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Improving access to medicines and devices in primary care

Dear Chris,

Thank you for the opportunity to comment on the PHARMAC proposal regarding changes to the purchase and distribution of medicines and medical devices. This response is on behalf of the Executive Board of the New Zealand Rural General Practice Network.

We appreciate that PHARMAC are offering genuine engagement with clinicians, to anticipate problems with these proposals. It would seem that the ideas are at an early stage of evolution but already there are aspects which suggest that, at least from a rural practice perspective, there would be concerns should the plans go forward.

Below are comments that have been developed in consultation with a number of rural practice staff:

1. You call it "Improving access to medicines and devices in primary care" but we have trouble seeing how things would improve for rural practices, which already have access to most agents through the rural MPSO.

We also frequently arrange for medicines intended for administration by a practitioner (e.g. local steroids, Zolendronate, antibiotics) to be delivered directly to our practices, whether it is on MPSO or on a normal prescription. It involves some teamwork with our rural pharmacists and courier services and is part of the rural ethos of delivering services as close to home as possible for our isolated communities.

2. We are concerned that while the initial proposal concerning purchase of vaccines might be manageable, if it is the thin end of a wedge that leads on to expanding responsibilities for drug and device purchases by general practices, what might start as some small inconveniences could develop into another significant burden of activity and risk carried by the practitioners.
3. It is unclear what the risks will be to practices in terms of getting reimbursement for the true cost of purchase, distribution and storage and what compensation would be available for loss or for stored drugs going out of date. PHARMAC's acknowledgement of the loss of investment through the lag time between purchase of and use of medicines and devices highlights another concern for practices running on tight budgets.
4. The proposal refers to administration costs being covered. This might be seen as a potential small area of revenue for a practice or an unwelcome extra burden. Again, what might start small and manageable might swell to require extra staff or staff time. It is another area of risk which would require much greater clarification before a practice might be happy to accept it. Of concern to *rural* based practices is that more

of them are small organisations with limited opportunity for merging with others. Such small practices often have less leeway for absorbing new administrative loads.

Regarding the single area of vaccine purchase:

Of the two new models described for the purchase of Immunisation Schedule vaccines:

1. One model is compared to current handling of flu vaccines. Practices may experience this variably as either straightforward and a useful source of income or a somewhat underfunded 'hassle'. Unused stock goes quickly out of date requiring numbers to be carefully planned? How might this risk expand when all the schedule vaccines are involved?

The other model is compared to "current community pharmacy model" which we presume corresponds to our rural MPSO requests.

2. It appears that the two purchasing options differ only in that one requires DHBs to reimburse "Schedule Price and Administration Fee" while the other involves DHBs reimbursing "Schedule Price, Administration Fee and Distribution Fee". There are potentially problems with reimbursement arrangements. As volumes grow there could be significant loss if there was a persistent delay in the reimbursements, though with electronic claiming it could be very rapid if set up correctly. It is also unclear how straightforward the purchase and delivery processes would be and the potential for bureaucracy, delays and other supply chain errors.
3. A further issue here is that in the second example PHARMAC is pointing out that there may be a difference in the DHB refund of distribution costs and the actual cost to practices. The proposal says: "this could be positive or negative". It would be hard to see whether the inevitably greater cost for rural distribution would be compensated by a rural adjuster in the reimbursement and how this would be calculated and scaled.

If having a positive outcome depended in part on a practice's ability to negotiate good distribution deals, would this again advantage larger practices and penalize the smaller, often more remote practices?

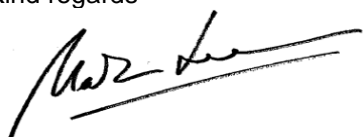
4. The paper does suggest that this process might be handled by PHOs rather than individual practices. Perhaps this would offer opportunities for negotiating better deals but there would then be another layer of bureaucracy and potential for delays and errors between PHOs and practices unless very cleverly set up.

SUMMARY

In summary, we can see nothing in the proposals that genuinely would improve access to medicines and devices for our rural patients and plenty in there that would increase risk and financial burden to the practices. Until these issues are convincingly resolved we cannot support the proposed changes. We would further ask what motivation was there for change to the current system, which could be improved in places but fundamentally works well.

Thank you again for the opportunity to present a submission on this proposal.

Kind regards



Dr Martin London – For and on behalf of New Zealand Rural General Practice Network¹

¹ This submission is based on views of the NZRGPN Executive Board but may not reflect the full or particular views of all of its members.