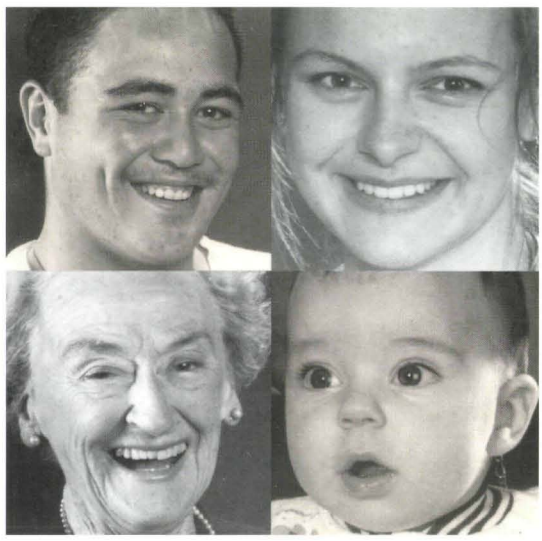
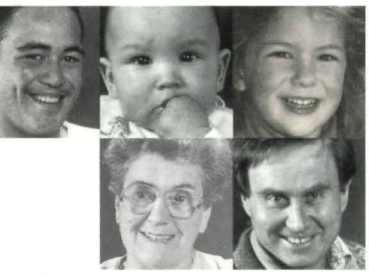
PHARMAC

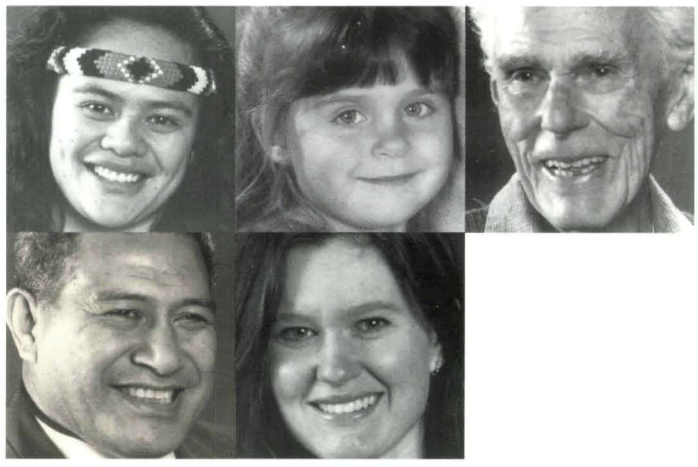
Pharmaceutical Management Agency Ltd





# PHARMAC

## the first 20 months



*measured responsible decisions*

# PHARMAC
## the first 20 months

***PHARMAC manages the subsidisation of pharmaceuticals for the benefit of all New Zealanders.***

*PHARMAC makes decisions that involve:*

**R**ational, scientific evaluation of medical, pharmacological and economic evidence

**T**aking account of patient needs

**P**rotecting taxpayers' interests

**S**eeking advice from independent medical experts

**C**onsulting with patient groups, pharmaceutical suppliers and health professionals

**E**valuating the evidence against balanced decision criteria

# PHARMAC

## Pharmaceutical Management Agency Ltd

### *PHARMAC's Role*

- negotiating with drug companies over supply of their products
- developing prescribing guidelines
- informing prescribers and pharmacists about the availability and cost of pharmaceuticals

### *Board of Directors*

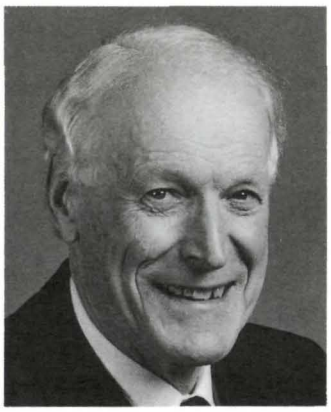
| | |
|---|---|
| J Denis Tait | Independent Chairman |
| Murray Burns | CEO, Central RHA |
| Graeme Edmond | CEO, Midland RHA |
| John Edwards | CEO, Southern RHA |
| Garry Wilson | CEO, North Health |

### *Staff*

| | |
|---|---|
| David Moore | General Manager |
| Dr Win Bennett | Medical Director |
| James Harris | Analyst |
| Lenore Jansen | Therapeutic Group Manager |
| Kyle Jones | Analyst |
| Jan McCombie | Therapeutic Group Manager |
| Dr Reinhard Pauls | Manager Research and Analysis |
| Loryn Scanlan | Therapeutic Group Manager |
| Peter Sharplin | Therapeutic Group Manager |
| Ailsa Surman | Therapeutic Group Assistant |
| Linda Whatmough | Office Coordinator |

### *Pharmacology and Therapeutics Advisory Committee (PTAC)*

| Committee Members | Nominated by: |
|---|---|
| Dr John Hedley, Chairman | Royal Australasian College of Physicians |
| Dr Barry Bruns | Royal Australasian College of Physicians |
| Dr Bruce Foggo | Royal New Zealand College of General Practitioners |
| Dr Keith Humphries | New Zealand Medical Association |
| Professor Gavin Kellaway CBE | Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists |
| Dr Sharon Kletchko | Regional Health Authorities |
| Associate Professor Tim Maling | Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists |
| Dr Les Toop | Royal New Zealand College of General Practitioners |



# PHARMAC BOARD well served by staff and PTAC

The Pharmaceutical Management Agency Ltd (PHARMAC) has developed a respected presence in the short time that it has been in existence.

From its establishment, PHARMAC has aimed to ensure that all decisions and procedures are transparent and without bias.

We are satisfied that in a relatively short time suppliers, prescribers and pharmacists have become aware of PHARMAC's policies and direction. We feel that the publication of the Pharmaceutical Schedule played no small part in this awareness.

The PHARMAC Board is well served by dedicated staff who bring wide experience and deep understanding of the pharmaceutical field. The staff, ably led by general manager David Moore, have managed the very heavy workload in processing the vast flow of information and subsidy applications.

PHARMAC has consulted widely during the decision making process, and has established a systematic basis for making decisions. We aim to ensure that there is logic and predictability in the process of listing on to and retaining medicines in the Pharmaceutical Schedule.

I want to take this opportunity to thank the clinicians who share their expertise with us. We insist on thorough assessment of applications or reviews before making a decision, and we know that we can rely on the independent, unbiased, critical assessments we receive. These come from the independent advisory body, the Pharmacology and Therapeutics Advisory Committee (PTAC), its subcommittees, and all the doctors, pharmacists and specialists who have been consulted.

There is immense pressure on everyone who takes a role in this advisory area. This is understandable in a competitive industrial environment and we are indebted to those who have tendered unprejudiced opinions and assessments on which we base our decisions.

Denis Tait
Board Chairman
Pharmaceutical Management Agency Ltd

# PHARMAC takes reasoned and logical approach

The health reforms, in particular the integration of funding for primary and secondary health care, have resulted in major changes to the funding of pharmaceuticals.

PHARMAC's aim is to ensure that there is fair and equitable patient access to medicines which contribute to the health of New Zealanders, through vigorous assessment of medicines.

To be fair to tax payers, who fund the budget, we also monitor spending carefully.

One of the key problems confronting PHARMAC in July 1993 was the strong and unsustainable level of growth in pharmaceutical expenditure. Unsustainable not only because of the cap placed on health expenditure by the government, but also because of the risk of high growth in pharmaceuticals crowding out other health needs. Concern about the growth was increased by a perception that not all additional expenditure in pharmaceuticals contributed as much to health gains as spending in other areas.

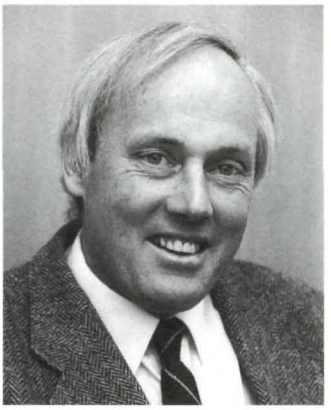
We are pleased to report that the rate of growth has slowed to less than 5% in the year to December 1994, a much healthier figure than the 11% annual growth New Zealand has been facing in the past.

Some groups find it difficult to accept that there should be a budget at all. But the reality is that overspending on pharmaceuticals will inevitably mean that there is less money to spend in other health services. For us then, the question is not *whether* we have to assess spending critically, but *how* we do it.

We cannot do this alone and we have been heartened by the response of individuals and groups who have contributed to the decision making process.

We have had a good beginning, but it is only a beginning. Twenty months is a short time to rebalance such large issues. The achievements to date are significant, but big challenges lie ahead. There is no easy answer - we work at the leading edge of issues that face all nations - but we are confident we will continue to achieve significant health gains for all New Zealanders.

David Moore
General Manager
Pharmaceutical Management Agency Ltd



# PTAC actively seeks comments and opinion

I am fortunate to chair a team of distinguished, dedicated, and highly ethical clinicians. It is not easy to find experts of this calibre who are willing to devote the time and energy to ensure that pharmacological and therapeutic expertise forms the centre of gravity for decisions taken on pharmaceutical subsidies.

The task of PTAC is not a job for one person as no one individual has wide enough expertise. It is definitely a matter of group consensus. The dynamism of the sitting members of PTAC makes for interesting meetings and sound recommendations.

The committee has been in existence for several decades. In fact, the longest serving member of the committee, Professor Gavin Kellaway CBE, has contributed for over 22 years. PTAC has always been independent and objective and I think it is even more so now. PHARMAC's Board listens to our views and recommendations and we respect its ultimate decisions, which are taken from a wider perspective.

Over this year, together with the new PHARMAC structure, PTAC has developed a high level of consultation with practitioners and specialists. We are open to challenge and have considered comments from all medical areas. But more than that, we actively seek comment and views from key opinion leaders.

The members of PTAC are keen to make sure the medical profession knows what they are doing, and why they make the recommendations they do. Members are accessible, often making themselves available to talk to professional groups, writing articles in medical journals whenever asked, and answering any queries that come into the PHARMAC office.

PTAC has had a very productive year and has advised on more than 100 applications to date, as well as assisting in group reviews. Two-thirds of the applications considered resulted in listing on the Pharmaceutical Schedule.

During the next year we will maintain our commitment to making sure our work is visible and continue to give the Board of PHARMAC sound pharmacological and therapeutic advice.

Dr John Hedley
Chairman
The Pharmacology and Therapeutic Advisory Committee

# Introducing PHARMAC

In the reformed health sector, the four Regional Health Authorities (RHAs) are required to decide which medicines and related products receive subsidies. They are also responsible for ensuring access to safe, cost effective quality medicines to meet reasonable health needs.
The Pharmaceutical Management Agency Ltd (PHARMAC), an RHA joint venture company, was established in mid 1993 to make these decisions.

The Directors of PHARMAC are the four RHA chief executives, with an independent chairperson.

PHARMAC operates the national Pharmaceutical Schedule which is the list of medicines and related products subsidised by the Regional Health Authorities. The Schedule was previously managed by the Department of Health's Drug Tariff Section, with the subsidies paid directly by the Crown.

Pharmaceutical suppliers apply to PHARMAC to have a medicine subsidised, after the product is registered by the Ministry of Health.

About 2,500 medicines and related products are subsidised. Most are available to all New Zealanders on prescription by a medical doctor. Depending on the circumstances, medicines can have a variety of guidelines or restrictions such as 'only to be prescribed by specialists' or 'only dispensed by hospital pharmacies' placed on them.

PHARMAC works closely with a team of independent medical advisors on the Pharmacology and Therapeutics Advisory Committee (PTAC), which advises PHARMAC on health needs and clinical benefits.
The eight committee members are all senior members of the medical profession and are actively practising doctors. The chair of PTAC sits with the PHARMAC Board in an advisory capacity.

PTAC helps decide which medicines are to be subsidised from public monies through providing recommendations to PHARMAC.

Decisions taken by PHARMAC incorporate a balanced view of the needs of both prescribers and patients. Decisions aim to achieve long term gains and efficient ways of supplying pharmaceuticals to the community.

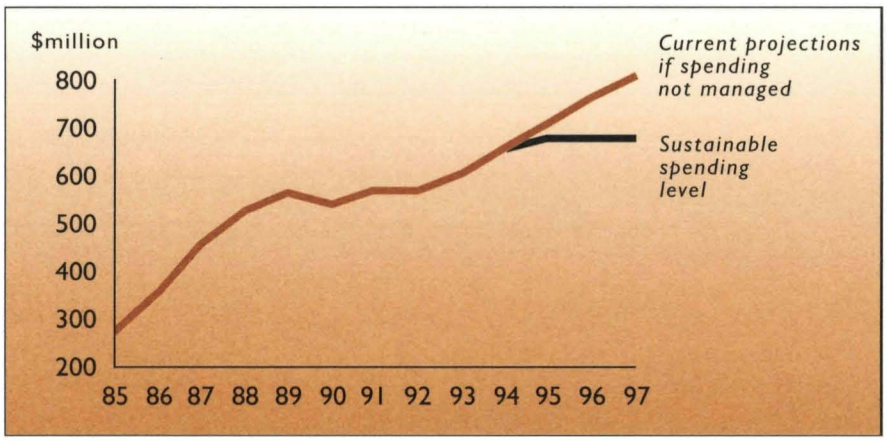
# Decision Criteria

## *PHARMAC makes its decisions taking into account:*

- health needs
- the availability and suitability of existing medicines, therapeutic medical devices or related products to meet health needs
- the clinical benefits, risks and costs of new medicines, therapeutic devices or related products
- the cost effectiveness of meeting health needs by purchasing pharmaceutical services rather than by purchasing other health care and disability services
- the overall budgetary impact of any changes to the Pharmaceutical Schedule
- the direct cost of pharmaceuticals to users
- any recommendations on core health and disability services made by the National Advisory Committee on Core Health and Disability Services
- such other matters as PHARMAC sees fit

# Pharmaceutical Expenditure

### *Historical costs and forecast 1985/97*




Expenditure above the "sustainable spending level" is at the expense of other health care services.

*Sources: Health Benefits Ltd data*
*Ministry of Health forecasts*

# PHARMAC's first 20 months

This formative period in PHARMAC's development has seen a strong emphasis on establishing sound foundations upon which to build the organisation. Foundations which have enabled a dynamic approach to operating within the commercially aggressive arena of the pharmaceutical industry, while at the same time ensuring that a highly professional, consistent, and fair approach to decision making is maintained.

This section outlines the key aspects of the operating framework established by PHARMAC and highlights the major achievements during its first twenty months of operation.

## Operational framework established

### Operating policies and procedures

The Operating Policies and Procedures were developed after extensive consultation with the industry. At the core of these policies and procedures are PHARMAC's Decision Criteria (*see page 7*) which reflect the natural tensions and conflicts of decision making in the health sector. For instance, they take into account the health needs of New Zealanders, the clinical benefits and risks of pharmaceuticals, as well as financial considerations.

### The team

The RHAs have significantly increased the resources devoted to managing pharmaceutical expenditure. A multidisciplinary team, including pharmacists, medical professionals and health economists, has been formed. This, together with investment in advanced information systems and technology, has enabled PHARMAC to manage the purchase of pharmaceuticals with a small, focused and highly productive team.

### Strengthened role of PTAC

PTAC's role has been strengthened to include assessment of both existing and new pharmaceuticals within an overall framework of a therapeutic group.

## *Therapeutic group management*

### The structure

The key to PHARMAC's efficient operation is managing the subsidies within a particular therapeutic group. Therapeutic group managers are the new focus of all negotiations and consultations with suppliers, prescribers and other relevant health professionals, and patient support groups. Group managers are responsible for formulating a strategic view of their therapeutic groups and for recommending changes.

### Focus on prescriber choice and patient access

Given the dynamic nature of the pharmaceutical industry, ongoing re-evaluation of drugs on the Schedule is essential to ensure that a range of products is available, offering prescribers sufficient choice amongst cost effective treatments.

### Therapeutic Group Reviews

Therapeutic Group Reviews are an integral part of our operation.

An important first in the management of New Zealand drug subsidies, the process of therapeutic group reviews ensures that all drugs on the subsidy list are regularly appraised within the overall context.

Six major therapeutic group reviews were begun in the 1993/94 year and a further two, selected on a priority basis, have since been initiated.

## *Reference pricing*

Reference pricing was introduced as part of the Operating Policies and Procedures. It refines the old system of therapeutic group policy and uniform pricing policy.

The technique is internationally recognised and is increasingly used around the world.

Reference pricing is based on the classification of pharmaceuticals into different therapeutic groups and further into subgroups.

- ***A therapeutic group*** is defined as a set of pharmaceuticals which are used to treat the same or similar condition(s).

- ***A subgroup*** is defined as a set of pharmaceuticals which produce the same or similar therapeutic effect in treating the same or similar condition(s).

Reference pricing means that all pharmaceuticals in a given subgroup are subsidised at the level of the lowest priced pharmaceuticals in that subgroup.

For example, *Ulcer-healing Agents* is a therapeutic group, while $H_2$ *Antagonists* is a therapeutic subgroup. This subgroup comprises the agents cimetidine, ranitidine, famotidine and nizatidine. The subsidy paid by Regional Health Authorities for ***all*** of these agents is equivalent to the price of the ***least expensive*** $H_2$ antagonist offered by any supplier.

Reference pricing is highly effective. It reduces the excessive market segmentation based on brand marketing that allowed suppliers to establish markets that were free from price competition. Reference pricing brings price competition back into the pharmaceutical market.

## Innovative contracting

PHARMAC has initiated a flexible approach to contracting and negotiated explicit supplier contracts that reflect true cost effectiveness. For example, some suppliers agree to contracts on the basis of average daily dose costs and others agree to price reductions as certain volumes are reached.

## Rationalised access to expensive drugs

PHARMAC and PTAC undertook the mammoth task of assessing the list of expensive and low-use drugs (section 99s). Access criteria have been reviewed and clarified under the new Special Authority category.

## *Removal of pharmacists' contract from the Pharmaceutical Schedule*

All relevant information previously covered in five different documents has been brought together into one Pharmaceutical Schedule.

The terms and conditions of payments for pharmacists were removed from the Pharmaceutical Schedule. These are now mainly covered in notices issued by RHAs under section 51 of the Health and Disability Services Act 1993.

At the same time, the language and structure of the Pharmaceutical Schedule were simplified and some historical anomalies tidied up.

## *Relationships*

### Better liaison improves understanding

In mid 1994 a medical director was appointed. Since this appointment, our ability to liaise and empathise with medical organisations has improved greatly.

PHARMAC seminars held with suppliers in both New Zealand and Australia, frequent visits to suppliers, and plans for one of the team to take up an overall relationship role with suppliers, are all initiatives aimed at improvements in relationships and understanding of our respective situations.

### Prescribers' Summit

A meeting in July brought together representatives from health agencies and medical colleges to discuss issues surrounding rational prescribing.

As a result of the Summit, PHARMAC and the Ministry of Health are now collaborating on a wider range of issues. A further initiative is for PHARMAC to provide more direct-mail prescribing information to practitioners, such as the recent information on the use of spacer devices for children with asthma.

# Achievements

## New Zealand Pharmaceutical Schedule

The material end product of our work is the New Zealand Pharmaceutical Schedule which is produced every four months, with monthly updates. Establishment of this publication within its first year of operation was a major achievement for PHARMAC.

For the first time, unbiased cost information is being circulated to doctors. By providing this information, we aim to increase the ability of prescribers to be cost effective.

The primary objective of the Schedule is to provide prescribers and dispensers with the list of subsidised pharmaceuticals that can be prescribed, and the conditions applying to them.

It includes information previously contained in the Drug Tariff, Pricing Schedules, Hospital Pricing Schedule, Special Foods List and Special Authority Pharmaceutical Subsidies (December 1993).

The Pharmaceutical Schedule enables users to see at one glance whether a drug is subsidised, whether there are any guidelines or restrictions and whether the patient is required to pay any premium on top of the normal user charge.

## The impact of generics

The purchase of lower priced generic $H_2$ antagonists, in combination with the application of reference pricing, has enabled PHARMAC to achieve a significant price reduction of almost 30% on all $H_2$ antagonists. This will generate savings of about $10 million in the coming year. Similarly, the entry of generic inhaled steroids for asthma achieved savings of $5 million in the 1994 year.

These two examples contrast sharply with the claim that generics do not save money. In fact, the impact of aggressively priced generics is magnified by reference pricing.

## *Subsidy Applications*

In its first twenty months of operation PHARMAC received 171 applications. By December 1994 final decisions had been made on 117 of these, 67% (78) were accepted and 33% (39) declined.

## *Responding to community and prescriber needs*

### The 1993 scabies outbreak

PHARMAC responded quickly to a widespread outbreak of scabies in September 1993. A priority decision was made to fully subsidise permethrin (Lyclear), a new but expensive treatment. This was the first subsidy decision where voluntary guidelines were applied, leaving the responsibility for rational prescribing fully with doctors.

### Asthma treatment for children given priority

The decision to subsidise a child spacer device was made while the review of asthma medications was still in progress, recognising the need for treatment of children with asthma.

### New anti-epileptic drugs

PHARMAC has enabled patients with epilepsy access to new therapies (vigabatrin and lamotrigine). The development of a budget holding plan for subsidy of these pharmaceuticals was a first for New Zealand and has meant subsidised access to these therapies for those patients who benefit most.

### Removing anomalies

PHARMAC has removed some historical restrictions considered obsolete to modern prescribing:

*Antibiotic constraints lifted* - removal of the four-day restriction on subsidised prescriptions of antibiotics and removal of the 15g restriction on antibiotic creams and ointments.

*Diabetic syringes* - doctors now only need to endorse the prescription form with the words 'insulin patient'.

*Specialist prescription restriction* - clarified the definition of 'specialist recommendation restriction' required for subsidisation of some medicines. As part of the ongoing debate, we are looking at alternative, more efficient ways of targeting pharmaceuticals to those patients most likely to benefit.

## Active management

### Dipyridamole

The decision to reduce the subsidy on dipyridamole is an example of active management of individual drugs on the Schedule. The 18 month review was as rigorous as the assessment of new drug applications.

PTAC found that there was insufficient evidence to conclude that dipyridamole is any more effective than aspirin for most conditions, and that the combination of dipyridamole and aspirin is no more effective than aspirin alone. The decision to reduce the subsidy to the same level as that of aspirin represents annual savings of up to $4 million.

The decision has generally been well supported by the profession. However, as with all decisions to change established practice, it has not been received well by everybody.

### Oxypentifylline

The reassessment of oxypentifylline focused on the clinical usefulness of the indications. Several indications were removed from the Pharmaceutical Schedule, but there was no reduction in the subsidy. This has resulted in annual savings of about $72,000.

## Financial Savings

Savings achieved by PHARMAC over its first 18 months of operation have been significant.

Decisions such as those highlighted above resulted in realised savings of $3.1 million dollars in the 1993/94 financial year. Savings for 1995/96 are forecast to be $32 million.

These savings and their longer term impact are explained in the expenditure section, pages 18 to 19.

## *Progress with Therapeutic Group Reviews*

### Antidepressant Treatments

*Total Expenditure*
*Years ending 30 June*

*Commenced September 1993 - mid 1995*

A particular concern is the strong annual growth in spending on antidepressants ($5 million in 1994). This rate of increase (around 40%) is not only financially unsustainable, but is also overriding other urgent health needs. The challenge is to make modern therapy available to patients while avoiding an expenditure blowout.

PHARMAC's response is to target the newer, more expensive drugs to those patients most likely to benefit. PHARMAC is working closely with psychiatrists and general practitioners to draw up guidelines and to develop other ways of achieving this goal.

### Antibiotic Therapies

*Total RHA Expenditure*
*Years ending 30 June*

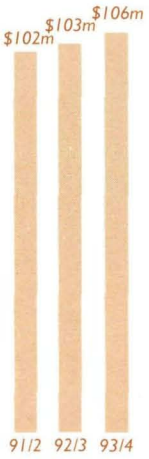
*Commenced December 1993 - ongoing*

Growth in antibiotic expenditure comes from both increasing volumes of antibiotic prescribing and the shift from cheaper/older agents to more expensive/newer antibiotics.

We are concerned by the increasing volumes of antibiotics prescribed when there appears to be no increase in the prevalence of bacterial infections. We also seek to minimise the unnecessary use of newer, more expensive agents where an older, cheaper alternative may successfully cure the patient. Not only is there a cost consideration involved with this, but also a fear that excessive use of these new agents may speed up the development of bacteria which are resistant to them, thus depriving patients and doctors of effective drugs for serious infections.

The review is tackling these issues and aims to maintain access to the newer antibiotics, while ensuring that the more familiar products continue as the mainstay of treatment.

## Asthma Medications



*Total RHA Expenditure*
*Years ending 30 June*

*Commenced June 1994 - completion early 1995*

This comprehensive review has established a structure for reference pricing of subsidies on asthma medications. The decision to fully subsidise a spacer device for young children was made before the review was finished because of the strong evidence as to the effectiveness of those devices in improving child asthma.

Decisions for this therapeutic group were based not only on clinical data, but also on the feedback gained after liaison with a wide range of interest groups, including the Asthma Foundation, health professionals, suppliers and medical specialists.

The reviewers are also developing a medium term strategy for subsidy of asthma medications and, as part of that, are assessing new drugs that have been offered and their potential place in asthma therapy.

## Nitrates

*Initial review 1993/94 - further review planned for 1995*

An initial review of nitrates by PHARMAC found that patches were much more expensive than alternative nitrate therapies, without demonstrable additional therapeutic benefit. The subsidies on nitrate patches were dropped 20% on 1 February 1994, bringing the cost closer to that of oral therapy. This represents an annual saving of around $1.4 million.

A further, more extensive review is planned, looking at the comparative efficiencies and subsidies of all medicines within the nitrate group.

## Special Foods

*Reviewed annually*

The 1994 review of Special Foods was extensive. PTAC established a subcommittee of specialists to assist with the task. The review also involved consultation with paediatricians, dietitians, gastroenterologists and other specialists.

It established clearer guidelines, introduced a wider product range and relaxed some of the Special Authority restrictions, taking greater account of consumer needs and access. The application process was also improved to enable GPs to make re-applications.

Although significant improvements were achieved through the review, there are still unresolved issues and the committee is to be reconvened.

## Extemporaneously Compounded Preparation and Galenicals (ECPs)

*Reviewed annually*

The emphasis of the 1993/94 review of ECPs was on improving the safety, stability and efficacy levels of admixtures dispensed. Although the changes actually increased expenditure, gains in quality are of greater importance. At times we were paying for preparations of dubious merit. The review made good progress in a controversial and much neglected area, but there is still room for further improvement.

## Lipid Modifying Agents

*Total RHA Expenditure*
*Years ending 30 June*

*Commenced September 1994 - completion mid 1995*

Total RHA expenditure on lipid modifying agents in the 1993/94 year was $11.5 million, an increase of 28% over the previous year. This review has been given priority because of the rapid rise in expenditure, and some evidence that lipid lowering agents were not being targeted to those people most at risk.

One of the difficulties in this review is the quite significant divergence in medical opinion regarding the management of dyslipidaemia. The review involves extensive consultation and intensive evaluation of the medical literature.

A key objective of the review is the development of new guidelines to provide the most equitable and cost effective use of lipid modifying agents.

PTAC has appointed a subcommittee of general practitioners and general physicians who are specialists in the treatment of hyperlipidaemia, to assist with this review.

## NSAIDs

*Total RHA Expenditure*
*Years ending 30 June*

*Commenced August 1994 - completion early 1995*

The medical concerns about the safety and inappropriate use of non steroidal anti-inflammatory drugs (NSAIDs) have triggered this review.

Furthermore, past pricing in this group has not been entirely consistent or logical.

A subcommittee has been appointed, in this case involving a sports specialist, rheumatologist, general practitioners and physicians. The aim is to develop the most cost effective use of these agents.

# Pharmaceutical Expenditure

## Past growth

Pharmaceutical expenditure has, for many years, been one of the fastest-growing areas of government expenditure. In the year to June 1994, pharmaceutical subsidies were $58 million (10%) higher than in the previous year.

This escalation is mostly due to a persistent pattern of very fast growth in the use of newly subsidised pharmaceuticals. A long-term analysis shows that the entire expenditure increase between 1985 and 1991 can be attributed to products introduced since 1986. There are two parts to this volume increase: new pharmaceuticals are used in place of older therapies (eg, $H_2$ antagonists displacing antacids); and more significantly, line extensions such as slow release preparations. Of the increase, 18% was due to the introduction of new chemical entities, and 62% to line-extensions of patented products.

The prices for new chemical entities and line extensions are usually much higher than for the therapies they displace, regardless of the level of therapeutic gain offered.

## Activity in 1993/94

Both expenditure and growth were driven by a relatively small number of pharmaceuticals. For example, over half the total cost was in the three largest groups - respiratory, cardiovascular, and central nervous system (CNS) products. Half the annual increase was in only five of 100 pharmaceutical groupings - ulcer healing products, systemic antibacterials, antidepressants, antihypertensives, and anti infective skin preparations.

The growth rates in these groups continued to be very high, antidepressants in particular having continued to increase at an annual rate of 38%, reaching $20 million in 1993/94.

### The impact of savings achieved

The savings accruing to PHARMAC's activities are significant. Decisions to December 1994 are predicted to save $32 million in the year to June 1996. RHAs have reinvested $2.3 million of the savings into purchasing new pharmaceutical products.

The savings have grown and will continue to grow as:

- past decisions build up to their full effect
- PHARMAC takes further decisions that save money

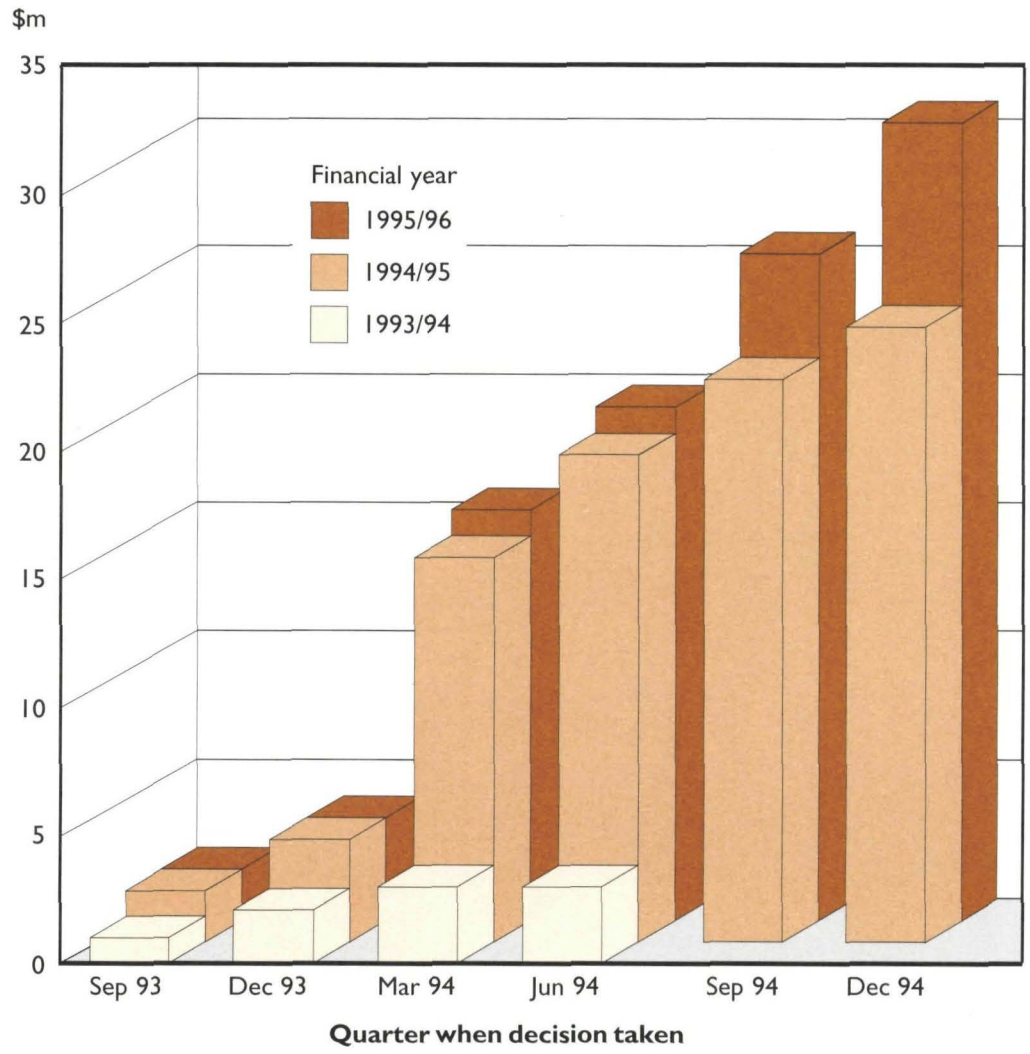
By June 1994, PHARMAC had saved $3.1 million; for the year to June 1995, savings will be $24 million; for the year to June 1996, $32 million.

The most significant decisions to date have been the price changes caused by increased competition in $H_2$ antagonists (ulcer healing therapy), asthma medications and nitrate therapy (angina).

The effects of these decisions can be seen in the subsidy costs for $H_2$ antagonists which have fallen from around $3 million to $2.5 million a month, and for dipyridamole which have dropped from about $380,000 to $20,000 a month.

## *Effect of PHARMAC decisions*

### *Cash savings momentum*



# Trends in 1994/95

## Reduced pharmaceutical expenditure growth

RHAs aim to bring the growth rate in their expenditure on pharmaceutical subsidies to a level that will fit within the increase in their overall budgets for health care. Current growth rates of 5% to 10% are not sustainable.

Growth targets apply to the pharmaceuticals that are already subsidised.

RHAs also must balance the purchase of pharmaceuticals against the cost and value of other health care. The pharmaceutical budget may be increased to purchase new products that reduce the need for other health care or offer more therapeutic benefits than any other potential use of funds. The budget may be decreased if Therapeutic Group Reviews identify pharmaceuticals that offer particularly low value for money.

## Looking forward

Prescriber budget-holding and incentive contracts are a new influence on pharmaceutical subsidies in 1994/95. Many prescribers are negotiating agreements with RHAs that give them strong incentives to increase the cost effectiveness of their overall prescribing. This should have a marked effect on the level and mix of prescribing in the near future.

*STATISTICS*

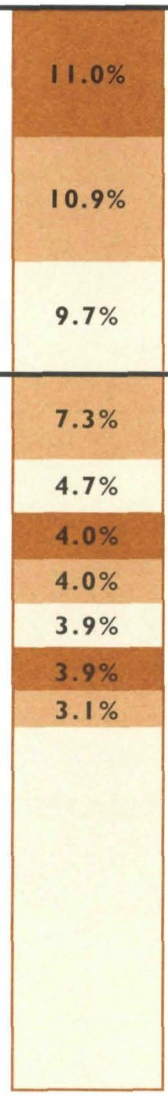
*Tables and graphs in this publication are based on Health Benefits Ltd (HBL) payments data and Ministry of Health forecast data. All cost figures include pharmacy wholesale and dispensing margins of 10% and 11.28%, plus dispensing fees and GST. They exclude payments made by patients - prescription charges and suppliers' premiums.*

# Breakdown of $58m increase year to June 1994

The three groups ulcer healing drugs, antibacterials and antidepressants, accounted for almost one third of the increase in subsidy cost between the years to June 1993 and June 1994, despite making up 15% of the total cost.

The "other" category contains the remaining 90 therapeutic groups and accounts for just over one third of the costs in the first year, yet accounted for less than a third of the cost increase. It includes 36 groups where subsidy dropped, for a total decrease of only $3.1m.

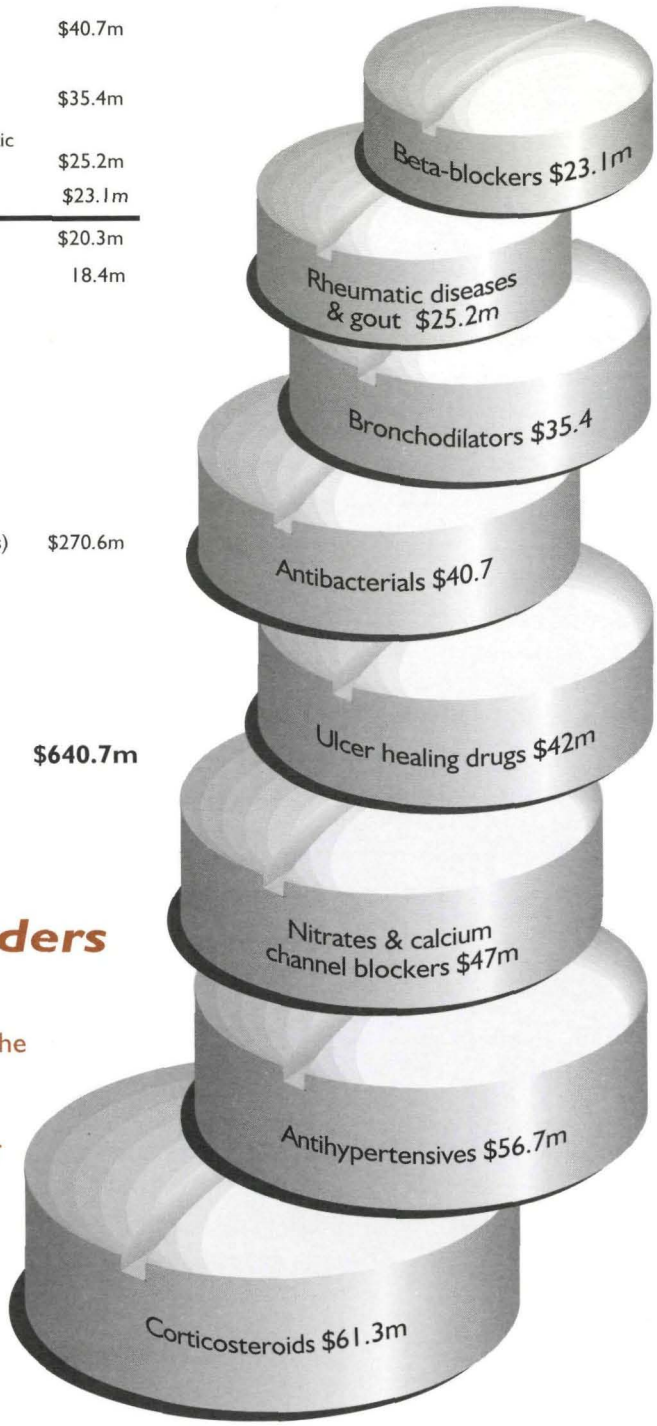
***The major contributors to cost increase 31.6%***



| | | |
|---|---|---|
| 11.0% | Ulcer healing drugs | $6.4m |
| 10.9% | Antibacterials | $6.4m |
| 9.7% | Antidepressants | $5.6m |
| 7.3% | Antihypertensives | $4.2m |
| 4.7% | Anti-infective skin preparations | $2.7m |
| 4.0% | Nitrates & calcium channel blockers | $2.3m |
| 4.0% | Corticosteroids | $2.3m |
| 3.9% | Drugs used for hyperlipidaemia | $2.3m |
| 3.9% | Sex hormones | $2.3m |
| 3.1% | Analgesics | $1.8m |
| | Others (90 therapeutic groups) | $22.1m |
| | **TOTAL** | **$58.4m** |

# Subsidy cost year to June 1994

| | | | |
|---|---|---|---|
| 51.8% | 9.6% | Corticosteroids | $61.3m |
| | 8.9% | Antihypertensives | $56.7m |
| | 7.3% | Nitrates & calcium channel blockers | $47.0m |
| | 6.6% | Ulcer healing drugs | $42.0m |
| | 6.4% | Antibacterials | $40.7m |
| | 5.5% | Bronchodilators | $35.4m |
| | 3.9% | Drugs used in rheumatic diseases and gout | $25.2m |
| | 3.6% | Beta-blockers | $23.1m |
| | 3.2% | Antidepressants | $20.3m |
| | 2.9% | Analgesics | 18.4m |
| | 42.1% | Others (90 therapeutic groups) | $270.6m |
| | | **TOTAL** | **$640.7m** |




## *The Big Spenders*

Eight of the 100 therapeutic groups account for over half the total subsidy cost. The most significant expenditure is on respiratory and cardiovascular pharmaceuticals.

# TOP 50 - Ranked by Subsidy Cost

| | British National Formulary Classification | Cost year to 30 June 1994 $ | Proportion of total cost % |
|---|---|---|---|
| 1 | Corticosteroids (Respiratory System) | 61,300,000 | 9.6 |
| 2 | Antihypertensive drugs | 56,700,000 | 8.9 |
| 3 | Nitrates and other vasodilators, and calcium channel blockers | 47,000,000 | 7.3 |
| 4 | Ulcer-healing drugs | 42,000,000 | 6.6 |
| 5 | Antibacterial drugs | 40,700,000 | 6.4 |
| 6 | Bronchodilators | 35,400,000 | 5.5 |
| 7 | Drugs used in rheumatic diseases and gout | 25,200,000 | 3.9 |
| 8 | Beta-blocking drugs | 23,100,000 | 3.6 |
| 9 | Antidepressant drugs | 20,300,000 | 3.2 |
| 10 | Analgesics | 18,400,000 | 2.9 |
| 11 | Contraceptives | 16,500,000 | 2.6 |
| 12 | Drugs used in diabetes | 15,500,000 | 2.4 |
| 13 | Drugs acting on the nose | 11,600,000 | 1.8 |
| 14 | Drugs used in the treatment of hyperlipidaemia | 11,500,000 | 1.8 |
| 15 | Sex hormones | 11,200,000 | 1.8 |
| 16 | Drugs used in Parkinsonism and related disorders | 9,900,000 | 1.6 |
| 17 | Topical corticosteroids | 9,300,000 | 1.5 |
| 18 | Monitoring and diagnostic agents (plasma or serum) | 9,300,000 | 1.4 |
| 19 | Prophylaxis of asthma | 9,000,000 | 1.4 |
| 20 | Drugs affecting the immune response | 8,900,000 | 1.4 |
| 21 | Anti-epileptics | 8,800,000 | 1.4 |
| 22 | Anti-infective skin preparations | 8,800,000 | 1.4 |
| 23 | Sex hormones and antagonists in malignant disease | 7,300,000 | 1.1 |
| 24 | Preparations for acne | 6,600,000 | 1.0 |
| 25 | Drugs used in psychoses and related disorders | 6,400,000 | 1.0 |
| 26 | Laxatives | 6,300,000 | 1.0 |
| 27 | Diuretics | 5,400,000 | 0.8 |
| 28 | Hypothalamic and pituitary hormones and anti-oestrogens | 5,200,000 | 0.8 |
| 29 | Antiplatelet drugs | 5,000,000 | 0.8 |
| 30 | Antiviral drugs | 4,800,000 | 0.7 |
| 31 | Treatment of glaucoma | 4,600,000 | 0.7 |
| 32 | Treatment of chronic diarrhoeas | 4,000,000 | 0.6 |
| 33 | Anti-arrhythmic drugs | 3,700,000 | 0.6 |
| 34 | Hypnotics and anxiolytics | 3,600,000 | 0.6 |
| 35 | Vitamins | 3,600,000 | 0.6 |
| 36 | Corticosteroids (Endocrine System) | 3,300,000 | 0.5 |
| 37 | Drugs used in other musculoskeletal disorders | 3,100,000 | 0.5 |
| 38 | Foods for special diets and nutritional support | 3,000,000 | 0.5 |
| 39 | Allergic disorders | 2,800,000 | 0.4 |
| 40 | Antacids | 2,600,000 | 0.4 |
| 41 | Emollient and barrier preparations | 2,500,000 | 0.4 |
| 42 | Drugs used in anaemias | 2,400,000 | 0.4 |
| 43 | Drugs used in nausea and vertigo | 2,300,000 | 0.4 |
| 44 | Antifungal drugs | 2,300,000 | 0.4 |
| 45 | Preparations for psoriasis and eczema | 2,000,000 | 0.3 |
| 46 | Minerals | 2,000,000 | 0.3 |
| 47 | Treatment of vaginal and vulval conditions | 1,900,000 | 0.3 |
| 48 | Drugs affecting intestinal secretions | 1,900,000 | 0.3 |
| 49 | Electrolyte and water replacement | 1,700,000 | 0.3 |
| 50 | Rectal and colonic drugs | 1,600,000 | 0.2 |
| OTHERS | | 40,100,000 | 6.2 |
| **TOTAL** | | **$640,700,000** | **100.0** |

NOTES: Subsidy is total cost to RHAs, including all markups, dispensing fees and GST, and excluding prescription charges and suppliers' premiums. Includes all subsidised prescriptions dispensed by retail pharmacies, and some hospital and practitioner dispensed items. Figures have been rounded to the nearest $100,000 or $10,000 as appropriate.

# TOP 50 - Ranked by increase in cost to RHAs

| | British National Formulary Classification | Increase year to 30 June 1994 $ | Growth rate % | Proportion of total increase % |
|---|---|---|---|---|
| 1 | Ulcer-healing drugs | 6,400,000 | 18.1 | 11.0 |
| 2 | Antibacterial drugs | 6,400,000 | 18.5 | 10.9 |
| 3 | Antidepressant drugs | 5,600,000 | 38.4 | 9.7 |
| 4 | Antihypertensive drugs | 4,200,000 | 8.1 | 7.3 |
| 5 | Anti-infective skin preparations | 2,700,000 | 45.1 | 4.7 |
| 6 | Nitrates and other vasodilators, and calcium channel blockers | 2,300,000 | 5.2 | 4.0 |
| 7 | Corticosteroids (Respiratory System) | 2,300,000 | 3.9 | 4.0 |
| 8 | Drugs used in the treatment of hyperlipidaemia | 2,300,000 | 24.9 | 3.9 |
| 9 | Sex hormones | 2,300,000 | 25.1 | 3.9 |
| 10 | Analgesics | 1,800,000 | 10.8 | 3.1 |
| 11 | Drugs used in diabetes | 1,300,000 | 8.9 | 2.2 |
| 12 | Drugs acting on the nose | 1,300,000 | 12.2 | 2.2 |
| 13 | Monitoring and diagnostic agents (plasma or serum) | 1,300,000 | 15.7 | 2.2 |
| 14 | Drugs affecting the immune response | 1,200,000 | 14.9 | 2.0 |
| 15 | Antiviral drugs | 1,000,000 | 28.0 | 1.8 |
| 16 | Intravenous nutrition | 900,000 | 399.4 | 1.5 |
| 17 | Sex hormones and antagonists in malignant disease | 900,000 | 13.3 | 1.5 |
| 18 | Vitamins | 800,000 | 29.4 | 1.4 |
| 19 | Preparations for acne | 800,000 | 13.6 | 1.3 |
| 20 | Drugs used in anaemias | 700,000 | 39.3 | 1.1 |
| 21 | Treatment of chronic diarrhoeas | 700,000 | 20.0 | 1.1 |
| 22 | Antifungal drugs | 700,000 | 41.2 | 1.1 |
| 23 | Topical corticosteroids | 600,000 | 6.8 | 1.0 |
| 24 | Anti-epileptics | 500,000 | 6.4 | 0.9 |
| 25 | Allergic disorders | 400,000 | 16.9 | 0.7 |
| 26 | Bronchodilators | 400,000 | 1.0 | 0.6 |
| 27 | Drugs affecting intestinal secretions | 200,000 | 14.5 | 0.4 |
| 28 | Contraceptives | 200,000 | 1.4 | 0.4 |
| 29 | Preparations for psoriasis and eczema | 200,000 | 12.3 | 0.4 |
| 30 | Antispasmodics and other drugs altering gut motility | 200,000 | 19.8 | 0.3 |
| 31 | Minerals | 200,000 | 10.3 | 0.3 |
| 32 | Other endocrine drugs | 200,000 | 22.9 | 0.3 |
| 33 | Anti-arrhythmic drugs | 100,000 | 3.8 | 0.2 |
| 34 | Emollient and barrier preparations | 100,000 | 5.6 | 0.2 |
| 35 | Treatment of glaucoma | 100,000 | 2.9 | 0.2 |
| 36 | Corticosteroids (Endocrine System) | 100,000 | 3.6 | 0.2 |
| 37 | Drugs used in urinary-tract disorders | 100,000 | 9.8 | 0.2 |
| 38 | Rectal and colonic drugs | 100,000 | 5.1 | 0.1 |
| 39 | Drugs used in nausea and vertigo | 100,000 | 3.5 | 0.1 |
| 40 | Central nervous stimulants | 100,000 | 75.7 | 0.1 |
| 41 | Drugs acting on the ear | 100,000 | 8.5 | 0.1 |
| 42 | Antidiarrhoeal drugs | 50,000 | 5.8 | 0.1 |
| 43 | Corticosteroids and other anti-inflammatory preparations | 40,000 | 7.1 | 0.1 |
| 44 | Anticoagulants and protamine | 40,000 | 4.6 | 0.1 |
| 45 | Drugs affecting bone metabolism | 40,000 | 9.1 | 0.1 |
| 46 | Anti-infective preparations | 40,000 | 3.6 | 0.1 |
| 47 | Drugs used in other musculoskeletal disorders | 30,000 | 1.1 | 0.1 |
| 48 | Drugs acting on the oropharynx | 30,000 | 3.2 | 0.1 |
| 49 | Drugs used in psychoses and related disorders | 30,000 | 0.5 | 0.0 |
| 50 | Electrolyte and water replacement | 30,000 | 1.7 | 0.0 |
| OTHERS | | 6,300,000 | 315.7 | 10.8 |
| **TOTAL** | | **$58,400,000** | **10.0** | **100.0** |

NOTES: Subsidy is total cost to RHAs, including all markups, dispensing fees and GST, and excluding prescription charges and suppliers' premiums. Includes all subsidised prescriptions dispensed by retail pharmacies, and some hospital and practitioner dispensed items. Figures have been rounded to the nearest $100,000 or $10,000 as appropriate.

Freepost 4072 Pharmaceutical Management Agency Ltd
PO Box 10 254 Wellington New Zealand
**Telephone 64-4-473 0152**
Facsimile 64-4-473 0516

*ISBN 0-473-03017-9*
*March 1995*