International Collaboration 29th Pharmintercom report: Boston Conference in the USA

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The Pharmintercom meeting was attended by the seven English speaking countries namely Australia, Canada, Ireland, New Zealand, South Africa, United Kingdom and hosted by the United States of America in the historic city of Boston. The attendees were the Presidents and CEOs of the various country associations, and I must admit that I was delighted to see many younger faces around the table. The agenda is determined by the hosting country, but during the presentation of the country reports any burning issues will be addressed. In many instances members can suggest a solution to common problems. The meeting is very open, but a member may discuss confidential issues to assist other member countries. The value of sharing information and projects is immense to everybody attending.

The meeting started on the Sunday night with a function to meet and greet all the other attendees and to pick up on old friendships. There were quite a few members that I knew from previous meetings that I had attended.

Monday programme

Monday was allocated to the country reports and each country was given an opportunity to present a report with the key developments. During this session additional information could be added and discussed. Other issues discussed were the changes in the pharmacy marketplace, pharmacy channel companies and globalisation. The statistical comparisons of the various countries were also discussed during the same session. This is valuable information as it could be used as a benchmark. We have to thank the Guild of Australia for collating these reports. However, these reports are sometimes regarded as an information overload, as described by several of the new attendees!

I want to highlight issues from the various country reports that are also relevant in our country.

Australia is currently engaged in negotiations for the 6th pharmacy agreement with the government on the payment model for the next five years. They will also review the regulations pertaining to pharmacy. They will have panel interviews with reference to a 140-point questionnaire with different stakeholders. The report will be scrutinized and suggestions implemented by 2020.

The Guild meets the different banks yearly to explain the current market and risk to the banks for providing credit to the members. They also list the HSDs (Highly Specialised Drugs) and negotiate a higher fee per item for these medicines while S1 and S2 medicine are on consignment. They are also looking at a fee for services through community pharmacies. They ran different programmes through the Guild and we can learn a lot from them in this regard. They are willing to share these programmes, e.g. “Discover more – Ask your Pharmacist”. They also have a handout programme to explain the Association and the value of a pharmacist to the politicians. The different software systems are streamlined to capture data and information for the members.

Canada is busy with changing the work flow systems in their pharmacies to accommodate technicians. They have ten provinces with very different practices. They also have huge challenges with mail order and centralised warehousing for the distribution of medicine. The pharmacist must still counsel the patient before the dispensing process, thereafter a technician can then take over the dispensing and sign off the medication. They also have a free medicine system, but access is still the key issue.

Ireland has a good model and has started with a minor ailment scheme through pharmacy to encourage patients to be less dependent on the state. The Irish Pharmacy Union has developed a good marketing tool for their members and also a data collection tool that could be useful for us. They are also busy expanding the role of pharmacists and receive remuneration for that service. They run radio programmes to promote better value and access to community pharmacies.

New Zealand is also busy negotiating a new contract with their government for the next five years. Their ownership model is open but 51% must still be community pharmacist owned. Their medicine margin is under threat. They are also looking at models to integrate with other healthcare professionals.
South Africa: I addressed and explained several issues, because our funding model is substantially different to the other countries, where their Governments are the main funders of the healthcare system. Other issues discussed were ownership, remote dispensing, additional services, e.g. PCDT, and the payment models.

England has an NHS model, but also experiencing price cuts by government. They also experience problems with wholesalers owning community pharmacies with vertical integration and remote dispensing. The NPA association established a committee to negotiate with government to develop a “hub and spoke model” with a central dispensing point and distribution to community pharmacy. This was a desperate measure to save costs.

USA has huge challenges with PBMs dictating the marketplace and we must be very aware of this practice. They have to do some contracts below cost at certain preferred provider networks, but pharmacists refuse to sign the economic unviable contracts. They experience huge challenges with collusion between courier and corporate pharmacies with PBMs. There is a programme that collates patient information on a centralised platform in certain states to establish an electronic health record. This programme also collates laboratory data, which may be accessed with patient consent.

Tuesday programme
Tuesday was spent on the different reforms including Government reforms in the member countries. Australia has a mandatory programme for codeine and pseudoephedrine recording. Many countries experience remuneration issues and are in negotiation with governments on contracts. This review is done every five years. In Ireland government is changing legislation to expand the role of the pharmacist and improving access to medicine and addressing a minor ailment scheme through pharmacy. The IPU will do an inspection to advise pharmacists and advance the practice of pharmacy and preventing overregulating by government. The Canadian government has implemented a model for the payment of services and management of chronic diseases through pharmacy. This resulted in a new workflow model in pharmacies. In New Zealand there are problems with policy and funding models as pharmacists and GPs are remunerated from the same budget via a PBM.

Wednesday programme
Wednesday was spent on new innovations and where we need to go with Pharmintercom in the next ten years to 2026, presented by Trent Twomey, a young innovative pharmacist from the Australian Guild. The organisations need to be member and patient centric, outwardly focused on promoting the role of the community pharmacist. Sharing of data is of utmost importance. Health economics will become very important as all the organisations and governments are under financial pressure.

A decision was taken that the Australian Guild, with other members, will interact with the health policy department of the European Union, to collate data and reference the PI countries. Pharmacies need to be separated from other retail business.

A presentation by one of the local pharmacists, Joe Moose, was very enlightening. He is involved in a community care programme in six pharmacies in North Carolina with a community care delivery system including hospitals, clinics, health care providers and community pharmacy. His slogan is “I am an investment and not an expense”. You have to run a team based approach for complex patients.

Summary
1. There is urgency for community pharmacy in all countries to influence policy makers.
2. Many concepts and patient care models must be managed and the transition recognised by governments.
3. Relook at minor ailment schemes for treatment of patients.
4. Fee for service model is developed in many countries and needs to be expanded.
5. Wellness programmes in community pharmacy.
6. Change of legislation to recognise pharmacists as providers and provide therapeutic outcomes.

I also had the opportunity to meet up with colleagues and made some new friends abroad who have extended a hand of cooperation and sharing. We had the opportunity to share a lot of information for purposes of addressing issues facing community pharmacy and not to re-invent the wheel again.