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11 Nov 2005

Commissioners Mike Woods, Helen Owens and Robert Fitzgerald
Productivity Commission Health Workforce Study
PO Box 80
Belconnen ACT 2616

Dear Commissioners,

RE: Future Provision of Cost-Effective Services for Women's Health and Infertility

We thank you for the opportunity to address the Commission's Position Paper for Health Workforce and Productivity enhancements.

We would like to inform the Commission of a field in women's health, Natural Procreative Technology. It is relatively new to Australian clinical practice, and holds much promise in many of the areas covered by your Terms of Reference.

- It provides for the efficient and effective delivery of health services, that addresses the emerging health needs of women, especially of infertile couples.
- The current demographic of infertility affects 10 – 15% of couples, and medical literature reports a small but continuing rise.
- This area of health need has been associated with an ever increasing cost of services utilising the Assisted Reproductive Technologies (ART), \$78.6 million in 2004, compared to \$25.6 million in 1991. Natural Procreative Technology (NaPro) achieves very comparable success rates, at a fraction of the cost of the ART.
- The medical applications, and many of the surgical applications of NaPro (Natural Procreative Technology) are conducive to provision in rural and remote centres, with obvious beneficial access and cost implications.

Issues with current infertility services

We will highlight some aspects of the current services available to those who are experiencing infertility, subfertility or recurrent miscarriages.

- Generally health services offered to infertile couples, incorporate those of GP-referred specialist services, supported by Medicare Australia, **or** a diverse range of other non-medical health professionals, generally on a user-pays basis.
- Many General Practitioner's do not have much to offer their patients clinically in this regard and a referral to a more expensive, and presently limitless, specialist infertility service ensues.
- Male infertility is ill-understood, and inadequately diagnosed and many women are undergoing months or years of IVF treatment as a consequence (Obstetrics and Gynaecology 2005; 7(3): 14-15)
- A recent systematic review of existing studies revealed a 30-40% increased risk of birth defects associated with ART (Human Reproduction 2005; 20: 328-338)
- "It is well known that currently approximately 50% of IVF embryos are chromosomally abnormal, which may explain many failed pregnancies" (City Fertility Centre, Synapse Newsletter, Aug 2005).
- Due to this high incidence, there has been a concomitant high demand for services using diagnostic technology during the collection, implantation and pregnancy stages of such ART pregnancies.
- Despite this, large percentages of ART pregnancies end in miscarriage, up to 80% in the 40-45 year old maternal cohort. (Medical Observer, quoting; Director of IVF Australia, 25/2/05)
- IVF cycles for women in their forties have a success rate of about 2% (quoting; the Director of the Australian Health Policy Institute, Uni of Sydney in Australian Doctor) This is physically, psychologically and economically very demanding.
- Mothers conceiving through ART are four times more likely to suffer anxiety, postnatal depression and parenting difficulties (Fertility and Sterility 2005; 84:426-30)
- Many couples are not able to utilise current infertility services due to non acceptance onto the program (e.g. due to age, past history or failed prior treatments), financial or geographic constraints and/or philosophical beliefs.

Natural Procreative (NaPro) Technology services

The science behind NaPro has been researched and validated over the last 29 years beginning with a team at the Creighton University School of Medicine, Nebraska, USA and is being validated in Centres throughout North and South America, Canada, UK and Europe. Australia's first Centre for FertilityCare and NaProTechnology opened in Mar 2002 in Subiaco, WA.

The services are provided within a co-ordinated team care framework, that utilises trained practitioners, medical doctors and procedural gynaecologists. Presently much of the health provider training is undertaken in the USA, with partial local courses only just becoming available.

The focus is on women's health monitoring, evaluation and maintenance, while encompassing all areas, from family planning through to infertility and miscarriages.

A synopsis of some clinical outcomes are:

- Family planning 99.5% method effectiveness, and 96.4% use effectiveness at 18 months (J Reprod Med 1998;43:495-502);
- Premenstrual syndrome treatment, 78% marked/moderate improvement compared with 43% on standard antidepressant therapy ($p < 0.0001$);
- Postnatal depression marked/moderate improvement in 96.7% of women;
- Non surgical treatment of ovarian cysts in 84% of women;
- When comparing IVF and NaPro, statistically improved 'per woman' pregnancy rates for Polycystic Ovarian Disease ($p < 0.0001$), endometriosis ($p < 0.0001$) and tubal occlusion ($p < 0.02$);
- 65% cumulative pregnancy rate at 30 months, infertility patients at Omaha centre;
- congenital anomalies of live births comparable to published frequencies in 'normal fertility' population;
- treatment protocols to reduce recurrent/threatened miscarriages;
- prematurity prevention program for high risk pregnancies, reducing preterm births by about 50% compared to comparison service ($n=775$, p -value 0.025 – 0.0031, depending on gestational age criteria)

From studies reported in, Hilgers,T, The Medical and Surgical Practice of NaProTechnology, PPVI Press, 2004.

Productivity advantages of NaPro

- As mentioned earlier, such NaPro services have been shown to be associated with considerable economic savings, in other health systems.
- The majority of services are able to be provided by nurse practitioners and general practitioners, with referrals for specialist care where necessary.
- Existing health infrastructure is utilised in the provision of services – GP's, obstetricians, gynaecologists, laboratory services and considerably cheaper pharmaceutical treatments. (e.g. low dose clomiphene, HCG, progesterone)
- The services are amenable to meeting the needs of regional and rural communities, with comparatively little extra associated costs.
- This may address some of the maldistribution of the obstetric/gynaecological workforce, as GP's or GP obstetricians are empowered to provide such services, especially for infertility.

Obstacles to provision of NaPro services encountered

- Presently nurse and medical practitioners, have to undertake most of their formal training in centres outside of Australia (USA or UK), the cost of privately funding such training is inhibitive.
- Prescribing legislation varies form State to State, and this impacts on the availability of NaPro services at a GP level, despite all having the requisite training in this field.
- Practitioners are usually nurses/midwives and as such are able to work in a General Practice setting. However, their NaPro instructional services do not attract a Medicare rebate in this area and become cost inhibitive for patients or the employing GP's.
- Inadequate remuneration for current medical services by GP's in this field, if we are to limit patient out of pocket expenses. Consequently, there is no ability to guarantee an adequate primary care physician uptake of NaPro technology.
- Developing a special clinical interest in this field exposes medical doctors to scrutiny by Medicare Australia, as consulting, referral and pathology use patterns are not within a normal general practice distribution.

Recommendations for consideration

- A Natural Procreative Technology infertility cohort study will begin in 2006, as developed by the IIRRM (International Institute of Restorative Reproductive Medicine). Australian Centres can participate in the pilot program for the study, if they receive appropriate financial support to meet the study protocol. It is anticipated that this will review the effectiveness of NaPro, as a potential means of providing cost effective care and services.
- Financial support be directed toward doctors/nurses/midwives/others undertaking training in this field, especially with regard to provision of infertility services, with preference to those practicing in an area of need.
- A possible co-ordination of relevant State prescribing legislation, or appropriate co-ordinated exemptions, for those doctors trained in this specific field.
- There needs to be a recognition of the services nurse/other practitioners offer in this field and an ability to attract a Medicare rebate, through either the Enhanced Primary Care scheme or via the delegating GP.
- There may need to be a consideration of a specific item number review, (e.g. primary care physician management of infertility) to monitor costs of the program as well as to allow patients equitable access to such services.

Conclusion

In Professor Kerryn Phelps' (Uni of Sydney) Medical Observer article (20/5/05), "Informed debate on IVF costs must still go ahead", she noted that in the recent IVF-Medicare funding issue, rhetoric won out over logic. "This issue is not done and dusted. It may have survived the Budget night axe, but an informed debate must still be had."

Similarly, Professor Stephen Leeder's (Aus Health Policy Institute) Australian Doctor article, "Big bucks and babies", notes, "Currently, there are huge variations in both the cost of different procedures and patterns of treatment in Australia, which are more consistent with professional arrogance and ignorance than with best practice."

What we believe is being presented here, is an opportunity to responsibly enhance existing women's health services, in a competitive fiscal environment.

In addition, Natural Procreative Technology has the potential to redefine best practice methods in the field of infertility for a large number of couples.

We are happy to provide further details should they be required.

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