

Pharmaceutical Management Agency

# Annual Review

2007

PHARMARMAC

Pharmaceutical Management Agency

PHARMAC annual review

# Highlights & key events of 2006-07

**We funded 11 new medicines,  
and made 39 new investments  
in medicine**

At least **2.69 million** people had their medicine subsidised

Subsidised prescriptions increased by **11.8%** to **31.92 million**, an all-time high

Pharmaceutical spending was managed within budget, and rose to **\$599.37 million**

The **Seminar Series** continued to provide a valuable contribution to improving clinical knowledge

The **Wise Use of Antibiotics** campaign entered its 10th year, and went digital with computer-animated TV commercials

New investments included treatments for high needs and high priority health areas, such as **heart disease, diabetes, HIV/AIDS, asthma and cancer**

We consulted on, and published, an updated version of the **Prescription for Pharmacoeconomic Analysis**, PHARMAC's guidelines for economic analysis

Internally, we created greater capacity to better manage the many contracts we have with **pharmaceutical suppliers**

The **One Heart Many Lives** campaign expanded into Northland, where cardiovascular disease is a major health concern

We adopted a **vision** and a set of **values** for PHARMAC, with a supporting framework to help guide and measure our performance

#### In this Review

'Year' means year ending June 30.

'This year' means the year ended June 30 2007;

'last year' means the year ended June 30 2006;

'next year' means the year ending June 30 2008.

Unless otherwise stated, all values are in New Zealand dollars

Unless otherwise stated, all references to expenditure are unadjusted for any rebates that may be due or paid by suppliers under risk-sharing agreements

## Every year PHARMAC faces new challenges, and last year was certainly no exception.

The spotlight of public interest focused on PHARMAC because of the high-profile media campaigns for expensive medicines, particularly Herceptin, and the Government's Medicines Strategy.

PHARMAC remained focused on its role of prudently managing the country's publicly-funded medicines, and worked to meet its legislative objectives. During the 2006-07 financial year, PHARMAC continued to improve New Zealanders' access to funded medicines while remaining within budget, in addition to producing greater benefits and efficiencies for District Health Boards (DHBs) through its hospital pharmaceutical procurement activities. And PHARMAC continued to develop and implement campaigns that promote the optimal use of medicines.

At the heart of these different strands to PHARMAC's business is our commitment to get the best possible value from health spending. This is a vital theme across the whole health sector. Ensuring that our spending is the best use of taxpayers' money means we won't jeopardise future funding opportunities, nor have people unnecessarily missing out on treatment.

This prioritising is totally centred on the overall welfare of New Zealanders. While managing a budget means we can't fund everything for everyone, it does force a very careful approach to ensure every dollar is spent wisely.

The approach ensures that new medicines become available in an affordable way; sustainability is one of PHARMAC's driving forces.

PHARMAC's primary role is, of course, to manage the country's pharmaceutical expenditure. This year spending was \$599.4 million, one tenth of a percent within budget. PHARMAC is legally required to remain within budget and, it is important to remember, any funds not used for pharmaceuticals remain available for DHBs for other projects.

Last year PHARMAC made 39 new investments, including 11 new medicines. The volume of prescriptions grew significantly, reflecting increasing use of medicines, population growth and the impact of Government access policies through the Primary Healthcare Strategy.

PHARMAC continues to contribute to the wider health sector by finding efficiencies in current spending, and continues to help DHB hospitals with national purchasing projects, which underlines the special relationship between DHBs and PHARMAC.

The Medicines Strategy work identified the optimal use of medicines as a key issue, an area where PHARMAC has a strong track record.

The well-established Wise Use of Antibiotics campaign entered a new phase with the use of animated television commercials. The One Heart Many Lives cardiovascular campaign grows from strength to strength – Northland has now embraced the concept, building on the Hawke's Bay successes where innovative approaches have raised awareness and reached men (in particular) at risk of suffering from cardiovascular disease. And this year PHARMAC commenced a new project promoting best practice use of medicines for gastric reflux and heartburn – the Gut Reaction campaign.

All these projects share the theme of making the best use of funded medicines which, in some cases, means more medicines (such as statins for lowering cholesterol levels) or sometimes not using medicines at all. PHARMAC, with its expertise and resources, is well placed to take a lead role in this 'optimal use' area.

I'd like to thank the members of the PHARMAC Board who have all continued to contribute hugely to the success of PHARMAC. There have been some changes on the Board, with Karen Guilliland retiring after six years of outstanding contributions; I'd like to thank Karen and wish her well. We welcome our new Board member, Dr David Kerr, a practicing GP who brings another important clinical perspective.

Finally, I wish to acknowledge the continuing commitment and dedication of PHARMAC's Acting Chief Executive Matthew Brougham, the whole PHARMAC team, and the members of PHARMAC's various advisory committees. It has been a trying and high profile year, which hasn't always been easy. Their collective efforts have been invaluable in working towards providing the best health outcomes for us all.



**The PHARMAC Board's chairman Richard Waddel reflects on 2006-07 – a year when PHARMAC faced major challenges and remained focussed on its role.**

## Significant projects included:

**Procurement of bulk intravenous fluids**, which mean savings of \$1.3 million over five years. Also, supplies of premixed heparin and potassium chloride solutions have been secured, which will be a safety improvement as they reduce the need to mix preparations on the ward;

**Radiological Contrast Media**, with estimated savings of \$1.5 million over five years;

**Anaesthetic gases**, with savings of \$4.1 million over five years;

Negotiations for the **national influenza vaccine** programme have produced savings of \$900,000 over three years; and

DHBs have asked PHARMAC to investigate national procurement of **orthopaedic prosthetic devices**.

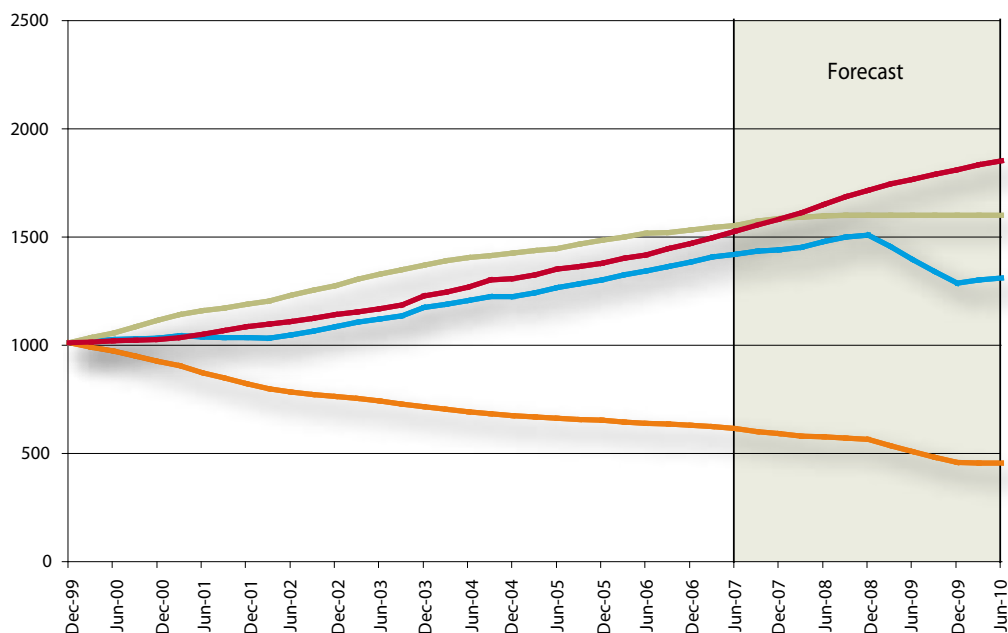
“The Medicines Strategy work identified the optimal use of medicines as a key issue, an area where PHARMAC has a strong track record”

### Subsidy, volume, mix and cost indices

Four-quarterly moving averages  
Base: four quarters ending June 1993 = 1,000.

#### Getting more for less:

The subsidy volume and mix indices are like the consumer price index, but for pharmaceuticals. The graph shows that while the amount of pharmaceuticals used, and their cost has been rising, the subsidy index is decreasing.



- **Cost Index** is the drug cost to DHBs ex-manufacturer before GST
- **Subsidy Index** is like the Consumer Price Index but for subsidised pharmaceuticals only
- **Volume Index** is the number of prescriptions multiplied by a standardised measure of the amount prescribed per prescription
- **Mix Index** is the residual from cost index divided by (volume index X subsidy index)

## PHARMAC often hears that we're (apparently) more concerned about the budget and money, rather than patients. I've lost count of the times I've heard this criticism, yet it couldn't be further from reality.

It's true PHARMAC observes its budget constraint. That's a legal requirement for us, but PHARMAC is also an instrument of the Government so, to do otherwise would be to take the choice of how to allocate resources away from the rightful owners – the elected representatives of our country. If the statement "PHARMAC cares only about the dollars" really means "it's unacceptable PHARMAC manages the Pharmaceutical Schedule within the budget", we'll wear the criticism. But we'll also (politely) try to point out the errors in this line of thinking.

Most households realise the importance of living within their budget while getting as much benefit as possible (however that benefit is measured). Households may happily make a choice between going out for a family dinner, versus eating in and using the saving to go to the movies later on. Every day we all make dozens of choices to make our hard earned dollars go as far as possible. It's called good housekeeping.

PHARMAC is no different. We're given a budget – and a mandate to derive as much health benefit as possible when subsidising pharmaceutical treatments. In drawing the analogy with good housekeeping, I'm not intending to trivialise the choices confronting PHARMAC. Choosing which or how much of a treatment to subsidise involves the analysis of a wealth of often complex information. My analogy draws attention to what is considered when making these choices. The good housekeeper, in making choices, does not focus solely on cost – that is relatively easy to track; instead the focus is firmly on the relative benefits of competing choices. Which mix of options will provide the greatest satisfaction? Similarly, when doing our job, PHARMAC focuses on the relative benefits of competing options. So, in reality, "it's all about the benefits".

One of our biggest communication challenges is around prioritisation; the core of PHARMAC's role. The term is not popular, partly because it is sometimes incorrectly seen as 'cost focused' or, as noted in our recent stakeholder survey results, 'overwhelmingly fiscal'.

Prioritisation is, however, pivotal in getting the best health for New Zealanders overall. Frankly, it is hard to argue against getting the best

health outcomes from available funding, whatever the budget. In essence, good prioritisation means getting more bang for your buck, by selecting things that create high health gains for New Zealanders and rejecting those that don't. Over the long term, good prioritisation means better health with more medicines funded than would otherwise be the case. This has to be good for every New Zealander.

We can't subsidise everything, in the same way that you or I can't afford everything that we see advertised on TV. But in deciding what to fund (and what not to fund), PHARMAC aims to fund the mix that provides the greatest health benefit. Putting this another way, as every dollar spent means a forgone opportunity elsewhere, we aim to minimise the health benefits sacrificed (the "opportunity cost") by the choices we make – like any good housekeeper.

I believe that through PHARMAC's good housekeeping we deliver significantly more health benefits to New Zealanders than a comparable budget would provide in possibly any other country. We continually take opportunities to provide the same pharmaceutical treatments at ever-diminishing prices, and at the same time look for ways to redirect those savings into other potential investments. In this way, as every good housekeeper knows, a greater proportion of the budget can be allocated to purchasing new items and, therefore, increasing benefits. And when we are considering funding new treatments, we endeavour, through careful analysis of the competing options, to maximise health benefits.

We won't always get it right. The information is complex and there is always a lot of it. In all respects we endeavour to make the best decisions based on the information we have. We don't expect people to always agree with our decisions – quite the contrary, with so many competing options it is inevitable that whenever a decision is made, there will be those disappointed by it.

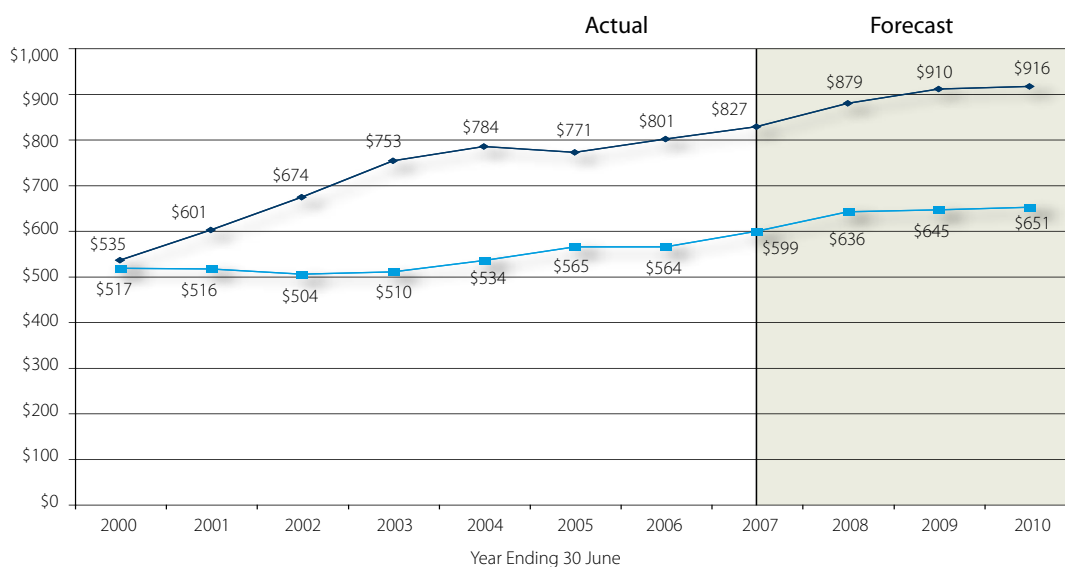
We work in a contentious environment, and criticism is to be expected. But criticism should consider what a good housekeeper would - "if we hadn't eaten out at a restaurant, we would have been able to have dinner and go to a movie too." Most critics make their criticism in ignorance of the budget. Good housekeepers don't.



PHARMAC's budget management is all about 'good housekeeping', writes Acting Chief Executive Matthew Brougham

## Impact of PHARMAC on Drug Expenditure over time

Drug cost (Millions)



The graph shows PHARMAC's influence on pharmaceutical spending. The spending pattern is rising at a slower and more manageable rate than would have occurred without PHARMAC's activity.

— Estimated Expenditure (assuming transactions delayed by 3 years)

— Actual and forecast expenditure with PHARMAC intervention

## Listing changes to the Pharmaceutical Schedule

In 14 years, 1166 new or enhanced products have been listed, access has been widened for a further 238, and 1170 have either been restricted or de-listed

Decisions made								Total since 1994
Decision type	00/01	01/02	02/03	03/04	04/05	05/06	06/07	
New Chemical entity listed	20	7	3	15	9	14	11	180
New Presentation listed	13	11	15	27	14	42	30	334
New Product listed	28	60	45	49	51	49	85	653
<b>Total new listings</b>	<b>61</b>	<b>78</b>	<b>63</b>	<b>91</b>	<b>74</b>	<b>105</b>	<b>126</b>	<b>1167</b>
Derestriction or expanded access	19	17	7	9	16	24	28	238
Changing access to improve outcomes						1		
Changes that restrict or limit access	6	4	1	2	3	0	0	47
Delistings	135	89	196	72	59	43	38	1170

“I believe that through PHARMAC's good housekeeping we deliver significantly more health benefits to New Zealanders than a comparable budget would provide in possibly any other country”

## PHARMAC has been around for 14 years now and it is worth reflecting on the changes that have happened in clinical practice since its establishment.

I try to spend one day a week working in clinical practice, in addition to my work at PHARMAC, so I have a foot in both camps when it comes to seeing what goes into making funding decisions, and the impacts of those decisions in the real world.

So often the focus is on what PHARMAC is doing “right now”, but looking back can reveal just how decisions have contributed both to clinical practice and to the public health system as a whole.

It always needs to be remembered that PHARMAC has a budget to work with, and this places a necessary discipline on the decision-making process. I expect that New Zealanders will demand that their taxes are spent wisely and efficiently. To that end PHARMAC steps carefully through its decision making processes to ensure that we make choices that deliver better health for New Zealanders, and at the same time that we obtain the best possible prices for pharmaceuticals.

PHARMAC was set up with the express purpose of managing medicines funding, and at the same time improving access to medicines has been an ongoing focus.

With my PHARMAC hat on, this means the needs of patients are very carefully thought through to make sure that when the next drug dollar is spent, we spend it on improving health and not on new and over-hyped drugs that don't really benefit people beyond what is already available.

These decisions can be looked at from different perspectives and we are always keenly aware of patient-related issues. We don't have to be sick ourselves to take on this role, it might be that we have a relative or close friend who we see suffering. Indeed, it could be that we are being treated for a risk factor where there are no symptoms of ill health at all, such as raised blood pressure or cholesterol levels.

People working at PHARMAC field calls from the public on a daily basis, including specialised staff who manage access to some high cost medicines. They ensure that people requiring high cost pharmaceuticals like beta interferon for multiple sclerosis or imatinib for chronic myeloid leukaemia receive their supplies in a timely and efficient manner. For these staff members regular contact with patients makes them very aware of the realities of serious diseases.

Naturally PHARMAC casts a critical eye over the medicine choices it is faced with, and I believe that what we end up with are good decisions that are of value to patients and sustainable to the sector. A good example is the statin drugs for lowering cholesterol. When these first came on the market they were expensive and there wasn't really good data to show long-term benefit. They were funded, but targeted at those at greatest risk.

PHARMAC was criticised for this decision, but I believe it was the right one. We gave people who most needed them the benefits statins offered, and we ensured the very real risk of blowing the budget with these drugs was managed. If there had been open access to statins in 1998, they would have consumed up to 40% of the available medicines budget. In 2002 we eventually saw both the cost of statins reduce and the evidence for primary prevention for high risk patients develop to the point where they could become more openly available and affordable. They are now used by nearly 300,000 New Zealanders.

We've seen this in other areas too. Proton pump inhibitors for heartburn and stomach ulcers, the selective serotonin reuptake inhibitor (SSRI) drugs for depression, long-acting beta agonists for asthma and atypical antipsychotics are all now part of the pharmaceutical furniture, and widely used and affordable largely through the efforts of PHARMAC.

Often we see pressure for new “wonder drugs” to be immediately funded for everyone. The reality in clinical practice is that when a new medicine becomes available, it takes a while for its use to become widespread – we see this in the prescribing data analysed at PHARMAC. This is true of any new technology or technique in medicine.

Clinicians now recognise that many new therapies should be used cautiously and only if existing therapies are not working. We don't see wholesale replacement of new for old overnight; most practice changes are evolutionary rather than revolutionary. It is that conservative approach which gains the confidence and respect of our patients.



**PHARMAC's efforts over 14 years have made a real and positive difference to how doctors do their jobs, writes Medical Director Dr Peter Moodie**

## The Top 20 Expenditure Groups

Year ending 30 June

\$ millions, cost ex manufacturer, excludes rebates and GST

Drug Type	Main Use	2007	2006	2005	2004	2003	2002
Ant ulcerants	heartburn, stomach ulcers	\$75.5	\$73.8	\$68.6	\$64.0	\$52.2	\$44.1
Lipid Modifying Agents	raised cholesterol (cardiovascular risk)	\$68.8	\$68.2	\$60.8	\$55.0	\$46.1	\$40.5
Antipsychotics	Mental health (psychoses)	\$56.9	\$53.4	\$48.6	\$45.2	\$40.9	\$36.7
Antidepressants	Mental health (depression)	\$30.6	\$29.7	\$27.3	\$27.6	\$32.8	\$28.1
Agents Affecting the Renin-Angiotensin System	Raised blood pressure (cardiovascular risk)	\$29.1	\$26.1	\$29.1	\$28.4	\$23.0	\$21.4
Immunosuppressants	Organ transplants, arthritis	\$27.9	\$28.3	\$27.8	\$19.7	\$18.1	\$16.1
Antiepilepsy Drugs	Epilepsy	\$27.8	\$24.8	\$21.4	\$20.7	\$19.0	\$17.5
Diabetes	Diabetes	\$26.3	\$22.5	\$20.6	\$19.2	\$19.0	\$18.6
Beta Adrenoceptor Blockers	Heart disease	\$24.5	\$21.3	\$17.6	\$11.5	\$9.2	\$8.0
Inhaled Long-acting Beta-adrenoceptor Agonists	Asthma	\$19.3	\$21.7	\$18.6	\$14.3	\$10.0	\$6.0
Analgesics	Pain relief	\$17.2	\$15.7	\$14.5	\$16.5	\$16.9	\$15.9
Diabetes Management	Blood glucose monitoring	\$17.1	\$16.3	\$19.5	\$19.8	\$19.4	\$18.1
Chemotherapeutic Agents	Cancers	\$16.6	\$13.7	\$11.3	\$10.9	\$5.1	\$1.1
Antibacterials	Bacterial infections	\$14.8	\$13.9	\$13.9	\$13.1	\$14.6	\$15.4
Calcium Channel Blockers	Heart disease	\$14.5	\$13.7	\$13.0	\$16.4	\$13.8	\$13.9
Inhaled Corticosteroids	Asthma	\$13.9	\$14.3	\$14.6	\$14.9	\$20.7	\$21.9
Calcium Homeostasis	Osteoporosis	\$13.5	\$11.8	\$9.8	\$8.3	\$7.7	\$5.7
Antianaemics	Anaemia	\$13.4	\$11.3	\$9.2	\$7.0	\$4.1	\$4.8
Antimigraine Preparations	Migraines	\$12.6	\$13.1	\$12.4	\$12.2	\$11.2	\$10.5
Antiretrovirals	HIV/AIDS, viral infections	\$11.5	\$10.4	\$8.9	\$7.3	\$6.4	\$5.7

This emphasises the message that just because a drug is new, it doesn't necessarily make it better. Are Proton Pump inhibitors always better than the drugs they replaced? What are the real advantages of SSRIs compared to older classes of antidepressants?

The role of PHARMAC is not an easy one and requires balancing the demand for new medicines, and the needs of patients, with the realities of a finite budget. It might seem cold comfort for those who feel that a new medicine they'd like to see funded hasn't received the tick. But PHARMAC's record shows a history of good funding decisions that really have made a positive difference.

**“PHARMAC was set up with the express purpose of managing medicines funding, and at the same time improving access to medicines has been an ongoing focus”**

# 10 years on – an evolution of ‘Demand Side’ management

It started as a quiet conversation in a Wellington office and has become one of PHARMAC’s cornerstones.

Managing demand for medicines is an important issue for the medicines system as a whole: how best to ensure that medicines are optimally prescribed and used. Significant resources are wasted each year because this is not achieved; resources that can be better used if this wastage can be avoided.

PHARMAC was set up in 1993 mainly to address pharmaceutical supply-related issues, such as negotiating on price. Thinking about the demand for medicines and how to manage the rapidly-growing prescribing of medicines would need a whole new way of thinking, and tactics that were relatively new in this country.

In 1996 the Regional Health Authorities laid the groundwork for establishing Demand Side management. Until late 1997, the main tool was budget-holding by some Independent Practitioners Associations (IPAs). PHARMAC established a demand side function to support IPA activities and support the implementation of other PHARMAC “supply side” (medicines purchasing) activities. The first Demand Side campaign – Wise Use of Antibiotics – started as an IPA-led project, then PHARMAC took on its management and funding.

In 2000 the Health & Disability Act spelt it out, PHARMAC would promote the “responsible use of pharmaceuticals”. The antibiotics campaign saw a rapid shift in prescribing patterns as clinicians bought into the Wise Use message. PHARMAC funded services to provide information to prescribers through the Best Practice Advocacy Centre, and PreMeC, and co-funded the Green Prescriptions programme - prescriptions for exercise, in conjunction with the then Hillary Commission (now SPARC).

Another important role was in providing information to help doctors, pharmacists and patients adapt to changes in medicine, providing information and increasingly sophisticated tools to get the message across.

Next came Asthma Management (1999), information on gout, and diabetes. ‘One Heart Many Lives’ (2002) focused on heart health ... all aimed at raising people’s consciousness about the merits of using medicines properly. 2002 also saw the development of PHARMAC’s Māori Responsiveness Strategy, which identified priority areas for action to improve the way PHARMAC dealt with Māori health issues (see more on the opposite page).

Celebrities have had their place in the campaigns. Antibiotics has involved a range of well-known figures from TV cook Alison Holst, to then health minister Jenny Shipley, Wellington MP Marian Hobbs, leading doctors and ESR scientists. All Black Carl Hoelt helped launch an asthma campaign in 1999 – an event swamped by the announcement of a coalition government that same day, such are the vagaries of planning for media coverage!

These days there are new tactics, like social marketing, closer co-operation from District Health Boards and other sector groups,

and a new name. Demand Side isn’t about more or less – it’s about addressing the overuse, underuse or misuse of medicines. “Optimal use” is the new catchcry and so the PHARMAC team has changed its name to Access and Optimal Use – more clearly reflecting what PHARMAC does in this important area.

It’s still addressing areas of high need, and where medicine usage has gotten out of step with best practice. The new Gut Reaction campaign is a case in point – encouraging people to think about long-term use of Proton Pump Inhibitors (like Losec) when cheaper, just as effective medicines may be just as appropriate.



**Karen Jacobs**

**Project Manager, Access & Optimal Use**

**Ko Ngati Whatua to iwi  
Ko Tutamoe te maunga  
Ko Kaihu te rohe  
Ko Kaihu to awa  
Ko Taita te marae  
Ko Watene tautari Watene te tangata  
Ko Karen Jacobs taku ingoa  
E mahi ana mo te Project Manager Access and Optimal Use team**



Karen Jacobs brought her family and English husband back to New Zealand for a better, safer life for her young children. After working overseas for 15 years, life in the UK had become hectic and congested. “Life in New Zealand is perfect,” says Karen.

Karen had worked in the pharmaceutical industry in the UK and in Sweden in various sales and marketing roles. An MBA from the University of Warwick was one goal that she enjoyed working toward and achieving, graduating in 1999. Prior to leaving New Zealand in 1990, Karen worked in the health sector as a registered nurse.

“I joined PHARMAC in 2005 and apply my commercial marketing skills to PHARMAC’s social marketing; same skills, totally different environment. Campaigns I am presently involved with are the Gut Reaction campaign, One Heart Many Lives and the Wise Use of Antibiotics. The One Heart Many Lives social marketing programme is about reducing cardiovascular risk in Maori and Pacific Island men in their thirties and older. My Dad has heart disease and is one of the lucky ones in that he is now nearly 80 and still going strong.”

“I work with some dynamic people. They bring experience and expertise from different disciplines within the health sector.

“Take a look at some of our websites: [www.kickthatbug.org.nz](http://www.kickthatbug.org.nz) and [www.gutreaction.co.nz](http://www.gutreaction.co.nz)”.

# Helping Māori stay well with medicines

PHARMAC's 'He Rongoā Pai, He Oranga Whānau - Whānau staying well with medicines' project is a campaign aimed at promoting the safe use of prescribed medicines for Māori.

The campaign aims to increase the benefits of subsidised pharmaceuticals to Māori by providing education to the Māori health workforce in relation to medication use, and by promoting medications as part of managing overall health. Issues such as access to health services, prescriber behaviour and cultural differences contribute to the lower prescription and uptake rates for Māori compared to non-Māori New Zealanders.

Consultation with Māori identified specific issues on safe use of pharmaceuticals such as storing, sharing and misuse of medicines, with many uncertain about the best use of prescribed medicines.

PHARMAC's focus is on increasing awareness of safe and appropriate ways to use medications, and on promoting medication use, as part of people's overall health care. Māori need to know more about what pharmaceuticals are subsidised, and how best to use and manage the medicines they are on.

Effective communication with Māori health workers, patients, and their whanau, is a top priority for PHARMAC – helping them understand, by showing that we understand. It's a big project, but it's very rewarding for PHARMAC's Māori health team.

We've developed a pilot health workforce education programme run in areas like Waitangi, Taranaki, Rotorua, and Auckland. Our target audience for the programme is Māori community health workers, and Māori primary care nurses – the front line in health.

There's been positive feedback from the pilot programme with 77% of course participants interviewed agreeing that the course added value to their work. Individual comments included:

*"I am more aware of what's available (subsidised medications), I have more information for our people"*

*"I don't think it has changed my practices, because if you want to get technical about it we work by best practice anyway. It's certainly changed my attitude for perhaps the way I would approach certain issues... I wouldn't say that it has changed my practice"*

*"I am more aware of what's available (subsidised medications), I have more information for our people"*

*"I always thought of them (PHARMAC) as legal drug peddlers who didn't really care much about people. But after doing this course ... the PHARMAC lady ... she just reinforced that they are there to help, they're not just somebody you ask for an authority number"*

One of the real tangible results of the campaign will be resources for Māori consumers of subsidised medicines and looking at things like bilingual patient medication cards, DVDs, an 0800 helpline, and links to local pharmacists.

*"We're taking nothing for granted – making sure people really do know PHARMAC's role; highlighting specific Māori health issues like diabetes, heart disease and obesity; educating people about the role of medicines; making sure we communicate effectively, accepting it's a slightly different culture; avoiding too much medical language which can be baffling to laypeople"*

**Mereana Wilson – Māori Health Analyst**

*"We'll have succeeded when Māori primary care nurses and health workers are familiar enough with the Pharmaceutical Schedule, to know which medicines are subsidised and can discuss these with their clients. We also want more Māori consumers to be aware of their entitlements in relation to subsidised medicines and understand how best to use medicines properly – and safely."*