



Name: Medicines Australia

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Participant background

1. For the purposes of this consultation, which of the following best describes you:
I am an industry or advocacy organisation, professional association or peak body
2. Which of the following care sectors will your feedback relate to? Please select all that apply.
Health
3. What kind of care supports, services and programs do you have experience with, and in what jurisdictions?
The participant did not respond to this question.

1. Reform of quality and safety regulation to support a more cohesive care economy

1. To what extent do differences in quality and safety regulation make it costly or complex to provide or access care services?
The participant did not respond to this question.
2. What are the reasons for your answer?
The participant did not respond to this question.
3. To what extent should quality and safety regulations be more aligned across the different care service sectors and jurisdictions?
The participant did not respond to this question.
4. What are the reasons for your answer?
The participant did not respond to this question.

2. Embed collaborative commissioning to increase the integration of care services

1. What is your experience with collaborative commissioning
The participant did not respond to this question.
2. What are the benefits of pursuing greater collaborative commissioning?
The participant did not respond to this question.
3. What are the barriers to collaborative commissioning, and do you have any suggestions for solutions that would lead to better collaboration in the commissioning of care services?
The participant did not respond to this question.

3. A national framework to support government investment in prevention

1. What are the main barriers to governments investing in evidence-based prevention programs across the care economy?

Government undervaluation of prevention interventions leads to underinvestment and delays, limiting the impact of evidence-based medicines and vaccines on the community, care and broader economy.

Australia invests 1.8% of its health spend in prevention. In the United Kingdom 3.7% of the health budget is invested in prevention, and in Canada 6.9% is invested.¹

Many medicines and vaccines are proven to prevent disease and keep people well, benefiting the community, health system, economy and reduce demands on government services. For example, immunisation is recognised as a “global health and development success story, saving millions of lives every year... It’s also one of the best health investments money can buy”². Australia is not acting to maximise the potential of medicine and vaccine interventions.

Methods utilised by the Australian Government to determine the cost-effectiveness of medicines, vaccines and disease prevention are cumbersome and significantly underestimate their worth. Currently, it takes an average of 466 days³ for a new medicine and 1,375 days from a vaccine being approved for use in Australia to it being funded and made available by Government.⁴ Similarly developed countries to Australia can provide access to medicines for their community in as few as 90 days.³

In this response Medicines Australia will focus on immunisations, as vaccines provide a clear example of where government systems and processes are creating barriers to limiting investment and benefits, although many of these issues will relate to medicines that prevent disease progression and complications.

Health Technology Assessment (HTA) is the process by which medicines and vaccines are assessed for health benefits and value of money compared to existing alternatives, before they are recommended for Federal Government funding. Once funded by Government, medicines and vaccines are then made available to Australians via Pharmaceutical Benefits Scheme (PBS) or National Immunisation Program (NIP) for free or at a limited (co-payment) cost.

Existing HTA processes are primarily designed for evaluating therapeutic interventions rather than preventive measures, which can delay or prevent the adoption of prevention programs. The HTA system does not take into account longer-term, community-wide gains or the economic gains of being well.

There are significant non-health benefits associated with preventative interventions such as productivity gains, caregiver benefits, and equity of access, which are valued by patients and society. These broader, non-health benefits have no current qualitative value framework to be assessed and are either unable to be considered in a cost-effectiveness analysis or treated as only supplementary analysis.

Furthermore, features of the current economic evaluation methods make health technologies that have high upfront costs and benefits that accrue over a long period of time appear less cost effective. For example, Australia may apply 5% discount rate per annum on the cost effectiveness of a vaccine. The discount rate acts like an interest rate

applied to economic modelling – it is designed to reflect the idea that people and government's prefer benefits now more than later. But a too high discount rate can devalue benefits that people find important. For example, a discount rate of 1.5% values the life of a baby who is vaccinated and avoids a fatal disease as if it will live another 48 years, and a 5% discount rate treats that life saved as less than 21 years.⁵

Australia's HTA system puts a lower value of human life than other sectors of Government such as transportation and similar countries overseas. As an example, Government policy frameworks value a year of life saved (quality-adjusted) for a vaccine at around \$15,000, whereas a year of life saved from a road fatality is valued at \$200,000.⁶ This means that the Australian Government is willing to invest significantly more in road safety measures than vaccines that will prevent disease. The Government is also not willing to pay the same price for extending life or improving quality of life with a vaccine as other countries.

There is increasing international recognition of the fiscal value of broad societal and health benefits of vaccine and disease prevention interventions. In England, Canada and the Netherlands carer and family impacts are now included in guidelines and methods in HTA.⁷ In Australia, these are only considered as a scenario analysis in limited circumstances.

As a result, all Australians do not have access to the vaccines that they need. Vaccines are being recommended by the Federal Government's clinical experts (the Australian Technical Advisory Group on Immunisation (ATAGI)) and not funded. In some jurisdictions, State/Territory Governments may elect to fund access to a vaccine or alternatively Australians may pay for a vaccine privately. This is resulting in postcode and incomes determining access to preventative health interventions and their benefits being limited. Immunisations impacted include Meningococcal B, influenza and whooping cough (pertussis).

The Federal Government is currently considering a review of HTA systems and policy. There is an opportunity to address these challenges.

Government's commitments to Medicare, the PBS, the National Preventative Health Strategy 2021-2030, the National Immunisation Strategy and the National Medicines Policy recognise the value of keeping people well to the community, economy and health services. Now is the opportunity to embed this recognition across Government policy and the Measuring What Matters framework. Investment in preventing disease and keeping people well is essential to Australia's future productivity and economic sustainability.

References

1. Kamal, R., Hudman, J. (2020). What do we know about spending related to public health in the U.S. and comparable countries? From What do we know about spending related to public health in the U.S. and comparable countries? - Peterson-KFF Health System Tracker
2. Immunization Agenda 2030. (2020). A Global Strategy to Leave No One Behind. World Health Organization
3. Medicines Australia. (2022) Medicines Matter 2022: Australia's Access to Medicines 2016-2021

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5. Australia's high discount rate is ignoring the health of our future generations (2022). Medicines Australia. Available at: www.medicinesaustralia.com.au/policy/submissions
6. Cubí-Mollá, P. et al. Resour Alloc. 2023;21(1):96.
7. The power of knowledge. The value of understanding. The Inclusion of Utility Values for Carers and Family Members in HTAs: A Case Study of Recent NICE Appraisals in the UK. (2019). RTI Health Solutions. [online] Available at: www.rtihs.org/sites/default/files/29662%20Basarir%202019%20The%20inclusion%20of%20the%20utility%20values%20for%20carers%20and%20family%20members%20in%20HTAs%20a%20case%20study%20of%20recent%20NICE%20appraisals%20in%20the%20UK.pdf

2. What are some examples of successful prevention programs (this could include discontinued programs)?

Australia's National Immunisation Program (NIP)

Routine immunisation of infants began in Australia in the 1950s. The first nationally funded infant program to prevent diphtheria, tetanus and polio began in 1975. Since then, the NIP has grown to a major public health program that has been recognised internationally for its success.

The NIP provides Government-funded vaccinations to Australians at no cost. The Federal Government is responsible for immunisation policy and the purchase of vaccines. State and Territory Governments are responsible for the distribution and the service delivery of vaccinations.

While the NIP does include a series of vaccinations throughout life, Government investment to date has prioritised protecting children from disease. The NIP has delivered results, with more than 90% of children fully immunised by the age of two and disease such as measles, polio and rubella almost or fully eliminated.¹

Government has begun to respond to the evolving Australian population in expanding the NIP's focus. In 2023, the Australian Government announced:

- \$826.8 million investment in the NIP for the prevention of shingles, providing the vaccine free to almost 5 million adults.
- Commitment to develop an adult vaccination coverage target.

There is an opportunity to further expand the NIP to protect more Australians from disease benefiting the community, economy and reducing demand on government services now and into the future. As detailed in the previous response, failure to recognise the value of immunisation is limiting investment and access nationally.

Increasingly, State and Territory jurisdictions are funding rapid access to innovative preventative vaccines and medicines, or Australians are self-funding. As a result, access to immunisations and their benefits is being determined by postcode and income, meaning benefits are not being maximised.

Examples of State/Territory Government's closing gaps in NIP access

South Australia Meningococcal B vaccination program

In 2018-2019, the South Australian Government introduced a state-wide vaccination

program providing free access to Meningococcal B vaccination for infants, children, adolescents and young adults. The program has delivered:²

- 63.1% reduction in Meningococcal B cases in infants
- 78.8% reduction in Meningococcal B cases in adolescents
- 100% vaccine effectiveness in infants who had three doses, and 83.5% effectiveness in adolescents who had two doses

Governments in Queensland and the Northern Territory have since recognised the value of this vaccination program and funded it for their infant and adolescent populations.

Invasive meningococcal disease (IMD) is a rare bacterial infection, which can progress rapidly. Whilst most survive, up to 1 in 10 of those infected may die, and around 1 in 4 may suffer serious long term disabilities including brain damage, deafness or loss of limbs. Children (less than two years of age) and adolescents (15–19 years of age) are most vulnerable to the disease.³ It is estimated that one severe case of Meningococcal Disease, causing lifelong disability could cost governments \$10 million,⁴ this includes carer, productivity, education and National Disability Insurance Scheme (NDIS) impacts. This vaccine is recommended by ATAGI for young children, adolescents and at-risk populations. Currently, it is funded on the NIP for Aboriginal and Torres Strait Islander infants. Limitations within the current HTA process mean access has not been expanded nationally.

Western Australia respiratory syncytial virus (RSV) infant program

Respiratory syncytial virus (RSV) is a major cause of acute lower respiratory tract infections in young children; it is the leading cause in Australia of hospitalisations during the first year of life.

In 2024, the Western Australian Government funded an RSV prevention program, that provided a monoclonal antibody that prevents RSV to all infants born during October 1 2023 – 30 September 2024. Aboriginal and Torres Strait Islander and children with conditions associated with RSV born during October 2022 and 30 September 2023 were also provided access to the program. The program delivered:⁵

- 57% reduction in the number of infants under 1 year of age admitted to hospital with RSV
- 505 avoided hospital admissions
- Estimated \$6.2- 6.9 million in avoided hospital costs

State and Territory Governments are funding similar programs nationally.

ATAGI recommends RSV vaccination for pregnant women, all people aged 75 years and older Aboriginal and Torres Strait Islander people aged 60 years and older as well as those at risk aged 60 years and older.

RSV monoclonal antibodies are recommended for infants whose mothers did not receive RSV vaccine in pregnancy, were vaccinated less than 2 weeks before delivery, infants and children who are at risk of severe RSV.

Currently, RSV vaccination is available to pregnant women on the NIP.

References

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2. Wang, B, Giles, L, Prabha Andraweera, McMillan, M, Almond, S, Beazley, R, Mitchell, J, Ahoure, M, Denehy, E, Flood, L & Marshall, H 2023, '4CMenB sustained vaccine effectiveness against invasive meningococcal B disease and gonorrhoea at three years post programme implementation', *Journal of Infection*, vol. 87, Elsevier BV, no. 2, pp. 95–102.
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4. Wright C, Wordsworth R, Glennie L. Counting the cost of meningococcal disease: scenarios of severe meningitis and septicemia. *Paediatric Drugs*. 2013 Feb;15(1):49-58.
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3. How can governments better support investment in prevention activities that have broad and long-term benefits for the Australian community?

Government can reform its systems and processes to recognise the value of medicines, vaccines and disease prevention. This includes embedding recognition across policy, and within the Departments of Treasury and Finance that funding disease prevention is an investment, not merely a cost.

For all Australians, access to the right medicine and vaccine at the right time is vital. Without it, diseases can progress quickly, quality of life suffers, demand on care and government services increases and lives may be lost.

New treatment options not only keep people healthier for longer, they also take pressure off our care economy.

The HTA Review currently being considered by Government provides a framework for the way forward. It includes recommendations to:

- o Recognise longer-term and broader societal impacts of being well, such as productivity gains and reduced demand for carer and government services. This includes the adoption of a lower discount rate
- o Develop new pathways to support faster access to vaccines and medicines that Australians need

The HTA Review was the most comprehensive review of Australia's HTA in more than 30 years. The input from stakeholders was extensive and has provided a clear view of where improvement is needed.

It is now up to Government to adequately fund the reforms. Industry stands ready with patients, patient advocacy groups and clinicians to implement the reform's recommended.

Investment in preventing disease and keeping people well is essential to Australia's future productivity and economic sustainability.