

PHARMINTERCOM MEETING REPORT
AUGUST 18 – 23, 2012
SOUTH AFRICA

Pharmintercom is an annual meeting of the Presidents and CEOs of eight pharmacy organizations from seven English-speaking countries (Australia, Canada, Ireland, New Zealand, South Africa, United Kingdom and United States of America). The meeting is an exchange of information on current issues affecting pharmacists and pharmacy practice.

The 2012 meeting was held at the Legends Golf and Safari Resort in South Africa, hosted by the Community Pharmacy Section of the Pharmaceutical Society of South Africa.

The summary prepared by the host organization is attached as Appendix 1. Prior to the meeting, each country prepares a country report. They are posted for information purposes only on the Board extranet. ***Please do not distribute these reports.*** The information is strictly confidential and is for Board members and staff of participating organizations only.

Highlights

- The most dramatic change is probably the introduction of a mixed fee for services/capitation model of payment for community pharmacy services in New Zealand. It is proposed that the majority of a pharmacy's fees will come from a capitation fee. This will be based on a core services fee and a long-term conditions service fee. The latter will be based on the number of eligible patients registered with a pharmacy (patient can only register with one pharmacy) and the core service fee will be for non-LTC patients and will be paid per patient on each day that they present a new prescription. Each prescription will have a handling fee of \$1.
 - This is obviously a dramatic shift in a payment model and has been driven by government's concerns that pharmacists have been abusing the current system by encouraging frequent, short-term dispensing (unlimited daily, weekly and monthly dispensing [160,000 scripts]). The annual agreement is now capped at \$370.5 million per year with an allowed growth factor of 1.5%. There is a three-year transition contract.
 - This will be one to watch closely, given the interest provincial governments have shown in the New Zealand drug purchasing model.
- Front store business is reported to be in decline in most countries, with Australia earning 70% of revenue from dispensing and this now being as high as 85-90% in the UK. Front store business in the UK had fallen by about 10% in the last year.

- There are significant developments in the UK around the wellness and health promotion role of community pharmacies. Up to 1.6 million patients a day visit a community pharmacy in England and this is being used to develop the role of community pharmacy as a part of the health care system. The Healthy Living Pharmacy concept (a pharmacy in which certain services, e.g., smoking cessation, are available may be designated as a Health Living Pharmacy) is seen as a key tool to support the development of the role of pharmacies in health promotion and disease prevention. Another UK statistic was that four times more people are seen by pharmacists than by any other health care professional – relatively simple statistics but powerful.
- Pressures on margins from drug purchasing continue in all countries, creating problems for independents, e.g., in the US independents might be reimbursed at AWP, -82% perhaps buying at AWP, -72-80% while chains are probably buying at 35% below that. The US has created their own problem by allowing the PBMs to control the markets. Audit recovery from some PBMs has caused audit legislation to be enacted in some states to clarify clear guidelines on audit procedures.
- The New Medicine Service (NMS) in the UK was being hailed as a success. In March 2012, 50,000 NMS were claimed. This service is for patients with asthma, COPD, diabetes, hypertension, or prescribed anticoagulants. On dispensing of a new medicine, the service consists of a payment for initial counseling then follow up at 7-14 days and a second follow-up 14-21 days after that. An important result from the NMS was an increase in the detection and reporting of ADRs.
- The Medication Use Review (MUR) service in the UK is now running at 220,000 claims per month and 28,000 pharmacies are accredited to provide the service. (80% adoption).
- Working on advanced services which look at cost, quality and capacity; pharmacy can do this best because they innovate, implement and measure.
- The most important difference with the UK, is that all pricing is transparent. All costs and profits from pharmacies are known to the government and used when discussing payment schemes, usually as a total envelope/amount to be used for specific initiatives.

PR Campaigns

Most countries have invested in major national PR campaigns. In the UK, extensive consumer testing had shown that “Ask Your Pharmacist” was the best theme for such campaigns. The UK had also used “Heart of the Community” as a successful theme. YoLo (you only live once) had been used in Australia for a men’s health campaign. Interestingly, NCPA had used play on words a lot in campaigns such as Independents Day on July 4, and a website that has a video “Who runs my drug plan” and “Phil My Pockets” to highlight to consumers the role of the PBM and Pharmacists Count in local campaigns. Australia had some experience using its own YouTube

channel as a tool to counteract negative messages generated in social media. It was agreed that a Dropbox would be implemented to share what each of the countries is currently doing.

Shortages of Medicines

Drug shortages were an issue in most countries, usually of brand medicines in the UK and generics products in other countries. In the US, there had been a death as a result of a compounded injectable product made from sub-standard ingredients. Shortages in New Zealand are a regular issue as a consequence of Pharmac contracting, and pharmacies have been using social media as a tool to share information on the availability of alternatives. In the UK, the shortages were seen as a result of brand manufacturers using supply quotas as a means of controlling parallel importing/exporting. The role of preferential supply models was discussed with anecdotal evidence from the UK and some harder evidence concerning Ranbaxy in the US. The drug shortages issue has raised a problem of patients buying medicines online from sources outside of their home countries. This raised concerns re the security of drug supply and the need for controls around products coming off market as well.

Pharmacy Technicians

The greatest difference between the organizations at the meeting is probably positions in relation to the use of pharmacy technicians. The UK and Canada are well along the road towards a significant expanded role for technicians; however, representatives from New Zealand and Australia have significant concerns, particularly with respect to the economic impact on pharmacy and pharmacists.

e-Prescribing

Electronic prescribing continues to grow, albeit slowly, but in Australia they are up to 3 million scripts per week; 60% of prescriptions in Australia are refills and 85% of e-prescriptions are for refills. The Guild in Australia has access to all of this information and in the pharmacy software it provides to members includes the tools provided within Mirixa. In the US, 40% of new scripts are electronic. This has been fuelled by incentives for family physicians in Medicare Part D (2% increase); e-prescriptions for controlled drugs are to be added to the system and this might increase the number of scripts by 20%. The EHR and the EMR are disjointed and medication management is still not fully integrated. Ireland, they are advocating for SNOMED and are in the standards stage with two major vendors; however, the government has refused to pay for SNOMED as a base.

The UK is moving from bar code to fully integrated e prescribing. The most concerning statistic was UK data that for every second added to the time taken to process an e prescription, on average, it cost a pharmacy £4000 per year.

Conclusion

From the discussions, three clear priorities emerged. First, the need to document and collect data relating to the uptake of newly funded services. This was extended to emphasize the importance of pharmacy taking a lead on the development of quality assurance, quality measurement and indicators relating to optimal drug outcomes. Some caution was expressed that measurements must be on outcomes not on the processes. A patient reporting mechanism was suggested as a measurement for outcomes as it relates to adherence, understanding of meds, access and wait times, since governments also measure access and wait times, these were seen as positive indicators to use. Second, gaining recognition that the community pharmacy is an important resource in the health care system. Third, the need to look at how the care provided in a community pharmacy would be integrated into the care provided by others in the primary care team, clinical care can be provided by the community pharmacy outside of the usual screenings (cholesterol, diabetes).

Overall, most of the countries have the same problems to some degree as we do. They struggle with clinical services and remuneration for them, the confidence of the pharmacist in delivering new services, funding models to support new services with outcomes measurements, the “worth” of the pharmacists and how to engage government to recognize pharmacists’ value. The further development of self care with access to information via the internet is challenging everyone to assess the role of pharmacy and where pharmacy is going.

Respectfully submitted

Sherry Peister, President-Elect & Jeff Poston, Executive Director

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LEGENDS GOLF AND SAFARI RESORT, SOUTH AFRICA

FINDINGS FROM PHARMINTERCOM 2012

- Pharmacies increasingly introduce new professional services within their practices.
- There is a worldwide trend of lowering the payment of dispensing fee to pharmacists
- It is imperative that pharmacists must record the services and if possible, the outcome.
 - Quality assurance program and outcomes
 - We must share intelligence from these outcomes
- Community pharmacy must be recognized as a primary healthcare centre
- Clinical care within pharmacy must include science, practice and ethics.
- We must expand the use of social media to reach membership, other health professionals and consumers
 - Website
 - Facebook
 - Drop box
 - Networking with other healthcare professionals
- Quality care indicators. This is only for the processes and not for the outcomes. We should improve the outcomes based indicators.
- The pharmacists' role in their community is important. Their influence must be supported with a positive message.
- Do we understand the supply of "primary healthcare"?
 - Supply of medicine
 - Supply of screening services, immunization etc.
 - Information
- We have to meet the needs of our members
 - Electronic newsletters Facebook
 - Negotiate contracts for pharmacists
 - Develop programs which will enable pharmacists to deliver extra services
 - Sell services to non members at a premium
- Promote pharmacy to consumers
 - We could collect the different campaign posters from Pharmintercom countries and circulate these to all the Pharmintercom members.
 - Look at a drop box
 - Pharmacy must be the first port of call
 - An iPad video could be made and posted on Utube
- Change of management to update the new services
- Measure the value of pharmacists and translate that into positive outcomes via PR and others.
- Measure the patient's satisfaction.
- Leadership development of pharmacists and to introduce them into other healthcare teams.
- Sharing of information amongst Pharmintercom members - it is ongoing.