New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

23 September 2016

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Agenda for the 57th meeting of the Medicines Classification Committee

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide comment to the Medicines Classification Committee (MCC) regarding the agenda for the 57th meeting scheduled for 1 November 2016. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of New Zealanders.

2. Our feedback is limited to the following items on the agenda:
- Item 5.3 Updating the guidance document titled 'How to change the legal classification of a medicine in New Zealand' and other MCC processes
- Item 6.4 Reclassifying selected oral contraceptives from 'prescription medicine' to 'a prescription medicine except when supplied by a pharmacist with training'.

Item 5.3 Updating the guidance document titled 'How to change the legal classification of a medicine in New Zealand' and other MCC processes

3. We note that changes are being proposed to improve the transparency of the MCC processes and provide better information to the Committee to maintain the quality of decision making. We are strongly supportive of the proposal for full reference lists for applications to be made available in the interest of meaningful consultation. We also support the proposal for all supporting documents or appendices to be published along with applications for reclassification.

4. We note that at the 55th MCC meeting, it was proposed that the criteria referred to when considering a medicine classification be reviewed. We have previously expressed our view that the MCC needs to take into account contextual factors beyond the direct effects of a medicine

when considering reclassification. These should include aspects such as impacts of reclassification on continuity of care, fragmentation of care and missed opportunities to address other health issues. We are disappointed that the revised parameters in the consultation document are still too narrow. It is of concern that the criterion 'communal harm and/or benefit' (which arguably could have encompassed wider contextual factors) has been omitted from the proposed new criteria.

5. We believe that when the MCC is considering an application for the reclassification of a medicine, it is essential to take into account **all** relevant factors, including the impact of the reclassification on the wider health and wellbeing of the population. This is of particular importance as there is no other agency or process that is able to consider these factors. We also believe that the MCC should retain the flexibility to go beyond checklists and criteria, and should be allowed to take into account all pertinent factors when making determinations.

Item 6.4 Reclassifying selected oral contraceptives from 'prescription medicine' to 'a prescription medicine except when supplied by a pharmacist'

6. We note that the modified proposal takes into account many of the concerns we have previously raised.[1] Importantly, it no longer proposes pharmacist initiation of oral contraceptives. We acknowledge that this change reflects concerns raised by medical groups. We understand that the modified proposal entails the following main aspects:

- Pharmacist supply can only be to women who have been prescribed an oral contraceptive in the past three years; it must be the same formulation unless the woman is from overseas and that formulation is not available in NZ, or there has been a gap in therapy.
- Women must be eligible for supply in accordance with the screening tool consistent with the WHO Medical Eligibility Criteria for Contraceptives. Doctor referral is to occur where a woman is ineligible according to the screening tool.
- Women will be screened for contraindications using the full screening tool at the first visit to the pharmacy and every 12 months. In intervening occasions at the same pharmacy they will be asked if any conditions have changed since the last dispensing. If the woman visits another pharmacy the full screening tool is automatically undertaken.
- A maximum of 6 months' supply can be provided on any one occasion.
- A woman's GP is informed of the supply unless the woman opts out of this process. Women are strongly encouraged to consent to having the GP informed of the supply.
- Verbal and/or written information is supplied on the need for smear tests, sexually transmitted infection checks (if necessary), contraceptive options including long-acting reversible contraception, compliance, adverse effects, and what to do if a tablet is missed or diarrhoea or vomiting occur.
- A private area must be provided for consultations.

7. While the current proposal is an improvement on previous applications, we are still concerned that the proposal will undermine the opportunity for opportunistic medical interactions as well as the act of forming a therapeutic relationship with a medical practitioner, both of which are important aspects of prescribing the oral contraceptive pill. We are also concerned that the proposal does not actively encourage the uptake of long-acting reversible contraception which has been demonstrated to be more effective in practice than contraceptive pill use.[2]

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[1] NZMA Submission on agenda for the 54th meeting of the Medicines Classification Committee. 28 September 2015. Available from https://www.nzma.org.nz/__data/assets/pdf_file/0003/44643/Subagenda-of-54th-meeting-of-the-MCC.pdf

[2] Winner B, et al. Effectiveness of long-acting reversible contraception. N Engl J Med. 2012 May 24;366(21):1998-2007.

8. Finally, we remain unconvinced that the need for a prescription is a barrier for access to the oral contraceptive pill in the New Zealand context. We note that pharmacists will charge a consultation fee for the time involved in the consultation. This fee may be considerably higher than that charged for a repeat prescription by a doctor. We expect that many motivated women who can afford to pay for their contraceptive pill may use the proposed pharmacist-supplied contraceptive service. By contrast, priority groups for greater contraceptive access include young people, Māori and Pasifika. If this proposed reclassification is agreed, we strongly agree that comprehensive audit and analysis of the scheme is necessary, including its impacts on access to contraceptives for these priority groups.

We hope that our feedback has been helpful and look forward to learning the outcome of this consultation.

Yours sincerely

Dr Stephen Child
NZMA Chair