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PHARMAC and statins—getting the best population health gains

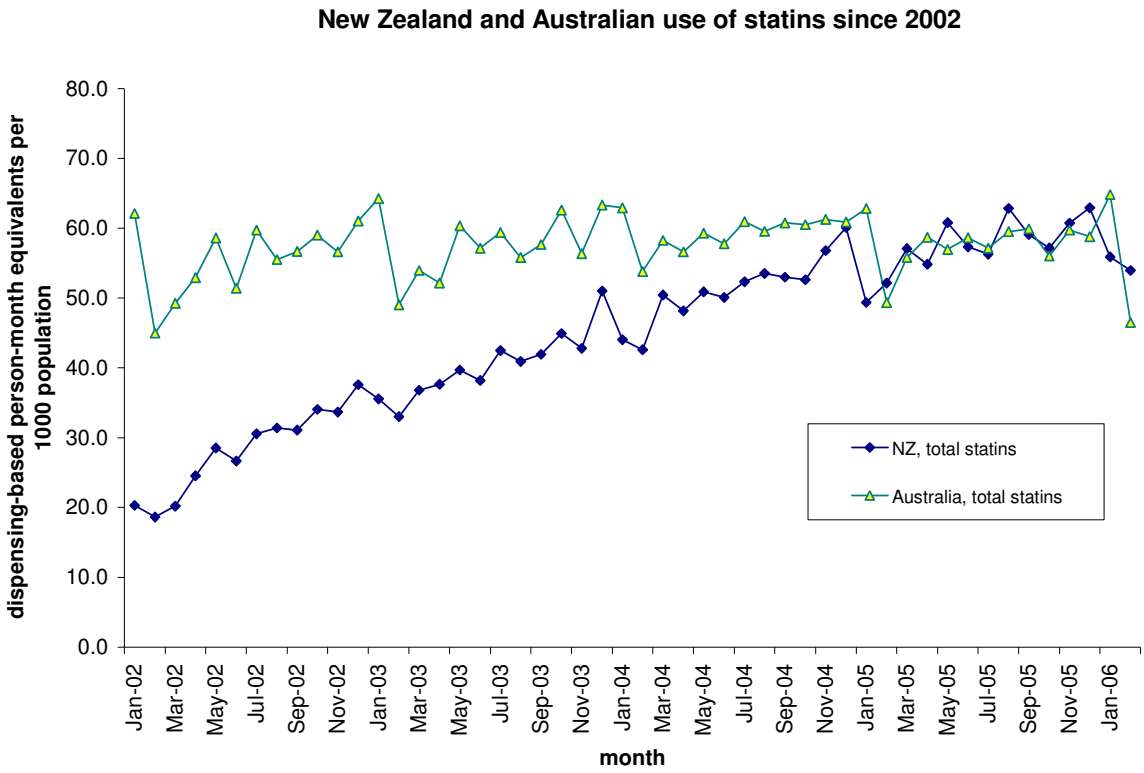
We note the commentary by Drs Ellis and White (http://www.nzma.org.nz/journal/119-1236/2033/) on the history of statin funding in New Zealand. Many of these specific points have been raised previously in the *Journal*,[1,2] and we have responded in detail (http://www.nzma.org.nz/journal/115-1163/203/ and http://www.nzma.org.nz/journal/116-1170/361/).[3,4]

In summary, access to statins was initially more restrictive than now—perhaps 45,000 patients were eligible prior to 1997, whereas around 300,000 are now eligible. The reasons for that were both clinical and financial. At that time the major studies related to secondary prevention and the price of statins was significantly higher than now—for example, 20 mg simvastatin cost over $1,000 per year (total expenditure was $16 million for perhaps 15,000 patients).

Widening access at that time in line with current NHF guidelines, at the above price could have resulted in expenditure of perhaps $200 million on one class of drugs—40% of total community pharmaceutical expenditure. Widening access to statins to allow the (now) 290,000 patients treatment was only achievable by using commercial opportunities to reduce the price of statins significantly. Wider access to statins then would have been at a significant cost to other patient groups.

PHARMAC is required to balance potential health gains for both high-risk individuals and the New Zealand population as a whole, amongst other criteria including costs, when making its decisions.[5] Historically, patients at highest overall cardiovascular risk have tended not to receive statin treatment, particularly Māori and Pacific men. That is why PHARMAC is working with DHBs and communities with its *One Heart Many Lives* programme attempting to redress this.

Access to simvastatin is now unrestricted, and atorvastatin remains available as a second-line agent for those who genuinely need a more potent statin or cannot tolerate simvastatin. Statin usage rates in New Zealand are now the same as in Australia (see graph below),[6] and a recent *BMJ* editorial has suggested that the United Kingdom should insist that simvastatin be the first-line statin therapy.[7] However, the critical issue is not which statins are available—but rather, whether they are prescribed for, and used by, those at highest risk.



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6. source: PHARMAC analysis of (1) NZHIS PharmWarehouse dispensings and scripts data for statins, and (2) PBS services data at http://www.medicareaustralia.gov.au/statistics/dyn_pbs/forms/pbs_tab1.shtml, using PBS codes (http://www9.health.gov.au/pbs/scripts/search.cfm) for atorvastatin, fluvastatin, pravastatin and simvastatin (codes 8213G, 8214H, 8215J, 8521L, 8023G, 8024H, 2833D, 2834E, 8197K, 2011W, 2012X, 8173E, 2013Y, 8313M, 2831B). Population denominators obtained from http://www.stats.govt.nz/ and http://www.abs.gov.au/.
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