Consultation on applying the PHARMAC model for hospital medical devices management

Invercargill Forum 12 December 2013

Key points raised by attendees

New Zealand Government

PHARMAC
Pharmaceutical Management Agency

It's essential that PHARMAC's work is informed by the views of the people who work with devices. The approach to these forums was to outline that PHARMAC is in an information gathering phase and that we wanted to hear from the sector. PHARMAC was not there to provide all the answers, but to hear what the issues were for those working in this space so they can help develop the proposed approach to management.

General question discussed:

What are the key considerations PHARMAC needs to take into account when developing its policies and processes for hospital medical devices management?

'Whole of life' costs; Associated costs

> There may be issues with support of / legacy of existing devices – when is it more cost effective to maintain existing equipment vs replace it?

Assessment, clinical input, funding decisions and implementation

> Clinical Input

> Clinical Engagement on a category by category basis;

> There are enough aligned preferences within DHBs to help with category decisions and clinical engagement.

> Gaining agreement is more of an inter-DHB issue rather than an internal DHB issue.

> If an expert panel (group of peers to any professional) does the research and can give scientific evidence as to why one product is better than the other, it may be more widely accepted.

> Assessment and evidence

> What evidence is assessed to evaluate whether the cheaper product is equivalent to the more expensive/ high-end one?

> Comes down to options and usability

> When a product will give the same health outcomes but is significantly cheaper;

> Will this be like switches to generic brands in pharms?

> How will it be assessed?

> Need to ensure modifications to a device are trialled before they are funded/ integrated.

> Evidence and data:

> Using the FMIS and National Catalogue to generate evidence on usage and preference;

> Could help determine which products to "shift to" over time?

> Appropriate specialist interpretation of relevant clinical outcomes – e.g. registry data are crude and do not appropriately assess effectiveness of a particular device

> Devices should have a track record. Anything brand new may be at higher risk of a recall

> Must be fit for purpose

> Recalls and poor performance

> Where is the product produced?

> What effect will this have on the cost, in terms of any failures that may occur?

> How would PHARMAC manage discontinuation?

> Contracts

> If a panel contract is set up and the DHBs favour one company, the others may drop off because of the lack of sales and then the market is restricted. If there is a recall or discontinuation, then there is a big problem in sourcing alternatives.

> Schedule Rules

> Is PHARMAC going to introduce rules around what situation a medical device should be used in, such as is done with Schedule Rules for pharmaceuticals at the moment?

> How will PHARMAC's decisions affect how procedures are carried out?

> Who is allowed to use devices and in what situations?

> Budget Management

> PHARMAC budget – distribution to DHBs? DHB underspend/overspend?

> Implementation: Learnings from previous experience:

> Blood glucose meters: Going forward; training for the patients on how to use the new meters was promised, but has not been carried out by all pharmacies. PHARMAC needs to ensure follow-through with patient training.

> Decision process generally went well and the meters are within international standards.

> What went well? : Implementation in general went well, apart from the training aspect.

> What is the impact on the "end user" of having to learn something new? Both in pharmaceuticals and medical devices.

> Insulin pumps: positive implementation in general.

> The clinical involvement of the panel was very important to the process, because the key clinical people were always involved, which helped with communication.

> What went well?: It's a relatively small community of clinicians, that meet regularly and talk about processes. There are good levels of communication within the group, which is why it was successful.

> Key lesson: PHARMAC needs to ensure that when it comes to implementation, that key groups and people are involved in the process so the communication can help make the process run more smoothly.

> Paediatrics deals with diabetes also, but wasn't involved in any of the discussion around the change of product, when round 40% of users are children.

> PHARMAC needs to make sure that in future, there is fair representation of the people involved in discussions and that it doesn't listen to just one opinion.

> Implementation: Education

> How do you tell someone that using one product over another will still reap the same cost and health benefits?

Supply of devices

> Security of supply – protect supplier presence

Flexibility to meet local/patient need; retaining choice and local expertise

> Usability is dependent on the "end user"/ professional and the size, height, gender differences between the people trialling a product and the one's using it may be relevant;

> There may be some requirements that are less obvious and may not be recognised until the product is already in use.

> e.g. Anaesthetists (female) in Invercargill, not being able to use issued equipment, because their hands were too small - this wasn't considered when the product was trialled.

> Standardisation (may impinge on) DHBs' preferences; clinical engagement is structured to ensure preferences are provided for

> How do they (PHARMAC) manage individual preference?

> Process for deviation to accommodate complexity

Training, education and support

> How do they (PHARMAC) manage a difference in training?

> Any changes to devices used by patients need to be supported by patients and staff education

> Education:

> > Could have a huge effect on timeframes in general

> > Contracts need to allow enough time for training and implementation, e.g. very short timeframes on HML

Issues for industry

> Maintain competition in the market place so that monopoly does not occur and NZ healthcare is not hamstrung by the failure of an individual supplier.

> See comment under Assessment, clinical input, funding decisions and implementation: Contracts

Relationships with other providers/entities

> Has PHARMAC kept its links with the groups and people that were involved in the initial discussions of PHARMAC taking on specific medical devices?

> > NZOA

> > Orthopods etc

Advances/changes in technology; innovation; research

> How do they (PHARMAC) manage new technologies?

> How is new technology assessed?

> > Are the appraisal methods applied to pharms appropriate for new medical devices?

> > Conflicts of interest?

> There are studies and information out there that will inform "users" on performance.

> > There is a lot of data out there on medical devices, just need to know where to look and how to bring it all together.

> > New technology needs to be properly assessed and it will take time to do so.

> Studies between products and their differences have not been done to the same extent as it has for individual products. In the end it comes down to personal preference and good sales tactics from suppliers.

> Herceptin principles – how will that principle be applied to new technologies when clinicians offer treatment when the (health improvement is negligible or nil, and this is therefore a significant waste of resources).