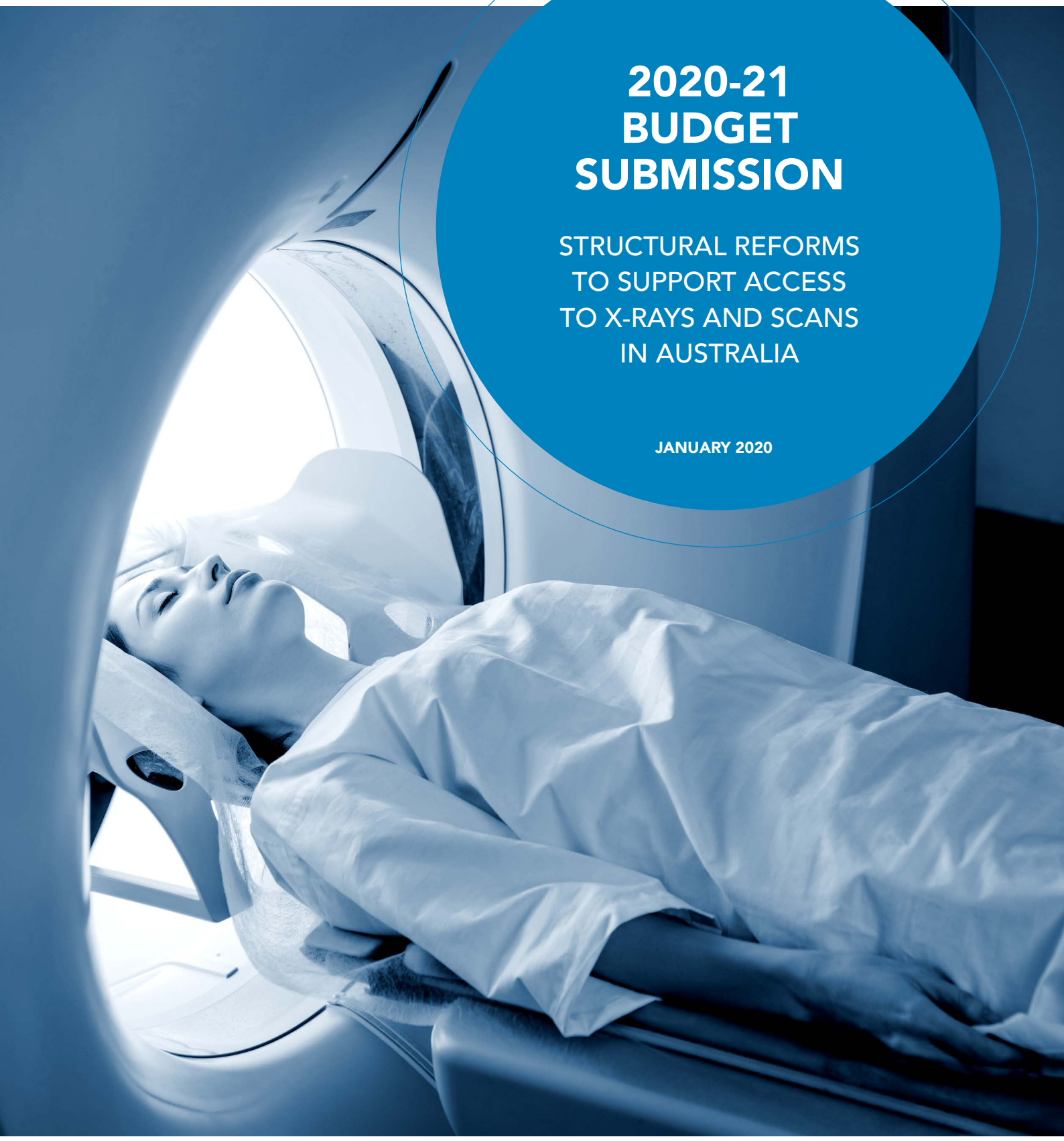


2020-21 BUDGET SUBMISSION

STRUCTURAL REFORMS TO SUPPORT ACCESS TO X-RAYS AND SCANS IN AUSTRALIA

JANUARY 2020

RADIOLOGY SAVES LIVES

ADIA
australian diagnostic imaging association

ADIA is the peak industry body representing private and not-for-profit radiology practices in Australia, with member practices providing x-ray, ultrasound, CT, MRI, nuclear medicine and PET services in more than 500 locations across the country. ADIA promotes the ongoing development of policy, standards and appropriate funding to ensure that all Australians have affordable access to quality radiology services. This supports radiology's central role in the diagnosis, treatment and management of a broad range of conditions in every branch of medicine.

PRESIDENT'S MESSAGE

Every year, Medicare helps more than nine million Australians to access radiology services – x-rays, ultrasound, CT, MRI, nuclear medicine and PET scans – to diagnose and treat a broad range of conditions, from broken bones to every type of cancer. Radiology is an indispensable part of a modern, first-class health system.

ADIA is very pleased that the Government committed to improve access to and affordability of radiology in early 2019. We are looking forward to Medicare rebates for x-ray, ultrasound, CT, mammography, fluoroscopy and image-guided procedures being indexed on 1 July this year for the first time in 22 years; and welcome the introduction of 53 new MRI licences across Australia.

However, there is more to do. In this Budget Submission, ADIA recommends structural reforms to make it easier for Australians to access the right radiology service at the right time, at an affordable cost for both patients and the Government:

- Patient bill relief by amending Medicare billing arrangements to allow patients to pay just the gap, rather than the full cost of radiology services upfront. This will address a significant barrier to accessing radiology for the many Australians who do not have the capacity to pay high upfront costs for complex services like CT, MRI and nuclear medicine.

- End the freeze on all radiology services by extending the reinstatement of indexation to include nuclear medicine and MRI. These services are essential for diagnosing and treating cancer and other conditions, but affordable services will not be sustainable in the long-term with Medicare rebates frozen indefinitely.

- Clarify appropriate roles for public hospitals and private providers by introducing funding settings which promote efficient provision of radiology services to outpatients. Public hospitals are effectively being funded twice (public hospital funding and Medicare rebates) for each service they provide, which presents substantial risks to the Budget.

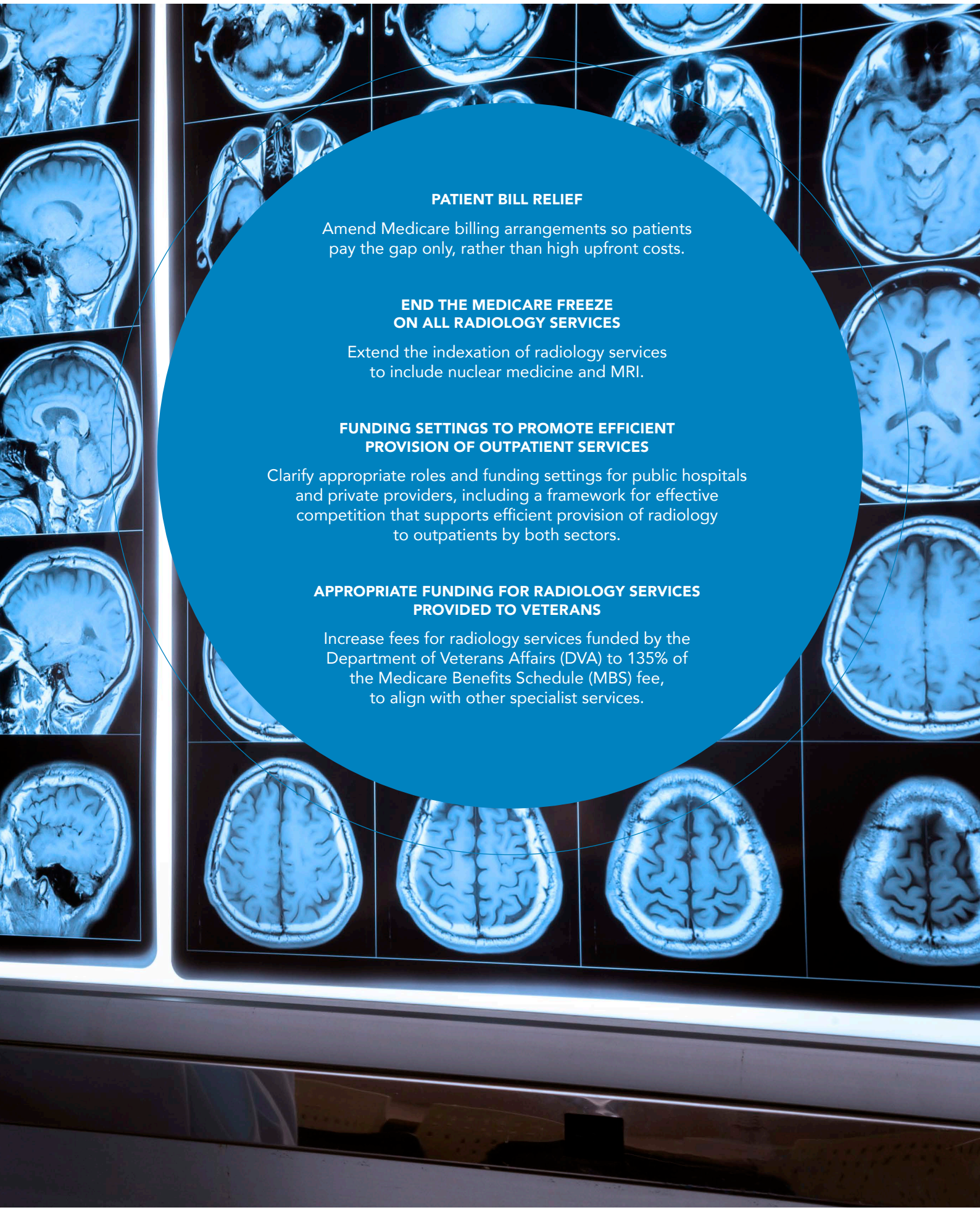
- Ensure appropriate funding for radiology services to veterans by aligning Department of Veterans Affairs (DVA) fees with the fees paid for other specialist services. The 21-year indexation freeze has changed the fee relativities between radiology and other services, and this should be addressed to support affordable services to veterans.

In addition, ADIA is currently developing long-term reform options for MRI. Access to MRI has improved through the introduction of 53 new and upgrades MRI licences in 2018 and 2019, however the limited number of licences means that affordable, convenient access to MRI is still out of reach for many Australians.

DR JULIAN ADLER | PRESIDENT

JANUARY 2020

RECOMMENDATIONS



PATIENT BILL RELIEF

Amend Medicare billing arrangements so patients pay the gap only, rather than high upfront costs.

END THE MEDICARE FREEZE ON ALL RADIOLOGY SERVICES

Extend the indexation of radiology services to include nuclear medicine and MRI.

FUNDING SETTINGS TO PROMOTE EFFICIENT PROVISION OF OUTPATIENT SERVICES

Clarify appropriate roles and funding settings for public hospitals and private providers, including a framework for effective competition that supports efficient provision of radiology to outpatients by both sectors.

APPROPRIATE FUNDING FOR RADIOLOGY SERVICES PROVIDED TO VETERANS

Increase fees for radiology services funded by the Department of Veterans Affairs (DVA) to 135% of the Medicare Benefits Schedule (MBS) fee, to align with other specialist services.

PATIENT BILL RELIEF

High gaps present a barrier to patients accessing radiology services they need, and this is exacerbated by the Medicare rules. Where a patient is charged a gap, they pay the full cost of the service upfront, before they can claim their Medicare rebate.

Upfront costs for radiology are the highest in primary care, averaging $219, and even higher for complex services like CT, nuclear medicine and MRI:

AVERAGE UPFRONT COST PER SERVICE (2018-19)

Ultrasound	CT	X-ray	NM	MRI
$217	$454	$111	$477	$526

Source: ADIA analysis of Medicare statistics

The sickest patients usually need multiple x-rays and scans in the course of diagnosis and treatment, creating a substantial financial burden. For example:

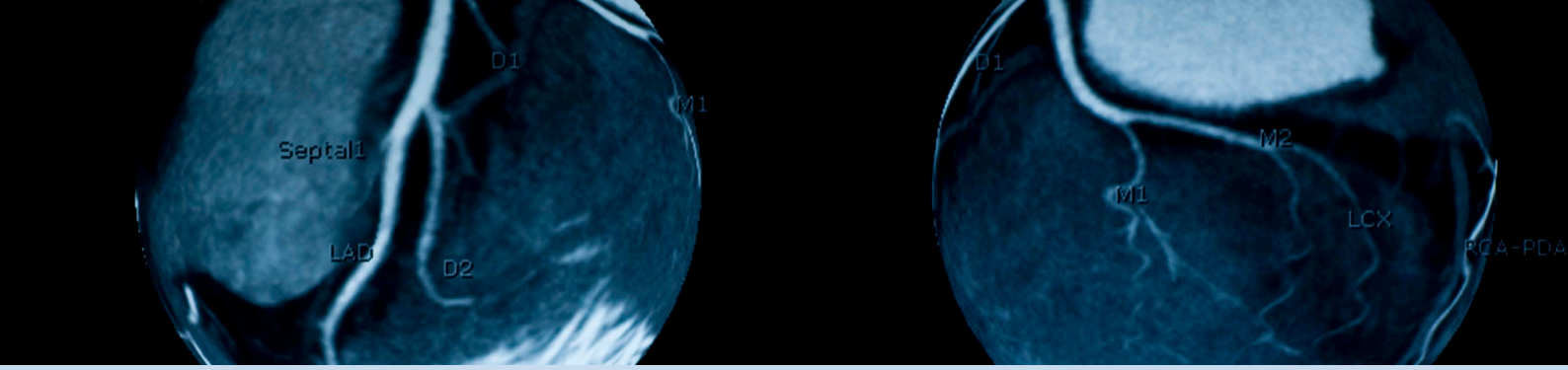
OVARIAN CANCER*

Service	Upfront cost	Gap
Ultrasound, pelvis	$175	$91
CT, upper abdomen and pelvis with contrast	$597	$189
CT, upper abdomen and pelvis with contrast	$597	$189
Ultrasound, pelvis	$175	$91
Total	**$1,544**	**$560**

STROKE*

Service	Upfront cost	Gap
CT, head with contrast	$316	$104
CT, spiral angiography	$616	$182
MRI, head and neck vessels for stroke	$559	$140
Ultrasound, carotid vessels	$228	$84
Digital subtraction angiography, 10+ runs	$1,376	$76
Total	**$3,095**	**$586**

*Average upfront costs and gaps based on ADIA analysis of 2014 deidentified Medicare data



CASE STUDIES: TYPICAL UPFRONT COSTS FOR PATIENTS WITH COMMON CONDITIONS

LUNG CANCER

A 46-year-old man presents to his GP with general shortness of breath and a persistent cough. The patient's GP refers the patient to a specialist radiologist for a standard chest x-ray **($69 upfront and a $27 gap** once the Medicare rebate is received).

The x-ray indicates the presence of a small solitary lung nodule, suggestive of a possible neoplasm. The GP refers the patient to a respiratory physician who further investigates the nodule and requests a high-resolution CT of the chest with contrast **($493 upfront/$157 gap).**

The radiologist reports that the nodule may be malignant and recommends a further FDG-PET for the evaluation of the solitary pulmonary nodule **($1131 upfront/$258 gap).**

The PET examination shows the presence of one solitary lesion. The respiratory physician requests that the patient return in 3 months to determine whether the lesion has grown.

Three months later, the patient receives a repeat CT of the chest with contrast **($493 upfront/$157 gap),** which shows that the lesion has increased in size.

The physician then refers the patient for a CT-guided fine needle aspiration **($897 upfront/ $317 gap)** at the hospital site. The patient is diagnosed with a non-small cell carcinoma and commences treatment.

12 months later, the patient is referred for FDG-PET to stage a proven non-small cell lung cancer **($1131 upfront/$258 gap)** to determine the success of the treatment.

Total upfront costs for radiology services:

$4,214

Total patient gap for radiology services:

$1,174

CORONARY ARTERY DISEASE

A 36-year-old woman presents to her GP with vague symptoms of feeling run-down and generally lacking energy. The GP requests a blood test to determine whether the patient is anaemic. The test comes back negative.

The GP refers the patient for a CT for calcium scoring **($160 private fee),** as the service is not funded by Medicare), which comes back elevated at 920.

After assessing the patient's calcium score, the GP refers the patient to a cardiologist for further investigation. The cardiologist refers the patient for a CT of the coronary arteries **($819 upfront/$195 gap)** which indicates a 75% stenosis (narrowing) of the right coronary artery – coronary artery disease.

The cardiologist then refers the patient for a combined stress and rest study with SPECT **($1046 upfront/$291 gap) t**o evaluate blood flow to the heart muscle.

The patient is treated with medication and lifestyle modification, and requires an ongoing follow-up echocardiogram **($298 upfront/$102 gap)** every two years to monitor the stenosis.

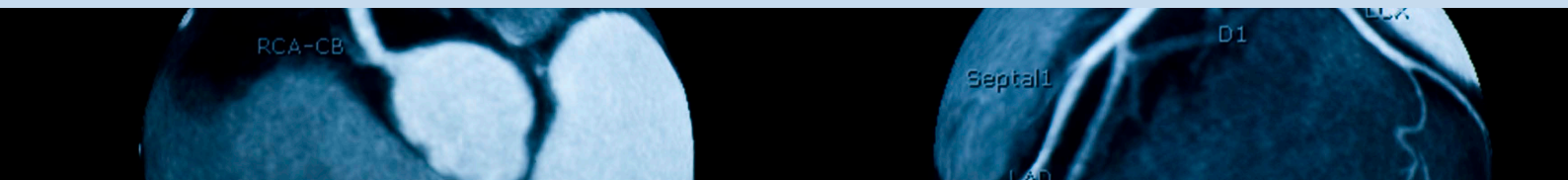
Total upfront costs for radiology services:

$2,323

Total patient gap for radiology services:

$748

*Average upfront costs and gaps based on ADIA analysis of 2014 deidentified Medicare data



Australians with private health insurance are able to pay the gap only at their dentist or physiotherapist, but patients needing high-cost, clinically necessary radiology services cannot do the same. The current Medicare billing arrangements actively discriminate against patients who don't have the capacity to pay large cash amounts on the day.

ADIA recommends introducing HICAPS-style billing for radiology services, in which the patient would pay only the gap at the time of the service, and Medicare would pay the practice directly.

RECOMMENDATION

Amend Medicare billing arrangements so patients pay the gap only, rather than high upfront costs.

END THE MEDICARE FREEZE ON ALL RADIOLOGY SERVICES

In the 2017-18 and 2019-20 Budgets, the Government announced that indexation of rebates for ultrasound, x-ray, CT, mammography, fluoroscopy and interventional radiology services will be reinstated from 1 July 2020. This will end a freeze lasting more than two decades, and will make radiology services more affordable in future.

However, Medicare rebates for nuclear medicine and MRI remain frozen indefinitely. These services have some of the highest gaps and upfront costs in all of Medicare:

AVERAGE UPFRONT COST AND PATIENT GAP PER SERVICE (2018-19)

	NUCLEAR MEDICINE	MRI
Upfront cost	$217	$454
Patient gap	$104	$184

Sustainability of affordable nuclear medicine and MRI services is at risk while rebates are frozen. These services are essential to diagnosis and treatment of a wide range of conditions:

- Nuclear medicine is used to diagnose and determine the severity of diseases, particularly cancer and heart conditions. It may also identify disease at the earliest stage, before symptoms occur or abnormalities can be detected with other diagnostic tests.

  These services are very expensive to provide, with the cost of radioactive tracers constituting 25 - 40% of the Medicare rebate alone for many nuclear medicine services.

- MRI allows radiologists to identify abnormalities without the use of radiation. It is used to diagnose conditions in all parts of the body, including cancer, injuries and diseases of the bones and joints, and neurological conditions.

RECOMMENDATION

The Government should extend the indexation of radiology services to include nuclear medicine and MRI.

FUNDING SETTINGS TO PROMOTE EFFICIENT PROVISION OF OUTPATIENT SERVICES

Public hospitals are effectively funded twice to deliver radiology services to outpatients, through hospital funding under the Australian Healthcare Agreement as well as Medicare rebates. This is an inefficient use of scarce health dollars, and also distorts the market for outpatient services by giving public hospitals a competitive advantage over private practices.

The competitive advantages include:

- Premises, equipment and staff in public hospital radiology departments are funded through the Australian Health Care Agreement;
- Employee-related tax exemptions and concessions; and
- Public hospitals are not required to achieve a commercial rate of return for services to outpatients.

These advantages allow public hospitals to bulk bill most outpatient services at significant profit margins, because the cost of delivering the service is already paid for. This has prompted many public hospitals to aggressively market their radiology departments to Medicare-funded outpatients and their referrers; and introduce incentive arrangements for radiologists who undertake Medicare-funded work through Rights of Private Practice arrangements. ADIA is aware of public hospitals that prioritise outpatients over inpatients due to these incentives.

Previous ADIA analysis showed that public hospitals were the fastest growing provider type between 2004-05 and 2010-11, and anecdotal evidence indicates that this trend has continued.

With public hospitals effectively funded twice, outpatient services provided by public hospitals rather than private practices result in additional costs to the taxpayer. This presents a significant risk for the Budget.

RECOMMENDATION

The Government should clarify appropriate roles and funding settings for public hospitals and private providers, including a framework for effective competition that supports efficient provision of radiology to outpatients by both sectors.

APPROPRIATE FUNDING FOR RADIOLOGY SERVICES PROVIDED TO VETERANS

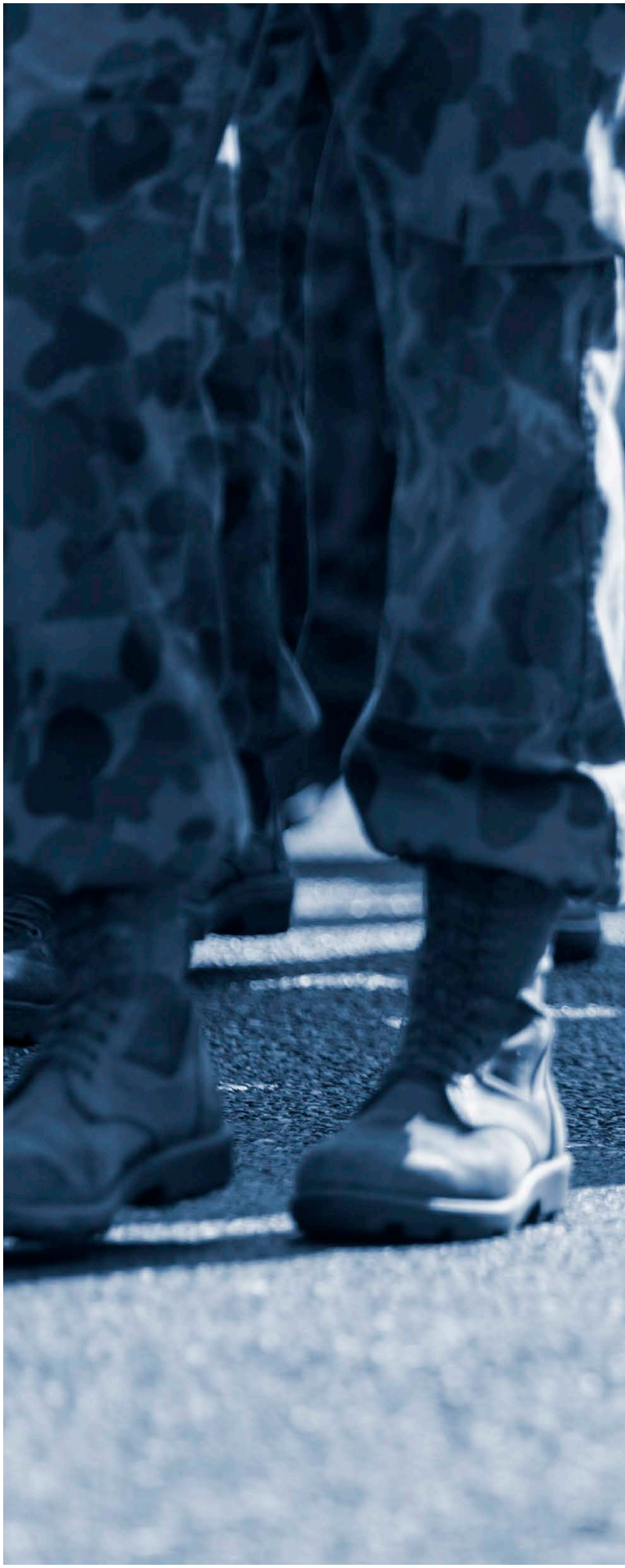
Radiology services provided to veterans are funded by the Department of Veterans Affairs (DVA), with fees set at 100% of the Medicare Benefits Schedule (MBS) fee.

The current fees were set following a DVA review in 2006, with funding as follows:

- Radiology services are funded at 100% of the MBS fee
- Pathology services are funded at 100% of the MBS fee
- GPs are funded at 115% of the MBS fee
- Specialist consultations are funded at 135% of the MBS fee
- Specialist procedures are funded at 140% of the MBS fee

Since these funding arrangements were set, most Medicare services have been extensively indexed, with MBS fees for GP and specialist consultations increasing by more than 20%. In contrast, all MBS fees for radiology have been frozen during this period. This has caused the fee differential between radiology and other medical services to increase well beyond what was recommended by the review.

The Medicare freeze has left fees for DVA-funded services well below what is required to deliver a quality service, which could put affordable radiology services to veterans at risk. ADIA considers that fees for radiology should be set at the same level as specialist consultations, which will ensure that DVA services are sustainable into the future.



RECOMMENDATION

The Government should increase fees for radiology services funded by the Department of Veterans Affairs to 135% of the MBS fee, to align with other specialist services.

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