Summary

The I-MED Network

The I-MED Network ("I-MED") is the largest provider of private radiology services in Australia with approximately 35% market share and operating 246 clinics across the nation under local brand names.

Response to Key Themes

A greater focus on prevention to the health system and
Addressing the growing burden of chronic disease

Establish public reimbursement for increased preventative health screening

Significant advances in diagnostic and interventional radiology over the last 35 years have enabled modern radiology to focus on preventative medicine and early diagnosis in their own right. Modern radiology can detect early illness, reduce mortality and morbidity rates, prevent illness and disease, and greatly assist in middle and advanced stage diagnoses and illness treatment.

Medicare reimbursement for preventative screening in appropriate clinical cohorts – such as breast screening in women, prostate screening in men and cardiac screening in men and women - would support the practice of good health management which would in turn reduce non-urgent accident and emergency presentations and help to contain Medicare budget blow-outs.

Establish public reimbursement for offshore radiology reporting

Currently, Medicare does not reimburse urgent films able to be read overnight in offshore radiology clinics for Australian patients. A commitment by the Rudd Government to introduce Medicare items to recognise this, provided an appropriate quality framework for offshore reporting was established, would assist to recognise same-day reporting of urgent films for Australian patients.

Establish permanent Medicare funding for Positron Emission Tomography (PET) imaging

The establishment of a permanent PET licensing scheme to enable patients in appropriate circumstances to access a Medicare rebate for PET scans would significantly improve the early diagnosis and effective treatment of prevalent conditions like cancer and heart disease.

Providing a well qualified and sustainable health workforce

Enable greater numbers of overseas radiologists to practice in Australia as a way of alleviating national doctor shortages and improving workforce effectives in radiology

I-MED recommends that radiologists from recognised culturally and educationally equivalent overseas jurisdictions (particularly the UK and New Zealand) have 'equivalence' more easily recognised by the Royal Australasian and New Zealand College of Radiologists so that more radiologists can be employed to fill critical areas of clinical need where Australian specialists are in short supply or are unavailable.

<u>Provide incentives through the AHCAs to enable more productive and cost effective use of the radiology workforce</u>

As a national provider, I-MED increasingly experiences the unproductive results of state governments permitting the operation of private radiology outpatient clinics on public hospital campuses, and allowing rights of private practice to public radiologists. In a number of critical ways this practice is hampering efforts to improve public hospital efficiencies and undermining efforts to reduce national radiologist shortages. These clinics are established on a non-level competitive basis with the private sector and they compete with the private sector for the fixed radiologist workforce and for private radiology work when mandated public hospital radiology work remains under-provided and in some cases unprovided.

I-MED makes a number of proposals in the body of this submission for incentives to be provided through the AHCAs to enable more productive and cost effective use of the existing radiology workforce.

* * * * *

The I-MED Network

The I-MED Network ("I-MED") is the largest provider of private radiology services in Australia with approximately 35% market share and operating 246 clinics across the nation under local brand names. We have a strong commitment to service provision in rural and provincial Australia where I-MED operates under local brand names. We also have a strong commitment to the development of sound public policies in service of radiology patients. I-MED is also the largest member of the Australian Diagnostic Imaging Association (ADIA) representing private radiology providers which is a signatory to the *Radiology Quality and Outlays Memorandum of Understanding* between the Commonwealth, the Royal Australian and New Zealand College of Radiologists and ADIA.

Response to Key Themes

A greater focus on prevention to the health system and
Addressing the growing burden of chronic disease

<u>Establish public reimbursement for preventative screening.</u>

Significant advances in diagnostic and interventional radiology over the last 35 years mean that modern radiology is now highly specialised and capable of greatly assisting a paradigm of health care which focuses on preventative medicine and early diagnosis in its own right. Through the use of world class equipment, highly scientific tests and the introduction of interventional procedures, modern radiology can play a significant role in the early detection of illness, reduce mortality and morbidity rates, prevent illness and disease, and also greatly assist in middle and advanced stage diagnoses and illness treatment.

Medicare reimbursement for preventative diagnostic screening in appropriate clinical cohorts would both reduce non-urgent accident and emergency presentations and limit Medicare budget blow-outs from situations such as the "Kylie Minogue effect", ie, where there is a one-time mass over-reaction to a celebrity illness as opposed to the more ideal scenario of the ongoing practise of good health management.

In our view, appropriate areas of the body for preventative screening are the breast, colon and heart:

- breast screening in women would be by magnetic resonance imaging (MRI) and ultrasound (US);
- prostate testing in men would be as a complement to blood tests using non invasive virtual computed tomography (CT) of the colonoscopy – and would recognise the Rudd Government's increased policy focus on men's health;
- cardiac screening in men and women would be in appropriate clinical cohorts using MRI and US.

We do not advocate preventative coronary CT/angiography screening because, unlike MRI and US, this technology is expensive and exposes to body to damaging radiation.

<u>Establish public reimbursement for offshore reporting</u>

Technological advances now enable much faster reporting to occur through the use of qualified radiologists in I-MED's offshore clinics. I-MED observes a 24 hour

reporting schedule where urgent films unable to be read overnight in Australia are sent to our UK clinics for analysis and reporting. This enables, in-effect, same day reporting in Australia.

Currently, Medicare does not reimburse films which are read offshore for Australian patients. The Howard Government indicated it favoured introducing appropriate Medicare items to recognise technological advances. We believe a similar commitment from the Rudd Government would be a further step, at an administrative level, to assist people to remain healthy and keep illness episodes from reaching crisis point.

Establish Medicare funding for Positron Emission Tomography (PET) imaging

As the Government has acknowledged by its announcement of supporting the purchase of PET scanners at the Royal Hobart Hospital and the Newcastle Calvary Mater Hospital, PET imaging is a highly effective way to detect cancer, examine the effects of cancer therapy and assess the presence of disease before anatomical changes detectable by other tests such as MRI or CT are detected.

The establishment of a permanent PET licensing scheme to enable patients in appropriate circumstances to access a Medicare rebate for PET scans would significantly improve the early diagnosis and effective treatment of prevalent conditions like cancer and heart disease.

Providing a well qualified and sustainable health workforce

Enable greater numbers of overseas radiologists to practice in Australia as a way of alleviating national doctor shortages and improving workforce effectives in radiology

In addition to increasing the quotas for the optimum supply and distribution of radiologists across Australia, we recommend that Radiologists from recognised culturally and educationally equivalent overseas jurisdictions (particularly the UK and New Zealand) must have 'equivalence' more easily recognised by the Royal Australasian and New Zealand College of Radiologists so that more radiologists can be employed to fill critical areas of clinical need where Australian specialists are in short supply or unavailable.

Provide incentives through the AHCAs to enable more productive and cost effective use of the radiology workforce

There are key systemic efficiency improvements involving the radiology workforce which have the potential to reduce waiting times for essential public hospital services like elective surgery.

As a national provider, I-MED increasingly experiences the unproductive results of state governments permitting the operation of private radiology outpatient clinics on public hospital campuses, and allowing rights of private practice to public radiologists. This practice is hampering efforts to improve public hospital efficiencies and undermining efforts to reduce national radiologist shortages. These private radiology outpatient clinics are established on a non-level competitive basis with the private sector and compete with the private sector for the fixed radiologist workforce. This increases supply pressures and creates wage inflation in radiology. The clinics also compete with the private sector for private radiology work when mandated public hospital radiology work remains under-provided and in some cases unprovided. I-MED knows this because we are routinely asked to undertake overflow public

radiology work at the same time as hospitals are permitted to operate private radiology outpatient clinics. These clinics are exacerbating inefficiencies and sabotaging efforts to improve radiologist numbers.

I-MED proposes the Government considers providing incentives through the AHCAs to enable more productive and cost effective use of the existing radiology workforce. We recommend:

(i) Amending the way radiology service offerings are structured and/or paid for between the sectors:
   - create incentives for the public and private sectors to share rather than compete for radiologists by:
     - establishing clearer definitions of public and private service offerings and tighter controls over public and private work boundaries;
     - accelerating the scope for involving the private sector in routine public sector radiology service provision across Australia;
   - introduce differential Medicare rates to remunerate appropriate to capital investment and risk levels, eg, have one Medicare rate apply for services provided in a public hospital or co-located radiology practice (where the capital equipment is financed from the public budget), and another Medicare rate apply for services provided in fully privatised practice (where capital investments are private).

(ii) Change the way the radiology workforce is utilised between the sectors:
   - only permit public radiologists rights of private practice when all mandated public sector radiology work is demonstrably completed;
   - provide opportunities for private providers to operate and manage outpatient radiology clinics on public hospital campuses – particularly in locations of acute radiologist shortages.

Conclusion

I-MED would be pleased to discuss any of the above issues in greater depth with the Commission. Please do not hesitate to contact Tim Morphy for more detailed discussion.

I-MED has raised these issues in submissions and meetings with, respectively, the 2020 Summit in April 2008, Labor's Health and Hospitals Advisory Group in September 2007, Ms Roxon as Shadow Health Minister in 2007, the ALP's National Secretary Tim Gartrell in 2007, Hon Simon Crean as Shadow Minister for Regional Development in 2007 and 2006, the then Opposition Leader's Social Policy Adviser (now the Prime Minister's Social Policy Adviser) in 2007, the then Chiefs of Staff of Wayne Swan, then Opposition Treasurer, Lindsay Tanner, then Opposition Finance Minister and Julia Gillard, then Opposition Health Minister in 2007, and relevant Deputy Secretaries and other officials in the Department of Health and Ageing in 2007 and 2006.