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Letter to the Editor

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Inequitable Access to IBD Therapies Extends Beyond Developing Nations

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New Zealand [NZ] has the third highest prevalence of inflammatory bowel disease [IBD] worldwide[1] and ranks 22nd for gross domestic product among Organisation for Economic Co-operation and Development [OECD] nations,[2] but has been left trailing behind comparable nations in the funding of therapies for IBD.

In NZ the only biologic agents funded for IBD are infliximab and adalimumab (the latter for Crohn's disease [CD] only). No new agent has been approved since 2009. The prescription of available drugs is tightly regulated, limiting the ability of physicians to optimise therapy. Patients often remain on suboptimal management with anti-tumour necrosis factor [TNF] therapy despite failing to achieve remission, exposing them to the risk of disease progression, surgery, and complications, simply because no other options exist. Meanwhile patients in most other comparable nations are benefiting from treatment with ustekinumab, vedolizumab, and tofacitinib.

Funding decisions in NZ are made by an independent organisation, Pharmac, who work within a fixed budget provided from central government. This approach has been celebrated for reducing the cost of pharmaceuticals, but there is a dark side to the current decision-making model that is creating inequities in access to drugs for different diseases. For example, IBD is often compared with other immune-mediated diseases [psoriasis, ankylosing spondylitis, etc]. Since the approval of adalimumab for CD in 2009, further biologics have been approved for these indications [Table 1], despite evidence to suggest that poorly controlled IBD has greater impact in terms of quality of life, health care utilisation and overall cost of care.[3] Pharmac decision making lacks transparency, undervalues the indirect costs of poorly controlled IBD and, when questioned, appears to have a poor understanding of the potential cost-benefit of newer therapies.

Interestingly, other countries have used cost reductions associated with the advent of biosimilars to re-invest savings in IBD-related care.[4] However, under the current Pharmac model, savings made on infliximab and adalimumab return to the central budget and are not re-invested in IBD. Therefore, the investment in IBD reduces over time in relative and absolute numbers.

There is growing discontent amongst patients and physicians at the apparent neglect of those with IBD in NZ. Recently, a petition raised by Crohn's and Colitis NZ raised 30 000 signatures and received widespread support from physicians, but we continue to be

Table 1. Comparison of the years when drugs for immune-mediated inflammatory diseases were funded in New Zealand.

Drug	Rheumatology [RhA, AS, PsA, JA]	Dermatology [psoriasis]	Gastroenterology [IBD]
Infliximab	Registered by Medsafe in 2000. Individual funding with variable use across specialties since mid-late 2000s		
Adalimumab	RA 2006; AS/PsA 2009; JA 2013	2009	2009
Etanercept	Pre-2003	Not effective	Not effective
Rituximab	2013	Not effective	Not effective
Tocilizumab	JA 2013; RA 2014	Not effective	Not effective
Secukinumab	Not effective	2018	Not effective [may worsen]

Rha, rheumatoid arthritis; AS, ankylosing spondylitis; PsA, psoriatic arthritis; JA, juvenile arthritis.

frustrated by the lack of engagement at a government level as we strive to provide the best for our patients. Despite this, a recently commissioned review of Pharmac conveniently excluded its budget in the terms of reference.

Hopefully, through continued attempts to raise awareness, we can change this and improve the lives of our patients.

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Author Contributions

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