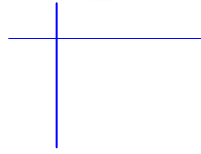




Medical Technology
Association of Australia



National Health and Hospitals Reform Commission

A Healthier Future for all Australians
Interim Report

Response by
Medical Technology Association of Australia

March 2009

Medical Technology for a Healthier Australia

1. Introduction

The Medical Technology Association of Australia (MTAA) represents the manufacturers, exporters, importers and distributors of medical technology products in Australia. Medical technologies are products used in the diagnosis, prevention, treatment and management of disease and disability.

MTAA welcomes the Interim Report of the National Health and Hospitals Reform Commission. The Report challenges all Australians to reflect deeply on the structure and operation of the healthcare system. As an industry which supplies essential medical technologies to the healthcare system, we have reflected on many of the challenges in the Report. We have identified certain health reform areas where we can usefully contribute to policy development and have confined our response to these areas.

2. About the Medical Technology Industry

MTAA represents the manufacturers, exporters, importers and distributors of medical technology products in Australia. Medical technologies are products used in the diagnosis, prevention, treatment and management of disease and disability. Products range from commonplace, everyday items such as bandages and syringes, to high technology items such as orthopaedic implants, cardiac defibrillators and pacemakers, diagnostic tools for both diagnostic imaging and *in vitro* diagnostics.

The medical technology industry in Australia has an annual turnover of \$6.0 billion (2007/2008), earns an export income of \$1.3 billion (2007/2008) and employs in excess of 17,500 people. It is characterised by a small number of global multinational companies (approximately 20% of the industry) and a large number of small and medium sized enterprises (80% of the industry). The Australian market is small - less than 2% of the global market for medical technologies, divided reasonably equally between the public and private systems.

3. NHHRC health reform theme 1 – taking responsibility: individual and collective action to build good health and wellbeing

3.1 Reform direction 1.1 – affirming the value of universal entitlement together with choice and access through private health insurance

MTAA supports the affirmation of the value of universal entitlement to medical, pharmaceutical and public hospital services under Medicare, together with choice and access through private health insurance. MTAA agrees that the dual public/private nature of the Australian health care system is one of its greatest strengths.

However MTAA also points out that there is a significant gap in the structure of the health care system in that, in many circumstances, patients are not able to readily access medical technologies. Access is restricted through waiting lists in the public system which arbitrarily cap availability. We note, for example, the information contained in Figure 4.4 of the NHHRC Report¹ dramatically illustrates the length of time that patients have to wait for surgery which their treating doctor regards as essential. Of patients waiting for a total hip replacement, 10% have a wait of close to a year, and for a total knee replacement 10% of patients have to wait 390 days. For cataract extraction the figure is again close to one year. These waiting periods are completely unacceptable for patients living in daily pain and discomfort or on the verge of blindness. It is not only the quality of a patient's life impacted by this position but also their capacity to contribute productively to their community and the Australian economy.

In the private health care system patients are now faced with gaps or co-payments on over 18% of the items listed on the Protheses List². In comparison, when the current listing scheme began in 2005 there were only 1.2% of items listed with a gap. The most significant groups of products with a gap are the most commonly required – 39.80% of all ophthalmic devices, 17.20% of orthopaedic devices and 18.40% of vascular devices.

Additionally, many private hospitals have adopted a policy discriminating against gapped devices which further narrows choice even if the patient is prepared to pay the additional amount.

As a consequence, in addition to the high cost of private health insurance, patients now have to contribute to the cost of essential devices including orthopaedic hips and knees, cardiac defibrillators, and intraocular lenses for the treatment of cataracts. Australian patients already contribute a higher percentage to health spending, in comparison with OECD averages³. The increasing difficulties in accessing medical technologies even for the privately insured, raises questions for consumers about the value of private health insurance. The alternative is for a patient to join a waiting list for what is deemed to be 'elective' surgery⁴.

If the Australian health care system is to be truly universal then reimbursement for medical technologies needs to be addressed among reforms. This is a topic for further discussion.

¹ National Health and Hospitals Reform Commission (December 2008) *A Healthier Future for all Australians* Interim Report, page 126

² MTAA's analysis of the most recent Protheses List issued in February 2009 identifies 18.4% of items listed with a gap.

³ NHHRC Interim Report supra Figure 13.4, page 305

⁴ See paragraph 4.2

3.2 Reform direction 1.8 – efficacy and cost-effectiveness of health promotion and prevention interventions based on evidence

MTAA strongly supports the use of health promotion and health prevention interventions. We agree that individuals need to be encouraged to take responsibility for their health and wellbeing, with assistance from appropriate prevention interventions where these are beneficial. MTAA also agrees that these interventions need to be undertaken on the basis of evidence as to effectiveness.

The best health outcomes occur where there are early interventions. The benefits of large scale public screening programs are evident. For example, earlier detection of breast cancer through widely-available mammography programs has reduced the death rate significantly⁵. Diagnostic imaging has revolutionised disease screening in ways that improve clinical outcomes and reduce costs. For example, bone densitometry can identify bone loss early enough to significantly reduce fracture risk. A 2005 study⁶ estimated that bone mineral density scanning of an additional one million women in the United States in 2001, followed by appropriate osteoporosis therapy, would have averted 35,000 fractures and generated US\$78 million in Medicare savings by 2003.

A similar study was undertaken in Australia by Access Economics for the Australian Diagnostic Imaging Association⁷. The report examines the cost-benefit of using a Dual Energy X-Ray Absorptiometry (DEXA) scan to diagnose osteoporosis (and treating it with biphosphonate and calcium therapy) versus no scan (and no treatment) in women aged 65-74 years with the main benefit being the prevention of osteoporotic fractures. The intervention showed a significant cost benefit of \$25,802 per Quality Adjusted Life Year (QALY).

There are circumstances where an intervention must be undertaken to forestall further deterioration of a person's health and return them to full productive participation in their community. A good example of an effective intervention which should be considered more broadly for public funding through Medicare, is bariatric surgery (gastric banding) for morbidly obese patients⁸. There are a wide range of co-morbidities identified in morbidly obese patients including high blood pressure, type 2 diabetes, cardiovascular disease, osteoarthritis, sleep apnoea, and depression as well as social conditions such as isolation. The economic cost of obesity is significant. A report by Access Economics in 2008 estimated the total cost to the Australian

⁵ Access Economics Pty Limited (2008) for the Australian Diagnostic Imaging Association, "The value of diagnostic imaging", 12 March 2008 at http://www.adia.asn.au/objectlibrary/156?filename=FINAL_The_Value_of_DI_12Mar08.pdf accessed 08.09.08

⁶ Study published in *Osteoporosis International* cited in National Electrical Manufacturers Association (2008), "The value of medical imaging: improving outcomes and reducing costs", page 17 at http://medicalimaging.org/news/value_of_medical_imaging_062408.pdf accessed 08.09.08

⁷ Supra, page 12

⁸ Johnson & Johnson Medical (2009), Addressing Australia's Challenge of Morbid Obesity

economy at \$58.2 billion⁹. This is made up of \$8.3 billion in financial costs and \$49.9 billion in the cost of lost well-being, costs that are borne not only by the individual patient but also by their family, the community, and the Government.

Bariatric surgery has been shown to be cost effective or cost saving when compared to conventional treatment. In the United Kingdom, an economic evaluation was performed to measure the cost effectiveness of bariatric surgery compared to non-surgical management and the relative cost effectiveness of different forms of surgery¹⁰. The evaluation looks at the costs of treatment relative to the health benefits achieved, measured in QALYs. The evaluation concluded that, when compared to non-surgical management, surgery was cost effective at £11,000 per QALY gained. Comparisons of the different types of surgery were equivocal.

In Australia, 90% of bariatric surgery procedures are performed in the private sector on patients who have private health insurance or are self-insured. In 2006/2007 the number of hospital separations for the Diagnosis Related Group (DRG) Code K04Z 'Major procedures for obesity', was 855 in public hospitals and 7531 in private hospitals¹¹.

While Medicare reimburses privately insured patients for the procedure, uninsured patients have very limited access to the procedure in public hospitals, which raises issues of equity. Persons living in the most socioeconomically disadvantaged group are less likely to have private health insurance – 72% compared with 28% in the most socioeconomically advantaged areas¹². Patients with a demonstrable clinical need are unable to access an intervention which has been shown to be clinically effective in addressing the co-morbidities arising from morbid obesity.

The gastric banding procedure should optimally be undertaken with support of appropriate ancillary health care providers such as psychologists, dieticians and exercise physiologists.

3.3 Reform direction 1.7 – establishment of an independent national health promotion and prevention agency
Reform direction 1.8 – national health promotion and prevention agency to collate and disseminate information about efficacy and cost effectiveness of health promotion and prevention interventions

MTAA supports the establishment of a national body which is responsible for leadership in Australia to facilitate meeting the proposed ten-year health goals.

⁹ Access Economics (2008) "The growing cost of obesity in 2008: three years on"

¹⁰ Clegg AJ, Colquitt J, Sidhu MK, Royle P, Walker A (2003) "Clinical and cost-effectiveness of surgery for morbid obesity: a systematic review and economic evaluation". *International Journal of Obesity*. 27, 1167-1177

¹¹ Johnson & Johnson Medical, supra page 18

¹² ibid

Co-ordination of these efforts at a national level is essential if the objectives of a sustainably healthy population are to be achieved.

We note that the agency would also have responsibility for building the evidence base for the value of health promotion and prevention intervention. MTAA comments that the Federal Department of Health and Ageing is currently conducting a review of health technology assessment involving government, industry, and payer stakeholders. One of the submissions MTAA will be making to the review is the need to have an independent national body capable of undertaking health technology assessment to establish clinical effectiveness and comparative clinical effectiveness of different medical treatments. Rather than create multiple bodies with similar capabilities, MTAA suggests that an HTA body should be equipped to undertake the evidentiary assessments required for the work of the health promotion and prevention agency.

We note the further comments of the NHHRC¹³ that the assessment of population-based health promotion and prevention interventions would be best served through a dedicated, expert agency focused solely on health promotion and intervention rather than being rolled into the same processes that currently apply for medical and pharmaceutical services. MTAA agrees that the current arrangements for these assessments (at least as they apply to non-pharmaceuticals) are not appropriate. We would argue, however, that a differently constructed independent national health technology assessment body would be suitable for this specific task. We would not like to see different modalities to address medical interventions dealt with by different bodies just because the focus of the outcome is different.

4. NHHRC health reform theme 2 – connecting care: comprehensive care for people over their lifetime

4.1 Reform direction 2.7 Reform direction 14.2 – facilitating access to care where doctors are scarce

MTAA supports the range of solutions proposed by the NHHRC to address access issues in circumstances where doctors are scarce. Many of the medical products which would be supplied under the Essential Care List proposed by MTAA¹⁴ can be readily prescribed and supplied by non-medical practitioners who are appropriately qualified and credentialed. For example, stomal nurses should be able to prescribe and supply suitable ostomy products to ostomates; woundcare nurses can prescribe and supply modern woundcare dressings; and diabetes nurse educators can work with patients to ensure that patients have the appropriate equipment, consumables and insulin dosage management to enable home-based care.

¹³ Supra at page 70

¹⁴ See paragraph 4.4 of this submission

4.2 Reform direction 4.4 – use activity-based funding for both public and private hospitals using casemix classifications

In its discussion on the case for change¹⁵ the NHHRC discusses at length the significant waiting times for public patients to undergo ‘elective’ surgery. In considering access guarantees, MTAA strongly supports the strategy adopted in the United Kingdom by the National Health Service (NHS) whereby the NHS procures elective treatments from the independent sector (approximately 15% of NHS elective procedures). More efficient use of the combined health care resources of a small country like Australia makes a lot of sense.

MTAA also notes the NHHRC’s support for the use of activity-based funding, using casemix classifications, in both public and private hospitals. The NHHRC notes¹⁶ that one of the strengths of activity-based payment is that it can be used in conjunction with scientific evidence and economic evaluation to determine what should, and what should not, be paid for. The argument is that if a particular treatment has not proven efficacy, or is less cost effective than an alternative, it is possible not to pay for the treatment under activity-based funding.

While MTAA understands the rationale for this approach we put forward some caveats. The updating of costing data in Australian Diagnosis Related Groups (DRGs) is retrospective rather than proactive which disadvantages and delays the dissemination of new and recognised medical technology. The current Australian DRG system is very slow, to the point where a DRG is based on data that can be up to five years behind when published. In a medical technology environment where innovation can take place in a rapid timeframe, a system that may take significantly more than six years to catch up is not supportive of timely access for patients to cost-effective technology, and contributes to budgetary pressures by basing budgeting information on outdated data.

In some European countries where DRGs are used extensively, they can have the effect of simply acting as a funding cap rather than as a true analyser of the merits of comparative treatments and products. DRGs and other prospective payment systems should serve patients and help drive efficiency by giving hospitals incentives to optimise patient outcomes. Restrictions such as volume limits on specific procedures, fixed annual budgets, and discounted payments for innovative therapies on lower-cost cases, all serve to undermine the efficiencies that can be delivered with a casemix approach.

4.3 Reform direction 4.10 – clinical leadership and governance

MTAA supports national clinical governance arrangements including, in particular, the need for national clinical standards as a core feature of new facility accreditation arrangements (and for that matter, ongoing accreditation

¹⁵ Supra at page 127

¹⁶ Supra at page 137

of existing facilities). MTAA notes the work currently being undertaken by the Australian Commission on Quality and Safety in Healthcare (ACQSH) in developing accreditation standards. In our view these standards should have regard to a range of activities which support improved patient safety in hospitals. While not an exhaustive list the requirements should include:

- Electronic patient records
- Advanced medication management systems
- Systems to prevent hospital-acquired infections
- IV safety medication management
- Mandating of practices that optimise health care worker safety such as the use of safety engineered devices.

MTAA notes the NHHRC proposes that care paths, based on the best available evidence, be used in patient treatment. We acknowledge the need to ensure consistency in standards of treatment but question whether a rigid application of ordained treatment paths might not also lock in redundant technologies and treatments. If care paths are to be used there needs to be a process for iterative development and examination of the best approach, taking into account the fact that many medical technologies (including diagnostic technologies) evolve very rapidly. The national HTA body referred to earlier in this submission¹⁷ may have a role in working with the ACQSH to review and advise on changes in technology and procedures which impact care paths.

4.4 Reform direction 5.6 – recognising the vital role of equipment, aids and other devices in sub-acute care

MTAA commends the NHHRC for recognising the often overlooked but vital area of medical equipment, aids and appliances which provide patients with mobility, independence, and frequently an improved quality of life. The NHHRC includes¹⁸ wheelchairs, walking frames, feeding tubes and compression bandages among the types of medical products used in sub-acute medical care.

In its submission to the NHHRC, MTAA outlined a policy to address the inequity of access by patients to a wide range of medical products, some of which come within the term ‘aids and appliances’ as used by the NHHRC. These could be better defined as ‘essential care items’, necessary for the care, well-being or, in some cases, survival, of patients. Many of these items can provide cost saving treatments for chronic conditions but their purchase is generally beyond the capacity of many Australians to afford over long periods of time. Some of these items receive reimbursement or subsidy from the Federal Government, some from the State Governments, and some receive no reimbursement at all. In some cases the level of reimbursement or subsidy depends on the State in which the patient is living. It can therefore be an

¹⁷ Paragraph 3.3

¹⁸ Supra at page 155

additional burden on the patient to identify an entitlement (if any) and to access the available funding or subsidy, where it is available.

MTAA has proposed the establishment of an Essential Care List that would operate in a similar, but much-simplified, manner to the PBS scheme for pharmaceuticals for a range of products that come within acceptable parameters of essential care. A qualifying criterion is that there be a form of healthcare professional intervention to determine the patient need before a prescription is issued. In other words items listed on the Essential Care List are not provided to consumers without appropriate validation of their clinical needs. Examples include modern wound care dressings, micro-infusion pumps, stoma products, and laryngectomy consumables.

The structure of an appropriate scheme requires further consideration and consultation. However the underlying aim is to address current inconsistencies in access to, and availability of, funding arrangements for a range of medical technology items essential to the well-being of patients with a wide range of conditions.

In addition to the coverage of products considered under an Essential Care List, there are many other assistive technologies that enable patients to remain in their own homes. There is now a well-recognised group who are 'aging in home'. Creating the capability for older people, and for patients of all ages, to remain in their homes delivers not only considerable savings to the health care system, but also a much improved quality of life.

5. NHHRC reform theme 3 – facing inequities: recognise and tackle the causes and impacts of health inequities

5.1 Reform direction 9.2 – mechanisms to ensure access by people in remote and regional areas

As a large and dispersed country, Australia should be at the forefront of remote care delivery through the use of telehealth and telemedicine practices. There are many systemic challenges to be addressed before these forms of technology-enabled care can be fully implemented. As the NHHRC notes¹⁹, Medicare has not adapted sufficiently to this form of service provision. Not only must the patient be present for the consultation but only one provider can bill for a service with the same patient at the same time.

Many of the emerging technologies deliver significant benefit both to the patient and to the health care system. However, many of the services (and the technologies which are provided through the services) are not adequately funded and on occasion not funded at all.

An example of a success story in rural and remote area health service is the Quality Assurance for Aboriginal Medical Services (QAAMS) funded in a

¹⁹ Supra page 231

separate grant by the Department of Health and Ageing, not Medicare. The QAAMS program uses Point of Care Testing (PoCT) technology to conduct pathology tests on Aboriginal and Torres Strait Islander people with diabetes.

PoCT is pathology investigation by or on behalf of the treating medical practitioner in his or her surgery at the time of consultation which allows results to be used to make immediate, informed decisions about patient care. In the case of QAAMS, PoCT investigations are generally performed by trained and certified Aboriginal and Torres Strait Islander health workers who provide information and education about diabetes at the same time.

The aims of the QAAMS program are to:

- assess the acceptability, usefulness and reliability of the PoCT technology in the Aboriginal Health Services (AHS) setting;
- empower AHS to better manage their community members with diabetes; and
- improve diabetic control among people with diabetes from participating Aboriginal and Torres Strait Islander communities.

There is no valid reason why PoCT cannot be rolled out to the wider community with the addition of reimbursement for some PoCT (for example, Glucose, INR, HbA1C, and Cholesterol tests) through the Medicare Prescribed Pathology Services. A prescribed pathology service is a service included in Group P9 of the Pathology Services Table. Group P9 contains 11 services which may be performed by a medical practitioner in his or her own surgery on his or her own patients. Many of these prescribed pathology services are outdated and PoC testing should be included.

Currently no PoCT has an MBS item number because Pathology item reimbursement is only made to an approved provider (pathologist) in a NATA accredited laboratory. As a result, for example, in remote areas a patient may wait for up to three days for a blood specimen to be sent to an approved laboratory and the result obtained (funded by Medicare). If a PoCT was used, the patient (and treating doctor) would have the result immediately. While some simple, basic pathology tests may be claimed by a GP through Group P9 (pregnancy tests etc) there is no provision for the more sophisticated and accurate PoCT.

In another area where access is limited, MTAA notes that on the recommendation of the Medical Services Advisory Committee (MSAC), the Minister for Health and Ageing rejected public funding (through the MBS) for the use of remote monitoring systems for patients with implanted cardiac devices.²⁰ Although the MSAC report found the procedure to be safe, it found that clinical effectiveness had not been demonstrated and a formal economic assessment was therefore not performed. While MTAA recognises that the clinical data provided did not meet MSAC's requirements, we note that remote

²⁰ MSAC report on Application 1111 noted that in 2007 there were 43,108 patients in Australia with pacemakers and 5,156 with implantable cardioverter defibrillators (ICD)

monitoring is reimbursed in several northern hemisphere jurisdictions and that the applicant would have welcomed the approval of interim funding in exchange for a commitment to data collection.

MTAA is a member of the Kidney Health Australia Home Dialysis Advisory Group and supports its objectives to increase access to home dialysis for those wishing to dialyse at home and to overcome barriers to home dialysis. Increased access to home dialysis has obvious advantages for Australians in remote and regional Australia not well served by dialysing services.

6. NHHRC reform theme 4 – driving quality performance: better use of people, resources, and evolving knowledge

6.1 Reform direction 12.1 – functions requiring national leadership

National leadership and governance is critical to the success of the health care system in the next decades. Everyone working in the health sector can cite numerous examples of the inequities, inefficiencies and poor outcomes that arise as a result of a silo-ed, fractured system. There are few incentives in the current system, for example, to deliver cost equalisation where one part of the health care system delivers savings or benefits to another part. An illustration of this is Radio Frequency Catheter Ablation of Atrial Fibrillation and Other Complex Arrhythmias (RFA). The number of Australians with atrial fibrillation (AF) was estimated at 165,000 in 2004²¹ with numbers rising substantially with the ageing of the population and associated increase in the prevalence of AF with age.

Recent advances have meant that the optimal treatment for AF is now a curative treatment through an RFA procedure²². The aim of RFA is to eliminate the tissue causing the arrhythmias thereby normalising and maintaining the electrical heart rhythm. This eliminates the risk of stroke from AF and improves quality of life due to the heart's improved pumping efficiency. In the financial year 2005/2006 840 of these item numbers were billed to Medicare. These figures only represent private patients treated in public and private hospitals. It is estimated that approximately 670 AF cases were performed on private patients treated in 2005/2006. The ablation catheter costs approximately \$4,500 and is designated as being for single patient use. The total consumables required for the case can amount to in excess of \$8,000. However these are not mandated to be reimbursed by health funds which mostly choose not to reimburse.

The current pharmacological costs of controlling AF are estimated to be \$1,500 per patient per year of treatment. This is based on the average cost of maintaining a patient on warfarin anti coagulant (including associated ongoing pathology and GP monitoring) plus one of sotalol, flecainide or amiodarone

²¹ Eikelboom JW (2004) "The beginning of the end for warfarin?" MJA 2004; 180(11): 549-551

²² Hakan, Oral, et al, (2006) "Circumferential pulmonary-vein ablation for chronic atrial fibrillation". NEJM 2006;354:934-41

antiarrhythmics. With 165,000 patients with AF, this represents a cost of \$248 million per annum to the Australian health care system²³. Assuming patients live for 20 years with the condition, the cost is \$30,000 per patient. This excludes the costs of hospitalisation and rehabilitation for severe AF conditions and/or co-morbidities associated with AF. The current health silos do not provide risk equalisation which acts as a disincentive to take up new technology.

MTAA strongly supports the NHHRC's proposal that there be national leadership in key nominated areas where the Australian health system, as a whole, will derive benefit and avoid the costs and inefficiencies resulting from a diffused system. MTAA supports national leadership in all of the areas identified by the NHHRC²⁴.

We would however like to debate the adequacy of the existing national approach to evaluation and funding of medical services. We make no comment on the assessment and funding of pharmaceuticals except to say that there are many emerging medical technologies that combine drugs and devices and the current systems will not be adequate in the future as these become more complex and more combinations are developed, such as devices and biologics.

We have already set out in our submission²⁵ that there needs to be an independent national health technology assessment body that can not only assess medical technologies but also provide a horizon scan of emerging technologies to ensure that potentially beneficial developments are identified early in their life cycle for use in the Australian market.

At present there are multiple agencies, national and State and Territory, which undertake a horizon scanning process. These should be subsumed into the national HTA body. We note the NHHRC comments²⁶ on a possible role for the National Institute of Clinical Studies in undertaking a 'clearinghouse' function to support the uptake of innovation across public and private sectors. MTAA strongly supports national leadership in innovation and comments further on this issue in paragraph 6.3.

6.2 Reform direction 13.4 – new safety net arrangements that are more integrated, cover a broader range of health costs and are family-centred

The issues discussed in this section of the NHHRC Interim Report are amongst the most challenging. MTAA has long advocated policy reforms that improve equity of access for patients. We have already discussed some of

²³ Submission by the Electrophysiology and Pacing Working Group of the Cardiac Society of ANZ to the House of Representatives Standing Committee on Health and Ageing's Inquiry into Health Funding (2007), page 4

²⁴ Supra pages 282-285

²⁵ Paragraph 3.3

²⁶ Supra page 285

these issues in paragraph 3.1. The NHHRC comments²⁷ that therapeutic appliances represent a significant cost burden to a small percentage of the population. MTAA's estimation is that the number of patients is much greater if the 'aids and appliances' category is expanded to include the range of medical products discussed at paragraph 4.4. There are many examples of products that can only be accessed by patients using their own funding, or through the good graces of their doctor. For example, a pressure wound in an aged, diabetic or bed-bound patient has been shown to be most cost-effectively treated through the use of modern wound care dressings. A study in 1997²⁸ showed in a case study of a 69 year old non-insulin diabetic a total cost of \$61,000 to manage a pressure wound. It has been estimated that chronic wounds, in particular leg ulcers and pressure wounds, cost the Australian community in excess of \$500 million per annum²⁹.

Modern wound care dressings are expensive but very effective in healing the ulcer. Left untreated a leg ulcer can develop to the point where amputation becomes unavoidable. However there is no funding or subsidy or reimbursement available in the community or residential setting to enable a patient to access these products. The impact on health and quality of life is dramatic.

Another example is the micro-infusion pump. While the drug delivered through continuous subcutaneous infusion may be PBS-listed, the pump and consumables required for continuous infusion are not covered and are therefore not accessible to patients unable to self-fund. One group of patients found to have benefited significantly from this type of therapy are those suffering from Parkinson's Disease where continuous infusion of apomorphine has been found to reduce the frequency and duration of 'off episodes'³⁰.

There are many good reasons to support a safety net arrangement to cover the range of medical products on the proposed Essential Care List. Funding for these items should be through a simplified PBS-style system, with an assessment of the need by a health care practitioner (who may be a qualified accredited nurse – see paragraph 4.1), a form of prescription or authority to access a subsidised product, and delivery of the product through the most suitable delivery channel. MTAA is continuing to develop this policy and consult with relevant health care and patient groups to refine the scope of a possible scheme which would address reform direction 13.4.

²⁷ Supra page 307

²⁸ Young, C (1997), "What cost a pressure ulcer" *Primary Intention* 5 (4 November) pages 24-31, cited in Sussman, G (2007), "Wound healing and cost impacts of interventions by pharmacists in community settings", page 7

²⁹ Sussman, supra page 7

³⁰ Hospira Pty Ltd (2008) Submission to National Health and Hospitals Reform Commission, "Incentives to encourage uptake of safety, productivity and patient outcome technologies in Australian hospitals" page 9

6.3 Reform direction 15.3 – NHMRC to consultatively set priorities for collaborative research centres which integrate multidisciplinary teams

Reform direction 15.4 – enhancing the spread of innovation through a clearinghouse function of the National Institute for Clinical Studies

Reform direction 15.8 – national approach to synthesis and dissemination of clinical evidence/research

MTAA strongly supports each of these reform directions. The collation and collaboration of medical research to drive innovation should be an essential feature of the Australian health care system. In recent years the United Kingdom government has taken innovation as the driver for health and medical research through the establishment of Innovation Centres and demand-led research. In 2002 the Wanless Report³¹ identified a problem with the ‘slow adoption’ and take up of new medical technology by the NHS. It called for investment in modern health care technologies. This was followed in 2004 by the report of the Healthcare Industries Task Force (HITF)³² that set the NHS on a course of encouraging and fostering innovative medical technology.

HITF recommended the establishment of a National Innovation Centre under the authority of the NHS Institute for Innovation and Improvement, and for two more intellectual property management hubs (on training and adoption) to join the existing nine. The HITF Report identified the need for the NHS, medical technology companies, and the health care sector, to work in partnership. There are good models for Australia to consider in bringing through innovative technology to meet identified needs of the health care sector.

6.4 Reform direction 15.6 – permanent, independent national body to lead the way on safety and quality

MTAA supports the establishment of a permanent, independent national body to provide leadership on safety and quality. MTAA is supportive of the work currently underway by the ACSQH to address safety and quality issues through accreditation. As discussed at paragraph 4.3 accreditation will ensure nationally consistent standards.

MTAA does not have a particular view about which body is the most appropriate to undertake the national role but would encourage an audit to be undertaken of existing work among the many agencies to ensure that it is captured and prioritised by a national body.

³¹ Wanless, D (2002), “Securing Our Future Health: Taking a Long-Term View” HM Treasury, United Kingdom, at http://www.hm-treasury.gov.uk/consult_wanless_final.htm

³² Healthcare Industry Task Force (2004), “Better health through partnership: A programme for action” Ministry of Health, United Kingdom, at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094982

7. Conclusion

MTAA commends the NHHRC on its Interim Report. The Interim Report proposes many far-reaching reforms that will fundamentally change some of the most challenging structural arrangements within the health care system. The core principles to underpin an equitable, effective and well-governed health care system are set out in Appendix F. MTAA supports these principles, many of which have formed the basis of our advocacy for some years. MTAA is an industry body whose members work very closely with health care practitioners and patients. This tri-partite and symbiotic relationship is essential to the development of new medical technologies which, by its nature, is iterative. The medical technology industry strongly supports the principles of equity of access, quality and safety, and transparency and accountability. We are particularly supportive of the recognition of the need for an evidence base to decision-making, and of the need for a nationally harmonised approach in essential areas.

We look forward to further engagement in the process of developing policies to underpin and implement reform directions as they are adopted by government.