Senate Select Committee on Health

Inquiry into health policy, administration and expenditure

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MTAA Medical Technology ASSOCIATION OF AUSTRALIA

Medical Technology
ASSOCIATION OF AUSTRALIA

www.mtaa.org.au

Level 12, 54 Miller St, North Sydney
NSW 2060 Australia
PO Box 2016 North Sydney
NSW 2059 Australia
P (+612) 9900 0650
F (+612) 9900 0655
E reception@mtaa.org.au

Executive Summary

The Medical Technology Association of Australia (MTAA) welcomes the opportunity to prepare this submission for the Select Committee on Health which has been established to inquire into and report on health policy, administration and expenditure.

MTAA supports reform to make innovative healthcare solutions accessible to all Australians. The medical technology industry is highly innovative and utilises high skilled manufacturing with significant investment in research and development (R&D). A robust Australian medical technology industry enables longer and better quality lives for millions of Australians, fosters economic and social growth, creates jobs in an innovative manufacturing sector, and contributes to healthcare solutions by improving efficiencies in both hospital and community healthcare services.

MTAA has provided a number of recommendations for each of the terms of reference. The submission is predominantly focused on telehealth and remote monitoring which is an important area for the medical technology industry. In summary these are:

Recommendation 1:

A comprehensive telehealth policy be developed that incorporates funding for a range of home consultations and assistive medical technologies - including remote monitoring of vital signs and implantable medical devices.

Recommendation 2

The Government consider increased health funding of remote monitoring/telehealth

Recommendation 3

Intelligent wearable technologies have the potential to help prevent the onset of chronic lifestyle diseases in healthy individuals. Consumers and health professionals need to have confidence that these devices are fit for purpose. The Government could develop an assessment process to test the clinical effectiveness of these devices.

Recommendation 4

Innovative technologies with remote monitoring capabilities are utilised to improve the quality and range of support services available to enable individuals to be treated in the home rather than in more costly aged care facilities

Recommendation 5

Funding for indigenous telehealth programs be increased to support those with chronic disease living in rural and remote regions

Recommendation 6

Seed funding for hospitals to establish telehealth monitoring of rural and remote patients with complex health conditions

Recommendation 7

Medicare Benefits Schedule (MBS) to recognise review of telehealth data and video conferencing consultations in patients' homes by GPs – with the proviso of a full reporting capability to validate the consultations

Recommendation 8

The Prostheses List Advisory Committee adopt a more flexible approach to the definition of prostheses to include non-implantable devices that can provide high quality patient outcomes

Recommendation 9

An Australian Essential Care List (ECL) be established to replace a range of state schemes and operate similarly to a very simplified Pharmaceutical Benefit Scheme with some degree of patient co-contribution.

We welcome the opportunity to discuss this further with the Select Committee on Health.

Susi Tegen
Chief Executive

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Introduction

MTAA is the national association representing manufacturers, exporters and suppliers of medical technology products in Australia. Members account for approximately 75% of products listed on the Australian Register of Therapeutic Goods (ARTG). Member companies cover the spectrum of the industry in Australia, from subsidiaries of major multinational medical technology companies to independent distributors and small and medium sized Australian innovator companies.

The major challenge state and territory health systems in Australia are facing is to change the culture of healthcare delivery to implement new ways of delivering services. MTAA supports industry and government strategically working together to prioritise technology adoption as a new approach to better, more cost effective health care delivery. These solutions must be in the form of faster, smaller, better technologies that represent a new and radical approach to address the finite budgetary resources of the states keeping people out of the health-care system, receiving care at home and improving their quality of life.

Central to MTAA philosophy is a concerted effort to develop and/or adopt state of the art technologies with remote monitoring capabilities keeping people out of the health care system and aged care system saving significant costs and improving quality of life.

a) impact of reduced Commonwealth funding for hospital and other health services provided by state and territory governments, in particular, the impact on elective surgery and emergency department waiting times, hospital bed numbers, other hospital related care and cost shifting

Funding challenges, ageing population and high rates of chronic diseases mean Australia needs to find smarter ways of delivering health-care services outside of hospitals and aged care facilities. In response to the looming demand for health services, MTAA sees the rapid adaptation of existing medical devices and development of new devices as part of the solution. The time is right for Australia to develop policies to integrate these technologies in a structured innovative way. They can be part of the solution to the increasing demand for resources and improved care in home care setting.

A diverse range of medical devices have wireless capabilities and can be used to monitor patient's vital signs in their homes, creating significant savings for the health care system as well as tailoring health care delivery to individuals. The conditions most suitable for home monitoring include many of those which are more prevalent with age, such as diabetes and cardiovascular disease.

Not only does the medical technology industry offer solutions to current healthcare needs but it is continually researching and developing solutions to the many heath issues that Australia and the world face as people live longer lives. The industry looks not only at the health costs incurred "in the medical system" but looks to develop solutions to help keep potential patients out of expensive healthcare facilities. This is particularly evident in such areas as early detection and potential cures for dementia.

Remote monitoring of vital signs and medical devices is a health equity issue. It is also an issue about the future sustainability of the healthcare system. Currently rural and remote patients do not have equal access to health services. Long term follow-up of patients with implantable medical devices is necessary to monitor and optimize device function, and to identify clinical and/or device-related problems.

Studies have shown that remote monitoring can be used to replace 50–63% of in-clinic visits without adversely affecting patient outcomes[1]. Approximately 90% of cardiac patients, who attend a clinic for routine monitoring, do not require changes to either their device or their medical treatment[2]. A range of implantable medical devices can now be monitored remotely for clinical or device assessment.

In 2013, the US Department of Veterans Affairs (VA) Telehealth Service provided care to 608,900 patients of which 45% lived in rural areas and who may otherwise have had limited access to VA healthcare[3]. The estimated savings was $2000 per patient per annum.

MTAA believes the medical technology industry and the Federal Government should work in partnership to establish a comprehensive telehealth policy that incorporates funding for a range of home consultations and assistive medical technologies – including remote monitoring of vital signs, implantable medical devices and telehealth consults.

Telehealth and remote monitoring can achieve considerable health system efficiencies and reduce costs in a number of ways

- reducing visits to specialists
- decreasing the number of hospitalisations
- reducing potentially preventable hospitalisations
- reducing emergency room visits
- reducing or delaying nursing home admissions
- keeping low care residential places in their homes
- decreasing the burden on healthcare professionals
- reducing patient transport costs
- improving resource management.

Clinical benefits associated with telehealth

Examples of the clinical benefits associated with telehealth and remote monitoring are numerous; a small number are listed below.

- 45% reduction in mortality rates and a 20% reduction in emergency room (ER) admissions in the UK Whole Systems Demonstrator (WSD) Trial, the largest randomised control trial of telehealth in the world (*n*=6,191 patients and 238 General Practitioner (GP) practices)[4]
- 71% reduction in emergency room admissions in respiratory patients who had oxygen saturation monitored daily[5]
- 25% reduction in numbers of bed days of care and a 19% reduction in hospital admissions in 17,025 veterans with chronic disease who were enrolled in a home telehealth program[6]
- 43% reduction in hospitalisations in cardiac patients who transmitted daily electrocardiogram and blood pressure data[7]

[1] Crossley, G.H., et al. and CONNECT investigators (2011). The CONNECT (Clinical Evaluation of Remote Notification to Reduce Time to Clinical Decision) Trial: The Value of Wireless Remote Monitoring With Automatic Clinician Alerts. *Journal of the American College of Cardiology, 57:*1181-89.

[2] Heidbüchel, H. et al. (2008). Potential role of remote monitoring for scheduled and unscheduled evaluations of patients with an implantable defibrillator. *Europace, 10:*351-7.

[3] Telehealth Services in the United States Department of Veterans Affairs, 2014

[4] London DHS. (2011). Whole Systems Demonstrator Programme: Headline Findings – December 2011.

[5] Vitacca, M. et al. (2009). Tele-assistance in chronic respiratory failure patients: a randomised clinical trial. *European Respiratory Journal, 33:*411-8.

[6] Darkins, A. et al. (2008). Care Coordination/Home Telehealth: The systematic implementation of health informatics, home telehealth, and disease management to support the care of veteran patients with chronic conditions. *Telemedicine and e-Health, 14(10):*1118-26.

- 50% reduction in mortality in a large sample (*n*=69,556) of patients with implantable cardiac devices who were remotely monitored[8].

In the Tasmanian Health System Study released in 2013, participants were asked for their views on consulting with a GP or a medical specialist over the phone or by videoconference to reduce the need to travel.

- There were more mixed reactions towards the aspect of speaking with a doctor over the phone or on a video conference.
    - While many felt that it would be acceptable in some instances, such as for the discussion of general symptoms, others felt that if they would need physical examination for a final diagnosis in many cases.
- Some of the older participants also expressed concerns that they would be unable to use video conferencing technology.
    - While they weren't exactly sure how the system would work, they were assuming that they would have to operate some form of computer or device at their end.
- However, some were strongly in favour of the concept, and suggested that if they were teamed with a GP who was consulting with a specialist on the conference call, this would be extremely beneficial, as the GP would be able to provide an accurate description of the physical aspects that the specialist could not determine remotely, and they would also be able to translate the medical jargon that the specialist used[9].

Activity Based Funding

Health reforms in Australia have been focused on the need for increased efficiency in the delivery of health services. A component of these reforms is the implementation of national Activity Based Funding (ABF) for Australian hospitals. The implementation of ABF provides helpful incentives for efficiency and increases transparency in the delivery and funding of public hospital services across Australia[10].

Funding is based on defined activities and outputs, and services are using agreed standards to define, classify, count, cost and fund activity in a consistent manner. There are strict rules on which activities in hospitals are eligible for Commonwealth funding under ABF.

In scope are all admitted programs including:

- hospital in the home programs
- all emergency department services
- all non-admitted services including outpatient clinics.

Recommendation 1

- **A comprehensive telehealth policy be developed that incorporates funding for a range of home consultations and assistive medical technologies - including remote monitoring of vital signs and implantable medical devices.**

[7] Goernig, M. et al. (2009). Ambulatory disease management in cardiac patients: 12 month follow-up of home care telemedicine in Thuringia by the management program Zertiva®. *Physikatische Medizin, Rehabilitationsmedizin, Kurortmedizin, 19:*9-13.

[8] Saxon, L.A. et al. (2010). Long-term outcome after ICD and CRT implantation and influence of remote device follow-up. The ALTITUDE survival study. *Circulation, 122:*2359-67.

[9] Tasmanian Health System Study, 2013

[10] http://www.ihpa.gov.au/internet/ihpa/publishing.nsf/Content/funding accessed 10 September 2014

b) impact of additional costs on access to affordable healthcare and the sustainability of Medicare

All too often, discussions focus on the increase in spending per person on health care rather than the benefits of improved health care that the spending brought. Medical technology can deliver significant savings to the health system over time. Unfortunately the benefits of medical technology are often poorly understood, insufficiently articulated and developed, and may be perceived as being a burden on the healthcare system.

MTAA developed the Value of Technology (VOT) project to contribute to an improved understanding of the impact of advances in medical technology on healthcare expenditure in Australia, and the associated costs and benefits for the Australian healthcare system and community. The outcome of the VOT research provides evidence based support for a range of technologies that might not have strong Australian evidence to date and/or lack of funding.

Finding from a recent VOT report show that home dialysis has been demonstrated to be the most cost-effective form of dialysis. Increasing the use of home dialysis over the next 10 years has been estimated to result in net savings of between $378 and $430 million for the Australian healthcare system.

Overall home therapies represent the most cost-effective dialysis therapy option by:

- reducing loss of productivity (ability to work)
- reducing transportation costs (includes patient's out-of-pocket cost and cost to government travel schemes since those receiving in-centre dialysis are likely to incur significant transport costs)
- reducing medication costs (frequent dialysis offers reduced dietary restrictions and use of medications)
- reducing hospitalisation
- improving mortality and morbidity
- improving individual's quality of life and increasing family engagement
- enabling patients in remote locations to stay in their own homes and with their community and family
- managing depression often linked with chronic disease.

Recommendation 2

- **The Government consider increased health funding of remote monitoring/telehealth**

c) impact of reduced Commonwealth funding for health promotion, prevention and early intervention

Telehealth technologies can play a critical role in early intervention because patients are managing their condition daily (monitored by clinic/hospital system, community care and other healthcare providers) with in-home telehealth and measuring their own vital signs on a daily basis, meaning they are constantly managing their conditions lessening the chance of needing urgent care or hospitalisation.

The growing prevalence of lifestyle diseases such as diabetes and cardiovascular disease are concerning. Intelligent wearable technologies (that have been approved by the TGA) have the potential to help prevent the onset of chronic lifestyle diseases in healthy individuals, as well as help prevent and/or potentially reverse disease progression in those already suffering from these conditions.

In healthy individuals, wearable devices can be used as a digital coach to help motivate and influence people to manage their own health, including the adoption of healthy lifestyle choices. In addition, these devices can be used to monitor specific clinical measures, which may alert health professionals to the early signs of disease or sudden exacerbation.

For those diagnosed with a chronic illness, wearable devices enable both patients and clinicians to continuously monitor relevant health metrics - and address problems promptly - avoiding the need for hospital admission if the patient's condition deteriorates. The devices have the potential to improve patient engagement with their health, enabling them to take a more active role in the management of their condition.

Recommendation 3

- **Intelligent wearable technologies have the potential to help prevent the onset of chronic lifestyle diseases in healthy individuals. Consumers and health professionals need to have confidence that these devices are fit for purpose. The Government could develop an assessment process to test the clinical effectiveness of these devices.**

d) interaction between elements of the health system, including between aged care and health care

Australia faces significant challenges in aged care delivery in the future with around 3.5 million Australians estimated to require aged care services by 2050, an increase of 250% over the next 35 years. [11] Medical care is traditionally provided in clinics, hospitals and residential care units and health care funding supports these traditional models of service delivery.

MTAA argues the provision of care that enables individuals to be treated at home is far more cost-effective than other alternatives. It is apparent there will be a fundamental shift of health and aged care services from the hospital, the doctor's office and residential aged care to in the home. It will be critical to improve the quality and range of support services available utilising innovative technologies with remote monitoring capabilities as part of this change.

There are a number of predictable factors that lead to older patients being placed in residential care which could be managed more effectively by accelerating adoption of assistive technologies across the aged care sectors.

A study of nearly 3000 older Australians over 14 years found that nursing home placements were primarily due to principal diagnoses such as dementia (44%) stroke (16%) and coronary heart disease (14%). Other research has found that the hazard of nursing home placement increases significantly with urinary incontinence, physical disability and depression.[12]

Falls are a major predictor of institutionalisation. In 2003-04 injuries from falls were the largest group of all cases of hospitalised injury (36%). Nearly half of all injuries from falls occurred in individuals over the age of 65 years.[13] Women over the age of 85 have the

[11] Productivity Commission 2011 Caring for Older Australians, Report no 53

[12] McCallum, J., Simons, L. A., Simons, J., & Friedlander, Y Patterns and predictors of nursing home placement over 14 years: Dubbo study of elderly Australians. Australasian Journal on Ageing. 2005;24(3):169-73.

[13] Berry, J.G., & Harrison, J.E. Hospital separations due to injury and poisoning, Australia 2003–04. Injury research and statistics series no. 30. AIHW cat no INJCAT 88. 2007:Adelaide: AIHW.

highest rate of falls injuries[14]. Assistive technology can be used to decrease falls by reducing potential trip hazards, warning of balance and vision problems via monitoring devices, and providing patients and caregivers with falls detectors and alerts for use in an emergency.

According to a 2012 survey by MetLife in the USA, a private room in a nursing home costs an average of US$248 daily, or more than US$90,500 annually; a semiprivate room costs US$222 daily, or more than US$81,000 per year. A report by Genworth Financial finds that long-term care costs have been rising at a 4.5 percent compound annual growth rate since 2008. Given projected growth in demand, it seems unlikely that such costs will decrease any time soon[15].

While cost is a major factor driving the search for alternative aged care solutions, it is not the only one. Research shows that 90% of people 65 and older want to stay in their homes as long as possible. Yet many seniors are unable to do so because their homes and communities cannot accommodate their particular needs.

To track seniors' medical conditions and surroundings more closely, researchers are experimenting with more advanced smart sensor networks that provide remote caregivers real-time insight into the health and well-being of in-home patients. For example, research teams led by Diane Cook, Ph.D., of Washington State University and Nirmalya Roy, Ph.D., of the University of Maryland, Baltimore County, supported by a grant from the National Science Foundation (NSF), are exploring how to retrofit homes with sensor networks that monitor a resident's behaviour and activity levels[16].

Compared to the high cost of traditional assisted-living facilities and nursing homes, sensor-enabled smart homes are relatively inexpensive. Retrofitting a home with sensor technologies costs US$2,500, on average, for hardware and installation fees, plus a modest monthly fee for monitoring and analyzing the data.

While smart homes will not eliminate the need for nursing homes, they may allow seniors to safely remain in their own homes longer, thus reducing the financial and emotional burden on them, their families, and the government. By some estimates, American states can save an average of US$9 million per day in health care costs by making it possible for just 10% of the elderly population to remain in their homes for an additional one to two years.[17]

Recommendation 4

Innovative technologies with remote monitoring capabilities are utilised to improve the quality and range of support services available to enable individuals to be treated in the home rather than in more costly aged care facilities

[14] Henley, G., Kreisfeld, K., & Harrison, J.E. Injury deaths, Australia 2003–04. Injury research and statistics series no. 31 AIHW cat no INJCAT 89. 2007:Adelaide: AIHW.
[15] http://deloitte.wsj.com/cio/2014/07/28/using-sensor-technology-to-lower-elder-care-costs/ accessed 10 September 2014
[16] http://deloitte.wsj.com/cio/2014/07/28/using-sensor-technology-to-lower-elder-care-costs/
[17] http://deloitte.wsj.com/cio/2014/07/28/using-sensor-technology-to-lower-elder-care-costs/

e) improvements in the provision of health services, including Indigenous health and rural health

Rural Australians have poorer health and access to fewer health services. People in remote areas make greater use of hospital emergency departments than primary care facilities. They also have the highest rates of potentially preventable hospitalisations due to inequitable access to health services, medical consumables and medical technologies. [18]

Aboriginal and Torres Strait Islander people have higher prevalence rates of many health conditions including heart disease, diabetes, respiratory illness and kidney disease. They also have lower life expectancy and higher levels of disability [19]. Implementation of a comprehensive telehealth model as described in this submission could be particularly beneficial to improve health-care services for indigenous people who live in remote communities. In addition, challenges in delivering health-care services to Aboriginal and Torres Strait Islander people are also impacted by ensuring health-care workers are culturally sensitive to Aboriginal family structures and circumstances. These are challenges that could be mitigated by implementing culturally appropriate remote monitoring services.

The Aboriginal remote telehealth (ART) pilot trial[20] program in Western Australia began in July 2011 to investigate the use of telehealth remote monitoring of chronic disease to improve the health status of people living in remote corners of Western Australia. Benefits of the telehealth services include reduced hospital use and easier access to ongoing health care monitoring for patients living in remote areas. The clients chosen had multiple co-morbidity health problems including diabetes, renal failure, heart disease and respiratory disease.

During the health care visits, aides help clients to take their own vital sign measurements and enter them into the telehealth equipment. The information is then uploaded to a secure website for a nurse to monitor. If any concerns are identified further action is taken, which includes home visits or consultation with the client's GP. The monitoring system has been recognised by both nurses and care aides as an important development in assisting clients manage their own health. This method could include a store and forward of retinal photographs as a screening tool preventing disease and later costs associated with chronic disease.

Staying Strong telehealth, an indigenous telehealth pilot conducted by community care organisation *integratedliving Australia Ltd*, addressed chronic disease management in rural and remote communities. It delivered a new model of care through telehealth monitoring of vital health signs for 120 older Aboriginal and Torres Strait Islander people across New South Wales and Queensland.

Registered practice nurses employed by *integratedliving Australia Ltd* work with participants and their GP to develop individual health and monitoring plans based on health needs, in particular in chronic disease. Using monitoring software and vital sign peripherals, participants monitor their own vital health signs. Data is then transmitted to the triage manager database, which prioritises readings for clinical triage. If a reading is outside the monitoring plan range, the triage manager will raise an alert and the nurse will coordinate the appropriate response, in consultation with the participant and their GP or health service.

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[18] Department of Health and Ageing, annual report at www.health.gov.au/internet/main/publishing.nsf/Content/Annual-report2008-09 Canberra 2009
[19] State of Public Health 2013 Population Health, Department of Health and Human Services
[20] Australian Government Department of Health www.healthinfonet.ecu.edu.au

The project has shown an increase in timely and accurate diagnosis, as well as a notable increase in patient awareness and self-management[21].

These strategies increase the likelihood that a patient in an isolated community can remain in their own home and not be transitioned into a residential care setting, which would most likely be located in a metropolitan area. Telehealth can improve access to care for these patients by easing logistical burdens and reducing or eliminating unnecessary travel for routine check ups.

In Victoria, Western Health's Department of Nephrology is using innovative telehealth solutions to provide greater levels of support and monitoring, enabling more patients to undertake home dialysis. For most patients, hospital-based dialysis involves travelling to a hospital three times a week with treatment lasting four hours.

'Patients who dialyse at home often have better outcomes. They can fit their treatment around their own lifestyle needs, feel much more in control of managing their condition and avoid coming into hospital'[22]

Recommendation 5

- **Funding for indigenous telehealth programs be increased to support those with chronic disease living in rural and remote regions**

Recommendation 6

- **Seed funding for hospitals to establish telehealth monitoring of rural and remote patients with complex health conditions**

f) better integration and coordination of Medicare services, including access to general practice, specialist medical practitioners, pharmaceuticals, optometry, diagnostic, dental and allied health services

There are two cost considerations:

1) cost of the service including the review of telehealth data and video conferencing consultations in the patients home by GPs – with the proviso of a full reporting capability to validate the consultations
2) cost of the medical technology

With respect to the first point:

- Medicare Benefit Scheme items for telehealth were introduced in July 2011. However the definition of telehealth was limited to video consultations
- geographical eligibility for telehealth items has been recently restricted
- consultations between GPs and patients in their home are *not* funded
- vital signs and remote monitoring of medical devices are *not* funded

In regard to the second point:

- improving patient access to innovative medical technologies is dependent on improving reimbursement of medical technologies by private health insurance
- medical technology is not funded by the Commonwealth Government in the same way as medicines

[21] http://ruralhealth.org.au/sites/default/files/publications/partyline-50-web.pdf accessed 10 September 2014
[22] http://www.health.vic.gov.au/healthvictoria/aug13/patients.htm accessed 10 September 2014

- medicines are listed on the Pharmaceutical Benefits Scheme after assessment by the Pharmaceutical Benefits Advisory Committee and agreement by the Government to fund a new medicine.

Medical technologies are reimbursed in the private health system by private health insurers at a level of benefit recommended to the government by the Prostheses List Advisory Committee. The government retains an interest in the reimbursement of medical technology in the private health system because of the private health insurance rebate - in general a benefit will only be paid for an item listed on the Prostheses List (PL). The PL uses an outmoded definition of 'permanently implantable' to determine eligibility for coverage. Occasional exceptions are covered by ex-gratia payments by private health insurance funds to members. Improvements to this system can be rectified by addressing the following issues:

- including non-implantable medical devices under the managed system for reimbursement for private patients will make payment of a benefit for these items transparent and predictable.
    - At present, payment is subject to decision at an individual level by a health insurance fund.
    - While the PL treats the reimbursement of implantable devices efficiently, there is uncertainty and inefficiency in the way non-implantable devices are managed.
- current structure of the PL hinders the introduction of more efficient and effective technologies because of the current outdated definition of a 'prosthesis'.
    - A more flexible approach would ensure access to more efficient solutions that can provide high quality patient outcomes.
- the criteria for listing medical technologies on the PL should be expanded to include non-implantable single-use medical technology in the following circumstances:
    - When compared to alternative treatments, the medical technology is assessed as clinically effective
    - The cost of the product is relative to its clinical effectiveness
    - It is used to prevent a more invasive product or treatment
    - It is likely to avoid the patient requiring a more expensive product or treatment.
- healthcare funding arrangements for new technology not covered by the PL can vary between individual hospitals and individual health funds, depending on their contractual, policy and commercial considerations.
    - A private insurer can have different funding approaches for the same procedure, with the benefit paid to members depending on the hospital in which the procedure is conducted.
    - These arrangements are not particularly transparent and not easily understood by health fund members.
- implement a mechanism for regular review of benefit levels with the objective of avoiding patient co-payments.
- improve the responsiveness of the Medical Services Advisory Committee (MSAC) processes when considering applications for new Medicare Benefits Schedule item numbers – a mandatory prerequisite for listing on the PL.

In addition to the PL, MTAA has proposed that an Essential Care List (ECL) be developed to ensure that subacute care medical products needed by patients for their care, and in some cases, survival, are readily available using a system that is equitable, transparent and affordable. The scheme will enable subsidised access to essential care medical technologies that provide necessities to chronically ill or incapacitated patients in the community setting.

The items intended for inclusion in the scheme are consumable, single use, non-implantable medical products, together with the hardware that the consumables are used with, essential to maintain an acceptable quality of life for afflicted patients who without government subsidy would not have adequate access to life supporting medical technology. Products identified in an initial scope of the scheme include:

- oxygen supplies/consumables
- compression hosiery, bandages and garments for lymphodaema
- continence products
- modern wound care devices (including wound dressings)
- breast prosthetics (non-implantable)
- pumps and consumables for insulin delivery, and continuous flow pumps for drug delivery, together with consumables
- continuous positive airway pressure (CPAP)/sleep apnoea devices
- laryngitic products
- diabetes consumables (pens, strips, pump consumables)
- home dialysis devices, consumables and set-up costs.

At present many of these essential care items are either unfunded or, if funded, vary in availability and subsidy depending on the place where the patient lives. Some assistance is available from the Federal Government; other support is from State Governments. MTAA's conception of an Australian scheme is that it will operate similarly to a very simplified Pharmaceutical Benefit Scheme. It is expected there would be some degree of patient co-contribution.

The ECL would replace a range of existing schemes that are currently run by Commonwealth, State and Territory Governments. These include:

Federal
National Diabetes Services Scheme (NDSS)
Stoma Appliance Scheme (SAS)
Continence Aids Payment Scheme (CAPS)
National Epidermolysis Bullosa Dressing Scheme

State and Territory
ACT Equipment Scheme (ACTES)
NSW Program of appliances for disabled people. (PADP)
NT Territory Independence and Mobility Equipment (TIME) Scheme
QLD Medical Aids Subsidy Scheme (MASS)
SA Independent Living Equipment Program (ILEP)
TAS Community Equipment Scheme (CES

Recommendation 7

- **Medicare Benefits Schedule (MBS) to recognise review of telehealth data and video conferencing consultations in patients' homes by GPs – with the proviso of a full reporting capability to validate the consultations**

Recommendation 8

- **The Prostheses List Advisory Committee adopt a more flexible approach to the definition of a prostheses to include non-implantable devices that can provide high quality patient outcomes**

Recommendation 9

- **An Australian Essential Care List (ECL) be established to replace a range of state schemes and operate similarly to a very simplified Pharmaceutical Benefit Scheme with some degree of patient co-contribution.**

Conclusion

MTAA supports reform to make innovative healthcare solutions accessible to all Australians. The medical technology industry is highly innovative and utilises high skilled manufacturing with significant investment in research and development (R&D). A robust Australian medical technology industry enables longer and better quality lives for millions of Australians, fosters economic and social growth, creates jobs in an innovative manufacturing sector, and contributes to healthcare solutions by improving efficiencies in both hospital and community healthcare services.