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ADIA Submission to the Productivity Commission Study (the Study) into the 'Impact of Advances in Medical Technology in Australia'

Introduction

The Australian Diagnostic Imaging Association (ADIA) represents practices providing more than 70 percent of private diagnostic imaging services in Australia.

The ADIA (with The Royal Australian and New Zealand College of Radiologists-RANZCR) is a joint signatory to the fixed or 'capped' funding **Radiology Quality and Outlays Memorandum of Understanding (MoU) I July 2003 to 30 June 2008** with the Commonwealth. The Radiology MoU covers the great bulk of Medicare eligible medical imaging services. The ADIA also participates in the management of the separate Nuclear Medicine and O and G Ultrasound MoU's. However, the separate Cardiac Imaging MoU is less transparent and is solely managed by the Cardiac Society of Australia and New Zealand and Commonwealth Health.

We appreciate this opportunity to present our views on matters pertaining to the Study.

The ADIA is concerned about the short timeframe and appreciates the extension allowed for our submission. Unfortunately, we do not have the exceptional research capabilities, resource base and information that are really required to make a comprehensive submission. However, we would greatly appreciate the opportunity to comment further on your draft report due at the end of March 2005.

The ADIA believes that a study of this nature represents both challenges and opportunities in the policy contexts. The impacts and outcomes of expenditure on healthcare technology are extremely variable and difficult to identify and quantify in the absence of detailed, longitudinal disease specific studies etc. This is exacerbated in the current Medicare environment where there is no perceived, overall objective healthcare delivery and financing model or policy base on which to benchmark and review such findings.

Notwithstanding our significant concerns about capacity to objectively measure the impacts of medical technology, we hope the following will be of assistance and we look forward to the opportunity for further comment on your draft report.

Overall observations on the Australian healthcare delivery and financing systems

It is unfortunate and rather telling that the ADIA has not been able to identify any clear public policies in respect of the following key components of efficient and effective diagnostic imaging service delivery:

- patient affordability;
- equity of access;
- industry sustainability (particularly in respect of reinvestment and investment in new technologies); and
- quality of care.

The Australian healthcare delivery and financing systems including Medicare support an 'illth' or treatment based model rather than a preventative approach. As such, our data collection systems are not oriented to produce tangible evidence of disease-specific costs or the effectiveness of treatment protocols and the benefits from the 'treatment' model over the years.

Further, we believe that the current treatment based model will only work successfully in an environment of adequate funding and the maintenance of independent clinical decision-making processes.

The current system has major difficulties in managing situations where rationing of services or other regulation of the medical market is desired by government. This situation is highlighted by the difficulties being encountered in developing a fair and equitable approach for patients and providers in relation to the controlled introduction of 'eligible' Magnetic Resonance Imaging (MRI) sites in an overall 'capped' funding environment.

Similar issues are involved in relation to the poor take up of Positron Emission Tomography (PET) which at best is seen as inept and not in the interests of good patient care.

In relation to independent clinical decision-making the ADIA strongly believes that a system of proper 'arms-length' referral for diagnostic imaging services holds significant clinical and economic advantages over the self referral of imaging by some groups such as Cardiologists and Vascular Surgeons. Self referral of diagnostic imaging services should be strongly discouraged as there are no arms-length constraints or accountability measures over levels of service provision! Charts US 2 (cardiac ultrasound) and US 3 (vascular ultrasound) in the Appendix 2 highlight this inappropriate phenomenon.

Likewise, the ADIA believes that the uncontrolled drain on private Medicare outlays by spurious 'rights of private practice' and other cost shifting of State and Territory health authorities through public hospitals is substantially distorting the costs of private healthcare delivery. Every dollar inappropriate siphoned out of Medicare 'capped' funds means a dollar less for legitimate private patients.

Orientation of and issues for the Study

The issues for the Study are multi-faceted.

For example, at one end of the spectrum it would seem that the costs associated with medical technology are initially driven by choice or lifestyle decisions rather than by clinical factors. They follow rising community wealth and expectations that the healthcare system will be able to deliver more and more for patients, improve their quality of life etc.

A good example of lifestyle choice is in relation to the increasing use of reproductive technology where, in many cases, they follow decisions to delay having children well beyond the optimal reproductive years for the female. Much of those decisions will be for understandable career and/or economic reasons but nevertheless do impact substantially on healthcare expenditures to be borne by the whole community.

It may be concluded that the availability of reproductive technology has therefore had a direct bearing on lowering the perceived acceptable risk of such lifestyle decisions. However, those decisions are primarily economic rather than being truly clinically driven. Such decisions are seen to have been promoted by expectations of Medicare universality.

It would be wrong, of course, to simply measure the direct costs of the use of reproductive technology and not take into account the broader economic and social benefits from females staying longer in the workforce, the resultant impacts on their families' wealth and disposable incomes, their reduced reliance on the social welfare system etc.

Social benefit offsets are therefore seen as particularly relevant to the Study and should not be dismissed as 'middle class welfare'.

Patient satisfaction and consumer expectation are also seen as important yet largely intangible issues for the Study.

Other changes which have contributed to rising healthcare costs are more subtle in terms of health outcomes. For example, advances in anaesthesia have allowed more risky procedures to be performed on younger, sicker and older patients even though the procedures and operating techniques themselves may not have changed significantly over the years.

Other changes are more dramatic and observable. For example, recent advances in diagnostic imaging technology such as MRI and expanding applications in CT and other modalities mean that less invasive, better quality images and more sophisticated and accurate measurements are available almost instantly to treating doctors and, indeed, are demanded by them for clinical as well as for medico legal, defence/indemnity reasons.

New imaging technologies and techniques have taken much of the 'guess work' out of clinical decision-making and have led to substantial increases in the productivity of treating doctors and broader ranges of patient treatment and management options, leading to substantial improvements in their patients' quality of life etc.

Unfortunately, the Medicare payment and policy processes have not kept pace with such change and appear to be caught in the early 1970s time warp when the MBS was first established. This means that potential and real offset 'savings' in areas such as reduced consultation times and fewer repeat patient visits, avoidance of unnecessary procedures, reduced hospitalisation, better staging and management of disease etc. have not been identified as genuine savings and appear to be largely ignored in the broader health financing decisions.

An unhelpful 'funding silos' mentality and compartmentalised responsibilities within and across jurisdictions including within and across Commonwealth, State and Territory jurisdictions continue to preclude effective evaluations of health care services and costs.

Some of our broader concerns about the inflexibility of existing MBS structural and review mechanisms were highlighted in the ADIA's submission to the Review of Medical Services Advisory Commission (MSAC) attached at Appendix 1.

It is also suggested that the Study should examine the factors which led to the dissolution of the Relative Value Study (RVS) which was conducted jointly by the Commonwealth and the AMA between 1995 and 2001 at considerable expense.

The RVS covered all medical services in the MBS except for pathology and diagnostic imaging. Unfortunately, the RVS failed to identify and promote an effective change-management strategy. It particularly failed to reach the necessary professional and political consensus on fundamental issues such as fair relativities between consultations and procedures despite workable benchmarks being available.

There was also a general reluctance within the RVS process to address changes in the structures of consultations and potential reductions in the MBS fees and relativities for high volume, 'bread and butter' procedural items of some specialty groups. One example is cataract operations and artificial lens replacements by Ophthalmologists. Despite overwhelming evidence that the MBS fees and relativities for that work did not reflect the significant changes in technology and massively reduced procedural times over recent years, there was little appetite or capacity to address such changes.

There are numerous other examples that are able to be provided along the same lines. However, our point here is to highlight that potential savings from the application of new technology will often be hidden.

The ADIA would therefore highlight the need for the Study to have regard to the political and economic landscape in which healthcare is delivered in Australia. This is illustrated by the privileged position and market capture of some professional groups, particularly those proceduralists and others (eg. Dermatologists) who are in short supply. Often that supply will be controlled to ensure that prices are maintained.

The ADIA also strongly recommends that the Study should review the service profiles of high volume providers of Medicare services by specialty group and the mixes of their work. In the past, those profiles have indicated that providers in the top quartiles of benefits outlays

typically provide in excess of 50 percent of the eligible services with exponential increases and decreases up and down the frequency scales.

It should be noted that Medicare figures for private specialists exclude additional substantial components of work under Visiting Medical Officer (VMO) arrangements in public hospitals and non Medicare eligible private work such as third party compensable cases. Many specialists will appear to have abnormally low incomes but, again, payments such as the salaries of public sector specialists are excluded from Medicare data.

Medicare information on individual radiologists and pathologists will be misleading as professional components of work are relatively low and billings will often reflect the arrangements of individual practices rather than the work of individual doctors.

Supply and demand factors clearly play a significant role in the overall drivers of healthcare expenditure and the 'gaps' to be met by patients, their private health funds or via the New Medicare Safety Net. The ADIA is concerned about the inflationary stimulus of the New Medicare Safety Net and the implications for the capped funding of the Radiology MoU.

There is a general expectation in the community that Medicare will pay benefits in all situations where medical care is provided. Greater patient and provider expectations of the healthcare delivery system are clearly significant drivers of general healthcare expenditure.

Notwithstanding the inherent difficulties, the ADIA believes that governments must be prepared to tackle the 'hard issues' around structural reform of the MBS. That is, the must address the current inbuilt tendency to ignore savings or offsets in the more traditional services such as consultations.

We believe that the current policy and review processes operate to the detriment of technology based services and make it almost impossible to achieve a 'level playing field' between the competing elements for the health dollar. That is, inappropriate and unfair rationing methods will continue to apply to new technology whilst a general lack of accountability will continue for more traditional services.

The impact of cost shifting

As highlighted earlier, another major issue for the industry is the unchecked manner by which public hospitals and the public sector generally are able to cost shift on to Medicare. This budget supplementation or 'double dipping' by public hospitals and lack of a 'level playing field' with the private sector not only distorts outlays but denies benefits to true private patients and is patently illegal.

The Health Insurance Commission does not appear to have any form of compliance audit of public hospitals and this appears to reflect a general malaise within the Commonwealth in this area. Further, the abuses seem to be rationalised by a perverse Commonwealth view that the capacity of public hospitals to bill on the basis of a marginal contribution to fixed infrastructure costs (rather than a full absorption cost recovery basis which commercial enterprises must meet) acts as a price control mechanism over the private sector.

Cost shifting by the public sector is also having a deleterious impact on the sustainability of the private DI sector which is finding it increasingly difficult to recruit trained radiologists because of the relative advantages (tax and otherwise) of public sector employment. The massive productivity gains which have been returned to the Commonwealth over recent years from increased corporatisation and greater economies of scale from the consolidated industry are likely to be eroded from shortages and the rising costs of recruiting and employing radiologists in the private sector.

The ADIA believes that there is a compelling need for a review of cost shifting and to ensure that appropriate guidelines are developed to effectively manage the interface (a 'level playing field') between the public and private sectors.

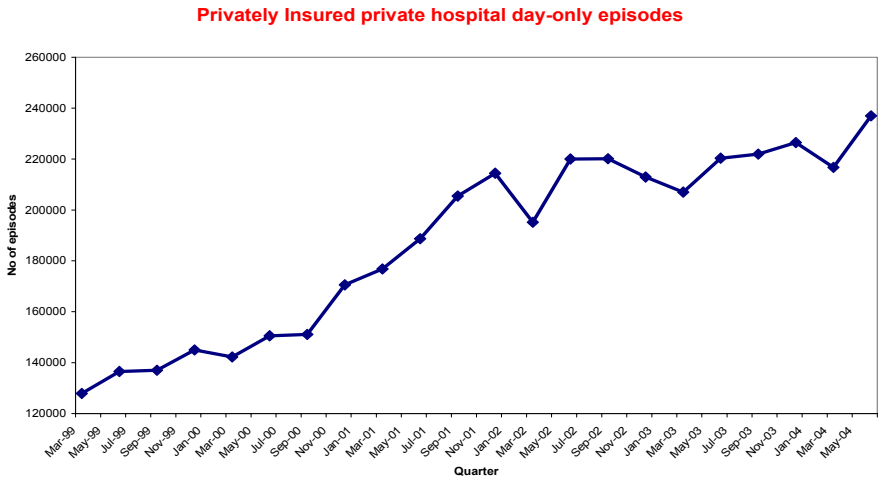
The impacts of changes in government policy

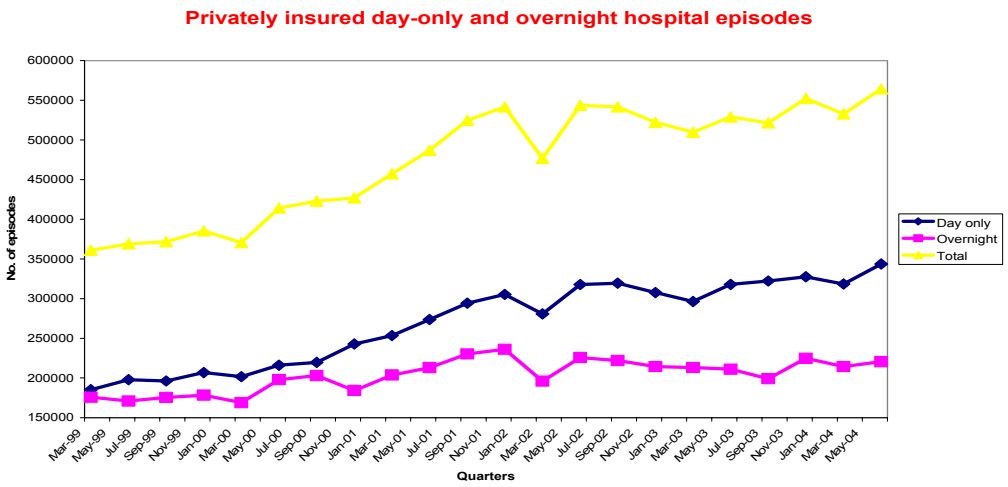
Changes in government policy have and will lead to increased demand for medical technology. These changes include:

- Recent Private Health Insurance incentives; and
- The New Medicare Safety Net.

The following charts which relate to privately insured hospital/day care episodes highlight the changes in utilisation of hospital services and associated medical services arising from recent private health insurance initiatives including the 30% rebate on private insurance premiums.

The charts reflect a massive surge in day-only hospital episodes as a result of private insurance 'incentives',





The ADIA has major concerns about the growing evidence of the inflationary impacts of the New Medicare Safety Net and its direct financial impact on the Radiology MoU's funding 'cap', including on the MoU's targeted patient affordability bonuses. There are also concerns that increased demand generated by the Safety Net will lead to unmanageable and largely unquantifiable changes in demand which could preclude effective management of fixed MoU funding in the longer term.

The Terms of Reference of the Study

a) Identify the key drivers of medical technology demand.

We have identified above some key factors which we believe are driving growth in expenditure and demand.

Overall ageing of the population is likely to be a factor but there appears to be no conclusive evidence that would identify ageing *per se* as a significant driver. Proximity to death has been identified as a significant driver in overseas studies. However, some lifestyle and related issues may be more significant.

It is clear that the greater expectations of patients and treating doctors and the greater availability of new, expensive technology are significant drivers of expenditure as is cost shifting by the States and Territories.

Government policy is also seen as a significant driver but there seems to be little desire, incentive or capacity to identify offsets or to address structural changes in Medicare eligible services. This leaves technology based areas such as medical imaging at a considerable disadvantage in competing with more traditional services for the health dollar.

b) Identify the net impact of advances in medical technology on healthcare expenditure over the past ten years.

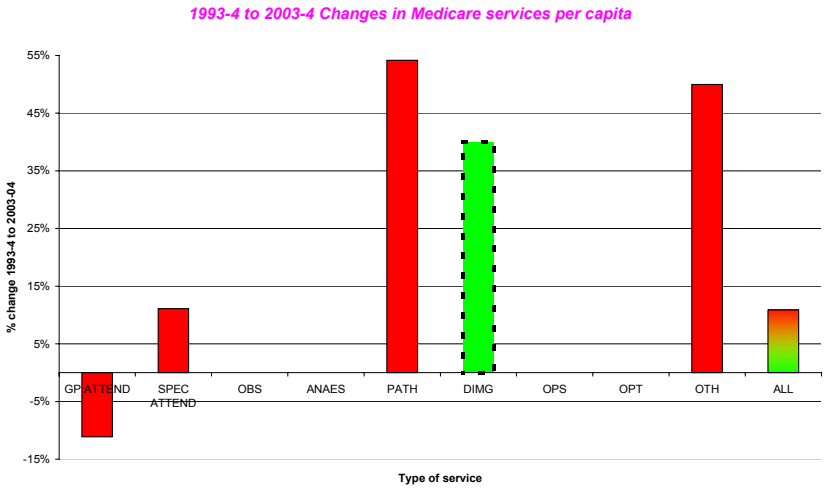
We have already commented on the need for the Study to identify offset savings as well as the directly measurable costs in its evaluation of the net impact of new technology. Such offsets will be reflected in improved productivity of treating practitioners, economic and social benefits for patient, their families etc. Ignoring these factors will produce spurious results.

Hidden savings such as those that arise from refinements in anaesthesia and operating techniques etc. must similarly be evaluated.

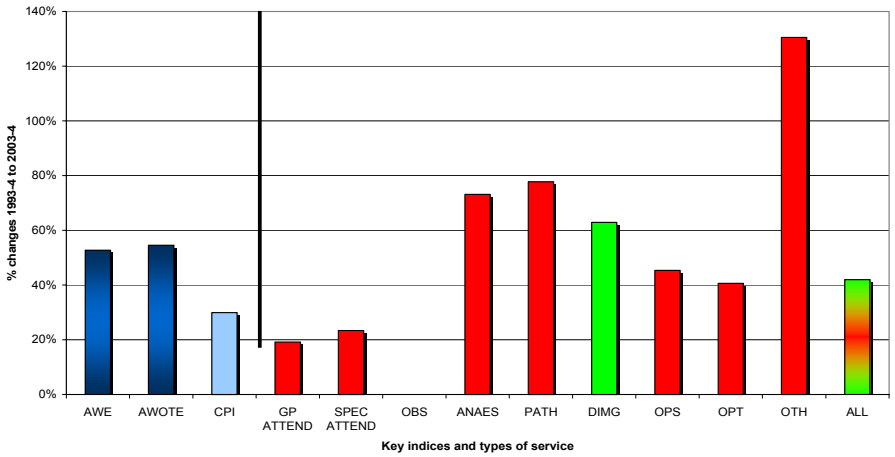
The following tables identify the changes in Medicare services and benefits by type of service from 1993-4 to 2003-4.

Overall services and benefits per capita for medical imaging (DIMG) services have increased. This is reflected in additional ordering by treating doctors, increasing self referral, cost shifting as well as a significant shift towards more expensive technology.

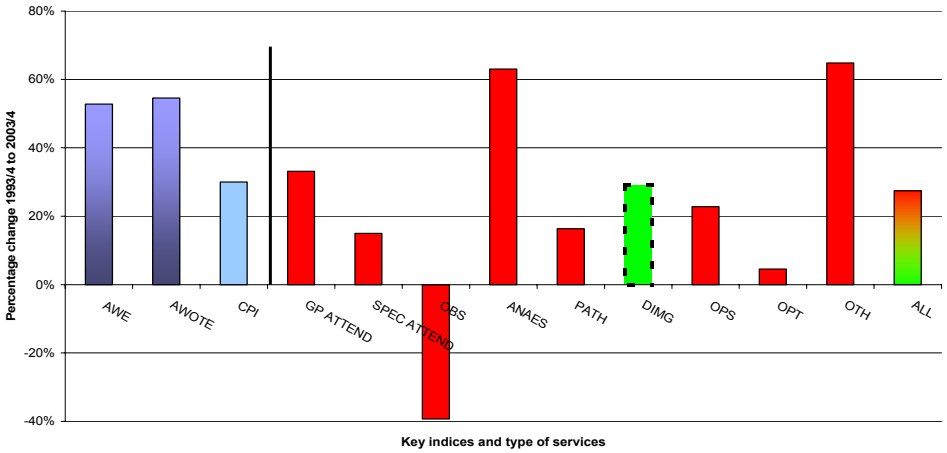
It is important to note however, that under 'capped' funding arrangements the average benefit per service for diagnostic imaging has been effectively contained.



1993-4 to 2003-4 Changes in key economic indices and Medicare benefits per capita



1993/4 to 2003/4-Changes in key economic indices and Medicare benefits per service



c) As far as practicable, identify the likely impact of advances in medical technology o healthcare expenditure over the next five to ten years, and identify the areas of significant potential growth.

This is a difficult and subjective item to deal with in the absence of any clear Commonwealth policy guidelines in relation to the introduction and application of new medical technology.

The absence of any clear policy focus has precluded the orderly introduction of eligible MRI services and PET into the MBS and this is likely to continue.

Some areas potential growth are identified below:

- Diabetes management.
- Non invasive imaging of coronary artery disease (MRI and CT).
- Molecular diagnosis in cancer (PET and MRI).
- Management of congestive cardiac failure (Ultrasound).
- Stroke prevention and aggressive management (MRI and CT).
- Peripheral disease (MRI and Doppler).
- Joint replacement (MRI and CT).
- Breast cancer (Mammography)
- Osteoporosis (DEXA)
- Total body screening (CT and MRI)

d) Identify existing mechanisms and processes for ensuring cost-effectiveness in the use of medical technology, and any gaps in these processes.

The ADIA believes that the general incapacity of the Medicare system to deal with structural change means that new medical technology will always be at a disadvantage in accessing the health dollar.

e) Examine the impact of changes in medical technology on the distribution of costs and financial incentives across different parts on the health system, including whether advances in one technology area result in reduced costs in others.

We have identified the need to take into account the considerable productivity gains to treating doctors and extended treatment options which have resulted from the increased availability on modern imaging technology.

f) Investigate the net impact of advances in overall and individual technologies on:

- ***economic, social and health outcomes, including exploring which demographic groups are benefiting from advances in health technology; and***
- ***the overall cost effectiveness of healthcare delivery.***

We have made some comments on these matters. The charts provided in Appendix 2 were compiled from information from the Health Insurance Commission We hope they will provide some insights into the changes in medical imaging services over recent years.

We trust our submission will be of assistance to you. We look forward to the opportunity for further comment on your draft report.

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