Royal Australian and New Zealand College of Obstetricians and Gynaecologists

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
- Are there any deregulation opportunities within the scope of this RIS?
  RANZCOG has no comment on this issue.
- What would be the changes in costs associated with any deregulation options?

RANZCOG has no comment on this issue.

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

The following sentence should be amended to include other imaging specialists:

- The person under the professional supervision of the radiologist would require the appropriate qualifications, credentials, or training to provide the service.

Amended to:

- The person under the professional supervision of the radiologist or other specialist medical practitioner would require the appropriate qualifications, credentials, or training to provide the service.

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

- Are the principles as outlined satisfactory to clarify the requirements?
  RANZCOG has no comment on this issue.
- What reasons, if any, are there for the personal attendance requirements for MSK ultrasound to remain?
  RANZCOG has no comment on this issue.
- Would a minimum set of guidelines for 'accepted medical practice' per modality be appropriate?
  RANZCOG has no comment on this issue.

- What savings are anticipated to be realised from removing the personal attendance requirements for MSK ultrasound services?
  RANZCOG has no comment on this issue.
- 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?
  RANZCOG has no comment on this issue.
- What other costs (if any) associated with the proposed changes?
  RANZCOG has no comment on this issue.
- What are the potential consequences of the proposed changes?
  RANZCOG has no comment on this issue.

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
RANZCOG has no comment on this issue.

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
RANZCOG has no comment on this issue.

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
- Are there any other services currently performed by non-radiology specialists?
  RANZCOG is not aware of any other services, apart from ultrasound, that would be commonly performed by an O&G specialist and be in the imaging schedule.

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

- Does the current rule meet its goal of increasing access for patients without compromising on quality?
  The 30 km rule seems a little small in this day and age. Many patients in the city have to travel over 30 minutes to get radiology services pertinent to their specialist needs. As such, 30 minutes in a car or bus, for those living in rural and remote settings, is frequently the sort of distance travelled for the supermarket and other specialist shopping needs. As such, access at this distance is comparable to city dwellers. Quality becomes the main concern and many people complain about travelling 100kms for specialist services; this is when travel funding should kick in. It would be reasonable to establish this as the limit and would be in-line with travel funding.

  RANZCOG believes that equity of access and continuity of provider contribute to overall "quality of service". The College is concerned as there is an implication that the term "quality" as phrased in this question refers to technical aspects only.

- Should exemptions be geographically/distance based rather than looking at population base and local availability of specialist services?
  Yes; RANZCOG recommends that distance/time are the relevant factors for exemption(s).

- Are there any other mechanisms that provide incentive for local service provision in rural Australia?
  The provision of tele-radiology and communication with remote GPS and radiologists would enhance the diagnostic care and outcomes for remote people.

- What is the role of tele-radiology? Should it be the only a service or an adjunct to local service provision?
  Tele-radiology should be available for all non comprehensive centres at a distance of more than 100km from a comprehensive centre. RANZCOG recommends that this is specified as real time as well as reporting services. Tele-radiology would increase quality for the remote country dwellers.

- Should the exemption not be available for certain types of services?
  The exemption should not be available for services that, for safety reasons, cannot be reported later. It should only apply to ultrasound services and x-rays performed by a suitably qualified clinician which can be reported later.

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

- Would changes to supervision be better placed in the diagnostic imaging accreditation scheme or remain in the regulations?
  It would be better in the accreditation scheme. This would make it easier to monitor and alter as required.
- How would a practice based supervision approach be incorporated into regulation?
  RANZCOG has no comment to make on this issue.
- Is it necessary to have a modality based approach in the regulations (as a minimum) and a practice based approach in accreditation?
  RANZCOG has no comment to make on this issue.

3. Any additional proposals, suggestions or comments?

Point of Care Ultrasound in Obstetrics and Gynaecology

Point of care ultrasound has become critical to the effective practice of specialist obstetrics and gynaecology. All trainees undertaking FRANZCOG training will be equipped to perform point of care ultrasound for the diagnosis of common problems in obstetrics and gynaecology.

This is an *essential* component of specialist O&G practice and all decisions around imaging must be cognisant of the imperative that point of care ultrasound remains accessible to both provider and patient. RANZCOG would make the following points:

- Point of care O&G ultrasound substantially reduces cost by avoiding the expense of referral to an imaging specialist for the diagnosis of a myriad of conditions within the province of the ultrasound skills of virtually every FRANZCOG.
- Point of care O&G ultrasound greatly increases convenience to women and in many cases avoids unnecessary delays (i.e. imaging attendance) and the need for a further consultation (i.e. review of the imaging result).

- Point of care O&G ultrasound improves quality of care with evidence showing that the absence of ready access to ultrasound leads to more misdiagnoses by the examining clinician in situations where the diagnosis may otherwise be enhanced by ready access to point of care O&G ultrasound e.g. antenatal diagnosis of a breech presentation.

RANZCOG is concerned that the current debate around diagnostic imaging may impact adversely on point of care ultrasound to the detriment of women. For example, a reduction in point of care O&G ultrasound may be inadvertently caused by complex credentialing demands intended for full-time imaging practice. Any reduction in point of care ultrasound has the potential to cause real harm to women and their offspring and is not without implications for their families more broadly. RANZCOG notes that full-time imaging specialists/practices that are currently advising government may not be familiar with the imperatives around maintenance of ready access for women to point of care O&G ultrasound

Advanced (Referred) O&G Ultrasound

FRANZCOG training does not routinely include ultrasound training for the diagnosis of complex fetal abnormalities as commonly performed at approximately 20 weeks' gestation. RANZCOG believes that these examinations (and others requiring advanced skills) should be performed by appropriately trained personnel. Ongoing credentialing for advanced O&G ultrasound should compulsorily include participation in an audit of personal clinical outcomes.