



# New Zealand Hospital Pharmacy Association (Inc)

Te Kāhui Whakarite Rongoā Hōhipera o Aotearoa

June 2026

Pharmac

Via email: [consult@pharmac.govt.nz](mailto:consult@pharmac.govt.nz)

## **Re: Consultation feedback on proposal to widen access to empagliflozin, dulaglutide and liraglutide for type 2 diabetic patients at risk of cardiorenal complications.**

Thank you for the opportunity to respond to this proposal. As co-leads of the Cardiology and Renal NZHPA Special Interest Networks (SIN), we support decisions that increase access to guideline directed therapy to patients with or at risk of cardiorenal syndrome. Unfortunately, we believe the proposed changes do not fulfill this objective, and do not address the unmet need for funding of sodium glucose cotransporter 2 (SGLT2) inhibitors for all spectrums of heart failure or chronic kidney disease (CKD) and glucagon-like peptide-1 receptor agonists (GLP1-RA) in obesity/cardiac kidney metabolic (CKM) disease.

The proposed removal of the pro-equity ethnicity criteria does not strike us as improving outcomes for our Māori and Pacific Island patients, and we feel it will in fact widen health inequities for them.<sup>i,ii</sup> This inequity was reflected in the Kia Manawanui Trust *Heart Disease in Aotearoa: Morbidity mortality and service delivery* report from July 2025<sup>i</sup>. The report discussed that while there has been “substantial and sustained reductions in heart disease hospitalisation and mortality rates over the past two decades”, it was noted that Māori and Pacific Island populations were still disproportionately affected, lived in areas of higher deprivation and with lower health resources. The ability of high socioeconomic groups to self-fund these medications for unfunded indications may widen inequity further, worsen health-related outcomes, and increase the resource burden on our already failing public health system.

A 2025 policy report regarding equity criteria in New Zealand for diabetes medication highlighted that type 2 diabetes is a ‘leading contributor to the life expectancy gap for Māori and Pacific people compared to non-Māori, non-Pacific people’<sup>iii</sup> and that this contributes to “deaths from other leading causes, including coronary heart disease, stroke and renal failure”, conditions which you are keen to target. Māori and Pacific people have lower rates of cardiovascular disease risk assessment (CVD RA) completion in NZ so the reduction from 15% to 10 % will have less impact in these groups. Cardiovascular disease (CVD) is in part a disease of longevity and therefore looking at disease risk over a period of 5 years strikes us as short-sighted; other international CVD calculators are now assessing 10 or 30-year risk. The criteria 2.2.3 and 2.2.4 are quite conflicting with one being driven by high lifetime risk and the other by 5-year risk which is likely only reached later in life. In our experience, most patients in our settings reach the funding criteria by virtue of ethnicity or existing disease, and not by risk calculation. On this basis we would like to see the ethnicity criteria retained or widened to other high-risk groups such as South Asian people, who are also at high risk of CVD<sup>iv</sup> and more consideration on lifetime risk.

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20 Karaka Street Hokowhitu, Palmerston North 4410  
PO Box 20046 Summerhill, Palmerston North 4448

Tel: 0204 021 8887  
Email: [nzhpa@nzhpa.org.nz](mailto:nzhpa@nzhpa.org.nz)



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Māori and Pacific peoples have disproportionately higher rates of both diabetic CKD and CKD not related to diabetes<sup>v</sup>. CKD is recognised as an independent risk factor for CVD, increasing cardiovascular morbidity and mortality even after optimisation/adjustment of traditional cardiovascular risk factors such as age, hypertension and diabetes. Cardiovascular related morbidity and mortality has been shown to be 10-20 times greater in severe CKD compared to patients without CKD<sup>vi</sup>.

The four pillars of diabetic kidney disease (RAS inhibitors, SGLT2, GLP1-RA and nsMRA (finerenone)) have been shown in large scale trials to improve both renal and cardiovascular outcomes, and are recommended by international guidelines globally<sup>vii</sup>. If Pharmac would like to target improved patient cardiac/renal outcomes then funding effective treatments (SGLT2 inhibitors and finerenone) for patients with either diabetic kidney disease, non-diabetic kidney disease or HFpEF, which is the major HF phenotype in type 2 diabetics, seems sensible<sup>viii</sup>.

With the current HbA1c criteria in place, there are many patients with CKD or HFpEF and impaired glucose tolerance, who cannot access therapy that would prevent their disease progressing.

What does not appear to have been addressed is the reduction of the HbA1c threshold to 48 mmol/mol for the diagnosis of type 2 diabetes, which takes effect from July 1<sup>st</sup>, 2026. When contacted earlier this year, Pharmac stated there were no plans to amend the Special Authority criteria to align with this change. Funding mechanisms must be updated in parallel with revised clinical criteria; otherwise, opportunities for timely intervention are lost. Without such alignment, we risk failing to prevent disease progression. This gap is particularly evident for patients with HFpEF or CKD and impaired glucose tolerance who, under current New Zealand funding restrictions, do not qualify as diabetic despite meeting diagnostic thresholds under international guidelines.

We would encourage you think long term and consider changes such as:

- Continue the pro-equity criteria for Māori and Pacific people and consider widening to this other high CVD risk groups.
- Look further ahead than 5-year CVD risk
- Increasing access of empagliflozin to non-diabetic patients with HFpEF or CKD/microalbuminuria
- Consider other medications with evidence in CKM – finerenone and GLP1-RA therapy for weight loss.

We look forward to hearing from you

Anthea Gregan, Ev Tolerton, Johanna Lim  
Pharmacist co-conveners of the NZHPA cardiology SIN  
Sarah Roberts  
Pharmacist co-convener of the NZHPA renal SIN

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<sup>i</sup> [Cardiac Impact Report — Kia Manawanui Trust | The Heart of Aotearoa New Zealand](#)

<sup>ii</sup> Paul R et al Inclusion of ethnicity in Special Authority criteria improves access to medications for Māori and Pacific peoples with type 2 diabetes. *NZMJ* 2023 Apr 28; 136(1574).

<sup>iii</sup> Chepulis, L., Gan, H., Simmons, D. *et al.* SGLT2 inhibitor use and disparities in all-cause mortality in type 2 diabetes: insights from a multi-ethnic population. *Diabetologia* (2026). <https://doi.org/10.1007/s00125-026-06733-2>

<sup>iii</sup> Tamatea J, Te Karu L, Grey C, McKree Jansen R, Jordan A, Loring B, Reid P. Indigenous Leadership and Advocacy in Pro-Equity Eligibility Criteria for New Diabetes Medicines in Aotearoa New Zealand [*Policy Report*]. *Health Syst Reform*. 2025 Dec 31;11(1):2592386. doi: 10.1080/23288604.2025.2592386. Epub 2025 Dec 8. PMID: 41360052.

<sup>iv</sup> <https://www.healthnz.govt.nz/health-professionals/guidance-standards/topic/conditions/diabetes>

<sup>v</sup> Walker RJ, Tafunai M et Krishnan A. Chronic Kidney Disease in New Zealand Māori and Pacific People. *Seminars in Nephrology*. 2019. 39 (3) p297-299

<sup>vi</sup> Marx-Schutt K et al. Cardiovascular Disease in Chronic Kidney Disease. *Eur Heart J*. 2025. 46 (23) p2148-2160

<sup>vii</sup> Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. *Kidney Int*. 2024 Apr;105(4S):S117-S314.

<sup>viii</sup> Gil-Millan P, Gimeno-Orna JA, Rodriguez-Padial L, Muniz J, Barrios V, Anguita M, Perez A. HFpEF as the predominant and underrecognized heart failure phenotype in type 2 diabetes: evidence from the DIABET-IC study. *Cardiovasc Diabetol*. 2025 Nov 3;24(1):419. doi: 10.1186/s12933-025-02995-z. PMID: 41185008; PMCID: PMC12581349.

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