Consultation on applying the PHARMAC model for hospital medical devices management

Christchurch Forum 11 November 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?

Scope, timeframes, definitions

> 2015 is not a realistic roll out timeline
> National consensus to achieve equitable service throughout NZ
> Need very clear definition of 'medical device' and also clear distinctions between which categories of device are or are not managed by PHARMAC
> Consideration of resource to deal with processes on national level

'Whole of life' costs; Associated costs

> The impact of PHARMAC decisions on local DHB budgets. Total life cycle costing's eg. Imposed service contracts, how will these be managed?

Assessment, funding decisions and clinical input

> Clinical Input
  > Stratified system to assess devices
  > Specialised – expert panel opinion
  > Register of groups so we know who to go to
  > Choice maintained
  > Communicate with clinicians is important – one size does not fit all
  > To gain further insight from those at the coalface to understand what patients actually need, not purely what accountants believe
  > All groups need to be considered in decision making, particularly neonatal and child health who have different needs to the adult population.
  > Open platform – neutral ground for concerns to be discussed – between suppliers and clinicians
> Assessment
  > Proven product performance
  > How to accommodate changes in medical device regulations which will occur during this PHARMAC process?
  > Forward thinking – accessible for remote access
> Contracts
  > (DHBs' have) Established contracts for a period of time, does PHARMAC continue with these contracts?
  > Does full management of medical devices include service contracts?
  > Often included in contract are equipment add-ons/ customisation – who purchases this? Is it looked at as an upgrade or an additional service?
> Recalls
  > Cardiac Devices – not restricted to 1.2.3 devices, if there is a recall there needs to be a robust procedure for recall
  > How to deal with on-going issues?
  > Recalls
  > Product complaints
  > Back order
  > Discontinued products
> Decisions
  > To be mindful of economic value?
  > The input and direction of QALYs in regard to treatment efficacy. What is the best added value for health, not what is the most politically advantageous.
> Exceptional Circumstances
  > Mechanism for exceptions?

Supply of devices

> Clinically unsafe to go with sole supplier
> Can the suppliers supply the whole company?
> If you are having hubs you need more people to manage them, so turn-around is quick
> We still need to deliver best practice care as bench marked around the world. If we don't have the same devices available then this could stop us delivering the best care and service for our patients

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

> Easy transition, not one size fits all. Each DHB will be different, uses different systems so this needs to be taken into account
> Identifying and recognising consultants and consultation expert groups
> Staff are able to provide best evidence based practice for patients
> Wide range of products to meet clinical need across the care continuum
> Will we have choice, best possible pick? There is currently a balance of cost/service/clinical requirement
> Demographics in area to consider
> Local knowledge, point of contact, communication
> What will happen with the nurses who are contracted out of ward?
> Consider cultures – different in each centre

Training, education and support

> Change from one company to another – who trains and covers the cost of the resource?
> Need for clinicians to be comfortable in Devices. Trained on specific devices – if different it takes time to train and therefore takes them out of practice whilst this occurs

> There is some support in Australia that are on hand to support us, the come over as soon as needed. If this moves to further afield the support may be jeopardised. Will this be looked at?

Asset management, maintenance

> Who is going to own the equipment long term? Maintain equipment?

Device use between primary & secondary care

> Different criteria for home-based care and hospital care

> Support GPs at CDHB – will this still be allowed by PHARMAC?

> Medical centres purchase products directly from CDHB – how will this be affected?

> Direct relationship with Primary Care

Issues for industry

> Companies have small holding within NZ, if they lose out on supply they can leave NZ

> Risk is that company becomes a monopoly

> Other companies are likely to leave the country

Relationships with other providers/entities

> Medsafe and TGA merging (ANZTPA) – how is it integrated within PHARMAC policies?

> Include just DHBs or services to DHBs also? Private providers with contracted services?

> What role do HBL play?

> Support of local business – govt policy on moving business to rural areas?

Compatibility of systems and devices

> Realising the relationship between access to medical devices and medical services (eg. Medical imaging)

> Every DHB has different back ends – not all devices can work with different systems

> Ability to integrate/interconnect electronic medical devices with local information service and systems which will vary between DHBs

> What will happen to DHB accreditation process – could be based on what products and equipment the DHB has? Each DHB differs especially since CDHB do design and modify equipment

Advances/changes in technology; innovation; research

> How long will the process for innovation be if new equipment comes out?

> Allowing for innovation and local practice

> > Responsiveness to changes in medical practice and technology utilization (not being outdated). Allowing innovation on a budget model

> How to incorporate new products when it hasn't been around that long?

> Volatile products – cardio very rapid movements in technology? Will these be kept up to date?

> Keep an ear and eye out for what is coming out in conferences – requirement to use (new) product from suppliers

> Niche products – how they fit in PHARMAC model?

> > Designed in house – custom made head plates to fit patient

> > Syringe pumps – automated

> Customisation process – do PHARMAC control this? Will there be individualism?

> Allowing innovation and clinical research to continue within individual DHBs

> Laboratories – research with companies which allows us to get specific products

> Product trial – Functional Assessment and technology assessment

> Currently can get devices on trial basis – how are PHARMAC going to manage this?

> Don't restrict innovation

> Provisions for local Research and Development of new devices?

Communication, engagement and consultation with the sector

> Engage sleep services (ASA) as a group within DHBs

> > Different policies and procedures

> Multi-disciplinary engagement

> Communication is key with all stakeholders that are involved

> Essential to have at least regional presence as a key point of contact

> To have a CPC at every DHB – being on site allows for faster communications