New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

18 August 2017

PHARMAC
PO Box 10254
Wellington 6143

By email: consult@pharmac.govt.nz

Change of access to funded Nicotine Replacement Therapy and the Emergency Contraceptive Pill

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. We note that PHARMAC is proposing amendments to the Pharmaceutical Schedule rules to allow pharmacists to independently authorise subsidy for certain pharmaceuticals without a prescription—in this case, nicotine replacement therapy (NRT) and the emergency contraceptive pill (ECP). Before considering the merits of this proposal as they apply specifically to NRT and the ECP, we believe it is essential to consider the underlying systemic implications of enabling pharmacists to provide funded pharmaceuticals to patients without a prescription.

2. We have major concerns that such arrangements result in conflicts of interest for the pharmacists involved. If pharmacists choose a treatment and then also dispense it, they receive the dispensing fee. The resulting conflict of interest is compounded when the treatment is funded and will therefore be easier to 'sell', as it will be less expensive. When a doctor decides that a certain treatment is, or is not, appropriate, financial conflicts of interest are eliminated because patients are sent to a pharmacy with their prescription. Doctors are generally not allowed to dispense to avoid precisely such a conflict of interest, and to ensure that their decision making is not influenced by commercial interests. This proposal implicitly supports both the provision of funded treatments and their dispensing by the one individual pharmacist—an act that has been disallowed for doctors for decades (except under particular circumstances in rural settings). This step by PHARMAC would tacitly allow for 'prescribing' and dispensing to be performed by community pharmacists, along with all the unintended consequences that might occur, and to which we allude in this submission.

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3. To date, pharmacist prescribers (those with advanced postgraduate training) have not been allowed to own community pharmacies in recognition of this commercial conflict of interest. We are concerned that the structural change being proposed would open the back door to funded pharmaceuticals being provided through community pharmacy (with all the attendant risks and moral hazard), as opposed to being prescribed by clinical pharmacists with their advanced postgraduate training. We seek clarification on whether the intent is to expand the number of funded pharmaceuticals provided through community pharmacy beyond NRT and the ECP and, if so, then allow doctors to own community pharmacies, and be able to dispense in addition to prescribe.

4. We note that PHARMAC's new bold goal of eliminating inequities in access to medicines by 2025[1] appears to align with our longstanding position on health equity,[2] and we support measures to improve access to NRT and the ECP where there are actual barriers. However, we are concerned that allowing community pharmacists to provide these products under subsidy will further fragment primary care and undermine continuity of care for patients. The provision of NRT and the ECP should not be viewed as discrete health interactions but rather as part of important ongoing wider health and wellbeing considerations (see paragraphs 8 and 9). This proposal, intended to improve access to NRT and the ECP, could, perversely and ironically, threaten net population health outcomes through harming wider access to effective integrated primary care.

5. We do not support parcelling off 'pieces' of patients' and their families' health in the way that could occur under this proposal. It is our view that the proposal does not meet several core principles of health workforce redesign,[3] including principles 8 (maintain or improve integration between involved medical services as well as integration of the patient within the healthcare system) and principle 11 (ensure all reform is based on an assessment of the best available evidence and/or practice). Furthermore, the skills involved for prescribing (after a comprehensive consultation) and for dispensing are qualitatively and quantitatively different. Doctors regularly take ultimate responsibility for medical decisions and diagnoses in situations of complexity and uncertainty, drawing on scientific knowledge and principles, clinical experience, and well developed judgement.[4] Their breadth and depth of training enables them to provide oversight of patient care in both acute and longer term care settings. Prescribing necessitates knowledge and skills of diagnosis, assessment and management that are built on years of clinical training and are holistic, taking into account patients' history, circumstances and environment, as well as wider population health considerations.

6. The argument that the proposal will reduce cost as a barrier to women accessing the ECP is spurious; community pharmacists currently sell the ECP for $30-50. Yet levonorgestrel 1.5mg costs $4.95 per tablet.[5] Most of the $30-$50 cost women pay is the consultation fee charged by the pharmacist. Extending subsidy for the ECP to community pharmacy is therefore only likely to reduce the cost of the ECP by $4.95 (unless DHBs enter into individual arrangements with community pharmacies).

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[1] Pharmaceutical Management Agency. Statement of Intent 2017/18 - 2020/21. Wellington: PHARMAC, 2017. https://www.pharmac.govt.nz/assets/SOI-2017.pdf

[2] New Zealand Medical Association. Health Equity. Position Statement. Wellington: NZMA, 2011. http://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf

[3] New Zealand Medical Association. Principles of Health Workforce Redesign. Position Statement. Wellington: NZMA, November 2011. https://www.nzma.org.nz/__data/assets/pdf_file/0018/1458/Principles-of-Health-Workforce-Redesign-2013.pdf

[4] New Zealand Medical Association. Consensus statement on the role of the doctor in New Zealand. Wellington: NZMA, November 2011. http://www.nzma.org.nz/__data/assets/pdf_file/0006/16980/Consensus-statement-on-the-role-of-the-doctor-in-New-Zealand-November-2011.pdf

[5] Pharmaceutical Schedule. August 2017. http://www.pharmac.govt.nz/2017/08/01/Schedule.pdf#page=6

7. We are disappointed that the consultation does not make it clear that both the ECP and NRT are already available, fully funded, via other mechanisms at minimal / nil cost to patients. For example, both the ECP and NRT are already available under Practitioners' Supply Orders from after hours and family planning clinics at minimal cost. Patients can also obtain fully funded NRT via a Quit Card obtained from a smoking cessation service such as Quitline. It is preferable for people wanting to stop smoking to engage with a cessation support service such as Quitline rather than attempt to quit on their own. We are concerned that the current proposal may encourage people to bypass Quitline and may therefore have the unintended consequence of reducing the overall success rates of quitting smoking.

8. With respect to NRT, the proposal neglects to consider the significance of the doctor-patient therapeutic relationship and the trust created, both of which are known to be important factors in supporting and sustaining smoking cessation. When GPs prescribe NRT, they use the consultation to explore the stresses behind the smoking habit, check for other cardiac risk factors, calculate the BMI, and request lipids and HbA1c—all part of managing overall absolute cardiovascular (including diabetes) risk. They also identify/assess and manage COPD, and are alert to possible early signals of oropharyngeal and/or lung cancers (persistent cough, haemoptysis) necessitating at least a clinical examination and a chest x-ray.

9. With respect to the ECP, an unplanned pregnancy event is generally a major stress for a woman and raises potential issues of consent, adequate contraception, the risk of STIs, and family planning. We find it difficult to envisage how it is possible to discuss the delicate subjects of non-consensual sex or family stigma / ostracism without well-developed consultation skills in the context of an ongoing professional relationship and within the confines of a private consultation room. When providing the ECP, it is important to address these issues as well as to inform women that increased weight can render the ECP ineffective. Many pharmacies fail to provide this advice.[6] Most General Practices understand the importance of urgent access with the risk of a crisis pregnancy and have emergency appointments to cater for this if timely access is a concern. Such appointments usually generate a lowered fee if cost concerns are a potential barrier.

10. If this proposal is progressed despite the major concerns we have raised, then we believe it is essential to monitor the impacts on clearly defined outcomes relating to smoking cessation and emergency contraception. We also submit that placing certain conditions on the subsidy may be a way to mitigate some of the risks identified. For example, eligibility for the subsidy for NRT might require patients to already be on a smoking cessation pathway. Eligibility for the ECP subsidy might require the pharmacist to officially document that some minimum level of discussion / consultation has taken place with the patient regarding risks/options etc. We seek confirmation that such requirements are already built in to the education programme accredited by the Pharmacy Council. Finally, for both NRT and the ECP, notification to the patient's GP should be both mandatory and audited.

We hope that our feedback has been helpful and look forward to learning the outcome of this important consultation.

Yours sincerely

Dr Kate Baddock
NZMA Chair

[6] https://www.stuff.co.nz/national/health/93859595