

2009

Funding Model and Contracting Options for Community Pharmacist Services

Discussion Paper

This discussion paper has been produced following a series of 5 workshop sessions with a sector stakeholder group and representatives of the group of DHBs involved in this project. The paper is intended to support wider stakeholder discussion and to be the basis for a consultation document that subject to DHB approval would form the core of a public and sector stakeholder consultation process



Disclaimer

Contributors

The following organisations were represented on the Working Group and contributed to the suggestions in this paper:

Participating DHBs

The Pharmacy Guild

The Pharmaceutical Society

All members of the Working Group consider that the issues in this document warrant wider discussion and that it would be appropriate to distribute to interested people. The discussion paper does not necessarily represent the views of individual members of the Working Group, or their organisations.

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2 Executive Summary

Over recent years the development of community pharmacist services has been marked by difficult funding and contracting discussions for community pharmacy and limited progress with the development of pharmacist services as part of the primary healthcare picture. This is despite the clear direction indicated from overseas experience, local strategies and working parties that supports a valuable wider role for pharmacists in the primary health care environment. A National Services Framework has been developed to support this with good cross sector buy in from funders, associations and providers but limited progress has been made with implementation.

The resulting potential for medication error and wastage remains substantially unchanged and potential health gain and financial savings from wider pharmacist roles unrealised. Meanwhile dispensing volumes paid for by District Health Boards (DHBs) have grown significantly impacted on by a mix of STAT and monthly prescribing, variable use of close control, a significant shift in copayments and underlying volume growth. These factors are not under the direct control of DHBs or pharmacy and they have created funding pressure on the system. With a period of static dispensing fees there has been an increasing tension in the sector between the pressures on community pharmacy and the funding growth pressure on DHBs. In this environment both DHB's as funder and Pharmacy as providers have been experiencing sustainability pressure.

There is joint sector interest in exploring alternative approaches to support forward progress and to this end fourteen DHBs have commissioned a working group process involving the Pharmacy Guild, Pharmaceutical Society and DHB representatives to propose alternative solutions. The primary focus of the working group was on creating a funding and contracting framework to enable full realisation of the contribution pharmacist services can make to the health and wellbeing of patients and the community as a whole.

This paper outlines the outcomes from the working group process and it is intended, subject to further consideration, to inform a public and sector consultation process. The approach proposed is based around recognising the different requirements for the following client and population groups

1. Those with acute medication needs only
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 a priority for funders
5. Those with minor ailments who may receive a direct response from a pharmacist

Different service responses are suggested for the different client groups 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. 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 potentially poor health outcomes.

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. Further consideration has also been given to the contracting approach. The working group was not able to reach consensus in relation to these areas but the associated discussion is presented to allow feedback from a consultation process. In particular the following areas are of interest

1. The value of restricting the number of contracted pharmacies to either improve service quality or overall system efficiency
2. How clinical pharmacists inputs that may provide value in the management of people with long term conditions are best purchased
3. Whether it is appropriate to have pharmacies specialising in meeting the needs of specific client groups
4. What the role of primary health organisations should be in purchasing community pharmacists services

The proposed funding models have been evaluated against standard prioritisation criteria by the working group 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 the group's view of placing the priority on clients with long term conditions.

It is noted that the proposals in this paper involve significant change and that this should be given careful consideration. 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. To support this, wider comment on this paper is suggested along with a full consultation process. Should there be a desire 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.

3 Context and Approach

Development of community pharmacist services is recognised as a key part of primary health care development both within New Zealand and overseas¹.

Recent reviews of the Scottish system², the English system³ and developments that have occurred within the United States have explored this extensively. A recent workshop facilitated locally by the Pharmaceutical Society reportedly explored many related issues⁴. Guiding New Zealand strategy documents have been developed including the Health Strategy⁵, the Primary Health Care Strategy⁶, Medicines New Zealand⁷ and Actioning Medicines New Zealand⁸.

Over the past 15 years there have been multiple reviews of pharmacy, pharmacists' roles, base dispensing, and of "value added" pharmacy/pharmacist activity. These have informed a progression of the approach to pharmacy funding and contracting including

- The shift away from a margin based structure
- Increased fee for service per item emphasis
- Exploration of variants to provide a management fee, cap or risk share around all or part of the fee per item payments
- Introduction of a range of "added value" services such as health education and medication review
- Separate contracting of specific services such as medication management for the elderly
- Smaller scale exploration other contracting options such as capitation
- Development of the national services framework (Appendix 2)

During this timeframe the role of clinical pharmacist input has developed substantially in a hospital setting and for a period of time, particularly during the period of Independent Practitioner Association (IPA) pharmaceutical budget holding, the role of clinical pharmacist input into a general

¹ Associate Minister of Health, Minister of Health. Medicines New Zealand: Contributing to good health outcomes for all New Zealanders. Wellington: Ministry of Health. 2007.

² Harry McQuillan, CEO Community Pharmacy Scotland, Presentation, Nov 2007

³ Secretary of State for Health, Pharmacy in England, April 2008

⁴ PSNZ, Springboard Meeting Report, Nov 2007

⁵ Minister of Health, The New Zealand Health Strategy, 2000

⁶ Minister of Health, The Primary Health Care Strategy, 2001

⁷ Associate Minister of Health, Minister of Health. Medicines New Zealand: Contributing to good health outcomes for all New Zealanders. Wellington: Ministry of Health. 2007.

⁸ Associate Minister of Health, Minister of Health. Actioning Medicines New Zealand. Wellington: Ministry of Health. 2007.

practice setting was also developed. Some IPA and Primary Health Organisation (PHO) use of clinical pharmacist input continues dependant on IPA, PHO and DHB priorities.

Aside from the work on the National Services Framework, the environment for pharmacy in more recent years has been characterised by significant focus on national contracting processes which have maintained a standard base contract for dispensing and revolved around the funding level in a fee for service model. This has not particularly supported developing the role of pharmacists within primary health care, service quality improvement, sector sustainability, realisation of any efficiency gains or implementation of locally tailored arrangements that better meet population need.

Over this recent time limited progress has been made with implementation of the National Services Framework or realisation of the value pharmacists can provide within the primary health care environment. The resulting potential for medication error and wastage remains substantially unchanged and the potential health gain and financial savings unrealised. Meanwhile dispensing volumes paid for by District Health Boards (DHBs) have grown significantly impacted on by a mix of STAT and monthly prescribing, variable use of close control, a significant shift in copayments and underlying volume growth. These factors are not under the direct control of DHBs or pharmacy and they have created funding pressure on the system. With a period of static dispensing fees there has been an increasing tension in the sector between the pressures on community pharmacy and the funding growth pressure on DHBs. This situation has placed sustainability pressure on both providers and funders.

To address these issues 14 DHBs (Appendix 1) have elected to develop an options paper for funding model and contracting options for community pharmacist services. This paper seeks to explicitly focus on the potential for improving the funding and contracting models for community pharmacist services in a manner that might both realise the potential gains while supporting a sustainable and efficient sector. The paper outlines options for achieving this aim and analyses implications that may arise from implementation of these options. It is intended that this discussion paper will form the basis for a public consultation document for the DHBs involved in this project.

3.1 Approach

Following initial DHB discussions a working group was established involving representatives from The Pharmacy Guild, the Pharmaceutical Society and the group of 14 DHBs. A series of 5 meetings was held to support the development of this paper⁹. Liaison has occurred with the Northern and Otago/Southland development processes to support the possibility of a coherent approach being taken nationally.

3.1.1 Scope

The working group identified four aspects to the work required as follows

- (i) A description of suggested funding and contracting approaches for the following categories of client / population served
 - a. Acute

⁹ Please note this paper does not necessarily represent the views of individual working group members or their organisations

- b. Chronic
 - c. Specific Client / Population Groups eg residential care
 - d. Population Health
 - e. Minor ailments
 - f. Supplementary/specific services eg clozapine
- (ii) The relationship to the national service framework which describes service components that may be appropriate in each of the above categories. There was no desire to relitigate this framework although it was noted that additional work in relation to minor ailments may be required
- (iii) Preliminary assessment of the suggested approaches against service and purchasing improvement criteria.
- (iv) Identification of potential transition issues

3.1.2 Key assumptions

The following key assumptions were noted in relation to the work

- (i) That the process needed to be separate from discussion regarding national contracting issues that were being resolved at the time
- (ii) That the focus in the first instance should be on appropriate funding mechanisms not rates or funding level (it was recognised this would be an important later discussion)
- (iii) That options should be prepared which provide each DHB with the ability to respond to local need and priorities, and accommodate where appropriate variable provider capacity and capability ie the funding mechanisms and contracting approach should allow a range of service delivery approaches appropriate to local requirements.
- (iv) The primary focus of the work should be on supporting effective pharmacist services however where appropriate linkages with the wider primary health care sector should be identified.
- (v) That there should be a continued expectation of delivery to a decent base minimum standard around any dispensing. The expectations associated with this should not prevent consideration of any innovative range of methods for delivering associated functions but any approach should ensure that they are able to be fully delivered in the case of each dispensing

3.1.3 Other Considerations

The following issues were also noted to be considered where appropriate

- Integration between hospital and community dispensing
- Regulatory impacts
- Alternative dispensing approaches including mail order, depot and robotics

Impact on access for high needs population and rural
 HealthPAC (MoH Sector Services)ability to change payment mechanism
 Core information collection requirements and information exchange within the system.
 E pharmacy
 Role of technicians

4 Client oriented service design

Primary consideration was given to service design from a client perspective in order to inform discussion regarding funding and contracting models. Five client categories were identified as outlined in the table below

Category
Acute only ¹⁰
Long term conditions ¹¹
Specific populations ¹²
Population Health
Minor Ailments

Supplementary / specific services such as clozapine dispensing were subsequently identified as either a subset of base dispensing or a response to a specific population group. This is explored further in section 8.

A description of the above categories with a focus on the acute and long term conditions groups was developed based on an example case and potentially relevant context. For the key categories the overall service aim was identified together with a brief description of potential service response. The intent of this exercise was not to be comprehensive but to ground consideration of funding and contracting models in a client / population centred discussion.

Substantive discussion was held regarding the definition of the different groups. From a pharmacist services perspective the following was suggested.

Acute clients would be those with no chronic conditions and would by definition only be receiving acute / short term medications. To support any analysis this group would be defined by the absence of any ongoing medication.

¹⁰ Clients with no long term conditions only requiring an acute medication

¹¹ Clients with one or more long term conditions requiring chronic medication usage

¹² For example Mental Health Consumers and Residential Care Clients

The long term conditions group would be those with one or more long term conditions requiring ongoing medication who may also be receiving some acute medications. This group would be defined by the presence of ongoing medication for a chronic condition. Specific populations may be a subset of either the acute client group where there was a specific dispensing requirement or of the long term conditions group where there was a specific situational factor eg residential care. The group would therefore be defined by specific medication or identified situation.

Population health is an activity that may not be specifically related to a dispensing that may be undertaken as part of a population health programme.

Minor ailments were considered because of recent discussion arising from the Scottish system.

4.1 Acute Only Service

Acute Only Service

Example Case

22 year old male with an upper respiratory tract infection (cold) who has been to the GP and received a script of amoxicillin/clavulanic acid

Additional Context

The prescription may be from an after hours clinic or a general practice. The person will probably be enrolled

There is a risk that the person won't go to the pharmacy to pick the script up. Expect this will be in part dependant on convenience eg located near doctor, parking or familiar shopping centre

The person is unlikely to have a regular pharmacy

Overall aim

Quality base dispensing completed efficiently

Service response

This is a straight forward dispensing with advice on taking the medication

Check for any other issues eg smoking

The person may also want some over the counter product for symptomatic relief

Additional Notes

This type of case is unlikely to be a priority for any added value activity

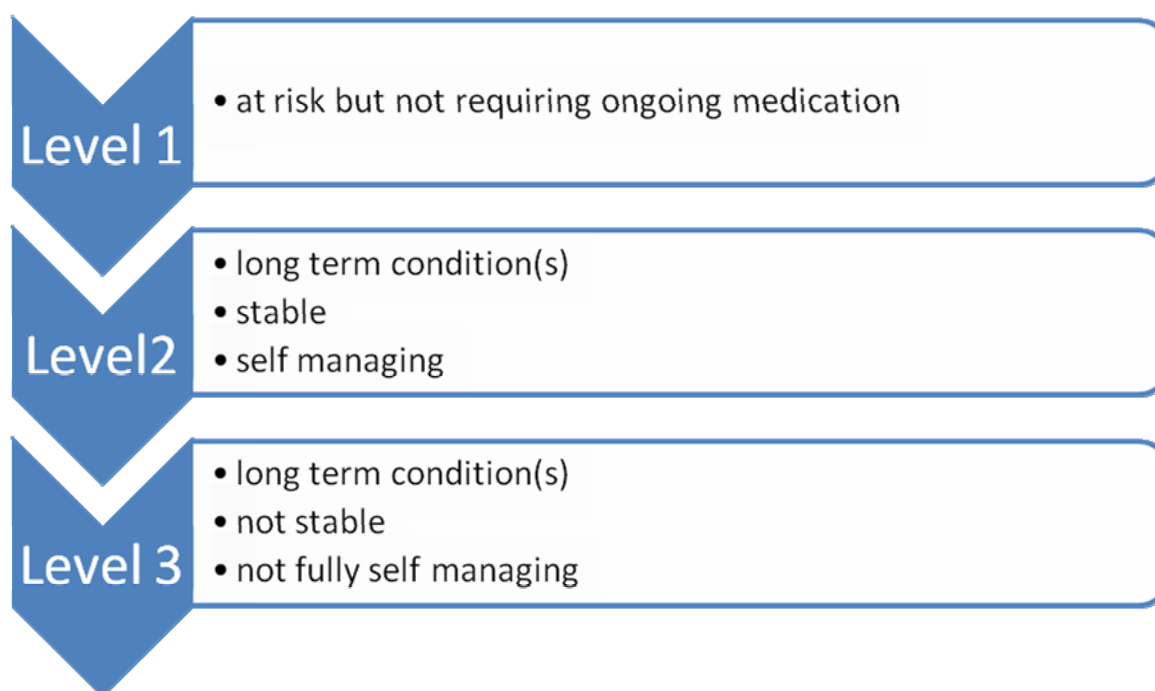
It is possible that the DHB may have a health promotion programme that includes a targeting of this type of person eg smoking cessation or sexually transmitted disease education. Any activity would

be associated with this programme and not the acute dispensing as such

If the client is new then some data capture/clarification of details for the pharmacy record will be required

4.2 Patient with long term condition(s)

For descriptive purposes the following framework was suggested to identify different categories of patients with long term conditions



These levels are sourced from a 26 Nov 2008 presentation by Professor Pieter Degeling, University of Southampton, delivered at Counties Manukau DHB. It was noted that people may shift between categories in a progressive fashion or switch between levels 2 & 3 depending on stability of their condition(s)

It was felt to be critical that any activity relating to supporting people with long term conditions was aligned across the system / different providers. This would include the areas of priority focus being aligned eg degree and nature of focus on different levels of need in the above classification

4.2.1 Level 1 Category patients

These patients would have acute only needs and may be targeted by a DHB as part of a population health programme. If a single or multiple condition was present that impacted on risk and required ongoing medication eg hypertension this would place a person in level 2 or 3 for the purpose of applying this framework to pharmacist services.

4.2.2 Level 2 Category patients

Level 2 Long Term Conditions

Example Case

65 year old male ex smoker, mild asthma/COPD not clearly diagnosed, cholesterol of 7, family history of CHF

Additional Context

Enrolled with PHO, receiving regular GP check ups

Expected to have a regular pharmacy

May have multiple prescribers eg ex hospital event

Overall aim

Base quality dispensing with regular compliance checking and management of exceptions

Service response

Safety / appropriateness check where multiple prescribers are involved

On any change to medication regime – update compliance support eg yellow card and/or explanation regarding new medications

Ideally an electronic feedback loop to General practice to confirm compliance and highlight exceptions that may generate risk eg irregular / incomplete collections. Concerns regarding condition or medications. Where compliance exceptions occur then provide some further compliance support / education and advise GP

Medicines use review may be valuable

Dispensing with advice and adherence checking critical

Additional Notes

To work well the service would need to be supported by an information system that automated GP messaging on compliance and any exceptions. Positive compliance could be noted in the GP PMS but not flagged. Significant exceptions could be flagged and perhaps require review prior to input in a similar manner to lab results

This group of patients may also be a priority group for health promotion programmes – this would be organised as per the programme

4.2.3 Level 3 Category patients**Level 3 Long Term Conditions****Example Case**

82 year old female. Diabetes, CVD, osteoarthritis, renal disease

Living alone, 5 hours Home based support per week, early cognitive difficulty

Limited finances

Additional Context

Likely multiple hospital visits. May be attending outpatient clinics,

Regular and multiple ad hoc GP visits

Enrolled/eligible for Care Plus

May be getting special foods

Likely regular pharmacy but may pick up some prescriptions from elsewhere due to access/ mobility issues (ie cant get to pharmacy to collect scripts)

Multiple potentially uncoordinated prescribers

Overall aim

Keep as well as possible, prevent avoidable hospitalisation, return to stability if possible

Service response

Key: Teamwork amongst health professionals working with the patient most likely to be based around GP as the point of continuity and management

Advice to prescribers as part of team input regarding medications

Medicines therapy assessment or comprehensive medicines management may be valuable

Dispensing with advice and checking critical

Additional Notes

Ideally all "team" members might be working off a single electronic patient record (subject to wider discussion around confidentiality and access)

Approach across all providers needs to be coordinated

The patient still has a key role in self management

If the patient is in a priority group then there may be a population specific programme eg frail elderly

Note cultural differences may be significant

4.2.4 Specific population groups

It was felt that this category would either be understood and have specific requirements such as clozapine and methadone clients or situational such as aged residential care. Any programme would

need to be developed specifically and may be a combination of what is described for level 2 and 3 chronic condition clients. Potential application is considered further in section 8.

4.2.5 Population health

Pharmacy already has a wider role in supporting the health of individual consumers for example through over the counter, pharmacist only, and pharmacy only medicines supply. A number of pharmacies have also developed or have been involved in population health programmes. These may be unrelated to dispensing of medication for example risk factor screening for coronary artery disease or skin cancer campaigns. Pharmacy already undertakes a role in this area often through work that is not directly funded by DHBs but that is undertaken for professional reasons or as part of a wider service and business approach. The role of Pharmacy may be as much about foot traffic through the shop as it is about dispensing activity depending on the target population group. Any programme that was developed would need to be tailored as appropriate to the target population group and the role of pharmacy would be dependant on how the overall programme was being managed. Noting this category however recognises the role of Pharmacy within population health and its potential role in specific programmes that a DHB may develop.

4.2.6 Minor ailments

This area requires further review. It is noted that the context of the Scottish minor ailment programme is different than New Zealand with our use of the Pharmacist Only Medicine category. It was felt that pharmacy may be completing a significant part of the minor ailment function in New Zealand on a user pays basis and the contribution of this to overall population health and wellbeing should be acknowledged but this may not be a priority for government health funding.

It was noted that this area may receive further attention as part of the national service framework review and would require consideration from the perspective of broader primary health care development (eg to determine the potential value / likelihood of releasing general practice resource)

4.3 Mapping Client Categories to the National Service Framework

Mapping to the National Service Framework (refer appendix 2 for details of the framework categories) was undertaken as per the table below

Category	Health Education	Medicines and clinical information	Medicines Utilisation Review	Medicines Therapy Assessment	Comprehensive Medicines Management	Base Dispensing
Acute only ¹³	No – note not as described in NSF – should not detract from base dispensing expectations	Yes ¹⁴				Yes (note need to revisit base dispensing expectations)
Long term conditions ¹⁵	Yes – as per defined DHB priority areas	Yes ¹⁴	Yes expect that medicines review services will be appropriate for a proportion of clients with LTCs. Patients may progress through different levels of review but at any one time would only be receiving one type of review process			Yes (as above)
Specific populations ¹⁶	Tailored programmes to reflect DHB priority areas. Note that there is evidence of value from previous experience for example in tailored					Yes (base dispensing could be tailored depending on

¹³ Clients with no long term conditions only requiring an acute medication

¹⁴ Medicines and clinical information is an activity pharmacists may undertake with prescribers. It is suggested that this would be relevant for both acute and chronic conditions

¹⁵ Clients with one or more long term conditions requiring chronic medication usage,

	programmes for people in residential care Programmes may include aspects of what is described in the National Service Framework but would be tailored to the specific population group	the needs of the specific population group eg (methadone)
Population Health	Programmes may include elements of health education as per the framework but are more likely to have a health promotion focus. Note that health education from the framework has a specific definition relating to advice provided to individuals and not populations	
Supplementary Services	A supplementary service would either be a tailored service to a particular population group eg methadone users or a component of base dispensing that is funded differently eg special foods	
Minor Aliments	As noted previously this would be a development on the current national services framework.	

The key aspect to note from this analysis is the broader application of the framework to the long term conditions group of clients. This is consistent with the emphasis on medication review services within the framework and targeting of added value such as health education to where it will achieve the most health gain. Medicines and clinical information will be relevant for all categories but again priorities may be targeted to areas of greatest health gain.

¹⁶ For example Mental Health Consumers and Residential Care Clients

5 Funding models

Overall principles identified for establishing funding models included

Model(s) should not be too complex

Any model will have some compromises

All models should be considered against standard prioritisation criteria¹⁷ of

- Inequality
- Health gain
- Effectiveness
- Efficiency
- Sustainability
- Quality
- Whanau ora
- Acceptability
- Ability to implement

The table below outlines the proposed funding model for each client category. Further background to the funding models considered is provided in Appendix 3.

Category	Proposed Funding Model	Comment
Acute	Fee for service plus drug cost (including wholesale distribution cost)	Further consideration around incentive to dispense vs not dispense may be valuable
Long term conditions	<p>Capitation plus drug cost(including wholesale distribution cost)</p> <p>Include all dispensing activity within the capitation formula</p> <p>Consider an optional % based increment for medication review services</p>	<p>Note the need to manage perverse incentives</p> <p>Management of casuals</p> <p>Need for enrolment</p> <p>Population categories would need to be defined for the formula that reflected the service delivery cost structure for different clients</p>
Specific Population	Programme - bulk funded with population adjustment plus drug cost(including wholesale distribution cost)	<p>Need to manage start up and services providing access in areas of low demand eg rural</p> <p>In effect for established services this model will provide a fee per patient</p>

¹⁷ The Best Use of Available Resources; MoH 2005

		(from the specific target group) per year
Population Health	Programme - mix of bulk funding and population adjustment depending on the nature of the programme	Location specific programmes eg “posters” funding likely to be per site versus client specific programmes which would more likely reflect population served
Minor Ailments	Bulk funded with population adjustment plus drug cost(including wholesale distribution cost)	

The proposed approach involves a significant change of funding model for clients with long term conditions. While this is designed to support the type of service delivery that is identified in section 4 it is noted that any change in funding model creates uncertainty and in a public – private partnership the impact of on viability needs to be carefully considered. How this might be supported is considered further under section 9 which explores how transition to a capitation model could occur.

5.1 Additional Considerations

The following issues were also identified

The potential value equation for pharmacist services purchased in a capitation model should include consideration of the following

- Reduction in medication wastage and the potential consequential utilisation of other services if medications are not appropriately managed
- The potential value of individualising STAT/repeat mix based on adherence
- Reduction in medication usage error and associated cost
- Improved outcomes
- Establishing potential value and realising this value may be difficult in the short term for example reduction in hospital utilisation as a result of less medication misuse
- The need to capture information from medicines review work that defines the value of the activity ie resulting change in medications and costs saved. This information could also inform medicines and clinical information activity.

Under the proposed approach further consideration should be given to how system efficiency is supported and maximised. This should consider alternative dispensing approaches including mail order, depot and robotics (see appendix 5)

After hours and rural

- Specific localised consideration will need to continue to be given to after hours and rural access issues. The proposed funding approaches may impact on some of these arrangements and this would need to be considered on a case by case basis.

Integration between hospital and community dispensing

- Pre 1991 Area Health Boards and previous Hospital Boards used to undertake discharge dispensing. Funding arrangements associated with the establishment of Crown Health Enterprises resulted in most hospital pharmacies exiting this function. During this time hospital only dispensing was also extensively used as a mechanism to manage access to certain medications. Many hospitals exited or subcontracted this function to community pharmacy in discussion with Health Authority Funders. There has recently been some revived interest in discharge dispensing for both quality and access reasons. Further improved integration between hospital and community dispensing may remove wastage and reduce error. In certain local situations there may be some benefit in hospital and community pharmacy cooperating to improve overall system efficiency

HealthPAC (MoH Sector Services)ability to change payment mechanism

- This is noted as a major potential barrier and source of delay for implementation of any changed funding model. Required development to support a capitation model would be significant.

5.2 Further exploration of the implications of a capitation model

The following additional detailed points were noted

1. Developing a capitation formula

This will be a critical part of the process. This is an area that requires specific technical expertise and should involve the sector to enhance understanding and ownership. Involvement should include DHB, Pharmacy, Pharmac and HealthPAC(MoH Sector Services).

A formula is likely to involve Age, gender, ethnicity, deprivation and may involve other adjustors that indicate complexity of long term condition management. This will be dependant on available data for establishing and implementing the formula.

2. Enrolment

Suggested process similar to general practice including

Enrolment form

Register duplication process

Public education

It was noted that general practice or PHO enrolment cannot be used as there is not a one on one match

It was suggested that the risks of patient churn (shifting of patients) are managed using the same incentives as general practice ie

Lower fee for service payment for casuals

Casual clawback against capitation payment to enrolled pharmacy

Possible higher patient copayment for casuals

It was noted that time will be required in the transition to implement enrolment. Possible timeframe of 6 months (given that by definition all long term condition clients should visit within 3 months)

3. Perverse Incentives

The following perverse incentives and potential mitigation strategies were noted

Perverse Incentive	Mitigation
Under Servicing	Audit, monitoring, client outcomes, comparative review between providers, competition, ethical responsibility
Cost Shifting	Monitoring of casuals with targeted follow up audit
Cream Skimming	Requirement to take all comers with audit to follow up any issues
Inappropriate enrolment incentives	Rules established around any such incentives

6 Contracting Considerations

The following contracting considerations were raised and discussed. Further discussion on collective DHB contracting and PHO interface is included in Appendix 4.

Question	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. Other mechanisms to support</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>No resolution was reached in the group discussion around either of these points. The following issues were raised</p> <ul style="list-style-type: none"> 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>efficiency</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>Noted that robotics are more viable in larger volume operations, population density and volume through pharmacies in the current market impact on viability. 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. It is important to note that there are different types of robotics suitable for Original Pack Dispensing, bottle and compliance packaging. Resolution of barriers may create efficiencies in the existing competitive environment (see Appendix 5 for further discussion)</p> <p>Individual pharmacies may be / feel they are already very efficient but system efficiency may not be maximised. Also noted that 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> <p>a. Through every pharmacy</p> <p>b. Through PHO’s</p> <p>c. Through another organisation</p> <p>d. A mix of the</p>	<p>Discussion identified that</p> <p>General practice is unlikely to want to / be able to support teamwork with a large number of different pharmacists. Also not all pharmacies want to / 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>Options identified to support this included</p> <ol style="list-style-type: none"> 1. DHB contracts with all pharmacies and pharmacies subcontract from an identified limited list of pharmacists able to complete this work (identified pharmacists may be independent, part of a pharmacy, or part of a separate organisation such

<p>above or left flexible</p>	<p>as a PHO)</p> <ol style="list-style-type: none"> 2. DHB contracts separately with pharmacies for other services and identified pharmacists for “teamwork” inputs (through selected pharmacies, independent providers or other organisations eg PHO) 3. DHB contracts to PHO who contracts via pharmacy and the pharmacy subcontracts as in 1 4. DHB contracts to PHO and the PHO contracts directly with pharmacists (via independent providers, selected pharmacies, or part of a separate organisation such as an IPA) <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>No agreement was reached on the preferred option. It was noted that each route may result in a similar list of pharmacists undertaking the services but have differing advantages for integration with other pharmacy activity versus integration with general practice activity.</p> <p>Where it is considered valuable to have a strong link with a PHO to help imbed this type of pharmacist activity, as part of primary health care, then contracting via the PHO may support this link. However it was felt in the current environment this would be highly dependant on the nature of the PHO and the extent of its focus beyond general practice. Prerequisites may be able to be established prior to any contracting via PHOs. Debate exists regarding this point however as some felt that contracting through the PHO would provide value as it would force it to have a wider focus (see further discussion in Appendix 4).</p> <p>The option (s) used by any DHB 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</p>
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	<p>or PHO 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> <p>a. Those providing an acute / casual service only</p> <p>b. Those providing acute and base service for long term conditions</p> <p>c. Those providing a full suite of services</p>	<p>Agreed that it is likely that some pharmacies would gravitate to providing an acute/casual service only. In a similar manner to the approach in general practice 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>Noted that a similar range of incentives could be structured into the capitation model for services provided to patients with LTC as has been used in General Practice capitation in particular:</p> <ul style="list-style-type: none"> ○ fee for service deductions from the capitation payment for any casual dispensing ○ the fee for service rate set at a lower level than the effective capitation rate recognising the higher level of service provided for an enrolled patient vs a casual visit
<p>4. What is the role of PHO’s in purchasing pharmacist services</p> <p>a. From teamwork type inputs identified in point 2 through to complete dispensing services</p>	<p>As discussed in point 2. Integration of pharmacy and pharmacist inputs into the primary health care environment is seen as important. Readiness of PHOs is seen as highly variable. Questions may arise around the administrative efficiency for some PHOs managing complex pharmacy contracts.</p> <p>It is beyond the scope of this project to fully consider how pharmacy and pharmacist inputs might be better integrated into primary health care. The services and funding approaches discussed do not in of themselves require contracting via a PHO 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 (see also appendix 4)</p>

7 Evaluation against criteria

The group completed an initial evaluation proposed funding models for each client group against the nine criteria identified. The funding model is evaluated in comparison to the status quo model (fee for service) for the three key client groups

Criteria	Acute Only Service	Long term conditions	Specific population groups
	Fee for service funding model	Capitation funding model	Bulk funded with population adjustment
Inequality	No change	Improve – incentive to retain clients. Enables targeting of resources. Service focus better aligned to needs of disadvantaged populations	As for LTC
Health gain	No change	Improve	As for LTC
Effectiveness	No change	Improve	As for LTC
Efficiency	No change	Improve – effort targeted to those with LTC and ability to benefit. Opportunity for improved provider efficiency	As for LTC
Sustainability	No change	Dependant on level of funding. Stability of funding in a capitation model may improve sustainability	As for LTC
Quality	No change	Improve quality for level 2 and 3 LTC clients as noted in previous descriptions	As for LTC
Whanau ora	No change	Improve – capitation funding supports tailoring of approach	As for LTC
Acceptability	No change	Improve – from a consumer satisfaction perspective	As for LTC
Ability to implement	No change	Expect initially negative with mixed market reaction. Expect to	As for LTC

		improve over time. Education and transition management will be crucial.	
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As expected this analysis demonstrates no change for the acute only group but shows expected improvement against all criteria over time for the long term conditions group operating under a capitation model. No change in respect of acute services assumes no negative impacts on providers resulting from a shift to capitation for the long term condition group.

Any significant shift of funding between providers associated with a capitation model could impact on the viability of some pharmacies and therefore impact on access. The likelihood or extent of any impact would be dependant on the ability to establish a capitation formula that reasonably reflects the current distribution of activity between pharmacies. Existing limited experience with capitation in the market does not appear to have had a detrimental impact on viability.

8 Specific populations and additional dispensing requirements

Discussion was held around the distinction / definition between these two situations and the funding implications for additional dispensing requirements.

8.1 Specific population groups

Aged residential care clients will almost always be at level 3 on the LTC framework however the Aged residential care environment reduces the requirement for adherence management

There was no consistent view about the need for any other specific population groups. Should any DHB wish to provide additional support to a specific group eg frail elderly, mental health or palliative patients then this could be managed by way of purchasing marginal additional programme components over and above a level 2 or 3 LTC service.

8.2 Additional dispensing requirements

The following products were identified

Special foods

Extemporaneous compounding

Section 29

Graseby Pumps

Clozapine

Methadone

All of these products were felt to have additional per item dispensing requirements. These could be funded by way of separate pool with associated costs removed from the base capitation formula or by use of a Schedule mechanism.

9 Transition Management

The following issues were identified as important to consider for the transition to the proposed model

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. A capitation model would be expected to result in some shift of funding between providers reflecting the needs of their clients however the amount of this type of shift cannot be determined until more detailed work is completed on the capitation model and funding formula. Where a capitation model resulted in any significant shift of funding between providers then the group felt time should be allowed for providers to adjust to this. Some extended timeframe may be appropriate for any providers who are significant outliers in terms of funding change.

Discussion was held around providing a definitive timeframe for providers to transition to give certainty and progress the change versus providing incentives for the willing to opt in. The group felt that if the approach was correct that all providers should change within a given timeframe with the possible exception of any significant outliers in terms of funding change. The length of time would need to be informed after detailed work was done on the model but may be between 1-2 years.

Introducing enrolment as previously noted would also be expected to require at least a six month timeframe to provide patients 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. The alternative approach would be to accept all current clients on ongoing medications as “registered” at the last pharmacy they collected a script from. This may be less ideal depending on the degree to which clients get medicines from different pharmacies.

Detailed work would be required to review the procedures manual and ensure that requirements were logical and consistent with the revised approach. A best practice type manual may be of assistance to support service delivery and operational management.

Given the concerns about potential perverse incentives in a capitation model clear protocols would need to be developed for audit. It was noted that there is a distinction between audit to confirm minimum contractual compliance and more supportive clinical audit to support practice improvement.

Requirements for the establishment of enrolment management and payment processes have not been established and these may impact on timeframes for introduction of the proposed capitation component of the model.

9.1 Next steps

The following key next steps were identified. Some timeframes are sequentially dependant and therefore indicative only

- | | |
|---|--------------|
| 1. Release of draft discussion paper for stakeholder review | Feb - Mar |
| Including participating DHBs, Guild, Society and Community Pharmacy Leaders Forum | |
| 2. Draft Consultation paper for DHB sign off | Apr - May |
| 3. Consultation | Jun - Jul |
| 4. Review following consultation as required | Aug – Sep |
| 5. Modelling and detailed design considerations | Oct – Feb 10 |

10 Summary

This paper outlines a proposed approach to funding and contracting for community pharmacists services for different client groups. The aim is to enable full realisation of the contribution pharmacist services can make to the health and wellbeing of patients and the community as a whole. A focus on clients with long term conditions is proposed reflecting the significant growth in need in this area and the value that pharmacists can add to the care of these clients. In order to better support community pharmacists to add value a shift to a capitated funding model for dispensing costs is proposed. This model would involve enrolment of clients who have a long term condition and ongoing medication needs with a pharmacy of their choice and payment to that pharmacy for a range of services to better support their enrolled clients.

Any change to funding models carries potential risk and opportunity for both providers and funders. Careful consideration of the proposed shift to a partial capitation model is required. To assist with this it is suggested that there is wider discussion in relation to this paper with stakeholders and a full public consultation process. In a capitation model the development of a suitable funding formula is vital to the success of the model. It is suggested that a multi stakeholder group be involved in this process.

Issues that might be considered in a transition to the proposed service focus and funding model are also explored, in particular allowing community pharmacy time to prepare for and adjust to operational and business requirements that flow on from an enhanced focus on clients with long term conditions and a capitated funding model.

Timeframes for any change will be dependant on sector discussion and consultation. The process of discussion, consultation, modelling and detailed implementation planning is expected to take 12 months and then a transition of up to two years may be appropriate depending on the extent and nature of the change.

Appendix 1 - DHBs Involved

Participating DHBs
Canterbury
Hawkes Bay
Lakes
Nelson Marlborough
South Canterbury
Tairāwhiti
Taranaki
Waikato
West Coast

Appendix 2 – National Services Framework

In addition to base dispensing there are five individual services in the framework that fall into two categories:

Information Services

Health Education: Education provided directly to patients.

Medicines and Clinical Information Support: Information for practitioners (this will include the pharmacist facilitator role currently provided by many PHOs).

Medicines Review Services

Medicines Use Review and Adherence Support: A four part review which assesses the patient's use, understanding and adherence to their medication regimen. This service is aligned with the NZ Pharmacy Council competency standards and titles.

Medicines Therapy Assessment: A comprehensive clinical review of an individual patient's medication as part of a multidisciplinary team.

Comprehensive Medicines Management: Case based active management of prescribing changes and (in the future) collaborative prescribing

Appendix 3 – Funding Models

Funding Models

There has been extensive consideration and some experimentation with alternative funding approaches for pharmacy over the past 15 years. This appendix provides background consideration of funding models as they might apply to pharmacist services to inform detailed discussion around the proposed funding models outlined in the body of the paper.

The following funding approaches are considered in this appendix

- fee for service
- bulk funding
- capitation
- case based
- risk sharing
- combined variants

Other approaches such as input focussed funding are not considered on the assumption that this would be a clear retrograde step. Each of the above options is discussed further below

Fee for service

This is largely the current model of funding. This is a relatively unsophisticated form of funding normally only contemplated where the service provider has limited ability to add value and where there are limited opportunities for efficiencies from scale or approach.

Advantages

- relative simplicity
- provides a payment that reflects activity and fits with defined specification
- can be informed by detailed costing
- incentive to increase volume to maximise profit (theoretical sustainability and long term market efficiency benefit)
- Familiarity for the patients and the community pharmacists
- Certainty of the business model

Disadvantages

- uncapped demand driven
- doesn't recognise marginal costing
- no incentive to manage volume or mix (perverse incentive relating to volume)
- limitations on flexibility for providers
- cost and quality minimisation risks
- Reliance on government (DHB) funding and government (DHB) decisions about funding increases

Fails to make full use of pharmacists skills and knowledge with the effect that work that could be done by pharmacists is pushed onto other parts of the primary and hospital care systems

Use of this approach for funding pharmacy has arguably been a useful development from the previous approach that had a higher focus on margins. Fee for service has provided the opportunity to more fairly reflect activity and cost of this activity.

The current fee for service funding model while unsophisticated in its nature should have provided opportunity and incentives for market efficiency and sustainability however this is complicated by the complex nature of the market and the interplay between dispensing, advice, added value and other retail pharmacy activity. As a result of these factors the model leaves significant residual tension between funder and provider where incentives are not well aligned.

Bulk Funding

This is typically a historically based unsophisticated funding model that is used where assurance of capacity is required. It has however been used in the pharmacy environment locally and internationally to try and achieve a shift in focus and incentives for aspects of service delivery. For example the southern region pharmacy agreement had a component of bulk funding distributed on a retrospectively adjusted activity basis. In the pure form of the model the following advantages and disadvantages exist

Advantages

- Historical level of funding certainty
- Lower financial risk for the funder and greater certainty for the provider
- Easy to operate
- Flexible use of defined inputs possible
- Incentives to manage mix and volume

Disadvantages

- Perverse incentives (Under servicing, Cost Shifting, Cream Skimming)
- Quality risk
- May not reflect need
- Windfall gains / losses
- Weak incentives for efficiency and effectiveness
- Adjustment over time can be contentious particularly where volume and mix drivers are external
- Uncertainty associated with a change in funding model

In essence bulk funding can be considered as an unsophisticated population or case based funding approach where the assumption is that historical need is a reasonable reflection of future need. The key advantage lies in capping short term financial risk arguably for both funder and provider and creating an incentive for a more flexible provider response within available funding.

Due to the significant perverse incentives and the inability to adjust over time this model is unlikely to be appropriate in the medium to long term for dispensing services in isolation from other funding models. Short of a population or case based adjustment mechanism bulk payment will either need to be adjusted to reflect activity or it will result in significant tensions. As was intended in the southern region pharmacy agreement it may however provide a useful transition mechanism as part of a mixed funding model where a more flexible response is required. This is more likely to make sense where pharmacy is seen as adding value beyond the distribution elements of dispensing.

Issues associated with inter district flows would need to be resolved to progress any form of bulk funded model. This includes identification of how the following areas are addressed

- “casual” service access from clients outside of the district

- “casual” service access from clients within the district to other districts

- Payment mechanisms for out of district providers who have contracts for service delivery with other DHBs

- How in and out of district is defined (prescriber, patient location and management of normal cross boundary flows associated with access patterns, holidays and work versus home location)

The application of a historically based bulk funding model to base dispensing services is unlikely to achieve much other than a short term transfer of volume risk. Adjustments would be required to reflect shift in volumes within the market and adjustments for total volume change over time will become contentious. Definitional issues regarding what is or isn't in the pool can also create significant issues as seen in previous triple region and national agreements.

Capitation

This model has only been explored in a limited fashion in NZ with a chain of pharmacies and a very simple capitation formula. It is however more extensively used overseas in particular within the United States. Variants on this approach involve capitation that includes drug cost as well as dispensing cost. The approach proposed in the body of this paper would involve capitation of dispensing costs and not drug costs

Capitation arrangements are normally employed where the following factors exist

- There is a defined (normally enrolled or insured) population

- There is sufficient data to develop a robust formula

- There is a relatively predictable average cost per person within the capitation formula

- There is limited opportunity for cream skimming or cost shifting or these risks are manageable

- The service provider has some opportunity to positively impact on volume and/or mix of service provision to achieve health gain

- Improved service delivery and outcomes for the service user can be contemplated within the capitation funding by the service provider changing the service delivery approach

- There are some measures or protections against under servicing or reduced quality. This may be in the form of performance or outcome measures, or through the ability of service users to make an informed provider choice

Advantages

- Funding reflects population characteristics
- Supports taking a flexible approach
- Reflects aspects of need
- Encourages service effectiveness
- Supports a preventative approach
- Provider financial risk moderated toward population driven change

Disadvantages

- Perverse incentives (Under servicing, Cost Shifting, Cream Skimming)
- May not fully reflect need
- Some financial risk sits with the provider
- No formula is 'right'
- Uncertainty associated with a change in funding model

It is interesting to note that internationally this is seen in some areas as a viable approach for pharmacy services particularly for populations with chronic disease and multiple medication utilisation¹⁸. In other countries this model has been actively sought by retail pharmacy in response to mail order dispensing and separated drug utilisation management programmes¹⁹. In these cases dispensing, added value services and drug cost may be included within the capitation package. Inclusion of drug cost makes less sense in a New Zealand environment given the Pharmac role. It may also make less sense to apply a capitation model to acute / short term dispensing where there is less opportunity to have a cost effective impact on mix or volume.

As for bulk funding arrangements there are some complexities associated with Inter district flows. In the case of a capitation model the management of casual access must be determined for all situations both inter district and within the district. Further to the areas highlighted under bulk funding the following must be considered

- Access to alternative pharmacies for reasons of urgency, convenience, practicality and confidentiality
- Separation of approach for different types of medications eg chronic medications may be able to be more consistently delivered from one provider and therefore more appropriate for a capitation model

Capitation funding provides the possibility of a more aligned set of incentives between funder and provider. There are however a number of technical and process issues that would need to be resolved to allow its use. It may be a more appropriate model for certain medication types.

¹⁸ Harry McQuillan, CEO Community Pharmacy Scotland, Presentation, Nov 2007

¹⁹ For an American Pharmacy perspective please refer to American Pharmaceutical Association www.aphanet.org

Case Mix

Consideration of a case based or case mix model is included for completeness. This is the model that is used to purchase the majority of inpatient services provided by hospitals. It is potentially applicable to populations of higher need service users where a predictable pattern of utilisation can be established or a sufficient sized population exists. It provides the potential for a more refined adjustment to reflect the relative level of service required by a person accessing a pharmacy.

This model provides potentially better funding allocations for individual service users there are significant risks around classification and funding models. Features include the following

- A classification system for service users / events is required
- Costing is complex
- Outlier management may be required
- The model is more suitable where clear outputs or outcomes are required

Advantages

- Reflects need to the extent of the validity of the classification system
- Supports flexibility
- Combines well with mechanisms to manage demand

Disadvantages

- Requires sufficient sized population
- Risk of departure from average
- Ability to develop costing model
- Uncertainty associated with change in the funding model

This is not currently seen as a viable model within the current New Zealand environment due to the costing complexities and lack of sophistication in market understanding about risk and potential return.

Risk and Gain Sharing

Each of the funding models described above has a different inherent base risk and gain profile for funder and provider however all models have the potential to have risk and gain sharing mechanisms overlayed onto the base funding model.

Capping and risk corridors as mechanisms of risk and gain transfer have been explored in the New Zealand market²⁰. These have been applied at an individual pharmacy level and at a regional pharmacy level. At an individual pharmacy level there has to be some form of adjustment mechanism over time if service user choice is maintained and associated shifts in volume occur. Adjustment mechanisms may be activity related in which case the model has a delayed fee for service incentive or population related in which case the discussion outlined under capitation applies.

²⁰ Refer Wairarapa experience, Southern region pharmacy contract, triple region contract, previous national contract and Care chemists contract

There is an argument for capping or limiting the increase in funding at a district or regional level. This could be a valid approach where volume and mix can be influenced or controlled by pharmacy (such as variable length of dispensing depending on adherence) but also where the potential economies of scale balance or mitigate the volume and mix risk. Coherence with other service developments also needs to be considered for example it may in fact be desirable to see improved access for high needs populations with chronic conditions resulting in increased medication volumes that may impact predominantly on pharmacies operating within high needs areas.

Combined Variants

There is some history within NZ and a range of international experience that involves mixed models of funding for pharmacy services. Mixed models clearly have the ability to mitigate risks while still providing incentives for change. The incentives provided from any particular component will be reduced.

The most commonly explored funding model mix is to have a component of activity based payment and a component of capped or population based payment. This may be structured across two dimensions as follows

- Different funding models for different types of medication for example as proposed in this paper dispensing for acute ailments being fee for service funded with dispensing for chronic conditions being capitation funded

- A mixed funding model for any dispensing for example a partial fee for service payment and a partial capitation payment

As noted previously these types of models offer the opportunity to mitigate risks associated with perverse incentives but they would dilute the pure positive incentives. Differentiation by acute versus chronic dispensing may make sense for funding for both base dispensing and added value services.

Appendix 4 – PHO and DHB contracting issues

Relationship between PHOs and pharmacist services

The working group agreed that PHOs should have a focus on integration of pharmacist services as part of their wider primary health care focus, there was however no consensus around the role of PHOs in contracting for these services. Concerns relate to the predominant focus of some PHOs on General Practice services. Having responsibility for contracting pharmacist services may help spread this focus but there are also concerns that undeveloped PHOs may not make a good job of this process.

The involvement of clinical pharmacists in PHO service provision is an established practice. The use of pharmacist facilitators was prevalent as part of previous Independent Practitioner Association budget holding arrangements. The current primary healthcare environment provides some ongoing incentives for PHOs to utilise pharmacists as part of their team directly or via management service organisations. In addition there are many examples of collocated pharmacy and general practice services across the country and some examples of integrated teamwork. The extent to which this might evolve into extended pharmacist input into the primary care team is not yet fully developed.

PHO focus on the potential extended role of pharmacist or pharmacy input has been limited in most cases. There is a variety of approaches that might improve this focus that range from pharmacist input onto PHO Boards, collaborative arrangements between PHOs and Pharmacy and PHO contracting of pharmacy services. The arguments that are typically applied to supporting any improved interaction relate to the potential role of pharmacists as part of the clinical team.

Contracting through 82 PHOs would significantly increase transaction costs and the range of mechanisms available to a PHO to create value in respect of base dispensing is no different to that of a DHB. PHOs may however have a better opportunity to support the development of teamwork and coordination between pharmacists and other primary health care services, in particular General Practice. From an information management and sharing perspective it may also be easier to envisage sharing of dispensing information within a Pharmacy – PHO association. Information about dispensing versus prescribing and sharing where appropriate information in relation to multiple prescribers may be more possible in a PHO environment provided concerns about patient consent are addressed. This type of interaction is dependant on good relationships between prescribers and pharmacists. Community pharmacy may be reluctant to support contracting via a PHO where there are concerns about lack of understanding or representation in relation to pharmacy

In an environment where there is a working relationship between prescriber and pharmacist it is possible to envisage pharmacists having a more developed role in supporting patients with long term conditions for example determining longer periods of STAT dispensing by identification of service users with reliable dispensing pick up history and lower likelihood of change in medication prescribed²¹. Incentives around any such approach would need to be carefully considered given the

²¹ This is planned in the Scottish system but as yet untested.

inherent perverse incentive to support longer STAT periods in a bulk funded or capitated model at the risk of additional medication cost.

From a wider primary health care development perspective there is some possibility that consolidation of general practice to larger medical centres could be associated with further collocation and consolidation of pharmacist services. The association of pharmacy with this type of development is a current market trend. This is an appealing pathway from patient access and pharmacist added value perspectives. It does provide opportunity for economy of scale without negatively impacting on access for patients to prescribed medications (there is a wider discussion about potential impacts on access from general practice consolidation itself which is beyond the scope of this paper).

Localised vs collective DHB process

There is no current requirement for DHBs to work jointly in relation to pharmacist services. Without any such requirement any cooperation needs to be justified in terms of potential added value for the population of any given DHB. This may be justified in terms of administrative efficiency in developing documentation and undertaking contracting processes but this needs to be balanced against the value of a differentiated approach tailored to the needs of the local population. DHBs involved in this project have stated that they wish to remain as part of the national collective supporting the continuation of the National Pharmacy Services agreement.

There are some significant issues that arise from the direction suggested by the working group that may benefit from national DHB cooperation or consideration. In particular the following issues should be considered

- Inter district flows as discussed in previous sections ie how service users travelling to different DHBs access pharmaceuticals and the impact on funding and contracting mechanisms

- National information datasets that inform for example the PHO performance management programme, PHARMAC decision making and policy development

- Potential different levels of service access in different DHBs

- The impact of different strategic directions on national engagement processes particularly with national organisations.

Further consideration of the value of a subset of DHBs working jointly in relation to funding and contracting models includes the following opportunities

- The completion of this project to examine options and provide common material for a consultation process

- Joint development of contracting processes and documentation where appropriate to the outcome of this work

- Potential value in operating a joint contracting approach.

It is the last opportunity that is of particular interest. This involves the consideration of any value beyond administrative efficiency of joint contracting. The following possibilities exist

- Cooperation to reduce regulatory barriers such as pharmacist technician ratios and roles. In particular the current 1:2 pharmacist technician ratio and the requirement for a pharmacist

to check any technician or robotically dispensed item including each blister in a repackaging system.

Jointly working with PHARMAC to explore both bulk supply and original pack dispensing which in turn could better support efficient dispensing including possible use of robotics
Better service definition for different client categories that may appropriately receive greater pharmacist input.

Retaining a competitive market. A number of providers operating across multiple DHBs may achieve economies of scale while preserving choice and competition.

Reducing the risk associated with natural variation in funding arrangements that involve some risk transfer. For example capped funding across more than one DHB (particularly smaller DHBs) may be a more attractive / workable proposition for providers while still providing risk mitigation for DHBs. The nature of the risk sharing between DHBs would need to be carefully resolved in this situation.

These possibilities provide significant opportunity for value. Realising these benefits will be dependant on each DHB determining that a given approach is most appropriate for its population.

Appendix 5 – Development of larger dispensing operations

In the current environment the development of larger dispensing operations is impacted by several factors as follows

Ability to use technologies and approaches that create cost efficiency. Key issues relate to regulations regarding pharmacist technician ratios and roles, and the impact of packaging (eg bulk supply and original pack dispensing) on the use of “robotic”²² dispensing technology.

Acceptability and appropriateness of remote operation eg through mail order.

Definition of what is required in terms of advice and other functions at the point of dispensing

Limited opportunity in the market to establish subcomponents of service delivery eg just providing a dispensing distribution service requires someone else to provide advice for service users and complicates the management of issues associated with potential multiple prescribers and medication interaction. Separation of functions may also be complicated by legislation regarding pharmacist and technician roles and ratios.

The net result of these factors has seen limited development of larger operations for community dispensing. It is useful to note that in some areas significant consolidation and presumably efficiency and or service benefits have been established for parts of the market in particular residential care dispensing and other areas where repackaging technology is used.

Assessment of the net efficiencies that might be obtained from larger dispensing operations for other areas of dispensing is complex. Most of the evidence coming from America includes parallel development of generic substitution, formularies, supplier management and automated utilisation review²³. Further there is a balance in impact of potentially more efficient distribution but higher collection rates²⁴.

²² Note robotic dispensing comes in different forms, those supporting compliance packaging, those producing bottle packs for self-managing, and a third variant, which selects original manufacturers packs for labeling, which is used in other jurisdictions where original pack dispensing is mandated. There are different supply issues associated with supporting each system. These devices have not found a significant place in the New Zealand market because of the variety of pack sizes purchased by Pharmac, population dispersion and size of dispensing operation in the current market.

²³ Carroll NV, Brusilovsky I, York B, Oscar R. Comparison of costs of community and mail service pharmacy. *J Am Pharm Assoc.* 2005;**45**:336–43.

²⁴ Johnsrud, M et al, Comparison of Mail-Order With Community Pharmacy in Plan Sponsor Cost, *J Manag Care Pharm*, 2007; 13(2): 122-134

There has been some development of remote dispensing for rural areas within recent years. Further development of rural dispensing is possible. Cost, efficiency and access considerations are different for each area but the dimensions of this are similar in nature. Rural dispensing is currently variably supported through extra funding from DHBs and requests for proposals for the provision of services to defined rural areas or agreements with specific pharmacies to provide depots. Funding typically reflects a historic or estimated costing and there are unresolved issues around service requirements for depots such as frequency of delivery, provision of advice and phone access costs.