The Paediatric Society of New Zealand
Te Kāhui Mātai Arotamariki o Aotearoa

NZCYCN
New Zealand Child & Youth Clinical Network

Tēnā koe Paula Bennett,

The Paediatric Society of New Zealand supports PHARMAC's decision to reintroduce funding for the preventative RSV immunotherapy for at-risk infants. At this time, you have reintroduced Palivizumab with improved criteria compared to its previously funded use in 2022 and 2023.

Our members are on the front line of providing care to at-risk infants, including managing the immediate and long-term effects of RSV infections. They witness the significant impact RSV has on tamariki under the age of 1 and the subsequent wheezy illnesses it causes.

We have directly observed the resource use and costs associated with RSV infections in high-risk infants, particularly the use of scarce intensive care cots and the seasonal burden on general paediatric wards. Therefore, we are very pleased to see the enhanced eligibility criteria for Palivizumab use as it is currently presented.

However, we have the following comments to improve this system and the prevention of RSV in infants:

1. Ethnic disparities in premature infants and RSV disease

The eligibility criteria overlook the significant ethnic disparities that exist in both prematurity and the prevalence of RSV infection. The burden of both conditions occurs at significantly higher rates in Māori and Pacific populations. This disparity is highly relevant to this programme due to access issues.

2. Access to immunisation with Palivizumab

The funding for vaccine administration is limited to hospitals, creating barriers for those with transport and time insecurities. There is a well-defined and described cost associated with accessing care or therapies in hospital settings, including time, transport, and parking fees. Successful prevention of RSV infection with Palivizumab requires multiple administrations, with monthly visits to hospital clinics.

This cost burden disproportionately affects those living in poverty, which is massively overrepresented in Māori and Pacific populations—the very groups bearing the highest burden of RSV disease.

It is our experience that whānau often find it difficult to complete the treatment course, undermining the programme's effectiveness. When treatments and therapies are provided

by outreach teams or through outpatient administration, costs are significantly reduced, and access is improved. This would ensure the best success for Palivizumab.

3. Nirsevimab

There are ongoing developments in both medicines and vaccines, and we understand the prioritisation of those most at risk. However, the vast burden of RSV disease is in healthy term infants during their first RSV season, often requiring primary care, emergency department visits, and hospitalisation.

The evidence for Nirsevimab is overwhelmingly compelling. As a long-acting passive immunisation, a single dose provides six months of cover, matching the usual duration of the RSV season. It has been successfully used overseas in both targeted and universal schemes. We believe Nirsevimab offers a significantly improved preventative regimen at a much lower cost for tamariki, their whānau, and the overall healthcare system.

Access to Nirsevimab would substantially reduce the burden of RSV in Aotearoa across all infants, rather than focusing on a small number of high-risk tamariki. We urge PHARMAC to work towards the earliest licensure, review, and consideration of long-acting immunisations like Nirsevimab. We also recommend a move towards a broader strategy to control the impact of RSV on all infants.

Ngā mihi nui,

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