

Uptake of new medicines: the Pharmaceutical Management Agency of New Zealand (PHARMAC) in the international context

Rajan Ragupathy, Zaheer-Ud-Din Babar

We read Barber and Sheehy's recent analysis of the time for PHARMAC to fund pharmaceuticals recommended by the Pharmacology and Therapeutics Advisory Committee (PTAC) with great interest.¹ Quantifying the gap between what the health system could ideally provide, and what is actually provided at any given time, is vital in debating the trade-offs in the public funding of pharmaceuticals. We would like to add further to the authors' discussion of this topic.

The authors note that the time to fund particular pharmaceuticals recommended by PTAC varies greatly, and is not correlated to the clinical priority assigned by PTAC. However, they do not explore possible reasons for these findings, stating "It is difficult to understand, however, why in some instances medicines with a lower PTAC priority have been funded ahead of those with a high priority".¹ We believe the answer lies in considering the operation of PHARMAC in the international context, and particularly the differences between PHARMAC and comparable agencies

PHARMAC differs from many of its counterparts in that it both decides whether a pharmaceutical should be funded and reprioritises the funding needed.² No new pharmaceutical—regardless of its clinical priority—can be funded unless room can be found or made within the capped pharmaceutical budget to pay for that particular decision. However, this is different in the United Kingdom. There, the National

Institute of Care Excellence (NICE) makes the decisions, but does not reprioritise funding. Reprioritisation is left to regional fundholding bodies, which are legally obliged to implement NICE decisions.^{3,4} This approach potentially allows for faster uptake of new pharmaceuticals.⁴ However, it comes with its own risks. If the health gain from the new pharmaceutical is less than those of a health service that must be foregone to pay for it, then perhaps, the result is a net loss to public health.³

PHARMAC also differs from its counterparts, such as NICE and the Australian Pharmaceutical Benefits Advisory Committee (PBAC), in that it directly negotiates prices of all pharmaceuticals with manufacturers, and uses this as part of the funding decision cycle.² PHARMAC uses a variety of techniques to obtain favourable prices, including competitive tendering, generic switches, bundling arrangements and therapeutic reference pricing.² The opportunities to obtain a favourable price for any given pharmaceutical could therefore change due to factors such as a therapeutic analogue going off patent, a tender competitor being willing to offer a lower price to gain market share, or a bundling arrangement due to the market entry of an unrelated product from the same manufacturer. These factors could explain why pharmaceuticals given a lower PTAC priority may in fact be funded earlier.

It is also worth remembering that pharmaceutical patents have a limited life, and PHARMAC has in the past been able

to achieve major price reductions when a given pharmaceutical goes off patent.² Any externally imposed time constraints for PHARMAC to fund a given pharmaceutical could hamper PHARMAC's ability to find the 'sweet spot' in its patent life, and thereby reduce the very efficiency cited by the authors.¹

For these reasons, caution is needed when drawing analogies between PTAC recommendations awaiting funding, and waiting lists for elective services such as surgery. The latter typically rank patients by clinical priority, and often set maximum waiting time for each patient.⁵ This is feasible because moving Patient A to the head of the surgical queue would, all things being equal, displace 'only' Patient B. Moving Pharmaceutical A prematurely to the head of the funding queue could potentially displace funding that could pay for Pharmaceuticals B, C and D, thereby resulting in a net loss to public health, despite the individual merits of Pharmaceutical A.³

The authors correctly note that New Zealand, unlike Australia, has a capped pharmaceutical budget. Space precludes a

full discussion of the benefits and drawbacks of capped budgets, particularly as these have been recently discussed elsewhere.^{6,7} We note, however, that Australia is also considering a pharmaceutical budget cap.⁶ Furthermore, the Australian government has in the past blocked pharmaceutical funding decisions to restrain costs.⁸

We conclude by noting that every country makes often unpalatable trade-offs in publically funding pharmaceuticals. New Zealand undoubtedly has delayed access to pharmaceuticals compared to many other countries.^{4,9,10} However, the positives in New Zealand are that it has universal pharmaceutical coverage (compared with, for example, the United States), and nationally consistent access for outpatient and hospital pharmaceuticals (compared with 'post-code prescribing' in the United Kingdom).⁴ Patient cost-sharing for funded pharmaceuticals is lower than many other countries, and New Zealand also has the certainty of pharmaceutical cost containment.^{4,9} Debate about the right balance between these competing priorities is of course healthy, and it is a topic we heartily encourage

Competing interests: Nil

Author information:

Rajan Ragupathy, Clinical Trials and Research Pharmacist, Pharmacy Services, Waikato District Health Board, Hamilton; Zaheer-Ud-Din Babar, Senior Lecturer, School of Pharmacy, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Corresponding author:

Rajan Ragupathy, Pharmacy Services, Waikato District Health Board, Pembroke Street, Hamilton 3240, Private Bag 3200.
rajan.ragupathy@waikatodhb.health.nz

URL:

<http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2015/vol-128-no-1416/6569>

REFERENCES:

further research and discussion on.

1. Sheehy K, Barber J. Uptake of new medicines in New Zealand: evidence of a waiting list. *N Z Med J.* 2015; 128:1412-10-20
2. Ragupathy R, Kilpatrick K, Babar ZUD. Pharmaceutical pricing in New Zealand. In: Babar Z-U-D, editor. *Pharmaceutical Prices in the 21st Century.* Switzerland, Adis/Springer 2015.
3. Barrett A, Roques T, Small M, Smith RD. Rationing: How much will Herceptin really cost? *BMJ.* 2006; 333: 1118-20.
4. Ragupathy R, Aaltonen K, Tordoff J, et al. A 3-dimensional view of access to licensed and subsidized medicines under single-payer systems in the US, the UK, Australia and New Zealand. *Pharmacoecconomics.* 2012; 30: 1051-65. doi:10.2165/11595270-000000000-00000
5. New Zealand Ministry of Health. Questions and answers- elective services. [Online]. Last Accessed 11 May 2015]. Available

at: <http://www.health.govt.nz/our-work/hospitals-and-specialist-care/elective-services/questions-and-answers-elective-services>

6. Taylor C, Wonder M. Exploring the implications of a fixed budget for new medicines: a study of reimbursement of new medicines in Australia and New Zealand. *Aust Health Rev.* 2015; doi:10.1071/AH14122
7. Ragupathy R, Babar ZU. "Comparing the reimbursement of new medicines between Australia and New Zealand" *Aust Health Rev.* 2015; (In Press)
8. Shaw B. (2012). Deferring PBAC decisions: industry view. *Australian Prescriber.* 2012; 35:3-4
9. Aaltonen K, Ragupathy R, Tordoff J, et al. The impact of pharmaceutical cost containment policies on the range of medicines available and subsidized in Finland and New Zealand. *Value Health.* 2010; 13: 148–56. doi:10.1111/j.1524-4733.2009.00598.x
10. Wonder M, Milne R. Access to new medicines in New Zealand compared to Australia. *N Z Med J.* 2011; 124:1346 12–28.