15 September 2025

Productivity Commission
Via webportal: Engage - Productivity Commission

Dear Productivity Commission (PC),

RE: PC should recommend government takes action today to deliver high quality care more efficiently

Medicines Australia (MA), welcomes the opportunity to make a submission on the **interim report** of the PC's enquiry into *Delivering quality care more efficiently.*

Broadly, MA agrees with the PC's framing of the problem

MA agrees with the PC's evidence that: (1) prevention in healthcare saves taxpayers money in the long-run, and (2) Australia's budget rules and timeframes, and siloing of administrative functions, prevent the proper evaluation and implementation of preventative measures. MA agrees with the PC's observation: Australia typically under-invests in healthcare prevention (p 57). As noted below, we think PC's discussion of the contribution of innovative medicines to prevention (and the barriers to maximising this) can be elevated and expanded.

Australia's innovative medicines policy demonstrates this underinvestment in prevention

The net investment in innovative medicines by the Commonwealth government via the PBS has declined (as a percentage of the health budget) from 14 per cent to 12 per cent over the last decade. Australia's approach to innovative medicines demonstrates our underinvestment in preventative healthcare. For example:

1. There is a 1,375 day delay between a vaccine being deemed "safe and effective" by the TGA and Australians receiving subsidised access to it.[i] This delay is far longer than for other medicines (for all innovative medicines, the average delay is 466 days between TGA approval and the granting of subsidised access).[ii]
2. Research finds the health technology assessment process by which medicines are evaluated in Australia generally assumes that a quality-adjusted year of life saved by a vaccine is worth only around $15,000 - this is much lower than other types of medicines, and much lower than for other government policy areas.[iii]
3. Australians do not have access to the vaccines they need. Vaccines are being recommended by the Federal Government's clinical experts (the Australian Technical Advisory Group on Immunisation (ATAGI)) yet not listed on the National Immunisation Program, which provides access to essential vaccines that help prevent serious disease. 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. Vaccines impacted include those against meningococcal B, influenza and whooping cough (pertussis).
4. The Australian Institute of Health and Welfare (AIHW) finds that Australians being overweight (including obesity) is the leading risk factor that is causing preventable health loss in Australia. Australians being overweight and/or obese increases the risk of chronic disease, including an increased risk of Type 2 diabetes mellitus. The PBS grants Australians subsidised access to Ozempic for Type II diabetes mellitus. However, it does not grant Australians access to Wegovy (essentially the same drug) for being overweight or obese. GLP-1s such as Semaglutide (Wegovy) are clinically

proven to achieve significant and sustained weight loss, improve glycaemic control, and reduce risks associated with conditions such as cardiovascular disease.[iv,v]

Current policy settings can be reformed to drive more investment in healthcare prevention

Currently the Government is considering implementation of recommendations from the HTA policy and methods review. These recommendations aim to improve Australians' access to innovative medicines, including preventative medicines.

In its Recommendation 3.1, the PC notes that the establishment of a "National Prevention Investment Framework" would "enable consideration of the second-round and longer-term fiscal effects of prevention programs" (p 4). So-called "second-round" effects are the long-term economic benefits of investing in prevention. These include: savings on government programs; additional labour-supply and tax revenue from healthier, more productive citizens (and their carers); and broader productivity benefits. The PC is making the commonsense argument that the Government should consider these benefits when it decides whether to invest in prevention. The PC's broader point is this is not occurring adequately under current policy settings.

MA agrees the Government must give more consideration to these long term "second-round" effects when deciding to invest in prevention. A substantial, current barrier to this is the PBAC guidelines, which specify that changes in productivity that result from innovative medicines should not be included in the base-case of economic analysis of innovative medicines. [vi] In practice, this means these impacts are not included in the economic modelling of innovative medicines, despite productivity being an outcome valued by patients.

The UK, Netherlands and Norway apply a disease severity modifier in the health technology assessment process, enabling higher cost-effectiveness thresholds to be applied for disease severity.

The PC should recommend Government takes action today to drive better prevention

MA recommends that the PC include the following points in its final report on *Delivering quality care more efficiently:*

1. The PC should elevate and expand its discussion of innovative medicines and their contribution to prevention, and the barriers that prevent Australians from accessing these medicines.
2. The PC should recommend the Commonwealth Government take meaningful action today to boost prevention. PC should recommend the PBAC guidelines be changed so the Government considers "second-round" effects as part of the base case when it evaluates innovative medicines.
3. The PC should endorse the efficient implementation of the HTA Review recommendations that aim to improve access to innovative medicines that boost prevention.
4. The PC should endorse these above practical steps to boost prevention, so they are not de-prioritised or slowed if a new Prevention Framework is implemented. If a new Framework is introduced, it must focus on delivering these practical changes (and others) to ensure it delivers net benefits.

Yours sincerely

Elizabeth de Somer
Chief Executive Officer

[i] Shawview 2021 Valuing Vaccines, see: Valuing Vaccines, p 58
[ii] Medicines Australia. (2022) Medicines Matter 2022: Australia's Access to Medicines 2016-2021
[iii] Shawview 2021 Valuing Vaccines, see: Valuing Vaccines, p 51
[iv] Wilding, JPH, et al. (2021). Once-weekly Semaglutide in adults with overweight or obesity. *The New England Journal of Medicine, 384*(11), 989–1002. https://doi.org/10.1056/NEJMoa2032183
[v] Lincoff, AM, et al. (2023). Semaglutide and cardiovascular outcomes in obesity without diabetes. *The New England Journal of Medicine, 389*(24), 2221–2232. https://doi.org/10.1056/NEJMoa2307563
[vi] Current PBAC Guidelines: Guidelines for preparing a submission to the Pharmaceutical Benefits Advisory Committee, Version 5.0, pg. 203 (Appendix 6)