

FINAL MINUTES

35th MEETING
23 August 2006
Brisbane

Members Present

Dr Stephen Blamey (Chair)
Professor Brendon Kearney
Dr Paul Craft
Dr Kwun Fong
Dr David Wood
Dr Terri Jackson
Dr Ray Kirk
Associate Professor Donald Perry-Keene
Mrs Sheila Rimmer
Associate Professor Frederick Khafagi
Ms Samantha Robertson
Dr Doug Travis
Dr Mary Turner
Dr David Gillespie
Dr Jane Hall
Dr Ewa Piejko
Professor Ken Thomson

Apologies

Professor John Horvath
Dr Michael Cleary
Dr Debra Graves
Professor Syd Bell
Associate Professor John Atherton

MSAC Secretariat

Dr Jane Cook
Ms Judith Davis-Lee
Mr Bill Matthews
Ms Julie Corr
Ms Sindy Ramanadhan
Ms Alex Lloyd (morning only)

1. OPENING OF MEETING

1.1 Welcome and Apologies

Dr Blamey welcomed all to the 35th MSAC meeting - in particular Mr David Learmonth, Deputy Secretary of the Department of Health and Ageing with responsibility for the Medical and Pharmaceutical Division.

He also welcomed from the Department Ms Judith Davis-Lee, the new Director of Health Technology Section, Ms Julie Corr who provides committee support to the MSAC Secretariat and Ms Sindy Ramanadhan a graduate on placement in the Health Technology Section.

He welcomed Ms Karen Duke of AUSCRIPT and reminded all members that AUSCRIPT is recording the minutes.

Dr Blamey noted that Dr Jane Cook would be joining by phone from Western Australia at 11am.

1.2 Conflict of interest and confidentiality

Dr Blamey explained that this standing agenda item was not applicable for this meeting as there were no final reports for consideration.

2. DRAFT MINUTES OF THE THIRTY FOURTH MSAC MEETING HELD ON 17 MAY 2006

The Minutes from 17 May 2006 were accepted with minor amendments.

ACTION: The minutes to be amended to correct minor errors.

2.1 Matters arising from the previous minutes

Paper on how the MBS deals with capital costs

(See discussion below at Agenda Item 4.1)

MSAC Recommendations with the Minister

Dr Blamey noted that the recommendations for the following applications are with the Minister for his endorsement:

- 1095 – Computed Tomography Colonography;
- 1091 – Laparoscopic Remotely Assisted Radical Prostatectomy;
- 1092 – Deep Brain Stimulation for Parkinson’s Disease; and
- 1093 – Endovascular Neurointerventional Procedures.

Reference 34 - Gamma Knife

Dr Blamey indicated the Gamma Knife recommendation is still awaiting a Ministerial decision.

Application 1087 – B-Type Natriuretic Peptide

Dr Blamey indicated the report is being reworked as suggested at the May MSAC meeting. The report will go back to the Advisory Panel prior to the MSAC meeting in November.

The MSAC process timeframes and links to international health technology agencies to be placed on the website.

Dr Blamey noted that this had been completed.

3. FINAL REPORTS FOR MSAC ENDORSEMENT

The Chair advised that there were no final reports for consideration at this meeting.

4. ECONOMIC DISCUSSIONS

4.1 Capital Costs Paper

Dr Blamey advised that a capital costs paper is to be prepared with external assistance engaged by the Department.

Dr Blamey explained that the MSAC would like the further development of the economic guidelines to reflect the way in which capital costs are dealt with in the setting of fees for Medicare Benefits Schedule (MBS) items.

A discussion took place about capital costs and the MBS. The following points were noted:

- The proposed paper will cover how capital costs have been treated historically in the three MBS tables and the extent to which they are included in Schedule fees.
- From an MSAC point of view, capital costs should be included in all economic evaluations to ensure accuracy;
- Guidance on methods currently used to approximate throughput - particularly for imaging machines - would be useful in determining incremental cost effectiveness ratios.
- The Department will commence work on addressing the issues raised by MSAC members.

ACTION: Department to engage a consultant to develop a paper about taking capital costs into consideration when completing the economic evaluation of a new technology or procedure.

4.2 MSAC Economic Guidelines

Co-payments

- The MSAC is seeking guidance on the inclusion of co-payments in cost effectiveness analyses.
- The Economic Subcommittee of the MSAC has expressed a preference for using a societal perspective in assessing the cost effectiveness of a new treatment. This would include all health system costs and all indirect costs related to a particular episode of treatment.
- A layered economic analysis would be one solution and would include the cost to Medicare, the whole of healthcare costs and societal costs.
- The underlying principle of MSAC economic evaluations is to maximise social benefit from limited resources, therefore, all costs are relevant.
- From a consumer perspective, co-payments and out of pocket expenses are important - if these are not included consumers will get an inaccurate indication of real costs.
- A co-payment for a new technology would be difficult to predict. An average co-payment could be incorporated to take account of variations in co-payments for different kinds of services. MSAC could reach an 'in principle' decision and then discuss further with the Department.

- The MSAC's intention would be to arrive at the best estimate of the total cost of the service.
- The PBAC has an interest in whole of healthcare costs. The MSAC guidelines should be consistent with the underlying principles of the PBAC guidelines.

ACTION: Economic sub-committee to meet with the Department to further discuss the issue of co-payments.

Indicative Cost Effectiveness Analysis

The next issue discussed was the use of “indicative cost effectiveness analysis”. This approach has been increasingly used for technologies which appear promising but for which there is limited evidence of clinical effectiveness. More guidance is required for evaluators and advisory panels about appropriate cost effectiveness analysis in this situation.

- The evaluators want guidance about how and when an indicative cost effectiveness analysis would be appropriate.
- All MSAC reports should include an economic analysis.
- MSAC is often presented with little, or low quality, evidence. The MSAC response has been to support a positive recommendation where something appears promising. The question is selecting an appropriate type of economic evaluation when there is uncertainty about effectiveness.
- If effectiveness is not demonstrated then further work should not be undertaken. More guidance is needed about the level of evidence on which the committee should support a technology.
- A probabilistic equivalence study can be used when trying to determine whether a procedure or technology is no worse or the same, but may be safer, less invasive or slightly less expensive.
- The Economic Subcommittee supports the use of probabilistic sensitivity analysis because it models a range of estimates about how effective the technology is. If the evaluators become familiar with the technique, MSAC economic evaluations will improve because they will reflect where the uncertainty lies.
- The Economic Subcommittee sought agreement from the MSAC that, in many cases, an indicative cost effectiveness analysis is appropriate. At this stage a decision in principle is required that can be translated into exact wording for the guidelines.

- It was confirmed that probabilistic sensitivity analysis would replace cost minimisation studies wherever possible.

ACTION: The committee agreed to the use of probabilistic sensitivity analysis rather than cost minimisation, and this will be reflected in the development of the economic guidelines.

Net Benefit Approach

- The general MSAC approach is to establish safety, then assess effectiveness. If a technology is effective, or if there is some uncertainty, an economic analysis is done. With a net benefit approach, the safety component could be rolled into the consideration of effectiveness to give a net benefit. This would help to compare the new intervention with comparator.
- A net benefit approach will require more work but should result in more robust reports, with economic analysis based on what the profession does in practice - which is to weigh up risks and benefits.
- Safety, or adverse events, are not generally reported in the literature.
- Information about adverse events should be mentioned in the Guidelines so that it is systematically looked for and to remind evaluators and advisory panels that safety issues impact on the Committee's decisions.
- Where the evidence is sufficient to allow a net benefit analysis in addition to safety and effectiveness, this should be performed but should not be mandatory in the absence of any meaningful data.
- The Economic Subcommittee would seek advice about PBAC procedure to make sure the MSAC has a comparable approach to PBAC in those instances where something appears slightly less safe, but more effective.
- The Economic Subcommittee suggested there would be merit in establishing a health economist's panel to provide independent peer review for those assessments where the economic analysis is complex and a third opinion would be useful.
- This was supported in principle. Advice to be sought from the Department about funding such a panel.

Economic Protocol

An economic protocol has been developed to assist Advisory Panel Chairs in their discussions with the evaluators. The key economic facts would be teased out and passed onto one of the health economists to advise the best approach.

Dr Blamey suggested that the MSAC Executive would review the general structure of the protocol before a trial takes place.

ACTION: Department to explore possibility of funding the establishment of a Health Economist panel.

ACTION: The MSAC Executive to review the Economic Protocol prior to its trial implementation.

5. RAPID REPORTING IN HEALTH TECHNOLOGY ASSESMENT

A discussion took place about 'rapid' health technology assessment. The following points were raised:

- There is a rapid reporting system – through HealthPACT, which does horizon scanning through the Australian and New Zealand Horizon scanning network. In general terms Australia leads the world in production of Horizon scanning reports.
- Technology has a life cycle. When it is new there is a period of low uptake. There are early adopters and enthusiasts who pick it up quickly. Then it becomes the dominant approach. Over time, it gets refined or replaced with a new product, then dies off.
- Dr Kirk's paper attempts to document the diffusion/assessment process. Horizon scanning is usually a jurisdiction's first look at new technology. Horizon scanning under Health PACT uses a triage system resulting in brief reports called prioritising summaries.
- MSAC could consider developing a triage system, whereby we develop a two page summary of the evidence related to a particular technology.
- Where there is some maturity in the data for a technology a rapid HTA may be an appropriate approach.
- Other jurisdictions have taken various approaches to rapid HTA. Arriving at a definition of what constitutes 'rapid HTA' is problematic. At the Adelaide HTA conference a session on rapid reviews revealed that there is no shared understanding of what constitutes a rapid review.
- Rapid HTA has occurred within hospital systems, but has a different framework and criteria from those used by the MSAC.

- A one-off ultra-rapid review was commissioned by the National Co-ordinating Centre (NICE) to provide the UK government with background information on Positron Emission Tomography in a 10 week period, however a full HTA was subsequently required. NICE has indicated that there is no intention of repeating the exercise.
- The outcome of the NICE HTA process is clinical guidance. A technology is assessed and the report used to formulate clinical practice guidelines.
- NICE is developing a process called single technology assessment - assessing a single technology with a single indication in a shorter timeframe.
- The work of HealthPACT and its Horizon scanning could give us more options earlier in the assessment process. MSAC could use reports produced through the Horizon scanning system and consider whether more detail is required.
- ASERNIP-S does a type of rapid review. These assessments of surgical technologies examine safety and effectiveness –but not cost effectiveness - and nearly always conclude that more research is necessary.
- If a technology is being considered for funding, a full HTA is required. If, for example, advice for the Minister was needed on a particular technology not yet assessed by the MSAC, a Horizon scanning report could be done to advise whether a full HTA is required.
- Rapid review could be used for those applications where the total cost to government or the total number of patients involved is very small, where the evidence is limited and trials are not possible.
- The MSAC tends to receive an application when access to reimbursement in the private sector is needed. Some of the technologies that come to MSAC are already diffused through the public health system because the control mechanisms for public hospitals are significantly different to those which apply following an MSAC assessment.
- The Senior Medical Adviser in the Department does some filtering of applications and there are times when the value of a proceeding with a full HTA is uncertain. This committee has only one assessment process - to do full HTA which linked evidence to policy.
- MSAC could consider developing more than one approach that can be used under different sets of circumstances.
- A sub-committee could look at the matter further to see how to progress the issue.

ACTION: Executive to use minutes and the rapid assessments paper as the basis for further discussion with the Department.

6. PROGRESS REPORTS ON APPLICATIONS AND REFERENCES

It was noted that

- Breast MRI is expected to go to the November meeting.
- Double Balloon Enteroscopy – there is a lack of evidence about the safety and efficacy for the comparator laparotomy.
- BNP should be ready for consideration at the November meeting.
- Fetal Fibronectin is also progressing well.
- PET – the new PET review is a standard MSAC review. The issue of funding mechanisms and licences for PET will not be part of the scope of the review.

Dr Blamey then mentioned the **nationally funded centres** work program. He told the committee that Professor Kearney is chairing the Advisory Panel for MSAC and invited him to report on progress.

Professor Kearney indicated that the work is progressing well and that draft assessment reports for all four applications have been received. Site visits are planned for September and October and he anticipates that draft reports will be ready for MSAC consideration in November.

Dr Blamey added that these reports are to inform AHMAC about the issues related to establishing nationally funded centres for the nominated procedures.

Dr Turner proposed that it might be useful for MSAC members to have a one or two page summary for each of the NFC assessments. The NFC process poses slightly different questions to those that are asked in an MSAC HTA. Dr Blamey indicated that this would be helpful to inform MSAC members about the scope of the NFC work.

7. OTHER BUSINESS

7.1 MSAC Review

By way of background Dr Blamey indicated that he had initiated the Review because he was concerned about the consistency of the reports and the report recommendations. He asked Ms Davis-Lee to report on progress.

Ms Davis-Lee gave a verbal report.

7.2 HTAI – Adelaide 2006

The Chair indicated that he was delighted that the Department was so supportive of the Conference and congratulated Professor Kearney on a well organised conference with excellent scientific content.

Professor Kearney thanked Ms Robertson for the financial and Departmental support.

7.3 Horizon Scanning

The Chair reminded the members that the minutes of the most recent Horizon Scanning meeting were provided for information. Professor Kearney indicated that HealthPACT have reported on a number of technologies that may come to MSAC in due course. Of particular interest is the test for Long QT Syndrome, continuous glucose monitoring and the Pillar® procedure for sleep apnoea.

7.4 The ASERNIP-S Management Committee

The Chair noted the report on the ASERNIP-S Management Committee provided by Professor Kearney. Professor Kearney informed members that ASERNIP-S reports that are of interest to MSAC members can be obtained.

Other Issues

Dr Jackson reported on the National Heart Foundation and Cardiac Forum on behalf of Associate Professor Atherton. She explained the aim was to focus attention on variations in State and Territory public hospital systems with regard to provision of sophisticated cardiac devices, the mechanisms for getting high cost cardiac devices into the health system and the need for the development of clinical guidelines.

8. CLOSE

Dr Blamey indicated that the next meeting is to be held in Canberra on 15 November 2006.