People

IN PHARMA

EXCLUSIVE

INTERVIEW WITH JESS HUF — HEAD OF ONCOLOGY, NOVARTIS AUSTRALIA

THE HUMANIST

TWENTY-FIVE YEARS TURNING A CAREER SHE STUMBLED INTO BY ACCIDENT INTO A MASTERCLASS IN LEADING WITH HUMANITY.

Contents

People in Pharma

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Editor's Note

WELCOME TO PEOPLE IN PHARMA

This issue pairs an exclusive profile of Novartis oncology chief Jess Huf with a briefing on the policy, regulation and science shaping Australian pharma right now. Enjoy.

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There's a version of this industry that lives on slides — market share, launch curves, days-to-listing. And there's the version that does the actual work: people who spend careers convincing cautious organisations to be braver, and who still get nervous every time they present.

This issue holds both. Our cover profile is Jess Huf, who has led oncology launches out of Shanghai and London and now runs that business for Novartis in Australia — and who speaks with unusual candour about anxiety, borrowed courage, and the leap she hasn't yet taken.

Around her we've gathered what's worth knowing now: the $25 co-payment that rewrote the pharmacy counter, the reform meant to close Australia's 466-day access gap, the regulator's sharper 2026 posture, and the trials reshaping oncology and obesity. It's built to stay useful a quarter from now.

The $25 script era

For most of the Pharmaceutical Benefits Scheme's life, the co-payment has moved in one direction. This year it moved the other way. From 1 January 2026 the maximum general co-payment dropped from $31.60 to $25.00 per prescription — a saving of $6.60 a script, or roughly $80 a year for someone filling one prescription a month.

It is only the second price cut in the scheme's history. The first came in 2023, when the general co-payment fell from $42.50 to $30. Concessional patients — pensioners and concession-card holders — still pay $7.70, with that figure frozen against inflation until the end of the decade.

ACCESS & AFFORDABILITY

The cut lands alongside the government's broader cheaper-medicines agenda, including 60-day prescriptions that let patients with stable conditions collect two months' supply on a single script. For patients, it's real money off a recurring cost. For pharmacy and manufacturers, it's a reminder that the co-payment — long treated as fixed — is now a lever the government is willing to pull.

THE HUMANIST - JESS HUF

She took her first pharma job with a heritage degree and no science since fifteen. Twenty-five years later she leads an oncology business.

Jess Huf will tell you, without much prompting, that she was a clueless young woman when she took her first job in this industry. She had a heritage and journalism degree, had dropped school science at fifteen, and had no real idea what a pharmaceutical sales territory even was. She simply nodded along — then drove a patch the size of a small European country.

On those long drives she found something that has quietly organised the rest of her working life: 'As much as I'm a chatterbox, I actually love my own company.'

The woman who would later lead global launch teams out of Shanghai and London, and now heads the oncology business for Novartis in Australia, began by finding joy in the parts of the job other people quietly endure. What rescued her early was not a sudden aptitude for biochemistry but meaning. Her first role was in women's health — things that touched her own life. 'Science finally became exciting,' she says, 'because it was connected to something I cared about.'

Ask about mentors and she resists the tidy version. The pattern is not about advice; it's about courage. A brand manager once asked why she hadn't applied for a junior marketing role. 'I focused on all the things I didn't have.' The manager simply said: I think you'd be great. You should apply. She got it. What she was given, in her words, was 'courage on my behalf.'

Pressed for the work she's proudest of, she doesn't reach for a launch or a sales figure. She reaches for a lung-cancer campaign that confronted the assumption that the diagnosis is somehow deserved. 'A lot of people who get diagnosed have never smoked a cigarette in their lives. But regardless, your life is still valuable. You still matter.'

For someone who spent her career in marketing, she holds a refreshingly unromantic view of it. 'I refer to marketers as the cat herders,' she says, 'but the more eloquent way to put it is that they're the conductors of the orchestra.' The baton, though, doesn't belong to marketing by right: 'I'm a big believer in parking titles. Who has the capability, the capacity, and who can do it compliantly?'

Asked how she'd like to be remembered, she answers without hesitation: 'I'd like them to say I was a humanistic leader — that I focused on the people, inside and outside the organisation, equally.' A beat. 'And ultimately, that I was a problem solver. A humanistic problem solver.' The funny thing is that people already say it about her now.

'We are humans trying to engage with humans.' — Read the full profile and hear the podcast in the People in Pharma digital edition.

THE ROUTE

Five companies, three continents and a string of Australian firsts. The career, plotted — from a pharmacy counter to the oncology desk.

Her first company was Organon — 'a little company that got bought by Schering-Plough, who got bought by MSD, who then spat them back out as an offshoot.' A short cardiovascular stint at Merck Sharp & Dohme followed, then a first run at Novartis — and then roughly twelve years at AstraZeneca, where the career went global.

The first global posting was Shanghai — 'not somewhere I had on my bingo card, but it ended up being one of the most incredible experiences of my life.' London came next, then a line she delivers with relish: 'I might be the first Australian to leave London for Auckland for a job.' She did exactly that, stepping into a national sales management role in New Zealand before personal reasons brought her home.

Along the way she collected a remarkable run of firsts: one of the first targeted lung-cancer therapies made available in Australia, the first gene therapy ever brought to market in this country, and the first CAR-T cell therapy. She declines to call it luck. 'You plan that. You look at the companies, you look at their pipelines, and if you're smart about it, you put your energy into landing roles in organisations that are really changing the landscape.'

There is one lesson she wishes someone had handed her two decades earlier. 'When you're an ABM you want to be a BM; when you're a BM you want to be an SBM.' What she has since learned is the value of staying put: 'You need to spend some time in a role, repeating the delivery, to truly become — maybe not a master — but really, truly competent. There's a piece around completion.'

Back in Australia, she felt she was 'becoming a little bit too familiar with all things AstraZeneca.' A move to a smaller company didn't fit culturally, and so she returned to Novartis — 'a repeat offender, as I like to say' — to build its new-product and launch-marketing capability from scratch. Seven years on, she leads its oncology business in this country.

It is, we suggested, a little like climbing the tower with the lightning rod: you dramatically increase your chances of being struck. Jess liked that. She admits she 'mangles every metaphor' she reaches for — but she knows precisely where she wanted to be standing.

'Mobility is key. You want your best talent influencing your global strategy.' — The route, continued in the digital edition.

THE BLANKET REMOVED

A caravan, a shy kid, drama class, and the leap she hasn't yet taken. The most personal part of the conversation.

She took drama in high school to force herself to become comfortable with people. 'I was so observant, I'd seen other people, and I had a sense of what I wanted my life to be like. I saw what was required to get there. And it meant having to grow beyond who I was.'

The confident presenter still gets nervous every single time she stands up — and has made her peace with that. 'It's good. It's healthy. It means you still care. And the more senior you are, the more you're actually representing a whole lot of other people who aren't you. You feel a duty of care to do justice to their work.'

The deepest root runs back to a single-parent childhood without much money, and the people who stepped in to help 'with no vested interest, literally nothing to gain' — not money, usually, but opportunity, exposure, introductions. It shaped how she leads more than anything else: a determination to pay it forward. In March she climbed Mount Kosciuszko for Rare Cancers Australia. Asked what always brings her back to centre, she answers after the longest pause of the afternoon: 'My mum.'

Asked what people don't know about her, she offers two things. The first: 'When I was first born, we lived in a caravan.' The second is harder won. 'Despite everything, I do still suffer quite significantly from anxiety. And I was a really shy kid — a chatterbox with my family and people I knew, but really quite introverted.'

And what's next? For all the candour, it's the one question that stumps her. 'There's part of me that would just love to have the courage to step away and go: you've learned enough. To start something that isn't me doing it on behalf of a bigger corporation.' The thing in the way is the thing that made the career possible: 'Every risk I've ever taken, I've had some level of the foundation of a corporation around me. There's safety in that.' Then she catches herself: 'You play it safe, Jess. You're such a safe player.'

'Nervousness is healthy. It means you still care.' — Hear the full exchange on the People in Pharma podcast.

THE EXTENDED CUT

The conversation ran to half an hour. More of it, lightly tidied, in her own words — the exchanges that would not quite fit.

On the industry's rules: 'My partner jokes about me being very rules is rules. I like structure — I like some rules and guardrails to show me where to go. But there's a huge creative side to me too, and the industry was actually a really nice balance. The creativity manifests through problem solving. The whole thing was this wild learning journey.'

On women helping women: 'I'm going to say something that might be the first controversial thing I say during this. I still grapple with how many women are really prepared to support and help other women. There is a gender divide in that behaviour that I've seen over the course of my career, and it irks me to even acknowledge it. But as you become more competent and more capable, that can be challenging for people. And it's shifted — the biggest shift I've seen is the number of women sitting at the leadership table. It has been a revolution.'

On engaging clinicians: 'In the days where it was all anchored to face-to-face discussions, we were exceptional. But when it comes to meeting humans where they are, with the right information at the right time, through the right mechanism? God, it changes every minute. I'm not sure we're there yet. I honestly live for the day somebody has the revelation of how we're going to do that better as an industry. Everybody's trying to build the muscle.'

On the purse strings: 'Maybe in some organisations marketing are the purse-string holders, but I've always had — and maybe it's just the socialist in me — a bit more of a we're-all-custodians view.'

On the decade ahead: 'Your ability to really quickly synthesise information into what matters. It's always mattered, but it matters so much more now, because of the abundance of data at our fingertips. The more information there is, the more possibility you'll make a judgement call not based on a complete picture. It's terrifying to think what platforms might be around in another decade. But at the core of what marketers do, it's about connecting with humans on problem solving. I still think there'll be a role for marketing.'

'We've got to park titles. Who has the capability, the capacity — and who can do it compliantly?' — Hear it all on the podcast.

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466 days

That's how long, on average, Australians wait between a medicine being approved as safe and it becoming affordable on the PBS. A landmark reform is meant to close the gap. Industry says the money to do it still isn't there.

Australia has one of the most respected medicines regulators in the world and one of the most cost-effective subsidy schemes anywhere. It also makes patients wait. On the most-cited measure, the average gap between a medicine winning TGA approval and reaching a subsidised PBS listing stretched to 466 days across 2016–2021 — up from 391 days in the preceding period, a 19 per cent increase.

By one industry estimate, only about 27 per cent of the innovative medicines available globally are reachable by Australians through the PBS.

The response is the most significant overhaul of the system in a generation. The Health Technology Assessment Review — Accelerating Access to the Best Medicines for Australians — landed in September 2024 with 50 recommendations.

THE BLUEPRINT EXISTS. THE FUNDING IS THE QUESTION.

Australia's medicines system is respected and cost-effective. Its persistent weakness is speed — and that is what the reform targets.

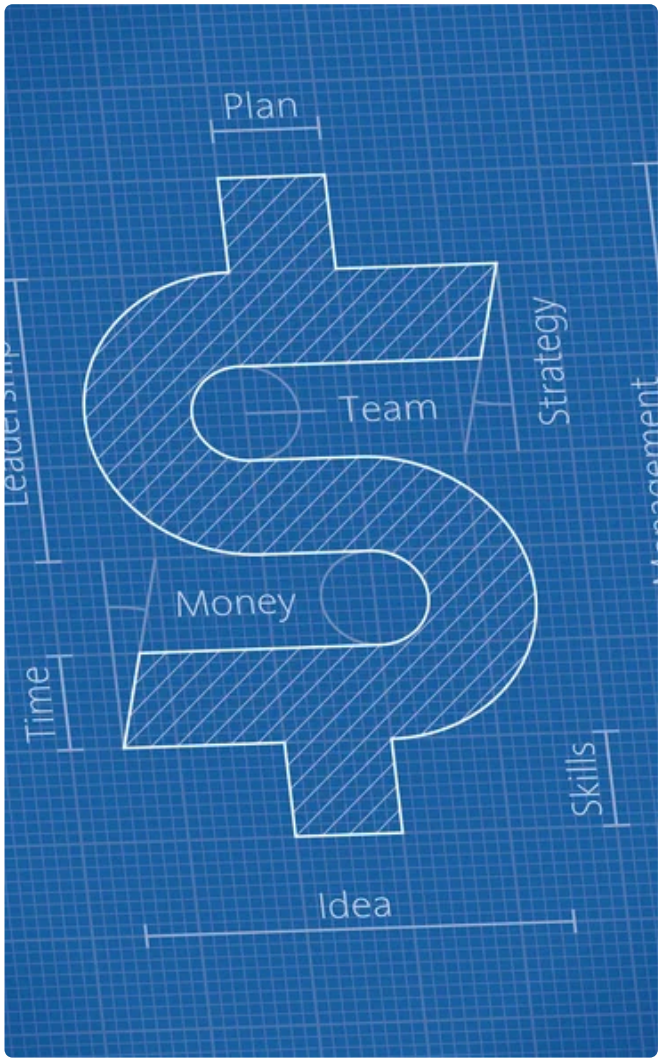
An Implementation Advisory Group, chaired by Professor Andrew Wilson, has met monthly since early 2025 to turn those recommendations into a workable roadmap, delivered to government in January 2026.

The recommendations cluster into five areas: improved access and equity, greater transparency, modernised assessment pathways, better data and evidence, and building HTA workforce capability. Among the first concrete moves is a rolling review of the PBAC Guidelines, prioritising two of the most contested levers in any submission — comparator selection and the discount rate applied to future health benefits.

The friction now is money. In May 2026, Medicines Australia said it held 'grave concern' that the 2026–27 Federal Budget contained no funded plan to implement the reforms.

By the numbers

- ***466 days**: average TGA-to-PBS wait (2016–2021).*
- ***391 days**: the prior period.*
- ***27%**: share of globally available innovative medicines reachable via the PBS.*
- ***50**: HTA Review recommendations.*



'Patients are waiting too long for access to new treatments,' said chief executive Liz de Somer, 'and without meaningful reform to the HTA system we risk falling further behind comparable countries.'

The blueprint exists. Whether it changes the 466-day number depends on what gets funded next — the difference between a landmark review and a landmark reform.

Inside the PBAC

Every subsidised medicine in Australia passes through the same gate. The Pharmaceutical Benefits Advisory Committee — the PBAC — is the independent expert body that recommends whether a medicine should be listed on the PBS, and on what terms.

Its rule is absolute: no new medicine can be listed unless the committee makes a positive recommendation. Not the minister, not the manufacturer, not the department — the PBAC.

It meets three times a year, in March, July and November. Each agenda is dominated by applications to list a new drug or vaccine, or to change the terms of an existing listing.

Sponsors submit clinical and economic evidence; the committee weighs whether the health benefit justifies the price the taxpayer is being asked to pay. A positive recommendation is the beginning of the funding process, not the end of it.

Consider Perjeta. Pertuzumab was approved as safe and effective by the TGA back in 2018, and the PBAC recommended it for a specific breast-cancer use in March 2025 — yet the confirmed PBS listing only took effect on 1 July 2026.

ONE DRUG'S LONG ROAD TO A LISTING

Perjeta shows both the strength and the strain of the system — a safeguard that works, and a timeline the reforms are trying to compress.

The listing — for eligible patients with HER2-positive high-risk early breast cancer — reaches around 2,500 Australians diagnosed each year. In the interval between approval and affordability, some families paid tens of thousands of dollars to access the medicine privately; some went without.

Perjeta is a useful lens because it shows both the strength and the strain of the system. The safeguard works exactly as designed: nothing is subsidised until the evidence and the price stack up, protecting a scheme that has to serve everyone.

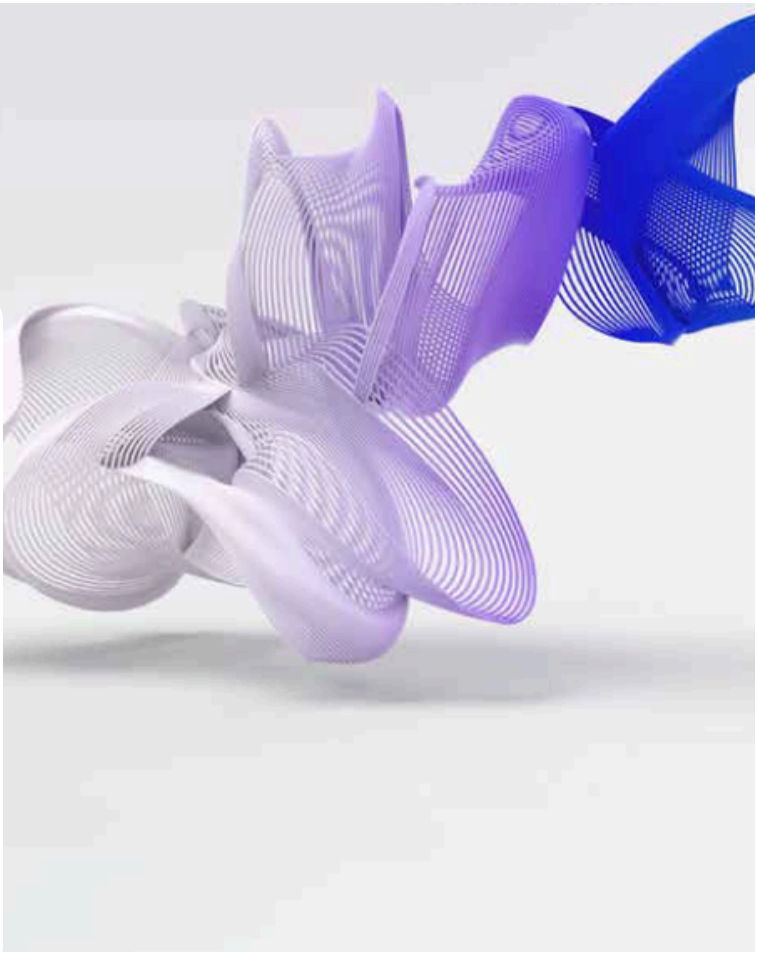
But the timeline — years from approval to affordability — is precisely what the current HTA reforms are trying to compress. Understanding how the PBAC weighs evidence, and where the delays creep in, is understanding where the real decisions in Australian pharma get made.

For commercial and market-access teams, the PBAC submission is the single highest-stakes document a medicine will ever have. Comparator choice and the economic model can decide whether it lists at all.

Perjeta (pertuzumab): TGA approved 2018 · PBAC recommended March 2025 · PBS listed 1 July 2026 · about 2,500 patients a year · HER2-positive high-risk early breast cancer.

It is also why the rolling review of the PBAC Guidelines matters so much: change the rules on comparators or discount rates, and you change how every future submission is built.

The TGA in 2026



A sharper enforcement posture, a dozen named priority areas, and a quiet shift toward trusting overseas regulators — while keeping the final decision at home.

Five principles, twelve focus areas

TGA Compliance Principles, 2026–27

The Therapeutic Goods Administration spent early 2026 telling industry exactly where it will be looking. Its Compliance Principles for 2026–27, released in February, set out five guiding principles — from safeguarding supply and countering online misinformation to modernising oversight of AI-enabled products — and, more usefully for planning, twelve named priority focus areas.

Several matter to pharmaceutical and consumer-health companies directly: weight-loss medications, medicinal cannabis, melatonin, listed-medicine advertising and software as a medical device all make the list, alongside sunscreens, vaping goods and cosmetic-procedure products. The framework is reviewed quarterly, so the targets can move as new risks emerge.

SEVEN PATHWAYS TO MARKET

The bigger structural story is how medicines get approved at all. Sponsors now have seven pathways to market: the standard route, Priority Review, Provisional Approval, two Comparable Overseas Regulator streams (COR-A and COR-B), the Access Consortium work-sharing program with Canada, Singapore, Switzerland and the UK, and Project Orbis with the US FDA.

The direction of travel is unmistakable: more reliance on trusted overseas assessments, while the TGA keeps the final decision. It's the same instinct driving the HTA reforms — keep the safety bar high, but stop making Australia re-do work that world-class regulators have already done.

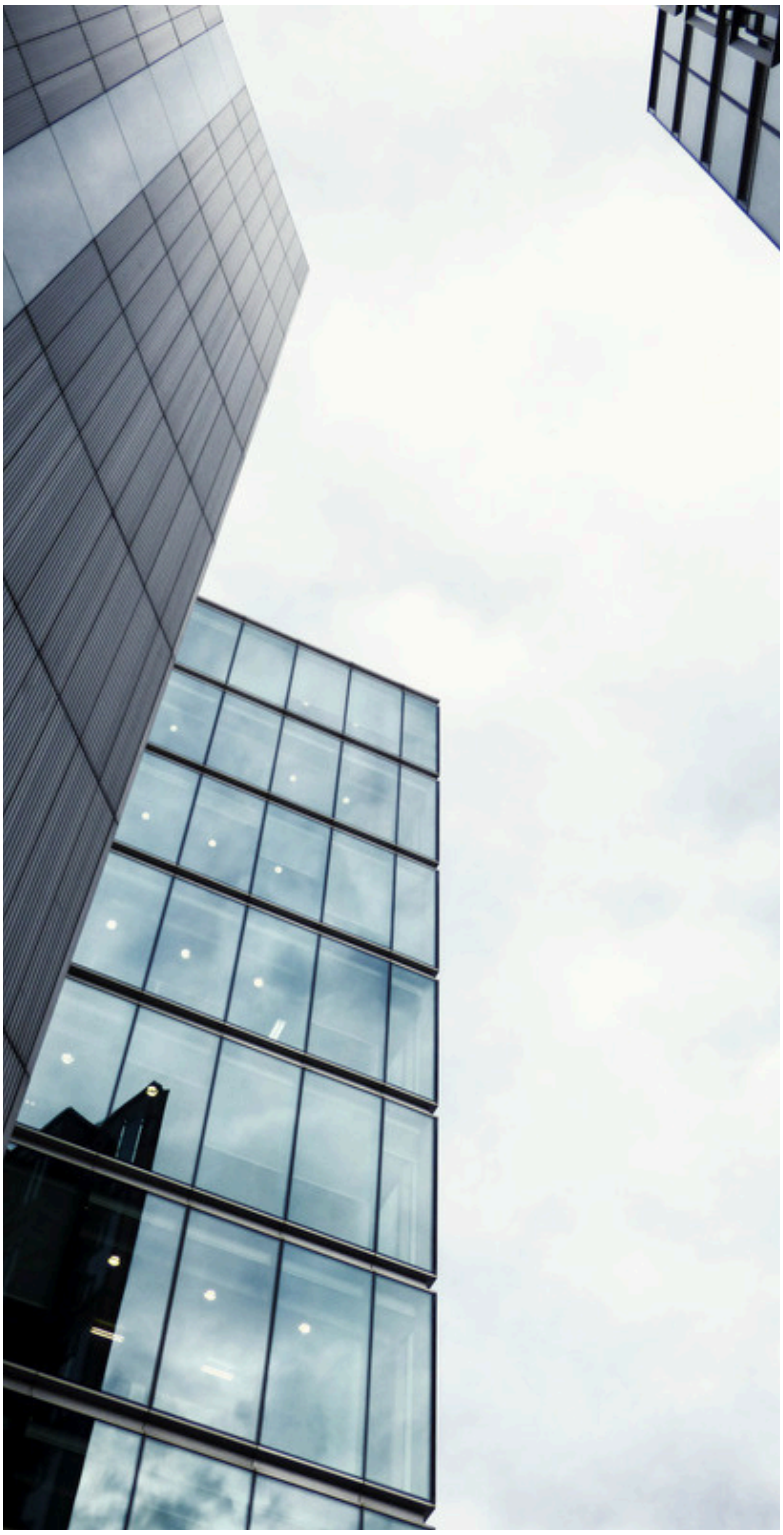
Also from 1 July 2026: some medical devices supplied in Australia must now carry Unique Device Identification (UDI) — a global-standard code that improves traceability and recall.

The seven pathways: Standard · Priority Review · Provisional Approval · COR-A · COR-B · Access Consortium (Australia, Canada, Singapore, Switzerland, UK) · Project Orbis (with the US FDA).

For sponsors, the practical question in 2026 is less whether a pathway exists than which one fits — and how much of an overseas dossier can be leveraged to shorten the Australian timeline.

Rewriting the playbook

Three 2026 storylines every commercial and medical team should be able to speak to.



A challenger to Keytruda. For a decade, Merck's Keytruda has been the reference point in cancer immunotherapy. In 2026 it has a credible challenger: ivonescimab, a bispecific antibody from Summit Therapeutics and Akeso that hits both PD-1 and VEGF in a single molecule.

Early data from China turned heads; the global HARMONI-3 trial in non-small-cell lung cancer is the read-out that will decide whether a bispecific can genuinely outperform the incumbent in a Western population. If it does, the entire immuno-oncology playbook gets rewritten — and every company with a PD-1 asset has to rethink its positioning.

The GLP-1 Story so far.

The obesity pill era. The GLP-1 story so far has been about injections. The next chapter is oral. Eli Lilly's orforglipron is among the first oral GLP-1s heading toward broad use, and next-generation triple-agonists like retatrutide have posted phase 3 weight loss near 29 per cent.

At the same time, the first GLP-1 agents are approaching loss of exclusivity — a reminder that even the defining drug class of the decade eventually meets the patent cliff.

A failure worth studying. Not every landmark result is a win. In November 2025, Novo Nordisk's EVOKE and EVOKE+ trials — testing oral semaglutide in early Alzheimer's disease across 3,808 patients — reported that the drug did not produce a statistically significant slowing of disease progression versus placebo.

The hypothesis had real grounding in earlier evidence, and disease biomarkers even moved; the clinical benefit simply wasn't there. For an industry increasingly tempted to extend blockbuster molecules into new indications, EVOKE is a cautionary tale about the distance between a promising signal and a practice-changing result.

The year ahead

If the first half of 2026 was about signals, the second half is about outcomes. The HTA reform roadmap has been delivered to government; the question now is which recommendations get funded, and on what timeline — the difference between a landmark review and a landmark reform.

What lands between now and December

The rolling review of the PBAC Guidelines, starting with comparator selection and discount rates, is the piece most likely to change how submissions are actually written. If you build economic models for a living, this is the reform to watch closely.

On the calendar, the PBAC's November meeting is the next major access milestone, with a fresh slate of listing decisions. And because the regulator reviews its compliance focus areas quarterly, the enforcement map can shift again before year's end — worth watching for anyone in weight-loss, cannabis or listed-medicine advertising.

THE THREAD IS ACCESS

World-class regulation, a cost-effective scheme, and one persistent weakness: speed. Everything now is aimed at that.

Scientifically, the back half of the year is dense with read-outs. Beyond the oncology and obesity storylines, watch pivotal data in cardiovascular disease, lupus, inflammatory bowel disease and next-generation vaccines — several of them potential blockbusters that will reshape their categories if they land.

The connecting thread across all of it is access. Australia has world-class regulation and a genuinely cost-effective subsidy system; its persistent weakness is speed. Every reform, every guideline tweak, every pathway that leans on an overseas assessment is aimed at the same target — getting proven medicines to patients faster, without lowering the bar that makes the system trusted in the first place.

That's the story to keep reading through the rest of 2026 — and the one this magazine will keep following, issue to issue.

For the people inside the industry, none of this is abstract. Faster listings change launch sequencing and forecasting. Guideline changes rewrite the submissions market-access teams live in. And a regulator leaning on overseas assessments changes what a local regulatory dossier even needs to contain. The next two quarters will tell us how much of the reform ambition survives contact with a Budget.

On the diary: PBAC November meeting — next listing decisions. HTA roadmap — funding decisions pending. TGA focus areas — reviewed quarterly. H2 read-outs — oncology, obesity, cardiovascular, lupus, IBD, vaccines.

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