Response to PHARMAC on access to new medicines in New Zealand compared to Australia

In the previous issue of this Journal we reported that public access to new medicines was poorer and slower in New Zealand (NZ) than in Australia over the previous decade.\(^1\)

We agree with the government reimbursement agency PHARMAC that the important issue is ‘the quality of health care and the quantity of health gain provided by all medicines’.\(^2\) However, this was not the focus of our article; furthermore, this level of information is not available and never likely to become available, which is why we (like PHARMAC before us) compared public funding of pharmaceuticals in two countries with closely linked economies and similar healthcare systems.

**Delays in reimbursement**—PHARMAC states: ‘Pharmaceutical suppliers decide when they will bring products to market in each country, which means Australia and NZ may not have the opportunity to fund them at the same time.’ Indeed, we reported a 9-month lag in registration of new medicines in NZ; but we also showed that the mean time from registration to reimbursement (which depends largely on PHARMAC, not the pharmaceutical industry) is almost 2 years longer in NZ than in Australia.

PHARMAC also states …‘although New Zealand may in some cases be slower to fund a new drug than Australia, the reality of a budgetary cap means that extra care must be taken to forecast expenditure.’ This is a puzzling remark. As we explained, the economic analyses that are submitted to the Australian Pharmaceutical Benefits Advisory Committee (PBAC) by suppliers of new medicines are scrutinised by academic economists and clinicians; economic models are evaluated in detail; and suppliers are given two opportunities to respond.\(^1\) This is a time-consuming process.

In contrast, PHARMAC generally applies a relatively cursory in-house analysis to the economic elements of submissions for listing new medicines.\(^3\) So the 2-year longer time from registration to listing in NZ cannot be attributed to ‘extra care’ in the assessment process.

PHARMAC asks rhetorically: ‘Was there any harm done by taking longer to fund a particular medicine in one country rather than another? The answer is yes. The harm is the net health benefits forgone by patients who could have benefitted sooner. There are exceptions (e.g. when a medicine is taken off the market because of late evidence of serious adverse effects) but these are uncommon.

**Expenditure under capped budgets**—As PHARMAC explains: ‘New Zealand has a budget which is set annually by the Minister of Health on the advice of PHARMAC, district health boards (DHBs) and the Ministry of Health.’ As we explained, having a capped pharmaceuticals budget means that any new medicines that are declined public funding on economic grounds are implicitly considered to be less cost-effective than the non-pharmaceutical therapies that they might displace from the Government’s total healthcare budget.\(^1\)
PHARMAC claims that New Zealand spends ‘half as much per person’ on pharmaceuticals as Australia. This would be laudable if the per capita health benefits were similar; but that has never been demonstrated and seems unlikely. Staying within budget is also laudable, provided that the budget is realistic. Our findings suggest that there is a case for re-assessment of the community pharmaceuticals budget within the Government’s total healthcare budget.

Given that PHARMAC is well placed to be the country’s strongest advocate for the health benefits of community pharmaceuticals, it would be helpful if PHARMAC could annually show the taxpaying public that it puts a strong case to the Ministry of Health and DHBs for further investment in new pharmaceuticals, based on their health benefits and cost effectiveness.

Unavailability of information on cost effectiveness—We thank PHARMAC for noting: ‘We well understand the authors’ frustration at the lack of available cost-effectiveness information; this is not entirely of PHARMAC’s making.’ Most of PHARMAC’s cost effectiveness analyses are adapted from submissions made by pharmaceutical suppliers. This information, with commercially sensitive aspects like drug prices blacked out, can be obtained from PHARMAC under the Official Information Act; but by that time the funding decisions are already history. As a matter of transparency, PHARMAC could (and we believe should) make these available routinely on its website in a timely manner in consultation with Industry.

Recent listings of new medicines—We welcome the Government’s recent once-off injection of new funds into pharmaceuticals and PHARMAC’s subsequent investment in new medicines. PHARMAC states: ‘Had they [we] reviewed the last 2 years, where the Government has invested significant new money in pharmaceuticals, the lists would have looked significantly different with some 59 new medicines funded in New Zealand during that period.’ It is unclear how PHARMAC defined a ‘new medicine’ as we could find only 12 new medicines in calendar year 2010 (see our Table 2) and 6 more in calendar year 2011 (lacosamide, modafinil, bortezomib, dabigatran, raloxifene and teriparatide). No comparison with Australia is available.

Details—PHARMAC suggests that some details of our analysis are incorrect. We disagree. Their selection of bivalirudin for anticoagulation prior to major surgery as an example of an infusion therapy that would not be covered in NZ is inappropriate because it is not indicated for such use and it is listed on the Pharmaceuticals Benefits Scheme (PBS) only for use in patients undergoing percutaneous coronary intervention. Our exclusion of levetiracetam from the analysis while it was funded under ‘Special Access’ provisions was justified in our ‘Methods’ section. PHARMAC states that rosiglitazone has been withdrawn from the market due to safety concerns, but rosiglitazone remains on the market in Australia (and elsewhere) and is still listed on the PBS, albeit with recently revised restrictions on its use.

PHARMAC states: ‘apart from pharmaceutical cancer treatments (PCTs), therapies in New Zealand used in a hospital setting are funded at the discretion of the individual DHB hospital and not PHARMAC.’ Only 2 of the 59 medicines in our common data set (eptifibatide & infliximab) are listed in the hospital pharmaceutical schedule (Section H) and this has little bearing on our conclusions.
We agree that patient copayments are lower in NZ, as we acknowledged in our article; however, copayments generally comprise only a small fraction of the total cost of new medicines. In both Australia and NZ, public access to new medicines is determined much more by government subsidies than by copayments.

Regarding medicines that are funded in Australia but not NZ, PHARMAC states: ‘The article’s Table 3 does not state what these medicines are, particularly when many have NZ-funded alternatives, no cost-effectiveness information is provided, and some cost over $100,000 per quality adjusted life year (QALY) in the New Zealand setting.’ This statement is also puzzling. Our Table 3 gives the names of all 77 of these new medicines. It does not include cost effectiveness information because this information is unavailable to researchers, as PHARMAC acknowledges. Given that the prices of new medicines generally are lower in NZ than Australia and the two populations are broadly similar, within any specified indication it seems unlikely that (if the medicine were funded in NZ) the cost per QALY would be higher than it is in Australia; which is usually far less than $A100,000. We make no claim that ‘me-too’ medicines on our list intrinsically have an additional population health benefit: but they do provide prescribers and patients with the benefits of therapeutic alternatives.

**Conclusion**—We acknowledge that government healthcare budgets cannot be expected to expand, especially in times of economic downturn; but we believe that high quality cost effective new medicines require more serious consideration within the total healthcare budget.

It is pleasing that PHARMAC agrees with us that ‘trans-Tasman comparisons of health gain from pharmaceutical expenditure invested and forgone may be valuable.’ This would take the emphasis back from the pharmaceuticals budget to the patients, where it rightly belongs.

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**References:**


