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Productivity Commission Interim Report – Delivering Quality Care More Efficiently - MTAA Response (Draft)

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About MTAA

The Medical Technology Association of Australia (MTAA) is the national peak body representing companies in the medical technology (MedTech) industry. MTAA works in partnership with governments across Australia to ensure that contemporary, innovative, and reliable medical technologies are effectively delivered to the Australian community.

Summary

MTAA welcomes the Productivity Commission's interim report *Delivering Quality Care More Efficiently* and supports many of the recommendations within it particularly those relating to the health care sector in Sections 2 and 3. The following is some additional commentary and information to help inform the final report.

1. Reform of quality and safety regulation to support a more cohesive care economy

MTAA broadly endorses the approach and has no comments on this section

2. Embed collaborative commissioning to increase the integration of care services

MTAA strongly supports the proposed approach to integrate services through transforming governance and funding arrangements. This is necessary to finally allow healthcare systems to take ownership for populations that need intervention to avoid deteriorating health and increasing costs. Overall, the importance of the capacity to evaluate and fund technology that will enable healthcare delivery should be emphasised. This includes digital health solutions.

Information request 2.2

Q: What types of funding could be pooled to support collaborative commissioning?
A: While funding for overall service provision should be provided there may be a need to specifically fund certain enabling technologies that deliver system-wide benefits. At present, there is no funding pathway for many medical devices that can be used by patients at home which would reduce the burden of disease and avoid readmissions.

Example: the Cardihab platform is delivers cardiac rehabilitation services a TGA-registered application, enabling patients to complete specialist rehabilitation programs at home with clinical oversight using multidisciplinary teams. Results from studies show that hospital bed days reduced 71% with a lower readmission burden.

Information request 2.3

Q: What else needs to be considered to implement the reform?

A: An important part of the governance of collaborative commissioning should be **frameworks for evaluating and procuring technology** including digital health using shared data and explicit value-based approaches where appropriate. A system seeking to be dynamically efficient will need to prioritise investment in technology. MTAA's initial submission provided a practical mechanism for implementing funding adjustments for medical technologies as part collaborative commissioning by tying payments for technologies to outcomes achieved where measurement is available.

Example: The Care4today program, where Johnson & Johnson MedTech partnered with St Vincent's Hospital to reduce hospital length of stay (LOS) for joint replacement surgeries. Through co-design of care pathways including patient education, streamlined at-home care, and standardised clinical practices - Length of Stay (LOS) for knee and hip replacements was significantly reduced, alongside improved recovery and reduced complications.

3. A national framework to support government investment in prevention

MTAA welcomes the Productivity Commission's draft recommendations to establish a National Prevention Investment Framework with a Prevention Framework Advisory Board. It seeks to establish clear lines of ownership for prevention initiatives and paths to evaluation and investment. The PC report rightly points out the potential challenges with intergovernmental alignment, budget approvals and evaluation of interventions in implementing this approach. MTAA makes the following points in considering the implementation of this proposal:

Information request 3.1:

Q: When prioritising different proposals, how should factors such as overall net benefits, net fiscal effects, cost-effectiveness, equity, ease of implementation, timescale and the value of future benefits and costs be weighted? Are there existing frameworks that do this well?

Q: Should there be minimum cost-effectiveness and/or cost-benefit ratios and how should they be set?

A: As noted in the draft report, compared to secondary and tertiary prevention, primary prevention often involves very long-term outcomes and the effectiveness of interventions may be difficult to measure with so many variables across populations and time. To account for the uncertainty, cost-effectiveness or cost-benefit ratios applied will typically need to be lower than secondary and tertiary prevention initiatives which often can demonstrate effects with greater confidence. However, HTA approaches have limitations with all interventions which typically have imperfect information and this will need to be considered. While it recognised different techniques for prevention modelling may be appropriate, the Framework should not give special dispensation to evaluate prevention interventions with lower hurdles (e.g. higher acceptable cost-effectiveness ratios) than PBAC/MSAC processes without very sound justification. In fact, approaches such as cost-benefit analysis may be appropriately applied to secondary and tertiary interventions when they are not currently. The National Institute of Clinical Excellence in England/Wales does offer examples of cost-effectiveness recommendations for preventative measures. Any approach should distinguish between guidance to current health authorities and care providers about interventions within their current scope of care

and funding (such as that provided in some cases by NICE on some prevention or public health issues) and funding entirely new programs. Both will have their place. Recommendations by a Prevention Framework Advisory Board should have specific regard for the technology component of prevention measures as the ability to purchase enabling technology, such as remote sensing and monitoring, can be a significant limiter on prevention initiatives.

Q: How should decision makers balance the need to assess early effectiveness of programs with the need to maintain consistent long-term funding for programs with long-term benefits?
A: Interventions can be appropriately gated in such a way to ensure continued funding in the case of success noting the long-term outcomes involved. Gating for any given program should consider two separate factors: 1) the effectiveness of the implementing organisation(s) in rolling out the program and 2) the overall effectiveness of the interventions themselves. Implementation ineffectiveness needs to be tracked and dealt with in a different way to overall effectiveness. Performance reporting by each implementing organisation should be compulsory. Evidence from each organisation's implementation should be used to update evidence on the implementation itself combined with overseas data with reversal of funding for the intervention overall only if there is substantial evidence that it does not work under any implementation scenario.

Information request 3.2:
Q: What is the best way to incentivise Australian, state and territory governments to invest in prevention to improve future outcomes and avoid future costs?
A: To incentivise Australian, state and territory governments to invest in prevention, priority areas need to be identified and communicated to stakeholders including the general public. The priority areas should consider disease areas and social determinants of health and financial incentives for evidence-based methods for disease prevention could be initiated and potentially supported with a public health campaign. Any preventative health program implemented across Commonwealth, states and territory governments need to have broader community support that expects evaluation of these programs over a long period to realise the benefits of investment.

Q: What changes if any to the existing budget operational rules would be needed to support consideration of recommendations from the Prevention Framework Advisory Board?
A: It is likely that a separate primary prevention budget will be needed to ensure adequate funding without the challenges of the standard budgetary process. It should not detract from current spending on secondary and tertiary prevention and acute care. The challenge will be accounting for existing programs so that the new budget does not end up funding measures that would otherwise be funded anyway. An audit should be conducted of all primary prevention initiatives now underway and their cost to allow tracking of whether any new process is creating perverse cost shifting.