PHARMACEUTICAL SOCIETY
of New Zealand Incorporated

23 November 2015

Trish Farrelly
Pharmacy Action Plan -Submissions
Ministry of Health
PO Box 5013
Wellington 6145
via email: pharmacyactionplan@moh.govt.nz

Dear Trish,

RE: Draft Pharmacy Action Plan 2015-2020 Consultation.

Thank you for the opportunity to submit comments on the Ministry's draft Pharmacy Action Plan document.

The Pharmaceutical Society of New Zealand Inc. (the Society) is the professional association representing over 3,000 pharmacists, from all sectors of pharmacy practice. We provide to pharmacists professional support and representation, training for continuing professional development, and assistance to enable them to deliver to all New Zealanders the best pharmaceutical practice and professional services in relation to medicines. The Society focuses on the important role pharmacists have in medicines management and in the safe and quality use of medicines.

The content of our submission has been informed by the views and comments of members of the Society and our National Executive.

We would like to note that two members of our National Executive assisted in the Ministry's development of this document as members of the Pharmacy Steering Group. Recognising this potential conflict, both Graeme Smith and William (Billy) Allan have not contributed to the development of the Society's response, other than participating in the National Executive meeting where the Action Plan and our response was discussed.

The Society strongly supports the Action Plan and its intended purpose. The focus areas and actions described in the Plan align well with the Society's own direction and strategy for the profession in the next 5-10 years. The Society also appreciates being recognised by the Ministry as having a principal role in the implementation of both this Pharmacy Action Plan, and the government's medicines strategy in Implementing Medicines New Zealand.

The Action Plan references the 'Partnership for Care: Vision 2020: pharmacists and doctors working together' joint vision statement released by the Society with the New Zealand Medical Association.[1] We are pleased to see this referenced in the Plan, as this document notes the commitment of the two pan-professional organisations to work towards an integrated and collaborative practice to improve patient care and health outcomes for New Zealanders. As the Action Plan is finalised and is implemented, the Society is committed to working in partnership with our medical and other health colleagues to develop and deliver pharmacist services that utilise the accessibility and specialist skills and knowledge pharmacists have in medicines management and optimisation. While the pharmacist is an autonomous health professional delivering health services to New Zealanders, we recognise the need for

pharmacy-delivered healthcare to be appropriately recognised by the wider health sector but also to ensure it contributes to the shared care of individuals.

The Society believes the pharmacy sector is well placed to contribute to the focus areas and actions described in the Action Plan. The Society released the National Pharmacist Services Framework in 2014 after extensive cross-sector consultation[2]. The Framework describes and defines a range of services that pharmacists can and are, delivering, and is a fundamental document in describing the "what" and "how to" of the actions described in the Ministry's Action Plan.

The feedback the Society has received on the Action Plan has been mostly very positive. However the overarching view of this feedback and of the Society itself, is that the successful implementation and delivery of the Action Plan is dependent upon appropriate and sustainable funding of the services and activities. The Society considers the foremost "enabler" for supporting the changes described should be "restructured funding". This does not necessarily reflect new funding, but that the funding systems within the health sector could be reconfigured to allow the Ministry to meet the government's aims to help "*set out how we can make better use of the knowledge and skills of our pharmacy workforce*" and to "*ensure pharmacy services are better integrated with other health professionals in multi-disciplinary teams*"[3]

An essential element of the "enabler" of restructured funding, and the requirement for the pharmacy profession's full potential to meet the aims and objectives of the Ministry's Pharmacy Action Plan, is that all issues related to the appropriate and sustainable funding of distribution and dispensing/supply of medicines are resolved.

The medicines dispensing and supply activity is the central function District Health Boards contract pharmacists and pharmacies to perform. There are a considerable number of regulatory, professional, ethical and clinical aspects to the dispensing and supply of medicines that many pharmacists believe the Ministry and DHBs have forgotten are performed on their behalf. The pricing and funding of medicines by Pharmac and funding of dispensing and medicines supply services by DHBs is disjointed, leaving pharmacies and the public themselves, exposed to extra financial costs in order to dispense some treatments as intended by prescribers.

A further enabler for the implementation of this Action Plan is to increase recognition of the unique role and capability of pharmacist-delivered healthcare, and see this acknowledged across the health sector. Community pharmacists are extremely frustrated with the perception that the healthcare and services they provide is for commercial gain only.

The free access and advice available from a community pharmacist is only possible due to the sale of medicines and health-related products. Community pharmacists provide personalised health and self-management advice and make a considerable number of clinical health interventions for the population on a daily basis that are not funded. The "funding" or "payment" for the treatment comes either through the sale of a medicine or product. However, the time taken by a pharmacist to assess the appropriateness of treatment or the requirement for medical referral is not in itself "funded". Many in the health sector and beyond, see pharmacies as businesses as opposed to healthcare providers due to the retail sale of medicines. Consumers and health funders appear to accept that the fees and costs associated with general practice appointments are a necessary part of accessing healthcare, yet pharmacies charging for the sale of medicines and health products to "fund" their healthcare provision is viewed as being profit-focussed or "making a buck". The Society looks forward to working with the Ministry, DHBs and wider health sector to improve the recognition of pharmacies as primary healthcare providers and in developing new mechanisms for the provision of pharmacist services to the community.

Comments on the focus areas and enablers of the draft Pharmacy Action Plan.

Focus area 1: Population and personal health

Pharmacists providing public health interventions that enable people to live well, stay well and get well

The Society supports a greater role for pharmacists in providing public-health level interventions. As will be mentioned throughout this submission, the Society contends that pharmacists already provide a considerable contribution to public health in assessing and addressing the health needs of individuals and communities. The issue is that this is not well acknowledged by the wider health sector, nor does this personal and population health advice and treatment receive funding.

Pharmacists in both primary and secondary care are called upon to provide advice and education on self-care and the pharmacological and non-pharmacological management of medical conditions. Pharmacists in primary-care provide lifestyle and treatment management advice and will instigate medical referrals, or where appropriate provide over the counter treatment and advice. Pharmacists are front-line health professionals that see those individuals and groups who cannot afford the fees to see their doctor, are not sure if their health concern requires their doctor's assessment, or whether their health concern is sufficiently "minor" that can be managed without medical involvement. As the referral processes between pharmacists and general practice are not formalised, a pharmacist's role in an individual presenting to their GP is not often recognised. Similarly, the extensive and varied health interventions that pharmacists make are not captured locally, regionally or nationally, therefore those activities are poorly understood outside of the profession.

Action examples on how to implement

The 'Health Promotion and Preventative Services" section of the National Pharmacist Services Framework presents the health education, immunisation and screening and intervention services that pharmacists already are, or could, deliver to their communities. The accessibility of pharmacists could be utilised for providing screening and intervention services appropriate for a pharmacy setting, and integrating these with local or national health promotion activities, strategies and/or targets. The Framework provides examples of how outcomes of such screening services might include a referral for full medical assessment/management, the provision of a pharmacist-only medicine, the provision of a prescription medicine in accordance with a standing order, or perhaps just data being collected which is then fed into a multidisciplinary shared-care plan.

The Society believes the enablers for delivering the actions associated with focus area 1 include:

- improving the recognition of the pharmacist/pharmacy contribution to healthcare delivery and in local and national health promotion campaigns
- the inclusion of pharmacist-delivered services in public health and health promotional funding streams
- recognise, utilise and promote the accessibility and expertise of the pharmacist as a source of reliable healthcare advice and point of entry to health services
- implementing formal and integrated two-way referral processes and information sharing between pharmacy, general practice and secondary care, including shared care and medication records
- ensuring services provided by pharmacists are complementary to other providers (doctors, nurses) and not in competition with
- incorporating pharmacist-delivered services in publically funded health programmes such as immunisation services and smoking cessation services. Smoking cessation and immunisation services are two key health areas that pharmacists contribute towards

and could make significant gains in improving health outcomes. Yet there has been an overt unwillingness for Pharmac, DHBs or other funders to fund pharmacists to deliver these.

Specific comments on Focus Area 1 of the Action Plan as written:
Wording Page 13: Opportunities for change: "pharmacists as a first point of contact…. "~~could~~" becomes "should".

Actions:
DHBs: references to "interdisciplinary" should reference the specific inclusion of pharmacists in the interdisciplinary models/approaches. There needs to be key accountability and evaluation of meeting these actions in DHB annual plans.

Sector:
Research: recognise the schools of pharmacy as the lead accountability, however, the Society also notes the pharmacy and pharmacist-service research that is undertaken by other universities and departments including departments of general practice, health management, health policy and others at Otago, Auckland, Massey and Victoria universities.

The New Zealand Pharmacy Education and Research Foundation (NZPERF) allocates funding grants for research projects and certain specific academic prizes. The Society sees NZPERF as having an important role in working with the sector and research organisations who may be participating in pharmacy practice research.

Health literacy practices: the Society has promoted health literacy as a key area for continuing professional development within the profession, developing education programmes and promoting health literacy resources.

Promotion and supply of over-the-counter products for which there is little evidence of efficacy: this is a highly complex area that balances professional ethics and practice against health demands and consumer choice, with risks and benefits of a product. This is also considered alongside the complications of direct-to-consumer advertising and the lack of funding for over the counter (OTC) health services. The arguments surrounding what may or may not be sufficient levels of "evidence of efficacy" for health products was the subject of the Society's recent submission to the Pharmacy Council's consultation on the wording of the Code of Ethics.[4] The Society notes that many areas of medicine have conflicting evidence surrounding treatments, and that choice of treatment falls to the professional judgment of the practitioner in meeting the best interests of the individual. The Society supports actions that will enable pharmacists to only promote and supply health products with appropriate evidence of efficacy.

Focus area 2: Pharmacist clinical services

Pharmacists working collaboratively as part of an integrated team to deliver a comprehensive range of medicines management services

The Society strongly supports the development and provision of medicines management and other clinical services by pharmacists. The Framework of Pharmacist Services presents medicines adherence and medicines optimisation services that aim to optimise use, effectiveness and understanding of medicines. Furthermore, the requirements for integrated and collaborative care associated with these services are very clearly described.

The Framework also describes the activities associated with hospital clinical pharmacy services that blend many of the services described in the Framework document, particularly Medicines Use Review, Medicines Optimisation (Medicines Therapy Assessment, Comprehensive

Medication Management), Health Education, Medicines Information and Pharmacist Prescribing.

In May this year, the Society published its Position Statement on Polypharmacy and Medicines Optimisation[5] to highlight the increasing prevalence of polypharmacy and potentially inappropriate medicines, and call for the widespread implementation of pharmacist-delivered medicines management services by pharmacists to assess, address and monitor these issues urgently. This had a specific priority for high-risk and vulnerable populations such as Māori, older people, those taking 4 or more medicines and those in residential aged-care. New Zealand data has demonstrated that the Medicines Therapy Assessment (MTA) service delivered by pharmacists can reduce acute hospital admissions and is a cost-effective intervention.[6]

Pharmacists are recognised by the health sector as having the specialist skills and knowledge to optimise medicines and are well-placed to deliver these services. Within secondary care, pharmacists are seen as essential members of the clinical team and recognition of this clinical capability needs to be extended into primary care. Many community and primary-care based pharmacists are already delivering medicines management services. However, there needs to be equitable access to these services throughout New Zealand, as access currently depends on how each DHB perceives and prioritises need and funding.

In secondary and tertiary care, the advanced clinical knowledge of pharmacists contributes specialised pharmacotherapeutic advice towards the complex patient care and medication treatment in this setting. In hospitals, pharmacists may specialise in many areas of medicine, as well as speciality areas uniquely suited to pharmacy such as medicines safety, medicines information and involving roles such as medicines reconciliation. Clinical pharmacists in hospital may also have roles in emergency departments, admissions, discharge planning and in primary-secondary care liaison roles.

Action examples on how to implement

The Society recommends the prioritisation of medicines optimisation services for high-risk patients and encourages pharmacists' participation in delivering such services, particularly for those in residential care facilities, those taking more than 4 medicines or those taking complex medications. We also support the inclusion and delivery of MTA services as an optional service available to general practice and Primary Health Organisations. Such services could be provided by accredited pharmacists working from community pharmacies, consulting pharmacists contracted specifically and/or by clinical advisory or 'general practice' pharmacists employed by practices in a medicines optimisation role.

Recommendations from the Society's Polypharmacy and Medicines Optimisation Position Statement[5] included:

- Increased collaboration between pharmacists and medical practitioners, non-medical prescribers, nursing and allied health professionals in optimising medicines
- The sustainable delivery of medicines optimisation services by pharmacists as described in the New Zealand National Pharmacist Services Framework. Particularly to high risk and vulnerable populations such as Māori, older people, those taking 4 or more medicines and those in residential aged-care
- The use of evidence-based screening and assessment tools to assess and review the use of multiple medicines such as PINCER, STOPP/START, Beers or similar protocols aimed at deprescribing
- The inclusion of pharmacist-delivered medicines optimisation services in strategic planning, health pathways, guidelines and standards of care where ever medicines are used.

Enablers for this focus area include greater opportunities for collaborative interactions and combined education between pharmacists, medical practitioners, nursing and the other health professions. Within the hospital environment, prescribers and nurses have the opportunity to learn and understand the role and skills of pharmacists in medicines management. Whereas the majority of interactions between pharmacists and general practitioners is unfortunately dominated by Pharmaceutical Schedule-related issues or prescribing regulations.

We note the pilot project being conducted by the Nelson-Marlborough DHB and 2 local PHOs exploring MTA services in rest homes. The outcomes of this pilot will inform local health providers of the contribution of pharmacist-delivered to the interdisciplinary care of patients can make. Similar pilots of MTA services are being conducted in Canterbury, Southern and other DHB regions. The Society would like to see support for other DHBs and PHOs to conduct their own pilots of these services, with a view to developing these into a sustainable ongoing service model.

The Society believes the role of pharmacists' extended medicines management sits separately to the dispensing and supply function. There are opportunities for pharmacists to bridge gaps between primary and secondary care, as well as across primary-care and medicines supply roles. This can be achieved through supporting the establishment of pharmacists in dedicated positions in hospital as a primary-secondary care liaison, in general practices as primary-care/general practice pharmacists, and community pharmacy-based medicines management pharmacists. Funding for these positions should be managed outside of the community pharmacy services agreement, although the funding system for dispensing pharmacists roles in medicines management must accommodate for the conflict in funding per item dispensed against potential recommendations to reduce the number of prescribed medicines.

In meeting actions related to services "that support older people and patients with complex health needs to live well in their own homes", the Society believes agreements need to include funded access to blister-packaging and other dose-administration aids. Such aids strongly support an individual to live independently and self-manage their medicines, however the costs of these can be a barrier for many older, high needs and/or vulnerable individuals with low incomes.

Clinical pharmacist services in hospital care
There is a significant body of evidence that supports a core set of patient-centred hospital clinical pharmacy services that impact positively on patient outcomes by reducing mortality and drug costs, and must be provided to all inpatients.

The Society seeks the recognition and development of the advanced specialised skills of hospital-based pharmacists. The Society supports the work of the New Zealand Hospital Pharmacists Association (NZHPA) in developing a national career structure for hospital pharmacy staff. We strongly recommend the Pharmacy Action Plan includes an action for the Ministry and DHBs to engage with NZHPA to develop and nationally implement this career structure project, to ensure the specialised knowledge and contribution of pharmaceutical care of complex patients is recognised and sustained.

The Society recommends actions on DHBs to ensure there is recognition and resource allocated for hospital pharmacy services to meet internationally recognised standards of clinical pharmacy service delivery. DHBs are not equitable in recognising the health outcomes and cost benefits gained by the specialised clinical pharmacist services in medical specialties such as paediatrics, oncology, antimicrobial stewardship/infectious disease as well as specialised pharmacist services such as medicines information and specialist compounding services.

The Society supports DHBs developing or expanding new models of hospital clinical pharmacist services such as in emergency departments, admissions, discharge, specialist outpatient clinics and in primary-secondary care liaison-type roles. These can assist with medicines reconciliation and transition of care processes, as well as increasing the accessibility to the specialised pharmacotherapeutic knowledge in optimising medicines use.

The Society recommends the Ministry and DHBs support and develop a model for the national delivery of medicines information services delivered by a network of medicines information centres to primary and secondary care health professionals. Comparable to the United Kingdom Medicines Information network, existing New Zealand medicines information centres receiving greater resourcing could provide independent and unbiased evidence-based information about medicines and advice on their therapeutic use to health professionals in secondary and primary care. This could contribute to optimised medicines use in prescribing and management of medicines. An excellent example of medicines information service provision to health professionals across both primary and secondary care within a DHB, is the highly respected Christchurch Clinical Pharmacology Department Drug Information Service.

The Society recommends DHBs allocate resources to develop or support specialised antimicrobial stewardship/infectious disease pharmacists to assist with meeting the objectives and actions related to the optimal use of antimicrobials – one of the impact areas of the government's Implementing Medicines New Zealand strategy.[7] Such roles should be DHB-wide and work with clinicians and infectious disease specialists to develop and deliver antimicrobial stewardship programmes across secondary and primary care. These programmes are increasingly recognised internationally as mandatory requirements to address antimicrobial resistance.

The Society encourages DHBs to recognise and develop pharmacist prescriber models in secondary care to complement and support prescribing in specialised clinical areas. The collaborative nature of the pharmacist prescriber scope of practice combined with the advanced clinical knowledge of specialised pharmacists provides an additional practical tool to the multidisciplinary team.

All health practitioners have a regulatory requirement for maintaining continuing professional development under the Health Practitioners Competence Assurance (HPCA) Act 2003. Many clinical staff employed in DHBs receive financial support and educational leave to meet this requirement. The Society recommends inclusion of an action for DHBs to support postgraduate education and continuing professional development for hospital pharmacists. We also recommend funding for continuing education in primary care through DHBs and PHOs incorporate access for community/primary-care based pharmacists.

Specific comments on the Action Plan as written:
Second paragraph: The Society recommends removing references to the Pharmacy Council's Medicines Management Competence Framework as it is out of date. It does not define competence requirements for the various "levels" of medicines management services. While the stated "boundary determinants" are confusing and do not clearly distinguish between the services. We, therefore, recommend removing this reference and highlighting the detailed definitions and descriptions outlined in the National Pharmacist Services Framework 2014.

Header "How can pharmacist clinical services contribute to improved health outcomes": first paragraph: we would suggest changing the reference "*suffering* from long-term conditions" to "*living with* long-term conditions".

The Society acknowledges reference to the "Impact of Medicines Therapy Assessment" report that indicated the clinical and financial benefits in pharmacists delivering this medicines management service.[6] We recommend the evidence from this report be considered by DHBs

and ensuring Aged Residential Care service agreements include equitable access to pharmacist-delivered medicines management services.

Actions:
DHBs: the Society wishes to highlight the importance of ensuring DHBs have a consistent approach to medicines adherence and optimisation services. There is currently no equitable access to pharmacist medicines management services across New Zealand. Some DHBs have contracted selected groups of pharmacies or pharmacists, a couple have quite wide availability of contracts, where others have no provision of contracts for these services.

Focus area 3: Acute demand management

Patients having equitable and timely access to self-care advice, treatment of minor ailments, acute demand triage and appropriate referral

As mentioned above under 'Focus Area 1: Population and personal health', pharmacists have a unique position in providing health advice and services to a community. The accessibility of pharmacists allows individuals with health needs to seek advice from a health professional without an appointment and mostly without charge. Pharmacists use their knowledge and professional judgement to assess the needs of that person, provide advice and/or treatment options, or where appropriate refer to their GP for medical assessment. Pharmacists see those patients who have barriers to attending their doctor, either through appointment costs, scheduling available appointment times with work and other commitments, or due to costs of prescriptions and the treatment itself.

Pharmacists have managed the assessment and treatment of numerous common, or "minor" ailments for centuries. The cost of the service is covered if a treatment is "sold", however if a treatment is not suitable, that health service was provided free. If an individual were to arrange and pay for an appointment with their GP, they could access funding of that over the counter treatment via the prescription subsidy. An overall cost to the patient for the appointment cost, the health system for its contribution to the GP consultation and then the funding of the treatment.

The government's 'care closer to home' focus encourages more services and care being provided in primary rather than secondary care. Pharmac are also shifting funding of complex pharmaceutical treatments such as clozapine and oral chemotherapy agents into primary care. The increasing complexity of care being asked of general practices will require greater coordination and sharing of care to free-up GP time to manage these cases. The Society supports a scheme that shifts management of comparably "simple" or "minor" complaints to pharmacists, with appropriate referral processes in place, while maintaining effective systems of shared care and recognition of the medical or healthcare home. An integrated model for such a scheme would help ensure health needs can be met by the multi-professional team, and meet the objectives of care closer to home.

The Society firmly believes that pharmacists should be able to access funded over the counter treatments for a defined list of common ailments that do not require a medical assessment. However, alongside such a system there needs to sit formal referral pathways from pharmacists to GPs, to facilitate access for urgent medical attention, and also to provide a means to communicate the pharmacists' assessment. If delivered appropriately, a referral and information sharing system would aid a GPs assessment in recognising what an individual has already described to the pharmacist, while also providing recognition for the contribution of the pharmacist to the health needs of that person.

Many people, particularly in high-needs populations, find the cost to see a GP a significant barrier, resulting in unmet health needs.[8] The Society has received feedback from our members that many people present to pharmacists because they cannot afford to see their

GP, or they cannot get a suitable appointment time with their GP due to scheduling times, GP availability, or work/school commitments. For many others, they are simply not sure if their health need is of sufficient concern to "warrant the cost" of seeing their GP.

Recently published New Zealand evidence suggests that people are struggling to afford charges associated with visiting their GP, and they will put up with painful and/or serious conditions as they cannot afford assessment and/or treatment costs. These include around $30-$40 for a consultation, or $15-$20 for prescriptions written following a phone request – without the patient having been seen.[9]

Pharmacists understand the potential for serious and complex conditions that may lie under a presenting "minor" or "common" ailment. They are fully aware of the signs and symptoms that flag such serious conditions and promptly refer for medical diagnosis and management. The Society strongly believes that individuals should not have to schedule appointments with their GP to access funded treatment for minor conditions such as headlice, hayfever, minor allergies or fungal infections. Or similarly for medications that may be provided by accredited pharmacists according to defined criteria such as trimethoprim for uncomplicated urinary tract infections, or the emergency hormonal contraceptive pill (ECP). Many DHBs are choosing to fund access to the ECP from pharmacists, initially in conflict with Pharmac's own role. The Society would like to see an action for the Ministry, DHBs and Pharmac to work on new models of care to permit access to funded pharmacist-only medications from a pharmacist without the requirement for a prescription.

Action examples on how to implement

The treatment and appropriate assessment is currently available from pharmacists, however the funding is not. The Society supports a collaborative approach to developing a funded common ailments service to ensure guidance related to assessment and advice is clear and evidence-based, and when necessary that medical referrals are made appropriately. To reduce the risk of incentives to supply treatment and/or specific commercial biases, treatment costs for such a service could be guided by the pharmaceutical schedule, and the pharmacist consultation funded separately, so where the pharmacist-delivered treatment was not appropriate, that assessment can be recognised.

A model of minor/common ailments could be based on the fee the DHB would have paid a GP to assess and treat that patient, being transferred to the pharmacist. The patient would not have to pay the co-payment to see the GP, they could see the pharmacist for free in their own time, perhaps contributing a $5 co-payment for the medication treatment. The time taken for that GP consultation could then be taken by another patient requiring medical assessment. We would see eligibility criteria applying to such a scheme, targeting high-needs and/or low-income populations only.

A recent study looking at reasons for presenting at Dunedin's free clinic indicated that prescription renewals were one of the most frequent triggers for GP contact.[8] While some pharmacists in New Zealand accommodate payment plans or even waive prescription fees for those patients who either cannot afford or have considerable difficulties in paying their prescription charges.[9] The Society would like to see an action for The Ministry, DHBs and the pharmacy and medicine organisations, along with social services agencies, to develop mechanisms for pharmacists to accessing funding that would address barriers for low-income individuals to access continued supply of medicines on prescription and either fund or remove co-payments.

Patients themselves want a greater role in self-management and seek more specific and detailed information about the treatment they have been prescribed.[10] New models of care that enable an increased role of pharmacists in acute demand management would meet this need while providing more time for doctors to assess and manage more complex cases.

Specific comments on the Action Plan as written:
Page 17 headline "how can pharmacists contribute to improved acute demand management": The Society supports the suggestion of pharmacists located in emergency departments to contribute to acute demand management and would like this role highlighted to DHBs. Such a role could assist medicines reconciliation and admission processes, could liaise with primary care and community pharmacists, and could also include a pharmacist prescriber scope of practice, to enable prescribing of appropriate medications for a patient being discharged from ED, or to chart regular medications at admission. A collaborative model working with the medical team could be developed to define the role of the ED pharmacist.

The Society supports the development of a funded common ailments scheme, and acknowledges that a service model would be highly collaborative to ensure individuals that do not fit the defined eligibility criteria for the scheme were referred for medical management.

The Society recommends an action for the Ministry to work with the Sector to consider a continued dispensing mechanism by pharmacists, comparable to what occurs in Australia. Whereby an eligible medicine that has been previously prescribed for a stable patient and where a clinical review by the prescriber supports a pharmacist to supply the medicine without a prescription once in a 12 month period.

Focus area 4: Dispensing and supply services
More effective use of the pharmacy workforce and technology to reconfigure the dispensing and supply process

The Society acknowledges that the call for the pharmaceutical margins issue to be addressed has been recognised by the Ministry and DHBs. The margin may seem a relatively minor barrier compared to the significance and wide-reaching aims and objectives of the Pharmacy Action Plan. However, the Society strongly recommends that the issues are addressed and resolved, so that everyone can move on to implementing the Action Plan over the next 5 years.

The Society strongly supports the role of the Pharmacy Accuracy Checking Technician (PACT) and has been responsible for leading the pilot project over the past year. The results and evaluation of the PACT project have been extremely positive, with a number of benefits identified. The Society has made a commitment to the nationwide development of the PACT role, which will be guided by the formal evaluation and project reports. Feedback from pharmacists participating in the pilot as well as information from a study investigating pharmacist opinions of advanced roles for technicians does suggest these roles allow pharmacists to have more time available for patient-centred activities.[11]

The Society acknowledges the opportunities and efficiencies that robotic dispensing offers for some pharmacies. However, comments from pharmacists have noted that robotic dispensing will not be suitable for all pharmacies and that there are risks with drawing away the dispensing and supply role from suburban/neighbourhood pharmacies to regionalised and centralised robotic dispensing services. Furthermore, robotic dispensing does not suit all supplies of medicines.

Pharmacists have identified original pack/single pack dispensing as being a significant enabler for a more effective dispensing and supply service. Pharmacists currently must manage large stock bottles and repackage these down for dispensing, while taking on the financial risk for having the remaining stock on the shelf. The significance of this issue, along with the wider issues associated with funding the medicine distribution chain cannot be understated. To enable a fully utilised pharmacist workforce requires the development of a new and more effective funding models for the distribution and supply of medicines that pharmacists perform on behalf of the health sector. The Society recommends greater links between costs and cost

savings of pharmaceuticals achieved by Pharmac and the distribution and service elements funded by DHBs.

The Society recommends that the Ministry and DHBs have actions to enable the uptake of electronic prescribing in all general practices. Pharmacies have been enabled to receive and process electronic prescriptions for some time, with the delays in widespread use of this technology being limited by general practice uptake. Furthermore, hospitals require a nationally consistent electronic prescribing and administration system that includes functions to enable electronic reconciliation on admission and discharge. An efficient and accurate medicines reconciliation process would reduce the risk of medication errors and facilitate the transition of care.

As previously mentioned, many individuals struggle to pay for the costs of prescribed medicines and frequently pick and choose which medicines to have dispensed if any, others are concerned about owing money to their pharmacist, while some pharmacies have taken it upon themselves to waive co-payment charges for their most vulnerable patients.[9] The Society recommends an action for the Ministry to lead an interagency approach with social services to find mechanisms for pharmacists to identify and manage individual cases where co-payments prevent patients from taking their prescribed treatment.

Targeted funding of blister-packaging or other dose-administration aids would support adherence and self-management of individuals with low incomes who struggle with balancing the number of cost-barriers associated with their treatment and the costs associated with independent living.

Focus area 5: Prescribing pharmacists

Prescribing pharmacists contributing to better health outcomes by optimising medicines management

The Society believes the principal enabler for developing the role of the pharmacist prescriber is a clear understanding of the scope of practice by all within the health sector. Despite the collaborative work happening between the professional bodies at a national level, many medical practitioners do not understand the collaborative nature of the pharmacist prescriber training or the role itself.

The prescribed qualification for the pharmacist prescriber scope of practice is a university-based postgraduate clinical pharmacy diploma followed by the postgraduate prescribing qualification. The prescribing qualification requires 600hrs of study including a prescribing practicum and a minimum period of supervised practice under a Designated Medical Practitioner. This training process facilitates development of the collaborative prescribing service model that the pharmacist prescriber could then practice under.

The Society believes the implementation of medicines therapy assessment (MTA) and comprehensive medicines management (CMM) services by pharmacists based in general practices will provide opportunities for greater understanding of the capability of clinical pharmacists by general practitioners. As these services develop, a prescribing role by those pharmacists could contribute to case-management in those practices and the experience gained would guide how individual practices might utilise a pharmacist prescriber. The Ministry and DHBs supporting the role of medicines management pharmacists in general practices would build confidence in the contribution of pharmacists to patient care, and would enable the prescribing role to develop over the next 5 years.

The Society supports the development of a single prescribing standard for all prescribers. As the profession responsible for dispensing of medicines pursuant to a prescription, pharmacists

identify the considerable poor prescribing practices - clinical and regulatory. Prescribing training and competencies must be standardised for all prescribers.

The Society supports the development of models of care and contractual and governance arrangements that would enable prescribing pharmacists to initiate relevant laboratory tests. Pharmacists are very familiar and have training in the laboratory tests associated with the monitoring of medicines treatment and also the parameters that influence the absorption, distribution, metabolism and elimination of medicines. Pharmacist prescribers have advanced training in clinical therapeutics and are very well placed to order and interpret those laboratory tests relevant to pharmacological treatment - we would contend more so than many medical practitioners. Pharmacists also have a greater understanding of the pharmacogenetics associated with individual variation in the pharmacokinetics of drugs and many are competent to interpret such tests.

A further enabler to support the development of the pharmacist prescriber workforce would be the regulatory amendments described below under 'Enabler 4 Regulation'.

Enabler 1: Leadership

The Society accepts the indicated lead accountability role for developing leadership as an enabler to support the implementation of the Ministry's Pharmacy Action Plan. The Society has effective and open communication with all areas of the pharmacy profession and maintains close working relationships with the principal health professional organisations.

The Society highly values its professional leadership role in providing key functions for the profession, and is the accredited provider of continuing professional development and intern training programmes for the profession. We also represent the viewpoint of practising pharmacists on forums and organisation groups. The Society chairs the Heads of Schools and Professional Organisations of Pharmacy (HOSPOP) forum, which we see as a fulcrum of leading sector views. We are also full organisation members of the PHO Alliance, the only pharmacy organisation in such a position. The Society has also been invited to join the International Pharmaceutical Federation (FIP) as an organisational member – providing international leadership connections and support to guide and enable national activities.

The Society has begun the initial stages of its own leadership development strategy that will serve to identify, develop and support leadership from pharmacists in early stages of their careers, through to national and international representative roles. The Society will look forward to engaging with the Ministry, DHBs and Sector as this strategy develops.

The Society believes that the appointment of pharmacists to leadership roles on health governance structures across the health sector, including Ministry, DHB and Pharmac committees, PHOs and clinical governance structures in primary and secondary care, will provide a significant contribution to enabling the implementation of actions in this Plan.

Enabler 2: Information and other technologies

Information technologies provide an important enabler for communicating and documenting the activities being conducted by pharmacists. As mentioned above, the Society recommends that the Ministry and DHBs have actions to enable the uptake of electronic prescribing in all general practices.

The Society also supports work by the Ministry to allow pharmacists to document immunisation activities in the National Immunisation Register (NIR). Recording events on the NIR will aid an

integrated expansion of pharmacy immunisation services, and document the contribution of pharmacist vaccinators to public health.

The Society also supports information technology development that documents the medicines management activities delivered by pharmacists in shared care records. Furthermore, IT systems with appropriate privacy management that would enable shared recording of the provision of pharmacist-only medicines, would contribute to a more complete shared medication record. Pharmacist access to a shared medication record would provide considerable assistance to medicines management services and medicines reconciliation activities across primary and secondary care.

Enabler 3: Workforce

The Society gratefully acknowledges the role Health Workforce New Zealand has taken in providing funded support for the piloting and evaluation of the CPAMS Service and recently the Pharmacy Accuracy Checking Technicians (PACT) pilot. We believe this model has proven benefits in identifying a potential area of workforce development which could be developed and tested in practice. Following the extremely positive evaluation of the CPAMS service, it was negotiated into the Community Pharmacy Services Agreement.

The Society seeks to work with DHBs and Health Workforce NZ to build a workforce model for pharmacists and pharmacy practice at the end of the Action Plan period in 2020. This would determine the shape of practice, and understanding this will allow funding and services to develop accordingly.

As mentioned above, The Society seeks an action from DHBs to engage with the NZHPA's national career structure programme, which will enable a robust and defined career pathway within hospital practice.

The Society seeks to work with The Ministry and DHBs to address pharmacist vacancies, particularly in rural areas. Similarly, alongside NZHPA to address vacancies in hospital pharmacy. A rural workforce programme, similar to that for general practitioners could assist recruitment of pharmacists in regional areas.

Enabler 4: Regulation

The Society recognises that the Ministry is currently conducting a full review of the therapeutic products legislation and has appreciated the ongoing engagement with officials developing the draft Bill. Many aspects related to regulatory enablers will be addressed as we contribute to the Bill's development.

The Society strongly recommends regulatory changes that would remove unnecessary barriers to the clinical role of pharmacist prescribers. In the review and development of the new therapeutic products legislation, the Society recommends revoking the Medicines (Designated Pharmacist Prescribers) Regulations 2013 and making appropriate amendments to the proposed new therapeutic products bill to add pharmacist prescribers the list of authorised practitioners who can prescribe medicines that lie within their scope of practice. Revoking the defined schedule of medicines in the Designated Pharmacist Prescribers Regulations and in Schedule 1B of the Misuse of Drugs Regulations, along with revoking Regulation 21(5)(b) of the Misuse of Drugs Regulations (that places a 3 day quantity of supply limit on prescribing of controlled drugs) will permit pharmacist prescribers to practice within a full range of clinical areas that are within their scope of practice.

In addition to the ongoing consultation between the Society and The Ministry in reviewing the Therapeutics Products Bill, The Society seeks actions in the Pharmacy Action Plan for the Ministry in supporting our submissions to:

- the Expert Advisory Committee on Drugs[12]
- the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill October 2015[13]

The Society recommends an action for the Ministry to lead the consideration of regulating pharmacy technicians, particularly PACTs.

Compliance with Pharmaceutical Schedule Rules
An unfair onus is placed on pharmacists to ensure prescriptions and orders for medicines supply comply with regulations and funding rules. The pharmacist must therefore spend time policing compliance with prescribers when the onus should sit with prescribers themselves. Prescriptions and orders that do not meet regulatory rules will not be funded, therefore pharmacists waste time chasing prescribers. The Society recommends investigating regulatory, funding and service models that remove the financial impact on pharmacists in ensuring prescriptions comply with regulations.

The Society supports the function of registered pharmacists being able to assess and supply pharmacy and pharmacist-only classified medicines outside of the walls of a licensed pharmacy. Medical practitioners are currently permitted under legislation to dispense and supply medicines anywhere. Extending this permission, under carefully controlled standards and/or regulated practice, could allow pharmacist services delivered outside of the licensed pharmacy premises to include an element of medicines supply, for example MTA services being delivered in a rest home.

The Pharmaceutical Society commends the Ministry in developing its Pharmacy Action Plan and in describing the key focus areas and actions it sees being implemented by the Ministry, DHBs and pharmacy sector over the next three to five years. The Action Plan complements the Society's own strategy for the profession, and we look forward to the clinical skills and capability of pharmacists being fully utilised to improve health outcomes and the optimal use of medicines.

Thank you for consideration of this submission. I would be happy to discuss any aspect of this submission further, as required.

Yours sincerely,

Richard Townley
Chief Executive Officer

1. New Zealand Medical Association, Pharmaceutical Society of New Zealand Inc. Vision 2020: Partnership for Care (Pharmacists and Doctors working together) [Internet]. 2014. Available from: http://bit.ly/1LizsOr

2. New Zealand National Pharmacist Services Framework [Internet]. Wellington: Pharmaceutical Society of New Zealand Inc.; 2014. Available from: http://bit.ly/1RZHcug

3. Coleman J. Minister of Health Media Release: Consultation begins on pharmacy 5 year plan [Internet]. 2015 Oct. Available from: https://www.beehive.govt.nz/release/consultation-begins-pharmacy-5-year-plan

4. Pharmaceutical Society of New Zealand Inc. Submission to the Proposed supplementary wording to clause 6.9 of the Code of Ethics 2011 [Internet]. 2015. Available from: http://bit.ly/1SWJt9w

5. Pharmaceutical Society of New Zealand Inc. Position Statement: Polypharmacy and Medicines Optimisation [Internet]. Wellington, New Zealand; 2015 May. Available from: http://bit.ly/1S085y4

6. Love T, Wright C. Impact of Medicines Therapy Assessment. Sapere Research Group; 2013.

7. Ministry of Health. Implementing Medicines New Zealand 2015 to 2020. Wellington: Ministry of Health; 2015 Jun.

8. Loh L, Dovey S. Who attends Dunedin's free clinic? A study of patients facing cost barriers to primary health care access. J Prim Health Care. 2015 Mar;7(1):16–23.

9. Norris P, Tordoff J, McIntosh B, Laxman K, Chang SY, Karu LT. Impact of prescription charges on people living in poverty: a qualitative study. Res Soc Adm Pharm [Internet]. [cited 2015 Nov 19]; Available from: http://www.sciencedirect.com/science/article/pii/S1551741115002594

10. Sheridan NF, Kenealy TW, Kidd JD, Schmidt-Busby JIG, Hand JE, Raphael DL, et al. Patients' engagement in primary care: powerlessness and compounding jeopardy. A qualitative study. Health Expect. 2015 Feb 1;18(1):32–43.

11. Napier P, Norris P, Braund R. Could it be done safely? Pharmacists views on safety and clinical outcomes from the introduction of an advanced role for technicians. Res Soc Adm Pharm. 2015 Nov;11(6):814–23.

12. Pharmaceutical Society of New Zealand Inc. Submission to the Expert Advisory Committee on Drugs: Proposed Classification of Tramadol as a Class C5 Controlled Drug under the Misuse of Drugs Act 1975. [Internet]. 2015. Available from: http://bit.ly/1LtGEqY

13. Pharmaceutical Society of New Zealand Inc. Submission to the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill October 2015 [Internet]. 2015. Available from: http://bit.ly/1Ynq9WQ