DELIVERING ON THE

PHARMACY ACTION PLAN

District Health Boards’ Consultation (5 March-10 April 2018)

Summary of consultation feedback

Prepared by TAS

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Introduction

Over five weeks, from 5 March to 10 April 2018, the 20 District Health Boards (DHBs) throughout New Zealand sought the views of pharmacy owners, pharmacists, other health professionals and providers, other health stakeholders and consumer groups on how to deliver on the strategic direction of the Pharmacy Action Plan 2016-20.

As part of the consultation, DHBs sought feedback on a proposed new contract for pharmacist services (the Integrated Pharmacist Services in the Community Agreement - IPSCA), and a one-year extension of the current Community Pharmacy Services Agreement (CPSA) 12.

DHBs want to sincerely thank everyone who participated in the consultation, whether by submitting feedback, attending roadshows or talking with DHB representatives in individual meetings. Your feedback is very much appreciated.

Consultation process

The primary consultation channel was an online questionnaire, through which 1017 submitted responses were received. 124 people and organisations sent an email submission.

The vast majority of submissions received were from current contract-holders or registered pharmacists. Submissions were also received from other community pharmacy staff, pharmacy and pharmacist representative groups, pharmacy wholesalers, other health professionals and their representative groups, other health providers, academic institutions, a government organisation, non-government organisations in the health sector, and members of the public.

During the consultation, there was significant engagement with a wide range of stakeholders throughout the country. Two meetings were held for representatives of a range of national organisations, attended by about 40 people. DHBs hosted another 22 regional roadshows attended by nearly 800 people. Two workshops hosted by early-career pharmacists and supported by DHBs were attended by about 60 pharmacists and interns.

DHB representatives also met individually with contract-holders across the country, pharmacy and pharmacist representatives, health professionals and providers and consumer groups.

All meetings contributed substantially to DHBs’ understanding of stakeholder perspectives, which were reflected in the consultation feedback received through the primary channels.

Graphic One: Respondents to DHB consultation
Approach to summary and analysis

This summary focuses on responses received to individual questions in the online questionnaire, and includes commentary from emails received from large organisations and individuals.

The online questionnaire was a qualitative survey designed to elicit comments and suggestions to inform the way forward.

While many responses were either wholly or partially consistent with a template, these comprised well under half the responses.

In analysing the submissions, DHBs are looking both for recurrent topics, and constructive feedback and suggestions on how to improve and move forward the proposal.

Summary

Local services to meet local needs

New opportunities

Respondents saw significant opportunities to develop new patient-centric local services. The lengthy list of suggestions included (but was not limited to) minor ailments care, wound care, more vaccination services, cardiovascular risk assessments, monitoring of lab work, and home visits.

Many respondents mentioned the opportunity for more integration with other local health providers. Suggestions included integrated health clinics, pharmacists working in PHOs and making joint decisions with general practitioners about medication, or a pharmacy clinic focussing on a particular field (for example cardio care or diabetes) disassociated from dispensing pharmacies to remove conflicts of interest. An integrated healthcare clinic focusing on cardiology problems, for example, could include a cardiologist, physiotherapist, pharmacist and social worker to enable more integrated and focused output, and improved outcomes.

Provision of new local services by pharmacists could free up time for fellow health professionals to spend on more complex patients, and provide an opportunity for people with minor complaints or needs to be seen quickly. It could also give other health professionals in the community more awareness of the value pharmacists can add.

Developing local services

Respondents were generally in favour of community involvement in development of local services, through such mechanisms as polls or surveys, development and advisory groups, and health committees. Community advice could be very helpful for targeting services to those who need them most. Feedback generally reflected the view that diversity of people and views needs to be acknowledged, and incentivising service based on community needs should be prioritised.

‘An inclusive and transparent process that involves communities is reasonable as long as objective decision-making criteria are agreed and a robust evidence base is used to support any service change.’

Some people pointed out that community involvement would require a community awareness campaign of the services pharmacists can provide.

Feedback was less consistent on involvement of other health professionals in development of pharmacist services. Many people considered their involvement absolutely essential. A wide range
of professions who should be involved was cited including general practitioners, nurses, occupational therapists, physiotherapists, podiatrists, dieticians and social workers.

Some respondents, however, expressed concerns that other health professionals may have a conflict of interest, and be competing for the same funding pool from the DHB.

**Challenges and mitigations**

Many respondents saw challenges in the local development of services – both to community pharmacy sustainability and to equity of access for patients.

A key concern was ‘postcode’ healthcare, meaning that service provision and service levels across the country could vary depending on an individual DHB’s approach to service development and funding. Some DHBs would be quicker to develop new local services than others. Some people were worried that DHBs would award services to the lowest bidder.

These respondents felt that instead of creating greater equity in health outcomes, this could lead to greater inequities as access to services could be variable.

Lack of certainty about the timing and nature of DHB funding for new local services was a repeated concern. Many respondents also thought that funding for new local services would be taken from core dispensing services, threatening community pharmacy sustainability.

Some people said a small population base did not justify 20 different DHB service specifications and delivery. Concerns were expressed that the outcome could be more costly bureaucracy resulting in less funding for community pharmacy and patient needs.

Suggestions to address concerns included removing barriers to uptake, and a clear commitment from all 20 DHBs to fund new services, report transparently on them, and undertake seeding projects to demonstrate commitment and foster networks.

**Future separation of pharmaceutical supply (Schedule 1) and professional advisory services (Schedule 2) in proposed IPSCA contract**

Some people saw some advantages to separating these services in future, on the grounds that the role of pharmacists would be better recognised. Also, if pharmacists were paid for professional advisory services, they may feel more valued. Pharmacists would have more time to provide advisory and new local services if medicine preparation was devolved to specialist providers. Some people thought the risks were being overstated by opponents of separation, as it was already occurring successfully with patient benefits in some settings. Other respondents saw opportunities to develop new business models. Separation of the services into two schedules was supported by some respondents so long as risks were mitigated by further analysis, a clear national approach and strong funding commitments.

Most people however expressed significant concern about the proposed separation and did not understand how it could successfully work in practice. Key risks were seen by respondents as follows:

- Separation would affect patient safety as patients would not be getting fully rounded care if they needed to obtain pharmaceuticals and advice from separate pharmacies. Would the product be available if required, would the advisory service be timely and relevant?
Separation of dispensing and advisory services may make it harder to manage prescriber errors.

Contracting services only to some pharmacists would reduce patients’ choice of pharmacy.

Separation would negatively impact on pharmacist job satisfaction as they may find themselves employed in low-level product supply and checking only, or a pharmacy that only offers this service.

Separation undermines the pharmacy sector re remuneration. Pharmacy runs the risk of becoming a low-paying business rather than a professional service. If core services continue to be de-incentivised, eventually who would bother training to be a pharmacist?

Separation could negatively affect sustainability of community pharmacies if they were only offered one schedule.

DHBs had presented no evidence that this model could work.

Many respondents, whether supportive or not, commented that IT changes would be needed to support the service split.

**IPSCA contract - understanding**

**Funding**

Funding concerns were a major theme throughout the feedback. Respondents were concerned that the new contract could remove funding from core dispensing into contestable local services, and that there was no certainty about when or how these would be developed by each DHB. They feared loss of pharmacy income to other parts of primary care. They wanted to know exactly how much the Professional Advisory Services payment would be. There were concerns that the separation of Schedules 1 and 2 would mean some pharmacies would lose income. They were also concerned that there was insufficient funding in the proposed contract extension. These comments were often made in the context of ongoing sustainability of community pharmacy.

Some people supported the proposed new contract so long as funding uncertainties were effectively addressed.

**Annual review and change processes**

There was considerable comment about the evergreen nature of the proposed new contract. Many respondents wanted more detail and certainty about the annual review process and exactly how it would work. Some respondents wanted more information about how this had worked for other health sectors contracted by DHBs.

Respondents also wanted more detail about change and consultation processes when new local services were developed, or when there was any change to service specifications.

While many respondents understood the proposal that in the first year of the new contract there would be no changes to funding or services, they were concerned about what would happen after the first year. Clarity over how fees were to be adjusted in the future was essential.

**Governance**

Some respondents wanted to see the governance of the proposed new contract more clearly defined in the proposed IPSCA contract. Some people supported the Contract Group structure as a governance mechanism, others did not.
Whatever the governance structure, many respondents from the pharmacy sector supported the current approach to pharmacy sector representation via sector agents, others wanted a wider group of pharmacists to have more say.

**Description of contract-holders**

Many people expressed concern that the proposed new contract referred only to providers, suggesting that in future DHBs could contract with not only community pharmacy owners, but also pharmacists or non-pharmacists to supply pharmacist services. They saw this as threatening the sustainability of community pharmacy.

**Proposed contract extension**

Respondents who commented on the proposed extension of the current contract generally wanted more funding. They did not understand why the funding for new local services and the Professional Advisory Services payment were not included in the extension. They also queried why there did not seem to be allowance for cost pressures or margins.

**Other comments**

A very clear division is evident between a large group of respondents who are completely opposed to both proposed contracts, and respondents who are very keen to progress the IPSCA, albeit with further work.

A large number of submissions expressed strong dissatisfaction with the proposed new contract, and were very concerned about the lack of detail in the proposal. These views are illustrated by the following comment. ‘In all, we consider the proposal presents unknown and unquantified impacts and risks for patients and the community pharmacy sector. Analysis needs to be prepared that demonstrates impacts on patient safety, patient outcomes, national service coverage, equity of access, value for money and community pharmacy sustainability.’

Some respondents however were highly critical of people who did not want to progress the IPSCA, saying, for example, that they ‘should not be permitted to interfere with the legitimate aspirations of those members of the profession who want to provide their communities, and colleagues in health care provision with a wider range of better services reflecting the 21st century needs of patients.’

**Graphic Two: Response to proposal**
Next steps

DHBs announced on 10 May 2018 a three-month extension to the current CPSA 12 2017-18 contract, to 30 September 2018, to allow sufficient time to consider the consultation feedback, engage with pharmacy and health sector stakeholders, and confirm funding for 2018-19.

DHBs are meeting with pharmacy sector agents, pharmacist professional groups and other key stakeholders individually and in smaller groups to jointly discuss the way forward.

In particular, DHBs are discussing opportunities to address key concerns emerging during the consultation – such as local commissioning, Schedules 1 and 2, funding, the evergreen nature of the contract, review and change processes, and contract governance.

DHBs expect to announce their final approach to community pharmacy contracts from 1 October 2018 by early July.
APPENDIX

This appendix identifies recurrent topics mentioned throughout the submissions. The topics in green indicate respondents’ desire to work at ‘top of scope’, for better ‘collaboration/integration’ to enable better ‘patient centric’ services. These are positive comments that reinforce respondent desire for better patient outcomes. Commentary on the other topics predominantly expressed concerns.

**Graphic Three: Topics - Pro forma and non pro forma**

![Graphic Three](image)

Graphic Three contrasts the prevalence of each topic between pro forma respondents (wholly or partially following a template) and non-pro forma respondents. For example, non-pro forma respondents are more likely to mention ‘patient centric’ as a theme than pro forma respondents.

**Graphic Four: Topics by respondent**

![Graphic Four](image)

Graphic Four compares recurrent topics by the three biggest groups of respondents. It shows, for example, that the three respondent groups had a similar level of concern about the risks of creating separate schedules for product supply and professional advice, while there was a marked difference in concerns about funding.

Email: [pharmacy@tas.health.nz](mailto:pharmacy@tas.health.nz)