

GENESIS CARE

GenesisCare Limited welcomes the opportunity to support Minister Ley MP, the Australian National Audit Office and the MBS Taskforce in the review of the ROHPG Scheme for Radiation Oncology. Consistent with the Vision of the Review, GenesisCare is committed to delivery of healthcare services that deliver value for the individual patient and the health care system at large.

GenesisCare is Australia's largest provider of Radiation Oncology, operating around one third of Australia's Radiotherapy departments across five states in both public and private hospital settings. GenesisCare acknowledges the role of ROHPG in funding new and replacement Radiation Oncology equipment and the approval process in developing new sites and services. The Australian Government is to be commended on implementing and maintaining the ROHPG Scheme; the outcomes have directly contributed to the provision of services in areas of need and with equipment that continues to service patients safely and effectively.

We understand the need for change and for all providers to contribute towards a more sustainable health care system which puts health care value for dollar and patient outcomes first. GenesisCare is keen to partner in the ROHPG review. We understand the Scheme was last reviewed in 1999 and to that end, we have sought the input of our clinical leaders (Radiation Oncologists, Radiation Therapists and Medical Physicists) and our health care managers to address the key issues listed in the briefing notes. Attached to this introductory letter is our response, which we believe addresses key regulatory, operational, strategic, opportunity and risk issues. Throughout our response, four key themes prevail and require ongoing consideration:

1. Maintenance of a regulatory and approval process tied to funding equipment to ensure services are delivered where needs exist. An unregulated environment creates significant risk which will result in a concentration of services in areas surrounding Tertiary and Quaternary Health precincts resulting in access inequality, particularly for rural and outer metropolitan communities;
2. Ongoing support for capital equipment with due consideration of the cost of borrowing in the private sector given the nature of upfront investment and a 10-year reimbursement cycle for Linear Accelerators ("Linacs") and CT Simulators and a 5-year cycle for treatment planning systems;
3. Consideration of the macro Radiation Oncology funding environment which links the ROHPG review into proposed outcomes from the current MBS review. It is essential that these reviews are coordinated and the impact on patients and service providers are assessed in a coordinated manner; and
4. The private sector provides over 40% of Radiotherapy in Australia and requires ongoing input into the ROHPG review. We believe that representation on key committees and review panels should include the private sector and to this end, we stand ready to support the Department of Health ("DoH") in this review.

Again, GenesisCare welcomes the opportunity to participate in the review. We are supportive of an ROHPG review and are open to our comments being made public. As GenesisCare is the largest stakeholder in Australia, we would also appreciate the opportunity to have a representative on the committee that will conduct this review.

<p>Benefits and limitations of the Scheme</p>	<p>GenesisCare owns and operates Australia’s largest fleet of Linacs, CT/Simulators, Treatment Planning Systems, Oncology Information Systems and High/Low Dose Rate Brachytherapy Systems. Our in-depth knowledge of the ROHPG system places us in a unique position to comment on both the benefits and limitations of the Scheme. Our considered views are:</p> <p>Benefits:</p> <ol style="list-style-type: none"> 1. <u>Coordination of service development:</u> The HPG approval process has ensured that new Radiotherapy services are located in “areas of need” as assessed by both a detailed desktop assessment and reference to State Cancer Plans. This coordinated approach to service development has ensured that services are developed in areas where patients live, rather than just accumulating services around major metro tertiary teaching hospitals. In our view, on the whole, the HPG approval process has worked extremely well, coordinating planning policy across State boundaries. <p>Coordination of national planning to ensure equity of access was a key recommendation of the 2002 Baume Inquiry into Australian Radiotherapy and the Tripartite National Strategic Plan for Radiotherapy. Furthermore, the Cancer Australia strategic plan notes the “importance of priority-driven investment in cancer control to guide the optimal use of available resources” which is a key benefit of the ROHPG Scheme. We believe that retaining this essential regulatory feature should be a priority when considering any changes to the ROHPG Scheme.</p> <ol style="list-style-type: none"> 2. <u>Better access for patients:</u> Since the introduction of the HPG Scheme, patient access to essential Radiotherapy services have improved dramatically. The improvement has been particularly significant for patients living in outer metropolitan and regional centres as the HPG approval process has ensured that centres are developed in areas of need. For example, in the last ten years GenesisCare has worked with the DoH and State Governments to develop services in areas such as Casey, Epping and Frankston in Victoria; Elizabeth and Kurralta Park in South Australia; Bunbury, Murdoch and Joondalup in Western Australia; Nambour, Southport and Rockhampton in Queensland; and Lake Macquarie, Ryde and Hurstville in New South Wales. For GenesisCare alone this represents more than \$200m of investment in Radiotherapy infrastructure in recognised areas of need. Provision of these services has reduced the cost and burden of travel for patients and increased utilisation and access to essential radiotherapy services. Further, this investment has reduced expenditure at the State level through transport and accommodation support (via State Based IPTAS schemes which reimburse patients for expenses where travel for essential health care exceeds 100 kilometres – e.g. VPTAS - https://www2.health.vic.gov.au/hospitals-and-health-services/rural-health/vptas-how-to-apply). 3. <u>Equipment modernisation:</u> With dedicated and capped funding for equipment replacement, ROHPG has ensured appropriate
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equipment replacement and investment in Radiotherapy equipment. This ongoing investment has supported consistent modernisation of treatment machines. Whilst no specific provision has been made for the additional cost associated with additional functionality, the sector has continued to invest in technology upgrades and enhancements to further improve the planning and delivery of treatments. Examples include technology to provide Image Guided Radiotherapy (specifically Cone Beam CT), Intensity Modulated Radiotherapy, Stereotactic Services (including small cones, robotic couches and stabilisation devices), Motion Managed Treatment (specifically gating and deep inspiration breath hold devices) and Planning Software (specifically image management software for multimodality image inclusion in the planning process). These investments have improved patient outcomes in terms of improved quality of life, reduced toxicity and sustained periods of tumour control. The investments have also reduced occupational injury to staff (Multileaf Collimation has significantly reduced manual handling injuries and Afterloaded Brachytherapy Systems have reduced occupational exposure to harmful radiation). As such, the Commonwealth has received excellent value from the Scheme with increased patient access to advanced technology without any additional funding cost to the Commonwealth.

Limitations:

1. **Annual reviews and adjustments reflecting shifts in technology costs and issues such as exchange rate variations:** Following the Baume Inquiry there was a commitment from the Commonwealth to a quarterly review of the actual cost of capital equipment to ensure that funding is reflective of the actual capital cost incurred by providers. This has not occurred over the last five years. Over this time period the equipment specifications required to provide a modern evidence based radiotherapy services have increased significantly.

Furthermore, significant fluctuations in exchange rates created significant swings in the cost of equipment procurement which have not been reflected in ROHPG grants rates. For example, the cost of an equivalent Linac has increased by 30%-40% over the last two years on the back of exchange rate variations alone. Despite assurances in 2007 that annual reviews would be conducted, providers have not been engaged in any reviews and there have been no adjustments in the documented HPG rates.
2. **Application and processing timelines:** The approval process can take many months to progress. There is no transparency around management of applications. This includes responses to applications of both new and replacement equipment.
3. **Transparency in the approval process:** In recent years, a number of approval decisions have seen the development of centres in areas which fail to meet planning guidelines based on population, population growth, available Linacs and capacity within existing services. Examples include recent approvals for

new services in and around Brisbane (Greenslopes, Northlakes and Redlands) and in Victoria (The Valley Private Hospital). In all cases, facilities within the catchment had capacity which could have been utilised to ensure access for all and avoid unnecessary cost and lost productivity. The Baume Inquiry specifically found that “new facilities should not be in the same catchment area as existing facilities unless there is clear reason why it cannot be expanded” and “The area of need should be clearly demonstrated, preferably having been identified in the relevant State and Territory Strategic Plan”.

Radiotherapy is a high fixed cost service (expense building, equipment and material minimum requirements for highly trained staff). As with all high fixed cost services, appropriate utilisation / demand is essential for service efficiency. In overseas markets, such as the US, unregulated roll-out of service has led to a material oversupply of treatment facilities. This, in turn, has resulted in significantly higher costs to patients, Governments and insurers as providers are forced to offset high fixed costs with higher per patient treatment fees. To ensure that Radiotherapy services remain efficient and good value for Governments and patients, we would encourage the DoH to try to ensure that services continue to be developed in recognised areas of need.

4. **Recognition of modern equipment:** The current schedules do not reflect the development of new technology and the manner in which services are provided, either through technology (Collimation, Imaging, Motion Management) or networking (Centralisation of Hardware and Data). Dual Energy Linacs (no kilovoltage imaging, no IMRT capability) are funded at a premium compared to Single Energy Linacs, which are equipped to perform high end services such as Stereotactic treatments. We also note that while Intensity Modulated Radiotherapy (IMRT) has been recognised on the Commonwealth Medicare Benefits Schedule (“CMBS”), the capital investment required to deliver this service has not been recognised under the ROHPG Scheme.
5. **Attendance based payment model:** The current attendance based model is not reflective of contemporary practice where shorter but more intensive treatments are being delivered, despite fewer attendances being delivered with certain evidence based protocols (e.g. breast and prostate hypofractionated Radiotherapy and stereotactic radiosurgery / Radiotherapy). While total treatment attendances are fewer, these Hypofractionated and Stereotactic treatments often take longer to deliver each attendance. For example, a Stereotactic treatment often takes over an hour to deliver. These longer treatment times and shorter fractionation patterns were not taken into account when the ROHPG reimbursement per service was calculated (it was based on 20 fractions per course and 15 minutes per attendance). As such, the implied fractionation pattern and treatment times are not reflective of modern practice. If the DoH maintains the current attendance based payment model, there is a real risk that

	<p>equipment replacement will be significantly delayed as shorter treatment courses and longer treatment times materially reduce Linac throughput and the time taken to work through the ROHPG capital balance.</p> <p>Before the introduction of defined HPG capital balances for public Linacs, the Baume Inquiry found that many public departments were operating machines over 15 years of age and concluded that this was a significant barrier to ensuring patient access to high quality radiotherapy. To avoid a repeat of this issue we would suggest that the DoH consider introduction of a course based funding model as this would ensure appropriate replacement of equipment (based on patients treated rather than attendances). GenesisCare is open to working with the DoH on a model which would be more equitable and sustainable.</p> <p>6. <u>Failure to recognise ROHPG for a number of evidence based treatments:</u> Stereotactic Radiosurgery (Item Number 15600), Intraoperative Breast Radiotherapy (Item Number 15900) and Superficial Radiotherapy are modern evidence based services which are recognised under the CMBS but are not recognised by ROHPG. These services require significant capital investment to deliver and the lack of recognition of this fact is a barrier to utilisation. These services are generally more efficient and cost effective to deliver, however underfunding drives underutilisation and ultimately inflates CMBS and EMSN costs. Further demonstrating the inconsistency, while these services do not attract any ROHPG payments, more expensive services (under the CMBS) and older Radiotherapy treatments do.</p> <p>7. <u>Administration burden:</u> The current attendance based model is administratively intensive and does not add value to the regulatory and replacement process.</p> <p>8. <u>Inconsistent coordination with reference groups such as RANZCR around horizon scanning to modernise the Schedule:</u> The Schedules fail to reflect new technology already available in Australia (with TGA Approval) or technology available in other countries but yet to arrive in Australia. Schedule review could be incorporated into a transparent process coordinated by the professional associations/bodies.</p>
<p>Purpose of the Scheme</p>	<p>The purpose of the ROHPG Scheme was:</p> <ol style="list-style-type: none"> 1. To improve access to Radiotherapy services; 2. Ensure appropriate replacement of equipment; and 3. Ensure that services were developed in recognised areas of need. <p>GenesisCare considers that the Scheme has proved effective against this agenda.</p> <ol style="list-style-type: none"> 1. <u>Improve access:</u> Coordinated national planning to ensure equity of access was a key recommendation of the 2002 Baume Inquiry into Australian Radiotherapy. Over the ten years from 2002 to 2012 the number of Linacs in Australia increased by 70% (from 99 to 168). GenesisCare believe that on the whole this significant

investment in Radiotherapy access has been well coordinated thanks to the ROHPG approval process. In our experience, GenesisCare has invested over \$200m in the last ten years in developing Radiotherapy services across five States in close collaboration with State and Federal Governments. This investment, in concert with a significant roll out of public services (e.g. Regional Cancer Centre), has significantly improved patient access to care. This has been evidenced by a demonstrable improvement in wait times across both the public and private sector. However, while improvement in wait times is encouraging, Radiotherapy remains materially underutilised with ~38% of patients accessing the service compared to an evidence based target of 48% of patients benefiting from the service. Radiotherapy underutilisation has real clinical consequences, including compromised outcomes, premature death, inadequate pain and symptom control and reduced quality of life. As such, closing the gap must remain a priority of State and Federal Governments.

However, persistent underutilisation of Radiotherapy can no longer be explained by a lack of treatment facilities with growth in Linacs (~7% p.a. over the last 12 years) far outstripping growth in cancer incidence (~3%) and little to no change in Radiotherapy utilisation. Continued growth in Linacs above cancer incidence, without an increase in Radiotherapy utilisation, will lead to significant service oversupply. As noted previously, oversupply in Radiotherapy will in turn decrease efficiency and increase costs to Government and patients. We believe that the DoH should consider a more realistic Radiotherapy utilisation target when assessing the need for a new service and direct consideration should be given to existing capacity within the system.

As such, it is increasingly evident that underutilisation of Radiotherapy is an outcome of non-evidence based practice rather than a lack of access to treatment facilities. There are clear competing market forces and a lack of patient and referrer awareness of the role of Radiotherapy which directly impacts Radiotherapy utilisation. These competing market forces are particularly evident in specialities where the referring specialists have a vested interest in an alternative treatment modality (e.g. prostate cancer). Addressing this cancer system weakness and supporting evidence based / Multidisciplinary care should be a key priority of the CMBS / ROHPG review.

2. **Ensure appropriate replacement of equipment:** A finding of the Baume Inquiry was that a “substantial proportion of Linacs in the public sector were more than ten years old. In three States, machines older than 15 years were still in use”. In a high technology area of healthcare, appropriate replacement and upgrade of equipment is essential to ensure that Australians receive best practice care. In our experience, the ROHPG Scheme has supported appropriate replacement of Australia’s Linac fleet. The Tripartite Strategic Plan evidenced a material improvement

	<p>in the average age of the Australian Linac fleet between 2000 and 2012 (with 60% of machines less than five years old, versus 40% of machines less than five years old in 2000). This result is at least partially explained by the capped funding offered through ROHPG, with funding linked to the opening capital cost of the equipment.</p> <p>As noted above, the ROHPG has significantly improved patient access to modern treatment techniques. These investments have improved patient outcomes in terms of improved quality of life, reduced toxicity and sustained periods of tumour control. This is a significant achievement and has come about directly as a result of the ROHPG Scheme and considered improvement to the Scheme post the Baume Inquiry.</p> <p>It is worth noting that for public services, the payment of ROHPG as a separate income stream to CMBS billings means funding can be quarantined and dedicated to equipment replacement (via dedicated bank accounts). This ensures that equipment is appropriately replaced and does not need to be funded through general recurrent budgets which historically have proved challenging.</p> <p>The ROHPG Scheme has the benefit of being able to recognise the cost of funding associated with Radiotherapy Capital Equipment for Private Providers, given that capital is purchased upfront but ROHPG payments are amortised against the opening capital balance over eight to ten years. This feature of the Scheme ensures appropriate replacement of equipment in the private sector.</p> <p>3. <u>Ensure services are developed in targeted areas of need:</u> As stated above, the ROHPG application process has generally ensured that services are developed in areas of need which has significantly improved patient access to Radiotherapy.</p>
<p>Potential alternative funding models</p>	<p>GenesisCare would be supportive of changes to the ROHPG Scheme which improve patient outcomes and create greater efficiency for Government and providers. Potential considerations include:</p> <ol style="list-style-type: none"> 1. <u>Move to course based Linac payments:</u> See previous comments in the section “Benefits & Limitations of the Scheme – Attendance Based Payment Model”. Current payments for Linac treatments are based on the number of treatment attendances. A move to course based Linac payments would significantly reduce the number of transactions the DoH has to administer and as a result will reduce the cost of administering the Scheme. 2. <u>Bundled payments for all services:</u> As an extension to the idea outlined above, the DoH could consider bundling all payments into a single treatment course payment, including Simulation, Dosimetry and Treatment. Again, this would significantly simplify the Scheme, and its cost to administer, while retaining the benefits to patient care that the Scheme has afforded. GenesisCare is open to working with the DoH on a model which encourages simplicity in administration, reduction in operating

costs and maintains adequate investment in service planning and equipment replacement.

3. **Linking the ROHPG payment to quality standards:** We would support linking payments under the ROHPG Scheme to accreditation under the ten National Standards and ultimately the Radiation Oncology Practice Standards. This would effectively ensure that implementation and use of quality management system is a prerequisite for Radiotherapy service delivery.
4. **Payments based on designated time periods rather than attendances:** The growing trend of shorter course treatments (Stereotactic and Hypofractionated Treatment Regimens) are resulting in fewer attendances per course. Under the existing model the risk exists where the age of equipment will increase as the attendance threshold (82800 for Linear Accelerator Treatments) will be difficult to achieve in the current 10-year life cycle period. Another option to the course based payment scheme discussed above would be to move to a time based payment model (like the current Network Grant Payment) and link payments to an overall life cycle of equipment, after which payments would either discount or cease.
5. **Reduce funding on lower scale equipment incapable of delivering modern treatment techniques:** Examples would include Linacs which are incapable of IMRT, Treatment Planning Systems incapable of IMRT or Stereotactic Planning.
6. **Link payments to CMBS submissions to reduce the costs of Administration:** Create payment logic based on submission of Item Number combinations (1 x Simulation, 1 x Dosimetry, 1 x Treatment) and remove the need to submit monthly data to enable account processing.
7. **Reduce the cost and burden of duplication and re-processing:** Create a single transaction point for both Medicare and ROHPG payments at the time of account processing. Current ROHPG rejection rates associated with incorrect data submission will be determined and corrected at the time of submission ensuring resubmission of ROHPG payments will cease. Current resubmission rates can be as high as 10% of all transactions – this consumes precious time and resources to re-process and adds significant cost to the transaction process.
8. **Roll ROHPG payments back into the CMBS schedule:** We understand that the DoH may be considering rolling ROHPG payments back into the CMBS. On face value, we have three key concerns with this approach:
 - a. **Coordinated service planning:** We would encourage the DoH to retain a coordinated approach to service development consistent with both the findings of the Baume Inquiry and the Tripartite Strategic Plan. See comments under the “Benefits and limitations of the Scheme” section. To retain this feature, the DoH could replicate this process through a licencing system.

	<p>b. Increased risk of funding leakage away from equipment replacement: CMBS income in public hospitals is typically used to offset operating expenses. As such, rolling funding into the CMBS increases the risk that capital funding is used to support operating expenditure and equipment replacement will not occur in timely manner. There is also a significant risk that the funds will be lost through Rights of Private Practice and Service Trusts. These were key considerations in the development of the ROHPG Scheme. It is essential that these considerations are taken into account if any alternate funding structures are developed.</p> <p>c. Recognition of the cost of capital for private providers: Currently, the ROHPG Scheme recognises the cost of capital required to fund Radiotherapy equipment in the private sector. As such, the private rate is a true reflection of the lifetime cost of the investment in Radiotherapy equipment and this mechanism needs to be retained. We understand that there may be moves to align the rate paid to public and private providers. However, it is important to remember that the public rate was intentionally set lower as a result of negotiations with State Governments regarding their broader block funding negotiations (which are not available to private providers).</p> <p>It is difficult to see how this differential payment model could be retained if the ROHPG was rolled up into the CMBS, unless the DoH paid all providers the private rate or created separate CMBS Item Numbers for public and private services.</p>
<p>Determining eligible equipment</p>	<p>Technology in Radiotherapy is constantly changing with advances improving the accuracy, safety and efficiency of treatment. Both the Baume Inquiry and the Tripartite Strategic Plan refer to a material delay to the introduction of new technology in Australia versus comparable overseas markets. Case studies in Australia include access to Cyberknife, Gamma knife, Intraoperative Breast Radiotherapy and Proton therapy. These technologies are all well accepted treatment modalities in overseas health systems, however patient access in Australia is ad-hoc or non-existent. The lack of eligibility of these technologies for ROHPG funding acts as a material limitation to the adoption in Australia.</p> <p>We accept that the DoH wants all new technology to undergo a detailed MSAC review to assess clinical effectiveness. However, the burden of proof required under the MSAC process remains a significant obstacle in a field like Radiotherapy which evolves through incremental technical improvement rather than the introduction of completely new services. Perhaps a compromised position could be found where technology could be assessed as at least equivalent to current practice and therefore eligible for current funding arrangements (CMBS and ROHPG). This would support early technology introduction and local assessment of outcomes ahead of a comprehensive MSAC review.</p>

	<p>The current ROHPG descriptors are very out of date. We would consider the following equipment descriptors to be a more contemporary reflection of Radiotherapy equipment:</p> <ol style="list-style-type: none"> 1. <u>Linear Accelerators or Equivalent</u> <ol style="list-style-type: none"> a. Base = Single or Dual Energy, MLC, IGRT, IMRT b. Base +1 = Motion Management (DIBH/Gating), VMAT c. Base +2 = Stereotactic (Robotic Couch, FFF, Micro Collimation / Cones) 2. <u>CT Simulators</u> <ol style="list-style-type: none"> a. Base = Dedicated Standard Bore MultiSlice CT b. Base +1 = Widebore CT MultiSlice CT c. Base +2 = 4D CT System, Motion Management 3. <u>Treatment Planning Systems</u> <ol style="list-style-type: none"> a. Base = 3D Conformal & IGRT Capability b. Base +1 = IMRT/VMAT Capability c. Base +2 = Advanced Functionality – Knowledge Based/Smart Planning/Dose Accumulation d. Base +3 = Incentive payments for upgrades and new applications 4. <u>Radiation Oncology Information Systems</u> <ol style="list-style-type: none"> a. No adjustment to current model required
<p>Workforce considerations</p>	<p>Through the adoption of the Radiation Oncology Practice Standards, issues associated with workforce will be addressed, including:</p> <ol style="list-style-type: none"> 1. <u>Staff Training:</u> All staff who operate equipment must be trained in accordance with the detailed equipment specifications as described in the Manufacturer and Practice Standards documents. 2. <u>Staff Credentialing:</u> All staff to be assessed and credentialed initially and bi-annually on all new technology platforms in accordance with the requirements specified in the RO Practice Standards. 3. <u>Students, Medical Trainees and Specialist Training:</u> Services should provide access to training programs for “students and medical trainees” to ensure education and development of a skilled workforce and also to ensure ongoing access to highly qualified radiation oncology staff to provide services in all areas, including regional and remote locations.
<p>Linking funding to quality measures (rather than throughput)</p>	<p>GenesisCare is of the opinion that ROHPG should be linked to the following quality measures:</p> <ol style="list-style-type: none"> 1. <u>Achievement of accreditation under the ten National Standards:</u> This would require a minimum of two days survey and assessment, specifically in the Radiation Oncology Department (with one day in each satellite site associated with a main location).

	<ol style="list-style-type: none"> 2. <u>Achievement of accreditation under the proposed Radiation Oncology Practice Standards:</u> This would require each Department to achieve and maintain accreditation under the National Radiation Oncology Practice Standards code. 3. <u>National Audit of all Equipment as part of the ACDS or equivalent Dosimetry Audit Program:</u> All newly commissioned equipment to undergo an independent dosimetry audit at the completion of commissioning and prior to commencement of clinical service delivery.
Billing practice complexity	See earlier comments under the “Potential alternative funding models” section. Reduction of complexity associated with the current model by bundling or consolidation equipment payments and titrating these over time as opposed to usage will ensure a significant cost and time saving to the system administrator.
Existing supply / potential saturation of services	<p>See earlier comments under the “Purpose of the Scheme” section. The regulatory function of gaining approval for the development of new centres and services has been an excellent feature of the current ROHPG Scheme. On the whole, Radiotherapy services have been rolled out in clear areas of need and their development has been highly patient centric rather than provider centric. While Radiotherapy remains underutilised, and we would suggest that addressing this shortfall should remain a priority of Government, there is strong evidence that services are moving to a state of oversupply. This oversupply is evidenced by:</p> <ol style="list-style-type: none"> 1. Wait times do not appear to be an issue in any geography; 2. Few, if any, departments operating above the benchmark of 414 cases per Linac per annum; and 3. ~7% growth in Linacs per annum over the last decade versus 3% growth in cancer incidence with no significant improvement in Radiotherapy utilisation. <p>We strongly believe the following principles should underpin the linkage of Equipment Grants to service planning and new centre approvals based on access, quality and economic considerations:</p> <ol style="list-style-type: none"> 1. <u>Service planning and approvals must demonstrate need:</u> Patient access to essential Radiation Oncology services is constrained by issues associated with access. Rural patterns of oncology care demonstrate different and often sub-standard access to evidenced based care (e.g. Breast Cancer Mastectomy rates are higher in areas where access is constrained). Evidence suggests a “drive time” of 45 minutes to a point of service delivery is the threshold of acceptability (Travel times and distances to Radiotherapy Centres for Head and Neck cancer patients in England [2006-2008]: Oxford Cancer Intelligence Unit http://www.ncin.org.uk/view?rid=1217). <p>Ensuring services are located in areas of need is an important outcome and an appropriate use of funds to provide services.</p> <ol style="list-style-type: none"> 2. <u>There is evidence in major capital cities and surrounding areas that saturation has been achieved and capacity exists without the need for new services or additional bunkers:</u>

	<p>Competing market forces, new targeted therapies and evidence lacking protocols (e.g. prostatectomy in patients with metastatic disease) has resulted in a real world Radiotherapy utilisation rate significantly lower than the 48% benchmark published in Planning and Service Development documents. Maintaining the regulatory function ROHPG approvals provide is essential in ensuring a cost effective Medicare system where demand and supply are matched and efficiency is maximised through the high utilisation of equipment and staff. Consideration should be given to utilising a more realistic Radiotherapy utilisation target (e.g. 40%) when assessing applications for new services. This target can be reviewed in line with actual Radiotherapy utilisation rates and actual capacity within existing services.</p> <p>3. <u>Approval of new services in locations where existing services are available creates service saturation and compromises the ability to deliver efficient high quality services:</u> The reduction of patient numbers (across individual tumour streams and across the service as a whole) associated with “saturation” results in lower quality outcomes as clinical and technical staff face barriers in developing and maintaining clinical currency. Data on the issue of clinical currency and minimum procedure thresholds has been published in the medical literature and has been demonstrated in producing poorer clinical outcomes (Robot-Assisted Surgery Compared with Open Surgery and Laparoscopic Surgery: Clinical Effectiveness and Economic Analyses - http://www.ncbi.nlm.nih.gov/books/NBK168924/.)</p> <p>4. <u>Approval of new services in locations where existing services are available results in additional health care costs associated with equipment and infrastructure replication:</u> The costs of replicating services in areas where services already exist is significant and should be avoided in order to manage escalating health care expenditure. This was a key finding of the Baume Inquiry in 2002.</p>
<p>Other issues – Responsible and timely introduction of new technology</p>	<p>New technology considerations</p> <p>The following statement reproduced from the TRIPARTITE NATIONAL STRATEGIC PLANFOR RADIATION ONCOLOGY 2012-2022 (http://www.radiationoncology.com.au/providing-a-quality-radiation-oncology-service/a-forward%E2%80%90looking-strategy-to-deliver-improved-radiation-oncology-services/) demonstrates the need for a well-coordinated and funded infrastructure planning framework – one which ROHPG has delivered but could be improved. A review of the Scheme must consider horizon scanning capability, link in with professional bodies, providers and vendors to better plan and manage review, introduction and funding of new technologies which improve outcomes and/or reduce the cost of care associated with greater efficiency and effectiveness.</p> <p><i>“The issues of new and evolving technologies are not new in Radiation Oncology and have been highlighted in the Baume Inquiry. Problems persist with the safe and timely introduction, reimbursement and dissemination of promising innovations in radiation oncology. The</i></p>

Commonwealth Department of Health and Ageing (DOHA) is a key agency which supports patient access to treatments through the Medicare Benefits Schedule and infrastructure improvement through the Radiation Oncology Health Program Grants (ROHPG). In the absence of DOHA support, the treatment is either not made available in Australia or is introduced on an ad hoc basis. In the latter case, the cost is passed to the patient or to the State/Territory Health Services. In radiation oncology, the effect of unavailability, delayed introduction or ad hoc introduction typically means that the service cannot be delivered to all those patients who require it for optimal cancer care. Existing delays in the introduction of modern radiotherapy techniques are around 10 years in comparison to North America. This gap is likely to continue to grow unless measures are taken.”