Managing Pharmaceutical Expenditure while Increasing Access
The Pharmaceutical Management Agency (PHARMAC) Experience

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Abstract
The role of the Pharmaceutical Management Agency (PHARMAC) is to manage pharmaceutical subsidy expenditure in New Zealand. PHARMAC has adopted a proactive approach. It selects the drugs that are to be subsidised and declines to subsidise others. It has established reference pricing across many drug groups, has entered into a range of innovative commercial contracts with pharmaceutical companies, and has encouraged greater price competition among pharmaceutical companies in order to lower prices and control expenditure risk.

These initiatives have all been part of an overarching strategy to improve the value of the government’s expenditure on pharmaceuticals. PHARMAC has also developed techniques of cost-utility analysis to assess the value of expenditure.

PHARMAC has slowed pharmaceutical expenditure growth, culminating in a fall in expenditure in the 1998/1999 year. At the same time, patient access has continued to expand, with more prescriptions being written and new drugs being...
subsidised. Therefore, PHARMAC has made dramatic strides to improve the value of the government’s expenditure on pharmaceutical subsidies and its actions have meant that more funds have been available for investment in other health services, than would have occurred if previous policies had remained unchanged.

Providing patients with the widest possible access to the drugs best suited to their conditions irrespective of patient income, while maintaining cost at the lowest possible level, are common goals of public (and private) pharmaceutical subsidy or reimbursement regimes. However, achieving these goals simultaneously, especially to the satisfaction of patients, doctors, taxpayers and pharmaceutical suppliers, is an impossible task. If fiscal discipline is imposed, some form of rationing is inevitable; if access is not curtailed, expenditure growth soon becomes unacceptable.

Much of the problem stems from the incentives created by subsidies. Subsidies mean that neither the patient nor the doctor faces the price signals or budget constraints that might otherwise regulate demand. This is exacerbated by conditions within the pharmaceutical market. Demand, driven by demographic factors and also the medicalisation of common conditions and advertising to consumers, is steadily increasing. At the same time, each generation of products is priced higher than its predecessors, although the new products may be little or no better than the earlier ones. As a consequence, there is an inevitable tendency for expenditure, if left unmanaged, to grow.

The question for a public agency is how to achieve an acceptable balance between the conflicting goals of access and cost. This article describes the approach adopted in New Zealand over the past few years. It has been written by current and former staff of the Pharmaceutical Management Agency (PHARMAC) to provide an insider’s view of the problems that have been faced and the policies that have been put in place to address them.

1. Background

PHARMAC is the part of the New Zealand public health system responsible for managing the government’s spending on pharmaceutical subsidies within community healthcare; its operation is separate from the purchase and use of pharmaceuticals within hospitals. The task of PHARMAC is to manage the Pharmaceutical Schedule i.e. the list of drugs subsidised in New Zealand, the prices and subsidies of those drugs and any restrictions on access to the subsidy. There are approximately 3000 items listed on the Pharmaceutical Schedule.[1]

To be eligible for subsidy, drugs must be prescribed by a medical practitioner (or, in some instances, dentists and midwives). Some drugs that are listed on the Pharmaceutical Schedule are also available over the counter; these are subsidised if prescribed but not if bought directly by the patient. In New Zealand, health and disability services are predominantly taxpayer funded. Public expenditure on health and disability services amounts to 76% of total health expenditure. The remaining 24% is funded through private health insurance (6%) and out-of-pocket consumer payments (18%).[2]

In most cases, public expenditure involves direct payments to the service provider from government funds, rather than the patient paying the service provider and then claiming from the government. In contrast, private health insurers usually require the patient to first meet the cost of the service and then claim from the insurer. It is estimated that one-third of New Zealanders have private health insurance; however, as noted above, insurance meets a much smaller proportion of health expenditure.

The government established the Health Funding Authority (HFA) as a purchasing body for the government’s spending on health and disability services; 4 Regional Health Authorities (RHAs), established in 1993, were merged to form the single HFA in 1998. The HFA decides, within priorities and requirements specified by the government, which services should be funded to best meet the