Proposal for sole subsidised supply of progestogen-only long-acting intra-uterine system (LIUS) (Mirena)

Submission to the PHARMAC

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the proposal for sole subsidised supply of progestogen-only long-acting intra-uterine system (LIUS) (Mirena).

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of NZNO's College of Primary Health Care Nurses, Women's Health Section, Pacific Nurses Section te Rūnanga, and nursing and policy advisers.

3. NZNO represents one of the largest sectors of the women's workforce and this submission is informed by that gendered perspective as well as by the clinical perspective of nurses and midwives whose work and expertise is related to women's health issues.

4. The proposal limits subsidised Mirena availability to a narrow range of conditions applying to a small proportion of New Zealand women. The benefits of a sole supply contract for both provider and purchaser are thus minimised, rather than leveraged.

5. The proposal effectively continues to disregard the potential of the therapy to address significant health need, and restricts the benefits of medical advances, often the result of publicly funded research, being equitably distributed.

6. It is inconsistent, in principle and in practise, with:

- PHARMAC decision- making funding framework: Factors For Consideration;
- the direction of government legislation and policy; and
- our international commitment to the United Nations Sustainable Development Goals (SDFs) and other global health and equity goals.

7. NZNO **does not support** the proposal.

8. We recommend that you reconsider the proposal and fully utilise this therapy to improve choice and the quality of life and healthcare for women, including equitable access to long-term reversible contraception. This would reduce the burden of ill-health, disease and unwanted pregnancy, which are disproportionately borne by disadvantaged and vulnerable women.

9. We suggest the recent Memorandum of Understanding between NZNO and PHARMAC and the special relationship you have developed with te Rūnanga, offers an opportunity to explore the impact of the proposal on Māori and the potential of wider access to reduce health disparities.

DISCUSSION

10. Currently very few women qualify for a subsidised Mirena. The cost of ~$300, while modest for some, is prohibitively high for many women, including those who would benefit most.

11. NZNO's view is that access to a hormonal IUD should be part of the range of options available for basic health care for all women, regardless of the ability to pay.

12. This is consistent with the tenets of primary health care (PHC) articulated in Alma Ata Declaration (1978) and adopted by the World Health Organization as the key to attaining health equity within and between countries.

13. PHC and equity have both been established as intrinsic to cost-effective health care (eg World Health Report, 2008; Commission on the Social Determinants of health, 2008) and have been incorporated into the UN SDGs which aim to strengthen health systems and promote interventions by focusing on policies and strategies that work, are pro-poor and cost-effective.

14. The SDGs that are relevant to this proposal include the health, gender equality and equity goals (Goal 3, 5 and 10 respectively) and more specifically Targets 3.7 and 5.6 which relate to universal access to

sexual and reproductive health-care and family planning, and 10.3 which targets discrimination.

15. The proposal should be, but is currently not, consistent with these and other commitments to enabling women to take charge of their health.

16. Nor, in our view is it consistent with the excellent decision-making funding framework PHARMAC developed after extensive consultation, or the recently updated Health Strategy which "pursues equitable outcomes for all New Zealanders" and prioritises a health system that is responsive to need and enables self-management.

17. We question for instance the extent to which the benefits to "health, person, society and government priorities" as per the Cost Utility Analysis (Appendix 1) of the funding framework were considered.

Restricted use

18. The proposal continues the current very restricted access conditions for subsidised mirenas for:

    - heavy menstrual bleeding in both the community and hospital settings; and
    - only in the hospital setting, for endometriosis confirmed by laparoscopy.

    and excludes widening funded access to contraception because of cost concerns, for which no information is available.

19. We suggest that failing to consider subsidising mirenas for contraception is akin to subsidising aspirin for migraine and ignoring its potential for cardiovascular disease; it significantly underutilises the potential of the therapy to deliver wider population health and cost benefits.

20. We also suggest that the unnecessarily high threshold for access to subsidised mirenas even for the conditions specified (ie a clinical diagnosis of heavy menstrual bleeding *and* failure to respond to or tolerate other appropriate pharmaceutical therapies as per the Heavy Menstrual Bleeding Guidelines *and* a serum ferritin level: < 16 mcg/l (within the last 12 months) or haemoglobin level: < 120 g/l) indicates a serious underestimation of (and lack of empathy for) the pain, cost and disruption to their lives that many women experience month after month for decades.

21. More generally, it ignores the adverse impact on population health and productivity and gives unwanted and unnecessary substance to perceptions such as those articulated by Alasdair Thompson, former

CE of the Employers Association that women are paid less than men because “once a month they have sick problems”[1].

22. Government and social expectations for women assume full participation in the labour market, while offering few concessions for their dominant role in reproduction, household labour and often parenting responsibilities. The very least women should be able to expect is to have access to safe, cost effective therapies that reduce the adverse consequences of conditions or therapies affecting their health, and allow them to live normal lives.

23. Despite women’s increasing workforce participation, there have been few investigations into productivity loss for heavy menstrual bleeding. However, one United States study found that: “*Menstrual bleeding has significant economic implications for women in the workplace: work loss from increased blood flow is estimated to be $1692 annually per woman*.” (Côté et al, 2002); we think it highly likely that similar results would be found here, if investigated.

24. A related study *Chronic Pelvic Pain in Women in New Zealand: Comparative Well-Being, Comorbidity, and Impact on Work and Other Activities* (Grace & Zondervan, 2005) indicates that women with chronic pelvic pain (CPP), are not more likely to take time off paid employment than women without CPP, and that the negative impact of CPP on women’s general well-being, including restricted activities, sleep disruption, and fatigue, is significant. The latter is consistent with other literature showing the negative impact of menorrhagia, one of the most common symptoms in gynaecology and a major cause of gynaecological diseases, on quality of life (Gokyildiz et al, 2013).

25. A PHC health approach would suggest wide access to a therapy which has the potential to alleviate symptoms and reduce mental and physical health issues for a significant number of people over recently extended reproductive timeframes.

26. Instead, access barriers have ensured that subsidised mirenas are primarily used by older, peri-menopausal women to reduce the need for hysterectomy, while younger women with similar symptoms who are seeking safe, long-term reversible contraception, are excluded. Eg Mirenas are not funded for women who try copper IUDs and experience heavy, painful or irregular bleeding.

27. The disparity impacts disproportionately on Māori and Pacific women who have a younger age and higher fertility rate profile, and who are

[1] http://www.newshub.co.nz/nznews/alasdair-thompson-on-female-productivity-and-periods--full-interview-2011062317#ixzz4Dma7NBNk

already disadvantaged in terms of health access and outcomes. I.e. the effect of very limited access is to increase rather than reduce health inequity.

28. Similarly, the strict criteria mean that some women are subjected to multiple trials and months, if not years, of discomfort, or have to get seriously anaemic before they are able to access a safe, effective therapy. This is neither cost-effective nor ethical. Women have a right for their health concerns to be taken seriously and to have access to modern quality health care, not to have to go through hoops or have their health compromised by delays.

29. The strict criteria limiting access to subsidised mirenas must be removed.

Contraception

30. Access to sexual and reproductive health-care and family planning is generally recognised as essential to women's health.

31. Although there are other subsidised options for long term reversible contraception, these are not as safe or as suitable for all women. Mirenas are easier to implant and to remove and there is no other hormonal IUD in the funded contraceptive options available.

32. With smaller families and a long period of fertility, long term reversible contraception offers women an important family planning tool which should be available to all women, regardless of the ability to pay. Apart from safety and effectiveness, mirenas have the additional benefit of significantly reducing menstrual flow, which is an important consideration in view of the ~360-400 periods women experience when they are most likely to have only two or three children.

33. The health risks and costs of unwanted pregnancy far outweigh the cost of safe, effective and convenient contraception. There is strong evidence that access to appropriate long term reversible contraception contributes to lower teen pregnancy and abortion rates in Aotearoa New Zealand and overseas.

34. We note that access to contraception is and has been central to a number of government documents including the Green Paper on Vulnerable Children which actually proposed some form of compulsory long-acting contraception for women receiving a benefit, and the Health Committee's excellent Report on the Inquiry into improving child health outcomes and preventing child abuse, with a focus on preconception until three years of age (2014).

35. The potential benefit of providing free contraception has been embraced by Work and Income New Zealand (WINZ), but as stated on

its website: “The cost of any unsubsidised device cannot be included in the Special Needs Grant to provide contraception”[2] .

36. Increasing the choice of subsided contraceptive options, including mirena, would provide all women with more effective contraceptive options and would improve health equity. It

37. Finally we note that by agreeing to an arrangement for sole subsidised supply of Mirena until the end of June 2019, Pharmac would lose the opportunity to enter an arrangement for full subsidisation of a generic levonorgestrel releasing intrauterine system for the next 3 years.

38. Women cannot wait another three years for this issue to be reconsidered.

CONCLUSION

39. In conclusion NZNO **does not support** the proposal and urges you to reconsider the proposal and fully utilise the potential of mirenas to reduce the burden of ill-health, disease and unwanted pregnancy, which are disproportionately borne by disadvantaged and vulnerable women.

40. We recommend that you:

    - remove access barriers to improve choice and the quality of life and healthcare for women; and

    - ensure equitable access to long-term reversible contraception, including a hormonal IUD.

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[2] http://www.workandincome.govt.nz/products/a-z-benefits/sng-contraception.html#null

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