



**Your Community Pharmacist:** the health professional you see most often

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Dear Sean

**RE: PHARMACEUTICAL SUBSIDY ELIGIBILITY AND DELIVERY REVIEW**

Thank you for the opportunity to provide feedback regarding the Pharmaceutical Subsidy Eligibility and Delivery Review.

This submission is divided into two parts, the first part answers the questions about the generation of subsidies for pharmaceuticals and the second part answers the questions about the delivery of subsidised pharmaceuticals. General comments and additional comments are made at the beginning and end of the document, respectively.

Once again, the Pharmacy Guild would like to thank you for the opportunity to provide feedback on the Pharmaceutical Subsidy Eligibility and Delivery Review. If you have any queries regarding this submission, please contact Rebecca Cheng on (04) 802 8218, or email queries to [r.cheng@pgnz.org.nz](mailto:r.cheng@pgnz.org.nz).

Yours sincerely

A handwritten signature in black ink that reads 'Annabel Young'.

Annabel Young  
Chief Executive

## **General**

Under the present model, generating a subsidy for pharmaceuticals is synonymous with holding prescribing rights. As these practices are so closely intertwined, this discussion document has created some confusion about terminology and has highlighted questions around how any changes to the process would work in practice.

The Pharmacy Guild of New Zealand (the Guild) believes that taking a broader approach to the subject, such as granting pharmacists collaborative prescribing rights or implementing a community pharmacy based minor ailments service, would be of greater benefit to all parties. The patients would have increased access to health care and costs would be taken out of the primary health care system. While not all community pharmacists welcome gaining prescribing rights, allowing certain pharmacists to prescribe would significantly increase patient health care. It would also evenly distribute the load of other practitioners, for example, allowing general practitioners time to focus on more complex clinical cases. The Guild appreciates that campaigning for wider prescribing rights is outside the scope of this discussion document.

### **Part one: Generation of subsidies**

*Should health professionals without prescribing rights be able to generate a subsidy for a pharmaceutical (as broadly defined in this document) in their own right, and what do you consider would be the benefits and risks of such a change?*

This is dependent upon the mechanics required for this to work in practice.

Although superficially there may be benefits in allowing other health professionals without prescribing rights to generate a subsidy for pharmaceuticals, closer analysis shows there may be significant risks to community pharmacy in doing this.

Key income streams for community pharmacy involve a combination of dispensing fees and small margins through dispensing pharmaceuticals from a prescription. If subsidised pharmaceuticals (generated without a prescription) are delivered through community pharmacy, the framework must ensure additional costs in generating the subsidy are not shifted into community pharmacy. We see significant financial risk in doing this. If a pharmaceutical is subsidised without a prescription and delivered through community pharmacy, it is likely to be sold at a set price. The pharmacist may also be required to

spend more time diagnosing, ensuring safety, counselling and providing advice about medicines. Administration costs are also likely to increase. It is important that this financial cost is recognised. A possible solution may be to differentiate between a "dispensing" fee and a "consultation" fee for the pharmacist's role and responsibility; paying either fee or both, depending on the specifics of what is actually done.

The Guild understands that widening the number of health professionals able to generate a subsidy will increase patient access to health care. However, widening access to subsidies may not necessarily increase access to pharmaceuticals that are currently under-utilised due to cost. There may also be unintended consequences due to the current business models for some health professionals. For example, we believe that the capitation model for general practice encourages excessive prescribing and, therefore, generates excessive subsidies for pharmaceuticals. It would be prudent to ensure that any changes do not encourage health professionals to add to the perceived value of their advice through the generation of subsidies for pharmaceuticals.

Other avenues could be explored to deliver greater benefit to all parties. For example, reclassifying more prescription-only medicines to pharmacist-only or allowing pharmacists to generate a subsidy for high needs patients within a minor ailments service framework. This avenue would, however, require ongoing support and recognition of additional work that pharmacists would be required to do.

The future of community pharmacy is an enhanced professional role for the pharmacist. While the Guild believes wider prescribing rights for pharmacists can add significant value to the health sector, we do not see generating a subsidy for pharmaceuticals as adding significant value. The Guild would like to see a greater role for community pharmacists in patient management and systems in place to support initiatives that build their professional role.

The Guild would support other health professionals without prescribing rights to be able to generate a subsidy for pharmaceuticals provided there are significant savings for patients and the primary health care system. The cost of these savings must not be shifted into community pharmacy.

Should any changes to the current system occur, they must be a part of a nationwide framework and communicated effectively to all parties to allow a smooth transition.

*If so:*

*Should this capability be limited to certain groups of health professionals?*

In the first instance, any person without prescribing rights able to generate a subsidy for pharmaceuticals must be a qualified health professional.

There is curiosity as to who would undertake audits to monitor whether health professionals were generating subsidies within their scope of practice. There is also concern that the pharmacist dispensing the pharmaceutical would have a new responsibility to ensure prescriptions are written in accordance with the regulations. This responsibility should not fall on dispensing pharmacists.

There is support for pharmacists to be able to generate a subsidy within a minor ailments service framework that is targeted at lower socio-economic patients.

*Should there be additional requirements, such as audit and compliance or further training or qualifications, be required in excess of standard practicing rules?*

Pharmacists are already professionally required to demonstrate that they are continually enhancing and maintaining competency, including their knowledge of the subsidy system. We believe that pharmacists would not need to undertake further training to generate a subsidy for pharmaceuticals. However, the Guild supports a greater role for pharmacists to prescribe collaboratively and believes this would require further training and auditing to ensure that pharmacists prescribe within their scope of practice.

If other health professionals were to gain new subsidy generation rights then extensive training would most likely be required to ensure the administrative costs of generating the subsidy were not shifted to the distributor of the pharmaceuticals.

*Should this capability be limited to a defined formulary of products, or should it be for any product that the relevant health professional has the legal right to provide? If for a defined formulary, what do you consider should be the criteria for determining which products should be included in this formulary?*

If other health professionals without prescribing rights are able to generate a subsidy for pharmaceuticals, the Guild believes there should be a defined formulary of products that reflects the scope of practice. When developing formularies, considerations should be made towards current access restrictions, the cost of the medicine, the pack size, the duration of treatment, pharmaceutical presentation, prescriber competency, potential interactions, potential to mask underlying conditions, complexity of the condition and restrictions on the limitations of use.

We believe there should be a focus on incorporating pharmaceuticals for acute care. By focussing on pharmaceuticals for acute care, the potential for gaming and the costs to the primary care health care system could be reduced.

It would be advantageous if formularies were imbedded in practitioner and pharmacy software to reduce the burden of ensuring compliance. Formularies would need to be reviewed regularly, with additions/removal of medicines made to reflect current changes in practice. Appropriate stakeholders must be involved in establishing and updating formularies.

*Do you consider that such a change would result in decentralised provision of primary care, and if so, to what extent would this be an issue and how could this be addressed?*

Community pharmacy already plays a central role in the provision of primary health care. If other health professionals without prescribing rights are able to generate a subsidy for pharmaceuticals, it would be prudent to ensure appropriate information links exist between pharmacy and general practice to allow awareness of patient management. The Guild believes that widening the range of health professionals who are able to generate a subsidy for pharmaceuticals may undermine the value of the central repository. This may increase the number of providers seeking access to the sensitive information held in the repository.

## **Part two: Delivery of subsidised pharmaceuticals**

*Should there be greater use of alternative delivery mechanisms for subsidised community pharmaceuticals, and if so, in what circumstances should these be employed?*

There is little doubt that when viewed as individual product lines, some alternative distribution methods seem more efficient than the current methods. However, this type of analysis is flawed; the analysis must be more 'holistic' in nature than a simple line-by-line analysis.

The current model for remunerating community pharmacy relies on averaging – some lines are profitable for pharmacy, others are not. The idea behind the system is the profitable lines average out with the unprofitable and so the net position of pharmacy is viable. From the funder's perspective this means that some lines appear to be distributed super-efficiently, while some do not. On average the Guild believes the system by which subsidised products are delivered via community pharmacy is efficient. There will always be the temptation for funder's to 'cherry pick' some of the more profitable/less efficiently delivered product lines out of community pharmacy and seek other, more efficient distribution channels for these lines. This threatens the system of averages that pharmacy relies upon and may destabilise community pharmacy without generating any real gains for funders. In most cases the pharmacies that will be most adversely affected by such changes would be those in rural and other marginal areas. Destabilising these pharmacies could lead to greatly reduced access for patients. This point is best illustrated by way of a fictitious example:

“Imagine if pharmacy dispensed subsidised widgets, and dispensing widgets was a highly profitable activity. Now suppose, in the interests of efficiency, funders supported a proposal that allowed widget dispensing to be delivered via an alternative distribution mechanism. Soon, a widget-dispensing robot situated in Auckland that services the entire country is established and uses its economies of scale to undercut everyone else in the widget-dispensing business. Initially, funders are able to extract the excess profits from dispensing widgets by reducing the payment to the widget-dispensing robot. However, the loss of the highly-profitable widget dispensing from community pharmacies is enough to destabilise the sector, resulting in an injection of rural funding to maintain the current level of access to pharmacy services that New Zealanders enjoy. In this way, the savings made through moving to an alternative distribution mechanism have been given back. Undoubtedly, under this scenario the pharmacy sector would

have changed, access in marginal areas would have reduced, but the underlying efficiency of the sector may not have changed in any meaningful way”.

It is imperative that any proposed alternative distribution methods are properly evaluated in a holistic way. Returning to the above widget example, the alternative distribution mechanism is preferable if, and only if, the efficiency gains are greater than the profits lost by the existing providers. Furthermore, a share of the efficiency gains needs to be returned to the existing providers to restore the lost profits. This will ensure the continuing viability of the existing providers.

Another aspect of alternative distribution mechanisms is that they tend to operate on a reduced-service model. If the only “gains” of the alternative mechanism are due to the reduced service aspect, then the true gains are greatly diminished. Efficiency needs to be evaluated from a patient perspective, not just from a funding perspective.

In summary, alternative distribution methods should only support genuine efficiency gains across the entire sector; it should never support cherry picking of profitable lines. Furthermore, any measure of efficiency must properly evaluate the level of service being provided to the patient.

*Should all community pharmacies be able to dispense medicines equally, or should the 'hospital pharmacy' (or similar) restrictions that limit subsidised dispensings to certain community pharmacies be retained? If this approach should be retained, what should be the basis for determining which products should be restricted in this way?*

Pharmacists are often relied upon to play the central role in having the most up-to-date patient medication information. This is particularly important for patients with multiple prescribers. Provided pharmacies can demonstrate that they are able to provide services to an acceptable and safe standard (for example clozapine dispensing or graseby pump provision), all pharmacies should have the opportunity to dispense all medicines.

By allowing pharmacies to opt-in to dispense pharmaceuticals, risks of fragmented patient care are minimised and pharmacies are better equipped to provide a high quality and complete service for patients. Recognition must be made towards any additional services that community pharmacy offers.

Some pharmacies may choose to opt-out of dispensing some pharmaceuticals, for example high-cost and complex pharmaceuticals. These pharmaceuticals can carry very real risks for some pharmacies of being left with unusable broken packs. This is particularly true for low turnover rural pharmacies. A possible solution to this could be to subsidise more "Original Pack" dispensing.

*For high-cost products, what do you consider would be the preferred approach for distribution:*

High-cost products are an excellent example of the risk of 'cherry picking' out profitable lines from community pharmacy. While, at first glance, it seems inefficient for funders to support a system where Humira, for instance, costs \$89.95 to be distributed via community pharmacy, it is the averages that should be considered not individual product lines. If Humira was directly distributed for, say \$10, then the "saved" \$80 would need to be injected back into pharmacy to ensure viability is maintained.

Community pharmacy provides a high level of service to patients, a level of service that is crucial for high-cost products. Key issues in the distribution of high-cost products are safety and continuity of care. Unfortunately, direct distribution to patients excludes a vital part of the patient management process – counselling, medication advice and adherence support. Many patients value the interaction with their community pharmacist, particularly customers with young children or chronic conditions. Direct distribution may also create time delays, particularly if patients are not at home to collect their parcel and are required to collect parcels from a courier depot. Direct distribution leads to fragmented patient medication records with possible implications on safety and storage of medicines.

High-cost products are easily incorporated into existing pharmacy stock orders and would not acquire additional freight costs. Delivery by this mechanism usually occurs in a timely manner.

The main inefficiency in the delivery of high-cost medicines is the very real risk for some pharmacies of being left with unusable broken packs. The Guild has the following suggestions for improving the efficiency of the distribution of high-cost medicines:

1. Higher service specifications could be imposed on pharmacy for the delivery of high-cost medicines in return for a relatively small fee increase. By increasing the

amount spent on the distribution of these medicines, pharmacy could add much value to ensure the optimal use of high-cost pharmaceuticals. This relatively small fee increase is likely to be a value-for-money health spend.

2. Manufacturers could supply broken packs to pharmacies.
3. Manufacturers could accept returns of broken packs. This would be particularly efficient for medicines that have a high price, yet the actual cost of production is low.
4. More consideration could be made with respect to subsidising more "Original Pack" dispensing to compensate for the financial risks associated with providing the service.

Wholesalers are well-positioned in the supply chain to offer a repackaging service. This would allow pharmacies to order broken packs from their wholesaler, thus, removing the risk of individual pharmacies being left with broken packs. Wholesalers will occasionally be left with broken packs under this system, but the incidence should be much lower, given the much higher volume going through a wholesaler than an individual pharmacy. The Guild has the following suggestions with respect to this:

1. Unfortunately, under current legislation this repackaging service would require a wholesaler to obtain a costly packing licence, though the requirements to meet the obligations of a packing license are an "overkill" for this limited type of repackaging operation. Workarounds may be possible and merit further exploration.
2. Currently, it is not legal for pharmacies to trade broken packs among themselves unless they have a wholesale license. Freeing up this unnecessary burden would reduce the wastage (and associated inefficiency) of broken packs.
3. There could be a role for DHBs and/or hospital pharmacies to play in the repackaging of broken packs. A workaround that meets the legal requirements of existing legislation may be possible by channelling prescriptions and/or medicine distribution through DHB-owned structures.

High levels of service should be available to ensure optimal use of high-cost pharmaceuticals. This should be the most efficient system for funders; more should be spent on dispensing these products, not less.

*Is community pharmacy via wholesalers the optimal channel for distribution of special foods, or would other options be more appropriate?*

Other distribution methods may well be more appropriate. Many special foods are heavy and/or bulky which has necessitated a differential pricing approach. It is worth bearing in mind that the high-cost in distributing special foods is not because pharmacy is involved, but because they are big, bulky, specialised items. Any plausible system is going to involve special foods being couriered from point A to point B at some point in the chain from manufacturer to patient. Whether the foods are couriered from wholesaler to pharmacy, or from manufacturer to patient, courier charges still apply.

Given the geography of New Zealand it is plausible that the optimal special foods distribution method varies between the North and South Islands.

There are advantages to retaining community pharmacy within the special foods chain:

- The face-to-face encounter received in community pharmacy leads to better relationships between patients and pharmacists. This has flow on health benefits for this often high need group of patients.
- Avoidance of fragmented patient medication records.
- The face-to-face interaction received in community pharmacy ensures the correct foods are provided to the patient, usually with a choice of flavour.
- There are disadvantages to couriering to patients' homes:
  - Correct storage conditions are available in a pharmacy and directions are explained to a patient.
  - The patient can visit a community pharmacy to collect special foods at a time most convenient for them, as opposed to waiting for a courier to deliver to their home.
  - If the patient isn't home when the courier arrives, the special foods are either left outside, or a "call to collect" card is left instead. This raises safety issues around storage, and may necessitate the patient to pick up their special foods from a depot.

The wholesaler-to-pharmacy courier fees are generally the best rates locally. Special foods deliveries "piggyback" off the current volumes going to pharmacy and may even reduce the average courier rates achieved. It is extremely unlikely that a nationwide service could compete with these rates.

In the Guild's opinion, distributing special foods via pharmacy is a high service, low cost activity. While it may be possible to make some savings by moving to direct supply, this is more than outweighed by the reduction in service enjoyed by patients.

Special foods are not currently subject to PHARMACs rigorous price reduction methods. Perhaps larger gains can be made in the area of special foods by lowering manufacturer prices, rather than seeking a sleeker distribution chain.

The Guild is aware of some proposals that advocate direct supply of one or two special foods product lines. These proposals are merely 'cherry picking' the high value special foods and would do little to improve the efficiency of the distribution of special foods as a whole. As such, these proposals should be avoided.

*Under what circumstances should products be available for direct provision by a clinician, and for what reasons should they be available in this way?*

Pharmacists are the medicines experts. Pharmacies have the capacity to store and dispense medicines to the acceptable standard. They are appropriately equipped and have trained staff to provide quality advice to patients about their medicines. They are often the provider with the most accurate and up-to-date patient medication records.

Clinicians have their own area of expertise and do not have the capacity to dispense medicines regularly. However, current provisions (e.g. Practitioner Supply Orders) that allow clinicians to provide medicines directly to patients are important for certain situations, for example, emergency situations, acute care, or situations where access to a pharmacy is difficult. In a rural setting it is vital that this continues – this is currently recognised by the provision of greater quantities of medicines and a more expansive list of medicines for remote practitioners. Pharmacies assist this process by pre-packaging medications with generic instructions. It is important that this step is recognised, particularly with respect to dispensing fees and the cost of packaging. Perhaps consideration could be made towards tendering for common pre-packs, such as paracetamol liquid or ibuprofen liquid.

It must be recognised that current provisions should be for certain situations only. If monitored and used appropriately (and not abused) these mechanisms should not require a co-payment by the patient. However, we believe that certain pharmaceuticals

not required for emergency purposes, such as testosterone implants, should attract a patient co-payment.

*Should prescribers (or PHOs) be able to claim a subsidy directly for usage of certain products, rather than obtaining them from a pharmacy?*

This is dependent upon how such a process would work in practice.

If prescribers (or PHOs) could generate a subsidy directly for certain products and the products were still physically obtained via community pharmacy, appropriate frameworks are required to ensure that community pharmacy is compensated for any additional work. Such direct supply should not be a mechanism for avoiding government charges or other costs.

*Should medicines with restricted criteria, such as those under Special Authority, be available directly to prescribers?*

The Guild understands that current Special Authority criteria are in place to impose restrictions on the access/subsidy of certain pharmaceuticals. We have doubts about the ability or willingness of many prescribers to manage their existing role in the Special Authority system.

If prescribers were to be able to directly access these pharmaceuticals, it is vital that there are appropriate quality control measures in place to ensure the Special Authority system is not undermined. Prescribers must be able to demonstrate that they are able to manage this process accurately without gaming to avoid Government charges or generate business at the taxpayers' expense.

*Should pharmaceuticals continue to be available through wholesale supply order, or should these instead be channelled through community pharmacy, either on prescription or practitioner's supply order?*

The Guild believes that pharmaceuticals should be channelled through community pharmacy. Pharmacists provide a fundamental step in the patient management process of educating patients about their medicines and medical devices. Community

pharmacies are easily accessible and patients often prefer to see their community pharmacist for devices such as spacers and peak flow meters. Community pharmacy should have the opportunity to provide such devices to patients with subsidy.

*Are there delivery mechanisms other than those already in place that should be considered; if so, for what types of products would these be suitable, and why?*

The system of distribution through community pharmacy (via wholesaler) generally provides a comprehensive delivery service. Community pharmacy plays an essential role in the reconciliation, adherence support and treatment coordination for patients – a role that is often under acknowledged.

Fragmented patient care must be avoided. Patients must be able to navigate a simple system for accessing pharmaceuticals – a system that community pharmacy has a central role in managing.

*Are there any other significant issues associated with delivery of subsidised community pharmaceuticals that you would like to comment on?*

### **Socio-economic targeting of subsidies**

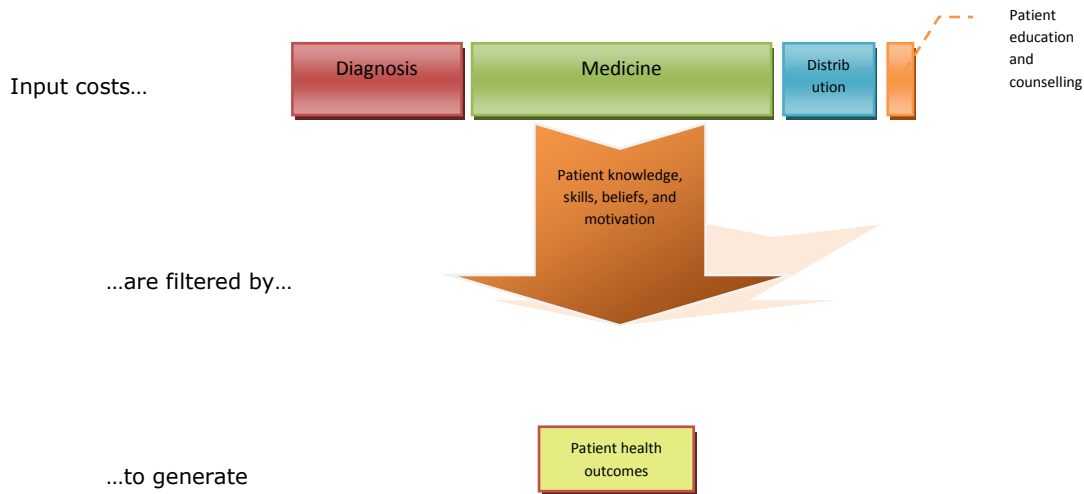
It is widely acknowledged that the combined effects of an ageing population, an ageing health workforce, and increasing health expectations, make the current health system in New Zealand unsustainable. The Guild believes PHARMAC have a key role to play, in conjunction with the Ministry of Health and DHBs, in ensuring that subsidies are taken up by the patients that need them the most. Subsidising medicines that patients are willing and able to buy is a luxury our country can no longer afford.

### **Optimal use of medicines**

As PHARMAC continues to reduce the cost of pharmaceuticals to New Zealanders, it is inevitable that less and less efficiency gains are able to be made through further price reductions. The Guild believes that the next area for significant efficiency gains is not by further price reductions, but by helping patients to take their medicines better. We believe PHARMAC should increase their focus on the optimal use of medicines. Community pharmacy is a valuable partner in the process of patient education and counselling.

## Summary

### The stylised process of purchasing health outcomes via medication treatments



There are many costs associated with providing medication treatments to patients. The cost of the medication itself is only one component, the other costs being those associated with diagnosing the disease and prescribing the treatment, the costs of distributing the treatment and the costs associated with ensuring the patient has the necessary information to use the medication. These inputs are then filtered by patients' knowledge, skills, understanding, beliefs, ability to accept the treatment (including meeting any private costs) and motivation. Unfortunately, medicine treatments are not all used optimally and the resulting health outcomes following treatment are less than might otherwise be achieved.

We have made some suggestions on improving the efficiency of the red "diagnosis" box. Significant savings in both public and private time and resources can be made by implementing collaborative prescribing and minor ailments programmes via community pharmacy. These gains are largely outside the scope of this discussion document. Unfortunately, the Guild does not believe large gains can be made by increasing subsidy-generation rights.

PHARMAC already do a good job of driving efficiency gains in the green "Medicine" box. We have assumed that this is outside the scope of the discussion.

The discussion document focuses on the blue distribution box in the illustration. While some gains in efficiency can be made here, and will continue to be made regardless of

the outcome of this discussion, the physical process of safely moving medicine from a port into the homes of New Zealanders has costs which must be met. We do not believe there are large gains to be made in this area.

We believe large gains can be made in the orange "patient education and counselling" box. By increasing funding in this area, gains can be made by generating better health outcomes from existing inputs. Community pharmacists, as medicine experts, strongly desire to work with PHARMAC and the rest of government on improving this vital area of the medication treatment process.