PSI
THE PHARMACEUTICAL SOCIETY OF IRELAND
Cumann Cógaiseoirí na hÉireann
THE PHARMACY REGULATOR

18 Shrewsbury Road,
Ballsbridge, Dublin 4,
Ireland.

T. 01 218 4000
F. 01 283 7678
E. info@pharmaceuticalsociety.ie
W. www.pharmaceuticalsociety.ie

Submission from the Pharmaceutical Society of Ireland to the Expert Group on Resource Allocation and Financing in the Health Sector

Introduction

The Pharmaceutical Society of Ireland (PSI), the Pharmacy Regulator, is pleased to submit this response to the recent call for submissions from the Expert Group on Resource Allocation and Financing in the Health Sector which was established to examine how the existing system of resource allocation within the Irish public health service can be improved to support better the aims of the health reform programme which are:

- Better Health for Everyone
- Fair Access
- Responsive and Appropriate Care
- High Performance

The PSI is a body established under the Pharmacy Act 2007 and its duties include to "give the Minister such information and advice about such matters relating to its functions as the Minister may call for", and "to take suitable action to improve the profession of pharmacy".

This response sets out the strengths and weaknesses of current resource allocation arrangements in regard to the pharmacy sector and recommends a radical shift in the way the sector is managed, having regard to its significant potential contribution to enhanced frontline services which can further support home care, 'self care' and cost-effective care at the lowest levels of complexity.

This submission identifies significant advances that can be made by moving patients from traditional primary care settings to a care regime under the expert supervision of an effective community service incentivised to provide a cost-effective professional service that delivers patient value, public value and best outcomes for patients.

Recommendations

To analyse the strengths and weaknesses of the current resource allocation arrangements for health and personal social services

- Ireland's healthcare system needs to be more effective in planning for, and meeting, the normative needs of its population, and in dealing effectively with the inherent conflict between the economics for providing for patient needs and the felt need/demand of patients for immediate instant care irrespective of the economic cost. A five-year strategic plan for pharmacy services should be

developed by the Department of Health and Children. This plan should be the basis of and a prerequisite to remodelling the resource allocation arrangements for pharmacy services. This strategic plan should ensure adequate and proper arrangements for continuing professional development of pharmacists and other staff as a component part of a funding system. The strategic plan should also ensure that performance and evaluation criteria are consistent with delivering the best outcomes for patients.

- Currently there is no evidence based, objective approach for allocating resources to pharmacy in hospitals or community services. A cost effective pharmacy service will make a further significant contribution to patient value. Re-allocation of resources from within the current health service will ensure further services can be provided more cost-effectively through pharmacies which would deliver significant benefits to both patients and the public purse.

- The schemes referred to in this submission are established under Section 59 of the Health Act 1970 (as amended) and are demand-led, with little or no discretion to take account of patients' normative needs or the cost to the taxpayer. Under this section, once a prescription has been issued to a patient then the patient has an entitlement to receive the prescribed medication or product regardless of any advice received from professionals such as medical practitioners or pharmacists. A model whereby patients are encouraged and required to nominate/register with a pharmacy of their choice (for example, as pertains under the High Tech Scheme) where they are provided with structured, systematic and consistent advice and clinical support, through the most cost-effective options for the patient and the taxpayer, should be extended to all patients who have a continuing care requirement, such as those with chronic illness.

- A new contract must be devised which provides adequate compensation for the professional inputs of pharmacists, including the clinical support they deliver. Pharmacists should be incentivised to support the best outcomes for patients and to ensure the delivery of the most cost-effective options of care and treatment for the tax-payers and for private patients.

To recommend appropriate changes in these arrangements, which would support and incentivise the achievement of the core objectives of the health reform programme

- The role of a pharmacist in a community or hospital setting as an autonomous clinician, with expertise in medicines, should be reflected in any new incentivised, contractual or direct employment system. Any system of funding must facilitate pharmacists in having an active and meaningful direct impact on clinical care and treatment of patients and the public. A model based on the "free market" should be discouraged and instead the normative need of the patients and population should be the driving forces behind a new generation of pharmacy services. Restrictions on new pharmacy openings should be considered and a methodology that optimises fair access for patients and ensures pharmacies are located where need is identified, should be developed.

- A strategic plan for pharmacy should examine carefully how to incentivise and enhance the ratio of pharmacists to pharmacies. It will be necessary to re-model and further develop clinical pharmacies to meet the needs of patients and the enhanced services they will provide in future. There is a need to develop and foster models where pharmacies are networked into primary care structures. Any new system must support networking and foster the autonomy and independence of pharmacies,

and protect them from inappropriate fiduciary and financial controls by medical and other prescribing professionals. The availability and accessibility of pharmacies should mean that patients and the public are supported and encouraged to use pharmacies as the significant first 'point of contact' in a new primary care system, where community pharmacies would be considered a more appropriate setting for the delivery of certain core elements of diagnosis and treatment.

- The public hospital pharmacies and senior hospital pharmacy personnel must be brought to the heart of the decision-making at the highest levels in clinical directorates and clinical networks, to ensure the most cost effective pharmaceutical care and treatment is available throughout all aspects of our hospital and treatment system. Key elements of our health services do not presently have the active direct professional involvement of pharmacists at clinical decision making level. The consequential deficits in areas such as mental health and the care of older people and those who have a high dependency on certain medications are well documented. Another case in point is the pharmaceutical care and treatment provided by the health system in our prisons, needs to be brought up to international evidence-based standards.

- Hospital pharmacy services are vey under developed by international standards. Best practice in other countries would suggest the need to develop advanced clinical pharmacy practitioners in areas such as cancer services, infection control, respiratory and endocrine disease. The active direct involvement of senior pharmacy personnel at the highest levels in acute hospital system will maximise the evidence based decision making that is essential to achieve best outcomes for patients with episodic or continuing care and treatment requirements. The Irish healthcare system has yet to realise its real potential in areas such as acute care. Hospital pharmacy component inputs must be dramatically increased to ensure best practice and cost effective outcomes are available to patients and the taxpayer.

- There exists are real opportunity for integrating the three schools of pharmacy directly into our health service system to ensure outputs from the schools in terms of graduates, postgraduate personnel and research personnel contribute in a meaningful way to the future delivery system. The schools of pharmacy should be charged with enhancing the competency of existing practitioners and delivering effective continuing professional development programmes which are easily accessible to all pharmacists.

- Pharmacy Services in other countries, for example the United Kingdom (UK), Australia, New Zealand, Canada and the United States are utilising evidence based approaches in the modernisation and enhancing the cost effectiveness of their pharmacy services. Pharmacy services in these jurisdictions are discharging increasing levels of essential frontline services, with an increasing potential to support home care, 'self care' and effective care at the lowest levels of cost and complexity. Examples of increased pharmacy services which are currently happening in other jurisdictions and are further outlined in this submission are minor ailment schemes, medicines management reviews and immunisation programmes. Introduction of schemes such as these into the Irish healthcare system would provide significant benefits to patients and would lead to significant savings to the public purse.

- Approved evidence based protocols and formularies should be developed for prescribing and dispensing, involving all stakeholder bodies including PSI, Health Information Quality Authority

(HIQA), Irish Medicines Board (IMB), Medical Council, Irish College of General Practitioners (ICGP), Colleges of Psychiatry, Schools of Pharmacy and Medicine. The most cost effective generic option where such is available should always be prescribed and dispensed. The State should direct and encourage pharmacists to deliver the most cost effective generic option where appropriate.

- The Pharmacy Act 2007 introduced a professional clinical management structure for pharmacies. There is now a need to develop a clinical management structure within the health service which includes pharmacy expertise with active involvement at senior management level across the health services.

In the light of its examination, to consider whether changes in the existing arrangements for financing public health services may be required for improved resource allocation and, if so, to make whatever recommendations it considers appropriate in this regard

- Changes in the existing arrangements for financing public pharmacy services are required and resource allocations must be made having regard to specific goals and targets of the health system and in particular the outcomes required from that health system. Resource allocation must incentivise pharmacist input, in both hospital and community pharmacy. The outcomes for patient care must be uppermost in the minds of pharmacy personnel and those resourcing the pharmacy services. Patients in need of episodic care and treatment require evidence-based protocol and formulary driven prescribing and dispensing practice to be applied. In the case of patients with a long-term requirement for medicines, it is imperative that their prescribing and dispensing is driven by evidence-based protocols and formularies that are agreed by all of the frontline health professionals. This is essential to ensure that persons with mental illness, cardiac disease, endocrine disease, respiratory disease, auto-immune disease, and those in remission from cancers and other conditions, secure the best possible outcomes.

- Pharmacies are easily accessible and available and they should be encouraged and incentivised to take lead roles in primary and secondary prevention in areas such as the management of obesity, smoking cessation, immunisation against influenza or pneumonia, cardiac assessment and monitoring and detection of other systemic disease. Protocols will need to be developed to ensure that pharmacy is better integrated with general practice, hospital services and specialist services such as mental health. Pharmacy has the potential to be at the heart of the development of the most cost-effective interventions when it comes to medicines and therapeutic regimes in Ireland. Four million visits to GPs and Accident and Emergency were avoided in 2007 because of patient pharmacy consultations. The re-allocation of significant additional resources to clinical pharmacy services is likely to further enhance cost-effective solutions to a cash-strapped Exchequer.

To base its examination and recommendations on the existing quantum of public funding for health

- The potential arising from the accessibility and availability of pharmacist care and treatment cannot be overemphasised. There is a need to resist the temptation to ‘over-medicalise’ pharmacy care and treatment in care and treatment settings. Services provided by pharmacists and pharmacies go much wider than this, they provide professional advice and counselling both in relation to medicine, healthcare, lifestyle, diet and many other areas. There is a need for a new contractual agreement for

community pharmacy and a major expansion of hospital service provision following consultation and dialogue between key service providers, healthcare professionals and stakeholders. One example where the transfer of existing resources in health to community pharmacy that has been successful in other jurisdictions is the expansion and development of the role of pharmacies in preventing influenza and pneumonia amongst high-risk patients. Another intervention is the use of pharmacies to deliver on the prevention of cardiac disease by making readily available, through pharmacies, medication to control cholesterol levels and lipids which are primary causes of cardiac disease.

Advancing Clinical Pharmacy Practice in Ireland

The Interim Report of the *Pharmacy Ireland 2020* Working Group of the PSI, on "Advancing Clinical Pharmacy Practice to Deliver Better Patient Care and Added Value Services",http://www.pharmaceuticalsociety.ie/Publications/upload/File/Publications/PSI%20Interim%20Report%20April%2008.pdf makes recommendations in relation to an enhanced role for pharmacy in the following areas:

- Chronic disease management
- Medication error reporting
- Pharmaceutical care
- Medicines management
- Medication use reviews
- The development of a national minor ailments scheme
- The development of national training programmes to address the requirements for additional skills development for currently registered pharmacists to implement the recommendations
- Reclassification of medicines
- Prescribing competencies for pharmacists with prescribing authority
- The further utilisation of clinical pharmacy in hospitals

The Report recommends that a national policy be developed for each of the elements listed above. In making its case the Report cites examples of where cost savings could be achieved by advancing pharmacy services in line with international practice. Some examples include:

- Management of chronic diseases currently characterised by under treatment, failure to achieve guideline management goals leading to unnecessary morbidity, mortality and increased healthcare costs.
- Adverse drug reaction currently leading to increased hospital admissions.
- Medication error being responsible for 13% of hospital admissions according to HIQA.
- Pharmaceutical care of diabetes, chronic obstructive pulmonary disease, heart failure and general cardiovascular disease are likely to be more clinically and cost effective approaches than the present arrangements.
- Needle exchange programmes can reduce the incidence of infectious diseases
- Evidence is accumulating that pharmacists managing and evaluating medicine use in hospitals can improve patient care and costs the cost savings due to antibiotic management by pharmacists in UK hospitals are estimated to have saved from £23,000 in one hospital to £500,000 in another per year. The management of the use of proton

pump inhibitors (PPIs) in hospitals and managing stocks of medicines also lead to cost savings, (in this regard the Interim Report points to a serious underdevelopment of hospital pharmacy practice in Ireland).

Based on the recommendations of the Interim Report, the PSI has requested the Economic and Social Research Institute (ESRI) to prepare two proposals for the Pharmacy Ireland 2020 Working Group. One of these proposals will outline how the ESRI could provide an economic model for three projects relating to patient outcomes in regard to pharmacy, for example how pharmaceutical intervention can improve patient outcomes, and can increase adherence to therapy in patients with certain illnesses, e.g. diabetes and heart failure.

The second proposal involves examining the broader context of different models of pharmacy in other countries and would provide a cost benefit analysis as to what the implications and impact would be if pharmacists were given an increased role in healthcare in Ireland.

International Experience

The lack of involvement of community pharmacy in the provision of frontline health services in Ireland is at variance with the situation internationally. In Ontario, $5M is provided annually to support evidence based research on the impact of drugs on patient outcomes. $50M in compensation is provided to pharmacists for medication reviews to improve patient safety and treatment and is seen as a professional service provision. In Australia, the advantage of the accessibility of community pharmacists has prompted the government to support consumer education and advice on healthcare lifestyle choices that could reign in the cost of chronic diseases. This includes community pharmacists being involved in programmes on obesity, smoking and alcohol use. Over 80 health topics are covered by self care projects. Services provided include blood pressure measurement, cholesterol screening, advice on common ailments, participation in community health programmes and the distribution of health education material. Pharmacists are also paid to conduct medication reviews in patients' homes and in residential care settings.

More than twenty years ago, the UK National Health Service began to develop policies which utilise community pharmacy as a frontline professional service rather than merely medication supply outlets. The service includes a set of nationally agreed essential services to be provided by all community pharmacist contractors, nationally specified advanced services requiring pharmacies to be accredited for the purpose, and enhanced services to be commissioned and funded by primary care trusts. Public health activities are integral to all three and one of the essential services is the promotion of healthy lifestyle and involvement in national and local campaigns.

A recent UK NHS White Paper states that "Pharmacy has much to offer in helping to meet rising expectations – not only in promoting better health and preventing illness but also in the effective delivery of care closer to home and in the community."

The White Paper proposes improvements which would include:

- Expanding the range of medicines available over the counter to treat the conditions that pharmacists can be involved in

- Pharmacists treating more people for common minor ailments on the NHS
- Recommending the use of the NHS LifeCheck service to help people to assess their own health and undertake behaviour change to support a healthier future
- Taking on a much more visible and active role in improving the public's health through the provision of stop smoking services, sexual health services such as chlamydia screening and access to contraception, immunisation services and administration of vaccines.
- Supporting people with long term conditions (e.g. diabetes or asthma) to improve their quality of life, health and wellbeing and to lead to as independent a life as possible by supporting self care
- Supporting better use of medicines
- Blood testing and interpretation of results for cholesterol levels, and helping to deliver screening programmes
- Close involvement in developing clinical pathways that support integrated care.
- Improving patient safety in hospitals and in community through leadership on the safe and effective use of medicines.

A number of pharmacy chains in the UK provide the range of the services described above.

In Scotland, the devolved system of Government has lead to a more enhanced role for pharmacists than in the rest of the UK. In Scotland the system of community pharmacy provides four core services – the acute medication service, the minor ailments service, the chronic medication service and the public health service. The system has moved away from dependence on payments by volume with two of the core services to be funded on a capitation basis. A brief explanation of the services is given below.

The acute medication service – this is where a pharmacist dispenses medication on a prescription for an acute condition and is paid for on a per item dispensed basis.

The minor ailments service – here patients who are exempt from prescription charges can have minor ailments treated free of charge in a pharmacy. To use the service patients have to register with the pharmacy. The pharmacist assesses the patient and offers treatment and advice, advice only or referral to another health professional. Payment is on a capitation basis determined by the number of patients registered, plus reimbursement for the cost of medicines supplied. Speaking of this scheme, the Head of Corporate Affairs at Community Pharmacy Scotland stated "Patients like it and pharmacists like it and it has really started to make a difference in the pharmaceutical care of patients who are exempt from NHS prescription charges. What I am most pleased about is that it is improving access to consultation, advice and medicines for common illnesses and allowing community pharmacists to prescribe where appropriate" According to the Interim Report referred to above, there are 70,000 consultations a month in Scottish pharmacies that previously would have taken place in GP surgeries and the average cost of medicines prescribed by pharmacists under the scheme is lower than those prescribed by GPs under the same circumstances.

The chronic medication service – This scheme enables a pharmacist to manage a patient's long-term medication for a year. Medicines are provided, monitored reviewed and, in some cases, adjusted as

part of a shared care agreement between the patient, the GP and the community pharmacist. Payment is made on a capitation basis and patients are required to register with the pharmacist.

The public health service – under this scheme pharmacies provide information on public health issues and create public health window displays. They take part in national and local public health campaigns. It is part of the Scottish Health Executive's drive to use the pharmacy network as 'healthy living' walk-in centres. Payment for this service is based on a fixed fee.

The scheme also provides for the provision of additional services to be agreed locally, additional services include oxygen supply, harm reduction measures, care home services, out-of-hours services and waste management. The Scottish system is a good example of where Irish community pharmacy could develop in the future.

Current Funding

Participating pharmacists currently receive funding from the State on a scale of fees basis for the General Medical Services Scheme (GMS), the Drugs Payment Scheme (DP), the Long Term Illness Scheme (LTI), the European Economic Area Scheme (EEA), the High Tech Drugs Scheme (HTD) and other smaller schemes. The annual report of the Primary Care Reimbursement Service shows the following payments to pharmacists for 2007.

GMS	€1,048.41M
DP	€310.11M
LTI	€124.46M
EEA	€2.33M
Patient Care Fees under the HTD Scheme	€11.66M

Other payments included payments of €1.74M in respect of drugs/medicines dispensed under the Health (Amendment) Act 1996, €8.74M in respect of the cost of Methadone dispensed under the Methadone Treatment Scheme, €0.60M in respect of the Dental Treatment Services Scheme (DTS), €0.42M in respect of Pharmacy Training Grant. Payments to wholesalers under the High Tech Drugs Scheme amounted to €238.51M. The total amount paid to pharmacists under the above mentioned schemes was €1,508.47M

The above figures outline the strengths of the current system as a medication supply service; however the services provided by pharmacy could be much wider than this, as outlined above

Commentary on current funding

According to the Irish Pharmaceutical Healthcare Association (IPHA), medicines account for 14.7% of Irish healthcare expenditure – 17.6% is the Organisation for Economic Co-operation and Development (OECD) average. Expenditure as a percentage of gross domestic product (GDP) is the lowest in EU and consumption of medicines is the lowest in Western Europe.

Given that the Central Statistics Office estimate that the population over 65 will double by 2036 and that resources are already under strain, the cost of the schemes mentioned above are likely to increase under current arrangements.

The case of chronic diseases is interesting as an example. It is estimated that 25% of the Irish population have a chronic disease. This accounts for 78% of healthcare spending, 80% of GP consultations and 60% of hospital days. It also accounts for two out of three medical emergencies. Most of the consequences and costs associated with chronic disease are avoidable through screening, early intervention, behaviour change and the elimination of key risks factors such as poor diet, inactivity and smoking. The current policy in regard to health screening is un-coordinated, ad hoc, not sufficiently resourced and not aligned to Health Strategies and Health Service Executive (HSE) Service Plans. Without such a policy there is no way of containing consequential costs. It has been estimated that we could save up to €75 million if pharmacist-supervised self-medication programmes were developed and encouraged.

Problems of inappropriate prescribing, poor compliance and lack of incentives to minimise costs are the result of limiting the service of community pharmacists to medication supply only, and of basing the payment system solely on a fee-per-item scheme. The supply of medicines inherently includes the provision by the pharmacist of the information and advice required for the safe and appropriate use of those medicines and this is not reflected adequately in the current arrangement.

It has been suggested by some that one of the options to contain pressures on public finances that may be considered is the imposition of prescription charges for GMS patients as a way of containing or reducing costs. However, the current model of paying pharmacists as medication suppliers on a fee-per-item basis ignores the huge potential the sector has for reducing costs and contributing to better health outcomes.

In regard to medication, the focus should be on ensuring that the schemes make available the most cost effective medicines, by limiting funding to the most effective medication consistent with patient need. This principle will require a significant re-engineering of the current community drug schemes. However, the current system is not designed to achieve this aim and needs to be re-structured.

In regard to improving public health, the following strengths of the current system are being ignored in current policy making:

- There is a readily available network of approximately 1,600 community pharmacists and their teams in the heart of communities where people can access a wide range of medicines and other healthcare products, as well as professional advice and information. The network services more than 10 million visits/consultations per annum.
- Pharmacies are open at times which suit the public and no appointment is necessary- the average community pharmacy is open 50% longer than GP clinics.
- People receive their prescribed medicines promptly, safely and efficiently.
- Pharmacies provide a convenient and less formal, more user-friendly, environment than other kinds of health services.
- There are more visits to the community pharmacists on a monthly basis than any other element of the primary health care service, with a recent survey reporting three quarters of the adult population using community pharmacists at least once a month.

There is no health service in Ireland with a higher throughput of the general population than community pharmacy yet there appears to be a lack of awareness of the potential for community pharmacy to deliver enhanced and more cost effective frontline health services. For example, the HSE National Service Plan repeatedly highlights important goals relating to prevention and management of chronic diseases with no mention of the professional role which pharmacy might play in spite of substantial evidence of such frontline service provision in other countries.

The system of paying community pharmacists is heavily based on a fee-per-item volume system, the concept of the High Tech scheme, with the payment of professional care fees, could be extended. An incentive scheme to promote the greater use of community pharmacy in reducing costs of medicines and other downstream health service costs and in improving health outcomes is urgently required.

The consequences of the current payment system are that the professional nature of the role of community pharmacist is unrecognised, underutilised and undervalued. In fact the current system, if not changed, will lead to further underutilisation of the pharmacy service – a service that employs an estimated 16,500 people. As currently managed it can be said that we know the cost of the current system but we do not know its value. A targeted evidence based approach, with clear outcomes and evaluation mechanisms, would add greatly to our current ad-hoc and uncoordinated approach. Our current system is not fit for purpose and needs radical structural and system changes.

Consideration should be given to introducing the payment of professional fees or capitation payments to community pharmacists for the provision of certain specified services.

A transition from a medication supply model to a frontline professional health service has occurred in the UK, the United States of America, Canada and Australia but has yet to begin in Ireland.