



Review of the Radiation Oncology Health Programs Scheme

Submission from Cancer Council Australia and the Clinical Oncology Society of Australia

Cancer Council Australia is the nation's peak non-government cancer control organisation. Its members are the eight state and territory Cancer Councils.

The **Clinical Oncology Society of Australia (COSA)** is the peak national body representing health professionals from all disciplines whose work involves the care of cancer patients.

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Contact: Paul Grogan (02) 8063 4155; paul.grogan@cancer.org.au

Recommendations:

- The ROHPG scheme should remain a Commonwealth funding initiative separate to the MBS.
- Align MBS service item descriptors and ROHPG funding for equipment that delivers optimal radiation therapy.
- Implement a regular, transparent process for adding new equipment or technologies to the list, and removal of those that are outdated or superseded by new equipment.
- Include equipment that is essential to the treatment planning phase of radiation therapy which is crucial to delivering an accurate dose and quality standard of care.
- Ensure the list of equipment is reflective of advances in technology and techniques which are typically incremental.
- Link a radiation facility's compliance with the Radiation Oncology Practice Standards with their eligibility ROHPG funding.
- To ensure that radiation therapy services are provided in an equitable manner, and according to need and sustainability, the process of granting ROHPG licenses should be more transparent and consultative by engaging with existing providers in the area and jurisdiction. This defined process would offer all relevant parties and opportunity to make a submission.

The Radiation Oncology Health Program Grant (ROHPG) scheme provides a contribution towards capital costs incurred by radiation oncology providers for major radiation oncology equipment. Along with this infrastructure funding, the Commonwealth also provides financial support for radiation oncology services in Australia through the Medicare Benefits Scheme (MBS).

The ROHPG scheme has been a successful funding model which has allowed Australian radiation therapy machines to be maintained and new services developed. Cancer Council and COSA encourage this model for infrastructure support but vigilance is required to ensure that funding directly reaches radiation therapy departments.

As population growth continues and the number of older Australians increases, so will the demand on radiation therapy services for the treatment and management of cancer. The majority of Australians diagnosed with cancer are aged 65 years or overⁱ and approximately 1 in 2 will benefit from radiation therapy as a component of their treatment planⁱⁱ. Incidence of cancer is expected to increase from an estimated 130,000 in 2016 to 150,000 new cases diagnosed in 2020ⁱⁱⁱ.

Therefore, a robust, sustainable radiation therapy sector will be increasingly important to service the growing number of people who will require radiation therapy as part of their cancer treatment plan.

Radiation therapy in Australia

Although the number of Australian radiation oncology facilities has increased over time and current waiting time to treatment is considered acceptable, inequalities and inefficiencies remain in delivering radiation therapy as a component of optimal cancer care.

When appropriate infrastructure is in place, radiation therapy is a cost-effective treatment option for many cancer patients. In 2014, the total Commonwealth spend on radiation therapy was \$389.90 million which was a combination of \$327.9 million spent on Medicare benefits (including \$49.9 million in Medicare Safety Net benefits) and \$62 million directed into infrastructure investment through the Radiation Oncology Health Program Grants (ROHPG)^{iv}. Based on the 2008-2009 Commonwealth spend on cancer, the total cost of radiation therapy to the Commonwealth amounts to less than 9 cents in every dollar spent on cancer. In comparison, \$595.9 million was spent by the Commonwealth on chemotherapy drugs alone in the financial year to 30 June 2014, it is evident that radiation therapy is a very cost effective treatment modality^v.

Overall purpose of the scheme:

The ROHPG scheme contributes to the capital cost of purchasing eligible radiation therapy equipment used by radiation oncology providers. The scheme has supported the introduction of linear accelerators (linacs) since 1988. Australia currently has a total of 184 linacs treating approximately 50,000 patients each year^{vi}. The ROHPG scheme is incentivised to encourage

the maintenance or installation of contemporary equipment capable of delivering appropriate treatment in accordance with accepted standards of clinical care.

The ROHPG scheme is an appropriate mechanism to address the rapid technological advancement of radiation therapy techniques and technologies by supporting the purchase of equipment that delivers quality care to patients. Such advancements and understanding of best practice techniques must also be reflected via the use of radiation therapy items listed on the Medicare Benefits Schedule (MBS) and the item descriptors aligned to quality for a rebate.

There is a critical need for the continued investment in infrastructure, as a gap remains between the current, and optimal utilisation rate for radiation therapy uptake. It is estimated that 48.3%^{vii} of cancer patients in Australia would benefit from radiation therapy as part of their treatment plan, however, only 38.1%^{viii} of patients undergo radiation therapy. This means thousands of patients are missing out on potentially beneficial treatment.

The ROHPG assists public and private providers in maintaining their equipment current by subsidising the replacement of outdated equipment, maintenance of existing equipment and can support the establishment of new services in areas of demonstrated need. In particular, the scheme has supported the establishment and growth of services in regional areas, which has improved access to radiotherapy for these populations. However, to ensure that radiation therapy services are provided in an equitable manner for cancer patients across all jurisdictions, the process of granting ROHPG licenses should be more transparent.

The delivery of quality care, through the use of best practice and optimal radiation techniques, can be further supported by the current ROHPG scheme. The Radiation Oncology Practice Standards^{ix} provide a framework of requirements to assist radiation therapy facilities to achieve best practice across various domains (e.g. machine calibration, documentation, safety, and quality improvement). The review of the ROHPG scheme offers an ideal opportunity to achieve national adoption of the Radiation Oncology Practice Standards across all jurisdictions, by linking a facility's compliance with the Practice Standards to its eligibility for ROHPG funding.

The ROHPG, supported by amended MBS item descriptors, can further improve the capability of service providers to deliver a service in line with best practice to support optimal cancer care outcomes. The ROHPG scheme can improve by ensuring equipment eligibility lists are reviewed systematically, and that patients can access services delivered by this equipment through the MBS.

Advances in technology and best practice treatment delivery

The delivery of radiation therapy to treat cancer requires multidisciplinary practice, reliance on custom built facilities and specialised equipment, and out-patient treatment programs. It is planned and delivered by a team of professionals which includes radiation oncologists, radiation therapists, and medical physicians, along with support staff. Advancements in technology have driven improvements in the quality, safety and accuracy of radiation therapy in recent years.

The optimal radiation therapy utilisation rate of approximately one in two cancer patients^x provides a benchmark for planning radiation therapy services on a population basis and based on current estimates, radiation therapy is an underutilised modality for the treatment of cancer.

Although advances in technology and our understanding of best practice delivery of radiation for many cancer patients has increased, the ROHPG scheme can do more to increase the adoption and delivery of these techniques. Areas of the scheme which can support this include:

- I. Interaction and impact on current Medicare Benefits Scheme item numbers;
- II. ROHPG eligibility criteria.

I. Interaction and impact on current Medicare Benefits Scheme item numbers

The current MBS billing structure does not reward providers or recognise where optimal therapy is being provided. The current review of the MBS, as well as this review of the ROHPG scheme, provide an ideal opportunity to mandate implementation of the Radiation Therapy Practice Standards through linking compliance with the Standards to funding eligibility.

If particular equipment is eligible for funding under the ROHPG scheme to deliver an advanced technique of radiation therapy as part of best practice treatment this must also be reflected on the MBS and the related item descriptor must promote the quality use of the service.

Recommendation:

- Align MBS service item descriptors and ROHPG funding for equipment that delivers optimal radiation therapy.

II. ROHPG eligibility criteria

To be eligible for capital support, a service must demonstrate that it has adequate staffing levels and that staff are trained in radiation delivery techniques the equipment. The capacity to deliver best practice radiation therapy is essential to complement the capital investment.

To encourage the delivery of advanced, optimal radiation therapy techniques the list of eligible equipment for funding under the ROHPG scheme must be frequently reviewed against best practice deliver of radiation therapy for various cancer types.

Recommendations:

- Implement a regular, transparent process for adding new equipment or technologies to the list, and removal of those that are outdated or superseded by new equipment.
- Include equipment that is essential to the treatment planning phase of radiation therapy which is crucial to delivering an accurate dose and quality standard of care.

- Ensure the list of equipment is reflective of advances in technology and techniques – which are typically incremental.
- Link a radiation facility's compliance with the Radiation Oncology Practice Standards with their eligibility ROHPG funding.
- To ensure that radiation therapy services are provided in an equitable manner, and according to need and sustainability, the process of granting ROHPG licenses should be more transparent and consultative by engaging with existing providers in the area and jurisdiction. This defined process would offer all relevant parties and opportunity to make a submission.

Conclusion:

The role of the ROHPG as a Commonwealth initiative to support radiation oncology services in Australia remains an important scheme for ensuring cancer patients have access to current and future radiation therapy treatment. It must recognise the incremental changes in radiation technology and outcomes for patients undergoing treatment.

The ROHPG scheme should remain a Commonwealth funding initiative separate to the MBS however, to encourage the efficient use of services and the delivery of best practice radiation therapy, they should align with the introduction of new techniques. There should also be a transparent process for the appropriate allocation of ROHPG funding for the establishment and/or expansion of radiation oncology treatment centres, based on where need exists. The ROHPG scheme supports the quality provision of essential cancer services ensuring patient access to timely, affordable and quality radiation therapy in Australia, and quality service provision could be further enhanced through linking eligibility for capital funding with mandatory adherence to the Radiation Oncology Practice Standards.

ⁱ Australian Institute for Health and Welfare. 2016. Australian cancer incidence and mortality booklets: All cancers combined. Accessed on 13th April 2016 via <http://www.aihw.gov.au/acim-books/>

ⁱⁱ Delaney GP, & Barton MB. 2015. Evidence-based estimates of the demand for radiotherapy. *Journal of Clinical Oncology*, vol. 27, pp. 70-76.

ⁱⁱⁱ Australian Institute of Health and Welfare 2012. Cancer incidence projections: Australia, 2011 to 2020. Cancer Series no. 66. Cat. No. CAN 62. Canberra: AIHW.

^{iv} (Australian Government Department of Options Paper on Future Funding Options for the Australian Clinical Dosimetry Service, May 2015).

^v Expenditure and prescriptions twelve months to 30 June 2014. Available at <http://www.pbs.gov.au/statistics/2013-2014-files/expenditure-and-prescriptions-12-months-to-30-june-2014.pdf> Accessed on 11 June 2015, http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp1415/ExpendCostDrugs

^{vi} In-house data from the RANZCR Faculty of Radiation Oncology self-reported facility-based census in 2015 (100% response rate)

^{vii} Delaney GP, & Barton MB. 2015. Evidence-based estimates of the demand for radiotherapy. *Journal of Clinical Oncology*, vol. 27, pp. 70-76.

^{viii} Radiation Oncology Tripartite Committee (Faculty of Radiation Oncology; the Royal Australian and New Zealand College of Radiologists; Australian Institute of Radiography; Australasian College of Physical Scientists and Engineers in Medicine), Planning for the Best: Tripartite National Strategic Plan for Radiation Oncology 2012-2022, version 1. 20 June 2012

^{ix} Radiation Oncology Practice Standards. Available at http://www.ranzcr.edu.au/component/docman/?task=doc_download&gid=441