Technology Adoption

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Context

- Rapidly expanding array of medical procedures, equipment and drugs
- Finite budget
- Growing community demands
- Growing clinicians demands
- Competing priorities

What do we want?

Early uptake of new technologies that are:

- ✓ Safe
- ✓ Effective
- ✓ Cost-effective
- ✓ Have strategic ‘fit’

Review and **reorient** current technologies that are:

- ✗ Unsafe
- ✗ Ineffective
- ✗ Cost-ineffective
- ✗ Do not ‘fit’ role or strategic direction

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A system for:

- **Balanced** focus on **introduction** of new effective technologies and **discontinuation** of old ineffective ones
- **Clear** and **fair** decision-making
- **Early identification** and **management** of workforce, service design, infrastructure and staff training needs

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The Focus

- **New technologies** *(e.g. Robotic surgery for radical prostatectomy, mini cardiopulmonary bypass system)*
- **New applications of current technologies** *(e.g. MRI for diagnosis of PE and RA, INR for stroke)*
- **Uptake of existing technologies by new sites** *(e.g.3T MRI at Rockingham)*

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Health Technology in WA

Three main streams of work:

1. Equipment replacement (MEWP)
2. Ten year planning/horizon scanning
3. Ongoing process to manage adoption/horizon scanning:
    - WAPACT as peak body advising SHEF
    - Managing the change – implementation/disinvestment
    - Responsibility at AHS/hospital level
    - Budget cycles
    - National mechanisms

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Why?

- Affects quality of care/safety if implementation poorly managed
- Affects basic care delivery
- Drives approx 2-3% of the 5-6% real annual growth in health expenditure in Australia (Prod Comm, 2005 – 1992/3 to 2003/04)
- Unclear best investment decisions made – equity/access
- Impact on capital in some cases

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Why?

Lack of transparency in decision making

- Poorly managed, little or no priority setting mechanisms
- Influenced strongly by vendors
- Politics, media, patronage
- Personal clinical/professional interest

Why? – Drug eluting stents experience

2000

RNS SALAMI program (study) – huge increase in angioplasty demand

2002

"free" DES by vendors to many tertiary hospitals

2003

Evidence available of clinical criteria for DES

% DES of total stents used in NSW tertiary hospitals ranged from 15% to 80% - RNS 0% to 60% in 6 mths

Advice from NSW clinical group 30% appropriate rate – but AHS decision

DES $2,500, bare stents $900 (2003 costs)

1.7 stents per patient

2007/8

Emerging evidence little benefit to DES over bare stents

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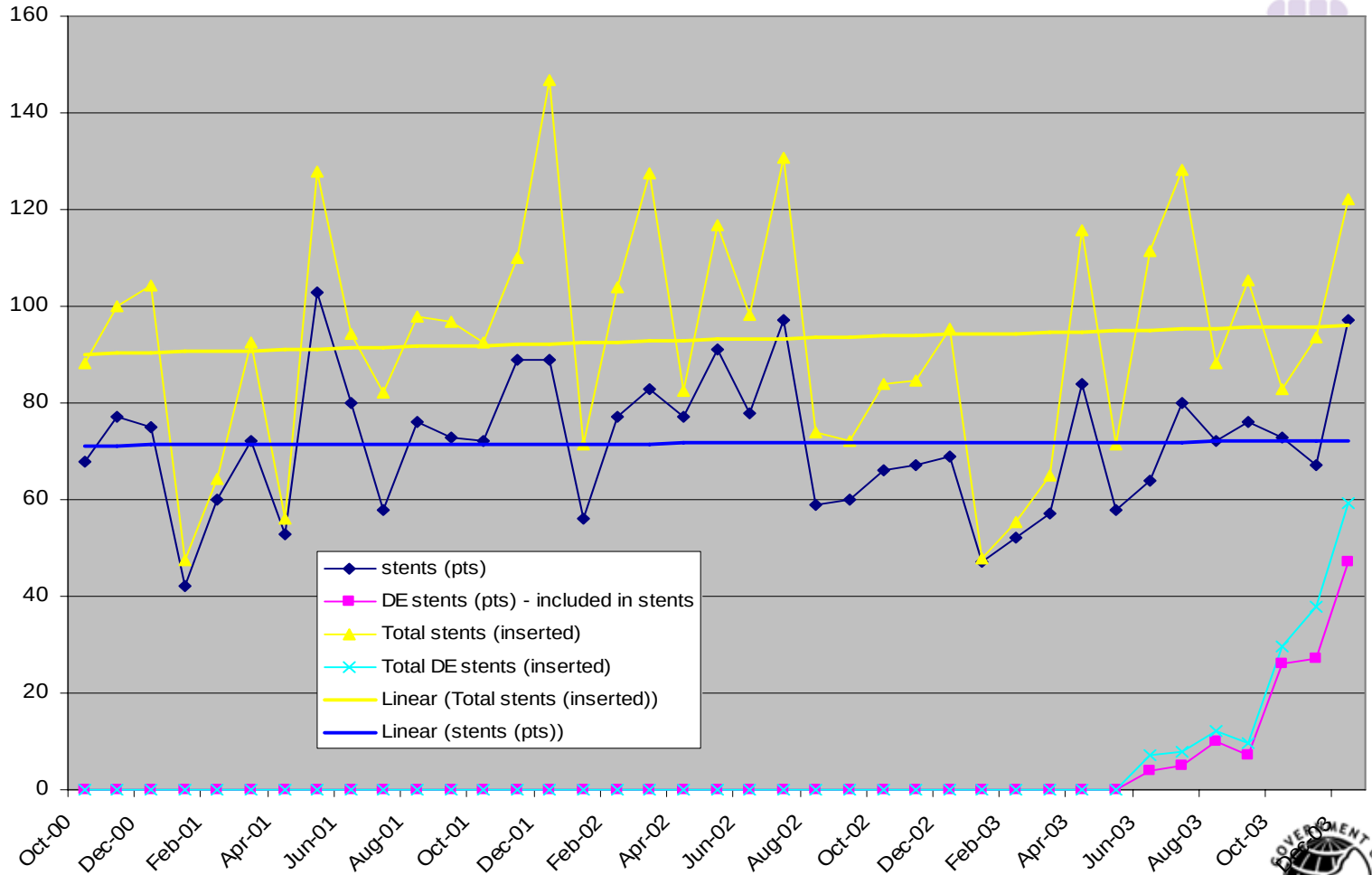
Why? – Drug eluting stents experience



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Why? – Drug eluting stents experience

WA 2006/07

Angioplasty patients	1,800
Total stents inserted	3,060

Cost estimates	*($'000)*
Cost bare stents	2,754
Cost 100% DES	7,650
Total costs at 30% DES	4,223
Difference	3,427

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From promising report to Government acceptance

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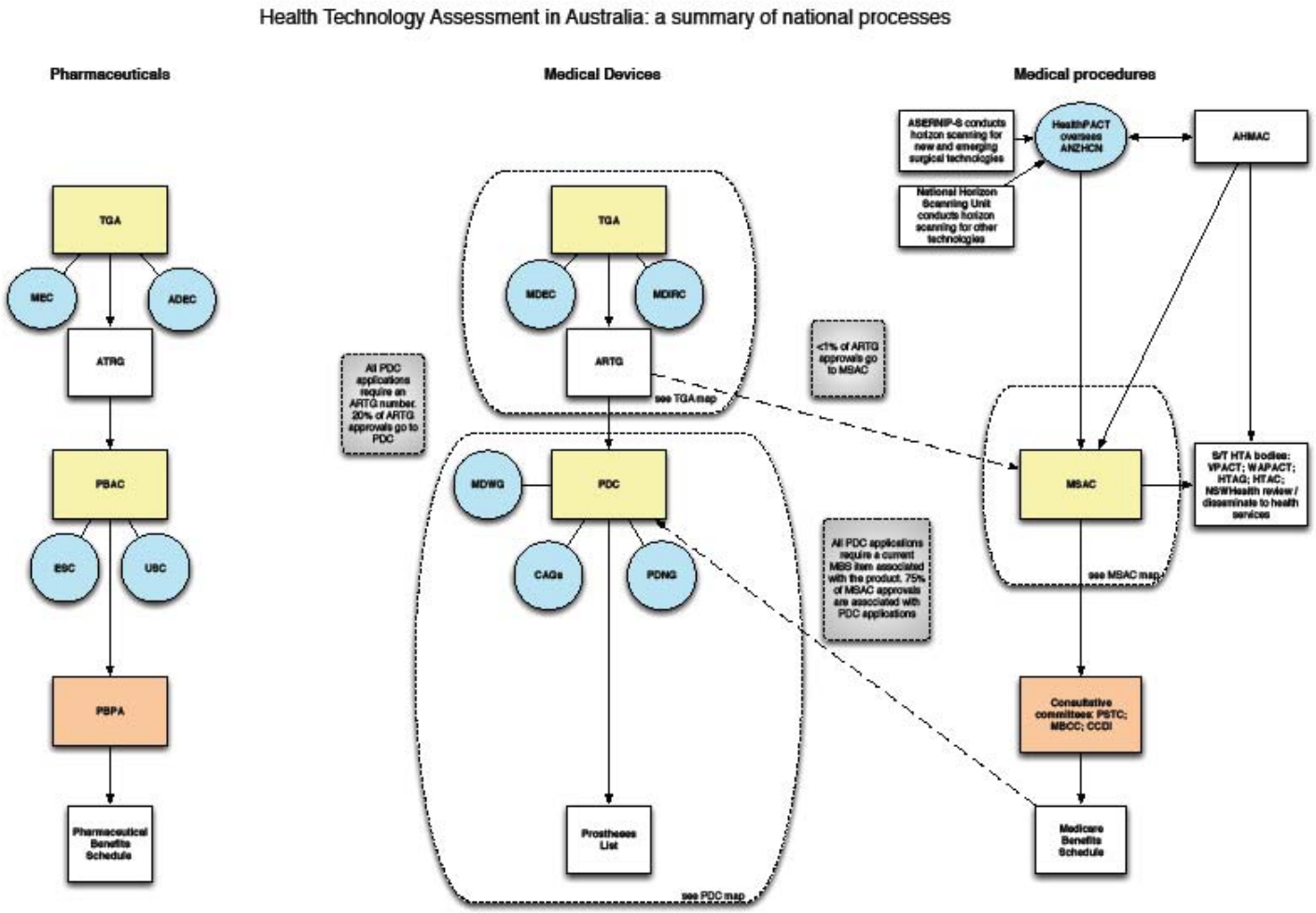
National Process



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National process - TGA

Therapeutic goods administration:

- Assesses quality, safety and efficacy of medicines, devices, blood, tissues and cellular therapies
- Assesses quality systems of producers
- For inclusion on Aust Register of Therapeutic Goods
- Post market monitoring

National process - PDC

Prostheses and devices committee:

- Advises Cth Minister on prostheses for inclusion on prostheses list and the benefits to be paid
- Private insurers only not public
- Undertakes its own health technology assessment
- Assesses clinical effectiveness using comparisons with other devices

National process - MSAC

Medical services advisory committee

Advice re public funding within MBS

Receives application for HTA from manufacturers (once TGA approved), Cth or State health Depts, AHMAC, HealthPACT

Assesses safety, effectiveness and cost effectiveness

Comparative assessment approach – service most likely to be replaced

National process - HealthPACT

HealthPACT:

- Horizon scanning of new technology
- Provision of short papers on emerging technologies before wide spread implementation

- ASERNIPs
- Australian New Zealand Horizon Scanning Network

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Health Technology in WA

1. Map of technology
2. MEWP
3. WAPACT
    - Advise and monitor implementation of new technologies
    - Provide early identification and advice on emerging technologies (Nat and local sources)
    - Advise on annual and longer term priorities for technology adoption
    - Establish mechanism for setting priorities for technology investment in WA Health
    - Disseminate information on new technology throughout WA Health
    - Represent WA interests at National level on HTA

Health Technology in WA

Will not do HTA – use National processes

Process needs to address:

- Scope of WAPACT process
- Accountability at facility/AHS level
- Local proposals that are not too onerous
- Resources to support – required at DoH
- Ability to allow innovation
- Fit into annual budget cycles and ERC/ forward estimates cycles
- Criteria developed to assess priorities
- Links to other groups – WATAG, MEWP, InfoHealth

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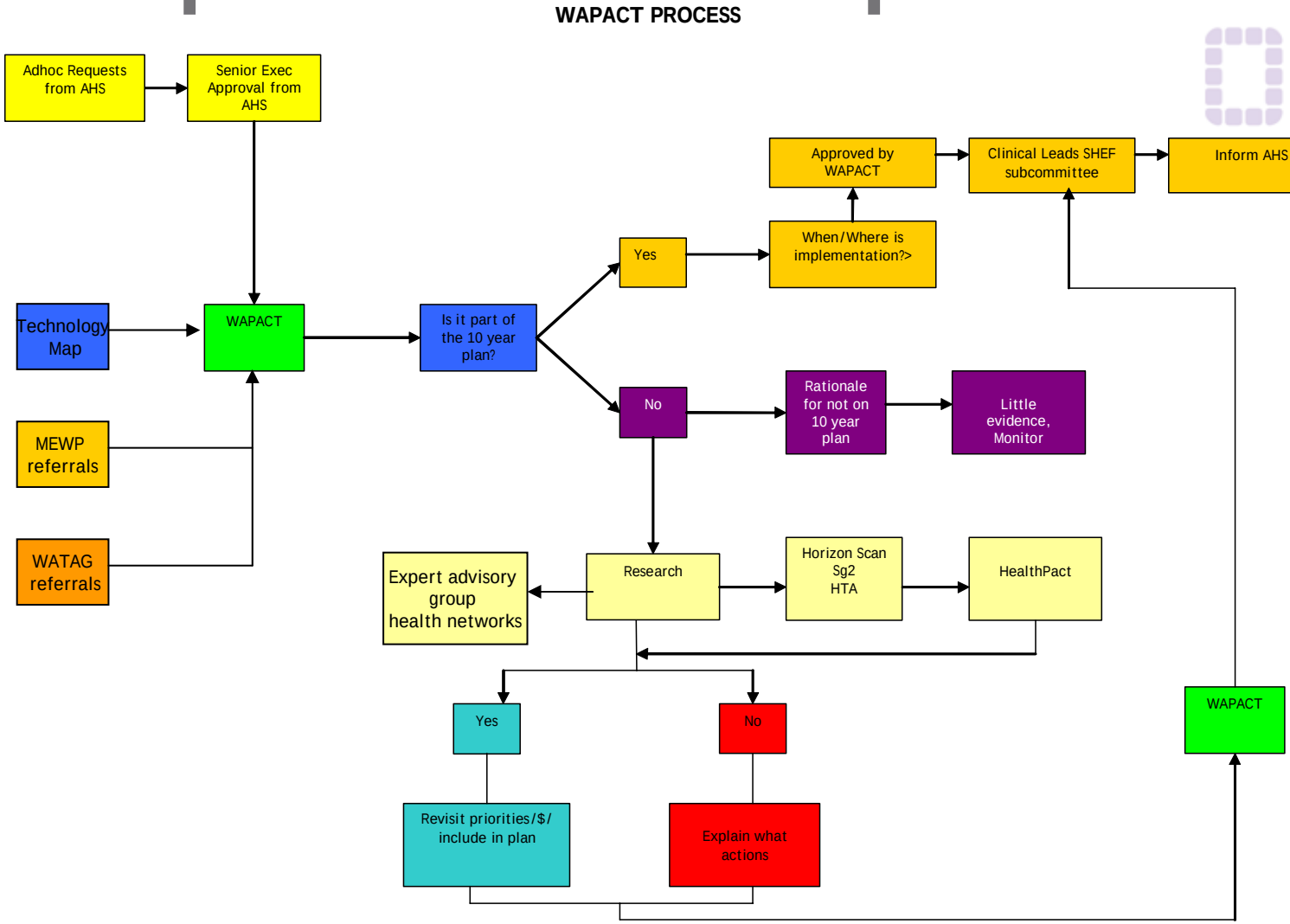
Proposed WA Health process



Draft only – budgets, MEWP, WATAG not incorporated

WA process - proposed

Definition

- Medical and surgical procedures, prostheses, implantable devices, diagnostic tests and equipment
- ICT medical vs ICT corporate
- Knowledge and support systems
- Capital recurrent cost over $1 million (not offset by disinvestment)
- Excludes pharmaceuticals but overlap (WATAG)

WA process - proposed

- Approvals by AHS CEs
- Small “business case” 3-5 pages
- May include requests for HTA
- Link to budget/estimates cycles
- Utilise current Cth processes and knowledge and SG2, ASERNIPs, etc
- NGO/philanthropic requests through same process
- Use of clinical advisory panels and community
- Needs to allow innovation as well as make the best investment decisions
- Decisions based on set of criteria

Ensure innovation is not discouraged

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WA process - proposed

2 main types of decisions:

1. That the technology should be adopted (adoption criteria)
2. What gets priority in a budget cycle

Rolling annual cycles

Ten year map updated with

- Innovative ad-hoc requests
- Watch lists
- Analysis lists
- Implement and monitor lists

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WA process - proposed

1. Adoption criteria

- CE endorsement
- Aligns with clinical planning direction
- Over capital or recurrent cost limit
- Approved by relevant Cth body
- Evidence of improvements in overall costs or outcomes
  - Comparator techniques current best practice

WA process - proposed

2. Priority setting

- On technology map
- Technology assessment exists/impact if not yet assessed
- Recurrent and capital cost implications
- Cost effectiveness
- Population factors – burden of disease, equity, access, socioeconomic implications, size of pop at risk
- Disinvestment opportunities
- Preventive vs reactive technology
- Credentialing required or skills available

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WA process - proposed

Community Consumer involvement

- Essential for transparency
- Agree priority setting criteria and weighting
- Mechanisms to participate in decisions

Other requirements

- Clinical networks
- Policy unit to be established
- Budget required for services to access – proposing $10-20M for 2009/10 (estimated technology costs 2008/09 in WA $80-120 million)

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WA process - proposed

Policy unit will:

- Establish the technology adoption process
- Manage priority setting and submissions process
- Provide secretariat to WAPACT
- Provide links to National HTA processes
- Hold the horizon scanning knowledge and provide research
- Monitor implementation and disinvestment
- Ensure technology planning is linked to clinical planning and infrastructure programs
- Provide health economics skills and advice for submissions

Final comments

- Planning through the ten year map provides the foundations
- WAPACT established BUT
- Process to set system priorities (ration) still needs to be established
- Should be applied to 2009/10 *some* budget decisions
- Huge amount of information Nationally and through groups such as SG2, Advisory Board
- Requires investment to make use of it for policy and budget decisions
- National and State processes seem unwieldy and very complex – is there an easier way?

We have to start somewhere – we already make these decisions tacitly

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