The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

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Tēnā koe Jayne

Pharmac – Proposed changes to the Options for Investment list

Thank you for the opportunity to contribute to shaping a transparent and equitable process for reviewing medicine funding applications and decisions on the Options for Investment (OFI) list.

The College notes that this consultation focuses on the management of the Options for Investment (OFI) list, not the medicines themselves. We urge a critical examination of the proposal to introduce a process that would remove the lowest-ranked 20% of pharmaceuticals after two years—a change that could have profound implications for equity, clinical decision-making, and public trust.

1. Summary of Position

The College acknowledges the intent by Pharmac to improve transparency and efficiency by addressing the prolonged waiting list of unfunded medicines. However, we have serious concerns that the proposed rule—to decline the lowest 20% of applications that remain at the bottom of the OFI list for more than two years—risks procedural clarity at the expense of substantive fairness, clinical equity, and public trust.

Although the *Factors for Consideration* framework includes equity principles, implementing this decline mechanism risks systematically disadvantaging groups in the population already facing health disparities and who encounter entrenched barriers to equitably accessing medicines. Applying a uniform cut-off rule could unintentionally deepen inequities for these groups.

Our key concerns:

- Equity factors are not sufficiently prioritised, risking the perpetuation of health inequities.
- The proposal could compound structural disadvantages for Māori and Pacific populations.
- Specialist GPs will face greater stress and workload pressures, especially in high-needs communities.

The College recommends:

That Pharmac adopts a principled, evidence-based review process rather than a mechanical cut-off rule, and to pair this with full transparency on prioritisation criteria and equity safeguards.

2. Transparency and Intent

We note Pharmac's commitment to improving clarity for patients and suppliers—especially those whose applications have remained unresolved for years—is a welcome and necessary step. A streamlined, more

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active Options for Investment (OFI) list has the potential to enhance decision-making and improve public confidence. However, the current proposal falls short in several critical areas that must be addressed to ensure it serves its intended purpose.

- **Transparency: a prerequisite for trust**

  The proposed ranking system lacks the transparency required for genuine accountability. Commercial confidentiality currently prevents the disclosure of specific rankings, leaving clinicians and stakeholders in the dark. Without clear insight into funding rationales, specialist GPs are unable to advocate effectively for their patients. This opacity undermines trust and impedes meaningful engagement with the system.

  The College recommends:

  That Pharmac publishes clear, accessible summaries for each ranking decision, including the rationale for any decline. These decisions must be explicitly linked to Pharmac's *Factors for Consideration* - not to arbitrary percentile rankings.

- **Equity prioritisation: from considered to mandated**

  While equity considerations are acknowledged in principle, they are not treated as priorities. This is a missed opportunity. Populations with persistent health needs—particularly Māori, Pacific peoples, Takatāpui and rural communities—require deliberate prioritisation to close the gaps. Equity must be more than acknowledged, it must inform the decision-making matrix.

  The College recommends:

  That equity-focused applications should be elevated within the decision framework, with clear mechanisms to ensure systemic barriers or procedural thresholds do not negatively impact on outcomes of these applications.

- **Systemic disadvantage: a hidden cost of the ranking rule**

  Medicines that serve Māori, Pacific, Takatāpui and rural populations often rank lower in cost-effectiveness analyses due to longstanding access barriers. Under the proposed system, these applications risk automatic decline after two years, not because they lack merit, but because these groups face entrenched and systemic disadvantage. This approach risks deepening existing inequities rather than addressing them.

  The College recommends:

  That Pharmac safeguard equity-sensitive applications from premature elimination by reassessing them and considering access barriers and population health needs.

- **Geographic and socioeconomic inequities: rural communities left behind**

  Rural populations already face significant deprivation due to their geographic isolation. When optimal pharmaceuticals are not available, rural GPs have fewer treatment options, and patients bear the burden of travel costs and delayed care. The proposed system compounds these challenges by not accounting for geographic disadvantage.

  The College recommends:

  Ranking decisions must incorporate geographic and socioeconomic factors to ensure rural communities are not further marginalised.

3. Arbitrary and mechanistic design: a risk to innovation and fairness

The proposal to eliminate the "bottom 20%" (or 10% if fewer than 100 items) after two years introduces arbitrary thresholds that may not reflect actual value or need.

- A medicine may fall into the lowest band merely because higher-priority cancer or biologic treatments have arrived, not because it lacks merit.
- The approach incentivises strategic behaviour by suppliers and discourages submissions for niche or equity-sensitive conditions.
- There is no link to explicit cost-effectiveness thresholds, QALY gains, or opportunity-cost analysis.

The College recommends:

Replacing the percentile rule with a time-triggered re-evaluation process, where applications older than two years are reassessed against current evidence, health need, and budget context before any decision to decline is made.

4. Equity and Rare Disease Impacts

The proposed approach risks disproportionately affecting:

- Medicines for rare diseases or ultra-small populations, which often rank lower due to higher cost per patient.
- Conditions that disproportionately affect Māori, Pacific peoples, and other underserved groups, where evidence bases are smaller and perceived lower cost-effectiveness. Automatic decline could lock in systemic inequities and contravene Pharmac's obligations under Te Tiriti o Waitangi.

There is a fundamental tension for Pharmac in upholding Te Tiriti principles, cultural safety and work within a funding system that perpetuates inequity.

The College recommends:

To exempt rare disease and equity-critical medicines from automatic decline and require an equity impact statement before any decision to remove such an application.

5. Ethical and Communication Considerations

While clarity is ethically preferable to indefinite uncertainty, the process must be handled with care:

- For patients and clinicians who have advocated for years, an impersonal "bottom 20%" decision may feel dismissive or devaluing.
- A removal without substantive explanation risks reinforcing perceptions that Pharmac is rationing by algorithm rather than by principle.
- The proposal risks widening health gaps by disproportionately eliminating applications that benefit underserved communities, and the paradox risks damaging trust with Māori, Pacific, and low-income patients.

The College recommends:

- **Accompanying any decision to decline with a clear explanation emphasising the role of budget constraints and comparative value, not triviality of the condition.**
- **Maintaining a transparent resubmission pathway for medicines that later achieve price reductions or new evidence.**

6. Systemic and Process Concerns

- **Two-year cut-off** – does not account for slow evidence accumulation or complex negotiations (e.g., oncology, biologics).
- **Duplication of past clean-ups** – Pharmac has already removed over 500 inactive applications since 2019; evidence that further culling is necessary has not been provided.

- **Lack of oversight** – No independent audit or appeals mechanism is described for deciding which items are "bottom ranked."

The College recommends:

- **A requirement for independent clinical and consumer review panels (e.g., PTAC/CTAC) to confirm any decline.**
- **A commitment to publishing annual reports on the number, type, and equity profile of declined applications.**

7. Constructive alternatives

To achieve the stated aims of clarity and efficiency without sacrificing fairness we suggest:

1. **Tiered Options for Investment framework**
   Likely to fund, *under review*, and u*nlikely to fund without major change*—each with transparent criteria.
2. **Re-evaluation trigger instead of automatic decline**
   Mandatory review at 2–3 years with published rationale for fund / retain / decline decisions.
3. **Equity-first safeguards**
   Retain applications that address rare or high-inequity conditions even if ranked low.
4. **Radical transparency**
   Publish ranking summaries and decision criteria in accessible language.
5. **Budget realism**
   Use this consultation to highlight that long waiting lists reflect **under-funding**, not merely poor list management.

8. In summary

Pharmac's proposal to cull the lowest 20% of applications may deliver administrative clarity, but without reforming ranking transparency and embedding equity safeguards, risks appearing as rationing by formula.

The proposal raises equity concerns which affect Te Tiriti principles and obligations. Potentially, medicines availability may worsen structural disadvantage and pose barriers to access.

The College supports a more deliberative model that combines time-based review, full disclosure of prioritisation methods, and independent oversight ensuring that clarity does not come at the cost of fairness.

Nāku noa, nā

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