

THE ROLE OF COMMUNITY PHARMACY IN THE OPTIMAL USE OF MEDICINES

**Submission by the Pharmacy Guild
of New Zealand (Inc) to the
National Medicines Strategy
Review**

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1. Executive Summary and Conclusion

In the Guild's view the most important statement in the consultation document is:

Decisions about which medicines should be publicly funded are prioritisation decisions. Prioritisation decisions need to be made across all health and disability support services because the demand for health services and interventions, including medicines, will always be greater than the resources - such as money, time, space and staff - that are available. Choices have to be made about how limited resources will be used and this requires difficult decisions about competing demands for funding.

Implications include the importance of selecting the optimal and least cost intervention, adoption of evidence-based decision-making to ensure health practitioners are aware of the outcomes and effectiveness of different interventions (which requires ongoing research and evaluation) and building public confidence in the fairness and equity allocation processes through ongoing public engagement.

The Guild supports the proposed objectives for the medicines sector with two additions:

- The access objective could be qualified to reflect the reality of resource limitations and consequent rationing decisions which accompany the use of all medicines regardless of whether they are prescribed or non-prescribed.
- The optimal use objective should be rephrased to focus on the steps involved in producing the outcomes desired. The Guild suggests "the systems and practices for the prescribing and administration of medicines are focused on producing the best possible health outcomes for patients."

Most medication is self-administered in a community setting. **This most crucial part of the entire medicines system is the least monitored, the least evaluated, and the least understood.**

The national medicines strategy should centre around what is required to ensure that medicines, when prescribed, had taken in accordance with the prescriber's intentions, any barriers to effective concordance are minimised. This could include recognizing a treatment hierarchy based on the principle of encouraging the optimal and least cost interventions to achieve the desired outcome. This would emphasise prevention rather than cure, treatment in the community rather than in an institution, and self-management rather than professional management as a first best approach.

The Guild endorses the six principles proposed but recommends two additional principles with the purpose of grounding the strategy in the reality of how most medications are actually prescribed, dispensed and administered:

- *Community-based*: funders, prescribers, dispensers and other health care workers understand and work with community-based processes which facilitate concordance.
- *Collaboration*: prescribers, dispensers and other primary health care workers are committed to and adopt the practice of collaboration as the primary means of ensuring optimal health outcomes for patients from the use of medicines .

The Guild supports the consultation document's priority for the optimal use of medicines of:

Increasing the role of pharmacists in ensuring the best use of medicines, improving information-sharing, including the interface between primary and secondary care, and the availability and quality of information given at the time of dispensing.

It identifies two barriers. The first is current institutional arrangements and the second the lack of evidence-based understanding of the potential of community pharmacy with the New Zealand.

The proposed priority should be seen as a national policy objective requiring action at a national level through appropriate policy-making arrangements. In practice, developing policy for the future role of pharmacy services has been devolved to DHBs as an operational matter. Their incentives focus more on cost reduction than on the "big picture" policy issues of how pharmacy can contribute to better health outcomes through the optimal use of medicine.

The second barrier effectively reinforces the first. There is virtually no New Zealand-based research evidence on either the costs to the health system, or the wider community, as a consequence of non-adherence and medication misadventure, or the potential gains through the development of pharmacy services as is increasingly the case in many overseas jurisdictions.

The limited research on New Zealand experience confirms the importance of clinical prescription interventions as part of pharmacy practice. We also have secondary research evidence suggesting that the cost to the health system alone of non-adherence and medication misadventure could be well excess of \$1 billion per annum. As well, international research demonstrates the significant gains through developing pharmacy care.

Further priorities for the national medicines strategy should include:

- Ensuring that good practice in pharmacy intervention is both documented and supported through institutional and funding arrangements.
- A strong emphasis on funding research to produce an evidence-based understanding of the principal causes of non-adherence and medication misadventure in a New Zealand environment, and provide a basis for developing initiatives to minimise this.

- Consideration of the institutional arrangements within which policy for the purchase of pharmacy services is developed, to ensure that an over emphasis on operational requirements does not detract from the need to address "big picture" policy issues such as minimising non-adherence and securing the gains which international research demonstrates can be had from improved pharmacy care.

The shift to a stronger emphasis on pharmacy care is best done on a pilot project basis, incorporating research and evaluation, so that any decisions on national roll-out are evidence-based. This should be accompanied by parallel measures to ensure that the appropriate training and development of the pharmacy workforce (including technicians) and for pharmaceutical researchers is also put in place. Priority areas for a pilot project approach include:

- Regular medication review for people on chronic medication, especially older people (medicines reconciliation).
- Pharmacists screening and referral services, for example, cardiovascular risk assessment.
- Chronic disease management within a treatment protocol established by the patient's GP. Possibilities include asthma, diabetes and hypertension.

2. Introduction

ROLE OF THE PHARMACY GUILD

The Pharmacy Guild is a professional organisation which represents the interests of community pharmacies to government, the DHBs and other stakeholders. It currently represents 80% of community pharmacies.

THE MEDICINES STRATEGY

The Pharmacy Guild of New Zealand (Inc) (the Guild) commends the government's commitment to developing a national medicines strategy. The Guild sees this as an essential complement to other recent strategies including the New Zealand Health Strategy, the New Zealand Disability Strategy and the Primary Health Care Strategy. In the Guild's view, achieving the optimal use of medicines is arguably the most significant issue confronting the New Zealand health sector, both in terms of improving health outcomes, and in terms of managing health sector costs.

Much of the Guild's work in recent years has been focused on the proper role of community pharmacy in delivering the government's primary health care strategy picking up on the vision set out in the Primary Health Care Strategy that:

People will be part of local primary health care services that improve their health, keep them well, are easy to get to and coordinate their ongoing care.
Primary health care services will focus on better health for a population, and actively work to reduce health inequalities between different groups.

The Guild sees the decision to develop a national medicines strategy as an essential next step in realising that vision.

The consultation document explicitly recognizes the interconnectedness of health systems worldwide. Emerging trends elsewhere will often impact on, or set the direction for, change within the New Zealand health system. This is especially the case with medicines because of the dominance of major pharmaceutical companies internationally. Amongst the trends which are important for New Zealand are:

- The very high cost of developing genuinely new drugs.
- The increasing tendency to develop "me too" drugs which are little different from others already available.
- The growing importance of generic medicines particularly as a means of extending the benefits of pharmaceutical innovation to a wider range of patients.
- The growing imbalance between demand for and supply of health professionals. The Guild expects the ongoing consequences of this to include upward pressure on costs and a relative scarcity of professional skills, emphasising the importance of making the best use of New Zealand's health sector labour force.

- The recognition that demand for health care, at whatever level, and expressed in whatever interventions, will continue to outstrip the ability of governments to afford all of the care which their citizens demand.
- Increasing public awareness of the implications of health rationing decisions.

In this context, the Guild considers that the following is the single most important statement in the consultation document:

Decisions about which medicines should be publicly funded are prioritisation decisions. Prioritisation decisions need to be made across all health and disability support services because the demand for health services and interventions, including medicines, will always be greater than the resources - such as money, time, space and staff - that are available. Choices have to be made about how limited resources will be used and this requires difficult decisions about competing demands for funding.

In the Guild's view, a number of implications follow from that statement. They include:

- a. Both individual interventions, and the health system as a whole, need to be as efficient as possible, not in a narrow cost minimisation sense but with an emphasis on long-term sustainability - of the health status of New Zealanders, of the financial viability of the health system, and of the efficiency and effectiveness of the people and other resources within it.
- b. The importance of selecting the optimal and least cost intervention to achieve the desired outcome. This means generally taking a "whole of system" approach, with a focus on where within the health system, and how, the health needs of the individual, their whanau, or a population group are best addressed. It requires a focus on the trade-offs between different interventions, whether those take place in a community setting, or within the hospital system.
- c. Unless health practitioners are aware of the outcomes and effectiveness of different interventions, including interventions which may lie outside their immediate area of professional practice, but are relevant for the patients they are treating, selecting the optimal and least cost intervention to achieve the desired outcome will not be possible. This highlights the need for evidence-based decision-making (that is decision-making which is firmly grounded in reliable research-based evidence) which in turn requires an ongoing commitment to research and evaluation.
- d. The importance of public confidence in the fairness and equity of the processes through which health sector resources are allocated, and people access the treatment required to meet their needs. In the Guild's view, this requires a shift from the standard practices of transparency and consultation, to public engagement (the appendix discusses these three separate concepts, and their different implications for managing health sector expenditure). This should serve at least three purposes. First it

should help raise public understanding of the resource constraints faced by the health sector. Secondly it should enable a sharing with the public of a sense of responsibility for the way in which resources are actually allocated. Thirdly it should mitigate against the risk of special interests exercising political pressure to seek the outcome they desire, regardless of relative costs and benefits.

In this submission the Guild will focus on the contribution which community pharmacy can make to achieving the objectives of a national health strategy. The reasons for this focus include:

- Community pharmacy is the Guild's primary area of expertise and accordingly the one in which it believes it can make the most effective contribution.
- Previous work undertaken by the Guild suggests that a stronger emphasis on the role of community pharmacy offers a very real opportunity for significant improvements, both in the health status of New Zealanders, and in the effective and efficient use of resources within the health system.

In choosing this focus, the Guild is conscious that there are other and important matters which need to be addressed. An obvious one is the apparently widespread public concern that current practices dealing with the registration and subsidy of medicines may be delaying or denying New Zealanders access to medications which could be of significant benefit. The fact that this submission does not deal with those matters should not be seen as suggesting the Guild considers them to be insignificant. Rather, it reflects a decision to concentrate on matters more directly related to community pharmacy because of the very significant fiscal and health gains which the Guild believes could be achieved if New Zealand were to follow the lead set in other jurisdictions of making greater use of pharmacy services.

3. Proposed objectives and principles

OBJECTIVES

The consultation document proposes the following objectives for the medicines sector:

- Quality, safety and efficacy of available medicines.
- Access to medicines that New Zealanders need regardless of an individual's ability to pay.
- Optimal use of medicines.

The Guild has two suggestions in respect of the proposed objectives:

- First, the access objective could be seen as raising the expectation patients will be able to access all medicines, subsidized and unsubsidized regardless of their ability to pay. This is at odds with reality. Access to subsidized medicines is governed by the statutory obligation Pharmac has under the New Zealand Public Health and Disability Act which is "to secure for eligible people in need of pharmaceuticals, the best health outcomes that are reasonably achievable from pharmaceutical treatment and from within the amount of funding provided". Similarly, with the widespread use of non-subsidized prescription and non-prescription medicines, the patient makes purchase decisions within the context of their personal circumstances. The objective in its present form could be seen as, in some circumstances, creating unfair expectations about access to medicines that pharmacists and DHBs will simply be unable to meet. Setting up this conflict of expectations seems inappropriate. Even an aspirational strategy must confront the realities of limited resources and rationing decisions which inevitably accompany the use of medicines in all settings.
- Next, The objective "optimal use of medicines" could usefully be more specific and focused on the outcomes from the use of medicines, which this submission will argue is where the greatest gains are to be made. The Guild suggests the objective be reworded along the following lines: "the systems and practices for the prescribing and administration of medicines are focused on producing the best possible health outcomes for patients."

In the Guild's view, this second suggestion goes to the heart of what a national medicines strategy should be about. What could be described as the "medicines system" is an extremely complex process beginning with the research and development, and clinical trials, associated with developing a new drug, and then on through registration, evaluation (leading to a decision on whether to subsidise) prescription and dispensing. It is not until after the medicine has been dispensed

that the purpose of the process can be achieved; the effective, usually self, administration of the medicine to achieve the intended outcome. **This most crucial part of the entire medicines system is the least monitored, the least evaluated, and the least understood.** As will be discussed later, this gap has very substantial consequences in terms of additional cost and poor health outcomes.

The national medicines strategy should centre around what is required to ensure that medicines, once prescribed, are taken in accordance with the prescriber's intentions, and any barriers to effective concordance are minimised.

There is a further reason for this focus. In a resource constrained health system it makes sense to recognize what the Guild would describe as a treatment hierarchy based on the principle of encouraging the optimal and least cost interventions to achieve the desired outcome. Implicit in this is an emphasis on prevention rather than cure, on treatment in the community rather than in an institution, and on self-management rather than professional management as a first-best approach. As will be argued later, practices such as medication management, using the skills of community pharmacy, in collaboration with other primary health care workers, can play a pivotal role in developing this approach. This approach is also consistent with the consultation document's statement (page 6) that "a key focus is implementing a population health approach, focused on health promotion, prevention and early intervention, while concurrently ensuring that high-quality treatment services continue to be delivered."

One of the frustrations in considering the impact of the health system as a whole is the tendency to measure or recognize only those activities which are a formal part of the government funded health sector. Much of the work of community pharmacy is a combination of prevention and early intervention, making available non-prescription medicines which are appropriate to deal with a range of relatively minor ailments and injuries many of which, if not attended to, have the potential to become more serious and impose significant costs on the government funded health sector. Other aspects of community pharmacy include working with people to manage long-term health prevention issues, again using non-prescription medicines. Calcium therapy as a means of retarding loss of bone density is one example, although commonly combined with prescription medications such as Fosamax. Another example is the use of low dose aspirin for cardiovascular disease prophylaxis which community pharmacy has provided for many years as a non-prescription service.

Another often unnoticed facet of community pharmacy is the role of the community pharmacist in maintaining a record of the various medications which a patient has either purchased (pharmacist and pharmacy only medicine, and alternative remedies where the pharmacist retails those) or obtained by prescription. For the great majority of patients, this will be an invaluable record as it contains information relevant to the management of the person's health which is held nowhere else.

The Guild considers there would be very real value in prescribers having access to this information when treating and prescribing patients and equally that there would be merit in pharmacists having appropriate access to relevant sections of the patient's medical records. The Guild considers the continued lack of access by one individual care provider to relevant patient information held by other care providers results in less well informed patient management decisions to a degree which should no longer be acceptable. The development of effective means for primary care providers to share information electronically should be a priority.

There are issues of privacy, information systems and the like which would need to be resolved for this to happen. The Guild recommends that the national medicines strategy provide strong encouragement for ensuring that patient information is more widely available to the group of health professionals who are collectively responsible for the patient's treatment.

The suggested approach of thinking of the health system as a hierarchy from self-management at one end through to tertiary level hospital treatment at the other, would not only put more emphasis on (increase the understanding of) the role of community pharmacy but at least as importantly shift the emphasis towards encouraging optimal and least cost interventions as a first resort. It would also recognize the very important role that the patient actually plays in managing his or her health status, and what is required to help patients do this as well as possible.

PRINCIPLES

The six principles proposed for guiding decisions on the detail of policy, systems and structures are all both appropriate and relevant. However, they are all somewhat abstract in the way in which they are expressed. There is a need to ground them in the actual context in which the majority of medicines are actually prescribed, dispensed and administered. Two additional principles are proposed; community-based and collaborative.

The majority of medicines are dispensed and administered in a community environment. Their effective use depends critically on the individual patient's understandings of the nature and purpose of the medicine, and how to use it, and often on the assistance of family members, caregivers, or other informal supports. Especially for patients on long-term medication, medicine is also a crucial element in treatment designed to manage the patient's condition (s) in a community setting rather than in an institution. For this to be effective, prescribers and dispensers need to understand and work with community processes, whether it is formal and informal networks which spread information and "best practice" to groups with a particular health condition, or whether it is working with families and others as a means of supporting concordance. This can also be seen as a form of collateral investment, matching the very significant financial and non-financial investment which patients themselves, their families, caregivers, prescribers and pharmacists all invest in seeking to optimise the management of conditions which require long-term medication. As with other aspects of health care outside or only partially within the government funded

health system, much of this investment is relatively invisible so that its quite crucial importance to maintaining the health status of many New Zealanders, and minimising the demands which they make on the government funded health system, can easily be overlooked.

Consistent with the importance which it attaches to the management of medication in a community setting (where most medication is actually administered) the Guild proposes as a further principle: "*community-based* - funders, prescribers, dispensers and other health care workers understand and work with community-based processes which facilitate concordance."

Section 4 of the Primary Health Care Strategy includes the following statements signalling the government's intention there should be greater collaboration amongst primary health care professions:

- Effective coordination of care will become even more important as we extend the focus of primary health beyond treatment and support services towards a more comprehensive disease prevention and management approach.
- There is good evidence that adopting a broader approach to primary health care can contribute to reducing health inequalities and improving outcomes.
- The broad vision of primary health care in this Strategy means that no single practitioner or type of practitioner can meet people's needs completely.
- The world of primary health care is changing and old isolated ways of working must be replaced by new collaborative models.

The Guild agrees with those sentiments but is disappointed that, in the nearly 6 years since the strategy was released, there is still much progress to be made especially in recognizing, integrating and utilizing the community pharmacist as a full member of the primary health care team. There is considerable evidence, which will be referred to below, that there are very significant unavoidable costs, and less than ideal health outcomes, if collaboration is not central to the practice of primary health care. To address this, the Guild proposes the following principle: "*collaboration* - prescribers, dispensers and other primary health care workers are committed to and adopt a practice of collaboration as a primary means of ensuring optimal health outcomes for patients from the use of medicines."

EXPECTATIONS SURROUNDING MEDICINES IN THE HEALTH SYSTEM

Patients perceive that they have rights in relation to access to medicines and pharmacy services.

Historically successive Governments have defined and maintained specific patient focussed entitlements to certain health services including by way of example access to GPs, maternity services, laboratory services and pharmacy services. Looking at the pharmacy service this entails defining the medicines patients can receive on a subsidised basis, the co-payment they must pay to receive such medicines and the service to be provided by a pharmacy. Such entitlements apply only to Eligible People as defined by the Government from time to time.

The Guild views it as the Government's right to define for health sector users the specific nature of entitlements that the taxpayer will fund and the rationing criteria implicit in such arrangements. In practical terms medicine access and medicine rationing policy is largely regulated through the Pharmaceutical Schedule.

Patient choice in terms of service providers is an important feature of New Zealand Health services. This is preserved and protected by the Code of Health and Disability Consumer Rights.

Providing choice in terms of access to pharmacy services is fulfilled through the maintenance of the ability of patients to select where pharmacy services are received. This in turn is facilitated by financial arrangements through contracts with pharmacies.

The Guild is concerned at the lack of focus on ensuring optimal use of medicines once they have been dispensed to the patient. The National Medicines policy should clarify the expectations which the public should have of health practitioners to promote optimal use, and the rights patients have to ensure this is done. Research highlighting the costs of failure in this area is one factor which argues for improvement. Another is the rights patients have under the Code of Health and Disability Consumers' Rights.

In the Guild's view, the medicines strategy could usefully provide guidance for patients and their care providers on this point.. To do so the Guild suggests the strategy incorporates the following explanation of the Code as it applies to medicines:

Right 4: Right to services of an appropriate standard

- Every consumer has the right to expect the medicines they have access to comply with relevant quality, efficacy and safety standards.
- Every consumer has the right to expect they will be offered access to the most appropriate medicine for their circumstances.
- Every consumer has the right to expect they will be offered access to any additional services supporting their medicine therapy that they may need to allow them to derive the benefits their health care providers expect from that medicine therapy.
- Every consumer has the right to expect their health care providers will work together to ensure the success of their medicine therapy..

Right 5: Right to effective communication

- Every consumer has the right to receive any essential information and advice they may need to understand their medicine therapy and use it appropriately in a manner they can understand.

Right 6: Right to be fully informed

- Every consumer has the right to essential information that a reasonable consumer would expect to receive including;
 - an explanation of the medicine options available, including an assessment of the expected risks, side effects, benefits, and costs of each option and
 - any other information required by legal, professional, ethical, and other relevant standards.
- Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.
- Every consumer has the right to honest and accurate answers to questions relating to medicines, including questions about:
 - the recommendation of the provider; and
 - how to obtain an opinion from another provider; and
 - the results of relevant research.

4. Community pharmacy and the national medicines strategy

In this part of the submission, the focus is on the potential for community pharmacy to contribute to the objectives of the national medicines strategy with a particular emphasis on the Guild's suggested reworking of the third objective as "the systems and practices for the prescribing and administration of medicines are focused on producing the best possible health outcomes for patients."

The consultation document identifies three priority areas where improvements could be made. For optimal use of medicines, the priority is:

Increasing the role of pharmacists in ensuring the best use of medicines, improving information-sharing, including the interface between primary and secondary care, and the availability and quality of information given at the time of dispensing.

The Guild supports this priority. Indeed, this emphasis has been part of the Guild's strategy for the future of community pharmacy for a number of years. As an example, the Guild had this to say in its 2005 publication, *Blueprint for the Future of Community Pharmacy*:

Demand for pharmacy services is growing and expected to continue to grow:

- Middle aged and elderly patients are the biggest users of prescribed medicines. Alongside their medicine needs, they will also need the additional patient support services pharmacy will provide in the future.
- Demand for new medicine management services will be strong once patients, prescribers and purchasers become familiar with the benefits. Projections indicate the over 40 years group is the only group in the population likely to experience significant growth over the next decade. By 2011 there should be almost 270,000 more people over the age of 40 than there were in 2004. The 65 years and older group will grow by 20% and the 40 to 64 years group by 14%¹.
- The emphasis DHBs are placing on providing additional community support for the illnesses of ageing suggests disease state and other medicine management services will become part of the subsidised support package.

Putting this priority into practice faces two significant hurdles. The first is the existing institutional arrangements within the health sector and the second the relative lack of evidence based understanding of the potential of community pharmacy within New Zealand.

¹ This trend is important as the elderly are proportionately the greatest users of medicines.

INSTITUTIONAL ARRANGEMENTS

BUDGETING PRACTICES

The consultation document recognizes the changing context within which medicines are utilised. This includes acknowledging the wide range of sector participants engaged in activities aimed at increasing the health of New Zealanders including strategies to improve the health gains that can be obtained from medicines.

The document acknowledges that this activity is occurring within a changing health and disability support system. As it states "the regulation of health practitioners has changed to encourage more flexible use of practitioners' skills, and with this change has come the extension of prescribing rights to new groups of health practitioners. PHOs provide new care delivery settings, focused on teams and low-cost access to primary health care."

That is a picture of an evolving and flexible system which places a high premium on inter-disciplinary working, and on drawing on the skills of health practitioners in new and different ways. The Guild considers that the National Medicines Strategy itself will need to go further than this, recognizing that the optimal use of medicines depends not only on prescribing and dispensing practices, and on developing a more flexible health care system, but crucially on what happens in the post-dispensing environment.

Community pharmacy is supportive of the emerging more flexible approach which it considers is essential if New Zealanders are to get the best value from the resources invested in the health sector. However, at least for community pharmacy, existing institutional arrangements are incompatible with this direction of travel.

The way in which the pharmaceutical and other budgets are set and managed prevents a flexible approach to making choices between the use of medications, and other options such as institutional care, and severely limits the potential for innovation in pharmaceutical care.

The pharmaceutical budget is set through a process of consultation between DHBs and Pharmac and then approved by the Minister of Health. There is scope during the consultation process for individual DHBs to consider possible trade-offs between the use of medication and other interventions but once the budget is approved, its expenditure is largely outside the influence of the DHBs themselves. The significance of this is that during the course of a financial year, DHBs have limited discretion to decide to trade off additional expenditure on medication in a community environment, against the possibility of additional hospital admissions. The Guild believes that this is a major barrier to the more innovative and cost-effective use of pharmacists' services.

There are similar issues with other budgets where there is the potential for cost saving and health gain through trade-offs. The rest home subsidy scheme

provides another example. That subsidy cannot be used to support intensive medication management as a means of enabling an older person to remain in the community, rather than requiring admission to a rest home, even although the potential gains both in savings, and quality of life, are considerable (see the discussion at page 16 below).

One of the difficulties with addressing this type of situation is that the New Zealand public sector has tended to have an "all or nothing" approach to change. Applying this approach to the trade-off issue would imply that the whole of (say) an individual DHB's non-pharmacy spending should be available for trade-off. This would clearly be impractical. Among the objections would be the increased uncertainty across the rest of the DHB's activities, the absence of systems and controls to ensure that the trade-off process could be managed properly, and in all likelihood the need to inculcate the necessary skills and understandings in the staff who would be responsible for trade-off decisions. Clearly, the better approach would be seek greater flexibility in the purchase of pharmacy services by moving incrementally to a trade-off approach, perhaps authorising an initial commitment of an amount equivalent to (say) 5% of an individual DHB's present pharmacy budget from non-pharmacy funding, and subject to evaluation and monitoring. This would allow the DHB and its staff to develop the necessary competencies and gather evidence of service effectiveness before any more substantial authorisation was granted.

PURCHASE OF PHARMACY SERVICES

DISPENSING IN THE MODERN CONTEXT

Over the last twenty to thirty years the best practice definition of dispensing has expanded significantly beyond the traditional actions of preparing and giving a medicine to the patient. In the modern context the service now includes checking the appropriateness and safety of the prescription, correcting the prescription where necessary, providing the patient or their caregiver with information and other support to allow the patient to derive full benefit from the medicine, and in some cases monitoring aspects of the patient's condition or supervising their use of the medicine on an ongoing basis. The continuing use of the term dispensing carries with it an outmoded understanding of the nature of the service. The Guild suggests that a better term would be "core pharmacy service" or "primary medicines management".

Although this core service is purchased against a standard service description the complexity of the process varies from patient to patient. The inputs required of the pharmacist are determined by the needs of the patient. In general, the greater the complexity of the patient's problems, the more time the pharmacist needs to commit to working with the patient.

INSTITUTIONAL PROBLEMS WITH THE PURCHASE OF PHARMACY SERVICES

Currently, DHBs purchase the core pharmacy service as part of their operational responsibilities, operating within a ministerially approved budget. The focus is understandably on securing the required services at the least possible cost.

A main thrust of the Guild's submission is that the National Medicines policy should promote the optimal use of medicines. Overseas research suggests that, in New Zealand, this would require the development of a new range of Pharmacy Services, available across the country, and focused on supporting patients in the optimal management of their medication. In the New Zealand public policy environment, a shift of that kind is not something which would be expected to emerge from the operational decisions of a series of government entities. Instead, it is something which would normally be initiated at a Minister/Ministry level and subject to Cabinet decision.

In the Guild's view, the fact that the evolution of pharmacy care has been left, by default, to 21 crown owned entities is in large part responsible for New Zealand's relative lack of emphasis on initiatives to support concordance, despite the evidence that the cost both in fiscal terms, and poor health outcomes, is very considerable.

To elaborate, from the Guild's perspective, there is an inherent conflict between the government's objectives as expressed in the consultation document, and the incentives which face DHBs in negotiating for the purchase of pharmacy services within the current set of institutional arrangements. These provide for a standardised approach which applies across all DHBs but within which individual DHBs are all seeking to minimise the cost to themselves of pharmacy services. The arrangements are formalised in a standard Pharmacy Services Agreement which is consulted on between the Guild and DHBs collectively through DHBNZ but then forms the basis of an individual contract between a DHB and each pharmacy within its district.

Experience shows the DHBs place more emphasis on the cost of the service than its value.

The current standard contract between DHBs and pharmacies, and the one which is about to replace it, both describe the core of base pharmacy services as follows:

Dispensing of Pharmaceuticals

Dispensing will comply with the Pharmaceutical Schedule, all legislation and regulations applicable to the practice of Pharmacy in New Zealand, the New Zealand Code of Good Manufacturing Practice for Manufacture and Distribution of Therapeutic Goods 1993: Part 3 Compounding and Dispensing (Ministry of Health), the Code of Ethics 2001 and any other

professional requirements which may be specified by the Pharmaceutical Society.

The Dispensing process includes:

- (i) ensuring the completeness of information on the Prescription Form, e.g. Service User details, legibility and legal requirements;
- (ii) verification of the appropriateness of the prescribed Pharmaceutical using any relevant available information, e.g. suitability of the prescribed medicine, dosage and possible interactions;
- (iii) checking acquired medication history for consistency of treatment, possible interactions and evidence of non-compliance or misuse.

(b) Provision of advice and counselling

You agree to provide essential professional advice and counselling and to take all reasonable steps to ensure that Service Users have sufficient knowledge to enable optimal therapy.

Provision of essential advice and counselling includes:

- (i) directions for the safe and effective use of the Pharmaceutical;
- (ii) the expected outcomes of therapy;
- (iii) what to do if side-effects occur;
- (iv) storage requirements of the Pharmaceutical;
- (v) disposal of unused Pharmaceuticals.

Payment both for dispensing, and for the range of other services included in the base pharmacy service, is through a single dispensing fee currently set at \$5.16 per script plus GST. One dilemma both for the Guild and for individual DHBs is how to measure the extent of the collateral services provided. The Guild is satisfied that the great majority of pharmacists conscientiously provide the full range of services set out above both in respect of dispensing pharmaceuticals and in the provision of advice and counselling.

In the Guild's view, the key issue is that present institutional arrangements give DHBs incentives to seek cost reductions from their contracts with pharmacies, rather than focus on the potential of pharmacy services to reduce costs across the system and improve health outcomes. The consequence is to create a somewhat negative environment for innovation in the purchase of pharmacy services. DHBs' focus on keeping costs down is compounded by a belief that a proportion of pharmacists are not delivering fair value. As one consequence, there is a tendency to negotiate the dispensing fee down to a minimal level, squeezing out any margin that would support innovation in pharmacy practice. Another consequence is a reluctance to shift from the transaction-based approach to remuneration to a service-based approach which again inhibits innovation.

Recently the DHBs announced that they propose fixing the dispensing fee at the current level until 2009. The declared purpose is to encourage rationalisation - in other words, to render smaller pharmacies so uneconomic that their owners will have little option but to close. Despite the far reaching implications for this policy, in the Guild's opinion, the DHBs did not engage in sufficient consultation before embarking on it. In the DHBs' vision, many rural pharmacies would be

replaced by medicine depots. In the Guild's view this decision illustrates the conflict between the cost reduction focus which has characterised the DHB approach to pharmacy remuneration, and the public interest in improved health outcomes. The Guild acknowledges that its members have a natural interest in protecting their income, which may make any critique of DHB decision-making appear primarily self-interested. Although there is certainly an element of self-interest in pharmacists' critique of the DHB approach, the over arching issue is the impact on the quality use of medicines within a community context. This raises questions which go beyond the immediate decision, to the question of what set of institutional arrangements will best optimise the health gains from the use of medicines within a community context (where the great majority of all medicines are administered). The negative impacts from the DHBs' decision in terms of the suggested objective of encouraging concordance are likely to include:

- Increased financial pressure on all pharmacies of whatever size, forcing their owners to focus on reducing the costs of providing the core dispensing service. The immediate incentive for many will be to cut corners in providing the full range of base pharmacy services, not because they wish to do so, but because they have little alternative.
- Relatively few smaller pharmacies will actually close as their owners have few if any practical alternatives. Closure would not mean sale of the business and an ability to retire (many rural pharmacists are middle-aged or older). Instead, it would mean shutting down the business, realising assets, quite possibly for a significant loss, and also losing whatever income the business currently generates. The likely alternative income source is quite literally the unemployment benefit as there are few jobs outside pharmacy for retiring rural pharmacists. As a consequence, most pharmacists in this situation will struggle on as long as they are able to continue paying their bills and will be tempted to do whatever they can to achieve this. It is a picture of an incentive framework which will encourage the exact opposite of the service focus which the government wishes to achieve.
- A devaluation of the worth of base pharmacy services. If collecting your medicines from a medicine depot is sufficient for a rural consumer, then why should an urban consumer be entitled to a higher standard of service? Certainly, in the Guild's view, purchasing different standards of service would be in direct conflict with the statutory objectives of DHBs including requirements such as:
 1. To reduce, with a view to eliminating, health outcome disparities between the various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programs designed to raise their health outcomes to those of other New Zealanders; and
 2. To exhibit a sense of social responsibility by having regard to the interests of the people to whom it provides, or for whom it arranges the provision of, services.

- Reduction of access to pharmacist only and pharmacy only medicines which are an important element of the total primary health care package, and could not be provided through a medicines depot option because their selection often requires professional advice - the very reason that access is restricted. The potential consequences are serious not only because of their importance in treating every day ailments but because these medicines are often the first treatment option for conditions which, if not treated, have the potential to require hospital admissions (skin lesions provide a good example with the risk that lack of treatment could result in the lesion becoming septic requiring admission to hospital).
- Discouraging innovation in pharmacy practice. Essentially, what the DHBs appear to be saying to community pharmacy is that they have no effective role, other than the relatively mechanical function of dispensing, in promoting good health outcomes. This attitude, if it indeed exists, reflects an unfortunate lack of understanding both of how community pharmacy is currently evolving, and of the very real potential for reducing costs in the health system generally, and improving health outcomes, through innovation in community pharmacy.

The Guild does not entirely blame the DHBs for the current situation. In the Guild's view, it is a regrettable but natural consequence of a set of institutional arrangements which have focused DHBs on reducing the cost of individual services, rather than on the "big picture" questions of how best to improve health outcomes through a collaborative and multi-disciplinary approach. What the current situation does illustrate is that New Zealand needs to find a new means for encouraging developments in pharmacy services similar to those which are now occurring, on almost a routine basis, in most developed countries. Amongst other things, it must now be clear to the government that a relationship focused on squeezing one partner financially to the point of business failure is not the ideal relationship for encouraging the same partner to be innovative in service delivery.

The immediate challenge is how should the national medicines strategy encourage innovation in pharmacy services, given the very significant evidence (discussed below) that gains both in reduced costs to the health system, and improved health outcomes should be very considerable, and far outweigh any benefits from the current strategy of squeezing community pharmacy.

This is another area where the "all or nothing" approach which typifies the New Zealand public sector would be unworkable. Rather than moving from the current dispensing fee basis for remuneration, to a pharmacy service purchasing regime substantially focussed on added value services; it would make better sense for DHBs to build on existing service arrangements on a selective basis by investing in purchasing additional services as part of improving the effectiveness of the use of medication, both in keeping people out of hospital, and in improving health status.

A question for the government, as it develops a national medicines strategy, is whether innovation in purchasing is best left to the initiative of individual DHBs, or whether it should be taken up by the government through the Ministry of Health as part of a national strategy. Government might conclude that, in order to get the process moving, it should take the lead until experience and confidence in broader service-based purchasing had built up to a sufficient level to be confident that individual DHBs would see this as a natural part of their management of the health status of the local population. Government might also conclude that leaving responsibility for service-based purchasing to encourage innovation with the same DHBs that are currently focused on cost reduction as their principal objective may not be the optimal strategy. Similarly, current suggestions promoting further fragmentation by devolving added value pharmacy service purchase decisions to PHOs before the government had developed guidelines on what it requires in order to support concordance could also inhibit innovation.

The argument in favour of direct government intervention in encouraging innovation in pharmacy services gains very real strength when the incentives in the current institutional arrangements are examined. Delegating the responsibility for purchasing pharmacy services to DHBs, at first glance, appears to be no more than delegating an operational responsibility to the government's chosen purchase agents for health services.

Closer examination suggests a quite different situation. By far the most significant issue with pharmacy services, from a government policy perspective, is the potential for innovation to address the major problems of cost to the health system, and poor health outcomes, resulting from non-adherence and medication misadventure, and to provide more effective options for gains in areas such as chronic disease management, and early intervention. The principal risk bearer in relation to potentially avoidable costs is the taxpayer as represented by the government. Delegating to district health boards the responsibility for managing innovation in the purchase of pharmacy services places the risk management responsibility with a group of agencies which themselves, at least over the medium term, are not the risk bearers (as their funding is set in relation to current understandings of the health status of the population which by definition factor in the consequences of non-adherence and medication misadventure). Furthermore, in the short term, DHBs operate with relatively fixed budgets so that their incentives are to reduce costs, rather than invest in new initiatives.

In the Guild's view, what we are really considering is a situation in which the responsibility for developing major policy initiatives with national impact has been devolved to an operational level. The current reality is that leaving the important question of the potential contribution of community pharmacy to reducing costs and improving health status to DHBs is leaving responsibility to a collection of 21 different organisations, each with its own priorities, understandings and agendas. Few practitioners of public management would suggest that a grouping of 21 separate entities each with its own interests is the optimal structure for encouraging innovation. The Guild recently experienced this when attempting to

foster a common service initiative across the 21 DHB districts. The logistics of the exercise were so difficult it was reluctantly abandoned.

A complicating factor to which this submission now turns is the dearth of New Zealand-based research both on the role of community pharmacy as currently undertaken, and on the potential benefits.

As was observed earlier in respect of the actual administration of medicines in a community environment, (which is normally patient self-management) **"This most crucial part of the entire medicines system is the least monitored, the least evaluated, and the least understood."**

In the Guild's view this is the principal reason there is a relative lack of emphasis on the potential of community pharmacy to further contribute to improving the health status of New Zealanders.

AN EVIDENCE-BASED APPROACH TO PHARMACY SERVICES

There are three principal areas which a national medicines strategy should focus on as a means of enabling community pharmacy to use its skills to further enhance the health status of New Zealanders, and reduce costs both to the health system as a whole, and to individuals in the community (through the non-health sector costs associated with factors such as loss of productivity and loss of quality of life). The areas are pharmacy practice, non-adherence and additional pharmacy based interventions.

PHARMACY PRACTICE

In preparing this submission the Guild has had access to research undertaken on pharmacist interventions by Kairuz & Jensen of the School of Pharmacy, The University of Auckland, as pilot studies in the districts of two district health boards. One of the studies was a retrospective study of clinical prescription interventions over a five-year period within a medium-sized urban pharmacy. The study reports the following reasons for interventions:

Reasons for interventions 2000-2005

Reason for intervention	Years						Total
	2000	2001	2002	2003	2004	2005	
Drug interaction	7	7	4	4	9	4	35
Drug therapy monitoring				1		1	2
Non-compliance	1				1		2
Prescribing error	46	23	27	28	29	32	185
Prescription omission	1			1	2		4

Most clinical interventions (51%;n=117/228) involved optimising drug therapy (PSNZ Grade 4) with **42% of interventions preventing moderate (n= 60) to life-threatening (n= 35) health events.** (Emphasis added).

The authors' conclusions from the overall study, which also involved a second pharmacy, are that the findings of these pilot studies indicate:

- Pharmacists perform a high frequency of administrative tasks related to funding issues.
- Clinical prescription interventions performed by pharmacists prevent serious adverse health outcomes for patients.
- Pharmacists contribute to reduced healthcare costs of the district (s) by intervening and preventing serious adverse events.

This degree of intensive intervention is, in the Guild's view, representative of current best practice in New Zealand community pharmacy. Neither its extent nor the benefits for both the health system, and individual patients, appear well understood either by funders or policymakers within the health sector.

The same pharmacy has been involved in another initiative which highlights both the potential gains from pharmacist interventions, and the budgetary issues which stand in the way of their widespread adoption. Its principal undertakes weekly dispensing for a number of potential rest home patients who are still living in their own homes. He makes up a blister pack for seven days. The blister pack is delivered and exchanged for the previous week's pack which should be empty. If it is not, that is a signal of a need to do something. In one case, he found that the patient was very good at taking medicine in the morning but not in the evening so that not all necessary medications were being taken. In consultation with the patient's doctor it was accepted that there would be only a minimal therapeutic impact from switching to taking once-a-day. This change was made and adherence is now 100%.

The average cost of rest home subsidy, through the Ministry of Health, is in excess of \$20,000 per resident so that the savings, from this pharmacy initiative, are very considerable. Currently there is no funding policy which will reimburse pharmacists for the cost of undertaking this service - the pharmacist concerned does it as a voluntary community service. Although this is commendable as far as the pharmacist is concerned, this example raises the question of the extent to which significant and avoidable costs may be resulting from the lack of funding for this type of service. Two different costs are involved. The first is the cost to Vote: Health of rest home subsidy for people who could be maintained in their own homes through this type of intensive medication monitoring. The second is the loss of quality of life for those older people who could have been maintained in the community but are not because they lack this service.

One priority for the national medicines strategy should be ensuring that good practice in pharmacy intervention is both documented and supported through institutional and funding arrangements.

NON-ADHERENCE

The consultation document reports a Commonwealth Fund finding that almost half of New Zealand patients do not take their medication as prescribed.²

This conclusion is not exceptional. A 2003 World Health Organisation report, *Adherence to Long-Term Therapies. Evidence for Action* notes that "A number of rigorous reviews have found that, in developed countries, adherence among patients suffering chronic diseases averages only 50%".

What is exceptional, given the recognized extent of the problem, is the absence of New Zealand-based research to identify causes, possible solutions, and costs.

Some evidence is provided by a recent New Zealand survey, *Cooperation, Compliance and Concordance. Investigating Ways of Improving Adherence to Prescribed Medication*, (Eagle et al 2005) . This survey involved an empirical study of the general population aimed at providing benchmark data regarding patients' beliefs and concerns about medicines in general and those that may have been specifically prescribed for them. The authors report that the study confirms the findings reported in the international literature. As with the WHO report, it emphasises the importance of understanding the influences on patient behaviour, stating that:

Drawing on models of health behaviour, knowledge of which beliefs are held with what strength across different population subgroups, including sensitivity to cultural differences, is an important step in designing potential interventions aimed at improving medical compliance rates. Potential intervention strategies targeting education, reminder and reassurance issues would therefore appear to warrant consideration.

Using North American data from studies of the cost of medication non-compliance, the authors sought to estimate the cost of non-compliance in New Zealand. They report that " the cost of medication non-compliance in New Zealand, in direct hospital or related nursing-home expenditure and productivity/mortality costs but excluding ambulatory (ie costs relating to outpatient rather than in patient or hospital clinic periods) can be crudely estimated, from 1990 USA data at approximately \$NZ700 million. Using 1995 Canadian data and including ambulatory costs, it can be estimated to be over \$NZ1.3 billion."

² In passing we note the heading "Accurate Dispensing" in the consultation document (page 64) implies 9% of prescriptions dispensed in New Zealand provide either the wrong medicine or the wrong dose. Whilst the text of this section correctly identifies the errors as being made either in the prescribing, dispensing or administration of medicines; a casual reader might easily be misled into incorrectly thinking the problem is confined to dispensing. Further, the text does not indicate the data relate to patients' retrospective perceptions of the reliability of the care they received rather than an objective measure of the accuracy of prescribing, dispensing and administration. These lapses are unfortunate.

Those figures are rough estimates. However, in the Guild's view, they represent a sufficient justification for regarding non-adherence as one of the major avoidable costs within the New Zealand health system. It should also be noted that those are estimates of health sector costs only. They do not include costs to the economy from the loss of productivity, nor do they include any estimate of the loss of quality of life for the patients involved.

Simply from the prevalence of non-adherence internationally, it is clear that both causes and solutions are complex. One important factor is literacy as the consultation paper itself recognizes. Others will include the language which health practitioners themselves use, the appropriateness or otherwise of the context in which instructions are given and received, and the extent to which there is any ongoing monitoring of adherence.

This latter point is quite significant. Currently, pharmacists undertake informal monitoring of patients on long-term medication simply by noting whether or not the patient collects a repeat when that falls due - but with stat prescribing this can mean a three-month gap before there is any indication of a problem which needs to be dealt with.

The Guild recommends that the National Medicines Strategy include a strong emphasis on funding research to produce an evidence-based understanding of the principal causes of non-adherence and medication misadventure in a New Zealand environment, and provide a basis for developing initiatives to counter these. The significance of the potentially avoidable costs should make this an extremely worthwhile investment.

The emphasis should include the consideration of the institutional arrangements under which pharmacy services are currently purchased. Funding research to identify the causes and quantify the costs of non-adherence and medication misadventure is only likely to take place if the funding responsibility rests with the principal risk bearer - the party who ultimately writes the cheques for the additional costs to the health system as a consequence. Unequivocally, this is the government, and not the DHBs themselves. The implication is that the government should pursue a more direct responsibility for ensuring that the necessary research - on causes, costs AND possible solutions - is actually undertaken.

ADDITIONAL PHARMACY BASED INTERVENTIONS

There is now considerable evidence, from international research, of the potential for community pharmacy to contribute significantly to improved health gains through a wide range of additional Pharmacy based interventions. Professor Charles Benrimoj of the University of Sydney's School of Pharmacy, an internationally recognized pharmacy researcher, in a personal communication has stated that "for most potential service interventions, the international research is now robust on how to evaluate. Communication is the main exception."

A very common approach to exploring the potential of new Pharmacy based interventions is to take a research-based approach. The intervention is designed as a pilot project, with a decision on whether to generalise the intervention taken only once the research itself has been completed and evaluated. The following example from Alberta illustrates both a typical research-based approach, and the potential benefits:

Community pharmacists are well positioned to identify and follow patients at high risk for CVD. The recently completed Study of Cardiovascular Risk Intervention by Pharmacists (SCRIP) examined the efficacy of a community pharmacist intervention program on cholesterol risk management. The intervention program consisted of an interview with the community pharmacist to identify cardiovascular risk factors, measurement of total cholesterol and blood pressure, education on risk factor management, and close follow-up. The study was stopped early due to striking benefit in the intervention group. A total of 675 patients were randomly assigned to receive either the intervention program or usual care. After 4 months of follow-up, 58% of patients in the intervention group reached the composite primary end point, demonstrating improvements in cholesterol risk management, compared with 30% in usual care ($p < 0.0001$).

A rich resource, demonstrating the potential range and benefits of community pharmacy interventions, can be found in the pharmacy reference library of the Community Pharmacy Foundation at http://www.tcpf.org/pharm_topics.php. It provides practical evidence of the extent to which there is already a strong research base supporting the proposition that the future role of community pharmacy will increasingly be in Pharmacy based interventions normally in collaboration with other health service professionals.

At the same time there are still significant institutional and other barriers which need to be overcome, and which should be addressed through the national medicines strategy. In 2002 the journal *Pharmacy World & Science* included *Community pharmacists' perspectives on pharmaceutical care implementation in New Zealand*, a report of the only significant piece of New Zealand research on pharmacists' attitudes to the changing role of pharmacy. Amongst the authors' findings were:

- The current study demonstrated that community pharmacists in New Zealand had a reasonable understanding of the pharmaceutical care process and were generally well-disposed towards it.
- Lack of time and absence of a recognized reimbursement system was cited as the greatest barriers to implementation of pharmaceutical care. The current study reinforces the findings of a similar study in the United Kingdom that identified time, remuneration and skills as major barriers to the implementation, and may indicate that the changes confronting the profession are an international phenomenon.

Strong support for this view can be found in a study released in November 2003 by the University of Aberdeen, *Evolution and Change in Community Pharmacy*. The study was a major literature research project designed to explore the following issues:

How is community pharmacy changing in terms of organisational management and ownership arrangements at both operational and strategic level?

- How is the composition of the pharmacy team changing and, how is the extended role of the pharmacy professional developing in the community pharmacy / primary care settings?
- What factors influence innovation in community pharmacy, including individual characteristics, professional objectives and the commercial context?

The study found that there were significant barriers which would need to be overcome if community pharmacy was to become more focused on pharmacy care. The following extract from the report summarises the findings in this respect:

In general, there was consensus that pharmacists are broadly in favour of implementing pharmaceutical care models as part of developing extended services. In this regard, creating an appropriate supportive working environment is a vital process if pharmacists are to be able to undertake such extended roles. Barriers to providing such services were, however, a prominent feature in the literature with critical barriers including time constraints, remuneration systems, and problems of securing appropriate staffing-mix. A central theme was the emphasis on the increasing utilisation of technicians as a means of releasing pharmacists from dispensing duties to perform other roles and support the general restructuring of work processes.

However, financial implications of providing extended services were highlighted as a major deterrent to changing work practices, with inadequate and inappropriate funding systems based ostensibly on dispensing volume, being the cause of many pharmacists not changing working systems or patterns of professional practice. Additionally, lack of access to patients' medical records was highlighted as a barrier to the adoption of pharmaceutical care models, especially in respect of medication reviews. Equally, professional indemnity issues require to be addressed, especially when pharmacists are working across different interfaces in primary or secondary care. Liability exposure is particularly highlighted in US studies. Despite such structural barriers, probably one of the most significant barriers is that of appropriate training and development to ensure that pharmacists have the necessary skills and competencies to perform extended services.

This research suggests that there are challenges in two areas which need to be addressed if the New Zealand health system is to secure the benefits from a pharmaceutical care approach. The first is staffing mix flexibility within pharmacies which will require attitudinal changes within pharmacy. This will in turn raise complex issues around legislative change, service remuneration and contracting, and access to professional development programmes.

The second is the institutional barriers which stand in the way of change, including the basis for pharmacist remuneration (this is discussed below) and access to patient records³ (liability exposure should be less of a problem given New Zealand's accident compensation scheme).

The national medicines strategy represents a very real opportunity to put in place a suitable framework for encouraging additional pharmacist interventions. Some of these will address issues such as non-adherence but others will contribute to better management, within the community, of a number of disease states which result both in significant costs to the health system, if not properly managed, and a poorer quality of life for the individuals involved and their families.

As the Aberdeen study suggests, there are significant transitional issues involved including remuneration, appropriate training and professional development, and encouraging the necessary shift of focus within individual pharmacies themselves. All of these point to taking a pilot project approach.

Community pharmacy would continue to rely on the dispensing fee as its principal source of funding for pharmacy services. Within a series of pilot projects, participating pharmacies would be paid on a cost of service basis reflecting a fair return on the pharmacist's time (it is worth recalling that one of the reasons why the Pharmaceutical Review Services scheme has not been successful is that the remuneration offered by DHBs is insufficient to cover the cost of providing the service). Evaluation would be designed both to assess the extent to which individual interventions could add value, and what would be required, as individual interventions were generalised, to ensure effective monitoring of performance. Crucially, the focus of evaluation would need to be very much on the benefits resulting from the intervention, and how to ensure that they could be replicated if the pilot were generalised. The benefits would include not only the reduced costs in health care terms (for example, through avoiding hospitalisation) but also in terms of better management of an increasingly scarce health sector workforce, and the benefits in terms of improved health status.

As part of the research in preparing this submission, the head of the School of pharmacy at Auckland University was asked for his views on where to put the

³ In the course of preparing this submission the Guild was told of an initiative by one district health board which had resulted in agreement for pharmacists to look at a patient's clinical records. This had assisted the pharmacist to understand both the context within which the GP was prescribing and the objectives the GP was hoping to achieve. It has also resulted in a better focus on monitoring (e.g. warfarin) and an increased level of pharmacist advice to GPs on prescribing - with about 80% of pharmacist suggestions being taken up.

research/pilot project emphasis if areas of high potential for savings were the target.

His first priority was a regular medication review for people on chronic medication, especially older people (Medicines reconciliation) - testing whether this would lead to better health outcomes.

His next was pharmacists screening and referral services. There are still real problems of patient access to GPs even in urban areas. Cardiovascular risk assessment is one possibility - taking blood pressure and assessing cholesterol levels. Other indicators would also be used such as obesity, smoking etc. This would allow pharmacists to come up with a risk profile permitting a judgement on whether the person should be referred for GP attention.

He noted that there was a fear on the part of GPs that this would amount to taking their patients away. An alternative view is that this could amount to recruiting patients for them, since the target group would be people who were not seeing GPs when they should be.

Other potential areas include chronic disease management - asthma, diabetes, hypertension. The community pharmacist is not a diagnostician but, once the decision to treat is taken, there could be a good case for delegating the ongoing management responsibility to community pharmacy, within the terms of the treatment protocol established by the GP.

The obvious recommendation for the national medicines strategy is that it support funding for an ongoing programme of research and development in pharmaceutical care based on pilot projects and designed to produce evidence which would support (or otherwise) the extension of individual pilots nationally. This should be accompanied by parallel measures to ensure that the appropriate training and development for the pharmacy workforce (including technicians) and for pharmaceutical researchers is also put in place.

Appendix: transparency, consultation and public engagement

These three concepts are all concerned with the rights of the public to understand and contribute to the decision-making process by public bodies which may affect their rights or interests. Typically, in the health sector, the focus is on the right of access to treatment.

The three concepts all have their part to play, but each has different implications both for the extent to which the public can be effectively engaged, and for the management of health services expenditure.

TRANSPARENCY

This is a term which is often used in public policy but seldom defined. The following statement is taken from the policy protocol of a New Zealand University:

Clarity and Transparency - Is the policy easily understood and clear in intent

In its use within the health sector, the concept clearly goes a stage further, it is not just whether the policy itself has the required characteristics of clarity of intent and ease of understanding. It is also the public's right to know what decisions have been made on its behalf and how, including the information on which the decisions have been based.

It is a principle which is easy to support but does require care in implementation.

Decision-making on access to medicines typically involves a number of separate steps taken sequentially. Applying transparency to one decision in the sequence, before a next and relevant decision has been taken, could have the potential to mislead rather than to inform. Assume, for purposes of argument, that the process of deciding whether to include a new drug in the pharmaceutical schedule, and the conditions on which it should be included, was amended somewhat so that, in sequence, the first decision was focused solely on considering the therapeutic benefits, without any consideration of costs and benefits. If the principle of transparency was applied to that decision, then the public would be told that the drug was considered to have certain therapeutic benefits without being provided with any information on the associated costs and benefits, as the economic analysis had yet to be done. The risk of this approach to transparency is that it could encourage significant political lobbying for funding of the drug before there had been any opportunity to consider the costs and benefits of subsidising it.

This does suggest that, from the perspective of managing health sector expenditure, the commitment to transparency should be qualified by ensuring that what was made transparent would result in a better informed public - this

may be simply a matter of releasing all information at once (waiting until the full decision sequence had been completed). It may require placing strong emphasis on the fact that costs and benefits had not yet been considered so that no judgement could be made about the appropriateness of subsidising the drug, or the conditions which might apply if it were decided to subsidise it.

CONSULTATION

The law and practice of consultation is reasonably well understood. The entity which is required to consult must publicise its proposal, allow interested parties a minimum period of time (usually at least a month) to respond, commonly also provide an opportunity for people to appear in person and only then make a decision, which must be made with an open mind.

Consultation, generally, is often subject to the criticism that it amounts to the entity required to consult doing so in respect of its answer to its own question when the public may have wanted to be consulted on what the question should be.

Within the health services, and especially in decisions on medication, the main issue of concern is that consultation is always focused on one particular decision. As a consequence it raises what can be termed the "silo" problem. The issue of what to do with a particular medication is considered in isolation from the implications for the provision of other medication, or other modes of treatment. As a consequence it can contribute to the special interest approach to debating access to new medicines and new treatment modes generally. The fiscal risk is that consultation can contribute to upward expenditure in vote: health because it is not will designed to factor in trade-offs.

PUBLIC ENGAGEMENT

Public engagement as a term for a different approach for enabling public input on funding of other decisions within the health sector. Rather than focusing on a single decision, and the opportunity for people to contribute to that, the focus of public engagement is on building up, over time, the capability in the community to consider where priorities will lie not just with new medicines or treatment modes, but with health services generally.

This has not been a practice in New Zealand with in recent years although there is some precedent from the early 1990s. One of New Zealand's four regional health authorities, which had inherited community liaison committees from the previous hospital boards, decided to keep these in place as what were then termed community health groups. Geographically, these were distributed as one group within the district of each local authority covered by the district of the RHA. Modes of appointment differed quite significantly reflecting the informal nature of the arrangement.

A small amount of funding was made available by the RHA for each group. In return, each group committed to providing the RHA with input on all of its

significant decisions particularly in respect of needs assessment and priority setting. This was quite a different focus from the normal consultative practice. Because the groups were committed to providing input on all significant decisions, by definition they really had to recognize that the RHA was in the business of allocating scarce resources in a situation of excess demand. As a consequence, several of the groups (there were 22 in all) were beginning to develop a real sense of the need to manage trade-offs and that there was a community responsibility to be concerned with the effective management of limited resources.

The groups were abolished in a subsequent health reform before they had been in existence long enough for this to become a normal practice in the groups recognized, by the RHA, for what they were, an important part of their overall risk management.

Public engagement of this type is not yet common but does appear to have significant potential, especially in terms of managing the fiscal risk which all too commonly arises as a consequence of special interest pressure when there is no requirement, within the process in which they operate, to take trade-offs and the management of scarce resources into account.

However, to do so the principle of transparency would need to come into play to ensure the public were fully aware of both the range of medicines requiring prioritisation and their relative merits. One could extend this approach to take in new medicines and other new treatment technologies.

IMPROVING DECISION MAKING

The considerations of transparency, consultation and public engagement lead the Guild to another conclusion. Decisions on medicine rationing seek to meet the tests of transparency, consultation and engagement, but in the Guild's opinion fail due to process.

Transparency is also a function of process. The present health system appears to be driven more heavily by process than perhaps it is by outcomes. Having open and transparent processes is deemed positive, many agencies claim such clarity. However, despite this the Guild postulates that there is a need to review decision making process in respect to medicine strategy and medicines rationing.

At the present time rationing decisions in respect to subsidized medicine utilisation are taken in apparent isolation from the funder. The Pharmaceutical Schedule controls access to medicines but is managed by a separate and distinct agency from the agencies responsible for the health of people – the DHBs. While there are linkages between them, DHBs do not and can not exercise the appropriate degree of control over these important rationing decisions. In the Guild's opinion, all rationing decisions should be taken by the funding body responsible for the population to be served.

In consequence, in terms of medicine strategy, the Guild recommends that Pharmac be reconstituted as accountable to DHBs.

In addition, we support industry views that there is merit in further consideration of separating clinical and cost effectiveness assessments of medicines from consequent procurement decisions. This would give DHBs the ability to make investment decisions on medicines and other therapeutic alternatives using common criteria backed by appropriate public engagement. The Guild anticipates the result would be both greater equity in decision making and greater transparency.