AWMA
Australian Wound Management Association Inc.
National
Healing Wounds Together

Purpose

In order to improve affordable wound management in Australia, changes in policy are required. This will need people to discuss the issue with both politicians and bureaucrats. The purpose of this document is to provide anyone with an interest in approaching politicians regarding wound care with a list of key talking points and a guide as to how best approach the meeting.

In addition it provides a key common goal so that everyone is giving the same message. This message is:

We are seeking a change in the Medicare reimbursement arrangements such that Doctors and Nurse Practitioners can prescribe subsidised compression therapy for the treatment of venous leg ulcers

The package includes:

- An outline of how to approach politicians and the dos and don'ts
- An outline of a 10 minute presentation/discussion you can have with a politician
- A background briefing paper that can be left with the politician or used as a basis for a media briefing.

This has been developed by AWMA and the Wound Management Innovation CRC.

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Approaching Politicians

In seeking action on an issue it is important to be proactive in approaching politicians. Write them a clear simple letter and/or make an appointment to see them, either in their electorate office or at Parliament House.

Be very clear about what is being asked. Hence we have prepared a series of talking points and messages to provide clarity on what is being requested. It is important to keep to the same message.

A good way to start is to talk to your local State or Commonwealth Member.

Do not forget to identify and talk to senior bureaucrats if possible.

Timing – is the time right to present the case?

AWMA Executive Members will take responsibility for contacting State and Commonwealth Ministers. It is important to make contact at the appropriate level, ie AWMA National President to contact the Commonwealth Health Minister.

When you write to or see a politician or bureaucrat please let the AWMA President know and send a copy of the letter to AWMA.

Common mistakes

- asking for too much, not being realistic
- seeking a meeting too late in the policy process when decisions have already been made
- presenting a problem without a solution
- not being clear about what you want the politician to do
- taking too many people into the meeting

Before the meeting

1. Approach the politician by letter. Be brief—keep it to one and a half pages maximum, plus an optional appendix with details. Your letter should clearly state what you want and if possible without any extra expenditure.
2. Practice how you are going to begin the meeting. A good way to begin is by describing the problem you are tackling; then follow this up with your solution. Cut to the chase—politicians do not have the time or interest to hear all the background.
3. Research the politician and make your work/problem as **relevant to them** as you can, so that they understand why you are meeting with them. Do they have aged cares facilities in their electorate? Are they on a committee that deals with the problem? Do they have a personal interest in the area?
4. Try to **link your work/problem to current issues**. Reducing health care costs is a big driver. Make your project or issue relevant to general community concerns.

During the meeting

1. Walk in confidently and begin by introducing yourself and thanking them for the meeting. After they have acknowledged you, explain in **one minute** why you want to see them.
2. Ask them **how much time** they have to spend with you. It could be anything from 5 to 45 minutes. Bear in mind that the meeting may be terminated suddenly if the politician is summoned to another meeting or to vote in the House.

3. Be specific about **what you want** out of the meeting. For example, you may want to raise their awareness in the area, engender more support or supply contacts. Ask them to do something concrete (e.g. write a letter, speak at a meeting, talk to someone on your behalf).
4. Be **honest and friendly**.
5. Give **good examples**—concrete ones, if possible. How much money can be saved? What are the social benefits for individuals or groups?
6. **Tell them a story** (keep it brief though). They are more likely to remember a story.
7. Provide **solutions to problems** rather than just problems—they hear enough problems.
8. Let your research outcomes **guide the** *direction* **of policy**— the detail is better left to the parliamentarians.
9. Keep in touch with them as much as you can. Leave them with some written information, write to them thanking them for meeting with you, invite them to visit you, and **keep them updated** on your progress.

Key talking points for discussing wounds with politicians

- A 10 minute approach*

Key message:

We are seeking a change in the Medicare reimbursement arrangements such that Doctors and Nurse Practitioners can prescribe subsidised compression therapy for the treatment of venous leg ulcers

1. Wound care – what are chronic wounds? (1 min)
   VLU, Diabetic ulcers, Pressure ulcers – people have wounds for months or years
   Magnitude of the issue - approx 400,000 sufferers in Australia at any one time and
   Increasing with aging and diabetes

2. Cost - $10,000 per patient/pa, approx 3% national health care budget (1 min)
   In the order of $3 billion pa
   Dispersed cost – Commonwealth and jurisdictions
   Cost incurred through doctor visits, community nurses and allied health professionals, aged care centres, hospitalisation.
   Cost of treatments – dressings, therapeutics

3. Best Practice treatment through compression therapy works - most wounds (VLU) heal in 4-8 weeks (1-5 mins)

4. Many people cannot afford or do not have access to best practice treatment (1-2 mins)

5. Current Medicare reimbursement does not cover compression therapy, the current arrangements are costly to patients and the health system (1 min).

6. We are seeking a change in the Medicare reimbursement arrangements such that Doctors and Nurse Practitioners can prescribe subsidised compression therapy for the treatment of venous leg ulcers.(1 min)

7. Modelling shows that subsidising compression therapy will result in no net increases in costs and results in savings with reduced health care costs delivered through faster healing, less visits to the doctor, reduced demand on nursing services and fewer hospitalisations. Patients are more mobile, able to cope at home for longer and have improved mental health. (2min)

*If there is more time the points can be expanded but do not lose the thread.

Background Briefing Paper

Wound Management in Australia - Improving Wound Care, Saving Money

Incidence of Chronic Wounds

Wounds that typically fall into the chronic wound category are pressure ulcers, venous leg ulcers, diabetic foot ulcers and ulcers associated with peripheral arterial disease. These wounds are slow to heal and often recur. Some patients may have the same ulcer for many months or years.

Wound management procedures are among the most frequently performed in the Australian health system. In general practice, three of the five most frequently performed procedures involve wounds (1). Other studies of community nursing have indicated that wound management constitutes between 50 and 80% of the caseload (2, 3). While the incidence of patients suffering from chronic wounds varies it is estimated that around 400,000 Australians suffer from ulcers alone at any one time.

Chronic wounds are disproportionately represented in patients that are elderly and from lower socio-economic backgrounds.

Cost

The management of chronic wounds creates a significant impost on the provision of healthcare. Chronic wounds are a major burden to patients and the health care system, and the cost has risen significantly over time. The Australian Wound Management Association estimated that the annual cost to the health care system and the community of treating and managing chronic wounds exceeded $3 billion in 2005.

It has been estimated that the direct treatment (medical and nursing staff and hospital admissions only) of venous leg ulcers alone cost between $775 million-$1 billion a year in the United States of America (4). This has increased annually with at least 150,000 new cases resulting in an additional $500 million cost (5). In the United Kingdom estimates range from £294 million to £949 million annually (6, 7).

Within Australia Baker et al (8) identified the national health expenditure on leg ulcers to be in the vicinity of $365 million to$431 million. Santamaria et al in 2002 (9) estimated an increase in expenditure, placing national costs between $553 million and $654 million.

Major costs are borne by patients because significant management costs are not subsidised. The average cost per patient of leg ulcer treatment has been estimated at $1,368 per year (10). For severe wounds, patients can be required to contribute as much as $750 per month.

Care

The management of chronic wounds have shifted over comparatively recent times from hospitals to the community. General practitioners are involved in the care of around 86% of

patients with a leg ulcer, and is estimated that community nurses spend up to 50% of their time treating leg ulcers (1 – 3).

The gold standard for the management of chronic wounds includes the early application of compression treatment, topical antimicrobial dressings (often silver dressings) and removal of non-viable tissue from the wound bed. In the overwhelming majority of cases effective treatments applied early will heal the wound within 12 weeks.

In many cases, this does not happen because people with chronic wounds are required to fund the dressings themselves. Given the demography of the patient cohort (aged and socially disadvantaged) many are unable to afford the associated costs. As a result, they may suffer from the chronic wound for months or years.

This creates enormous pressure on their personal finances, limited health resources in the community, and especially on hospital beds.

The Problem

Current Medicare subsidy arrangements do not encourage best practice care. Australia does not fully subsidise essential costs of best practice care outside the acute hospital system. This leaves major costs, including the cost of compression bandages and stockings, with patients. Because many of the patients are elderly pensioners, they cannot afford this treatment.

The result is a false economy where wounds do not heal, patients suffer and the health system is burdened with substantial avoidable costs, including:

- Ongoing consultations with general practitioners and community nurses;
- Antibiotic prescriptions for recurring infections;
- Analgesic prescriptions for ongoing pain management; and
- Repeat admissions to hospital for recurring complications, adding to public hospital pressures.

Within Australia, the cost of inpatient care alone was calculated by Grindlay et al (11) who estimated hospital costs for an average stay of 23.9 days to be approximately $8734 per admission.

Solution

Addressing this problem will require a three pronged approach: providing subsidised wound management for patients suffering from chronic wounds and ensuring judicious use of wound management products. This will facilitate best practice wound care and deliver health system savings.

1. Implement through Medicare a subsidy for the full cost of best practice wound management, including compression bandages, stockings and dressings.

This will promote best practice care with a consequent expectation that most chronic wounds will be healed within 12 weeks. This in turn will minimise repeat doctors

appointments, pharmacy bills worsening complications and avoidable and costly admissions to hospital.

2. Develop an evidence based wound product listing with Medicare reimbursement linked to qualifications and services provided.

This will ensure that only qualified health professionals prescribe approved products based on best available evidence.

3. Develop a chronic wound registry to accurately monitor the ongoing extent of the problem and the impact of new solutions.

A proposal is being developed to aggregate current wound datasets into a single wound registry. All data will be contributed in a de-identified form using available technology and security measures. While the implementation of such an endeavour is complex the development of a chronic wound registry is seen as an essential part for ensuring the efficient use of wound management resources.

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