

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

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.<sup>1</sup> The November 2011 Update to the Pharmaceutical Schedule is a refreshing change.<sup>2</sup> 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 practice<sup>1,3</sup> 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.<sup>4</sup>

This sort of 'pharmacop' activity potentially displaces the time that could be spent counselling consumers and working with primary care colleagues.<sup>1,4,5</sup> 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.<sup>6</sup> 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;<sup>7,8</sup> however, there are significant barriers to doing so<sup>4,7,9</sup> 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.

*Shane Scabill and Zabeer Ud-Din Babar, School of Pharmacy, University of Auckland, and Associate Professor Amanda Wheeler, School of Human Services, Griffith University, Brisbane*

#### References

1. Scahill SL, Harrison J, Carswell P, Shaw J. Health care policy and community pharmacy: implications for the New Zealand primary health care sector. *NZ Med J.* 2010;123(1317):41–51.
2. Update to the Pharmaceutical Schedule, November 2011: The Pharmaceutical Management Agency, Wellington, New Zealand.
3. Bryant LJM. Evaluation of the barriers to and implementation of comprehensive pharmaceutical care in New Zealand, PhD thesis, University of Auckland; 2006.
4. 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.
5. Harrison J, Scahill SL, Sheridan J. New Zealand pharmacists' alignment with their professional body's vision for the future. *Res Soc Admin Pharm.* 2010; In Press, Corrected Proof, doi:10.1016/j.sapharm.2010.12.001.
6. Babar Z-U-D, Grover P, Stewart J, et al. Evaluating pharmacists' views, knowledge, and perception regarding generic medicines in New Zealand. *Res Soc Admin Pharm.* 2011;7(3):294–305.
7. Crump K, Boo G, Liew FS, et al. New Zealand community pharmacists' views of their roles in meeting medicine-related needs for people with mental illness. *Res Soc Admin Pharm.* 2011;7(2):122–133.
8. 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.
9. Dunlop J, Shaw JP. Community pharmacists' perspectives on pharmaceutical care implementation in New Zealand. *Pharm World Sci.* 2002;24(6):224–230.

#### 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.<sup>1</sup> 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.<sup>2</sup> Recent New Zealand research has shown that over

Letters may respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary health care. The best letters are succinct and stimulating. Letters of no more than 400 words may be emailed to: [editor@rnzcgp.org.nz](mailto:editor@rnzcgp.org.nz). All letters are subject to editing and may be shortened.

half of older people are lonely some of the time, and 8% are severely and chronically lonely.<sup>3</sup>

Where loneliness is a factor, we suggest that GPs consider referral to community-based interventions such as one-to-one visiting, or social/supportive group activities. The Ministry of Health has evaluated these types of intervention as being effective for socially isolated older people.<sup>4</sup>

As an example, the Age Concern Accredited Visiting Service (AVS) client satisfaction surveys show that 86.6% of respondents feel happier for having a visitor. A case example sent in by a service coordinator demonstrates the potential benefits of the relationships formed:

An 84-year-old client was widowed three years ago. She was increasingly anxious about security and paying bills, and would continually go down to the local Health Service and talk to the nurses, who were very busy. Age Concern matched her up with a visitor. This client no longer 'bothers' the local health services, but pops in occasionally, and tells them about the new 'daughter' Age Concern found for her."

Local Age Concerns around the country provide a range of social support options for older people including the AVS. They also hold information about services available through other organisations.

The following groups of older people have been identified as being disproportionately at risk for loneliness:<sup>5</sup>

- lower socioeconomic groups
- the widowed

- the physically isolated
- people who have recently stopped driving
- those with sensory impairment
- the very old.

We ask that GPs explore whether loneliness is a factor when patients from the above groups present with depression, anxiety, or non-specific symptoms, and that they remain abreast of community-based referral options for people whose primary need is for more company.

*Louise Rees*

*Professional Adviser, Age Concern New Zealand*

#### References

1. Hassink-Franke L. et al. Effectiveness of problem-solving treatment by general practice registrars for patients with emotional symptoms. *J Prim Health Care*. 2011;3(3):181–189.
2. Hawkey LC, et al. From social structural factors to perceptions of relationship quality and loneliness: the Chicago health, aging, and social relations study. *Journal of Gerontology: Social Sciences*. 2008;63B(6): 375–384.
3. Neville S, LaGrow S, Alpass F. Loneliness in older persons. Paper presented at the New Zealand Association of Gerontology and Age Concern New Zealand Conference, Wellington, New Zealand. 7–9 October, 2009.
4. University of Auckland contracted by Ministry of Health. An evaluation of befriending services in New Zealand—Final report. 2004 [cited October 2011]. Available from: [http://www.moh.govt.nz/moh.nsf/pagesmh/6127/\\$File/befriending-report.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6127/$File/befriending-report.pdf)
5. Age UK. Loneliness and isolation evidence review. 2010 [cited 2011 October]. Available from: [http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Evidence\\_Review\\_Loneliness\\_and\\_Isolation.pdf?dtrk=true](http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Evidence_Review_Loneliness_and_Isolation.pdf?dtrk=true)

## BOOK REVIEWS

### Miracle Pill: Will You Take the Polypill?

Shaun Holt

Reviewed by **Linda Bryant** MCLinPharm, PhD, FHZHAP, FNZCP, FPSNZ, MCAPA, NZRegPharm; Clinical Advisory Pharmacist, Comprehensive Pharmaceutical Solutions

A controversial concept that has often generated great debate by medical practitioners and pharmacists, usually in the extreme, has been well debated in this easily read and informative book. The book is written for the public in a chaty and informative style, with the first half explaining what cardiovascular disease is and the medicines to treat this. The second

half provides the debate about the concept of the polypill, particularly for primary prevention. Yet, any health professional would enjoy the book as it is easily read and the first half could be skimmed, getting straight to the controversy.

Providing an explanation about cardiovascular disease for the public, and then

discussing the controversy and the pros and cons of the polypill is an aim of the book, and that is achieved. As clearly indicated in the title, the book discusses cardiovascular disease and medicines, plus the development, or lack, of the polypill, finally leading to two chapters debating the pros and cons of the polypill—the concept proposed by Wald