Consultation on applying the PHARMAC model for hospital medical devices management

Counties Manukau Forum 25 October 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?

Issues for Industry

> Currently Suppliers have different contracts with different DHBs. How is PHARMAC intending on managing the contracts already in place once it takes over management?

> Price-certainty: The patent procedures for medical devices differ from those for medications and therefore it could be hard to assess this.

> The FMIS System could reduce competition, which could lead to suppliers going offshore and leaving the NZ market.

> If there is going to be criteria and high administration costs that only a few suppliers can meet when it comes to the medical devices that are included on the national schedule, there may be a loss of suppliers in NZ, and therefore clinicians could only have a limited amount of choice on which products to use.

> Multi-national suppliers for particular products have the only credentials or presence in the market when the national catalogue or PHARMAC Schedule is updated. They can then push up price on medical devices.

> The goal of doing studies for the next two years before fixing what is known to be broken will further frustrate New Zealand based vendors

> Will suppliers be able to give input to 2014 and management from mid-2015?

One size does not fit all

> A single approach will not fit all situations

Maintaining choice

> There is some frustration round the idea that there will be a reduction in choice, so PHARMAC needs to be mindful of this

> A restriction in the choice of medical devices could create a change in practise, which can be positive as well as negative.

'Whole of life' costs; Associated costs

> Cost savings and efficiencies; How is PHARMAC taking this into account and where is the importance going to be put when making decisions on these?

> Total-cost of ownership (needs to be considered)

> When looking at total-cost of a medical device, that figure should also capture such things as evaluation elements and the variation of devices and this process should be transparent.

Assessment, funding decisions and clinical input

> Has PHARMAC thought about outsourcing services? This comment was made in relation to bundling or splitting services and components of a treatment.

> > An example of this would be the imaging devices that come with an implant. How will this work with subsidising?

> > Services shouldn't be split up, but bundled

> > PHARMAC should make for sure it is aware of international movements and development, not only in this but in general. For example, Australia's approach (including to orthopaedics)

> How do you value the attributes of a device?

> The constraint shouldn't be budgetary, but based on a devices attributes and usability

> Economic assessment: Clinicians and patients should be taken into consideration

> Clinical input into decision-making:

> > When considering changing a device or reducing choice, make sure clinicians are consulted first and that some weight is put on experience of that clinician's use of the device.

> > This will be a learning curve when it comes to looking at training and re-training staff and therefore on-going education needs to be factored in also.

> There needs to be a mechanism of on-going support when changing the funding from one medical device to another.

> > This needs to be "part of the package", when assessing cost.

> > There also needs to be an on-going relationship with clinicians

> How will PHARMAC get the correct clinical input from all the relevant groups and who needs to be involved?

> Assessment criteria need to encompass more than just cost, but should include:

> > Service support

> > Education

> > Reliability of supply

> Support and maintenance and the timeframes that come with that need to be taken into account, as well as redundancy and fixing

> There should be a single approach for all DHBs

> Try implementing devices that are ready now and tested to NZ standards and have had human trials in NZ and is proven to work.

> So why wait until 2015?

Relationships with other providers/entities

> Will PHARMAC be looking at purchasing in both the private and public sector? (PHARMAC responded: PHARMAC's mandate lies in the public sector)

> In relation to the above comment, will PHARMAC be looking to expand its scope in future and how does this fit in with ACC as it is a public service? (PHARMAC responded: As ACC is funded through private investment it falls under the private sector and is therefore out of scope, but can't be ignored completely)

> PHARMAC needs to state its intention of transition and what that will mean for the sector and hA needs to do the same.

> Will these decisions be incorporated under one umbrella between PHARMAC and hA?

Equality of access to treatment (public vs private)

> From a patients perspective, once management begins, there may be a difference between what devices and treatments are available in private settings versus publicly funded settings. This currently happens in Australia and there for could be relevant to PHARMAC and the NZ Health Sector.

> Items are sold to the private sector only (because of the high cost and the margins are low in public/ DHBs), demand for these items then puts pressure back on the public system.

> Public contracts in the private sector should have access to the PHARMAC Schedule or National Catalogue for medical devices

Flexibility to meet local need

> Regional experience of medical devices needs to be taken into account when looking at clinical advice.

> Same goes for low use items and the experience that comes with that

Advances/changes in technology

> What will happen when a new technology is introduced?

> The attributes in innovation criteria will be different for medical devices.

> Innovation in regards to ICT

> The capability to capture data is constantly increasing and the usability of this data for medical devices is also changing, which will mean a fundamental change of usability of a medical device and PHARMAC needs to ensure it encompasses this change.

> Immediately open procurement for new technologies

Data capture

> Some DHBs have more data capture capability, which could drive differing use patterns of medical devices

> PHARMAC should be aware of the ability of devices to use both "live" and regularly updated data to improve performance i.e. the device world is changing and data capture ability must somehow equal data use ability.

Interim Procurement activity undertaken by PHARMAC

> Why is PHARMAC consulting when procurement is already occurring in 3 areas?

Communication with the sector

> PHARMAC needs to get as much information on current procedures as possible

> DHBs are all very different in structure, how medical devices are procured, how they are staffed and the data systems they use. PHARMAC needs to think about how it will interface with DHBs in regards to these differences

> When communicating with Industry representatives it could be useful to set up "go to meetings" virtually, so representatives who can't attend the forums or future meetings, still have an opportunity to contribute.