Independent Community Pharmacy Group Inc.

Briefing to the incoming Ministers: Health

December 2023

To:	**Hon. Dr Shane Reti**	Minister of Health
	Hon. Matt Doocey	Minister of Mental Health Associate Minister of Health
	Hon. David Seymour	Associate Minister of Health (Pharmac)
	Hon. Casey Costello	Associate Minister for Health
	Hon. Penny Simmonds	Minister of Disability Issues

Tēnā koutou

Congratulations on your appointments to the important ministerial portfolios of Health, Mental Health, and Disability Issues.

Through these responsibilities, you have key leadership roles to play in enhancing the health and wellbeing of all of Aotearoa New Zealand, including via easy and equitable access to vital medicines and primary healthcare for all communities, including rural communities, and people facing chronic conditions and/or mental distress.

As independent community pharmacists, we are proud to also have a role to play to achieve these goals, and we look forward to working with you to do so.

As outlined in this briefing, the high-quality healthcare provided by the independent community pharmacy sector 1. would be immediately compromised by the plan to re-introduce prescription patient copayments for most people; and 2. needs to be secured with a strengthening of ownership regulation.

We request a meeting with you and your staff to discuss these issues as soon as possible.

We also urge you to consult widely with the independent pharmacy sector before making *any* changes to primary healthcare, in order to ensure all changes will have net positive effects on the health and wellbeing of Aotearoa New Zealand, now and into the future.

Ngā mihi,

Independent Community Pharmacy Group

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 due to the real fear of repercussions from their local contracting bodies / Te Whatu Ora | Health New Zealand districts. Website: ICPG.NZ Contact: [email here]

There are serious threats facing the high-quality healthcare provided by the independent community pharmacy sector.

The plan to re-introduce patient copayments for prescriptions for most people will have serious unintended consequences. It would:

- Reduce access to vital medicines
- Reduce preventative care and early intervention for all patients (regardless of whether or not they are charged for prescriptions)
- Reduce patient safety
- Reduce continuity of care
- Reduce pharmacy sustainability, workforce retention and morale due to high "gatekeeping" administration and abuse from patients

See section 1 of this briefing for more information.

Any move toward deregulation would likely:

- Reduce healthcare access equity for rural communities
- Reduce services for vulnerable patients
- Reduce healthcare quality overall
- Reduce independent community pharmacy viability.

See section 2 of this briefing for more information.

ICPG Recommendations:

1. Keep current fees-free prescriptions for all patients, and remove the patient copayment fee from dental and specialist prescriptions.
2. Increase the share of each pharmacy that must be owned by pharmacists from over 50% to at least 75%, in order to ensure patient safety; provide a reliable foundation for innovations which enhance healthcare quality, access, equity; and provide embedded community resilience based on trusted relationships in times of crisis.

Introduction to Independent Communities Pharmacies

There are ~1000 independent owner-operated pharmacies serving communities throughout New Zealand. "Healthcare first" is the cornerstone principle for independent pharmacies: on top of dispensing medicines, pharmacists offer healthcare such as vaccinations, disease screening, patient education and medication checks, spending 15%-50% of their working day on largely-unfunded healthcare services other than dispensing.[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[1]

[1] Aziz, Y. H. A., Heydon, S. J., Duffull, S. B., & Marra, C. A. (2021). What free services do pharmacists offer? Investigating the provision of unfunded pharmacy services in community pharmacies. *Research in Social and Administrative Pharmacy*, *17*(3), 588-594.

Some of the many *unfunded* healthcare services performed by independent community pharmacies
Examples from Aziz et al (2021)[2] • 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, on home visits • Serving patients who need a particular service but who do not meet funding criteria (for example, for medicines use reviews) • Blood pressure and glucose monitoring (either free of charge or below-cost) *ICPG member reporting (see Cannons, 2023)*[3] • Phoning and visiting anxious, isolated patients during crises (eg the Covid lockdown) with practical support (medicines, groceries etc). Community pharmacies are an important part of community resilience facing disaster. • 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

Pharmacists in local pharmacies are committed long-term to their communities, building up trust and understanding over decades. They discover and nurture innovations and solutions for local needs in partnership with their communities. For example:

- An ICPG pharmacist has set up and chairs a Medicine Advisory Committee for a local 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.
- 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.

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[2] Aziz, Y. H. A., Heydon, S. J., Duffull, S. B., & Marra, C. A. (2021). What free services do pharmacists offer? Investigating the provision of unfunded pharmacy services in community pharmacies. *Research in Social and Administrative Pharmacy*, *17*(3), 588-594.

[3] Cannons, C (2023) ICPG Submission to the Health Select Committee on Pharmacy ownership. ICPG.

Section 1: Enhance community health via extending fees-free prescriptions for all

The immediate positive impacts of introducing universal fees-free prescriptions in July 2023 in Aotearoa New Zealand have far exceeded expectations,[4] supporting the case to extend patient copayment removal to dental and specialist prescriptions.

- As well as far better and more equitable access to vital medicines, benefits reported by community pharmacy staff include: better preventative care & early intervention for all patients; better safety for all patients; and better continuity of care.
- A key factor is the significant freeing up of pharmacist time, which can now be used for longer patient consultations (in 92% of community pharmacies surveyed) and other health services (in 67%) such as vaccinations, minor ailment prescribing services and cardiovascular screening. Such benefits are *systemic* effects which affect every single patient (even if they could easily afford prescriptions fees) and whole communities, as well as the individuals now able to access medicines where previously they could not.[4]

New information – which has come to light post-election – shows that the plan to reintroduce patient copayments for most people would be destabilising for the sector – equivalent to removing 128 fulltime pharmacists from the sector nationwide. This would put services and capacity in jeopardy for *all* patients, whether or not they are paying prescription fees.[4]

- The fees-free targeting plan will take up pharmacists' time with administrative red tape such as checking eligibility and assisting patients with applying for community services cards, reducing the time pharmacists have to enhance their patients' health, reducing consultations and services. We expect this time sink to be similar to that before the universal copay removal; ie, 10 hours a week per pharmacy including 5 hours of pharmacist time.[4]
- Due to targeting, pharmacy staff will face high levels of patient distress and abuse, due to misunderstandings, unmet expectations and frustrations. This will have a negative effect on workforce morale and increase sector-wide staff retention issues.

Most people earning minimum wage are ineligible for the Community Services Card, and will face prescription fees, which can reach up to $50 in a visit or more (depending on patient needs and family size). Of particular concern is families with teenagers (ineligible over 13 years old for free prescriptions), and patients facing mental distress.

- Patients living "paycheck to paycheck" but ineligible for targeting will likely again disengage with the health system to the detriment of their health, and this deterioration of health due to inaccessibility of primary health care will increase stress on and costs for the secondary and tertiary health services.[5]

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[4] McAllister, J. (2023) Better healthcare for all: Community pharmacy staff on the effects of universal fees-free prescriptions. ICPG:NZ

[5] Norris, P. et al. (2023). Impact of removing prescription co-payments on the use of costly health services: a pragmatic randomised controlled trial. BMC Health Services Research, 23(1), 1-11. See also McAllister, J. (2023) "It is devastating": 'Patient co-payment' prescription fees and their effect on communities, as witnessed by community pharmacists. ICPG: NZ.

Positive consequences of universal fees-free prescriptions	
Benefits to **all** patients	• System Change: More health services • System Change: More sustainable pharmacy futures • System Change: Pressure alleviated from the rest of the health system • More time, advice and personalised care from pharmacists • No prescription charge
Additional benefits for patients with at least some financial concerns	• Meds prescribed by need, not cost • All meds in sync/alignment • Less anxiety/worry about an unknown cost • Pharmacy choice by service & location, not dictated by cost • Continuity of care • Mitigates Cost-of-Living crisis
Further additional benefits for patients who struggle to afford medicines	• No need to pick and choose - can take home all medications • No need to wait till payday • No need to claim costs back from WINZ, ACC & NGOs • No shame about not being able to pay • No debt • No requirement for proof of eligibility

ICPG is deeply concerned by the Prime Minister's assertions on 11 December 2023[6] that, if patients cannot afford the government's prescription fees, they can simply go to corporate pharmacies who currently pay or discount the government fee on behalf of their patients as a "loss-leader" commercial strategy. Our concern is for the following reasons:

1. The directive supports the loss-leader commercial strategy of corporate pharmacies, a strategy which has deeply detrimental effects on the primary healthcare sector, putting into jeopardy the types of services mentioned above in the introduction, which are offered by independent community pharmacies but very rarely – if at all – by corporate pharmacies. Corporate pharmacies have already led to some community pharmacies closing their doors, leaving areas poorer in healthcare.

   Brooke van Velden referred to the need to ameliorate this serious situation on TVNZ Breakfast 1 May 2023 prior to the co-payment removal: "*I actually believe we should get rid of the pharmacy co-payment and it's for this reason: we've got local pharmacies who are struggling, they struggled through Covid, they were our corner shop during the pandemic, but they are in competition now with people who are using pharmacy co-payments as a loss leader. There are chains that aren't passing on that cost [to patients] because they're taking it up with other things that they're selling in store. That's pretty anti-competitive and it means that a family who might be struggling to pay for that co-payment are going to a particular store because another pharmacy is still needing to charge for that $5 co-payment. So I think just to have an even playing field for all families and also for pharmacies – it's actually a good move to have the same fair rules for everyone.*"

[6] "Christopher Luxon insists fees-free prescriptions will go" TVNZ, 11 Dec 2023

2. The directive does not address the serious administrative burden of targeting carried by community pharmacies, which will greatly reduce the time clinicians have available to enhance patient health (128 pharmacist FTE nationwide, plus a further 128 administrative/support FTE).
3. The directive removes patient choice: unaffordable fees forces patients to go to a particular health service due to cost, not due to the particular service offered or patient-provider relationship, which severely reduces patient ability to choose the most appropriate healthcare for them.
4. Prior to the introduction of universal fees-free prescriptions, patients with high health needs tended to go to corporate pharmacies until they reached the $100 (20 item) eligibility threshold for fees-free prescriptions for the year, and then they would return to their community pharmacy of choice. Being forced to do this reduces continuity of care which, in turn, reduces patient safety – potential drug-drug interactions may not be identified if prescriptions are picked up from multiple unlinked pharmacies. As one pharmacist reported in our October survey: "*It is imperative that patients on complex meds stick to one pharmacy. I witnessed hospital staff directing patients to [corporates] in order to save money, I then subsequently witnessed mistakes being made with meds due to using different pharmacies, and because multiple prescribers are involved (GP and hospital) sometimes changes are not picked up. These issues are across all socioeconomic levels*."[7]
5. The directive is impossible for many patients to follow, particularly those in rural areas. Corporate pharmacies are only accessible to some patients in limited urban areas, risking inequities "for our most under-served population" (MoH, 2019).[8]

See our April 2023 position paper on removing prescription charges for more information about how other suggested work-arounds have failed communities.[9]

In short: reinstating the patient co-payment fee on prescriptions for most people would harm physical and mental health and wellbeing, by increasing health crises, pain, shame, and unnecessary hospitalisations around the country.

Without easy access to prescriptions, patients' pain and/or illness and/or likelihood of a mental health crisis gets worse – *even after they have sought help from the health system*. Prior to July 2023, people reported going without pain relief, heart medication, and/or medication to prevent migraines, in order to afford anti-depressants; reported going without asthma prevention and thyroid medication to pick up acute asthma medication; and putting up with seizures due to needing to prioritise anti-depressants over antiepileptics.[10]

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[7] McAllister, J. (2023) Better healthcare for all: Community pharmacy staff on the effects of universal fees-free prescriptions. ICPG:NZ

[8] MoH (Oct 2019) Abolition of Pharmacy (Prescription) Co-Payments. P1. (Document 6 p26/28 of MoH OIA 3 June 2022 release)

[9] ICPG (2023) Submission to the Petitions Committee on removing prescription charges 27 April 2023, ICPG:NZ

[10] Norris, P., Tordoff, J., McIntosh, B., Laxman, K., Chang, S. Y., & Te Karu, L. (2016). Impact of prescription charges on people living in poverty: a qualitative study. *Research in Social and Administrative Pharmacy*, *12*(6), 893-902.

In March 2023, community pharmacists reported[11] that the patient co-payment prescription fee contributed to:

- Patient outcomes such as stroke, heart attack, sight loss, failed kidneys, and amputations (including amputation leading to job loss)
- Patients having to go to hospital due to breathing problems, mental health crises and infections requiring IV antibiotics
- Family stress, including exacerbating abuse and violence; and (separately) families having to choose between medicines and food
- Patients feeling ashamed and whakamā about not being able to afford the fee. (Shame adds to toxic stress, and can lead to low self-esteem, depression and despair.[12] In a previous study, a participant told researchers he forewent an anti-psychotic rather than take pharmacy charity: "Mum brought us up not to just take."[13])
- Doctors and other prescribers making treatment decisions without receiving vital information about how prescribed medications have been taken, if at all.

People will sometimes go without good food, heating and/or clean clothes in order to access their medicines, or they take less than the prescribed dose to make the prescription last longer. These forced strategies increase the risk of further illness, and needing further medicines.

These impacts not only affect the patient but can also affect their children, family and friends, support networks and wider communities, as well as placing further demand on an already over-stretched healthcare system struggling with staffing shortages. Some detrimental impacts would be immediate, and immediately noticeable, within our communities.

There is overwhelming community support to keep prescriptions universally fees-free: 86% of New Zealanders support keeping prescriptions free for everyone, making it one of the most popular policies ever in Aotearoa NZ.[14]

ICPG recommendation 1:

Keep current fees-free prescriptions for all patients, and remove the patient copayment fee from dental and specialist prescriptions.

[11] McAllister, J. (2023) "It is devastating": 'Patient co-payment' prescription fees and their effect on communities, as witnessed by community pharmacists. ICPG: NZ.

[12] Kim, S., Thibodeau, R., & Jorgensen, R. S. (2011). Shame, guilt, and depressive symptoms: a meta-analytic review. *Psychological bulletin*, *137*(1), 68.

[13] Norris, P., Tordoff, J., McIntosh, B., Laxman, K., Chang, S. Y., & Te Karu, L. (2016). Impact of prescription charges on people living in poverty: a qualitative study. *Research in Social and Administrative Pharmacy*, *12*(6), 893-902.

[14] Prescription Access Initiative (2023) Massive Support Across The Political Spectrum To Keep Prescriptions Free For All: Talbot Mills Poll 11 Dec 2023.

Section 2: Putting patients before profit: Protecting NZ pharmacy healthcare from corporate control

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[15]

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 to 75% ownership, 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 grant 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 to curb profiteering. In addition, it would be constitutionally inappropriate for Parliament to deregulate pharmacy ownership while the case is on appeal and before the courts.

ICPG does not support pharmacy ownership deregulation. Deregulation is unnecessary and/or counter-productive to all the Ministry of Health'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).[16] 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.

[15] Farquar, S. quoted in Thomas, R., (23 Feb 2023). "Pharmacists worked through cyclone by candlelight to get meds to patients". Stuff.
[16] Chemist Warehouse New Zealand Facebook post 15 February 2023.

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[17]

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.[18]

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[19]

See the table in the "introduction to independent community pharmacies" for examples of the unfunded healthcare services likely to be greatly reduced or lost if pharmacy ownership were deregulated.

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, our argument for strengthening ownership protections is about care and focus. 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[20],[21]. In New Zealand, the key factor identified as important for pharmacists when considering providing extended services are owner and management support.[22] 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

[17] Farquar, S. (23 Feb 2023).
[18] Aziz et al. (2021)
[19] Ibid.
[20] Ibid.
[21] McDonald, J., Morris, C., Pledger, M., Dunn, P., Fa'asalele Tanuvasa, A., Smiler, K., & Cumming, J. (2021). A national survey of pharmacists and interns in Aotearoa New Zealand: provision and views of extended services in community pharmacies. *BMC Health Services Research*, *21*, 1-13.
[22] Ibid.

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.[23]

Recently, overseas corporations have established pharmacies in NZ, most notably Countdown (since 2012) and Chemist Warehouse (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 could not be circumvented (so majority shareholding must be by pharmacists, ie more than not equal to 50%). 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".[24]

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).

Importantly, the courts' direction is 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", making regulation difficult.[25] 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[26];[27]. 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.

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[23] For legislation history, see Cannons, C (2023) ICPG Submission to the Health Select Committee on Pharmacy ownership. ICPG.

[24] [2023] NZHC 1486 at [310]: *New Zealand Independent Community Pharmacy Group v Te Whatu Ora* [2023] NZHC 1486.

[25] Ministry of Health (2021) Pharmacy Ownership and Licensing Regulatory Impact Statement

[26] Vogler, S., Arts, D., & Sandberger, K. (2012). Impact of pharmacy deregulation and regulation in European countries. Commissioned by Danmarks Apotekerforening (Assoc of Danish Pharmacies).

[27] Moodley, R., Suleman, F. (2020) To evaluate the impact of opening up ownership of pharmacies in South Africa. *J of Pharm Policy and Pract* 13, 28.

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[28]

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."[29] 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 business sector.

Overseas, after deregulation, pharmacists reported inadequate rest breaks[30], lower work satisfaction and higher workloads.[31] 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.[32] Commercial interests also favour 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".[33]

2. Reduced equity of access to rural areas and to Māori

The Ministry of Health (2021) acknowledges ownership deregulation means "risks to rural areas", such as stagnation and even potential reduction of rural pharmacy services,

[28] Yong, F. R., Hor, S. Y., & Bajorek, B. V. (2023). Australian community pharmacy service provision factors, stresses and strains: A qualitative study. *Exploratory Research in Clinical and Social Pharmacy*, *9*, 100247.

[29] Ministry of Health (2021) Pharmacy Ownership and Licensing Regulatory Impact Statement

[30] Bush, J., Langley, C. and K. Wilson (2009), "The corporatization of community pharmacy: Implications for service provision, the public health function, and pharmacy's claims to professional status in in the United Kingdom", Research in Social and Administrative Pharmacy, 5, 305-318

[31] Vogler et al., (2012)

[32] Ibid

[33] Bush et al. (2009)

including potential closure of community pharmacies.[34] 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.[35]

Māori are more likely than non-Māori to live in rural and small urban areas,[36] and therefore the likely increase in inequity of access for rural communities would impact Māori more than non-Māori overall.

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 should work with Māori specifically on the question of pharmacy services. 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.

3. Reduction of health services for vulnerable communities

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.[37] 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" (emphasis added).[38]

4. 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**: many jurisdictions showed dominance of corporatisation after deregulation: Norway (96%

[34] Ministry of Health (2021) Pharmacy Ownership and Licensing Regulatory Impact Statement
[35] Bush et al. (2009)
[36] EHINZ (n.d). Environmental Health Intelligence New Zealand "Urban–rural profile". Massey University webpage. Accessed 22 August 2023.
[37] Bush et al. (2009)
[38] Jo, W., Nam, H., Choi, J., 'Opening the OTC drug market: The effect of deregulation on retail pharmacy's performance" (2022) 39(3) *International Journal of Research in Marketing* 847–866.

corporate after deregulation), Sweden (86%), US (64%), and the United Kingdom (61%).[39] Ownership deregulation would primarily benefit corporate owners,[40] including those found to be operating unlawfully. Pharmacy ownership deregulation would specifically give more power to supermarkets, in the vital sector of primary healthcare, thereby undermining efforts elsewhere to curb supermarket profiteering,[41] counter to the economic and health interests of New Zealand as a whole.

5. 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. In Europe, "deregulation policies do not seem to be producing the desired effects"[42]: 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."[43] The researchers found the objectives of deregulation were sometimes not well-defined (an issue here also: the Ministry of Health's (2021) RIS 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.[44]

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.

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.

[39] Moodley, R., Suleman, F. (2020) To evaluate the impact of opening up ownership of pharmacies in South Africa. *J of Pharm Policy and Pract* **13**, 28.
[40] Vogler et al., (2012)
[41] Commerce Commission (2022) Market study into the retail grocery sector.
[42] Gallone, E. L., Enri, L. R., Pignata, I., Baratta, F., & Brusa, P. (2020). The 2017 deregulation of pharmacies in Italy: Introducing non-pharmacist ownership. *Health Policy*, *124*(12), 1281-1286.
[43] Vogler et al., (2012)
[44] Ibid.

- 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 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.

New Zealand public health leaders 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".[45] This is because "[f]lexibility for professional discretion, time per consultation and service responsiveness are informed significantly by profit imperatives and commercial responsibilities to shareholders".[46]

The same authors 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*[47]

ICPG recommendation 2:

Increase the share of each pharmacy that must be owned by pharmacists from over 50% to at least 75%, in order to ensure patient safety; provide a reliable foundation for innovations which enhance healthcare quality, access, equity;

[45] Reidy, J., Matheson, D., Keenan, R., Crampton P. (2023a), 'The ownership elephant is becoming a mammoth: a policy focus on ownership is needed to transform Aotearoa New Zealand's health system' 136(1576) *New Zealand Medical Journal* 74–81.

[46] Ibid.

[47] Reidy, J., Matheson, D., Keenan, R., Crampton P. (2023b), "Ownership matters: using ownership as a policy tool for reaching health system goals" Country Connector on Private Sector in Health (CCPSH), WHO.

and provide embedded community resilience based on trusted relationships in times of crisis.