PHARMAC
Pharmaceutical Management Agency

Annual Review 2002

Building *relationships*

PHARMAC

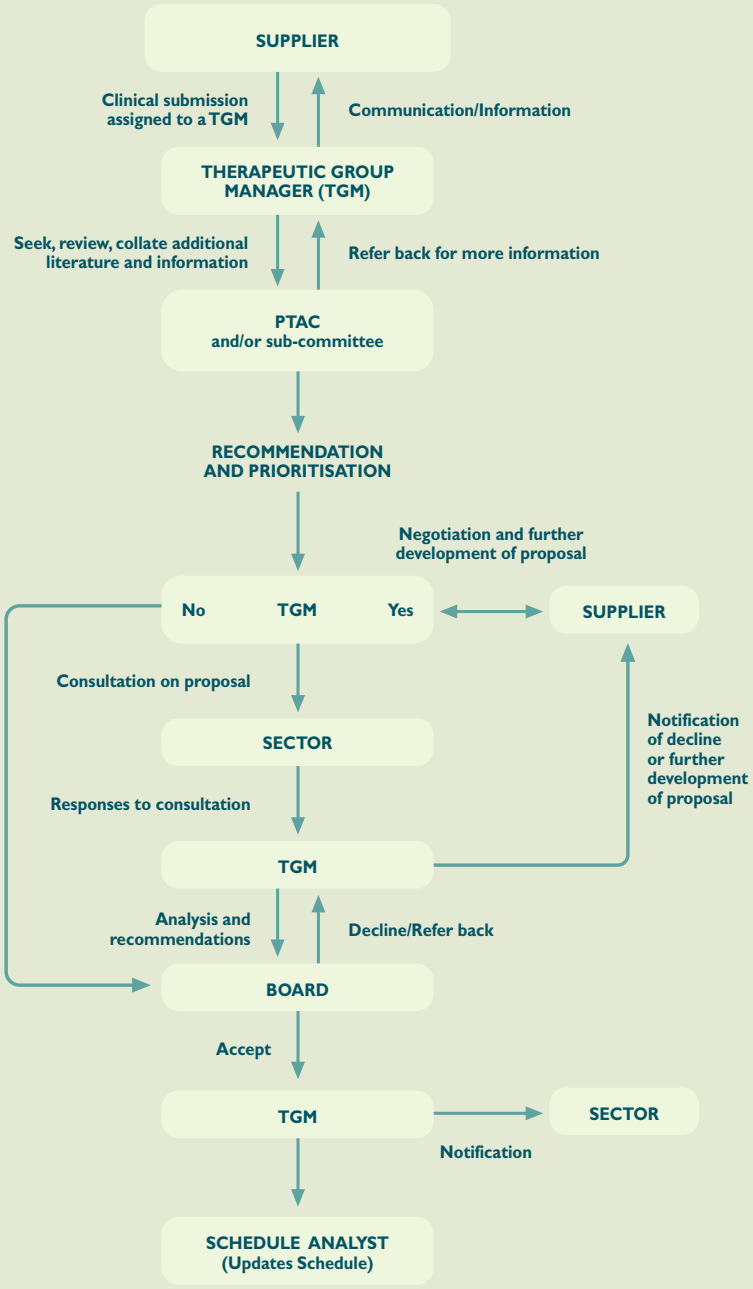
(the Pharmaceutical Management Agency) is a Crown Entity established under the New Zealand Public Health and Disability Act. Its statutory objective is to secure for those in need of pharmaceuticals the best health outcomes that are reasonably achievable from pharmaceutical treatment within the amount of funding provided. PHARMAC's primary function is to manage the national Pharmaceutical Schedule, which is a list of over 2,600 prescription drugs and related products that are subsidised by the Government. The Schedule applies consistently throughout New Zealand and is updated monthly.

The Schedule records the price of each drug, the subsidy it receives from public funds and the guidelines or conditions under which it may be funded.

The PHARMAC Board makes the final decisions on subsidy levels and prescribing criteria and conditions with independent advice from medical experts on the Pharmacology and Therapeutics Advisory Committee (PTAC) and advice from its specialist sub-committees, and PHARMAC's managers and analysts.

In all its decisions PHARMAC seeks to balance out the needs of patients for equitable access to healthcare with the needs of taxpayers for responsible management of the costs they ultimately bear.

Process for listing a new pharmaceutical on the Pharmaceutical Schedule



The process set out in the diagram above is intended to be indicative of the process that may follow where a supplier wishes to list a new pharmaceutical on the Pharmaceutical Schedule. PHARMAC may, at its discretion, adopt a different process or variations of this process.

Highlights of 2001-02

Major PHARMAC achievements in 2001-02 were:

- Providing new or wider access to 24 subsidised treatments, including those for raised cholesterol, multiple sclerosis, schizophrenia, epilepsy, arthritis and hay fever under cost-neutral and/or financially sustainable arrangements.
- Containing pharmaceutical expenditure growth by successfully negotiating savings worth approximately $36.8 million.
- Developing a National Hospital Pharmaceutical Purchasing Strategy.
- Being authorised by the Minister of Health to manage hospital pharmaceutical purchasing on behalf of District Health Boards.
- Formalising relationships with District Health Boards through the development of DHB Relationship Agreements.
- Developing and implementing a Maori Responsiveness Strategy.
- Assuming responsibility for the assessment and approval process for pharmaceutical cancer treatments.
- Establishing a Consumer Advisory Committee to provide a patient or health consumer perspective on PHARMAC decisions.
- Running information campaigns such as the Wise Use of Antibiotics, Take Control of Your Cholesterol and Adult Asthma Management.
- Assuming responsibility for managing the Exceptional Circumstances scheme.

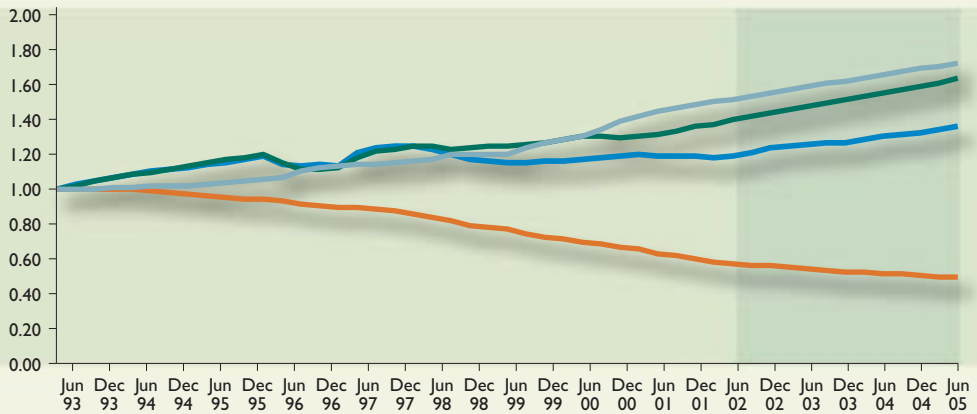
In this Review:

- *"Year" means year ending 30 June. For example: "this year" means the year ended 30 June 2002; "last year" means the year ended 30 June 2001, "next year" means the year ended 30 June 2003.*
- *Unless otherwise stated all values are in New Zealand dollars.*
- *Unless otherwise stated all references to expenditure are unadjusted for any rebates that may be due or paid by suppliers under risk sharing agreements.*

Strengthening

SUBSIDY, VOLUME, MIX AND COST INDICES

Four-quarterly moving averages
Base: four quarters ending June 1993 = 1,000.



Cost Index is the drug cost to DHBs ex-manufacturer before GST

Subsidy Index is like the Consumer Price Index but for subsidised pharmaceuticals only

Forecast

Volume Index is the number of prescriptions multiplied by a standardised measure of the amount prescribed per prescription

Mix Index is the residual from cost index divided by (volume index X subsidy index)

PHARMAC Chairman Richard Waddel reviews the year

It has been another busy and eventful year at PHARMAC, one in which a great deal has been achieved.

LINKS

In our first full financial year as a stand-alone Crown Entity, PHARMAC has developed further to meet the challenges of managing pharmaceutical expenditure in both the community and hospital sectors.

If there has been a common theme to the year, it has been one of strengthening links to various parts of the health sector, and the community at large. This has been done by building on our existing policy of consulting with the sector on funding decisions, and by developing closer relationships with District Health Boards (DHBs), the Ministry of Health, clinicians, community groups and the pharmaceutical industry. Stronger links with the Maori community will be vital to the success of PHARMAC's Maori Responsiveness Strategy, which was developed this year, while health consumers will have extra input to the PHARMAC Board through the Consumer Advisory Committee (CAC).

These enhanced links are vitally important for the future of PHARMAC and the health sector as a whole. While I have faith in PHARMAC's continued ability to perform its key roles, PHARMAC can be most effective when it is part of a team working with other organisations within the health sector.

This year PHARMAC has expanded its focus and operations to include the hospital sector, while maintaining its focus on health outcomes through its assessment of new medicines, management of the pharmaceutical budget and promoting the responsible use of medicines.

PHARMAC has formalised its standing with District Health Boards through the development of Relationship Agreements with all 21 DHBs. PHARMAC has worked with DHBs in the development of a National Hospital Pharmaceutical Purchasing Strategy so that PHARMAC can have a real and positive impact on the ability of DHBs to successfully manage their pharmaceutical budgets.

The Hospital Pharmaceutical Advisory Committee (HPAC), comprising hospital pharmacists and managers, provides advice to PHARMAC on the hospital strategy. New sub-committees of the Pharmacology and Therapeutics Advisory Committee (PTAC) have also been established to provide advice on new pharmaceutical cancer treatments and analgesics.

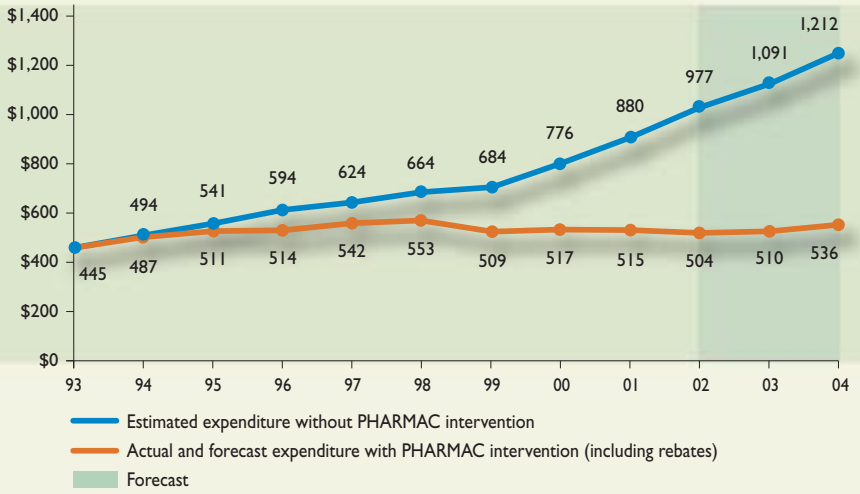
This year saw PHARMAC embark on its largest face-to-face public consultation exercise, a series of hui around the country to consult on the draft Maori Responsiveness Strategy.

Our important relationship with the pharmaceutical industry has continued to develop, with meetings at Board-to-Board level. The PHARMAC Board also met with a cross section of health professionals to examine issues faced by them in dealing with patients.

Through all this PHARMAC has been able to continue to successfully manage the pharmaceutical budget while providing more choice and new medicines for New Zealanders. In the past year PHARMAC has negotiated subsidy reductions totalling $36.8 million and provided new or enhanced access to 24 products. One of the major decisions this year involved the significant widening of access to statins, for the treatment of high cholesterol. Wider use of these drugs is anticipated to produce health benefits, resulting in healthier New Zealanders as well as potential savings elsewhere in the health

IMPACT OF PHARMAC ON DRUG EXPENDITURE OVER TIME

Total subsidised, non-hospital-funded, drug cost in millions of dollars (excluding GST), year ending 30 June. Without PHARMAC interventions, it is estimated that the drug subsidy bill this year would have been $473 million higher (this estimate is based on an assumption that no price changes would have occurred without PHARMAC's interventions).



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sector. An increase in usage has already been measured.

PHARMAC's year-end pharmaceutical expenditure for 2001/02 was $504 million compared with a budget of $528 million. Lower than expected expenditure was mainly the result of greater savings than originally forecast, and because of the late setting of the budget and problems early in the year with late availability of data, due to implementation of a new processing system. This meant new investment decisions were not made until towards the end of the year.

While PHARMAC's control of expenditure has been very successful, it is of concern to the Board that the budget to which PHARMAC must work has only had small annual increases over recent years. There will be a real challenge in the future in working with DHBs to ensure there are adequate annual budget increases so that pharmaceutical expenditure plays its part in improving the overall health of the population, and in particular for those with the greatest health needs. PHARMAC would find it extremely difficult, if not impossible, to ensure the adequacy of pharmaceuticals available to the population if reasonable increases in subsequent annual budgets were not made. Ideally, PHARMAC needs a three-year funding path so it is able to plan properly.

It is a tribute to the dedication and professionalism of PHARMAC's staff that, in a year in which funding in the health sector has continued to be a high-profile issue, the team at PHARMAC has again managed pharmaceutical expenditure within budget. I would like to express my appreciation for their efforts in the past year and look forward to continuing to work with them.

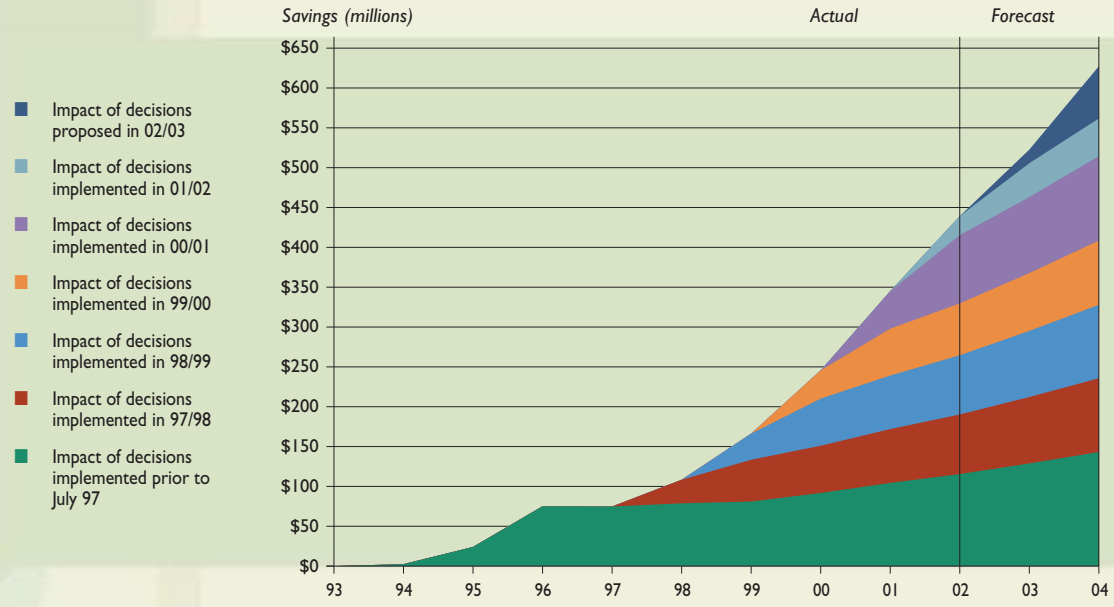
I would also like to express my thanks for the support of my fellow directors, and particularly Ross Black for the contribution he made before deciding not to seek reappointment when his term ended at the end of June 2002. We wish him all the best for the future, and welcome Helmut Modlik to the Board. Helmut brings a new perspective to the PHARMAC Board, with links to DHBs through his membership of the Capital and Coast DHB Board, and to the Maori community.

Finally I would like to acknowledge the tremendous support we received from the Minister of Health Annette King throughout the year, and look forward to continuing to work with her in the future.

TOTAL CUMULATIVE IMPACT OF PHARMAC'S DECISIONS

Years ended 30 June (GST Exclusive)

The chart illustrates the impact of each year's decisions on savings over time before the inclusion of rebates.



Going forward with stronger *Community Links*

Chief Executive Wayne McNee sees enhanced community links improving PHARMAC's ability to deliver better health outcomes

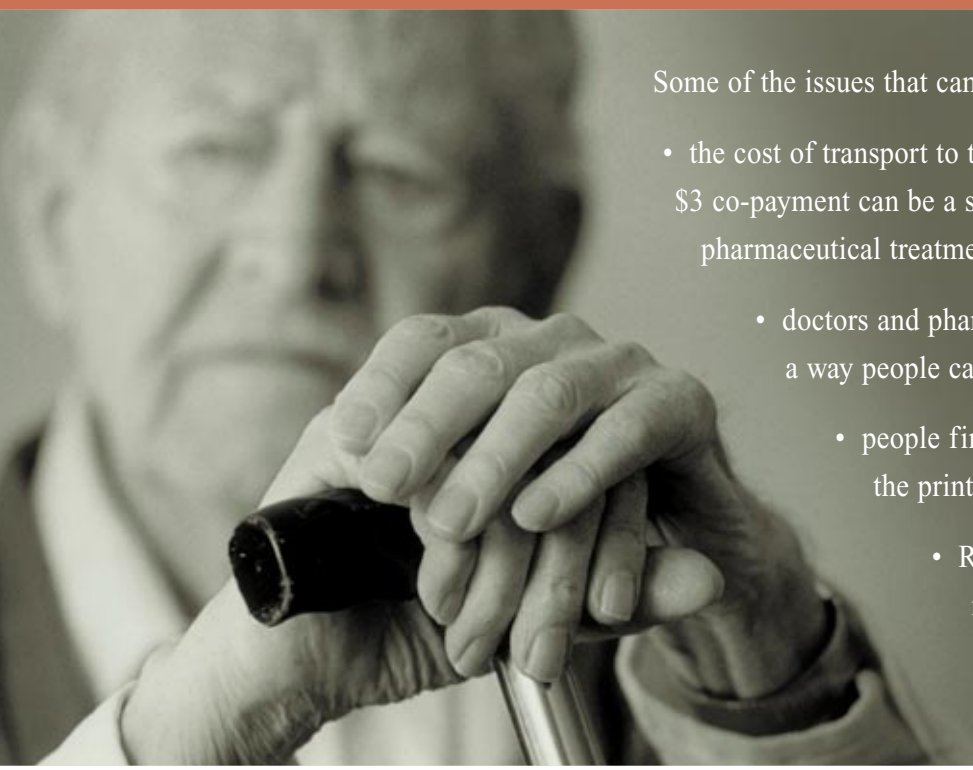
Ngati Porou kaumatua Rongo Wi Repa (second from left) accompanies PHARMAC staff including chief executive Wayne McNee (left) and medical director Peter Moodie (right) as they are welcomed onto Takapuwahia Marae, Porirua.

In September 2001 PHARMAC embarked on its largest public consultation programme, a series of hui around the country to develop its Maori Responsiveness Strategy.

Few of us could have imagined the impact this process would have on individuals within PHARMAC, and on the organisation as a whole.

This was the first time PHARMAC had undertaken major face-to-face consultation with Maori, and for some PHARMAC staff this was their first experience of a marae.

It also provided an important opportunity for PHARMAC staff as a group to meet with, and hear the views of, the people who are ultimately affected by the decisions PHARMAC makes. While PHARMAC staff attend many conferences and meet regularly with medical groups and pharmaceutical suppliers, their views can be very different to those of the public at large.



Some of the issues that came up during these hui included:

- the cost of transport to the doctor or pharmacy, or even a $3 co-payment can be a significant barrier to people accessing pharmaceutical treatment
- doctors and pharmacists don't always explain things in a way people can understand
- people find it difficult to understand some of the printed information they are provided with
- Rongoa Maori (Maori traditional medicine) has a place and deserves Government funding.

The comments PHARMAC received during the hui were then used to help develop the finalised strategy. We have already begun implementing some parts, others will be rolled out over time.

The hui and the messages we received from them underline a very important point. If public sector health organisations such as PHARMAC are to succeed in improving people's health, it is vital that they hear the views of the end user – the patient – as part of their decision-making processes. If they don't do this, they risk making decisions that don't reach the people they are aimed at, or are not understood by them.

PHARMAC has been engaging the public for its views on pharmaceutical funding ever since its inception in 1993 through consultation on its proposals, and this continues to be a popular forum for people to make their views known to PHARMAC. Judging by the number of responses we received during consultation in the past year, people are continuing to take a great deal of interest in PHARMAC's operations. PHARMAC welcomes this feedback and often uses it to improve its decisions.

One of these major consultation exercises was around the development of the new Consumer Advisory Committee, a process that began towards the end of 2001 when we circulated a draft Terms of Reference. There were 54 responses to our initial call for feedback, and more than 90 people were put forward when we called for nominations for the Committee itself. The Committee provides input to the PHARMAC Board from a patient or consumer perspective and is expected to focus primarily on issues around PHARMAC's Demand Side activities. We look forward to working with this committee to give PHARMAC the community's views on pharmaceutical funding issues.

Another big response came through the development of the National Hospital Pharmaceutical Purchasing Strategy. This strategy was developed to help District Health Boards (DHBs) manage their pharmaceutical purchasing and to ensure equal access to treatments across the country.

More than 60 responses were received during consultation. Positive feedback from DHBs reflected a degree of confidence in PHARMAC's ability to assess pharmaceuticals used in hospitals and to manage expenditure. This in turn gives us the confidence to go forward

knowing we have the support of one of our key stakeholder groups. By the end of the financial year three dedicated PHARMAC staff were engaged in developing a list of hospital products for tender and talking with pharmaceutical suppliers and DHBs as implementation of the strategy got underway.

The relationship with DHBs is one of our most important, because the pharmaceutical budget PHARMAC manages is actually DHB money. It was pleasing to be able to formalise these relationships through the signing of agreements with all 21 DHBs, which set out what PHARMAC and DHBs expect of each other and how we are going to achieve these goals.

These stronger relationships with key groups don't just exist for their own sake. The aim is to use them to help meet our legislated objective – to obtain for eligible New Zealanders in need of pharmaceuticals the best health outcomes that are reasonably achievable from pharmaceutical treatment, and from within the funding provided. Involving the community and other stakeholder groups in decisions is important because it gives those affected an input and a sense of `ownership'. Looking ahead, it is important that PHARMAC works at maintaining these relationships and continues to build on them. PHARMAC is certainly committed to building on the relationships it has formed in the past year.

During all these processes PHARMAC has continued to pursue its core function of managing expenditure on community pharmaceuticals. This year PHARMAC has contained expenditure within the $528 million budget set by the Government, at $504 million.

Part-way through the year we became aware that savings flowing from our tender process were larger than originally thought, and this gave us the opportunity to accelerate a number of funding proposals. This included the agreement with Merck Sharp and Dohme that allowed us to widen access to statins for the treatment of high cholesterol, the decision to lift the expenditure cap on beta interferon for the treatment of multiple sclerosis, the listing of leflunomide for severe rheumatoid arthritis, and the widening of access to latanoprost eye drops for glaucoma and to the schizophrenia treatment quetiapine.

The statins agreement reflected another positive aspect of the year – that of the desire of pharmaceutical companies to reach mutually beneficial agreements with PHARMAC. This agreement was a win-win-win – it gives more people access to statins; it provides the potential for ongoing savings in the health sector at reduced cost to the taxpayer; and it gives the company an opportunity to sell more of its product.

Our relationship with the industry has been formalised in the shape of Board-to-Board meetings and dialogue between the respective chairs. While we accept that there will continue to be tension between PHARMAC and the industry, we hope the links that have been developed in the past year will continue to build understanding of our respective roles and provide us with the opportunity to work through issues in a constructive manner.

Part of the challenge ahead for PHARMAC will be to continue to balance these sometimes competing demands – the need to obtain positive health outcomes at reasonable cost, the need for patients and clinicians to access cost-effective medicines, and the need for pharmaceutical companies to run a profitable business – for the benefit of all New Zealanders.

I would like to also take this opportunity to recognise the dedication and hard work of PHARMAC staff for their contribution to a successful year, and the PHARMAC Board for its support.

PHARMAC's Decision Criteria

Seeking best health value for the pharmaceutical dollar

PHARMAC seeks to operate in an open, transparent and accountable way. Its reviews and changes to the Pharmaceutical Schedule are governed by its Operating Policies and Procedures – a public document developed in consultation with the pharmaceutical industry. The document emphasises the importance of basing decisions on the latest research-based clinical information, and it sets out criteria to be taken into account in decisions about the Schedule. These criteria are:

- the health needs of all eligible[1] people within New Zealand;
- the particular health needs of Maori and Pacific peoples;
- the availability and suitability of existing medicines, therapeutic medical devices and related products and related things;
- the clinical benefits and risks of pharmaceuticals;
- the cost-effectiveness of meeting health needs by funding pharmaceuticals rather than using other publicly funded health and disability support services;
- the budgetary impact (in terms of the pharmaceutical budget and the Government's overall health budget) of any changes to the Pharmaceutical Schedule;
- the direct cost to health service users;
- the Government's priorities for health funding, as set out in any objectives notified by the Crown to PHARMAC, or in PHARMAC's Funding Agreement, or elsewhere; and
- such other criteria as PHARMAC thinks fit. PHARMAC will carry out appropriate consultation when it intends to take any such "other criteria" into account.

[1] *As defined by the Government's then current rules of eligibility.*

PHARMAC has relationship agreements with all 21 District Health Boards. This is a good example of agencies within the health sector working together, says District Health Boards New Zealand Chief Executive Julian Inch

As the dust settles on the last round of health sector reforms, one thing remains clear. Government health agencies need to maintain strong ties with each other to align their activities and reach common goals.

The link forged in the past year between District Health Boards New Zealand and PHARMAC, which has led to the development of relationship agreements between PHARMAC and all 21 District Health Boards (DHBs), is a good example of co-operation within the sector to enable more effective management of resources and improved health outcomes for patients.

District Health Boards New Zealand (DHBNZ) was formed to provide support and co-ordinate DHB activities at a national level, working with DHB experts and the Ministry of Health on topics of collective interest to DHBs. DHBNZ is a small organisation that plays an important role in co-ordinating responses to many of the issues faced by all District Health Boards, and providing links to other government agencies, such as PHARMAC.

During early discussion between DHBNZ and PHARMAC, it became clear that there was no formal accountability arrangement between DHBs and PHARMAC. PHARMAC was responsible to the Minister of Health for managing pharmaceutical expenditure on behalf of DHBs, who were separately accountable to the Minister. Having identified this accountability gap, DHBNZ and PHARMAC agreed that a relationship agreement would provide a mechanism through which we could co-ordinate our activities and respond effectively to common issues.

Development of these agreements began in October 2001, and the process included PHARMAC attending a number of meetings with DHB chairs and CEOs. In response to their feedback, PHARMAC modified the agreements.

Issues covered by the agreements include:

- processes for setting and managing the community pharmaceutical budget
- management of Exceptional Circumstances
- the need to develop a robust information base
- processes for working together on common issues
- co-ordination of information to patients and clinicians, including information on the responsible use of pharmaceuticals
- management of rebates

Feedback from the sector has been extremely positive, and all 21 DHBs have now signed the Relationship Agreement. There is strong DHB

PTAC Chairman John Hedley welcomes a maturing of clinicians' attitudes to conflicts of interest

The 1997 PHARMAC Annual Review contained a small reference to the potential conflict of interest that clinicians exposed themselves to when they accepted gifts and sponsorship from pharmaceutical companies.

The reference may have been small but it certainly struck a raw nerve amongst some of my colleagues who were upset at the suggestion that they could be influenced by "minor gifts". Indeed, even in 1999 a cartoon on the same theme created a strong response.

Times have now changed and the potential for conflicts of interest is a common discussion point in medical journals (BMJ 2002). The point is not that clinicians were or are being duplicitous, but rather it has been something that did not really occur to them as a serious issue.

Now that we are more aware of the potential pitfalls it allows us to look at the benefits of therapy with a more analytical eye. Clinicians have an ethical responsibility not only to ensure best practice is followed but also to conserve society's resources, and this means making cost-effective prescribing choices.

Our prescribing practices can be influenced by suppliers and other outside forces, but we can also influence each other. Like it or not, even specialists in large hospitals have the ability to influence prescribing and expenditure in the community. A patient prescribed an expensive therapy by a specialist in an outpatient setting is likely to have that therapy continued by the general practitioner, particularly if the patient has a life-threatening condition such as heart failure.

The message here is that prescribing from hospital formularies cannot stand in isolation, and this is particularly true now that PHARMAC is moving to harmonise the availability of community and hospital pharmaceuticals nationally. There is an opportunity here to create commonalities of pharmaceutical use.

With the development of the national hospital pharmaceutical purchasing strategy by PHARMAC, the Pharmacology and Therapeutics Advisory Committee (PTAC) now has a role in examining some of the hospital medicines. A specific area is that of oncology drugs which are reviewed by the Cancer Treatments Sub-Committee of PTAC (CaTSOP).

In addition to creating new sub-committees, PTAC has moved to refresh the existing ones and has undertaken an extensive review of both their membership, and their roles. This was a natural progression from the review of the PTAC guidelines but in many senses this was a formalisation of existing operations.

What the review did show us was that the work PTAC has done in past years has laid a solid foundation for sound judgements, and this has paid off in enduring affordability in the pharmaceutical budget. This in turn has helped give PHARMAC the capability to make new investments in pharmaceuticals. In many ways the "heavy lifting" work has been done and it is now time to ensure that the processes developed and in place work efficiently. This is an opportunity for PTAC to again look at its role, and formulate a work plan for the year ahead.

My thanks to my fellow PTAC members and to all those clinicians who provided advice through the sub-committees.

support for the way PHARMAC has sought to align its activities with the work of DHBs.

The Relationship Agreement is maintained by the DHBNZ Primary Health Group, and PHARMAC has a standing invite to the Group's monthly meeting. This has allowed PHARMAC to raise key issues and seek feedback on proposed solutions. In the future, this relationship will continue to grow, including more difficult issues such as joint advice to the Minister on setting the PHARMAC Budget for 2003/04.

The development of the national hospital pharmaceutical strategy is another good example of how DHBs and PHARMAC can work together to meet a common goal. The hospital project is aimed at gaining efficiencies for DHBs from joint purchasing and national assessment of pharmaceutical treatments used in hospitals. During the development of the strategy, PHARMAC staff met with hospital managers and clinicians around the country to outline what was proposed and listen to feedback. An extended period of consultation resulted in a number of modifications to the strategy. These changes reflect the unique needs of the hospital sector and what the individuals consulted want to achieve from the strategy.

PHARMAC seeks expert advice in this area from the Hospital Pharmaceuticals Advisory Committee (HPAC), which is made up of DHB pharmacists and purchasing managers. This committee gives DHBs direct input into PHARMAC's decision-making on hospital pharmaceuticals and, in return, is an important body through which PHARMAC can strengthen its links with a key stakeholder group.

A lot of work has been done to date, however we recognise that a lot remains to be done, including improving the provision and exchange of information and improving the process for establishing the pharmaceutical budget.

With the building blocks in place DHBNZ looks forward to continuing to develop our positive relationship with PHARMAC, and working together to further the sector-wide objective of improved health of all New Zealanders.

PTAC's purpose and structure

Independent, expert evaluation and advice

The primary purpose of the Pharmacology and Therapeutics Advisory Committee (PTAC) is to provide PHARMAC with independent objective advice on pharmaceuticals and their benefits including the pharmacological and therapeutic consequences of proposed amendments to the Pharmaceutical Schedule.

PTAC is a committee of vocationally registered medical practitioners nominated by professional bodies and appointed by the Director-General of Health.

PTAC's work includes considering and making recommendations on the medical implications of:

- all significant applications by pharmaceutical companies and/or clinicians for inclusion on the Pharmaceutical Schedule, or amendment to it where there are clinical issues to consider;
- requests by PHARMAC for de-listing;
- the management of the Schedule; and
- the need for reviews of specific pharmaceuticals or groups of pharmaceuticals.

PTAC has a generalist focus, but increasingly it seeks advice from known experts in their field, often via its sub-committees.

PTAC members and those co-opted to sub-committees are paid an hourly rate plus expenses for attendance at meetings and time spent preparing for meetings. PTAC meetings are usually held in Wellington four times a year. Sub-committees are convened as and when required.

PHARMAC's funding decisions in 2002 have underlined the need to identify both the benefits and costs, writes PHARMAC Medical Director Dr Peter Moodie

A number of funding decisions have been made this year that have highlighted the delicate balance between clinical need, the capacity of people to benefit from therapy, and cold, hard fiscal reality.

That balance is hard to achieve at the best of times but is even harder when advocacy groups make a stand. Advocacy is an essential role for clinicians, but there are times when wider issues need to be considered than just the needs of patients with a particular condition. Indeed, there may be many others with entirely different conditions with even greater ability to benefit.

Economists refer to this as `opportunity cost' – the reality that with a fixed budget, if the money is spent in one area others may miss out. It is a consideration that is uppermost when deciding where the pharmaceutical budget is to be spent and a key reason as to why PHARMAC has put so much effort into ensuring it has a robust prioritisation process.

Some decisions in the past year have sharply highlighted this issue and put PHARMAC's cost-benefit modelling to the test.

The most contentious of these has been around the issue of funding for imatinib mesylate (Glivec) for the treatment of chronic myeloid leukaemia (CML).

Continued over page

This was a new therapy, only approved for use in New Zealand in October 2001. As the evidence mounted, it became obvious that imatinib made a real difference to the treatment of an inevitably fatal condition and with fewer side effects than the alternative treatments.

However, even with relatively few patients who could be easily identified, the potential cost to the health system (between $60,000 and $100,000 per patient per year) meant that any decision had to be made carefully and weighed against the desire to fund other pharmaceuticals, and against wider health funding needs. The reality is that the total health budget must be considered, and if one sector of it is to expand it is at the expense of another.

A second example was the widening of access to the cholesterol-lowering HMG-Co A inhibitors (statins). Subsidised access to these drugs has been a contentious issue for some years and as part of the negotiation of a lower price with a supplier it was a good opportunity to be able to widen that subsidised availability.

Evidence shows statins are effective at lowering cholesterol levels and improving health, and now that they are at an affordable price there is a real opportunity to produce down-stream benefits in the health system, such as a decrease in heart attacks. However, the costs and benefits are still very dependent on the accurate targeting of the drugs, and there is a continuing issue with uptake rates. We already have figures that show low use of these drugs by those who would benefit the most. For example, we estimate that less than half of those eligible patients with proven cardiovascular disease are on a statin. It is small comfort to note that these low uptake rates are common around the world.

In the months since access was widened there has been a significant increase in the use of these drugs. However, the danger is that without careful monitoring, the usage will go up in the easy to reach but low risk patients while those with the greatest need will miss out if they are hard to reach.

The third example concerns the treatment of Alzheimer's disease. The new therapies available (known as acetylcholinesterase inhibitors) are expensive and the potential number of people who could take them is very large.

There is no doubt that Alzheimer's is a distressing condition for patients and relatives and there is a real need for treatment, but the capacity to benefit from the medications is still open to debate. These drugs do work for some people but for how long and how much is contentious. If those who did not benefit could stop the treatment then the cost benefit would improve, but even determining when to stop therapy is an issue in itself. This is an issue PHARMAC is examining through a working party that has been convened.

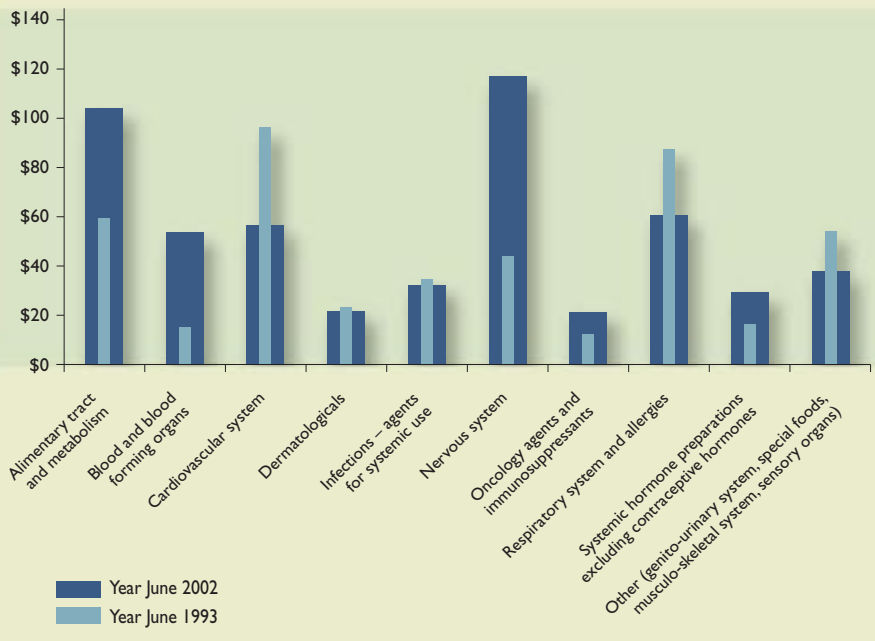
The essence of good clinical care, and also cost benefit analysis, is the clinical evidence upon which it is based. Relying on poor clinical evidence risks not only patients' lives but also can waste precious public funds, which in itself is unethical.

Prioritisation within a set healthcare budget is an area where New Zealand has taken the lead. It appears that other countries will have to come to terms with the realities of a constrained budget in the near future. In Australia, for example, government pharmaceutical expenditure has increased on average 14 percent per year over the past decade, and was a major driver of a healthcare budget blowout in the 2001-02 financial year. Moves are now afoot to address this issue. And in the United States, pharmaceutical prices increased 17 percent in 2001.

PHARMAC was established to manage New Zealand's pharmaceutical expenditure and has been successful, even when the volume of drugs prescribed has been rising at a steady rate. However that success has been sustained because the New Zealand public and the medical profession have accepted the need for and the reality of prioritisation in the health sector.

CHANGES IN THERAPEUTIC GROUP EXPENDITURE

Changes in expenditure patterns since PHARMAC's inception in 1993 highlight the need for continued management of pharmaceutical prices and prescribing.



review by therapeutic group

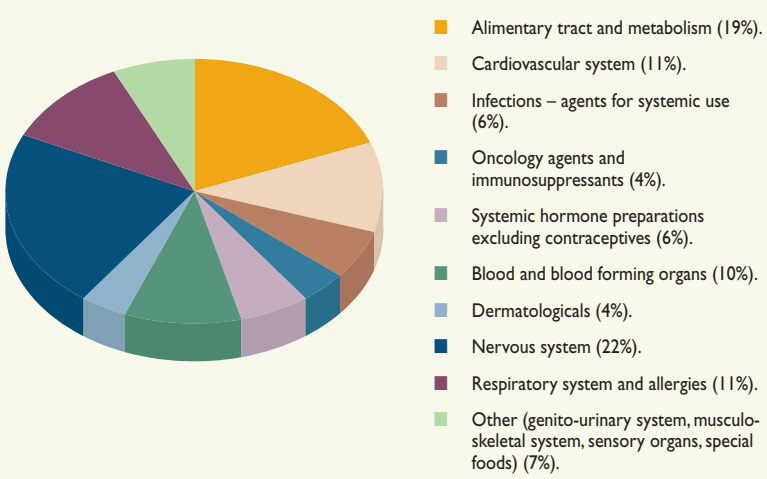
At the beginning of the 2002 financial year it appeared there would be little opportunity for PHARMAC to make new investments.

However, data towards the end of 2001 indicated that expenditure was tracking below forecast, driven by greater than expected savings being realised through such strategies as the PHARMAC tender.

PHARMAC was able to accelerate a number of proposals and implement them, including widening access to statins for high cholesterol, listing leflunomide for chronic rheumatoid arthritis, and removing the cap on beta interferon for the treatment of multiple sclerosis. By year's end there was an underspend of about $24 million, caused in part by the necessity to consider the impact of new funding decisions and the expenditure growth they cause impacting on the budget in future years.

INVESTMENT BY THERAPEUTIC GROUP

Year ended 30 June 2002



The tender continues to be a major tool for delivering savings in the pharmaceutical budget. From the 2001-2002 tender, 160 three-year sole supply contracts were awarded, with savings from these estimated at $20.6 million over three years.

New Zealand continues to be a leader in this regard. In Australia, a tender similar to PHARMAC's is seen as one way of curbing the continuing increase in pharmaceutical expenditure that is one of the main drivers of a budget blowout in the health sector. Pharmaceutical expenditure growth across the Tasman has risen on average 14 percent over the past decade. The Australian Federal Government is now exploring a number of options for reducing pharmaceutical expenditure,

including increasing patient co-payments, tendering for off-patent medicines and running a scheme along the lines of the Green Prescriptions programme that is jointly funded by PHARMAC and Sport and Recreation New Zealand.

In the United States the growth in value of pharmaceutical sales is on a similar scale, rising more than 17 percent in 2001.

Pharmaceutical expenditure in New Zealand, by comparison, has averaged less than 3 percent since PHARMAC's inception in 1993.

While tendering continues to be a successful way of making savings, pharmaceutical companies have again shown in the past year that they are prepared to initiate legal proceedings as a way of protecting the markets for off-patent products. This has been in line with international trends where pharmaceutical companies have developed strategies to protect their markets through use of litigation as their products come off-patent.

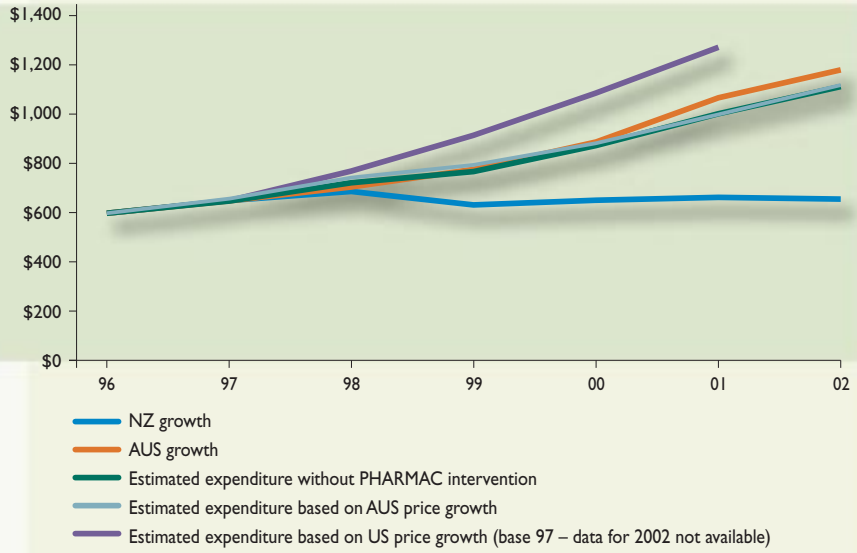
Elsewhere, savings have been driven by reference pricing and through multi-product agreements. Multi-product agreements have enabled PHARMAC to list new products like the heart failure drug carvedilol (Dilatrend) and the anti-anaemia drug erythropoietin-beta (Recormon), and to widen access to a range of products such as latanoprost eye drops (Xalatan) and the schizophrenia drug quetiapine (Seroquel).

The discontinuation of small volume listed products by major suppliers has been a recurring theme throughout the year. Discontinuations included the antidepressant Nardil, the eye and ear drops Betnesol and Betnesol N and the steroid tablet Betnesol. In some cases,

NEW ZEALAND PHARMACEUTICAL EXPENDITURE COMPARED TO AUSTRALIA, USA

Year ending June

Base 96 (millions)

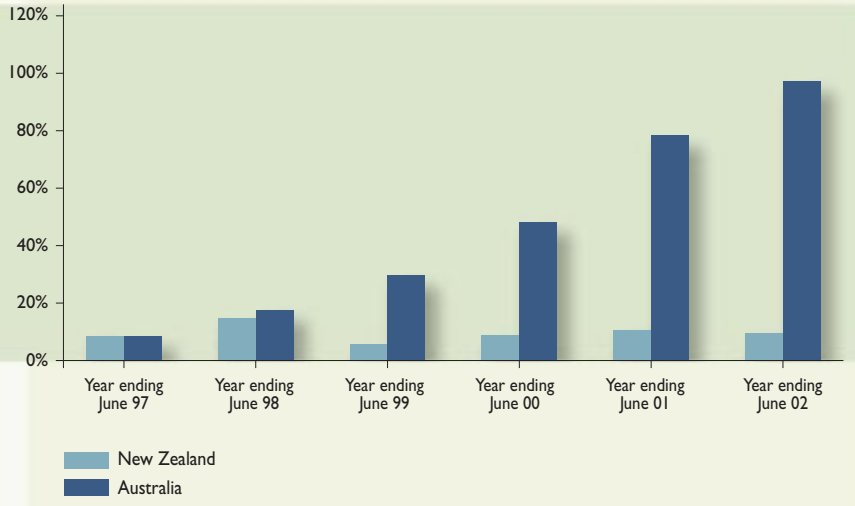


Sources: National Institute of Health Care Management (US); Pharmaceutical Benefit Scheme (Australia); PHARMAC (New Zealand).

GROWTH IN CUMULATIVE SPENDING

c.f. year ending June 96

% growth since year ending June 96



Sources: Pharmaceutical Benefit Scheme (Australia); PHARMAC (New Zealand).

there were few or no alternative products available, raising the risk of patients being denied access to necessary treatments.

The most significant discontinuation was the announcement that beclomethasone metered dose inhalers for asthma management, then used by about 50,000 people, would be withdrawn. At the end of 2001, PHARMAC consulted on sourcing a generic form of beclomethasone that did not use chlorofluorocarbons (CFCs) as a propellant. This move was consistent with PHARMAC's aim of converting the New Zealand aerosol inhaler market from CFC-containing products to those free of CFCs. This initial proposal was dependent on approval from Medsafe and a positive recommendation from the Pharmacology and Therapeutics Advisory Committee (PTAC), and this approval was delayed. When the withdrawal announcement was made, PHARMAC had to then move to source another generic CFC-containing beclomethasone to ensure continued supply of the product.

Where it has been appropriate, PHARMAC's Demand Side team has supported significant changes to the Pharmaceutical Schedule with information to patients and clinicians, and this is a strategy that will continue in future. This information is aimed at minimising the impact on patients to ensure that where people are faced with changing their medicine or paying a surcharge, they and health professionals have enough information to make that decision fully informed.

The top 20 expenditure groups

$ millions, cost ex manufacturer, GST exclusive

Drug type	***2002***	*2001*	*2000*	*1999*	*1998*
Anti-ulcerants	**44.0**	42.7	36.1	29.0	32.3
Lipid Modifying Agents	**40.4**	44.8	37.2	23.7	14.7
Antipsychotics	**36.4**	30.1	23.9	10.5	5.0
Antidepressants	**28.0**	25.0	28.6	31.9	33.0
Inhaled corticosteroids – metered dose inhalers	**21.9**	18.7	19.7	24.9	21.6
Agents affecting the Renin-Angiotensin system	**21.3**	27.2	27.2	26.7	52.0
Diabetes	**18.6**	17.1	18.0	17.2	16.1
Diabetes Management	**18.1**	16.2	14.0	12.6	11.8
Anti-Epilepsy Drugs	**17.4**	16.0	15.2	13.7	12.1
Immunosuppressants	**16.1**	15.7	12.0	11.7	9.7
Antibacterials	**15.3**	16.2	23.1	28.3	34.7
Analgesics	**14.6**	13.7	13.5	13.7	14.1
Calcium Channel Blockers	**13.9**	15.6	17.5	24.9	28.1
Antimigraine Preparations	**10.5**	9.6	8.3	7.3	5.7
Antidiarrhoeals	**8.7**	8.4	7.6	7.4	6.9
Beta Adrenoceptor Blockers	**8.0**	8.0	9.0	11.8	17.0
Inhaled beta-adrenoceptor agonists – metered dose inhalers	**7.8**	4.7	4.7	4.6	5.1
Contraceptives – hormonal	**7.7**	8.0	8.2	9.3	9.6
Antifungals	**7.7**	7.5	6.2	5.2	4.5
Trophic Hormones	**7.7**	7.2	6.6	5.5	3.2

Blood and blood-forming

The most significant decision in this category involved the widening of access to statins. Prior to this decision being implemented (1 April 2002) fully subsidised statins were available to an estimated 180,000 New Zealanders. The lowering of the overall cardiovascular risk threshold saw this number jump to about 300,000, and in the first two months after the access widened an extra 30,000 prescriptions (representing approximately the same number of patients) were written. A price decrease negotiated with a supplier means that this access widening is not associated with a significant rise in expenditure in this area. PHARMAC's decision was supported by an information campaign encouraging lifestyle change to reduce cardiovascular risk.

Another development in this area was the listing of a second agent for anaemia associated with chronic renal failure, erythropoietin (EPO)-beta, as part of a multi-product agreement. However, there continued to be concerns over access to EPO, and PHARMAC signalled its intention to review access.

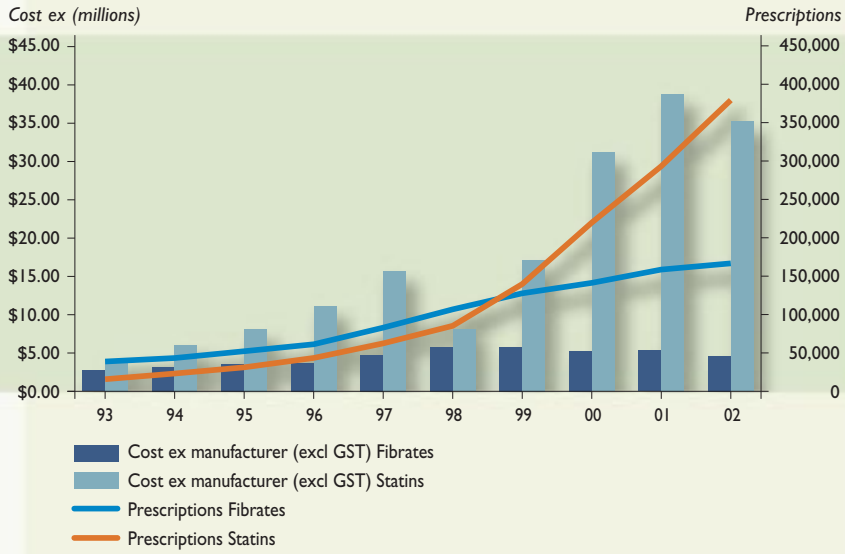
Cardiovascular

Expenditure on ACE inhibitors for raised blood pressure and heart failure continued to drop, despite the number of prescriptions continuing to rise. Further price reductions were negotiated during the 2002 year when the ACE inhibitor enalapril came off-patent and a generic version (Enahexal) was listed, and a generic captopril (Captohexal) was also subsidised. These listings continue a trend that has seen this class of drugs go from being the top expenditure area on the Pharmaceutical Schedule in 1998, to now be ranked sixth.

A multi-product agreement with Roche saw a further drug for the treatment of heart failure, carvedilol, obtain full funding.

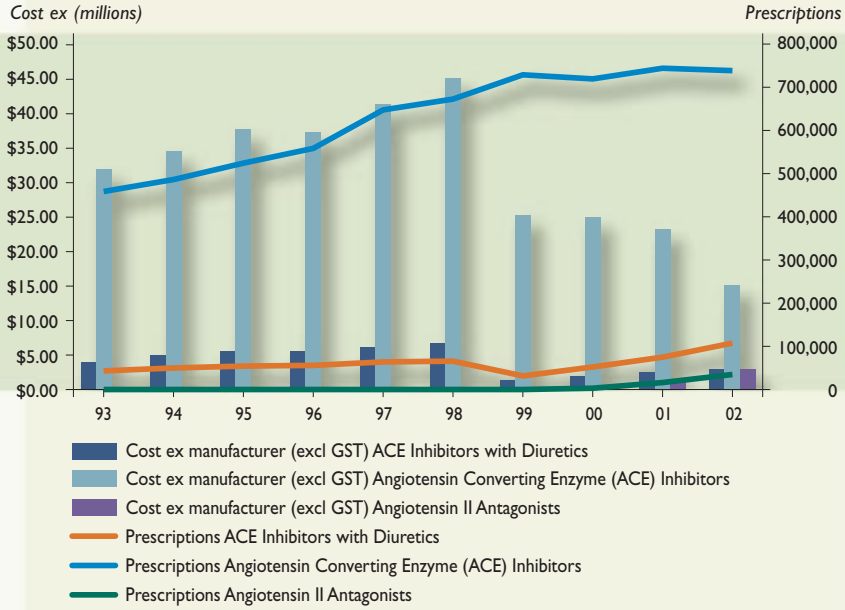
LIPID MODIFYING AGENTS

The number of people eligible for subsidised statins has further increased, while a price reduction meant more people were treated at less cost to the taxpayer.



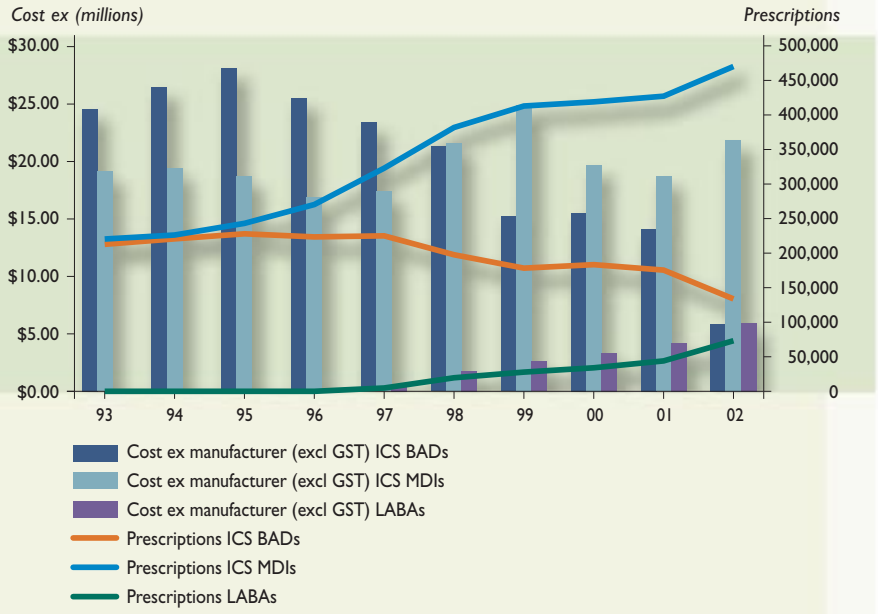
ACE INHIBITORS AND ANGIOTENSIN II ANTAGONISTS

The number of people accessing ACE Inhibitors remained steady while further price reductions saw expenditure fall for the fourth year in a row.



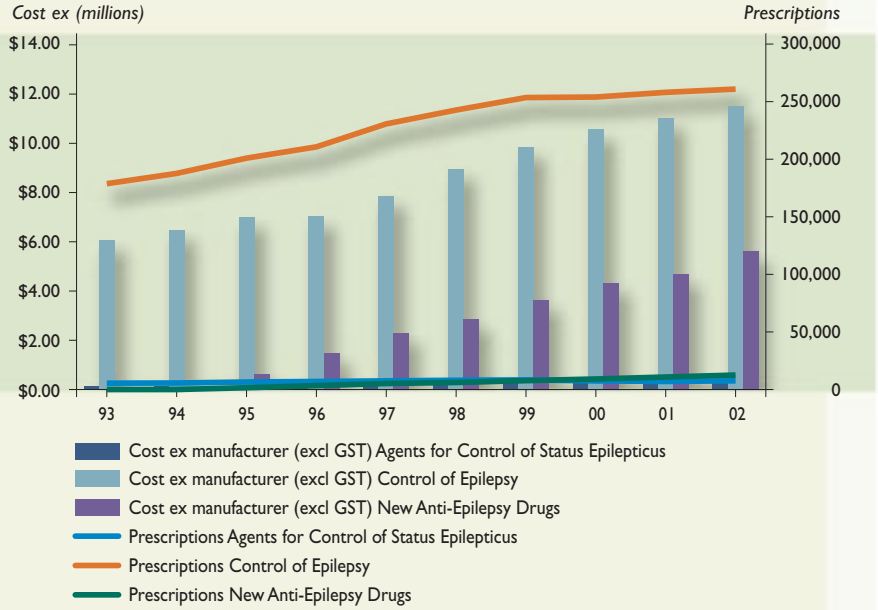
ASTHMA

A shift from breath activated devices (BADs) to metered dose inhalers (MDIs) in the inhaled corticosteroid market accelerated this year, while the increased number of prescriptions for long acting beta agonists (LABAs) reflected the widening of access to these drugs.



ANTI-EPILEPTICS

An increase in prescribing continued to be the driver of a rise in expenditure on anti-epilepsy drugs.



Respiratory

The effects of widening access to long-acting beta agonists (LABAs) during 2001 were shown by the number of prescriptions for this type of asthma medicine increasing in the 2002 financial year, with expenditure on these devices rising to nearly $6 million. Overall there was a decrease in the number of people using breath activated devices (BADs) and a corresponding rise in the number of people using aerosol inhalers. Expenditure on aerosol corticosteroid inhalers grew to $21.3 million.

A new fully funded spacer device for children with asthma was also made available.

Debate continued over the funding of combination corticosteroid-LABA inhalers. PHARMAC's position continues to be that these treatments are available separately and the combination inhalers offer no clinical advantage over separate inhalers, and are comparatively expensive. One combination inhaler is subsidised under Special Authority.

Sensory

New agents for the treatment of glaucoma, widening of access to dorzolamide, and providing subsidy for latanoprost in combination with other agents were the major changes in this area. From 1 April, PHARMAC fully subsidised the combination treatment dorzolamide and timolol maleate for glaucoma, while widening access to dorzolamide eye drops. Two other eye drops, timolol maleate with pilocarpine and timolol maleate gel-forming eye drops also became fully subsidised.

Access to latanoprost was widened to enable it to be used in combination with other agents, if it had not been effective on its own. Prior to this decision, latanoprost could only be used as a monotherapy.

Nervous system

Access to the atypical antipsychotic quetiapine (Seroquel) was widened in a move which is expected to see more of this drug prescribed. Expenditure for this group of new-generation antipsychotics is now more than $30 million per annum.

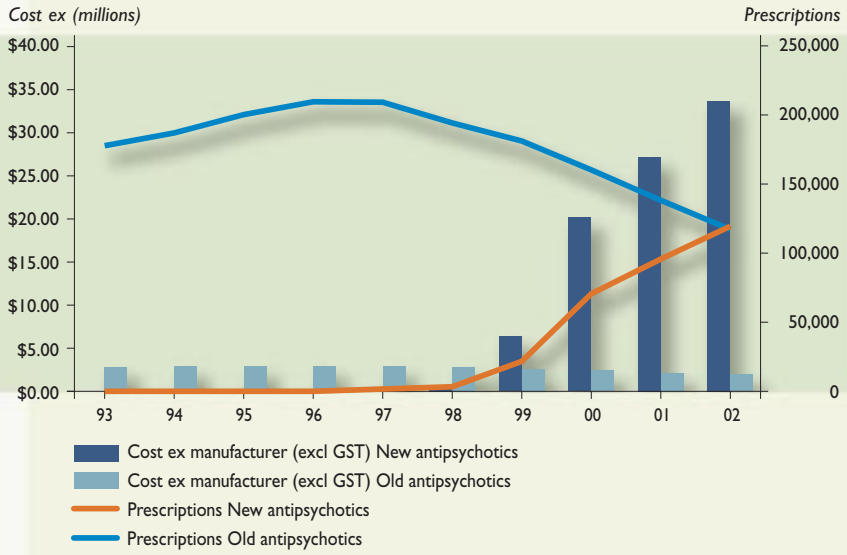
Full subsidy was extended to the anti-epilepsy drug carbamazepine (Tegretol) and a new brand of the antipsychotic clozapine (Clopine) was listed.

Concern continued to be expressed over the lack of funding for anti-Alzheimers drugs, known as acetylcholinesterase inhibitors. PTAC re-examined two of these drugs in the past year, and found them to offer at best moderate benefits. However, PHARMAC agreed to consider developing a way of making the drugs available to at least some patients, as this is a disease state for which no pharmaceuticals are currently listed. A working party was convened, comprising psychiatrists and psycho-geriatricians, to develop a pilot programme, that would look at the best way to fund anti-Alzheimer's drugs.

Prescribing of methylphenidate (Ritalin) continues to be an issue and PHARMAC noted an increase in overall prescription numbers. However, this appears to be largely due to the availability of two dosage strengths, and with most people being prescribed both strengths, PHARMAC estimates the rise in prescription numbers does not translate into a corresponding rise in patient numbers.

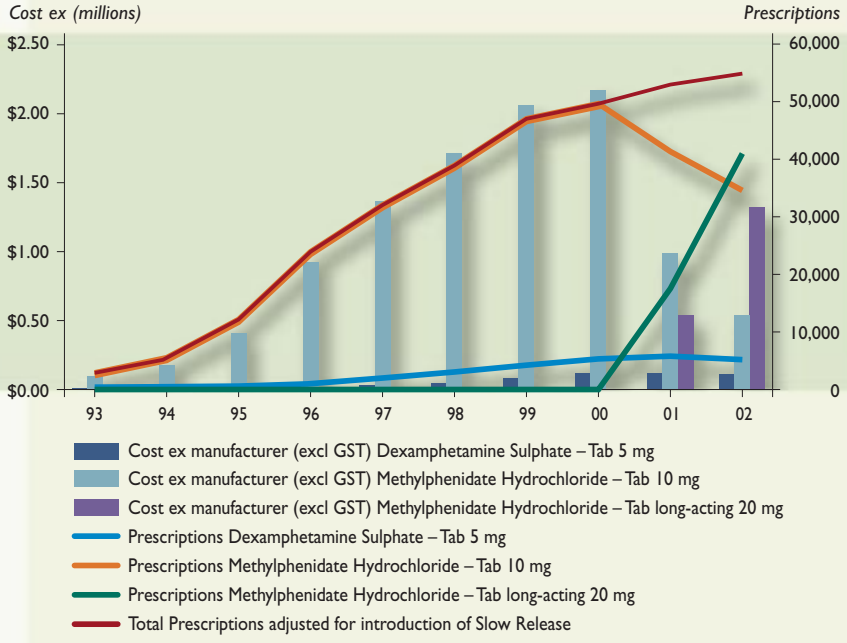
ANTIPSYCHOTICS

Prescription numbers for new generation anti-psychotics are now on a par with older preparations. Expenditure has risen in line with the trend towards prescribing atypical anti-psychotics.



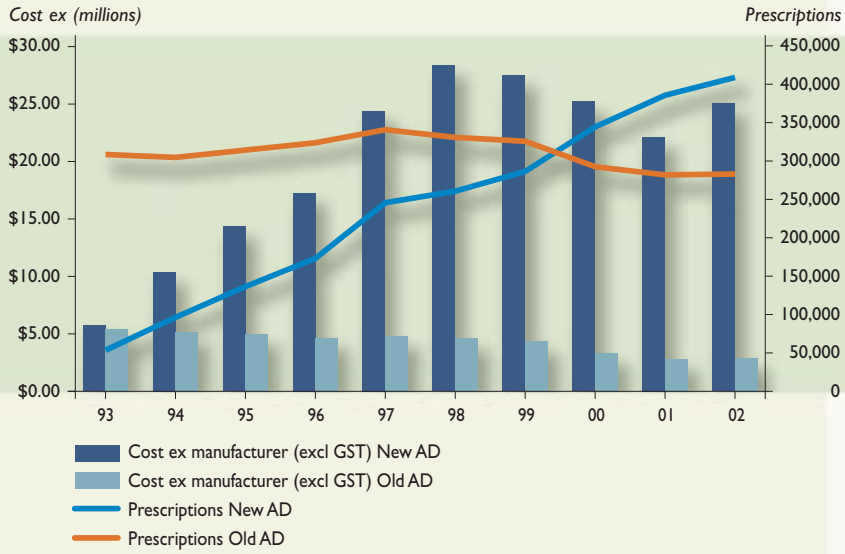
ADHD TREATMENTS

Adjusted for the introduction of a slow release formulation, the increase in prescriptions for methylphenidate slowed in 2002. Most patients would be prescribed both long and slow-release versions. Prescriptions must be written monthly.



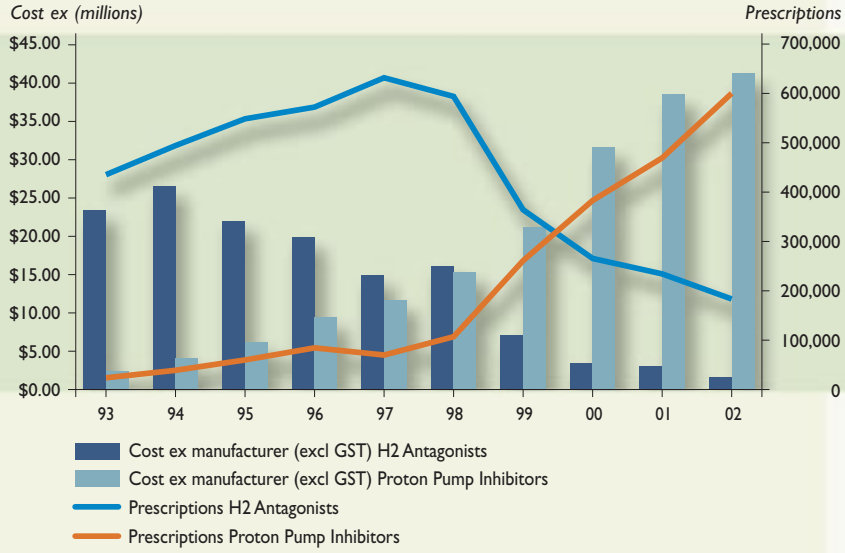
ANTIDEPRESSANTS

Total expenditure on antidepressants rose following reductions in the last four years. A continuing rise in prescriptions for new generation antidepressants appears to be the main driver of this increase.



ANTI-ULCERANTS

Continuing clinical preference for proton pump inhibitors over H2 antagonists was the main driver of a further increase in expenditure in this therapeutic group.



Musculo-skeletal

A new agent for the treatment of severe rheumatoid arthritis became available under full subsidy last year. Leflunomide is a new generation disease modifying anti-rheumatic drug (DMARD) that was listed from 1 May 2002. This was a drug that had been the subject of attention from patient groups so the decision to fund it was received positively. Concern continues to be expressed about PHARMAC's decision not to fund the class of drugs known as COX-2 Inhibitors, however PHARMAC's advice is that these drugs provide little additional benefit over traditional non-steroidal anti-inflammatory drugs and are comparatively expensive.

Access to alendronate for severe osteoporosis was widened further by removing the need for patients to reapply for Special Authority after two years. This followed a recommendation of the osteoporosis subcommittee of PTAC. Access to alendronate had previously been widened in April 2001 with the listing of a weekly dose preparation. Expenditure on alendronate increased to $3.3 million in the 2002 financial year.

A gout treatment, probenecid, was re-listed on the Pharmaceutical Schedule from 1 July 2002.

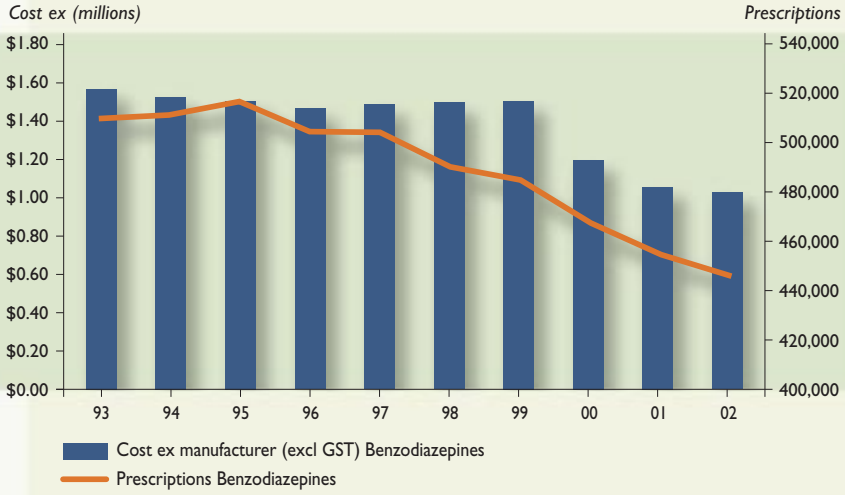
Oncology and immunosuppression

The pharmaceutical that gained the most media interest in the past year was imatinib mesylate (Glivec), a new drug for the treatment of chronic myeloid leukaemia. The drug was approved for use in New Zealand in October 2001, but had already been examined by PTAC in August 2001. It became the first drug examined by the new Cancer Treatments Sub-committee of PTAC (CaTSOP) in February 2002. PHARMAC consulted on a funding proposal in late May 2002, however by the end of the financial year no funding decision had been reached.

PHARMAC removed the expenditure cap on another drug that had been the subject of considerable media attention, beta interferon for the treatment of multiple sclerosis. Expenditure had been capped at $3 million with additional patients meeting the access criteria having to go onto a waiting list. Removal of the cap meant those 50 patients on the waiting list gained access, and there were no further limits on the number of patients. The access criteria themselves are to be the subject of a separate review.

BENZODIAZEPINES

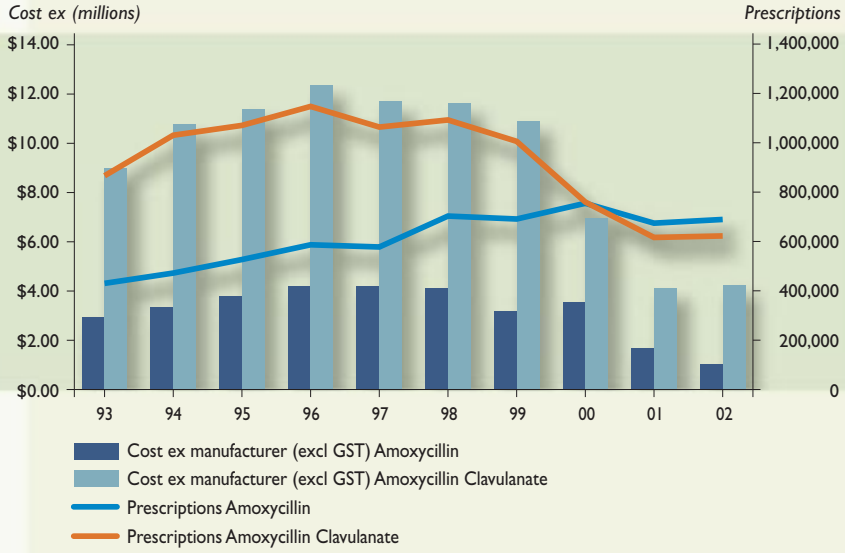
Prescription numbers for benzodiazepines continued a steady trend downwards in 2002.



Prescriptions for these drugs must be written monthly. Therefore, approximate patient numbers can be derived by dividing the number of prescriptions by 12 (months).

ANTIBACTERIALS

Use of both the narrow (amoxycillin clavulanate) and broad spectrum amoxycillin agents increased slightly, while the slight preference for the broad spectrum agent continued the trend established in 2001.



Summary of PHARMAC Operations

The organisation

PHARMAC has continued to incorporate new functions during the 2002 year. A new team has been established to manage PHARMAC's new role in assessing and managing expenditure on hospital pharmaceuticals, and PHARMAC has also taken on the management of the Exceptional Circumstances scheme. This enables people to obtain access to drugs that are not otherwise funded, if they have a rare condition and if they can show a particular need.

A number of new positions emerged following the structural review of PHARMAC that was completed in May 2001. These include a Manager, Supply Side, a communications advisor, additional Demand Side managers and positions analysing and managing hospital pharmaceutical purchasing.

PHARMAC Board

PHARMAC's Board consists of six members with a range of backgrounds, representing a diverse range of skills and professional knowledge from both the public and the private sector.

The terms of three members ended in 2002, and chairman Richard Waddel and David Moore were reappointed for further three-year terms. Ross Black chose not to seek reappointment and the Minister of Health subsequently appointed

Listing changes to the Pharmaceutical Schedule[1]

Year ended 30 June

Decisions made *Decision type*	***2002***	*2001*	*2000*	*1999*	*1998*	*1997*	***Total since 1994***
New Chemical entity listed	**7**	20	18	32[4]	14	11	**128**
New Presentation listed	**11**	13	21	40	33	24	**206**
New Product listed	**60**	28	39	56	53	20	**374**
Total new listings[2]	**78**	**61**	**78**	**128**	**100**	**55**	**708**
Derestriction or expanded access[3]	**17**	19	17	34	14	10	**154**
Changes that restrict or limit access	**4**	6	6	3	7	6	**40**
Delistings	**89**	135	362[5]	51	106	14	**757**

In 9 years, 708 new or enhanced products have been listed, access has been widened for a further 154 and 797 products have either been restricted or de-listed.

1. *Based on the date on which decisions are implemented.*
2. *Does not represent the total number of products added to the Schedule, since the listing of one new chemical entity can result in the listing of more than one presentation.*
3. *By decision, not necessarily the number of chemical entities affected.*
4. *Applications for new chemical entities in the Special Foods therapeutic group were declined.*
5. *A higher than usual number of products were de-listed in 2000 due to sole supply arrangements and the completion of the review of Extemporaneously Compounded Products.*

Applications declined by PHARMAC Board[1]

Years ended 30 June

Number	***2002***	*2001*	*2000*	*1999*	*1998*	*1997*	***Total since 1994***
New chemical entities	**4**	32[3]	1	20[2]	2	14	**69**
New presentations	**–**	1	2	0	10	3	**31**
New products	**–**	0	0	0	2	11	**31**
Derestrictions	**–**	0	0	3	1	1	**11**
Totals	**4**	33	3	23	15	29	**142**

This year, the PHARMAC Board considered 80 applications for subsidy for 80 products of which 76 were listed, and 4 declined. The acceptance rate, therefore, was 95 percent.

1. *Based on the date on which decisions are implemented.*
2. *A higher than usual number of declined applications for new chemical entities is due mainly to the Special Foods review which resulted in 18 declines.*
3. *A higher than usual number of declined applications for new chemical entities is due mainly to the Special Foods review which resulted in 28 declines.*

Helmut Modlik, a Wellington management consultant with experience of the health sector and a member of the Capital and Coast DHB Board, as the new PHARMAC Board member. These appointments provided continuity on the Board while adding Maori representation at PHARMAC's governance level.

Staffing

PHARMAC's first full financial year as a stand-alone Crown Entity has seen its staffing numbers increase. An expansion in operations to encompass the assessment and management of hospital sector pharmaceuticals, an increase in the size of the Demand Side team and the decision to internalise a number of tasks that were previously done externally have been the primary catalysts for growth in staff numbers.

PHARMAC makes an effort to recruit people who will bring both the right mix of skills and experience, and also fit the team pattern and culture at PHARMAC. Despite considerable effort this can take time and some areas of PHARMAC's operations experienced less than optimal staffing levels for part of the year.

PHARMAC recruited 11 new staff in the year to 30 June 2002, and three resigned.

Demand Side

PHARMAC's legislated function to promote the responsible use of medicines has grown to become a significant component of PHARMAC's operations. Three dedicated staff now work in this area, co-ordinating information campaigns, communicating with health professionals working with Independent Practitioner Associations (IPAs) and other representative groups, ensuring PHARMAC has a profile at significant health conferences, and managing contracts to promote the responsible use of medicines.

PHARMAC contracted an external agency to undertake an independent

Significant information campaigns run by PHARMAC in the past year included:

• *Wise Use of Antibiotics:* PHARMAC funded and coordinated this campaign, led by the Independent Practitioners Association, for the fourth year and it continues to gain a high profile. The campaign is built around the message that antibiotics are not the universal cure-all for colds and flu, and the campaign is timed to coincide with the winter flu season. Since the campaign began PHARMAC has recorded a 15 percent drop in antibiotic usage, though this trend is now flattening out.

• *Take Control of Your Cholesterol:* A new campaign was launched at Parliament by Health Minister Annette King encouraging people to embrace lifestyle changes, such as physical activity or stopping smoking, to lower their overall cardiovascular risk. Its launch coincided with PHARMAC's decision to widen access to statins, which saw the number of prescriptions for statins increase by about 30,000 in the first two months from 1 April 2002. A notable aspect of this campaign is the decision to spend $1.5 million, returned to PHARMAC over a three-year period by a pharmaceutical supplier, on a public information campaign to promote the key messages, a step PHARMAC has not taken in the past.

• *Adult asthma management:* PHARMAC developed brochures for clinicians on best practice for adult asthma management, in conjunction with leading researchers and clinicians. The brochure followed the decision to widen access to long acting beta agonist medicines during 2001.

• *Type 2 diabetes:* PHARMAC sponsored this audio-visual presentation, which was a dramatic portrayal of the effects of type 2 diabetes. A brochure was also produced in 10 different languages using graphic pictures to illustrate the effects of the disease. The audio-visual presentation was shown at Wellington Railway Station and the Museum of New Zealand, Te Papa Tongarewa during Diabetes Awareness Week in November 2001.

• *Support for supply-side decisions:* These included brochures distributed to pharmacists and prescribers explaining the decision to widen access to ranitidine, and a number of other supply side changes. PHARMAC also reprinted the "My Medicine Looks Different" brochure, which is designed to assist health professionals when they explain changes in medication brands.

evaluation of the impact of the Tender on patients, prescribers and pharmacists. As a result of the evaluation PHARMAC is considering how it can improve communication about tender changes to these groups.

PHARMAC is re-contracting for services to promote the responsible use of pharmaceuticals, to ensure that services are co-ordinated across the sector and recognise the requirements of PHARMAC and DHBs. PHARMAC issued an invitation for expressions of interest followed by a request for proposals. It is envisaged that the new services will be in place in early 2003.

PHARMAC supports the implementation of the 2001 Government review of Direct to Consumer Advertising (DTCA) of prescription pharmaceuticals. PHARMAC considers DTCA to be a major driver of pharmaceutical demand. Of the 2.26 million extra dispensings of subsidised pharmaceuticals in 2002, PHARMAC estimates 21 percent were attributable to the effect of DTCA. PHARMAC's main arguments against DTCA are that:

• Advertisements do not comply with internationally recognised standards of health promotion information and make claims that are not balanced. In the past year advertisements for two asthma drugs, marketed by two different companies, made claims of superiority without balance, and this led to a degree of confusion among people with asthma over what was the most effective, and most appropriate medicine for them.

• It drives demand for expensive drugs that may not be appropriate for patients, who put pressure on clinicians to prescribe them. A study published in the British Medical Journal showed that doctors were put under pressure by patients to prescribe advertised drugs. If the advertised products are subsidised this can put pressure on the pharmaceutical budget and may mean that funds are not available to subsidise other pharmaceuticals.

• PHARMAC has been providing input to a trans-Tasman review of therapeutic products regulations. Demand Side staff have provided information on DTCA as part of this process.

Maori Responsiveness Strategy

In early 2001 PHARMAC consulted with Maori on its interactions with the Maori community. Following feedback on this initial consultation, a draft Maori Responsiveness Strategy was developed and a series of hui was held to consult on the draft strategy. Nine hui were held across the country and were attended by about 200 people, including Maori health providers, District Health Board representatives, mainstream health providers, and whanau and patients.

Hui were held at:

• Taitokerau – at Waitangi Marae, Bay of Islands

• Auckland – at Awataha Marae, North Shore

• Waikato – at Kirikiriroa Marae, Hamilton

• Waiariki/Bay of Plenty – at Wairaka Marae, Whakatane

• Taranaki – at Parihaka Marae, Taranaki

• Tairawhiti/Takitimu – at Tangoio Marae, Napier

The Maori Responsiveness Strategy identified six main areas for PHARMAC to improve its responsiveness to Maori:

• ***Strategy One*** – improving strategic business planning processes, by establishing Maori health priorities and ensuring that focussed effort from PHARMAC is directed towards these priorities.

• ***Strategy Two*** – improving human resource development by developing a culture within PHARMAC that is responsive to Maori requirements, through a Training and Development programme focussed on achieving this.

• ***Strategy Three*** – improving the processes and procedures that PHARMAC uses to collect and analyse ethnicity data, so that Maori issues are explicitly addressed, and Maori health priorities specifically considered.

• ***Strategy Four*** – improving "supply side" activities by improving drug benefit analysis for Maori and improving consultation processes so that the expertise of more Maori providers, health professionals and researchers is included.

• ***Strategy Five*** – improving "demand side" activities including use of targeted promotional materials, Maori media channels and the use of Maori translations / te reo.

• ***Strategy Six*** – improving Maori representation and participation in key decision areas (including the Board, staffing, advisory groups and committees).

• Manawatu/Whanganui a Tara – at Takapuwahia Marae, Porirua
• Ngai Tahu – at Rehua Marae, Christchurch
• Te Tau Ihu – at Whakatu Marae, Nelson.

This was PHARMAC's largest public consultation exercise and was positively received by those attending. A report on the consultation process was prepared to summarise the feedback received, and this was used to prepare the final strategy document.

By the end of the financial year aspects of the strategy were being implemented, including appointing Maori members to the PHARMAC Board and Consumer Advisory Committee, and implementing a training and development programme for PHARMAC staff to raise their awareness of Maori issues and requirements.

Hospital Pharmaceutical Strategy

In May 2001, the Minister of Health asked PHARMAC to work with District Health Boards (DHBs) to help them manage hospital pharmaceuticals. This led to the development of a draft strategy for the national purchasing of hospital pharmaceuticals, approved by the Minister in February 2002, which received over 60 responses to consultation. PHARMAC takes advice in this area from the Hospital Pharmaceuticals Advisory Committee (HPAC), which comprises hospital pharmacists and DHB managers.

The strategy is being implemented progressively and will be reviewed after two years. Part of the strategy asks pharmaceutical suppliers for commercial proposals to supply hospital drugs nationally, leaving scope for hospitals to use other drugs if a clinical need is identified. The draft list of 484 products includes drugs that account for 90% of DHB expenditure on pharmaceuticals.

PHARMAC is also developing an assessment process for new hospital drugs, which parallels the assessment of community drugs, with input from hospital pharmacists. The Cancer Treatments Sub-Committee of PTAC (CaTSOP) has also been set up to assess new applications for pharmaceutical cancer treatments used in both the community and hospitals.

Relationships with DHBs

PHARMAC manages pharmaceutical expenditure on behalf of the District Health Boards, so developing and enhancing our positive relationships with DHBs has continued to be a priority for PHARMAC this year. This is further underlined by PHARMAC accepting responsibility for managing expenditure on hospital pharmaceuticals, and involving DHB pharmacists in PHARMAC's decision-making processes through the Hospital Pharmaceuticals Advisory Committee (HPAC). Feedback from DHBs on the draft hospital pharmaceutical strategy was positive, indicating a high degree of confidence in PHARMAC's ability to manage this role.

PHARMAC has signed Relationship Agreements with all 21 DHBs, which outline how we will work together. PHARMAC considers it a significant achievement that it has ratified agreements with all District Health Boards.

Advisory Committees

The range and number of specialist committees providing advice to PHARMAC has continued to grow. The Hospital Pharmaceuticals Advisory Committee (HPAC) is made up of hospital pharmacists and purchasing managers, and provides advice on the funding of drugs in the hospital sector.

The new Cancer Treatments Sub-committee of PTAC, CaTSOP, has been established to assess new pharmaceutical cancer treatments for their use in both the community and hospital settings.

The scope and memberships of sub-committees providing advice to PTAC was the subject of an extensive review. This led to new members being appointed to some committees, and the establishment of a new sub-committee for analgesic and anti-nausea products.

The Consumer Advisory Committee has been established to provide a patient or health consumer point of view on PHARMAC's processes. Nine members have been appointed to the committee by the PHARMAC Board.

Exceptional Circumstances

PHARMAC has assumed management of the Exceptional Circumstances scheme, formerly managed by the Ministry of Health. The scheme is primarily used by patients with rare conditions, or with particular health needs, to access pharmaceuticals that are not otherwise funded.

The EC committee meets every fortnight via teleconference and decisions are usually made within three weeks of an application being lodged.

The annual cost of PHARMAC

Derived from audited figures for years ended 30 June

$000s	**2002**	*2001*	*2000*	*1999*	*1998*
Staff costs (includes Directors' and professional fees) (1)	**2,330**	1,763	1,598	1,539	1,440
Office costs (includes depreciation, rent, phones, library, purchase of data, ordinary legal costs)	**2,452**	2,326	1,744	1,701	1,176
Responsible use of medicines (2)	**2,141**	0	0	0	0
Consulting services (includes PTAC, PR, general consulting, audit fees, HRM and accounting)	**901**	597	695	1,215	1,409
Schedule production (printing and postage only)	**287**	348	464	424	479
Costs associated with litigation	**318**	251	736	594	1,039
Total cost	**8,429**	5,285	5,237	5,473	5,543

At balance date, fixed assets comprised $475,000 of office and computer equipment, furniture and fittings

(1) Eleven staff were recruited, and three resigned during the 2001-02 year as PHARMAC moved towards optimum staffing levels.

(2) Funding for these services in previous years was provided via the Ministry of Health.

A panel of clinicians has been set up to assess applications and decide on funding. A review committee has also been established to handle appeals on decisions. One appeal was lodged in the 2001-02 period, but was later withdrawn.

Financial performance

Staff costs for 2002 increased as PHARMAC reached full employment potential to ensure that its responsibilities under the New Zealand Public Health and Disability Act, 2000 were met.

Office costs have increased as a reflection of our commitment to review our contracts and legal costs. PHARMAC also upgraded its telecommunications system and other assets.

The major increase in operational expenditure relates directly to new services that have been undertaken by PHARMAC, such as administration of Exceptional Circumstances and the Hospital Purchasing strategy.

Schedule production costs reduced again in the 2002 financial period.

Publications Available on PHARMAC's Website

- The Pharmaceutical Schedule and Monthly Updates
- PHARMAC's Operating Policies and Procedures (including minutes from meetings relating to the review of these)
- PHARMAC's Annual Report to Parliament
- PHARMAC's Post Election Briefing to the Minister of Health
- PHARMAC's Annual Business Plans
- Annual Reviews
- A Prescription for Pharmacoeconomic Analysis (an explanation of PHARMAC's methods for Cost-Utility Analysis)
- Various consultation letters
- PHARMAC's invitation to suppliers to tender for sole supply of pharmaceuticals
- Media releases
- Special Authority Forms
- Patient leaflets
- Statistics about pharmaceutical spending in New Zealand

THE PHARMAC BOARD

Richard Waddel, BCom, FCA
Chairman
David Moore, MCom, Dip Health Ec, CA
Liz Coutts, BMS, CA
Ross Black, BCom
(departed July 2002)
Karen Guilliland, RM, RGON, MA, MNZM
Prof Gregor Coster, MSc, MBChB, FRNZCGP
Helmut Modlik, BCA, MBA
(appointed June 2002)

Committee members

Pharmacology and Therapeutics Advisory Committee (PTAC)

John Hedley
MBChB, FRACP, FACCP, Member Thoracic, Cardiac and Gastroenterology Societies of Australia and New Zealand,
Chairman
Robin Briant
MBChB, MRACP, MRCP, MD, FRACP
Carl Burgess
MD, MRCP (UK), FRACP, pharmacologist
Bruce Foggo
MBChB, Dip Obst, FRNZCGP
Jim Lello
BHB, MBChB, DCH, FRNZCGP,
general practitioner
Colleen Lewis
MBChB, general practitioner
Peter Pillans
MBChB MD, FCP, FRACP
Tom Thompson
MBChB, FRACP
Paul Tomlinson
BSc, MBChB, MD, MRCP, FRACP

PTAC Sub-committees

Respiratory — John Hedley (PTAC), Innes Asher (paediatrician), Carl Burgess (PTAC)

Analgesia – John Hedley (PTAC, chair), Bruce Foggo (PTAC), Derek Snelling (physician), Geoff Robinson (physician), Howard Wilson (physician), John Adler (physician), Neil Whittaker (general practitioner), Rick Acland (physician), Ross Drake (paediatrician), Lindsay Haas (neurologist).

Antibiotics – Bruce Foggo (PTAC), Mark Thomas (infectious diseases specialist), Robin Briant (PTAC), Sandy Smith (microbiologist), Paul Tomlinson (PTAC).

Anti-retroviral – Dr Stephen Chambers, Dr John Hedley (Chair), Dr Richard Meech, Dr Mark Thomas, Dr Paul Tomlinson, Dr Evan Begg

Cardiovascular – John Hedley (PTAC, chair), Alan Moffitt (PTAC), Gary Gordon (cardiologist), Lannes Johnson (general practitioner), Miles Williams (cardiologist), Peter Pillans (PTAC).

Central Nervous System Stimulants – John Hedley (PTAC chair), Paul Tomlinson (PTAC), Martin Pollock (neurologist), John Werry (psychiatrist).

Diabetes – Tom Thompson (PTAC, chair), Pat Carlton (diabetes nurse specialist), Paul Drury (diabetologist), Tim Kenealy (general practitioner), Peter Moore (diabetologist).

Hormonal Contraceptives – Sharon Kletchko (physician, chair), Bruce Foggo (PTAC), Frances McClure (general practitioner), Christine Roke (general practitioner), John Hutton (reproductive endocrinologist)

Mental Health – Peter Ellis (psychiatrist, chair), Robin Briant (PTAC), Carl Burgess (PTAC), John Hopkins (psychiatrist), Janet Holmes (general practitioner).

Neurology – John Hedley (PTAC, chair), Tom Thompson (PTAC), Alistair Dunn (general practitioner), Lindsay Haas (neurologist), William Wallis (neurologist).

Opthalmology – Robin Briant (PTAC, chair), Allan Simpson (ophthalmologist), Justin Mora (eye specialist), Mark Elder (eye specialist).

Osteoporosis – John Hedley (PTAC, chair), Anna Fenton (endocrinologist), Ian Reid (endocrinologist), Richard Sainsbury (geriatrician), Les Toop (public health physician).

Special Foods – Paul Tomlinson (PTAC, chair), Kery McIlroy (dietician), Jo Stewart (dietician), John Wyeth (gastroenterologist).

Tender – Bruce Foggo (PTAC, chair), Andrea Shirtcliffe (pharmacist), Peter Cook (pharmacist).

Pharmaceutical Cancer Treatments – Tim Hawkins (haematologist), Peter Ganly (haematologist), Vernon Harvey (oncologist), Simon Allan (oncologist), Bernie Fitzharris (oncologist); Andrew Macann (radiation oncologist).

Hospital Pharmaceuticals Advisory Committee (HPAC)

Sarah Fitt (Pharmacy manager, Auckland DHB)
Paul Green (Material management, Auckland DHB);
Marilyn Crawley (Pharmacy Services Manager, Waitemata);
Bruce Hastie (Clinical Pharmacy Manager, Counties-Manukau);
Elizabeth Plant (Chief Pharmacist, Taranaki);
Neville Winsley (Pharmacy Manager, Hawke's Bay);
Julie Yee (Service leader, Pharmacy, Capital & Coast);
Stephanie Chapman (Purchasing Manager, Canterbury);
Brian Ellis (Clinical Practice Group Manager, Otago);
Ian Winwood (Clinical co-ordinator of Pharmacy Services, Southland);
Andre Mutavidzic (pharmacist, Waikato).

Consumer Advisory Committee

Vicki Burnett (Mental health consultant, Auckland)
Sharron Cole (National Trainer, Parents Centres, Wellington)
Anna Dillon (CanTeen national secretary, Otago)
Sandra Coney (Women's Health Action, Auckland)
Paul Stanley (Social sciences lecturer, Mt Maunganui)
Matiu Dickson (Te Runanga o Kirikiriroa chairman, Hamilton)
Kuresa Tiumalu-Faleseuga (chief executive, Pacificare, Auckland)
Dennis Paget (Grey Power, Blenheim)
Deirdre Nehua (chief executive, Te Hotu Manawa Maori, Auckland)

THE PHARMAC TEAM

Chief Executive
Wayne McNee BPharm, PG Dip Clin Pharm, MPS

Medical Director
Peter Moodie BSc, MBChB, FRNZCGP

Corporate
Olivia Paterson BCA, BA Hons
Manager Corporate

Mary Chesterfield
Receptionist

Jan Edwards NZ Dip Bus
Office Manager

Simon England
Communications Advisor

Jessica Nisbet
Receptionist

Melanie Pemberton BA (Hons), HND
Executive Assistant

Special projects
Jan Quin RCpN
Project Manager

Dilky Rasiah MBChB, Dip Public Health
Project Manager

Supply side team
Philip Crampton BCA
Manager, Supply Side

Andrew Davies BSc (Hons)
Tender Analyst

Natalie Ganley MSc
Therapeutic Group Intern

David Goldsmith MBChB, MLIS
Therapeutic Group Manager

Katie Harris BA
Therapeutic Group Assistant

Sarah Schmitt BSc
Therapeutic Group Manager

Martin Szuba MD, MBA, MSc
Therapeutic Group Manager

Schedule team
Ursula Egan Dip Pharm, MPS
Schedule Analyst

John Geering BA, BSc, Dip (Safety Management)
Programmer/Analyst

Jan McNee BPharm, MPS
Schedule Analyst

Demand side team
Rachel Wilson BA, NZIMR
Manager, Demand Side

Tracey Barron DipPharm, MSc (ClinPharm), MPS
Demand Side Manager

Jeanine van Kradenburg RCpN, Dipl Nursing Education
Demand Side Manager

Analysis team
Matthew Brougham MSc (Hons), Dip Health Econ
Manager, Analysis and Assessment

Jason Arnold BSc, PG Dip Stat (Dist)
Forecast Analyst

Sean Dougherty BCom
Analyst

Scott Metcalfe MBChB, DComH, FAFPHM
Epidemiologist/public health physician (on contract)

Hew Norris BMS
Analyst

Hospital Pharmaceuticals Team
Cristine Della Barca Dip Pharm, MPS, Dip Bus Admin
Manager Hospital Pharmaceuticals

Rachel Grocott Bcom (Hons)
Hospital Pharmaceuticals Analyst

Matthew Perkins BSc, BCom, PG Dip Com
Hospital Projects Advisor

For further information

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