Northern Cancer Institute

Inquiry into the supply of chemotherapy drugs such as Docetaxel

Answers to Questions on Notice – 28 March 2013 – Sydney

As requested by the Committee at its hearing of Thursday 28 March 2013, herewith the further information in relation to the two matters I undertook to reply to:

Private facilities - Charging and Health Fund relationship model:

In the establishment of a Private Day Procedure Facility for the delivery of chemotherapy the hospital is licensed with State health, a Federal Provider number is obtained and Accreditation is undertaken. Upon achievement of accreditation, Health Fund negotiations are commenced. In the negotiations the procedures to be performed are described and prices discussed. Upon agreement of the rates the facility then can charge the Health Fund for the bed fee. The bed fee is inclusive of PBS drugs (chemotherapy, premedication and antiemetic administered whilst at the facility) and consumables (cannulas, IV lines, fluids, pumps, and dressings) – this is a case payment (all these costs are bundled). The patient pays (co-payment) for discharge medications which are tablets to be taken at home on the following days post treatment.

Should a patient require a non PBS drug then this is discussed with the patient. The Health Fund is approached for consideration on a case by case basis to fund all or part of the drug cost. If this is declined then the patient is asked if they can self-fund the cost. If they are unable to pay then the Pharmaceutical Company supplier may provide the drug on a compassionate basis or as part of a funded program. If all these options are not possible then a different drug will be considered, however this may not be as effective as the first drug of choice.

Response to presentation by Cancer Voices:

The following comments are made specifically in response to the statement and representations put forth by Mrs Sally Crossing, representative of Cancer Voices Australia.

It would be fair to say that we were astounded as to the content of Mrs Crossing statement, which we found difficult to comprehend as it was neither factual nor coherently presented. It contained sweeping statements such as: the care given in the public hospitals is superior to that provided by the private sector and that public hospital services are best practice whereas the private sector is not. Approximately 60% of cancer care is delivered in the private sector and as presented at the hearing, a number of studies have established conclusively that the quality of care in the private sector is equal to that being delivered in the public sector. In light of these facts as well as our own experience in the delivery of cancer care, it extremely difficult to believe that care in the private sector is somehow suboptimal to the public sector. If anything, I think that having 60% of patients treated in the private sector by choice, supports the view that optimal care is delivered in a "best practice" environment, otherwise private facilities would not continue to operate and grow. Additionally, from our own experience we find that care is delivered more efficiently and in almost all cases, private facilities accommodate the patients needs without a waiting list, which is not the case with many public sector services.

As the committee will no doubt already be aware, guidelines for policies and procedures have been developed in partnership (public and private) and are utilised by both sectors to ensure that the care given is not only consistent, but is evidence-based medicine.

A submission to the Productivity Commission, which studied the Performance of Public and Private Hospital systems by the Private Cancer Physicians of Australia in August 2009 noted key characteristics of services and service delivery models – greater homogeneity of services in private, greater specialisation, which includes purpose built facilities for ranges of services, responsiveness, flexibility and established relationships between service providers, higher patient volumes, greater consistency and continuity in personal relationships with increased responsiveness to patient needs. It has been found that the growth of the private sector has been in response to the deficiencies of the public sector.

It also saddens us that Mrs Crossing would stand up and represent cancer patients with such a negative and biased point of view. Should she wish to press her negative outbursts, then evidence ought be presented that cancer patients are dissatisfied with the private sector. In any event, we doubt that the "members" of Cancer Voices had even been consulted and/or would even remotely agree with the statements that were being made on their behalf.

Mrs Crossing also stated that patients were being sent to private facilities for treatment not knowing that it is private and are then being issued with bills for their care. Again we find this hard to believe as financial eligibility checks are done prior to the commencement of treatment for chemotherapy at private facilities to ensure the patient has sufficient health fund cover, if not, they are given the option to self-fund or be treated at a public facility. To our knowledge, no one is treated in a private facility without informed financial consent.

I trust the additional information provided above meets with the Committee's approval, and if we can assist in any other way, please do not hesitate to call on us.