



19 January 2021

Cancer Australia
Level 14, 300 Elizabeth Street
Surry Hills
NSW 2010

Dear Sir / Madam,

RE: CANCER AUSTRALIA LUNG CANCER SCREENING ENQUIRY REPORT

The Australian Society of Medical Imaging and Radiation Therapy (ASMIRT) is the peak national body representing the medical imaging and radiation therapy professions.

Cancer Australia, the Australian Government's national cancer agency, recently concluded an enquiry into the prospects, process and delivery of a national lung cancer screening program in Australia.

Cancer Australia has invited stakeholders to comment on the finding of the enquiry as presented in the Enquiry Report.

We look forward to working closely with Cancer Australia, as a major stakeholder in the design and effective delivery of a national lung cancer screening program.

Yours sincerely,

Sally Kincaid
Chief Executive Officer
ASMIRT

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THE AUSTRALIAN SOCIETY OF MEDICAL IMAGING AND RADIATION THERAPY (ASMIRT) COMMENTS TO THE CANCER AUSTRALIA LUNG CANCER SCREENING ENQUIRY REPORT

ASMIRT wishes to make comment in the following areas of the Lung Cancer Screening Enquiry Report.

The comments on this enquiry report have been compiled with the input from the ASMIRT's Professional Standards and Education Committee in conjunction with the Computed Tomography (CT) Nuclear Medicine (NM) and General Radiography Reference Group who are clinically involved in the full spectrum of CT scanning within medical imaging.

Comment No. 1

"Section 5.4 Eligible Population"

"Using the criteria (ages 50 to 74 years for the Aboriginal and Torres Strait Islander population and ages 55 to 74 years for other Australian who are current or former smokers) would result in approximately 2.9 million men and women who have a smoking history and are currently within the age parameters of the Program. Of this population and estimated 580,000 would be eligible for LDCT upon completion of the risk assessment tool".

If a potential participant aged 55 to 74 years (or for Aboriginal and Torres Strait Islander people aged 50 to 74 years) scores a PLCom2012 of greater than 1.51% over 6 years, they will be invited to have a LDCT.

In conjunction with "Section 8.1 Program Costings".

"There are a number of key assumptions underpinning the indicative costing. A participation rate of 60% has been applied, whereby 60% of the eligible population (ie. 60% of the 580,000 ever-smokers in the designated age range meeting the risk threshold) – will actually undergo screening".

By ASMIRT's calculation the amount of ever – smokers within the designated age range meeting the risk threshold will be in the region of 348,000 individuals, who will undergo LDCT screening.

To put this number into perspective, the number of individuals undergoing this CT imaging examination could be viewed in the context of the total number of Medicare rebated CT examinations nationally. In the 2019-2020 financial year, the total number of Medicare rebated CT examinations nationally was 3,714,716.

The state-by-state breakdown of these examinations are as follows:

NSW	1,277,954
Vic	848,997
Qld	843,390
SA	261,838
WA	344,557
Tas	72,938
NT	17,376

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ACT 47,518

Adding an additional 348,000 CT examinations (which is almost the equivalent of the entire Western Australian CT examinations in that financial year), to the overall CT numbers is a significant increase to the national capacity.

ASMIRT requires some clarity as to what number of LDCT examinations would be performed in a financial year, as the report states that a potential participant who scores a PLCom2012 of greater than 1.51% over 6 years will be invited to have a LDCT.

ASMIRT assumes that the major public hospitals who provide a non-Medicare rebate CT scanning service are functioning at near full capacity and could not take any part of this potential increase on a consistent basis.

Comment No.2

“Section 8.1 Program Costings”.

“The LDCT costs provided by private radiology clinics are calculated according to the existing MBS schedule fee of \$295 for a CT scan (the recently updated MBS scheduled fee is \$299.40). Savings could be achieved if a lower designated fee item was introduced”.

ASMIRT notes that all MBS scheduled fees for Diagnostic Imaging examinations are based on the images produced and a medical specialist (radiologist) report of those images.

ASMIRT notes that these LDCT examinations will be “double-reported”, using two “independent radiologists” (along with any computer assisted diagnostics). Given this, ASMIRT assumes that these reports will attract a specific radiology reporting fee, (twice over.)

ASMIRT would recommend that the fee for reporting these LDCT examinations be struck in conjunction with the Royal Australian and New Zealand College of Radiologists (RANZCR) and the Australian Diagnostic Imaging Association (ADIA). Once this has been agreed to, the fee should be then subtracted from the recently updated MBS scheduled fee of \$299.40. The fee residual should be then paid to the private radiology clinics who perform these examinations to obtain the imaging data.

Comment No.3

“Section 5.7 Low Dose Computed Tomography”.

“The most appropriate pathway to LDCT will vary across Australia and within implementation sites. In most cases private sector radiology services will be the provider and the designation of a specific Program schedule fee item may be appropriate. State radiology services can also provide access to LDCT and in other locations, particularly in remote and very remote locations or correctional facilities, access will be by means of mobile vans”.

“With some exceptions, the existing infrastructure of LDCTs in each State / Territory is likely to meet the demand generated by the roll out of the Program. Assessment so far indicates shortfalls of infrastructure in Tasmania and in remote locations on the mainland. To rectify this shortfall, it is proposed as part of the capital costs that one fitted mobile van be made available for each State of Australia and the Northern Territory”.

ASMIRT would agree that the existing infrastructure of LDCTs in each State / Territory is likely to meet the demand generated by the roll out of the Program. However, to ensure the accuracy this

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statement ASMIRT would recommend that Cancer Australia ascertains the geographical locations of all CT imaging units / facilities throughout Australia.

In order to achieve this, ASMIRT recommends that a data review of CT imaging is undertaken using information available from the Location Specific Practice Number (LSPN) used by the Department of Human Services to uniquely identify practice sites that provide diagnostic imaging services.

ASMIRT understands that the LSPN will ascertain the geographical location of each CT unit in Australia, as it covers all the CT scan services provided by private imaging practices funded by the Medicare Benefit Schedule. There also will be CT imaging units in public hospitals who may have the capacity to perform some Medicare payable CT imaging examinations. These public hospital CT scanning services should also be financially rebated for these LDCT examinations, in the same way private practice imaging facilities will be under the commercial terms to be negotiated. This will ensure that any additional resources required, and radiology financial budgets are able to be maintained.

If a particular geographical metropolitan location is considered vital for the provision of the national lung cancer screening program, then dedicated CT facilities for the early detection of lung cancer may need to be constructed.

Using this data will ensure that accurate calculations can be obtained by looking at population centres, distance to nearest hospital or medical imaging centre with a CT facility (with the potential of volumetric acquisition), the size of hospital, the population in regional catchment and the number of CT imaging examinations within a hospital, or private imaging facility.

A review of the Medicare Benefits Schedule payment fees to each CT imaging service in Australia will have the effect of ascertaining just how many CT examinations are being performed in each geographical location. Understanding the amount of CT examinations performed at a particular CT location, compared to the "full CT capacity", will determine the amount of "spare CT capacity" at each location.

While the concept of one fitted mobile van be made available for each State of Australia and the Northern Territory is commendable in terms of State / Territory equality, ASMIRT believes that it may not be the best use of this resource. It may be of value to review the geographical regional and remote areas of the nation and given the geographical size of States such as Western Australia, with a view to strategically place these resources where they can have the most benefit.

Comment No.4

"Section 6.1 Key Workforce Groups".

"A diverse clinical and non-clinical workforce will be required to successfully support and operationalise the lung cancer screening and assessment pathway – drawn from existing public and private sector providers. The categories of the workforce are as follows:

Radiographers:

ASMIRT notes that the numbers of undergraduate Diagnostic / Medical Imaging who graduate from the eleven (11) Medical Radiation Science courses nationally and being registered to practice by the Medical Radiation Practitioners Board of Australia (MRPBA) under the auspices of the Australian Health Practitioner Regulation Agency (AHPRA) should be sufficient to support this national program, certainly in the initial stage of the national program.

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While the LDCT examination (and the associated protocol of image acquisition) will be identical if it is performed in a fixed CT facility or within a fitted mobile van, Cancer Australia would appreciate these examinations will be performed in very different working environments.

ASMIRT is of the opinion that it is not feasible or practical for a radiographer to be working on a permanent full-time basis performing (only) LDCT examinations from a fitted mobile van in rural / remote Australia.

To this end, ASMIRT recommends that those radiographers who are employed to perform LDCT examinations in the fitted mobile van environment, be also employed within significant fixed CT facilities in major regional cities (or in some cases capital cities) and are "seconded" to work rotationally in the fitted van environment for an allocated period of time, in accordance with a negotiated contract with the National Lung Cancer Screening Program.

Comment No.5

"Section 8.1 Program Costings"

"The following table outlines an indicative costing to the Commonwealth for the first four years of the Program.

Mobile screening van set up: \$11,200,000

ASMIRT notes that there will potentially be seven (7) of these fitted mobile vans (one of each State and the Northern Territory), which equates to a cost of \$1,600,000 (AUD) for each mobile van.

ASMIRT would be interested to see a financial breakdown of the costings of these mobile units and would be pleased to be involved in any future "tender to purchase" process, if thought necessary by Cancer Australia.

In conjunction with "Section 2.5 International Initiatives".

"There is international recognition of both the effectiveness and feasibility of lung cancer screening and acknowledgment of the importance of continuing efforts to reduce deaths from lung cancer. Whilst a number of countries are implementing targeted LDCT screening programs, these tend to be pilot projects or limited to specific locations within these countries. Examples include:

In the UK, targeted LDCT screening programs have been recently introduced in Manchester and Liverpool under the title of Lung Health Checks (LHC). These programs specifically target "deprived communities" who have high respiratory morbidity. The community based LHC program was developed as a "one-stop" holistic program with mobile LDCT screening vans (one for assessment and one van for scans) located next to local shopping centres".

ASMIRT notes with interest that the United Kingdom have used fitted mobile vans in both the cities of Manchester and Liverpool to conducted these CT examinations. It would be of great benefit to integrate the findings of both the Manchester and Liverpool experiences in both the technical imaging acquisition of LDCT scanning, and the associated transfer of image data sets to the particular national Picture Archive and Communication System (PACS) for evaluation within the structure of a National lung cancer screening program.

ASMIRT recognises the enormous scope of this national rollout, on all levels, from program development and program delivery, which directly impacts both patients and a significant array of health professionals. ASMIRT would also suggest that that the governance and the organisational aspect of fitted mobile vans, use the BreastScreen national mobile van experiences as the initial benchmark for LDCT examination service.

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ASMIRT recommends that serious consideration be given to an initial state-wide pilot study to be conducted to allow for any flaws in the rollout to be identified and corrected before a national implementation occurs. Since the nature of the rollout requires a mix of fixed CT facilities in regional cities, in combination with the LDCT screening serviced from a fitted mobile van is required, ASMIRT would recommend that the State of Queensland be nominated, if all stakeholders believe a pilot study is necessary.

To conclude, ASMIRT would like to thank Cancer Australia for the opportunity to comment on the findings of the enquiry, on a program which if implemented will permanently change the lives of those individuals diagnosed with lung cancer.

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