

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2010-11, 23 February 2011

Question: E11-018

OUTCOME 3: Access to Medical Services

Topic: Medical Services Advisory Committee (MSAC)

Written Question on Notice

Senator Siewert asked:

- a) Can the Government explain why MSAC approved research protocols for the PET data collection process failed to answer important questions about PET's effectiveness and cost effectiveness? (For example, in response to Question: E09-094 it has been revealed that MSAC could not determine the cost effectiveness of PET in colo-rectal cancer restaging and was unclear if PET resulted in overall health benefits)
- b) How often has MSAC failed to implement procedures that allow 'definitive and clear judgements on medical procedures based on scientific and clinical grounds'?
- c) Is it true that after the PET data collection process MSAC claimed it did not have an accurate cost of PET scans to use in its economic modelling?
- d) Why didn't MSAC design a prospective assessment of cost effectiveness as part of the PET data collection project?

Answer:

- a) The positron emission tomography (PET) data collection exercise provided valuable information on the change in clinical management relating to the use of PET. While the study was intended to answer as many questions as possible, it is very rare that a single study provides enough information to allow definitive conclusions about all aspects of a procedure. In practice, health technology assessments rely upon multiple sources of evidence. The fact that some PET assessments were unable to draw definitive conclusions reflects the paucity of the international evidence base and the conflicting nature of that evidence in relation to PET.
- b) In providing advice to the Australian Government on the circumstances for public funding to improve health outcomes for patients, MSAC has instituted processes to allow the assembly and review of available evidence. MSAC's appraisal of evidence associated with medical services has, since 1998, been an integral part of the process for the listing of new medical technologies and services on the Medicare Benefits Schedule.

MSAC's membership is suitably qualified to consider the scientific and economic evidence regarding medical services and to advise the Minister about the strength of the evidence and the circumstances under which public funding should be supported.

- c) As part of the Australian PET data collection project, the cost of providing PET services in each of eight funded centres was estimated. There were limitations in the data as presented in the costing report, and the range of estimated costs of a PET scan varied very widely, between \$761 and \$2,067 for a “standard” whole-body scan (appropriate for recurrent colorectal and ovarian cancer), and between \$1,096 and \$3,719 for a “long” whole-body scan (appropriate for melanoma). Nevertheless, these represented the best available estimates of the current cost of PET in Australia.

- d) In 2000 MSAC evaluated the available evidence for the clinical effectiveness of PET with ¹⁸F-fluorodeoxyglucose (FDG) for several indications including recurrent colorectal cancer, ovarian cancer and melanoma. The evaluation at that time found insufficient evidence from which to draw definitive conclusions about the clinical effectiveness and cost-effectiveness of FDG PET. Interim funding was subsequently provided for nine clinical indications, conditional on the funded centres participating in a prospective study which would collect data including patient demographics, pre-PET and post-PET management plans and disease progression during follow-up.

The data collection study was designed with the assistance of the Australian and New Zealand Association of Physicians in Nuclear Medicine (ANZAPNM). Discussions were held with the Department and MSAC about the study’s design and limitation and it was agreed that the aim of the data collections would be to further inform MSAC’s appraisal of PET, but it was not feasible to definitively answer every area of uncertainty.

The data able to be collected did not determine clinical effectiveness as a single measure (such as quality-adjusted life years), and therefore the incremental cost-effectiveness ratio for PET compared to conventional staging was not able to be determined for any of these indications. However, a cost-consequence analysis was undertaken, examining the cost of PET against the consequences of avoiding radical surgery which was unlikely to benefit the patient found (by PET) to have incurable or extensive disease. This information, synthesized with other relevant evidence, was appraised by MSAC in formulating its advice regarding the circumstances under which public funding for PET should be supported.