AUSTRALIAN MEDICAL ASSOCIATION
ABN 37 008 426 793
T | 61 2 6270 5400
F | 61 2 6270 5499
E | info@ama.com.au
W | www.ama.com.au
42 Macquarie St Barton ACT 2600
PO Box 6090 Kingston ACT 2604

AMA submission – Inquiry into the availability and accessibility of diagnostic imaging equipment around Australia

community.affairs.sen@aph.gov.au

The AMA appreciates the opportunity to contribute to this important inquiry. The AMA would be pleased to expand on this submission if required.

Diagnostic imaging saves money

This Inquiry focuses on diagnostic imaging equipment, but it is important that the AMA's response to the specific terms of reference are considered in the context of the broader diagnostic imaging environment and its critical role in a word-class, 21st century health system.

Diagnostic imaging is a key clinical tool in assessing, diagnosing and treating disease early. It provides crucial information to enable doctors to assess and diagnose a patient's condition and to determine the best approach for treatment.

Early diagnosis provides cost effective treatment and significantly improves patient outcomes.

Once a treatment plan is implemented, many medical conditions require follow-up imaging to determine when treatment has successfully addressed the condition, for example the healing of a fracture or the successful remission of cancer.

Many minimally invasive procedures require an associated diagnostic imaging service in order to be carried out. Minimally invasive surgery reduces the length of hospital stay and improves patient recovery and outcomes.

Radiologists not only provide expert opinion as diagnostic imaging, but perform a host of interventional procedures as a less invasive alternative to surgery. These range from treatment of intracranial aneurysms, extraction of acute clot from vessels in the brain in acute stroke patients to draining of abscesses. Image guided biopsies are provided by all radiology practices. The patient is the beneficiary as is the whole of health in the cost saving in avoiding surgery.

Diagnostic imaging is therefore integral in delivering cost-effective treatment as well as ongoing patient management.

Investment in high quality diagnostic imaging services that reflect best clinical practice ultimately saves tax payers from much higher downstream costs in the acute care sector, and can greatly improve patients' experiences and outcomes.

Therefore, the AMA's view is that government policies, regulations and funding arrangements for diagnostic imaging services should:

- place primary importance on safety, quality, access and affordability;
- facilitate patient care and convenience, including in regional and rural areas;
- be based on evidence of enhanced management of patients and improved patient outcomes;
- support sustainability of the diagnostic imaging sector including the sector's ability to support ongoing training, research and development;
- recognise the savings to the healthcare system and the general economy from early diagnosis and intervention and monitoring of chronic disease which are facilitated through diagnostic imaging services; and
- appropriately reimburse the patient for the full cost of providing diagnostic imaging services.

Out-of-pocket costs mean patients suffer

The Senate Committee will be well aware that the MBS rebates for diagnostic imaging services have been stagnant for 18 years. While very modest rebate increases were announced in the 2017-18 Budget for some very limited diagnostic imaging services from 2020, this does little to compensate for inevitable cost increases over this extended period.

Increased costs are inevitably leading to increases in out-of-pocket expenses for patients. And it is the sickest and most vulnerable individuals in our community that can end up paying the most.

ABS population surveys tell us that a significant proportion of patients delay or simply do not proceed with important diagnostic tests because of cost. Unlike a visit to a non-bulk billing general practitioner, the upfront cost for a scan may be hundreds of dollars, with only a small rebate collected sometime in the future (if at all).

Research has also repeatedly demonstrated that the impact of increasing out-of-pocket costs is greatest on those most vulnerable in our population (the elderly, the chronically ill, the unemployed, the 'working poor', Indigenous peoples).[i]

When people defer or avoid care due to costs there are downstream consequences. An episode of acute care in a public hospital is vastly more expensive to taxpayers than preventive or first line treatments, with a greater impact on workforce participation and flow-on economic impacts.

The woefully low MBS rebates are also impacting on the quality of services. Private diagnostic imaging practices rely on MBS rebates for a considerable proportion of their revenue, given that the ability to recover an increasing proportion of revenue from patients is limited.

Practice costs are primarily driven by labour costs – radiologists, radiographers, sonographers, etc. Diagnostic imaging services rely on highly trained staff including medical practitioner

specialists to supervise the examination and analyse the results. When margins are continually squeezed, the level of staffing, training and the comprehensiveness of services offered is compromised. As commercial viability decreases, there is a risk that unprofitable services will be withdrawn.

Ultimately, when practices are no longer able to invest in an experienced and highly trained team, quality equipment, or offer comprehensive diagnostic imaging services, it is patients – again – who bear the impact with less choice and even more limited access.

Also concerning is the lack of any MBS rebate for some types of imaging services despite an established evidence base. MRI scans are accepted as a standard element in the continuum of diagnosis, treatment and management for prostate, cervical and breast cancers, yet access to clinically appropriate MRI scans is severely restricted or unavailable for many patients being treated in the private sector. For example, while pelvic MRI is currently funded under the MBS, it can only be claimed once in a patient's lifetime. This is simply not rational given contemporary standards of cervical cancer treatment.

The AMA calls for three actions to address this problem.

Firstly, there must be real increases in MBS rebates to ensure that they are better aligned with the cost of service provision.

Secondly, the introduction of a payments model should be explored which protects patients from needing to pay up front to access diagnostic imaging services. For example, the Australia Diagnostic Imaging Association has proposed a billing system that would require amending the Medicare rules so that patients were allowed to pay just the gap through a HICAPS-style billing system. This should also be available for other out-of-pocket MBS rebate eligible services but is a particular priority for diagnostic imaging.

Thirdly, there must be an expansion of medical indications eligible for the MBS rebate, reflecting evidence-based, current practice.

These three actions would do much to improve the circumstances of both patients and practitioners.

Focus on quality not numbers

Government policies regulating diagnostic imaging services should be underpinned by the objective of ensuring that the right patients are receiving the right service at the right time.

The Government's MRI licensing system makes no sense. It only serves to limit patient access through rationing. Limits through licensing are not applied to any other MBS eligible diagnostic imaging service.

Patient access to MRI examinations should be based on clinical need and evidence-based clinical guidelines, not on geographic availability or other arbitrary factors used by the Government to determine the number and locations of machines. Imaging referrals based on best practice will save money as well as improve patient care.

Diagnostic services should be eligible for Medicare benefits as long as they: reflect evidence-based clinical practice; are performed by qualified practitioners with appropriate training, knowledge and expertise; are provided in facilities that meet accreditation standards; and are undertaken using high quality equipment.

The *Imaging Wisely* movement, based on international, evidence based best practice, strongly recommends using imaging modalities which have no radiation but can give the same or better information whenever possible, particularly in patients with chronic disease and a normal life expectancy, in order to reduce the risk of developing radiation induced cancer. Medical radiation has a small but definite risk to the population as a whole. If it can be avoided it has to be of benefit.

MRI is the perfect modality in many cases, but not easily available or not allowed under the current MBS ruling.

The Government already has systems in place to ensure MRI services, like any other diagnostic imaging service, are clinically appropriately and reflect best practice.

The Medicare Benefits Schedule lists the services and specific circumstances under which MBS rebates apply. These services are assessed for effectiveness and cost-effective by the Medical Services Advisory Committee (MSAC).

Compliance audits and investigations of services, billing and individual practices are regularly undertaken by government as part of the normal business of administering the Medicare program and ensuring its integrity.

The Government's Diagnostic Imaging Accreditation Scheme also ensures that all providers, practices and sites offering diagnostic imaging services meet certain standards of safety and quality in order for patient services to be eligible for Medicare benefits.

If the Government needs additional assistance in determining the circumstances under which general practitioners should refer patients for an MRI, then it should refer to the Royal Australian and New Zealand College of Radiologists' evidence-based practice guidelines. The College also sets standards for MRI machines.

The AMA supports the established MSAC process, Medicare audit and compliance programs, and the quality measures already in place to support evidence-based and cost effective medical services. It therefore opposes any equipment-based licensing system because it is irrelevant and only acts as a barrier to clinically appropriate, safe and quality care.

The AMA considers that all MRI units that meet the quality requirements set by the Royal Australian and New Zealand College of Radiologists, and are staffed by radiologists and radiographers that meet the College's MRI accreditation standards, should be eligible for MBS benefits. The focus should be on supporting MRI services as part of a good quality, comprehensive practice that applies appropriate quality controls and employs a range of staff with broad and specialist expertise.

If Australian health care is to reap the downstream benefits that timely access to diagnostic imaging delivers, it must ensure there is adequate supply to meet demand.

Country Australians are not second class citizens

Unlike some other diagnostic testing, such as pathology tests where samples can be sent to central locations for assessment, to conduct diagnostic imaging it is of course necessary for the patient to be physically present.

This leads to high financial and personal costs to many individuals living in regional and remote areas of Australia where services are not locally available. Costs include time off work, travel and accommodation costs, costs for accompanying family members, and the need to make arrangements for family left behind. The difficulties are exacerbated when patients are children. Travel and accommodation assistance schemes for remote patients available in each state and territory are administratively difficult and complex to access and provide relatively small reimbursements.

There is often a wait for appointments at the nearest public hospital, unless the referring doctor is able to request a private practice to take on the patient as a pro bono bulk billing case. AMA regionally based general practitioner members report that private city practices often volunteer to absorb the costs of providing expensive scans for country patients. However, this is clearly an unsatisfactory, inconsistent and unsustainable arrangement.

Funding arrangements and systems must be developed that recognise the clinical and ethical importance of access to local services, and that local services may need additional funding to be viable. Australians living in regional and remote areas should have access to practices that can afford to offer comprehensive services; attract and retain competent medical staff with general and specialist expertise; and to purchase, operate and maintain appropriate equipment.

The Medicare system of medical practitioner referral for diagnostic services also needs to be rationalised to prevent people living in the country having to travel back and forth to obtain multiple referrals as they move along the diagnostic and treatment pathway.

For example, a patient initially presenting to a general practitioner with chest pain would generally be referred for an X-ray; then if showing an abnormal result, for a CT scan. If the CT scan indicates a possible tumour, the patient will need to be referred to a specialist medical practitioner who may then arrange a fine needle biopsy, with the sample referred to a pathologist for assessment. Under this scenario, a country patient moving through this pathway of care would need to return to the city for these services three separate times, because each time a new referral is required from the general practitioner and then specialist medical practitioner. Not only are multiple trips expensive and disruptive for the patient, but a definitive diagnosis is delayed by many weeks, even assuming the patient complies with each referral promptly.

We need to develop a flexible and adaptive system of referrals and patient management to address these problems. Providing radiologists with the capacity to proceed with additional diagnostic scans, substitute a requested scan for a more clinically appropriate scan, and/or to refer a patient directly to another medical practitioner – in consultation with the patient's initially referring doctor – would be a first important step.

This has the potential to not only enhance and shorten a patient's journey through the health care system, but also save on Medicare expenses by skipping unnecessary services. As in the earlier discussion regarding arbitrary limits on MRI machines, the usual tools of Medicare audits and compliance activities are available to government ensure radiologists follow evidence-based and cost-effective diagnostic and treatment pathways.

Summary

The AMA calls for:

- increases in MBS rebates for diagnostic imaging services
- the introduction of new MBS rebates for clinically appropriate, evidence-based diagnostic imaging services, reflecting current practice
- the introduction of a billing system to allow patients to pay just the gap upfront
- the MRI licensing system to be scrapped
- funding and referral arrangements that support better access to high quality, timely and affordable services in regional and remote Australia.

October 2017

[i] There is a large body of Australian and international research illustrating the negative impact of out-of-pocket costs/copayments on people seeking timely health care, particularly those in low socioeconomic groups. The following Australian article summarises the key evidence and provides additional references:

Duckett, S., Breadon, P., Farmer, J., 2014, *Out of Pocket costs: Hitting the most vulnerable hardest*, Grattan Institute