



australian diagnostic imaging association

ADIA SUBMISSION TO COMPETITION REVIEW

April 2024

ADIA is grateful for the opportunity to provide further information on competitive neutrality issues in the outpatient radiology market to Treasury's Competition Taskforce. This follows a meeting with Marcus Bezzi, [REDACTED] and their Taskforce colleagues on 26 April 2024.

If you have any questions about this document, please contact Chris Kane (CEO) [REDACTED].

EXECUTIVE SUMMARY

Public hospital radiology departments are funded by state and territory governments to provide radiology services to both inpatients and outpatients, and also receive Medicare funding for outpatient services. This funding structure provides a range of competitive advantages for public hospitals over private practices in the radiology market, and creates incentives for inefficient or clinically inappropriate service provision.

- These arrangements have resulted in public hospitals seeking to increase their volumes of lucrative outpatient services, including investing in new services solely with Medicare revenue in mind; incorporation of Medicare revenue into departmental budgets; reduced efficiency in private practices, and private practices reducing their services offering and being unable to invest in new or improved services. Rights of Private Practice arrangements also distort the labour market for radiologists.
- Governments are impacted because increased volumes of public hospital outpatient services reduces efficiency and has a substantial impact on Medicare expenditure.
- Patients are affected when public hospitals routinely prioritise Medicare-eligible outpatients over inpatients, and when public hospitals limit their offering of essential services such as breast imaging and obstetric ultrasound because Medicare rebates are low.

Competitive advantages and impacts are discussed in detail in this document.

ADIA is the peak body for radiology practices, representing over 750 clinics throughout metropolitan, regional and rural Australia, both in the community and in private and public hospitals. ADIA promotes the ongoing development of policy and appropriate funding to ensure that all Australians have affordable access to quality radiology services. This supports radiology's central role in the diagnosis, treatment, and management of a broad range of conditions in every branch of medicine.

BACKGROUND

Radiology

1. Radiology is an integral part of modern healthcare, being used to diagnose and treat injuries and disease, and therefore has a critical role in the health and wellbeing of Australian patients.
2. Radiology includes a host of imaging techniques (known as 'modalities'), such as x-ray, ultrasound, CT, nuclear medicine, PET and MRI. These techniques are used for a range of purposes, such as an x-ray to diagnose a broken arm, a foetal ultrasound to identify physiological concerns during pregnancy, or using image-guidance to conduct a biopsy or insert a catheter.¹ Most radiology services are provided by or under the supervision of a specialist radiologist.
3. In 2020-21, almost 30 million radiology services were funded by Medicare.² The volume of non-Medicare services (such as those provided to public hospital inpatients and services funded by third-party insurers such as workers compensation) is very substantial.
4. Radiology is provided in Australia in a variety of settings, including:
 - Public hospitals, to inpatients and outpatients
 - Private hospitals, to inpatients and outpatients
 - Community radiology practices
 - Private radiology practices providing reporting services to public hospitals
 - Non-radiologist clinicians such as cardiologists, vascular surgeons and O&G specialists, providing diagnostic and interventional services within their area of specialty.

CURRENT FUNDING ARRANGEMENTS BREACH COMPETITIVE NEUTRALITY PRINCIPLES

5. Competitive neutrality is important: to patients, to private radiology practices, and to governments funding radiology services. Despite the good intentions, however, in the case of radiology, where private providers compete with public hospitals in the provision of services to outpatients, the principles of competitive neutrality are largely ignored and not enforced.
6. ADIA's primary concern is the impact of public hospitals providing Medicare-funded radiology services to outpatients, in competition with private radiology practices operating in community clinics and in private hospitals. This breaches competitive neutrality principles because public hospital radiology departments derive a competitive advantage by virtue of government ownership.
7. 'Cost shifting' in public hospitals, which relates to services delivered to public patients (primarily inpatients) being inappropriately billed to Medicare, is a separate concern and not the subject of this document.

¹ Deloitte Access Economics (2020) The value of radiology. Australian Diagnostic Imaging Association.

² 2020-21 Medicare data published by Services Australia

The distinction between public and private radiology providers relates to government funding sources

8. Public hospitals typically provide radiology services to both outpatients and inpatients. Their funding is split 55-45% between State and Territory and Commonwealth governments under the National Health Reform Agreement. State and Territory governments contribute through activity-based funding (ABF), block funding and other programs; while the Commonwealth Government contributes through a mixture of activity-based funding (ABF), block funding, and through National Partnership Payments to States and Territories.³
 - In radiology, public hospital funding covers staff costs, facilities, equipment, and consumables.
9. Public hospitals also claim Medicare rebates for outpatient services, using radiologists' rights of private practice; while in private practices, government funding for each service is limited to Medicare rebates.
10. For many years, ADIA has raised concerns about the lack of competitive neutrality in provision of radiology services to outpatients, including through submissions to the Competition Policy Review (2014) and the subsequent Competitive Neutrality Review conducted by the Treasury (2017); meetings with ministers with portfolio responsibility for competition policy, the Productivity Commission and the Australian Government Competitive Neutrality Complaints Office; and most recently, participating in the Independent Pricing and Regulatory Tribunal's (NSW) Review of NSW Competitive Neutrality Policies and Processes.
11. ADIA has received legal advice that, while it can clearly be demonstrated that there are breaches of competitive neutrality principles in outpatient radiology, the current frameworks in each jurisdiction do not easily allow for measures to address competitive non-neutrality. This is because the frameworks include public benefit tests, that would likely outweigh cost considerations in any determinations made by competition authorities because the public benefit tends to be construed narrowly without regard for broader implications.
12. In addition, this competitive neutrality issue may fall between competitive neutrality policies in the various jurisdictions. The competitive advantage enjoyed by public hospitals is derived from their *state or territory* government ownership, while Medicare funding (available to all providers of outpatient radiology) is provided by the *Commonwealth* government. There is no COAG or Commonwealth-state competitive neutrality policy or process in place that ADIA is aware of.

COMPETITIVE ADVANTAGES ENJOYED BY PUBLIC HOSPITALS

13. Public hospitals derive a series of competitive advantages due to their status as government-owned entities, including hospital funding which covers service costs; rent foregone; tax exemptions and the ability of their staff specialists to utilise rights of private practice.

³ Australian Institute of Health and Welfare (2020) Health expenditure Australia 2018-19. Health and welfare expenditure series no.66. Cat. no. HWE 80. Canberra: AIHW.

Public hospital funding

14. Public hospitals receive funding from State or Territory health departments, provided under the National Health Reform Agreement. They then fund radiology departments to provide radiology services to inpatients and outpatients. Costs that are covered include:

- Staff wages and on-costs, including radiologists and nuclear medicine specialists, technical staff including radiographers and sonographers, nurses, and administrative support
- Equipment, including purchase of assets, installation, repairs and maintenance, and IT system costs
- Consumables, covering a host of items from eyewear, gloves and hand protection, to biopsy needles and ultrasound gel, to patient and radiation protection
- Utilities including electricity
- Administration costs

Rent

15. Private providers normally rent or buy premises in which they operate, while public hospitals do not usually charge rent to radiology departments.

Tax exemptions

16. Public hospitals enjoy several tax exemptions which are not available to private practices:

- Land tax is imposed on commercial property in all States and Territories except the Northern Territory and the Australian Capital Territory.⁴ Therefore, in most of Australia, private radiology practices pay land tax when they own the property, while public hospitals do not. While it is common for radiology providers to be tenants and therefore avoid land tax, it is likely that the rental payments reflect some of the land tax borne by the landlords, depending on vacancy rates and the ability of the tenant to vacate the premises.⁵ However, radiology practices are not able to easily change premises due to the value, size, and specialist fittings of their equipment.
- Public hospitals are exempt from payroll tax. In private radiology, payroll tax is a significant cost, varying between 4.75% and 6.85% above the eligible thresholds, depending on the State or Territory.⁶
- Hospitals are exempt from fringe benefits tax (FBT), up to \$17,000 per employee.⁷ Some public hospitals use the FBT exemption to contribute to attractive salary packages to attract and retain staff.

⁴ NSW Government, The Treasury (2013) Interstate Comparison of Taxes 2015-16, Research & Information Paper trp 16-01, December, p.31.

Available at: https://www.treasury.nsw.gov.au/sites/default/files/pdf/TRP16-01_Interstate_Comparison_of_Taxes_2015-16_-_pdf.pdf (Accessed 29/06/21)

⁵ Access Economics (2007) Scope for differential private/public Medicare rebates for radiology services, Report prepared for ADIA.

⁶ Payroll Tax Australia (no date) Payroll tax rates and thresholds.

Available at: <https://www.payrolltax.gov.au/resources> (Accessed 9 May 2023)

⁷ Australian Government, Australian Taxation Office (2023) 'FBT-exempt organisations'.

Available at: <https://www.ato.gov.au/business/fringe-benefits-tax/fbt-concessions-for-not-for-profit-organisations/fbt-exempt-organisations/> (Accessed 9 May 2023)

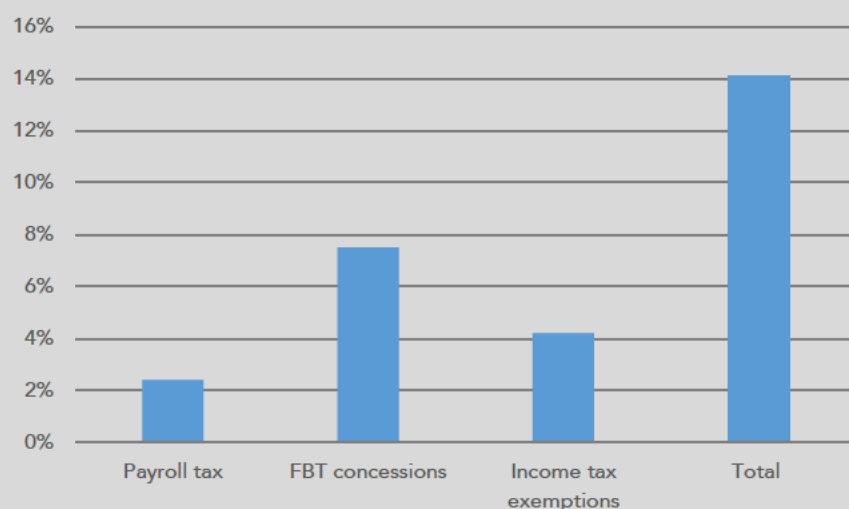
- Public hospitals are exempt from income tax, an exemption that extends to radiology provided to private outpatients,⁸ despite those Medicare-eligible services being provided using public hospital funding.
- Hospital employees can access to up to \$5,000 per year in salary packaged 'meal entertainment', which can include meals, and associated accommodation and travel.⁹

17. These tax advantages amount to a substantial competitive advantage over the public hospitals' private competitors.

Value of tax exemptions available to public hospitals

Verve Economics found that "The overall advantage public hospitals gain through tax advantages is relatively large. If the income tax exemption, payroll tax exemptions, fringe benefit tax exemptions, entertainment leasing expenses exemptions were to apply to a private practice they could potentially enable the practice to lower charges by up to approximately 14 per cent without affecting the aftertax return on capital achieved by the practice."¹⁰

Figure 9: What concessional tax arrangements would save a typical private practice in 2015-16 (% of revenue)



Rights of private practice

18. Public hospitals access Medicare funding by having medical specialists (including radiologists) provide services to patients privately, including outpatients. These arrangements are known as Rights of Private Practice (RoPP).¹¹

⁸ Verve Economics, op cit.

⁹ Australian Government, Australian Taxation Office (2023) 'Entertainment exemptions and reductions for not-for-profit and government organisations'.

Available at: <https://www.ato.gov.au/Business/Fringe-benefits-tax/Types-of-fringe-benefits/Entertainment-related-fringe-benefits/FBT-and-entertainment-for-not-for-profit-and-government-organisations/Entertainment-exemptions-for-not-for-profit-and-government-organisations/> (Accessed 9 May 2023).

¹⁰ Verve Economics (2017) Competitive neutrality issues with provision of outpatient diagnostic imaging services in public hospitals: A submission to the Competitive Neutrality Review. Canberra, Verve Economics. Available at:

<https://www.adia.asn.au/public/3/files/ADIA%20Submission%20to%20Competitive%20Neutrality%20Review.pdf> (Accessed 9 May 2023)

¹¹ Ibid

19. Claiming Medicare rebates for radiology services where the costs are covered by public hospital funding is effectively being funded twice to deliver the service – ‘double dipping’. This is at the heart of the lack of competitive neutrality in radiology.
20. As most or all costs are already covered, public hospitals generate substantial profit margins for outpatient services. In contrast, private practices rely on Medicare rebates and (for some services) patient gaps to fund services.
21. When utilising RoPP to provide services to outpatients, radiologists either:
 - assign the Medicare benefit to the hospital, and receive an allowance; or
 - retain all Medicare revenue generated but pay a facility charge and administrative fee to the hospital. Earnings may be capped at a specified level; or
 - share in the Medicare revenue generated with the hospital.¹²
22. Public hospitals are not required to ensure that facility charges reflect the true value of facilities and services used by radiologists when they exercise their RoPP. Evaluations of RoPP arrangements in Australian public hospitals have all questioned the adequacy of the fees that medical specialists are charged for the use of facilities, equipment and services when seeing private outpatients. For example, based on a 2008 audit of RoPP arrangements in Victoria the Victorian Auditor-General concluded:

“...there was no evidence that the ‘fee’ paid by the medical specialists as part of the facility agreements for the use of facilities, staff and other services reflected the real value of public resources being used.”¹³
23. This system enables radiologists in public hospitals to earn substantial incomes from outpatient work, which is not available to radiologists at private practices. This is a powerful recruitment tool for public hospitals, and drives up market rates for radiologists in private practice.
24. ADIA commissioned an independent, comprehensive workforce survey of private radiology practices in 2021. The survey found that the radiologist shortage totalled 172.4 FTE, equivalent to 24% of the current radiologist workforce employed at the practice groups surveyed. The shortage was estimated to grow to 346 FTE over the following three years, and is most pronounced in outer metropolitan (outer Modified Monash 1) and regional (MM 2 and 3) areas.¹⁴

¹² Ibid.

¹³ Victorian Auditor-General (2008) *Private Practice Arrangements in Health Services*: Report 2008-09:4, p. 23. Available at: <https://www.audit.vic.gov.au/sites/default/files/20081029-Health-Services-Private-Practice-Arrangements.pdf> (Accessed 9 May 2023)

¹⁴ Vendelta (2021), *ADIA workforce survey*.

IMPLICATIONS OF CURRENT FUNDING ARRANGEMENTS

Implications for the radiology market

Public hospitals seek to increase volumes of lucrative outpatient services

25. To increase outpatient volumes, some public hospitals and health services establish private-style branding and market to local GPs and specialists. Some hospitals particularly focus on high-value services like MRI and PET.
26. For example, Barwon Health (servicing Geelong and surrounding areas in Victoria) has established 'Barwon Medical Imaging', with its own brand, logo and website.¹⁵

Case study

SA Health has rebranded its entire public hospital radiology service as 'South Australian Medical Imaging' (SAMI): "A new brand identity has been launched for South Australia Medical Imaging (SAMI) to strengthen our position as a recognisable and competitive provider of medical imaging services for the state and to make it easier for the public to recognise our services. The brand features a new SAMI logo which will be used in conjunction with the Government of South Australia logo, and it will be visible across our website, corporate stationery, referral forms and site locations. The SAMI logo draws inspiration from the cells and layers of the human body and the technology and equipment that is used to 'look within'. There is no change to our services as a result of the new brand."

In June 2021, SAMI advertised the position of Business Development Manager, a role that has a strong focus on profit. Responsibilities include the "promotion of SA Medical Imaging services across private General Practitioners and Specialists to maintain and increase profitable referrals." The income generating aspects of the Business Development Manager are further articulated in other duties, such as: "Utilise your sales strategy, networking, relationship building and state mapping skills, identify and pursue new business opportunities within existing referrer client base as well as new referrers" and "Plan and deliver promotional events for GP's and Specialists and other key stakeholders to promote brand awareness and services provided by SA Medical Imaging."¹⁶

SA Health put out a tender for a mobile x-ray service, in competition with existing services provided by private practices. The tender requirements included service level standards that were impossible for private providers to meet (but not necessary for a clinically appropriate, quality service), and the contract was awarded to SAMI.

27. There are also cases of public hospitals asking referrers to 'take sides.' For example, one hospital established a PET service in competition with a private provider, and wrote to all referring specialists in the area asking them to refer to the hospital instead.
28. Pressure on specialists to 'support' public hospital services can be intense where they hold an appointment at the hospital.

¹⁵ <https://barwonmedicalimaging.com.au/>

¹⁶ Government of South Australia, Department for Health and Wellbeing (2020) Invitation for Expressions of Interest (EOI) to Supply Mobile X-Ray, Part A (Ref. SAH2020-879). pp. 4-5.

Case study

A regional public hospital built new specialist consulting rooms, and provided them to private oncologists at no charge. Those oncologists previously referred their patients to private radiology practices, but now refer all radiology to the hospital.

29. These activities are increasing public hospital market share. This is to be expected, due to the incentives for these providers to perform Medicare-funded services.

Growth in market share

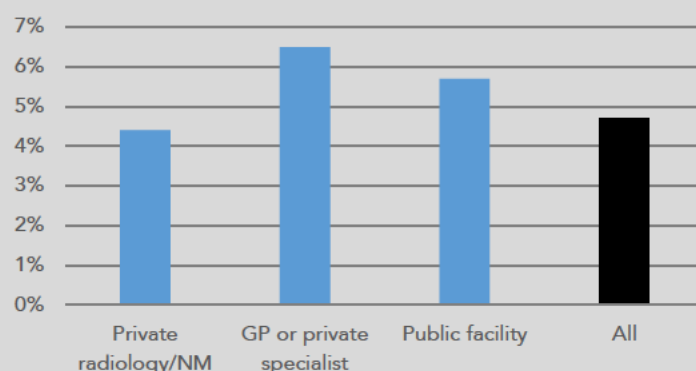
In 2020-21, rebates for 28.4 million radiology services were claimed under Medicare, at a cost of \$4.32 billion.¹⁷ Of these services, around 26.5 million were provided to outpatients.

Data provided by the Department of Health in 2017 indicated that public hospitals provided approximately 11% of radiology services to outpatients in 2015-16. However, this is likely to underestimate the true market share of public hospitals, as previous analysis of the LSPN register showed that many public hospital facilities are incorrectly classified.

ADIA has previously recommended reviewing practice types in the LSPN register, and offered to assist the Department of Health to conduct this work, which will provide a better understanding of public hospital outpatient services funded by Medicare.¹⁸

Noting the shortcomings in how the data is categorised, analysis commissioned by ADIA in 2017 found growth in public hospital volumes has been higher than growth in private radiology practices.¹⁹ This suggests that the market share of public hospitals is growing.

*CAGR for radiology services funded through Medicare,
By provider type, % per year, FY05 to FY16*



Incorporation of Medicare revenue into radiology department budgets

30. ADIA is aware of public hospital administrators setting radiology department budgets inclusive of Medicare revenue, so that the fixed costs of the department can only be met by generating substantial revenue from Medicare outpatients. Hospital leadership, then, drives the focus of the department, rather than allowing radiologists and other clinical staff to focus on their primary role: caring for inpatients.

¹⁷ 2021-22 Medicare data published by Services Australia

¹⁸ Presentation to the Diagnostic Imaging Advisory Committee, 6 June 2018

¹⁹ Analysis of Medicare data provided by the Department of Human Services. Adapted from and cited in Verve Economics (2017) Op cit.

Case study

The radiology department in a metropolitan public hospital introduced a new business case, built around thousands of additional outpatient services billable to Medicare. The business case was designed to generate a profit for the statewide health service, while also providing additional funding for clinical services to inpatients.

Public hospitals invest in new services to generate Medicare revenue

31. Some public hospital investments in particular services are driven by a desire to generate Medicare revenue, rather than meet the needs of inpatients.

Case study

A public hospital invested in an additional CT scanner to provide cardiac CT. The volume of inpatients requiring the service only utilises the scanner for one day per week, leaving four days to conduct outpatient examinations. As the costs of the scanner and staff are already covered by public hospital funding, Medicare revenue is almost entirely profit because providing those services requires minimal additional expenditure by the hospital.

32. MRI licences are a particular driver of Medicare revenue for public hospitals, because not all MRI scanners are licensed. This reduces the competition for outpatients, guaranteeing significant Medicare revenue streams.

Case study

A public hospital was successful in obtaining an MRI licence in the MRI expansion round (2018-19). At a media conference announcing the award of the licence, a hospital official stated that the licence would generate significant revenue for the hospital, which would be used for other purposes.

33. ADIA occasionally notices very high growth in Medicare volumes (more than 15% on a year-on-year basis) among certain items or modalities in particular jurisdictions, and in seeking to understand the reasons for this growth, consults with private practices in those locations. On several occasions, the growth has been attributable to aggressive public hospital activity.

Reduced efficiency in private radiology practices

34. Radiology is primarily a fixed cost business, with staffing, equipment, administration, and facilities costs comprising more than 60% of the cost of providing the service.
35. A shift in volumes to public hospitals reduces the efficiency of private practices, which limits their ability to bulk bill in competition with those public hospitals – this is a vicious cycle caused by the lack of competitive neutrality.

Private practices reduce their service offering due to public hospital competition

36. Competition on a non-neutral basis from public hospitals has led some private radiology practices to close certain services.
- Public hospitals do not need to generate revenue to fund the equipment and staff used to provide outpatient services, as those resources are paid for with public hospital funding.
 - In contrast, private practices are under greater pressure – the services they invest in need to generate sufficient revenue to break even. This pressure is particularly acute for advanced services with high capital costs and relatively small volumes.

37. The introduction of a Medicare-funded service at a public hospital in competition with private providers puts some services at risk.

Case studies

A private practice introduced the first PET/CT service in the state, next door to a tertiary public hospital. Initially, the practice provided PET/CT services to public hospital patients under a contract with the hospital, which combined with referrals from outside specialists made the service financially viable. However, public hospital clinicians lobbied the state government to provide a PET/CT scanner within the hospital itself, which was provided at a cost of \$5 million literally metres from the existing service. This forced the private practice to close its PET/CT service, as there were insufficient PET/CT volumes to support two scanners at the location.

Another private practice introduced PET/CT in their area several years ago. Subsequently, the local public hospital introduced a PET/CT service in pursuit of Medicare revenue. As a result, the private practice's scanner ran at a loss for years and is only now breaking even as demand for PET/CT increases.

38. Private practices do not take decisions to withdraw services lightly, as it is in their interest to offer a comprehensive suite of services even where some services are financially marginal:
- It makes the practice attractive for referrers, who can send their patients to one practice for all radiology services.
 - Patients have a 'one stop shop' rather than needing to attend different practices depending on the service.
 - It makes them an attractive employer, as staff have the ability to provide a range of examinations. This assists them to maintain their accreditation, for example sonographers providing ultrasound.
39. There are instances where public hospitals make investments in new services, and are very successful in attracting patients to the point where they have long waiting lists. Nevertheless, the hospitals are often reluctant to send patients on to private practices in the community, even where those practices offer to assist on a bulk billing basis.

Inability to invest in new services due to public hospital competition

40. Non-neutral competition from public hospitals limits the ability of private clinics to invest in certain services, particularly those with high capital costs where available volumes are relatively limited.
- The risk of a public hospital opening a competing service (which could make its own service unviable) is a factor for private practices making investment decisions.
 - Competition is particularly distorted in metropolitan areas where public hospitals have an MRI licence, while nearby private providers do not.

The market for radiologists is distorted

41. The structural advantages enjoyed by public hospitals in remuneration of radiologists are detailed in the previous section.

42. As private practices and public hospitals operate in the same market, public hospitals effectively act as the “price setter”, with private practices obliged to offer competitive packages to attract radiologists.

- Radiologists have significant power in the labour market due to the long-standing supply shortage.
- Private practices regularly report losing radiologists to public hospitals.

43. High wage costs are ultimately passed on to patients in higher costs.

44. Public hospitals that compete with private practices for outpatients can also obstruct the ability of those practices to recruit staff.

Case study

A private practice in an outer metropolitan area (classified as a district of workforce shortage) was looking to recruit a new radiologist. The practice enlisted the support of a recruitment agency to find an International Medical Graduate to work in the practice. A candidate was found, and under the Area of Need process, the practice needed a letter of support from their local area health service to complete the recruitment process. However, the health service indicated that they would not support the candidate, as they themselves had not had trouble attracting radiologists.

Implications for governments

Services in public hospitals cost the taxpayer more than services in private practice

45. As outlined in the previous section, outpatient radiology services provided by public hospitals are funded through two sources: public hospital funding (of which the Commonwealth contributes 45% through the National Health Reform Agreement) and Medicare rebates.

46. Therefore, the Commonwealth is providing significantly more funding for outpatient services provided by public hospitals than for those in private practices (which receive Medicare rebates only). Growth in public hospital market share presents a risk to the Commonwealth health budget.

47. Anecdotally, public hospitals are less efficient in procurement than private practices.

Case study

A regional hospital was granted an MRI licence, and installed an MRI scanner including a ‘cage’, at a cost of \$6-7 million. Private practices who reviewed this activity were confident that they could achieve the same outcome for under \$2 million.

Implications for patients

Prioritisation of outpatients over inpatients

48. ADIA understands that at some public hospitals, the wait times for radiology services for inpatients is longer than for outpatients, who are prioritised. The difference in waiting time between inpatients and outpatients can be several days.

49. Some patients (at their own request or at the request of their families) are discharged from hospital to attend a private radiology provider, then are readmitted once the examination is completed.

50. ADIA is aware of patients who spent longer as admitted patients in hospital than would have occurred had they been prioritised for radiology over outpatients.
51. The presence of an MRI licence at a particular site can encourage public hospitals to prioritise outpatients over inpatients, with inpatients waiting longer for MRI scans or being transported to another location.

Case study

A public hospital in a metropolitan area sends inpatients requiring MRI to another hospital in the network around 30 minutes away (which has an unlicensed MRI scanner), so that it can maximise the number of Medicare-funded outpatient examinations on its licensed MRI scanner.

Registrars reporting inpatient examinations

52. Only fully qualified radiologists have access to a Medicare provider number, which enables them to claim Medicare rebates for outpatient services. ADIA understands that at some public hospitals, reporting of non-Medicare eligible inpatient examinations is performed primarily by registrars, which allows consultant radiologists to focus on reporting outpatient examinations which generate revenue.
53. It is entirely appropriate for registrars to report inpatient examinations, with input from supervising radiologists as required depending on complexity. However, where allocation of reporting is determined by financial rather than clinical considerations, the risks to patient safety are increased.
54. In some cases, routine inpatient examinations are not reported at all, or are only reported after a long delay. This carries serious risks for patients.

Case studies

A public hospital combined inpatient work with the pursuit of outpatient referrals to such an extent that it created huge pressures on radiologists and registrars. Eventually, the hospital requested a private provider to assist by reporting a backlog of some 30,000 unreported examinations, including a cancer examination conducted eight weeks earlier.

200,000 x-rays over a three-year period went unreported at the Gold Coast Hospital and Health Service.²⁰ This may have put the safety of some patients at risk.

Likewise, staff at the Concord Hospitals reported that their radiology departments faced a backlog of 30,000 examinations in mid-2023.²¹

55. A public hospital radiology department lost its training accreditation after the Royal Australian and New Zealand College of Radiologists found that supervision of trainees was inadequate and trainees were not being given appropriate standards of teaching and education. ADIA

²⁰ Stephanie Bedo and Sarah Vogler (2014) 'Gold Coast Hospital and Health Service X-ray scandal report reveals 200,000 X-rays went unreported', *Courier Mail*, 6 November 2014. Available at: <https://www.couriermail.com.au/news/queensland/gold-coast-hospital-and-health-service-xray-scandal-report-reveals-200000-xrays-went-unreported/news-story/f1ff1c41bce149543850c8f64a4607e3> (Accessed 9 May 2023).

²¹ Angus Thomson and Carrie Fellner (2023) 'Staff in revolt as 'thousands of scans' go unchecked at Sydney hospital', *Sydney Morning Herald*, 1 July 2023. Available at: <https://www.smh.com.au/national/nsw/staff-in-revolt-as-thousands-of-scans-go-unchecked-at-sydney-hospital-20230627-p5djuo.html> (Accessed 29 April 2024).

understands that this situation arose in part because consultant radiologists focused on revenue producing outpatient work, while neglecting their supervision and teaching responsibilities.

Some public hospitals 'cherry pick' the outpatient services they offer

56. The Medicare rebates for radiology services vary depending on the modality, from basic x-rays averaging around \$50, to PET services averaging over \$900. Some public hospitals target higher-value examinations like CT, MRI and PET, and avoid or limit provision of ultrasound, breast imaging and interventional procedures to outpatients because of low rebates.
57. In some instances, patients presenting to a public hospital with a referral for lower-value services are told to attend a private practice instead, either because the hospital intentionally limits capacity with resulting waiting lists or does not offer the service at all.
58. While private practices may welcome these volumes, it demonstrates that for some public hospitals, the overriding objective of providing outpatient services is revenue generation.
59. In contrast, private providers generally aim to provide a comprehensive range of services, which is necessary to attract referrers.

Case study

One private practice sees a lot of patients referred for ultrasound, who have attended a nearby public hospital and been told that ultrasound is not offered. This policy extends to ultrasounds for diagnosis of deep vein thrombosis or miscarriages. However, the same practice rarely sees patients who attend the public hospital for more lucrative CT and MRI scans directed to them.

60. Mammography is one radiology service for which availability in public hospitals is particularly limited, and many patients are directed to attend a private practice.

Case study

A major regional public hospital offers only four diagnostic mammography appointments on three days per week, with a typical wait time of 10 days. If patients are not prepared to wait, they are directed to a nearby private practice which charges a gap of more than \$150. Where the mammogram shows suspected cancer and a breast biopsy or fine needle aspiration is required, the hospital has a similar policy.

RECOMMENDATIONS

It is important to emphasise that ADIA is not making moral judgements about administrators or healthcare professionals operating within Australia's public hospitals. As outlined in this document the structure of funding imposes pressures on them which distract from their core mission treating their communities according to clinical need. In addition, we are not arguing for a reduction in funding to public hospitals under the National Health Reform Agreement, as the quantum of funding required for public hospitals is not for ADIA to determine.

Instead, the policy objective of reform should be to define reasonable expectations about what should be available to public patients, and establish more efficient and cost-effective delivery of Medicare-funded radiology services in Australia.

1. From a competition policy point of view, we suggest introducing policies and administrative capacity to address competitive non-neutrality which occurs across levels of government.

- This would ensure that market participants in all sectors (not just health care) are subject to competitive neutrality rules.

2. From a policy perspective, we suggest mitigating the impacts of competitive non-neutrality by introducing differential rebates

- ADIA considers that competitive neutrality could be achieved through differential Medicare rebates for radiology, which recognise the difference in costs incurred by public hospitals to provide outpatient services compared to private practices, as well as tax exemptions enjoyed by public hospitals.
- A lower rebate would apply to outpatient services provided by public hospitals that operate radiology services using public hospital funding, but not outpatient services provided by private providers operating radiology services in a public hospital under contract (who do not receive public hospital funding).
- There is precedent for differential rebates between public and private providers in pathology:
 - Public hospitals receive a bulk billing incentive of \$1.40, while private providers receive between \$1.40 and \$3.40 depending on the services provided.
 - Public hospital COVID-19 tests attracted an MBS fee of \$50, while the same tests conducted in a private laboratory had an MBS fee of \$100.
- Competitive neutrality would deliver substantial benefits: for the Commonwealth, a net reduction in Medicare spending in medical imaging by the Commonwealth through avoidance of double-dipping and by incentivising the most cost-efficient service provision; and for patients, public hospitals prioritising inpatients and outpatients based on clinical need rather than revenue generation.
- Public hospitals would continue to provide radiology services to outpatients following discharge, but would be less likely to pursue inefficient but less active pursuit of community referrals.