PHARMACY GUILD OF NEW ZEALAND

24 April 2025

PHARMAC
PO Box 10254
The Terrace
Wellington 6143

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

Dear Sir/Madam,

Re: Proposal to make it easier to access Mirena and Jaydess IUDs (contraceptives)

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.

This submission focuses on Guild members' concerns around general economic, funding, access and supply issues. Guild submissions should not be taken as any endorsement of, or any attempt to comment on, issues of medicine safety, efficacy, or appropriateness for individual patients.

The Guild strongly opposes the proposal to allow Mirena and Jaydess IUDs to be funded on a Practitioners Supply Order (PSO) and to increase the number of Jadelle implants which can be ordered on a PSO. While the proposal is positioned as an effort to improve equitable access to long-acting contraceptives, we have significant concerns about the justification for the proposal, the consultation process, its potential impact on patient safety and the integrity of the medicines supply chain.

Key concerns and rationale

1. Loss of professional touchpoints and potential impact on patient outcomes

Each dispensing interaction in a community pharmacy represents a vital touchpoint where pharmacists conduct clinical reviews, provide patient counselling, perform safety checks, and support adherence. Pharmacists play an indispensable role in the patient care continuum, providing tailored guidance to ensure that patients understand the proper use of their contraceptives, recognise potential side effects, and appreciate the importance of regular follow-up care. The proposal risks undermining this vital role. The removal of these structured, pharmacist-led interactions compromises the quality of patient care by reducing opportunities for timely, expert advice and oversight at a crucial stage of the treatment journey.

Pharmacists play a critical role in healthcare as they are often the only health professional with a comprehensive, or at least expanded, view of a patient's complete medicine profile, especially in comparison to fragmented prescriber networks. General practitioners and other prescribers may not have visibility of all the medicines a patient is using, including IUDs, which should not be considered in isolation. This is especially true when patients are receiving care from multiple providers or are using other contraceptives, over-the-counter medicines, herbal products, or dietary supplements. Without pharmacist oversight, harmful drug interactions can be missed,

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significantly increasing the risk of serious adverse effects, deteriorating health, long-term harm, or even hospitalisation.

Without direct patient engagement, pharmacists lose the opportunity to identify issues with the incorrect use of these products, monitor for side effects, educate patients on managing potential risks, support adherence to treatment regimens and detect early signs of complications, which are essential for achieving optimal therapeutic outcomes. Removing this face-to-face clinical oversight significantly weakens the safeguards that ensure the safe and effective use of long-acting contraceptives, putting patients at greater risk of adverse outcomes and diminishing the overall quality of care patients receive.

2. Lack of evidence for access barriers

The proposal assumes that collecting IUDs from a community pharmacy presents a significant barrier to access. However, analysis of national dispensing data paints a different picture. In 2023, the level of uptake, when adjusted for population size, suggests that IUD use in New Zealand is likely approaching, or even exceeding, the international average of 14% of contraceptive users, based on available global data.

Data from the HNZ Pharmaceutical Data Web Tool shows that Mirena usage in New Zealand is notably higher than the United States, where it accounted for 10.4% of contraceptive use in 2023, and comparable to global usage rate for IUDs of around 14%. These figures strongly suggest that access to Mirena is already high, and any access barriers are likely not related to the pharmacy supply pathway. When other IUDs are included alongside Mirena, the percentage of IUD use in New Zealand appears to exceed global trends, further reinforcing the view that the current pharmacy-based distribution model is effective and not a limiting factor to access to contraceptive care.

While some sexual health clinicians have advised Pharmac that a single appointment may now be sufficient for some patients seeking an IUD, this practice is not applied consistently across the country and its feasibility depends on several factors, including whether the patient has previously used an IUD and whether timely access to insertion appointments is available. Many other IUD providers prefer a model where the IUD is prescribed first and dispensed, and the patient returns with it for insertion. This approach ensures a controlled, accountable, and patient-specific process, unlike the PSO supply model, which promotes a "stock and administer" approach that not all practices are equipped, funded, or resourced to support.

Since Mirena and Jaydess became funded, many general practices and clinics have successfully collaborated with their local community pharmacies to ensure timely and reliable access to prescribed IUDs, and feedback from pharmacists indicates that this model has not posed access issues. Moreover, alternative supply models that can improve access without compromising safety or oversight deserve further consideration in future service design, such as verified pharmacy-to-clinic delivery or digitally coordinated supply with patient notification and pharmacist-led counselling. These models will build on existing community pharmacy infrastructure and can be readily adapted to meet the needs of clinics and other prescribers.

The true limiting barriers to IUD access lie in the insufficient clinical capacity to perform insertions and the additional out-of-pocket costs faced by the public for these procedures, not in the process of obtaining them from community pharmacies. Unfortunately, the proposal overlooks these critical access issues and instead shifts focus away from an already well-functioning pharmacy supply chain. By prioritising solutions that address clinical capacity,

expand access to trained healthcare professionals who can insert IUDs, along with making the cost of insertion procedures more affordable, the proposal could more effectively achieve its goals of improving access and better health outcomes, without undermining the essential role community pharmacies play in delivering equitable, safe, and patient-centred contraceptive care.

3. Reduced patient safety and traceability

Supplying prescription medicines directly from prescribers to the public via the PSO mechanism, without integration into a centralised record system, does not link the medicines with an individual patient, significantly reducing the visibility to track who received the medicine, when it was provided or administered, and which healthcare provider issued it, whether through paper and digital records, such as Conporto, TestSafe, HealthOne. This lack of traceability reduces prescriber accountability, diminishes medico-legal protection, and introduces gaps in a patient's medicine history. As a result, healthcare providers may not have access to accurate and up-to-date dispensing records, making effective pharmacovigilance more challenging, particularly for long acting or high-risk products like IUDs, where clinical oversight is essential.

Pharmacovigilance relies on maintaining accurate, patient-specific records to monitor adverse reactions, evaluate treatment effectiveness, and manage any complications that may arise after treatment. The absence of robust traceability not only weakens this vital process but undermines healthcare providers' ability to promptly identify and address potential concerns, raising the risk of missed drug interactions, contraindications, or duplication. In situations involving monitoring, product recalls or adverse events, clear and traceable records are essential for ensuring a swift and effective response, safeguarding patient safety and minimising harm. By bypassing these crucial systems, the proposal creates significant gaps in accountability, potentially compromising continuity of care and putting patients at unnecessary risk. As noted in the HQSC's contraceptive use methodology report (2020), widespread PSO use can obscure patient-level data and compromise equity monitoring across regions.

4. Erosion of community pharmacy remuneration

Supplying IUDs through a PSO bypasses the established community pharmacy model, excluding pharmacists from key stages of care, such as the clinical review, dispensing and patient counselling process, which has long been an integral component of the healthcare system. This shift will have a financial impact, given the ongoing economic challenges faced by the sector, including rising operational costs and inadequate reimbursement for essential services.

Approximately 27,000 Mirena units are dispensed through community pharmacies each year, according to the Health New Zealand Pharmaceutical Data Web Tool, reflecting both the high demand for this product and the integral role community pharmacies play in the supply of contraceptive care. By shifting the supply of these products away from community pharmacies, and removing the dispensing fees paid to community pharmacies for these products, the proposal will add to the ongoing list of changes undermining the financial stability of the sector at a time when community pharmacies are already facing mounting fiscal pressures and further erode the sector's capacity to maintain essential frontline services which are a vital component of the primary healthcare network. This is particularly important given Pharmac appears to be making more medicines available via PSO, a trend which will continue to impact community pharmacy's sustainability.

5. Insufficient sector engagement

Despite assertions of broad sector consultation, the proposal appears to be driven by the preferences of a limited group of prescribers from Sexual Wellbeing Aotearoa, rather than being shaped by a comprehensive, inclusive consultation process involving all relevant stakeholders, including community pharmacy and general practice. Given that general practice delivers most contraceptive prescribing and IUD insertions across New Zealand and that there are only 29 Sexual Wellbeing Aotearoa clinics – some of which operate part-time and in limited locations – it is reasonable to assume these clinics do not account to for the majority of annual IUD usage. Any proposal to change the national distribution model should be grounded in robust data that reflects the reality of prescribing patterns and service provision across the country.

Pharmacists, as highly trained and regulated healthcare professionals, play a vital role in ensuring access to medicines, patient safety, and health education. The exclusion of pharmacists from the early stages of this process undermines the proposal and reveals a troubling gap in collaboration across the sector, which not only weakens the consultation process but also fuels growing disengagement and dissatisfaction. By failing to engage the pharmacy profession meaningfully, the proposal misses out on the valuable insights and expertise that pharmacists could contribute, particularly regarding the practical aspects of medicine supply and patient safety. This lack of early involvement can result in proposals that are disconnected from the realities of frontline healthcare delivery, potentially leading to solutions that do not adequately address the actual challenges and true needs of patients and healthcare providers.

6. Risk of product wastage and fragmentation of the medicines supply system

Community pharmacies are highly regulated under strict legislative and professional standards and are equipped with well-established, robust inventory control systems, including temperature monitoring, expiry tracking, and secure storage conditions, to ensure safe handling, stability, and management of sensitive medicines, such as Mirena, Jaydess, and Jadelle. Shifting the supply of these products to prescriber clinics, many of which lack equivalent infrastructure and are not routinely resourced or funded to maintain these standards, introduces greater risk of improper storage, premature expiry and product wastage, leading to inefficiencies and unnecessary financial strain on the healthcare system.

Under the proposed changes, the PSO mechanism will allow prescribers to order up to 25 Mirena units at a time, with no prescription-level or detailed oversight, increasing the risk of unnecessary stockpiling. Even if just 5% of PSO-ordered stock is wasted, this could result in the loss of approximately 1,350 Mirena units, equating to $363,825 in annual product wastage. Such outcomes would not only strain the system financially but also undermine efforts to deliver cost-effective and accountable healthcare.

The availability of Mirena and Jaydess through the PSO supply mechanism was first raised in 2019 but was not supported by Pharmac at the time, largely due to the common two-appointment model, which remains necessary and preferred in many clinical settings, and the need for robust data collection. This proposal now appears internally inconsistent. If transparency, traceability, and oversight were deemed essential then, it is unclear why bypassing the community pharmacy dispensing model – one that provides expiry tracking, patient-level data, and national visibility – is now considered acceptable in favour of a PSO supply model that lacks these safeguards. Community pharmacy is currently the primary point at which individual prescription records are reliably captured. Without a mandated and comprehensive PSO reconciliation framework, there is a real risk of diminishing independent oversight of contraceptive distribution, not just for Pharmac, but for wider health sector stakeholders and monitoring bodies.

7. Limitations of co-payment-centric PSO models

It appears that Pharmac is increasingly favouring the expansion of PSO models, as demonstrated in recent initiatives such as the rural PSO supply pilot in suburban medical centres. While these efforts are often positioned as mechanisms to improve access, they are also framed as strategies to reduce or eliminate prescription co-payment barriers for patients. However, focusing narrowly on co-payments, which are set by the government, as the primary barrier fails to address the broader, systemic challenges that patients face when accessing care, including clinical workforce shortages, long wait times for procedures, limited appointment availability, and geographic disparities in service delivery. In many cases, the primary bottleneck for accessing care is not the cost of a prescription, but the lack of clinical capacity to initiate or deliver treatments, particularly for procedures like IUD insertions that require skilled procedural care, or the costs associated with the insertion procedure itself.

By promoting PSO models under the assumption that bypassing community pharmacy will alleviate access issues, the proposal fails to address these deeper, structural constraints. It also diverts attention away from more sustainable, system-wide solutions, such as improving public funding for consultations and insertion procedures, enhancing regional health service coordination, and investing in workforce development to train and retain skilled clinical staff. Without addressing these broader interventions, the expansion of PSO supply mechanisms may amount to a short-term fix that fragments care delivery, undermines the vital role of community pharmacies in medicines stewardship, safety and continuity of care, and does little to meaningfully improve equitable access in the long term.

8. Legal context and PSO purpose

The Pharmac Pharmaceutical Schedule Rule 1.3.2(e) stipulates that medicines will "*only be subsidised [on PSO] to ensure they are available for emergency use, teaching and demonstration purposes, and for provision to certain patient groups where an individual Prescription is not practicable*." This language clearly signals that PSOs are intended as a supply mechanism for specific, limited circumstances, and they were never designed as a workaround to initiate standard treatment courses that could otherwise be provided by a standard prescription.

It also arguably conflicts with the intent of Regulation 42 of the Medicines Regulations 1984, which positions PSOs as a mechanism for practitioners to access stock for immediate clinical needs, rather than as a convenience to bypass prescriptions for individual patients. The proposal as it stands would significantly stretch the definition and scope of PSOs beyond their legal and intended purpose and Pharmac should uphold the established legal framework and avoid using PSOs to expand routine access to medicines. Any such significant change in how medicines are supplied should be subject to formal regulatory review rather than implemented solely through a funding decision.

Effective healthcare delivery depends on strong collaboration and communication between all healthcare providers, including general practitioners, prescribers, and pharmacists, to ensure true patient-centred care. While we fully support efforts to improve equitable access for patients, this should not come at the expense of dismantling a safe, efficient, and accountable distribution model that is already functioning well. Such an approach would ultimately undermine the very objective it seeks to achieve, which is better outcomes for patients. We strongly believe that community pharmacies remain the most effective, safe, and equitable mechanism for medicine distribution in New Zealand and urge Pharmac to reconsider this proposal and instead focus on strengthening partnerships between prescribers of IUDs and community pharmacies to better serve our shared healthcare objectives.

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,

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