27 August 2012

Sean Dougherty
Funding Systems Development Manager
PHARMAC
PO Box 10254
Wellington 6143
sean.dougherty@pharmac.govt.nz

Dear Sean,

Consultation on Potential Pharmaceutical Schedule Rules for Hospital Pharmaceuticals

I write on behalf of the Breast Cancer Aotearoa Coalition (BCAC) in response to your consultation dated 9 July 2012. BCAC has the following feedback based on your consultation document.

Impact of Proposals on Patients

- The consultation makes no mention of the way in which proposed changes will impact patients. This should be central (not peripheral) to any proposal to introduce new processes. Specifically, the consultation should address how the proposals will impact health needs of patients with reference to the status quo.
- It is particularly important to patients that there is continuity of care across the various sectors of health care. This means that medication initiated in the hospital setting can be continued outside, (when the patient is discharged and becomes an outpatient), and that seamless care also goes in the other direction i.e. that medication which a patient is taking as an outpatient can be continued should they be admitted to a hospital. This also applies to various other sectors under DHB jurisdiction such as rest homes, domiciliary care, hospices etc. The patient must be seen to be holistically and continuously under the care of the DHB. They should not have to grapple with inconsistencies imposed by rules about access to medicines that may vary from institution to institution.

- From the patient perspective, BCAC supports the notion of equity of access to medications between DHBs. This appears to be a worthwhile and achievable goal of a national approach to purchasing. In this regard, BCAC is concerned about the "local restrictions" which may be imposed on particular treatments as outlined in the next section.
- The requirement to consult about changes to the Schedule is part of Pharmac's current operating procedures. This consultation is carried out before implementation of any changes. Although BCAC has separate concerns about the nature of consultation processes (as outlined below), an important issue is how local restrictions that may be imposed after consultation and implementation of national listings, will possibly undermine any (earlier) consultation processes.

Range of Pharmaceuticals for Inclusion in Section H

- According our information, the system is meant to be inclusive at this stage – i.e. all items that are currently being purchased by DHB hospitals will be included on the initial "Section H" list. This should facilitate equity of access across DHBs and continuity of access to the medicines currently being used in particular hospitals. As earlier stated, BCAC endorses this to help eliminate current inequities in access that exist between DHB hospitals. However, any local prescriber restrictions that are implemented may serve to subvert this aim.
- In future, there will be a whittling down of items which will be nationally available. This will further the goal of consistent access to pharmaceuticals across DHBs. However, there is real concern that this "consistency" should not be down to the most restricted access i.e. the lowest common denominator. For example, certain pharmaceuticals would be more frequently used in tertiary hospitals where certain specialities exist and this needs to be taken into account. The proposal needs to specify the process for this to occur (see next section).

Processes for Deleting Currently Available Items and Listing New Items

- BCAC is concerned about how the process of creating the ultimate "Section H" will unfold. In particular, a huge concern is that there is appropriate consultation of relevant stakeholders (including relevant medical specialists, patients, pharmacists and nurses) within decision making. The proposals need to specify how and when appropriate stakeholder input will be integrated into decision making. There is no point in waiting until the consultation phase when proposals (from our experience) are unlikely to result in substantial change.
- There is a general concern about whether advice from the current PTAC is appropriate for specialist inpatient areas and therefore the way in which views will be integrated needs to be clarified. It is absolutely essential that the required level and breadth of specialist expertise is integrated into decision making.
- There is also an unanswered question about what process will be implemented to list new items on the hospital section of the Pharmaceutical Schedule in the future i.e. many of the same concerns voiced as part of the consultation on the OPPs will also apply here. Undue

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PO Box 90224 Auckland Mail Centre
Auckland 1142, New Zealand
P 09 428 3385 E bcac@breastcancer.org.nz
www.breastcancer.org.nz

delays in listing items on Section H may have critical impact on patients being treated in the hospital setting. Pharmac needs to clarify how the process will be undertaken and by whom and with whose input/advice.

- Listing of items in Section B appears to be currently driven by availability (principally by manufacturers who have a commercial interest in making applications) rather than need. This is therefore a reactive rather than proactive process. This may not always result in optimal availability of treatment options from the patient perspective. There should be consideration given to how needs of patients in hospitals will proactively determine listing and availability, particularly where there is insufficient commercial interest by manufacturers to make applications for listing or to enter the negotiation process.

Restrictions on Individual Pharmaceuticals Included in Section H

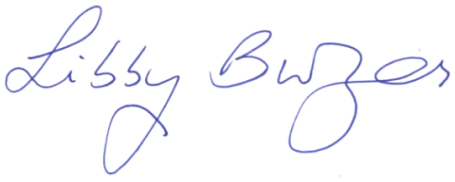
- It is not clear how national indication restrictions (clinical circumstances and/or patient population) will be set.
- There is little information on the number of inpatient pharmaceuticals which will be restricted and there is concern about the impact of waiting for approvals for individual patients particularly where urgent use is needed. In acute situations, delays may be critical.
- It appears there will be new restrictions that will hinder patient access to pharmaceuticals. Of particular concern is that the processes for approving individual patient access (be this via Special Authority or NPPA) currently entail burdensome bureaucracy and unacceptable delay. The current NPPA system needs speeding up and "other exceptions" should not be subject to delays.

Monitoring of Policy Change

- There is no indication of how this policy change will be monitored in terms of the outcomes for patients. It will be important to ensure that performance of the new policy is not merely evaluated by way of audits which are intended to assess compliance or budgetary outcomes.

I look forward to hearing PHARMAC's response to this feedback from BCAC.

Yours sincerely,



Libby Burgess, MNZM
BCAC Chairperson

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