

There were several errors in the data presented by O'Malley and Jordan which we would have liked to expand on in greater detail than is available in this forum. Briefly, however, Table 1 lists MSAC applications commenced since the inception of HS in Australia with no prior PS, with the clear implication that a PS should have been conducted. It would be unrealistic for an HS network, founded in November 2003, to assess these first ten mature technologies assessed by MSAC. A prioritizing criterion of the ANZHSN is that technologies must be *likely* to emerge in the Australasian health scene *within 3-years* (3)—at the point of MSAC assessment the technology has already received regulatory approval and is well established in the health system. Table 3 lists MSAC applications that had a PS completed beforehand. It should be noted that the MSAC process supports applications for MBS reimbursement, that are submitted independently by industry and the clinical community, regardless of whether an HS assessment has occurred.

O'Malley and Jordan refer to the "extreme example" of digital mammography being assessed by the ANZHSN and MSAC several times. The authors, however, have cited a PS followed by an HS report (2004) on mammographic computer aided detection (CAD) systems as supporting their contention, in addition to the one PS completed on digital mammography in 2005, which was referred to MSAC. An MSAC assessment was completed and public funding for the technology granted in 2008. CAD and digital mammography are distinct technologies: CAD involves processing film X-rays to produce a low resolution digital image, whereas digital mammography by-passes the use of film completely.

The ANZHSN has a valuable role in providing timely information to jurisdictional and federal policy makers. The fact that the ANZHSN has received ongoing funding from federal and jurisdictional governments since 2003 indicates that policy makers at the coal face of technology introduction and reimbursement, at all levels of the Australian health system, are finding this early alert system is a useful resource to enable the coordination and control of technology diffusion across the country.

CONFLICT OF INTEREST

All authors inform their institution has received a grant from the Commonwealth Government of Australia to conduct horizon scanning.

Linda Mundy, MPH
Email: linda.mundy@adelaide.edu.au
Senior Research Officer
Adelaide Health Technology Assessment
Discipline Public Health
School Population Health and Clinical Practice
University of Adelaide
Mail drop DX 650 545
Adelaide, South Australia 5005

Janet Hiller, PhD
Email: janet.hiller@adelaide.edu.au
Professor and Chair of Public Health, Director
Discipline Public Health
School Population Health and Clinical Practice
University of Adelaide
Mail drop DX 650 205
Adelaide, South Australia 5005

Tracy Merlin, MPH
Email: tracy.merlin@adelaide.edu.au
Senior Lecturer, Manager
Adelaide Health Technology Assessment
Discipline Public Health
School Population Health and Clinical Practice
University of Adelaide
Mail drop DX 650 545
Adelaide, South Australia 5005

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Reply to the letter by Mundy, Hiller, and Merlin on the true role of horizon scanning in Australia

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To the Editor:

Thank you for the opportunity to reply to the letter by Mundy, Hiller, and Merlin "The true role of horizon scanning in Australia: Who it informs and why". This letter states that our paper (1) "Horizon scanning of new and emerging medical technology in Australia: Its relevance to Medical Services Advisory Committee health technology assessments and public funding," published in July 2009, contains fundamental errors and misunderstands the process it claims to describe.

The HealthPACT Terms of Reference, current when accessed in November 2008, that formed the premise upon which our paper was based (in contrast to that quoted by Mundy et al.) included “The role of HealthPACT is to assist the introduction of new and emerging medical technologies into the public sector, *with consideration to the private sector*, in Australia and New Zealand through horizon scanning, including reporting on safety, effectiveness and cost implications.” This term of reference is also consistent with the statement by Brendon Kearney, the chairperson of HealthPACT that “The horizon scanning program was established under MSAC to provide advance notice of significant new and emerging technologies to *health departments* in Australia and New Zealand, and to exchange information and evaluate the potential impact of emerging technologies on their respective health systems” (2). We assume that the Australian Government Department of Health and Ageing comes under the definition of “a health department.”

Although the Australian healthcare system, with regard to the funding of new and emerging medical technology, is a dual system (as stated in the first sentence of our paper), the stated policy of the Australian Government is that all Australians will have equal access to health services regardless of insurance status. The statement by Mundy et al. that “the majority of technologies assessed relate to the *public* hospital system and, therefore, do not require reimbursement through the MBS or an MSAC assessment” would appear to suggest that there are different technologies being used in the public system compared with the private system and, therefore, go through different assessment pathways. Our paper does not claim that all technology should have been assessed by MSAC but rather that any technology assessed by MSAC should have been previously identified by the horizon scanning process.

While acknowledging that the statement in our paper “all prioritizing summaries are carried out as a result of a *recommendation* of HealthPACT” should have read “all prioritizing summaries are carried out as a result of a *prioritization* by HealthPACT”, we are unsure that this is crucial to the main point made in our paper.

Mundy et al. state that “there were a number of errors in the data presented” in our paper and that it would be unrealistic for an Horizon Scanning network, founded in November 2003, to assess these first ten mature technologies assessed by MSAC listed in Table 1 in our paper (MSAC applications lodged from March 2004 onward that had no prior Prioritizing Summary or Horizon Scanning Report). Despite this claim, the first technology to be subjected to horizon scanning (report dated November 2003) was capsule endoscopy. The date of this report was fifteen months *after* the very same technology was lodged for a (successful) full MSAC HTA in August 2002.

Mundy et al. state that “A prioritizing criterion of the ANZHSN is that technologies must be *likely* to emerge in the Australasian health scene *within 3-years*—at the point of

MSAC assessment the technology has already received regulatory approval and is well established in the health system.” Despite this claim, a large number of technologies identified and assessed by the horizon scanning process are already TGA approved. It would seem that there is some confusion as to how to define “new and emerging.” This issue was addressed in our paper and used the example of the Radi coronary pressure wire that did not have an MSAC application lodged until May 2004 (positive recommendation for funding in March 2006) yet there were clinical papers dating back to 1993. We suggest that because the ANZHSN and MSAC are both concerned about funding, “new and emerging” should refer to any as yet unfunded technology.

Our paper was extensively reviewed with the reviewers’ comments clearly indicating that they had an intimate knowledge of the Australian horizon scanning process. All of the reviewers’ comments and recommendations were addressed and we would like to take this opportunity to thank them.

We stand by the basic contention of our paper that a medical technology submitted to MSAC, especially one that gets a positive recommendation for funding, should have been previously identified by the horizon scanning process. It should not matter that MSAC assesses technology for funding in the private sector because the Australian Government has a policy of making the same technology available in the public sector. As we move into the second half of 2010, MSAC applications are still being lodged for technologies that 3 years ago could have been identified by the horizon scanning process. For example, Application 1140: Matrix-induced Autologous Chondrocyte Implantation (MACI) and Autologous Chondrocyte Implantation (ACI), lodged May 2009.

CONFLICT OF INTEREST

Both authors report having no potential conflicts of interest.

Susanne P. O’Malley, MEC
 Email: med.intel@bigpond.com
 PhD student, MGSM
 Macquarie University
 North Ryde, Sydney
 NSW, 2109, Australia
 Reimbursement Strategist
 Medical Intelligence
 13 Cudgee Street
 Turramurra, Sydney
 NSW, 2074, Australia

Ernest Jordan, PhD
 Email: ernest.jordan@mq.edu.au
 Director, Higher Degrees Research Marketing
 and Development
 Macquarie International
 Macquarie University

North Ryde, Sydney
NSW, 2109, Australia

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1. O'Malley SP, Jordan E. Horizon scanning of new and emerging medical technology in Australia: Its relevance to Medical Services Advisory Committee health technology assessments and public funding. *Int J Technol Assess Health Care*. 2009;25:374–382.
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ICER is good for us—Possibly not for you, he or she

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To the Editor:

Cleemput et al. make a point that the incremental cost-effectiveness ratio (ICER) alone is not a sufficient criterion to guide decision making in health care, and needs many other supplementary inputs. This is nothing new, it has been well known for years to researchers and decision makers alike. ICER serves as an important ingredient to guide decision making, at least in some healthcare systems.

The authors' main argument is that ICER is not applicable in insurance-financed healthcare systems, with major patient co-payments or co-insurance, where "it is unclear which amount of money needs to be allocated efficiently." It is much easier in NHS-type systems where "Patients' out-of-pocket expenditures are relatively small compared with public expenditure. The budget to be allocated efficiently is therefore clearly defined."

It appears that the authors have fallen in a quite common (payers') trap and focused only on the payers' perspective. Usually CEA and ICER adopt societal perspective and analyses costs and outcomes irrespective of who pays the costs and receives the benefits. The societal perspective includes all payers, and costs and benefits can be attributed to different parties.

In practice, CEA is often performed from the healthcare sector's perspective (and thus does not necessarily cover effects to social services or patient's family and friends, etc.). The healthcare perspective in these analyses covers all costs

irrespective of the funding party, that is, includes costs borne by the government, local authorities, insurers, employers, patients, etc. This is often an adequate perspective for national healthcare decision makers.

It is obvious that the ICER is different if only costs to a single payer (e.g., insurance) are included, and costs to other parties are excluded. In NHS-type systems, with minor co-payments, the healthcare perspective produces roughly the same ICER as the payers' perspective. In insurance-based systems, the healthcare perspective and payers' perspective may lead to greater deviance, in particular if there are several payers (insurers). In this case, it is normal to perform a CEA from a societal or healthcare perspective which produces an ICER that can be used to assess if an intervention (procedure, treatment, medicine, appliance, etc.) is worth adopting for the society, irrespective of who is paying it. This analysis is then supplemented with a budget impact analysis indicating financial consequences to different payers.

In summary, the authors' argumentation is about right if the question is asked from a single payers' perspective: Is one single ICER useful for all payers—when they consider only effects falling on them and not to other parties involved?

The authors may be less right if the question concerns the societal or healthcare perspective, asking: Is the ICER a useful ingredient in decisions judging whether an intervention provides sufficient health benefits allowing for the costs it incurs to health care (or to society at large)—irrespective of who eventually covers the costs?

CONFLICT OF INTEREST

The author reports having no potential conflicts of interest.

Markku Pekurinen

E-mail: markkupekurinen@thi.fi

Professor in Health Economics and Director
of Service System Department

National Institute for Health and Welfare (THL)

P.O. Box 30

FI-00271 Helsinki

Finland

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