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AMA submission to the Medical Services Advisory Committee – New mobile imaging services for residential aged care facilities

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Background

The AMA thanks the Medical Services Advisory Committee for the opportunity to comment on the application for new mobile imaging services at residential aged care facilities (RACFs). The AMA is generally supportive of introducing MBS items for such a service, and believe it can significantly improve medical access to older people and save on expensive costs that come with transferring a resident from a RACF to a hospital. The AMA has supported mobile imaging services in recent submissions[1] and position statements[2]. This submission provides overarching feedback on MBS funding for mobile imaging services.

Australia is experiencing an ageing population, many of whom have high care needs. This trend will continue to grow, as the number of older Australians (aged 65+) is projected to be 8.7 million by 2056, 22 per cent of the whole population[3]. The aged care system must be adequately resourced so older people can access quality medical care into the future. Access to medical care should be efficient and should not put the older person at further risk of harm.

The incidence of fall-related injuries for residents of RACFs is five times higher than older people living in their home[4], which can lead to the requirement for imaging services. Transferring a resident to receive imaging services usually requires an ambulance, which is costly. A single transfer from a RACF to an emergency department (ED) has been estimated to cost up to $1800 in Victoria[5].

[1] https://ama.com.au/submission/ama-submission-house-representatives-standing-committee-health-aged-care-and-sport-%E2%80%93
[2] https://ama.com.au/position-statement/aged-care-resourcing-2018
[3] Australian Institute of Health and Welfare (2017) *Older Australia at a glance*, p4
[4] Australian Institute of Health and Welfare (2018) *Trends in hospitalisations due to falls by older people, Australia, 2002-03 to 2012-13*. p24
[5] Morphet et al (2015) *Resident transfers from aged care facilities to emergency departments: can they be avoided?*. Emergency Medicine Australasia. 27:5, p412-418

Staying in the hospital can also increase the risk of infection[6] and delirium[7], and can be disorientating and stressful for the patient. It is also disruptive to an already-busy RACF, as an individual (either a family member or carer) must accompany them to the service. On average, RACF staff accompany a resident for 4-5 hours to go to hospital to carry out an imaging service, while family members may need to take time off work to assist with the transfer[8]. Scandinavian countries have found savings of 30-60 per cent per examination when using mobile imaging services in comparison to outpatient services[9], indicating that mobile imaging services are economically viable to the health system[10].

Introducing mobile imaging services typically results in three outcomes[11]:

- increased access to imaging services;
- fewer in- and outpatient services; and
- fewer hospital transfers.

A study of the Royal Melbourne Hospital's mobile x-ray service found an 11.9 per cent reduction in ED presentations for plain x-ray a year after its implementation[12]. Introducing mobile imaging services also has the potential to:

- increase capacity for community care and care-in-place;
- improve the timeliness of required investigations and therefore also improve timely transfer of care and care outcomes;
- improve patient and carer experience; and
- decrease unintended issues of transfer such as infections, delirium, disorientation and distress in the patient.

Intervention

The AMA agrees with the imaging types outlined in table 1 of the discussion paper. However, pelvic ultrasound should also be included in the list, as older people can experience torted ovarian cysts and malignancy.

[6] Avci, M. et al. (2012) *Hospital acquired infections (HAI) in the elderly: comparison with the younger patients*, Archives of gerontology and geriatrics, vol. 54, no. 1, pp. 247.
[7] Caplan, G et al (2015) *Appropriate care for older people with cognitive impairment in hospital*. The Medical Journal of Australia. 2015:23-15
[8] Kjelle, E and Lysdalh, KB (2017) *Mobile radiography services in nursing homes: a systematic review of residents' and societal* outcomes. 17:231
[9] Kjelle, E and Lysdalh, KB (2017) *Mobile radiography services in nursing homes: a systematic review of residents' and societal* outcomes. 17:231
[10] Dozet Lic, A et al (2016) *Radiography on wheels arrives to nursing homes – an economic assessment of a new health care technology in southern Sweden*. Journal of Evaluation in Clinical Practice. ISSN1365-2753.
[11] Kjelle, E and Lysdalh, KB (2017) *Mobile radiography services in nursing homes: a systematic review of residents' and societal* outcomes. 17:231
[12] Montalto, M et al (2015) *Evaluation of a mobile x-ray service for elderly residents of residential aged care facilities*. Australian Health Review. 35:517-521.

Service initiation and request

It is imperative that only treating medical practitioners are able to refer a resident to a mobile radiology service, and not RACF staff. For example, our members have reported that some RACF staff are requesting blood tests on all patients every couple of months, regardless of the clinical need to do so. A medical practitioner is suitably qualified to assess whether their patient's needs can be managed in the RACF with the mobile imaging service. It also ensures there are no delays in transferring a resident to a hospital if their situation requires it. However, there are barriers for GPs and other medical practitioners in attending RACFs (please see 'other comments') that must be rectified in order for them to provide timely medical care to residents.

Service delivery

The viability and quality of mobile imaging services depends on the quality of the equipment, the expertise of the radiographers, and appropriate case selection by an experienced medical practitioner.

The AMA agrees that the individuals providing mobile imaging services should be appropriately qualified and registered radiologists and radiographers. The quality of x-rays from mobile imaging services can vary due to the lack of access to infrastructure that allows optimal positioning of the patient. Due to the limitations that come with mobile equipment, it is essential that an appropriately qualified professional is carrying out the service to ensure the optimal quality image is obtained. Difficulties may arise when an ultrasound and x-ray is required on the same patient, as radiographers are usually trained in only one method.

The role of RACF staff should also be considered under this model. RACF staff are already stretched thin due to a high workload and a lack of appropriately qualified and trained carers. The proportion of registered nurses is currently in decline[13], and this should be addressed so that mobile imaging services have appropriate assistance when handling residents.

The AMA notes in the discussion paper that imaging reports will be sent via facsimile or email to the treating medical practitioner. It is important to ensure that there are systems in place where the medical practitioner is called if there is a finding that requires urgent medical attention.

Representation under the Medicare Benefits Schedule

Our members report that many RACF residents are poor or do not have the capability to provide payment for a medical service. This usually results in bulk-billed services. If new items are to be contemplated to provide for mobile imaging and bulk-billing remains a priority, then the MBS rebate has to be adequate for the service to be financially viable. If a co-payment is to be charged, it is essential that the MBS rebate adequately compensates the patient. Otherwise, large out of pocket costs may result in an inequitable supply of medical care.

[13] Mavromaras et al (2016) *The aged care workforce, 2016.* Department of Health

The current MBS items do not reflect the true value of a medical service. For this reason, the MBS items should incorporate costs of travel and setting up the service at the RACF. This is especially required for rural, regional, and remote, areas who may need to travel long distances. However, consideration of a fee should include whether it would encourage unnecessary imaging, and/or undermine the work of current diagnostic imaging providers.

Our members report that previous mobile imaging services had to close down because they were financially unviable. MBS item numbers allow a more reliable system that gives businesses more financial security to grow these services. However, a start-up incentive may be required to ensure the setup of a mobile imaging service is financially viable.

The AMA agrees that mobile imaging services should be reflected in the MBS as separate radiology items that can be co-claimed with the other radiology service items.

Restrictions, quality assurance and standards

There should not be restrictions around resident eligibility for this service. The purpose of RACFs is to care for older people who have high care needs, so the majority of residents are frail and have difficulty being transferred for imaging. There is also the risk of an individual being ineligible due to an unforseen condition or circumstance, which could create an inequitable service. It also overcomplicates the service, as eligibility would be challenging to assess or enforce. Whether a mobile imaging service is required should be the discretion of the patient's treating medical practitioner. Similarly, there should be no restrictions on the maximum number of imaging services per day as is may result in unintended consequences on access.

The Department may observe an increased number of investigations, however this is likely to be due to previous unmet demand. For example, a medical practitioner may not request an x-ray if the journey to the hospital or other provider imposes a significant health risk to the resident. Older people can also experience fear from the thought of being transferred to a hospital, and may refuse to go[14]. Conversely, a study that observed resident experience with mobile imaging services found that the residents felt safe, and were pleased that they didn't have to leave the RACF or stay in hospital[15].

The discussion paper asks whether there should be restrictions on the age of the technology used in mobile imaging services. The AMA is against different MBS rebates known as the Capital Sensitivity Rules[16], on the basis of equipment age because of the potential perverse incentives it encourages. For example, too short a depreciation period might disadvantage a diagnostic imaging provider who invests in a top-of-the-line machine that can produce good quality images for a long period with periodic upgrades, and instead encourages a provider to purchase a

[14] Kjelle, E and Lysdalh, KB (2017) *Mobile radiography services in nursing homes: a systematic review of residents' and societal* outcomes. 17:231

[15] Eklund, K et al (2012) *Positive experience of a mobile radiography service in nursing homes*. Gerontology. 58:107-111

[16] http://www.health.gov.au/internet/main/publishing.nsf/Content/capsensfaq-di

cheaper quality machine that produces poorer quality images but that can be replaced more often[17].

Service equity and accessibility

The discussion paper outlines uncertainties regarding the quality of the imaging services resulting in RACF transferring their residents to the hospital. It is important that there is clear messaging and communication around the benefits and processes behind mobile imaging services to RACF staff and medical practitioners to avoid this.

Special consideration needs to occur for the implementation of mobile imaging services in rural, regional, and remote, areas. Non-sealed roads can damage imaging equipment. The broadband required for sending digital images is sometimes scarce. It may be difficult in some areas to justify a business model around mobile imaging services, so more specific funding may be required in rural, regional, and remote, areas.

Many of the issues raised concerning accessibility and equity apply equally to existing services (e.g. limited imaging services in rural areas). This is not a reason to dissuade the implementation of MBS items for mobile imaging services. It is the clinical situation plus the wishes of the resident, or their representative, that determines the course of action. A mobile imaging service simply provides more options.

Other comments

Medical practitioners are required to refer their patients to the proposed mobile imaging service. However, there are barriers for GPs to visit RACFs that may result in unmet demand for mobile imaging services:

- MBS funding for GP attendances at RACFs do not adequately compensate for the significant non-face-to-face time that accompanies caring for a resident, or the opportunity cost of a GP leaving their practice.
    - Examples include travel time, the time it takes to find the patient or a RACF staff member, and answering questions from family members.
- There is on occasion no appropriate staff member (i.e. nurse) to ensure a clinically reliable handover to appropriately care for the patient.
- RACFs are not adequately set up for medical practitioner visits, including barriers in access to the facility (swipe cards and parking availability), access to patient records, and the absence of clinically-equipped doctor treatment rooms.

For optimal results and cost efficiency of mobile imaging services, the above barriers to GPs visiting RACFs should be addressed. It is important that the existing limited MBS funding for medical services provided in RACFs is not diverted to the mobile imaging service items. This will result in further barriers for RACF residents to access medical care.

[17] https://ama.com.au/position-statement/diagnostic-imaging-2018

Conclusion

Mobile imaging services have great potential to save health care costs, and also avoid unnecessary and sometimes harmful hospital transfers of RACF residents. Currently, there seems to be concern that cost savings would only occur for State and Territory governments, so there are challenges in justifying funding from the Federal Government. Regardless, there must be more focus on the health of residents in RACFs to uphold their basic human right to health[18]. The health of older people must be the priority, not a focus on internal financial difficulties within the health system divisions.

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[18] http://www.who.int/mediacentre/factsheets/fs323/en/