Submission

Senate Inquiry: Medicare funding for Hyperbaric Oxygen Treatment

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This submission is made as a private submission because notice has been too short to enable the consultation necessary for a formal submission on behalf of The Alfred Hospital.

I am a senior staff specialist (0.8 EFT) at The Alfred and have been in practice in Diving and Hyperbaric Medicine at The Alfred since 1987. I was involved in the original meetings with Medicare staff that resulted in the establishment of the item numbers 13020, 13025 and 13030 for hyperbaric oxygen therapy, and the subsequent restriction of those item numbers from use for sporting injuries and multiple sclerosis, prior to MSAC becoming involved. I have not been involved in the more recent developments with respect to the establishment of item 13015 and the most recent MSAC review of this item number, but I am aware of much of the detail of these developments as a result of regular communication with my interstate colleagues who have been involved in various ways and who have made submissions.

Along with most of my colleagues from other public hospitals interstate, these developments with respect to Item number 13015 will have limited direct impact upon our operations as an integrated clinical unit within a public hospital. There will be some financial impact upon the Hospital and our unit as a result of reduced private practice income and this is of concern but this is small compared with impact of the change on our private hospital colleagues and most importantly, the patients denied effective treatment as a result of these changes.

I share the concerns of my colleagues about the major shortcomings with both the process and the outcomes of using MSAC to review existing technologies such as hyperbaric oxygen therapy to create diagnosis based limitation of funding. Despite the calibre of the professionals involved in the committee, a process aimed at limiting funding if possible is inherently problematic for the patients we aim to serve, especially if the approach to evidence does not strongly focus on comparative effectiveness against optimal alternative therapies. These issues of process will have been described in much more detail in submissions by others.

I can understand the concerns of Medicare about the potential over-use of hyperbaric oxygen therapy for what is a very heterogeneous group of conditions falling within the “problem hypoxic wound” category. In my experience, however, all of my current colleagues in hyperbaric medicine in Australia (in both public and private practice) take a very considered approach to this, and over-use seems very unlikely. The high

burden of time and often travel to receive hyperbaric oxygen make patients and their referring doctors unwilling to consider this therapy unless there is a high potential for benefit and likely or actual failure of alternative approaches. Further, hyperbaric medicine practice inherently brings a degree of multi-disciplinary oversight of clinical appropriateness in that multiple nurses, technical staff and doctors become aware of each patient's indication, personal circumstances and progress over the multiple weeks of 5 treatments per week that make up a typical course of hyperbaric oxygen therapy. I would therefore be very surprised if there is or has been any significant inappropriate use of hyperbaric oxygen in Australia in the medically overseen sector. (There is a problem with some non medical private clinics that do not bill Medicare but this issue is separate from the CMBS Item 13015 issue)

Unfortunately, removing the "problem wounds" diagnostic category from Medicare reimbursement will be seen by some healthcare professionals and administrators as an indication that "there is no evidence" or that "hyperbaric oxygen is inappropriate" for these conditions when this is clearly not the case. Regrettably, some do not see the difference between clinical appropriateness and funding rules.

Inability of private patients to receive Medicare reimbursement and the private health fund reimbursement that is linked to this will result in multiple patients being referred to public hospital services such as ours and the financial viability of private hyperbaric units may be threatened. This will create significant difficulties in Victoria where The Alfred relies on the two private sector facilities (Hyperbaric Health in Brunswick and Berwick) to offer timely treatment closer to home for a significant number of Victorian patients. The Alfred would have great difficulty in providing treatment for all patients who are suffering problem hypoxic wounds where hyperbaric oxygen is justified – our overall activity level and our responsibilities for providing emergency and high acuity inpatient care would create logistic conflicts between priorities if we had to become the only provider in Melbourne for these conditions. A significant waiting list would be likely. Travel for affected patients would also often be very burdensome.

It is obviously reasonable for Medicare and the Government to want mechanisms to ensure clinically appropriate and cost effective use of medical therapies funded by the Commonwealth. This author submits that diagnostic limitations within the item number descriptive text of the Medicare Schedule, developed upon the advice of MSAC, is an inappropriate mechanism for achieving this aim. More appropriate mechanisms might be a requirement to follow clinical guidelines (developed de-novo or adopted from an appropriate source such as the Undersea and Hyperbaric Medical Society guidelines) perhaps with a requirement for peer review of the prescription of hyperbaric oxygen therapy in diagnostic categories where the threshold for treatment is a matter of judgement, such as problem wounds. A suitable "second opinion" process could include need to gain agreement as to the appropriateness of therapy from clinicians with no direct financial interest in the delivery of the hyperbaric oxygen therapy. A further option could be to require a national registry of treatments provided and outcomes to ensure that clinical effectiveness review could be undertaken on an ongoing basis. The core of this is already in place in the form of the national problem wound study but this could be usefully expanded to become a universal registry. For maximum utility, any such registry would need to have connections made with relevant disease based registries so that comparison of patients

receiving hyperbaric oxygen could be made with others who do not receive hyperbaric oxygen for their condition.

I would be happy to provide further information or opinion upon request,

Yours Sincerely

Dr Ian Millar