AUSTRALIA'S HEALTH WORKFORCE
Position Paper 2005

Submission

I wish to make the following submission on the above position paper as released by the Productivity Commission in September 2005.

I am a radiographer with a post graduate Master of Applied Science (Medical Ultrasound). Currently I am employed as a full-time specialist grade sonographer in a Brisbane based private radiology practice.

The following submission is made in the light of 33 years experience in medical imaging. Most of this period has been spent in a small rural hospital in Far North Queensland. I also worked at the largest medical facility in Queensland, the Royal Brisbane and Womens' Hospitals over two separate periods. I have experience in both the public and the private sectors.

There are two issues I wish to address, firstly sonographer practitioners and secondly rural and remote sonography.

1. Sonographer practitioners

What is a sonographer?

A sonographer is a person who holds a post graduate qualification in medical ultrasound. The majority of general sonographers hold a degree in medical imaging, and have practiced radiography for a minimum of two years prior to undertaking a two year post-graduate diploma in medical ultrasound. There are also some sonographers who come from allied health and nursing backgrounds.

In Queensland at least cardiac sonographers who practice echocardiography only often hold science or human movement degrees.

A general sonographer conducts dynamic diagnostic examinations with the use of high definition ultrasound imaging equipment covering a wide range of clinical areas. These include obstetrics and gynaecology, abdominal, vascular, musculo-skeletal, paediatrics, breast, and the superficial glands. An ultrasound examination is quick, harmless, relatively inexpensive, and in the hands of a properly trained operator very diagnostic.

Sonography in Australia

The field of medical ultrasound is a relatively new diagnostic tool in medicine. However since the 1970's its use has mushroomed. An ultrasound unit is now considered second only to x-ray equipment in any hospital or practice with medical imaging equipment.

In Australia as in the UK and the US, and in parallel with the evolution of medical ultrasound, the profession of a sonographer has emerged and evolved. In fact the profession in Australia has evolved to the extent that our sonographers are considered world leaders in the field.

Sonography in Australia is now a fully mature profession with a national focus on the provision of education and training, registration, continuing professional development and standards of practice. In 1994 the Australian Sonographer Accreditation Registry (ASAR) was established for this purpose. In fact the functions of the ASAR are in accordance with the Commission's Draft Proposal 7.1 "Registration boards should focus their activities on registration in accordance with the uniform national standards developed by the national accreditation agency and on enforcing professional standards and related matters."

The primary roles of the ASAR are:

- Accredit and reaccredit ultrasound programs offered by various institutions in Australia and New Zealand.
- Maintain a register of accredited sonographers and student sonographers
- Monitor and record Continuing Professional Development (CPD) of accredited sonographers.

The Commonwealth Department of Health and Aging has stipulated that in order to obtain a medical benefits rebate for an ultrasound examination the examination must be conducted by a sonographer registered with the ASAR.

How to improve efficiency and effectiveness in the delivery of ultrasound services

As acknowledged by the Commission, P XXIII, 'Widespread shortages of health workers', sonographers are in short supply. In fact in Queensland there are ten rural hospitals that have ultrasound equipment but cannot employ qualified sonographers to operate the units[1]. Since I left the Atherton Tablelands in Far North Queensland in June 2000 there has been no public ultrasound service at either the Atherton or Mareeba hospitals. Similarly I resigned from my position as senior sonographer at Logan Hospital in the southern suburbs of Brisbane in February 2005. The position has been advertised twice with not one application submitted.

There are several factors influencing this shortage. In Queensland Health these include a lack of recognition and a subsequent lack of adequate remuneration. However sonographers are also in great demand in the private sector. The Australian

[1] Weipa, Mareeba, Atherton, Charters Towers, Ingham, Bowen, Emerald, Longreach, Charleville, Beaudesert.

Sonographer's Association (ASA) has recognized this trend for some time. They have identified the lack of recognition and the lack of an adequate career path as major contributors to the sonographer shortfall across the board. This largely reflects the attitude of other allied health professionals, as expressed to the Commission, and outlined under '*Making the best use of existing competencies*' P12…..

"Using the skills of the existing workforce in the most effective way possible is an obvious way to lessen the impact of workforce shortages and distribution problems. In this respect, many concerns were expressed about impediments affecting allowable scopes of work, appropriate mix of competencies and job redesign and substitution. Representatives of registered nurses, physiotherapists and pharmacists, for example, considered that their training and skills suited them for 'higher level' tasks."

Australian sonographers conduct a dynamic examination which is completely operator dependent. In the private sector and most major referral hospitals the official examination report is issued under the name of a radiologist or clinician. This report is almost entirely framed around the written observations of the examining sonographer.

The 'higher level' task that sonographers are seeking is simply recognition of the reality of the ultrasound examination and the right to put their own name to the official report. Sonographers currently issue official reports in several large public hospitals in Queensland, Ipswich, Redcliffe, Logan, Rockhampton, and Maryborough. In the UK sonographers there are expected to issue their own reports.

This professional acknowledgement accords with the view put by Professor Wayne Gibbon (sub. 48, p. 5). "In many cases, other countries appear to have moved faster and more proactively than Australia in workforce innovation. The specific institutional and regulatory arrangements of these countries appears more favourable towards a strategic and systematic approach to such innovation than in Australia. For example, the United Kingdom has trialed a large number of new roles in recent years, across the spectrum of health professionals."

Professor Gibbon sights the example of radiographer reporting, which in effect is current practice for sonographers in Australia. "It is imperative that radiographers are trained to read and report plain films, particularly films that require rapid reporting such as those within an emergency department. International evidence substantiated through meta-analysis and published in February 2005 indicates radiographer competence as being equivalent to radiologists in this function, if appropriately trained." (sub. 48, pp. 5–6)

For sonographers the workforce innovation, referred to above, simply amounts to allocating the credit (and the responsibility) for the examination to the person who is actually performing it rather than the person (radiologist) who is charging for it.

I believe the Productivity Commission has recognized the professional frustration of many health workers including sonographers and the potential benefits they have to offer the system. "The Commission considers that more sustainable and responsive workforce

arrangements can be achieved by addressing barriers and impediments in the current institutional and procedural frameworks that create perverse incentives, or otherwise detract from the efficient and effective delivery of health workforce services" (P36).

Draft Proposals 8.1 and 8.2 attempt to address this, however, the major flaw lies in 8.2, "***For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:***
• the service would be billed in the name of the delegating practitioner; and
• rebates for delegated services would be set at a lower rate, but still sufficiently high to provide an incentive for delegation in appropriate circumstances…".

The problem in this recommendation is its reliance on the holder of the MBS provider number to delegate the service. This is effectively what happens at present with ultrasound examinations. The radiologist delegates the sonographer to perform the examination and the service is billed in the name of the radiologist. I must add here that most private radiology practices pay a premium for experienced sonographers. <u>This submission is not about gaining more income for sonographers. It is about gaining the dignity of proper recognition and the right to practice as an independent professional entity.</u>

If the community wants to maximize the skills that sonographers have to offer and encourage people to seriously contemplate medical ultrasound as a career path two incentives are required:

A. Recognition by Governments and medical bodies that the person performing an ultrasound examination has the greatest appreciation of its findings and as such should be the author of the results of the examination. Where a sonographer is primarily responsible for the examination the sonographer should be the author of the results, and accept responsibility for the results as reported.

B. Sonographers post graduate level of qualifications and their additional skills should be recognized such that they have the ability to obtain a MBS provider number. The public would then have the opportunity to be referred by their GP to an ASAR registered sonographer practitioner. As with other practitioners if the patient's condition warranted further assessment the sonographer could either directly refer the patient onto a specialist such as a radiologist, maternal fetal medicine specialist or vascular laboratory. The sonographer could otherwise recommend referral from the GP.

- Improved efficiencies are achieved by firstly ending the current duplication of ultrasound reporting and making more efficient use of the available workforce. Efficiencies are also achieved through the added competition such an initiative would generate in this field of medical imaging.

- Improved effectiveness is achieved by allocating responsibility for the ultrasound examination to the person actually performing the examination.

The following recommendation is made for the reword of Proposal 8.2:

"For a service covered by the MBS, there should also be a rebate payable where provision of the service is delegated by the practitioner to another suitably qualified health professional. In such cases:
• the rebate would be paid to the health professional performing the service and
• rebates for delegated services would be set at a sufficient level to provide an incentive for delegation in appropriate circumstances.."

2. Rural and remote issues.

I believe draft proposals 10.1, 10.2, and 10.3 all have merit. From my experience with public sector health workers their major concerns are on-going training and education, access to clinical support and remuneration. For example, why would you work in a hospital like Mareeba or Emerald when you can work in Brisbane, earn more (even in a public hospital), have better working hours, have less responsibility, have regular opportunities to attend educational meetings, plus enjoy the cheaper cost of living!

Specifically in relation to sonographers the measures mentioned above would provide a huge stimulus to provision of diagnostic ultrasound to rural and remote communities. Firstly there is the incentive of formal recognition of the responsibilities already carried out by most rural sonographers through recognition as sonographer practitioners. Secondly and very importantly allowing sonographer practitioners to establish their own independent practices is a key incentive for attracting quality diagnostic ultrasound services to rural communities.

The overheads born by the corporate medical imaging firms are a disincentive for them operate in rural communities. They are also having problems maintaining the facilities they have due to a shortage of radiologists. Sonographer practitioners with the security of Medicare provider numbers could fill the gap.

I also wish to comment on the issues raised in relation to the use of telemedicine as a means of improving services to rural and remote areas. (*'Remote service provision'* p175-176). Queensland Health operates an extensive network through the Queensland Telemedicine Network. High bandwidth connections allow videoconferencing for a range of medical and educational services between metropolitan centres, all regional centres and many smaller rural hospitals via its Service Delivery Network (SDN).

There are two regular tele-ultrasound programs underway. Firstly there are weekly live obstetric ultrasound sessions between maternal-fetal medicine specialists at Brisbane's Mater Mothers' Hospital and obstetricians at the Townsville hospital.

Secondly the Centre for Online Health (COH), a joint Queensland Health and University of Queensland program offers, amongst a range of tele-peadiatric services, a tele-echocardiography ultrasound service to centres such as Mackay and Hervey Bay.

There is a need to build on these programs due to the concentration of medical specialists in the metropolitan hospitals. A 2004 needs analysis incorporating 27 Queensland regional and rural hospitals, and the Royal Flying Doctor Service, found 92% support for the extension of telemedicine into ultrasound amongst sonographers and clinicians performing ultrasound in these areas[2].

Preliminary work through the COH to address this need is currently underway enlisting specialist sonographers, radiologists and clinical specialists.

Admittedly, telemedicine is not the panacea for improved health services for the bush. However, with the current role out of high band width telecommunications linkages to rural and remote hospitals and clinics, telemedicine can certainly play a far greater and very effective role and this needs to be recognized.

The major impediment at present is not the technology it is finding the specialists to provide the service. At present there is a total reliance on over burdened public hospital staff or visiting medical officers. Apart from radiology there is little application of this technology, if any, in the private sector. An important factor in this is the rebate difficulties other specialties, e.g. maternal fetal medicine specialists, experience with tele-consultations. This is an issue that could be addressed in the Commission's findings in the following manner:

- A further point added to draft proposal 10.2:-

  Assess the application of telemedicine for providing improved access to specialist services to rural and remote communities.

- Included in the preamble to draft proposal 10.3 relating to reviewing " ***the provision of financial incentives through the MBS rebate structure versus practice grants***" a reference to the provision of specialist services/consultations via telemedicine facilities.

Thank you for giving this submission your consideration.

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[2] Lewis C, Journal of Telemedicine and Telehealth, 'Tele-ultrasound needs analysis in Queensland', Due for publication in December 2005, RSM Press London.