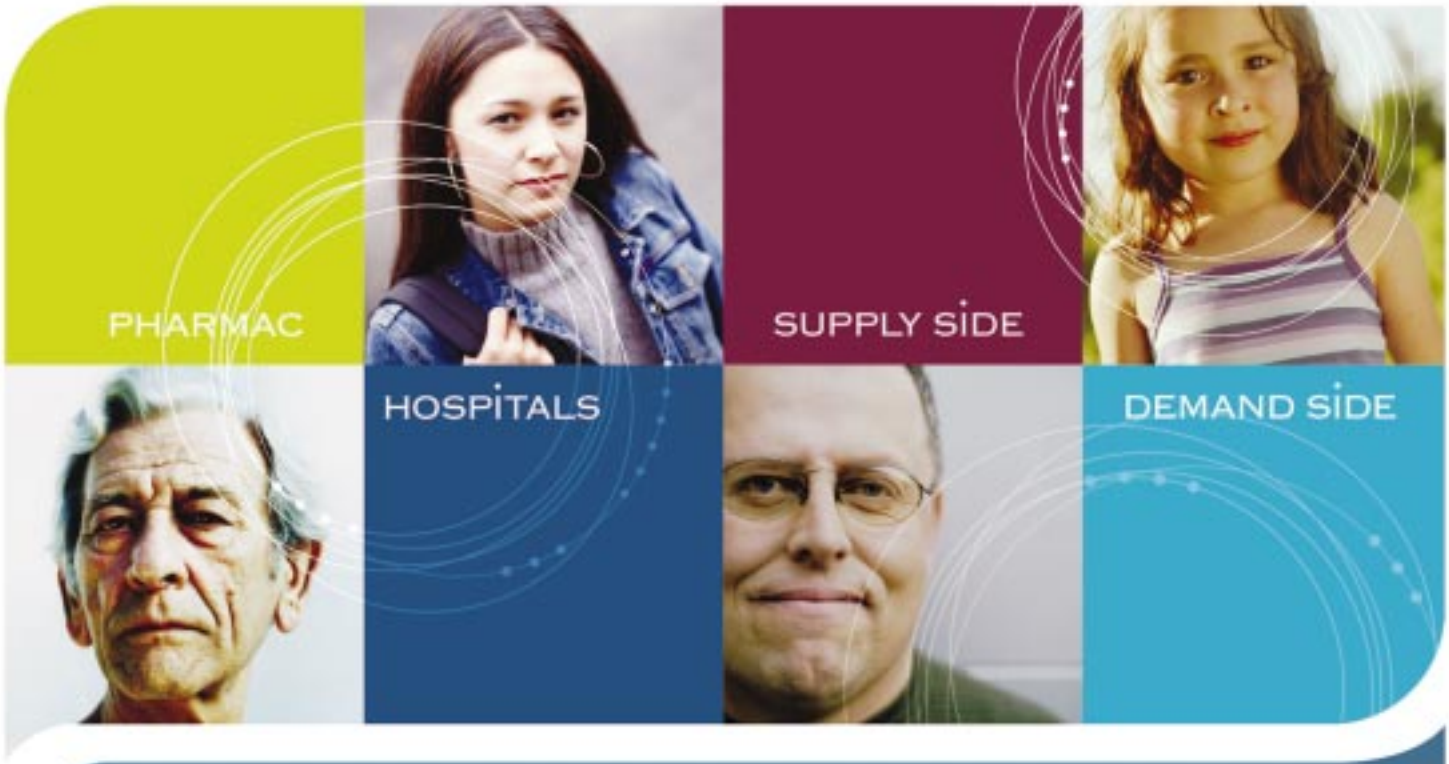


t agency pharmaceutical managemen
aceutical management agency pharma
pharmaceutical management agency

Annual Review 2004

PHARMAC
Pharmaceutical Management Agency

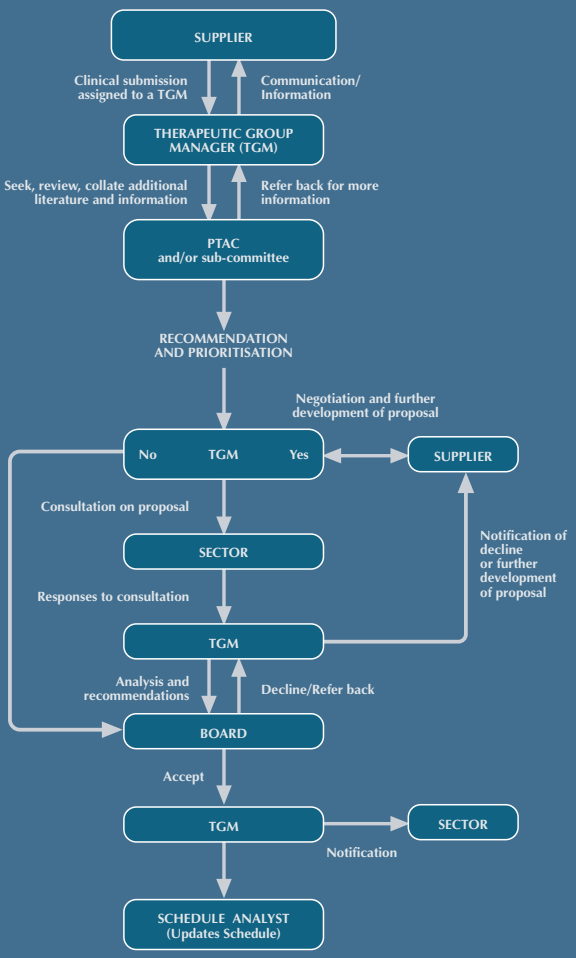
PHARMAC (the Pharmaceutical Management Agency) is a Crown Entity established under the New Zealand Public Health and Disability Act. Its statutory objective is to secure for those in need of pharmaceuticals the best health outcomes that are reasonably achievable from pharmaceutical treatment within the amount of funding provided. PHARMAC's primary function is to manage the national Pharmaceutical Schedule, which is a comprehensive list of 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.

In this Review:

- "Year" means year ending 30 June. For example: "this year" means the year ended 30 June 2003; "last year" means the year ended 30 June 2002, "next year" means the year ended 30 June 2004.
- 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.

Highlights of 2003-04

- *Providing new or expanded access to 24 subsidised treatments*
- *New or improved access to treatments for hepatitis C, depression, alcohol addiction, breast cancer, childhood arthritis, glaucoma*
- *Treating 13,000 more patients than the previous year with subsidised medicines while negotiating savings worth $50.7 million*
- *Negotiating nationally-consistent contracts for 50 percent of DHB hospital medicines (by value)*
- *Hospital drug savings now worth in excess of $10 million per year*
- *Successfully piloted the cardiovascular risk management campaign One Heart Many Lives*
- *Wise Use of Antibiotics campaign producing increased awareness about the use of antibiotics for colds and flu*
- *Increased funding by 40 percent for the Green Prescriptions programme, jointly funded with SPARC*
- *Partial return to all at once dispensing to save DHBs $132 million over 5 years*

PHARMAC Board chairman Richard Waddel says

PHARMAC is committed to sharing its expertise to benefit the wider health sector

In the past year PHARMAC was responsible for implementing one of the health sector's biggest funding shifts in recent years, the return to all-at-once (or stat) dispensing of prescription medicines.

Since being appointed chair of the PHARMAC Board in 2000, I have learned that when you make difficult decisions, you have to be prepared for criticism.

That was certainly the case with all-at-once dispensing. Even before we began consulting on the proposal we knew there would be opposition from some groups. What surprised us was the form this opposition took against PHARMAC and its staff during this time. There was even a challenge to the ethics and integrity of senior PHARMAC personnel through a professional association, a spurious action that has now been discontinued.

We regret that the campaign against all-at-once dispensing was reduced to such personal attacks, however we don't regret proposing and then implementing the policy.

This was a decision with tremendous benefits for the health sector, releasing an estimated $132 million over five years for District Health Boards to reallocate to priority areas. It also made collecting medicine more convenient for patients, and took allowance of safety considerations by enabling doctors to give people their medicines in smaller amounts more frequently if their personal circumstances require it.

Skills

PHARMAC does not exist in isolation, it is an integral part of the public health system infrastructure and has skills that can be shared to produce wider benefits. That was certainly the case with all-at-once dispensing.

PHARMAC has a continuing desire to assist District Health Boards, and the government as a whole, to manage expenditure on pharmaceuticals and other related products. Its expertise in economic

evaluation, negotiating and contracting with suppliers can be brought to other areas of health purchasing. Over the past year discussions with DHBs have led to an agreement that PHARMAC will initiate national purchasing of some other products used in hospitals, such as radiological contrast media and bulk intravenous fluids during 2004-05. We'll also be taking on the role of purchasing the influenza vaccine for the 2005 flu season, a task previously undertaken by the Ministry of Health.

And PHARMAC will be continuing to make new investments in pharmaceuticals. The three-year funding path agreed with District Health Boards gives greater certainty to planning and the ongoing increases in funding, combined with PHARMAC's continuing cost management, will ensure New Zealanders have even greater access to pharmaceuticals.

Sharing our skills and expertise is a real way for PHARMAC to increase our contribution to health purchasing, a role it already excels in through its management of the community pharmaceutical budget, and increasingly, in purchasing medicines used in DHB hospitals.

Budget target

In the past year PHARMAC has again managed pharmaceutical expenditure within budget, while making new investments in pharmaceuticals. At the start of the year the indicative budget was set at $539 million. It was then increased to make allowances for anticipated growth in medicine volumes as a result of the return to all-at-once dispensing (which would see more people get the medicine prescribed for them), and the implementation of lower dispensing fees through the introduction of Primary Healthcare Organisations.

At the request of pharmacists the government's introduction of the lower prescribing fee structure was delayed, and this meant that the anticipated increase in volumes didn't occur. At the same time, there has been a greater than forecast use of Close Control, the prescriber mechanism that allows medicines to be dispensed more frequently. Again, this has led to lower volumes of medicines being dispensed than anticipated.

So during the year the expenditure target was revised, and re-agreed by the Minister of Health at $541 million. Expenditure for the year was $533 million. In addition DHBs and PHARMAC are working on developing a research fund of $6 million.

Contributions

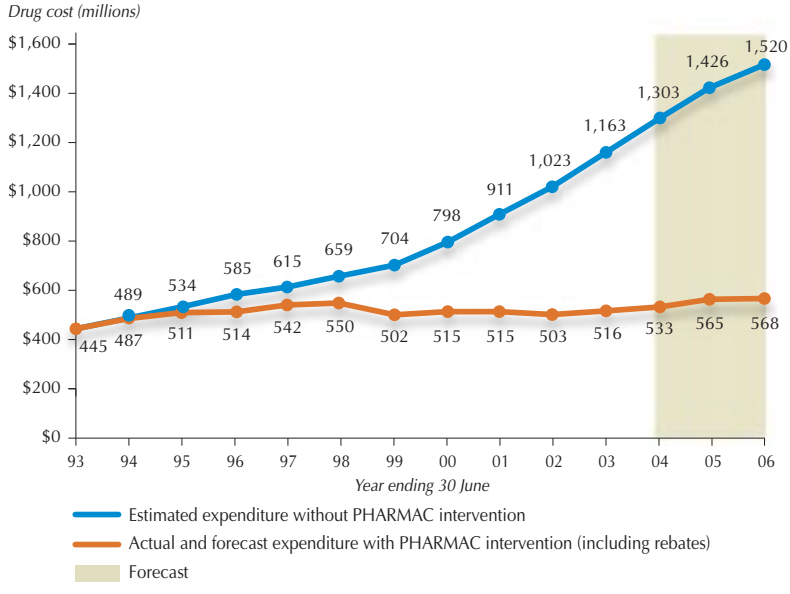
We welcomed Adrienne von Tunzelmann to the PHARMAC Board during the year. Adrienne brings a strong background in public policy work and is a valuable addition to the range of management, medical and other skills present on the Board. I would like to thank my fellow board members for their continuing dedication and enthusiasm during what has been a challenging year.

PHARMAC's advisory committees continue to provide valuable insights to both PHARMAC staff and the board. The Pharmacology and Therapeutics Advisory Committee (PTAC) has continued to function effectively under Professor Carl Burgess, and it is pleasing to see the Consumer Advisory Committee (CAC), under the guidance of chair Sandra Coney, having a real impact on PHARMAC and its operations. The PHARMAC Board values the range of views it receives from these independent committees which all bring differing perspectives to the work of PHARMAC.

Finally, and most importantly, I need to acknowledge the outstanding work throughout the year of Wayne McNee and his staff at PHARMAC, whose dedication and professionalism have been among the year's highlights.

Impact of Pharmac on Drug Expenditure over time

Without PHARMAC's activities (assuming no other price changes would have occurred), the community drug bill would have been $770 million higher.



A three-year funding path paves the way for even more medicines to be funded

writes Chief Executive Wayne McNee

Over the years, PHARMAC has deservedly earned a reputation as an organisation that gets a lot out of the money it manages.

This has meant getting better value from the more than $700 million (including hospitals) that New Zealand taxpayers pay for medicines on the one hand, and maintaining and growing the list of medicines that are subsidised on the other.

Since its inception in 1993 PHARMAC has been successful in providing New Zealanders with continued access to new medicines while managing growth in expenditure. This has meant putting in place a range of buying strategies that mean the runaway price growth of the 1980s and early 1990s is now under control. This approach has enabled us to maintain universal access to subsidised medicines, while adding 146 new products to the Pharmaceutical Schedule since 1993.

New focus

However, there has been a subtle shift in focus towards even greater investment in new medicines during the

past year, and this will continue for the foreseeable future. This has been made possible by our success in managing expenditure to date, and by ongoing increases in funding provided through a three-year funding path for pharmaceuticals, which has been agreed by the Minister of Health.

This three-year path is something PHARMAC has been working towards for some time, so it is pleasing to be able to look ahead with more certainty and make plans that can be implemented long-term.

The increase in funding comes at a time when New Zealanders will obtain more subsidised medicines through low prescription fees, implemented as part of the rollout of Primary Healthcare Organisations. We see this as a good thing, as more people will be obtaining the prescriptions their doctors have decided they need. We recognise the importance of medicines in both managing people's health and in helping return ill people to good health.

Here's how PHARMAC's future expenditure targets look:

Year to June	Pharmaceutical Budget
2002-03	$512 million (actual expenditure)
2003-04	$533 million (actual expenditure)
2004-05	$565 million
2005-06	$568 million
2006-07	$579 million

It goes without saying that PHARMAC will continue to take a responsible approach to spending taxpayers' money. Again, this is a hallmark of PHARMAC's work. We put a lot of effort into making sure new funding goes to those medicines that provide advances over current treatments, and provide good value for money.

That means continuing to tender for off-patent medicines, and to pay the same for those products that do the same or similar things. These are some of the strategies that have helped bring PHARMAC to the point where it can plan for continuing growth in medicine volumes, and look to make more new spending decisions with confidence.

Investments

We saw the beginnings of this new focus during 2003-04. The new investments made are discussed in more detail later in this edition of PHARMAC's Annual Review. They include:

- venlafaxine for severe depression
- etanercept for childhood arthritis
- pegylated interferon in combination with ribavirin for hepatitis C
- naltrexone for alcohol addiction
- widened access to alendronate for osteoporosis
- widened access to tacrolimus for organ transplants

Together these decisions represent more than $39 million spending on 14,000 New Zealanders over the next five years.

Since 2002 PHARMAC has also been involved in purchasing a range of medicines on behalf of DHB hospitals. We now purchase more than 50 percent by value of all hospital pharmaceuticals, and estimate savings in excess of $10 million per year.

Overseas issues

Looking at some of the health sector issues in other countries, pricing and access to pharmaceuticals continues to be a hot topic, particularly in the United States. The US has no large-scale public health structure as there is in New Zealand, and no universal subsidised medicine scheme. So the 75 percent of America's elderly and 44 million other Americans who don't have health insurance have to pay for their medication themselves.

But it is interesting to note that there are organisations in the US doing similar work to PHARMAC. One of them is Kaiser Permanente, one of America's largest Health Management Organisations which puts considerable work into assessing value for money in its purchasing and encouraging evidence-based prescribing from its physicians. Dr Sharon Levine, Kaiser's associate executive director, discusses some of these initiatives later in this Annual Review.

Our heritage of success is one that we are proud of and is what has given us the platform to look forward to spending more on medicines to improve the health of New Zealanders.

The evidence-based medicine movement has had an enormous effect on modern medicine, but talking it is easier than walking it. Not only is there the issue of the evidence for new therapies, there is the constant questioning of those older therapies often developed at a time when rigorous evaluation was not undertaken and expert opinion was king.

With easier access to clinical information a number of non medical groups have taken a real interest in that evidence. The economists and accountants will look closely at efficiency or value for money elements; however the public and the media are also questioning the safety of therapies. These groups will still be influenced by opinion leaders but for those who seek evidence, the internet has made access to the original documents much easier; this has all served to make the public better informed.

Rapid access to information is changing the way new evidence impacts on medicine, and changing clinical behaviour

writes Medical Director Dr Peter Moodie

However, New Zealand is one of the few countries in the world where direct to consumer advertising (DTCA) is legal and it acts as a potent method for influencing behaviour. Advertising by its very nature is designed to influence behaviour and will lean toward accentuating the positive attributes of the product; however concern remains as to whether a short advertisement allows sufficient time to highlight both the benefits and risks of a medicine.

Impact

Over the last year or so the burgeoning of evidence and the speed of change has had a dramatic effect on some prescribing patterns. For example the messages from the Women's Health Initiative (WHI) study have had a profound impact on the use of hormone replacement therapy (HRT) with a 49 percent reduction in HRT prescribing in New Zealand in 2003, and a further 30 percent reduction this year. That drop was equalled only by the switch from 3rd to 2nd generation oral contraceptives in 1998-9. Plainly clinicians responded to the evidence but at the same time the public and the media had huge parts to play in the dissemination of that evidence.

Regulatory authorities are the ultimate arbiter on whether access to medicines should be restricted, but if there is to be limited access then this is likely to be managed through funding mechanisms. In response to public questions, PHARMAC consulted with both the public and health professionals about whether there should be funding restrictions placed on HRT through the Pharmaceutical Schedule. Some groups seriously questioned whether all clinicians had really understood the HRT message but the majority of women and clinicians felt that this was a matter for patient and doctor to decide. The right to treat was important but the responsibility to fully inform was critical.

The evidence for and against HRT has now been summarised by the New Zealand Guidelines Group and was distributed to clinicians. PHARMAC is assisting with a further distribution of those guidelines along with patient information brochures.

The right to treat was important but the responsibility to fully inform was critical.

The responsible use of antibiotics in the community has been a matter of scientific concern for some years both in New Zealand and internationally. However, over the last five years New Zealand has had a 16% drop in community antibiotic usage accompanied by a similar change in patient understanding of the issues. That change has occurred as a result of public and media interest in the issues and could not have happened without their support.

We are now seeing increasing public concern about the benefits and risks of SSRI anti-depressants for adolescents and it will be important to track prescribing patterns and see what changes in prescribing occur as a result.

Tracking

New Zealand has increasingly sophisticated tracking systems to identify trends in medicine usage and these will become much more useful as National Health Identifier (NHI) numbers are added to the prescription data. The NHI numbers are encrypted to ensure anonymity of individuals but have the potential to be linked to some morbidity and mortality data. In the future it may be possible to better identify specific safety issues with specific drugs. However, our current tracking systems do not extend to unsubsidised prescription medicines such as rofecoxib (Vioxx) that has been widely advertised to the public. In the future it may be important to capture all prescription data.

PHARMAC has been circulating evidence-based literature for some time, so it was pleasing this year to be able to join with ACC in funding a pilot scheme that provided free access to the British Medical Journal's Clinical Evidence publication. There was a high level of support for this project from its users, and PHARMAC and ACC will be assessing how the pilot went before deciding whether to roll access out further.

As patients take an increasing interest in evidence based medicine it is critical that health professionals remain fully informed and critically aware.

The faces may change but the work goes on,

writes PTAC chair Professor Carl Burgess

Some more new faces appeared at the PTAC meeting table this year, but the work of the committee has continued apace.

PTAC welcomed three new members, who have an interest in the use of medicines, to the committee during 2003-04.

The new members are:

- Dr Ian Hosford from Hawke's Bay
- Dr Howard Wilson from Akaroa
- Dr Sisira Jayathissa from the Hutt Valley

Their individual specialties (respectively mental health, rural general practice and geriatric medicine) have broadened our knowledge base with obvious benefits to the committee and therefore to PHARMAC.

It has been a busy year reviewing applications for many new medicines. This has also involved the various subcommittees of PTAC. Thus, for example CATSoP (Cancer treatment subcommittee of PTAC) has completed the mammoth task of reviewing all the medicines in the oncology basket in addition to assisting PTAC in assessing new cancer treatments.

The Committee has also been heavily involved in the development of the Discretionary Community Supply (DCS) list and members of PTAC take a leading role in both the Community and Hospital Exceptional Circumstances panels. Through these panels, PTAC is kept informed of developments in drug usage (need) in the community.

PTAC's opinion was sought in regard to a number of matters, including controversies surrounding HRT, the use of some cardiovascular drugs and the use of new agents for the treatment of HIV/AIDS.

The highlight of the year was the attendance of seven members of PTAC at the World Conference of Clinical Pharmacology and Therapeutics held in Brisbane in August. We are grateful to PHARMAC for funding this endeavour.

Our relationship with PHARMAC through the Medical Director and Therapeutic Group Managers is excellent and has enabled the committee to function to a very high standard.

Professor Carl Burgess

- Professor and Head of Department, Dept of Medicine, Wellington School of Medicine
- Consultant physician, Dept of Internal Medicine, Capital Coast DHB
- Member of Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists (ASCEPT)
- Member NZ Medical Association
- Chair, SAC in Clinical Pharmacology , RACP (NZ)
- PTAC member since 2000

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.

Dr Sharon Levine is the associate executive director of Kaiser Permanente (KP), an Oakland, California-based Health Maintenance Organisation. Kaiser Permanente is a fully integrated health care delivery system – with medical, hospital and pharmacy services all "under one roof". Its Medical Group and Pharmacy organisation collaborate to provide evidence-based, high health-and-economic-value prescription drug therapy for enrollees in the Health Plan.

Providing balanced, evidence-based information to doctors has led to dramatic differences in the practice of Kaiser Permanente doctors compared to their colleagues in other parts of the US,

writes Dr Sharon Levine

Kaiser Permanente(KP), based in Oakland, California, is one of the United States' largest Health Maintenance Organisations. Kaiser Permanente is a fully integrated health care delivery system – with medical, hospital and pharmacy services all "under one roof". Kaiser Permanente's associate executive director, Dr Sharon Levine, outlines how the Medical Group and Pharmacy organization collaborate to provide evidence-based, high health-and-economic-value prescription drug therapy for enrollees in the Health Plan.

There are enormous differences between the healthcare landscape and access to pharmaceuticals in the United States and New Zealand. While New Zealand has adopted a government-funded universal access model, in the United States only about 3/4 of insured individuals have access to coverage for prescription drugs, and the vast majority of that coverage is through employment-based health insurance. For most individuals whose clinical conditions require expensive prescription drugs, health insurance with pharmaceutical benefits means the difference between obtaining needed therapies and going without.

Among our more than eight million Kaiser Permanente members, however, more than 96 percent have coverage for prescription drugs, and KP and PHARMAC face similar challenges – how to provide appropriate access to high value prescription drugs for eligible individuals, while effectively managing the impact of the cost of drug therapy on the total health care budget.

In trying to understand the challenge KP faces, it's worth a brief look at the overall pharmaceutical market in the United States. The US is essentially an unregulated market where pharmaceutical companies

theoretically compete with each other on price. Yet the US has the highest prices for prescription drugs in the world. In practice, outside of integrated delivery systems like Kaiser Permanente or the Veterans Administration, there is little price competition, and little ability of health care organizations to force manufacturers to compete for their business. Manufacturers set launch prices based on their own perception of the market's willingness to pay. This is especially true for the "blockbuster" drugs most heavily promoted to doctors and advertised to patients, and thus the most heavily prescribed drugs also tend to be very costly.

Much of the overall growth of cost in the last six years (since the FDA loosened the restrictions on direct-to-consumer advertising of prescription drugs) has been driven by heavily promoted pharmaceuticals to treat conditions such as elevated cholesterol (statins), chronic "heartburn"(proton pump inhibitors like omeprazole) and arthritic and musculoskeletal pain (Cox-2 inhibitors). While appropriate, low-cost generics are available for these conditions, newer, still-patent-protected, heavily promoted drugs are widely used by the general prescriber community in the US, due partly to the fact that physicians practicing outside organized systems of care largely depend on manufacturer representatives for information about therapeutic options. The absence of independent, credible and easily accessible information about the relative effectiveness (head-to-head comparisons) and relative value of different drugs has made it difficult for physicians to distinguish "new" from "improved".

The primary tool for promoting quality while containing costs is assuring that physician prescribing is driven by good evidence, and not marketing hype.

The primary tool for promoting quality while containing costs is assuring that physician prescribing is driven by good evidence, and not marketing hype. Within KP, practising clinical experts develop clinical guidelines and drug utilisation strategies based on the best available evidence. Because the information is developed by expert pharmacists working for Kaiser Permanente, and the recommendations are made by their own expert clinical colleagues, evidence-based prescribing information is valued and relied upon by physicians as a guide to optimal drug selection.

Empowering physicians with the best available evidence to assist them in targeting the use of new drugs only in situations where they are most likely to provide benefit has led to dramatic differences in Permanente physician prescribing compared to community physician practice. Generically available drugs are prescribed less than 50 percent of the time by US physicians, while among Permanente physicians the rate of generic prescribing is approximately 75 percent. Relying on available evidence that Cox-2 inhibitors,(no more effective at relieving pain or inflammation than traditional non-steroidal anti-inflammatory drugs, yet dramatically more expensive) offered some benefit of gastro-intestinal safety to only the highest risk patients, Permanente physicians prescribe Cox II's in just 4 percent of cases calling for an NSAID, and most of that for patients who are at high risk of gastro-intestinal bleeding. Among community physicians in the US, COX II's represent 50% of all NSAID prescribing – literally billions of dollars spent by US consumers on this class of drugs since 1999, with minimal gain in health value or safety. (Rofecoxib, recently removed from the market due in part to research conducted at Kaiser demonstrating increase in vascular events, was the only Cox-2 inhibitor that actually demonstrated some GI risk reduction.)

There's little doubt that the ability to expand access to available drugs is constrained by expenditure of scarce resources on drugs or health interventions where there is no evidence of benefit. As accountable participants in an integrated health care financing and delivery system, our physicians know that every dollar wasted on unnecessary (or unnecessarily expensive) drugs is a dollar not available for other health care purposes. And as members of a non-profit healthcare organisation, our enrollees legitimately expect that the resources they provide not be wasted, and that Permanente physicians act as responsible stewards of their patients' resources – just as taxpayers want to know that their resources are being used effectively in a tax-financed national healthcare scheme..

When physicians are empowered to apply the best evidence, and supported in doing the right thing through rapid access to credible, high-integrity information, they take pride in their ability to provide high quality care that is also cost-effective – and they take pride in being able to do this free from the influence and the high pressure promotional tactics of pharmaceutical companies. The first step is objectively analysing the data in a collaborative process with expert physicians. The next step is communicating it in a useful form to all prescribers. Building the infrastructure within our Pharmacy organisation to accomplish this has required substantial upfront investments. But we have found the investments to pay great dividends, and Kaiser Permanente today is widely regarded as among the highest quality pharmaceutical benefit providers in the US, and an organisation concerned with quality, safety and value of prescription drugs, not just cost.

Therapeutic Group Review

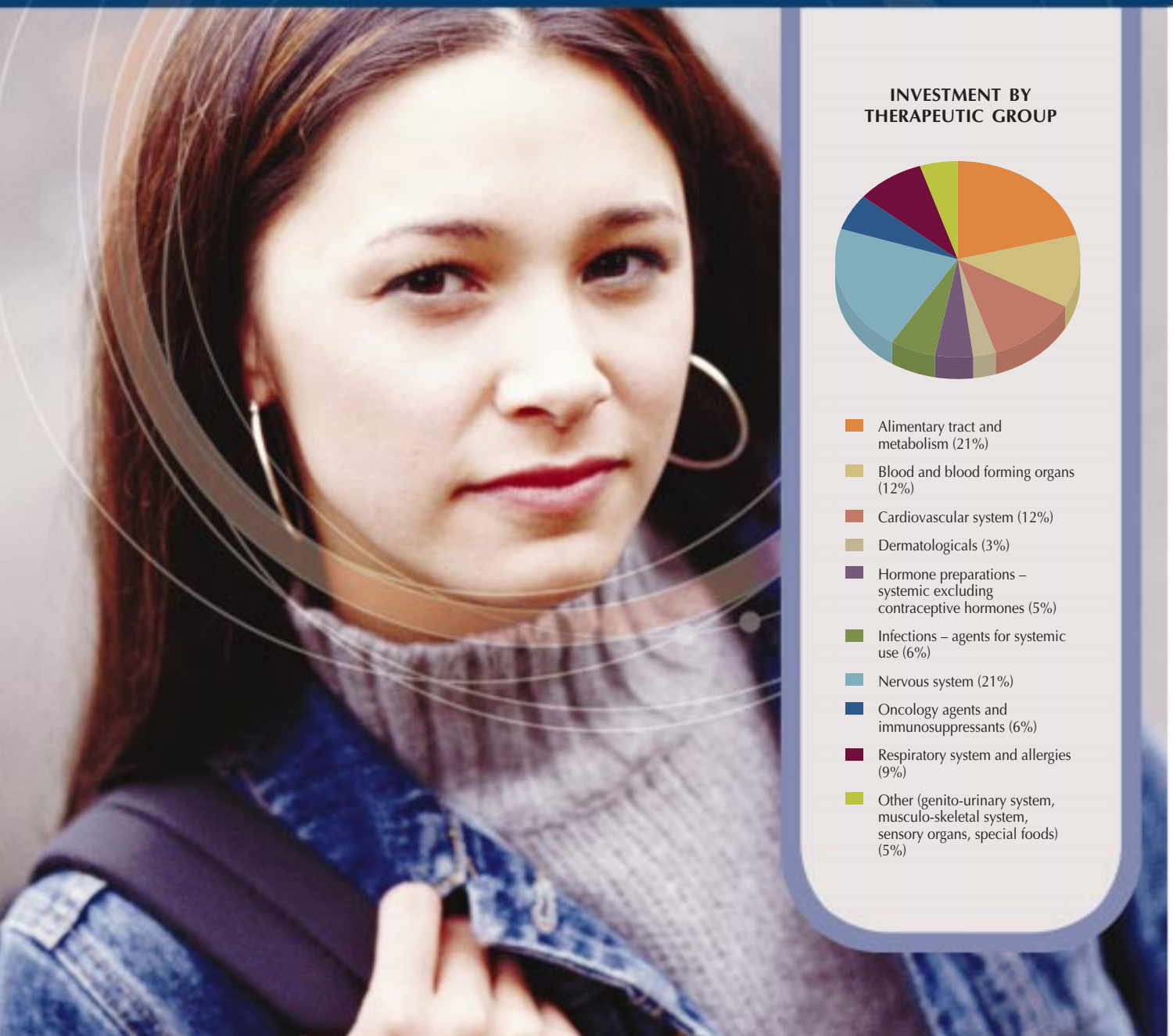
The activities of PHARMAC's Supply and Demand Side teams are becoming increasingly aligned.

The Demand Side team, which works on information campaigns to assist both prescribers and patients, has been targeting areas of high pharmaceutical expenditure including cardiovascular disease and asthma.

The cardiovascular campaign, One Heart Many Lives, has included promoting the prescribing of statins, which have been shown to have benefits in preventing heart attacks and strokes. This supports the widening of access to cholesterol-lowering statins in 2002.

Similarly, the adult asthma management campaign targets an area where overuse of the primary prevention medicine, inhaled corticosteroids, has been an issue both in NZ and internationally. This has had an impact on expenditure, but perhaps more seriously, it has the potential to have a significant effect on New Zealanders' health if it continues.

Mental health continues to be an area of high and growing expenditure. Antipsychotics and antidepressants are



INVESTMENT BY THERAPEUTIC GROUP

- Alimentary tract and metabolism (21%)
- Blood and blood forming organs (12%)
- Cardiovascular system (12%)
- Dermatologicals (3%)
- Hormone preparations – systemic excluding contraceptive hormones (5%)
- Infections – agents for systemic use (6%)
- Nervous system (21%)
- Oncology agents and immunosuppressants (6%)
- Respiratory system and allergies (9%)
- Other (genito-urinary system, musculo-skeletal system, sensory organs, special foods) (5%)

among the top expenditure groups, and there was continued investment during 2004. Venlafaxine, a new type of antidepressant, became fully funded, while a new treatment option was provided for alcohol addiction, naltrexone.

New spending

The biggest single investment made during the year involved pegylated interferon, a new type of interferon treatment for hepatitis C patients. Initially, this decision involved spending some $14 million over five years, although a subsequent decision to widen access will see this figure grow even more.

In all, PHARMAC has added 15 new products to the Pharmaceutical Schedule during 2003-04, a significant rise on previous years, and a result that means continuing access to new and better medicines for New Zealanders. Analysis shows that 13,000 more New Zealanders than in the previous year were able to be treated with subsidised medicines. And as many of the decisions were implemented part-way through the year, this is a number that will continue to grow.

Anti-ulcerant medicines, and in particular the proton pump inhibitors such as omeprazole and pantoprazole, continue to be the biggest area of expenditure, accounting for more than $50 million (nearly 10 percent) of the pharmaceutical budget before rebates.

The Top 20 Expenditure Groups

$ millions, cost ex manufacturer, excludes rebates and GST

	Year Ending 30 June				
Drug Type	***Jun-04***	*Jun-03*	*Jun-02*	*Jun-01*	*Jun-00*
Anti-ulcerants	**$63.9**	$52.2	$44.1	$42.7	$36.1
Lipid Modifying Agents	**$54.9**	$46.1	$40.5	$44.8	$37.2
Antipsychotics	**$45.0**	$40.9	$36.7	$30.1	$23.9
Agents Affecting the Renin-Angiotensin System	**$28.4**	$23.0	$21.4	$27.2	$27.2
Antidepressants	**$27.5**	$32.8	$28.1	$25.0	$28.6
Anti-Epilepsy Drugs	**$20.7**	$19.0	$17.5	$16.0	$15.2
Diabetes Management	**$19.8**	$19.4	$18.1	$16.2	$14.0
Immunosuppressants	**$19.5**	$18.1	$16.1	$15.7	$12.0
Diabetes	**$19.2**	$19.0	$18.6	$17.1	$18.0
Calcium Channel Blockers	**$16.3**	$13.8	$13.9	$15.6	$17.5
Inhaled Corticosteroids – Metered Dose Inhalers	**$14.9**	$20.7	$21.9	$18.7	$19.7
Analgesics	**$14.8**	$15.6	$14.7	$13.7	$13.5
Inhaled Beta-adrenoceptor Agonists – Long Acting Inhalers	**$14.3**	$10.0	$6.0	$4.2	$3.3
Antibacterials	**$13.0**	$14.6	$15.4	$16.2	$23.1
Antimigraine Preparations	**$12.2**	$11.2	$10.5	$9.6	$8.3
Beta Adrenoceptor Blockers	**$11.5**	$9.2	$8.0	$8.0	$9.0
Chemotherapeutic Agents	**$11.1**	$5.3	$1.3	$1.3	$1.2
Antifungals	**$10.2**	$7.9	$7.7	$7.5	$6.2
Trophic Hormones	**$9.5**	$8.5	$7.7	$7.2	$6.6
Antidiarrhoeals	**$9.5**	$9.2	$8.7	$8.4	$7.6

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.

Cardiovascular

The One Heart Many Lives campaign was extended into five high-need areas after being piloted successfully in Gisborne and Porirua during 2003. The pilots used newspaper, billboard and poster advertising and promoted community responses to address New Zealand's high rates of cardiovascular disease, particularly in Maori and Pacific men aged 35 and over.

An assessment of the pilots found:

- An increased awareness of cardiovascular disease among the target group
- More people being referred for Green Prescription
- A higher than the national average increase in statins prescribing

One Heart Many Lives emphasises the role of both lifestyle changes and medicines in lowering overall cardiovascular risk. The campaign's aims were also supported by other PHARMAC decisions during the year.

A new agreement saw PHARMAC and SPARC increase the funding for Green Prescriptions, following an independent evaluation of the programme. Green Prescriptions provide managed physical activity programmes for people referred by their doctor to their local sports trust, and was found to provide excellent value for money.

An agreement with Pfizer saw up to 11,000 more people given the opportunity to use nicotine replacement therapy to help them stop smoking, another significant risk factor for cardiovascular disease.

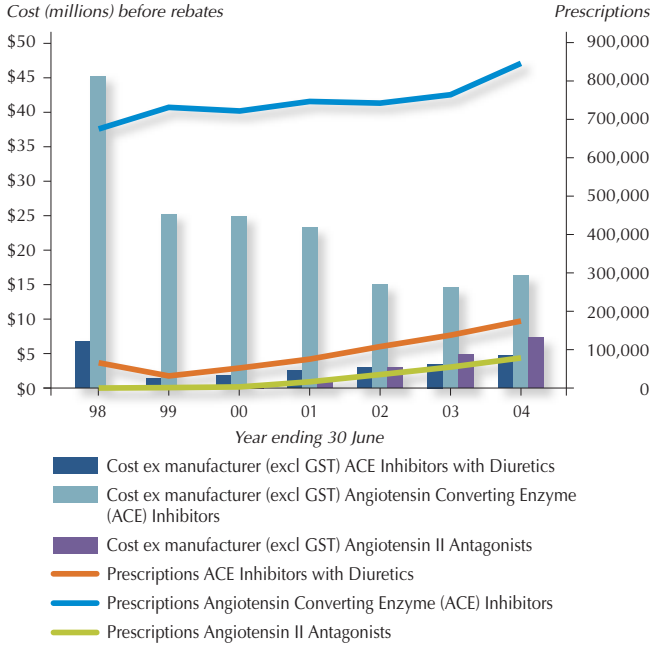
Meanwhile, prescriptions for cholesterol-lowering statins continued to rise, with an estimated 216,000 New Zealanders prescribed them by year-end. And a decision to implement reference pricing of atorvastatin saw about 27,000 patients forecast to change to simvastatin, while those patients on higher doses, and those unable to tolerate simvastatin, could have continued access to fully funded atorvastatin.

The year also saw access widened to the angiotensin II antagonist losartan to make it available for patients with raised blood pressure, and the listing of a new combination product, losartan with hydrochlorothiazide (Hyzaar), for patients who cannot tolerate beta blockers or ACE Inhibitors.

PHARMAC Medical Director Dr Peter Moodie with Te Puke health promoter Grant Smith at the launch of the One Heart Many Lives campaign in Rotorua.

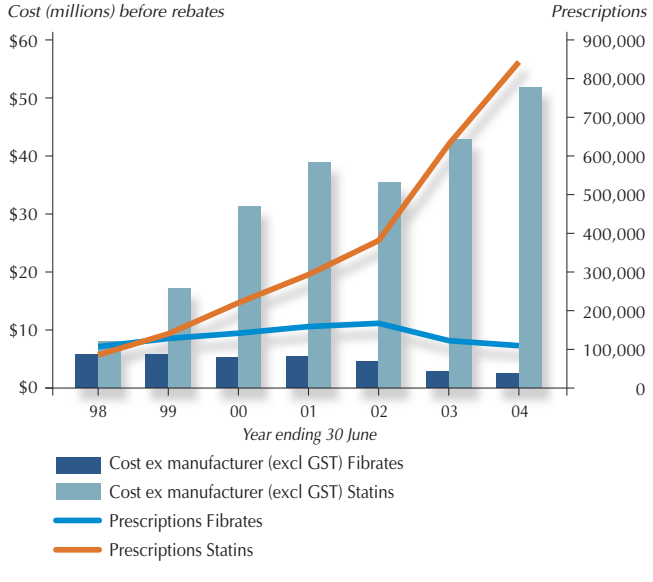
ACE and ACE II Inhibitors

Continued growth in the prescribing of Angiotensin 2 Antagonists and ACE Inhibitors with diuretics continue to be the main features. The rise in prescriptions for ACE Inhibitors is largely due to the introduction of Primary Health Organisations.



Lipid modifying agents

Prescriptions for statins grew sharply in 2004, reflecting widened access and continued promotion



Asthma/respiratory

Doctors and asthma educators were provided with help to better manage their patients' use of asthma medicines during 2003-04.

Concern had been expressed both in New Zealand and internationally that doses of inhaled corticosteroids were too high, and PHARMAC developed a campaign with the Asthma and Respiratory Foundation of NZ and other interest groups to address the problem.

The adult asthma management campaign, Responsible Use of Inhaled Corticosteroids, initially provided prescribers with resources to help them review their patients' doses of inhaled corticosteroids (such as fluticasone and budesonide). The campaign also provided training for pharmacists, asthma educators and nurses.

The launch of a new patient-oriented flip chart provided a further tool for asthma educators to help patients understand how to manage their asthma.

The flip chart was developed by PHARMAC in consultation with the Asthma and Respiratory Foundation and the Porirua Asthma Group, and was launched at the national Maori asthma educators' hui in Wainuiomata in April 2004.

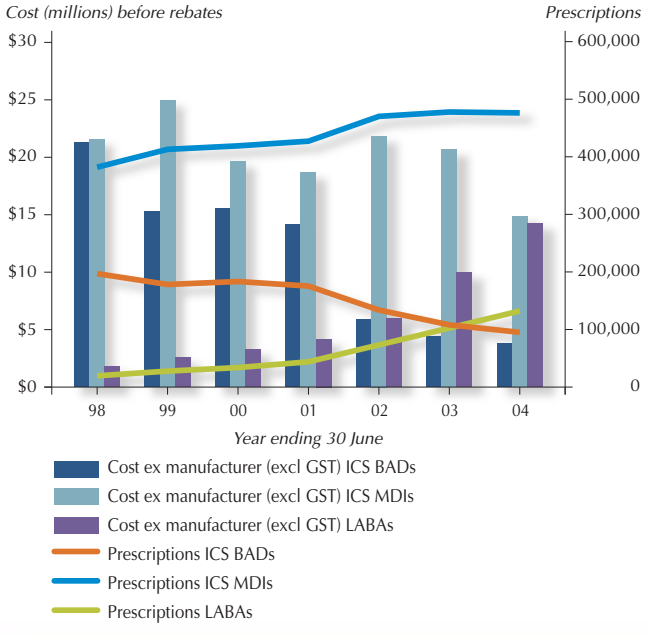
During the year an evaluation of the campaign's early work was carried out. This showed that there had been an 8.6 percent decrease in daily doses, which was in line with the aims of the campaign.

PHARMAC Maori health manager Marama Parore Katene launches the new asthma resource kit.

Asthma educators (from left) Angeline Peakman, Raewyn Hawera and Aroha Te Tai-Dempsey with the PHARMAC-developed asthma educator flip-chart.

Asthma

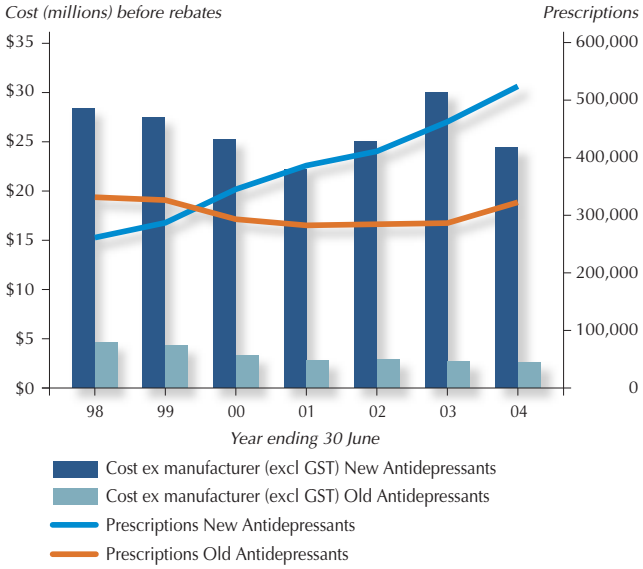
Prescription numbers for long acting beta agonists (LABAs) continue to grow, while prescriptions for inhaled corticosteroids metered dose inhalers (ICS MDIs) were static.



Mental health

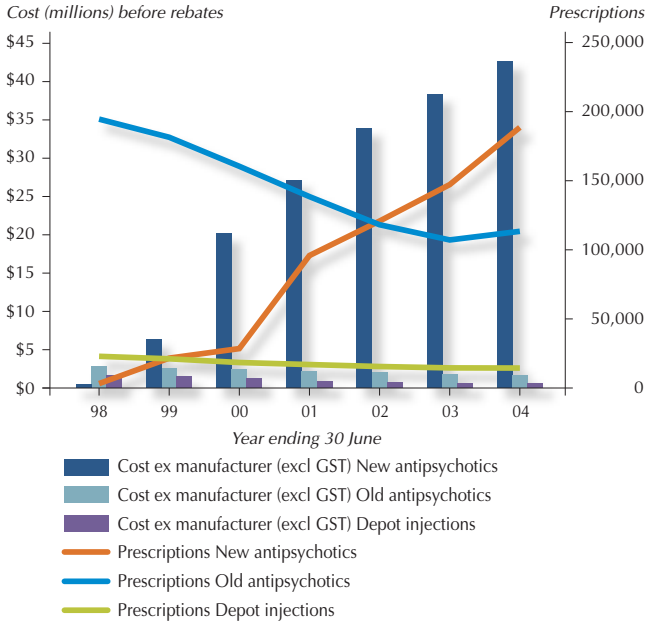
Antidepressants

Prescriptions for new and old antidepressants rose. Costs for new antidepressants fell, reflecting a price reduction for citalopram in 2003.



Antipsychotics

Prescriptions and costs for new generation antipsychotics continue to rise sharply.



Mental health was a significant area of investment during 2004. A further treatment for depressive illness, venlafaxine (Efexor XR), became fully funded from 1 January 2004. Venlafaxine inhibits the uptake of two chemicals in the brain (serotonin and noradrenaline) and is a useful treatment option for clinicians treating patients with severe depression.

Another new listing was naltrexone (ReVia), for the treatment of alcohol addiction. Naltrexone is regarded as an advance on other treatments for alcohol addiction as it stops people getting the "high" they normally expect from drinking alcohol, and has fewer side effects. Naltrexone became fully subsidised on 1 June 2004.

During the year there was continued media attention on possible increased risks of using newer antidepressants, in particular the group known as selective serotonin reuptake inhibitors (SSRIs).

The reports in both medical publications and the wider media focussed on heightened risks of suicidal ideation (thoughts of suicide) in children and adolescents, and produced a range of responses by medicine regulatory bodies overseas and in New Zealand.

In the UK, the Healthcare Products Regulatory Agency stated that the use of all SSRIs other than fluoxetine was not recommended for patients younger than 18 years of age.

No new recommendations came out of the United States, where the Food and Drug Administration and the American College of Neuro-psychopharmacology carried out reviews and raised concerns about the validity of the suicide data, and called for further analysis.

In New Zealand, Medsafe sent new advice to prescribers (following a recommendation from the Medicines Adverse Reactions Committee) alerting them to the issues raised internationally and advising that none of the SSRIs have been recommended for use by patients under 18. According to PHARMAC's data, about 1600 New Zealanders aged 18 and under are prescribed SSRIs.

Following the issuing of the Medsafe letter, PHARMAC began a review of access to SSRIs and other newer antidepressants, this had not been completed by year-end.

Antibiotics

PHARMAC has been funding and co-ordinating the Wise Use of Antibiotics campaign for six years. The campaign, supported by the Plunket Society, the Royal New Zealand College of General Practitioners and the Pharmaceutical Society, is timed around the winter cold and flu season and promotes the message that antibiotics are not an effective treatment for colds or flu, but for people to see their doctor if they are in doubt.

Since the campaign's inception there has been a 16 percent decrease in antibiotic prescribing. Most of this reduction occurred in the early years, and though overall volumes are continuing to decline, the campaign is now focussed on continued vigilance and increasing people's understanding of the issues. Reducing overall antibiotic use and making sure they are used appropriately helps minimise the risks of bacteria becoming resistant to antibiotics.

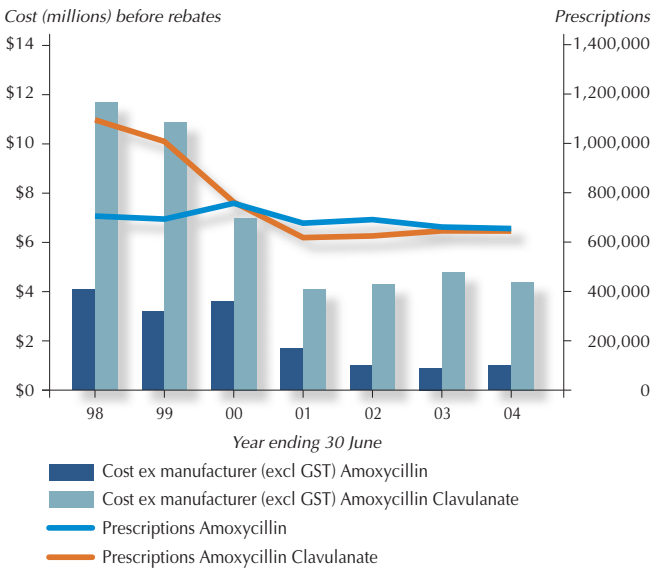
Research carried out by Colmar Brunton indicated that people have a greater understanding of the proper use of antibiotics than they did four years ago. In 2000 only 20% of New Zealanders understood that antibiotics were not an effective way to treat their cold or flu. The same research was conducted at the end of the 2003 winter, revealing that nearly half the people who visited their doctor understood the role of antibiotics in treating colds and flu.

Antibiotics continue to be a significant source of expenditure, accounting for $13 million of the pharmaceutical budget.

PHARMAC's medical director Dr Peter Moodie gives children at Palmerston North's College St Normal School a lesson on the Wise Use of Antibiotics (top). And in Levin, an antibiotic and a virus do battle to illustrate the campaign's key message – antibiotics don't work against colds or flu.

Antibiotics

Prescription numbers for the most commonly-used antibiotics continue to remain stable.



Musculo-skeletal
– arthritis and osteoporosis

Access was widened to two treatments for osteoporosis, etidronate and alendronate, during the year.

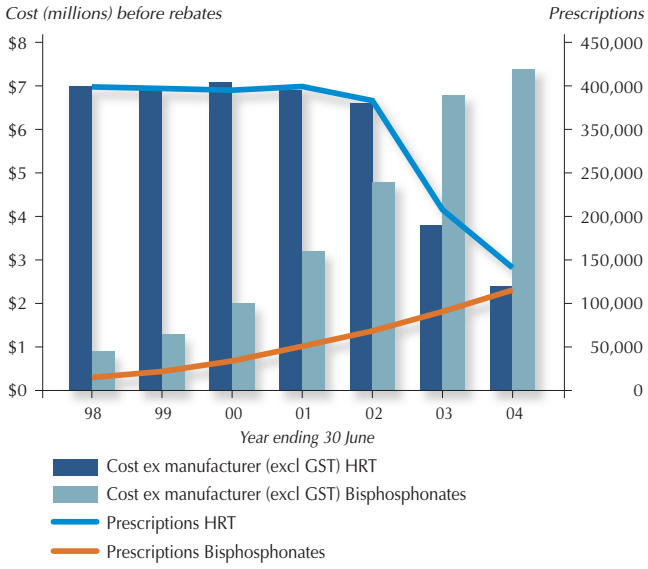
Etidronate, a first-line treatment for the brittle bone disease osteoporosis, became available for prescription by general practitioners from 1 July 2003. And alendronate, like etidronate a member of the bisphosphonate group of drugs, was also made available for prescription by vocationally-registered general practitioners.

Overall prescriptions for bisphosphonates rose, possibly as many women sought alternatives to hormone replacement therapy. Use of HRT continued to fall during 2004, by a further 32 percent following a 49 percent reduction in prescriptions during the previous year.

A new treatment, etanercept (Enbrel), became fully funded for children with arthritis from 1 February 2004. Etanercept is a disease-modifying treatment for arthritis, attacking the underlying cause of the disease. It is the first of a new generation of anti-arthritis drugs, TNF-alpha blockers (or biologicals) to be subsidised in New Zealand.

Hormone Replacement Therapy and Bisphosphonates

HRT prescriptions dropped a further 32 percent, while a continuing rise in bisphosphonates prescriptions (alendronate, etidronate) reflected a widening of access, and women preferring bisphosphonates as an osteoporosis treatment over HRT.



Sensory

People suffering the progressive eye condition glaucoma have more fully funded treatment options available, with two new products approved for funding during 2004.

Travoprost (Travatan) and brinzolamide (Azopt) add to the range of funded treatments available and provide greater choice for eye specialists.

Glaucoma, usually characterised by an increase in pressure within the eye, is the leading cause of preventable blindness in New Zealand.

Oncology and Immunosuppression

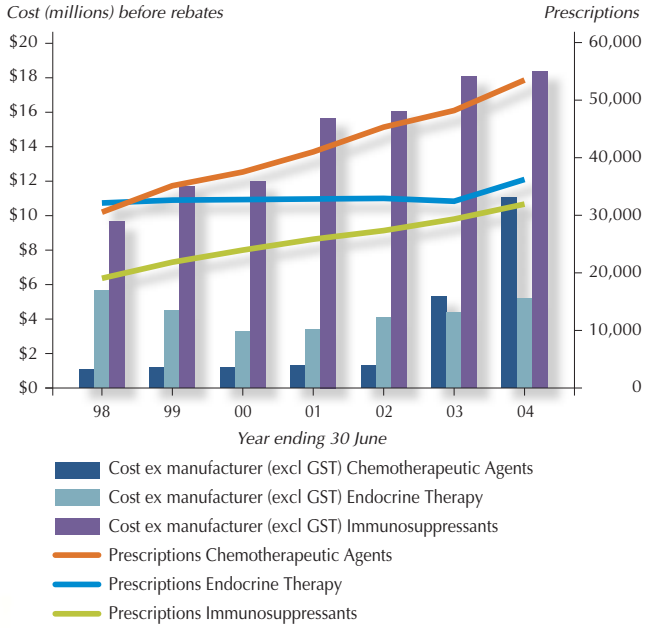
A new combination treatment for hepatitis C, pegylated interferon in combination with ribavirin, was listed on the Pharmaceutical Schedule from 1 March 2004. This is a form of interferon therapy that has been shown to have better response rates than the current therapy of standard interferon in combination with ribavirin.

Pegylated interferon was initially targeted at the largest single patient group (genotype 1), however following further negotiation access was widened to all other genotypes from 1 July 2004.

Access was widened to tacrolimus, a treatment for organ transplants.

Oncology and Immunosuppressants

A significant rise in the cost of chemotherapeutic agents was mainly due to a full year impact of imatinib (Glivec).



Information for Prescribers

PHARMAC signed a new agreement with BPAC NZ to provide a range of support services for GPs, including prescribing audits and guides on best practice. The Best Practice Advocacy Centre NZ (BPAC NZ) is contracted to PHARMAC to promote the responsible use of pharmaceuticals to general practitioners and community pharmacists. It targets key high priority areas such as cardiovascular disease, asthma management, depression, and dyspepsia management.

BPAC NZ provides evidence-based best practice resources and tools to GPs and pharmacists; and prescribing reports to GPs and PHOs. It provides individualised prescribing feedback so that doctors can identify where they differ from their peers and can monitor the changes they make to their prescribing.

A new initiative this year was the decision to jointly fund (with ACC) a pilot programme to supply doctors with the British Medical Journal's Clinical Evidence publication. This provides guidance on evidence around treatments for various conditions, and is highly regarded as an independent and authoritative source of information.

Information was also provided to patients and doctors about the return to all-at-once dispensing from 1 October 2003. This was a change to medicine dispensing that saw greater convenience for patients and savings for DHBs, forecast at $132 million over five years.

Hospital pharmaceuticals

PHARMAC continued its work in purchasing medicines on behalf of DHB hospitals, and making more information available on new pharmaceutical technologies. This is one of the key areas in which PHARMAC is able to help DHBs manage costs within the hospital environment.

The hospital purchasing strategy was introduced in 2002. The publication of a nationally-consistent list of hospital medicines (Section H of the Pharmaceutical Schedule), and the inclusion of hospital medicines in the annual PHARMAC tender, will see savings of over $10 million per year achieved this year and for the next two years.

This year a review was carried out of the hospital purchasing strategy, which included an assessment of financial impacts and qualitative research.

The review found that the strategy has had a positive financial impact on DHB hospitals.

As at December 2003 PHARMAC had implemented national contracts for 40% of annual hospital pharmaceutical expenditure.

Qualitative research identified the costs and benefits seen in the strategy by senior DHB officials. It also identified areas for continued work, such as improving communication, improving the provision of data, and the national Quality and Safe Use of Medicines strategy.

Following the success of the pharmaceuticals purchasing programme, PHARMAC has agreed with DHBs to manage purchasing of influenza vaccines, radiological contrast media, and bulk intravenous fluids from 2005.

Work has also continued on distributing information to DHB hospitals on new pharmaceutical technology assessments, including in-house work completed by PHARMAC.

During 2004 PHARMAC has completed and distributed nine cost-utility analyses to DHBs as part of this process.

The gross savings achieved by national contracts are estimated to be:

Year Ending June 2004

$10,110,710

Year Ending June 2005

$10,548,723

Year Ending June 2006

$10,492,929

Year Ending June 2007

$8,717,556

quality safe use of medicines

Top 20 most prescribed medicines

Year ending June 2004

Most commonly prescribed subsidised drugs. Note: This does not include non-subsidised prescriptions (i.e. those paid for by the patient or those where the cost falls under the patient co-payment).

Chemical Name	*Prescriptions*
Paracetamol	1,149,351
Omeprazole	727,667
Simvastatin	663,664
Amoxycillin	648,605
Amoxycillin Clavulanate	638,714
Salbutamol	568,258
Fluticasone	393,042
Quinapril	372,563
Frusemide	347,150
Metoprolol Succinate	335,518
Aspirin	324,094
Cilazapril	312,861
Diclofenac Sodium	301,729
Felodipine	277,990
Prednisone	277,142
Ethinyloestradiol with Levonorgestrel	258,265
Zopiclone	249,611
Bendrofluazide	240,492
Thyroxine	221,956
Calcium Carbonate	214,920

Prescribing for paracetamol keeps the popular painkiller at the top of the most-prescribed medicines list for 2004. With smaller volumes of the drug that fall below the $15 co-payment threshold, and over-the-counter sales also accounting for a considerable amount, these 1.1 million prescriptions make up only part of overall paracetamol use. Prescribing of paracetamol tablets grew compared to the previous year, this was the presentation of paracetamol that made the largest single contribution to the overall growth in the drug's prescribing.

Omeprazole (Losec), a treatment for gastric reflux and stomach ulcers, was the second most-prescribed drug, with simvastatin (Lipex) for raised cholesterol third. Simvastatin showed the largest prescription growth among the most-prescribed medicines, driven by the widening of access to statins in 2002 and continued promotion, including as part of PHARMAC's One Heart Many Lives campaign.

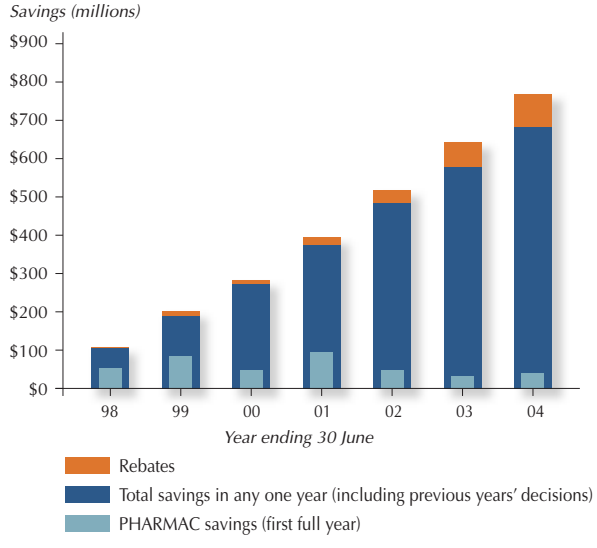
Antibiotics continue to be heavily prescribed, with the two most popular (amoxycillin and amoxycillin with clavulanic acid) registering fourth and fifth respectively.

Treatments for asthma come in at sixth and seventh, salbutamol (Ventolin) is an asthma symptom reliever, while fluticasone (Flixotide) helps prevent the onset of asthma symptoms.

Cardiovascular treatments round out the top 10, with quinapril (an ACE Inhibitor) 8th, frusemide (a diuretic) 9th, and metoprolol succinate (a beta blocker) 10th.

Impact of PHARMAC decisions – savings and rebates

Cumulative savings, and rebates, as a result of PHARMAC decisions.



The Organisation

PHARMAC moved to new premises during 2003-04. In addition to providing space to accommodate the staff responsible for the various roles now performed by PHARMAC, the decision to sub-let some of the new office space to DHBNZ has helped foster a closer working relationship with the group linking all 21 District Health Boards.

PHARMAC continued to more closely integrate the work of Exceptional Circumstances and of the high-cost medicines panels. This was underlined during the year with the positions responsible for these roles being relocated from Auckland to Wellington.

Summary of PHARMAC operations

PHARMAC Board

The PHARMAC Board consists of six members who bring a range of backgrounds and skills from fields as diverse as general practice, accountancy, economics, management consultancy and midwifery to the governance of PHARMAC.

The Board was joined this year by Adrienne von Tunzelmann, a Tauranga-based expert in governance and public policy issues. Adrienne von Tunzelmann has had a diverse public sector career that has included executive positions in central government, including lead roles in the Department of Justice, The Treasury and Office of the Clerk of the House of Representatives. Her broad experience in both the public and private sector brings valuable expertise to the PHARMAC Board.

Staffing

PHARMAC continues to develop its staff's ability to meet the demands of roles it has absorbed from other areas of the health sector, such as management of Exceptional Circumstances applications and purchasing medicines on behalf of DHB hospitals.

A new position of Maori Health Manager was created, this is in line with the aims outlined in PHARMAC's Maori Responsiveness Strategy. The hospital team also grew to accommodate the continued work on managing expenditure on pharmaceuticals and related products in DHB hospitals.

PHARMAC had a slightly higher level of staff turnover than in previous years, with 11 people joining PHARMAC and 10 leaving. Overall, PHARMAC consists of 38 employees (one more than the previous year) plus two independent contractors.

Listing changes to the Pharmaceutical Schedule[1]

Decisions made

Decision type	***2004***	*2003*	*2002*	*2001*	*2000*	*1999*	*1998*	***Total since 1994***
New Chemical entity listed	**15**	**3**	7	20	18	32[4]	14	**146**
New Presentation listed	**27**	15	11	13	21	40	33	**248**
New Product listed	**49**	45	60	28	39	56	53	**468**
Total new listings[2]	**91**	**63**	78	**61**	**78**	**128**	**100**	**862**
Derestriction or expanded access[3]	**9**	7	17	19	17	34	14	**170**
Changes that restrict or limit access	**2**	2	4	6	6	3	7	**44**
Delistings	**72**	196	89	135	362[5]	51	106	**1025**

In 11 years, 862 new or enhanced products have been listed, access has been widened for a further 170, and 1069 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.*

Exceptional Circumstances

The Exceptional Circumstances scheme provides a mechanism for patients to access non-subsidised medicines for rare or unusual conditions. Access criteria are published in the Pharmaceutical Schedule and applications are considered by a panel of practising clinicians. As of 1 July 2003 the scheme was renamed Community Exceptional Circumstances (CEC) as an additional scheme was introduced – Hospital Exceptional Circumstances (HEC). The criteria for CEC remain unchanged.

The HEC scheme is limited to current inpatients who are going to be discharged from hospital and the sole criterion is cost effectiveness to the DHB. It provides a mechanism for DHB hospitals to fund medicines in the community.

The CEC panel held 27 teleconferences and two face-to-face meetings in the year to 30 June 2004. A total of 1291 CEC applications were received during this period (about six per day). Of the 837 approvals, 342 were examined by the panel and the remaining 495 were dealt with by the Panel Co-ordinator under set criteria.

A total of 1216 HEC applications were received during the year ended 30 June 2004.

Summary of CEC applications:

Applications	1291
Approvals	837
Declines	342
Ended [1]	78
Deferred [2]	19
Referred elsewhere [3]	15

1 Applications ended due to the applicant withdrawing the application or the patient dying.

2 Applications deferred back to the applicant for more information.

3 Applications where the applicant was referred to Special Authority for funding.

Of all declined applications 47 were subsequently appealed. Of these one was referred to the PHARMAC Review Committee; the panel's decision was upheld.

Expenditure for the year was $2.94 million against a budget of $3 million.

Advisory Committees

The memberships of PHARMAC's advisory committees has continued to evolve. Professor Carl Burgess has assumed the chair of the Pharmacology and Therapeutics Advisory Committee (PTAC), with Dr Paul Tomlinson as deputy chair. Under their guidance the committee and its sub-committees have continued to provide timely and meaningful advice to PHARMAC. In addition to the departure of former chair Dr John Hedley, Dr Coleen Lewis also left the committee during 2004. New members appointed to PTAC are:

- Dr Sisira Jayathissa (MBBS, MD, MRCP (UK), FRCP (Edin), FRACP, FAFPHM, Dip Clin Epi, Dip OHP, Dip HSM, MBS) is a physician/geriatrician at Hutt DHB;
- Dr Howard Wilson (BSc, PhD, MB, BS, Dip Obst, FRMZCGP, FRACGP) is a general practitioner in Akaroa. Dr Wilson has been Chair of the Exceptional Circumstances Panel since its inception; and
- Dr Ian Hosford (MBChB, FRANZCP) is a psychiatrist working in psychogeriatrics in Hawke's Bay

There were some further adjustments to the membership of PTAC sub-committees, while the Antiretroviral and Antibiotic sub-committees were combined into the Anti-infectives committee, and the Transplant Immunosuppressants sub-committee also began its work.

A review of the Consumer Advisory Committee (CAC)'s Terms of Reference was carried out during the year. This involved consultation with the CAC, and internal work by PHARMAC. Following this process, the PHARMAC Board approved changes to the Terms of Reference which largely reflect the working culture the committee has developed.

Deirdre Nehua resigned from the committee in November 2003. PHARMAC had commenced a process to appoint a further member to the committee, to restore membership to nine.

CAC held three meetings during the year, and also met to consider issues via teleconference.

HPAC (Hospital Pharmaceuticals Advisory Committee) continued to provide advice on the National Hospital Pharmaceutical Strategy and its two-year review. During 2003-04 the Chair of HPAC, Brian Ellis, resigned from his role at Otago DHB to take up work in other areas of the health sector. As HPAC members are all employees of DHBs this was also a loss for HPAC. Ian Winwood from Southland DHB piloted the committee as Acting Chair throughout the review process. Some valuable feedback was gained from the 2 year review process and it is likely that in the coming year there will be some new faces on HPAC.

The annual cost of PHARMAC

Derived from audited figures for years ended 30 June

Dollar 000s	***2004***	*2003*	*2002*	*2001**	*2000*	*1999*	*1998*
Staff costs (includes Directors' and professional fees)	**3,174**	2,753	2,330	1,763	1,598	1,539	1,440
Office costs (includes depreciation, rent, phones, library, purchase of data, ordinary legal costs)	**2,916**	2,801	2,452	2,326	1,744	1,701	1,176
Responsible use of medicines**	**2,284**	2,262	2,141	0	0	0	0
Consulting services (includes PTAC, PR, general consulting, audit fees, HRM and accounting)	**999**	1,251	901	597	695	1,215	1,409
Schedule production (printing and postage only)	**245**	267	287	348	464	424	479
Costs associated with litigation	**206**	242	318	251	736	594	1,039
Total cost	**$9,824**	$9,576	$8,429	$5,285	$5,237	$5,473	$5,543

At balance date, fixed assets comprised of $354,619 of office and computer equipment, furniture and fittings

** Figures for 2001 are a composite of audited figures for the period 1 July 2000 – 31 December 2000, and the figures for 1 January 2001 – 30 June 2001.*

*** Traditionally funding for the responsible use of medicines had been provided as a separate funding stream from the Ministry of Health. This funding is now provided out of PHARMAC's operational budget.*

High Cost Medicines has been included in Consulting Services

Financial performance

PHARMAC has continued to manage its operational costs within budget.

Staff and office costs rose, reflecting the new positions created to undertake new initiatives, the wider role played by PHARMAC, and the relocation of the PHARMAC office to larger premises. There was also a change to the way telecommunications costs are accounted for.

The cost of producing the Pharmaceutical Schedule fell for the fourth straight year, a result of continuing efficiencies in printing costs, while costs associated with litigation were at their lowest level since 1996.

Directory

The PHARMAC Board

Chairman
Richard Waddel, BCom, FCA

Directors
Professor Gregor Coster, MSc, MBChB, FRNZCGP
Adrienne von Tunzelmann, MA (Hons), Master of Public Policy
Karen Guilliland, RM, RGON, MA, MNZM
Helmut Modlik, BCA, MBA
David Moore, Mcom, Dip Health Ec, CA

Pharmacology and Therapeutics Advisory Committee (PTAC)

Chair
Prof. Carl Burgess MBChB, MD, MRCP (UK), FRACP, FRCP, physician/clinical pharmacologist

Deputy Chair
Dr Paul Tomlinson BSc, MBChB, MD, MRCP, FRACP, paediatrician

Committee Members
Dr Ian Hosford MBChB, FRANZCP, psychiatrist

Dr Sisira Jayathissa MBBS, MD, MRCP (UK), FRCP (Edin), FRACP, FAFPHM, Dip Clin Epi, Dip OHP, Dip HSM, MBS, physician

Dr Peter Jones BMedSci, MB, ChB, PhD, MRCP (UK), FRACP, physician

Dr Jim Lello BHB, MBChB, DCH, FRNZCGP, general practitioner

Dr Peter Pillans MBBCh, MD, FCP, FRACP, physician / clinical pharmacologist

Dr Anthony Ruakere MBChB, Dip Obst, Dip General Practice, FRNZCGP, general practitioner

Dr Tom Thompson MBChB, FRACP, physician

Dr Howard Wilson BSc, PhD, MB, BS, Dip Obst, FRMZCGP, FRACGP, general practitioner

PTAC Sub-committees

Analgesic – Dr Peter Jones (PTAC, physician, chair), Dr Bruce Foggo (palliative medicine specialist), Dr Derek Snelling (physician), Dr Geoff Robinson, (physician), Dr Howard Wilson (PTAC, general practitioner), Dr Jonathan Adler (palliative medicine specialist), Dr Lindsay Haas (neurologist), Dr Neil Whittaker (general practitioner), Dr Rick Acland (physician), Dr Ross Drake (paediatrician)

Anti-infective – Dr Paul Tomlinson (PTAC, paediatrician, chair), Dr Richard Meech (infectious disease specialist), Dr Stephen Chambers (infectious disease specialist), Dr Mark Thomas (infectious disease specialist), Dr Iain Loan (general practitioner), Dr Sandy Smith (microbiologist)

Cardiovascular – Prof. Carl Burgess (PTAC, physician/clinical pharmacologist, chair), Dr Allan Moffitt (general practitioner), Dr Gary Gordon (cardiologist), Dr John Elliott (cardiologist), Dr Lannes Johnson (general practitioner), Dr Miles Williams (cardiologist), Dr Peter Pillans (PTAC, Deputy Chair, physician/clinical pharmacologist)

Cancer Treatments (CATSoP) – Prof. Carl Burgess (PTAC, physician/clinical pharmacologist, chair), Dr Andrew Macann (radiation oncologist), Dr Anne MacLennan (palliative medicine specialist), Dr Bernie Fitzharris (oncologist), Dr Peter Ganly (haematologist), Dr Simon Allan (oncologist), Dr Tim Hawkins (haematologist), Prof Vernon Harvey (oncologist)

Diabetes – Dr Tom Thompson (PTAC, physician, chair), Dr Bruce Small (general practitioner), Dr Paul Drury (diabetologist), Dr Anthony Ruakere (PTAC, general practitioner), Dr Rick Cutfield (diabetologist), Dr Tim Kenealy (general practitioner), Pat Carlton (diabetes nurse specialist)

Hormone and Contraceptive – Dr Bruce Small (general practitioner), Dr Christine Roke (family planning specialist), Dr Frances McClure (general practitioner), Dr Michael Croxson (endocrinologist)

Mental Health – Prof. Carl Burgess (PTAC, physician/clinical pharmacologist, chair), Dr Crawford Duncan (psychiatrist), Dr Janet Holmes (general practitioner), Dr John Hopkins (psychiatrist), Dr Verity Humberstone (psychiatrist), Prof. John Werry (psychiatrist)

Neurological – Dr Tom Thompson (PTAC, physician, chair), Dr Alistair Dunn (general practitioner), Dr Peter Jones (PTAC, physician), Dr Lindsay Haas (neurologist), Dr William Wallis (neurologist)

Ophthalmology – Dr Tom Thompson (PTAC, physician, chair), Dr Allan Simpson (ophthalmologist), Dr Justin Mora (ophthalmologist), Dr Mark Elder (ophthalmologist), Dr Rose Dodd (general practitioner)

Osteoporosis – Dr Peter Jones (PTAC, physician, chair), Dr Anna Fenton (endocrinologist), Prof. Ian Reid (endocrinologist), Prof. Les Toop (general practitioner), Prof. Richard Sainsbury (geriatrician)

Respiratory – Dr Jim Lello (PTAC, general practitioner, chair), Dr Ian Shaw (paediatrician), Dr John Kolbe (physician), Dr John McLachlan (physician), Prof. Carl Burgess (PTAC, physician/clinical pharmacologist)

Special Foods – Dr Paul Tomlinson (PTAC, paediatrician, chair), Dr John Wyeth (gastroenterologist), Jo Stewart (dietician), Kerry McIlroy (dietician),

Tender Medical – Dr Paul Tomlinson (PTAC, paediatrician, chair), Geoff Savell (pharmacist), Andrea Shirtcliffe (pharmacist), Dr Jim Lello (PTAC, general practitioner) Dr Tom Thompson (PTAC, physician), Sarah Fitt (hospital pharmacist), Dr David Carroll (physician), Dr Nigel Patton (haematologist)

Transplant Immunosuppressant – Dr Paul Tomlinson (PTAC, paediatrician, chair), Dr Peter Pillans (PTAC, physician/clinical pharmacologist), Prof. Stephen Munn (surgeon), Dr Richard Robson (physician), Dr Peter Ruygrok (cardiologist), Dr Ken Whyte (physician)

Consumer Advisory Committee (CAC)

Chair

Sandra Coney (Women's Health Action, Auckland), Chair

Committee Members

Vicki Burnett (Mental Health consultant, Auckland)

Sharron Cole (National Trainer, Parents Centres, Wellington)

Matiu Dickson (Te Runanga o Kirikiriroa Chairman, Hamilton)

Anna Dillon (CanTeen National Secretary, Otago)

Dennis Paget (Grey Power, Blenheim)

Paul Stanley (lecturer in social sciences, Tauranga)

Kuresa Tiumalu-Faleseuga (Chief Executive, Pacificare, Auckland).

Hospital Pharmaceuticals Advisory Committee (HPAC)

Interim Chair

Ian Winwood (Clinical co-ordinator of Pharmacy Services, Southland).

Committee members

Stephanie Chapman (Purchasing Manager, Canterbury)

Marilyn Crawley (Pharmacy Services Manager, Waitemata)

Sarah Fitt (Pharmacy manager, Auckland DHB)

Paul Green (Material management, Auckland DHB)

Bruce Hastie (Clinical Pharmacy Manager, Counties-Manukau)

Elizabeth Plant (Chief Pharmacist, Taranaki)

Neville Winsley (Pharmacy Manager, Hawke's Bay)

The PHARMAC Team

Chief Executive

Wayne McNee BPharm, MPS, PG Dip Clin Pharm (Dist)

Medical Director

Peter Moodie BSc, MBChB, FRNZCGP

Corporate

Stuart Bruce MA, BA (Hons) – *Manager Corporate*

Simon England – *Communications Advisor*

Jan Edwards NZ DipBus, AT – *Finance Manager*

Marama Parore-Katene, Ngati Whatua, Ngati Kahu, Nga Puhi – *Maori Health Manager*

Melanie Pemberton BA (Hons), HND (UK) – *Executive Assistant & Web Administrator*

Jessica Nisbet – *Receptionist (General Enquiries)*

Hayley Bythell – *Receptionist*

Special projects

Wendy Adams BA, BCom – *PTAC Secretary*

Jan Quin RCpN – *Project Manager*

Dilky Rasiah MBChB, Dip Public Health – *Project Manager*

Panel/Pharmaceutical co-ordinators

Jayne Chaulk MSc (Hons) – *Exceptional Circumstances Panel Co-ordinator*

Katie Harris BA – *Hospital Exceptional Circumstances Panel Co-ordinator*

Wiebke Tod NDMDI DNM – *Panel Co-ordinator*

Mary Chesterfield PTecC (UK) – *High Cost Pharmaceuticals Co-ordinator*

Supply side team

Cristine Della Barca Dip Pharm, MPS, Dip Bus Admin – *Manager, Supply Side (on parental leave)*

Deepti Chotai BSc, MBA – *Therapeutic Group Manager*

Steffan Crausaz BPharm, MSc, MRPharmS – *Therapeutic Group Manager*

Sophie Dalziel MSc – *Therapeutic Group Manager Intern*

Andrew Davies BSc (Hons) – *Tender Analyst*

Natalie Ganley MSc – *Therapeutic Group Manager (resigned)*

Hew Norris BMS – *Therapeutic Group Manager*

Martin Szuba MD, MBA, MSc – *Therapeutic Group Manager (resigned)*

Schedule Team

Ursula Egan BPharm – *Schedule Analyst (resigned May 04)*

John Geering BA, BSc – *Programmer/Analyst*

Linda Wellington Dip Pharm, MPS – *Schedule Analyst*

Kaye Wilson – *Schedule Analyst*

Demand Side team

Rachel Mackay BA, NZIMR – *Manager, Demand Side*

Tracey Barron DipPharm, MSc(ClinPharm) – *Demand Side Manager*

Karolina Johnson – *Demand Side Assistant /Designer*

Adam McRae BCom, BNurs – *Demand Side Manager*

Analysis and assessment team

Matthew Brougham MSc (hons), Dip. Health Econ. (Tromso) – *Manager, Analysis and Assessment*

Jason Arnold BSc, PG Dip Stat (Dist) – *Senior Analyst, Analysis & IT Support*

Sean Dougherty BCom (Hons) – *Analyst*

Derek Kan, BRP (Hons) – *Analyst*

Scott Metcalfe MBChB, DComH, FAFPHM – *Epidemiologist/Public Health Physician (on contract)*

Rachel Grocott Bcom (Hons) – *Senior Analyst, Hospital Pharmaceuticals Assessment*

Hospital Pharmaceuticals team

Sarah Schmitt BSc – *Manager, Hospital Pharmaceuticals*

Andrea Dick BSc, Bcom – *Hospital Pharmaceuticals Contracts Manager*

Stephen Malcolm Arztliche Prufung (Germany) – *Hospital Pharmaceuticals Contracts Manager*

Matthew Perkins BSc, Bcom, PG Dip Com – *Hospital projects manager (on leave).*

Publications available on PHARMAC's Website include:

- 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
- Minutes of PTAC and CAC meetings
- 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

Visit PHARMAC online at www.pharmac.govt.nz