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To whom it concerns

**Re: Submission regarding the Productivity Commission's Research Study into the Australian Health Workforce**

This submission responds to the Productivity Commission's Research Study to examine the issues impacting on Australia's health workforce including the supply of, and demand for, health workforce professionals, and propose solutions to ensure the continued delivery of quality healthcare over the next ten years.

I am aware that the closing date for submissions was 31 July 2005. I apologise that this submission is late but I first learned about the Research Study in late August. In the interests of submitting to the Commission as soon as possible, this submission is short and lacks substantiating data regarding the issues raised. I-MED/MIA Network will provide substantiating data in a further submission during the public consultation phase of the Productivity Commission's Draft Report. Thank you for your consideration.

## 1. I-MED/MIA Network

The I-MED/MIA Network is a wholly owned subsidiary of the publicly listed DCA Group Limited. It is the combination of the previously separate I-MED and MIA Groups and currently has approximately 35% of the private radiology market in Australia.

The I-MED/MIA Network consists of over 240 clinics throughout Australia and the UK extending across all Australian states and territories, covering all major metropolitan areas as well as significant parts of rural and regional NSW, Victoria, Queensland, South Australia, Northern Territory and Tasmania. There are more than 300 radiologists, nuclear physicians, radiation oncologists and other medical specialists.

I-MED/MIA Network's innovative business model differs from the corporate models of other radiology groups in that it offers radiologists full clinical independence, devolved responsibility supported by standardised support services, the latest medical technology, scale benefits and shared best practice.

## 2. Response to the Research Study

This paper suggests three strategies to derive greater productivity from the radiology workforce to improve health outcomes. The strategies are complementary to one another and address productivity outcomes in the short term, medium term and long term[1].

[1] They complement the Productivity Commission's issues paper's recognition that while productivity is hard to measure in the health sector there are indications that some workers may be under or inappropriately utilised to achieve productivity outcomes required.

The strategies suggested are:

- For short term productivity outcomes – expand the role of the private sector in the provision of radiology services and in the management of radiology clinics;
- For medium term productivity outcomes – maximise the use of IT in radiology service provision; and
- For longer term productivity outcomes - increase private sector involvement in the training of radiologists.

### 2.1 Short term productivity outcome – expand the role of the private sector in the provision of radiology services and in the management of radiology clinics and associated service infrastructure

Workforce research conducted by the Royal Australia and New Zealand College of Radiologists (RANZCR), our own experience and recent reports[2] suggest that the shortage of radiologists in Australia is a threat to future productivity. The problem is compounded by the ageing population of radiologists. The Department of Employment and Workplace Relations' list of national and state skills shortages[3] states that supply shortages also extend to diagnostic radiographers and sonographers. In fact, shortages of radiologists is not only evident in terms of the number of available radiology training places but also in the number of vacancies in established radiology positions in the state and territory public systems.

Some stakeholders recommend relaxing demarcations through role extension to expand the roles of radiographers and sonographers. Forms of role extension already exist but the introduction of radiographer and sonographer reporting should only be considered after consideration of the potential negative impact of such a decision. Such role extension will exacerbate existing staff shortages of radiographers and sonographers, have a cost impost for training and require the development of appropriate protocols for supervision by radiologists. We would not support radiographers and sonographers being given direct access to Medicare Benefits because of the significant impacts this would have on the Diagnostic Imaging outlays. We appreciate that role extension is being considered in other allied health professions and overseas but specific radiology guidelines would need to be applied.

In I-MED/MIA Network's view this would not make more productive use of the radiology workforce. In addition to radiographers also being in short supply as referenced above, this solution raises quality issues such as those acknowledged in the PC Issues Paper, eg, "even small shortfalls in skills can cause significant problems such as over-worked and tired workers more likely to make clinical errors".

A more strategic way to economise on workforce requirements to deliver better health outcomes is to expand the role of the private sector in the provision of radiology services. This would be more productive in several ways:

- Through providing a more productive work culture. Assuming the same number of radiologists at the same price, a private work culture fosters greater work flow and more rigour in measurement. This in turn leads to higher through-put and greater productivity[4].
- Through providing a more productive supporting infrastructure. A private work culture also places more importance on investing in infrastructure (equipment, systems, technology and also the clinics themselves) so that radiologists are able to work with systems that will

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[2] ACCC/AHWOC *Report to Australian Health Ministers Review of Australian specialist medical colleges*, July 2005 "the ACCC/AHWOC Report"), Productivity Commission Issues Paper, *The Health Workforce*, May 2005 ("the PC Issues Paper").
[3] Quoted in the PC Issues Paper.
[4] We acknowledge however that there is generally less complicated pathology in private radiology compared with public acute hospitals.

enhance their productivity. This serves to leverage the more productive work environment and also assumes risks the public sector has less incentive to assume

- Through the retraining of senior radiologists to expand their exposure to diagnostic modalities and to expand and extend their medical careers.

I-MED/MIA Network believes there are large untapped opportunities for enhanced productivity through private involvement in public hospital radiology work, particularly in rural and remote locations with higher workforce shortages. Although some state and territory governments are involving the private sector, progress is slow and practices vary considerably in this regard.

We recommend that state and territory governments:

- accelerate the scope for involving the private sector in public sector radiology service provision across Australia;
- extend the scope of private sector service provision to include clinic management;
- to this end, identify pilot opportunities to trial this proposition and implement these recommendations if the trials are successful; and
- work together to develop a medical registration process that has a federal structure and is not state based.

### 2.2 Medium term productivity outcome – maximise the use of IT in radiology

Productivity levels will also vastly improve through greater uptake of IT. It is estimated that a 20%-30% increase in provider efficiencies, patient outcomes and cost savings can be achieved through establishing a digital environment[5].

This requires significant investment from the Federal Government now for the benefits to take effect over the next 3-5 years. And because of the connectivity of health services across functions, systems and jurisdictions, IT improvements in radiology imply IT improvements in health generally.

In I-MED/MIA Network's view, what is needed is not simply adding IT to a 'business as usual' model of healthcare/radiology. It is applying an interconnecting 'network of networks' to healthcare systems involving locally, nationally, and in some cases internationally, consistent standards and business processes spanning different organisations and jurisdictions. It must assume that information is securely shared between clinicians, health entities, jurisdictions and individuals, and that people will increasingly expect to connect and communicate as they receive treatment in hospitals, clinics, their offices, at home or in transit. The infrastructure for this needs to standardise around secure, converged, fast networks capable of delivering data, voice and video. Overlaying this need to be layers providing a strong web foundation, common authentication, directory, messaging and security services and a range of increasingly interoperable applications and solutions for patient care and clinical support.

I-MED/MIA Network is aware that e-health is a high priority for the Federal Government. In radiology, the Government recognises that online access could save a significant part of the Government's current $3 billion annual outlay in diagnostics[6]. The Government acknowledges that more needs to be done to implement e-health and that there has been a comparatively slow start - partly because the Government has been unclear on the preferred architecture for such a complex task. The establishment of the National E-Health Transition Authority (NEHTA) in 2004 signals its clearer focus and an increased tempo of change.

In I-MED/MIA's view, IT in healthcare should be characterised by:

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[5] Minister Abbott speech at the Health Informatics Conference, 2 August 2005.
[6] Minister Abbott speech as above.

- technology which communicates, collaborates and coordinates across boundaries of health care and geography;
- systems that support teams over traditional hierarchies;
- healthcare workers able to 'see' across the whole system and collaborate effectively within it as a part of a whole community of interest; and
- a shift from 'ego-centric' to network-centric thinking, engendering more transparent and collaborative management.
- a movement from state registration of medical practitioners to a federal process to align with registration with the RANZCR.

Although this requires a medium-long term, sustained transformation of the structure, process and culture of healthcare generally, decisions about the IT architecture, applications and infrastructure must involve network-centric thinking and need to be progressed now.

### 2.3 Longer term productivity outcome - increase private sector involvement in the training of radiologists

The PC Issues Paper asks whether current education and training provide the skills and knowledge base required for effective health care service delivery and whether there is an appropriate balance between public and private sector training.

Training of radiologists currently is a complex process involving registrar training positions within State funded Teaching Public Hospitals with the curriculum being developed and supervised and the two part examination program being conducted by the RANZCR.

The curriculum and aspects of the training program are currently under review under various projects through the Commonwealth funding the Royal Australian & New Zealand College of Radiologists (RANZCR) to develop and implement the Quality Use of Diagnostic Imaging (QUDI) Program for radiologists. Across all medical colleges there is a variety of means (although little standardisation) to involve employers in selecting candidates for training[7]. On a piecemeal basis across colleges employers are also becoming more involved in the training of specialists.

The main feature of this training environment is the dominant public sector culture. This is mainly because the public sector through State Government funding has been the principal funder and partly because fragmentation in the private specialist industry has prevented an organised sectoral contribution to training. Growing consolidation and corporatisation presages an increasing ability and will to meaningfully contribute to training.

In I-MED/MIA's view, a more strategic approach to productivity will be to increase the involvement of the private sector in the training of radiologists. This could occur by:

- Registrars in training spending at least two of their five year training program within RANZCR accredited private practices to increase the number of available training positions; and
- Funding vocational training and fellowships in private practice (perhaps targeted to regional and remote delivery of health services) where radiologists are exposed to higher workload environments.

The benefits would be:

- Better use of training budgets and financial investments;
- A more efficient and productive work culture over the longer term;
- An increase in the number of training positions and the number of graduates and abroadening of the medical experience of trainees

[7] The 2005 ACCC/AHWOC Review.

The 2005 ACCC/AHWOC Review supports this and recommends greater moves towards competency-based training models and greater involvement of employers in determining which trainees they will employ. The Review does not specify how this should occur and it will be up to jurisdictions, further informed by the PC's Research Study, to develop policies to respond to this recommendation.

I-MED/MIA therefore recommends that jurisdictions develop policies which stipulate greater involvement of the private sector in the training of radiologists.

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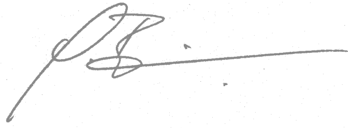
There may be other solutions discussed in our further submission in response to the Productivity Commission's Draft Report.

In the meantime, I would be very happy to discuss these recommendations with you.

Yours sincerely



**Gary Barnier**
**Chief Executive Officer**