

Community pharmacy does not appear as part of the collaboration discourse within New Zealand primary care

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I read with interest the *Viewpoint* by Professor Jenny Carryer in the *Journal of Primary Health Care* relating to collaboration between doctors and nurses within the New Zealand (NZ) primary health care sector.¹ Prof. Carryer should be congratulated for bringing to the surface some of the discourse around interprofessional collaboration through the recent work she has been conducting. It is pleasing that collaboration within primary care is getting more attention, gaining traction and to some extent is 'bedding in' at the coalface of NZ general practice.

This encouraged me to write from a pharmacy perspective, spurred on by the introductory

primary care workforce in addition to doctors, nurses and pharmacists, including dietitians, physiotherapists and mental health workers to name a few. This paper is founded on the realisation that one of the most common medical interventions is the prescribing of medication, and, as such, community pharmacists are in some way or other involved in most primary care consultations. As such, I address a significant yet incremental change in calling for the 'addition' of community pharmacy into the discourse around collaboration at multiple levels.

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quote by Steele which omits the place of the pharmacist in delivering primary health care.² Collaboration amongst the multidisciplinary team needs to be repositioned as a three-way affair, including doctor, nurse and pharmacist as the core, whilst being inclusive of other health professions. The multidisciplinary team is a broad term that is often used, and is poorly defined both in policy and practice, with the expectation that everyone knows what a multidisciplinary team 'looks like' and knows how its constituents interact. There are many other 'allied' health professionals that contribute significantly to the

to move forward under an agenda of interprofessional socialisation. There are many reasons why there is little discourse of three-way collaboration and, in this viewpoint, I provide some of the reasons and suggest next steps to continuing the impetus for wider dialogue from policy, practice and academic viewpoints. There is no denying that general practice is the hub of primary care service delivery in NZ. In the main, general practice continues to be well supported by Primary Health Organisations (PHOs) and through capitation-based funding mechanisms appear to be financially better off than they

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were previously. The same applies to population-based programmes.

This level of support from policy through to implementation far exceeds that of other professional groups such as community pharmacy. At the meso level, the level of health funding, planning and implementation, supportive policy for general practice is evidenced by the morphing of many Independent Practitioner Associations (IPAs) into PHOs whose governance structures seemed to have changed in very subtle ways. Anecdotally, it seems that general practice and to some extent nursing are well represented at a governance level while community pharmacy has struggled to find a way in. This anecdote requires further research.

High level representation of medical and nursing practitioners within health policy circles is a good thing. General practice needs to be sustainable and doctors and nurses must be supported to deliver care. However, in other respects, having a dominance of one or more practitioner groups at the exclusion of others is contra to macro health policy, which calls for equitable, convenient and high quality health care through technological integration, multidisciplinary teamwork and well supported system-wide change. Collaboration is hard to achieve at the ground level, particularly if it is not supported by policy discourse. At the higher level of policy development neither the New Zealand Primary Health Care Strategy^{3,4} nor *Better, Sooner, More Convenient* primary health care⁵ makes explicit the involvement of pharmacy within the health care sector. Medicines New Zealand⁶ is more of an implementation strategy than a high level policy document and, as such, does highlight the need to involve community pharmacy, albeit in an implicit fashion.

The notion from the quote by Steele² that no single discipline can effectively deliver health care was made in the context of increasing levels of complexity of illness and associated service provision way back in the mid-80s. Levels of complexity have increased further since the mid-80s, particularly in the area of pharmacotherapy. The two disciplines of doctoring and nursing, interwoven as their roles are, may not be in a position to deliver optimal health care without the services of the community pharmacist.

The point has been made that nurses haven't felt part of the team, and research highlights that pharmacists in NZ express similar sentiments.^{7,8} Pharmacists may be even more removed, especially through not being a formal member of the general practice team. This is expected to change with the introduction of Integrated Family Health Centres (IFHCs) through National Government policy, but surely it is not that simple! Perhaps more collaboration needs to take place between the nursing fraternity and pharmacy at all levels; after all, these two professions are under a similar power discourse. The pharmacy profession has much to learn from the experience of the nurse practitioner. It would appear that in NZ the nursing profession has been particularly good at putting itself forward for advanced roles. Pharmacy has not demonstrated this same

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vigour.^{7,9} The more confident and clear nurses are about their autonomy and role, the more they are respected and the easier they achieve collegiality and collaboration with doctors;¹ pharmacy could learn from this.

Research on 'the pharmacist' suggests that generally they are keen to adopt new enhanced services that will optimise patient health care and potentially relieve some of the burden placed on general practice through, for example, management of minor ailments.⁹ Despite pharmacists' interest in participating in these activities, significant barriers have been identified.^{7,8} It seems from Carryer's article¹ that pharmacy may be in a similar climate to that of the nursing profession prior to the development of the nurse practitioner role. Barriers for pharmacy re-professionalisation include external factors such as systems and teamwork, manifesting as patch protection by doctors and relationships with health planners and funder stakeholders.⁷ Equally

important are internal factors labelled 'pharmacist humanistic' which describe how pharmacists think and act and include such characteristics as lack of professional voice, inward thinking and being negative about the current health care environment.⁷ This suggests that pharmacists are in some ways their own worst enemies for moving forward.

In line with this, doctors are perceived by pharmacists as being a barrier to collaboration and re-professionalisation through enhanced service provision and the uptake of new roles.⁷ However, this may be less of an issue than pharmacists think. Like nurse practitioners, as long as pharmacists are well trained and trusted by other health professionals, then this seems to facilitate collaboration. Bryant reports a gap in general practitioner perceptions regarding the role of NZ community pharmacists, with general practitioners more readily accepting pharmacists' techni-

port from the health care sector to allow greater collaboration to take place.¹¹ There is some alignment between pharmacy and nursing regarding this, which is a recent change from how it was a decade ago. The challenge of lifting the collaboration discourse to the policy and legislative table is as difficult through the eyes of the pharmacy profession as it is for nursing, and perhaps more so. A recent commentary in the *New Zealand Medical Journal* highlights the implications of policy for the whole sector with respect to community pharmacy. It would appear that relationships between community pharmacy and funder-stakeholders and other health care providers need to improve at the coalface for true three-way collaboration to occur.¹¹

One strategic approach to progress the collaboration discourse across the whole of the primary care sector is through a research agenda centred on the application of Social Network Analysis

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cal roles than their clinical roles.¹⁰ Barriers to increased involvement of community pharmacists in clinical services included a perceived lack of mandate, legitimacy, adequacy, and effectiveness. This aligns with work I have been involved with which suggests that pharmacists have a high degree of agreement around undertaking traditional roles, but demonstrated a more tempered response to the adoption of new enhanced clinical or collaborative roles.⁹

Historically, policy makers have been calling for increased multidisciplinary teamwork and collaboration in both their policy^{3,5} and their implementation plans.⁴ Now it is the health professionals themselves and their academic representatives who are calling for more sup-

(SNA).¹² There is general acceptance that the development of relationships is central to collaboration, and networks develop through social interaction usually around common interests or goals.¹² Social networks manifest within and across organisations and may influence the functioning of the health system as a whole. Cutting through and across levels of health care, SNA can help us to understand the interprofessional communication taking place and identify who the important players are, who is engaged, and, more importantly, who is not. Individuals within a network complete a survey of the interactions they have with others and an SNA pictogram is generated. The pictogram can be used in multiple ways, but most commonly to identify interactions and those individuals who

are most or least engaged within a network. This is valuable for health planners and implementers who will be in a better position to understand who the key influencers might be within a network. Another powerful application is as a change management tool which can be applied in an action research fashion.

The pictorials previously described can be used to provide feedback to individuals or organisations immersed in health systems which may or may not be 'interacting'. Feedback can be obtained through interview using findings from the SNA pictogram analysis as anchor points for discussion about the networks, providing a deeper and richer understanding. In this way SNA is expected to be a powerful way of facilitating interprofessional collaboration through feedback to networks about the communication that is taking place.

This theory and the associated method has been applied to the identification of social interactions between individuals within general practice.¹³ There is no reason why this approach cannot be applied to the broader primary care network, including all of the 'allied' groups outlined previously. This tool could help to answer the question 'what constitutes the multidisciplinary primary care team?' There are a couple of SNA projects underway in Auckland, including one exploring social networks across primary and secondary care and the impact on performance in managing chronic care patients; the other is a primary care project about collaboration which focuses on community pharmacy within the wider team.¹⁴

In summary, there is no denying that collaboration in primary care is on the increase, albeit between doctors and nurses. This is probably due in equal measures to health policy expecting it, doctors realising it is inevitable, and some seeing benefit in it. The solid and proactive stance that the nursing profession takes with regards to its own re-professionalisation agenda also assists this. Currently the same cannot be said for community pharmacy. There is a need for pharmacy to 'help itself' and to 'gain a stronger voice',⁷ but equally, the wider primary care sector needs to be supportive of this.¹¹ There are nursing and medical advisors at the policy-making level within the Ministry of Health, yet there is no position

for pharmacy and pharmacy has no voice at this level. Equally, there is little discourse and many barriers to three-way collaboration, and yet the expectation by policy makers is that multidisciplinary teamwork will be commonplace.¹¹ As

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such, this paper calls for an increased awareness of three-way rather than two-way collaboration at the levels of policy making, funding and planning and within academia. It is hoped that this will go some way toward supporting a greater level of integration at the coalface.

References

1. Carryer J. Collaboration between doctors and nurses. *J Prim Health Care*. 2011;3(1):77–79.
2. Steele JG, editor. *Issues in collaborative practice*. Orlando, Florida: Grune & Stratton; 1986.
3. Ministry of Health. *New Zealand Primary Health Care Strategy*. Wellington; 2001.
4. Ministry of Health. *Primary Health Care Strategy: Implementation Work Programme 2005–2010*. Wellington; 2005.
5. Ministry of Health. *Better, sooner, more convenient primary health care*. Wellington; 2007.
6. Ministry of Health. *Medicines New Zealand*. Wellington; 2007.
7. Scahill SL, Harrison J, Sheridan J. The ABC of New Zealand's ten year vision for pharmacists: awareness, barriers and consultation. *Int J Pharm Pract*. 2009;17(3):135–142.
8. Harrison J, Scahill SL, Sheridan J. New Zealand pharmacists' alignment with their professional body's vision for the future. *Res Soc Admin Pharm*. 2011; in press.
9. Scahill SL, Harrison J, Sheridan J. Pharmacy under the spotlight: New Zealand pharmacists' perceptions of current and future roles and the need for accreditation. *Int J Pharm Pract*. 2010;18(1):59–62.
10. Bryant L, Coster G, Gamble GD, McCormick RN. General practitioners' and pharmacists' perceptions of the role of community pharmacists in delivering clinical services. *Res Social Admin Pharm*. 2009;5(4):347–362.
11. Scahill SL, Carswell P, Harrison J. Community pharmacy and health care policy: implications for the whole of primary care. *N Z Med J*. 2010;123(1317):41–51.
12. Scott J. *Social network analysis: a handbook*. 2nd ed. London: Sage; 2006.
13. Scott J, Tallia A, Crosson JC, et al. Social network analysis as an analytic tool for interaction patterns in primary care practices. *Ann Fam Med*. 2005;3(5):443–448.
14. Carswell P. *Social network analysis project: pharmacy integration within primary care*. Personal communication. Auckland; August 2010.

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COMPETING INTERESTS

None declared.