

The Australian Health System and HTA

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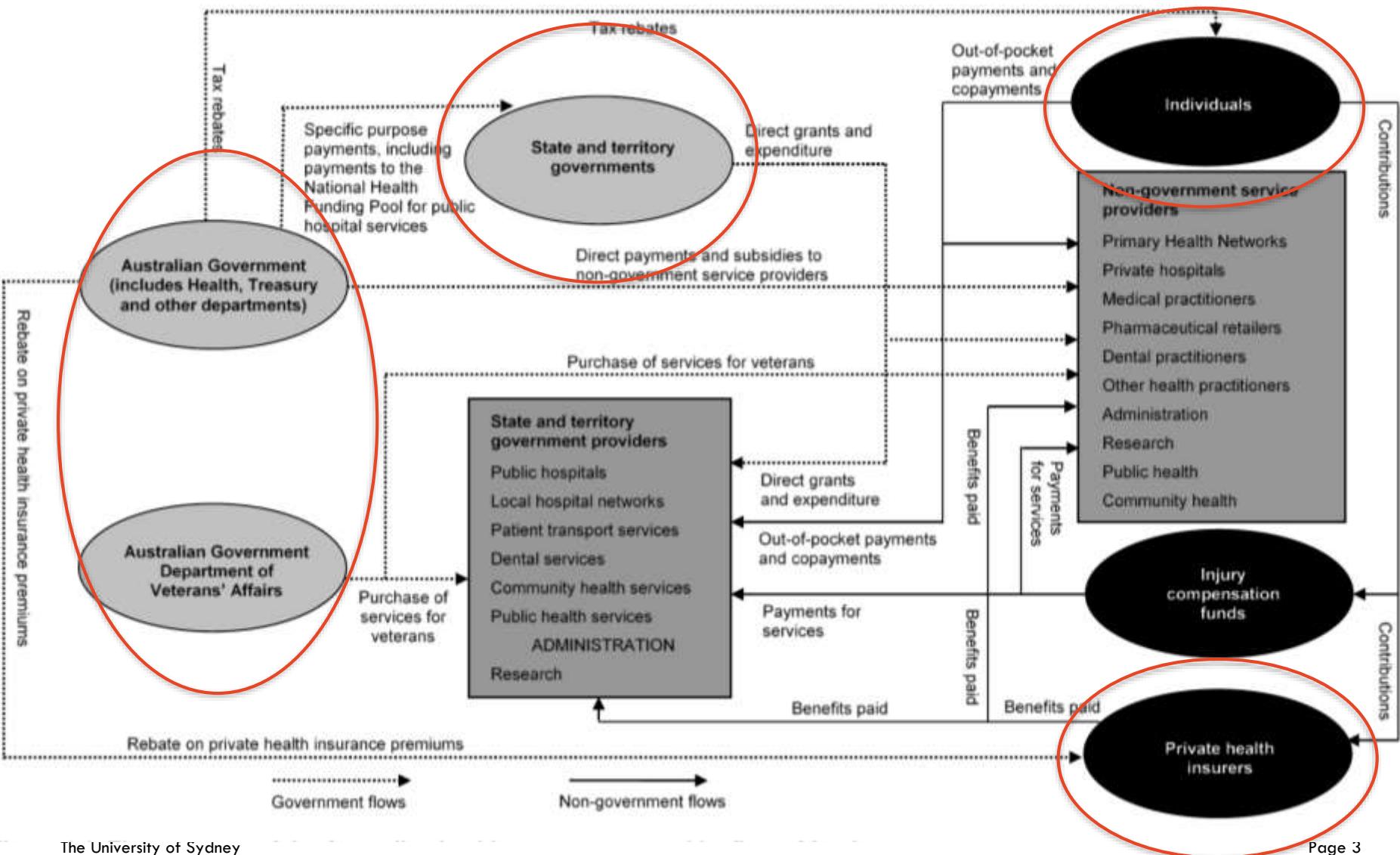
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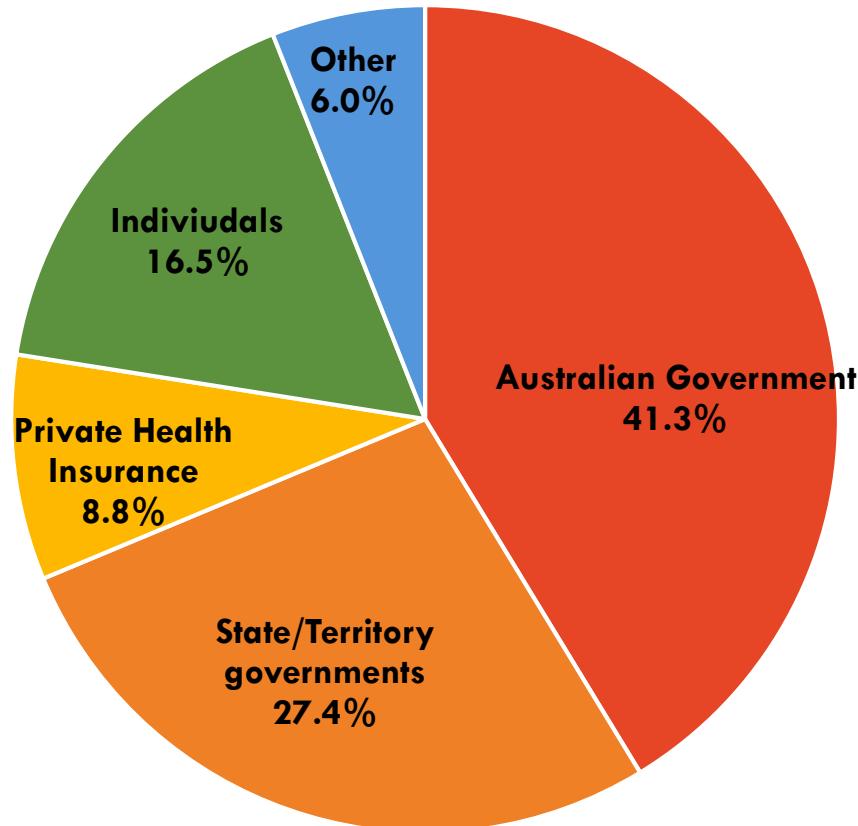
Australia's Health Care System

- Shared Australian Government and state government responsibility reflecting Australia's federal system of government.
- Mixed public and private sector provision of services.
- Universal access for Australian residents (but 20% health expenditure from patient contribution).
- Australia spent \$180.7 billion on health in 2016–17 - 10.3% GDP
- The Australian Government believes this model of private and public health services is integral to the provision of universal access to high quality and affordable health care services for all Australian citizens and permanent residents.

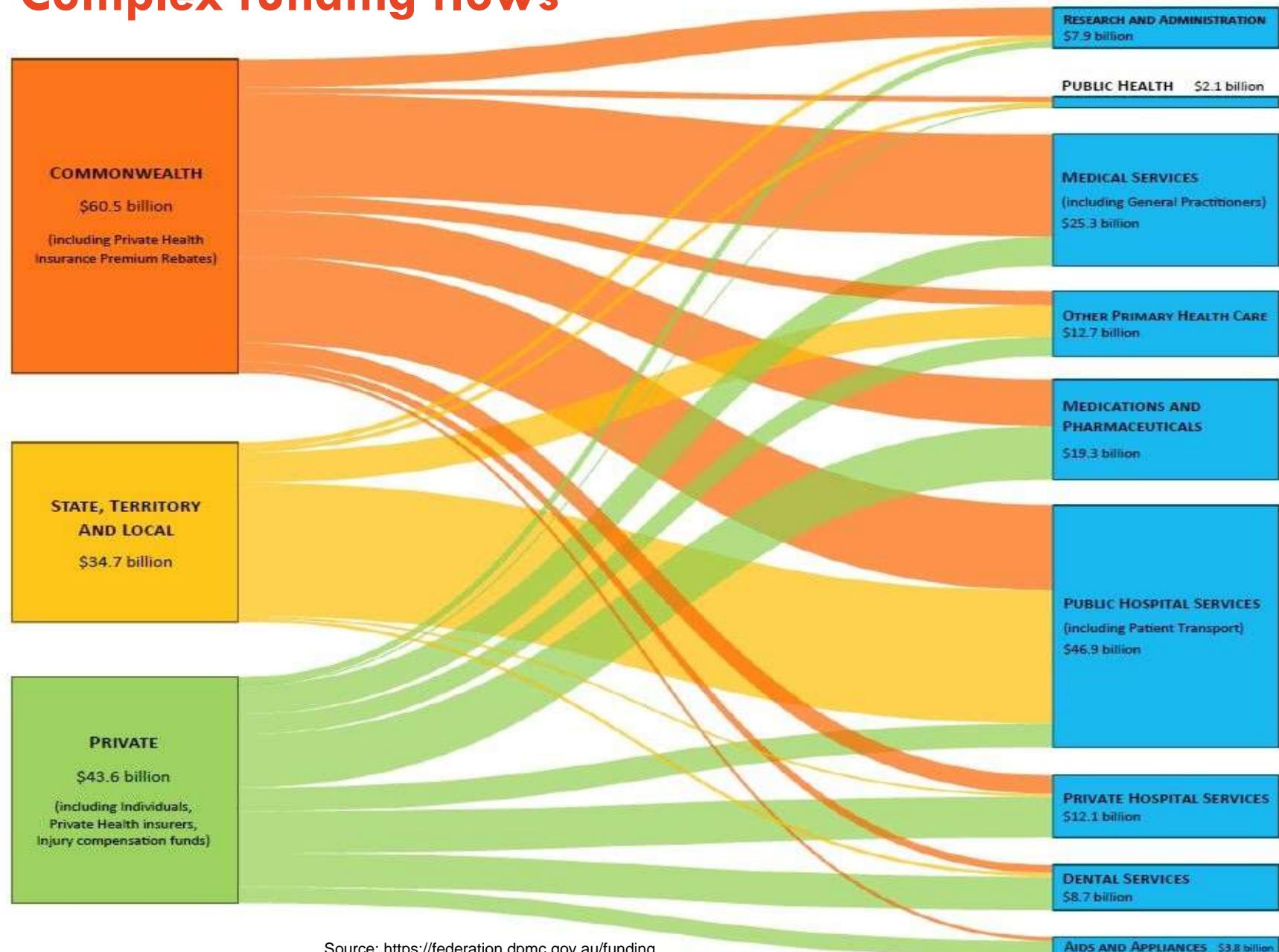
Structure



Government and private sector health expenditure 2016-17 (AIHW Health Expenditure 2016-17)



Complex funding flows

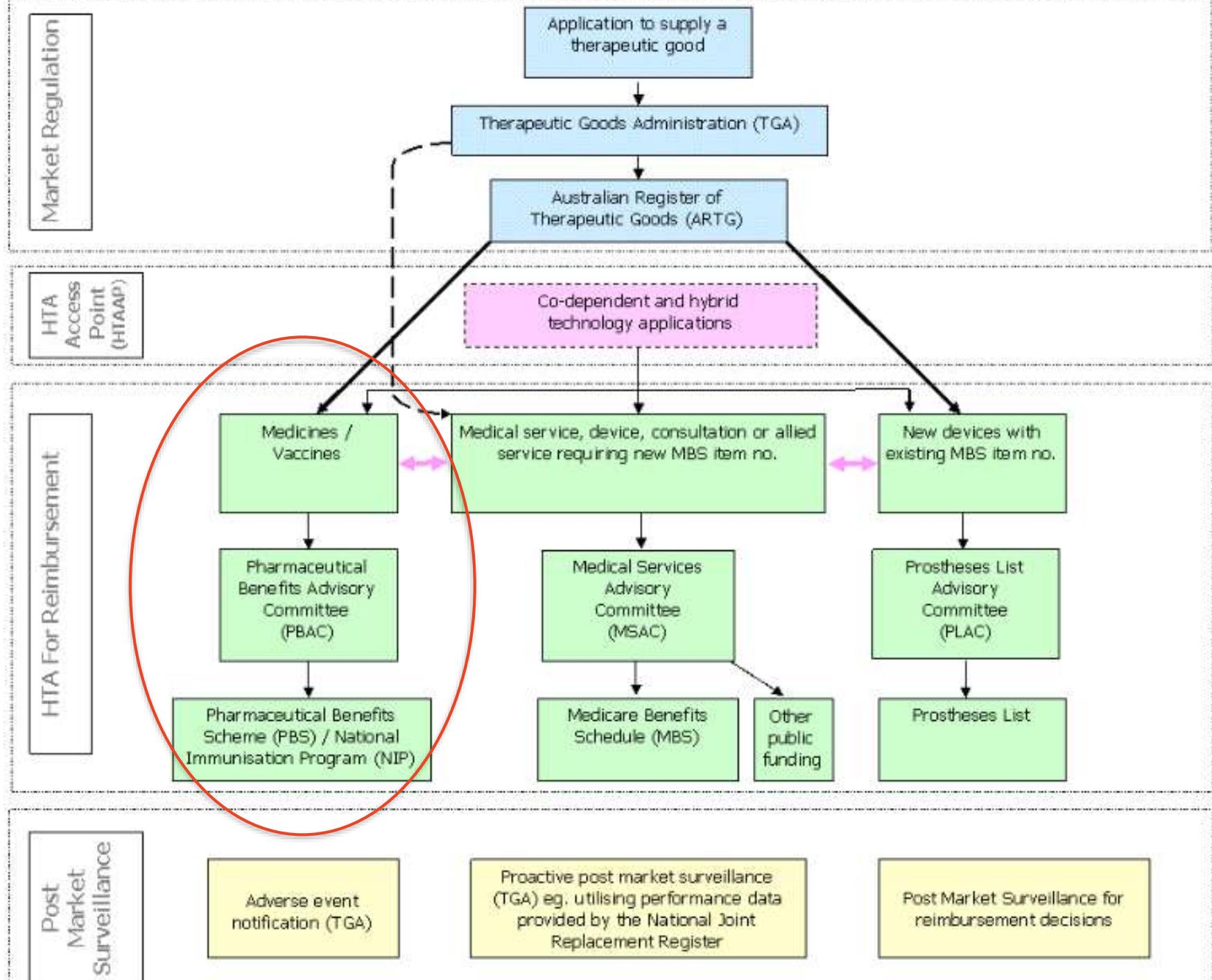


Australia's Health Care System

- Medicare is Australia's universal health system.
- Introduced in 1984 to provide eligible Australian residents with affordable, accessible and high quality health care.
- Medicare comprises:
- The Pharmaceutical Benefits Scheme (PBS),
- The Medicare Benefits Schedule (MBS), and
- The National Health Care Reform Agreement (NHRA) (Commonwealth & States agreement for public hospitals)

HTA in Australia

- The Australian Government cannot financially support every new health technology that comes onto the market
- HTA aims to help direct government funding, in the form of subsidies, to health technologies that are both clinically relevant, cost effective and safe
- Main subsidy/ funding schemes require HTA
 - Pharmaceutical Benefits Scheme (PBS) (pharmaceuticals and vaccines)
 - Medicare Benefits Schedule (MBS) (diagnostic tests, medical (GP and specialist) services, medical procedures)
 - Prostheses List (for private health insurance reimbursement of devices and implanted prostheses, such as cardiac pacemakers and defibrillators)
 - Also National Immunisation Program (via PBAC); National Blood Program
- Less formalised HTA process at a State/Territory level; eg public hospital formulary committees



PBS Overview – one HTA example

- Main but not only federal Government subsidy program for medicines
- All Australian permanent residents are eligible
- In operation for over 60 years
- Over 5,300 brands/products
- Over 209 million scripts in 2015-16
- \$13.4B cost to govt in 2015-16 (23% increase before rebates).
- Increasing proportion spent on high cost drugs especially cancer and immunomodulating drugs
- Since 1993 Cost-effectiveness assessment mandatory
- Underpinned by strong legislation

Choosing drugs for subsidy

- Prerequisite: registered drug (TGA)
 - Assesses efficacy, safety, quality
- Pharmaceutical Benefits Advisory Committee (PBAC) “recommends”
 - Assesses comparative effectiveness, comparative safety, comparative costs
 - Cost effectiveness
- Minister “declares”
 - Accepts/rejects recommendation
 - Government provides the funding
 - **Minister cannot list a drug for public subsidy on the PBS without a positive PBAC recommendation**

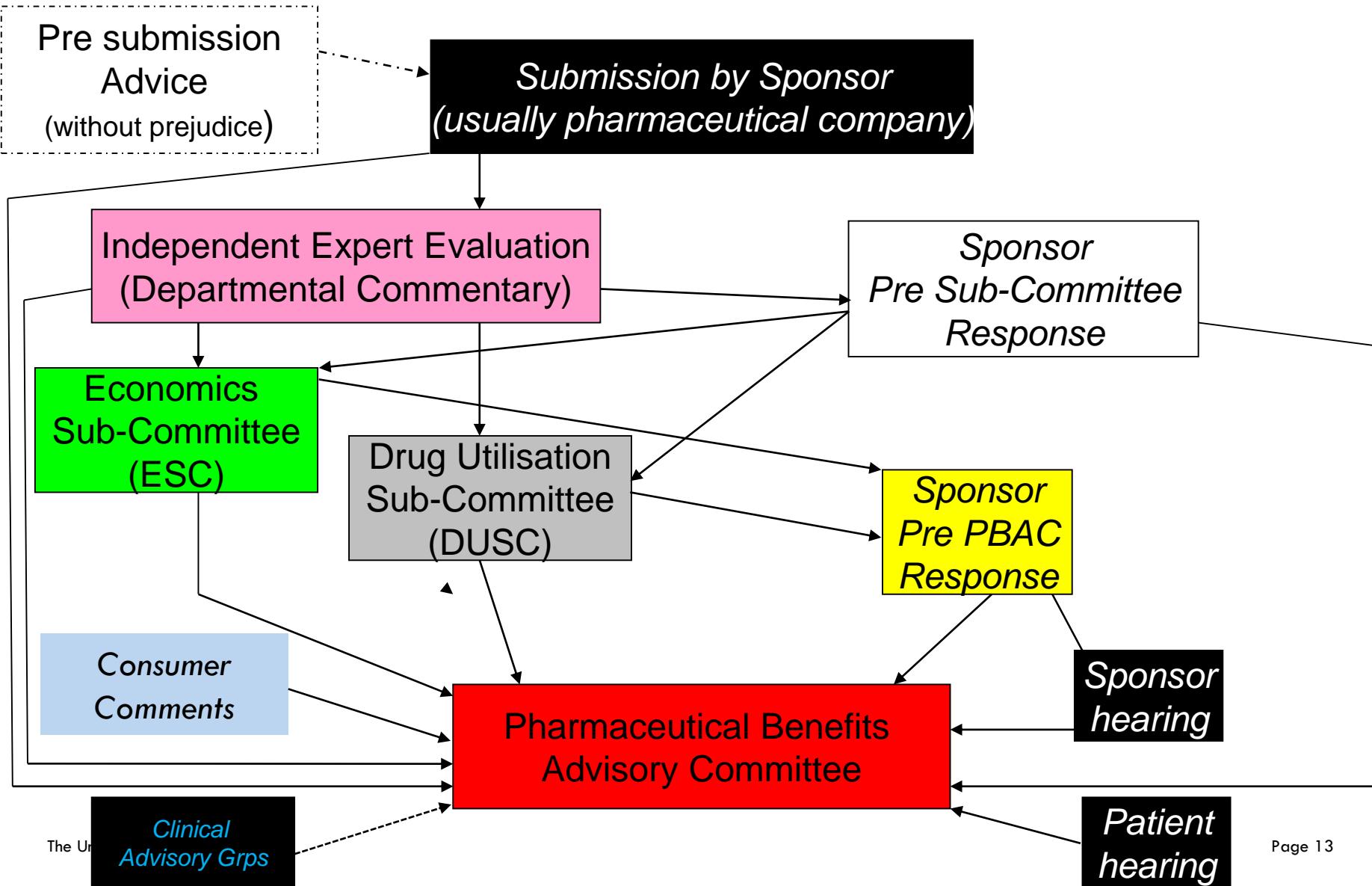
Legislative context of PBAC decision making

- Established under the *National Health Act 1953*.
- Recommends to the Minister for Health which medicines should be subsidised under the PBS.
- Required, under the Act, to consider the effectiveness and cost of the proposed medicine compared with existing (alternative) therapies (s101).
 - The incremental benefits are set against the incremental costs
- **It cannot make a positive recommendation for a medicine that is substantially more costly than an alternative medicine unless it is satisfied that the proposed medicine also provides a significant improvement in health for at least some people.**

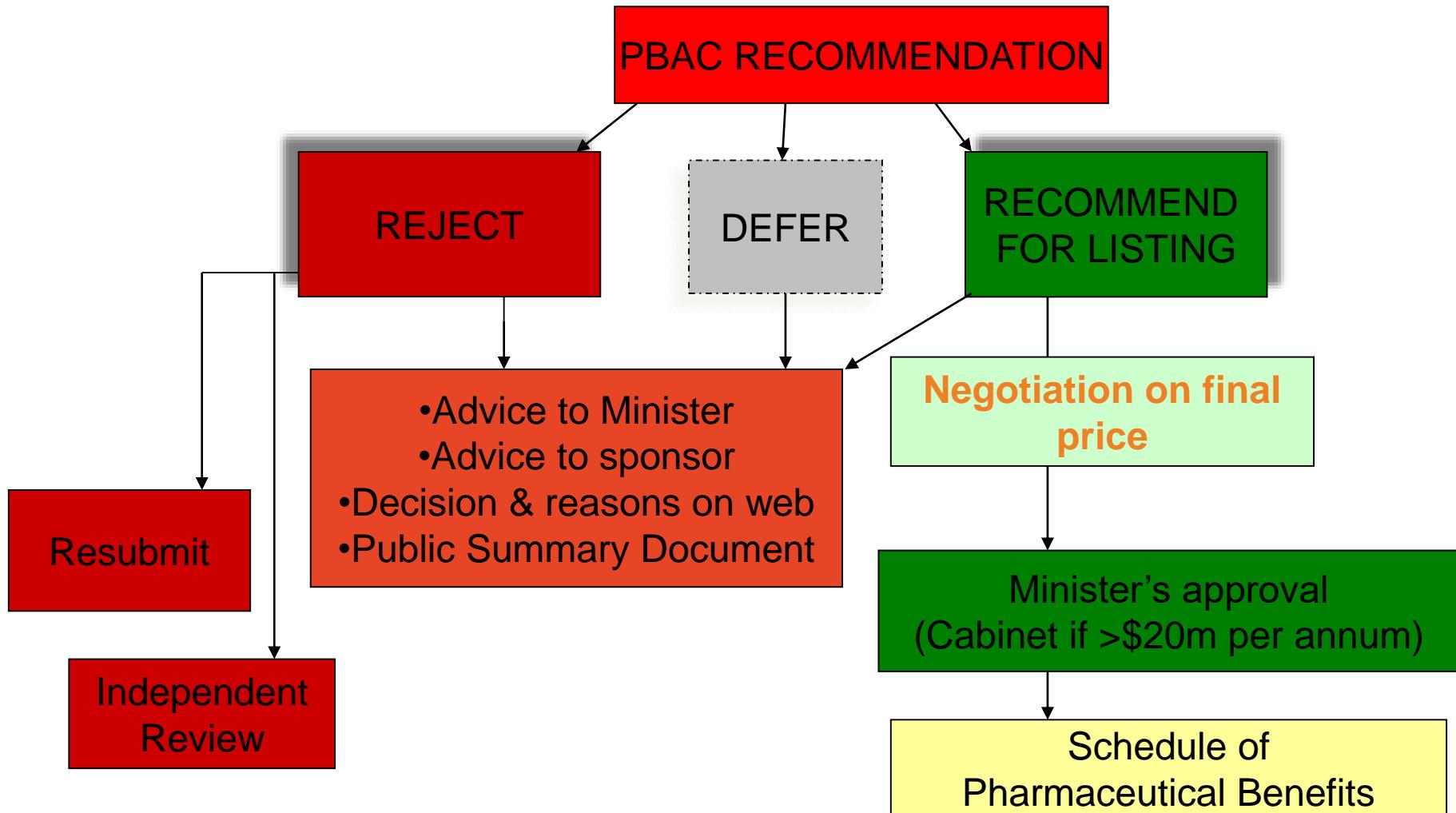
PBAC Outcomes

- Recommend
 - Cost-minimisation (no price advantage)
 - Acceptable cost-effectiveness (price advantage)
 - Target use with restrictions
- Reject
 - Incremental cost-effectiveness ratio unacceptably large
 - High level of uncertainty – quality of evidence
 - Concerns about total cost
 - Concerns about usage beyond restriction
- Deferral
 - Other information requested by the PBAC
 - Not yet registered with the TGA
- This information is made publicly available on the PBS website
 - Public Summary Document

PBAC HTA Process: 17-week cycle



Process for listing 2: post-PBAC



Factors influencing PBAC decision making

Quantifiable

- Comparative health gain
- Comparative cost-effectiveness
- Patient affordability in the absence of PBS subsidy
- Predicted use in practice and financial implications for the PBS
- Financial implications for the Australian Government health budget

Less Quantifiable

- Overall confidence in the evidence and assumptions relied on in the submission
- Equity
- Presence of effective alternatives / clinical need
- Severity of the medical condition treated
- Ability to target therapy with the proposed medicine precisely and effectively to patients likely to benefit most
- Other public health considerations
 - Eg prudent use of antibiotics, QUM

PBAC Decision Making is becoming harder

- Less certainty about comparative effectiveness and harms
 - Early data, accelerated pathways, necessitating complex HTA methods
- Understanding the value of incremental gains
- Community expectations of earlier access
- Rare and Rarer diseases
- Higher price expectations

Conclusions

- HTA is a tool that assists with decisions about investment in health care including pharmaceuticals
- The existing PBAC process ensure that the value of public expenditure on pharmaceuticals is probably the clearest of any aspect of Australian health care investment.
- Uncertainty in evidence is not going to improve in the short term with increasing requirement for alternative entry models with evidence development.

Questions?