Community Pharmacy Services Agreement 2012

Summary Report

Feedback from Consultation on Pharmaceutical Margins and Subsidised Unregistered Section 26 & 29 Medicines

Prepared by the Community Pharmacy Programme
30 April 2016
Disclaimer:

Feedback cited in this Report is in most cases verbatim. However, there are some instances whereby identifiable names have been removed to maintain the anonymity of the respondent(s).

In addition, some responses had formatting inconsistent with this document and those responses have been reformatting for the purposes of the Report.

Not all feedback received is contained within this Report – it encompasses the broad range of feedback received.
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Background to Consultation

Community pharmacy and District Health Boards (DHBs) believe the pharmaceutical margin model is no longer fit for purpose and needs to be amended. Currently, a small number of pharmacies (2.6%) receive one quarter of total margin funding for higher cost medicines ($150 and over). Further, 37% of DHB expenditure for margins goes to under 1% (by volume) of medicines costing $150.00 and over.

Under the current funding model formula of 4% and 5%, this inequity would continue with a $2M per annum projected increase in margin funding going towards that small number of pharmacies. In addition, there is also a disconnect between what pharmacies are charged by wholesalers and what they are reimbursed by DHBs for high volume low cost medicines (under $5.00).

In January 2015, DHBs mandated the Community Pharmacy Services Governance Group to address these issues. The Pharmaceutical Margins Taskforce was set up and directed to develop a proposal for amending the current margin model with a solution that could be implemented by 1 July 2016. The modelling work undertaken by the Taskforce was carried out on a funding neutral basis. To support the work there is representation from community pharmacy, the Ministry of Health, DHBs and PHARMAC. The Taskforce also had discussions with subject matter experts including pharmaceutical wholesalers; and Markhams an accountancy firm providing advice to the pharmacy sector.

In August of 2015, the Taskforce sought feedback from the sector on a number of funding model options. In considering feedback it was noted that there was a preference for a model that reflects both a percentage of the Pharmaceutical Schedule subsidy that applies to a particular medicine, commonly known as the margin payment, and a fixed ($) payment per pack.

In March 2016, the DHBs consulted on a proposal that went to pharmacy owners and the sector for consultation and was a twin proposal with two components:

1. **Pharmaceutical Margins Hybrid Model** with values that the Taskforce believe are fit for purpose as it better recognises the value and volume sensitivity of the underlying supply chain costs associated with supplying pharmaceuticals.

The Hybrid Model would reduce future volatility in funding to community pharmacies, diminish the impact of future Pharmaceutical Schedule subsidy reductions on funding to community pharmacies and distribute funding more fairly among pharmacies. The Hybrid Model means the majority of pharmacies would receive more margins funding and, if the proposed Hybrid Model is implemented, the DHBs have committed to discussing with any significantly negatively impacted pharmacies what

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1 In the last four years, there has been significant growth in medicines with a high value subsidy (those with a Pharmaceutical Schedule pack subsidy of $150.00 and over). In the 2011/12 financial year, 25% of DHB expenditure on the Margin related to these medicines with a high value subsidy. By the 2014/15 financial year this had grown to 37%.

2 Pharmaceutical Margins Taskforce minutes 27/1 & 15/2 2016. DHB representatives clearly indicated prior to Consultation that there was no additional funding beyond what DHBs are forecast to pay under the current model. The “true cost of the supply chain” work will inform the ongoing discussion about adequacy of funding, and any change in margins funding formula would be managed through the usual contracting processes.
support that pharmacy may need to transition to the proposed model in the event those pharmacies elect to transition.

2. **Subsidised unregistered medicines** (section 26 & 29 of the Medicines Act 1981) that will address the additional compliance costs incurred and services delivered by pharmacy when ordering and dispensing subsidised unregistered (section 26 and section 29) medicines.

**Collection of feedback**

Consultation began on 22 March 2016 and closed 22 April 2016. There were several channels for capturing feedback:

- online survey
- dedicated email address
- provide feedback to DHB Pharmacy Portfolio Manager
- attending a webinar session
- attending a DHB meeting
- via sector agents who would in turn make a submission on behalf of members.

**Feedback Received**

Significant feedback was received with over 640 individual submissions from 980 pharmacies, a 65% response rate which is more than double the standard response rate. This number excludes sector agent responses on behalf of its members or combined feedback captured during attendance at a DHB meeting:

- 386 survey responses
- 261 direct feedback responses via email
- three (3) individual wholesaler responses
- three (3) responses from sector agents (Green Cross, Pharmacy Partners, Pharmacy Guild)
- one group response from 33 pharmacies (Nirvana Group)
- notes from the seven DHB roadshow meetings.

**Table 1: Online Survey Respondents**

<table>
<thead>
<tr>
<th>Online Survey Respondents Only</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy owner</td>
<td>304</td>
</tr>
<tr>
<td>Pharmacist/Technician</td>
<td>78</td>
</tr>
<tr>
<td>Supply Chain Member</td>
<td>1</td>
</tr>
<tr>
<td>Wholesaler</td>
<td>2</td>
</tr>
<tr>
<td>Interested party</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>386</strong></td>
</tr>
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</table>
Table 2: Online Survey responses on Proposed Model vs Current Model

<table>
<thead>
<tr>
<th>Online Survey Responses on Preferred Model</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Current Model</td>
<td>197</td>
</tr>
<tr>
<td>Hybrid Model</td>
<td>21</td>
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<tr>
<td>Hybrid Model - Conditional</td>
<td>4</td>
</tr>
<tr>
<td>Something Else</td>
<td>4</td>
</tr>
<tr>
<td>Don’t Know</td>
<td>29</td>
</tr>
<tr>
<td>Did Not Specify</td>
<td>131</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>386</strong></td>
</tr>
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</table>

Analysis of all Feedback

In considering the feedback eight themes emerged and these will be covered in more detail later in this Report and are illustrated in the following Tables 3 & 4 and Graphs 1 & 2.

General Comments

Overall feedback has been wide-ranging from short responses to the more lengthy thoughtful responses with detail on how changes could be made. Responses are in italics and broadly represent the range of comments received.

“The hybrid model may help improve products less than $5 but losing money from high price items.”

“I feel we need more clarity around the new margin model as I feel I still can’t tell what real impact it will have on my business.”

“Need to have a model we can understand clearly.”

“Status quo not acceptable – true costs (and value) need to be established through independent review. The dispensing process is not purely a distribution function - there is potential to improve outcomes through clinical input at this stage. A sustainable, adequately funded service is essential to maximise benefits to patients.”

“The best thing DHBs could do is to allow pharmacies to retain $1 of each $5 prescription fee, currently only $3.00 goes toward the prescription cost and $2.00 to Tax. By reducing the Tax to $1.00 per item and allowing pharmacies to retain the other $1.00 would allow pharmacies to cover costs of procurement and stocking, ensuring the public retain a pharmacy service that meets the supply standards outlined in the CPSA 80% supplied within 2 hours.”

“Pharmacy and Wholesalers have no control or influence on Pharmac re pharmaceutical pricing decisions. There needs to be a direct correlation between the three. This is the mistake that has occurred in the past and has created this margin imbalance in the supply chain. The DHBs and Ministry need to be made aware of this imbalance as this proposed model will only be a short term
fix if this continual downward pressure continues. A simple mandate to Pharmac to bring in a 'ceiling' for tender prices below a $ threshold will be of benefit to the entire supply chain.”

“Well I disagree with the proposal so it should not be assumed that this model will be adopted. MOH should not need to assist with implementation of the proposed model as it should not be so different that assistance is required. We have to also suffer the consequences of increased costs that the wholesalers will charge us with this reduced margin therefore every pharmacy will be worse off under the proposed model.”

“Listen to our submissions. Pay us 3.5 % not a loss providing 2.5 .”

“The current model seems to be the lesser of two evils. The proposed system does not help address the issues raised.”

“I prefer a model that reimburses the true cost of the medicine plus a small margin for managing the risk.”

“Need increased margin because costs increase and will continue to increase with aging population and high needs patients.”

“Hybrid model - unworkable, current model – unsatisfactory.”

“Neither, as both cost pharmacy money. If DHBs are strapped for cash, then they need to go to Pharmac and get their hands on some of the money Pharmac is clawing back from their pricing policies.”

“Stop the weird formula, I have scholarship for my mathematics and yet I have no idea how you come up with 0.27 cents per pack. If it’s only 10% of your total funding anyway like the chairman said in the meetings then you should fund us. How? The formula is pay us what the medicine actually cost us, nothing less, whether it’s under 5 or over 150. The problem is we have a middleman called the wholesaler which takes all the margin away. Now if you think you can do better as a DHB then the wholesalers then you can hire your own warehouse and operate the whole supply chain. No doubt it will be profitable too. But until then, you should not pick on us retailers who really gets nothing from your proposal.”

“The proposed model will work if it is adequately funded. Wholesaling will always be a transactionally based operation, and the margins involved should not discourage the dispensing of high priced medicines in favour of low priced medicines. The idea of being able to even out the shocks of medicines coming off rebate is appealing and the market is starting to concentrate at the extremes of price, both high and low. However, one portion of the market (high priced medicines) is not evenly spread across the country, with some pharmacies handling far more high priced medicines than others. The margins signalled at 2.5% for high priced medicines at wholesale level will see those pharmacies lose money on each dispensing. High price meds also carry more risk in that many are cold chain supply, and a simple handling error through the chain of supply can yield costly consequences. I feel we should not be confusing activity with price, and the market needs to be assessed across the entire supply process, and most importantly and assessment needs to take place where we can look at patient management and align the management of pharmaceuticals with patient need. High price medicines can take up vastly more time in patient coordination and management than the common LTC meds that are becoming less expensive. Therefore, to aid the
sale of the proposed scheme - margins need to be maintained at the current level and a compensation made for increased activity with no return at the bottom end of the spectrum. Please do not confuse the volume issue with margin as happened at out consultation meeting. DHB’s are paying a steady percentage of margin currently, and where volumes go up; but the percentage margin remains the same then more more funding has actually been injected into the supply chain - merely the supply chain has been recompensed for services performed efficiently. on time and in full.”

“The Pharmacy Guild estimate that an additional $4 to $5 million more is what needed to make the hybrid model fair in the 2015/2016 funding year. The hybrid model proposal MUST adjust the per pack fee to account for the cost pressures in the supply chain to make it sustainable.”

“Cut the fluffy words/talking in riddles and give resources/seminars etc that explain the direct impact of the changes in the CPSA to regular pharmacists and pharmacy in general, so that a regular/non-proprietor pharmacist may understand how this affects their business and livelihood too.”

“DHB should look into other ways of getting money other than stressing on pharmacies to lose.

- Increase co-payment per item to $10.
- Decrease fully funded items to include expensive items to have a co-payment of $30 or more.
- Introduce a hospital surcharge for non-urgent visits i.e. if your visit turns to be non-urgent a charge of $49 will apply.
- Introduce a public awareness campaign to collect $1 Mil to lock in trust bank account to spend on approved cases of people who can not pay for the services.
- Ask the crown to increase the fund to health sector.
- Ask the government to increase money allocated to NZ health fund on expenses of DONATING money to other governments (tornado here or there is not my patient issue)
- Squeeze on med companies to supply products at prices matching what they do in other places of the world i.e. price of Brufen 800 in MANY parts of the world is around $2.00 why we get it in NZ for $8 and many other ideas. If you are keen to get ideas.. ASK and you’ll get.”

“Our group is experiencing significant growth in spend of the >$150 category from one year to the next. The category growth being 25.5%, highlighting the risk around acceptance of the proposal, recognising the medicine cost breakeven point of $18.00 will leave a significant margins deficit for the growing category. At individual medicine level, the difference in procurement cost from margin payment could be a large amount depending on the cost the medicine. Given these items have a higher cost into store that that reimbursed, this means the cornerstone principle agreed from day 1 of the CPSA 2012 is not being met, namely:

**CPSA Agreement Paragraph 13 states:**

**Core Dispensing**

- There is a commitment to ensure the Core Pharmacy Services Service Fee for initial dispensing (comprising the Service Fee, Handling Fee and the Transition Payment) retains consistency with the current $5.30 dispensing payment, maintaining a balance with the LTC Pharmacy Services Service Fee within the funding envelope.

Options:

1 DHB agree to fund this deficit onto the patient
2 Pharmacy wears this deficit (actually this is untenable and breaches the cornerstone principle above)

3 Pass the deficit onto the patient.

If the deficit is passed onto the patient, it carries a risk that the patient cannot afford to get their medicine. Given the high cost of some of these expensive medicines, it is not a stretch to suggest that the medicine is critically important to the patient, so without this medicine we are talking about significant patient health risk.”

Eight Key Themes

In total, there were 647 individual submissions (386 online survey responses and 261 emails) with comments from respondents reflected in eight key themes and numerically illustrated in the following Tables and Pie Charts.

Table 3. Key themes from Online Survey

<table>
<thead>
<tr>
<th>Theme Code</th>
<th>Key Theme Descriptions</th>
<th>Number</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>T01</td>
<td>Impact of changing pack size on per pack fee</td>
<td>53</td>
<td>14%</td>
</tr>
<tr>
<td>T02</td>
<td>Access to high cost medicine</td>
<td>24</td>
<td>6%</td>
</tr>
<tr>
<td>T03</td>
<td>Equity of funding from high cost to low cost</td>
<td>46</td>
<td>12%</td>
</tr>
<tr>
<td>T04</td>
<td>Reduction of funding of medicines over $18</td>
<td>11</td>
<td>3%</td>
</tr>
<tr>
<td>T05</td>
<td>Funding of high cost medicine</td>
<td>16</td>
<td>4%</td>
</tr>
<tr>
<td>T06</td>
<td>Twin proposal</td>
<td>72</td>
<td>19%</td>
</tr>
<tr>
<td>T07</td>
<td>Patient surcharging</td>
<td>48</td>
<td>12%</td>
</tr>
<tr>
<td>T08</td>
<td>Overall funding of margins</td>
<td>213</td>
<td>55%</td>
</tr>
</tbody>
</table>
### Table 4. Summary from Direct Feedback*

<table>
<thead>
<tr>
<th>Theme Code</th>
<th>Key Theme Descriptions</th>
<th>Number</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>T01</td>
<td>Impact of changing pack size on per pack fee</td>
<td>143</td>
<td>55%</td>
</tr>
<tr>
<td>T02</td>
<td>Access to high cost medicine</td>
<td>78</td>
<td>30%</td>
</tr>
<tr>
<td>T03</td>
<td>Equity of funding from high cost to low cost</td>
<td>65</td>
<td>25%</td>
</tr>
<tr>
<td>T04</td>
<td>Reduction of funding of medicines over $18</td>
<td>62</td>
<td>24%</td>
</tr>
<tr>
<td>T05</td>
<td>Funding of high cost medicine</td>
<td>127</td>
<td>48%</td>
</tr>
<tr>
<td>T06</td>
<td>Twin proposal</td>
<td>62</td>
<td>24%</td>
</tr>
<tr>
<td>T07</td>
<td>Patient surcharging</td>
<td>95</td>
<td>36%</td>
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<tr>
<td>T08</td>
<td>Overall funding of margins</td>
<td>158</td>
<td>60%</td>
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</table>

*Direct feedback includes responses from individuals but excludes feedback from Sector Agents.
TO1. Impact of changing pack size on per pack fee

Of the 196 respondents who gave feedback on pack sizes, Atenolol and Atorvastatin were the most commonly mentioned medicines to illustrate that changing pack sizes sits outside of Pharmacy control. While there were those who agreed with the hybrid model, the pack sizes in the funding model were not agreed with by many respondents. Comments that encompass the range of feedback are in italics below.

“I agree with the switch to the hybrid model to attempt to try to more evenly distribute the margin funding. However, I don’t really agree with how the flat fee per pack (pack volume) of 27 cents has been determined. Pack sizes are continuously changing, (which is very much out of our control and determined by Pharmac), usually to larger sizing and if this occurs more frequently this would again short change pharmacies (not only are larger pack sizes more time consuming to count, but also use up more bottles/labels etc which are not accounted for by this pitiful 27 cents!).”

“The hybrid model is a good idea, but the margin and pack fee are wrong.”

“Whilst generics become more stabilised the cost to these will become greater as PHARMAC negotiates further price reductions from their tenders which usually involves larger pack sizes, resulting increased repackaging and administration costs.”

“This proposal certainly does not address known current and future issues. Current examples include the trend to increasing pack sizes such as Metoprolol and Atorvastatin. The new model proposed does not take this into account in a way that is cost neutral to all parties, including pharmacy.”

“... the suggested benefit of the 27c pack fee will be quickly eroded by PHARMAC generated changes to medicines outer -packs eg: Atorvastatin moving from 90’s to 500s and Metoprolol moving from 30’s to 90’s. This is a double loss for Pharmacy as we lost the proportion of pack fee and we need to provide the time and resource (dispensing bottles etc) to dispense in the necessary quantity...”
“...Ensure Pharmac does not subsidise large pack sizes which would reduce margins for pharmacy and increase packaging costs and time taken to dispense medicines....”

“Need to swap the per pack to a "standardized pack" eg a fee per 100 tablets or per tube of cream or inhaler, not per pack of tablets this is because with Pharmac constantly funding bigger and bigger pack sizes it is not equitable to be paid the same fee for a 1000 pack compared to a 30 pack.”

“...We would also ask that pack sizes be more consistent and user friendly, as we frequently dispense from bulk packs (500+) for prescriptions of 90 or less. The 27 cent + GST reimbursement would be extremely stretched in these cases....”

TO2. Access to high cost medicines

Of the 102 respondents who commented on high cost medicines there were some who mentioned ‘cherry picking’ as a likely situation with some pharmacies unwilling to dispense very high cost medicines on a prescription.

The below comments capture the broad feedback on procuring, stockholding and dispensing high cost medicines.

“I am happy to dispense high cost medicines, but not at a loss or with an increased risk of holding stock. I have recently been made aware of the possibility of local pharmacies already “cherry-picking” and being unwilling to dispense very high cost medicines on a prescription. This situation will only be more prevalent, as the medicine costs rise, and if we are not fairly reimbursed the true cost of procuring and holding stock of these expensive medicines. This will, inevitably, have a negative impact on patient care.”

“Many of these medicines do not allow for wastage, or original packs, to be claimed, often leaving us with broken packs which we are legally not able to sell back to the wholesaler, or to other pharmacies. A large number of high cost medicines also require special storage, e.g. refrigeration. With high cost medicines losses for us can be extremely high for reasons beyond our control like a PHARMAC schedule change, or a failure in refrigeration resulting in stock having to be destroyed. The slightly higher margin on these items provides a financial recognition of the stockholding risks for these medicines. By including high cost medicines on the pharmaceutical schedule considerable risk is placed with pharmacies.”

“If the margin for higher price items is reduced to 2.5% it will deter more pharmacies from taking the risks and lead to greater concentration of dispensing from those pharmacies with already high volumes of these products.”

“It is likely that some pharmacy operators in metropolitan areas will gently and discreetly send patients and their expensive prescriptions to another pharmacy (and subsequently have an impact on patient care). This will occur as the evident loss on the dispensing becomes more significant with this proposal as the loss is greater than the dispensing remuneration being received.”

“Under the existing system, the loss is on a greater number of products and so the dollars lost are subsequently spread across that greater number of items.”
“...With the increasing number of expensive medicines the margin above purchase price may need to be capped at a $per pack value and this might need to be banded by cost.”

“Pharmacies who have decided to go into a specialised field where medicines over $150 are frequently dispensed really lose out on the twin proposal. I am one of those pharmacies - we specialise in Rheumatoid Arthritis, Lupus and non-specific origin pain management. All the extra up-skilling and patient resources the pharmacists/pharmacy has developed to cater to these specific patient groups will no longer be justly reimbursed. It takes a considerable effort into building up a specific-conditions patients base and to see that the medicines margin decrease from 5% to 2.5% is disheartening. The extra care we take in managing these patients and helping them carry out their daily lives often amounts to a service, (feedback from meetings with the public have all mentioned the exceptional service pharmacy provide by way of relationship building, providing a listening ear when support is needed for example), that cannot be commercially defined and is never paid for by the customer or the DHBs…”

“High cost medicines have more risk involved in the dispensing. Cold chain items cost more to oversee and administer. Large original packs mean extra costs involved in counting and extra container fees which have not been accounted for.”

“There needs to be recognition of the higher risks and costs associated with handling more expensive medicines (e.g refrigeration & cold chain handling & risks associated with this, greater risk of expiry etc.). This proposal severely reduces funding for higher cost medicines and as a result, pharmacies may reduce their service levels in this area e.g not carrying the stock to reduce the risk of expiry/failure). I do not think it is equitable to reduce funding for handling more expensive medicines to subsidise the cheaper ones. There needs to be more funding to help manage the increased volumes of cheaper medicines rather than redistributing funding from more expensive medicines.”

**TO3. Equity of funding from high cost to low cost medicines**

Equity of funding from high cost to low cost medicines attracted 111 individual comments from respondents that discussed pharmacies losing funding on high cost medicines. The hybrid model considered previous feedback from the sector which had highlighted that low cost medicines were the key issue for pharmacies with many citing a 50% loss on medicines under $5.00. The feedback received from this consultation indicates that high cost medicines would be an issue if the proposed model goes ahead as it is.

Comments made included the following:

“I agree we need to change the margin on expensive medicines over $500 but we should not reduce the margin percentage, as bulk dispensing increases the per pack fee of 27 cents is not relevant.”

“By reducing the volatility of the high cost medicines from the new hybrid model we can already see the low cost generic to generic changes are worse off for pharmacies. Is this shift of resilience neutral? If we consider that PHARMAC is incentivised to make purchase decisions for larger packs sizes then this chain of effect will be hastened and the trend to fund higher cost medicines will grow at a even faster pace compared to now.”

“In the Hybrid model it is proposed that the increase in funding for low cost medicines will be achieved by funding less for procuring and stock-holding of expensive medicines. This is not a solution
I am prepared to support as high cost medicine already require me to invest considerable amounts of money to keep them in stock and I am not prepared to carry the risk of losing a substantial amount of money when there are broken packs, expiring medicines and other issues that I have very minimal control over.”

“It is not appropriate, and counterproductive, for one function to cross subsidise the other.”

“The answer is not about moving margin money around but investing more money in margin to pay pharmacies fairly for the job undertaken (procurement, storage, cold chain).”

“The model is simply shifting money from some pharmacies that have developed a service model that caters for their patients requirements.”

“It is a fundamental question of fairness that pharmacists should not dispense any medicine at a lower cost than what is paid. This still happens under the hybrid model at both the top and bottom ends of the scale.”

“…. The amount of funding has simply been switched from high cost to low cost meds - leaving pharmacy owners very exposed to the dispensing of these expensive meds. What do we do when a script for an expensive med comes in? We will be persuaded to tell the patient to go to one of the ‘specially funded high cost dispensaries ’ - leading to a splintering of services…”

TO4. Reduction of funding of medicines over $18

Seventy-three individual comments were made on funding of medicines over $18.00 and the following comments in italics capture in detail what pharmacy sees as the break-even point with the proposed hybrid model.

“I don’t agree with the proposed values. I don’t want a system where I am worse off when dispensing medicines with a cost price of > $18.00, but especially the very high cost medicines. I don’t want a system that penalises my business for dispensing high cost medicines. The problem was with ‘low cost’ medicine funding.”

“$18 break even point would mean many pharmacies lost money. Also encourages larger pack size to decrease funding.”

“…$0.27 per pack is not enough to cover the loss in 1.5% margin (of the current model) of anything over $18 per pack, especially the higher value meds, the higher you go, the more money we lose. The funding model assumes that we get full outer pack discounts from the wholesalers where in real practice, we do not, especially the more expensive meds under $150, those are the ones we make a loss on since the ones that are more commonly used and we can get outer pack discounts on are the ones that are cheap. The extra $0.27 per pack is not enough to cover the loss on expensive under $150 meds that we are already making a loss on at the moment with the current model if we do not get outer pack discounts, so a further 1.5% reduction in margin for those meds will make us lose even more money. Classic examples are Champix and Strattera. Also, the proposed model is supposed to address the loss we make on anything under $4 as the wholesaler is charging us 10% mark-up on those items. $4 + 10% = $4.40, but we get paid $4 +2.5% +$0.27 = $4.37, we still lose money....”
“Under this proposal high cost pharmaceuticals, that is those over $18.00, will be dispensed at a large loss. Very unfair as more high cost pharmaceuticals will come onto the market. Perhaps the DHB could take over the dispensing of pharmaceuticals over $18.00 via the hospital dispensaries.”

“I accept the proposed funding model in general BUT - It is not acceptable that pharmacies are now losing money by dispensing any medicine that costs above $18 per pack. Stocking expensive medicines is more of a financial risk than stocking low cost medicines and should be represented by a higher margin - Pharmacy will be penalised by a larger amount each time a medicine is dispensed from a large pack size, (which is happening more and more eg Atorvastatin going from 90 to 500) by dividing the 27c fee - The current situation provides a very efficient and cost effective form of distribution. The only thing it needs is for more funding, especially for the lower cost medicines and larger pack sizes.”

**T05. Funding of high cost medicines**

Funding of high cost medicines attached 143 individual responses with the majority of respondents commenting that high cost medicines would be an issue should this proposed model go forward as it is. The high cost of Humira was cited from a number of respondents. The following statements in italics are directly taken from submissions and reflect community pharmacies concerns around high cost medicines under this model.

“…and agree that the cost mix of pharmaceuticals has changed significantly since the present regime was implemented. The document however addresses only the supply chain implications of the changed mix of pharmaceutical costs but does not address in any way the original purpose of the extra 1% margin for higher priced packs. The original intention was to compensate pharmacies for the cost and risk of dispensing higher priced items.”

“COSTS

1. The cost of insurance. Clearly it costs more to insure $1,000,000 of stock rather than $50,000.

2 The opportunity cost of funding the higher level of stock.

3. Higher staff costs relative to prescription volume.” (Expanded later)

“RISKS

1. It is inevitable that not all pharmaceuticals purchased can be dispensed. There are losses due to product going out of date, patients moving or having their regimes changed, Drug Tariff changes by PHARMAC and recalls that compensate only original packs. Correctly disposing of two tablets that cost five cents each is very different from disposing of two tablets at $50 each.

2. Refrigerated Stock. Many high value stocks require cold chain procedures. These products cannot be returned for any reason, being incorrect ordering, reduced demand or expiry. These products are often short dated.”

3. Burglary and Catastrophic risk, including fire, flood and earthquake. Higher stock values attract higher insurance excess and costs.”
“It is now some time since the previously designated “Hospital Only” products have been released for dispensing to all pharmacies, yet the dispensing of these products is still concentrated in a small number of pharmacies. Although location is an issue, it also reveals that many pharmacies are reluctant to accept the risks associated. As an example if an expensive medicine is purchased in a 30 pack, but dispensed in a blister pack (i.e. 28 units per dispensing) it will take 14 months before the pharmacy receives a positive cash return on the item. A lot can happen in 14 months and the risks are deemed unacceptable by many pharmacies.

“There are advantages to concentrating the dispensing of high cost items in a limited number of pharmacies. These items are generally low volume or specialised. It is reasonable to assume that all pharmacists are equal in care and intervention, but pharmacists familiar with the medicines and who have mature relations with clinics can save prescribers time with regard to unnecessary queries and be more alert to interventions that need to be made. I know that clinicians value this relationship.

“As noted before our pharmacy has a high number of pharmacists and interns (two pharmacists and two interns) in relation to the volume of prescriptions dispensed. This reflects a higher level of professional input required to safely dispense specialist medicines. Some of this is captured by LTC, but remuneration is also volume related.

“It seems that the hybrid model is solely based on supply chain issues and does not address the original intention of compensation for loss and risk. The hybrid model rewards those pharmacies that don’t accept the risks involved in dispensing high priced medicines and penalises those who do.”

“It is also difficult to see that altering the remuneration equation to pharmacies will benefit the supply chain which is primarily a wholesaling issue.

“The unit pack (27 cent) compensation is a risk to pharmacy. PHARMAC is rightly motivated by the cost of supply and larger packs come cheaper. We already have 1000 packs of Meprobamate and there is no reason why PHARMAC could not list larger packs, for example a 500 pack of Simvastatin.

“I note on page 14 the statement, ‘The total margins payment is less than 10% of DHB funding to pharmacy. By addressing this we can move on to the next piece of work to build a sustainable future for pharmacist services in the community”. Our pharmacy has developed a system for the supply of Erythropoietin to dialysis units. It is quite labour intensive as it requires two way communication between us and the various dialysis units on a weekly basis involving all changes to individual patients dosage requirements. The system has been subject to evaluation and audit and showed that we were 100% reliable over the survey period. The savings are considerable in that there were no doses claimed for payment that were not administered. (This could not have been achieved where there is not constant communication with the dialysis units, where stat dispensing is preferred and dosage changes are frequent). Over the past three years we have had three meetings with representatives of the DHB who expressed great interest in the system, each of the three have subsequently left the DHB and we are struggling to find a person in the DHB who can make a decision on this issue. Needless to say we find the above statement somewhat vacuous. This initiative is already financially tenuous and will become more so under the hybrid model.”

“Concern that patients on high cost medicine will not receive the same high standard of service and access. Stock holding for these medicine will need to be kept to an absolute minimum.”
“Higher cost medicines have higher risks and costs – insurance, broken packs, expire stock and price changes.”

“...more and more high cost hospital only medications are being transferred to the community pharmaceutical schedule .... meaning a greater burden and risk of high cost medicines being passed onto community pharmacies - ...... we understand that this opens up better access to patients but under the proposed model it would make consistent supply of these medications difficult.”

“After reading your proposed hybrid model option, I am very disappointed in the likely effect it will have on our business. The suggested drop in revenue is circa $15K. This is a very big reduction in our income....”

“We have a very complex and varied business here and we provide unique and varied pharmacy services to a large group of vulnerable clients in our local community. The intensity and complexity of these services is above your average count and for pharmacy dispensing and we get no more from the DHB for provision of these services.”

“For instance, let me describe the service we provide to a community Mental Health Service. We are sent a complex excel spreadsheet each Friday with an order for high cost long acting injections like Risperdal Consta , Zyprexa Relprevv and Invega Sustenna. These are specialise high cost items some of them cold chain dependent items which we have to order overnight and deliver expediently the next day. We organise new prescriptions for doctors to sign, run accounts for two separate groups of mental health patients, and administer the paper work and payments, and liaise with staff over changes and deliveries of emergency dispensings. We spend a lot of extra time and petrol doing this service and have felt that the reimbursement through the over $150 item was enough to cover the overheads.”

“We have 2-3 pharmacists here all week and one on weekends. There are FIVE small one man pharmacies that have sprung up around here who would not be able to be so flexible and reactive and could not offer what we give. These are the pharmacies you are going to give more money to in the hybrid margin model and strip it away from us. How does this help the service delivery we provide?”

“We also do not understand why the Alcohol and Drug service, which we provide intensive medico dispensing to, has been designated an Age Related Community facility. This means we can only dispense once monthly to them. They have always had weekly dispensing and the pharmacy had an agreement with the previous Health Board administration to do this but that was wiped with the Transitional agreement put in place a year or so back. Once again our funding for the specialised work was downgraded and we are for ever spending time changing medico packs and re-dispensing because of the volatile nature of the health consumers that use that facility.

“Without being too dramatic, if the large multinational supermarket next to us, that sells millions of dollars of cigarettes to your health clients, aggressively discounts the Govt $5 tax and undercuts our retail, you will find us gone and a bunch of understaffed, barely viable pharmacies scrabbling around trying to deliver quality pharmacy services to our community.

“I wish to have a face to face meeting with the decision makers at the DHB and let them see first hand the quality and experience we provide to our community. Excellence comes from bigger, comprehensive and viable pharmacies, not small one man bands that can barely function viably.
“It would be great to see your decision makers being sensitive, pro-active and brave in dealing with these issues, not hiding behind outdated and inflexible legislation.”

TO6. Twin proposal

The twin proposal generated 134 individual comments. Many respondents stated that the proposal was fair, however, that it should be decoupled from the Margins proposal.

The many comments in italics below reflect community pharmacies thinking on the section 26 & section 29 component of the proposal.

“Section 26 & 29 proposal for once is fair. But unfortunately its such a small part of my business. I would accept it but can’t as it would mean accepting part 1 of the proposal.

- The Pharmaceutical Margin Task force was meant to address the lack of funding of margins not just rearrange it. There doesn’t appear to be any commitment from the DHBs to provide additional funding to cover procurement or stockholding costs.
- This proposal takes $1.5 million away from margins. According to the Guild estimates, the hybrid model will save the DHBs approximately $1.5 million next year. The Guild believes PHARMAC will be funding more expensive medicines next year. Any margin model must shield pharmacy from fluctuating process (be it high or low cost). This remuneration must be fair.
- 70% of the drug bill is comprised of drugs costing $18 and over. These drugs leave pharmacies very exposed to dispensing at a loss.
- The professional fee should not have to subsidise the cost of the drug. For drugs above $557, the professional fee does not even subsidise the absolute loss to pharmacy.
- The proposal doesn’t even cover the cost of the drug into the dispensary never mind, procurement, stock holding and wastage costs.
- I am not going to accept a proposal based on 2014/2015 figures without any mechanism to future proof the funding. More recent analysis needs to be done for robust analysis. We need some indication of how the models behave under 2015/2016 data.
- Community pharmacy should not be penalised for increases in drug volume or drug price.
- There will be an increase in expensive drugs being funded. The proposed model does not have any mechanism to address these increases.
- The negotiations are not complete but an interim solution. Will there be compensation for what pharmacy has been losing for so long?
- Much effort appears to have been put into the section 26 & 29 drugs. These are a very small part of my business. For once the funding proposal of these seems fair but I can’t accept the proposal as I would then have to accept part 1 of the proposal.
- We have reason to believe this proposal will decrease margins into the future based on bigger pack sizes and more expensive medicines coming through...unless the DHBs can prove us otherwise.
- A modest margin increase to 3.5% and 20c per container would be a fair level of funding.
- It would be very helpful if the DHBs proposed a model that was fair and addressed the concerns and lack of funding that is the current model. In addition that the funding model is future proofed to the rise of expensive drugs on one hand and the rise of cheap high volume drugs in large containers that we have to manually count. Pharmacy is left with the cost of manually counting from these bulk packs. Again the DHBs and the drug companies win at the cost of retail pharmacy. Pharmacy is left to carry another uncompensated cost.
- As a retail pharmacist of over 30 years one gets very weary of proposals that just screw more money from pharmacy and make it harder. Deloitte identified that NZ has one of the
best medicine supply chains in the world. Instead of wrecking a very lean mean & efficient system – why not give it the modest funding being requested to continue it."

“The twin proposal is ridiculous. It’s been based on old data. Over the next year we have having more products go into large pack sizes (all products that most pharmacies dispense large amounts of). Example Cilazapril (90 going to 200). Atorvastatin (90 going to 500) Metoprolol (30 to 90s). This will have a massive impact on the funding and take money away from pharmacies. The DHB has given positive numbers to most pharmacies in the hope that they won’t look at the system properly and realise that everyone is actually worse off. They must become more transparent in their dealing with us.”

“The s29 and all procurement and any additional work that pharmacy is required to do should be reimbursed from a different pool not the usual pharmaceutical funding pool. as this is an additional work thus additional funding is required not chopping the pie to smaller bits and saying here is more.”

“The interim solution for S26/S29 seems fair. Long term it would be good if the legislators could be persuaded to do away with those classifications. There must be a fast track mechanism for granting temporary registration for products proven overseas.”

“If this goes ahead we will be done over by the Pharmac vs DHB issue as we have several times before.”

“This should not be a twin proposal, section 29 makes a small part of most pharmacies . i should not be out of pocket for dispensing section 29. if i accept this i see i will lose money over the rest of the margin. audit compliance, all costs of procurement keep rising , stock holding costs , but margin keeps decreasing.”

“Why is S26 and S29 taking up so much of the discussion document, when a large number of S29 medicines provided have to dispensed due to the current inefficiencies in our supply system? Propranolol, Zovirax Eye ointment replacement -Virgan, Propylthiouracil are but 3 of the items that should be readily available and not on S29.”

“This should not be a twin proposal. Sec 26 and 29 make up x % of my business. I see that I would lose on the rest of the margin offered going forward.”

“There should not be a TWIN PROPOSAL. Each should be a proposal on its own as we are dealing with substantially different issues. It is almost saying we accept both or none, but that is not what was intended by the Ministry.”

“Why does it have to be a twin proposal when they are separate issues? Surely individual issues can be discussed separately.”

“Split the sec 29 offer and the hybrid offer. They do not need to be linked. The Sec 29 offer looks fine but the hybrid is still underfunded. If not funded then patients will be compromised as there is too much risk holding stock. A reduction from 4% and 5% to 2.5% is not good enough. We are moving in the wrong direction and the 27c doesn’t mean anything with Pharmac increasing the pack sizes. Losec 30 to Omeprazole 90’s, Metoprolol 30’s to 90’s, Atorvastatin 90’s to 500’s!! etc”
TO7. Patient surcharging

There were 143 respondents who mentioned patient surcharging. Many respondents raised that community pharmacies should be able to surcharge patients or pass costs onto patients.

The following comments in italics illustrate the range of commentary on this issue.

“Given that this proposal does not ensure that we will not lose money on high cost meds, we should be allowed to pass on the costs to patients. PHARMACIES SHOULD NOT BE FORCED TO LOSE MORE THAN $45 TO FILL A 3 MONTH HUMIRA PRESCRIPTION. MOH and DHBs should be responsible for explaining this to the public as well.”

“Given that this proposal will leave pharmacy out of pocket when dispensing a large number of prescriptions, if we are in the unfortunate position of having it implemented, we should be given the ability to pass on outstanding costs to our patients, and have the ability to turn away prescriptions that would cause the pharmacy to lose money. The DHBs/MOH should then take care of informing the public why pharmacies are having to pass on these costs, and/or turn away prescriptions.”

“With the right to charge for items not fully funded by current model.”

“Need to give more funding so we are being paid the actual cost plus a markup to take into account the stock holding and part packs expiring etc OR Allow surcharging so we don't have to dispense at a loss.”

“We must reserve the right to surcharge. Wastage payments on all expensive medicines.”

“Actually understand what the delivery of Pharmaceuticals to the NZ public entails and at what costs. Further, come out of your ivory towers and accept the simple fact that the NZ Health System CANNOT afford to pay for the services that are expected from pharmacy. Simply allowing pharmacy to charge our customers will provide the shortfall.”

“Undertake an independent review. Allow pharmacy to surcharge to an agreed level if funding shortfall not met by DHB or government. Introduction of efficiency to reduce the cost of delivering the service. Acceptance that the very least of payments should be made for each dispensed item covering the true cost of the drugs plus a fair fee for dispensing (includes cost of holding stock and cost of providing an efficient business).”

“...If the DHB's/MOH can’t put more money in then please allow us to charge an appropriate surcharge. Obviously we will face competition from other pharmacies if we charge and that will keep charges to reasonable/justifiable amounts. Other things that would help are ensuring that Pharmac tenders for subsidy take into account the extra cost to pharmacy of large pack sizes -extra work to dispense, extra cost in containers. There should be no expectation that pharmacy will dispense any medicine at a loss. The DHBs/MOH should also bring in a dispensing only fee to cover the numerous times we dispense medicines and they aren't collected. There is always a cost to us in deleting these dispensings, undoing the work which has been done for no payment and through no fault of ours.”
TO8. Overall funding of margins

The final theme covered submissions that detailed feedback on the overall funding of Margins with 317 respondents commenting specifically on this issue. The majority of respondents stated that margins is underfunded.

A range of comments are listed in italics below.

“The hybrid model is ok but is still underfunded.”

“I understand that the DHB needs to make cost savings, however there has to be an allowance to provide pharmacies such as ourselves to be able to innovate and use technology to create cost savings. Underfunding allows us very little room to make improvements and create automation for cost savings, for patient centric outcomes.”

“A Hybrid model that is sustainable and addresses the current underfunding of the supply chain.”

“At the end of the day, the current model would be workable if the reimbursement was closer matched to the actual cost of getting the medications to pharmacies. A manufacturers cost should be based on what we can buy the medication from the manufacturer. Most don’t allow pharmacies to buy direct from them, and the ones that do still have a 5% margin on it. Therefore the "manufacturers cost" isn’t actually a legitimate number to use if there is no way of actually purchasing medications for this price.”

“Neither model. The current model is the reason the consultation process was started, since we were being paid less than what the medicines cost for us to get them in. What other industry would accept this sort of nonsense? Hence, to continue with this model makes no financial sense. We are extremely hard working people running businesses and helping vast legions of customers. The proposed hybrid model, according to the figures I have received will end up costing me more money. Why on earth would I vote for that? After reading the document, it looks like the same money is just being shuffled around in the hope that we will, as per the previous norm, accept it as something new. I have absolutely no doubts that pharmacy will, once again, have to accept the motion, since veiled threats will be made if we don’t. This could all be solved by adding in an extra $5 million, which, given the massive savings Pharmac is making, is a mere drop in the bucket. Will it happen? I’m not holding my breath.”

“Provide pharmacy with additional funding so we are not left out of pocket regardless of what items we dispense.”

“Not implement model. Go back to the old way of doing things. Currently as an owner I no longer have any idea on how I am being paid. It is not as transparent as before. What we need in more funding, or if that is not possible then the ability to charge for the shortfall which is being created by the DHBs.”

“Provide additional funding to cover the risk associated with high cost medicines.”

“The current model is fit for purpose, it is simply underfunded. If a hybrid model is introduced, it will also be unfit for purpose unless it is funded appropriately (i.e. more money is put in to make it work). With the current funding, the new model will not be fit for purpose: It incentivises inefficiency in pack sizes: Every time Pharmac introduces a new bulk pack size, the pharmacy loses several pack fees and then has to pay more for containers and time spent repacking medications etc. This means reduced
ability for the pharmacy to provide services to their patients. It makes dispensing expensive medicines uneconomical which will result in suddenly reduced access to these medicines as pharmacies will refuse to carry them in stock. Patients will then have to travel from pharmacy to pharmacy looking for their urgent expensive medicines. Notwithstanding the underfunding, the hybrid model is unnecessarily complex introducing another variable (numbers of packs and pack sizes) into the equation and it makes expensive medicines too uneconomical to dispense. Expensive medicines have increased costs and risks associated with their procurement and storage which required the higher level of funding. A suitable alternative would be to maintain the current margin payments and introduce a small pack fee on under $5.00 medicines. Once again this would require an injection of funding.”

“The DHB needs to realise that they are underfunding a growing pharmaceutical budget and aging population. They need to realise that underfunding pharmacy will lead to decreased services. I do not support surcharging the patient although this has been proposed. Many of the patients in my population already struggle with the increased $5 co-payment fee. They already experienced difficulty when the co-payment was $3. The DHB needs to realise that underfunding pharmacy, will only lead to increases in other budgets such as hospital care, more rest homes admissions. They need to look at the total picture and not just at the pharmaceutical expenditure. They also need to look at adequately funding high cost medicines. I already seem to operate as a warehouse for many pharmacies who don’t keep stock of high cost medicines such as Lucrin, Neulastim. Underfunding the supply of high cost medicines will likely to lead to more pharmacies refusing to stock them. The initial figures you supplied for the calculated margin under proposed model showed me having an increase of about $5300. The updated figures you gave me showed me to have an increase of about $1100. I imagine with me dispensing more and more high cost medications due the hospital pharmacy doing less, and also with PHARMAC planning to fund more high cost medicines and also less pharmacies willing to do them I will be soon operating at more a loss. For example we got a script for Strattera yesterday where we were using only 25% of two of the strengths and only 50% of the third strength. This would mean I will have a loss of $236 for this dispensing unless there is a sudden surge in the prescribing of this medicine. This is unlikely as the last part pack of this medication I had expired. If you want pharmacies to supply high cost medicines you must also ensure that they are insured against losses of this magnitude. This could be easily achievable with working with IT providers and having expiry dates of these high cost medicines entered into computers etc.”

“The Hybrid model still shows a lack of funding for pharmaceuticals for the New Zealand public. I think that the Health Department should exercise one of the following options:

1. Inject more capital into the basic funding model so that the pharmacists are not helping to pay for the public’s medicine - out of the pharmacy’s own pocket and let’s face it does the health department or any other government agency get their own employees to pay out of their personal income to fund schools, roads etc. I think not. Why should Pharmacy act as a bank for the health department?

2. Come up with a more viable option - which is going to take more time yet again. Which would beg the question what have the task force been doing up till now.

3. Admit there is not enough money in the budget and allow pharmacies to charge the patients for the current loss of 6%. From my discussion with patients they would prefer to pay the extra miserly 20c to 50c and get a more fair and effective health system. All three will be a bitter pill to swallow, but option 3 might be the best option for all concerned.”
“Introduce more funding or let Pharmacies charge patients the shortfall. No business can run at a loss. The DHBs state that more finding has been introduced but what has happened is that volume growth has occurred which means more work done by pharmacy that is a cost to the DHB. An additional $6m of added funding would solve this problem. A mere drop in the ocean as to what has been saved by the DHBs in the reduction of medicine costs over the years due to Pharmac activity.”

“Add more funding. Have a flat fee per dispensing not per pack. Per pack only encourages larger pack sizes. Have an additional 10% on s29/s26 making it 12.5% so we still have a contribution to margin and stock holding. The extra funding for counselling and the paper work is appreciated. Have an inflation/CPI tool to future proof the stability of Pharmacy supply chain. Rents and wages keep going up. We are doing more and more work for less unless the fees are tied to CPI.”

“More funding is required NOT LESS. Our wholesaler has run an analysis and we are actually WORSE with this new model and will only get worse as more high cost medicine are introduced into community from hospital which appears to be the current trend.”

“Unless more funding is introduced - this is not a viable proposal. If there is sufficient additional funding provided (ie not just that to cover volume increase) - then ensuring appropriate IT by working with current software vendors will be all that should be required to implement this successfully.”

“So much energy is spent on the whole funding issue when such energy should be put into running our pharmacy and meeting the needs of our community. Quite simply if you will not fund the services as they should be then give us the right to charge as we see fit. Trust us, we are trustworthy members of the community and besides this market forces will soon determine the right price to be charged as any excessive pricing will result in customers going down the road as happens in all other retail outlets. The reality is that your continued pressure to get more for less will result in passionate pharmacists leaving the profession as is happening now. Pharmacy has the potential to save so much through preventing further expensive healthcare. We have been involved in this prevention, setting a system up largely at our own cost and yet due to the lack of funding, despite positive results, have had to turn our back on such projects as the support required from the health sector has not been continued. You can only do this so many times. Over and above this is the investment in dollars and people’s lives. The DHB cannot afford to lose pharmacy goodwill. Once lost it will take much to reinstate.”

**Sector agent and wholesaler feedback**

Sector agent and wholesaler feedback largely reflects that of the individual submissions. Additional feedback includes the following:

**Green Cross Healthcare** writes that the status quo is not an acceptable outcome to address the drug margin sustainability. Pharmacists should also be viewed as a valuable member of the primary care team and are not supply chain.

It recognises the fiscal constraints on the health sector and wants the proposal on margins to be sustainable for pharmacists to deliver ongoing care and access to local communities.

**Pharmacy Partners** writes in support of the use of the hybrid model to resolve the issue of periodic margin price shocks but recognises the proposed setting for the model are unworkable for and unacceptable to community pharmacists. It believes revised model setting which recognise the high
cost product issue are essential for acceptance of the model. It would like to see provision of a suitable report that supports reconciliation between margin payments from DHBs and payments to wholesalers in pharmacy practice management software as this will be essential to build pharmacist confidence in a hybrid model and system.

It would also like to see a robust communications package that explains the final model including how the system will work and how it will reduce the impact of the underlying disparity between medicines expenditure and pack volume growth.

*The Pharmacy Guild* writes that the medicine margin shortfall (particularly for low cost medicines) arises because PHARMAC is making real dollar savings on the purchase of medicines. It is the considered view of our members, that there is therefore real money available to appropriately fund medicine margin in a way that maintains the efficient supply chain we have both in the short and long term rather than continuing to use those savings in more and more medicines.

The Guild would also like to see national implementation of:

- OP and wastage payable on all high cost medicines
- CPI adjustment paid to all flat fees annually
- An agreed mechanism to adjust for increases in pack sizes with additional loading for non-dispensing pack sizes.

*Pharmacy Wholesaler (Bay of Plenty Limited)* writes that the nature of the proposed model is complex and that the PHARMAC policy of cheaper pharmaceuticals will continue to have an adverse effect on community pharmacy.

*CDC Pharmaceuticals* writes that the Pharmaceutical Margins issue has been recognised as an issue for some seven years now. CDC Pharmaceuticals are also of the opinion that the hybrid model continues to ignore other increasing costs in the supply chain – labour, freight, regulatory (cold chain, controlled drugs, expiry issues, wastage).

*Propharma’s* objective from the consultation process was for the current lack of supply chain funding be addressed to ensure patients continue to benefit from a world class supply chain and pharmacies do not wear the burden of increasing supply costs in the future.

In addition Propharma stated it cannot change their current terms of trade to pharmacies.
Summary

Community pharmacy has given a significant amount of feedback on the twin proposal with over 600 individual responses as well as sector agent/membership organisations /wholesalers feedback.

The feedback received has highlighted a number of educational needs:

- For broader education on any funding model and what this may mean at an individual pharmacy level as well as at regional and national levels.
- Education on how each of the three organisations, PHARMAC, DHBs and the Ministry of Health, operate
- How the supply chain does work
- How data that is presented in the Consultation Document (or supporting information) is derived – for example the data was supplied to pharmacy for the consultation was ‘real time’ data that was the actual claims data processed by that individual pharmacy.

Reviewing all consultation feedback is a key part of any DHB decision on an interim solution for pharmaceutical margins.

Work is underway to look at the true cost of the supply chain. This is due to be finalised before 1 July 2016 and will inform a long-term solution for margins.