Reducing the burden associated with bureaucratic practice in primary care: a welcome move by PHARMAC

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A degree of criticism has been levelled at the Pharmaceutical Management Agency (PHARMAC) with respect to the compliance costs associated with policing General and Other rules associated with the Pharmaceutical Schedule.1 The November 2011 Update to the Pharmaceutical Schedule is a refreshing change.2 It is likely that this administrative burden has negatively impacted on the way in which community pharmacists have practised. These types of compliance interventions have dominated daily practice1-3 and the bureaucratic nature of the primary care environment has been reported by pharmacists to be a barrier to the implementation of a vision which would see them more involved with patient-based care.4

This sort of ‘pharmacop’ activity potentially displaces the time that could be spent counselling consumers and working with primary care colleagues.1,4-5 A component of the dispensing fee relates to this activity and our nation spends significant amounts of money paying pharmacists to dispense prescription items that are handed to consumers by pharmacy assistants, whilst pharmacists attend to the next compliance-associated query on a prescription. This process is not only frustrating for pharmacists and prescribers, but for consumers who have no insight into the administrative requirements and the resulting delays in ‘getting their medicines’. Additionally, this has probably not been the best use of taxpayers’ money.

On the flipside, these changes mean that community pharmacists should theoretically spend less time chasing prescribers and more time undertaking duties associated with patient care. One thing is certain; there must surely be fewer complaints from the community pharmacy sector about the bureaucratic requirements generated by PHARMAC policy.6 As we see it, what is less certain is whether the excessive time spent dealing with administrative issues will be switched to activity which is associated with improved patient outcome. PHARMAC is attempting to do their bit and, now it is time for the community pharmacy sector to step up to the plate and become more clinically focussed, with the extra time they will have. We know that representative samples of New Zealand community pharmacists are generally keen to do so;7,8 however, there are significant barriers to doing so5,9 and one of these has just been removed.

Of course, the impact of such a policy change requires evaluation in order to fully understand the ramifications. Before and after studies are required to answer this question. There is baseline data available (albeit from some time ago), but often the evaluation of policy intervention comes as an afterthought; or not at all. In short, this is a welcome move by PHARMAC and hopefully just the start of a series of wide-ranging changes which will see a reduction in administrative burden and more time spent delivering primary health care.

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References

Consider loneliness with depressed older adults

It was positive to read the article about a problem-solving approach to treating patients with depression in last month’s issue.1 Barriers to implementation under a fee-for-service model appear to be that it will require training of the GP workforce, buy-in from GPs, and a considerable amount of GP time per patient.

As an alternative, Age Concern suggests that GPs consider whether loneliness is a factor when patients present with anxiety and depression. Research now shows that loneliness can have serious health effects including depression, cognitive deterioration, entry to rest home care, and mortality in older adults.2 Recent New Zealand research has shown that over