

# Pharmacy and the future of healthcare in Ireland – Part One

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## Medicines and their role in healthcare

Medicines are an irreplaceable component of the Irish health service. They form part of the overwhelming majority of medical interventions and of all surgical interventions. They are central to the control and resolution of acute and of chronic infectious and non-infectious conditions in their minor and serious presentations. And they improve patients' quality of life. The benefits are considerable and should not be underestimated.

Medicines are also a pervasive part of our culture. Patients and the public are exposed directly and indirectly to medicines almost every day of their lives. Not surprisingly, this multiplicity of exposures influences society's beliefs about and knowledge of medicines, and establishes the context in which medicines use occurs.

Patients' use of medicines is dependent upon their knowledge and understanding of their medicines. They are also affected by the availability and promotion of non-prescription medicines and by the attitudes and educational interventions of the healthcare professionals who prescribe and dispense medicines. The policies of the health authorities about medicines, and about the professionals who prescribe and dispense them, set the health service context in which medicines use is understood by patients and, more generally, the attitudes towards medicines that are the norms of the society.

Each stage of the process of using medicines in society, from legislating and regulating, providing medicines information, purchasing and supplying, prescribing and dispensing, to the monitoring of the safety of, and compliance with, medicines, must be dealt with as interdependent in order to realise fully the benefits and minimise the likelihood of harm.

This requires a systems approach to devising strategies for medicines use that ensures that the appropriate individuals with specialist knowledge, expertise and skills can work within a framework of carefully conceived policies, regulations and operating procedures that enables them to use their specialist talents to their full potential. Instead, at the moment, thinking appears to be reductionist, breaking the process down into parts, implementing a fix for each part without any consideration of how the next part's form and function will be affected.

In every industrialised country, including Ireland, evidence from descriptive and analytical studies confirms anecdotal reports that systems

failures, information barriers, inappropriate prescribing and poor patient compliance with medicines, results in the ineffective, inefficient and wasteful use of medicines. Consequently, sub-optimal therapeutic effects, avoidable medicines-related adverse events, patient discomfort and distress, and loss of confidence in the health service all occur. These lead in turn to increased morbidity and GP consultations, avoidable complications and hospital admissions, use of unproven and of ineffective approaches to treatment, and most seriously, patient deaths. The loss of achieved benefits and the foregoing of potential benefits, from the appropriate and safe use of medicines, are an additional burden that the health service must pay for.

## The Practice Environment

Healthcare in Ireland is provided at four levels: self care, Primary Care, acute general hospital care and tertiary specialist hospital care. At each of these levels community and hospital pharmacists provide advice, recommend treatments, changes in lifestyle or behaviour, and refer patients to other healthcare professionals. A patient's movement from one level to another is determined by several factors: the perceived seriousness and degree of unfamiliarity of the symptom/condition, knowledge, influential others, cost and access. A pharmacist's behaviour is determined by patient need, patient preference, available relevant clinical information, evidence base of potential treatment/lifestyle/behaviour change, practice guidelines, standards of practice, health service procedures, reimbursement and remuneration, expectations of prescribers, expectations of the health service. Significantly, for all who work in Primary Care, the evidence base and the availability of relevant clinical information is insubstantial at self care level, is variable at primary care level, but rises sharply at each subsequent level.

At each level there are facilitators and barriers to the patient's movement from one level to the next. The most significant barrier is affordability. Does the patient or the State pay? In Ireland this is often referred to as the two-tier system. Medical card patients have no monetary barriers, just logistical ones, and consequently their use of the system is high and unrestrained. They seek the highest level of care possible for even minor illness. Non-medical card patients may have access through their occupation to a health service that has few barriers, but that has a capacity and budgetary limit. The majority of the population

has both monetary and logistical barriers and these lead them to seek advice and treatment at the least costly and most easily accessed level.

Similarly, there are barriers and facilitators to the effective delivery of care by practitioners at each level. The most obvious for Primary Care practitioners is the influence of the hospital sector. It is estimated that around one half of the medicines prescribed by GPs are a continuation of a medicine initiated in hospital, particularly for chronic diseases. Shared care is the term used to describe an approach to GP-hospital care and for almost every study of chronic disease management in Primary Care in Ireland GPs view the lack of shared care arrangements as a barrier to their greater involvement. The other principal barrier for them is funding.

For pharmacists the barriers are slightly different. The securing of prescription medicines and of poisons, the provision of prescription medicines through reconstitution and dispensing, and the provision of non-prescription medicines and of medical devices requires a pharmacist to organise their practice and manage their staff so that their knowledge and expertise are most efficiently deployed. Much of this is done via standard operating procedures or protocols and is performed in the dispensary. Because of this, it is invisible to patients and the public.

Non-prescription medicines are readily available through pharmacies, and 'open' or 'general' sale medicines are available through certain other types of retail outlets. Consultation with a pharmacist or a prescriber is recommended but, from the patient's viewpoint, this is primarily sought if an extended period of use is needed. Partly because of the marketing and promotional activities that drive sales, and partly because of their familiarity with the products and the attitudes of the public towards non-prescription medicines, personal choice, speed of service and price dominate the patient's concerns. There are few messages from the health service about these products to the public and fewer still that highlight the pharmacist's role. Unless the patient is receptive to the pharmacist and pharmacy staff as medicines advisors, the context of the interaction with the patient focuses on those three aforementioned aspects. As a consequence, checking the nature of the patient's symptoms and of the suitability of the product, by systematic questioning through the use of an acronym such as WWWHAM\* puts the pharmacist or the staff member potentially in conflict with the patient's wants.

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Thus the present non-prescription medicines market is becoming one that incentivises pharmacies to provide these products quickly without any attempt at VVHAM but with a smooth link to the sale of a related product. Unless the health authorities promote the appropriate use of non-prescription medicines as a part of healthcare, and of the role of the pharmacist in advising and recommending medicines and referring on those in need of more extensive investigation, this is unlikely to change. Convenience, it seems, is more precious than care in Irish society.

## The role of the pharmacist

The traditional role of Community Pharmacy was the securing of medicines and poisons on behalf of society, as outlined above. However, Clause 9 of the current contract made explicit aspects of the pharmacist's role that the health service required them to perform.

Four types of activities are described:

- Medication review
- Medication counselling
- Patient consultation and assessment
- Monitoring the standards of prescribing and the rational and cost-effective use of the medicine, including the choice of the medicine and the potential for wastage

The screening of prescriptions for dose, strength, form and appropriate quantity and directions for use, for therapeutic duplication, for actual and potential drug-drug and drug-diet interactions, as well as actual or possible misuse are all to be carried out as a matter of routine care. However, the patient's expectations are that the prescription is perfect and that it will be dispensed as quickly as product can be acquired, logged and put into a bag. If there are problems, the pharmacist's respect for the prescriber and for the integrity of the health service means that they must be resolved quickly and only involve the patient as and when absolutely necessary. Hence much of this work is also invisible.

Clause 9 also allows for counselling about "any such matters as the pharmacist in the exercise of his/her professional judgment deems significant". This goes far beyond what most of the public and others imagine pharmacists can and should do. Some patients and some of the public do have concerns about medicines, their conditions and their treatment, for which they seek the pharmacist's help. However, the more complicated the problems, the less transparent the therapeutic purpose of the prescription and the more extensive the patient's concerns, the more likely the pharmacist's attempt to help will bring them to the boundary of what the prescriber considers represents the pharmacist's appropriate role.

Monitoring the standards of prescribing to ensure rational and cost-effective use of medicines, including the choice of medicine and the potential for wastage, were realised at the time of the formulation of the contract as topics that would provoke conflict with some prescribers. The understanding given by the Department of Health at that time was that they would bring the professional bodies together to enable this work to be done. This has never happened.

Many pharmacists have worked hard to carry

out these activities, particularly for patients whom they think are at risk of drug-related problems. They have attended ICCPE courses for therapeutic update and many have obtained postgraduate Diploma or Masters qualifications in order to stay current and to develop their skills. In many instances, they have advised prescribers only to be told that it was not their place to provide such advice, or they have advised patients and have had prescribers intervene to tell them not to advise 'their' patients. The fact that pharmacists have a duty of care to patients, both separately and in conjunction with prescribers, particularly in respect of medicines, and that they have contractual obligations beyond the provision of dosing instruction is not, I believe, accepted by the prescribers' organisations. Nor has it been recognised, supported and translated into policies, regulations or procedures by the HSE or the DoHC.

However, many people within the health authorities do not perceive that Clause 9 activities are the norm in community pharmacy practice. The reason they don't is because practices vary in their approach to dispensing and to managing the balance of activities and services that the pharmacy provides. Even in those practices in which Clause 9 activities are routine, they may happen inconsistently, perhaps only when a certain group of staff are working the same period. This is because the work requires dedicated time and this removes the provider from routine activities which must then be carried out by other staff.

## The Primary Care Strategy

The Primary Care Strategy's approach to pharmacy is illustrated by the vignette of the pharmacist – it is a portrait of a polite, conscientious, dispenser; of a bystander in the process of care – and this is consistent with many people's view of the pharmacist's role. The principal author of the Strategy has the instincts of a collaborative practitioner but it would appear that the existence of Clause 9 was never brought to his attention by any of those who read and commented upon drafts of the document as it was being prepared in the DoHC. As a consequence, the Strategy does not incorporate any Clause 9 activities into its view of the patient care process, and little has been done to realise those roles in Primary Care.

To what extent the pharmacist portrayed in the Strategy has a duty of care to his patients is difficult to discern. However there is no such ambiguity in a court of law. All involved in the care of the patient, having shared responsibility to do their best for the patient and to ensure that other healthcare professionals do likewise, must exercise their 'duty of care'. In reality therefore, professionals are *primus inter pares* (first among equals). Furthermore, legal judgments make it clear that patients are expected to act responsibly as well – in other words, healthcare is a collaborative process between professionals and patients in the view of the courts.

Crucially, while most pharmacists want to intervene on behalf of their patients, when they do, they may have to do so in contradiction of the patient's expectations of what pharmacists do, or of the prescriber's expectations, and the expectations of the health service. And those three sets of expectations about the pharmacist's role are inter-connected, just as expectations and

beliefs about medicines are also linked. Change one and you influence the others. Reinforce one and you strengthen the others.

The problem is exacerbated by the fact that those patients who do not hold a medical card (approximately 70% of the population) must pay to see their GP, thus creating an economic incentive for prescribers to set extensive boundaries for the care of these patients, to limit the role of other healthcare professionals. This results in opposition to the promotion of a health service policy about the use of non-prescription medicines for minor illness and of the role of the pharmacist as an advisor about prescription medicines to prescribers and as a monitor of the quality of prescribing. Health promotion and health screening are also opposed and doubtless this opposition translates into lobbying of the health authorities and wider political system. In the Irish Primary Care system, the scale of private practice for GPs and other healthcare professionals creates two types of practice and must be governed by two sets of policies.

It's hardly surprising then that, with time, pharmacists' confidence and stamina to pursue proactive patient care roles may diminish in the absence of support from any other part of the health service. In addition the time spent making telephone calls and dealing with difficult situations, while at the same time not alarming the patient or compromising another healthcare professional's reputation, goes unrecognised and uncompensated.

Because of these unresolved issues, the present practice environment and remuneration system incentivises pharmacies to dispense prescriptions as speedily as possible, which means without asking any questions or providing counselling about any potentially difficult issues. Unless a different view of this process is promoted by the health authorities, it will not happen spontaneously.

Competition is intended to be the answer to these problems. However, competition only promotes an increase in the quality of those services that are visible and are perceived as valuable by the patient. It does not act as an incentive to practitioners to practice to the highest standard in healthcare.

Competition policy asserts that competition drives up quality and drives down costs – but this isn't true in healthcare for several reasons, and a lack of clarity about the pharmacist's role means that the patient is unlikely to access the aspect of a pharmacy's services that contribute most to their clinical wellbeing. The market for prescription and non-prescription medicines cannot be significantly increased by promotion and marketing; its size depends upon the incidence of illness. Thus, increased competition rewards the speedy, no-fuss version of prescription dispensing and non-prescription medicines provision expected by patients and encouraged by the competition policy approach. It creates market forces that drive pharmacies to concentrate resources in those sectors that can be expanded by promotion and advertising, i.e. the non-pharmaceutical products sectors. The public and patients know that regulation of healthcare professionals and facilities by bodies like the PSI is supposed to ensure that every practice reaches an appropriate standard. People understand that, and assume that as a result, each practice is essentially similar in the quality of the care it provides and that they are distinguished by their other characteristics. In the

same way, private hospitals are compared to public hospitals, by the public, on the speed with which patients can obtain the appointment and procedures that they need and on the quality of their 'hotel' services and facilities. It is hard for patients to judge the quality of the clinical care that they provide and the league tables used in other countries to overcome these problems are based on crude indicators that don't allow realistic comparisons of individual patient's situations.

Evaluation of the provision of prescription medicines by community pharmacists is usually carried out as a cost effectiveness analysis. Because the State pays part of the medicines costs of private patients through the DPS Scheme, it has access to the pharmacies' payments data and can compare the two main prescription payment schemes. The costs of the service are easily identified as the costs of a supply service and when the medical card and DPS schemes are compared, the simple conclusion is that the DPS scheme is not cost-effective. However, this is an incorrect analysis. In every case in which a pharmacist correct mistakes, or clarifies confusing and ambiguous prescriptions, they prevent and resolve problems that would add to the cost to the health service through adverse effects and wastage. These benefits for medical card and non-medical card patients go unrecognised and unvalued. The State gains greater benefits from the community pharmacist caring for non-medical card patients because they advise and treat more minor illness among these patients, and thus fewer of them consume GP time, fewer are

prescribed drugs through the DPS scheme and fewer consume hospital resources inappropriately. The latter is something that the HSE has begun to realise during the past winter, as it has advised patients to seek help before going to an A & E department. The reality is that the disparity in payments between the two schemes was the result of a pragmatic realisation that some cross-subsidisation would be needed to make GMS practice attractive to pharmacists. Such disparities are the result of the two-tier health system.

## Consequences

Pharmacists have considerable responsibilities to fulfill their Clause 9 obligations and their duty of care to patients, but the health service has not given them the authority to meet those obligations.

Similarly while the legal view and patient expectations are that patient care should be collaborative, the DoHC and HSE have not set out to facilitate this.

Pharmacists' interventions around prescribing and prescription medicines are not recognised, supported or promoted. A network of community pharmacies practising to a high standard is needed, not because the standard of prescribing in Primary Care is so poor that it endangers the public, but because the health service needs a proper system of quality assurance checks and balances to ensure that medicines are used optimally.

Primary Care involves dealing effectively with

the routine, while being alert for the unusual and the spotting the potentially serious as early as possible, so that they can be referred on for specialist investigation. Pharmacists responding to queries about minor illness are generalists who can detect a problem that requires more investigation. To detect and refer these problems appropriately, the health service needs the community pharmacy network to perform this function.

Finally, reassurance is not an outcome that is usually identified and measured in clinical trials, but in Primary Care, that is what GPs, pharmacists and others often provide, and its value to patients is immense.

Primary Care policy and health service management seems to view the pharmacist and community pharmacy as providers of products, whose services are to be valued and paid accordingly. By doing so, the DoHC and HSE is constraining the community pharmacist's contribution to Primary Care and to population health, and concomitantly limiting the benefits, and failing to contain the adverse effects that medicines can produce.

These policies are not saving the health service money; they are giving rise to opportunity costs it can ill afford.

**\*WWHAM = Who – Is it for you?; What sort of symptoms do you have/What are you taking it for? How long have you had the symptoms? Action – Have you tried anything else? Medication – Are you taking any other medicines at the moment?**

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