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LETTER TO THE EDITOR

# Comment on "Ahead of Its Time? Reflecting on New Zealand's Pharmac Following its 20th Anniversary"

## Clarification from PHARMAC: PHARMAC Takes No Particular Distributive Approach (Utilitarian or Otherwise)

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We appreciated Robin Gauld's assessment of PHARMAC's role in New Zealand's medicines funding, published in *PharmacoEconomics* [1]. The article [1] reflects PHARMAC's (New Zealand's Pharmaceutical Management Agency) attempts to achieve in New Zealand the best health outcomes from pharmaceuticals within available funding [2–4]. We would like, however, to clarify a common and easily made assumption about PHARMAC's approach to decision making.

The article states, "Pharmac's utilitarian approach of providing the greatest good for the greatest number within its budget has worked well, …". However, although PHARMAC is required to work within budget limits, PHARMAC does not take a utilitarian approach, or indeed any particular distributive approach, to its decisions.

PHARMAC's main statutory objective is set out in the *New Zealand Public Health and Disability Act 2000* (NZPHD Act), specifically:

> "to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided."
> Section 47(a) NZPHD Act [5]

The Act's statement of securing "best health outcomes" is not necessarily 'maximum quality-adjusted life-years (QALYs)' or any other outcome defined using a particular distributive approach. "Best" is simply the aim of our funding decisions.

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PHARMAC uses nine decision criteria (DC) in its funding decisions [6], covering *inter alia* health need, availability, clinical benefits and risk, cost-effectiveness and cost. All nine criteria are taken into account when making funding decisions, without pre-determined weightings. Therefore, although health benefits may be maximised as a result of considering cost-effectiveness, this is not in itself an objective of PHARMAC.

Adding to earlier PHARMAC [7] and international [8–15] discourse, PHARMAC's consultation on its DC and a proposed new decision-making framework [16] has included discussion on distributive value systems [17], with Rawlsian/utilitarian equity-efficiency trade-offs [18, 19] between maximising QALYs and to whom those QALYs accrue [20–22].

PHARMAC does, implicitly, use utilitarian frameworks embedded in the systematic use of QALY gains in cost-utility analysis (CUA) to inform its cost-effectiveness decision criterion (DC5) [23]. This aligns with international use of QALYs saved as a measure of health benefits within CUA. QALYs are also used to help assess Health Needs (DC1) through the use of absolute QALY losses and proportional shortfalls [9, 10, 24–26].

We note that in the past we may not have always explained sufficiently our approach to the use of QALYs in decision making, in particular, by referring to maximisation of health outcomes [27–29] rather than referring more broadly to optimising health outcomes [17, 24]. Also, in recent articles, PHARMAC has outlined how CUA is a useful tool for those organisations seeking to maximise health benefits [29, 30]; however, this differs from the use of a utilitarian framework for overall decision making when other criteria are also considered.

In summary, despite the implicit use of the utilitarian framework when assessing the cost-effectiveness of

pharmaceuticals, PHARMAC does not take an explicitly utilitarian approach when defining "best health outcomes". Rather, value (as best health outcomes) is the result of consideration of all of PHARMAC's nine DC [6, 31].

**Authors' declarations** The authors are employees of PHARMAC (New Zealand's Pharmaceutical Management Agency).



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