

MEDICAL TECHNOLOGY ASSOCIATION OF AUSTRALIA (MTAA)

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1. Introduction

In 2015, as part of the Australian Government's Healthier Medicare initiative, the Medicare Benefits Schedule (MBS) Review Taskforce was established to undertake a review of the entire MBS to ensure it reflects current best clinical practice and promotes the provision of health services that improve health outcomes.

Commonwealth funding for radiation oncology is provided through the MBS for medical services and the Radiation Oncology Health Program Grants (ROHPG) Scheme. The ROHPG Scheme was introduced in 1988 to provide funding towards capital costs incurred by radiation oncology providers for major radiation oncology equipment. The Scheme has not been formally reviewed since and due to the linkages between radiation oncology MBS items and the ROHPG Scheme, the Department is initiating a review of the ROHPG Scheme and is seeking stakeholder input.

The formal review of the ROHPG Scheme being undertaken in 2016, aims "to ensure that Commonwealth funding of radiation therapy equipment in Australia is contemporary, fair and equitable".

MTAA welcomes the opportunity to respond to the recent review of the ROHPG Scheme. In this submission, MTAA provides comments and feedback on the following key areas of the review:

- Benefits and limitations of the Scheme
- Purpose of the Scheme
- Potential alternative funding models
- Determining eligible equipment
- Linking funding to quality measures (rather than throughput)
- Billing practice complexity
- Existing supply/potential saturation of services.

2. Radiation Oncology Health Program Grant Response

The ROHPG Scheme was introduced in 1988 under Part IV of the Health Insurance Act 1973 as an alternative method for funding the capital cost of expensive radiotherapy equipment, which was formerly funded through Medicare arrangements.

Australian Government funding for radiation oncology is provided through a range of funding measures including Medicare Benefits Schedule (MBS) funding for medical services, the ROHPG Scheme funding for high-cost equipment and one-off funding grants for the construction of new and improved radiotherapy facilities.

Payments are in addition to Medicare rebates that patients receive for radiotherapy (RT) services. The Scheme is open to public and private providers who are recognised as an 'approved health service' (at a specific location) under the Act.

RT is a critical and inseparable component of comprehensive cancer care used in combination with surgery and/or chemotherapy. Approximately 40% of cancer cures are

attributed to RT.¹ Recent evidence-based estimates suggest that around 50-60% of patients with cancer would benefit from radiotherapy at some stage during the course of their illness.² RT uses X-rays to destroy or injure cancer cells so they cannot multiply. RT can be used to treat the primary cancer or metastatic cancer. It may be the only treatment used, or used in combination with surgery and/or chemotherapy. It can also be used to reduce the size of the cancer and relieve pain, discomfort or other symptoms.

At least 48% of all patients with cancer would benefit from RT.³ However, in Australia, only 1 in 3 cancer patients receive RT – which is significantly lower than clinical recommendations.³ Despite the clinical recommendations and established evidence showing the effectiveness of RT use to treat cancer, access to RT through the Scheme remains low and is currently not meeting the clinical need of the increasing cancer incidence in Australia, that is projected to increase. Importantly, waiting times for patients to receive RT have been recognised as not the cause of limited patient access to RT - rather it is the number of RT facilities in Australia that is inadequate to meet the clinical need – as outlined by Atun et al., 2015.²

a. Purpose of the Scheme

The key initiative of the Scheme is to address accessibility for patients to radiotherapy i.e. since its introduction in 1988 it has successfully removed the capital cost of linear accelerators as a barrier to accessing RT. The purpose of the Scheme is to ensure that RT, which improves the health outcomes for cancer patients, continues to be available and accessible in Australia.

The success of the ROHPG Program and treatment of cancers using RT is largely driven by accessibility to linear accelerators. It is imperative that access to linear accelerators remains funded and access to newer and more advanced linear accelerators should be made available. The ROHPG Programs should provide incentive to replace equipment once it has reached its expected output; ensuring contemporary Linacs are capable of delivering the appropriate treatment in accordance with accepted standards of clinical care.

b. Benefits and Limitations

Benefits

The application process of the ROHPG Scheme is an effective method for the Australian governments (Federal and State/Territory) to ensure the correct placement of new facilities across the country. This has meant that most patients receiving RT wait less than two weeks for treatment and almost all emergency cases begin their treatment on the same or next day.⁴

The Scheme successfully manages public and private providers to ensure government policy is implemented appropriately and is balanced against commercial considerations. An example is the increase in rural RT facilities achieved by encouraging the development of facilities through the ROHPG Scheme.

¹ Tripartite National Strategic Plan for Radiation Oncology. Available at: www.radiationoncology.com.au.

² Atun et al., 2015

³ Barton et al., 2013

⁴ AIHW, 2015

Limitations

Determining the equipment that is eligible to be funded by the Scheme

The Faculty of Radiation Oncology Position Paper on ‘Techniques and Technologies in Radiation Oncology’ highlights the dependence on technologies to deliver best clinical practice for treating cancers using RT.

The Review should include the revision of the ROHPG definitions to consider current RT technologies i.e. definition of Single Photon Linear Accelerators (SPLA), Dual Modality Linear Accelerators (DMLA), and Planning workstations.⁵

Current definitions of eligible Linacs are:

- Single Photon Linear Accelerator (SPLA) with Electronic Portal Imaging (EPI) and Multi Leaf Collimator (MLC)
- Dual Modality Linear Accelerator (DMLA) with Electronic Portal Imaging (EPI) and Multi Leaf Collimator (MLC).

The current definitions of ‘Eligible Treatment Planning Computer Systems’ are:

- CT Interfacing Planning Computer System with 3 or less workstations
- CT Interfacing Planning Computer System with 4 or more workstations.

The delivery of contemporary RT treatment techniques - Intensity-modulated radiation therapy (IMRT), Volumetric modulated arc therapy (VMAT) and Stereotactic body radiation therapy (SBRT) - is not considered in these definitions. Additionally, new MBS items have been issued for IMRT, which reflect contemporary clinical practice and RT treatment techniques (Table 1). The ROHPG definitions should also appropriately reflect contemporary clinical practice and use of technologies in RT i.e. SPLA or DMLA should include kV imaging capability – to ensure the appropriate technologies are eligible for funding.

⁵ RANZCR Position Paper. Available at:

http://www.ranzcr.edu.au/component/docman/?task=doc_download&gid=1456

Table 1: Summary of RT and MBS items

Category	MBS Code	Description	Comment
Simulation	15550 15553	CT SIM CT SIM with Contrast	Most departments use a CT Simulator for simulation.
Planning	15559 15562	3D Conformal Dosimetry 3D Conformal Dosimetry	Code depends on how many critical volumes are outlined or multiple phase treatments.
External Beam Treatment	15221 15236	Breast 1 to 6 fields	A maximum of 6 fields can be charged for. IMRT treatments can range from 6 to 12 fields per treatment. Codes differ for single energy and dual energy Linacs. The reimbursement value is the same.
	15215 15230	Lung 1 to 6 fields	
	15218 15233	Prostate 1 to 6 fields	
	15224 15239	Other Primary 1 to 6 fields	
	15227 15242	Secondary disease 1 to 6 fields	
	15700 15705	Treatment verification Imaging	
IMRT	15555	IMRT simulation	From 1 January 2016, IMRT and IGRT are listed under their own MBS items. This includes VMAT.
	15565	IMRT dosimetry	From 1 January 2016, IMRT and IGRT are listed under their own MBS items. This includes VMAT.
IGRT	15715	Treatment verification using IGRT	IGRT is a prerequisite for IMRT. From 1 January 2016, IMRT and IGRT are listed under their own MBS items. This includes VMAT.
Brachytherapy	15536	HDR Brachy Planning	Value depends on single plane or multi-plane implant.
	15328	HDR Brachy Implant	
	15539	LDR Brachy Seed Implant	
Stereotactic	15600	Stereotactic radiosurgery	Code includes all radiation oncology consultations, planning, simulation, dosimetry and treatment.

Abbreviations: CT, computed tomography; HDR, high-dose-rate; IGRT, image-guided radiation therapy; intensity-modulated radiation therapy (IMRT), LDR, low-dose-rate; volumetric modulated arc therapy (VMAT).

In addition to the ROHPG definitions, the rates for planning workstations are not:

- aligned to the demands of a modern RT service and
- addressing a barrier to access for RT, limiting planning capabilities.

As highlighted in Table 2, only 17% of facilities operate with less than three Planning workstations, while 36% are operating with more than eight Planning workstations. The largest facility recorded had 31 Planning workstations.

Table 2: 2016 Surveyed sites planning workstations

Sites and TPS	Percentage (%) of total sites
Sites with 1-3 TPS	17%
Sites with 4+ TPS	47%
Sites with 8+ TPS	36%
Average Total TPS per Site	11%

Abbreviation: TPS, treatment-planning system.

Source: Courtesy of MTAA member

c. Potential Alternative Funding Models

Currently, the Scheme does not enable patient access to newer RT technologies and other technologies for cancer treatment i.e. more advanced technologies with established evidence to show improved patient health outcomes during cancer treatment – Table 3 summarises the year of instalments of Linacs in Australia, highlighting the ageing RT technologies currently in service. Furthermore, with the increasing incidence of cancer in Australia⁶ (Figure 1), the Scheme should provide further incentive to encourage the adoption of cost-effective contemporary clinical treatment techniques that would provide cost savings to the Australian Government and the healthcare system.

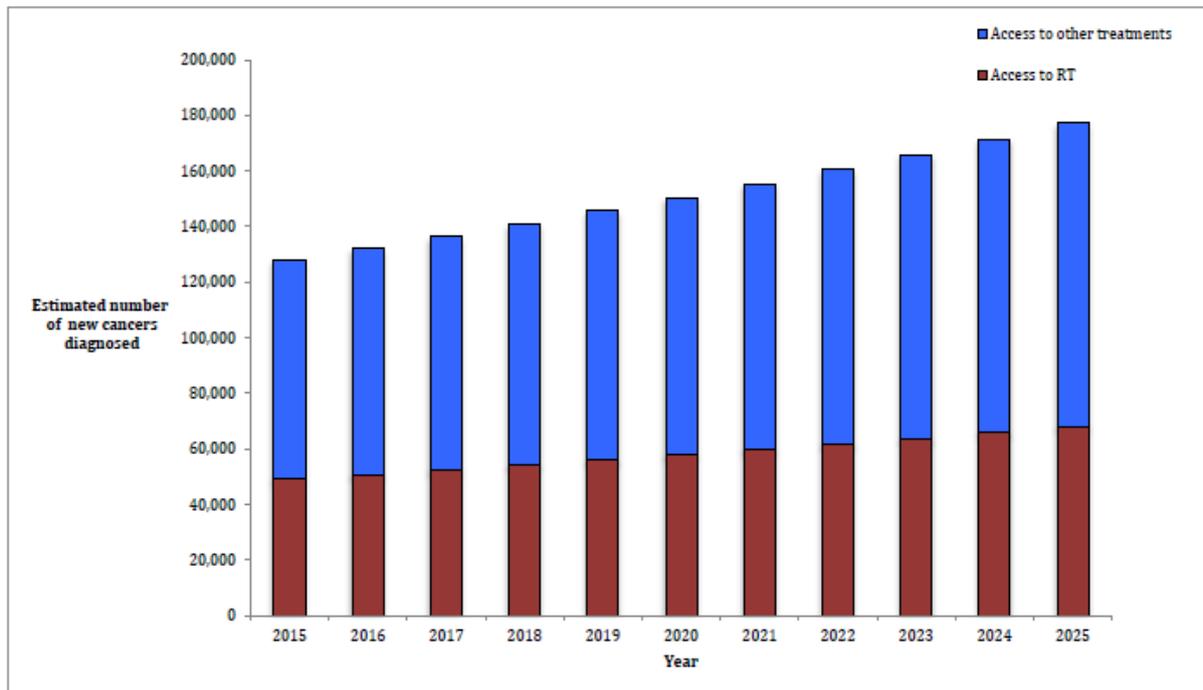
Table 3: Linear Accelerators (linacs) across Australia

	Year of Installation			
	2000	2011	2013	2015
>10 years	14.0%	9.0%	6.5%	3.8%
>5 to 10 years	39.0%	28.3%	38.7%	42.3%
1 to 5 years	40.0%	60.7%	51.8%	50%
In the survey year	7.0%	2.1%	3.0%	3.8%

Source: RANZCR.

⁶ AIHW 2014.

Figure 1: Projected increase in the incidence of cancer in Australia (2015 – 2025)



Source: MTAA analysis

d. Linking funding to quality measures (rather than throughput)

The Review should consider the importance of the continued support of the ROHPG Scheme. Currently, waiting time data is used to support performance management of cancer treatment. However, waiting times can only provide limited information on the performance of RT services available to patients with cancer who would benefit from RT treatment. Performance measurements should ensure the whole of healthcare system (and not just the capacity of the service provider) is captured - to ensure that the clinical need of Australian cancer patients is appropriately addressed and that it is in accordance with clinical practice guidelines. Consideration of the Radiation Oncology Practice Standards may also be considered in the review; compliance with the Practice Standards as a prerequisite to eligibility for ROHPG funding and MBS reimbursement.

The Scheme should also support the adoption of advanced RT treatment techniques in Australia i.e. there is a need to support the delivery of IMRT, VMAT and SBRT with kV imaging capability.

e. Billing Practice Complexity

The current ROPHG Scheme is well established. MBS billing and the ROHPG Scheme are designed to achieve two very different objectives - as outlined in the previous sections. Therefore, combining them would not reduce (but instead increase) the complexity of the 'Billing Practice'.

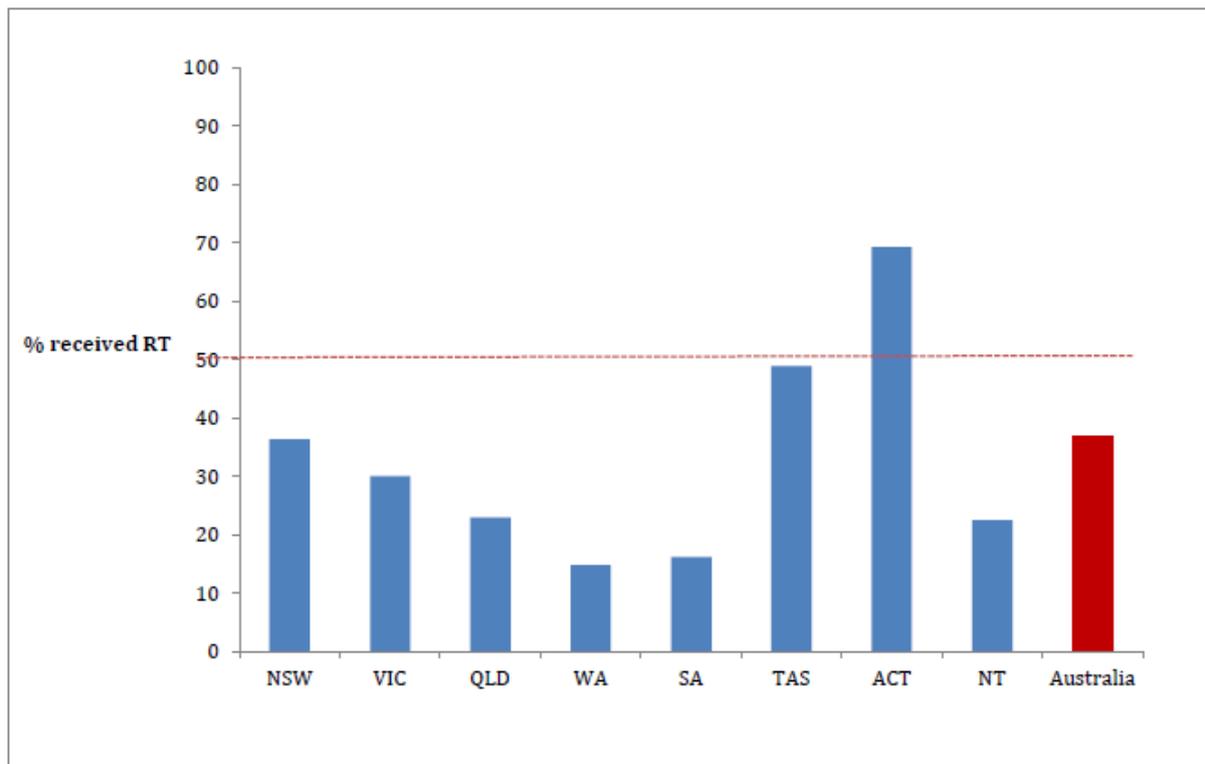
f. Existing Supply/Potential Saturation of Services

There is currently no evidence of saturation of the existing RT services. There is however evidence that Australian RT delivery is significantly lower than the clinical recommendations

i.e. 50-60% of all cancer patients.⁷ As outlined in Figure 2, of all cancer patients diagnosed in 2014, only 38.4% received RT treatment - with all States and Territories (with the exception of ACT) demonstrating that less than 50% of all patients received RT treatment. Of all female specific cancers diagnosed in Australia, 42.0% were treated with RT (Figure 3A). By comparison, of all male specific cancers diagnosed in Australia, 35.5% received RT treatment (Figure 3B).

In the next decade (2015 to 2025), with the increasing incidence of cancer in Australia and the underutilisation of RT – the clinical need of at least 200,000 Australians diagnosed with cancer will not be met.⁸

Figure 2: Proportion of cancer patients with access to RT in Australia



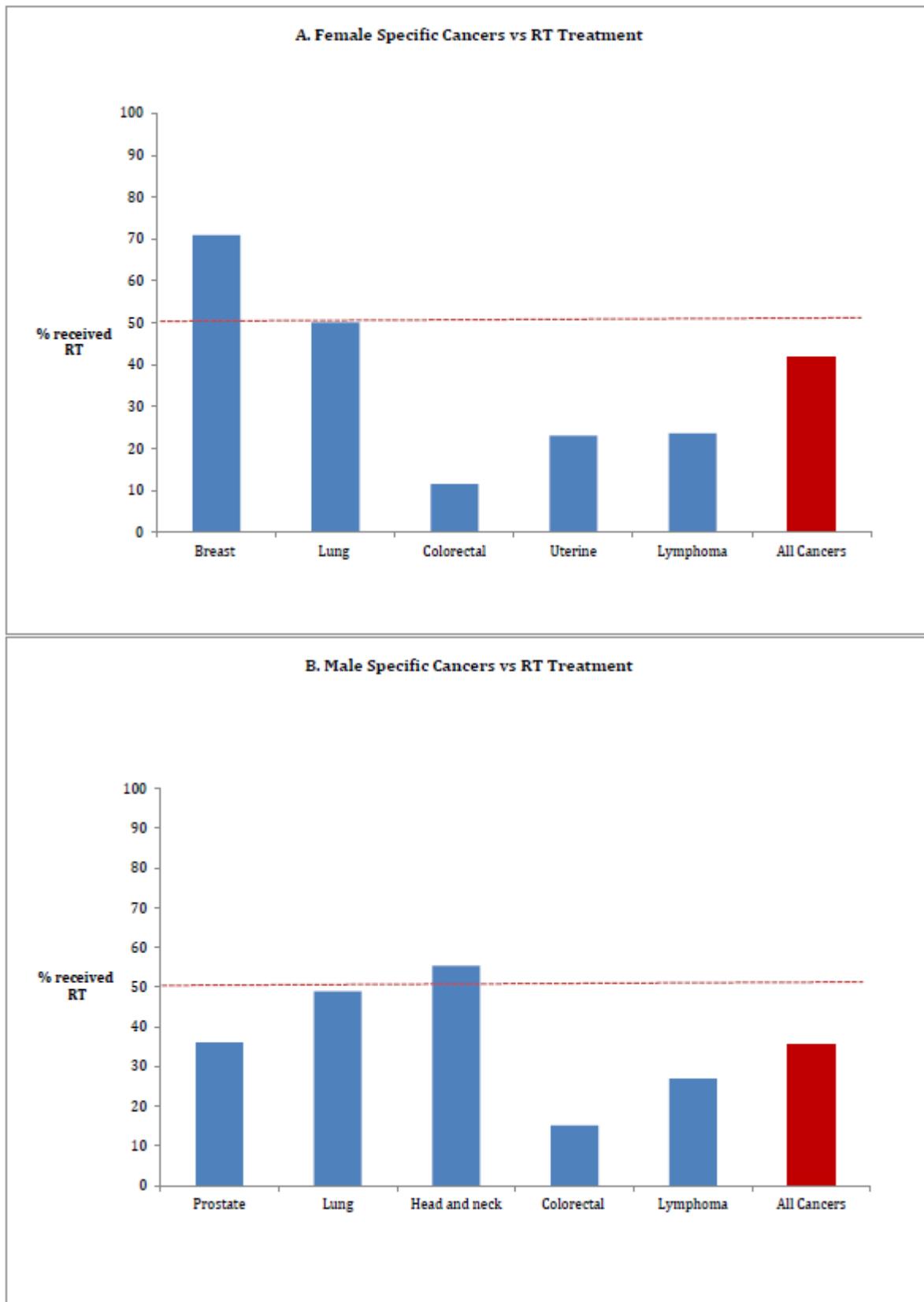
Abbreviation: RT, radiotherapy

Source: MTAA analysis.

⁷ Atun et al., 2015

⁸ MTAA analysis.

Figure 3: Proportion of female and male specific cancers treated with RT in Australia



Abbreviation: RT, radiotherapy
Source: MTAA analysis.

3. Summary

The role of ROHPGs is as vital today as when it was introduced in 1988. The increasing incidence of cancer in Australia further highlights the importance of the ROHPG Scheme in providing access to RT treatment for cancer. It continues to perform its function; encouraging appropriate adoption of new technology and introduction of new facilities.

The Scheme has helped address the limited number of RT facilities in Australia, however the number remains insufficient to meet cancer treatment requirements. Furthermore, use of RT in Australia remains low when compared to other countries and what is clinically recommended.

The ROHPG Scheme should continue to address the issue of out-dated RT technologies used to treat cancer patients in Australia. The Scheme continues to effectively provide patient access to modern (advanced) RT treatment techniques that able to be delivered economically.

It is critical that the Scheme and future cancer funding model(s) ensure that a holistic contemporary clinical practice to achieving the best health outcomes is provided equitably to cancer patients in Australia.

4. Recommendations

MTAA recommends that the ROHPG Scheme remains in place to provide access to RT treatment for cancer so that it can continue to effectively provide:

- a national approach to service planning and delivery of a quality RT service; and
- equitable services and access to RT treatment for cancer patients across all states and territories.

MTAA further recommends that the eligible Equipment Definitions (and MBS descriptors) be revised to align with the current best clinical practice.