Australian Health Service Alliance

11th November 2004

Parliamentary Secretary to the Treasurer

The Productivity Commission
Study of the Impact of Advances in
Medical Technology on Health Care
Expenditure in Australia

Dear Sir,

Re: The Productivity Commission Study of the Impact of Advances in Medical Technology on Health Care Expenditure in Australia

Thank you for the opportunity to provide comments in relation to the usage and cost of new technology. The Australian Health Service Alliance represents 26 Private Health Insurance Funds and none are exempt from the significant financial impact of new technology. This submission pays particular attention to surgically implanted prosthetic devices, although the comments could be equally applied to high cost non prostheses medical devices.

Whilst the introduction to this country of innovative devices that enhance lives is welcomed, there is little evidence available to determine whether particular high cost devices provide better outcomes to consumers than lower cost, similar devices or other available treatment such as drug therapy in some cases.

The recent Government reforms propose to improve the current process of prostheses price negotiations, however it is extremely difficult to control usage without clear clinical practice guidelines being available. Health funds have seen a significant increase in the use of technology due to clinical changes in prostheses use which include new prostheses in areas where they have not previously been used and substitution of existing prostheses with new and generally more expensive prostheses. Internal AHSA studies suggest that the overall effect of new technology has increased prostheses costs by up to 10% per annum without any consideration of increases in volume (at times substantial) and prices increases for existing prostheses (generally about CPI).

As an example, drug eluting coronary stents have been shown in the short term to reduce inflammation and re-stenosis but many patients have no need of such costly technology and could receive the alternative bare stent. In addition there is little evidence to suggest that there are savings to funds by a subsequent reduction in Coronary Artery Bypass surgery cases.

The use of drug eluting stents is restricted in the public sector because of the high cost. However, in the private sector it seems every patient requiring an intra-coronary stent receives a drug eluting stent at enormous cost to payers and ultimately to consumers due to unavoidable health fund premium increases.

There is also growing concern about the potential cost blow-out due to increased use of cardiac resynchronisation therapy in selected heart failure patients. The Companion study (1) provides some supporting evidence and this will probably lead to more implants of defibrillators. However there is no set criteria for use of defibrillators for the appropriate group of patients. The evidence that defibrillators are superior to biventricular pacemakers has not been established in practice despite the theoretical advantages claimed. Indeed no direct comparisons were made between biventricular pacemakers and defibrillators. If the tenants of evidence based medicine are followed then there is no justification for selecting defibrillators over biventricular pacemakers.

There are major concerns about the appropriateness of general use of these devices without determining which subgroups will benefit from such devices. It is also noted that there was a significant risk of moderate or severe adverse events associated with device implantation (~10%) although this does not seem to have been regarded as an adverse event in the trial.

The median age of the patients in the Companion study was ~65 years and those for admissions to Australian hospitals in one of the heart failure DRGs is over 80 years. All patients in the trial had had at least one prior admission with heart failure within the preceding twelve months and were suffering from severe heart failure in that they were New York Heart Association classification III and IV. This was clearly a selected subgroup of heart failure patients and it is very questionable whether the trial results should be generalised to all heart failure patients. However this could happen in the Australian private sector given the open nature of funding for approved devices and the absence of any need to justify device use according to agreed clinical guidelines. Any such guidelines should also be formulated in light of the appropriate interpretation of clinical trials as discussed in some recent papers (2, 3).

Another significant issue impacting on health funds in relation to the cost of technology is the disparity of pricing between the public and private sector, especially for big ticket items. There is some evidence to suggest that discounts in the public sector for drug eluting stents and defibrillator devices can be up to 50%, yet the devices are charged to the fund at list price. The implications of this are that the funds pay thousands of dollars more. It should be further noted that the volume used of many devices is similar in the public and private sector hance this difference cannot be explained by economies of scale. This seems unreasonable when consumers ultimately end up bearing the burden of this cost.

It is appropriate that the Productivity Commission are researching the impact of medical technology and healthcare expenditure and AHSA looks forward to recommendations that may ensue to minimise the cost impost of new technology whilst still offering the benefit to those who require such technology.

Thank you once again for the opportunity to comment.

Yours sincerely,

Lynn McDonald-Duke

National Manager Member Services