Health care policy and community pharmacy: implications for the New Zealand primary health care sector

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Abstract
The aim of our paper is to expose the challenges primary health care reform is exerting on community pharmacy and other groups. Our paper is underpinned by the notion that a broad understanding of the issues facing pharmacy will help facilitate engagement by pharmacy and stakeholders in primary care. New models of remuneration are required to deliver policy expectations. Equally important is redefining the place of community pharmacy, outlining the roles that are mooted and contributions that can be made by community pharmacy.

Consistent with international policy shifts, New Zealand primary health care policy outlines broad directives which community pharmacy must respond to. Policymakers are calling for greater integration and collaboration, a shift from product to patient-centred care; a greater population health focus and the provision of enhanced cognitive services. To successfully implement policy, community pharmacists must change the way they think and act.

Community pharmacy must improve relationships with other primary care providers, District Health Boards (DHBs) and Primary Health Organisations (PHOs). There is a requirement for DHBs to realign funding models which increase integration and remove the requirement to sell products in pharmacy in order to deliver services. There needs to be a willingness for pharmacy to adopt a user pays policy. General practitioners (GPs) and practice nurses (PNs) need to be aware of the training and skills that pharmacists have, and to understand what pharmacists can offer that benefits their patients and ultimately general practice. There is also a need for GPs and PNs to realise the fiscal and professional challenges community pharmacy is facing in its attempt to improve pharmacy services and in working more collaboratively within primary care.

Meanwhile, community pharmacists need to embrace new approaches to practice and drive a clearly defined agenda of renewal in order to meet the needs of health funders, patients and other primary care providers. There are significant barriers to change. Some of these are financial but many are professional and organisational and require a genuine commitment from the whole primary health care sector.

The past decade has seen policy reform result in significant challenges for community pharmacy. Internationally, policy is driving change in community pharmacy, although ‘reprofessionalisation’ from within pharmacy is a contributor. Policymakers and professional pharmacy bodies are advocating significant change to ensure community pharmacy contributes to primary health care.

In New Zealand community pharmacy is an integral part of primary health care but has been an underachiever in terms of the expectations of current policy. Pharmacists
are highly trained however in many instances community pharmacists spend their time counting tablets in a dispensary. Pharmacists and their support staff undertake bureaucratic roles on behalf of other agencies often with minimal access to prescribers. This is in direct contrast to where energies need to be directed to facilitate health gains.

New Zealand policymakers request integration and collaboration between community pharmacy and other providers including general practice. In part, these policies are underpinned by increased demand for primary care services in the face of declining numbers of general practitioners. This is an international trend and professional bodies of pharmacy see opportunity through role extension. One example of this role extension (or reprofessionalisation) is Medicines Use Review and Adherence Support (MUR).

MUR is an enhanced service which involves assessment of patients’ medication regimens, their understanding and concordance, and recommendations being made to the patient and general practice team. Tension characterises this position, particularly with regard to the relationship between community pharmacy and general practice based on the overlap of current and future roles and professional boundaries.

The thrust of our paper is outlining the implications of policy change for both community pharmacy and key stakeholders. General practitioners, primary care nurses, health funding and planning groups including DHBs and PHOs are all expected to collaborate with the community pharmacy sector. In this context, we describe the changes community pharmacy must make to deliver the expectations of primary health care policy and reform.

We highlight the implications, challenges and opportunities for both community pharmacy and external stakeholders. To this end, we aim to create awareness and debate amongst the primary care sector.

**Policy drivers**

The Governments of New Zealand and the United Kingdom have implemented major reforms since the mid 1990s that impact on community pharmacy. The UK Government has been prolific in its commissioning of consultation reports, literature reviews, and health policy outlining current and future roles for community pharmacy.

The NHS White Paper for Pharmacy released in April 2008 draws on what Galbraith describes as the attributes of a good pharmaceutical service, and outlines the potential contribution of pharmacy at various levels. Galbraith describes the distinguishing features of a world class pharmacy (Panel 1) which provides a benchmark for New Zealand.
Panel 1. Distinguishing features of a world class pharmacy

- Primary source of health information and advice
- Helping people to stay healthy and to improve health where needed
- Routinely promoting self-care and being associated with key public health initiatives
- Providing new services to help people with acute conditions and long-term conditions
- Skilled, knowledgeable, competent and considerate staff
- Part of a strong local network of health improvement services and local leaders for health in the community
- A wider information retailer of medicines but also broader health, wellbeing and social matters—i.e. sustainable development

Galbraith suggests that the fundamental principles underpinning a contractual model for community pharmacy practice include models of practice which enhance patient experience, support wellbeing and promote the safe use of medicines. Additionally, community pharmacy needs to develop an integrated ‘pharmaceutical care management’ service. This approach should include a greater clinical focus, be integrated with other providers, have a quality focus and be underpinned by adequate incentives to drive best practice.

In New Zealand, primary health care reform has followed much the same model as in the UK. The main difference is that the community pharmacy sector has been central to these reforms from the beginning in the UK by representation through a Chief Pharmaceutical Officer. Since the 1990s, pharmacy has gained the attention and respect of high level health policymakers and advisors from other health professions. Despite the importance of medicines and medicines provision in the modern health care system this post does not exist in New Zealand, whilst medicine and nursing do have such representation.

The New Zealand Primary Health care Strategy (NZPHCS) is much more subtle in outlining roles for community pharmacists, simply as a provider of education in addition to medication supply and distribution activities. The NZHPCS calls for the delivery of high quality care through improved access and equity. This is expected to be facilitated by integration between service providers and development of culturally competent multi-disciplinary primary health care teams. The NZPHCS does not provide detail of what community pharmacy needs to deliver in order to improve health outcomes.

Medicines New Zealand (MedNZ) is a strategy which provides more direction, citing three objectives:

- To ensure the quality, safety and efficacy of available medicines.
- To improve access to medicines that New Zealanders need regardless of an individual’s ability to pay.
- To optimise the quality use of medicines.
The MedNZ strategy dictates increased roles for pharmacy and highlights the central position of community pharmacy in assisting patients to understand their medicines better, to use their medicines appropriately, to monitor side effects and adverse reactions and to optimise therapeutic outcomes through medicines use and adherence.

New Zealand and the UK do not stand alone, with governments and professional pharmacy bodies in Australia\textsuperscript{13}, Canada\textsuperscript{14} and the United States\textsuperscript{15} generating policy and vision documents. Along with the New Zealand and UK policies and vision, these documents highlight themes of change (Panel 2) which need to be addressed by community pharmacy and the rest of the primary care sector in order to deliver expected health outcomes.

**Themes of change**

If value is to be gained from community pharmacy, the wider primary health care sector needs to understand the current model of care and therefore the change that is required including professional, structural and remuneration models.

### Panel 2: Health care policy and challenges for community pharmacy and stakeholders

- Policy setting for pharmacy has been dominated by funding stakeholder bodies with varying levels of consultation with key stakeholders
- Vision setting by national pharmacy bodies has been formulated predominantly through input from within the sector
- There is a call for integration and collaboration of pharmacy services within primary health care systems
- There is a focus on the provision of quality evidence-based health care
- There is a change from a product to a service orientation and from individual patient to population focus
- The provision of enhanced pharmaceutical services or cognitive services is an important way for the pharmacy profession to improve population-based health outcomes whilst contributing to their own professional development.
- There is development with respect to new models of pharmacy practice
- There is an expectation of support for academic pharmacy practice and research in line with national pharmacy body and funding stakeholder requests
- Sustainability will be gained through an adequate level of publicly funded remuneration
- Planning and implementing a defined agenda of change for pharmacy will be a significant determinant of pharmacies future

**A greater emphasis on integration and collaboration**—Community pharmacy will need to work towards complete integration within the primary health care system. This will require integration in terms of technology and patient flow to ensure population-based health care delivery. There is a need for engagement between community pharmacy and DHBs which undertake health funding and planning activities and ultimately dictate the use of funding streams involving community pharmacy.\textsuperscript{16} The same applies to PHOs which implement coordinated health initiatives for general practice teams.\textsuperscript{17}
For some proprietors and managers this will require a significant refocus on relationship management, and being aware of the environmental situation outside of the ‘four walls’ of their pharmacies. For DHBs and PHOs this may require an equal level of self-reflection and pro-activity.

Collaboration with the wider primary health care team including general practitioners and nurses is expected. Pharmacists will need to demonstrate that they are medicines experts who can effectively communicate not only with their patients, but also with other health professionals and representatives from health funding and planning organisations.

A focus on the provision of quality primary health care—As with general practice, demonstrated evidence of the delivery of quality primary health care by community pharmacy will be mandatory. Clinical and process audits will become commonplace within community pharmacy. There is a greater expectation that community pharmacies contribute to both patient and population health outcomes as a result of increased multidisciplinary teamwork and integration at both practitioner and organisational levels.

The requirement for standardisation and benchmarking across pharmacies will impact on those delivering the services through increased compliance costs. The need to integrate and collaborate in order to improve the quality and seamless nature of primary health care delivery will require up-skilling at all levels within community pharmacy.

A focus on ‘service provision’ versus ‘selling a product’—Like general practices, community pharmacies are small to medium sized businesses in New Zealand and two key issues prevail for proprietors. First, the delivery of value to key stakeholders is important for sustainability. Second, a level of financial viability is required when making changes to the way services are delivered.

Shifting from the need to make a companion sale to the delivery of a range of quality assured patient oriented services will require two significant changes. First, workflows will need to be re-engineered and staff trained accordingly. Second, adequate remuneration needs to be provided.

Pharmacists in New Zealand are generally positive about adopting new enhanced services which require collaboration which is in agreement with findings from the UK. However, the difference between New Zealand and the UK is that for too long community pharmacy in New Zealand has been providing services to the public for which there has been no reimbursement outside of the sale of a product. Enhanced and collaborative roles require an adequate level of remuneration in New Zealand so that this focus can be reversed.

Activities such as minor ailments programmes are a good example. Historically these activities have involved assessment of and response to patient symptoms with the sale of a product or direct referral to a general practitioner as appropriate. Despite fears to the contrary, pharmacists do not see this as diagnosis.

Pharmacists recognise that diagnosis is not a core part of their underlying training, whilst many have a good understanding of diagnostic processes they are very well aware that this is not their primary role. In line with the UK model, minor ailments
programmes will be more formalised, have restricted protocols for funded medications that can be dispensed, have associated funding streams for pharmacists’ time, will require training and accreditation and have standard deliverables.

The model of shop assistants providing triage and much of the advice about minor ailment management may come under scrutiny and may precipitate a reassessment of the roles and levels of work within community pharmacy.

**Looking after your patient...looking after your population**—The expected health gains through implementation of the NZPHCS are underpinned by a population-based focus on health care provision. Ten years ago this was a new phenomenon for general practice which now applies to community pharmacy. Brief screening and intervention for alcohol consumption is one example whereby integration and coordination with other health professionals and with PHOs will be required.

It is not a matter of simply putting a poster on the wall or having a product-based shop front display. Training, taking a wider view of activities and the environment outside of the pharmacy and relationship management of key collaborators will be important drivers of success.

**The provision of enhanced pharmaceutical services**—Days are numbered for the handing out of ‘the brown paper bag’ which contains a pile of medications for which little or no advice is given and for which concordance is not supported or monitored. The provision of value-added patient oriented services will become the norm. Coordinated MUR, minor ailments programmes and public health screening will be targeted at high risk patients for whom the most benefit will be gained.

Structural changes will be required to ensure private consultation areas are available for assessment and counselling. Systems and processes will need to be in place to ensure that general practitioners, primary care nurses, nurse practitioners and receptionists are kept informed of the actions which community pharmacy has taken or the recommendations that are made.

Changes in human activity will also be required to implement enhanced services. Pharmacist confidence, an unwillingness to leave the comfort zone of the dispensary, uni-professional cultures and pharmacy’s inexperience of the commissioning process have been cited as barriers to change in the UK. Similarly in New Zealand the way pharmacists think and act and their relationships with stakeholders has been cited as a barrier to moving forward.

**Developing new models of pharmacy practice**—The old adage of ‘location, location, location’ - or being near to a general practitioner, thereby ensuring high prescription turnover will not be enough to deliver the wide range of services that pharmacy is expected to undertake. Just as general practice has had to change over the last thirty years, community pharmacies will need to develop and implement new workflows and models of practice as well. Activities such as the management of minor ailments that have been routine clinical practice will become more formalised and require re-engineering in order to deliver services.

New services will require different models of practice and the strengthening of relationships. MUR is a service that will require substantial re-engineering. Many pharmacies now have consulting rooms or private areas and there are a growing
number of examples of these services. To develop this widely, more pharmacists will need to be trained, support staff will need to be aware of the process, private space allocated, documentation systems put in place and there will need to be increased liaison with general practitioners and nurses.

**A defined agenda and processes for change**—The ability to think, develop vision, cement key stakeholder relationships and adapt through strategic change are prerequisites for the survival of community pharmacy. Tsuyuki and Schindel have started thinking about this process in a systematic way. Applying the well established model of change by Kotter highlights the need for developing a sense of urgency, forming a guiding coalition, achieving short-term gains toward longer-term goals and embedding a focus on the future within the culture of community pharmacy. To some extent policy is helping to develop a sense of urgency. The rest must come from within the pharmacy sector.

**A challenge to community pharmacy**

We have argued that the reform of New Zealand primary health care is having, and will continue to have, significant implications for community pharmacy and key stakeholders. All too often, Government policies are seen by those working at the coal face as didactic, idealistic, unachievable and non-sustainable and this appears to be the case with community pharmacy.

In moving forward, seven barriers need to be addressed by community pharmacy including: the way pharmacists think and act, improved systems of care and teamwork, improved funder relationships and remuneration, appreciation of pharmacists knowledge and skills, support for research, up-skilling current expertise and having a unified pharmacy voice.

Pharmacists themselves may have to make attitudinal changes in order to take on new roles and integrate within the primary care team. Our previous work reports pharmacists’ apathy, narrow and inward focus, negativity of the current health care environment, silo thinking and taking a subservient approach. This thought and behaviour needs to be replaced with a level of outgoing confidence, underpinned by pharmacy placing ‘value’ on itself as a profession.

Lack of adequate remuneration has been cited as a significant barrier to the adoption of enhanced services. Whilst general practice has been subject to the challenges and pressures of primary care reform, historically it has developed a stronger negotiating position, is better supported by government funded organisations such as PHOs and has had substantially more funding reserves and remuneration policies such as Capitation and Services to Improve Access (SIA).

These funding streams have provided sustainable revenue outside of fee for service payment arrangements. To remain viable as a respected health care professional, the community pharmacy sector as a whole needs to demonstrate a willingness to adopt a “user pays” policy for services that have historically been provided for free or subsidized by retail sales.

Tied in with the lack of adequate remuneration to provide education, enhanced pharmaceutical services and public health initiatives, is the historic relationship between community pharmacy, DHBs and the Ministry of Health (MOH).
Zealand pharmacists perceive their relationship with DHBs and the MOH and their bureaucratic processes to be a significant barrier to community pharmacy moving forward.\textsuperscript{23}

As a profession, community pharmacy has to become indispensable, deliver value, and attempt to improve relationships with funder stakeholders to assist in securing a funding model which enables the provision of enhanced services to be sustainable. There is a need to decrease the reliance on selling product to fund consultations. Pharmacists complete a four year degree and a one year structured internship. Pharmacists need to utilise their skills and demonstrate that a high level of clinical pharmacy is actually practiced in their pharmacies.

Overseas experience suggests that pharmacists are generally positive about the uptake of new roles\textsuperscript{27}, however this enthusiasm has not always occurred at the pace expected by stakeholders\textsuperscript{8}. In part this is due to the barriers outlined by us previously. The New Zealand pharmacy sector will need to take heed of these barriers and address them in a systematic fashion to enable the change required to deliver these services. In order to demonstrate the value expected by policymakers and other key stakeholders, the academic community needs to implement a research agenda in conjunction with professional pharmacy bodies.

Community pharmacy must fully commit to service evaluation and actively participate in practice-based and organisational research. In this manner pharmacists will demonstrate what they do achieve, rather than what they could achieve.

Although significant, the above mentioned challenges are not insurmountable and the pharmacy sector needs to rise to the challenge and embrace opportunity.

**Challenges and opportunities for the rest of primary health care**

There will be significant value for general practice, DHBs and PHOs when community pharmacy is more integrated with primary care and gains traction in delivering enhanced pharmaceutical services. It is expected that general practice will have patients who are better informed about their medications, more likely to be concordant and who achieve the health targets expected by the DHBs.

By engaging community pharmacy, PHOs will be seen not only to contribute to population health outcomes, but also to the development of a robust multi-disciplinary workforce and primary care infrastructure which is an expectation of primary care policy.\textsuperscript{17} Community pharmacy has been shown to contribute to positive health outcomes through involvement in disease management programmes similar to those operating through general practice in the United States.\textsuperscript{28}

Disease management is a comprehensive approach to preventing and treating disease that:

- Targets patients with specific diseases;
- Provides integrated services across organizational and professional boundaries;
- Utilises services based on the best scientific evidence available; and
- Focuses on outcomes.
Disease management differs from pharmaceutical care services in that pharmaceutical care targets not only patients with specific diseases but also those with risk factors for drug-related problems, a history of non-adherence, and frequent changes in medication regimens. Smoking cessation is an example of a successful disease management program implemented in community pharmacy.

Gaining traction and developing effective working relationships between community pharmacy and general practice relies on both parties being amenable to working together, respecting and valuing each other and having a common goal of improved health outcomes. As such, responsibility lies as much with general practitioners and nurses as it does with staff in community pharmacies to ensure that this happens for the benefit of the patient.

Ongoing debate in The New Zealand Herald regarding pharmacist involvement in the swine influenza pandemic highlights ignorance about the training and skill-set of pharmacists at the time of graduation and the services that pharmacists can offer. As it is, community pharmacists spend significant amounts of time policing for other agencies such as The Pharmaceutical Management Agency (PHARMAC), with poor access to prescribers. The ill-informed comment in the lay press does little to create a harmonious working environment where collaboration prevails over ignorance, fear and patch protection.

Community pharmacy cannot be solely responsible for integration within the primary health care infrastructure and teams. Although some PHOs are taking a lead in developing relationships with community pharmacy and there are small pockets of activity around the country, integration of community pharmacy representation into PHO governance structures appears to be slow. Involvement of community pharmacy in integrated primary care initiatives also appears to be tardy.

DHBs have a role to play and significant responsibility in the development of integrated community pharmacy services. In much the same way as the PHOs, DHBs have been relatively slow to engage with community pharmacy.

The MedNZ strategy calls for increased involvement of community pharmacy to ensure the optimal use of medicines and DHBs need to fully support this strategy. In some regions this has occurred through the formation of district wide advisory groups and project leaders who are assigned to community pharmacy development portfolios. Involvement of community pharmacy in integrated care projects has flowed from this approach but requires full engagement by community pharmacy.

Last but not least, the policies of PHARMAC impact significantly on the activities of community pharmacy in New Zealand. Historically community pharmacy has spent considerable energy ‘policing’ PHARMAC policies rather than delivering the best possible health care. The most recent example is the need for community pharmacists to check the scope of practice of the prescriber for every prescription received.

This requirement for ‘PHARMAC policing’ needs to stop and the considerable time and energy spent chasing insignificant and distracting bureaucratic problems needs to be channelled back into patient care. PHARMAC has considerable responsibility in ensuring that this transition happens.
We suggest the entire primary health care sector within New Zealand is made aware of and understands the ramifications of policy reform for community pharmacy as a key partner in the delivery of primary health care. Equally, we call for the community pharmacy sector to understand the challenges ahead, to drive the change necessary to overcome barriers to moving forward under current health policy reform.

There is a need to think about how the community pharmacy workforce should evolve and how further integration of community pharmacy services will be undertaken to ensure that pharmacy contributes to health outcomes through coordinated approaches with other primary health care providers. This cannot be undertaken by community pharmacy alone.

Summary

The implications of primary health care reform are significant for New Zealand community pharmacy and there is positive stakeholder opinion of what community pharmacy should be able to achieve. However, there is only so much that can be addressed through health policy, the rest needs to come from change within the pharmacy sector with awareness, understanding and support from key external stakeholders including health funders and planners and other primary care providers.

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