



Australian Government

**Medical Services Advisory Committee**

## Public Summary Document

### ***Application 1180r – Review of items for the surgical treatment of obesity***

**Date of MSAC consideration: 54th MSAC meeting, 29-30 November 2011**

#### **1. Purpose of application**

The review of Medicare Benefits Schedule (MBS) items for the surgical treatment of obesity commenced as a demonstration review in mid-2010 under the MBS Quality Framework.

The department contracted Deloitte Access Economics (formerly Access Economics) to conduct the review of existing MBS items for the surgical treatment of obesity.

The review considers surgical interventions for the treatment of obesity, including adjustable gastric banding (AGB); vertical banded gastroplasty (VGB); sleeve gastrectomy (SG); Roux-en-Y gastric bypass (RYGB); and biliopancreatic diversion (BPD) with or without duodenal switch (BPD-DS).

The review covered existing MBS items 14215, 30511, 30512, 30514, 30518 and 31441.

Obesity is a disease in which fat has accumulated to the point where health is impaired, defined in the review report as a body mass index (BMI) of over 30 kg/m<sup>2</sup> for adults and for children and adolescents aged 2 to 18 years, a set of age-gender specific BMI thresholds.

Clinically severe obesity is a condition generally defined as BMI  $\geq$  40 kg/m<sup>2</sup>, or between 35 kg/m<sup>2</sup> and 40 kg/m<sup>2</sup> where there are other major medical conditions such as high blood pressure and diabetes.

#### **2. Background**

In the 2009 Budget, the Australian Government funded a two-year evidence-based framework for managing the MBS through the measure *Medicare Benefits Schedule – A quality framework for reviewing services (MBS Quality Framework)*. A key component of the MBS Quality Framework was to implement a systematic approach to reviewing existing MBS items to ensure they reflect contemporary evidence, offer improved health outcomes for patients and represent value for money.

In the 2011 Budget a further 2 years' funding was allocated to the Comprehensive Management Framework for the MBS (CMFM). Under the CMFM, rolling reviews of the quality, safety and fee levels of existing MBS items will be undertaken to examine the evidence of the clinical quality and appropriateness of existing MBS items and MBS fees in order to maximise health outcomes for patients. Under these arrangements, MSAC provides advice to the Minister for Health on the outcome of reviews.

This review is one of four demonstration reviews initiated under the MBS Quality Framework. Each demonstration review has been conducted in two stages: (1) the development of the review protocol, and (2) the evidence-based evaluation in line with the agreed protocol. The protocol development, evidence collection and review report have been undertaken by external consultants. The protocols and review reports have both undergone public consultation.

Each review was supported by a clinical working group (CWG), made up of a group of expert advisors with experience relevant to the MBS services being reviewed. The role of the CWG was to:

- provide clinical input to an evaluator, particularly in relation to specific clinical questions that formed the direction for the review, as documented in the draft review protocol; and
- ensure that the review reflected an understanding of current Australian clinical practice and drew valid conclusions from the available evidence as documented in the draft review reports.

To meet MSAC requirements, all future reviews will need to seek MSAC Protocol Advisory Subcommittee (PASC) agreement to the protocol before progressing to the evidence assessment. See Section 8 for PASC comment on the established review protocol for the review. PASC comment has been obtained to inform the alignment of MBS Quality Framework processes with MSAC processes under the CMFM.

### **3. Prerequisites to implementation of any funding advice**

The review report concluded that:

- ideally, bariatric surgery should be performed by a surgeon who has substantial experience, performs bariatric surgeries frequently (50–100 cases per year), operating in properly equipped, high volume weight loss centres (>100 cases per year) with integrated and multidisciplinary treatment, as there is a steep learning curve associated with bariatric surgery and experience reduces operative mortality; and
- further consideration should be given to the merits of allowing suitably trained and qualified staff, such as practice nurses, nurse practitioners, physician assistants and residents, to adjust gastric bands under the supervision of a medical practitioner. The medical practitioner under whose supervision the adjustment is provided would retain responsibility for the health, safety and clinical outcomes of the patient.

### **4. Proposal for public funding**

Obesity rates in Australia present one of the greatest population health challenges. Epidemiological data on prevalence and demographic data from the Australian Bureau of Statistics indicate that, in 2008, 3.71 million Australians (17.5% of the population) were obese, and by 2025 this is projected to increase to 4.6 million Australians (18.3% of the population).

Downstream effects of obesity (from associated diabetes, cardiovascular disease, cancers and osteoarthritis) impacts on the MBS, health system expenditures, productivity and other impacts, with the financial costs of obesity totalling around \$8.3 billion in 2008. MBS expenditure on the six items considered as part of the review has increased from \$6.3 million in 2005 to \$19.3 million in 2009.

The review of an area of increasing cost to the MBS, and for a treatment option for an increasingly important medical condition was undertaken to ensure MBS funding reflected contemporary evidence, represented value for money and offered improved health outcomes.

Consideration of the input costs for fees for the obesity surgery MBS items were not in the review's scope.

### MBS items reviewed

MBS item	Item description
14215	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, accessing of to add or remove fluid ( <i>for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band</i> )
30511	MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.)
30512	MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.)
30514	MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) MBS Explanatory Note T.8.19*
30518	PARTIAL GASTRECTOMY (Anaes.) (Assist.)
31441	LONG-TERM IMPLANTED RESERVOIR associated with the adjustable gastric band, repair, revision or replacement of (Anaes.)

Some of these MBS items include a range of different procedures, for example:

- item 30511 includes LAGB, VBG and SG; and
- item 30512 includes RYGB and BPD-DS.

On the other hand, for some procedures, various item numbers may be used. For example given the ambiguity of some of the MBS item descriptors SG is likely to have been claimed against item 30511 (as above) or item 30518. The complexity of the MBS data does not permit breakdown of items into specific types of surgical procedure, nor enable a reclassification of items. A key aim of the stakeholder consultations and literature review was to determine the extent to which each of these procedures is performed in Australia and which MBS items against which they are likely to have been claimed.

Bariatric surgery in adolescents is not recommended for:

- children under the age of 14 years;
- pregnant or breastfeeding adolescents;
- patients with significant cognitive disabilities;
- patients with untreated or untreatable psychiatric or psychological disorder; or
- patients with Prader-Willi syndrome or other similar hyperphagic conditions.

In Australia, bariatric surgery is recommended for adults with a BMI > 40kg/m<sup>2</sup> or with a BMI > 35kg/m<sup>2</sup> and serious medical co-morbidities who have instituted but failed adequate non-operative measures for weight loss with integrated components of a dietary regimen, appropriate exercise, and behaviour modification and support.

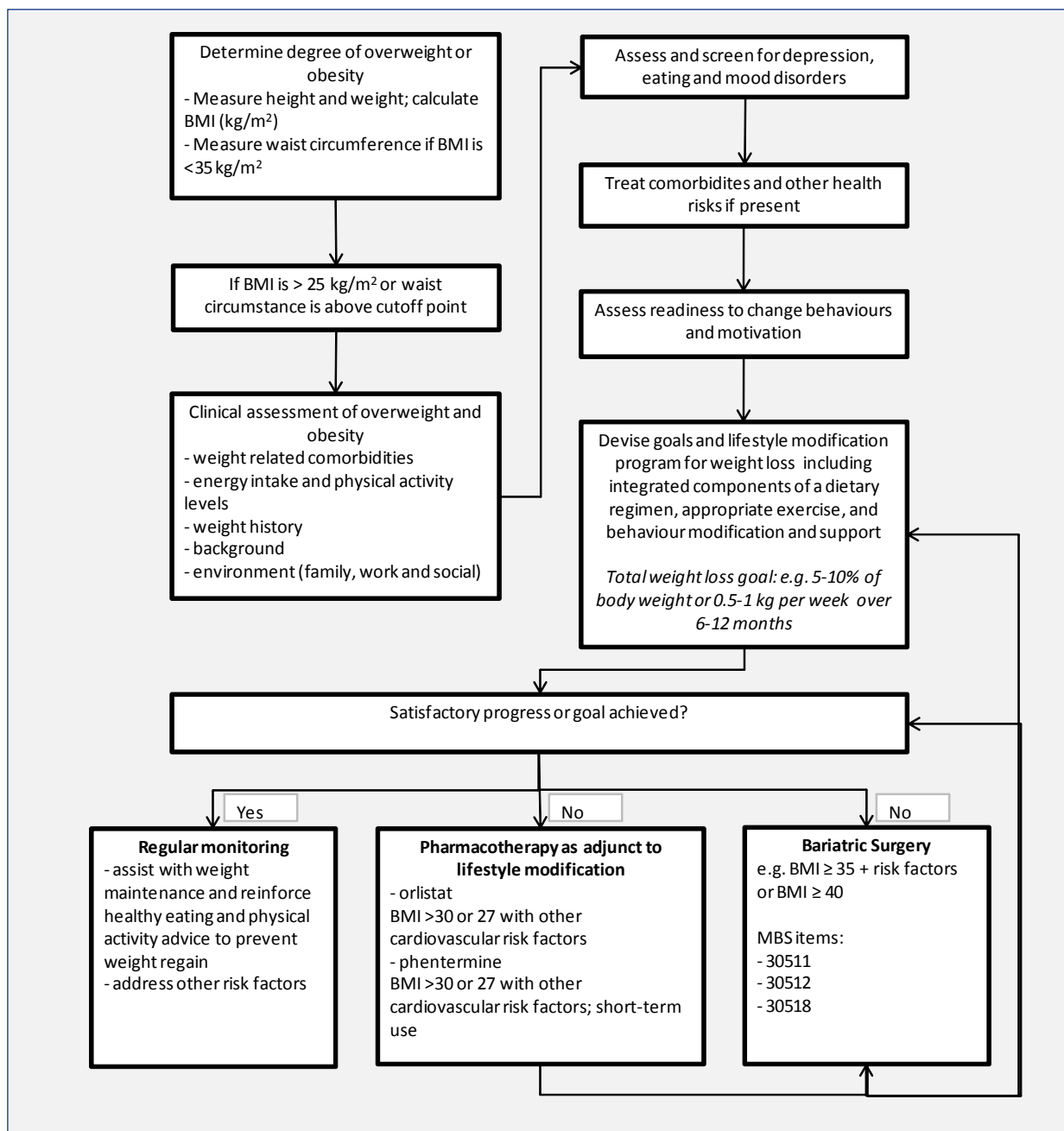
Surgery for adolescents (15 to 18 years old, and in exceptional circumstances at age 14) is only recommended in circumstances involving appropriate pre-operative education and post-operative follow-up, long-term multidisciplinary care, and adequate engagement of the young person and the family. There are certain other patient subgroups for whom bariatric surgery is not recommended – for example, patients with significant cognitive disabilities and patients with untreated or untreatable psychiatric or psychological disorders.

## 5. Consumer Impact Statement

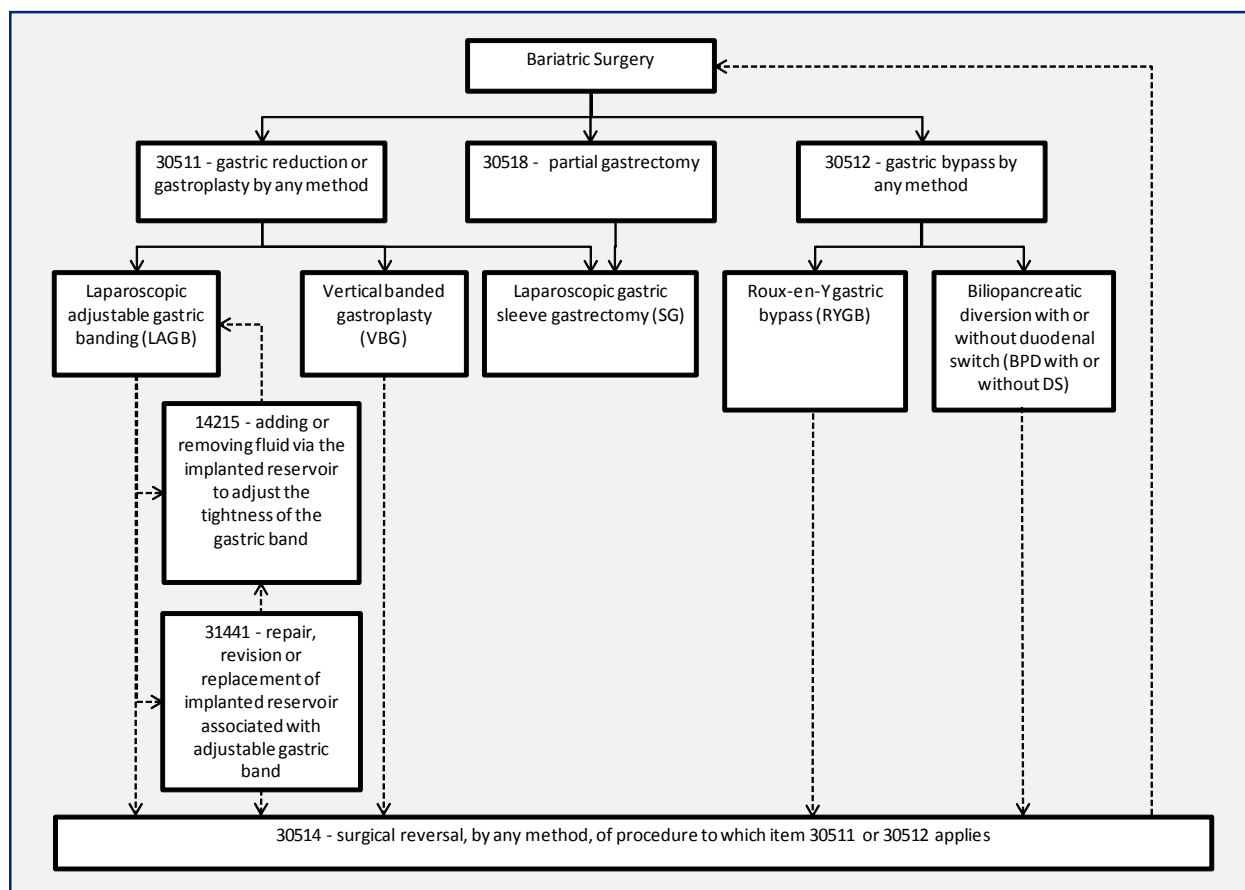
The Consumers Health Forum of Australia welcomed the review report, but made no specific comments on the report's conclusions other than recommending that the report be made 'more consumer-friendly'.

## 6. Proposed intervention's place in clinical management

### Clinical decision pathway for the management of the overweight or obese person



## Flowchart of patient pathway through MBS items under review



Source: CWG. Dotted line indicates 'if required'. Note: Roux-en-Y gastric bypass (RYGB) includes open and laparoscopic RYGB with or without duodenal switch.

## 7. Other options for MSAC consideration

In February 2011, the Protocol Advisory Sub Committee (PASC), as part of the alignment of future reviews into MSAC processes, considered the final protocol, which had been released for public consultation, and observed that the protocol's flowcharts did not necessarily reflect all healthcare resources involved in the procedure both before and after the interventions which are the subject of the review; and the protocol did not address possible risk that while some surgeons see surgery as a definitive option, the follow up costs had not been fully considered.

PASC also made the general observation that access to data on associated MBS items related to surgical MBS items, and a process to distinguish within MBS items the particular clinical need for the procedures in order to determine which patients have undergone the procedure and the actual resources they have received is in ongoing development.

As the Demonstration Reviews were also testing different review methodologies initiated under the MBS Quality Framework, the review protocol was not revised after PASC's consideration. PASC's comments will however inform the alignment of Reviews with MSAC processes as will comment from MSAC's Evaluation Subcommittee (ESC) and MSAC itself.

## **8. Comparative safety**

MSAC considered the evidence regarding safety and clinical effectiveness of the primary procedures outlined in the report, but found there was limited information available on the comparative effectiveness and safety of the procedures. The report considered five main surgical approaches: gastric banding; gastroplasty (mainly VGB); gastric bypass (mainly RYGB); biliopancreatic diversion (BPD); biliopancreatic diversion with duodenal switch (BPD-DS) and sleeve gastrectomy (SG).

## **9. Comparative effectiveness**

MSAC agreed that, compared to other interventions, surgery is more effective in the longer term than non-surgical treatment of obesity and is associated with more acceptable levels of morbidity and mortality in correctly selected patients and in the hands of experienced surgeons..

## **10. Economic evaluation**

The review was to consider whether the approach to surgical treatment of obesity and the items as currently listed on the MBS offer value for money in achieving health outcomes against contemporary evidence. Conclusions reached by the review report's authors from the economic literature review include:

- Most economic evaluations of bariatric surgery for obesity have been published since 2005 and evaluated LAGB and gastric bypass. Importantly, there is a lack of well-performed Australian studies and cost-utility analyses. There is limited economic evidence for VBG; however, published data suggest more recently developed surgical techniques are cost effective when compared with VBG.
- Bariatric surgery for obesity is universally reported to be cost effective compared with no surgery even across extensive deterministic and probabilistic sensitivity analyses. Many studies show surgery to be cost saving after several years, although the scope of costs in these studies should be carefully considered.
- On balance, surgery appears to be more cost effective in women and younger people (due to greater life expectancy over which benefits accrue), and people with higher BMIs and co-morbidities such as diabetes (in whom surgery makes the greatest clinical difference). Surgery is also more cost effective in people with newly diagnosed diabetes compared with established diabetes (at least two years since diagnosis).
- Generally, lower incremental cost-effectiveness ratios are reported for LAGB than for bypass, when compared with no surgery. However, the cost effectiveness of one procedure versus another should only be compared using the incremental costs and benefits for one procedure versus another procedure, and within the same study to control for other factors.
- When compared directly, bypass appears cost effective relative to banding (or banding is not cost effective relative to bypass) with a favourable cost for the additional clinical benefits. However, this outcome may in part be driven by the underlying data since there are (a) a lack of head-to-head study data, and (b) a lack of evidence on long term outcomes for banding.
- Laparoscopic bypass appears to be cost effective compared with open bypass, assuming similar outcomes, since savings in complication costs outweigh any additional procedure costs. From an economic viewpoint, laparoscopic bypass should potentially be used over open bypass unless laparoscopic procedures are contra-indicated in the patient or conversion is required during surgery.

MSAC noted that bariatric surgery was not necessarily cost-effective in the short-term, but was over long term follow-up. Laparoscopic RYGB was more cost effective than open RYGB. MSAC also noted that it was very difficult to conclude which procedure was the most cost-effective as studies used different time periods in comparing the outcomes of the procedures and few studies compared the different procedures directly.

**Summary of review report's key conclusions for obesity surgery items**

Item no	Current descriptor	Possible change
30511	<p>MORBID OBESITY, gastric reduction or gastroplasty for, by any method (Anaes.) (Assist.)</p> <p>Fee: \$817.35</p>	<p>Split into four separate items for:</p> <ul style="list-style-type: none"> <li>▪ Adjustable gastric banding (AGB) by laparoscopy;</li> <li>▪ AGB by open surgery;</li> <li>▪ Vertical banded gastroplasty (VGB) by laparoscopy;</li> <li>▪ VGB by open surgery.</li> </ul> <p>'Gastric reduction' re-named 'adjustable gastric banding'.</p> <p>VGB is potentially an obsolete procedure so could be removed in the future.</p>
30512	<p>MORBID OBESITY, gastric bypass for, by any method including anastomosis (Anaes.) (Assist.)</p> <p>Fee: \$1,005.80</p>	<p>Split into four separate items for:</p> <ul style="list-style-type: none"> <li>▪ Gastric bypass by laparoscopy;</li> <li>▪ Gastric bypass by open surgery;</li> <li>▪ Biliopancreatic diversion (BPD), with or without duodenal switch (DS) by laparoscopy;</li> <li>▪ BPD or BPD-DS by open surgery.</li> </ul>
30518	<p>PARTIAL GASTRECTOMY (Anaes.) (Assist.)</p> <p>Fee: \$950.10</p>	<p>Specify the type of gastrectomy operation and the surgical indication:</p> <ul style="list-style-type: none"> <li>▪ create a unique item number for sleeve gastrectomy (SG) for treatment of obesity, or</li> <li>▪ 30518 should be respecified so that it is for treatment of obesity only.</li> </ul>
30511 and 30512		<p>Consideration be given to splitting all relevant MBS items for obesity surgery (currently items 30511 and 30512) into separate items for laparoscopic and open procedures, to ensure consistency with other MBS items.</p> <p>See above</p> <p>Consider replacing term 'MORBID OBESITY' with 'clinically severe obesity' and redefine in terms of BMI (+/-presence/absence of specific comorbidities)</p>
30514	<p>MORBID OBESITY, surgical reversal, by any method, of procedure to which item 30511 or 30512 applies (Anaes.) (Assist.) MBS</p> <p>Fee: \$1,480.80</p>	<p>Indicate type of reversal in code</p>

## **11. Financial/budgetary impacts**

From 2005–06 to 2009–10, 506,264 MBS surgical obesity services were claimed; more than 97% were claimed under just two items: item 14215 (gastric band adjustments) formed 87% of the total, and item 30511 (which includes LAGB, VBG and SG procedures) 10.1%.

MBS expenditure for the six items over the same period had growth rates averaging well over 30% a year, more than tripling growth rates in total MBS expenditures. In current dollar terms, expenditure on the six items increased from \$6.3 million in 2005 to \$19.3 million in 2009.

The downstream impacts of obesity (diabetes, cardiovascular disease, cancers and osteoarthritis) affect other MBS items and health system expenditures. The total financial costs of obesity in Australia in 2008 were estimated to be \$8.3 billion. Of these costs, the Australian Government bears over one-third (34.3% or \$2.8 billion per annum), and state governments 5.1%.

Hiatus hernia repairs—to reduce rates of complications such as reflux post surgery—are performed in about 25 to 50 per cent of patients undergoing surgery.

MSAC noted that:

- financial and budgetary impacts were not outlined in the report. There was a big growth in services over the last five years from (55,000 in 2005 to 147,000 in 2009) and there has been a recent decline in claims for MBS item 30511 (gastric reduction or gastroplasty by any method);
- the report did not cover future trends analysis (ie expected patient numbers, procedures and costs per year were not estimated);
- the report did not advise on the effect of increasing BMI in the population on the number and mix of procedures in the future, nor the possible effect should the BMI threshold for surgery change.
- while MBS item 30511 has continued to decline in the last year; band adjustments and reversals are increasing. MSAC felt it would have been useful to have information on why the number of reversal and maintenance procedures were increasing;
- the economic analysis mainly compares surgery versus non surgery, and there was no information on the use of bariatric procedures in public hospitals (only 5% are performed in public hospitals for MBS item 30511); and
- equity was not considered, yet volume of procedures in private hospitals suggested that this is a substantive issue.

## **12. MSAC key issues**

MSAC members discussed and noted the following:

- there was limited information available on:
  - comparative cost-effectiveness of the procedures;
  - laparoscopic gastric sleeve gastrectomy because it is a relatively new approach for obesity;
  - a review of the schedule fees was not undertaken as part of this review, but MSAC noted ESC comments on the value of seeing such data including how long each procedure would take;



- longer term laparoscopic adjustable gastric banding outcomes were required; and
- cost-effectiveness analyses should include non-primary procedures (reoperation, adjustment and surgical reversal);
- the review does not report fully on the projected use/costs into the future, the appropriateness of use, and equity;
- there were numerous out-of-pocket expenses for surgery and approximately 95% of patients are private patients;
- splitting the items may be useful to enable MSAC to see the utilisation trends for each individual procedure, as they are currently claimed under one MBS item.

MSAC agreed that:

- long-term efficacy of laparoscopic gastric sleeve gastrectomy should continue to be reviewed and suggested that it should not be removed from the MBS. It was also suggested that periodic reviews of long term cost-effectiveness of non-primary procedures be undertaken;
- consideration be given to a clinical trial to allow non-medical practitioners, for example practice nurses and nurse practitioners, to adjust gastric bands. The Committee noted that there was no evidence at present to support this practice, which if effective, could substantially reduce costs;
- it is desirable that a register of patients who have undergone bariatric surgery be established. Both MSAC and ESC provided in-principle support to the establishment of such a register subject to seeing a detailed project proposal. Members noted the following difficulties in establishing such a register:
  - if linking of patient data were to occur, it would require express consent;
  - there was the need to look at the competing resources, ie. clinical trials, and how best to use such resources;
  - there is potential that the data provided by a register may be captured more simply and cheaply by more explicitly defining the MBS items;

Members also identified additional information that should be captured which includes the attempted lifestyle changes that patients have undergone before surgery (given that it is a prerequisite to have the surgery), what types of support systems the patient has at the time of the surgery, quality of life at baseline and if there is a reversal of diabetes in patients who have undergone these procedures.

### **13. Other significant factors**

MSAC noted the report's recommendation to re-define the term 'morbid obesity' in terms of BMI/co-morbidities but agreed that it may be too restrictive, inadvertently causing some patients to just miss out on treatment reimbursement through the MBS.

MSAC suggested that splitting the items may be useful to enable MSAC to see the utilisation trends for each individual surgical procedure, as they are currently claimed under one MBS item.

### **14. Summary of consideration and rationale for MSAC's advice**

MSAC considered a review report on bariatric surgery that was originally commissioned under the MBS Quality Framework and has provided the following comment on conclusions reached in the Report regarding MBS items, adolescent patient population, eligibility definitions and future reviews.

MSAC noted the recent commencement of a review by the NHMRC of current clinical guidelines for obesity. Further review of MBS funding in this area may need to be undertaken to consider alignment with best clinical practice once the review of the 2003 NHMRC Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Children and Adolescents has been undertaken (due for completion mid 2012).

MSAC agreed that obesity is a significant population health issue that has implications for both short and with longer term medical issues, in particular the development of diabetes, hypertension, cardiovascular disease, cancer and osteoarthritis. Bariatric surgery provides an opportunity to reduce desire for and actual intake of food, and achieves early and sustained weight loss.

MSAC agreed there is a high clinical need for bariatric surgery which is an important strategy for achieving necessary weight loss and avoidance of the complications of obesity. MSAC agreed that the number and type of interventions have grown, and that existing MBS descriptors do not capture this complexity and may be claimed for other non-bariatric procedures.

MSAC agreed the more invasive procedures such as biliopancreatic diversion and RYGB were generally associated with higher morbidity compared to LABG, but were more likely to be used where the required weight loss was greater. MSAC noted that sleeve gastrectomy is a relatively new procedure and that RYGB was mainly undertaken in the US, but that all primary procedures lacked long term data on health outcomes.

MSAC noted that the associated side effects that may accompany bariatric surgery indicate that surgery should be performed as part of a multidisciplinary approach to best facilitate individual management for improved long term patient health outcomes. MSAC agreed that bariatric surgery should be performed in the context of a multidisciplinary service – with a concentration of surgical experts working not only with physicians, but also with dietitians, exercise physiologists, and psychologists. MSAC considered that these services are best delivered in high volume centres with appropriate credentialing.

MSAC noted that reduction of diabetes in clinically obese patients as a result of receiving bariatric surgery is likely to result in significant cost savings to the health system, but no data were presented in the report supporting this assumption. There was also limited evidence on non-primary procedures such as reoperation, adjustment and surgical reversal to inform a robust cost effectiveness analysis.

MSAC noted that MBS utilisation data were reviewed which showed growth in services from 55,000 patients in 2005 (\$6.3 million) to 147,000 patients in 2009 (\$19.3 million). Use of item numbers is likely to continue to rise because of increases in clinically severe obesity in Australia (from 17.5% of population in 2008 to an estimated 18.3% by 2025 – almost another million people). MSAC considered that the increase in MBS services is likely to be due to an increase in prevalence as well as an increase in awareness of bariatric procedures.

MSAC also noted that between 2005 and 2009 that there has been significant increase in the utilisation of the MBS items considered in the report but noted a lot of this may have been due to claims for MBS item 14215 for adjustment of the lap band. MSAC noted that more recently there appears to be a flattening in utilisation.

MSAC considered that bariatric surgery could be cost-effective in women and younger people due to reduction in downstream costs associated with a longer productive life, as well as cost-effective in those with existing or recently developed morbidities such as diabetes.

### MSAC advice on MBS Items:

MSAC agreed that the current MBS items should be split so that each major category of bariatric surgery can be more easily monitored in terms of utilisation. MSAC advised that doing so would also provide Australian baseline data on VBG given expert opinion and trends that suggest it may be becoming obsolete due to possibly higher revision rates and more disappointing results longer term compared with other procedures. It would be useful to capture utilisation at least in the short term to verify assumptions.

MSAC did not support separate items to distinguish whether surgery was performed via a laparoscopic or an open approach, noting that surgeons would generally choose laparoscopy where possible, and there is no financial benefit to providers to do the open approach (longer hospitalisation and duration of care). MSAC did however note that government may wish to consider whether there is any value in creating a MBS item that explicitly identifies when a laparoscopic procedure converts to an open procedure.

MSAC also suggested the government consider deleting MBS item 14215 (Long-term implanted reservoir associated with the adjustable gastric band, for adding or removing fluid via the implanted reservoir to adjust the tightness of the gastric band). MSAC noted that this is a procedure where costs have grown but it is quite simple, and does not require specialised skill. MSAC also considered that the revision procedure could be included in the lap band item 31441 (Long-term implanted reservoir associated with the adjustable gastric band, repair, revision or replacement of (Anaes.)) rather than separately, so figures are not skewed.

MSAC supported the appropriate use of bariatric surgery in adolescents and noted that there is some evidence of better outcomes in women and younger people. MSAC agreed there was merit in early intervention in adolescents (>15 years after all candidates for surgery have been assessed by a multi-disciplinary team) especially when a family history of obesity and insulin resistance was present.

MSAC agreed that there are issues around the definition of 'morbid obesity' including BMI cut-offs to determine eligibility for surgery and that, in the presence of co-morbidities, surgery should be considered earlier rather than waiting for non-surgical interventions (diet and exercise) to be exhausted. MSAC supported the suggestion that the term *morbid obesity* be replaced by the term *clinically severe obesity*. MSAC considered that some degree of clinical judgement rather than specific BMI or other threshold indicators be considered to reduce the possibility of a perverse incentive for patients to inappropriately gain weight in order to meet threshold levels for access to subsidised treatment.

MSAC also agreed that consideration should be given to a descriptor flexible enough to accommodate differences in threshold measures for BMI due to ethnicity or other factors.

MSAC noted the potential for significant side effects from surgical treatment and variability in long term sustained weight loss.

MSAC noted the relative lack of data included within the report and supported collection of relevant data to inform future review of the safety, clinical effectiveness and cost-effectiveness of current and emerging surgical techniques within the broader approach to management of obesity. MSAC was surprised that there was no Australian registry given the number of cases being undertaken and the useful data that could be recorded through a register.

In particular, while recognising current legal restrictions on government linking MBS and PBS data, MSAC considered that access to linked de-identified MBS and PBS data would inform future reviews by enabling better monitoring of the impact of surgery and reduction in the use of pharmaceuticals (such as insulin or hypertension medicine) especially from those patients with pre existing diabetes mellitus.

## **15. MSAC's advice to the Minister**

After considering the strength of the available evidence in relation to the safety, effectiveness and cost-effectiveness of surgical items to treat obesity, MSAC agreed that bariatric surgery is a valuable intervention that is likely to be cost-effective but long-term data is lacking, especially around the delay or prevention of diabetes. MSAC supports initiatives that will improve the understanding of what procedures are being done and to better define the target groups appropriate for different procedures.

## **16. Context for decision**

This advice was made under the MSAC Terms of Reference.

MSAC is to:

Advise the Minister for Health and Ageing on medical services that involve new or emerging technologies and procedures and, where relevant, amendment to existing MBS items, in relation to:

- the strength of evidence in relation to the comparative safety, effectiveness, cost-effectiveness and total cost of the medical service;
- whether public funding should be supported for the medical service and, if so, the circumstances under which public funding should be supported;
- the proposed Medicare Benefits Schedule (MBS) item descriptor and fee for the service where funding through the MBS is supported;
- the circumstances, where there is uncertainty in relation to the clinical or cost-effectiveness of a service, under which interim public funding of a service should be supported for a specified period, during which defined data collections under agreed clinical protocols would be collected to inform a re-assessment of the service by MSAC at the conclusion of that period;
- other matters related to the public funding of health services referred by the Minister.

Advise the Australian Health Ministers' Advisory Council (AHMAC) on health technology assessments referred under AHMAC arrangements.

MSAC may also establish sub-committees to assist MSAC to effectively undertake its role. MSAC may delegate some of its functions to its Executive sub-committee.

## **17. Linkages to other documents**

MSAC's processes are detailed on the MSAC Website at: [www.msac.gov.au](http://www.msac.gov.au).