Dr Jeff Brownscombe
Assistant to the Chief Health Officer
PO Box 40596
Tiwi NT 0810
jeff.brownscombe@nt.gov.au

Medical Technology Study
Productivity Commission
LB2 Collins Street East
Melbourne VIC 3003

To the Productivity Commission

Re: Submission on the draft report Impact of Advances in Medical Technology on Healthcare Expenditure in Australia

I am a Public Health Registrar and Assistant to the Chief Health Officer in the Northern Territory. Part of my job includes working with the Chief Health Officer to prepare for HealthPACT meetings, reading Health Technology Assessments from MSAC and other sources, disseminating information to departmental colleagues and remaining updated regarding current issues in health technology assessment.

I read your report with great interest and I believe it is a very sound and comprehensive descriptive document, outlining the "state of play". I believe the report could go further in identifying the ground-level workings that lead to the current economic issues facing our health system around health technology. The nature of the doctor-patient interaction has been thoughtfully considered on many occasions. The mechanics of the decision making process at the organisational level has been less thoroughly examined. I believe this has an important impact on whole systems output and should be given greater consideration when developing a workable vision for the future around this important issue.

On this point I refer to a recently released report from NZ, which I read around the same time as your report:
Decision-Making about new health interventions: A report to the NZ Minister of Health, May 2005. National Health Committee (attached).

A series of specific remarks follow, relating to Chapters 2, 5, 7 and 8.

2 The market for medical technology
2.1 Key demand drivers

<u>The impact of medicolegal litigation needs to be considered in the discussion of key demand drivers.</u>

Legal precedents consider the individual situation but may not be in a position to balance this against the downstream, collective impact of subsequent changes in doctors' practices. Courts have the benefit of hindsight when considering when certain investigations should have been undertaken to prevent an unfortunate but rare complication of treatment for a particular person. They tend to overstate the value of investigation findings (typically expensive, technological tests) over clinical findings, perhaps because they are seen to be more objective,

their findings are less open to dispute and perhaps because of a misplaced faith we have in the reliability of findings generated through technological means. Courts also do not factor in other costs such as small increases in risk of cancer due to radiation exposure, which may be relevant at the population level but are difficult to measure and of little relevance when assessing an individual's damages entitlements.

This is one of many examples where systems priorities come into conflict with the decision making process of doctors, driven by the precedents set by the courts. Medicolegal litigation remains highly emotive. However, the tests ordered to cover medicolegal possibilities, whilst consistent with priorities established by our own legal justice system, would nonetheless be acknowledged by many doctors as "low yield". The benefits to the population are marginal, impacting negatively on the cost-effectiveness of the use of medical technology, in addition to driving up costs in absolute terms.

This may suggest that appropriately targeted legal reform could impact positively on the benefits derived from the use of medical technology.

Additional factors could be discussed when considering consumer expectations

The report rightly notes that demand for medical technology is explained by factors beyond income and price (modulated by third party purchasing) but extending to consumer preferences and tastes. The comment from the Australian Nursing Federation (page 24) is well made.

Rising consumer expectations are more complex than demand for the best treatment. They extend to perceptions of what is the best treatment. Many conditions may be treated by both technological (high unit cost) and conservative (low unit cost) means. Often these may achieve equivalent results, or the conservative option may be superior. However, frequently the technological solution is chosen in spite of this. Reasons include:

- The perception that technological solutions are superior despite doctors explanations to the contrary. People feel they have been better treated if they have been allowed to access expensive technology. This interacts with the placebo effect in a complex way and is linked to our value systems. It is an important topic for public education.
- Conservative management often necessitates lifestyle change, the need for which people may deny and which many people only do when there are no other options. Technological treatments offer an alternative to these, yet this may be detrimental in the long term (example: medications for the management of smoking-related respiratory disease may delay quitting).

Consumer expectations should not be considered fixed or heading inevitably in a certain direction. Public education and provision of more detailed information over time may change expectations. The phenomenon of the "wellness revolution" suggests this may be already underway.

Impact of systems and funding characteristics on consumer decisions

The funding mechanisms for technological and conservative treatments have become uncoupled under our current funding system, with the latter subject to greater cost and volume constraints. Once a medicine is listed on the PBS or a procedure on the MBS, there is no limit to the volume of a drug that can be prescribed (provided it is clinically indicated) or a

procedure that can be performed (within workforce constraints). In contrast, conservative treatments often involve allied health staff, whose public funding is limited and rationed. Lifestyle changes that underpin conservative treatments can be enhanced at a population level by health promotion messages. This area of the health has its funding tightly regulated and sometimes cut; it certainly has not grown to the same extent as the PBS or MBS. Conservative treatment is often facilitated by simple education on the part of general practitioners: the phenomenon of the “10 minute consultation” does not lend itself to expanding this aspect of GP’s work.

A good example is the management of depression. Medical evidence shows both SSRI medications and six sessions of cognitive behavioural therapy (delivered by psychologists) can have a similar impact on outcomes. SSRIs are widely available and a major expense for the PBS, yet doctors find it very difficult to refer for CBT due to lack of public funding. This may not be a cost effective decision, especially in the long term as SSRI scripts are often ongoing.

Similarly, many expensive cardiac drugs offer minimal survival benefits for high cost. However, brief interventions for smoking, with proven efficacy and more substantial survival benefits, remain at the periphery of treatment.

5 Benefits of advances in medical technology
5.4 Distribution of benefits

The capacity of medical technology to exacerbate inequities already present in the community, through multiple mechanisms including information, access and systems issues, is an important one. It is of particular concern in the Northern Territory, considering our high mortality rates and high proportions of indigenous people. Mechanisms to address inequities produced by diffusion of health technologies have not been stated, perhaps because they are underdeveloped, complex and diffuse.

Perhaps the creation of new inequities should also be raised when examining the costs of medical technology, since the policy-driven response to inequities within the health sector is to fund programs to address these.

A 2002 NZ publication (National Advisory Committee on Health and disability. 2002. New Technology Assessment in New Zealand: a discussion document. Wellington: National Advisory Committee on Health and Disability) identified five principles decision makers should take into account when considering the adoption of new interventions: effectiveness, cost, equity, indigenous health and acceptability. The 2005 report mentioned above acknowledges that the former two principles dominate under the current system.

7 Health technology assessment: pharmaceuticals

In Chapter 7 I particularly support the findings regarding the need for greater consumer consultation and downstream evaluation of pharmaceuticals following listing on the PBS, especially in light of the escalating costs of the PBS and the resultant opportunity costs for other sectors of the economy.

8 Health technology assessment: procedures, devices and ICT

I support the findings of this section and would like to add the following points:

It may be appropriate to mention where Health Technology Assessment (HTA) sits in the overall process of decision-making regarding the adoption of technology. This takes place in a complex environment, including politics, media and decisions taken in other jurisdictions, to name just a few.

This may lead to a discussion of how HTA may more effectively feed into dialogue within these domains.

This is related to the frequent observation that the information provided by HTA processes is rarely in a usable format for the majority of decision makers. This reduces the utility of the HTA product. The process of dissemination of HTA information is a major challenge for me in my position at the Department of Health and Community Services, NT.

This phenomenon exacerbates information asymmetry – not just between doctors and patients, but between doctors and managers/finance staff, perpetuating clinician dominance in decision making processes, with significant opportunity costs for the community.

The 2005 NZ report above refers to the literature around group decision-making as one means to address this.

The absence of HTA concepts from undergraduate and postgraduate education and professional development, both in health sciences and management, is notable in light of expenditure trends.

Another useful resource relating to these points is:
Rosen R, Gabbay J. Linking health technology assessment to practice. BMJ 1999;319:1292

Please also note the following:

- On page 174, the report refers to the theoretically clear demarcation between HTA work undertaken by NHSU and NET-S/ASERNIP-S. In practice, these institutions at times compete for work.
- HealthPACT is considered a subcommittee of MSAC, an important issue in recent discussions around governance.
- On page 176, Figure 8.1 and the section entitled National Advisory Committees may be misleading regarding the role of the Therapeutic Goods Administration (TGA). In practice, the TGA has a very limited role in HTA: it mainly addresses safety, does not look at cost effectiveness and plays no role in the diffusion of technology at the level of service delivery.

In summary, I found this document very thorough, informative and thought provoking. I hope my suggestions are useful, coming from the viewpoint of someone who works in both the clinical and policy domains. I hope your work can lead to better processes around decision making and more effective use of our scarce health dollar.

Yours sincerely
Dr Jeff Brownscombe MBBS(Hons) DCH MPH
Public Health Registrar
Assistant to the Chief Health Officer, Northern Territory