2020-10/001

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PHARMAC
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By email: consult@pharmac.govt.nz

Tēnā koe

PHARMAC proposal to fund two new medicines for Type 2 Diabetes

Tōpūtanga Tapuhi Kaitiaki o Aotearoa, New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the above proposal.

NZNO has consulted its members and staff, in particular members of; Aotearoa College of Diabetes Nurses, Te Rūnanga o Aotearoa (Te Rūnanga), professional nursing and policy advisers. NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand, representing 51,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment matters. NZNO embraces Te Tiriti o Waitangi and contributes to the improvements of the health status and outcomes of all people of Aotearoa New Zealand through influencing health, employment and social policy development.

NZNO strongly support the intent of the proposal to fund the two new medicines; Empagliflozin and Dulaglutide for type 2 diabetes. From an equity perspective, we have focused on accessing and affordability of the medications to those that suffer the burden of the disease. We have given feedback from that equity perspective, particularly focused on Māori. We request further information on funding criteria and equity matrix.

Overall, our members are supportive of the changes, however understandably they are concerned with the unintended consequences of the potential increase in medication charges.
Please find specific feedback below.

1. We support these medications (SGLT-2 inhibitor and GLP-1 agonist)being fully subsidised for our T2DM patients, as these medications have excellent results in preventing chronic kidney disease (CKD) and End-stage renal failure (ESRF). In the past these medications have not been available or accessible to our whānau who live in poverty and could help prevent progression to haemodialysis.

2. Te Rūnanga are supportive of the proposal however they require further information about the availability and drug subsidy information. Particularly from an equity perspective, to ensure that Māori complex needs are met with support and education for health and wellbeing.

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3. Diabetes & Endocrinology Service nurse practitioner strongly supports the funding of these two medicines, particularly because:
    a. These medications are vital for Māori, Pasifika, and South East Asian people with type 2 diabetes who are significantly burdened by type 2 diabetes and its associated complications. Funding these medications would be a step in the right direction to enable equitable diabetes care for these high risk populations.

    b. Further, we strongly recommend including Registered Nurse Prescribers (along with medical or nurse practitioners) as a group of clinicians able to complete a special authority. Further, long Term Condition Nurses and Diabetes Specialist Nurses often have greater involvement in the care of the patients these medications are proposed for; therefore allowing Registered Nurse Prescribers to complete the special authority would reduce a barrier for the commencement of these drugs.

    c. Additionally, we strongly support that Nursing Council of New Zealand updating the Registered Nurse Prescribing medication list (feedback was sought on this in January 2020) and add SGLT-2 inhibitors and GLP-1 agonists to the list of medications able to be prescribed by Registered Nurse Prescribers.

    d. As nurses are most likely the professional to teach patients how to self-administer subcutaneous injections for GLP-1 agonists, it is appropriate that the nurse could also complete the special authority, to reduce the number of encounters the patient would need to commence on this drug (i.e. wouldn't need to see a doctor or nurse practitioner to have the special authority completed, and then need to book in separately to see a nurse to be taught how to administer the medication). Given diabetics are a vulnerable patient population group, and current inequities that exist in these patients accessing and being able to afford primary care, consideration must be made to address barriers and avoid unintended consequences of any actions.

    e. Additionally, an updated national type 2 diabetes treatment algorithm would be extremely useful resource for clinicians to provide guidance on when to utilise these medications. The current outdated treatment guidance is from the New Zealand Guidelines Group (2012) Primary Care Handbook, needs to be replaced.

    f. The criteria of a "Patient that has not achieved target HbA1c (of less than or equal to 53 mmol/mol) despite maximum tolerated doses of oral antidiabetic agents and/or insulin for at least 6 months" implies that the patient would need to be on more than one oral agent and/ or insulin to be eligible to go on an SGLT-2 inhibitor or GLP-1 agonist. This information, is opposite to international guidance (ADA & EASD 2018 Management of Hyperglycemia in Type 2 Diabetes) that GLP-1 agonists and SGLT-2 inhibitors are recommended as second line medications in most instances (after Metformin) above other oral agents such as sulfonylureas, glitazones, DPP-4 inhibitors and also insulin. This is confusing information and should follow best practice guidelines. Clarification is required to advise our patients to commence on inferior or less efficacious medications prior to being able to go on SGLT-2 inhibitors and GLP-1 agonists.

g. Special authority approvals not requiring further renewal is an excellent option. This would reduce a barrier for long term use of these medications.

4. We agreed that the agents from the SGLT-2 inhibitor and GLP-1 agonist classes can provide benefits for people with type 2 diabetes beyond glycaemic control. However the criteria should be in line with EASD and ADA guidelines (i.e. the rest of the Western world) that agents from the SGLT-2 inhibitor and GLP-1 agonist classes be added as second-line treatment after metformin, not after failure on other oral diabetes agents and/or insulin in high risk patients and overweight people.

As part of improving equity access and reducing health disparities over time, we recommend that PHARMAC develop a more proactive engagement with the communities to help people with diabetes and their whānau access to these medicines. This includes:

a. Facilitating and encouraging prescribers to work with the communities. Co-design engagement should be encouraged by getting communities to work in partnership with PHARMAC. What works in Hawkes Bay may not necessarily work in Wellington.

b. Engaging Māori and Pacific nurses' access to the communities to understand what works best for them. Some providers prefer to have the drugs on hand at the clinics to hand out to clients as they know that there are issues with pharmacy charges, that patients will not pick up their medications. So there is a distribution problem, between the patient and pharmacy. By understanding some underlying issues, PHARMAC may be able to improve the distribution process.

c. Understanding te Tiriti o Waitangi and engagement strategy with Māori and Pacific communities. Education sessions can be set up in the community in an environment that suits the whānau and the community.

d. Increasing cultural competence such as communicating using tikanga Māori, te reo Māori and Pacifica languages can help bridge the gap. Co-design education sessions can be set up in the communities.

5. NZNO also recommends that PHARMAC develop a new or strengthen an existing equity framework for assessing unintended consequences of these new medicines. This is to ensure cost barrier are reduced and health needs are met especially in Māori and Pacific communities.

6. Whilst PHARMAC acknowledged Māori and Pacific people carry the burden of diabetes, our Policy Advisor Māori has ongoing concerns about the medicines affordability and prescription use from an equity perspective. This includes:

    a. *Will the medicines be fully or partially funded?*
    As the cost alone would limit Māori and Pacific and vulnerable whānau from accessing it.

    b. *What are PHARMAC strategy to improve access to or benefits of accessing these medicines?*

The benefits of the medicines will have other disadvantaging effects on the whānau as the ongoing cost (to the household) of the medicines will impact on whānau economic wellbeing i.e. not everyone can afford to fill the prescriptions, unless fully subsidised. Therefore the cost barriers will create persistent inequities on economic and social aspects of the whānau wellbeing.

In conclusion, please note our concerns with any unintended consequences of introducing these drugs, particularly for those with the greatest burden, which may impact on their social determinants of health and wellbeing. Please feel free to contact my colleague Leanne Manson, Policy Advisor Māori if you wish to discuss her comments on equity further.

Nāku noa nā

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