



Association of British Healthcare Industries

Access to Medical Technology in Wales

[National Assembly for
Wales](#)

[Health and Social Care
Committee](#)

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Evidence from Association of British Healthcare Industries (ABHI)

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National Assembly for Wales: Health & Social Care Committee

Inquiry into access to medical technologies in Wales

Introduction

1. The Association of British Healthcare Industries (ABHI) welcomes the opportunity to contribute to this inquiry.
2. ABHI is the industry association for companies operating in the UK medical technology sector. We represent over 240 member companies, both large multi-national organisations and small British-based businesses. Our purpose is to promote the benefits, value and adoption of innovative, safe and effective medical technologies to ensure optimum and high-quality patient outcomes in the UK and key international markets.
3. Product development in Medical devices can be characterised by models, both running simultaneously. Firstly innovative and step change introduction of technology as described below and secondly rapid and incremental adaptation and improvement to existing products. It is important that processes are in place to enable both types of product developments to rapidly reach the market.
4. This response sees 'new or alternative medical technologies' as being either a) new or novel technologies that offer a beneficial step change in care delivery; or b) those that are in use at the moment, and form an integral element of existing best-in-class clinical practice, but are not consistently used across the NHS.
5. Every day, advances in medical technologies help improve and save the lives of patients in the NHS by enhancing treatments of many life-threatening diseases and long-term conditions. It is estimated that, across the UK, nearly 40 million people come into contact with a medical device every day.
6. Modern healthcare offers patients with ill health dramatically improved treatment outcomes and quality of life compared to the past. This is in part because continuous innovation in medical technologies changes the way health care is delivered, as it has done over most of the existence of the NHS, for example through developments of implants (the hip replacement), surgical techniques (laparoscopic surgery) or imaging (CT and MRI scanners).
7. Demand for healthcare is set to rise as an aging population, the growing prevalence of chronic diseases, and increasing public expectation continue to exert pressure on already stretched resources. The NHS faces unprecedented change to meet these challenges and must evolve to stay ahead of these societal shifts at a point when public expenditure is unlikely to grow significantly.
8. Against that background, the NHS needs innovation in medical techniques and equipment to make continuous improvement in delivering high quality patient care. For the medical technology industry – an important manufacturing sector for Wales as for the UK - developing innovations is a key driver for long term growth.
9. The challenge now is to change the relationship between the NHS and its suppliers of all kinds, to get better value from the technologies available, in order to enable the kind of service transformation that has been seen in other sectors of the economy.

Key needs

10. There needs to be a focus on monitoring and rewarding innovation uptake, specifically to streamline access to funding of innovations. A regime is needed in which there is measurement and monitoring of the uptake of innovation against national benchmarks of some sort, ensuring that variances in spread of "best clinical practice" in localities are scrutinised and addressed.
11. Procurement processes should be aligned to clinical needs, to become strategic enablers of innovation adoption. This includes basing purchasing decisions on specifications drawn up by clinicians that focus on

solutions that achieve required clinical outcomes rather than a simplistic version of “Most Economically Advantageous Tender” (MEAT).

12. There needs to be a link between evaluation systems and reimbursement processes (here we mean the system by which procedures/episodes of care are remunerated). This would allow for the seamless translation of a judgement about clinical effectiveness and economic utility of a technology into costing and payment systems. Further, there is the need for flexibility of reimbursement systems to embrace technological developments part way through funding cycles to avoid systematic delays in adoption.
13. Minimise the “pilot” culture Greater national coordination is required to trial innovations consistently such that local organisations do not continually pilot but rollout innovations based on experience and findings of early adopters or accepted national or international HTA processes.
14. Emphasis on achieving outcomes across the whole patient pathway. Quality standards and clinical indicators should be outcomes-based and define levels of care across whole patient pathways. Innovations that can aid the achievement of the outcomes being targeted should be explicitly referred to and clinicians encouraged to embed them in each step of a patient pathway.
15. Adopt a longer term view of investment return that also breaks down budget silos. The need hitherto to financially account much innovative equipment in a single year often inhibits the matching of benefits to cost over the medium/long-term. The positive impact of innovations must take into account the value brought across different budget cycles and silos. Breaking-down silos and bridging budgeting cycles requires greater collaboration across all parts of the NHS and across care settings. A whole system view of efficiency savings can be generated by a new approach to financing and investment decisions.
16. Strategic partnering with industry. The medical technology industry has potential solutions to assist the NHS meet the challenges it faces. To realise these solutions Board-level sponsored strategic relationships with industry must be the norm rather than the exception in the NHS.

Purchasing for outcomes

17. Medical technologies are a key element in the achievement of high quality clinical outcomes and modern healthcare is based partly upon the convergence of clinician skills with an extraordinarily diverse and specialised base across every aspect of engineering. The diversity of products and services that constitute medical technologies means that the mechanism by which they impact on outcomes varies. Some do so through their direct application, for instance cardiac implantable devices, and others indirectly, for example those technologies that reduce the amount of time taken to conduct a procedure or intervention. Taken together, changes in healthcare delivery have complemented and supported those in demography and public health, supporting people to continue to live active lives despite increased prevalence of long-term disease conditions.
18. Determining the outcomes being sought and how medical technologies can aid their achievement requires analysis across the care pathway to identify the extent by which care needs to improve, and an objective process to distinguish and purchase the technologies that may aid that improvement. For example in haemodialysis and peritoneal dialysis of adults with chronic renal failure, there is an understanding of high quality renal care across settings, age groups, and complexities to incentivise vascular access via a fistula or graft over other forms of access (as these have infective and thrombotic complications).

Purchasing for value

19. In public procurement, contracts are let by contracting authorities through a process of competitive tender. The aim is to achieve best value for money by opening-up public procurement to competition. What is sought is a balance between price and value – the Most Economically Advantageous Tender. A range of factors other than cost is taken into consideration, from reliability to training and support.

20. Total Cost of Ownership and Life-Cycle Costing are vital considerations and in the private sector are typically used to compile a return on investment (RoI) calculation or other cost-benefit analysis to inform a business case to support the investment strategy.
21. These concepts are known to NHS purchasers but they are not embedded in MEAT. The de facto application of MEAT is a system which places greater significance on unit cost of a product/service above quality and long-term benefits, though the MEAT principle was developed to level the price-value equation. This means that the benchmark for decision-making most often defaults to lowest acquisition price.
22. Purchasing for value will mean a better understanding and application of MEAT. In a publicly funded healthcare system the concept of “economically advantageous” must address whether public money is put to good use and primarily from the perspective of the taxpayer. In this context, both buyers and sellers, often stumble with cost-benefit equations, the quantification of benefits and the creation of ROI.
23. Suppliers develop economic models to convey value, taking into consideration elements such as opportunity cost and long-term benefits realisation, but are not able to convey their message to the correct decision maker. From the buyer’s perspective, the focus on current year savings leads to decisions that forsake the long-term.
24. To overcome these scenarios, an investment model needs to be jointly developed that:
 - underpins the procurement of medical technologies across the medium/long-term horizon, very likely over several years;
 - can withstand the scrutiny of a variety of stakeholders; and
 - is capable of informing value for money decisions.
25. This would be a significant development for the management of NHS resources. In the current climate, the historical approach in the NHS - “to improve quality more money has to be spent” - is redundant. The complex relationship between clinical improvement and finances has to be unpicked, to ensure that achieving quality and outcomes gains are routinely seen as returns on investment, gained from the use of scarce resources.