PHARMAC REVIEW
Te Arotake i Te Pātaka Whaioranga

New Zealand Government

Submission form

To help us to consider your submission we are asking that you focus on the following questions. There is the opportunity to provide additional feedback at the end. We expect to get a high response and ask that, where you can, you are concise. Once you have completed your submission please send it to: pharmacreview@health.govt.nz

Note that submissions are subject to the Official Information Act and may, therefore, be released in part or full.

If your submission contains any confidential information please state this within submission, and set out clearly which parts you consider should be withheld and the grounds under the Official Information Act 1982 that you believe apply. We will consult with submitters when responding to requests under the Official Information Act.

Submission questions

Tell us about your current experience with PHARMAC and how it functions

1. What is your understanding of what PHARMAC does?

The Association of Salaried Medical Specialists (ASMS) represents senior doctors and dentists (predominantly specialists) employed by district health boards (DHBs) and other employers of health care professionals. We have over 5,000 members.

We are familiar with the work PHARMAC does to decide which medicines should be publicly funded and to negotiate contracts with pharmaceutical companies. We are aware that PHARMAC is currently expanding its model to include DHB hospital medical devices.

We know that PHARMAC is required to stay within a fixed budget each year (the Combined Pharmaceutical Budget) and that this budget is insufficient to fund all the medicines that New Zealanders need. We are aware that PHARMAC needs to make annual savings on the cost of already funded medicines to fund the cost of future growth in demand and to fund new medicines. We understand that PHARMAC uses aggressive negotiation tactics with suppliers to bring the price of medicines down. These include competitive tendering, sole supply contracts and promoting generics.

PHARMAC has been very effective at cutting drug costs. However, we are aware that some pharmaceutical companies are choosing not to put in funding applications for new drugs because of PHARMAC's hard bargaining environment. As a result, New Zealanders are missing out on important drugs that are available in other countries because some new drugs are not being put forward for consideration for funding.

2. What has been your experience of working with PHARMAC?

ASMS does not work directly with PHARMAC. However, many of our members work with PHARMAC, including on PTAC and clinical advisory subcommittees. Many members deal with PHARMAC in their professional clinical capacity caring for patients. PHARMAC's decisions directly impact on our members' work.

We are aware of the high workload for PTAC members that requires a considerable time commitment, both to prepare and attend meetings. The hourly rate is low for this participation and has not changed for a long time. We consider that PHARMAC and the Ministry of Health should review the fees paid to committee members to appropriately recognise the extent of work involved and to make the role more appealing, particularly to a wider and more diverse group of doctors. In our view, the current makeup of PTAC lacks gender and ethnic balance and should better represent the workforce and different populations. Vacancies on PTAC are not well advertised and candidates are often simply recommended by the medical colleges. Some committee members can sit for years as there is no fixed term of service.

We are concerned at the possibility that PHARMAC hand-picks committee members who tend to follow the PHARMAC philosophy of cost above all else. We have heard reports that there is an element of 'groupthink' that takes place on committees whereby members are influenced by, and conform with, the deeply embedded PHARMAC culture. Another issue is the lack of transparency with the funding decisions made after PTAC has assessed the efficacy and harms of medicines and provided its clinical opinion.

A particular concern for medical specialists pertains to decisions to switch drugs to save money. We are aware that each time a funded drug is switched to another drug to save money - even a generic drug that looks different but is the same drug entity - around 20% of patients lose effect from the new drug or get side effects due to the nocebo effect. In our view, these consequences are not appropriately considered by PHARMAC in its decision-making.

Another significant problem for medical specialists is the way PHARMAC considers applications for funding medicines not listed on the Pharmaceutical Schedule using its Exceptional Circumstances Framework. This includes the Named Patient Pharmaceutical Assessment Policy (NPPA) for seeking approval. We consider the NPPA policy to be flawed. There is a lack of transparency and clarity around the process, the deliberations of the NPPA panel are not published, and the process is difficult for clinicians to navigate. It is frustratingly slow and the exclusion criteria (the 'NPPA core principals') prevent approval being given even when the treatments sought would save future costs (including costs to the wider health system). The process is extremely time-consuming for clinicians to make applications on behalf of their patients and often applications are turned down because they are 'technically inadequate'.

3. What are the challenges with PHARMAC's functions for funding medicines and devices?

The problems with PHARMAC's functions for funding medicines and devices stem from its statutory objective:

> *"…to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided"*[1]

This directive effectively sets drug cost as the primary criteria when considering treatments in a way that does not allow for full assessment of the consequences of not funding a drug. The consequences include patients needing further treatments, such as surgeries, progression of disease, inability to work and lost productivity. The focus on drug costs sets an upper ceiling for consideration of treatments, i.e., it does not enable a vision of what is possible with increased funding. ASMS suggests there could be a table of drugs, showing their priority and costs with a cut-off line at the limit of current funding available. It would show what New Zealanders and the New Zealand economy would gain if the line was moved upwards.

What do you know about PHARMAC's processes and how they work?

4. What do you think works well with the processes PHARMAC uses to assess the funding of medicines and medical devices?

PHARMAC's processes work well to achieve its objective of funding pharmaceuticals within a fixed budget. The processes work to support the focus on reducing the price of medicines and limiting the number of new medicines funded.

[1] New Zealand Public Health and Disability Act 2000, Section 43(a).

5. What do you think are the barriers to accessing medicines and devices?

New Zealanders are being deprived access to medicines available in other countries due to PHARMAC having to stay within its fixed budget. PHARMAC's policies, processes and protocols are designed to achieve the overriding objective of saving costs. In particular, the processes create a barrier to accessing new and innovative medicines, including medicines that are suited to an individual, or personalised for patients. There is little room for flexibility (apart from the limited Discretionary Pharmaceutical Fund) in decision-making. This funding model gets in the way of good value spending through delays in approving new medicines. As a result, opportunities to improve health outcomes are missed.

We also view the $5 patient co-payment to collect a prescription item as a barrier for people on limited incomes, especially if they are prescribed a number of drugs. We note that people who pay for more than 20 prescription items each year are eligible for a subsidy and are not charged once they have paid for 20. However, take-up of the subsidy can be difficult for people who do not go to the same pharmacy or who move around. Some people may not even be aware of the subsidy programme. In addition, patients are not eligible for the co-payment if the prescription is from a private specialist, or the prescriber is not approved by a DHB.

6. Is there any other country that does it better? What is it that it does better and would any of those systems apply here?

Neither Australia nor the UK have fixed pharmaceutical budgets. In Canada, the budget is flexible and has increased significantly mainly in response to a growing population and funding for new drugs for cancer and rare diseases. In addition, multiple drugs are available within each therapeutic class offering alternatives for intolerance, which is not the case in New Zealand.

New Zealand performs well below other countries, such as Finland, France, Germany, Sweden and Australia, in terms of funding for cancer drugs.

Access to drugs is much quicker in other countries compared to New Zealand, where decisions can take years. In Singapore, for example, decisions to fund a drug typically take 5 to 9 months and can be expedited to take 2 to 3 months.

New Zealand's spending on pharmaceuticals is lower per capita than many other countries, which may partly reflect PHARMAC's success in reducing prices. Nevertheless, the PHARMAC model denies access to many medicines funded in places such as Australia, the UK and Singapore. The consequence of the fixed budget model for pharmaceuticals in New Zealand, compared to other countries, is unmet need. The cost-containment approach risks people being hospitalised due to certain drugs not being funded, e.g., for cardiovascular disease or inflammatory bowel disease.

What should PHARMAC's role include in the future?

7. How might PHARMAC look in the future? And what needs to change for this to happen?

ASMS recommends that:

- The Combined Pharmaceutical Budget is not fixed.
- Funding for pharmaceuticals is via a separate budget from health services.
- The budget-setting process with Health NZ (in the future) should consider the consequences on peoples' lives and the economy of limiting funding for new medicines (including quality of life indicators and lost productivity).
- There should be greater transparency in decision-making at all levels of PHARMAC.
- The membership of PTAC should be more diverse.
- The NPPA process should be changed, including resetting current rules and exclusions, which are illogical and can result in perverse decisions and increased health costs; and the time clinicians spend on applying for approval for medicines on behalf of their patients should be looked at.

8. Are there additional or different things that PHARMAC should be doing?

PHARMAC should:

- reflect on the clinical consequences and patient outcomes of its decisions not to fund medicines in addition to outcomes from funding medicines
- be able to, and in fact be required to, advocate for more funding for medicines where it is clear there will be benefit for New Zealanders
- actively benchmark its performance against countries in the OECD

9. What do the wider changes to the Health and Disability system mean for PHARMAC?

PHARMAC will need to build relationships with new entities in the health sector - Health NZ, the Māori Health Authority, and the Ministry of Health.

PHARMAC will no longer manage the Combined Pharmaceutical Budget (CPB) on behalf of DHBs. Removing the strong motivation of DHBs to make budgetary savings due to their deficits and funding pressures may help towards an acceptance that the pharmaceutical budget is too small. Health NZ and the Māori Health Authority will also have new priorities that could support this view.

ASMS will be interested to see whether the New Zealand Public Health and Disability Act reflects any changes to PHARMAC's objectives or functions.

How should PHARMAC address the need for greater equity in the decisions it takes, in particular for Māori, Pacific and disabled people?

10. How well does PHARMAC reflect the principles of Te Tiriti o Waitangi?

As noted, PHARMAC's committees need a better balance of under-represented groups. A diverse makeup of committees that include more Māori would assist PHARMAC to make decisions that focus on Māori health outcomes. Specific attention needs to be given to the illnesses and diseases suffered disproportionately by Māori, including cancers and chronic illnesses, that can be successfully treated by new medicines.

Te Rautaki o Te Whaioranga (Māori Responsiveness Strategy) is PHARMAC's framework for meeting its Te Tiriti o Waitangi obligations. Te Whaioranga reflects the articles of Te Tiriti and the developing set of principles recommended by the Waitangi Tribunal in 2019. Te Whaioranga is a useful document that describes the priorities and actions PHARMAC is taking to improve its responsiveness to Māori.

Nevertheless, ASMS considers that the timeframes for achieving some priorities may be slipping. We note, for example, that a Māori Advisory Committee to guide senior leaders and the Board was planned to be in place by August 2021. However, PHARMAC's website shows it is now aiming to establish the committee by the end of 2021[2].

11. How can PHARMAC achieve more equitable outcomes?

To achieve more equitable health outcomes, PHARMAC must understand the health needs of Māori, Pacific, disabled people, rural and other vulnerable groups and incorporate informed advice into its decision-making processes. This includes gaining a full understanding of unmet health need in New Zealand, which affects the listed groups disproportionately. Unmet need is a gaping hole in our knowledge of health service requirements in New Zealand.

PHARMAC acknowledges that Māori continue to receive funded medicines at a lower rate than non-Māori and it believes inequitable outcomes for Māori "unfair, unjust and avoidable" and is "actively working to eliminate them"[3]. However, ASMS considers that PHARMAC will not achieve equity of access to medicines on its own. It needs to engage and work with other stakeholders (including health professionals) to support changes that will address structural issues that contribute to this inequity. Similarly, PHARMAC cannot operate alone to achieve equitable health outcomes for Pacific communities, people with disabilities or other vulnerable groups.

[2] https://pharmac.govt.nz/te-tiriti-o-waitangi/te-whaioranga/te-rautaki-te-whaioranga/priority-maori-leadership-and-advice/

[3] https://pharmac.govt.nz/te-tiriti-o-waitangi/te-whaioranga/ p3

Additional feedback

Is there anything else that you think the Review Panel should consider?
PHARMAC's statutory objective has unfortunately empowered a fundamental culture in the organisation that sees pharmaceuticals as a cost, rather than as an investment in better health outcomes for New Zealanders. Reporting by PHARMAC on quality-adjusted life-year (QALYs) achieved from its funding decisions should be improved and the impact on health outcomes publicly communicated. ASMS believes that there needs to be a national conversation with the public, as well as with clinicians, about PHARMAC's role that is wider than the terms of reference for this review.

Contact information

Your feedback is important to us. If you are comfortable for us to get in touch if we have any questions or points of clarification regarding your feedback, please provide your name and contact email address below.

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If you do not want your personal details to be shared for any other purpose (for example if we receive a request for information under the Official Information Act) please signal this using the box below.

☒ I do not want my personal details to be shared for any purpose other than this review.

Thank you for providing your feedback.

Tēnā koe mō tō tuku urupare mai.