
1171

Final Decision
Analytic Protocol to
guide the assessment
of sexual health
medicine professional
attendance and case
conferencing items

June 2012

Table of Contents

- MSAC and PASC 2**
 - Purpose of this document 2
- Summary of key matters for consideration by the applicant 3**
- Purpose of application 5**
- Background 5**
 - Current arrangements for public reimbursement 5
- Intervention 7**
 - Description 7
 - Prerequisites 7
 - Co-administered and associated interventions 8
- Listing proposed and options for MSAC consideration 9**
 - Proposed MBS listing 9
 - Clinical place for proposed intervention 11
- Other relevant considerations 12**
- Clinical claim 13**
- Economic analysis 13**

MSAC and PASC

The Medical Services Advisory Committee (MSAC) is an independent expert committee appointed by the Minister for Health and Ageing (the Minister) to strengthen the role of evidence in health financing decisions in Australia. MSAC advises the Minister on the evidence relating to the safety, effectiveness, and cost-effectiveness of new and existing medical technologies and procedures and under what circumstances public funding should be supported.

The Protocol Advisory Sub-Committee (PASC) is a standing sub-committee of MSAC. Its primary objective is the determination of protocols to guide clinical and economic assessments of medical interventions proposed for public funding.

Purpose of this document

This document is intended to provide a decision analytic protocol that will be used to guide the assessment of an intervention for a particular population of patients.

Protocols guiding the assessment of the health intervention are typically developed using the widely accepted “PICO” approach. The PICO approach involves a clear articulation of the following aspects of the question for public funding the assessment is intended to answer:

- Patients** – specification of the characteristics of the patients in whom the intervention is to be considered for use
- Intervention** – specification of the proposed intervention and how it is delivered
- Comparator** – specification of the therapy most likely to be replaced by the proposed intervention
- Outcomes** – specification of the health outcomes and the healthcare resources likely to be affected by the introduction of the proposed intervention

However, as discussed on p.5 below, in the case of sexual health medicine professional attendance and case conferencing items, PASC resolved that the adoption of the standard PICO approach was not appropriate as an assessment focussed on such an approach may be so narrow that it would not be informative to MSAC.

Summary of key matters for consideration by the applicant

The PASC requests that the applicant note the following issues and address these issues in its assessment:

- An assessment report is sought that presents the overall body of evidence that could inform a judgement as to the overall comparative effectiveness, safety and cost-effectiveness of a model of care involving sexual health medicine specialists compared with alternative models of care (e.g., management of patients by GPs only). In addition to considering models of care that differ by provider of medical service, models of care that involve different types of services should also be compared e.g., in this case where both professional attendance and case-conferencing items are sought, a model of care involving only professional attendances should be compared with a model of care that involves both professional attendances and multi-disciplinary case-conferencing activities.
- On the basis of the likely claims of potential clinical equivalence or superiority for the model of care involving sexual health medicine specialists compared with alternate models of care, PASC considered that the assessment report would present either a cost-minimisation or cost-effectiveness analysis, respectively.
- Broader considerations besides the impact on a patient's quality-adjusted survival should be presented in an application requesting the availability of additional sexual health medicine MBS items. For example, workforce issues that may be addressed (and the downstream impact on patient outcomes) by availability of such items could be addressed. Similarly, impacts on factors such as transmission rates of sexually transmitted infections could be reported.
- In addition to a comparison of models of care involving sexual health medicine specialists with alternative models of care, PASC recommended that any assessment presented to MSAC should address a wider set of claims including:
 - What evidence is available to demonstrate that there is unmet need for sexual health medicine specialists in the private sector, in the public sector and overall (e.g., how long does a patient have to wait to see a sexual health medicine specialist; what proportion of patients with sexual health problems in whom the services of a sexual health specialist are indicated do not access such services; has a shortage of supply been identified by other parties such as state health departments, etc)?
 - What evidence is available in relation to the consequences of unmet need (e.g., if a patient has a communicable disease and has to wait to receive treatment, this might translate to increased transmission of the disease)?
 - To what extent is the failure to access sexual health medicine services due to shortage of sexual health medicine specialists (i.e., due to workforce shortage)? To what extent is the failure to access sexual health medicine services due to other factors (e.g., requirement for a referral, fees)?
 - What evidence exists to support the claim that increasing reimbursement for services delivered by sexual health medicine specialists in the private sector results in an increase in supply of sexual health medicine specialists?

- Will an increase in supply of sexual health medicine specialists result in improved access to sexual health medicine services (i.e., expansion in number of patients accessing sexual health medicine services)?
- What evidence is available with respect to the effects of different approaches to funding for the various models of care that are possible? To what extent will increased funding in the private sector cause a transfer of services from the public to the private sector? To what extent will increased funding in the private sector result in an overall increase in expenditure on these services?

FINAL

Purpose of application

An application requesting the listing of four time-tiered professional attendance (consultation) items and six time-tiered case conferencing items on the Medicare Benefits Schedule (MBS), to be provided by sexual health medicine specialists, has been progressed by the Department of Health and Ageing (DoHA) in consultation with the Australasian Chapter of Sexual Health Medicine (AChSHM). The AChSHM initially requested access to a greater number of MBS items than DoHA actually proposed to PASC (e.g. items for complex planning and management were also requested). DoHA considered that the time-tiered and case conferencing items as proposed could potentially be used for such purposes, and AChSHM did not object. PASC did not determine that the application be broadened to include items for complex treatment and management planning, but did not rule out the issue. The applicant is seeking a funding model that reflects contemporary sexual health medicine practice.

PASC noted that the approach of a traditional MSAC HTA assessment would seek to derive estimates of the comparative effectiveness, safety and cost-effectiveness of MBS of the proposed scenario (where four time-tiered professional attendance and six time-tiered case-conferencing items would be available and claimed) versus the current scenario (where currently available specific MBS professional attendance and case-conferencing items are claimed) using the standard MSAC PICO (plus economic evaluation approach). PASC considered that such an approach was not appropriate in this case for two reasons: (i) the approach was too narrow to permit assessment of various claims made by the AChSHM; and (ii) the approach was likely to be unhelpful in informing MSAC about the value of services provided by sexual health medicine specialists because data and evidence to inform such a specific approach were unlikely to be available. For example, there were unlikely to be data to answer the question as to what the health outcomes associated with a funding mechanism involving 4 time-tiered services would be compared with a funding mechanism that had only an initial assessment item and a review item.

Although PASC considered that MSAC would be unlikely to be able to answer a question as to whether it would be preferable to have four time-tiered professional attendance (consultation) items and six time-tiered case conferencing items on the MBS for sexual health medicine specialists, compared with currently available and used items, PASC considered that evidence may be available to permit MSAC to provide advice to the Minister as to the comparative effectiveness, safety and cost-effectiveness of services delivered by sexual health medicine specialists versus alternative models of care (e.g., management of patients by GPs only) i.e., evidence was likely to be available to permit MSAC to determine a response to the question as to whether dedication of resources to this specialty was worthwhile in a general sense. PASC agreed that the final DAP should reflect this approach.

Background

Current arrangements for public reimbursement

There are currently no specific sexual health medicine professional attendance or case conferencing items available on the MBS.

Sexual health medicine was recognised as a speciality in 2009 by the Australian Medical Council. It was reported to PASC that there are currently approximately 115 sexual health medicine specialists in Australia and that a minority of sexual health medicine practice is provided in the private setting.

In the 2010/11 Federal Budget, sexual health medicine specialists were granted access to the Group A3 specialist items on the MBS. Medicare data as of 26 October 2011 indicate that 23 sexual health medicine specialists had registered to use A3 specialist attendance items. The large majority of sexual health medicine specialists have not registered with Medicare because they prefer to seek Medicare reimbursement for their services in their capacities as GPs, other medical practitioners, etc, as below, rather than through items included in A3 of the MBS. It is suggested that this decision appears to be influenced by the fact that, given the mode of practice used to deliver sexual health medicine services, the A1, A2, and A15 item structures provide a higher level of remuneration than the A3 item structure. Reimbursement for services is currently claimed under the following groups of MBS services:

- **GROUP A1 – GENERAL PRACTITIONER PROFESSIONAL ATTENDANCES**

Figures provided by the AChSHM indicate that 19% of sexual health medicine specialists hold Fellowship of the Royal Australian College of General Practitioners and are able access to this group of items.

- **GROUP A2 – OTHER MEDICAL PRACTITIONER PROFESSIONAL ATTENDANCES**

Sexual health medicine specialists who are non-vocationally registered GPs, specialist trainees or other medical practitioners and are able access to this group of items.

- **GROUP A3 – SPECIALIST PROFESSIONAL ATTENDANCES**

March 2011 data indicate that only two medical practitioners have registered with Medicare Australia as sexual health medicine specialists.

- **GROUP A4 – CONSULTANT PHYSICIAN PROFESSIONAL ATTENDANCES**

Figures provided by the AChSHM indicates that 10% of sexual health medicine specialists hold Fellowship of the Royal Australasian College of Physicians (RACP) and are able to access to this group of items.

- **GROUP A8 – CONSULTANT PSYCHIATRIST PROFESSIONAL ATTENDANCES**

The Chapter has indicated that one sexual health medicine specialist holds a Fellowship of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and would have access to this group of items.

- **GROUP A15 – CASE CONFERENCING**

There are no existing case conferencing items for specialists. However, sexual health medicine specialists who have not registered with Medicare Australia as Group A3 'specialists', and for Medicare purposes are 'GPs', have access to existing Group A15 case conferencing items 721-758. Consultant physicians have access to case conferencing items 820-858; and consultant psychiatrists have access to case conferencing items 861-880.

The proposal notes that the traditional structure of specialist professional attendances (e.g., Groups A3 and A4 of the MBS) provide a more generously rebated item for an initial attendance and a less generously rebated item for a follow-up attendance. The AChSHM argues that the attendance items in this section of the MBS have been available to, and reflect the nature of the practice of, procedural specialists, i.e. those whose practices also involve significant procedural work. The proposal suggests that this traditional structure does not suit discussion-based, cognitive specialties such as sexual health medicine, which rely on time spent with a patient to assess and resolve more complex issues.

The AChSHM claims that the A3 items provide inadequate reimbursement for clinically effective sexual health medicine practice because they are a consulting rather than procedural specialty. Hence, it is proposed that an application be submitted to MSAC requesting listing of four time-tiered professional attendance (consultation) items and six time-tiered case conferencing items on the MBS, to be provided by sexual health medicine specialists.

Intervention

Description

In relation to professional attendance items, a sexual health medicine specialist would, typically, obtain a patient's sexual clinical history, conduct expert examination, order relevant testing, and provide follow-up treatment and management (via a number of consultations, as required).

As initial and follow-up consultations can be either shorter or longer, depending on a patient's needs, time-tiered items have been proposed to enable sexual health medicine specialists to bill the relevant item based on time spent with a patient.

In relation to case conferencing items, it is proposed that these items would only apply to a service in relation to a patient who suffers from at least one medical condition, that has been (or is likely to be) present for at least 6 months, or that is terminal, and has complex needs requiring care from a multidisciplinary team. PASC presumed that a note would be included in the item descriptor for case conferencing items directing physicians to explanatory notes associated with the item that specify these criteria.

The case conferencing items would enable a multidisciplinary team to carry out the following:

- discuss a patient's history;
- identify a patient's multidisciplinary care needs;
- identify outcomes to be achieved by members of the case conference team giving care and service to the patient;
- identify tasks that need to be undertaken to achieve these outcomes, and allocating those tasks to members of the case conference team; and
- assess whether previously identified outcomes (if any) have been achieved.

Prerequisites

REFERRAL

The proposed item descriptors (provided in Table 1) indicate that the patient must be referred for the intervention by a medical practitioner other than the sexual health medicine specialist who is to provide the intervention. The referral process will be in accordance with the MBS G6.1 Referral of Patients to Specialist or Consultant Physician.

ALTHOUGH THE PROPOSED ITEM DESCRIPTORS FOR PROFESSIONAL ATTENDANCES INCLUDE THE REQUIREMENT FOR A REFERRAL FROM A MEDICAL PRACTITIONER, THE PROPOSAL NOTES THAT THE NEED TO OBTAIN A REFERRAL FROM A GP MAY COMPROMISE ACCESS TO TIMELY SEXUAL HEALTH SPECIALIST ADVICE AND TREATMENT.

TRAINING

It is proposed that only qualified sexual health medicine specialists will be able to claim for the delivery of the proposed MBS items.

In order to be accepted into the training program to acquire fellowship of the AChSHM, an applicant must firstly satisfy all three of the following conditions:

- (i) Be a registered medical practitioner in Australia or New Zealand.
- (ii) EITHER hold Fellowship of one of the following Colleges or Faculties:
 - Physicians (FRACP) Adult Internal Medicine or Paediatrics & Child Health
 - Dermatology (FACD)
 - Obstetrics and Gynaecology (FRANZCOG)
 - General Practice (FRACGP and FRNZCGP)
 - Pathology (FRCPA)
 - Psychiatry (FRANZCP)
 - Public health Medicine (FAFPHM)
 - Rural and Remote Medicine (FACRRM)
 - Surgery (FRACS – urology)

OR in the case of overseas trained specialists (including general practitioners) hold a qualification considered equivalent by the relevant Australian or New Zealand medical college

OR have completed Basic Training of the RACP (including success in the FRACP Examination)

- (iii) have a satisfactory practice history (no professional misconduct or disciplinary issues).

Trainees are then expected to complete formal instruction via units in university courses in the following areas:

- Fertility regulation
- Sexual health counselling
- HIV medicine
- Sexual health medicine
- Epidemiology
- Biostatistics
- Sexual assault
- Principles of adult education

The proposal for an application notes that, by requiring fellowship with another accredited medical college and then requiring a further three years advanced training in sexual health medicine, specialists in sexual health medicine in effect train for approximately 10 years.

Co-administered and associated interventions

As noted above, a requirement will be that referral from a medical practitioner be required prior to a professional attendance by a sexual health medicine specialist.

No other specific services are required to be administered prior to, with or following the proposed medical services. However, follow-up services that might need to be rendered following a sexual health medicine service would be discussed during the consultation. A sexual health medicine

specialist may order various pathology tests or diagnostic imaging services during an initial or subsequent consultation for assessment of a patient's status.

Listing proposed and options for MSAC consideration

Proposed MBS listing

The proposed MBS item descriptors are provided in Table 1 (Please note: Items for complex treatment and management planning are not included in this table, as the issue was not resolved at PASC)

Table 1: Proposed MBS item descriptor for proposed sexual health medicine services

Category 1 – Professional attendances	
<u>MBS Item XXX</u>	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an attendance of not more than 15 minutes duration Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA
<u>MBS Item XXX</u>	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an attendance of more than 15 minutes, but not more than 30 minutes duration Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA
<u>MBS Item XXX</u>	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an attendance of more than 30 minutes, but not more than 45 minutes duration Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA
<u>MBS Item XXX</u>	Professional attendance by a sexual health medicine specialist in the practice of his or her specialty, following referral of the patient to him or her by a medical practitioner - an attendance of more than 45 minutes duration Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA
Case conferencing items	
<u>MBS Item XXXX</u>	CASE CONFERENCES - SEXUAL HEALTH MEDICINE SPECIALIST Attendance by a sexual health medicine specialist, as a member of a case conference team, to ORGANISE AND COORDINATE A CASE CONFERENCE , where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA
<u>MBS Item XXXX</u>	Attendance by a sexual health medicine specialist, as a member of a case conference team, to ORGANISE AND COORDINATE A CASE CONFERENCE , where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines (Fee: \$TBA Benefit: 75% = \$TBA 85% = \$TBA)

Table 1: Proposed MBS item descriptor for proposed sexual health medicine services

Category 1 – Professional attendances		
<u>MBS Item XXXX</u>		
Attendance by a sexual health medicine specialist, as a member of a case conference team, to ORGANISE AND COORDINATE A CASE CONFERENCE , where the conference time is at least 45 minutes, with a multidisciplinary team of at least three other formal care providers of different disciplines		
Fee: \$TBA	Benefit: 75% = \$TBA	85% = \$TBA
<u>MBS Item XXXX</u>		
Attendance by a sexual health medicine specialist, as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is at least 15 minutes, but less than 30 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines		
Fee: \$TBA	Benefit: 75% = \$TBA	85% = \$TBA
<u>MBS Item XXXX</u>		
Attendance by a sexual health medicine specialist, as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is at least 30 minutes, but less than 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines		
Fee: \$TBA	Benefit: 75% = \$TBA	85% = \$TBA
<u>MBS Item XXXX</u>		
Attendance by a sexual health medicine specialist, as a member of a case conference team, to PARTICIPATE IN A CASE CONFERENCE , (other than to organise and to coordinate the conference) where the conference time is at least 45 minutes, with a multidisciplinary team of at least two other formal care providers of different disciplines		
Fee: \$TBA	Benefit: 75% = \$TBA	85% = \$TBA

TBA = to be advised. Fees will be calculated based on cost inputs for time-based professional attendances.

Although the proposed item descriptors do not specify the patient population to whom the items may be delivered, PASC considered it reasonable to assume that a sexual health medicine specialist would only be attending to patients with sexual health problems. However, it noted that patients requiring the services of a sexual health medicine specialist are a heterogeneous group. PASC agreed that no specification of the patient population to whom the items may be delivered needs to be included in the MBS item descriptors.

As discussed on p.5, PASC resolved that the traditional MSAC HTA assessment approach, which would seek to derive estimates of the comparative effectiveness, safety and cost-effectiveness of MBS of the proposed scenario (where four time-tiered professional attendance and six time-tiered case-conferencing items would be available and claimed) versus the current scenario (where currently available specific MBS professional attendance and case-conferencing items are claimed), was not appropriate for two reasons: (i) the approach was too narrow to permit assessment of various claims made by the AChSHM; and (ii) the approach was likely to be unhelpful in informing MSAC about the value of services provided by sexual health medicine specialists because data and evidence to inform such a specific approach were unlikely to be available. For example, there were unlikely to be data to answer the question as to what the health outcomes associated with a funding mechanism involving 4 time-tiered services would be compared with a funding mechanism that had only an initial assessment item and a review item. Although PASC considered that MSAC would be unlikely to be able to answer a question as to whether it would be preferable to have four time-tiered professional attendance (consultation) and six time-tiered case conferencing items on the Medicare Benefits Schedule (MBS)

for sexual health medicine specialists compared with the currently available and used items, PASC considered that evidence may be available that would permit MSAC to provide advice to the Minister as to the comparative effectiveness, safety and cost-effectiveness of services as delivered by sexual health medicine specialists versus alternative models of care for patients (e.g., management of patients by GPs) i.e., evidence was likely to be available to permit MSAC to determine a response to the question as to whether dedication of resources to this specialty was worthwhile in a general sense.

Thus, PASC resolved that the “intervention” should be more broadly defined than as proposed above. PASC resolved that it would be appropriate for an assessment report to present the overall body of evidence that could inform a judgement as to the overall comparative effectiveness, safety and cost-effectiveness of a model of care involving sexual health medicine specialists compared with other potential models of care (e.g., management of patients by GPs or management of patients by consultant physicians). In addition to considering models of care that differ by provider of medical service, models of care that involve different types of services should also be compared e.g., in this case where both professional attendance and case-conferencing items are sought, a model of care involving only professional attendances should be compared with a model of care that involves both professional attendances and multi-disciplinary case-conferencing activities.

Due to the wide range of reasons patients may consult a sexual health medicine specialist, and in recognition that the strength of evidence for some sexual health conditions may be better than for other sexual health conditions, PASC recommended that the overall body of evidence should be presented in a systematised manner so that evidence for similar conditions is presented together. For example, at the highest level, services delivered to patients could be classified on the basis as to whether the patient has presented with a communicable or a non-communicable disease. Further breakdown of the evidence could be possible. For example, services delivered to patients presenting with a communicable disease could be classified on the basis as to whether the patient has a blood borne or non-blood borne communicable disease; and services delivered to patients presenting with a non-communicable disease could be presented separately depending on whether the patient seeks treatment of dermatoses, sexual function/dysfunction, pain syndromes, reproductive health services, etc. It was important, however, that the number of classifications remained limited so that conclusions could be drawn that could be considered applicable to other sexual health conditions where the evidence was more limited.

Clinical place for proposed intervention

Patients of sexual health medicine include people of all ages who suffer from any type of sexual health disorder. Sexual health medicine involves the assessment, diagnosis and treatment of a variety of sexual-related diseases and symptoms (e.g. HIV and other sexually transmitted diseases; genital pain; sexual function; and skin problems). Sexual health specialists manage a range of complex medical and other issues with patients. It is claimed that access to specialists ensures patients are exposed to greater expertise than otherwise would be available. Benefits flow to partners, families and the community as a whole.

The proposal for an application indicates that the clinical place for a professional attendance by a sexual health medicine specialist occurs at the point at which a general practitioner makes a clinical judgement that such an attendance is necessary.

Other relevant considerations

In considering comments received on the Consultation DAP, PASC noted that the fundamental claim made by sexual health medicine specialists is that the current MBS rebate structure are insufficient to support a viable private practice specialising in sexual health medicine.

PASC noted that the fundamental objective of the MBS was not to provide a remuneration system for health practitioners but, instead, the MBS is a public subsidy system intended to ensure that Australian public have equitable access to effective, safe and cost-effective medical services. However, PASC acknowledged that, if a model of care involving sexual health medicine specialists, provided incremental health benefits at a reasonable incremental cost compared to other models of care, and if there was currently a shortage of sexual health medicine specialists such that patients requiring such care were unable to receive it, then expansion of the number of services provided by sexual health medicine specialists in the private sector would be desirable.

In addition to a comparison of models of care involving sexual health medicine specialists with alternative models of care, PASC recommended that any assessment presented to MSAC should address a wider set of claims including:

- What evidence is available to demonstrate that there is unmet need for sexual health medicine specialists in the private sector, in the public sector and overall (e.g., how long does a patient have to wait to see a sexual health medicine specialist; what proportion of patients with sexual health problems in whom the services of a sexual health specialist are indicated do not access such services; has a shortage of supply been identified by other parties such as state health departments, etc)?
- What evidence is available in relation to the consequences of unmet need (e.g., if a patient has a communicable disease and has to wait to receive treatment, this might translate to increased transmission of the disease)
- To what extent is the failure to access sexual health medicine services due to shortage of sexual health medicine specialists (i.e., due to workforce shortage)? To what extent is the failure to access sexual health medicine services due to other factors (e.g., requirement for a referral, fees)?
- What evidence exists to support the claim that increasing reimbursement for services delivered by sexual health medicine specialists in the private sector results in an increase in supply of sexual health medicine specialists?
- Will an increase in supply of sexual health medicine specialists result in improved access to sexual health medicine services (i.e., expansion in number of patients accessing sexual health medicine services)?
- What evidence is available with respect to the effects of different approaches to funding for the various models of care that are possible? To what extent will increased funding in the private sector cause a transfer of services from the public to the private sector? To what extent will

increased funding in the private sector result in an overall increase in expenditure on these services?

Clinical claim

PASC anticipated that an application considering the comparative effectiveness, safety and cost-effectiveness of a model of care involving sexual health medicine specialists with alternative models of care would claim that:

- Patients who are managed by a model of care involving delivery of services by a sexual health medicine specialist experience either equivalent or superior quality-adjusted survival compared to patients managed by alternative models of care.
- Appropriate funding (via the listing of the proposed items) for services provided by sexual health medicine specialists is likely to create a financial incentive for sexual health medicine specialists to provide additional services to patients in the private sector and this will have a positive impact to the community overall.

In relation to the outcomes that should be used to judge the effectiveness of various models of care, PASC noted that, ultimately, quality-adjusted survival would be the appropriate metric to consider. PASC thus advised that studies reporting outcomes that had an impact on a patient's quality-adjusted survival would be relevant for presentation in an application. PASC agreed that the outcomes such as rate of recurrence of infection, prevention of serious sequelae, effect of successful contact tracing, relief of psychological symptoms through treatment of erectile dysfunction were examples of outcomes that could either directly or indirectly be shown to have an impact on quality-adjusted survival.

Economic analysis

On the basis of the likely claims of potential clinical equivalence or superiority for the model of care involving sexual health medicine specialists compared with alternative models of, PASC considered that the assessment report would present either a cost-minimisation or cost-effectiveness analysis, respectively.

An appropriate economic analysis could also incorporate costs and benefits associated with transfer of services delivered under the public system to the private system and also costs and benefits associated with expansion of availability of sexual health medicine services through the MBS. Estimates of transfer rates should be supported with evidence.

Broader considerations besides the impact on a patient's quality-adjusted survival should be presented in an application requesting the availability of sexual health medicine MBS items. For example, as discussed in the previous paragraph, workforce issues that may be addressed by availability of such items could be addressed. Similarly, if, for example, a claim is made that provision of services by sexual health medicine specialists will result in reduced transmission of certain infections, then there will need to be a consideration of these impacts.