The Paediatric Society of New Zealand
Te Kāhui Mātai Arotamariki o Aotearoa

June 2026

Submission: Proposal to Amend the Special Authority Access Criteria for Type 2 Diabetes Medicines

From: Te Kāhui Mātai Arotamariki o Aotearoa | Paediatric Society of New Zealand (PSNZ)

PSNZ welcomes the opportunity to submit on PHARMAC's Proposal to Amend the Special Authority Access Criteria for Type 2 Diabetes Medicines

PSNZ is the national professional body representing paediatricians and child health professionals across Aotearoa. Our multidisciplinary membership works directly with tamariki, rangatahi, and their whānau every day. It is from this frontline child health perspective that we offer our feedback.

What We Support

We support lowering the 5-year CVD risk threshold. The proposal provides a clear clinical rationale: earlier initiation of these medicines reduces complications and supports better long-term outcomes. We also support retaining 'any relevant practitioner' prescribing access, which is particularly important in communities where specialist access is limited.

However, CVD risk calculators underestimate risk in Māori and Pacific peoples, and clinician discretion cannot fill the gap. The reduction in the CVD risk threshold does not compensate for the removal of ethnicity criteria, because the calculator's known limitations mean the threshold reduction cannot substitute for ethnicity-based criteria.

What We Oppose: Removal of the Ethnicity Criteria

No rationale has been provided

The consultation document provides detailed justification for lowering the CVD threshold, but no justification at all for removing the ethnicity criteria: no clinical reasoning, no evidence, no equity impact analysis. This directly contradicts PHARMAC's own Access Criteria Policy,[1] which states that *"each access criterion for inclusion will be justified in relation to these principles"* and that *"access criteria should account for challenges faced by any population group experiencing a disparity of access and/or health outcome."* By the same logic, removing a criterion requires equivalent justification. None has been provided.

[1] PHARMAC. (2025). Access Criteria Policy (December 2025).

Additionally, the 2025 Access Criteria Policy states that criteria should define the target population *"most likely to benefit from the medicine."* The evidence consistently shows that Māori and Pacific peoples with Type 2 diabetes are among those most likely to benefit from early access to SGLT-2 inhibitors and GLP-1 receptor agonists.

Removing ethnicity criteria contradicts PHARMAC's prior commitments

In 2019, PHARMAC's Chief Executive acknowledged that Māori "continue to receive medicines at lower rates than non-Māori, despite their health need being higher" and committed to eliminating inequities in medicine access.[2] The ethnicity criteria was in direct response to this. And it worked: Paul et al. (2023) found that including ethnicity in the Special Authority criteria improved access to these medicines for Māori and Pacific peoples.[3] Chepulis et al. (2026) confirmed that more than 50% of eligible Māori and Pacific people accessed empagliflozin within the first 1-3 years, compared with 30–40% of Asian and European patients. Removing the criteria risks reversing this progress.[4]

The evidence shows these medicines save more lives in Māori and Pacific peoples

Chepulis et al. (2026) found that empagliflozin use was associated with a 52.5% reduction in the hazard of all-cause mortality in Māori and 49.3% in Pacific people, compared with 33.3% in European people (HR 0.475, 0.507, and 0.667, respectively).

Crucially, the survival benefit for both Māori and Pacific people was independent of established cardiovascular or renal disease; it applied even to those who would not qualify under the CVD risk threshold. The paper's authors concluded that the findings "support prioritised access of these medications for these populations."[4]

Māori had the highest crude mortality rate in the study: 55.81 deaths per 1,000 people per year among those with cardiovascular or renal disease who did not receive the medicine, nearly twice the rate of European patients. SGLT2i access reduced this to 16.24 per 1,000.[4]

Removing the criteria that ensure Māori and Pacific peoples can access medicines that deliver this magnitude of benefit is directly at odds with any commitment to health equity.

CVD risk calculators underestimate risk in Māori and Pacific peoples, and clinician discretion cannot fill the gap

This concern applies to both elements of the proposal: the reduction in the CVD risk threshold does not compensate for the removal of ethnicity criteria, because the calculator's known limitations mean the threshold reduction cannot substitute for ethnicity-based criteria.

PHARMAC may intend the lowered 10% CVD threshold to capture Māori and Pacific patients previously accessing medicines via the ethnicity criteria. This assumption is not supported by evidence. Standard CVD risk calculators were developed primarily in European populations and are known to underestimate cardiovascular and lifetime risk in Māori and Pacific peoples. Many high-risk individuals will not reach 10% on a calculator despite their true risk being substantially higher,

[2] PHARMAC. (2019). Achieving medicine access equity in Aotearoa New Zealand: Towards a theory of change.
[3] Paul et al. (2023). Inclusion of ethnicity in Special Authority criteria improves access to medications for Māori and Pacific peoples with type 2 diabetes. NZ Med J, 136(1574), 93–97.
[4] Chepulis et al. (2026). SGLT2 inhibitor use and disparities in all-cause mortality in type 2 diabetes: insights from a multi-ethnic population. Diabetologia.

particularly younger patients, who develop Type 2 diabetes earlier and accumulate complications faster than New Zealand Europeans.[4]

Additionally, Leitch et al. (2021) found a consistent trend toward less clinician action on medication risk alerts for Māori and Pasifika patients than for European patients in New Zealand general practice, even after adjusting for clinical complexity. This is consistent with broader evidence of ethnicity-related disparities in prescribing and clinical decision-making in New Zealand primary care. The ethnicity criteria provides a structural safeguard against these patterns, reducing reliance on the very mechanism, individual clinician discretion, where such disparities have been observed.[5]

Additional Recommendation

We recommend that PHARMAC consider funding continuous glucose monitoring (CGM) for children and young people with Type 2 diabetes who require intensive management.

Youth-onset Type 2 diabetes is a more severe and progressive condition than adult-onset disease, and Māori and Pacific children are disproportionately affected. CGM supports improved glycaemic management, earlier identification of problems, and reduced diabetes distress.[6]

Additionally, we also recommend that PHARMAC consider funding GLP-1 receptor agonists (GLP-1RA) and SGLT-2 inhibitors (SGLT2i) concurrently for people at high lifetime risk of cardiovascular or chronic kidney disease. These two drug classes have distinct mechanisms and complementary cardiorenal benefits, and dual therapy is recommended in international guidelines for high-risk individuals. Unlike alternative agents such as insulin, which carry risks of hypoglycaemia and lack cardiorenal protective effects, concurrent GLP-1RA and SGLT2i use is associated with improved outcomes for this population.

Ngā mihi nui,

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[5] Leitch et al., (2021). Medication risk management and health equity in New Zealand general practice: a retrospective cross-sectional study. International Journal for Equity in Health, 20, 119

[6] Shah et al., (2024). ISPAD Clinical Practice Consensus Guidelines 2024: Type 2 Diabetes in Children and Adolescents. Horm Res Paediatr, 97, 555–583.