[redacted]

SUBMISSION FEEDBACK

Please provide comments on all or any of the following, particularly in relation to each Option outlined in the Consultation Regulation Impact Statement:

- The appropriateness and feasibility of the proposals.
- Whether the proposed changes will address current concerns with the regulations in the diagnostic imaging sector.
- Potential costs associated with each option.
- Potential benefits associated with each option.
- Potential workforce impacts.
- Impacts on patient access to appropriate imaging.
- Rural and remote access for patients.
- Time required to implement the potential changes.
- Impact on both smaller diagnostic imaging practices and larger practices.
- Any other comments, questions and concerns that relate to the proposed options.

In addition, you may wish to respond to questions listed against specific Options.

Submissions should include substantiating evidence, where possible.

Option 1 – No regulatory changes or deregulation (refer to page 23 of the RIS)

Features:
- The current supervision requirements remain unchanged.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.

Comment:
The Diagnostic Imaging reform package noted its objectives were to reflect best clinical practice and are performed by qualified practitioners.

- Radiographers and sonographers are qualified practitioners Both Radiographers and sonographers must be qualified and credentialed under APHRA.
- It is recognised that the radiologists is the most qualified individual within the practice.
- We must also recognise the nature of imaging service performance requires all staff involved in performing scans to meet required standards in in radiation safety and all aspects clinical care.
- Technology is also developing to reduce the amount of radiation a person is exposed to when requiring scans. The latest CT scanners have a 90%+ reduction in the dosage of radiation compared to levels of the machines operating 10 years ago.
- Supervision does not require the radiologist to be on site but available to address any queries from the qualified on site staff in a timely manner.

Option 2 – Minor changes including clarification of current requirements (refer to page 24-26 of the RIS)

Features

- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
  - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.
- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment:

- Amendments are required to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
- Currently a radiologists must be on site for MSK and this should be amended to align with all other ultrasound items which do not require this.
- A radiologist may cover several sites in a day but is available to supervise and address queries from the radiographer.
- Interventional procedures such as injections will continue to require radiologist attendance.

Musculoskeletal Ultrasound (refer to page 25-26 of the RIS)

Questions:

- Are the principles as outlined satisfactory to clarify the requirements?
- What reasons, if any, are there for the personal attendance requirements for musculoskeletal ultrasound to remain?
- Would a minimum set of guidelines for 'accepted medical practice' per modality be appropriate?
- What savings are anticipated to be realised from removing the personal attendance requirements for musculoskeletal ultrasound services?
- What additional costs are anticipated to be incurred by requiring a medical practitioner (eg radiologist) to be in close proximity to attend on a patient personally within a reasonable period of time in circumstances where this is not currently the situation?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment
Personal attendance requirements for musculoskeletal ultrasound is only required for direct intervention. Eg: Injection by radiologist.

- Deregulation of the MSK ultrasound services would allow patients to have their scans in a timely manner.
- Interventional procedures eg: injections are the only times the radiologist is required for MSK ultrasound.
- There would be not additional costs associated with implementing this but it would result in less wait time for patients.
- As the staff performing the actual scan are qualified in their area of expertise and have the availability to discuss with radiologist any concerns the change to this would only be positive.
- Policies and procedures established by the radiologists and his team are in place to provide appropriate guidelines for clinical care in this area.
- Deregulation of MSK ultrasound would provide improved access for these items to patients.

Option 3 – Practice based approach (refer to page 27-34 of the RIS)

Features

- Amendments to the current supervision requirements to clarify the circumstances under which a radiologist and/or specialist or consultant physician must provide supervision and how the supervision must be provided.
  - Professional supervision would require: the medical practitioner be available to observe and guide the conduct and diagnostic quality and safety of the examination and if necessary in accordance with accepted medical practice, attend the patient personally, within a reasonable period of time.
- The personal attendance requirement of musculoskeletal ultrasound would be amended to align with all other ultrasound items.
- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.
- Computed Tomography services would only be able to be provided in a comprehensive practice, with the exception of CT of the coronary arteries (items 57360 and 57361).
- Supervision would be tailored to the type of diagnostic imaging practice.
- A comprehensive practice would require a radiologist to be available during agreed operating hours.
- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to determine the supervision requirements for the practice and have the flexibility to implement and supervise efficient and effective processes.
- Where a radiologist is on site during ordinary operating hours, the radiologist would be allowed to substitute a requested service for a more appropriate service, without the need for consultation with the requester, if the substituted service has a lower MBS fee than the requested service.
- The current substitution rules in the *Health Insurance Act 1973* remain.
- Where a radiologist is NOT on site during ordinary operating hours, a radiologist must be on site for the performance of the following services:
  - Mammography;
  - The administration of contrast; and

    - Image guided intervention procedures/surgical interventions.
- The reporting and supervising radiologist would not have to be the same person, but practices would be required to maintain records which indicate the name of all the radiologists involved in the service.
- Rural and remote exemptions.
- Specified qualification requirements for ultrasound providers.
- Definition of diagnostic ultrasound.

Comment

- The definition of a comprehensive practice is not in line with all current models of contemporary imaging practices
- Most CT services with the exception of interventional and contrast CT can be safely conducted without onsite radiologist attendance.
- Mammography requires radiologist review
- MSK ultrasound does not require direct radiologist supervision/attendance and should be deregulated.
- DIAS or delegated quality organisation should audit practices to ensure adequate maintenance of records.

A Comprehensive practice (refer to page 28-29 of the RIS)

Questions:

- Are there any other types of practices which have not been identified?
- Are there comprehensive practices that do not currently have a radiologist onsite?
- What are the costs of employing a radiologist onsite during ordinary operating hours?
- What are the costs of non-comprehensive practices expanding to become comprehensive practices?
- Are there enough radiologist for this to occur? What are the barriers?
- Is there any role for standalone CT and, if so, how would current safety and quality concerns be addressed? What will be the impact of this change on providers and patients?
- What other costs (if any) might be associated with the proposed changes?
- What are the potential consequences of the proposed changes?

Comment

- There are more recent models of imaging in place that are a variation on the traditional comprehensive model noted in the RIS. These models have evolved in response to patient needs for greater accessibility and affordability for imaging procedures.
- Traditional models of comprehensive practice have relied heavily on expensive co-payments to fund lower examination numbers and inefficiency.
- The current radiologists workforce in Australia, we contend is insufficient to meet the growth and patient demand.
- The proposed models of traditional comprehensive practice are grossly inefficient, costly and provide poor service to the community. They also represent poor value for the government from a Medicare funding perspective.
- The pool of radiologist is biased towards the public hospital model of radiology service provision which is also grossly inefficient in meeting both service, demand and community expectations.

- Equally the distribution of radiologist workforce between metropolitan and rural continues to be inadequate.
- We see no role for stand- alone CT in diagnostic imaging.
- The proposed changes under option 3 quite clearly include reduced levels of efficiency, increased radiologist remuneration/costs and reduced affordability and accessibility to patients.

Non-radiologist specialist practice (refer to page 30-31 of the RIS)

Question

- Are there any other services currently performed by non-radiology specialists?

Comment

In line with previous comments there are newer models which are not noted in the RIS Smaller medical centers provide the opportunity for patients to have X-Ray completed on site.

ADDITIONAL ISSUES FOR CONSULTATION

1. Rural and remote exemptions (refer to page 31-32 of the RIS)

The intention of having rural exemptions is to ensure patients have access to services without compromising on quality. However, current arrangements for rural exemptions vary for each of the modalities, creating confusion due to an inconsistent approach. The current approach is also difficult to administer.

Questions

- Does the current rule meet its goal of increasing access for patients without comprising on quality?

- Should exemptions be geographically/distance based rather than looking at population base and local availability of specialist services?
- Are there any other mechanisms that provide incentives for local services provision in rural Australia?
- What is the role of tele-radiology? Should it be the only service, or an adjunct the local service provision?
- Should the exemption not be available for certain types of services?

Comment:
- Tele-radiology has been in use for many years and has proven that it is an effective way of managing conditions within these rural regions.
- In many regional areas and out of hours reporting of CT can only be achieved by teleradiology. This development which has been in successfully implemented in practice for years without adverse consequences must be considered in all aspects of reporting in Radiology.
- If a service is available and provided by a suitably qualified radiographer or sonographer and reported on by a radiologist using the IT advancements - phone/Skype and tele-radiology it would be negligent not to utilise these services.

- Where possible this would be an adjunct the local service provision but it is well recognised there is a limited number of qualified personnel and rural regions struggle to recruit.
- Rural communities should not be disadvantaged by location if the service is available through the above means.

2. Implementing any changes and the relative role of regulation and the Diagnostic Imaging Accreditation Scheme (DIAS) (refer to page 33-34 of the RIS)

The relative role of regulation and accreditation in enhancing the quality framework for MBS funded diagnostic imaging services will be determined following feedback received from stakeholders under this consultation process.

Questions
- Would changes to supervision be better placed in the DIAS or remain in the regulations?
- How would a practice based supervision approach be incorporated into regulation?
- Is it necessary to have a modality based approach in the regulations (as a minimum) and a practice based approach in accreditation?

Comment
- Changes to supervision would be better placed with DIAS and the quality system regulated in line with other health services which are currently audited by organisations such as or ISO or ACHS or NATA.
- Each practice is unique but adherence to quality standards which are implemented and audited to ensure ongoing compliance.
- The current system of completion of documentation by sites to note compliance with the current 15 standards needs review needs to be expanded.

3. Any additional proposals, suggestions or comments?

Comment

- DIAS system needs to be in-line and further developed as with other quality auditing providers and include the NSQHS standards within the auditing process.
- This review is excellent opportunity to reflect on advances in imaging and the impact this has on clinical practice.
- It is important that any regular forum takes in to account the full diversity of all clinical practice and balances important competing issues covering quality, safety and cost effectiveness.