

2009

Funding Model and Contracting Options for Community Pharmacist Services

Consultation Paper

This paper outlines a proposed direction forward for funding and contracting community pharmacist services. It is based on the output from a series of workshops that were held with sector stakeholder groups and representatives of participating District Health Boards.

The intent of the proposed direction is to create a funding and contracting framework that would enable fuller realisation of the contribution pharmacist services can make to the health and wellbeing of patients and the community as a whole.

The paper is designed to support a consultation process. It summarises output from the discussion paper arising from the workshops and specific questions are included to assist with feedback and analysis of responses. More detailed information can be found in the accompanying Discussion Paper.

The final date for consultation feedback is 30th October 2009

All feedback should be sent to Keith Wright, keith.wright@lakesdhb.govt.nz
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Respondent Details

Question 1:

Can you please identify which stakeholder group you are part of and which of the DHB area(s) you provide services in:

- a. Member of the public
- b. Client / Patient
- c. Pharmacist – pharmacy owner
- d. Pharmacist – non pharmacy owner
- e. General practitioner
- f. Nurse
- g. Primary Health Organisation
- h. Independent Practitioner Association
- i. Hospital based clinician
- j. Other please specify
- k. Lakes, Tairāwhiti, Taranaki, none of these.

What are Community Pharmacists Services?

Community pharmacist services are commonly provided by pharmacists working in a community pharmacy. In some situations pharmacists may also work in the community independently from a pharmacy. These pharmacists may be self employed or work for Primary Health Organisations or Independent Practitioner Associations.

There are over 900 pharmacies in New Zealand, which are visited every day by thousands of people to have their prescriptions dispensed or to buy pharmacy-related products. Community pharmacy provides advice and counselling on taking medications and on the maintenance of good health.

In the year ended June 2008 over 33 million prescriptions nationally were funded or part funded by District Health Boards. The total expenditure on medicines for these prescriptions was \$635million and expenditure on dispensing was \$300million. Patients contributed \$62million towards the total \$935million cost and the balance of \$873million was publicly funded through District Health Boards.

Some District Health Boards have also funded additional community pharmacist services. In particular this has involved pharmacists reviewing the medications used by patients and providing advice to prescribers on medicines use.

Community pharmacy also provides health advice to many people who may or may not be collecting a prescription. A Ministry of Health survey undertaken in 2002/3 showed that 86% of adults visited a pharmacy in a year. In particular most people over the age of 65 will visit a pharmacy at some point during the year.

Recent reviews internationally of the Scottish and English systems and local New Zealand strategies suggest a potentially important role for community pharmacists as part of the primary health care team. Key areas of discussion have included the potential role of pharmacists in managing minor ailments, supporting good

prescribing, reducing medication errors, and supporting the care of patients with long term conditions.

Question 2

Do you agree that community pharmacists have a wider role than just the provision of medications to patients?

Yes

No

Comment:

Changes in the funding and contracting approach for Community Pharmacist Services

Over the past 15 years there has been a progression in the approach to pharmacy funding and contracting. In the mid 90's this included a shift in the funding model to include less emphasis on the mark up on medication cost and more emphasis on a fee per item dispensed. In the southern region for a period of time a management fee was paid to each pharmacy. There has also over time in different areas of the country been some introduction of funding for a range of "added value" services such as health education and medication review, and contracting of specific services such as medication management for the elderly.

For a period of time, when Independent Practitioner Associations were managing pharmaceutical budgets, the role of clinical pharmacist input into a general practice setting was also developed. In particular over this period, clinical pharmacists, usually employed by the Independent Practitioner Association, assisted with education and prescribing review processes. Some Independent Practitioner Association and Primary Health Organisation are making continued use of clinical pharmacists in this role dependant on local priorities.

The current contracting approach for community pharmacy uses a standard base national contract and a funding model that is predominantly focussed on a fee per item dispensed with a small mark up on medication cost. A national service framework has been developed to describe the potential broader roles of community pharmacists but little progress has been made with implementation

The fee per item dispensed has remained static from 2002 to 2008, however dispensing volumes and associated overall funding has grown significantly. Volume growth has been as a result of changes in the mix of three monthly and monthly dispensing, variable use of close control (more frequent dispensing), a significant decrease in patient copayments (meaning more items have become partly or fully funded) and underlying volume growth. Many of these factors are not under the direct control of District Health Boards or pharmacy and they have created significant funding pressure on the system. As a result there has been an increasing tension in the sector between the pressures on community pharmacy and the funding growth pressure on District Health Boards. In this environment both District Health Board's as funder and Pharmacy as providers have been experiencing sustainability pressure.

Drivers for Change

The premise of this paper is that the current approach to funding and contracting for community pharmacist services has not provided a good platform for community pharmacists, prescribers and District Health Boards to work together on the most appropriate usage of medications. Incentives in the current system are not aligned.

The main suggested drivers for change in how community pharmacist services are funded and contracted are as follows

1. As our population ages a significant increase is expected in the number of people with long term conditions such as diabetes, respiratory and cardiovascular disease. This increase is expected to put pressure on our health system across the continuum of care from primary health care through to increased demands on hospitals. Appropriate use of medications is one of the important factors in supporting people with long term conditions and we will need all available professionals working together to keep people supported in the community. This means we need pharmacists working as part of the primary health care team helping to ensure the most appropriate use of medications.
2. The current method of funding based on a fee per item dispensed does not best support the role of pharmacists in providing advice and counselling or the broader role of pharmacists within the primary health care environment.
3. In the current fee for service system, community pharmacy receives more funding if medications are dispensed more often and patients receive more medications. For some patients this may be very appropriate however for other patients if a pharmacist completes a medication review that suggests less medication items then they will be penalised with a decrease in their dispensing income.
4. In the current constrained financial environment the growth in expenditure on dispensing services requires financial resources to be taken away from other areas. Significant potential wastage of medications and consequences of medication error are also not being addressed. The current focus on dispensing does not make full use of pharmacist's skills. Growth in dispensing expenditure is occurring without obtaining the best value for money
5. Pharmacists training, professional skills and potential contribution are not being fully recognised, utilised or valued

Question 3

Do you agree with the suggested drivers for change? Yes Partly No

Comment

Proposed client and population groups

To facilitate the development of a client centred model consideration has been given to potential different client and population groups that might benefit from a different service response. The approach proposed in this paper is based around recognising the different requirements for the following client and population groups

1. Those with acute medication needs only (one off or short term medications)
2. Those with long term conditions and associated longer term medication needs
3. Specific population groups such as people living in residential care or requiring specific medication types with different dispensing requirements
4. Targeted population health initiatives across a range of areas that may be an agreed local or national priority
5. Those with minor ailments who may receive a direct response from a pharmacist

Question 4

Do you think the suggested client and population categories are a useful framework?

Yes No

Comment

Service response

The discussion paper outlines examples of the potential service response to each client and population group. Different service responses are suggested with a priority focus on the rapidly growing group of clients who have long term conditions and a range of medication needs. This reflects both the significant emergent need in relation to long term conditions and the value that community pharmacists can offer in supporting better care of these clients.

Question 5

Do you agree with the priority for pharmacist services being placed on clients with long term conditions?

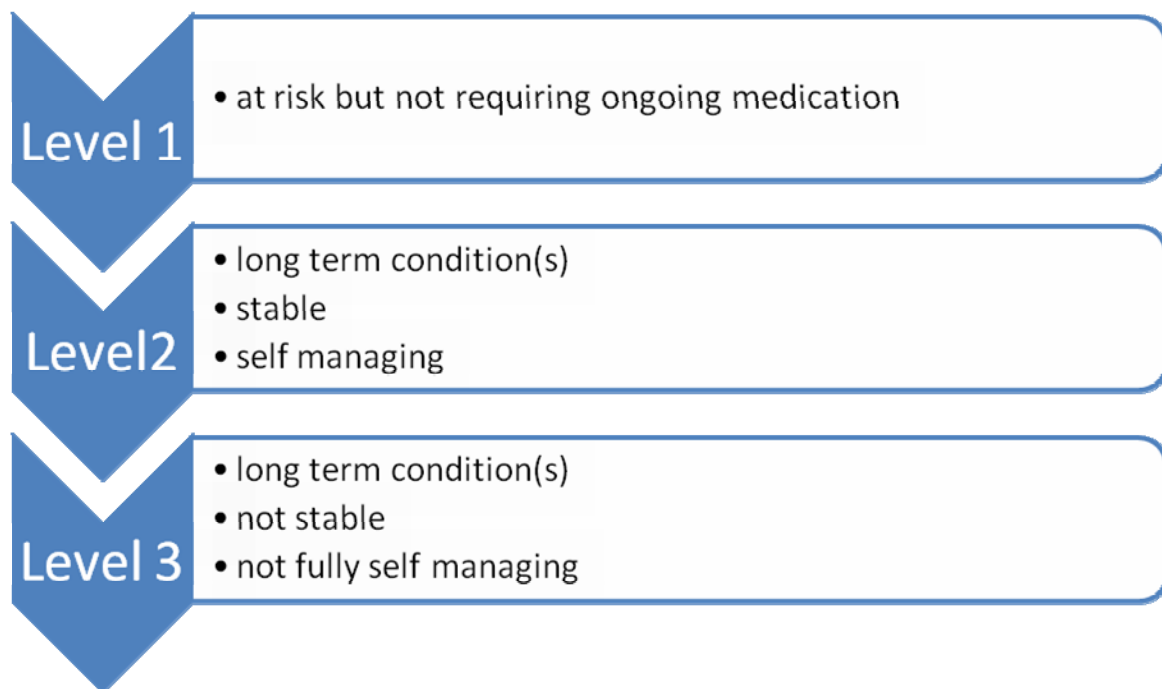
Yes

No

Comment

The approach for proposed for clients with long term conditions suggests that three levels of need should be recognised as outlined below.

Levels of need for people with long term conditions



Level 1 clients would only have acute medication needs but it is noted that Community Pharmacy may form part of health promotion programmes with this client group.

It is proposed that a focus on advice and adherence is particularly important for Level 2 clients to retain wellness. This is about people getting the medication they need and understanding the importance of continuing to take it. Community Pharmacy is often aware of compliance issues when prescription collection is delayed or the client only wants part of the prescription filled. It is suggested that pharmacists take a role in supporting compliance by helping people understand the importance of continuing their medication and providing tools such as prescription cards to assist people who struggle to remember multiple medication requirements. Ideally systems would also

be available to let the prescriber know if there are any issues. Some clients at this level of need may have multiple medications and could benefit from a Medicines Use Review being undertaken by a pharmacist.

It is proposed for level 3 clients that teamwork between the prescriber and pharmacist will be important. Most often this will be expected to be based around the person's general practice as the point of continuity and ongoing management. A pharmacist may work as part of the general practice team providing advice on medication use. From the national services framework Medicines Therapy Assessment or Comprehensive Medicines Management may be valuable. Advice and checking at the point of dispensing are considered to be critical. There may be multiple prescribers for clients with this level of need. Ideally all prescribers and dispensers would be working off a common electronic record to reduce the likelihood of errors.

Question 6

Do you agree with the key elements of the proposed service approach for people with long term conditions?

	Yes	Partly	No
Comment			

Funding models

A significant shift in funding model to a capitation based payment approach for clients with long term conditions is proposed in order to better support the type of service delivery identified. Specific population groups such as those living in residential care will in most cases have long term conditions but situational factors change service delivery requirements and therefore a specific population adjusted bulk funding model is proposed. For those clients with acute medication needs only it is proposed that there is a continuation of the fee for service mechanism recognising the episodic nature of service delivery. While a decent base standard of service delivery would be expected for all clients, those with long term conditions are considered to be a higher priority for investment of pharmacist time in order to achieve greater health gain and minimise any wastage. Wastage and errors may be significant for this group of clients resulting in unnecessary financial cost and poor health outcomes.

A summary of the proposed funding models is outlined overpage.

Proposed funding models

Category	Proposed Funding Model
Acute	Fee for service plus medication cost
Long term conditions	Capitation plus medication cost All dispensing activity to be included within the capitation formula Consider an optional percentage based increment for medication review services Fee for service for casual access
Specific Population	Programme - bulk funded with population adjustment plus medication cost
Population Health	Programme - mix of bulk funding and population adjustment depending on the nature of the programme
Minor Ailments	Bulk funded with population adjustment plus medication

Question 7

Please indicate if you agree with the proposed funding models for each category as follows

- | | | |
|-------------------------|-----|----|
| 1. Acute | Yes | No |
| 2. Long term conditions | Yes | No |
| 3. Specific Populations | Yes | No |
| 4. Population health | Yes | No |
| 5. Minor Ailments | Yes | No |

Comment

Evaluation against prioritisation criteria

The proposed funding models have been evaluated against standard prioritisation criteria and this analysis supports the shift to a capitation approach for people with long term conditions and population adjusted bulk funding for specific population groups. Retaining the current fee for service approach for clients with only acute needs achieves no change and this reflects placing the priority on clients with long term conditions.

A summary of the analysis of the capitation funding model against the prioritisation criteria is outlined below.

Analysis against prioritisation criteria

Criteria	Long term conditions Capitation funding model
Inequality	Improve – incentive to retain clients. Enables targeting of resources. Service focus better aligned to needs of disadvantaged populations
Health gain	Improve
Effectiveness	Improve
Efficiency	Improve – effort targeted to those with LTC and ability to benefit. Opportunity for improved provider efficiency
Sustainability	Dependant on level of funding. Stability of funding in a capitation model may improve sustainability
Quality	Improve quality for level 2 and 3 clients
Whanau ora	Improve – capitation funding supports tailoring of approach
Acceptability	Improve – from a consumer satisfaction perspective
Ability to implement	Expect initially negative with mixed market reaction. Expect to improve over time. Education and transition management will be crucial.

Question 8

Do you agree with the analysis against the prioritisation criteria? Yes Partly No

Comment

Contracting approach

Consideration has also been given to the contracting approach. Key areas of discussion are presented to allow feedback from the consultation process. The particular areas of interest and a summary of discussion is outlined below.

Contracting approach – Areas of interest

Area of Interest	Discussion
<p>1. Should there be any restriction on the number of pharmacy contracts?</p> <p>a. If so what should the nature of these be?</p> <p>b. What other mechanisms could be used to support efficiency</p>	<p>The purpose of any restrictions would need to be identified including</p> <ul style="list-style-type: none"> Service improvement Generation of efficiencies (from a system perspective) <p>The following issues were raised</p> <p>Competition enhances the ability of consumers to make choices and this does provide an incentive for improved quality. Decreased competition may have the opposite affect.</p> <p>The benefits may be very dependant on the circumstance. For example it may be very sensible to identify one provider to cover a rural area that does not have sustainable volumes for a fully efficient operation</p> <p>A period of restriction may support consolidation of provision</p> <p>If the purpose is to improve the service then care needs to be taken over any reduced level of competition and alternative approaches such as revised service specification / standards could be considered instead</p> <p>Robotics are more viable in larger volume operations. Population density and volume through pharmacies in the current market impact on the viability of robotics. There are also other barriers to entry of robotics that would need to be resolved in particular technician ratios and Pharmac purchasing impact on original pack dispensing and compliance packaging. Resolution of these barriers may create efficiencies in the existing competitive environment</p> <p>Individual pharmacies may be / feel they are already very efficient but system efficiency may not be maximised. Coexisting retail operation may impact on net efficiency of the dispensing operation.</p>

<p>2. For level 3 long term conditions clients in particular how should the “teamwork” type inputs be purchased?</p> <ul style="list-style-type: none"> a. Through every pharmacy b. Through Primary Health Organisations c. Through another organisation d. A mix of the above or left flexible 	<p>General practice is unlikely to want to or be able to support teamwork with a large number of different pharmacists. Also not all pharmacies want to or are able to be directly involved in providing this type of service. Therefore pharmacist inputs where teamwork is valuable ie level 3 clients need to be provided from a “managed” set of pharmacists with suitable skills.</p> <p>In all options consideration would need to be given to what criteria were used to form any identified list of pharmacists to complete the work. This could be via accreditation to deliver the service and potentially combined with a request for proposal process or left open to any provider to opt in</p> <p>Contracting via a Primary Health Organisation may help strengthen links and help imbed this type of pharmacist activity, as part of primary health care team. However it was felt in the current environment this would be highly dependant on the nature of the Primary Health Organisation and the extent of its focus beyond general practice. Prerequisites may be able to be established prior to any contracting via Primary Health Organisations.</p> <p>The option (s) used by any District Health Board may be situational depending on the configuration of general practice, interest and capability of pharmacy and pharmacists. For example in a rural area or a specific suburban area where there is one general practice and one pharmacy with capability to provide the service then the solution may be more likely to involve contracting via the pharmacy than in an urban area with multiple practices and pharmacies where independent or Primary Health Organisation based resource may make more sense. These issues could be resolved through a Request for Proposal process selecting the best option for each area.</p>
<p>3. Should there be multiple pharmacy “levels”? eg</p> <ul style="list-style-type: none"> a. Those providing an acute / casual service only b. Those providing acute and base service for long 	<p>It is likely that some pharmacies would gravitate to providing an acute/casual service only. This may not be seen as desirable due to loss of continuity (not including after hours which needs to be considered as a separate issue)</p>

<p>term conditions</p> <p>c. Those providing a full suite of services</p>	
<p>4. What is the role of Primary Health Organisations in purchasing pharmacist services</p> <p>a. From teamwork type inputs identified in point 2 through to complete dispensing services</p>	<p>Integration of pharmacy and pharmacist inputs into the primary health care environment is seen as important. Readiness of Primary Health Organisations is seen as highly variable. Questions may arise around the administrative efficiency for some Primary Health Organisations managing complex pharmacy contracts.</p> <p>The services and funding approaches discussed do not in of themselves require contracting via a Primary Health Organisation to make them work. Some value may be provided as discussed in point 2 in particular where teamwork type inputs are important and there is an environment of multiple pharmacies and general practices that need to interact</p>

Question 9

Should there be any restriction on the number of pharmacy contracts?

Yes No In some circumstances

Comment

Question 10

For level 3 long term conditions clients in particular how should the “teamwork” type inputs be purchased?

- | | | |
|---|-----|----|
| a. Through every pharmacy | Yes | No |
| b. Through Primary Health Organisations | Yes | No |
| c. Through another organisation | Yes | No |
| d. A mix of the above or left flexible | Yes | No |

Comment

Question 11

Should there be multiple pharmacy “levels”? Yes No

Comment

Question 12

Should Primary Health Organisations have a role in purchasing community pharmacist services? Yes No

Comment

Implementation and transition requirements

Proposals outlined in this paper involve significant change and careful consideration should be given to associated transition requirements. Consideration should be given both to the nature of the changes proposed but also the potential impacts of any changes on the current service delivery system, in particular Community Pharmacy. Should there be a decision to progress with the proposed capitation funding model then logistical work, in particular, around a capitation formula would be required and it is suggested that this work would be undertaken with a sector group to ensure robustness of the process and consideration of the impacts.

The proposed funding models, in particular the shift to a capitation model for the long term conditions group, have significant detailed implementation and transition requirements. Approaches are suggested to manage these and mitigate any associated risks. Discussion is summarised below.

Implementation and Transition Issues

Issue	Proposal
Timeframe for clients to enrol	Introducing enrolment would also be expected to require at least a six month timeframe to provide people on long term medications with an opportunity to sign up. During this period it is proposed that fee for service payment would continue to reduce overlap between payment methods.

Enrolment Process	It is proposed that only clients with long term medication needs would enrol with a community pharmacy and this could be achieved by signing an enrolment form. Enrolment registers would be cross matched and the most recent pharmacy of enrolment would be used. Public education regarding this would be required
Casual access	<p>People may wish to access a pharmacy that they are not enrolled with for casual access. Subject to further analysis of likely access patterns it is proposed that the following be considered</p> <p style="padding-left: 40px;">A lower fee for service payment for casuals</p> <p style="padding-left: 40px;">A higher patient copayment (note practicality and potential perverse incentives and access issues would need to be considered)</p> <p style="padding-left: 40px;">That casual use be offset against the capitation payment to the enrolled pharmacy</p>
Timeframe to transition	It is proposed that a period of time would be allowed to enable pharmacies to reorient to the core service expectations for people with long term conditions and to allow time to transition business model and operational infrastructure. The length of time would need to be informed after detailed work was done on the capitation formula but may be between 1-2 years
Should there be an option to remain on the current funding model?	It is proposed that all providers should change within the given timeframe with the possible exception of any significant outliers in terms of funding change.

Question 13

Do you think providers should have an option to remain with the status quo payment method?

Yes No

Comment

Question 14

What do you think might be a reasonable timeframe to allow for transition to a capitation model?

..... Years months

Comment

Question 15

Should a longer time period be offered for any providers who have a larger change in funding as a result of the change to the capitation model?

Yes No

Comment

Integrated Family Health Centres

Chapter 3 of the National Government Health Discussion Paper (Better Sooner More Convenient, 2007) outlines intended developments for Primary Care. This includes a focus on the development of Integrated Family Health Centres. Pharmacists are identified as one of a range of professional groups that could be involved in these centres. The intent of these centres is to build on the strengths of general practice, in particular continuity of care, high quality and strong clinical leadership, and personal service, through co-location and establishment of multidisciplinary team practices. Benefits identified include receiving a wider range of healthcare in a more convenient location, a seamless approach to delivery, better coordination and less duplication of information provision and tests, a greater focus on prevention with associated health professionals at hand.

The Centres are also specifically identified as supporting a multidisciplinary approach to supporting chronic-care patients helping improve outcomes, particularly through approaches that focus on helping patients self-manage their conditions. The need for further development of infrastructure at the primary care level is identified in order to provide sufficient spaces for nurses and allied services to treat people and operate

their own clinics. Health professionals are identified as benefiting from the development of these centres through improved collaborative working relationships, allowing focus on areas of special interest, greater job satisfaction and flexibility, and shared administrative function.

Cooperative development of infrastructure that included Pharmacy can be readily envisaged as part of this policy direction. Pharmacists could form a critical part of the multidisciplinary team, particularly in regard to management of chronic conditions through supporting self care and improved medication management. The changes outlined in this paper could be supportive of this direction.

Question 16

Will the proposed changes outlined in this document support the involvement of pharmacists in Integrated Family Health Centres?

Yes Partly No

Comment

Any other general comments?

Thank you for participating in this consultation.