Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2010-2011, 23 February 2011

Question: E11-017

OUTCOME 3: Access to Medical Services

Topic: MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

Written Question on Notice

Senator Siewert asked:

MSAC first began assessing PET in 1999, and approved the subsequent research protocols for the PET data collection program it recommended. The Senate has been told on several occasions that the data collection would address questions that were unanswered about PET at that time of the original reviews in 1999 and 2000.

a) Can the Government explain why PET scanning has received so much attention for MSAC yet is still unfunded for many cancer patients, regardless of the fact that determination of optimal management pathway relies on the PET result?

b) Can the Government explain why a process that was scheduled to take three years took so long to complete?

c) Can the Government detail the cost of the PET data collection process?

Answer:

a) MSAC considers available evidence regarding the safety, effectiveness and cost-effectiveness of medical services before formulating advice to the Minister for Health and Ageing. While MSAC's advice to the Minister describes the strength of available evidence, other considerations such as access and equity issues, ethical considerations and patient preference also appropriately influence MSAC's advice regarding the circumstances under which public funding should be supported. MSAC has assessed the use of positron emission tomography (PET) for 33 separate cancer indications since March 2005. MSAC considered the available evidence regarding the safety, effectiveness and cost-effectiveness for each indication before advising the Minister for Health and Ageing that public funding should be supported for 21 of these indications. MSAC separately evaluated the use of PET for each clinical indication in the Australian context because the information from the PET scans influences treatment decisions in different ways for different types of cancer. Implementation of this advice may result in consolidation of several of these indications within single Medicare Benefits Schedule items.

b) The Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM), which is the peak body representing nuclear medicine specialists in Australia and New Zealand, was commissioned to conduct an Australian PET data collection project. The project, conducted over the period of interim funding for PET in Australia, collected data on the effect of PET scanning, in particular on patient management decisions. The primary objective of the PET evaluation was to collect additional data to assist to MSAC in advising Government about the circumstances under which public funding for PET should be supported.

The data collection program was specific to the Australian clinical setting and was comprised of three elements:

- Demographic Data - describing basic patient information such as: age, gender, date and location of scan, disease/indication, history, investigations performed, pre-PET management plan, PET assessment and whether the scan was Medicare rebatable;
- Prospective Clinical Data - detailed protocol data from studies of particular clinical indications that included: patient demographics as above, clinical data at the time of PET scan, PET scan findings, management plan after the PET scan, status at prescribed follow-up intervals, and any adverse events; and
- Cost Data - total costs for a standard whole body PET scan, total costs for a long whole body scan, labour costs and non-labour costs.

Timing for the finalisation of the PET data collection program took into consideration:

- the complex nature of this multi-centre study - data from eight PET facilities was collected and evaluated;
- the increase in the number of clinical indications that was included in the data collection from an initial nine clinical indications to a total of 33 indications;
- larger patient numbers than anticipated;
- the collection of data could not be accelerated because the protocols for certain indications included the assessment of changes in patient management post treatment and finalisation of the data had to wait until the patient had completed their prescribed treatment; and
- the department's contracted independent evaluators needed to obtain and augment the data provided by ANZAPNM by synthesizing it with additional information from other sources (in particular, literature reviews).

c) Expenditure for the program included $2.4 million (GST inclusive) to ANZAPNM for management of the data collection program, and payments to the facilities for the costs of their participation, (including costs and expenses of collecting and providing the data). Facility payments were:

Royal Prince Alfred Hospital	$395,000.00
Liverpool Hospital	$293,170.00
Peter MacCallum Cancer Institute	$305,000.00
Medical Imaging Australasia (MIA)	$337,500.00
Wesley Hospital	$266,340.00
Sir Charles Gairdner Hospital	$330,691.67
Royal Adelaide Hospital	$175,000.00
Total	**$2,102,701.67**