AACP

AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS

Submission to the

Strategic Review of Future Funding Arrangements

for

Diagnostic Imaging and Pathology Services

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Submission to the Department of Health and Ageing Strategic Review of Future Funding Arrangements for Diagnostic Imaging and Pathology Services

The Australian Association of Consultant Physicians (AACP) welcomes the opportunity to make a submission to the Department of Health and Ageing (DoHA) in the context of the conclusion of the Diagnostic Imaging Memorandum of Understanding. The MOU covered growth targets and financial outlays for each of radiology, nuclear medicine, cardiology and obstetrics and gynaecology ultrasound.

The MOU concluded with an underspend in radiology and nuclear medicine, while the outcome for cardiac imaging, obstetrics and gynaecology are unknown. However, cardiac imaging outlays were growing well above those set in the MOU, as were those for obstetrics and gynaecology – a fact known from the beginning of the MOU.

The diagnostic imaging profession is divided on its support for a further MOU – nuclear medicine physicians are open to the idea, radiologists are opposed.

The terms of reference for the review of future funding arrangements for diagnostic imaging and pathology services assume the availability of data and information that is not accessible to the medical profession or the AACP.

This submission addresses some issues related to appropriateness, efficiency, cost-effectiveness, and performance assessment of diagnostic imaging services. These are discussed within the context of the changes in the environment in which diagnostic imaging services are provided and how this has changed over the life of this MOU, and their effect on the availability of services to the community and the profession. The submission also identifies key issues identified by AACP as needing to be addressed by DoHA and the Australian Government to ensure that diagnostic imaging services continue to be accessible and affordable to the community. It also comments on the future of diagnostic imaging services and policy implications.

Consultant physicians – who they are

The AACP represents the interests of the group of consultant physicians, including those who provide diagnostic imaging services. Other specialists including radiologists and obstetricians and gynaecologists also provide diagnostic imaging services but are not represented by the AACP.

Most diagnostic imaging services are generated by a referral from a general practitioner (GP) so the demand for services is principally driven by others. Often a number of diagnostic imaging services are ordered by the GP before the patient is referred to a consultant physician, who may order a further set of diagnostic imaging services based on their clinical assessment of the patient and expertise. This raises the sensitive issue of whether there would have been more efficient use of funds if the patient had been referred to the consultant physician earlier.

There is also scope for self-referral for diagnostic imaging services, thereby directly driving demand for services. Consultant physicians (and other specialists such as surgeons for endoscopy and arthroscopy) are in the position of being able to self-refer for diagnostic procedures that are not covered by the Diagnostic Imaging Table of the Medical Benefits Schedule (MBS). The issue of self-referral for MBS diagnostic imaging services is contentious because it raises the issue of potentially clinically inappropriate unnecessary self-referral practices. The AACP believes however that the majority of referrals are justifiable and clinically relevant. The view of the AACP is that medical professionals are bound ethically to provide services that are clinically relevant to the patient. This is codified and reinforced in the Royal Australasian College of Physicians Code of Professional Standards. If the government has concerns about this practice, the department could revisit the Prohibited Practices legislation with a view to ensuring that all specialties are affected equally.

The government has invested funds into the MOU to support programs aimed at improving the appropriate use of diagnostic imaging technologies. These complement continuing professional development programs offered by medical specialist colleges and training of general practitioners. The AACP is unable to comment on the impact of government funded quality programs but supports the continuation of the programs.

Environmental Drivers of Demand

- **Diagnostic technologies are central to health care**

Diagnostic technologies including imaging and pathology have a more central role in health care today than they did five years ago. They are used more routinely to establish diagnosis and monitor treatment and are widely accessible. They provide clinicians with more accurate and improved diagnostic information for clinical management.

In some specialties, certain diagnostic procedures have become routine, for example, anaesthetists require cardiac ultrasounds to be performed pre-operatively on patients with a history of cardiac illness.

Some diagnostic procedures complement longstanding approaches. For example, echocardiography is being used more widely and stress echocardiography is being used now as a first step prior to or as an alternative to cardiac catheterisation to diagnose coronary artery disease. This means that a number of people may be able to avoid a diagnostic cardiac catheterisation which involves an anaesthetic, operating theatre and support staff, and recovery ward. The invasive nature of the procedure is costlier and carries risks and the need for patient hospitalisation and time off work/away from home makes it a procedure that has had to be used selectively. The broader scope for use of this technology among people presenting with less serious symptoms but nevertheless potentially life threatening, is obvious – earlier diagnosis means earlier treatment and potentially less complications. It also has considerable value in the management of the acutely unwell, particularly the older patient with multiple co-morbidities who may not tolerate cardiac catheterisation.

It is important to recognise that diagnostic technologies available now also have an important role in indicating where treatment is not necessary or possible, and AACP would

argue that this is good practice in terms of avoiding costs to the health system and the patient. Expenditure on diagnostic procedures cannot be viewed as an indicator of its overall value in isolation of the role these services have in determining the clinical management of the patient. Diagnostic services and procedures are an integral part of the continuum of care.

- **Population and patient expectations are increasing**

There are population factors driving growth in volume of diagnostic technologies and apply across health care generally. More people are using the internet to access information on the latest developments in medical and diagnostic technologies. Overall, consumers are better informed and their expectations are that if the technologies are available, they will be able to access them.

The number of Australians older than 55 years is increasing and will increase into the future. Morbidity increases with age, and the most common conditions associated with ageing are cancers, cardiac disease, respiratory disease, and musculoskeletal conditions, all of which rely on diagnostic technologies for diagnosis and monitoring of treatment.

Over the past five years, Australia has experienced the highest birth rate in decades, peaking at around 200,000 live births in the last twelve months. Ultrasound is the most common diagnostic technology used in obstetric care and gynaecology and it is likely to increase. As the risk of complications in pregnancy increases with age, the trend of Australian women having their first babies at an older age, the use of this technology will continue to increase as will the associated expenditure. Older women too are likely to have ultrasounds for gynaecological conditions associated with ageing because these are less invasive than previous approaches to investigation, carry less risk and cost less.

Another trend that has emerged over this period is the increase in the use of diagnostic technologies and interventions on people who previously would have been considered too old. Now elderly people that are generally well and independent but have a condition that is manageable, such as a heart valve replacement, will be treated well into their eighties. This trend is likely to increase as subsequent generations of old people expect to stay fitter and more active than past generations.

There is also the unquantifiable impact of the expanded immigration program of around 100,000 a year, on the growth in demand for diagnostic technology services over the period of this review.

Together, population demography and technological developments have increased demand for services. However, for DoHA and the government, growth in volume of diagnostic technologies translates into budgetary concerns and understandably raises questions about the cost effective use of these services. However, growth in volume of services and expenditure are not measures of the efficiency or cost-effectiveness of these services and using these as proxies avoids addressing the difficult question about the adequacy of funding in the present set of community expectations. The AACP would support the establishment of a body to undertake data collection and analysis on these issues.

- **The workforce is satisfactory but maldistributed**

There is no shortage of consultant physicians with a diagnostic specialty in metropolitan areas. Shortages persist in rural and regional areas and are likely to stay this way into the foreseeable future, despite advances in remote consultations and remote technical reporting capabilities which will offer next best options.

For most patients, a face-to-face consultation involving a clinical examination with a physician is the safest option. However, in some regions, population size highly unlikely to be able to sustain all medical specialties or full time because the demand for the services is too low making it cost ineffective. At times, conditions dictate that the reporting be undertaken remotely and may involve a life or death situation, for example, in regions where there is no resident local consultant physician. This is not an ideal situation because the legislation requires the consultant physician to be present. Consultant physicians who do report remotely are in breach of the health legislation and face prosecution. While the alternative option to the consultant physician is to refuse to provide the service, it runs counter to the notions of accessibility and patient centred care.

There are some regions of Australia where there will never be a consultant physician and the provision of urgent and non-urgent diagnostic imaging services will need to be done remotely by a consultant physician. In these circumstances, the challenges for the profession and government are:

1. how to ensure that consultant physicians act lawfully in situations where they cannot be present with a patient; and
2. ensure that there is a quality assurance framework in place to support practice that is as comparable as possible to a face-to-face consultation.

The AACP would be willing to work with the department to develop a mechanism that regulates the use of remote technologies in specified circumstances.

From a medical specialist workforce perspective, there is scope for improving the accessibility of services of consultant physicians in regional areas by encouraging general physicians that have one of more sub-specialities to provide these services also. This approach would be a more viable long-term approach to the current situation. The AACP would be prepared to work with DoHA to assess this idea.

- **The issue of role evolution**

The provision of diagnostic imaging services involves technologists who take the images and review the quality of the image before a clinical review is undertaken and a report is prepared by the consultant physician or by a radiologist (where appropriate). Technologists are in demand as are other technicians. There has been some discussion about extending the clinical component of reporting of some images to technologists. While this might seem like a quick fix to the shortage of consultant physicians in rural areas, there remain the questions of who carries the risk and the professional and legal responsibility for non-clinicians making clinical decisions.

In the Australian medical environment, the term *consultant physician* refers to a specialist. In the United States, the term *physician* is the equivalent to general practitioners in Australia. The use of the term *physician assistants* is an imported term from the United States and its use in the Australian health policy setting and community is misleading and inappropriate.

Funding diagnostic imaging services - issues

- **Cost –effective diagnostic services - Medical Benefits Schedule (MBS) review and indexation issues**

There are several issues that the AACP raises in respect of the Medical Benefits Schedule (MBS). There is no general principle about regularly reviewing MBS fees for diagnostic technologies. For the cardiac ultrasound items which have not been reviewed for 10 years, the relative value of the MBS fees have been reduced by up to 50% linked to increased equipment costs and the higher costs of the technicians.

There is no mechanism to adjust MBS fees for parity taking into account changes in technology that might result in procedures of similar cost, and complexity and professional up-skilling required to undertake the procedure. As a consequence, this can result in the fees for some services being higher than they should be and for others lower than they should be.

AACP appreciates that the department and government's primary focus is on the growth in volume that flows to expenditure and regards lower fees as being an indicator of cost-effectiveness. However, this position ignores the input cost factors of delivering services as well as growth in volume from changing practices which are supported by evidence about improved patient outcomes. Consequently the increased costs borne by practices are being passed onto patients through greater out of pocket costs. These are likely to increase in the current economic environment if there is no mechanism in place to review or index fees to keep up with increasing costs.

Diagnostic technology is set to become even more important in determining most appropriate treatments as they become available in the future and the AACP advocates proper access to diagnostic imaging and pathology services, without unreasonable patient gaps. Indexation of MBS fees for diagnostic imaging services undertaken by consultant physicians would be a first step.

- **Costing of services is out of date**

As indicated above, MBS fees for diagnostic imaging services have not been reviewed for a decade. The department has moved to expand the MBS items into endless numbers of sub components to allow each person who carries out a small technical part of the service (under the direction of the specialist) according to their area of expertise/qualification to charge a fee. In part, this appears to be a response to the role evolution/substitution /delegation considerations. From an efficiency perspective, this will increase overall administration costs to the government via Medicare, private health funds, and patients having to seek more reimbursements of costs.

In the view of the AACCP, it would be preferable to address this issue through recognition of the existing technical component and expansion of the existing technical component, where appropriate. AACP encourages DoHA to re-open the discussions on updating the diagnostic imaging fee structures and would be willing to assist with progressing this work.

- **Assessment of new medical technologies - Medical Services Advisory Committee (MSAC)**

AACP understands that there are many issues for the government, the diagnostic technology industry and the medical profession that relate to funding new medical technologies and welcomes the forthcoming review of the Medical Services Advisory Committee, foreshadowed by the government in its pre-election commitment. AACP looks forward to having an opportunity to make a submission to that review.

Corporatisation

The MOU was negotiated under the policy position of the previous government that saw advantages in the corporatisation of the pathology and diagnostic imaging services. The government saw potential efficiencies from negotiating funding and growth parameters with a few large groups. The loss of smaller private practices was seen as increasing the efficiency of the sector and the market forces at work. This environment led to the closure and privatisation of public hospital pathology and diagnostic imaging services that could not compete with the corporate companies. It was also accompanied by some rationalisation of services in both metropolitan and regional areas. AACP supports a review of this area in the context of the review's TORs and the current financial crisis.

Recommendations

AACP makes the following recommendations:

1. DoHA recognises that demand for diagnostic services is a factor of multiple pressures from population, demographic changes, societal expectations and cultural changes, improvement in diagnostic technologies and their increasing value in determining treatment and monitoring and growth in costs of services.
2. DoHA continues to fund quality use of diagnostic imaging programs for general practitioners and medical specialists.
3. DoHA establishes a body to undertake data collection and analysis of diagnostic imaging services (beyond expenditure and volume) to identify measures for effectiveness and cost-effectiveness within the context of the continuum of care provided to patient and the outcomes.
4. DoHA and the government ensure that consultant physicians act lawfully in situations where they cannot be present with a patient to provide a face-to-face diagnostic imaging service, and ensure that there is a quality assurance framework in place to support practices that are as comparable as possible to a face-to-face consultation.

5. DoHA considers working with AACP to improve the accessibility of services of consultant physicians in regional areas by encouraging general physicians that have one or more sub-specialties to provide services in those areas.
6. DoHA accepts that the term *physician assistant* is an imported term from the United States and its use in the Australian health policy setting and community is misleading and inappropriate.
7. DoHA supports accessible and affordable diagnostic imaging services to patients by introducing indexation of MBS fees to keep up with increasing costs.
8. DoHA re-opens the discussions with AACP on updating the diagnostic imaging fee structures.

President
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