




# Budget Submission

January 2021



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

Healthcare relies on radiology.

Radiology plays a critical role in diagnosis and treatment of conditions in almost every branch of medicine, from musculoskeletal conditions like neck and shoulder pain, broken bones and sporting injuries; heart conditions; and every type of cancer. Medicare supports more than 9 million Australians each year to access the x-ray, ultrasound, CT, MRI, nuclear medicine and PET scans recommended by their referring doctor.

Radiology practices have continued to provide x-rays and scans during the CoVID-19 pandemic. ADIA acknowledges the Government's support for ongoing service provision through temporary amendments to several Medicare rules, which protected the radiology workforce and patients.

This submission includes recommendations to address five key structural barriers to affordable and accessible radiology for Australian patients:

- Medicare rebates for MRI are restricted to MRI scanners with a 'licence', which limits access to affordable scans. ADIA has developed a proposal to incrementally remove the licence system, to increase the availability of affordable MRI around Australia.
- Patients who are charged a gap by their radiology provider must pay the full cost of the service upfront before claiming the Medicare rebate. This is a major barrier for many Australians, who are unable to pay \$500+ upfront for services like CT, nuclear medicine and MRI. ADIA recommends amending Medicare billing arrangements to allow patients to pay just the gap upfront.
- The reintroduction of indexation for x-ray, ultrasound and CT scans in July 2020, after 22 years, was a milestone for radiology patients and will make those scans more accessible and affordable. ADIA recommends extending



indexation to nuclear medicine and MRI scans, to ensure sustainability of these essential services for cancer and other conditions.

- Public hospitals are funded twice to deliver radiology services to outpatients, as well as enjoying a number of tax advantages over private practices. This distorts the radiology market and is wasting taxpayer dollars. ADIA recommends that the Government works with stakeholders to develop structural funding reforms for consideration as part of the next National Health Reform Agreement.
- Clinical uses for PET are expanding rapidly, with patients paying significant out of pocket costs because Medicare has not kept pace. ADIA recommends that independent MSAC consideration of three current applications for Medicare listing of PET services is fast tracked.

ADIA is working with the Department of Health and other stakeholders on development of national digital health infrastructure, which will require Government funding in future Budgets to support implementation and ongoing use by providers. In addition, we are engaging with the Department on reforms to funding for specialist training, to increase the number of Australian-trained radiologists practicing in regional and rural areas.

**Dr Julian Adler**  
**President**





## Recommendations

### Pathway to improve access to MRI

To improve access and affordability of MRI, set a long-term pathway to remove the MRI licence system by allowing patients to claim Medicare rebates for a limited number of paediatric and cancer MRI services on all MRI machines.

To protect private hospital inpatients from excessive out of pocket costs for MRI, grant limited Medicare eligibility to MRI scanners at private hospitals. Medicare eligibility would be limited to private inpatients at that facility admitted for at least one night.

### Patient bill relief

To protect patients from high upfront costs, introduce a new billing arrangement to allow patients to pay the gap only, with the rebate paid to providers by EFT thirty (30) days after the claim is lodged.

### Medicare freeze

To support bulk billing and reduce patient gaps, extend the indexation of radiology services to include nuclear medicine and MRI.

### Medicare funding of outpatient radiology services

To improve efficiency of radiology services to outpatients, work with the radiology sector to develop reform options for Medicare funding of outpatient services provided by public hospitals, with a view to implementing structural reform in the next National Health Reform Agreement.

### Medicare funding of PET services

To support access to clinically appropriate PET services, expedite independent consideration of MSAC applications for FDG PET scans for diagnosis of Alzheimer's disease, PSMA PET prostate scans, and streamlining of Medicare items for PET scans for FDG-avid tumours.

MRI is a gold-standard radiology modality, allowing 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.

**However, MRI is the only radiology service for which access to Medicare rebates is restricted by Government policy.**

Patients are only eligible for Medicare rebates where the MRI service is provided on one of 379 'licenced' MRI machines. Patients pay privately, usually between \$300 and \$1000 depending on the complexity of the service for all MRI examinations performed on around 110 'unlicenced' machines.

There is broad agreement in the radiology sector that access to Medicare rebates should be determined on the basis of each patient's clinical need, rather than restricted by the arbitrary licencing system. However, removing the licence system without a transition period would have a very significant impact on Medicare expenditure, be highly disruptive, and could lead to workforce shortages.

ADIA has developed a proposal to incrementally removing the licencing system, starting by removing licence restrictions on 12 paediatric MRI services and 12 cancer MRI services (breast, prostate, cervical, rectal, pancreatic and liver cancers). This would increase the availability of these services around Australia.

**Some private hospitals provide MRI services but do not hold an MRI licence, which forces inpatients in those hospitals to pay for the full cost of the service.**

Private health insurers do not fund these examinations, as they will only pay for services funded by Medicare.

As inpatients, these patients do not have the option of attending another practice or hospital that holds an MRI licence for examinations. ADIA estimates that up to 400,000 patients per year are falling through the cracks, paying between \$300 and \$1000 per MRI service.

This problem (which does not apply in public hospitals because hospitals are funded to provide MRI to their patients) could be addressed by introducing limited MRI Medicare eligibility for private hospitals that applies only in specific circumstances.



## Pathway to improve access to MRI



## Recommendation

To improve access and affordability of MRI, set a long-term pathway to remove the MRI licence system by allowing patients to claim Medicare rebates for a limited number of paediatric and cancer MRI services on all MRI machines.

## Recommendation

To protect private hospital inpatients from excessive out of pocket costs for MRI, grant limited Medicare eligibility to MRI scanners at private hospitals. Medicare eligibility would be limited to private inpatients at that facility admitted for at least one night.

Most patients who are charged a gap for radiology services pay the full cost of the service upfront, before claiming their rebate from Medicare.

Due to the high costs of services, upfront costs paid by radiology patients are the highest in primary care, averaging \$227, and even higher for complex services like CT, nuclear medicine and MRI:

#### Average upfront cost per service (2019-20)<sup>1</sup>

Ultrasound	CT	X-ray	Nuclear medicine	MRI
\$219	\$458	\$120	\$479	\$523

Previous ADIA analysis has shown that patients with common diseases like lung cancer and heart disease pay upfront costs totaling many thousands of dollars for the multiple radiology services required to diagnose, treat and monitor their condition:

#### Typical upfront costs and gaps<sup>2</sup>

	Total upfront cost	Total gaps
Lung cancer (7 services)	\$4,214	\$1,174
Coronary artery disease (5 services)	\$2,323	\$748

ADIA has previously proposed a HICAPS-style billing for radiology services to replace the Pay Doctor via Claimant cheque system. Under this arrangement, the patients would pay only the gap at the time of the service, and Medicare would pay the practice directly.

While Deloitte Access Economics found that "Payment of the gap (alone) up-front is not inflationary as there is effective competition in the sector",<sup>3</sup> concerns about gap inflation could be addressed paying the Medicare rebate after 30 days. This would retain the existing cash flow incentive for practices to bulk bill, inherent in the Medicare policy design.

<sup>1</sup> ADIA analysis of Medicare statistics provided by the Department of Health.

<sup>2</sup> ADIA analysis of 2014 deidentified Medicare data (see ADIA 2020-21 Budget Submission).

<sup>3</sup> Access Economics (2016), *Mind the gap: consideration of an up-front gap only payment model in diagnostic imaging*.



**Patient  
bill relief**





## Recommendation

To protect patients from high upfront costs, introduce a new billing arrangement to allow patients to pay the gap only, with the rebate paid to providers by EFT thirty (30) days after the claim is lodged.

On 1 July 2020, the Government ended the 22-year indexation freeze for most radiology services, with Medicare rebates for all x-ray, ultrasound and CT services indexed for the first time since 1998. This has reduced upward pressure on patient gaps and will make provision of these services more sustainable into the future.

However, Medicare rebates for nuclear medicine and MRI services remain frozen. These services are 'standard of care' for a wide range of conditions including cancer, heart and neurological conditions, and injuries and diseases of the bones and joints.

Nuclear medicine and MRI have very high upfront and out of pocket costs, which are likely to continue to increase while rebates are frozen:

#### Average upfront cost and gap per service<sup>4</sup>

	Upfront cost	Gap
Nuclear medicine	\$473	\$102
MRI	\$524	\$179



## Medicare freeze

<sup>4</sup> ADIA analysis of Medicare statistics provided by the Department of Health.



Medicare

**Recommendation**

To support bulk billing and reduce patient gaps, extend the indexation of radiology services to include nuclear medicine and MRI.

Public hospitals benefit from a range of competitive advantages in the provision of Medicare-funded radiology services to outpatients, including through being funded twice to deliver each service. This encourages public hospitals to pursue additional outpatient services, at a substantial cost to the taxpayer.

Competitive advantages in the market for outpatients include:

- ‘Double dipping’ - Public hospitals are funded through the National Health Reform Agreement (NHRA). This funding covers the cost of providing radiology services to inpatients and outpatients, which includes labour (radiologists and nuclear medicine specialists, technologists and administration staff), equipment, electricity, consumables and the premises. Meanwhile, they claim Medicare rebates for each service.
- Tax advantages – employee-related exemptions and concessions, including a payroll tax exemption, and an FBT exemption up to \$11,600 per employee (which in some states is shared with the employee. Public hospitals are exempt from land taxes in all states.

These advantages allow public hospitals to bulk bill almost all outpatient services at substantial profit margins. This encourages them to pursue Medicare funding by establishing private-style outpatient clinics, marketing these services aggressively to patients and referrers. In addition, some public hospitals structure radiologist remuneration packages to incentivise them to perform Medicare-funded services.

The focus on outpatient revenue distracts public hospitals and radiologists from their core business of caring for inpatients. ADIA is aware of public hospitals that prioritise outpatients over inpatients for some tests to generate Medicare revenue.

In contrast, private practices competing in the same market are funded through Medicare rebates and patient gaps, and consequently are unable to bulk bill a comprehensive range of services.

ADIA encourages the Government to work with stakeholders to reduce the incentive for public hospitals to provide inefficient services, which would generate Budget savings in the long-term. Structural reforms could be considered in the context of the next NHRA, due to be signed in 2025.



## Medicare funding of outpatient radiology services

Outpatient  
services  
Drop Off  
OutPatient  
parking

**Recommendation**

To improve efficiency of radiology services to outpatients, work with the radiology sector to develop reform options for Medicare funding of outpatient services provided by public hospitals, with a view to implementing structural reform in the next National Health Reform Agreement.

PET is a nuclear medicine imaging technique used to diagnose and stage a range of conditions, including cancer, neurological conditions such as epilepsy and Alzheimer's disease, and heart disease.

However, the clinical indications eligible for Medicare rebates is highly restricted, with many patients paying between \$700 and more than \$1000 for unlisted PET scans. With the clinical applications for PET expanding rapidly, it is important that Medicare keeps pace with medical advances so that more patients do not miss out.

MSAC is currently considering three applications associated with PET:

- FDG PET scans for diagnosis of Alzheimer's disease (AD). FDG PET is considered superior to existing diagnostic techniques available on Medicare, allowing earlier diagnosis and management of AD.
- PSMA PET prostate scans, for staging and restaging prostate cancer prior to treatment. The MBS Review Taskforce noted that PSMA PET is superior to conventional imaging for the staging and restaging of prostate cancer, and recommended that MSAC consider Medicare listing.<sup>5</sup>
- Streamlining of Medicare items for PET scans for FDG-avid tumours, commencing with consideration of a single Medicare item for initial staging, to replace the current condition-based items. Single items could subsequently be created for diagnosis, surveillance and restaging of FDG-avid tumours.

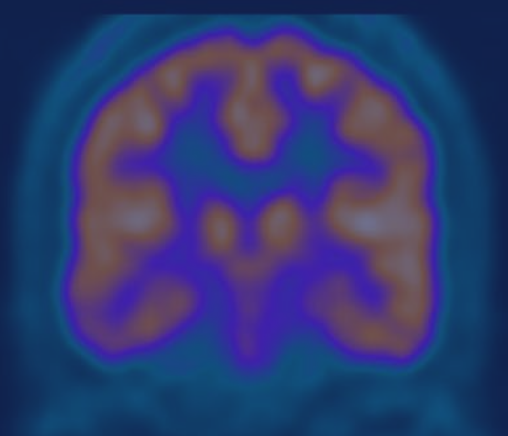
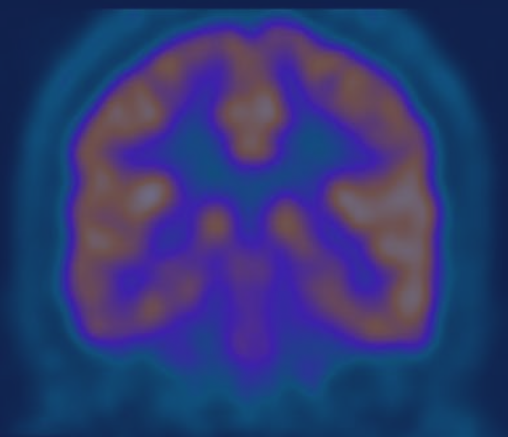
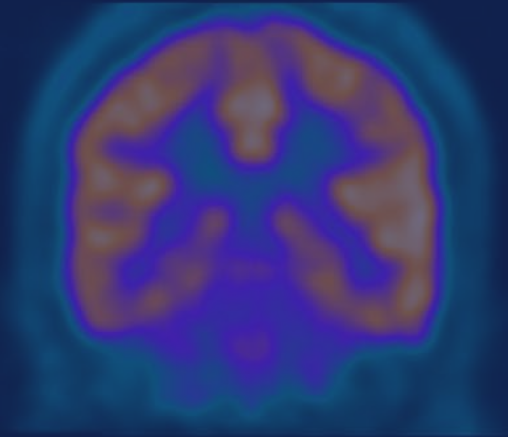
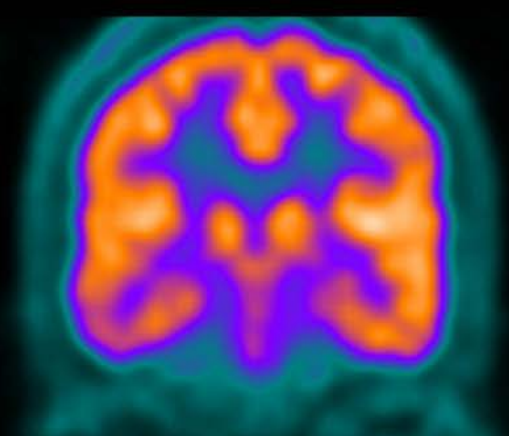
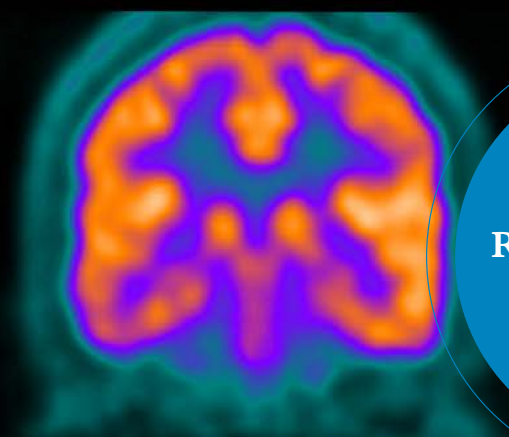
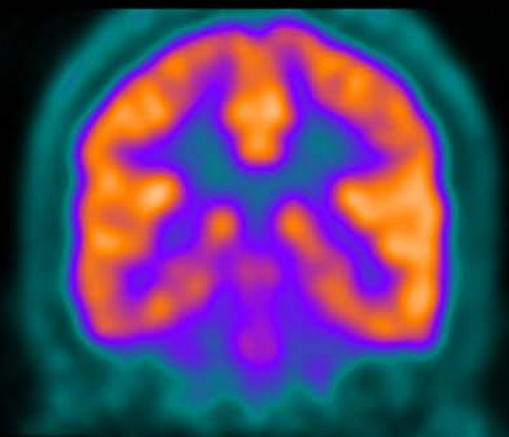
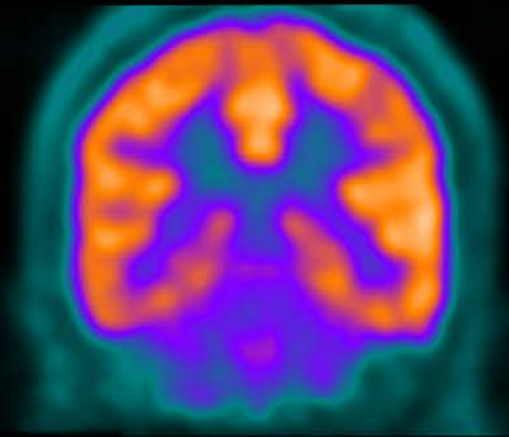
This approach to funding would accelerate access to clinically appropriate use of PET for all patients with FDG-avid tumours.

The MSAC process is conducted independent of the Government. However given the substantial clinical benefits associated with these services for Australian patients, ADIA suggests that assessment of the applications be expedited.



## Medicare funding of PET services

<sup>5</sup> Medicare Benefits Schedule Review Taskforce (2018). Report from the Diagnostic Imaging Committee - Nuclear Medicine, pp.31-32.



## Recommendation

To support access to clinically appropriate PET services, expedite independent consideration of MSAC applications for FDG PET scans for diagnosis of Alzheimer's disease, PSMA PET prostate scans, and streamlining of Medicare items for PET scans for FDG-avid tumours.

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