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5th November, 2012

Standing Committee on Finance and Public Administration
References Committee

Dear Sirs,

Re: **Inquiry into Medicare funding for Hyperbaric Oxygen Treatment**

Thank you for the invitation to provide information to this inquiry. I am a senior consultant Anaesthetist and Medical Director of the Hyperbaric Medicine Unit at the Royal Adelaide Hospital. I was a member of previous MSAC supporting committees for reports 1018-1020 (2000) and 1054 (2003). I have signed confidentiality documents related to my involvement with MSAC.

I note that the MSAC website describes the development of a framework in 2009 for review of existing MBS items; however Hyperbaric Oxygen Treatment (HBOT) was reviewed in report 1018-1020 published in the year 2000 and HBOT had been publicly funded since the early 1980's. Review of existing procedures is not the same as reviewing a new procedure and this is realised by the development of the 2009 framework. Unfortunately, it also means that HBOT has been reviewed by a body who was tasked, at that time, with reviewing new technologies and who did not have the framework to deal with a technology that has been funded for almost 30 years. The result was a corrupted interpretation of the evidence and a lack of procedural fairness that exists to this day.

I really still don't understand why HBOT was subjected to this ordeal in the first place. MSAC report 1018-1020 was initiated by a scrappy application by a private citizen with no medical qualifications and for purposes that had nothing to do with current HBOT practice. To my knowledge, the use of the existing item number was stable and there were no "red flags" indicating a need for scrutiny. What were the MSAC application criteria and was this a properly complying application? Who authorised the "mission creep" into a broad review of Hyperbaric Medicine? To my knowledge, this had never been done before.

In spite of this, report 1018-1020 approved public funding of HBOT for a number of conditions (including HBOT for non-healing wounds in people with diabetes). Report 1054 specifically reviewed non-healing wounds in non-diabetics and soft-tissue radiation injury. Evidence in support of HBOT for non-diabetic ulcers was presented to the committee however it was apparent some senior members of this committee did not believe the evidence was adequate, despite its long history of use in the clinical setting. No guidance was provided as to what level or amount of evidence was required however. This led to considerable discussion around the committee table at our last (I think) face-to-face meeting. I do recall the discussion and I am not surprised if the meeting minutes do not record this – they were always woefully inadequate. I recall the discussion was along the lines of: MSAC would be keen to see more evidence for HBOT and so if it is given a temporary item number, what evidence can we provide over the next few years? We openly discussed what we could do, including detailed randomised controlled trials and large clinical prospective databases. Both have advantages and disadvantages and with other limitations including time, there was no clear preference. The MSAC supporting committee, including the MSAC-proper members, were present during this and no one expressed any concern with our discussion of a prospective wound database

or suggested it would not be accepted – they were encouraging for us to improve the evidence.

I was not involved with the latest MSAC application 1054.1 however I was surprised to find that MSAC had basically dismissed our Australasian Wound Database results. To my knowledge, this is the largest prospective wound study of any therapy with a 12 month follow up. It found that patients referred for consideration of HBOT had their ulcer on average for 16 months and yet follow up over 12 months post HBOT revealed great success in healing. MSAC's guidelines do demand that MSAC consider comparator therapies and their effectiveness. This is only logical; if you are going to say that the evidence for HBOT is not good enough, what are you comparing it to? And particularly, if you are talking about removing an existing therapy, what is left to treat it and what is the evidence for that therapy? This is absent, MSAC have completely failed this requirement. Apart from procedural failure, this is just bad medical practice.

MSAC are a very powerful organisation. They can alter their procedural guidelines at will, choose who they wish to review, remain opaque about what is expected from their victim, substantially alter the wording of their own expert supporting committee reports and when people complain, MSAC get to review their own processes and decisions.

If you were to look at usage of the MBS item numbers for HBOT, I believe you will find fairly stable utilisation over many years, including the time before the MSAC reviews. If anything, there are probably more HBOT claims now than before MSAC report 1018-1020, so Medicare have not reduced the use of this therapy. To me, this reflects the large degree of self-regulation exercised by the medical providers in Hyperbaric Medicine, who are all specialist trained doctors. We were already treating the appropriate conditions. Our stewardship of this therapy has not been appreciated by MSAC, who have been dismissive of our expertise. I do not believe MSAC's involvement in this process has been well-considered and I don't think it has improved anyone's health.

Yours sincerely,

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