NZMA
New Zealand Medical Association

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Feedback on PHARMAC'S Initial Medical Device Activity

Dear Maree

The New Zealand Medical Association (NZMA) welcomes the opportunity to provide feedback on PHARMAC'S Initial Medical Device Activity consultation paper.

The NZMA is the country's largest voluntary pan-professional medical organisation with over 5,000 members. Our members come from all disciplines within the medical profession and include specialists, general practitioners, doctors-in-training and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders. Our submission has been informed by consultations with our Specialist Advisory Council, General Practice Advisory Council, Doctors-in-Training Advisory Council and the NZMA Board.

We note that the current consultation document represents the continuation of formal consultations on this important and highly complex initiative. We draw PHARMAC'S attention to our submission of 25 March 2013 on obtaining clinical input into managing medical devices. A copy of this is appended with our current submission and is also available on our website.[1] The NZMA recognises the enormity and complexity of the task of developing a nationally consistent system to manage medical devices. We believe that central to the success of this initiative will be ensuring clinician buy-in relating to all decisions that are made, including those at the strategic level. Meaningful engagement with clinicians that are nationally representative of their respective specialist groups is imperative. We also wish to reiterate our earlier request for greater clarification on the decision making criteria for devices, processes (including in relation to appeals) and whether there will be a legislative obligation for PHARMAC to stay within budget (as is the case with pharmaceuticals). The NZMA also wishes to ascertain whether PHARMAC

[1] www.nzma.org.nz/policies/advocacy/submissions

envisages an ‘exceptional circumstances’ type provision for devices to cover those patient-specific scenarios where devices on the schedule are not suitable.

The NZMA is satisfied that the device categories identified in the current consultation as areas for initial activity are probably appropriate. We note that PHARMAC acknowledges that building and implementing procurement systems takes considerable time, and that the agency believes that taking on some specific procurement activity while these systems are being established will assist with developing long term systems and provide valuable experience in device management.

While we understand that this initiative relates to the management of hospital devices, there are likely to be significant implications for the wider sector including General Practice. The market effects of decisions relating to procuring/funding hospital devices could impact on the suppliers of devices to primary care. The NZMA recommends that PHARMAC take these wider implications into consideration when progressing this initiative. It is also likely that General Practice will have a strong interest in being able to access many of these devices, should they be placed on a schedule. This is particularly the case for the following identified categories: hand hygiene products; sterile surgical gloves; sutures; disposable sterile instruments; thermometers; wound care. The NZMA would welcome PHARMAC’s views on possible mechanisms by which non-hospital sectors including General Practice could access these devices at the negotiated price.

In our previous submission, the NZMA raised concerns relating to the definitions of what would constitute a device. This is not always straightforward, given the sometimes inextricably linked nature of a substance and the device it is stored in or dispensed from. For example, would oxygen be considered as a medical device or a drug? This has considerable implications for cost. Currently, there is a duopoly of oxygen suppliers that rent out cylinders and charge for refills. The option to purchase cylinders and refill as required has been lost. The costs associated with regular cylinder rentals are considerable compared with the purchase of a cylinder, even with regular testing. It has been suggested that if oxygen was supplied to hospitals and was also available on a Medical Practitioner Supply Order (MPSO) for General Practices with the cylinders being rotated around back to the hospital or ambulance service, there could be potential cost savings for both primary and secondary care. We suggest that further consideration be given to this possibility.

While other organisations and individuals are likely to be in a better position to provide specific comment on the individual device categories that have been identified in this consultation, we have been alerted to some concerns relating to anti-embolism stockings. We have been advised that TED white hose stockings are widely purchased but are actually categorised as class 0.5 hosiery and thus do not provide compression when the patient is ambulant, even though they are often used for such purposes. This is likely to be area where considerable savings could be made. This example also illustrates the importance for all decisions relating to procurement to be guided by robust evidence including, but not limited to, efficacy.

We hope that our feedback on this consultation document is helpful and look forward to working closely with PHARMAC as this initiative progresses.

Yours sincerely

Dr Mark Peterson
NZMA Chair