Availability and accessibility of diagnostic imaging equipment around Australia

I am a radiologist who works in a large public hospital in Victoria (though I am not writing on behalf of the institution). I write as I think it is important that the committee understand the enormous pressures that face the public hospitals with regard to diagnostic imaging services. I suspect there will be great lobbying from private sector radiology companies that have the time and resources to put together stellar submissions that argue their points - probably particularly related to deregulation of MRI services.

I suspect that you may receive an under-representation from the public sector, so I hope to convey to you some of the resourcing issues that we face.

As a radiologist that works in the public sector, there is no specific diagnostic imaging funding provided for the care of our patients. We receive some medicare billing in the form of outpatient services that we provide… and this helps fund some of the complex (and expensive) inpatient work that we do. This lack of funding for inpatients makes management of sick hospital patients very difficult. Many inpatients are ineligible for medicare funding and resourcing in the public sector is increasingly difficult as it is lost to the private sector. Some of the work that public radiologists do that goes unrecognised are:

1. Public radiology departments are responsible for the lion share of radiologist and radiographer training. This is extremely time consuming and important work to ensure that there are quality radiologists and radiographers going into the future. It takes 5 years to train a radiologist and a lot of this is one on one time between consultant and registrar to ensure the training and teaching they receive is of high quality. The private corporate sector gain fabulous workers as a result the public sector work. Yet the contribute little if anything to this process. There is no remuneration for this important job.
2. Public radiologists manage very complex patients, and consequently their imaging is more complex, and that is not reflected in the remuneration of diagnostic imaging. It is not uncommon for the private sector to perform the imaging (at expense to the patient) and then clinicians are not happy with the private sector report and thus bring their complex scans to the public system for a “second opinion”. This second opinion requires time for the public radiologists and there is no remuneration or acknowledgement of that expertise.
3. Responsible for management of multidisciplinary meetings. These MDM’s are important tools in the public sector to manage complex patients (see point 2) and are extremely time consuming from a radiologist’s point of view. Again, there is often review of inaccurate private radiology reports, and review of patient case histories. A one hour MDM can take up to 4-5 hours of pre-meeting preparatory time for the radiologists to ensure that the correct information is conveyed at the meeting to guide patient management. None of this important work is remunerated in any way.

There are large discrepancies between the public sector resourcing and private sector. I think it is imperative upon the committee to take that into consideration of this discrepancy during their review. The private sector radiology companies will have very potent and strong arguments to increase their funding - yet they are unwilling to deal with complex and time consuming patients. Often their expertise is variable and they are not held accountable for the services they provide.

A strong and well resourced public radiology service will ensure the ongoing provision of quality diagnostic imaging services now and into the future. It will ensure good training and care of the very sickest individuals in our community.