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Response to the Preliminary Report

**Review of access to high-cost, highly
specialised medicines in New Zealand**

Report to the Researched Medicines Industry

17th February 2010

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1. Introduction

The Researched Medicines Industry (RMI) has asked NZIER to examine the Preliminary Report from the Review of Access to High-Cost, Highly-Specialised Medicines in New Zealand (referred to as the Review).

Our assessment is that the Review:

- does not address the real problem
- Does not offer a solution for managing future demand.

2. Review does not address the real problem

The Review Panel was asked to review access to high-cost, highly-specialised medicines and the exceptional circumstances fund, and advice on practical and affordable means to improve this access.

Its Terms of Reference observed that 20 innovative new medicines were subsidised in New Zealand compared to 78 in Australia over the same time period.

The Review has not undertaken an empirical analysis of whether there is an access issue. Its empirical analysis is limited to quoting a PHARMAC analysis that the majority of these new innovative medicines offer no or little additional benefit over those already funded in New Zealand (p18). No other comparative analysis is offered in the report.

The PHARMAC analysis seems to imply there is no problem, but the Review states:

“Spending relatively small amounts on pharmaceuticals, particularly high-cost, highly specialised medicines, might suggest that the Government’s and New Zealand’s priorities are misplaced in broad terms” (p26).

Furthermore, the Review points to some key weaknesses in the health system:

- spending on other healthcare is not subject to the same rigorous cost-effectiveness test as medicines (under the PHARMAC-subsidy regime), raising the possibility that funding allocated to other healthcare has a lower benefit-cost ratio than is on offer from medicines¹
- the process for setting the total pharmaceutical budget (involving 21 DHBs agreeing what part of their budget to give up to fund PHARMAC) is ‘somewhat fraught’ (p27).

¹ For example, Roche (2009, p21) show that dialysis is a high cost treatment used to prolong life for end stage renal failure. Managing access to dialysis is not consistent with other treatments targeting end of life conditions. Under current conditions, if dialysis was a pharmaceutical, instead of a treatment, it would not be funded.

Both these weaknesses have the same implications: there is a likelihood that the share of Vote Health allocated to the pharmaceutical budget is too low. A reallocation of funding would thus likely generate an improvement in health outcomes for the same outlay.

Regrettably, the Review does not provide practical recommendations on how the first issue might be resolved. We accept this is a hard ask, but agree with the Review Panel's recommendation that the same cost-effectiveness analysis disciplines be adopted when decisions are made to fund other health services.

A more serious failure, though, is silence on how the process for agreeing the PHARMAC budget might be improved. The Review states on p40 that the current process for setting the total pharmaceutical process is about right. But it does not present an analysis of the information and incentive problems that makes that process 'fraught', and how these might be mitigated if not resolved.

This is a major omission in the report, as it might be an area where it would be possible to offer practical recommendations that would improve access to (any, including high-cost) medicines and that could be cost-neutral. We recommend that the Panel address this omission in its final report.

3. No real solution for managing future demand

Most of the draft recommendations tinker around the edges. The Review also seems to downplay the future potential demand for pharmaceuticals. This seems to be based on an assessment that there do not appear to be major 'blockbusters' in the pipeline, and that a cohort of medicines will soon come off patent, which will lead to continued price reductions and so provide PHARMAC further headroom.

Whether this analysis is correct is debatable. Some evidence suggests that bio-pharmaceuticals are becoming more targeted and that these pharmaceuticals are likely to be highly specific and high cost.

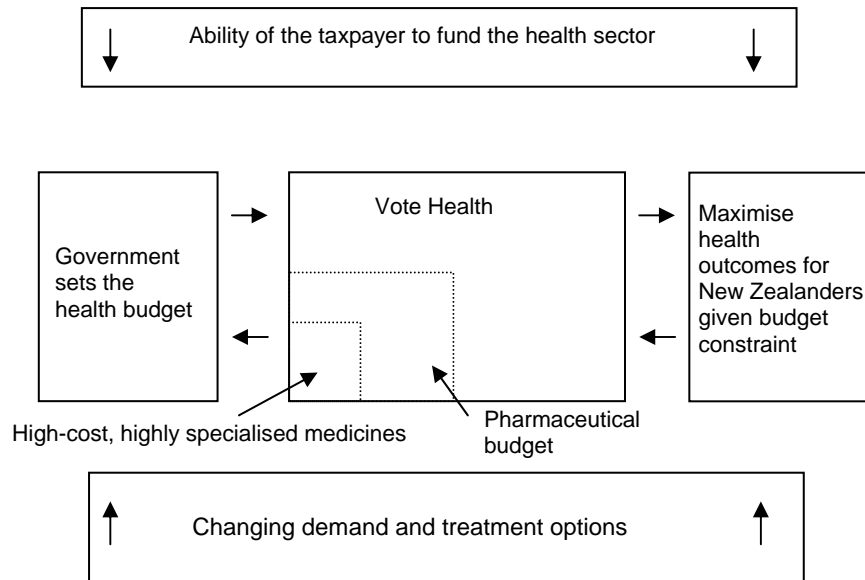
In addition, the lack of a wider framework also means the Review has a number of blind-spots to future pressures that may raise the demand for pharmaceuticals, or that might change the benefit/cost ratios of treatments today or in the future.²

While longer term issues (such as the continued pressures from new technology, rising consumer expectations, and demographic volume growth) may not speak to the immediate question of access, the Review is a unique opportunity to examine the issues and improve the process for the longer term. It would be a shame to forego it now.

² For example, if rising demand for psychogeriatric care raises the demand for scarce specialist healthcare providers, the change in relative price of labour intensive care vs other treatment and care options, could in future change the relative cost-effectiveness ranking of treatment and care options that rely more on pharmaceuticals.

Figure 1 represents one way of looking at the government funded health system albeit in a very stylised way. It highlights the interactions between various elements within the government funded health system illustrating where pharmaceutical funding fits in the health funding environment.

Figure 1: Stylised frame of reference



Source: NZIER

By setting out the context, the Review would have been able to set the parameters of the debate and pinpoint where the pressures need to be managed more effectively.

4. Improving the current mix

The focus of the Review appears to be entirely on improving access to the next high cost medicine brought to market to add it to an otherwise unchanged Schedule – it concludes that the only feasible option to find resources appears to be to reduce wastage in the medicines system (p1-2).

The Review seems to have dismissed, without due analysis, the opportunity of improving access to new innovative medicines by re-examining the cost-effectiveness rankings of medicines already on the Schedule. It may be the case that new innovative medicines are now not funded even if they have a favourable dollar per QALY gained ranking because PHARMAC has insufficient budget, and that budget could be freed up by removing subsidies on currently subsidised medicines that now have a significantly higher dollar per QALY gained.

While we do recognise that PHARMAC force the price down of “old” medicines (see, for example, the price reductions for fluoxetine 1993-2007, p20 of the Review), there is no explicit divestment policy in place the could assist in creating “head room” in the PHARMAC budget for newer high-cost, highly specialised medicines, if these can be demonstrated to offer a better dollar per QALY gained.

5. Summary

Those expecting a blueprint for the future will be disappointed. The Review Panel seems to be aware of some of the main issues, but has chosen not to tackle these. The proposed solutions do not tackle the more fundamental systemic issues, namely the annual determination of the PHARMAC budget, and the apparent lack of a comprehensive regular review of the Schedule and opportunities for reallocation to generate space for new innovative medicines.

The Review should also take a much broader view of the health system (and PHARMACs role in it) and the pressures and funding and delivery challenges this will present, and what the implications might be for managing access to medicines, including high-cost, highly-specialised medicines.

In this respect, the Review does PHARMAC no favours and does not help navigate what will be a difficult phase in their history. PHARMAC will need to look to other reports and other advice if it is to deliver on its mandate (e.g. the recommendations coming out of the MRG report).

6. Recommendations

As a first step we recommend the following:

- That PHARMAC's role be extended so that it is responsible for all pharmaceutical pricing decisions and that the budget allocation be determined at the national level (rather than budgeting decisions being devolved to DHBs);
- That an explicit disinvestment policy should be put in place that could assist in creating "head room" in the PHARMAC budget for newer high-cost, highly specialised medicines, if these can be demonstrated to offer a better dollar per QALY gained. This may require further refinement to the programme budgeting and marginal analysis (PBMA) approach already being used.

7. References

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