Independent
Community
Pharmacy
Group Inc.

Putting patients before profit:
Protecting NZ pharmacy healthcare from corporate control

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An ICPG Position Paper on Pharmacy Ownership Regulation

> *You can't say no to somebody when you can help them. And you can't worry about money.*
> - Susie Farquhar, pharmacist and owner of Napier's Unichem Pharmacy Greenmeadows

Summary: To protect healthcare quality from interference from outside business interests, pharmacies are legally required to be majority-owned by healthcare professionals (pharmacists) and to be under the "effective control" of pharmacists. The Independent Community Pharmacy Group (ICPG) supports this well-tested and fit-for-purpose law, and recommends it be strengthened in order to provide a reliable foundation for innovations which enhance healthcare quality, access, equity; and to provide embedded community resilience based on trusted relationships in times of crisis.

Overseas evidence shows ownership deregulation reduces access equity for rural communities, risks reducing services for vulnerable patients, and risks compromising healthcare quality overall. The High Court has found the approach adopted by the Ministry of Health to the granting of licences to certain supermarket pharmacies is not lawful, because those pharmacies are not under the effective control of pharmacists. Overseas evidence is overwhelming that ownership deregulation would primarily benefit international corporate owners; in NZ this would include those found to be operating unlawfully, countering efforts elsewhere in government to curb profiteering.

ICPG does not support pharmacy ownership deregulation. Deregulation is unnecessary and/or counter-productive to all the Ministry's stated policy aspirations. ICPG recommends the Ministry works closely with Māori, pharmacies, pharmacists, and patient groups to fulfil policy aspirations using appropriate policies with well defined, measurable goals.

Pharmacy healthcare run by health professionals without interference from corporate business interests is the best way to support equitable and safe access to medicines and quality pharmacy services for all New Zealanders now and into the future.

Community pharmacies vs corporates: the difference in care is stark and substantial

In Hawkes Bay, February 2023, after Cyclone Gabrielle knocked out electricity and flooded supply routes, a corporate pharmacy in Hastings opened for only two hours per day. It did not dispense let alone deliver any prescriptions, and – as EFTPOS was down – it made people pay cash (even though the ATM machines weren't functioning at the time) (CW, 2023). In contrast, independent Napier pharmacist Susie Farquhar and her staff dug through paper records by candlelight, for patients too in shock to remember their prescriptions; delivered medicines to patients trapped at home; and gave baby supplies to new parents for free.

> *If people don't have medicines, some people will die, that's the fact of it ... Pharmacists just have to find a way to make it work .*
> - Susie Farquhar, pharmacist and owner of Napier's Unichem Pharmacy Greenmeadows (2023)

As an independent pharmacist, Susie Farquhar was able to offer a vital lifeline for many vulnerable people - because she owned her pharmacy. In contrast, the corporate pharmacy made sensible business decisions – but decisions based solely on business interests have no place in a core healthcare sector.

"Healthcare first" is the cornerstone principle for independent community pharmacies – and not just in times of crisis. On top of dispensing medicines, New Zealand pharmacists spend 15%-50% of their working day on largely-unfunded healthcare services (Aziz et al; 2021; see table 1).

> *I have gone and done house calls [for free, to check blood pressure, because] it's either they are going to have a hospital admission […], or I go out and take out 10 minutes of my day during my lunch break or during work time to test their blood pressure, see how they are getting on and then feedback to the GP.* - Pharmacist (in Aziz et al, 2021)

Table 1: Some healthcare services performed by independent community pharmacies

Examples of the unfunded healthcare services likely to be greatly reduced or lost if pharmacy ownership were deregulated
Examples from Aziz et al (2021) • Taking medicines-related phone queries from doctors, patients and resthomes (which can require time, taking involved patient histories on unknown patients) unrelated to the pharmacy's own dispensing • Identifying and following up on risks for falls or disease progression when on home visits • Serving patients who need a particular service but who do not meet funding criteria (such as for a medicines use review) • Blood pressure and glucose monitoring (either free of charge or below-cost) *ICPG member reporting (see Cannons, 2023)* • Phoning and visiting anxious, isolated patients during crises (eg the Covid lockdown) with practical support (medicine deliveries but also groceries etc). Community pharmacies are an important part of community resilience in the face of disaster. In the short-medium term, New Zealand is likely to face ongoing extreme-weather crises (Corlett, 2021); and the chance of another global pandemic in the next 10 years is over 25% (Pringle, 2023). • Identifying community need, working with community to develop, test and implement solutions and sourcing funding for those solutions (eg gaps in wound management services; barriers to medicine adherence) • Referrals to other health professionals and community support agencies • One-on-one educating in health literacy • Alerting prescribers if prescribed stock is unavailable nationwide

In contrast, pharmacy-owning corporations have no non-commercial incentive to permit their pharmacists to use dispensing subsidies to cross-subsidise healthcare services such as those above, or take extra time with patients, as independent pharmacies do on a daily basis. Therefore deregulation – which has created corporate oligopolies overseas – risks removing these vital services.

At its core, the argument for strengthening ownership protections is about care and focus. Pharmacists in local pharmacies are committed long-term to their communities, building up trust and understanding over decades. They discover and nurture innovative equitable solutions for local needs in partnership with their communities:

- Concerned about the barriers for kaumātua to taking medicine as directed, an ICPG pharmacy formed a partnership with a local marae. Hui were held and solutions discussed. Pharmacists spent time with kaumātua and their whānau to allow for comprehensive assessment of health needs. Referrals were often made to other health professionals and community support agencies. The results were significant improvements in management of long term health conditions of kaumātua.
- An ICPG pharmacist has set up and chairs a Medicine Advisory Committee for a national rest home provider.
- In response to increasing medication complexity, a provincial member has partnered with the local hospice to provide services such as medication reconciliation on admission and patient education on discharge.
- An ICPG pharmacy in a medium-sized rural town initiated after hours, weekend and public holiday care to their local community.
- A rural ICPG member now has digital integration with a primary care practice, enabling integrated care for patients.

For corporates, pharmacy is a way of selling commodities. But globally, the pharmacy profession is moving away from the traditional supply and distribution role towards the provision of patient-focused care and service using pharmacist clinical skills (Aziz et al 2021; McDonald et al, 2021). In New Zealand, the key factor identified as important for pharmacists when considering providing extended services are owner and management support (McDonald et al, 2021). If the pharmacy sector is deregulated, New Zealand risks going from being one of the leaders in the positive trend of patient-focussed care to making the same mistakes other jurisdictions have made, rather than learning from overseas experience.

The situation: patient care and community pharmacies are unnecessarily at risk

Currently, to support quality assurance, only a qualified pharmacist with a current practising certificate can be a majority owner of a pharmacy. A company may hold a pharmacy licence only if (a) pharmacist(s) has more than 50 percent of share capital and if pharmacists have effective control of the company. A company may not operate more than five pharmacies, and an individual may not hold the majority interest in more than five pharmacies. Such restrictions protect pharmacists from outside investor pressure to “cut corners” on health services in order to increase profits (see Cannons, 2023, for legislation history).

Recently, overseas corporations have established pharmacies in New Zealand, most notably Countdown pharmacies (since 2012) and Chemist Warehouse pharmacies (since 2017). Fitting in with overseas patterns, these corporate pharmacies have set up perhaps exclusively in urban areas which are already well-served by pharmacies, "cannibalising" demand. But the High Court decision in *New Zealand Independent Community Pharmacy Group v Te Whatu Ora* (2023) found that Countdown's pharmacy ownership structure did not provide pharmacists with "effective control" as was required by law. The Court found that pharmacists must have effective control of the *company*, not merely day-to-day pharmacy operations, and also that the "effective control" requirement was designed to ensure that minimum shareholding requirements (of majority shareholding by pharmacists, ie more than not equal to 50%) could not be circumvented. In the words of Justice Gwyn, the "effective control" wording is in the legislation "to ensure that the company was there to serve independent pharmacists and not some outside interest and thus to protect public safety" ([2023] NZHC 1486 at [310]). The judgment has provided greater clarity about the meaning of the legislation, but is now under appeal. At the very least, it would be constitutionally inappropriate for Parliament to deregulate pharmacy ownership while the case is on appeal and before the courts (an appeal process that may last at least 18 months). Parliament should also take its lead from the courts' direction that there is a link between pharmacist control of pharmacies and public safety. Effective control of the company includes having decision-making power on issues such as contracting, services offered, recruitment and wages.

Ministry of Health (2021) advice was given under the misapprehension that currently, supermarket pharmacies "comply with the letter of the law" and was therefore making regulation difficult. However, with the 2023 High Court judgment discussed above, the courts have clarified that the current corporatisation does not comply with the law, and therefore the key reason to change the law has been found not to exist. The law is now clear.

International research shows removing these restrictions on ownership would result in large corporates (such as overseas-owned supermarket chains) owning and controlling more pharmacies: likely, the vast majority of the nation's pharmacies (Vogler et al, 2012; Mooney & Suleman, 2020). Deregulation would encourage growing corporate control of healthcare and a loss of relationship-based pharmacy practices. This would have a number of concerning consequences regarding patient rights, quality control, access and equity.

New Zealand public health leaders Johanna Reidy, Don Matheson, Rawiri Keenan, and Peter Crampton recently published a landmark article in the *New Zealand Medical Journal*, pointing out that "there are downsides to corporatisation, especially related to market failure, unresolved tensions between professional ethics and profit imperatives and the corporate models' impact on continuity of care for vulnerable people who live with complex health needs" (Reidy et al, 2023). This is because "Flexibility for professional discretion, time per consultation and service responsiveness are informed significantly by profit imperatives and commercial responsibilities to shareholders" (Reidy et al, 2023). Where health providers have responsibilities to make returns to shareholders – as when pharmacy services are provided by corporations, as opposed to community pharmacies – there are likely to be

incentives for those health providers to oppose regulation that may limit shareholder returns. The authors state "[o]wnership interests can drive the behaviour of system actors" and that "[a]t the individual level, ownership shapes how service users are conceptualised: as consumers of services provided by the market, as patients in a professional encounter or as citizens exercising their right to healthcare" (Reidy et al, 2023a).

The same authors (2023b) detail the issues in a post written for the World Health Organisation:

> *Downsides [to market models] are linked to the fact that health services do not operate in a proper market, they only mimic a market. Within the health market there is information asymmetry between supplier and service user and demand will always outstrip supply […] [H]ealth professionals report difficulty in balancing professional and fiduciary duties in some ownership paradigms, where the ultimate duty to return a profit to shareholders can erode professional satisfaction and professional clinical autonomy. Further, a dominant market-led model leaves high-need populations underserved. High-need populations require services that can be uneconomic in a market paradigm […] Bluntly, serving the high health needs is rarely a good business proposition* (Reidy et al, 2023b)

Likely consequences of pharmacy deregulation/ corporatisation in Aotearoa NZ

1. Reduced quality control

Deregulation of pharmacy ownership will water down the legal protection of patient interests.

> *In reality, depending on which type of pharmacy you work at, you would have to make compromises. For example when I work at those big chain discount pharmacies, I would get the pressure from the employer or manager that I can only spend no more than 5 min on counselling or even Medscheck, for example.* - Staff pharmacist, Australia (Yong, 2023)

Potential owner influence is a concern under a deregulated model. The Ministry of Health (2021) expects "increased vigilance" would be required to ensure pharmacists "have necessary authority to carry out their obligations without undue influence from pharmacy owner": "Overseas evidence suggests vigilance by regulating authority [is] required to ensure authority not encroached on by owner." Not all such encroachments would come to the attention of the authorities, however, meaning pharmacists' authority will be undermined in situations that do not come to light. That is a grave concern. Primary healthcare is too important and complex, and carries too many risks, to be treated like any other business sector.

Overseas, after deregulation, pharmacists reported inadequate rest breaks (Bush et al, 2009), lower work satisfaction and higher workloads (Vogler et al, 2012). This last is because the number of pharmacies may increase after deregulation, but the number of pharmacists per pharmacy decreases, reducing the opportunity for cooperation and leading to doubling of effort. These have a knock-on effect on safety and quality of service provided. The opportunity to provide patients with advice is also potentially reduced: over half the pharmacists interviewed in post-deregulation research in Norway believed that the advice given on prescription-only medicines was not sufficient, while consumers in Sweden

perceived a deterioration in pharmacy staff skills and information services (Vogler et al, 2012). Commercial interests also favoured quantity over quality: in the UK, there was some evidence that pharmacy companies were imposing target volumes on pharmacists for certain government-paid services, and "even threatening disciplinary action if employee pharmacists fail to achieve the targeted number"(Bush et al, 2009).

2. Reduced equity of access to rural areas

The Ministry of Health (2021) acknowledges ownership deregulation means "risks to rural areas", such as stagnation and even potential reduction of rural pharmacy services, including potential closure of community pharmacies. Decreasing access equity is counter to Ministry and pharmacy sector goals of increasing equity and access. Low income, and rural, patients are among those least served by market forces (Bush et al, 2009).

3. Reduction in equity for Māori

Māori are more likely than non-Māori to live in rural and small urban areas (EHINZ, n.d.), and therefore the likely increase in inequity of access for rural communities would impact Māori more than non-Māori.

Concerningly, the Ministry of Health's 2021 advice does not appear to be based on genuine consultation with Māori on the question of pharmacy ownership: the Ministry's 2021 Regulatory Impact Statement acknowledges no specific consultation with Māori ("There was no strong Māori perspective provided during [the multi-faceted Therapeutic Products Bill] consultation on pharmacy ownership restrictions").

The Ministry's few stated policy aspirations – such as expanding access to pharmacy services on marae – do not require ownership deregulation, and would be far better resolved with policy responses other than wholesale ownership deregulation and pharmacy corporatisation. Innovative arrangements are already in place in numerous sites around the motu through contractual partnerships with pharmacies that have trusting relationships with local whānau or other groups.

The Ministry should work with Māori specifically on the question of pharmacy services, as it should have done before the 2021 RIS. It needs to hear and seriously consider Māori aspirations for services, and prioritise Māori-led policy ideas and design, rather than imposing its own. An absence of engagement with Māori carries legal vulnerability, including risks of a Waitangi Tribunal claim on pharmacy policy, which could well delay the implementation of the Ministry's other policy objectives.

4. Reduction in community responsiveness

It is not core business for large corporates to take the time and care required to understand the structural inequities in the communities in which they operate, and work to ameliorate them. It is highly unlikely that international corporations will develop bespoke solutions to equity issues that vary from community to community and whānau to whānau.

Tackling inequity alongside communities is time consuming and expensive. The solutions are as complex as the issues and are not just about cost. Solutions are only found by talking and listening to those affected. Such solutions involve considering access to the pharmacy, how consultations occur, liaising with prescribers, involving whānau in treatment decisions,

forming partnerships with marae and other community providers and seeking funding for all costs relating to medicines (not just prescriptions). Receiving the medicine is only a small part of the medicine pathway. After gaining feedback from communities, pharmacies have begun to address inequities through visiting kaumatua, meeting iwi leaders, sourcing extra funding, and running outreach programmes in people's homes.

Some innovations have arisen due to a specific need in a community. The most recent example is Te Whatu Ora | Health New Zealand's response helping people impacted by Cyclone Gabrielle to get easier access to healthcare by funding a range of primary care initiatives across pharmacies, clinical telehealth and general practice. These innovations are actioned by all pharmacies under the current ownership model, which is also compatible with technical innovations in the sector (such as dispensing robotics).

In addition, public health services for vulnerable communities were compromised by commercial interests in the UK: supermarket pharmacies were less likely than small chains and independent pharmacies to provide home delivery services and home visits. Supermarkets also appeared to be less likely to provide emergency contraception without prescription (Tesco stopped providing this altogether to people under 16 without a prescription), needle exchange schemes and the supervised administration of medicines (mostly for withdrawal treatment of drug addiction), as such "controversial" services were seen to be in conflict with commercial interests (could reduce grocery sales from certain consumers). This left vulnerable young people and those attempting to manage or eliminate their addictions with reduced healthcare. (Bush et al, 2009). Similarly a recent study of deregulation in South Korea found that deregulation came "at the cost of lessened access to overall pharmacy *services*, which is contrary to the intent of deregulation" (Jo et al, 2022; emphasis added).

5. Increase in corporate control of healthcare

Unregulated ownership would greatly reduce the number of community pharmacies practicing independently from corporate control. Such corporate takeover/oligopoly offers little or even less competition than the previous regulated market: Norway (96%), Sweden (86%), US (64%), and United Kingdom (UK) (61%) showed dominance of corporatisation after deregulation (Moodley & Suleman, 2020). Ownership deregulation would primarily benefit corporate owners (Vogler et al, 2012), including those found to be operating illegally. Pharmacy ownership deregulation would specifically give more power to supermarkets, in the vital sector of primary healthcare, thereby undermining efforts elsewhere in government to curb supermarket profiteering (Commerce Commission, 2022; Clark, 2022), counter to the economic and health interests of New Zealand as a whole.

6. Deregulation expectations not met

Assessments of the waves of overseas pharmacy deregulation find many risks and few benefits in deregulation for patients and communities, indicating it is not a wise or useful course of action to take. In Europe, "deregulation policies do not seem to be producing the desired effects" (Gallone et al, 2020): a pan-European review found expectations of deregulation were often disappointed: "A liberalisation in the pharmacy sector is often connected to rather broad aims such as better accessibility and lower medicine prices

which, eventually, turn out to be false expectations." (Vogler et al, 2012). The researchers found the objectives of deregulation were sometimes not well-defined (an issue in New Zealand also: the Ministry of Health's (2021) Regulatory Impact Statement did not offer detailed objectives for deregulation which could be easily measured).

In Europe, contrary to stated policy goals, "over the counter" medicine prices did not drop and patient satisfaction on surveys did not increase – urban residents were pleased if after-hours availability increased (not always the case), but patient satisfaction with pharmacy services was already high pre-deregulation, and there were concerns about the level of information offered in pharmacies (Vogler et al, 2012).

Conclusion

Deregulation of pharmacy ownership is irrelevant, unnecessary and/or counter-productive to the Ministry of Health's stated priority aspirations. There is no evidence that deregulation and corporatisation would support the shift to more tailored commissioning of pharmacy services. Neither would it remove barriers to more innovative approaches to service delivery, including to remote or disadvantaged communities.

In contrast, strengthened ownership regulation would protect and encourage the many innovations, integrations, interventions, and services already underway in independent pharmacies, services which are often unfunded. Ownership regulation could be strengthened by requiring pharmacy share capital to be at least 75% owned by pharmacists.

Pharmacies effectively controlled by pharmacists build up decades of trust with patients, allowing them to understand local issues and demographics, which is imperative to fully address inequity in any community. Evidence-based solutions to local need must be formulated in partnership with communities. Further examples of independent pharmacy-community solutions which fulfil this aspect of the Pharmacy Action Plan include:

- A rural ICPG pharmacist liaised with a community district nurse, to help patients in an isolated community one hour's drive from the pharmacy. Couriers and rural post were no longer reliable, so the district nurse delivered the medicine directly to the patients.
- An ICPG pharmacy noticed that mental health patients in their area were falling through the cracks, and initiated home visits to patients who are struggling. Time was made available to help with the issues patients were struggling with – referral to housing services, food assistance, WINZ assistance, social engagement.
- An owner pharmacist wanted to proactively encourage conversations about health, rather than waiting for people to come into the pharmacy. Outreach pharmacists visited community support groups to talk about managing conditions – Parkinsons, Asthma, COPD, Diabetes, Arthritis. The outreach then expanded to schools, sports clubs, and service groups, and ultimately helped promote uptake of the Covid-19 vaccine.

Many of these initiatives are followed up with referrals to other health and social providers in the area. These referrals and integration – highlighted as necessary by the Simpson report (2020) – are only possible because of the good relationships community pharmacists have at a grass roots level. This is a fantastic service which New Zealanders rely on, and it should not be demolished for corporatisation, lower quality assurance and less equitable healthcare.

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The Independent Community Pharmacy Group (ICPG), est. 2021, is an Incorporated Society representing 115 independent pharmacy owners across Aotearoa New Zealand. Our purpose is to promote, protect and improve owner-operated community pharmacies in New Zealand. Many of our members prefer to remain anonymous to avoid any potential due to the real fear of repercussions from their local contracting bodies / Te Whatu Ora | Health New Zealand districts.