Australian Diagnostic Imaging Association
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22 December 2003

Mr Jonathan Curtis
Secretary
Senate Select Committee on Medicare
Parliament House
CANBERRA ACT 2600

Dear Mr Curtis

Thank you for your letter of 27 November 2003 inviting the Australian Diagnostic Imaging Association (ADIA) to make a submission to the Medicare Select Committee in relation to **MedicarePlus** proposals.

The ADIA is Australia's private radiology industry body representing the interests of around 70% of comprehensive private practice.

Our primary role is to assist the Government and The Royal Australian and New Zealand College of Radiologists manage the Radiology Quality and Outlays Memorandum of Understanding (MoU) 1 July 2003 to 30 June 2008. We also review and analyse issues which affect the radiology profession and strive to influence the development and implementation of government policy

You will be aware that the ADIA made a submission to the Committee on 19 June 2003 in relation to **A Fairer Medicare** proposals. As our issues and concerns over **MedicarePlus** are similar we have attached our previous submission for reconsideration.

Our key issues and concerns relate to:

- 'watering down' of Medicare universality by the introduction of different classes of Medicare eligible patients and rebate levels;
- safety net type arrangements replacing the key principle of fair and reasonable rebates for all Australians in relation to the fair and reasonable costs of their health care;
- the lack of objective criteria in determining the levels of funding for diagnostic imaging services that are necessary to ensure that patients are able to access timely and quality services within a framework of patient affordability and industry sustainability; and
- implications and uncertainties created for radiologists and diagnostic imaging practices regarding the management of the MoU.

The fundamental shifts in Medicare policy and the resultant implications for patients in relation to the first two dot points will, no doubt, be addressed in a broader context of Medicare policy. We do not propose to dwell on those issues.

The third and fourth points highlight the difficulties for radiologists and the industry in managing large 'capped' Medicare DI funding targets over the five years of the radiology MoU when it is unclear what changes in utilisation and service mix might occur as a result of such significant policy shifts.

In the case of high technology services such as MRI and CT, it is unclear if variations in patterns of servicing could arise as patients approach or exceed their thresholds for their out-of- pocket expenses. It would seem inappropriate if patients' options regarding cost effective and timely health care are determined by where they stand in relation to an artificially determined threshold.

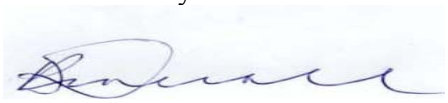
We are also concerned about potential conflicts with the 'patient affordability bonuses' in the MoU which are intended to release additional funds to the MoU 'pool' in years two to five if the ratio of patient gaps to total fees charged remains below 16.7% in the previous year.

We have asked the Department of Health and Ageing to identify any potential impacts on the MoU and its management from **MedicarePlus** but no real information has been provided at this stage.

As regards the general sustainability of the industry, the ADIA continues to be concerned about the capacity of our practices to provide quality based, professionally satisfying working environments for radiologists and other key staff under the general funding constraints of the MoU. Although we cannot draw direct implications from **MedicarePlus**, the general climate of Medicare cost containment could dampen investment in modern technology and this will contribute to shortfalls and lower retention rates of radiologists and other professionals in Australia's diagnostic imaging practices.

Again, thank you for inviting this submission.

Yours sincerely



Dr Ron Meikle
President, ADIA

ATTACHMENTS

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19 June 2003

The Secretary
Select Committee on Medicare
Suite S 130
Parliament House
Canberra ACT 2600

Dear Secretary

The Australian Diagnostic Imaging Association (ADIA) which represents the interests of the vast majority of private diagnostic imaging practices in Australia appreciates this opportunity to bring to the attention of the Committee some potential and previously not considered ramifications of the introduction of 'A Fairer Medicare".

Although the Terms of Reference focus on general practice, the links between efficient and effective primary healthcare and the availability of affordable, quality and cost effective diagnostic services such as diagnostic imaging and pathology are inseparable.

The Committee will be aware that the ADIA and the Royal Australian and New Zealand College of Radiologists (RANZCR) are finalising a Memorandum of Understanding (MoU) with the Commonwealth for the funding of DI services (other than Nuclear Medicine, Cardiac Imaging and O and G Ultrasound) under Medicare for the next five years (2003/04 to 2007/08). Due to probity issues, we are not in a position to canvass the full details of the proposed MoU but key details are contained in the joint ADIA/RANZCR Press Release of 4 June 2003 (Attachment A).

Although the profession is committed to an effective joint management of the MoU with the Commonwealth in order to achieve the maximum cost benefits for patients it is expected that there will be significant and compounding difficulties as the MoU moves beyond the range of current known factors and norms. The last three years of the MoU could prove to be particularly difficult in this regard.

At this stage it would appear that the allowances in funding growth may not be sufficient to meet the compounded effects of cost escalation and demand growth which will be heavily influenced by factors such as the relative position of the Australian dollar, wages and cost escalation and increasing demand generated from an ageing population and accelerated use of newer, more expensive technology. Some of the latter will be offset by savings elsewhere in the healthcare system, such as in reduced consultation times, but this has not been taken into account in the rationing of Medicare DI funding by the Commonwealth.

Another key issue facing practices is the extent to which increasing cross subsidisation will adversely impact on longer term patient care and the quality and future affordability of DI services.

The cross subsidisation is occurring on four major fronts:

1. From the increasing gaps met in patient billed services (currently about 40% of total DI services) which subsidise the remaining 60% of direct (bulk) billed DI services. This means that for every 1% decline in the real levels of rebates, gaps for patient billed services must increase by approximately 2.5% to maintain the status quo.

2. CT and Medicare eligible MRI services are heavily subsidising marginal activities such as diagnostic radiology (plain X rays).

3. The lack of a level playing field between the public and private sectors and cost shifting from the public sector to Medicare means that less funding is available for true Medicare eligible services.

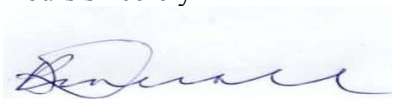
4. The lack of equity from the current rationing of Medicare eligible MRI sites is impacting on patient access and affordability and the viability of those DI practices without funded sites.

Although the negotiations on the new MoU have been difficult and protracted, there is reluctant acceptance in the DI profession that the Commonwealth is unwilling to provide additional funding for DI services. The funds from the MoU will be fixed. Any shortfalls in the funding targets, such as from higher than anticipated demand, will have to be met through increased gaps or cost cutting or, possibly, the curtailing of services in marginal situations.

The profession feels that policy and other changes such as those arising from the 'A Fairer Medicare' Package being proposed by the government could exacerbate the funding problems outlined above. The ADIA has sought responses to the questions at Attachment B which were raised with the Commonwealth Department of Health and Ageing on 30 April 2003 during the MoU negotiation process.

The profession is particularly concerned that the 'A Fairer Medicare' Package provides no clear policy direction from the Commonwealth on ways to address the ongoing inequities from the continued rationing of Medicare funded MRI sites and the consequential disparities in access and affordability of those services and their impact on the viability of DI practices.

Yours sincerely



Dr Ron Meikle
President, ADIA

Attachments A and B

ATTACHMENT A

The Royal Australian and New Zealand College of ~~Radiologists~~

DIAGNOSTIC IMAGING FUNDING AGREEMENTS

The College and the Australian Diagnostic Imaging Association (ADIA) are able to following extensive negotiations with the Commonwealth Department of Health and Ag of a five-year Radiology Outlays and Quality Memorandum of Understanding (M developed and forwarded to the Government for consideration.

The current Diagnostic Imaging Funding Agreement expires on 30 June 2003. In the recent Federal Budget the Government announced that four new agreements covering radiology, nuclear medicine, obstetric and gynaecological ultrasound and cardiac imaging will come into effect on 1 July 2003.

The Government announced that Medicare funded Magnetic Resonance Imaging (MRI) activity would be fully included within the new Radiology agreement and that the Government would be working with the profession to improve access to MRI services within agreed funding limits. It also foreshadowed development of strategies to manage patient contributions.

If the Government agrees to the proposed terms of the Radiology MoU, the main components would be:

- MBS outlays for Radiology services over the five year period from 1 July 2003 as follows:

	Base	2003-04	2004-05	2005-06	2006-07	2007-08	Total
Funding $m	979.9	1,033.6	1,088.4	1,142.8	1,199.9	1,259.9	5,724.6
Growth rates (a)		5.5%	5.3%	5%	5%	5%	
Patient co-payment initiative $m (b)		4.9	10.9	11.4	12.0	12.6	51.8
Maximum Funding $m		1,038.5	1,099.2	1,154.2	1,211.9	1,272.5	5,776.4

(a) Higher growth rates in the first two years allow time for the current high growth rates in MRI services to be brought into line with the allowable funding growth rates for other modalities.
(b) Provision for a further $4.9m in 2003-04 to develop initiatives that address the Government's concern to minimise costs to patients with additional 1% funding in subsequent years to be contingent on defined levels of patient contributions.

- Inclusion of the College and the ADIA in an open and transparent MRI Monitoring and Evaluation Group (MEG), which provides an opportunity for the profession to be involved in the process for providing greater access to MRI. As part of the new MEG process the parties will develop options for a controlled expansion of access to MRI.
- Pursuit of a range of separately funded quality initiatives.

The final MoU has not yet been signed off by the Government but we are hopeful this will occur in the near future.

We believe the results outlined above are the best possible outcomes for the profession in the current economic circumstances. We also believe that the way forward now is to continue to work closely and cooperatively with the Department of Health and Ageing in the management of the agreement and to further negotiate any issues that may arise as they unfold.

Dr Paul Sprague
President, RANZCR

Dr Ron Meikle
President, ADIA

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ATTACHMENT B

Questions about the Potential Impacts of the "Fairer Medicare" Package on DI services

1. What is the estimated impact of the "Fairer Medicare" package on outlays and demand for DI services for each of the years of the MoU?
    - What is the expected impact on different population groups, eg the aged, etc?
    - Is increased availability of direct billed GP services to concession card holders likely to lead to more and/or longer consultations and greater demand for DI services?
2. What is the estimated DI component of the expected cost of the 'stronger safety nets' (80% of total out of pocket expenses over $500) for Commonwealth concession cardholders?
    - Will the additional outlays for the DI services contribution to this cost impact on MoU funding or will this initiative be entirely funded outside the MoU?
    - Is a $500 "safety net" threshold likely to result in increase in demand for DI services once the threshold has been exceeded?
3. Why has the concept of participating practices/doctors been limited to GPs when issues of bulkbilling and gaps similarly apply to DI services?
    - Should not Commonwealth concession cardholders be given the similar consideration with regard to billing for DI services, especially given the declining real levels of Medicare rebates? Is this an option that may be developed cooperatively within the MoU management process?
    - Is the Government not concerned that the expected shortfall in revenue in participating practices will be met by higher gaps for others including the non insured or cost shifted to private health insurance?
4. What are the implications of the new arrangements (incl. 2. above) in terms of the 1% contingency escalation adjustment in the Radiology MoU and the calculation of the 16.7% patient contributions to total fees? Will the new private health insurance product impact on the 1% contingency adjustment in any way?
5. More detail about the proposed private health insurance product:
    - Would you please confirm that it covers all DI and radiation oncology services that attract the 85% Medicare rebate?
    - Would you please confirm that patients will <u>not</u> be required to have other private health insurance to be eligible for the new product?
    - Will the 30% Rebate on private health insurance apply if patients do not also have in- hospital cover?
    - How much flexibility/discretion will the health funds have in their packaging of the new product?
    - What will be the impact on the current tax rebate for Medical expenses? Will the current tax arrangements, which are not restricted to out of hospital Medicare services, continue for those who exceed the current limits but chose not to take out private health insurance?
    - Will it be possible to include currently unfunded MRI units in the coverage by the new health insurance product-either in full or in part? Is there now scope for more 'innovative' MRI arrangements under the MoU such as differential benefits for Commonwealth concession cardholders versus others in association with the new insurance product?
6. What monitoring arrangements are to be introduced to assess the impacts of the proposed changes? What mechanisms will be available under the MoU to take into account increased costs as a result of this policy initiative?