Record of the Diabetes Advisory Committee Meeting held on 26 June 2025

Diabetes Advisory Committee records are published in accordance with the Terms of Reference for the Specialist Advisory Committees 2021.

Note that this document is not necessarily a complete record of the Diabetes Advisory Committee meeting; only the relevant portions of the meeting record relating to Diabetes Advisory Committee discussions about an application or Pharmac staff proposal that contain a recommendation are generally published.

The Diabetes Advisory Committee may:

(a) recommend that a pharmaceutical be listed by Pharmac on the Pharmaceutical Schedule and the priority it gives to such a listing;

(b) defer a final recommendation, and give reasons for the deferral (such as the supply of further information) and what is required before further review; or

(c) recommend that Pharmac decline to list a pharmaceutical on the Pharmaceutical Schedule.

Pharmac Advisory Committees make recommendations, including priority, within their therapeutic groups of interest.

The record of this Advisory Committee meeting will be reviewed by PTAC at an upcoming meeting.

Specialist Advisory Committees and PTAC may differ in the advice they provide to Pharmac, including recommendations' priority, due to the committees' different, if complementary, roles, expertise, experience, and perspectives.

Pharmac is not bound to follow the recommendations made below. Applications are prioritised by Pharmac against other funding options and progressed accordingly. The relative priority of any one funding choice is dependent on a number of factors, including (but not limited to) the recommendation of PTAC and/or Specialist Advisory Committees, the mix of other applications being assessed, the amount of funding available, the success of commercial negotiations and/or the availability of clinical data.

Table of Contents

1. Attendance

Present
Bruce King (acting Chair)
Angela Renall
Christine Pihema
Esko Wiltshire
Karen MacKenzie
Jessica Keepa
Kate Smallman
Matt Dawes
Rinki Murphy
Sean Hanna
Sue Tutty (part of meeting)

Apologies
Diana McNeill
Helen Lunt
Liza Lack (Chair)

2. The role of Specialist Advisory Committees and records of meetings

2.1. This meeting record of the Diabetes Advisory Committee is published in accordance with the Terms of Reference for the Pharmacology and Therapeutics Advisory Committee (PTAC) 2021 and Specialist Advisory Committees 2021.Terms of Reference describe, *inter alia*, the establishment, activities, considerations, advice, and the publication of such advice of Specialist Advisory Committees and PTAC.

2.2. Conflicts of Interest are described and managed in accordance with section 6.4 of the SAC Terms of Reference.

2.3. The Diabetes Advisory Committee is a Specialist Advisory Committee of Pharmac. The Diabetes Advisory Committee and PTAC and other Specialist Advisory Committees have complementary roles, expertise, experience, and perspectives. The Diabetes Advisory Committee and other Specialist Advisory Committees may therefore, at times, make recommendations for treatments for Diabetes that differ

from PTAC's, including the priority assigned to recommendations, when considering the same evidence. Likewise, PTAC may, at times, make recommendations for treatments for Diabetes that differ from the Diabetes Advisory Committee's, or Specialist Advisory Committees may make recommendations that differ from other Specialist Advisory Committees'.

Pharmac considers the recommendations provided by both the Diabetes Advisory Committee and PTAC and any other relevant Specialist Advisory Committees when assessing applications for treatments for Diabetes.

3. Welcome and introduction

3.1. The Chair welcomed the Committee with a karakia followed by whakawhanaungatanga.

3.2. The Chair welcomed Dr Matt Dawes (PTAC member, Physician and Clinical Pharmacologist) and Dr Jessica Keepa and Dr Sue Tutty (General Practitioners), who joined the Committee to support this agenda.

4. Pharmac Update

4.1. The Committee noted a brief Pharmac Update.

5. Review of empagliflozin and dulaglutide/liraglutide Special Authority Criteria

Discussion

Background

5.1. The Committee noted the purpose of the meeting was to review whether the current special authority criteria for the treatment of diabetes for empagliflozin, dulaglutide and liraglutide remained appropriate and consistent with legislation relating to Pharmac's funding of medicines, the public services expectations by government (Cabinet Office circular CO (24) 5: Needs-based Service Provision. 13 September 2024), including for Pharmac, that any targeted investments must have empirical evidence about why such interventions are necessary (being the disparity in outcomes between the target and the general population and why non-targeted services are not sufficient to address this), and internal policy relevant to Pharmac's funding of medicines.

5.2. The Committee noted that the intended target population for the funding of the two classes of medicines (SGLT2i/GLP1a) was those people with type 2 diabetes experiencing inadequate glycaemic control and either with established CV disease or at high risk of poor outcomes from cardiovascular or renal disease.

5.3. The Committee noted that the inclusion of specific pro-equity ethnicity criteria had been included as discretionary affirmative 'Special Measures' in the original funding decision in 2020/21 for empagliflozin (SGLT2i) and dulaglutide (GLP1a), in recognition of the high rates of type 2 diabetes in the Māori and Pacific populations, their lower rates of access to funded diabetes medicines despite their high need (where other groups with high need were nonetheless accessing medicines commensurate with need, Chan et al. Counties Manukau Health, 2020), and following extensive consultation feedback and meetings with a range of healthcare stakeholders supporting the use of specific ethnicity criteria to help remove access barriers for these populations.

5.4. The Committee noted that the basis for Pharmac's 2021 funding of SGLT2i/GLP-1a used strict analytical criteria to meet human rights legislation requirements for

'Special Measures', under s.19(2) of the New Zealand Bill of Rights Act and s.73 of the Human Rights Act. Members noted those analytical criteria comprising:

5.4.1. that including ethnicity in the access criteria would improve health outcomes for a disadvantaged group, particularly disadvantage from discriminatory treatment in the health system

5.4.2. a lack of reasonable (and similarly effective) alternative solutions that do not make distinctions based on ethnicity

5.4.3. a real prospect that ethnicity criteria would address the disadvantage

5.4.4. consideration of those not able to access the medicines

5.4.5. consideration of over- or under-inclusion (where people who do not need a measure benefit simply because they belong to the targeted group, while others who may need it are denied the benefit because they belong to a group considered not to be disadvantaged)

5.4.6. consideration whether use of ethnicity as a criterion is wider than necessary

5.4.7. consideration whether, if ethnicity is a direct proxy for other causative factors, it may be more effective to address those factors directly.

5.5. Members noted additional advice was provided via email in late 2020 by members of the Diabetes, Cardiovascular and Nephrology Subcommittees and by PTAC members on the consultation feedback, and that that the final proposed amendments to the SA criteria that included ethnicity were considered clinically appropriate.

Current access to SGLT2i / GLP1a

5.6. The Committee agreed that in the absence of funding restrictions that there would be a significant health benefit gained if more people with type 2 diabetes were able to access SGLT2i / GLP1a, than that defined by the current criteria.

5.7. The Committee reviewed the concept of using surrogate measures such as BMI as determinates of health need rather than ethnicity criteria, however it was considered that these would be poor approximations of health need, with factors such as differences in body composition across ethnicities adding complexity.

5.8. The Committee considered that there remained systemic barriers for Māori and Pacific peoples in achieving equitable access to health care, these barriers including affordability, approachability and geographic factors (Norman et al. Prim Health Care Res Dev. 2024;25:e34).

5.9. The Committee noted a Pharmac commissioned internal analysis of patient access to SGLT2i and GLP-1a medicines. The analysis was designed to gauge how well the current access criteria (special authority) were working in practice to enable funding access to the intended target population. The analysis looked at the numbers of people who potentially would meet the criteria, and the use of formal cardiovascular risk assessments.

5.10. The Committee noted that the analysis indicated that approximately 89% (ie. most but not all) of Māori and Pacific people with type 2 diabetes would be able to access the medicines through the current clinical criteria alone.

5.10.1. The Committee noted that the Pharmac access analysis indicated that the current level of cardiovascular risk clinical indicator assessment for Māori was 91% versus 83% for non-Māori. This was interpreted by the Committee as representing some progress in achieving more equitable assessment and treatment for this population.

5.11. The Committee considered that there would be non-Māori, non-Pacific patients who would currently not meet the access criteria but would still be classified as being within the scope of the intended population for funding, indicating that the current Special Authority criteria may be too restrictive.

Consideration of the ethnicity criteria for access to SGLT2i / GLP1a

5.12. Some Members considered that the current Special Authority form encourages prescribers to actively consider the benefits to Māori and Pacific patient by prescribing the medicines concerned, and that if the criteria were revised to exclude the ethnicity component, then it was possible that prescribing for these populations would reduce.

5.13. The Committee noted a recent systematic review (Wheeler et al. Lancet Reg Health West Pac. 2025;56:101511) reporting extensive and inequitable gaps in cardiovascular risk assessment and management for Māori and Pacific peoples (compared with other ethnicities), with inadequate cardiovascular risk assessment in Māori and Pacific peoples when measured against the 90% national target.

5.14. Members noted a recently published study (Chepulis et al. BMC Health Serv Res. 2025;25:433) examining patient and practice-level variables associated with the initiation of SGLT2i/GLP-1a prescribing in people with type 2 diabetes, reporting:

5.14.1. Nearly half of eligible individuals with type 2 diabetes were prescribed SGLT2i/GLP-1a under SA criteria in the 18-months following those agents' February 2021 funded availability (ie. of 57,743 patients with type 2 diabetes, 22,331 were eligible for funded SGLT2i/GLP-1a access, and 10,272 of those were prescribed, 46.0% of eligible, 17.8% of all type 2 diabetes patients).

5.14.2. Nearly a third of all Māori and Pacific patients with type 2 diabetes were prescribed SGLT2i/GLP-1a, compared with the 17.8% of all patients with type 2 diabetes being prescribed these medicine

5.14.3. Initiation of therapy was highest in Māori (50.8%) and Pacific (48.8%) patients (vs. 36.2% to 40.7% of other ethnic groups; $P < 0.001$), but was comparable in those with and without cardiovascular and/or renal disease or risk (CVRD) in the Māori and Pacific cohorts (47·1% vs. 48·9%; $P = 0.2$).

5.14.4. Initiation of therapy in Māori and Pacific peoples with known CVRD (50%) was similar to rates in those without CVRD (and only slightly higher than that for unknown CVRD (38%)) suggesting that the ethnicity criteria may have had limited impact in achieving better access for those in the high CVRD group. The ethnicity criteria have enabled access to a broader group of individuals while not necessarily achieving the uptake in the population likely to gain the greatest health benefit.

5.14.5. Prescribing was highest in practices with higher doctor/patient numbers, low-cost fees, Māori health providers and clinics without after-hours access.

5.15. Members noted that, using the analytical criteria for affirmative 'Special Measures', the 2020/21 funding decision had considered or recognised:

5.15.1. There is widespread evidence that Māori and Pacific people were (very) disproportionately impacted by type 2 diabetes (Yu et al. Lancet Glob Health. 2020:S2214-109X(20)30412-5). These populations have disease burden 6-7 times that of non-Māori/non-Pacific people that is not compensated by diabetes medicines' prescribing rates (dispensings being at least 54-61% less than they should be were Māori and Pacific people to have the same dispensing rates, adjusted for disease burden, as occur in non-Māori/non-

Pacific people), and that the gaps remain entrenched (Metcalfe et al N Z Med J. 2018;131:27-47).

5.15.2. Māori and Pacific peoples with type 2 diabetes have demonstrated differential cardiovascular and renal risk that cannot be fully captured in any other way and is independent of clinical variables. Pharmac (and it's clinical advisors) had been unable to identify any other factor that could be used to identify this group that could be workably applied as a criterion in clinical practice.

5.15.3. The health system had not met Māori and Pacific peoples needs including for equitable access to cardiovascular and renal risk assessment tests that would enable funded access for them under the original proposed criteria.

5.15.4. Māori and Pacific peoples had the capacity to benefit from these treatments.

5.15.5. Pharmac was unable to identify any other means in the Pharmaceutical Schedule for redressing entrenched access inequities, and where evidence was lacking from other programmes of sustained improvements that were rapid, sufficiently large and sufficiently timely to rapidly redress inequities.

5.15.6. Having ethnicity criteria recognised that SA criteria are but one of many parts of a system that will be required to redress funded access inequities; alone as an action it was insufficient, but it was still necessary (where if each component was excluded because in itself it was insufficient, there would be no components; each plays a part and as such is necessary).

5.15.7. Although South Asian ethnic groups were at higher risk of type 2 diabetes compared with other groups, in contrast to Māori and Pacific people, systemic barriers and outcomes disparities did not appear to be as significant (Chan et al. Counties Manukau Health, 2020). With the ethnicity-inclusive criteria, South Asian people would still get good access regardless, being people who would not meet the ethnicity criterion but who would benefit most from treatment, who would be captured through the other criteria used to define people at high risk of cardiovascular or renal complications of diabetes.

5.15.8. People who did not meet the proposed ethnicity criterion, but who would benefit most from treatment, would be captured through the other funding criteria used to define those at high risk of cardiovascular or renal complications of diabetes.

5.15.9. The criteria were such that it was unlikely that significant over-inclusion would occur because the criteria, coupled with the clinical judgment of prescribers, would ensure that only people who would benefit significantly from the treatment would receive it.

5.16. The Committee agreed with past assessment and evidence used to support Pharmac's 2020/21 funding decision made using the strict analytical criteria for 'Special Measures'. The Committee considered that the assessment using the strict analytical criteria aligned with the public services expectations by government (Cabinet Office circular CO (24) 5: Needs-based Service Provision. 13 September 2024) that any targeted investments must have empirical evidence about why such interventions are necessary, and considered the evidence remained unchanged and that the reasons for including ethnicity criteria remained valid.

5.17. Members considered that no evidence had been provided to change its previous considerations that the ethnicity criteria were clinically appropriate.

Consideration of high-risk population definitions for access to SGLT2i / GLP1a

5.18. The Committee noted that there are multiple cardiovascular risk assessment tools in use for people with type 2 diabetes including PREDICT and VAREANZ CVD

(NZSSD), but that there is inconsistency in how ethnicity is factored into their risk scores. It was noted that the 5-year 15% risk score was quite a high threshold. The Committee noted that the NZSSD guidelines are currently under review and that the cardiovascular risk threshold guidance for the prescribing of SGLT2i and GLP1a medicines for people with type 2 diabetes may be reduced from the current level of 15% 5 year risk.

5.19. The Committee noted that currently the way the Special Authority form is presented, it is easier for prescribers to tick the Māori or Pacific option rather than consider the other clinical factors listed. Some members considered the current format may inadvertently enable prescribers to not carry out a thorough clinical assessment including cardiovascular risk assessment/scoring, although other members considered this would be poor clinical practice reflecting wider issues beyond the Special Authority form.

5.20. The Committee considered that the current threshold requirement of an HbA1c of 53 mmol/mol may be an unnecessary barrier to access, and it was noted by Pharmac staff that there is currently a separate application for a revision of the HbA1c threshold for empagliflozin under assessment.

5.21. The Committee considered that introducing criteria that enabled prescribers to make a subjective assessment of high cardio-renal risk may make some of the existing clinical criteria redundant, however the Committee considered that retaining the existing clinical criteria does encourage prescribers to properly assess the cardio-renal risk of patients.

5.22. The Committee considered that if a subjective criterion was adopted in relation to a patient's cardio-renal risk, then it would be useful to include the factors that may contribute to this risk in the notes for the respective criteria, and that this should include a patient's ethnicity. Members considered that there may be a risk that prescribers would fail to identify a patient's actual level of clinical risk.

5.23. The Committee noted that the intent of Special Authority criteria is not to explicitly guide clinical practice nor serve as an educational tool but to ensure that funded access was targeted to the defined population for which funded medicines access was intended.

5.24. The Committee agreed that including discretionary criteria in relation to a patient's cardio-renal risk based on a prescriber's clinical assessment would enable a level of access that was more inclusive than that currently used and would likely fully capture the intended target population. However, the Committee acknowledged that this would have substantial budgetary implications for Pharmac.