PHARMACY GUILD OF NEW ZEALAND

31 August 2026

PHARMAC
PO Box 10254
The Terrace
Wellington 6143

Sent via email to: *consult@pharmac.govt.nz*

Dear Sir/Madam,

Re: Submission on proposed changes to the Practitioner Supply Order list and rules

The Pharmacy Guild of New Zealand (Inc.) (the Guild) is a national membership organisation and the largest representative of community pharmacy owners in New Zealand. We provide leadership on all issues affecting the sector and advocate for the business and professional interests of community pharmacy.

We support modernising the Practitioner Supply Orders (PSO) framework where there is a demonstrated need. This includes clarifying that PSOs are intended for episodic and point-of-care use, rather than for the ongoing supply of long-term medicines.

However, we do not support the proposed permanent expansion of the PSO list in its current form. Pharmac has not yet provided sufficient evidence to demonstrate that the proposed expansion addresses a defined problem with patient access or that expanding PSO is the most appropriate solution.

Our concern is not principally with modernising the PSO framework, appropriate PSO use or the individual medicines proposed, rather, it is the broader policy direction. Expanding the PSO mechanism before the need has been demonstrated and the necessary safeguards established risks shifting PSO from an exceptional supply mechanism towards a parallel route for routine "see and treat" primary care. Pharmac has not shown that such a shift would improve patient access and outcomes without fragmenting care, duplicating existing services or weakening established medicine-safety safeguards.

We raised many of these concerns before the pilot and in our 2025 submissions on Mirena and Jaydess and budesonide with eformoterol inhalers. The current proposal reinforces those earlier concerns and, in our view, does not yet provide sufficient evidence or safeguards to justify moving from limited and controlled PSO use to broader permanent availability.

Key findings from our review

1. **The proposed permanent expansion is materially broader than the pilot and is not supported by sufficient published evidence**

In its response to the Guild dated 20 December 2024, Pharmac described a small pilot involving approximately 1% of practices. Pharmac advised that it was intended to support particular models of care, including acute services involving paramedics, extended-hours services operating beyond community pharmacy business hours and outreach services for underserved populations over wide geographical areas. Pharmac also advised that medicines would generally

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be administered within a single episode of care and that the pilot was not intended to inform the replacement of established medicine-dispensing models.

The current proposal is materially broader. It would permanently expand the national PSO list and introduce "treatment of single-episode presentations" as a new basis for PSO use. Pharmac has not demonstrated that findings from the small number of selected pilot practices are transferable to general practice more widely. It is also unclear whether the proposed additions would be limited to general practice or would be available to all authorised prescribers able to issue a PSO.

Pharmac states that the pilot produced feedback about timely treatment, improved workflow, and reduced pressure on prescribers, and that PSO medicines were commonly used to manage skin conditions, asthma, headlice, allergies, pain, and infections. While those observations are useful, they do not, by themselves, establish that patients were unable to obtain those medicines through existing pathways, that access to community pharmacy was the barrier, or that wider PSO access improved patient outcomes.

The consultation does not publish the number or characteristics of participating practices, utilisation rates by medicine, whether medicines were administered at the practice or supplied for use at home, time-to-treatment comparisons, patient outcome measures, safety events, medicine wastage, stockholding, equity effects, displacement of community pharmacy dispensing, or the forecast expenditure. Before making a permanent national change, Pharmac should publish the full pilot evaluation and explain both what would have happened to these patients without expanded PSO access and why the findings justify expansion beyond the specific practice models included in the pilot.

2. The proposal does not address the underlying barriers to accessing primary care

New Zealand data show that timely access to general practice is itself constrained. The 2024/25 New Zealand Health Survey reported that 25.5% of adults identified the time taken to obtain an appointment as a barrier to visiting a GP in the previous 12 months. The 2025 adult primary care patient experience survey found that 61% of respondents were able to obtain an appointment within a week, down from 90% in 2020, while 12% waited more than two weeks.

Expanding medicines held within general practice may improve convenience and avoid an additional journey for patients who have already obtained an appointment, but it does not necessarily improve access for those unable to obtain one.

We recognise that PSO access may provide genuine benefits in defined circumstances, including extended-hours, outreach and urgent-care services where timely community pharmacy dispensing is not reasonably practicable. Those specific needs do not, however, establish a case for broad national expansion, particularly where the implications for patient-level traceability and existing medicine-safety safeguards have not yet been adequately addressed.

Community pharmacy provides an established and widely accessible medicine supply network, supported by medicine expertise, patient-level dispensing records, and an independent clinical check. It should therefore remain the default supply pathway for medicines except where Pharmac can demonstrate a defined point-of-care need for which an individual prescription and timely community pharmacy dispensing are not reasonably practicable.

3. Digital patient-level traceability should be a precondition, not a future aspiration

We support digital patient-level traceability for medicines administered or supplied from PSO stock. However, this functionality should be a precondition of wider PSO access, rather than a future aspiration implemented after the supply pathway has expanded.

A PSO records the supply of stock to a practice, but it does not identify the individual to whom the medicine is ultimately administered or supplied. Unless a separate patient-level record is created at the time of administration or supply and made visible to other relevant healthcare providers, expanded PSO use risks creating gaps in medicine histories, clinical decision-support systems, adverse-event investigations and product-recall processes.

In its decision to fund Mirena and Jaydess on PSO, Pharmac acknowledged that products supplied through PSO would not appear in a patient's community pharmacy dispensing history. Following further clinical advice, Pharmac concluded that the change would not increase clinical risk, noting that IUDs supplied through some hospital services are not captured in dispensing histories and that a dispensing record does not confirm whether or when an IUD was inserted. In practice, insertion should instead generate an appropriate clinical procedure record.

We raised the same patient-level traceability concern in our May 2025 submission on the proposal to add budesonide with eformoterol inhalers to the PSO list. In its July 2025 decision, Pharmac acknowledged concerns about the absence of individual patient records but noted that only around 5% of inhaler use was expected to occur through PSO, largely for teaching purposes, and that the PSO form allowed only one inhaler to be supplied at a time. These were narrow use cases with specific controls.

That reasoning cannot automatically be extended to the current proposal, which includes antibiotics, analgesics, antivirals, antihistamines and topical treatments that may be supplied to patients for use at home. For these medicines, the record of supply may be clinically important to other healthcare providers and may not otherwise be visible outside the supplying practice.

Pharmac and HNZ should specify the minimum patient-level information that must be recorded whenever a medicine is administered or supplied from PSO stock. This should include the medicine, strength, quantity, date, indication where appropriate, responsible clinician and practice. Pharmac and HNZ should also establish minimum data standards and explain how the required information will be recorded consistently across different prescribing practice management systems and made accessible to other relevant healthcare providers through interoperable or nationally accessible shared-care patient records.

4. The proposed rule does not provide an adequate boundary against routine in-practice dispensing

The consultation's explanatory material states that PSOs are intended for episodic use rather than the ongoing supply of long-term medicines. While this clarification is directionally correct, the proposed categories of "single-episode presentations" and "routine administration within a clinical setting" can overlap. Unlike the existing provision applying to certain groups of patients, the proposed "treatment of single-episode presentations" category would provide an independent basis for PSO subsidy without requiring either that obtaining an individual prescription or that timely community pharmacy dispensing be impracticable.

Almost any acute or short-term condition could be characterised as a single-episode presentation. Without clearer boundaries, practices could progressively use PSO stock to provide

complete treatment courses that could otherwise be readily prescribed and dispensed through a community pharmacy. Repeated treatment of different patients could therefore become an established in-practice dispensing service while each individual supply continued to be described as episodic.

The rule should distinguish direct administration within a clinical setting from medicines supplied to patients for subsequent use. It should expressly state that PSO may be used for an immediate or episodic clinical need only where obtaining an individual prescription and timely community pharmacy dispensing is not reasonably practicable. It should prohibit use primarily for convenience, commercial advantage, avoidance of charges that would otherwise apply, or to establish a general in-practice dispensing service.

Compliance with any restriction to the "treatment of single-episode presentations" cannot be reliably monitored or independently verified without consistent, auditable patient-level records of each medicine administered or supplied. This reinforces the need for the patient-level traceability requirements outlined in section 3.

Where different medicines require different circumstances or safeguards, Pharmac should also consider medicine-specific conditions in Section B of the Pharmaceutical Schedule rather than relying solely on a broad General Rule.

5. **The proposal does not demonstrate alignment with the Extended Pharmacy Service or adequately assess financial and equity effects**

The proposed PSO list includes several medicines and presentations that have only recently been made available through the Extended Pharmacy Service (EPS), including ibuprofen oral liquid, compound electrolyte solution with glucose, chloramphenicol eye drops and ointment, dimethicone lotion and permethrin lotion. HNZ introduced the EPS to support community pharmacy as an accessible first point of care, with defined patient eligibility, clinical requirements, service reporting, monitoring and evaluation.

The consultation states that the proposed PSO expansion is intended to complement community pharmacy services but does not explain how these parallel pathways would work together. It does not assess whether wider PSO access would duplicate or displace the EPS, create inconsistent eligibility or clinical requirements, or undermine the opportunity to evaluate the newly established pharmacy services.

The different supply pathways may also alter which provider receives the dispensing and service remuneration and may allow some patients to obtain medicines without charges that apply through other pathways. We do not oppose removing genuine financial barriers to care for patients, however, policy should address those barriers transparently and equitably rather than create differential access through a medicine-supply mechanism. Any analysis should consider the total cost to the patient, including consultation and medicine charges, rather than considering prescription co-payments in isolation.

Pharmac and HNZ should jointly assess and quantify the expected annual pharmaceutical and service costs of this proposal, including wastage, stockholding, administration and monitoring costs, and any effect on community pharmacy dispensing and service remuneration. This should be compared with the costs and benefits of the existing EPS and with alternative investment in community-based access, including further expansion of the EPS. Pharmac should also explain

how the proposal aligns with HNZ's primary care commissioning and the monitoring and evaluation already established for the EPS.

6. Each proposed medicine requires a defined use case and proportionate safeguards

We acknowledge that the proposed medicine list is generally confined to familiar medicines and that a number of items have plausible point-of-care uses, particularly where a medicine is administered directly within a clinical setting or immediate treatment is required and timely community pharmacy dispensing is not reasonably practicable. However, inclusion on the PSO list should be based on demonstrated need and a defined use case, rather than simply because a medicine was used during the pilot.

For each medicine, Pharmac should specify the intended clinical presentation and patient group, whether the medicine is to be administered at the practice or supplied for use at home, why an individual prescription is not reasonably practicable, the expected volume of use, the rationale for the proposed quantity, and the clinical, recording and monitoring safeguards required. Pharmac should also assess whether the same access objective is already being met or could be met more safely or efficiently through community pharmacy.

Caution is required for medicines that constitute complete treatment courses or carry greater risks relating to adverse effects, interactions, antimicrobial stewardship, diversion, or monitoring requirements, including cefalexin, codeine, diclofenac, valaciclovir and antimicrobial-containing ear preparations. Although the proposal specifies maximum quantities per PSO, it does not specify cumulative ordering or stockholding limits, or how frequently PSOs may be submitted. Pharmac should therefore explain how cumulative ordering, stockholding, expiry, reconciliation and unusual ordering patterns would be monitored. For medicines that are already readily accessible through community pharmacy, including antihistamines, emollients and several topical treatments, Pharmac should demonstrate what access barrier PSO availability would address and what additional patient or system benefit it would provide.

7. Implementation should not proceed before the necessary safeguards are in place

The consultation opened in early August and closes on 31 August, with an expected implementation date of 1 November 2026. This provides a relatively short period in which to consider consultation feedback, make any substantive changes, complete the necessary operational planning and communicate the final requirements to affected providers.

We recognise that proposed implementation dates are not unusual in consultations. However, the proposed date should remain provisional and should not constrain Pharmac's consideration of the issues raised. The consultation process must allow feedback to materially influence the decision, the medicines included, the Schedule wording, the required safeguards and implementation timeframe.

If the pilot evaluation has not been published, or if material issues relating to digital patient-level traceability, clinical governance, alignment with the EPS, fiscal impact or operational readiness remain unresolved, implementation should be deferred.

8. Independent pharmacist oversight is an important medicine-safety safeguard

We recognise that Pharmac must consider access, health outcomes and fiscal sustainability when making funding decisions. However, the proposal has not yet demonstrated how the medicine-safety functions currently provided through the community pharmacy dispensing pathway will be preserved or replaced when that pathway is bypassed.

Community pharmacy dispensing provides an independent clinical checkpoint between prescribing and medicine supply. Pharmacists routinely identify and resolve issues involving medicine selection, dose, quantity, interactions, contraindications, monitoring and the intended treatment regimen before a medicine is supplied. The independent pharmacist check is not theoretical. The 2025 Te Manawa Taki SCRIPT Audit provides direct evidence of this interception role. Across 68 participating pharmacies, 1,145 reports containing 1,257 prescription issues were recorded in one week. Of these reports, 26% were assessed as having high or significant potential for harm had the pharmacist not intervened, and pharmacists spent 347 hours resolving prescription-related problems.

The audit also identified prescribing software functionality as an important contributor to these issues. Although the audit did not examine PSO supply, it demonstrates the nature and scale of issues identified through independent pharmacist review. Medicine-related issues could still arise when medicines are supplied directly from practice stock, but they would not necessarily be subject to the same independent pharmacist check.

Responses to Pharmac's specific consultation questions

3. Do you agree with the proposed medicines to be added to the PSO list?
Partly.

We acknowledge that the proposed list is generally limited to familiar medicines and that several have legitimate urgent or point-of-care uses. However, we cannot support the proposed list as a whole. We only support medicines for which Pharmac can demonstrate a defined access problem, a clear clinical use case and proportionate safeguards. Our reasons are set out in section 6 above.

4. Are there any proposed medicines you do not support being added to the PSO list?
Yes.

We do not support the unrestricted addition of codeine, diclofenac, cefalexin, valaciclovir or antimicrobial-containing ear preparations under the proposed general framework without medicine-specific cases and safeguards. We would consider their inclusion only where Pharmac establishes narrowly defined clinical use cases and proportionate controls relating to safety, interactions, diversion, stewardship, traceability, and monitoring. Further detail is provided in section 6 above.

5. Are there any medicines you believe should be included that are not currently proposed?
No.

We do not propose any additional medicines until Pharmac has published the pilot evaluation, established transparent criteria for PSO inclusion, implemented patient-level digital traceability, and demonstrated that the proposed expansion addresses a defined access gap. Once those foundations are in place, future additions can be considered.

7. Do you support the proposed amendments to the Schedule General Rules clarifying permitted PSO use in general practice?
No.

We support explicit clarification that PSO is intended for episodic use and not for the ongoing supply of long-term medicines. However, we do not support the proposed wording. Our concerns and recommended approach are set out in section 4 above.

8. Do you think the proposed rule wording provides sufficient clarity?
No.

The proposed categories of "treatment of single-episode presentations" and "routine administration within a clinical setting" do not provide sufficiently clear boundaries. In particular, a practice could interpret the repeated treatment of common presentations as episodic even where the practical effect is a routine dispensing service. See section 4 above for further comments.

9. If no or unsure, please explain
The rule should preserve the original exceptional purpose of PSO while accommodating genuine modern point-of-care needs. We recommend wording along the following lines:

"*PSO supply is intended for an immediate or episodic clinical need where administration or supply at the point of care is clinically appropriate and it is not reasonably practicable to issue an individual prescription and obtain timely dispensing through a community pharmacy. PSO must not be used for ongoing supply for long-term treatment, as a routine alternative to individual prescribing and dispensing, primarily to avoid charges that would otherwise apply, or to establish a general in-practice dispensing service*."

Separate requirements should ensure that every patient-level supply or administration is recorded in a manner accessible to other relevant healthcare providers. Further detail is provided in sections 3 and 4 above.

10. Are there any unintended consequences of the proposed rule changes that Pharmac should consider?
Yes.

Potential unintended consequences include routine in-practice dispensing beyond the intended scope, the absence of an independent pharmacist safety check for medicines supplied directly from practice stock, gaps in patient medicine histories, reduced visibility for interaction and monitoring tools, duplication or inappropriate supply where patients use multiple providers, antimicrobial stewardship risks, stockpiling and expiry wastage, diversion risk for medicines such as codeine, inequity arising from different patient charges depending on supply route, duplication or displacement of the EPS, and erosion of the viability and reach of the existing community pharmacy network.

The changes may also create additional obligations for general practice relating to stock management, storage and cold chain management where applicable, product recalls, reconciliation, audit, staff training and clinical governance.

11. Do you foresee any operational challenges with implementing the proposed PSO changes?
Yes.

The principal operational challenge is digital integration. Pharmac and HNZ should explain how electronic PSOs will be generated consistently across diverse prescriber patient management

systems, transmitted through the New Zealand ePrescription Service (NZePS), reconciled by community pharmacies, and linked to the individual patient when PSO stock is ultimately supplied or administered, and made visible to other relevant healthcare providers. A PSO order used to replenish practice stock is not, by itself, a patient medicine record. A dependable patient-level recording and information-sharing process is therefore required.

Other challenges include stock control, expiry management, storage, recalls, auditing, reconciliation of unused stock, training of non-prescriber team members, clinical governance, and clarity about who is accountable for counselling and follow-up. Further detail is provided in sections 3, 5 and 6 above.

12. Are there any other comments or considerations you would like Pharmac to take into account before making a decision?

We ask Pharmac to publish the full pilot evaluation and expected annual fiscal impact before making a final decision, and to provide a joint assessment with HNZ of how the proposal aligns with the EPS and wider primary care commissioning. The proposed implementation date should remain provisional until the material issues identified in this submission have been resolved. Further details are provided in sections 1, 5, and 7 above.

Thank you for the opportunity to provide feedback on this consultation. If you have any questions about our feedback, please contact our Senior Advisory Pharmacists, Martin Lowis (martin@pgnz.org.nz, 04 802 8218) or Cathy Martin (cathy@pgnz.org.nz, 04 802 8214).

Yours sincerely,

Nicole Rickman
General Manager – Membership and Professional Services

References:

1. **Pharmacy Guild of New Zealand.** *Submission on the Pharmac Practitioner Supply Order (PSO) Pilot Proposal and Request for Expressions of Interest*, 12 December 2024.
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4. **Pharmac.** *Decision to make it easier to access Mirena and Jaydess IUDs (contraceptives) - Pharmac | Te Pātaka Whaioranga | NZ Government*. 9 July 2025.
5. **Pharmacy Guild of New Zealand.** *Submission on the Pharmac proposal to support access to budesonide with eformoterol inhalers.* 9 May 2025.
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7. **Pharmac.** *Changes to the Practitioner Supply Order (PSO) list and rules - Pharmac Consultations - Citizen Space*. Consultation closing 31 August 2026.
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9. **Ministry of Health.** *Annual Update of Key Results 2024/25: New Zealand Health Survey | Ministry of Health NZ*. 19 November 2025.
10. **Bay of Plenty Community Pharmacy Group and Midland Community Pharmacy Group**. *Microsoft Word - SCRIPT MASTER REPORT FINAL*. Release version 3.1, 19 November 2025.
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12. **Pharmac.** *Decision to extend Pharmacy Services - Pharmac | Te Pātaka Whaioranga | NZ Government*. 20 May 2026.
13. **Health Quality & Safety Commission | Te Tāhū Hauora.** *Amended questions on how patients access care | Health Quality & Safety Commission Te Tāhū Hauora*. 5 December 2025.