiple services rule has resulted in issues with Medicare benefits being claimed on multiple items on the same day. The committee considers that this is inefficient and places additional costs on regional, rural and remote residents.

6.23 The committee understands that the MBS Review Taskforce is currently reviewing all of the items on the MBS. As part of that review, the committee understands that the MBS Review Taskforce will consider the multiple services rule. The committee urges the MBS Review Taskforce to consult with stakeholders on whether the multiple services rule should be altered or abolished.

Recommendation 5

6.24 The committee recommends that the Department of Health review the operations of the multiple services rule to ensure that it is achieving its policy intent and consider any changes required.

6.25 The committee also understands that the MBS Review Taskforce will consider the current capital sensitivity measures. Capital sensitivity measures encourage providers to update their equipment by halving the available Medicare rebate if the equipment is beyond the life age specified by the Department. In chapter five the committee considered the evidence it received that the pace of innovation in medical technology meant that capital sensitivity measures may be too long and should be reviewed.

6.26 Submitters raised concerns with the committee that lax capital sensitivity measures may be leading to patients having MRI scans on older rather than newer machines. Currently, the MRI licences that entitle patients to Medicare rebates are attached to older machines and because there is little incentive for providers to update their equipment early, more patients are having scans on older rather than newer machines. The committee considers that this scheme should be reviewed.

6.27 Submitters also told the committee that the current capital sensitivity measures meant that older equipment is being sent to country areas, resulting in regional, rural and remote Australians receiving lower quality images.

6.28 The committee accepts that it is difficult for regional, rural and remote health services to acquire the funds necessary to replace equipment on a regular basis. Therefore, the committee supports, in the short term, the current capital sensitivity exemptions for regional, rural and remote Australia. The committee also acknowledges that the exemptions from section 19(2) of the *Health Insurance Act 1973* help rural and remote health services to afford the cost of new equipment. The committee heard from some submitters that the exemptions are vital to the

continuation of services in regional, rural and remote areas. The committee hopes that the combination of these two measures will permit health services in regional, rural and remote areas to purchase more modern diagnostic imaging more frequently, resulting in better imaging for country Australians.

Recommendation 6

6.29 The committee recommends that the Department of Health consider tightening capital sensitivity measures in metropolitan centres.

Recommendation 7

6.30 The committee recommends that the Commonwealth Government reinvest into the Medicare Benefits Schedule, savings obtained from the removal or alteration of diagnostic imaging items in the Medicare Benefits Schedule Review.

Recommendation 8

6.31 The committee recommends that the capital sensitivity exemptions and the *Health Insurance Act 1973* section 19(2) exemptions for regional, rural and remote Australian health services should be reviewed to establish the impact on regional, rural and remote health outcomes.

6.32 The committee received evidence that teleradiology, where expert radiology advice on images is provided from an off-site location, has the benefit of being able to harness expertise that may not be locally available. However, the committee received evidence that in Tasmania discs containing the patient's images must be sent via post to a hospital in Victoria to obtain this specialist advice.

6.33 The committee considers that this is not acceptable. If teleradiology is to work in the interests of all patients, Australia's services for securely sharing diagnostic images must be improved.

Recommendation 9

6.34 The committee recommends that state and territory governments investigate how data sharing measures between public hospitals can be improved to support teleradiology services and that these improvements are implemented as soon as practicable.

6.35 The committee understands that the Medical Services Advisory Committee (MSAC) is responsible for assessing whether an item ought to be added to the MBS. There are several diagnostic imaging applications that are currently pending before MSAC. Submitters told the committee that some applications made to MSAC could take a number of years. In some cases, this meant that the most up-to-date technology had evolved whilst the application was being considered.

6.36 The committee appreciates that MSAC needs to be thorough in its assessment of the clinical and cost effectiveness of an item before it is added to the MBS. However, the committee is concerned that MSAC's processes are delaying access to affordable treatment for patients and may be leading MSAC to make decisions without the most up-to-date information.

Recommendation 10

6.37 The committee recommends that the Minister for Health commission a review into the Medical Services Advisory Committee's processes with a view to reducing the time between submission of an application and a decision being made.

Workforce

6.38 In chapter four the committee also considered the effect of workforce shortages on diagnostic imaging. The committee heard that Australia has and will continue to have a shortage of radiologists. The committee understands that part of the reason for the shortage of radiologists is that the Royal Australian and New Zealand College of Radiologists (RANZCR) limits the number of trainee radiologists that it accepts every year.

6.39 The committee understands that the Department administers the grant program for specialist training which is delivered by RANZCR. A review by the Department in March 2017 recommended that the number of radiology positions in the Specialist Training Program be increased to address the shortfall. The committee understands that the Commonwealth Government has increased the number of radiology positions that are available in the Specialist Training Program. The committee welcomes the increase in radiology positions but considers that more are needed to address the dramatic shortfall.

Recommendation 11

6.40 The committee recommends that the number of radiologists trained each year be increased following consultation between the Department of Health and the Royal Australian and New Zealand College of Radiologists.

6.41 The committee also heard that there is a longstanding shortage of sonographers and that at the same time, trainee sonographers are experiencing difficulty finding clinical placements to complete their training. Submitters told the committee that sonography is a highly operator dependent and requires specialist training to avoid misdiagnosis or false negatives. The Australian Sonographers Association and the Australasian Society for Ultrasound in Medicine requested that a subsidy be provided to radiology practices to encourage the training of sonographers.

6.42 The committee understands that training a sonographer requires some investment, however, the current sonographer shortage will only be remedied with the assistance of private radiology practices. The committee considers that private radiology practices should be encouraged to hire a trainee sonographer.

Recommendation 12

6.43 The committee recommends that the Department of Health consider if there are mechanisms that can be put in place to encourage private radiology practices to train sonographers.

Recommendation 13

6.44 The committee recommends that private radiology practices train more sonographers.

6.45 In the absence of an adequate supply of sonographers, the committee understands that, in some cases, nurse practitioners have been trained to perform pelvic ultrasounds. The committee considers that practitioners should be encouraged to expand their scope of practice with appropriate supervision and training. The committee understands that some scans are already being safely performed in regional, rural and remote areas and the committee considers that an expanded scope of practice ought to be open to nurses and nurse practitioners in other areas.

Recommendation 14

6.46 The committee recommends that the Department of Health work with stakeholders to facilitate nurses and nurse practitioners expanding their clinical scope of practice to include certain ultrasounds, where they have received proper training and sonographers are not available to do so.

Senator Rachel Siewert

Chair