

Submission on proposed changes to Special Authority criteria for Type 2 diabetes medicines

1. Do you support this proposal?

No – not in full.

2. Do you have any feedback you wish to provide on this proposal?

Thank you for the opportunity to provide feedback on Pharmac's proposal to amend the Special Authority access criteria for type 2 diabetes medicines.

Overall Position

We support aspects of the proposal that expand access to effective treatments, particularly the lowering of the cardiovascular disease (CVD) risk threshold from 15% to 10%. Earlier intervention is clinically appropriate and aligns with strong international evidence on the cardiovascular and renal benefits of SGLT2 inhibitors and GLP-1 receptor agonists (ADA Standards of Care 2026; NICE NG28).

However, we **strongly oppose the removal of Māori and Pacific ethnicity as a stand-alone access criterion**. This change is not supported by evidence, risks reversing demonstrable gains in equitable access, and is inconsistent with long-standing evidence on inequities in diabetes outcomes and access to medicines in Aotearoa New Zealand.

Equity Impacts

The current criteria were intentionally pro-equity – and they worked

The inclusion of Māori and Pacific ethnicity in the 2021 Special Authority criteria was a deliberate policy decision to address well-documented inequities in access to medicines and diabetes outcomes. Māori and Pacific peoples experience:

- Higher rates of cardiovascular disease, renal failure, and premature mortality
- Earlier onset and more rapid progression of type 2 diabetes
- Lower prescribing rates relative to need, even after adjusting for disease burden

These inequities are longstanding and have been clearly established in the literature (e.g. Yu et al., 2021; Jansen et al., 2020).

Subsequent research demonstrates that the ethnicity criterion significantly improved access:

- A large real-world study of over 50,000 patients found higher uptake among Māori and Pacific peoples compared with other groups (Chepulis et al., 2025).
- More than half of Māori and Pacific patients with relevant comorbidities were prescribed these medicines within the first 1–3 years of funding.
- Nearly half of early Special Authority approvals utilised the Māori/Pacific eligibility pathway.

This aligns with broader evidence showing that targeted pro-equity approaches can meaningfully improve access where universal criteria alone have failed (Tamatea et al., 2025).

Removing the ethnicity criterion risks reversing these gains

The proposed removal of ethnicity-based access assumes that lowering the CVD risk threshold will adequately preserve equity. This assumption is not supported by evidence.

Threshold-based criteria rely on patients successfully navigating multiple steps in the health system – including risk assessment, GP access, and ongoing monitoring – all of which are known points of inequity. Research shows:

- Māori receive significantly fewer prescriptions relative to their disease burden (“million missing scripts”) (Metcalf et al., 2013; 2018).
- Māori are more likely to face cost barriers to GP visits and prescription collection.
- Structural barriers (including access, system navigation, and culturally unsafe care environments) reduce the likelihood of meeting formal eligibility thresholds.

In practice, “equal criteria” in an unequal system does not result in equal access. Removing the ethnicity criterion would reintroduce structural disadvantage into the eligibility pathway.

Primary care feedback reinforces this concern. Even in smaller practices, clinicians anticipate that a meaningful proportion of Māori and Pacific patients currently receiving treatment would lose access under the proposed criteria. At scale, particularly in high-need areas such as South Auckland, the impact could be substantial.

Clinical benefit may be greater for Māori and Pacific populations

Emerging New Zealand evidence suggests that the benefits of these medicines may be greater for Māori and Pacific peoples:

- A recent multi-ethnic study found significantly larger reductions in all-cause mortality associated with SGLT2 inhibitor use among Māori (HR 0.475) and Pacific peoples (HR 0.507), compared with European populations (HR 0.667) (Chepulis et al., 2026).

This strengthens the case not only for maintaining access, but for prioritising it. Removing a mechanism that has improved uptake among populations who derive the greatest benefit is difficult to justify from a clinical, equity, or health system perspective.

Assessment of the Proposal

What we support

- Lowering the CVD risk threshold from 15% to 10%
- Expanding access to effective medicines earlier in the disease pathway

What we do not support

- Removal of Māori and Pacific ethnicity as a standalone eligibility criterion

This element of the proposal represents a **significant step backward** in equity-focused health policy. It removes a targeted intervention that has demonstrably improved access and outcomes, without presenting compelling evidence that the underlying inequities have been addressed or that alternative mechanisms will maintain those gains.

Recommendations

We recommend that Pharmac:

1. Retain Māori and Pacific ethnicity as a specific access criterion within Special Authority settings.
2. Proceed with lowering the CVD risk threshold to 10% to broaden access.
3. Continue to strengthen pro-equity approaches, including addressing adherence and access barriers beyond funding criteria.

Conclusion

This proposal presents an opportunity to expand access to highly effective diabetes treatments. However, removing the ethnicity criterion risks undoing one of the few evidence-based policy interventions that has successfully improved equity in access to medicines in New Zealand.

Where a targeted equity intervention has demonstrably improved access and outcomes for populations with the greatest burden of disease, the threshold for removing that intervention should be exceptionally high. Based on the available evidence, that threshold has not been met.

We **urge Pharmac to retain the ethnicity-based access pathway** alongside broader eligibility criteria to ensure that gains in equity are not only preserved, but strengthened.

3. How do you identify?

Other – ProCare is a leading healthcare provider, and New Zealand's largest primary healthcare organisation.

4. If you're submitting feedback on behalf of an organisation or group, please specify.

ProCare is a leading healthcare provider that represents more than 140 general practices Auckland and Northland.

ProCare is dedicated to supporting excellence in primary care and delivering services that uplift the health and wellbeing of our communities. In Auckland alone, the practices we work with support about 700,000 people.

We are committed to honouring Te Tiriti o Waitangi and advancing population health and equity to improve outcomes for Māori, Pacific Peoples, and others in need.