Consultation Survey on MSAC Application 1724

Cardiac technical support services provided by industry employed allied health professionals

MSAC welcomes feedback on MSAC applications for public funding from individuals, organisations representing health professionals or consumers and/or carers, and from other stakeholders. Please use this template to prepare your feedback. You may also attach additional information if you consider it may be useful in informing MSAC and its sub-committees.

Sharing consultation feedback

Submitted consultation feedback will be shared with the Applicant and with MSAC and its sub-committees.

- The applicant will receive a summary of comments from individuals, with the individual's name and other identifying information removed.
- MSAC and its sub-committees will receive both the summary and copies of the comments, with the name of the individual and other identifying information removed.
- Consultation feedback from groups or organisations will be provided in a complete form to both the Applicant and to MSAC and its sub-committees.

Please do not include information in your feedback that you do not want shared as outlined above. In addition, to protect privacy, do not include identifying personal (e.g. name) or sensitive (e.g. medical history) information about third parties, such as medical professionals or friends/relatives.

How consultation feedback is used

MSAC and its sub-committees consider consultation feedback when appraising an application, including to better understand the potential impact of the proposed medical technology/service on consumers, carers, and health professionals. A summary of consultation feedback will be included in the Public Summary Document (PSD) published on the MSAC website once MSAC has completed its appraisal. The PSD may also cite feedback from groups/organisations, including the name of the organisation. As such, organisations should not include information or opinions in their feedback that they would not wish to see in the public domain.

Consultation deadlines.

Please ensure that feedback is submitted by the pre-PASC or pre-MSAC consultation deadline for this application. Consultation deadlines for each PASC and MSAC meeting are listed in the PASC and MSAC and ESC calendars available on the MSAC website. They are also published in the MSAC Bulletin. Feedback received after the respective deadlines may not be considered.

For further information on the MSAC consultation process please refer to the MSAC Website or contact the Consumer Evidence and Engagement Unit on email: commentsMSAC@health.gov.au.

Thank you for taking the time to provide your feedback. Please return your completed survey to:

Email: commentsMSAC@health.gov.au

Mail: MSAC Secretariat,
MDP 960, GPO Box 9848,
ACT 2601

PART 1 – PERSONAL AND ORGANISATIONAL INFORMATION

1. Respondent details

Name: Miriam Norman

Email: chair@picsa.org.au; miriamnrmn@gmail.com

Phone No: 0439 388 055

2. Is the feedback being provided on an individual basis or by a collective group?

☐ Individual
☒ Collective Group

If an individual, specify the name of the organisation you work for

If a collective group, specify the name of the group

Professionals in Cardiac Sciences Australia (PiCSA). *Please note that I am only speaking on behalf of PiCSA. I do not formally represent the CSANZ AHST Council Executve in this response.*

3. How would you best identify yourself?

☐ General Practitioner
☐ Specialist
☐ Researcher
☐ Consumer
☐ Care giver
☐ Other

If other, please specify

Cardiac Physiologist, specialising in cardiac devices and echocardiography. - Current Chairperson of Professionals in Cardiac Sciences Australia (PiCSA - the peak representative body for Australia's cardiac physiologists) - Executive of the Allied Health, Science and Technology Council of The Cardiac Society of Australia and New Zealand (CSANZ)

PART 2 – CLINICAL NEED AND PUBLIC HEALTH SIGNIFICANCE

4. Describe your experience with the medical condition (disease) and/or proposed intervention and/or service relating to the application form

I am the senior Cardiac Device Specialist for the Royal Hobart Hospital (RHH). My qualifications include a MSc (clinical physiology), Dip. of Med. Ultrasound (cardiac) and formal certification as a Cardiac Device Specialist by the International Board of Heart Rhythm Examiners (IBHRE).

In my position at the RHH I am an example of a **non-industry employed cardiac device specialist**: I provide the full complement of cardiac device technical support services, including implant support, pre discharge checks, out-patient follow-up, after hours on-call, and remote monitoring for all 5 brands of cardiac device.

I achieved the 3rd highest score worldwide in the 2012 IBHRE cardiac device exam for allied health professionals.

I have been employed by the Heart Rhythm Society (HRS - a leading international resource on cardiac pacing and electrophysiology) to provide online educational material for doctors and allied health professionals preparing for their IBHRE accreditation exams (in 2013 and 2016).

I am the current chairperson of my profession's national body, Professionals in Cardiac Sciences Australia (PiCSA) and have served on their board for 10 years. This organisation represents all cardiac physiologists, regardless of their employer (industry, non-industry, private or public).

I am a founding member of the ACCP (a public register of Accredited Clinical Physiologists)

I helped write the CSANZ 2022 position statement on cardiac device management and am currently part of the Executive of the Allied Health, Science and Technology Council of The Cardiac Society of Australia and New Zealand (CSANZ).

I have an active interest in teaching and regularly provide *brand-independent* education sessions for other cardiac physiologists through PiCSA. I have also been a guest presenter at an industry sponsored educational event.

I am frequently asked to speak to other (non-cardiac physiologist) health professionals about cardiac device issues. Audiences to date have included Cardiologists, Cardiology Nurses, Paramedics, Emergency Department staff, Anaesthetists, Palliative Care Staff, Radiographers, Mortuary workers, and ICU staff.

5. What do you see as the benefit(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

The role of the industry employed allied health professional is a complex issue in Australia, where it is currently quite common to see reps used as "free labour" despite the international guidelines which state that it is not appropriate for industry employed allied health staff (company reps, IEAPs, or industry employed cardiac physiologists) to substitute for non-industry employed cardiac device specialists (for one example see Lindsay BD, Estes NA 3rd, Maloney JD, Reynolds DW; Heart Rhythm Society. Heart Rhythm Society Policy Statement Update: Recommendations on the Role of Industry Employed Allied Professionals (IEAPs). Heart Rhythm. 2008 Nov;5(11):e8-10. doi: 10.1016/j.hrthm.2008.09.023. Epub 2008 Sep 24. PMID: 18984523).

Consequently, the private rebates for the purchase of cardiac devices (and the cost of private health insurance) are very high compared to New Zealand and the UK.

Industry created this problem in the first place by offering the labour and then coupling the cost of the follow-up services to the cost of the prosthesis. It is regrettable that regulatory bodies allowed this to occur in the first place and then allowed it to continue. We welcome robust discussion, review and reform in this area.

In theory, Medicare rebates for device follow-up services are intended to cover the labour costs associated with that service, but if the clinic or hospital does not actually use the rebate to pay for the labour it becomes profit for the clinic/hospital.

We completely agree that it is now unreasonable to expect industry to provide ongoing follow-up care without allocating a specific reimbursement for that care.

The main benefit of the proposed medical service is that it would help to **uncouple** the **cost of the follow-up** from the **cost of the prosthesis** and to **fund the labour** of follow-up care more appropriately.

Locally and internationally the IEAP is an invaluable resource, even if they do not act as a substitute labour force. Even if a clinic or hospital uses their own staff (or a brand independent locum or 3rd party service provider) for labour as per international guidelines, they are still reliant on industry to provide product specific education, to supply and maintain the cardiac device programmers, and to provide the remote monitoring infrastructure and website platform which the non-industry cardiac physiologist uses to perform the labour.

This appropriate industry support role is a core essential service: no clinic or hospital (whether public or private) can provide an adequate and up-to-date cardiac device service without it. We risk jeopardising that foundational support if we expect industry to continue to provide the labour of ongoing follow-up care without adequate reimbursement. If the companies fall over and can't afford to provide expertise and equipment, then cardiac device care all over Australia is jeopardised.

Uncoupling the cost of follow-up from the cost of the prosthesis also makes more sense when it is known that many patients move in and out of private care. They may not keep their private insurance for the life of their device, and they might also get their implant as a public patient and then transfer to private care.

6. What do you see as the disadvantage(s) of the proposed medical service, in particular for the person involved and/or their family and carers?

PiCSA cannot support any proposal which creates (or perpetuates) a disincentive for cardiologists/hospitals/clinics to directly employ their own staff: **A cardiologist must be able to choose to whether or not to employ their own staff without that option being financially inferior**. Likewise, we cannot support a proposal that biases a provider against using a 3rd party *non-industry* provider (e.g., an independent business or locum) for cardiac device follow-up services. **We categorically oppose any funding model which makes it cheaper/easier for a doctor to utilise IEPS versus non-industry cardiac physiologists.**

The discussion about **labour shortage** needs to acknowledge that it is difficult to increase the numbers of non-industry cardiac physiologists if many employers (particularly private employers) don't offer paid positions. A device physiologist may legitimately ask "why would a clinic or hospital employ me to do their cardiac device checks, when they can get the labour done "for free" by the company reps?".

We do agree that, appropriate or not, many cardiac device follow-up services in Australia do currently rely on industry labour. It would not be advisable to remove industry suddenly or completely from that role, even though it is NOT endorsed by international guidelines and statements from professional organisations. **Any planned change would need to be gradual, in order to minimise service disruption.** The proposal states that "without appropriate funding of cardiac technical support services provide by IEAPs there will be a disastrous void with no parallel system to replace these services". We think that there **is** a parallel system (of non-industry cardiac physiologists) that would grow to meet the demand if changes were made over an appropriate timeframe. We also think that exceptional circumstances do occasionally apply, and that there should be some flexibility in those instances, at least in the short term. It would also not be

unreasonable for the existing rebate received by cardiac centres to be passed on to industry to reimburse them for labour provided.

We note that the proposal **misrepresents** the international literature in its support of labour substitution: **the guidelines quoted do NOT endorse a labour substitution role for IEAPs** (in fact, they specifically oppose it) but they do emphasise the value (and necessity) of industry support in other areas (as described in section 5 above). It is not appropriate to take the industry supportive comments in the guidelines and use them out of context to imply that *labour* substitution is supported.

Cardiac centres in Australia currently use the Medicare reimbursement funds to pay the cardiac physiologists who perform their **echocardiograms** (whether they are direct employees or as locums). They do not expect the echo machine's manufacturer to pay the echocardiographer. It should be no different for cardiac device services.

I contest that current employment numbers inside and outside of industry are partly the result of a historic lack of leadership/oversight at a national level, and the historic financial bias of hospital or clinic administrators not wanting to pay for labour. Remove that bias, and it will follow that we will start to see job positions being created and advertised for direct employees, plus we'll also see the use of industry-independent locums and third-party providers becoming a viable option.

It is false to imply that only IEAPs can currently provide technical support for private centres in Australia. Non-industry employed cardiac physiologists are not replaced by industry employees in some private and in most public Australian healthcare centres, and many patients currently receive a similar model of care to patients in NZ and the UK. Some centres also utilise a non-industry 3rd party for specific services (e.g., remote monitoring).

The proposed medical service not only *minimises* the existence of a non-industry labour force, but it fails to list PiCSA and its members (which include industry and non – industry employed cardiac physiologists) as a professional body/organisation that may be impacted by the proposal. This is a massive omission. PiCSA is the representative body for over 280 cardiac physiologists and represents the interests of the employee rather than the employer.

It is also false to imply that industry is better equipped/qualified to provide cardiac device follow-up services. The "best possible clinical outcome" goal does not favour industry labour over non-industry labour. The proposal's many listed advantages of cardiac technical support services can also be used to describe the support provided by a non-industry employed cardiac physiologist. Compared with an IEAP, an *appropriately experienced and qualified* non-industry employed physiologist has less restrictions on their scope of practice, which provides some very real advantages to both the patient and the cardiologist.

For example, they are allowed to access a patient's medical records, and can directly provide perioperative and periprocedural advice, they can also recommend different brands and features for different patients according to their unique clinical needs, and they may accommodate mixed-brand clinics (which improves patient access to care). A non-industry employed physiologist is also more likely to provide robust feedback and discussion to the cardiologist without fear of them switching to another company for support (e.g., if a doctor doesn't like being told their protocols are out of date). Although IEAP's are supposed to adhere to a very well written code of conduct (and usually do), it is not ideal to have the manufacturer's employee routinely influencing battery consumption settings or making recommendations about device replacement when their employer (who is not the doctor) stands to profit from the sale of replacement devices, and where there may be a perceived pressure to blur the lines between the support role and the sales role.

Given that many cardiologists who currently oversee cardiac device services do not themselves have a specific qualification or proof of competency in cardiac device management, it is particularly worrying to encourage cardiologists to favour a reliance on industry for labour.

The non-industry employed physiologist is expected to read the same textbooks and sit the same IBHRE examination as the IEAP, and when suitably experienced and qualified *both* are eligible for registration through the ACCP (which is a publicly visible registry with associated education and continuing professional development requirements). Registration with the ACCP is strongly encouraged by PiCSA and is comparable to registration of NZ cardiac physiologists with the Clinical Physiologist Registration Board (CPRB). Notably, although our roles differ, the cardiac device textbooks and guidelines we study are the exact same ones that the consultants train on, and many of us (in and out of industry employment) have a direct role in training physicians. We are (or should be) experts in our own right and provide valuable support to cardiac services in Australia.

PiCSA does not differentiate between cardiac physiologists based on their employer: Some of us work in public, some in private, some are industry employed, others are not – we are all cardiac physiologists, and have similar needs for support, advocacy, and education. **There is no need to set one group against the other**, and there is a tremendous opportunity for us all to work together in advancing our profession.

7. What other benefits can you see from having this intervention publicly funded?

Public funding for Cardiac Physiologists (industry or non-industry employed) may potentially reduce patient out of pocket costs.

8. What other services do you believe need to be delivered before or after this intervention, eg Dietician, Pathology etc?

Cardiac physiologists are healthcare science professionals who play a critical role. You can find us supporting hospitals and heart clinics performing a professional role across 5 distinct modalities:
ECG (12-lead ECGs, Holter Monitors, Stress ECGs, Tilt Tests etc), Cath Lab, Echocardiography, Cardiac Devices and electrophysiology
We are not currently eligible for AHPRA accreditation; however, we are a self-regulated profession with publicly visible registration and associated education and CPD requirements.
- Registration to in the roles of ECG, Cath Lab, Cardiac Devices and/or Electrophysiology is voluntarily available through the ACCP
- Echo registration remains with the ASAR, which was initially also a voluntary registry. Some Cardiac Physiologists work in multiple modalities and are encouraged to join both registries.
PiCSA believes that **registration should become mandatory** for all cardiac physiologists, regardless of their employer.

PART 3 – INDICATION(S) FOR THE PROPOSED MEDICAL SERVICE AND CLINICAL CLAIM

9. Do you agree or disagree with the proposed population(s) for the proposed medical service as specified in Part 6a of the application form?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☒ Strongly Disagree

Specify why or why not:

We sympathise with the cardiac device manufacturers, and agree that changes need to be made, but we cannot support the proposal *in its current form*.

Changes need to be in the best interests of the cardiac physiology profession as a whole, and there needs to be a visible acknowledgement of the different roles of industry versus non-industry employed cardiac physiologists.

PiCSA cannot support any proposal which creates (or perpetuates) a disincentive for cardiologists/hospitals/clinics to directly employ their own staff: **A cardiologist must be able to choose to whether or not to employ their own staff without that option being financially inferior.** Likewise, we cannot support a proposal that biases a provider against using a 3rd party non-industry provider (e.g., an independent business or locum) for cardiac device follow-up services. We categorically oppose any funding model which makes it cheaper/easier for a doctor to utilise IEPS versus non-industry cardiac physiologists.

We also think it is inappropriate to perpetuate a model of care that is contrary to international guidelines.

10. Have all the associated interventions been adequately captured in Part 6b of the application form?

☐ Yes
☒ No

Please explain:

The applicant does not adequately consider the services provided by non-industry employed cardiac physiologists.
Whilst we agree that **the Medicare funding should cover the cost of the labour**, we should not support a system which favours IEAP substituting for non-industry employed cardiac physiologists. Just because things are being done a certain way now, does not mean we can't do better in the future.
The applicant does not accurately represent or support international guidelines.

11. Do you agree or disagree that the comparator(s) to the proposed medical service as specified in Part 6c of the application form?

☐ Strongly Agree
☐ Agree
☒ Disagree
☐ Strongly Disagree

Please explain:

The proposal states that "without appropriate funding of cardiac technical support services provided by IEAPs there will be a disastrous void with no parallel system to replace these services".

PiCSA thinks that there is a parallel system (of non-industry cardiac physiologists) that would grow to meet the demand **if changes were made over an appropriate timeframe**.

Australia should be aiming for a healthcare model that aligns with the international recommendations regarding the role of the IEAP, and which recognises and supports the different and necessary roles of both industry and non-industry employed cardiac physiologists.

12. Do you agree or disagree with the clinical claim made for the proposed medical service as specified in Part 6d of the application form?

☐ Strongly Agree
☐ Agree
☐ Disagree
☒ Strongly Disagree

Specify why or why not:

The applicant does not adequately consider the services currently provided by non-industry employed cardiac physiologists within the public and private sector, and which comply with international guidelines.

Data used to estimate the frequency of service delivery is based on a pre-COVID-19 model of care and predates the recommendations made in the 2022 position statement from CSANZ. I don't believe it is an accurate representation of the current care model.

There is an implied superiority (in terms of safety and effectiveness) of IEAP labour versus non-industry cardiac physiologist labour, which is inaccurate, unnecessary, and unhelpful to the overall needs of the cardiac physiology profession as a whole.

PART 4 – COST INFORMATION FOR THE PROPOSED MEDICAL SERVICE

13. **Do you agree with the proposed service descriptor?** MSAC is transitioning to new application forms so the relevant question in the application form will vary depending on the version used. For medical services on the MBS, see question 51 or 53. For medical services seeking funding from a source other than the MBS, see question 52 (new application forms only—labelled v. 2.5).

- ☐ Strongly Agree
- ☐ Agree
- ☒ Disagree
- ☐ Strongly Disagree

Specify why or why not:

Industry versus non-industry employment of the clinical physiologist who provides the labour should make no difference to the reimbursement cost.
The times given in table 7 are inordinately long and suggest a questionable scope of practice for IEAPs.
I'm wondering if travel times are being built into this proposal. If so, travel costs should be a separate fee on a case-by-case basis.

14. **Do you agree with the proposed service fee?** MSAC is transitioning to new application forms, so the relevant question in the application form will vary depending on the version used. For medical services on the MBS, see question 51 or 53. For medical services seeking funding from a source other than the MBS, see question 52 (new application forms only—labelled v. 2.5).

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Specify why or why not:

There is no question 51,52 or 53 on the application form available online, so I cannot comment on this point.

PART 5 – ADDITIONAL COMMENTS

15. Do you have any additional comments on the proposed intervention and/or medical condition (disease) relating to the proposed medical service?

We are extremely concerned that discussions and formal proposals that affect the cardiac physiology workforce have and are being made without early and integral engagement with PiCSA as **we** are the professions' representative body. PiCSA has much to contribute to the conversation and hopes that the various organisations will be quick to invite us to the table in future.

We have previously contacted CSANZ and the MTAA with concerns and recommendations regarding the regulation, accreditation and registration of cardiac physiologists. We periodically conduct our own workforce surveys and are in discussion with universities, employers, students, and our international counterparts (especially the SCT). We are already providing brand independent CPD, and we often promote and support industry educational events.

Your proposal talks about a commitment to "develop and transition to a compulsory industry wide accreditation process for IEAPs". We think that there should be accreditation for the **whole profession**, regardless of the employer, and we have spent years working with lawyers and other organisations to create a legitimate registry (the ACCP). Our membership supports (and has helped guide) the processes which we have established.

We do not wish to see these efforts undermined/erased and we do not wish to see IEAP's and non-industry cardiac physiologists being artificially positioned in opposition to each other.

PiCSA would welcome direct involvement from the MTAA, CSANZ and other bodes. We are very open to formally welcoming/inviting representatives from other organisations as clinical advisors or board members so that we better can coordinate our efforts and avoid working at cross-purposes in the future.

16. Do you have any comments on this feedback survey? Please provide comments or suggestions on how this process could be improved.

Again, thank you for taking the time to provide valuable feedback.