

Medicines Australia submission to Productivity Commission Inquiry: Delivering quality care more efficiently

Section 4. A national framework to support government investment in prevention

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 medicines 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

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