PHARMACY GUILD OF NEW ZEALAND

18 November 2014

New Zealand Productivity Commission
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To Whom It May Concern

**RE: MORE EFFECTIVE SOCIAL SERVICES ISSUES PAPER – OCTOBER 2014**

Thank you for the opportunity to provide feedback on the above issues paper.

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

Community pharmacy plays a fundamental role in improving the wellbeing of New Zealanders. They do this by directly providing services as well as by working with many of the other social service providers listed in Figure Three of the issues paper. Community pharmacy provides support and services to patients resident in rest homes, respite and residential care as well as those in their own homes. Pharmacists look after patients recently discharged from hospital and those under the care of mental health, disability support or rehabilitation services. Community pharmacy is very experienced in the coordination of services and helping patients to navigate through the health and social services systems.

A key challenge for community pharmacy is that currently their only purchaser is health, even though they provide services that cover many other areas. Much of the social services work that community pharmacy provides is not recognised by way of formal contract. Because of this we believe that patients are not always getting the best outcomes or funded support that they are entitled to, and which would support them to lead more productive lives in the community.

We wish to respond individually to some of the questions raised in the issues paper as follows.


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**Q1 – What are the most important social, economic and demographic trends that will change the social services landscape in New Zealand?**
The increasing age of New Zealand's population will have major impacts on social services in the future. It will become increasingly important to develop services that enable people to remain in their own homes for longer (Aging in Place) and better coordination of services to avoid duplication.

Community pharmacies already provide a number of services to their communities, which are not being directly funded through the health budget. Increasingly patients are being required to fund these additional services, and in areas of high need this is sometimes not possible. Given that these services contribute to keeping people well in the community and out of residential care it would be of value to the social sector as a whole for these services to be readily available.

**Q8 – Why are private for-profit providers significantly involved in providing some types of social services and not others?**
For any private for-profit provider to be involved in service provision there must be continuity of contract and realistic funding that will enable the provider to invest in service provision and make a realistic return for their owner.

The typical business structure for a community pharmacy is a for-profit provider. In addition to their core medicines provision role, community pharmacy has a "triage, treat and navigate" role for the community. The accessibility of community pharmacy means that community pharmacy is the first port of call for many people with common ailments looking for health professional advice.

The role of community pharmacy across the country does differ dependent on the funding model supporting the pharmacy in individual DHB regions. In other countries community pharmacy is also funded to provide:

- vaccinations
- diagnosis and treatments for common ailments
- chlamydia testing
- health checks and lifestyle advice.

In New Zealand community pharmacy provides some of these services but only to patients who can afford to pay the full cost, otherwise the pharmacy has to refer the patient to a doctor.

While seen as an essential provider of primary health care, community pharmacy is often in the position of both provider and client advocate. Some of the services undertaken include:

- referring patients to ACC, WINZ, MoH
- providing extended services to rest homes, and community residential care facilities
- helping vulnerable patients to navigate the health system
- supporting older patients to remain in their own homes as long as possible.

While the community pharmacy role extends far beyond health, we do not yet have contracts for these patient support roles.

**Q9 – How successful have recent government initiatives been in improving commissioning and purchasing of social services? What have been the drivers of success, or the barriers of success, of these initiatives?**
We are yet to see any success or real change in what is being delivered. We think that one of the limitations is that health alliances are predominantly general practice driven rather than being inclusive of all local health providers as envisaged by the policy. In part this is driven by the requirement that PHOs/General practice contribute their "population funding" to the flexible funding pool.

A driver for success would be a policy change to widen the inclusion to all providers as well as a contribution to the flexible funding to enable this.

**Q10 – Are there other innovations in commissioning and contracting in New Zealand that the Commission could explore? What lessons could the Commission draw from these innovations?**
The Ministry of Health, DHBs and the pharmacy sector, through the Community Pharmacy Services Operations Group, have been effective in developing a collaborative approach to pharmacy contracting and we applaud this.
The Guild would like to see innovative cross-sector commissioning to support healthy aging in the own home. Pharmacy would be keen to be included in an innovative and collaborative approach to this. We also believe there needs to be cross-sector help for those people who cannot currently afford to pay for health services (including their pharmacy co-payments).

**Q11 – What other international examples of innovative approaches to social service commissioning and provision are worth examining to draw lessons for New Zealand?**
In Scotland patients choose from where they wish to access their primary care. Many common medical conditions can be treated in a variety of settings including a community pharmacy or a nurse lead clinic. The patient chooses the setting that they feel most comfortable receiving the service from. Funding is based on the patient and not on where they chose to access their treatment.

**Q12 – What are the barriers to learning from international experience in social services commissioning? What are the barriers and risks in applying the lessons in New Zealand?**

To apply learnings from any international experience, consideration must be given to the underlying funding models. Different funding models drive different behavioural incentives and it is important that these are recognised and considered before learnings are applied to our unique funding model.

**Q13 – Where and when have attempts to integrate services been successful or unsuccessful? Why?**

Much of the integration in primary healthcare has focused on co-location rather than true integration; therefore we do not believe that patients have seen the potential benefits that these attempts at integration had envisioned. Patient choice can be limited in situations of co-location.

Organisational integration could be aided with the use of IT, such as a shared care record and the ability for different providers to securely message each other about a patient.

**Q15 – Which social services are best suited to client-directed budgets? What would be the benefit of client-directed budgets over existing models of service delivery? What steps would move the service in this direction?**

There are a number of services that community pharmacy provides that are well suited to a client-directed budget:

- Preventative health interventions e.g. vaccinations
- Healthcare monitoring e.g. Community Pharmacy Anti-Coagulation Management Service (CPAMS)
- Managing in the home e.g. weekly preparation and delivery of medication packs.

We would like to be involved in helping you explore these examples.

**Q18 – How could the views of clients and their families be better included in the design and delivery of social services?**

By asking clients and their families where they would like to access their services. For instance the accessibility of services and the option of patient choice are important to clients and their families. Vaccinations are an example of a service provided by pharmacy where the views of clients show a clear preference for pharmacy provision of this service.

Pharmacies are often situated in areas where there is no other form of social service, particularly in rural communities. For very isolated communities, some pharmacies

provide a depot service where the patient's medicines are delivered to a depot which hands out the medicine to the patient. This service ensures continuity of care for the patient, yet the service is provided for free by the pharmacy. It is important that clients in these rural and isolated areas are consulted as to what social services are essential to them and whether they believe community pharmacy is an appropriate location to provide these.

**Q19 – Are there examples of service delivery decisions that are best made locally? Or centrally? What are the consequences of not making decisions at the appropriate level?**

At present there is inconsistent accessibility of services by communities across New Zealand. The Guild would like to see national consistency of services, but there will need to be some flexibility in how these are delivered at a local level.

The following services are funded by some DHBs but not others:

- Smoking cessation
- Emergency contraceptive pill
- CPAMS
- Returned medicines collection
- Disposal of medical sharps e.g. diabetic and other needles.

In the case of community pharmacy, a service that is now embedded in primary care is the Community Pharmacy Anti-Coagulation Management service (CPAMS). Community pharmacies were given the opportunity to explain how they would provide a quality monitoring service to their warfarin patients. There are now over 3400 patients working directly with their local pharmacist to manage their warfarin levels. The service is an excellent example of the pharmacist and GP working collaboratively for the benefit of the patient, and as integral members of the primary health care team. It has been proven to be safe, effective and cost-effective alternative to 'standard' anticoagulation management provided through medical centres. Patients much prefer the pharmacy service: pharmacies use the finger prick method (not venous blood), it gives an immediate result, a print out of new dose chart is available, pharmacists ensure they have the right strength tablets and the time that patients remain therapeutically stable is significantly better than with other providers.

This helps free up more GP/nurse/lab time and resources.

**Q20 – Are there examples where government contracts restrict the ability of social service providers to innovate? Or where contracts that are too specific result in poor outcomes for clients?**

Community pharmacy has experience with a DHB contract that in some areas has been so specific as to restrict those patients with complex needs access to a higher level pharmacy care. While understanding the need to define the service, this needs to be done in such a way as to not accidentally exclude patients who would benefit from the increased level of care especially those considered as vulnerable with complex needs.

Funding for patients with mental health issues and for daily observed doses for very high needs patients is not adequate to cover the extra service provided by pharmacists to these patients.

The Community Pharmacy Services Agreement introduced a new service to increase the adherence of patients with long-term conditions to their medicines. This service has very specific eligibility criteria that the patient needs to meet before a pharmacy receives payment for the care of this patient. Often high needs patients, who clearly require adherence support from a pharmacist, do not meet the eligibility criteria. In these instances either the pharmacy provides the support to the patient for free, or the patient does not receive the service.

This example illustrates that if services are to be specific, there still needs to be funds set aside for those people who do not meet the criteria, but who still need the service.

**Q25 – What are the opportunities for and barriers to using information technology and data to improve the efficiency and effectiveness of social service delivery?**

The transfer of knowledge and sharing patient information between providers is an opportunity that improved information technology provides. With multiple health professionals and support workers all having access to the same data, the opportunity for true integration between providers is possible.

Barriers or pitfalls to using information technology would be breaching of patient privacy or any unauthorised access or use of patient information. Security and data access rules will help to protect against these pitfalls.

**Q28 – What are the characteristics of social services where contestability is most beneficial or detrimental to service provision?**

Research shows that there are better outcomes with contestability. There are a number of services where pharmacies compete with each other e.g. CPAMS (as mentioned above) and specialised services like mental health in home dose administration.

The lack of experience in tendering processes may limit some quality providers from getting involved in contestability. This is certainly true for community pharmacy, which have traditionally not needed to apply for contracts for services through tendering

processes. Currently, pharmacies compete with each other to provide the CPAMS service. Research clearly indicates that patients prefer the pharmacy service over that provided by GPs and laboratories. True contestability would be where pharmacy competes against all other warfarin-monitoring providers such as GPs and labs.

**Q 29 – For which services in which parts of New Zealand is the scope for contestability limited by low population density?**

In some parts of New Zealand where there is a low population density, services such as CPAMS may not be viable for pharmacies to offer. In this instance there would be no scope for contestability, however we believe there should be adequate funding provided to ensure all New Zealanders have access to this valuable service. Isolated and rural areas have a low scope for contestability for other services such as WINZ, mental health services, addiction support, and community care and support.

Many of these support services that are unable to be sufficiently provided in isolated and rural areas could be adapted and made available through community pharmacy.

**Q 34 – For what services is it most important to provide a relatively seamless transition for clients between providers?**

It is extremely important for clients to transition smoothly through between health providers. Community pharmacy provides an easy flow between different health services and in a limited number of DHB areas is now funded to provide an increased amount of effective service in this area, e.g. hospital discharge reconciliations. Patient-to-pharmacist relationships are often very consistent, with patients remaining loyal to a particular pharmacy over a long period of time. This is in contrast to their contact with other healthcare providers, where they are likely to have contact with a number of doctors or other healthcare providers. Pharmacists are still recognised as the health professional that is seen most often by the patient. Community pharmacies often have deep roots within their community, and many pharmacists have long-standing relationships with their patients and their families. This bond can prove valuable when a clear, accurate, medical history is required, as it is considered that community pharmacy is the holder of the most current health record.

**Q 41 – Which types of services have outcomes that are practical to observe and can be reliably attributed to the service?**

The Long Term Conditions (medicines adherence support) service provided by community pharmacy helps monitor patient adherence to their medication. The outcomes for this service, that of increased patient adherence, fewer doctor visits and hospital admissions are all observable outcomes that can be attributed to the support provided to patients by community pharmacy.

There is research about the superior effectiveness of smoking cessation advice when provided through pharmacy. Smoking cessation services within community pharmacy give patients another point of access to community based cessation service, timely access and follow up support and is available to smokers that do not frequently access other primary care services. Successful quit rates from patients who have accessed services within community pharmacy are directly measureable.

When provision of the emergency contraceptive pill (ECP) and contraceptive counselling by community pharmacy was funded in MidCentral DHB, there was a reduction in unplanned pregnancies.

The increased uptake of influenza vaccinations has been attributed to pharmacy provision. A 2012 study[i] showed that community pharmacy provision of immunisations had a direct impact on the uptake of the influenza vaccine. Forty-two percent of those immunised in community pharmacy had not been immunised the previous year, and stated the reason they had not been immunised was that they were too busy to visit a doctor.

**Q 44 – Do government agencies and service providers collect the data required to make informed judgements about the effectiveness of programmes? How could data collection and analysis be improved?**

Data collection in community pharmacy has dramatically improved over the last couple of years, and numerous systems are now being launched or improved to help the patient record and share patient information. Measures are now being taken to analyse the data and report on the effectiveness of pharmacy services provided throughout NZ.

Access to IT funding and collaboration with more health organisations would increase data collection.

We believe that the implementation of the Community Pharmacy Services Agreement should be properly assessed including the outcomes of the provision of medicines adherence support.

**Q 48 – Would an investment approach to social services spending lead to a better allocation of resources and better social outcomes? What are the current data gaps in taking such an approach? How might these be addressed?**

We need to move away from an attitude of services 'costing money' to an attitude of investing in a patient's health outcomes. Money spent on medicine can be considered a cost or alternatively it can be considered an investment. This investment can improve the patient's health and reduce their future health care needs, keeping the patient as an active contributing member of society for longer.

There is a desperate need to invest in pharmacy IT solutions. Currently community pharmacy has limited ability to record patient services, interventions and outcomes. Investing in IT solutions for community pharmacy will allow this information to be documented and shared, resulting in improved prescribing, reduced error rates, better patient outcomes as well as a more seamless transition between healthcare providers.

When healthcare teams are able to see a patient's whole "care plan" they are all able to work together and improve the patient's wellbeing, reducing the need for duplication of social services.

Thank you for taking the time to read our response to your issues paper. If you have any questions about our feedback, please contact our Pharmacist - Professional Services and Support, Tracey Sullivan, at t.sullivan@pgnz.org.nz or 04 802 8209.

Yours sincerely,

**Lee Hohaia**
Chief Executive

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[i] Hook, S & Windle, J. Community pharmacy influenza immunisation increases vaccine uptake and gains public approval. *Australian and New Zealand Journal of Public Health.* 2013;37(5):489-490.