Draft Pharmacy Action Plan 2015-2020

Submission to the Ministry of Health

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces Te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

PREAMBLE

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Ministry's Draft Pharmacy Action Plan 2015-2020 ("the Plan").

2. NZNO has consulted its members and staff in the preparation of this submission, including members of Colleges, Sections, Te Rūnanga o Aotearoa, nurse practitioners, and nursing, research and policy advisers.

3. The Plan has stimulated significant interest among nurses, particularly from primary health care nurses, public health and district nurses, clinical nurse specialists and nurse practitioners. It has been discussed in a number of professional meetings, and with Ministry officials at the national teleconference held at NZNO on November 18, 2015.

4. We consider some of the broader implications of the document in the discussion below; answers to the consultation questions follow.

DISCUSSION

5. There are many aspects of the Plan which we believe are right on track for moving towards an integrated operating model for pharmacy, that is person-centred, improves access and health outcomes, and utilises health workforce skills efficiently.

6. These include the exemplary focus on patient safety and wellbeing in the initiatives described in the early part of the document, and the identification of a suite of integrated actions that need to be incorporated into the primary health care (PHC) model to achieve the goals.

7. However, we suggest that a more holistic focus on the role of pharmacy in improving population health is needed, rather than one limited to the potential of expanded practice for pharmacists, and on utilising the skills of "pharmacists, nurses, GPs and other doctors".

8. The Plan is intended to inform the development of a new regulatory framework for therapeutics products and therefore needs to leverage the safety and flexibility afforded by the Health Practitioners Competence Assurance Act 2003 (HPCA Act) to optimise collaboration and clinical expertise across the spectrum of health care.

9. While Plan references the expansion of pharmacist roles in other countries and other settings, it doesn't expand on the collaborations other than medical ones referred to in the international context (p2).

10. There are disappointingly few references to the allied health workforce, despite the extension of prescribing rights to registered health practitioners besides doctors. Similarly there are few actions, apart from prescribing, which would facilitate a fully collaborative, integrated approach to complex, multifactorial health conditions such as diabetes, where the expertise of eg dietitians, podiatrists, optometrists, psychologists should be available to provide the 'wrap around' care and information that people need.

11. It is this comprehensive primary health care approach at all service levels that is needed to improve population health and the efficiency and effectiveness of the health workforce. Such an approach would also profoundly lift the quality of the patient experience, improve health literacy, and empower and enable self management. A systemic change is needed to address the systemic issues which entrench health disparities, such as lack of access to information, medicines, advice.

12. A particular challenge in providing opportunities for expanded practice to improve access and choice *where there are service gaps* is to ensure that care is not fragmented, nor the integrity of health disciplines undermined. Care must be taken to ensure workforce complementarity, rather than substitution or duplication.

13. In this context we note the importance of comprehensive assessment, which is the primary role of nurses and the focus of their education and training. "*Registered nurses utilise nursing knowledge and complex nursing judgment to assess health needs and provide care.*" (RN scope of practice, NCNZ).

14. We suggest that there is significant scope for developing alternative PHC services using nursing and other expertise in collaboration with pharmacists (and others) eg pharmacy based walk-in nurse clinics, rather than anticipating incremental additions to the pharmacists' role. The Plan would be enhanced by identifying specific actions to facilitate co-located, collaborative services in communities, for example.

15. Caution around the safety and feasibility of pharmacists being able to provide high quality, holistic assessment and protect consumers' privacy within the confines of a busy commercial enterprise tops the lists of nurses' concerns.

16. Screening, for example, often involves exploring sensitive issues, and requires a platform of trust and knowledge built up over time. Similarly education around the choice and use of medicines/medical devices eg inhalers, diabetes testing strips, is not just a matter of conveying technical information, but of careful consideration of a range of health, and other factors, to arrive at the optimal choice for that person. And, of course, there are many people are unable to make choices for themselves and who must be protected.

17. Actions must be driven by health need rather than commercial opportunity; clearly there is increased potential for conflict of interest issues when pharmacists are prescribing and dispensing within a commercial environment, particularly in Aotearoa New Zealand, one of the few countries to allow direct to consumer marketing of drugs (DTC).

18. Ownership/ employment models vary, eg pharmacist-owned GP practices and pharmacies, pharmacists employed in community pharmacies, pharmacists employed by DHBs etc. and the Plan may affect the business and employment environment. That has implications for the pharmacy/health workforce, and potentially the mix of public /private services, and health equity and outcomes.

19. We are confident these issues can be managed through good policy and regulation, but the failure to address such a fundamental issue in the Plan, or to distinguish between pharmacists, pharmacies, and the services the pharmacy business may provide (eg vaccination), is somewhat disconcerting.

20. The conflation of the practitioner role with a part or wholly funded public health service, which also occurs with GPs and PHOs, obscures the impact of financial barriers and incentives on access to primary health and subsequent care, and can lead to perverse incentives eg to overprescribe.

21. These issues should be explored more fully from a consumer perspective. The Plan as it stands is likely to improve access and choice for *some* individuals and communities, but it is pharmacist- rather than people or health-centred.

22. Access to medicines eg the emergency contraceptive pill, vaccines, has improved by being available from pharmacists and at pharmacies, but it comes at a cost to the consumer. In the case of vaccines, which are administered by vaccinators (who may or may not be pharmacists), there is a requirement that consumers are informed if they are entitled to free vaccination elsewhere, but this does not apply to other medicines. What is the impact of this cost differential? What is the potential *health loss* because of financial barriers? Are there alternative delivery mechanisms?

23. Similarly, consumers bear the costs of medication changes which can be considerable, particularly if pills are blister packed. Nurses note that many consumers reveal that they 'use up' their old medication packs before they change to new medications, which is wasteful, expensive and counteracts the value of skilled assessment and medication.

24. Improving timely access and choice requires such issues to be addressed, because, as with many well-meaning health initiatives, if they are not, they can be discriminatory and exacerbate disparities. The most vulnerable people do not have increased access or more choice if their ability to get to a pharmacy is just as limited as their ability to get to a clinic, or if the only choice they have is to pay a lot more.

25. Indeed in terms of medicines, PHARMAC's records (see fig 1 below) indicate that Māori not only don't get the medicines they need to address the conditions that they are disproportionately vulnerable to, but are also disproportionately prescribed and sold medicines which provide short term symptom relief rather than prevention or treatment of ill health.

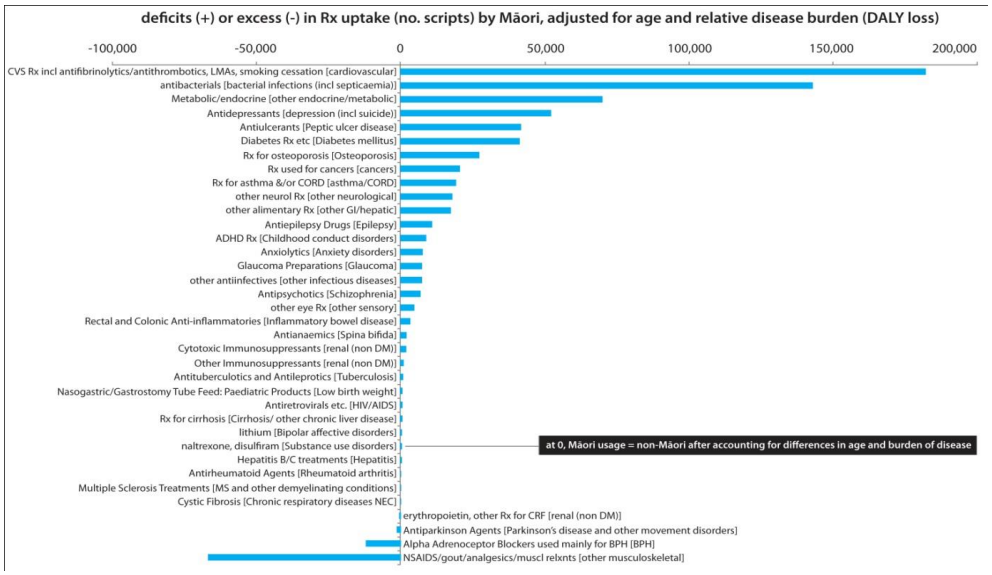

Fig 1: Māori access to medicines. Courtesy Marama Parore, PHARMAC 2012.

26. Similarly, the Ministry of Social Development apparently spends ~ $50million pa paying for medications (mainly pain relief) for people on benefits. This is an inhumane and unacceptable misuse of resources. Access to affordable medicines must be linked to proper assessment, diagnoses and a treatment plan regardless of the government agency involved.

27. Aotearoa does quite well on many international comparative indicators of health, but the Commonwealth Fund in 2014 places us 10th out of 11 for equity and 9th out of 11 for healthy lives, outcome measures for which include 'mortality amenable to health care'; and 'healthy life expectancy'. Access to appropriate medicines is a key factor affecting health equity, and while ethnicity is certainly an important indicator of disparity, and we welcome the actions to improve pharmacy for Māori and Pacific peoples, there are other many others, including poverty, location, health status etc.

28. Addressing inequity is the major challenge for the health system because it reduces suffering, cost and health demand. However, we note that in contrast to the factual statements in the Plan about our aging population and workforce and the growing burden of chronic disease, inequity is not acknowledged, and access and equity are framed in terms of actions to address ethnic disparities (p4) rather than the full range of socio-economic factors which give rise to structural discrimination and health disparities.

29. We recommend to your attention the Public Health Association's excellent document: *Te Turi Whakaruruhau: Code of Ethics for Public Health* (2015)[1] which provides a very helpful framework for developing a plan such as this, where there is potential conflict, and note that Te Tiriti o Waitangi lies at the heart of it, setting the basis for ethical relationships and actions.

30. NZNO strongly recommends that the Plan makes use of the Code as a health equity lens, acknowledges Aotearoa New Zealand's abysmally low ranking for health equity and identifies and prioritises actions that will *reverse current trends* in access to, and the use of, medicines.

31. In this context we warmly welcome and endorse the identification of improving health literacy as fundamental to making effective health decisions. We believe this is an area where pharmacists can make a vital contribution.

32. The Plan and upcoming legislation presents a rare and important opportunity to stop DTC in Aotearoa New Zealand, an unintended

[1] Te Ture Whakaruruhau – Code Of Ethical Principles For Public Health In Aotearoa New Zealand www.pha.org.nz/documents/120305code-doc.pdf

consequence of inadequate provisions in the Medicines Act 1981 which did not specifically disallow it.

33. DTC remains contentious, (eg World Health Organization, 2009[2]) though internationally the weight of evidence and practice in developed countries apart from the US, does not support it.

CONSULTATION QUESTIONS

Vision

Q1. *Does the vision adequately address the strategic context for the future of pharmacy services as part of an integrated health and disability system in the next three to five years? If not, what is missing or what needs to be added?*

34. No. As indicated, though we agree that improving access and choice is important, the most important focus should be on ensuring the optimal use of medicines which is predicated on universal access to high quality, holistic assessment.

35. Medicines should be used to improve population health, not just increase access and choice for some. Although the vision refers to "all New Zealanders" it does not reflect an aspiration to equity, or reducing health disparities. Health equity is essential to the vision.

36. NZNO does not agree with the focus on what the pharmacy sector will deliver. Pharmacists have a primary role in managing and dispensing medicines, but medicines are a health tool which all health practitioners have a responsibility to ensure are appropriately used. The Plan needs to be multidisciplinary and aligned with the Health Practitioners Competence Assurance Act 2003.

37. We also question who or what 'social sector partners 'are; the term is not defined in the glossary, and may encompass community groups, NGOs, DHBS, local government or corporate or 'social' investors. The nature of such partnerships, including the funding and commissioning of services have significant implications for population health and health system outcomes. While it may not be possible to determine all the details at this stage, the Plan should clearly indicate the intended direction.

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[2] Eg World Health Organization. (2009). Direct to Consumer Advertising Under Fire. *Bulletin*, *87*(8), 565–666. Retrieved from http://www.who.int/bulletin/volumes/87/8/09-040809/en; Susanna Every-Palmer, Rishi Duggal, David B Menkes. 2014. Direct-to-consumer advertising of prescription medication in New Zealand, *NZMJ* Vol 127 No 1401: 29 Aug 2014; Kevin Sheehy. 2015. DTCA in New Zealand, finding a healthy balance; *NZMJ* 26th September 2015, Volume 127 Number 1403; Public Health Association's Position statement on DTC Advertising retrieved November 2015

38. In this context, we note the Productivity Commission's Report *More Effective Social Services* (2015) and recent government initiatives such as the social sector trials. We take this opportunity to inform you of NZNO's firm opposition to towards such "social investment", where partners tend to be bankers rather than clinicians, as there is no supporting evidence for such an approach, in contrast to the overwhelming evidence in favour of equitable public health systems (Marmot, 2008).

Focus Area 1: Population and personal health

Q2. *Do you agree that pharmacists should have a greater role in providing public-health level interventions?*

39. Yes. Pharmacists could provide vaccination, blood pressure, screening etc. as suggested, and have a very important role in reinforcing health messages and improving health literacy. However, we suggest the focus should be on leveraging and enabling pharmacists' skills and facilitating collaborative practice, rather than expanding the pharmacists' scope of practice, which risks diluting health workforce expertise.

40. It will also be important to avoid fragmentation, through good information and communication channels, access to health IT portals etc. and ensuring appropriate assessment and referral.

41. Self assessment is not always reliable, and it may challenging for community pharmacists (eg in terms of space, time, scope) to be able to conduct an assessment/screening beyond the issue initially presented.

42. This applies in tertiary settings too. Nurse Practitioners working in hospitals note that even where there is good communication over medicines management, there are other issues such as patients' understanding, transport, family circumstances, age, capability etc. which are integral to ensuring the best health outcomes for the patient.

43. Medicines are a key health tool, but assessment /treatment is not just a matter of matching medications to medical conditions, but of developing a health plan to suit individual circumstances.

Q3. *Do you think the population and personal health actions could encourage pharmacist-led population and personal health initiatives as part of integrated health services?*

44. Yes. There are several areas where pharmacists could lead the promotion of safe and appropriate use of medicines, and to help people navigate online information that ostensibly enables them to 'self-manage' but in fact may be contradictory, confusing and/or inaccurate. In Australia there is some discussion around the

scheduling of over-the-counter codeine medicines and whether this is necessary to reduce inappropriate and potentially harmful use; public education on such an issue could usefully be addressed by a pharmacist-led initiative, for example.

45. We support the identified actions for this focus area especially those for the DHB and the Sector.

Focus Area 2: Pharmacist clinical services

Q4. *Do you agree with the focus in this section on optimising pharmacists' medicines management expertise to be used across the health and social sectors in a broader range of settings as part of an interdisciplinary team?*

46. Yes. Pharmacists' knowledge and expertise is invaluable in ensuring optimal use of medicines, preventing/reducing inappropriate polypharmacy, and risk etc. They are an integral part of the interdisciplinary health team particularly in rural areas where nurses, NPs, doctors and pharmacists work closely, and innovatively, together. Facilitating team practice is probably the most important way in which workforce skills can be leveraged to deliver better health outcomes.

Q5. *How important is it to change funding and contractual agreements (CPSA, PHO, and Aged Care) for successful integration across primary health care services (including pharmacist services)?*

47. Very important. Note that pharmacies are businesses and will not be providing free public services unless provision is made for that. The priority for the Plan is to deliver equitable access to affordable medicines that are needed.

Q6. *How important is it that pharmacists are part of interdisciplinary teams?*

48. Essential. As above.

Focus Area 3: Acute demand management

Q7. *Do you agree with the focus in this section on pharmacists having a greater role in contributing to the treatment of minor ailments, acute demand triage and appropriate referral?*

49. Yes. It is useful to utilise the expertise of all health professionals and we welcome recognition that timely access to assessment, treatment, and appropriate referral is the most cost effective way of reducing health demand and improving efficiency.

50. Assessment is critical to the treatment of minor ailments, acute demand triage and appropriate referral and this is nurses' primary role, whose training and education equips them to assess, triage and refer

appropriately. There are 52,729 nurses practising in Aotearoa New Zealand, who have long advocated for this primary health care approach at all levels of care and by all health professionals (NZNO Health Matters).

51. As indicated previously, we support providing opportunities for expanded practice to improve access and choice (particularly where there are service gaps) and facilitating integrated practice to fully utilise skills across the health workforce. I.e. ensuring workforce complementarity, rather than substitution or duplication.

Q8. *Do you agree with the focus in this section on developing a minor ailment service?*

52. Yes if it is appropriately staffed. Refer to our earlier comments about the need for holistic assessment and the conditions needed to ensure privacy, and optimise the opportunities for holistic assessment and screening.

53. We support most of the actions, particular sector actions – i.e. e-prescribing and a culture of open disclosure.

54. However with regard to managing "the removal of non regulatory barriers to supply chain efficiency to ensure reward in balanced with risk across the sector" we draw your attention to our recent submission to Pharmac *opposing* the proposal for the supply chain for vaccines.

55. We also suggest that actions must be focused on sustaining health rather than businesses.

Focus Area 4: Dispensing and supply services

Q9. *Do you agree with the focus in this section on driving efficiencies in the medicines supply chain through the broader use of technologies, for example, robotic dispensing and more flexible regulation?*

56. Yes, pending costs.

Q10. *How important is the role of the pharmacy accuracy checking technician (PACT) in driving dispensing efficiencies?*

57. N/A (technicians could be defined in the glossary)

Focus Area 5: Prescribing pharmacists

Q11. *Do you agree there should be greater integration of prescribing pharmacists into a wide range of primary and secondary health care teams, including residential care facilities?*

58. Yes. There is considerable potential to leverage pharmacists' expertise in multidisciplinary teams in many health settings, particularly where

multiple medications are prescribed eg palliative care, aged residential care and mental health.

59. After hours and weekend access is critical, but there are costs and these must be considered and addressed. Many people on low incomes do not have prescriptions filled after hours because there is an extra charge. Weekends are particularly problematic – it is not unusual for people to wait until after the weekend to have a prescription filled even if they (or their children) are very sick.

60. Cost and access are not the only issues, however. Respiratory nurses find that people can often only afford one medication and with asthma, they will often choose the reliever rather than the preventer. Health literacy is key to empowerment and ensuring better medicines management and healthier living.

61. NZNO has confidence in the safety and effectiveness of the HPCA Act and supports exploring and developing models for prescribing for any registered scope of practice, as appropriate. It is not necessary for this action to be limited to any one profession.

62. NZNO supports the concept of a generic prescribing standard, which includes an agreed level of clinical assessment.

Enabler 1: Leadership

Q12. *How important is leadership as an enabler to the actions in this plan?*

63. Essential.

Enabler 2: Information and other technologies

Q13. *How important is information technology (IT) in terms of the potential to transform pharmacy practices?*

64. Very important to ensure access to accurate and up to date clinical information that is relevant to the role of the health practitioner at that time.

65. Note that there is a “digital divide” which may be exacerbated by rising inequality, and that there are still outstanding issues around the privacy of health information. It will be very important to identify safe processes/alternative access points to ensure <u>all</u> people have access to their health information, that confidentiality of that information is protected, and that health practitioners only have access to relevant information.

Q14. *How important is it for pharmacists to be able to have full readable/ writeable access to patient health records?*

66. See above. A pharmacy is a business; pharmacies are public spaces. How happy are the public to have their information available in that environment? Has this issue been explored fully?

Enabler 3: Workforce

Q15. *How important is it to have pharmacists less involved in the technical aspects of medicines supply and better utilised to provide patient-centred care across a range of practice settings?*

67. We reiterate the importance of utilising rather than watering down health workforce skills and expertise, through duplication and/or overlapping scopes of practice.

68. The Kaiāwhina Workforce Action Plan being jointly developed by Health Workforce New Zealand and Careerforce anticipates encompassing all unregulated roles such as “health navigators” to provide consistent training and qualifications and recognised career pathways for unregulated health workers.

69. We suggest that this is where the lead accountability for this development should lie, rather than with PSNZ/PGNZ, to avoid duplication or confusion.

70. We warmly support actions to improve cultural competence and improve proportional representation of Māori and Pasifika in the pharmacy workforce.

71. Nursing Council’s 2015 annual report notes that “*Nursing education programmes are involving nursing students in team-based learning with other health professional. The literature shows that there are patient safety benefits when team members have a clear understanding and appreciation of the roles and responsibilities of their colleagues*”.

72. We recommend that the draft strategy include actions supporting such interprofessional education.

Enabler 4: Regulation

Q16. *How important will a more permissive prescribing and dispensing framework be for changing the future direction of pharmacy services*?

73. Very important – we suggest the framework be described as ‘enabling’ rather than ‘permissive’.

Q17. *How important will potential changes in ownership and/or licensing arrangement be for changing the future direction of pharmacy services?*

Potentially very important; it will be important to prioritise public health interests.

Q18. If you had to prioritise the actions in this plan what would be your top three actions for implementing in the next five years?

74. Focus on actions that will:

- improve population health i.e. deliver equitable access to affordable medicines that are needed (note health literacy vital for any form of self management and other factors which may influence environment for medicines eg IT (patient portals /health professional access), DTC advertising etc.)' eg Actions on P 16 re models of care and contractual agreements to provide equitable access; developing a consistent approach; actions to improve cultural competence, proportional representation of Māori and minority groups (ethnic, refugee, etc.) in the health workforce

- facilitating integrated practice to fully utilise skills across the health workforce – planning, education, complementarity, expanded scopes etc. eg P14 DHBS – annual planning and funding to enable interdisciplinary services; Actions P 21 – support models of care to enable the integration of prescribing pharmacists (health practitioners would be better) into primary and secondary health care teams ; single prescribing standard;

- moving away from a pharmacy business model towards a pharmacy public health model eg P 27 …"licensing arrangements that are focused on ensuring appropriate control of pharmacies rather than business ownership" and the regulatory actions described on P 28

Q19. Are there any actions in this plan that you particularly agree with or disagree with, and if so why?

75. See discussion above –concerns around holistic assessment; expanding scopes at the expense of utilising existing workforce; not identifying potential collaborations/collocation of services eg nurse led clinics; potential to increase access for some, potentially not the most vulnerable.

76. Considerable disquiet about unidentified "social sector partners" – note our opposition to "social investment" initiatives.

Q20. Are there any actions that you think have been omitted that should be included, and if so what are they and why should they be included?

77. Fully considering the socio-economic issues which are a barrier to equity and actions to address them; interprofessional education/ workforce planning – coordinating planning, education, employment, immigration strategies; privacy issues – consumer input etc.

78. We again recommend your attention to the *Te Ture Whakaruruhau, Code Of Ethical Principles For Public Health* (PHA, 2015)

79. in Aotearoa New Zealand