NT HEALTH

As part of the formal review of the ROHPG Scheme, the Northern Territory Department of Health submits this letter, complied from feedback received from local Radiation Oncology clinicians, leaders and other key stakeholders.

Feedback is provided under the following headings:

Its purpose

We agree that the ROHPG Scheme should continue as it has enabled contributions to be made towards capital costs incurred by radiation oncology providers for major radiation oncology equipment.

The benefits of the scheme for us

- The ROHPG scheme has enabled an upgrade of our radiation oncology service IT infrastructure and dosimetry equipment. It has also allowed us to improve our efficiency and confidence in our radiation dose accuracy.
- The ROHPG scheme provides the incentive for radiation oncology centres to constantly keep up with the latest technology and techniques which are directly linked to improved clinical outcomes for cancer patients undergoing radiation therapy treatment.
- The ROHPG scheme discourages centres to continue using equipment that are out-dated or exceeding their notional life.
- The Network Information System (NIS) payment has provided valuable support for the IT infrastructure required in a radiation oncology environment.

The limitations of the scheme

- Regional radiation oncology units with lower patient activity are disadvantaged under the current scheme. It is extremely important that jurisdictions with small population bases are not disadvantaged.
- The equipment in our radiation oncology centre has the capacity to treat 700 to 800 patients annually but we can only treat approximately 350 annually due to our low population in the NT. Even though the numbers are small, because of our large distances from other centres and the challenges of equipment service, it is necessary and essential that a minimum critical infrastructure is maintained.
- The total ROHPG amount accrued at any time is substantially less than the amount accrued by our counterparts in the eastern states. This again is due to our small population base.
- The total ROHPG amount accrued at the end of the equipment's notional life will not be sufficient to replace the equipment. For example at our centre we would have accumulated $730,000 a unit at the end of the notional life of a linear accelerator whereas it will cost $2.4 million to replace the machine. This predicament is the same for all the ROHPG equipment in our centre.
- The ROHPG scheme provides a 10 year notional life for Linear Accelerators and CT simulators and a 5 year notional life for the treatment planning system.

- We know that our equipment could last longer because of lesser usage but we face the dilemma of technological obsolescence. Radiotherapy technology and techniques changes every few years thus imposing more upgrades and modifications on existing equipment has its capability limitations towards upgrades. It is also well evident that older machines produce more errors.
- It costs more to maintain and service ROHPG equipment in Darwin. We also need to pay a higher premium for all our specialised radiation oncology staff including engineer and IT.

Potential alternative funding models

- The ROHPG scheme could consider regional loading as it more expensive to deliver a unit of service on the equipment. Among other higher operating cost in Darwin, our service contract is also more expensive as compared to major metropolitan cities like Sydney and Melbourne.
- The ROHPG payment could be split-up into two components to take into account a) time depreciation and b) patient activity (usage). This will address the disadvantage of regional centres with lower patient activity.
- Private radiation oncology centre could use part of their private medical billing revenue to add to the replacement cost of the equipment.
- NIS payments could provide an incentive for radiation oncology centres who embrace "paperless" or fully electronic environment to promote safety, quality and efficiency.

Determining eligible equipment

- Options could be available for linear accelerators to be retrofitted with newer technology to extend the life of the machines. Incentives could be provided to do so and the notional life extended accordingly.
- The ROHPG scheme could be extended to include expensive physics equipment for calibration and dose measurements. Thus providing the incentives for centres to purchase and use appropriate equipment ensuring accurate and safe radiotherapy.
- The scheme does not take into account the high-end or low-end model of the equipment. The scheme could provider loading for Intensity Modulated Radiation Therapy (IMRT), Volumetric Arc Radiation Therapy (VMAT) and Stereotactic Ablative Body Radiotherapy (SABR) activity as these techniques are considered the standard technology in radiotherapy.
- The ROHPG scheme could provide incentive to properly serviced equipment to ensure safety and quality for radiotherapy patients.
- Criterial that determine the quarantined use of ROHPG funds could be revised to include a broader base of equipment and software which would reflect the rapid emerging technologies in radiation oncology including IMRT, Image Guided Radiation Therapy (IGRT), VMAT, SABR and Gating Radiotherapy.

Workforce considerations

- NT faces specific workforce recruitment and retention challenges. These can include difficulties attracting specialist staff, higher recruitment costs to secure those staff and higher premiums in relation to ongoing employment costs for highly qualified and specialised radiation oncology staff.

Linking funding to quality measures (rather than throughput)

- The NT would agree with changes that may link funding to quality measures that would overall benefit the safety and quality of patient care.

Billing practice complexity

- NT supports any measures that result in the billing process being made as simple as possible and reiterates that jurisdictions with small numbers should not be disadvantaged.

Existing supply/potential saturation of services

- NT supports future planning guidelines that explore equity, support and incentives for areas of need for radiation oncology services.