



2011 ANNUAL REPORT OF IPU EXECUTIVE COMMITTEE

AGMS OF THE IPU AND IPU SERVICES LTD



IRISH
PHARMACY
UNION

The voice of community pharmacy

THE LYRATH ESTATE HOTEL,
KILKENNY

8 MAY 2011

2011 AGM IPU and AGM IPU Services Ltd

Sunday 8 May 2011 (confined to paid up members of the IPU)

Chairperson: Mr Darragh O'Loughlin, President

Agenda

- 9.30 Registration**
- 10.00**
1. **Welcome**
 2. **One minute's silence in memory of pharmacists who died since the 2010 AGM.**
 3. **Financial Report and Accounts 2010**
 - a. Adoption of Audited Statement of Accounts
 - b. Appointment of Auditors
 - c. Union Membership Subscriptions
 4. **IPU Services Ltd, AGM**

Minutes of 2010 AGM

Financial Statements 2010

 - a. Adoption of Directors' Report
 - b. Adoption of Audited Statement of Accounts
 - c. Remuneration of Auditors
 5. **Minutes of 2010 AGM** (Page 7 of Report)
 6. **Report on Motions from 2010 AGM** (Page 8 of Report)
 7. **President's Address**
 8. **Union Secretariat Report** (Page 13 of Report)
 9. **Group Reports / Open Forum: Introduction and Update**
 - a. Pharmacy Contractors' Committee Report (Page 18 of Report)
 - b. Community Pharmacy Committee Report (Page 22 of Report)
 - c. Employee Pharmacists' Committee Report (Page 26 of Report)
 - d. Public Relations Report (Page 28 of Report)
 - e. International Pharmacy Matters (Page 30 of Report)
 10. **2011 AGM Motions** (Page 37 of Report)
 11. **Any Other Business**
- 12.00 Close**

MESSAGE FROM THE PRESIDENT

It has been another frustrating year for the Irish Pharmacy Union and for our members, as the pharmacy profession has endured an ongoing series of ad hoc direct and indirect cuts to our income, which, coupled with the difficulties caused by the adverse economic circumstances, have made it increasingly difficult to deliver the high quality service that our patients expect and deserve. However, the Union continues to fight on every front on behalf of its members and to advocate for greater recognition of the potential of the pharmacy profession to deliver cost effective, accessible and patient-friendly healthcare services to the public.

In a detailed submission, entitled “Time for a New Approach”, which we presented to the Minister during the last FEMPI review process and a copy of which was sent to all members, the Union highlighted that there was no scope for further unilateral or arbitrary cuts as pharmacists had already suffered far deeper cuts than any other sector. Nevertheless, we believe that additional efficiencies and savings can be achieved by adopting a new approach; one which involves substantial and direct engagement between the Union, the Department of Health and the HSE. This would offer an orderly and efficient way to bring about real and lasting change, offering tangible and substantial benefits for patients and the exchequer and providing a more secure basis for pharmacists to structure and plan their professional activities and their businesses.

I hope that by this time next year we will have seen some progress in advancing our hugely positive agenda for change with the new government with the consequent benefits for the profession, the State and our patients.

Your representatives on the Union’s committees have worked ceaselessly over the past year, demonstrating genuine dedication and unity of purpose. They have been ably assisted by all the staff in Butterfield House. It’s worth pointing out that the IPU didn’t increase employee numbers during the boom times and has continued to maintain a very lean staff complement, all of whom remain absolutely dedicated to supporting and advocating for the Union’s members. The organisation itself has no agenda other than to further the interests of its members and of the pharmacy profession.

The IPU has worked successfully to improve communications with members with a massively improved website, weekly email newsletters and, most recently, the launch of a members’ internet forum on which we can share tips on best practice and solutions for commonly encountered problems and also discuss the more esoteric and obscure issues which frequently raise their heads in a community pharmacy. I encourage you all to make the best use of the resources which the Union provides, to keep yourself informed and to participate in Union activities.

We should all take great pride in this year’s inaugural IPU National Pharmacy Conference. It is a superb event, a showcase for the best aspects of the community pharmacy profession in Ireland and just the sort of event the profession needs and deserves. This conference is the culmination of the extraordinary efforts of a small group of people who deserve our thanks and our congratulations for a job well done.

Finally, I would like to express my gratitude to Séamus Feely, Secretary General; Rory O’Donnell, Vice President; and Kathy Maher, Honorary Treasurer, for their loyalty, support and hard work over the course of the year and also to my family who have adjusted to my frequent and often unplanned absences with stoicism and good grace.

Darragh O’Loughlin MPSI



DARRAGH O’LOUGHLIN, President, IPU



RORY O’DONNELL, Vice-President, IPU



KATHY MAHER, Hon. Treasurer, IPU

ANNUAL REPORT 2011

Contents

	Page
1. Executive Committee	5
2. Financial Statements.....	6
3. Minutes of 2010 Annual General Meeting.....	7
4. 2010 AGM Motions and Report on Action Taken	8
5. Union Secretariat Report.....	13
6. Pharmacy Contractors' Committee Report	18
7. Community Pharmacy Committee Report.....	22
8. Employee Pharmacists' Committee Report	26
9. Public Relations Report	28
10. International Pharmacy Matters	30
<i>a. PGEU Report</i>	<i>30</i>
<i>b. Report on FIP Congress.....</i>	<i>32</i>
<i>c. Europharm Forum Report.....</i>	<i>35</i>
11. 2011 AGM Motions.....	37
12. Appendices.....	38

The Financial Statements for the Irish Pharmacy Union and IPU Services Ltd have been circulated to all members of the IPU.

Appendices

	Page
I Extract of Submission by the IPU to the Review Under the FEMPI Act 2009 <i>3 June 2010</i>	39
II Extract of Submission by the IPU to the HSE on Review of Methadone Treatment Protocol <i>24 June 2010</i>	40
III Extract of IPU Submission to Department of Environment Heritage and Local Government on a Review of Retail Planning Guidelines (2005) <i>June 2010</i>	42
IV IPU Submission to the PSI on Draft Guidelines on Sourcing, Storage and Disposal of Medicinal Products within a Retail Pharmacy Business <i>17 September 2010</i>	43
V Submission by the IPU to HIQA on Draft National Standards for Safer Better Healthcare <i>4 November 2010</i>	45
VI Extract from Submission by the IPU to the Independent Monitoring Group for A Vision for Change <i>19 November 2010</i>	47
VII Executive Summary of Report prepared by the IPU Review under The FEMPI Act 2009 – Time for a New Approach <i>5 January 2011</i>	48
VIII VAT Submission to Revenue Commissioners Extracts from Speech by Mr Darragh O’Loughlin MPSI, IPU President’s Dinner <i>10 November 2010</i>	50
IX Some key letters and responses received throughout the year:	
■ Financial Emergency Measures in the Public Interest Act 2009.....	52
■ Fees for Pharmacists and Pharmacies.....	56
■ Prescription Charges.....	59
■ Rejected Claims.....	62
■ Needle Exchange Programme.....	65
■ Hardship and Psychiatric.....	68
■ DPS Reimbursement.....	70
■ Memorandum of Understanding.....	71
■ IT Issues.....	72
■ Generic Substitution and Reference Pricing.....	73
■ New Services.....	73
■ Methadone Treatment.....	73
X A Selection of Press Releases issued to the National Media during the year on various issues.....	74
XI A Selection of Letters Published in Newspapers.....	81

The Financial Statements for the Irish Pharmacy Union and IPU Services Ltd have been circulated to all members of the IPU.

Executive Committee 2008 – 2010

PRESIDENT: DARRAGH O'LOUGHLIN
VICE-PRESIDENT: RORY O'DONNELL
HONORARY TREASURER: KATHY MAHER

REGIONAL REPRESENTATIVES (8)

John MacNamaraEast
Kathy MaherNorth East
Conan Burke.....North West
Tadhg O'Leary.....South
Niall MulliganSouth East
Michelle Concannon.....Midland
Vacant.....West
John Gleeson.....Mid West

COMMUNITY EMPLOYEE GROUP (3)

David Carroll
Fearghal O'Nia
Catriona O'Riordan

PAST PRESIDENT

Liz Hoctor

CO-OPTIONS

Ann Marie Horan
Michael Kennelly
Sean Reilly

NB: Up to five members may be co-opted by the Executive Committee

FINANCIAL STATEMENTS

Irish Pharmacy Union

Financial Reports and Accounts for Year Ended 31 December 2010

In accordance with the Constitution of the Union, the Executive Committee submits the audited accounts for consideration by members.

The full details of the Accounts have been circulated to members with the Summary of the 2011 Annual Report of the IPU Executive Committee.

If the Accounts are approved by the meeting after their presentation, members will be asked to formally adopt the Accounts for the year ended 31 December 2010 and agree the election of Auditors. In this context, the following motions will be put to the meeting:

- a. *“That the Executive Committee Report and Audited Statement of Accounts of the Irish Pharmacy Union for the year ended 31 December 2010 as submitted to this meeting, be and are hereby adopted.”*
- b. *“That this meeting agrees to the election of Baker Tilly Ryan Glennon for a further year as Auditors for the IPU and IPU Services Ltd.”*

Membership Subscriptions:

Subscriptions have been reduced by 38% over the past two years and no further change will be made until the completion of the work of the Group established by the Executive Committee to review the funding of the Union.

IPU Services Limited

Financial Reports and Accounts for Year Ended 31 December 2010

At this Annual General Meeting of IPU Services Ltd, members are asked to consider the Report of the Directors and the Auditors' Report on the Accounts for Year Ended 31 December 2010.

The accounts and financial reports have been circulated to all members.

If the Accounts are approved, members will be asked to resolve: *“That the Directors' Report and Audited Statement of Accounts for the year ended 31 December 2010 as submitted to this meeting, be and are hereby adopted.”*



Minutes of the 37th Annual General Meeting of the Irish Pharmacy Union and IPU Services Ltd

Mullingar, Co Westmeath

24 April 2010

Present:

The President, Ms Liz Hoctor, and 62 members.

In Attendance:

Mr Seamus Feely, Ms Ciara Enright, Ms Kate Healy, Mr Darren Kelly, Ms Wendy McGlashan, Ms Roisin Molloy, Ms Aoibheann Ni Shúilleabháin and Ms Zuzanna Zwolan.

Apologies:

Apologies were received from 38 members.

[A full report of the 2010 AGM is available from the IPU offices.]

1. The President welcomed the attendance to the 37th Annual General Meeting of the Irish Pharmacy Union.

2. On the proposal of the President all present stood in silence in memory of deceased members including Mr John Burke, Trustee of the Union, and all those who had died since the 2009 AGM.

3. Financial Reports and Accounts 2009

a. Dermot Twomey (Honorary Treasurer) presented the Union's Financial Report. The Honorary Treasurer drew members' attention to the Pension figure for 2009 on Page 28 of the Annual Report. The correct figure is €147,788 resulting in an over statement of the Profit by €26,459. The actual Profit for this period should read €545,579.

Following the presentation, the following motion approving the accounts was proposed by John Gleeson, seconded by Mark Beddis and carried.

"That the Executive Committee Report and Audited Statement of Accounts for the Irish Pharmacy Union for the year ended 31 December 2009 as submitted to this meeting be and are hereby adopted."

b. The following motion was proposed by Marie Hogan, seconded by Jack Shanahan and carried.

"That this meeting agrees to the election of Baker Tilly Ryan Glennon for a further two-year period as auditors for the IPU and IPU Services Ltd."

c. It was announced that the Executive Committee had agreed not to change to the annual subscription payable, pending the completion of the work of the Group established to review the funding of the Union.

4. IPU Services Ltd AGM

The minutes of the 2009 AGM were taken as read.

On the proposal of Joe Britton, seconded by Ross McEntegart, it was resolved:

"That the Directors' Report and Audited Statement of Accounts for the year ended 31 December 2009 as submitted to this meeting, be and are hereby adopted."

This motion was carried.

5. Report of 36th AGM

The report of the 36th Annual General Meeting was approved as a true and accurate record. The report had been circulated to all members prior to the meeting.

6. Report on Motions from 2009 AGM

The report on motions from the 36th Annual General Meeting was taken as read and agreed.

7. President's Address

Ms L Hoctor, President addressed the meeting and thanked members and the staff of the Union for their support during the year.

8. Union Secretariat Report

The Union Secretariat Report was circulated to all members, prior to the meeting, as part of the Executive Committee report. The Secretary General, Mr Seamus Feely, introduced the Secretariat report.

9. Group Reports

a. Pharmacy Contractors' Committee (PCC) Report

This report was introduced by Mr Ger Browne, South Regional Representative of the PCC.

A summary of the report was circulated in advance of the meeting and the full report published on the members' section of www.ipu.ie.

b. Community Pharmacy Committee (CPC) Report

This report was delivered by Mr Keith O'Hourihane, Chairman of the Community Pharmacy Committee.

c. Community Pharmacy Committee (CPC) Report

This report was delivered by Mr Bernard Duggan, Chairman of the Community Employee Committee.

A summary of the report was circulated in advance of the meeting and the full report published on the members' section of www.ipu.ie.

d. Public Relations Report

This report was circulated in the Annual Report and was taken as read.

e. International Pharmacy Matters

This report was circulated in the Annual Report and was taken as read.

10. Update on Strategy Review

This issue had been addressed by the Secretary General in his address to the meeting and was taken as read.

11. 2010 AGM Motions

The 2010 Motions and action taken on them are on Pages 8 – 12 of this report.

12. A.O.B

The President, Ms Liz Hoctor, announced the new Standing Committee. Mr Darragh O'Loughlin was elected as President of the Union; Mr Rory O'Donnell as Vice-President; and Ms Kathy Maher as the Honorary Treasurer. Ms Liz Hoctor officially passed the chain of office to the new President of the Union.

The Past President thanked all those who attended for their participation and also thanked the Vice-President, Darragh O'Loughlin and Honorary Treasurer, Dermot Twomey for the work they had

undertaken over the last year. The Past President also thanked the Secretary General and staff of the IPU for their hard work.

The incoming President addressed the meeting and thanked the outgoing President for all her leadership and efforts during a very difficult two year period. He said that he was committed to providing leadership for the next two years and would do everything possible to maintain and promote the interests of all members.

2010 AGM MOTIONS AND REPORT ON ACTION TAKEN

The following motions, proposed in accordance with Article 29 of the Constitution, were brought before the 2010 AGM for consideration:

1. **Proposed:** Liz Hoctor
Seconded: Darragh O'Loughlin

"That this AGM calls on the HSE and the Department of Health and Children not to introduce the Prescription Levy for patients on the Medical Card and Long-Term Illness Schemes but instead to work with pharmacists to ensure more cost-effective use of medicines through structured medicine use reviews for patients, where appropriate."

This motion was carried unanimously.

Action: In 2010 the Government announced the introduction of a prescription levy from 1 April 2010. However after repeated requests by the Union and other organisations, the introduction of the levy was delayed until later in the year. In August and September, the Union met with and wrote to officials from the Department a number of times to discuss the prescription levy, highlighting many concerns around its introduction, the impact it would have on patients and calling on the Government to refrain from introducing the levy. The Union also put forward other ways in which structured medicine use reviews could be implemented.

On 1 October the prescription levy was introduced. The Union issued members with posters and leaflets to alert patients to the levy being imposed on them. Since the introduction of the levy, the Union has been liaising with the HSE to answer any questions which have arisen since the introduction of the levy and a number of updates have been issued to members over the past few months. The Union also met with representatives of Nursing Homes Ireland in an effort to resolve the issue over non-payment of the levy by nursing homes.

The Union lobbied Opposition Spokespersons on the matter and called on them to announce that they would repeal the legislation if in power. In advance of the General Election in March 2011, all Opposition Spokespersons confirmed to the Union that they would scrap the levy if in power.

Within the last few weeks the new Minister for Health, Dr James Reilly has given a commitment to abolish the levy on medical card patients. The Union welcomes this development.

The Union participates in the HSE Pharmacy in Primary Care Group which has just completed a pilot Medicines Use Review (MUR) programme through GPs and community pharmacists. The results of the pilot are currently being analysed by TCD and it is hoped that an MUR service will be rolled out nationally.

2. **Proposed:** Rory O'Donnell
Seconded: Paul Fahey

"That this AGM calls on both the Minister for Enterprise, Trade and Innovation and the Minister of Health and Children to ensure that any exemption that may be granted in the new Competition Act to the Irish Medical Organisation should also apply to all representative bodies for healthcare professionals."

This motion was carried unanimously

The Union wrote to the previous Minister for Enterprise, Trade and Innovation a number of times on this matter and raised it in meetings with the previous Minister for Health and Children. The Union lobbied Opposition Spokespersons on the matter and called on them to announce that they would ensure that any exemption that may be granted in the new Competition Act to the Irish Medical Organisation should also apply to all representative bodies for healthcare professionals if in power. Before the election, the now Minister for Health, Dr James Reilly, confirmed to the Union that he believes in the right of trade unions to represent and negotiate on behalf of their members and would have no reservations regarding the Department of Health or the HSE engaging with the unions or representative bodies of professions.

3. **Proposed:** Noel Stenson
Seconded: Morgan Power

"That this AGM calls on the Minister for Health and Children to exercise caution if she decides to introduce Reference Pricing and to ensure that the supply of vital medicines to patients is maintained and the viability of community pharmacy is not further undermined."

This motion was carried unanimously

Action: In 2010 the Union made two submissions and an oral presentation to the Department of Health and Children's Reference Pricing and Generic Substitution Group chaired by Mark Moran. The Union advocated for a pharmacy led generic substitution and felt that this was important if any new system were to succeed. The Union also warned about a race to the lowest price and used European

examples where there have been ongoing medicine shortages due to reference pricing systems.

The Department published their report in June 2010. The report set out a proposed model for the operation of a system of interchangeable medicines and reference pricing. The report also stated that generic substitution should be pharmacy led as recommended by the Union. The Union welcomed the move by the Minister to allow pharmacists to offer patients the choice of a cheaper generic medicine but cautioned the Minister to be careful in taking steps towards the introduction of reference pricing as pharmacists had already suffered a major blow due to cuts imposed in 2009.

The Heads of Bill for Reference Pricing are currently being prepared by the Department and are at an advanced stage. The PCC has requested a meeting with the Department.

The Union has written to the new Minister for Health, Dr James Reilly asking to meet with him to discuss a number of issues related to pharmacy including reference pricing.

4. **Proposed:** Stephen Nolan
Seconded: Rory O'Donnell

"That this Union calls upon the Minister for Health and Children and the HSE to implement the recommendations of the Joint Committee for Health and Children, published in their Report on Primary Medical Care in the Community, that the role of the pharmacist be expanded to provide additional health services to patients."

The motion was carried unanimously.

Action: The Union raised this issue in a meeting and follow up letter with the previous Minister for Health and Children. The Union also met with Dr Barry White, National Director Quality and Clinical Care, in relation to the extended pharmacist's role within the HSE's Clinical Care programme. Meetings also took place with Dr James Reilly and Jan O'Sullivan at which the extended role of the pharmacist was discussed.

Before the election, the now Minister for Health, Dr James Reilly, confirmed that the introduction of Medicine Use Reviews was a good idea, particularly in improving compliance and ensuring better outcomes for patients; that a minor ailments scheme would make absolute sense as it would allow more timely access to medicines for medical card patients and would reduce congestion in GP surgeries; that pharmacists are ideally positioned to communicate health promotion messages to the public; that Fine Gael would see a role for pharmacists in health screening; and that he sees no reason vaccination programmes delivered by pharmacists cannot be done here.

The Union participates in the HSE Pharmacy in Primary Care Group which is looking at a number of extended roles for community pharmacists such as Medicine Use Reviews, Compliance and Wastage schemes, vaccination, etc.

5. **Proposed:** Bernard Duggan
Seconded: Catriona O’Riordan

“That the Employee Pharmacists’ Committee of the IPU calls on the Minister for Health and Children to ensure that funding is provided for the one year practical intern training completed under the supervision of a practising tutor pharmacist in line with similar practical training funding already provided to other Primary Healthcare Professionals such as GPs and Nurses.”

The motion was carried by the majority vote. There was one abstention.

Action: The Union raised the issue of funding for pharmacists who act as tutors to pharmacy interns in meetings with the previous Minister for Health and Children and the Pharmaceutical Society of Ireland.

6. **Proposed:** Fearghal O’Nia
Seconded: Catriona O’Riordan

“That the Employee Pharmacists’ Committee of the IPU calls on the Minister for Health and Children to ensure that funding is provided for the one year practical intern training completed under the supervision of a practising tutor pharmacist in line with similar practical training funding already provided to other Primary Healthcare Professionals such as GPs and Nurses.”

The motion was carried unanimously.

Action: The Union raised the issue of the removal of bankruptcy from the PSI registration rules at meetings with the previous Minister for Health and Children and the Pharmaceutical Society of Ireland. The Union also wrote to the Law Reform Commission on the matter.

7. **Proposed:** Joe Carroll
Seconded: Brian Walsh

“That this Union calls upon the Minister for Health and Children to proactively engage with the Pharmaceutical Industry and the Irish Medicines Board to encourage the deregulation of appropriate medicinal products from prescription only to pharmacist supervised sale”

The motion was carried unanimously.

Action: The Union participated in a *Switch on to Self-Care* Working Group over the past 18 months.

The Group was composed of representatives from key stakeholder organisations including the IPU, the School of Pharmacy TCD, the Department of General practice UCC, and representatives from the pharmaceutical industry. The Group has now finalised a Self-Care Framework for Ireland which recommends that the range of medicines made available to patients should be expanded through switching. The Union has also raised this matter in meetings with the IMB. The Union also advocates for centralised switching by the European Medicines Agency under the PGEU umbrella. Following the deregulation of Norlevo in February this year, it is understood that the IMB has now formed a committee to look at this issue further.

8. **Proposed:** Joe Carroll
Seconded: Ultan Molloy

“That this Union calls upon the Minister for Health and Children to ensure that Medical Card Holders, who are experiencing huge delays in having their cards renewed because of HSE structural reorganisation, are not placed in position of financial hardship by having to pay for their medicines while their cards are expired.”

The motion was carried unanimously.

Action: Due to structural reorganisation, the HSE announced the centralising of Medical Card Applications. Unfortunately this has led to patients experiencing significant lengths of time for their medical cards. The Union has highlighted these delays in correspondence with the HSE and also raised the matter at the Joint Consultative Group Meetings which took place throughout the year.

A knock on effect to the delay in issuing valid medical cards was pharmacies experiencing rejected claims throughout 2010. The Union received a large volume of calls from pharmacists in relation to the rejection of claims by the PCRS and some of the reasons given by the PCRS were invalid/out of date medical card number.

The Union worked with the HSE last year to implement an Incomplete Claims Protocol which addresses this problem. This was finalised in October 2010. As well as addressing the issue of payment for members, this protocol also alerts patients to problems with their cards and gives them the time to contact the HSE and resolve the matter before it gets to the point whereby the HSE refuses to pay for the patient’s medicine. The HSE stopped rejecting GMS claims in October claims. The Union continues to monitor this situation in order to make sure that pharmacists are paid for medicines supplied to patients and patients, in turn, are not put in a position whereby they must pay for their medicines.

The Union participates in the HSE Pharmacy in Primary Care Group which is looking at a number of extended roles for community pharmacists such as Medicine Use Reviews, Compliance and Wastage schemes, vaccination, etc.

5. **Proposed:** Bernard Duggan
Seconded: Catriona O’Riordan

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The motion was carried by the majority vote. There was one abstention.

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8. **Proposed:** Joe Carroll
Seconded: Ultan Molloy

“That this Union calls upon the Minister for Health and Children to ensure that Medical Card Holders, who are experiencing huge delays in having their cards renewed because of HSE structural reorganisation, are not placed in position of financial hardship by having to pay for their medicines while their cards are expired.”

The motion was carried unanimously.

Action: Due to structural reorganisation, the HSE announced the centralising of Medical Card Applications. Unfortunately this has led to patients experiencing significant lengths of time for their medical cards. The Union has highlighted these delays in correspondence with the HSE and also raised the matter at the Joint Consultative Group Meetings which took place throughout the year.

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9. **Proposed:** Richard Collis
Seconded: Edward MacManus

“That this AGM endorses the IPU in its work to support IPOS purchasing pharmacists and calls on the Union to continue its endeavours in working towards a fair, equitable and timely resolution of all outstanding issues between stakeholders ”

The motion was carried by the majority vote. There were three abstentions.

Action: The Union set up an IPOS Purchasing Pharmacists’ Committee to oversee this issue. A number of meetings were held over the past year and the Committee has worked tirelessly with Uniphar to achieve an outcome which one hopes is acceptable to the majority of Purchasing Pharmacists. Uniphar announced the outcome of these negotiations at a meeting on 7 April 2011.

10. **Proposed:** Ultan Molloy
Seconded: Pdraig Loughrey

“That this AGM urges the Irish Pharmacy Union to consider exploring new avenues of working in partnership with the three third level institutions offering degree courses in Pharmacy in Ireland.”

The motion was carried by the majority vote. There was one abstention.

Action: The issue of the IPU supplying a teacher practitioner in the Schools of Pharmacy was discussed at length by the Community Pharmacy Committee. The Committee was of the view that there were other ways of working in partnership with the Schools of Pharmacy. In the meantime, the Union has given a number of talks to students at the three Schools of Pharmacy, awarded a prize for the best intern project and had students write articles for the IPU Review.

Union Secretariat Report

1. INTRODUCTION

Over the past year the activities of the Union have been overshadowed by the ongoing problems with our rising national debt and efforts to bridge the gap between expenditure and revenue. All parts of society and the economy are adjusting to this harsh new reality. Pharmacy has played its part by continuing to deliver professional services at greatly reduced levels of payments in what is an economically depressed time for patients.

The Union has also had to adjust to this new environment and we continue to deliver services and support to you, our members, to assist you in your professional and business activities. The Union did not expand or increase staff numbers during the boom years but used its resources wisely to provide more and more services with the same level of resources. The commitment of the staff of the Union to meeting the demands of and supporting our members is second to none. I would like to thank all my colleagues, the Officers of the Union and members for their continuing support. It is through this support and unity that we can all maintain our focus in ensuring the continuing viability of our businesses and profession. This is the only agenda and focus of this Organisation and we will not be deflected from this task.

2. DETAILS OF IPU MEMBERSHIP AND PHARMACY OWNERSHIP (AS AT 27 APRIL 2011)

(a) MEMBERSHIP OF THE IPU

Community Proprietors	878		
Industry & Wholesale	7		
Community Employees	851		
Hospital	9		
Army, Academic & Admin	4		
Associate Members	8	(1757)	

(b) NUMBER OF COMMUNITY PHARMACIES

Pharmacist Owned:

Single shops	753		
Chains	591	1344	

Non-Pharmacist Owned:

Single shops	69		
Chains	166	235	(1579)

(c) TOTAL NUMBER OF CHAINS (2 AND OVER)

	Pharmacist	Non-Pharmacist	
Two pharmacies	113	4	235
Three	31		93
Four	13		52
Five	7		35
Six	4	1	30
Seven		1	7
Eight	3		24
Nine	1		9
Ten		1	10
Thirteen	1	1	23
Fourteen	1		14
Fifteen	1		15
Sixteen	1		16
Twenty	1		20
Twenty-Four	1		24
Twenty-Six	1		26
Fifty		1	50
Seven-two		1	72
	(591)	(166)	(757)

3. PRODUCT FILE UNIT

The IPU Product File is managed by Fiona Hannigan and her team: Ger Gahan, Eilish Barrett and Aoife Garrigan. As well as supplying price updates and product information for members, they provide the following services and advice:

- Product sourcing
- General queries on the IPU Product File
- GMS pricing issues
- Short Supply & Discontinued Lists

The IPU also provides a Drug Interaction File and information files on drug use in Pregnancy and Breastfeeding, produced by the School of Pharmacy in Trinity College Dublin, linked to the IPU Product File. These are based on the ATC classification system and are designed to warn pharmacists of the possibility of an interaction. A PwC survey found the IPU file to be highly regarded and valued by users.

The following areas are a priority in the Product File area during 2011

- Enhancements to the IPU Product File to facilitate reference pricing and generic substitution.
- PA/PPA/DPA/EMEA numbers, verification of products, etc.
- Direct links to the IMB website to facilitate access to SPCs and PILs.
- A toolkit to assist system vendors in incorporating the IPU Drug Interactions File into their dispensary systems.
- Roll out of IPU Live Download of the IPU Product File.
- Development of a protocol to allow for broadband transmission of electronic orders.

4. ADMINISTRATION UNIT

The Administration Unit has four staff members: Patrice O'Connor, who works part-time, looks after reception and assists in the day-to-day running of the office; Ciara Enright, who works part-time as the Union's accountant, is Secretary to the Finance Committee. She maintains books of account and advises members on a range of taxation and accountancy problems. Wendy McGlashan is responsible for IPU publications, including the production of the IPU Review and co-production of the IPU Yearbook, event organisation, general administration and personnel matters. Roisín Molloy is responsible for all aspects of membership and the management of the Secretary General's office.

5. CONTRACTUAL AND OTHER RELATED ISSUES

Jill Lyons, and Caroline Mulligan deal with a wide range of contractual issues. Jill Lyons is Secretary to the Pharmacy Contractor's Committee (PCC). Jill and Caroline have played a key role in developing many of the key PCC initiatives throughout the year and in

the resolution of some problems with the Health Service Executive, Primary Care Reimbursement Service and the Department of Health & Children. Throughout 2010 Jill Lyons was involved in preparing two submissions and two oral presentations to the FEMPI Reviews [June 2010 & December 2010], preparing for the implementation of the prescription levy, preparing for the implementation of a Needle Exchange Programme, and preparing the submission and oral presentation to the DoHC's Working Group on Reference Pricing. Jill also represents the Union at the PGEU Economic Working Group. Jill and Caroline have spent much of the year participating in the Joint Consultative Group with the HSE and the implementation of the Incomplete Claims Protocol as well as addressing all other contractual queries that arise. Caroline also deals with remuneration queries, compiling information on the raids on pharmacies and collecting information on stolen and forged prescriptions.

6. POLICY AND PUBLIC AFFAIRS

Gerard Howlin was appointed on 15 November 2010 as Head of Policy and Public Affairs. Following the departure of Paul Fahey there was a reorganisation of responsibilities at Butterfield House and Gerard has taken responsibility for communications, publications, events, business, policy research and public affairs. Subsequent to the announcement of the FEMPI review in December 2010 Gerard worked with Jill Lyons to organise a survey of members and to deliver *Time for a New Approach*, the IPU's submission to the Department in January. Gerard is working with the Secretary General on an ongoing basis to liaise with stakeholders in Government and across the political parties. Gerard initiated a successful lobbying campaign to ensure that community pharmacy was included in the party manifestos. He is leading for the secretariat on the Clinical Platform Project and working with colleagues to ensure that plans in all his relevant areas are rolled out effectively

7. MEDIA AND COMMUNICATIONS

Kate Healy, who ceased employment with the IPU in April was responsible for the promotion and coordination of all national and regional media coverage for the Union. She was secretary to the Executive Committee and assisted the Secretary General in the development and coordination of all regulatory, policy and political activities. She was responsible for the editorial content of the IPU Review and managed IPU advertising campaigns. Aoibheann Ní Shúilleabháin works on the co-ordination of all communications activities, organises events, manages the IPU website and the advertising for the IPU Review. She is Secretary to the Organising Committee for the IPU National Pharmacy Conference. Gerard Howlin has assumed overall responsibility for this area.

Communications

- **Market Research:** The Union undertook market research amongst the general public, which assessed how people had actually reacted to the dispute and how it had affected their view of the profession. The research showed that pharmacists continue to be held in high esteem by patients.
- **Advertising and Public Relations:** The Union ran radio advertising campaigns in October, November and December. The ads aimed to promote the role of the pharmacist and to encourage people to visit their pharmacy as a place to shop in the run up to Christmas. Public relations activities also raised the profile of pharmacists in the media, including a number of interviews on RTÉ One's "Four Live".
- **Communications with Members:** A lot of work has been done in terms of getting members' feedback on our communications and, as a result, we have made great progress but we are working to develop better two-way communications and the greater use of e-communications. We have the IPU website, a dedicated IPU YouTube channel, the email service @ipumail.ie which provides members with easier and instant access to all IPU services and information and the weekly e-newsletter, which was launched during the year.
- **Publications** The IPU Review, Yearbook and a weekly e-newsletter are now all produced in-house rather than through external contractors for efficiency reasons.

8. PHARMACY SERVICES

The Director of Pharmacy Services, Pamela Logan, co-ordinates all Professional, Business and Training matters within the Union. Pamela acts as Secretary to CPC and details of issues covered by this Committee can be found in the CPC report. She works with relevant departments and agencies, both nationally and internationally, to promote the role of the pharmacist. Pamela also represents the Union at ICCPE, PGEU, FIP and Europharm Forum.

9. TRAINING DEPARTMENT

Susan McManus, Training and HR Manager, organises and co-ordinates a range of training courses for pharmacy staff. Janice Burke assists Susan in this department. The Pharmacy Technicians' Course saw 112 students graduating in March 2011. There are currently 150 students participating in Year 1 and 146 students in Year 2 of the course. In addition, 132 students completed the MCA Course in 2010 in Claremorris, Cork, Dublin, Galway, Kilkenny and Tralee. 76 students completed the Interact course and 33 completed the Interact Plus course. The FÁS Pharmacy Sales Traineeship course was administered in Baldoyle and Loughlinstown, Dublin; Douglas, Cork; and Mervue, Galway. Susan also acts as Secretary to the Employee Pharmacists' Committee, co-produces the IPU Yearbook and Diary and advises members on HR issues.

10. BUSINESS SERVICES

The Business Development Manager, Darren Kelly, is responsible for business services to members. In 2010 "Strategies for Growth" business training was held around the country to help members understand their business and maximise their profits. A number of affinity schemes have been negotiated for members on a range of products and services and details can be found on the IPU website. Members are kept up to date with current legislation through notices in the IPU Review, Yearbook, E-Newsletter and General Memoranda. Darren also produces the Business Newsletters on specific relevant topics which are sent out to members throughout the year. In addition, individual advice on retail and business issues is given to members on request. Members who paid their subscriptions for 2010 would have received their IPU membership card, "What the IPU does for you" information booklet and a discount booklet outlining the discounts available to IPU members. Darren also oversees the general maintenance and upkeep of Butterfield House.

11. EXTERNAL CONSULTANTS

Gordon MRM (PR Consultants); Coolamber (IT Consultants); John Behan (Industrial Relations Advisor) and Sean McHugh (Industrial Relations Advisor); provide advice and support to the Union as requested on an ongoing basis. Leaf Environmental has been retained as consultants to the Union on matters regarding environmental and waste management issues.

12. MAILINGS TO MEMBERS

The number of mailings to members over recent years were: 2003, 25; 2004 19; 2005, 20; 2006, 24; 2007, 47; 2008, 59; 2009, 53; 2010, 38.

13. MAIN COMMITTEE MEETINGS

The number of committee meetings was:

	'10	'09	'08
Executive Committee	6	9	10
Community Pharmacy Committee	5	6	5
Pharmacy Contractors' Committee	8	8	6
Finance Sub Committee	7	7	7
All Committee Meetings	0	3	3
Employee Pharmacists' Committee	4	3	4

14. UNION PUBLICATIONS

The following are sent to members, on a regular basis:

- IPU Review
- IPU Weekly Newsletter – sent to members by email
- General Memoranda
- Price Index List Updates
- IPU Product File on Disk and CD
- Yearbook & Diary
- Wall Planner
- Training Course Updates
- Employee Pharmacists' Committee Newsletter
- Reap the Rewards of IPU Membership

15. PENSIONS AND INSURANCE

AIC (Corporate) Ltd, Pharmacy Insurance Ireland and Liberty Asset Management provide insurance and pension services for members.

16. ENQUIRIES

Union Staff handle enquiries on a wide range of topics and deal with questions raised by members regarding their difficulties with companies, Government and other agencies as well as a wide variety of professional, business and personnel issues including:

- Advertising
- Banks
- Computerisation
- Contracts of Employment
- Credit Cards
- Customs & Excise
- Data Protection
- Dismissals; unfair, etc.
- Dispensing, extemporaneous price list
- Drug Donations
- Education & Training / Training Grants
- Employer/employee disputes
- Employee Status

- General Medical Services; Fees, etc
- Health Centres
- Health & Safety
- Health Promotions
- Health Screening
- Health Services and Schemes
- HSE
- HSE PCRS queries
- Industrial Relations law; general
- Insurance
- Internet pharmacy
- IPHA
- Leave; Annual, Maternity, Compassionate, Public Holidays, Holiday Pay, etc.
- Legal issues
- Locum Lists / Situations Vacant
- Maternity Legislation
- Medical Translations
- Membership
- Methadone Treatment Scheme
- Monitored Dosage Systems
- Openings; pharmacy
- Pay; National Minimum Wage, etc.
- Part-time workers
- Pharmacy Contract
- Pharmacy Legislation
- Photographic issues
- Prescriptions, Emergency Hospital
- Prices; including negotiations
- Products; agents, availability, confined, discontinued, etc
- Professional Indemnity Insurance
- PRSI
- Prescriptions; Stolen, Forged, etc.
- Psychiatric Scheme
- Publishing Scams
- Record Keeping
- Redundancy
- REPAK charges
- Returns; for credit, etc
- Salaries
- Security; Pharmacy Raids, etc.
- Sickness
- Signage
- Standard Operating Procedures
- Suppliers
- Taxation
- Trading Terms

■ Union Posters requested on a regular basis include:

- Medicines & Pregnancy
- DPS Threshold
- Paracetamol
- EHC
- Prescription Validity
- Refunds on Medicines
- Privacy
- Tax Relief

■ Unit Pricing

■ Unlicensed Medicines

■ VAT; IPU Scheme, etc

■ Waste Management

■ Withholding Tax

■ Wholesalers

17. SUBMISSIONS

The following submissions were made during the year. Extracts of these are published in the appendices to this report and all are available on the IPU website:

- Review of Methadone Treatment Protocol – HSE – June 2010
- Review under the FEMPI Act – DoHC – June 2010
- Retail Planning Guidelines – DEHLG – July 2010
- Oral Presentation on Methadone Treatment Protocol Review – HSE – Sep 2010
- Draft Guidelines on Sourcing, Storage and Disposal of Medicines – PSI – Sep 2010
- Draft National Standards for Safer Better Healthcare – HIQA – Nov 2010
- Mental Health Vision for Change – DoHC Independent Monitoring Group – Nov 2010
- IPU VAT Scheme – Revenue Commissioner – January 2011
- Review under The FEMPI Act 2009 – Time for a New Approach - January 2011

18. IPU REVIEW

The IPU Review is produced in-house by Gerard Howlin, Wendy McGlashan and Aoibheann Ní Shúilleabháin.

19. CONCLUSION

Finally, I would like to thank all the staff of the Union for their support to me and their hard work on behalf of members throughout the past year.

Seamus Feely,
Secretary General.

Pharmacy Contractors' Committee (PCC) Report 2011

The current Pharmacy Contractors' Committee, under the Chairmanship of Liam Butler, took office following the 2010 Annual General Meeting (AGM) in April. Morgan Power was elected Vice-Chairman. The PCC met seven times since the AGM 2010.

This year the PCC's energies have been focussed on preparing for two reviews under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI) along with many other urgent issues which have arisen during the year.

THE MAIN ITEMS ON THE COMMITTEE'S AGENDA SINCE THE LAST AGM:

FEMPI Act 2009:

- Preparing the Submission and Oral Presentation to the FEMPI Act Consultations in June 2010;
- Preparing the Submission and Oral Presentation to the FEMPI Act Consultations in January 2011;
- Communicating with members in advance of both FEMPI Act reviews; and
- Communicating with members in the aftermath of the FEMPI Act reviews.

HSE Matters:

- Participating in the Joint Consultative Group with the HSE;
- Resolving any issues on the re-issuing of Contracts to Members
- Negotiating a streamlined system for unlicensed medicines under the Hardship Scheme and Drugs Payment Scheme;
- Advocating for an agreed list of medicines for the LTI Scheme;
- Negotiating an agreed Protocol with the HSE around Incomplete Claims and ensuring all outstanding claims were paid;
- Monitoring of the Psychiatric Scheme and dealing with changes which took place in the Scheme in 2010;
- Advising Members on matters related to the Drugs Payment Scheme;
- Ongoing preparation and discussions for the introduction of a Needle Exchange Programme with the HSE and Elton John Foundation;
- Liaising with the HSE and DoHC to resolve issues around the Community Pharmacy Contract;
- Monitoring all pharmacy payments; and
- Ongoing HSE PCRS Administration issues.

Department of Health and Children Matters:

- Preparing for the implementation of the Prescription Levy;
- Preparing the Submission and Oral Presentation to the DOHC's Working Group on Reference Pricing; and
- Meeting with the Minister for Health and Children.

Monitoring the Cost of Medicines:

- Monitoring the reduction in the cost of medicines from APMI in September 2010; and
- Monitoring the reduction in the cost of medicines from IPHA in January 2011.

FEMPI Act 2009:

Submission and Oral Presentation in June 2010

Last year's Review under the FEMPI Act 2009 began in May. The PCC, along with economist Jim Power, worked on the submission to the Minister. The Union also engaged PwC to conduct a survey of members on the impact of the previous FEMPI cuts in relation to pharmacy income, services and viability. Members of PCC also made a presentation to officials in the Department of Health and Children and the HSE.

In the submission and at the oral presentation the PCC highlighted:

- The reduction of 30% in pharmacy income due to the cuts in 2009;
- The inconsistencies in the figures provided to the Union; and
- The impact of the cuts on individual pharmacies, which is of the order of €100,000 per pharmacy.

In July, after further representations by the PCC, the Minister wrote to the Union informing it that she had completed her review of the operation, effectiveness and impact of the amounts and rates fixed by the regulations and would not be making any further cuts at this time. The PCC welcomed this decision from the Minister.

Submission and Oral Presentation in January 2011

On 8 December the Minister for Health and Children launched a third review of pharmacy payments under the FEMPI Act 2009. A further survey from PwC was conducted which built on the survey earlier in the year. The PCC also sought data from the PCRS which was helpful in formulating the submission.

The submission was sent to the Minister for Health and Children on 5 January 2011. A delegation from the PCC made an oral presentation to the Department of Health and Children on 7 January.

In both the submission and oral presentation, the PCC stressed that:

- pharmacists had taken more than their share of cuts over the past two years; direct and indirect cuts of 32% or €153m which is more than that suffered by any other sector;
- additional efficiencies and savings could be achieved but only by adopting a new approach which would involve substantial and direct engagement with the Union to review all existing administrative, contractual and payment arrangements;
- if arbitrary cuts continue to be inflicted on the pharmacy profession; it would have a detrimental impact on pharmacists and patient care.

Follow up letters were sent the week after the presentation to the Department and the Minister. In March, a new Minister for Health was appointed, Dr James Reilly. The PCC wrote to him requesting a meeting immediately and asked him to consider the issues raised in the submission made in January. The PCC again strongly argued against any cuts being made to pharmacy payments, particularly against any reductions in dispensing fees and margins.

On 31 March, the Minister for Health announced further cuts to pharmacy payments.

On initial examination, it is estimated that the cuts will reduce pharmacy payments by €24m from May to end December 2011 and over €36m in a full year. This amounts to an 8% decrease across the sector and an estimated loss of €15,000 to the average pharmacy business.

The PCC wrote to the Minister on 1 April requesting that any changes be delayed for a minimum period of six weeks to allow for the appropriate IT amendments to software systems to take place. The Committee stated that they hoped that this would be the end of the recent ad hoc and arbitrary cuts. The PCC believed that discussion on a wider agenda would offer an orderly and efficient way to work together in bringing about real and lasting change in the future and offered to meet with the Minister on this matter.

HSE Matters:

Participation in meetings of the Joint Consultative Group

The Joint Consultative Group met three times since the AGM. As part of this Group, the Union and the HSE agreed to cooperate in the areas of modernisation, efficiency and flexibility. The Group is also a forum for discussion on matters of concern for members.

Return of Contracts

Since August 2009 the PCC had been in constant contact with the HSE and the Department of Health and Children to resolve this matter. A slightly amended contract was negotiated between the PCC and the HSE in early 2010 and this was issued to all the members involved in May. The PCC encouraged members to return the contracts and welcomed the resolution of this issue which had caused members considerable strain.

Changes to dispensing ULMs

Over the past few years the PCC had been raising issues and concerns around the dispensing of Unlicensed Medicines (ULMs) to patients under the Drugs Payment Scheme (DPS), the Long Term Illness (LTI) Scheme and Hardship Arrangements in correspondence and at meetings of the Joint Consultative Group.

In May 2010 the HSE issued a circular which outlined changes to the dispensing of unlicensed medicines and also a list of reimbursable unlicensed medicines. The list included details of the supplier, the cost of the medicine and a reimbursement code. The PCC will continue to monitor the dispensing on medicines under this list and will work with the HSE to make the system even more user-friendly.

Clarification of Medicines allowed on the LTI Scheme

After ongoing requests from the PCC for clarity and transparency around the LTI Scheme, the HSE issued an LTI Circular in July 2010. The HSE included a list of automatically approved items for LTI patients with Diabetes Mellitus and Epilepsy. The circular is intended to increase transparency and reduce administrative burden for pharmacists. There are still ongoing issues around LTI which the PCC will continue to monitor.

Introduction of an Incomplete Claims Protocol

The PCC has been monitoring this matter since it first arose in 2010. The PCC's primary concern was securing payment of all outstanding claims and safeguarding payments going forward. The Union received a large volume of calls from pharmacists in relation to the rejection of claims by the PCRS.

The PCC pursued the matter vigorously and met with the HSE numerous times to work towards a resolution and payment of all outstanding claims. An Incomplete Claims Protocol was finalised in October which addressed the matter and ensured that problems such as this would not occur in the future. The HSE stopped rejecting GMS claims and paid all outstanding amounts to members with their October claims. However, pharmacies who claim manually continue to have problems with their claims and these are being followed up by the PCC on an ongoing basis.

The PCC believed that this was a reasonable outcome as it addressed the first priority of the Union which was to ensure that pharmacists got paid for the services that they provided with the minimum of delay. The PCC asked all members to comply with the terms of the Protocol. The PCC and the HSE will be monitoring the implementation of the protocol at the JCG meeting throughout the year.

Psychiatric Scheme

In September 2010 Psychiatric Clinics in the Old Northern Area Board (north of the Liffey) took the decision to refer all GMS Psychiatric Patients back to their GP to have their medicines written on a GMS prescription form. The changes took place in Areas 6, 7 and 8. Patients attending these clinics were told that from 1 October they need to go to their GP to get a GMS prescription to take to the pharmacy. The change was introduced without any discussion with the PCC and apparently with no thought given to the impact of the changes on this vulnerable cohort of patients. The PCC complained to the HSE about the manner in which this change was implemented and argued that the new arrangements had placed a barrier in the pathway to accessing medicines for these patients and would compromise patient safety. The HSE intended to introduce this change to all areas in 2010; however, the roll out was halted after the PCC complaint. The PCC continue to monitor this issue.

Advice on the Drugs Payment Threshold

Throughout the year, the PCC dealt with a large number of queries in relation to the Drugs Payment Threshold. The advice to members was that it is entirely a matter for each individual pharmacist to decide for themselves what price they charge to private patients, including sub threshold patients. The legislation only applies to the amount that the State reimburses to healthcare professionals and the level of refunds that are made to patients under the various State Schemes. The matter now appears to form part of the IMO agreement with Government and this is a very worrying development. The PCC will continue to pursue this matter with the HSE and Department of Health and other relevant Departments.

Roll out of a Needle Exchange Programme

Throughout 2010 there were on-going discussions about the introduction of a Needle Exchange Programme between the PCC, the HSE and the Elton John Foundation. Subject to further discussions with HSE officials, the PCC has committed to participate in this worthwhile service for the Community.

Department of Health and Children Matters:

Meeting with the Minister

Officials from the Union met the Minister for Health and Children on 29 April 2010. The Union raised a number of issues at the meeting including the prescription levy, reference pricing, and the FEMPI review. The officials from the Union also left a copy of the 2010 AGM motions with the Minister for consideration by her and her officers.

Prescription Levy

The prescription levy was originally due to be introduced in April 2010. Throughout the summer there was constant contact between the PCC and the HSE/DoHC. Members of the Union met with and wrote to officials from the Department a number of times to discuss the prescription levy, highlighting many concerns around its introduction and the impact it would have on patients.

On 1 October the prescription levy was finally introduced. The Union issued members with posters and leaflets to alert patients to the levy being imposed on them. The PCC has been liaising with the HSE to answer any questions which have arisen since the introduction of the levy and a number of updates have been issued to members over the past few months. The Union met with Nursing Homes Ireland in an effort to resolve the issue over the collection of the levy from patients in nursing homes. The PCC continues to seek the abolition of this levy or, at the very least, further exemptions for nursing home patients and other vulnerable patient cohorts. The incoming Government has indicated its intention to abolish the levy. The PCC will keep the issue under review.

Reference Pricing and Generic Substitution

The PCC Sub Group on Reference Pricing made two submissions and an oral presentation to the Department of Health and Children's Reference Pricing and Generic Substitution Group chaired by Mark Moran. The PCC advocated for a pharmacy led generic substitution and felt that this was important if any new system were to succeed. The PCC also warned about a race to the lowest price and used European examples where there have been ongoing medicine shortages due to reference pricing systems, which put patient welfare at risk.

The Department published their report in June 2010. The report set out a proposed model for the operation of a system of interchangeable medicines and reference pricing. The report also stated that generic substitution should be pharmacy led as recommended by the PCC. The PCC welcomed the move by the Minister to allow pharmacists to offer patients the choice of a cheaper generic medicine but also asked the Minister to be careful in taking steps towards the introduction of reference pricing as pharmacists had already suffered a major blow due to cuts imposed in 2009.

The Heads of Bill for Reference Pricing are currently being prepared by the Department and are at an advanced stage. The PCC has requested a meeting with the Department.

Monitoring the Costs of Medicines

Reduction in the Cost of APMI Medicines

The new APMI Agreement came into effect on 1 October. In advance of the implementation date the PCC wrote to the Department of Health and Children stressing that the implementation of any price reductions should allow sufficient time to update pharmacists' IT systems and to allow them to try to dispense stock reimbursed at the higher price. The PCC also requested a deferral of the implementation date; however, the Department would not consider any deferral of the Agreement. As soon as the price changes were received from the HSE, the IPU Product File for October was emailed and posted out to members.

Reduction in the Cost of IPHA Medicines

As part of the Budget 2011 in December, the Department announced that they would make savings of €140m through reductions in the cost of medicines from 1 January 2011.

The PCC:

- advised members to manage their stock:
- wrote to the Department, the Minister, the Chief Executive of the HSE and the wholesalers on the matter; and
- was also in constant contact with officials from the Department, the HSE and IPHA.

The Department only informed the Union of the changes that were taking place on 23 December. The Union was informed on 5 January that *'all associated Parallel Imported products will be reduced pro rata'*. The manner and the speed in which these price reductions were implemented were totally unacceptable and there was considerable annoyance among members about this. The PCC met with and wrote to the DoHC complaining about the manner in which these reductions were implemented and requesting that they put in place safeguards to prevent the high level of loss experienced by pharmacists in January in any future reduction in the price of medicines. The DoHC have confirmed to the PCC that they will strive to give as much notice as possible in the event of further price reductions. The PCC will continue to monitor this matter having regard to the current economic situation.

Conclusion

The above provides a summary of some of the major issues dealt with throughout the year. However, officials of the Union intervened in many other instances to resolve individual issues for members.

The PCC is actively working with the HSE on members' behalf. Progress can be slow and discussions take time. There are often difficult issues to resolve, but at all times, the PCC continue to pursue issues on behalf of members until a resolution is found.

Liam Butler,

Chairman PCC.

Community Pharmacy Committee (CPC) Report 2010-11

The Community Pharmacy Committee (CPC) is chaired by Stephen Nolan with Bernard Duggan as Vice-Chairman. CPC's mission statement is ***CPC – working to serve and support community pharmacists in their practices and to promote and expand their role as pharmacists by continually developing professional, ethical, business and technological ideals and standards.***

The CPC is split into three sub-groups as follows:

Professional Development Steering Group

Bernard Duggan, Oonagh Harnett, Niamh Murphy, Ultan Molloy (Ciara Cronin resigned in September 2010).

Business and Policy Steering Group

Roy Hogan, Michael Tierney, Daragh Connolly, Elizabeth Lang, Aidan Walsh (replacing Peter Fox in January 2011).

IT Steering Group

Louise Begley, Ross Mc Entegart, Jack Shanahan, Rory O'Donnell. Sean Reilly (Exec), Brian Walsh (PCC) and John Barry have also been co-opted onto ITSG.

CPC has met five times since the April 2010 AGM (May, August and October 2010 and January and March 2011). The Committee has dealt with a wide variety of issues over these meetings. The following is a summary of the key issues dealt with during this time.

PROFESSIONAL ISSUES

PSI Consultations and Inspections

Championships in Athy in September instead of the Over 50s Show.

SOPs / Guidelines

CPC has made a number of submissions to the PSI over the year: Consultation Areas; Codeine Guidance; and Sourcing, Storing and Disposal of Medicines. All of these submissions are available on the IPU website.

In July 2010, the PSI produced guidance on the sale of medicines containing codeine. To assist members in complying with the new guidance, CPC produced a Codeine Sales Protocol and posters and leaflets were sent to pharmacies to assist them in communicating with patients.

The PSI Guidelines on Patient Consultation Areas in Retail Pharmacy Businesses came into effect on 1 November 2010. To assist members in the implementation of the guidelines, CPC put guidance on issues to consider when designing and equipping a Consultation Area and guidance on the layout of the area on the IPU website. A Privacy Poster was sent to all pharmacies in July.

The IPU Inspections checklist was updated to reflect new PSI guidance and also to include issues around CDs that have been reported by members following inspections. Much positive feedback has been received from members who have used the Inspections checklist and CPC recommends that all pharmacies utilise it to prepare for inspections. The checklist can be downloaded from the IPU website.

The final PSI Guidelines on Sourcing, Storing and Disposal of Medicines have yet to be published but in anticipation of the final draft, CPC has produced a set of SOP templates to assist members in complying with the guidelines. These can be downloaded from the IPU website.

The PSI Service Plan for 2011 proposes the production of guidelines on: Supply and Counselling of NPMs; Premises and Equipment; Supply of POMs; Record Keeping; Management and Supervision; and; Supply of Medicines to Nursing Homes. CPC will produce SOP templates to cover these guidelines when drafted.

Extended Pharmacy Services

Health Screening Pilot

43 pharmacies participated in the Union's Health Screening pilot from July 2009 until February 2010. The results are now being analysed by TCD to provide evidence to support the expansion of the professional role of the pharmacist. Aisling Reast, who coordinated the pilot on behalf of the Union, presented preliminary findings at FIP in Lisbon in September 2010 and at the All Ireland Pharmacy Conference in February 2011.

Medicine Use Review Pilot

The Union is participating in the HSE Pharmacy in Primary Care Group which is considering a number of extended roles for community pharmacists. A Medicines Use Review (MUR) pilot took place over the past six months and the results are now being analysed by TCD. It is hoped that MURs will soon be rolled out nationally.

Asthma Management Demonstration Project

The Asthma Management Demonstration Project ran from October 2009 until July 2010. The aim of the project was to identify facilitators and barriers to the implementation of evidence-based asthma management guidelines. 25 GP practices and 70 community pharmacies participated in the project. All patients recruited received a written Asthma Plan and subsequent GP visits were based on the patient's clinical status. At the same time, the Union has been participating in the HSE's Asthma Health Policy Project Team which is looking at best practice care pathways for the treatment of asthma. It is hoped that the asthma project will soon be rolled out nationally.

Needle Exchange Scheme

The HSE has received funding for a pharmacy-based needle exchange scheme from the Elton John Aids Foundation. The scheme will initially commence in 65 pharmacies around the country with further expansion of the scheme over the next three years. As part of the scheme, a National Pharmacy Coordinator for methadone will be appointed by the HSE. The scheme should commence shortly.

Methadone Treatment Protocol

The Union made a written submission and oral presentation to the HSE on the Review of the Methadone Treatment Protocol. The Union's presentation highlighted the issues facing community pharmacists involved in the Methadone Treatment Scheme and we made a number of recommendations to improve the Scheme: the appointment of a National Pharmacy Coordinator; a system for filtering unstable methadone patients; a support system for community pharmacists; correct payment for take-away doses of methadone; a review of patients in Garda custody and the prison system; and pharmacists being able to correct errors on methadone prescriptions.

The Review acknowledged that pharmacy involvement is a critical component in the overall delivery of the Methadone Treatment Protocol, allowing for a large number of opiate dependent persons to be treated in their own local area. The Review Group recommended that the methadone regulations be redrafted to incorporate buprenorphine and buprenorphine/naloxone treatment. Consequently, the title of the protocol was changed to The Opioid Treatment Protocol.

Patient Safety

The Union continues to participate in the Department of Health's Medication Safety Forum which currently is focusing on: the development of a national prescription form; development of SOPs for pharmacies; guidelines for codeine medicines; the roll-out of the Asthma Management Programme; the re-launch of PIP; and the management of patient discharge.

Palliative Care

The IPU has participated in a number of initiatives under the End of Life Forum umbrella over the past year. The Forum seeks to extend access to palliative care to people with illnesses other than cancer such as COPD, heart failure and dementia. The IPU's submissions and presentations focused on the role of the community pharmacist in palliative care, highlighting provision of timely access to essential palliative medication for patients cared for at home, the information resource of the community pharmacist and the liaison with other healthcare professionals on issues related to pharmaceutical care. The Forum's Report and Action Plan, published in June 2010, acknowledged the importance of the role of the community pharmacist in these areas.

The Union is also participating in a project run by Our Lady of Lourdes Hospice, focusing on the primary care role of community pharmacists in the treatment of palliative care patients.

Deregulation of Medicines

The Union participated in a Switch on to Self-Care Working Group over the past 18 months. The Group was composed of representatives from key stakeholder organisations including the IPU, the School of Pharmacy TCD, the Department of General Practice UCC, and representatives from the pharmaceutical industry. The Group has now finalised a Self-Care Framework for Ireland which recommends that the range of medicines made available to patients should be expanded through switching. The Union also advocates for centralised switching by the European Medicines Agency under the PGEU umbrella. Following the deregulation of Norlevo in February this year, the IMB has formed a committee to look at this issue further.

Health Promotion

In May 2010, the IPU ran a health promotion around European Obesity Day. Posters and leaflets were displayed in pharmacies, advising people to ask their pharmacist about obesity and healthy eating.

In June, the Union collaborated with Western Alzheimers in a mini health promotion to raise awareness of Alzheimers in Counties Galway, Mayo and Roscommon. Leaflets were displayed in pharmacies and the Western Alzheimers ran a radio appeal.

In September, the IPU had a stand at the National Ploughing Championships in Athy which was attended by over 200,000 people. Pharmacists promoted the role of the pharmacist in veterinary medicines and gave lifestyle advice to people following basic health-checks.

In March 2011, the Union provided pharmacies with promotional materials to assist in the supply of Norlevo to patients.

SOPs / Guidelines

A range of Standard Operating Procedures, Guidelines and Protocols are available in the members' only section of the IPU website under Professional Assistance > Guidelines and Protocols. These simple guidelines have been produced for members so that they can easily draw up protocols saving them money and time in doing. Topics covered include:

- Dispensing Process (including a guide to SOPs);
- Prescription Collection and Delivery;
- Dispensing Errors Log;

- Dispensing EEA Prescriptions;
- Parallel Imports;
- Health Screening including Lifestyle Advice;
- Medicines Sales Protocol;
- Codeine Sales Protocol;
- alli Sales Protocol;
- Levonorgestrel Sales Protocol
- Methadone Guidelines;
- Needle Exchange;
- Sharps Disposal;
- Asthma Inhaler Technique;
- Consultation Areas;
- Nursing Home Guidelines;
- Sourcing, Storage and Disposal of Medicines.

Medicines Shortages

The Union wrote to the Department of Health, the Irish Medicines Board and the Health Service Executive in March 2011 expressing concern at the significant number of medicines shortages that we had experienced in Ireland in previous months. We noted that other European countries had introduced a public service obligation which requires wholesalers to guarantee permanently the provision and timely delivery of medicinal products to meet the needs of patients. Obviously, wholesalers can only fulfil this type of obligation if they receive the medicines in the first place. We felt that it was time that the Department, IMB and HSE introduced a similar provision in Irish legislation.

Training

The Union produced its first IPU Open Learning Programme for Pharmacists in March 2011 on emergency contraception as part of our ongoing service to members, another benefit of IPU membership. The programme was free of charge to all IPU members; this was supported by HRA Pharma as a service to pharmacy. We would hope to produce more continuing education resources for members in the coming year to assist them in their CPD.

Susan McManus, Training and HR Manager, organises and co-ordinates a range of training courses for pharmacy staff. Janice Burke assists Susan in this department. The Pharmacy Technicians' Course saw 112 students graduating in March 2011. There are currently 150 students participating in Year 1 and 146 students in Year 2 of the course. In addition, 132 students completed the MCA Course in 2010 in Claremorris, Cork, Dublin, Galway, Kilkenny and Tralee. 76 students completed the Interact course and 33 completed the Interact Plus course. The FÁS Pharmacy Sales Traineeship course was administered in Baldoyle and Loughlinstown, Dublin, Douglas, Cork and Mervue, Galway.

IPOS

The Union set up the IPOS Purchasing Pharmacists' Committee to assist IPOS Purchasing Pharmacists (PPs) following the liquidation of the IPOS funds. The Committee has met six times since April 2010 and had a number of meetings with Uniphar to resolve issues. Uniphar announced the outcome and a possible resolution to the issues at a meeting on 7 April 2011 and this will now be discussed with individual purchasing pharmacists.

Business Issues

The Business Steering Group has met three times since the April 2010 AGM to discuss a range of issues that would assist members in running their businesses.

Business Training

The Union, in conjunction with Cara Healthcare, developed the Strategies for Growth business training sessions for members. The training took place in Dublin (3 sessions), Cork, Galway, Limerick, Dundalk and Sligo. Over 100 pharmacists, owners, and pharmacy managers attended. CPC has agreed that the Union should work with Cara Healthcare again for 2011.

Business Newsletters

Business Newsletters with information on: Health & Safety; an Index of Business Services; and Business Regulations were sent out to members in 2010. Further Newsletters in 2011 will cover issues such as Maintaining Profits and Cash Flow; and Dealing with the PCRS.

Buying Group Pilot

30 pharmacies participated in a buying group pilot scheme for front-of-pharmacy products. Order volumes were disappointing and following discussions with the wholesaler the CPC agreed that the Union should not continue with this initiative.

Benchmarking for Pharmacies

The Union is looking to collate business information from members in order to help them to benchmark their business. We hope to be able to build up data on the pharmacy sector that will assist members in running their businesses more efficiently.

Business Checklists

The Business Steering Group has developed a Business Review Checklist and a Data Protection Checklist as guides to help members review their business and ensure that key areas of the business are addressed. The checklists are available on the IPU website.

Key Performance Indicators (KPI) Template

The Business Steering Group has developed a KPI Template to help members monitor and benchmark the different categories and departments within their pharmacy. The KPI Template is available to download from the IPU website.

Affinity Schemes

The Union has set up a number of affinity schemes for members for a range of products and services including Business Management and Coaching, Insurance (Business, Professional Indemnity and Travel) and Pharmacy Consumables. Further details of these and existing affinity schemes can be found in the members' section of the IPU website.

IT Issues

The CPC IT Steering Group has met six times since the April 2010 AGM (April, August, October, November, December 2010 and March 2011) to discuss a range of IT issues.

IPU Product File

The Union's Product File Department is in the process of implementing a number of developments to the IPU Product File so that it continues to meet the needs of members and other users. Live downloads of the IPU Product File are being facilitated. System vendors adapted their systems to incorporate the FEMPI regulations and prescription levy. The Union is working on a toolkit to assist system vendors in incorporating the IPU Drug Interactions File, produced for the Union by TCD, into their dispensary systems. The IPU Product File will soon have direct links to the IMB website to facilitate access to SPCs and PILs. The Union is working with frontline wholesalers and system vendors to allow for broadband transmission of electronic orders. The IT Steering Group will continue to monitor user requirements for pharmacy systems and communicate these to system vendors. Work will soon commence on facilitating reference pricing and generic substitution with the IPU Product File and dispensary systems.

PCRS and ITSG Meeting

The IT Steering Group met with officials from the HSE PCRS in March 2011 to discuss a number of IT issues that had been referred by the Joint Consultative Group: Pharmacy Security Certificates; Electronic Reports; Multiple File Submissions; Nursing Home Issues; High Tech Interface; First Generation Wind Down; Manual Claiming; Owings; DPS Records; Electronic Prescribing; and Reference Pricing. These discussions will continue through the Joint Consultative Group.

IT Communications

The Union has received very positive feedback from members on the new IPU website, the ipumail service, e-Newsletter and text alert service. These media allow members to have easier and instant access to all IPU services and information.

I would like to take this opportunity to thank all of the Committee members and Union staff for their dedication, support and enthusiasm over the past year.

Stephen Nolan

Chairman CPC

Employee Pharmacists' Committee (EPC) Report 2011

The Employee Pharmacists' Committee (EPC) represents the interests of community pharmacy employee members of the Irish Pharmacy Union. The committee is chaired by Louise Begley with Caitriona O'Riordan as Vice-Chairperson. The mission statement of the EPC is: "To promote the professional and economic interests of employee pharmacists and constructively engage with other Committees of the Union and other stakeholders through the Employee Pharmacists' Committee." At present there are 851 community employee members of the IPU members which constitute 48.5% of the entire membership.

Work Programme

The EPC has met four times since the 2010 AGM (May, August, November 2010 and February 2011). The EPC also continues to have active representation on other IPU committees, with an allocation of three employee representatives on the Executive Committee and four representatives on the Community Pharmacy Committee. This ensures that the views of employee pharmacists are expressed and heard on the other committees of the Union, thus enabling employee input into decisions and in the development and implementation of the policies of the IPU.

The EPC has continued to communicate through regular articles in the IPU Review magazine which have covered topics such as Entitlement to Sick Leave, Locum Pharmacists- Employed or Self Employed, Pharmacy Jobs Crisis, Mediation Service and the EPC Survey Results-Reveals Pay Cuts. The EPC has also issued their fourth newsletter, in two parts, to community employee members. Both newsletters provided information on tax issues, credits and allowances. It aims to assist employee members to navigate their way through the complicated tax system and ensure they are in receipt of all their entitlements under this system.

Mediation Service

The EPC feel that the current climate in the community pharmacy sector presents the opportunity to introduce a structured mediation service for the resolution of disputes. Although driven by the EPC, this service is available to all members of the IPU. It could be beneficial to all parties by helping to achieve an early resolution of a dispute at a local level and, at the same time, avoid unnecessary legal costs, save time and maintain a good working relationship. The Mediation Service was launched in July 2010 and was this was highlighted in the IPU Review.

After the success of the first IPU Pharmacy Employee Seminar that was held in February 2010, the second Employee Seminar will be held during the National Pharmacy Conference in May. This Seminar will be designed specifically for Employee Members and will deal with Employment Law and HR issues as they present to the

employee. These will include Performance Management for Staff, Recruiting Safely and Effectively, Managing a Dismissal and Negotiating Terms and Conditions.

Locum Pharmacists

In December 2010 Revenue clarified, in their letter to the IPU 17 December 2010, its position on the issue of locum pharmacists remains unchanged. Revenue considers that all locum pharmacists should be treated as employees and that any remuneration is subject to deductions under the PAYE system, PRSI and Universal charges. This was communicated to all members of the IPU in February 2011 and the Revenue letter may be viewed on www.ipu.ie/locum-issues.

Interns

In September 2010 the IPU organised an information evening for Pharmacy Interns. The evening consisted of a presentation to the interns which covered background information on the inception of the IPU, the role of the IPU, the key strategic objectives, public affairs activates and current situation within the community pharmacy sector. The benefits of IPU membership were also highlighted.

Benefits of IPU Membership

In March 2011 the EPC produced a leaflet on the benefits of IPU membership. The objective of this leaflet is to remind current members of the array of benefits that is available, while also informing employee pharmacists who are currently not members of the benefits that IPU membership provides. This leaflet was also circulated to 1571 pharmacies.

Next Steps

- The EPC is half-way through its second term of office at the AGM. The current committee will continue to pursue its objectives with intent and to actively represent the interest of employee members. It will also ensure that the IPU continues to provide services and support to employee members within the community pharmacy sector. The future years will be challenging for all in community pharmacy. It is important now, more than ever, that employee pharmacists have a representative body which supports on their behalf. The EPC will continue to be this body and it encourages the involvement of more employees at both a regional and national level within the IPU so as to strengthen the resolve of employee pharmacists both in the IPU and the profession.
- The EPC encourages employee members to utilise their membership to the fullest and keep themselves informed on professional and business issues by

reading the General Memoranda, IPU Review magazine and other information provided by the Union. In June 2010 all IPU Members were designated with an @ *ipumail.ie* email account, the EPC would urge employee members who have not activated their account to do so immediately. The EPC would also recommend that employee members check the *members' only* section of www.ipu.ie, in particular the employee pharmacist's area of the website on a regular basis.

I would like to thank all the members of the EPC for all their work over the last year and the staff of the IPU, in particular Seamus, Pamela and Darren for their support and advice on all matters. I would especially like to thank the Secretary to the EPC, Susan McManus, for her hard work and commitment to the EPC and the President, Darragh O'Loughlin, for all his advice and assistance throughout the year.

Louise Begley,

Chairperson.

Public Relations Report

Public Relations Strategy played a key role in communicating the key messages of the Irish Pharmacy Union and its members over the past year. Once again, it has been an extremely busy time for the Communications team.

Political Engagement

The build up to the General Election was a very active period in generating opportunities for the IPU to engage in a meaningful way with political parties and to build new relationships within the political arena generally. This resulted in a successful lobbying campaign of the main parties to get them to include community pharmacy in their individual manifestos. A significant step in this regard was the IPU's breakthrough in securing the inclusion of pharmacy in the Fine Gael's Manifesto. Pharmacy had not been included in their original health document 'Fair Care'.

The President of the Union led a delegation of IPU members at the 'Health Hustings' initiative last February where the health spokespeople of each of the main five political parties, including the now Minister for Health Dr James Reilly, outlined their policies on a range of key services for patients and customers for the future. In addressing the IPU concerns, Darragh O'Loughlin highlighted the vital role pharmacists have to play as healthcare professionals in developing and delivering an efficient and cost-effective health service. Among the Union's key messages at this forum were the fact that there is no further scope for cuts to pharmacies and a call to expand the role of the pharmacist in primary care to include public health programmes such as Health Screening and the participation in national immunisation programmes.

FEMPI

The draconian FEMPI Cuts was also high on the PR agenda again this year. As a key priority for the Union and its members we responded strongly to the initial review of the FEMPI cuts last June pointing out that 1,600 jobs have been lost in the wake of the cuts and that patient services have been curtailed. In our submission of January 2011 to the Department of Health 'Time for a New Approach', we highlighted how pharmacists suffered large and disproportionate cuts in payments since July 2009 at the hands of the former Minister for Health and Children. Most recently in March we came out again in a strongly worded statement to the media reiterating the unsustainable impact of the cuts on our members.

Advertising Campaign – 'Ask Your Pharmacist First'

Following on from the success of previous marketing campaigns, we also invested in a major awareness campaign on radio to promote the 'Ask Your Pharmacist First' message. The campaign ran during November and

December 2010 and received very positive feedback from members and key stakeholders alike. The IPU message was heard by 1.8 million listeners.

Media Relations

Other key issues that contributed to the media relations agenda this year included:

- **Emergency Hormonal Contraception** – A call for the medication to be provided through pharmacies and a response to the development of Boots introducing this medication under the Patient Group Directives. Finally, a welcome to the landmark decision that this choice of medication was to be made available through all pharmacies across the country.
- **Prescription Levy** – The introduction of the Prescription Levy in October led to a high profile hard hitting media relations campaign by the IPU highlighting the impact on patients and members. The reversal of this decision in March of this year by Minister for Health, Dr James Reilly gave the IPU an opportunity to speak to key audiences welcoming this decision in the interest of our most vulnerable patients.
- **Consultation Areas** - The mandatory introduction of private consultation areas gave the IPU the opportunity to talk about the professional role of the pharmacist as medicines and health care professionals. We linked the successful advertising campaign on radio with the consultation areas to highlight 'Ask Your Pharmacist First'.
- **Generics** – We continue to beat the drum of generic substitution and issued a press release on behalf of members welcoming the decision to introduce generic substitution.

TV Opportunity

To promote the role of the pharmacist, we secured a very high-profile TV slot on RTE's *Four Live* show, which has a viewership of 107,000. The 'On the Couch' pharmacist series covered a number of topics including advice on quitting smoking, children's health and generic medicines, which helped to reinforce pharmacists as healthcare experts who can provide advice to patients.

Lose Weight Campaign

Our main Health Awareness Campaign last year was the Obesity Health Campaign which we ran in association with the Diabetes Federation of Ireland and GlaxoSmithKline to coincide with European Obesity Day. Promotional material was made available to members for the campaign including an information leaflet and a poster.

Ploughing Championships

The Union had a stand at the National Ploughing Championships in September 2010, providing a valuable opportunity to engage with the public on health issues. Pharmacists were on hand to give free advice to patients and to provide free blood pressure and BMI testing.

Media Coverage

All of the above generated extensive media coverage to keep the Union and its members in the news and on the airwaves during what has been overall a saturated media agenda with regards to the economy and the banking crisis.

Communications to Members

Following the revamp of the IPU website in February 2010, extra features have been added to improve communications with members. Over the past year, a template for mobile phones has been developed and the recently-launched IPU Members' Forum. IPU News, the weekly e-news update for IPU members, was launched in May 2010 and is designed to keep members up-to-date on all issues relating to pharmacy on a weekly basis. The SMS service was launched in November 2010 so that members can be alerted of urgent news or deadlines for pharmacy.

Finally, this year the communications team of Kate Healy and Aoibheann Ní Shúilleabháin, along with our external advisers saw the strengthening of the team with the arrival in November of Gerard Howlin as Head of Policy and Public Affairs, which has already had an impact on our engagement with key political stakeholders.

International Pharmacy Matters

1. PGEU REPORT

The Pharmaceutical Group of the European Union (PGEU) is the European association representing community pharmacists in 32 European countries including EU Member States, EEA countries and EU applicant countries. Overall, PGEU represents over 400,000 community pharmacists in Europe through their professional bodies and pharmacists' associations.

The IPU is represented at PGEU by Liz Hocter, Past President, Pamela Logan, Director of Pharmacy Services and Jill Lyons, PCRS Contract Manager. The Union has been very active within PGEU over the past year, ensuring that community pharmacy is considered in a wide variety of EU Directives. 70% of legislation in Ireland comes from EU Directives so it is vital that lobbying is done at this level rather than waiting for transposition into Irish legislation.

Overview of 2010

2010 was a year of extraordinary activity in European pharmacy. PGEU was involved to an unprecedented extent in the shaping of European legislation. We saw the adoption of the Directive on Pharmacovigilance, which for the first time recognises the crucial contribution pharmacists make to ensure the risks of medicines are fully understood and adverse drug reactions properly recorded. Other Directives such as the Patient's Rights Directive, the Directive on Falsified Medicines and the Directive on Information to Patients were hotly debated. 2010 also saw pharmacy in the European Court of Justice once again with important rulings relating to the establishment of pharmacies and pharmacy opening hours.

Directives

PGEU actively worked on seven Directives throughout 2010:

- Pharmacovigilance – the creation of a new system of managing the risks of marketed medicines;
- Information to Patients – a proposal to allow the pharmaceutical industry to provide information on medicines directly to patients;
- Falsified Medicines – the creation of a system of authentication of medicines at pharmacy level and the regulation of the sale of medicines through the internet;
- Patient's Rights – the legal obligation to recognise prescriptions from another Member State;
- Recognition of Professional Qualifications – a revised system of recognition of the professional qualifications of pharmacists from other Member States;
- Late Payments – the creation of a legal obligation for health authorities to pay contractors on time; and
- Consumer Rights – the harmonisation of consumer rights in all EU countries.

Pharmacovigilance

The Pharmacovigilance Directive was published in the official journal on 31 December 2010 and national governments now have 18 months in which to introduce legislation to implement it. PGEU succeeded in getting many of its amendments included in the final text, including the recognition of the role of the pharmacist in pharmacovigilance and pharmacists' role in reporting ADRs, including medication errors. Pharmacists will report to the national regulatory agency (IMB) who will then forward collated reports to the European Medicines Agency (EMA). The text of the Directive has suggested that these reports should be confidential, i.e. contain no personal data; however, it will be up to individual Member States to clarify the scope of the confidentiality.

Information to Patients

This Directive which proposes relaxing restrictions on industry providing information to patients has proved most controversial. The European Parliament has voted on this Directive and made it less centred on the industry agenda and more patient-centred. Information from industry must be approved by the relevant competent authority (IMB). The Council of Ministers is concerned that the current proposals may give industry an opportunity to promote medicines directly to patients. The Commission has now decided to produce a new version of the Directive and has indicated that it will be given priority during the Hungarian Presidency. It accepts that material must first be approved by the competent authority. In addition, there will be no suggestion that pharmacists would be obliged to distribute this material.

Falsified Medicines

This Directive was adopted by the European Parliament in February 2011. It is the most significant legislation that has happened to pharmacy in Europe for years. The Directive requires that a safety feature be placed on medicines open to counterfeiting and that pharmacists and wholesalers will authenticate.

The Directive also refers to the internet, proposing an awareness of the dangers of medicines purchased on the internet; a requirement for a community logo and register for internet pharmacies; and the right of Member States to prohibit the sale of prescription-only medicines (POMs) on the internet.

One significant effect this Directive will have on pharmacy is with regard to the selling of non-prescription medicines (NPMs) on the internet. PGEU had wished to ensure that the country of destination rules applied. Although this wording is not specified in the Directive, it does say that Member States can place restrictions on the sale of NPMs by internet as long as they are justified in terms of public health. The Directive also makes it clear that licensing of medicines is a matter for the national competent authority (IMB) therefore POMs may not be sold on the internet in Ireland.

While this Directive to put in place a medicines verification system was adopted in February 2011, the European Commission is using its powers, i.e. 'Delegated Acts', gained in the Lisbon Treaty, to design the technical aspects of the Directive. This means that two key aspects have not yet been decided – the systems of verification and authentication in pharmacy. There is a reference to the need to respect the ownership of data to the pharmacist and the Directive also says that manufacturers must pay for the database to host the authentication system as well as the safety feature. There is an obligation for wholesalers to verify packs.

The following assumptions can be made:

- Safety Feature – most likely a serial code in a 2D bar code presentation along with an anti-tamper seal;
- Risk Assessment – will be carried out as to whether the safety feature is required on both POMs and NPMs. All POMs will carry a safety feature unless shown not to be at risk, i.e. on black list, and NPMs will not carry a safety feature unless shown to be at risk, i.e. on white list.

PGEU's position is that all medicines should carry a safety feature.

The Directive permits the use of the safety feature to be extended to include reimbursement, pharmacoepidemiology and pharmacovigilance. If Member States wish to use the safety feature for these purposes, generic medicines would need to be included.

There is no strict obligation on Member States to adopt medicines authentication, only to apply the safety feature. However, it is hard to argue not adopting authentication when all of the systems are in place to facilitate it.

PGEU has produced a "Ten Principles Paper" which will form the basis of discussions with the Commission during the Delegated Acts process. The position paper is supported by EFPIA (industry), GIRP (wholesalers).

1. Combining tamper evident packaging with a unique serial number.
2. Guaranteeing continuity of protection throughout the entire supply chain.
3. Ensuring a single coding and identification system on each pack across the EU.
4. Ensuring product verification database systems can work together across the EU.
5. Verifying every serialised pack at pharmacy level.
6. Maximising all the potential benefits of mass serialisation.
7. Focusing on securing patient safety and protecting patient privacy.
8. Using safety features that are simple, robust and cost effective.
9. Working together in the interests of patient safety.
10. Involving other stakeholders.

Patient's Rights

The purpose of this Directive, adopted in March 2011, is to establish a clear community framework to facilitate cross border health care. The Commission will need to develop a system to recognise prescriptions and PGEU will monitor and attempt to influence the development of this system of recognition. The PGEU Statement on the Recognition of Prescriptions will ensure that national dispensing practices are not undermined by the new legislation and that pharmacists' roles in dispensing cross border prescriptions are well understood. In relation to internet pharmacy, PGEU proposed that Member States' rules on internet pharmacy should be respected and this was adopted.

Recognition of Professional Qualifications

The original Directive was adopted in 2005 and is now being reviewed by the Commission with the aim of publishing a Green Paper in early 2011 and a new Directive in 2012. The proposal advocates for a minimum level of education for pharmacists and a minimum duration of the undergraduate degree/ Masters.

The revised Directive will include new skills with regard to the expanded role of the pharmacist, e.g. pharmaceutical care and CPD. It is also likely that the 3 year derogation, which is enshrined in the current Directive, will be abolished.

Late Payments Directive

The aim of this Directive is to combat late payment in commercial transactions. Public and private hospitals and health services will be allowed 60 days to pay their bills. Those who fail to pay in time will pay penal interest rates of “at least 9%” higher than the statutory rate as well as a fixed fee of €40 compensation for recovery costs. The Directive has been published in the Official Journal and will be transposed into national legislation by March 2013.

Consumer Rights Directive

This Directive has been on-going since October 2008 and is reaching conclusion. There have been a lot of disagreements in relation to the degree of harmonisation. PGEU has been successful in having pharmaceuticals removed from the 14-day time frame for returning goods when withdrawing from distance-sales contracts. The Council has also agreed to exclude health service contracts from the scope of this proposal as these require special regulations.

ECJ Rulings

The European Court of Justice (ECJ) delivered its ruling in June 2010 in the case regarding the demographic and geographical rules limiting the establishment of pharmacies. The ECJ decided that such rules are justified in the interests of public health and are therefore compatible with European Union law. Specifically, they contribute to an even distribution of pharmacies across the territory and therefore ensure a reliable and high quality pharmaceutical service for citizens.

In July, the ECJ ruled on a case regarding national legislation governing opening times and closing days of pharmacies. The Court judged that European law was irrelevant for opening hours' restrictions.

Professional Issues Working Group (PIWG)

The mandate for PIWG is to explore and develop pharmacy practice in Europe. PIWG considered a number of topics during 2010 that were of particular relevance to pharmacy practice, including eHealth, patient information, patient safety, pharmacy education and the pharmacists' role in non-prescription medicines.

2. REPORT ON FIP CONGRESS, LISBON, PORTUGAL FROM 28 AUGUST - 2 SEPTEMBER 2010**Introduction**

The International Pharmaceutical Federation (FIP) together with the Associação Nacional das Farmácias (ANF) opened the 70th World Congress of Pharmacy and Pharmaceutical Sciences on 28 August 2010 in Lisbon, Portugal. Through its 120 member organisations and 4000 individual members, FIP represents and serves almost two million practitioners and scientists around the world. FIP President, Dr Kamal Midha, greeted the audience of almost 3000 pharmacists, pharmaceutical scientists, academics, researchers, students and guests who had come together for a week of pre-satellite symposia, workshops, lectures and meetings focused on this year's Congress theme – From Molecule to Medicine to Maximising Outcomes: Pharmacy's Exploratory Journey.

FIP's mission is “to improve global health by advancing pharmacy practice and science to enable better discovery, development, access and safe use of appropriate cost-effective quality medicines worldwide.” The focus of FIP over the past year and over the next few years is pharmacy education, present and future workforce needs, collaborative pharmacy practice and counterfeit medicines.

New FIP President

The FIP Council elected Dr Michel Buchmann (Switzerland) as the new FIP President. Dr Buchmann will serve a four year term (to 2014) following the Presidency of Dr Kamal Midha, who will carry on as FIP Immediate Past President. Dr Buchmann is assuming the role of FIP President after extensive experience within FIP Boards, community pharmacy practice and Swiss politics. In his remarks following the release of the election results, Dr Buchmann reiterated his commitment to advancing FIP's Strategic Plan to advance pharmacy practice, the pharmaceutical sciences and pharmacy education on a global level.

FIP and Pfizer Joint Survey

A new international survey, launched at the Congress, showed that over 90% of pharmacists believe they are key to improving patients' health, and while most pharmacists surveyed see their responsibilities increasing, they voiced concerns on training and pay. The survey showed that almost 3 in 4 pharmacists (73%) now provide patients with health promotion and management services. Nearly all (9 in 10) pharmacists agree that more information and advice - including on specific medications and treatments - are expected from pharmacists than ever before. However, most pharmacists (78%) say that they are

asked to provide additional services, such as advice, without fair and proper compensation.

“Pharmacists’ roles are changing, and we find ourselves increasingly working with patients and other healthcare professionals to prevent and treat disease. This survey shows that pharmacists welcome this expanded role, as it highlights what they like doing most - helping deliver better patient outcomes - while increasing visibility of pharmacists’ expertise. However, we also see an education and income gap that will need to be closed to ensure the pressure on current pharmacists isn’t too great, and so that we can continue to attract the best and brightest to the profession in the future,” said Ton Hoek, Chief Executive Officer of FIP.

Pfizer, in collaboration with FIP, commissioned the international survey to better understand the needs, concerns and attitudes of pharmacists. Interviews were held with over 2,000 community, retail and hospital pharmacists in 8 countries (Australia, France, Germany, Italy, Portugal, Turkey, the UK and the U.S.) between April and June 2010. The full survey results can be found on www.fip.org

Does pharmacists’ changing role offer value for money for the health system?

Suzete Costa from Portugal posed this question and discussed how pharmacy has been practising a trade-off between monopoly, prestige and reward - benefits sought since the foundation of the profession – and patient safety and expertise – responsibilities demanded by the public. Even though pharmacists’ role and pharmacy itself has greatly evolved in the past 20 years, this social contract in the public interest between pharmacy and the public preserves its main elements today. The added value generated by pharmacist-led initiatives for health systems in various parts of the world was highlighted, with an emphasis on the economic value and potential benefits that pharmacists could bring as the scope of practice is expanded in response to consumer expectations and behaviour changes. For every US\$1 invested in pharmacist clinical services, US\$4.81 was achieved in reduced costs or other economic benefits.

Emerging Pharmacy Business Models

Charlie Benrimoj from Australia discussed how community pharmacy has developed an excellent logistic and business capacity to dispense and sell medicinal and other products. The infrastructure, including personal management, information technology, physical structure, marketing and positioning, have been directed to optimise a business model that increases the efficiency and volume of products. Essentially the viability of the business models has been dependant on products. In recent years, the profession has attempted to incorporate cognitive pharmaceutical services into the

professional practice of pharmacists. Even with direct payment of services, implementation has become a challenging task. Recent research has demonstrated that a key issue in the implementation of services is the strategic decision by the pharmacy proprietor to position his business in the healthcare market by offering a service/product mix. With the availability of payment for services, some parts of the community pharmacy industry have commenced to differentiate away from purely using price/product and to using health care services as the differentiator. These emergent models can be classified into classic, health solution, retail destination and network business models. The evidence suggests that professional development needs to be linked to the business development of the pharmacy. Unless this integration of business and professional occurs, service provision may not occur or be sustainable. Some of the current business models will need to focus on evolving to become service /product models with ensuing changes in infrastructure.

Negotiating for New Pharmacy Services

Warwick Plunkett from Australia explained how, as health care expenditure rises, there has been a greater scrutiny on costs associated with pharmaceuticals. The area of pharmaceuticals has been seen by governments as a soft target. Maintaining current levels of remuneration for dispensing pharmaceutical products is very much under threat, leaving pharmacy to evolve its business model from the past product supply to one of product and service. The challenges for community pharmacy have included: the task of convincing community pharmacists of the need to change and commence delivering services along with the sale and supply of products; the identification of suitable health and medication management services for pharmacy to deliver cost effectively; finding resources to provide support for community pharmacies to implement new services; and developing the right strategy to negotiate payment from governments, health insurers and patients. Successive five year agreements between the government and the Pharmacy Guild of Australia for the payment of dispensing fees and additional professional services have worked successfully over the past 20 years. Australian examples of aligning research results, health policy priority, support for practice change and the key ingredients for successful negotiating were presented. Developing and maintaining a strong and effective lobbying presence is one of the essential foundations for government negotiations but it must be followed with a clear understanding of how services provided by community pharmacy can deliver cost effective solutions that fit the needs of existing health policy.

Pharmacy in Canada

Jeff Poston from the Canadian Pharmacists' Association described the legislation and regulations that have been introduced in Canada over the past 3 years to enable an expanded scope of practice for community pharmacists, including some form of prescriptive authority. Pharmacist prescribing includes a wide range of activities: prescribing over-the-counter and prescription medicines to treat minor, self-diagnosed or self-limiting conditions; providing emergency supplies of prescribed medication to a patient; monitoring and authorising the refill of existing prescriptions to ensure appropriate and effective care; modifying a prescription written by another prescriber to alter dosage, formulation, regimen or duration of the prescribed drug; independent prescribing in collaboration with the GP.

OTC Market 2020

Per Troein from IMS described how the OTC market is now worth €69bn and continues the recent trend of outgrowing prescription-only medicines. While Pharma growth experiences a number of constraints, e.g. generics, demand constrained by payers, etc. OTC benefits from a range of growth drivers, e.g. emerging markets like Russia and China, increased access through new channels, switching from POM to P. In European countries where medicines are largely state funded, many countries are looking at drastic measures to curb growth and reduce costs of medicines: price cuts; margin adjustments; generic strategies; reduction of new innovations; etc. Patients are willing to spend money on medicines that give immediate reward, e.g. headache relief, but in general prefer reimbursed prescriptions as opposed to self-paid OTC.

Community Pharmacy Services at the Primary-Secondary Care Interface

Bernard Duggan, community pharmacist from Dublin and Vice-Chairman of the IPU Community Pharmacy Committee, explained how the primary-secondary care interface provides significant opportunities for medication errors. The views of a nationwide stratified sample of community and hospital pharmacists were sought in anonymous, self-administered postal questionnaires. A record of community pharmacy-hospital communications was kept for 365 days and a 6 month review of new discharge and post-discharge prescriptions for medication errors was performed. Results of the survey showed that there is currently little communication across the interface at discharge. 11% of community pharmacists reported no hospital contact at this time and a further 80% only occasional contact. Hospital pharmacists reported on-going difficulty obtaining medication histories on admission. Both parties agreed that standard protocols and designated seamless care pharmacists would improve safety. Discharge/post-discharge prescription analysis showed a 27% error rate.

Health Screening in Pharmacies in Ireland

Aisling Reast, community pharmacist from Dublin, presented a poster on the IPU's Health Screening Pilot. Pharmacies selected patients either for monitoring or for screening for clinical signs and each performed all or some tests of total blood cholesterol, blood pressure, blood glucose, body mass index (BMI), waist circumference and carbon monoxide. Standard Operating Procedures and guidelines were provided by the IPU while patient data recording forms and physician notification letters were developed and tested for face and content validity by Trinity College Dublin. 164 patients (97 women) were screened at 15 sites and 161 total blood cholesterol, 152 blood glucose, 145 blood pressure, and 101 BMI measurements were made and recorded and a decision whether to refer was recorded in 107 cases.

Problems with Prescriptions and their Significance in Primary Care

Martin Henman from TCD, Dublin, presented a poster on prescription and medicine-related problems and their potential impact on pharmacists and patients. A study was carried out in a convenience sample of community pharmacists in a region near Dublin over one week. Nine pharmacies returned information on 905 prescriptions and 1,340 problems. Almost 80% of problems occurred with the first dispensing and problems with the prescription form accounted for 54% while problems with prescribed items comprised 44%. The most frequent categories of prescribed item problems were dosing and regimen issues (43%) while possible adverse drug reactions (5.6%) and interactions and allergies (3.5%) were the least frequent. In almost 14% of cases, pharmacists were unable to provide a medicine without further clarifying details and in around 10% of cases a change, an omission or a reintroduction of a prescribed item occurred without a reason being apparent to the pharmacist. Omission of a child's age was the most common problem with drugs for infections whereas dosing and regimen problems were common for cardiovascular drugs. Pharmacists reported that 9.2% of problems were potentially serious and they considered that 12.2% were potentially serious from the patient's perspective. Multiple methods were used to resolve most problems, with patients (61%), computerised medication records (57%) and prescriber contacts (39%) the three most frequent. Over 800 of prescriptions with problems were completely resolved while 58 were partially resolved and 13 remained unresolved. Pharmacists deal with a wide range of problems, particularly at first dispensing and most problems if unresolved would have a clinical impact on the patient.

The 71st World Congress of Pharmacy and Pharmaceutical Sciences 2011 will take place in Hyderabad, India from 2-8 September 2011. The theme

of the conference will be “*Compromising Safety and Quality, a Risky Path*”. The FIP Centennial World Congress 2012, celebrating 100 years of Advancing Pharmacy Worldwide, will take place in Amsterdam, The Netherlands from 3-8 October 2012. The FIP Congress will be held in Dublin, Ireland in 2013.

Pharmacists are encouraged to attend FIP to meet and share experiences with pharmacy colleagues from all over the world.

3. 19TH GENERAL ASSEMBLY OF EUROPHARM FORUM AND PROFESSIONAL CONFERENCE

The 19th General Assembly of the Europharm Forum was held in Copenhagen on 2 October 2010, preceded by a Professional Conference on 30 September – 1 October. Over 50 people attended the meeting representing 20 countries and a range of observer organisations. The IPU was represented by the President and the Director of Pharmacy Services.

Europharm Forum Priorities

Europharm Forum is a joint network of national pharmacy associations and the World Health Organisation (WHO) Regional Office for Europe. The mission of Europharm Forum is to improve health in Europe according to priorities set by WHO and to strengthen the position of pharmacists by showing their value to people involved in health issues.

The Forum's Vision to Practice 2020 is based on six key principles:

- Practice adapted to new public expectation;
- Practice close to patients;
- Provide up-to-date and evidence-based therapies and services;
- Ensure quality based on Good Pharmacy Practice;
- Secure a competent workforce (education, training);
- Provide integrated care in a collaborative practice.

To achieve this vision, Europharm Forum translates WHO and FIP strategies into the European context and supports PGEU activities in order to inspire national associations and practicing pharmacists to implement good practice.

Professional Conference

The main theme for the Professional Conference was Pharmaceutical Care. There was much discussion about the definition of Pharmaceutical Care and there was general consensus with the FIP 2003 definition:

- Pharmaceutical Care is the responsible provision of pharmacotherapy for the purpose of achieving definite outcomes that improve or maintain a patient's quality of life;
- It is a collaborative process that aims to prevent or identify and solve medicinal product and health-related problems;
- There is a continuous quality improvement process for the use of medicinal products.

The outcome indicators of Pharmaceutical Care should be based on ECHO: - Economical, Clinical, Humanistic Outcomes.

Economic indicators, to measure outcomes, include:

- Cost-effectiveness or cost benefit for society or healthcare;
- Cost-effectiveness or cost benefit for payers;
- Drug expenditure;
- Patient costs; and
- Pharmacy business viability.

Clinical and humanistic outcomes include:

- Mortality;
- Morbidity;
- Health status;
- Quality of life; and
- Patient satisfaction.

However, it is recognised that preventable, drug-related morbidity is so preventable and costly that improved quality may be possible without additional total cost to the healthcare system.

Choosing which indicators to use to measure Pharmaceutical Care is a question of choosing purposes and audiences, for example:

- Health authorities;
- Healthcare professionals;
- Pharmacists, pharmacy management, pharmacy staff;
- Politicians;
- Patients, public, press.

General Assembly

The General Assembly opened with addresses from Kees De Jancheere from WHO Regional Office for Europe; Thony Bjork, Vice President of FIP; Cecilia Bernsten, Vice President of the European Society for Clinical Pharmacists; and Dick Tromp, President of Europharm Forum.

Over the last two years, Germany, Austria, Latvia, Italy, France, Switzerland and Spain have notified Europharm Forum of termination of their membership of the Forum. At the GA, further withdrawals were notified from the Czech Republic, Belgium, Iceland and the Irish Pharmacy Union.

FIP described Europharm Forum as the 'arms and legs' of FIP in Europe and sees the Forum's role as implementing FIP strategy in Europe. FIP cannot fulfil the needs of all FIP regions as local differences are considerable; therefore it needs organisations such as Europharm Forum. FIP has broadened its scope with other organisations such as United Nations, World Bank, WHO Geneva and other global donors. FIP is willing to support Europharm Forum in having access to these organisations.

WHO (Europe) acknowledged the importance of Europharm Forum in assisting WHO to improve health in Europe and offered to assist the Forum in communications with WHO Geneva (Global). Both WHO and FIP expressed their concerns about the number of withdrawals by national associations from the Forum.

The Treasurer of Europharm Forum reported that the Forum had operated within its reduced means during 2010 and was therefore in a position to continue operating in 2011, despite its reduced membership, as it still had reserves left.

It was agreed that the Forum would continue to participate in meetings where pharmacy practice and the role of the pharmacist were on the agenda. The Forum will focus on one or two projects on developing pharmacy practice, continue to develop and expand the Observatory and run an annual professional conference.

Executive Committee

The Executive Committee is composed of:

- Th(Dick) Tromp (The Netherlands), President;
- Balázs Hankó (Hungary), Vice-President;
- Lidija Petrusevska-Tozi (FYR Macedonia);
- Frans van de Vaart, (The Netherlands);
- Gerald Alexander (UK);
- Kaidi Sarv (Estonia);
- Carin Svensson (Sweden).

The 20th Annual Meeting of the Europharm Forum will take place on 14-15 October 2011 in Ohrid, Republic of Macedonia.

2011 AGM Motions

The following motions, proposed in accordance with Article 29 of the Constitution, are brought before the meeting for consideration:

1. **Proposed:** Liam Butler
Seconded: Grainne O'Leary
"That this AGM calls on the Minister to recognise that there is no scope for any further unilateral and arbitrary cuts to pharmacy payments and to engage substantially with the IPU, under a process similar to that set out and agreed with the Health Service Executive and the Department in April 2008, to review all existing administrative, contractual and payment arrangements."
2. **Proposed:** Louise Begley
Seconded: Bernard Duggan
"That the IPU welcomes the recent Irish Medicines Board decision to reclassify the emergency hormonal contraception product Norlevo from prescription to non-prescription status and calls on the IMB to reclassify other appropriate medicines in order to improve the public's access to medicines."
3. **Proposed:** Caitriona O'Riordan
Seconded: Fearghal O'Nia
"That the IPU calls on the Irish Medicines Board, HSE and Department of Health to take all necessary steps, including the adoption in Ireland, as in other European countries, of a public service obligation, to ensure the uninterrupted supply of prescription medicines to patients."
4. **Proposed:** Rory O'Donnell
Seconded: Noel Stenson
"That this AGM calls on the Minister to act on his proposition to enable pharmacists to provide a vaccination service; including for swine flu, seasonal flu, travel vaccines."
5. **Proposed:** Kathy Maher
Seconded: Morgan Power
"That the IPU calls on the Minister for Health to engage positively with the IPU to agree a time-lined series of specific steps to deliver a better and more cost-effective primary care system for patients, which must necessarily include an enhanced role for community pharmacists as the single most accessible part of Ireland's primary care network."



Appendices

Appendix I

EXTRACT OF SUBMISSION BY THE IPU TO THE REVIEW UNDER THE FEMPI ACT 2009 SECTOR

EXECUTIVE SUMMARY

1. Last June the Minister for Health and Children announced reductions in payments to pharmacists under the Financial Emergency Measures in the Public Interest (FEMPI) Act (2009) in order to reduce the cost to taxpayers of drugs and medicines dispensed under the GMS (medical card) Scheme, the Drugs Payment Scheme, the Long Term Illness Scheme and other community medicine schemes. The Minister estimated at that stage that the income received by pharmacists under these schemes would decline by €55m in 2009 and €133m in a full year. The Union disputed these figures at the time and have now concluded that its original reservations were well founded.
2. The annualised savings accruing to the Exchequer will amount to a minimum of €144m, even taking into account the lower than anticipated level of consumption. However, the figure could be as high as €166m and further information and clarification is required from the Department to provide an accurate figure of the true level of savings from the pharmacy sector.
3. The Exchequer also benefited by virtue of the lower than predicted level of activity while, in contrast, pharmacists had to spread their fixed costs over a reduced income base. The cuts imposed last year are having a significant impact on services rendered by pharmacists, which we illustrate elsewhere in this submission.
4. In January 2010, a survey of Irish Pharmacy Union members conducted by PricewaterhouseCoopers (PwC) estimated that the average pharmacy has seen a reduction of 30% in public medicine scheme earnings. This decline occurred despite no associated reduction in the nature or complexity of dispensary activity. The estimated decline of 30% has to be considered in the context of the many other difficulties and challenges that the pharmacy sector is already facing as a result of the very difficult economic environment. At the same time, the level and general nature of expenses and commitments of pharmacists have not substantially changed over that period.
5. The Union recognises that the Department of Health and Children (Department) and the Health Service Executive (HSE) are also being challenged to deliver cost effective healthcare in these difficult economic times.
6. The Minister for Health and Children has a number of issues and initiatives to be implemented. The HSE also has an agenda for change. The Union, for its part, has issues that it wishes to have addressed. Therefore, the time is right to embark on a new relationship with the Minister, the Department and the HSE to chart a strategic approach to the challenges that now confront all of us.
7. For this reason, the Union is calling on the Minister to facilitate a dialogue and discussion through a structured process on an agenda for change, which we have outlined in this submission. The Union is prepared to engage in a constructive manner and real progress can be achieved through partnership and agreement.
8. The level of savings being achieved of between €144m and €166m is significantly in excess of the target set by the Minister last year. It is also considerably in excess of that achieved from other parts of the medicine supply chain and from other healthcare professionals. Having regard to the impact and extent of last year's cuts, the Union does not consider the level of cuts imposed in 2009 to be either fair or appropriate.
9. The analysis conducted by PwC on behalf of the Union clearly shows that the savings of €133m sought by the Minister have been exceeded. According to our analysis, even with the reduced volume of dispensing, the annualised savings will not be less than €144m and could be as high as €166m. The final figure can only be determined when clarification is provided by the Department on a number of outstanding issues
10. In the circumstances, the Union is calling on the Minister to:
 - Reinststate the Over Seventies Fee;
 - To eliminate the €3.50 fee band, which is unsustainable (the minimum fee should not fall below €4.50); and
 - Establish a process to address the many challenges being faced by all stakeholders.

This is the Executive Summary from the IPU's Submission to the FEMPI Review 2010. The full submission was sent to all members in June 2010 and is available on www.ipu.ie.

Appendix II

EXTRACT OF SUBMISSION BY THE IPU TO THE HSE ON REVIEW OF METHADONE TREATMENT PROTOCOL

24 June 2010

1. INTRODUCTION

The Union applauds Action 35 in the National Drugs Strategy (interim) 2009-2016 that requires that a review of the Methadone Treatment Protocol take place to maximise the provision of treatment, to facilitate appropriate progression pathways and to encourage engagement with services. The Union welcomes the opportunity to make a submission to the Health Service Executive (HSE) on this review.

2. METHADONE TREATMENT SCHEME

The Methadone Treatment Scheme was set up in the old Eastern Regional Health Board Area (ERHA) to enable patients to receive methadone treatment in their local community pharmacy, as opposed to visiting one of the methadone clinics which were set up by the ERHA in the 1980s. There was major public opposition to the building of methadone clinics in local communities at that time and the network of community pharmacies provided the solution for the delivery of methadone treatment.

Patients currently receive methadone treatment through the 470 community pharmacies who participate in the scheme. Pharmacies are not obliged to participate in the Methadone Treatment Scheme under their contract with the HSE; they do so, on a voluntary basis. The scheme has been very successful to date, enabling those addicted to heroin to regain control of their lives, allowing them to re-enter employment or education, provide for their families and be positive contributors to society in general. Needless to say, methadone is only part of the solution; an ideal situation would be where patients would be free of addiction completely. For this to happen, patients need other support services, such as addiction counselling.

There is an urgent need to reach out to heroin addicts who are not currently receiving treatment. There are 14,000 opiate addicts and only 8,000 in treatment according to the Mid-Term Review of the National Drugs Strategy. Patients are faced with a waiting list for accessing treatment. There is also considerable scope to expand the numbers of pharmacies participating in the Methadone Treatment Scheme, with a network of 1,540 pharmacies across the country. Pharmacists are interested in developing their role in this scheme, provided there is adequate support given to them.

Delivering methadone treatment through community pharmacies is not only beneficial for the patient, but it is also less conspicuous and more convenient for them to receive treatment from the local pharmacist than to travel to one of the methadone clinics. It has also been proven to be more cost-effective for the State. It is worth noting that the National Advisory Committee on Drugs, in its report on the *Use of Buprenorphine as an intervention in the Treatment of Opiate Dependence Syndrome* in March 2002, confirmed that it is up to twelve times more cost-effective to treat opiate addiction in the community setting than in a specialist clinic.

Pharmacists have been keen to get involved in the scheme in order to help people who have made the brave decision to tackle heroin addiction. Pharmacists get great personal satisfaction from providing this vital service in their local community. However, the people involved in providing this service need support and there is a critical lack of support for pharmacists, both financially and in terms of general support, involved in the Methadone Treatment Scheme.

Community pharmacists have experienced a number of problems in recent years relating to the scheme, which is likely to lead to the numbers of pharmacists participating in the scheme to decrease over time. This will have a knock-on effect on the HSE's resources, as well as increasing the cost to the HSE of providing the service to patients.

The Methadone Treatment Scheme was originally intended to cater for patients who had already been stabilised in the methadone clinics; however, the scheme has been expanded outside of the ERHA area, where there are few clinics. Many patients are currently referred to community pharmacies for treatment before they have been stabilised in a clinic. In some areas, there are no clinics and unstable patients will take their first dose of Methadone in a community pharmacy. Outside of the ERHA area, the only person with regular contact with the patient is the community pharmacist. Pharmacists experience severe difficulties in managing such unstable patients.

3. IPU RECOMMENDATIONS

The Union suggests a number of recommendations which, it believes, would improve the Methadone Treatment Scheme delivered through community pharmacies.

- a. The appointment of a National Pharmacy Coordinator
- b. A system for filtering unstable methadone patients
- c. A support system for pharmacists dispensing methadone
- d. Correct payment for takeaway doses of methadone
- e. Review of patients in the prison system

4. CONCLUSION

These issues have been on the agenda with the Department of Health and Children and the HSE since 2005. Whilst there has been a little progress in some areas, it has been slow. In conclusion, the Union would ask the HSE, as a matter of urgency, to appoint a National Pharmacy Coordinator who would be able to liaise with pharmacists, local Pharmacy Liaison Officers and the Union to address any issues of concern that arise. This will ensure the continued long-term participation of community pharmacists in the Methadone Treatment Scheme and will help to attract new community pharmacists to join the scheme. This is essential to maximise the provision of treatment, to facilitate appropriate progression pathways and to encourage engagement with services.

Appendix III

EXTRACT OF IPU SUBMISSION TO DEPARTMENT OF ENVIRONMENT HERITAGE AND LOCAL GOVERNMENT ON A REVIEW OF RETAIL PLANNING GUIDELINES (2005)

June 2010

This submission was prepared by BMA Planning on behalf of the IPU in response to an invitation by the Minister for the Environment, Heritage and Local Government seeking submissions by stakeholders in the retail industry in relation to the Review of the Retail Planning Guidelines for Planning Authorities, 2005 (RPGs).

The IPU position was that pharmacies are an essential component of and make a very positive contribution to the vitality and viability of town, neighbourhood and local centres and that this should be maintained and strengthened in the forthcoming RPGs.

The submission focussed on:

1. The planning implications and threat to community pharmacies posed by the development of large superstores with on-site pharmacies,
2. The planning implications and associated threat to community pharmacies posed by the location of pharmacies in large out-of-town health centres. In this regard, the IPU consider it imperative that pharmacies should not be considered as an “*ancillary use*” within a health/ medical centre but rather as an independent unit or “*shop*” and assessed accordingly in accordance with the “*sequential approach*”.

A number of recommendations were presented to address these issues in the context of the RPGs Review.

The outcome sought was that the Revised RPGs should:

- a. Outline policy which recognises the important health, economic and social function of pharmacies in the context of town centres and local centres and in meeting the needs of patients in the community e.g. the elderly, people with special needs, families with children, and those without access to a car.
- b. Specifically identify that all pharmacies should be subject to the sequential test in the same way as other local shops and that pharmacies should be discouraged within out-of-centre Superstores and Health Centres where they would have an adverse impact on the vitality and viability of existing town centres or local/ neighbourhood centres

This is a short extract from the IPU’s Submission to the Department of Environment Heritage and Local Government on a Review of Retail Planning Guidelines (2005). The full submission is available on www.ipu.ie.

Appendix IV

IPU SUBMISSION TO THE PSI ON DRAFT GUIDELINES ON SOURCING, STORAGE AND DISPOSAL OF MEDICINAL PRODUCTS WITHIN A RETAIL PHARMACY BUSINESS

17 SEPTEMBER 2010

1. INTRODUCTION

The Union welcomes the opportunity to make a submission to the Pharmaceutical Society of Ireland (PSI) on its draft guidelines on Sourcing, Storage and Disposal of Medicinal Products within a Retail Pharmacy Business.

2. TIMING/FORMAT OF THE GUIDELINES

The Union welcomes the decision by the PSI to extend the deadline for submissions to 17 September 2010 as August is a key month for staff holidays. In this context, the PSI may wish to consider not issuing any future draft guidelines for consultation during the summer months or over the Christmas period. These recent draft guidelines are the third published for consultation by the PSI this year. It would be helpful to the Union and its members if the PSI could provide a work plan for the next 12 months on what further draft guidelines it hopes to publish for consultation, so that the views of members can be sought, fully considered and collated for submission. It would also be useful if future guidelines were circulated in 'Word' format to facilitate people making highlighted comments in the text.

3. OVERVIEW

Pharmacists are fully committed to providing a professional service to their patients but a balance must be struck between meeting the needs of patients and maintaining paper trails and written procedures. Pharmacists are getting increasingly concerned about the ongoing imposition of bureaucracy and paper trails in pharmacy practice. These guidelines alone require in excess of 20 different types of procedures and processes to be developed. It is vital that pharmacy does not become dominated by having written procedures rather than the more fundamental requirement in pharmacy to have skilled, well trained and alert staff at the interface with patients which is the ultimate guarantee of patient safety. It is fully accepted that there is a need for Standard Operating Procedures (SOPs) that cover some fundamental operations of a pharmacy but the documenting of every procedure has the added risk that the important gets lost in the ever growing paper pile.

The Union would ask the Society, therefore, to review their current approach in this area and recognise that there is a need for balance and reasonableness in all of these changes and, above all, to recognise

that pharmacists' first priority is to provide timely, professional and cost effective services to their patients. While the Union is fully committed to supporting high pharmacy standards, it is vital that the important does not get lost in a paper melee. We make some specific points on the draft guidelines in the remainder of this submission.

4. STORAGE OF MEDICINAL PRODUCTS

The Union would like to make the following comments on specific issues dealt with under *Draft Guidelines on the Storage of Medicinal Products within a Retail Pharmacy Business*.

Humidity Monitoring

The draft guidelines require that, where particular humidity storage requirements are prescribed, humidity monitoring should be incorporated as part of the monitoring of the storage area. When PSI inspectors have visited Retail Pharmacy Businesses, inspectors have requested that the pharmacy monitors humidity on a daily basis. The PSI should issue pharmacies with standards for measuring humidity, e.g. how is humidity measured, what is the range to monitor, etc., and guidance on what type of humidity monitor to use and also consider the associated costs.

Controlled Drugs Cabinet

The Regulation of Retail Pharmacy Businesses Regulations 2008 (S.I. No. 488 of 2008), Paragraph 4(4), require that the CD cabinet meets the requirements of Regulation 5 of the Misuse of Drugs (Safe Custody) Regulations 1982 (S.I. No 321 of 1982) (as amended by Regulations 26(2) of the Misuse of Drugs Regulations 1988 (S.I. No. 328 of 1988)). In order to comply with these regulations, the cabinet must meet the specifications set out in the standard specification for Burglar-Resistant Cabinets for the Storage of Controlled Drugs 1985 (I.S. 267:1985). The cabinet must either be marked permanently with (i) the manufacturer's name and address, (ii) the capacity of the cabinet in cubic metres, (iii) the type approval test reference number and (iv) the inscription "I.S.267: 1985" or a member of An Garda Síochána (not below the rank of Superintendent) may issue a certificate which will last for 2 years.

It has been brought to our attention that I.S. 267:1985 is not available in Ireland. Consequently, it is not possible for safe manufacturers to inscribe the cabinet with this standard. This leaves the pharmacist with only one option – to get a member of An Garda Síochána (not below the rank of Superintendent) to issue a

certificate. Members have reported that when they have contacted the Gardaí to obtain a certificate, many Gardaí are not aware of this requirement and are reluctant to sign a certificate. We would suggest that the PSI produce an updated standard which can be given to both manufacturers of CD cabinets, so that they can inscribe the cabinet appropriately, and also brief the Gardaí so that they are aware of the requirements and advise them on the matter.

Veterinary Medicines

The draft guidelines propose that veterinary medicinal products requiring 2-8°C storage should be kept in a separate animal medicines refrigerator reserved solely for this purpose. Whilst this may be a reasonable requirement for a pharmacy which has a significant veterinary business, it is neither practical nor efficient for a pharmacy which deals in a small amount of veterinary medicines to have a separate fridge for veterinary medicines. We would ask that the PSI guidelines reflect some practicality in this matter.

High Tech/Exempt Medicines

We do not feel that it is practical to require that documentation for High Tech medicinal products or Exempt medicinal products be kept with the medicinal products. Pharmacies have a comprehensive, logical, filing system for suppliers' invoices, copies of prescriptions, etc., and it does not make sense for paperwork for these products to be stored in a different manner. Likewise, it is not practical to store such paperwork in the fridge with the product.

5. DISPOSAL OF MEDICINAL PRODUCTS

The Union would like to make the following comments on specific issues dealt with under *Draft Guidelines on the Disposal of Medicinal Products within a Retail Pharmacy Business*.

Storage of Waste Medicines

The draft guidelines require that waste medicinal products should not be stored in the dispensing/working area of the pharmacy. The Union would argue that, as long as these medicinal products were segregated from normal stock and clearly labelled '*Medicines for Destruction*', there would be no issue with them being stored in an area of the dispensary where they would be under the control of the pharmacist. Equally, as explained further in the next paragraph, the PSI should ensure that the HSE has a nationwide system in place for the disposal of such waste.

Patient Counselling

The draft guidelines suggest that patients should be encouraged to return unwanted or expired medicinal products to the pharmacy for disposal. Whilst many pharmacies provide this service as a gesture of goodwill to their patients, it is unfair to expect

pharmacies to cover the considerable cost of such disposal. Some HSE areas provide a DUMP scheme through pharmacies in their area but many more do not. The Union has, for many years, called for a national DUMP scheme to be put in place. Indeed, this was a recommendation of the Joint Committee on Health and Children in their report on the Adverse Side Effects of Pharmaceuticals. The PSI should be cognisant of the costs involved in expecting pharmacies to provide such a service and should liaise with the Department of Health & Children and the HSE to ensure that a DUMP scheme, funded by the HSE, is put in place nationally before imposing such a requirement on community pharmacies.

6. STANDARD OPERATING PROCEDURES

The draft guidelines impose requirements for a significant number of SOPs to be put in place as part of the implementation of these guidelines; the Union has noted 22 separate SOPs! Whilst the Union acknowledges the appropriateness of setting standards in community pharmacies, the PSI should consider practicalities, costs and the workload involved for a single pharmacist pharmacy to produce such a suite of SOPs. We would hope that the PSI would acknowledge the professionalism of community pharmacists and that practicality and common sense would prevail in the methods used to apply such standards. We would be concerned that the onerous requirements involved in producing so many SOPs would result in many pharmacies spending their time writing and reviewing SOPs instead of advising and counselling patients. This has the added risk of critical SOPs not getting the attention they deserve and pharmacists, and their staff, drowning in paper and procedures. We would also expect that the implementation date of these and any further guidelines should reflect the time it will take most pharmacies to produce even just a selection of these SOPs.

7. CONCLUSION

In conclusion, whilst the Union accepts that all pharmacies should meet the appropriate standards in sourcing, storing and disposal of medicinal products, the Union would expect that the PSI be cognisant of the practicalities from a pharmacist's perspective in relation to the large number of SOPs required to implement these guidelines. There is now a serious risk of SOP overload and critical patient care issues losing out to the maintenance of written procedures and practices. The PSI should seriously review the level of bureaucracy now being imposed on pharmacists and prioritise what they view as the critical SOPs. The Union looks forward to working with the PSI on the production of a more practical version of these guidelines which will incorporate the issues addressed in this submission.

Appendix V

SUBMISSION BY THE IPU TO HIQA ON DRAFT NATIONAL STANDARDS FOR SAFER BETTER HEALTHCARE

4 November 2010

1. THE ROLE OF THE PHARMACIST IN SAFER BETTER HEALTHCARE

Patient care is becoming increasingly complex with: an ever increasing range of disease-specific medicines, both prescription and non-prescription; the impact of pharmacogenomics; the demands of pharmacoconomics; the plethora of drug and disease evidence and other interventions available to the healthcare team. Superior clinical practice founded on collaboration among healthcare professionals is a key solution to this complexity. Collaborative pharmacy practice is defined as the clinical practice where pharmacists collaborate with other healthcare professionals in order to care for patients, carers and public. Integrating pharmacists into a collaborative healthcare team improves patient outcomes. There is strong evidence that pharmacists' interventions on prescriptions are clinically appropriate and have a high acceptance rate. There is also strong evidence of the value of medication review services where pharmacists review a patient's medication regime and make appropriate clinical recommendations. There is growing evidence of enhanced clinical benefit and good patient acceptability when pharmacists' practice is advanced collaborative practice. The number of preventable medicines-related problems makes a compelling argument for a collaborative approach to medicines use and healthcare generally. The greater complexity of healthcare, the complex diseases afflicting patients, the growing sophistication of medication therapies all support the need for, and the value of, community based pharmacists, who are medication experts, to be fully engaged in collaborative pharmacy practice with the one aim to ensure safer and better health outcomes for patients.

2. STANDARDS AND CRITERIA

In this section, we make general comments on the Standards and Criteria under each of the themes laid out in the HIQA document. However, before we do, we would like to point out that, while the Standards Advisory Group had representation from ICGP, Nursing and Midwifery, Surgeons, Health and Social Care Professionals, Anaesthetists and Paediatricians, disappointingly there was no representation from the pharmacy sector. This is surprising given the key role that pharmacists play in healthcare delivery and that pharmacists are invariably the first port of call for most patients.

Theme 1: Person-Centred Care

The IPU agrees with the Standards and Criteria identified to cover Person-Centred Care. The Union regularly undertakes consumer research through Behaviours & Attitudes to ascertain what new services patients would like to see in community pharmacy and to review what patients feel about the services offered. The Union has always highlighted community pharmacy as being the most accessible part of the health service. Other jurisdictions, having recognised this, have moved to provide an increasing number of primary care services through community pharmacies, for example, vaccination, health screening, medicine use reviews and health promotion.

Theme 2: Leadership, Governance and Management

Most of the Standards and Criteria identified in this section are addressed for community pharmacy through pharmacy regulations and guidelines produced by the PSI under the Pharmacy Act 2007. Pharmacies have Standard Operating Procedures in place to ensure the required standards for pharmacy activities are met and maintained. Some of the criteria in this section would only be applicable in larger healthcare settings, e.g. hospitals, rather than in community pharmacies. A balance always needs to be struck between the maintenance of written procedures and the focus on patient safety so it is important to ensure that guidelines focus on the important rather than try to cover every single aspect of professional practice.

Theme 3: Effective Care

The PSI is responsible for registering community pharmacists and pharmacies and for monitoring and auditing the quality of pharmacy services. The Union welcomes the Standards and Criteria on integrated care as we have regularly highlighted concerns about the lack of integration across the primary and secondary care interface and indeed within primary care itself, e.g. recent changes to the Psychiatric Scheme which were introduced with little regard to their impact on patients. In this context, it is important that the Health Service Executive (HSE) consults with the relevant healthcare professionals before making changes to any scheme to improve operational efficiencies to ensure that patient safety is preserved.

Theme 4: Safe Care

The Union will shortly become a signatory to the Department of Health and Children's Patient Safety First initiative and we therefore support the ethos behind the Standards and Criteria identified in this section. New national legislation to support the new Pharmacovigilance Directive will also go some way to addressing these criteria. However, in a bid to learn from and prevent adverse events, it is vital that a 'no blame' culture be adopted to encourage reporting of adverse events by healthcare professionals.

Theme 5: Workforce

PSI regulations under the Pharmacy Act 2007 incorporate a requirement for pharmacy owners to ensure that their staff has the necessary training and competencies to deliver services to patients. In addition, the PSI has recently announced the introduction of a mandatory CPD system for pharmacists.

Theme 6: Use of Resources

The Union has always advocated for community pharmacists to have an increased role in the delivery of primary care as evidence has shown pharmacy to provide value for money, an important consideration in these economically challenging times. Examples of such services are medicine use reviews, disposal of unused medicines, health screening, etc.

Theme 7: Use of Information

Community pharmacies are all registered with the Office of the Data Protection Commissioner and are well used to treating all patient information with the utmost confidentiality. The Union hopes to work with the Department of Health and Children and the HSE in the introduction of electronic health records and electronic prescribing, both of which will improve delivery of healthcare services to patients and patient safety.

Theme 8: Promoting Better Health

Community pharmacy is the ideal place for health promotion and the Union has run a number of health promotion campaigns nationally over the years.

3. CONCLUSION

In conclusion, whilst the Union welcomes the new HIQA standards to promote safer better healthcare, it is important that clarity on the role of HIQA and the PSI is given to avoid overlap and confusion.

Appendix VI

EXTRACT FROM SUBMISSION BY THE IPU TO THE INDEPENDENT MONITORING GROUP FOR A *VISION FOR CHANGE*

19 November 2010

1. THE ROLE OF THE PHARMACIST IN MENTAL HEALTH

Community pharmacists are in a unique position to contribute to the care of people with mental health difficulties, especially those with mental illness, and to alleviate the workload of other healthcare professionals in tackling often complex health problems. Pharmacy is the most accessible and visited part of the health service for patients with mental illness.

2. PROBLEMS FOLLOWING CHANGES TO THE PSYCHIATRIC SCHEME

Recent changes to the arrangements in place for the dispensing of prescriptions within the Psychiatric Scheme have caused much disruption to the lives of patients with mental illness. The Psychiatric Scheme has operated in the greater Dublin area since 1998. It has enabled patients with full eligibility (GMS patients) to present a prescription issued by one of the clinics operated by the Community Mental Health Services at a community pharmacy and subsequently obtain their medication free-of-charge. Since 1 October 2010, GMS patients must obtain a medical card prescription from their GP in order to obtain medication prescribed for them by the Community Mental Health Services. The patient is now given a prescription or a list of their medication by the clinic which then has to be transcribed by their GP onto a medical card prescription.

The Report of the Commission on Patient Safety and Quality Assurance 2008 stated that *“when patients move from one care setting to another...a significant level of discrepancy between actual medication treatment and what was intended can arise.”* Recent national research found that, when prescriptions issued by acute general hospitals were transcribed by GPs, 30% of medicines were transcribed incorrectly. This error rate was found to be consistent for all transcribed prescription items over a six month period.

Patients attending the Community Mental Health Services represent a particularly vulnerable group within society. The Psychiatric Scheme has enabled these patients to readily access essential medicines and professional advice from their community pharmacist in a timely fashion. The new arrangements have placed a barrier in the pathway to accessing medicines for these patients and will compromise patient safety. The IPU believes that these new arrangements should be reconsidered in light of their detrimental impact on this vulnerable patient group.

3. PHARMACY SERVICES

Patients need better services and health outcomes and Government continues to seek better value for money, particularly in these difficult economic times. In this context, the IPU has been advocating for the introduction of a number of initiatives, for example, Medicines Use Reviews, Monitored Dosage Systems and Structured Health Promotions, which would be relevant to patients with mental health problems. The Joint Committee on Health and Children in its report *Primary Medical Care in the Community* recommended that the HSE should consider how pharmacists could provide these services.

Minister Harney is supportive of an expanded role for pharmacists in the delivery of services at primary care level as *“part of a structured framework of patient care”*, which demonstrates *“direct benefits to patients.”* The Minister recently referred in the Dáil to *“a number of developments taking place in community pharmacy practice; namely, reviews of medicine use, the introduction of private consultation areas in pharmacies and the involvement of pharmacists, both community and hospital based, in ongoing work to implement the recommendations of the Report of the Commission on Patient Safety and Quality Assurance.”*

4. CONCLUSION

The existence of a relationship between patients with mental illness and their community pharmacist provides the ideal framework to deliver primary care services, which would result in positive outcomes being achieved in a cost effective manner. The IPU believes that recent changes in arrangement to the dispensing of medicines to patients under the Psychiatric Scheme have led to problems for patients with mental illness and these changes should be reconsidered. People with mental illness need timely and uncomplicated access to medications and advice on how to take them. This is important from a reassurance perspective.

Appendix VII

EXECUTIVE SUMMARY OF REPORT PREPARED BY THE IPU “REVIEW UNDER THE FEMPI ACT 2009 – TIME FOR A NEW APPROACH”

5 January 2011

COMMUNITY PHARMACY ROLE

- the pharmacy profession plays a critically important role in the Irish healthcare system, being the most accessible and efficient element of the national primary healthcare network;
- the cost-effective nature of the service, and the significant potential offered for the generation of additional system-wide cost savings, has been highlighted by a series of independent bodies, most recently the ESRI (October 2009) and the Joint Oireachtas Committee on Health & Children (February 2010);
- health authorities in other jurisdictions are now effectively leveraging this potential to the significant benefit of taxpayers, healthcare providers and patients alike;
- the Irish Pharmacy Union (IPU) and its membership wishes to engage in a meaningful dialogue with the Department of Health & Children (DoHC) and the Health Service Executive (HSE) on how such experiences can be replicated in the Irish context – at a time when the need for cost-effective healthcare services has never been greater;

COMMUNITY PHARMACY REIMBURSEMENT

- the community pharmacy sector suffered large and disproportionate cuts in payments as a result of the introduction of FEMPI provisions in July 2009;
- using HSE data, community pharmacists have contributed €123m in savings directly to the Exchequer from the FEMPI Cuts;
- the FEMPI impacts, are compounded by a number of other policy initiatives which have or will serve to further reduce earnings, including:
 - a series of reductions in the price of off-patent medicines in 2010;
 - introduction of a prescription levy for GMS patients;
 - planned introduction of generic reference pricing;
 - new costs of regulation; and
 - implementation of the IPHA Agreement in 2011.

- with regard to the IPHA Agreement, it is estimated that the community pharmacy sector will deliver €20m of the targeted €200m in savings in 2011 and will also have, and continues to, contributed €10m from the IPHA and APMI cuts that took place in 2010 on an ongoing basis;
- this means that pharmacy has yielded savings of €153m or about €95,000 per pharmacy as a direct consequence of changes since July 2009 – this is a direct hit on bottom line profit;
- this equates to a reduction of more than 32% in the payments made directly to community pharmacy contractors in the year to end-June 2010;
- taking into account the sub-threshold or gross DPS, pharmacists have suffered a loss of revenue of €181m or over €112,000 per outlet;
- using CSO Annual Services Inquiry data, this equates to more than 45% of average outlet operating profit in 2007 – the final year of the economic boom;
- operating profit is that sum of money available to cover the capital costs of the business (i.e. interest and depreciation), taxes, owner profits and reinvestment in the business;
- moreover, pharmacists will incur losses as a result of the devaluation of stock holdings as a result in the recent IPHA cuts – estimated at more than an average of €10,000 per outlet;
- this means that, in addition to the €20m that pharmacists will contribute on an ongoing basis from the recent IPHA cuts, the cost of the first month’s savings totalling €12m will come directly from pharmacists (who purchased stock at the old price) and not from the pharmaceutical companies;
- the collapse of the DPS yielded public scheme savings of more than €75m in excess of the targeted €133m, with more than €16m of these savings lost to community pharmacy outlets;
- in the computation of FEMPI impact, no account is taken of this development and this should also be taken into account in this review;

COMMUNITY PHARMACY RESPONSE

- in order to maintain viability, pharmacies have reduced costs by cutting staff numbers. Regrettably services and opening hours have also been cut;
- in human terms employment in the community pharmacy sector has been reduced by 10%, with pharmacist employment falling by 4%;
- despite severe retrenchment, it is clear from PwC survey research (December 2010) that a sizeable proportion of the community pharmacy network is now struggling for financial viability;
- in calendar year 2009, when FEMPI had been in operation for only six months, 14% of pharmacy contractors reported net losses after tax - combined, these contractors account for 20% of the national outlet network;
- any further reduction in payments and any significant change in interest rates in the coming months may permanently compromise the viability of these outlets;
- the IPU recognises the importance of effective and transparent regulation, however that regulation comes at a significant cost that should be recognised;
- there is a limit to which any profession or business can cut costs and sustain a high quality service. Community pharmacy has now reached this point;
- given the substantial savings that have already been achieved from community pharmacy and further savings planned for 2011, the IPU believes that no further cuts should be made at this time;
- current reimbursement rates are, quite simply, inadequate to support the development of the community pharmacy sector in line with best international practice and to the benefit of all stakeholders;
- a more strategic approach should be taken to achieve savings and efficiencies;

TIME FOR A NEW APPROACH

- the IPU is calling on the DoHC and the HSE to engage substantially with the IPU and its membership within a defined time period to review all existing administrative, contractual and payment arrangements with a view to identifying the scope for the realisation of pharmacy-specific, system-wide efficiencies and savings;
- this could be carried out through a process similar to the one agreed with the HSE and DoHC in April 2008;
- unilateral and arbitrary cuts with limited engagement result in short-term savings which generate long-term costs and serve to alienate the most accessible, affordable and cost-effective element of the Irish healthcare system, particularly in the context of the current economic climate and the increasing demand for community based patient services;
- the time for a new approach is now.

This is the Executive Summary of the IPU's Submission to the FEMPI Review 2011. The full submission was sent to all members in January 2011. The submission is also available on the IPU website.

Appendix VIII

EXTRACTS FROM SPEECH BY MR DARRAGH O'LOUGHLIN MPSI, IPU PRESIDENT'S DINNER, 10 NOVEMBER 2010

Minister, Deputies, Senators, Honoured guests, colleagues and friends

Tonight is an important occasion – it's that time of the year when we in the Irish Pharmacy Union, and I as the elected President, say a sincere "thank you" to all who work with us. In this room tonight are members of our Union who give of their time to keep us the strong, professional and focused representative body that we continue to be.

Present here too are representatives of the Department of Health and Children, the Health Service Executive, the Pharmaceutical Society of Ireland, the Irish Medicines Board, our colleagues from Europe, the Northern Ireland and the UK and the many other stakeholder and representative organisations we interact with on a daily basis, most of which have been mentioned already.

I especially want to welcome Minister Mary Harney and her husband Brian Geoghegan here this evening. Your presence here tonight Minister is an important signal to us of your commitment to community pharmacy (and I welcome your comments earlier).

We here may come from different organisations and from different perspectives but we share a common goal. That common goal is a better, more efficient and more cost effective health service which delivers the best possible outcomes for patients. As health care professionals, delivering high quality care for our patients is our life's work.

However, we need to reflect tonight that Ireland is not on a steady course. The best case scenario facing our country is one of extraordinary challenge and unprecedented difficulty. And that's the best case scenario; it cannot be automatically assumed. A business-as-usual strategy will not suffice if we are to succeed in putting our country back on a path towards prosperity. And – to be blunt – policy-makers, pharmacists and patients all share a vested interest in restoring national prosperity.

Right now, there is a compelling case for doing things differently from how they have been done before and this equally applies to healthcare delivery. As a representative organisation, the Irish Pharmacy Union has a clear agenda for pharmacy. We aim to position community pharmacy not only as the most readily available and the most accessible interface for patients – which it already is – but also to build on that accessibility and convenience and on the care community pharmacists already provide by delivering more services and delivering them cost-effectively, achieving positive outcomes for patients.

While the IPU is in the vanguard, advocating a bigger role for pharmacy in the delivery of health care for patients in the community, we are not alone in this: we are greatly

encouraged by recent reports from both the ESRI and the Oireachtas Committee on Health and Children. Like us, these interested, expert and astute observers of health care believe that pharmacists could and should be doing more for the benefit of all.

As well as hard times, there have been many positive developments in pharmacy. The Pharmacy Act is an important and positive step forward. Adjusting to increasing regulation is costly and never easy. In the cultural shift away from the assumption of quality to the assurance of quality, a reasonable balance has to be found between increasing accountability requirements and the costs of meeting those requirements and also the need to ensure pharmacists are not detracted from their focus on patients, who are the reason we do what we do.

The roll-out of a new regime of Continuing Professional Development and Competency Assurance will undoubtedly pose an additional challenge for all of us, but we must see it as providing the solid concrete foundation on which our ambitions for the future of our profession will be built. It ensures that patients who trust and rely on the professional judgment and discretion of their pharmacists can continue to have full confidence in the professionals caring for them. We, as a profession, are now better placed than ever to deliver more for patients and to bring better value to health care delivery.

Pharmacies have stepped up to the mark in a whole range of different ways. In difficult times, pharmacists have invested in making the changes needed. Last year, in the shadow of the flu pandemic, almost 1,000 pharmacists were trained, at their own expense, and were ready to participate in the national immunization effort if the need had arisen.

More recently, we have installed private consultation areas where patients can discuss their health in private with their pharmacist, thus enhancing their experience of using a pharmacy. Clearly these new consultation facilities make a whole range of patient services more feasible as well as more patient friendly. These are the ideal locations for providing diabetes and cardiovascular screening, cholesterol testing, for blood pressure testing, for helping patients manage their chronic illnesses and for delivering services locally – at times and in locations that meet the diverse needs of people in the community.

And we are not just talking about this; we're doing it. Pharmacists are now engaged in a number of important patient and public health pilot programmes – including Health Screening, Medicine Use Reviews and Asthma Management. We are working with the HSE and with other stakeholders because we believe that these programmes have the potential to deliver real value to patients and to

deliver an efficient and economical model of preventative healthcare. These ongoing projects are gathering concrete evidence of the benefits of the services being provided.

Innovative approaches and solutions like these need to be found. The status quo is not an option. Neither do I accept that an ad-hoc series of reactive and uncoordinated spending cuts – ultimately self-defeating – leaving an already inadequate state of affairs further decimated, but putting nothing different or better in its place is the way to proceed.

I have a vision of a patient dropping into a pharmacy after she finishes work or at the weekend in a response to a targeted cardiovascular screening programme. She has her blood pressure, her cholesterol and her blood glucose measurements taken by her pharmacist. Where those measurements indicate that she is at risk of cardiovascular disease, because her blood pressure or other measurements are outside of the normal range, she is given the necessary lifestyle and dietary advice to make the changes necessary to improve her health prospects and she is also referred to her GP. At the GPs, her doctor would start her on an appropriate treatment plan which has been drawn up by clinical specialists in the area based on international best practice. She comes back to the pharmacy with her care plan and her prescription. And then, on an ongoing basis, the pharmacist can monitor her progress for example by measuring her blood pressure, and, if necessary, adjust the doses of her medication step by step in line with the care plan agreed with her doctor. This ensures that she gets the full benefit from her medication, that she has support in managing her condition and that she achieves the best outcome possible for herself, potentially avoiding an unnecessary hospital stay down the line.

Minister, you and the Government rightly call on all to play their part and to pay their share. Pharmacists have already paid more than their fair share – in the twelve months since we last enjoyed this dinner, employment in the pharmacy sector has declined by well over 10%; 1,600 of our members or their staff have lost their jobs.

The future of pharmacy and of patient care generally depends greatly on all of us engaging together in a constructive manner for the common good. That common good is clear. We have together a shared responsibility to ensure our country pulls through this crisis, that patients continue to be cared for, and that we deliver a sustainable, convenient and cost effective model of healthcare that will serve Ireland well for the future.

In conclusion:

- As a Union of professional pharmacists we are strong and we are united.
- As Irish citizens we recognize and we understand the realities our country faces. These are hard times. There are no easy choices.
- The choice we want to embrace is that of dramatic change and not of piecemeal retreat. We can glumly face a slow death by a thousand cuts or we can say NO! We can say instead that there is a different way.
- It is a way that points to the bigger picture and to the longer term.
- Its achievement requires a collaborative, team-based approach to the delivery of sustainable healthcare.
- It involves care in the community and pharmacy is central to this new model of healthcare. We are there in every community. We are accessible and we are passionately dedicated to our patients.
- Minister, we are part of the solution and we are committed to playing our part.



Appendix IX

SOME KEY LETTERS AND RESPONSES RECEIVED THROUGHOUT THE YEAR

Topics

- **Financial Emergency Measures in the Public Interest Act 2009**
- **Fees for Pharmacists and Pharmacies**
- **Prescription Charges**
- **Rejected Claims**
- **Needle Exchange Programme**
- **Hardship and Psychiatric**
- **DPS Reimbursement Letter**
- **Memorandum of Understanding**
- **IT Issues**
- **Generic Substitution and Reference Pricing**
- **New Services**
- **Methadone Treatment**

FINANCIAL EMERGENCY MEASURES IN THE PUBLIC INTEREST ACT 2009

Financial Emergency Measures in the Public Interest Act 2009 – Letter 1

From Secretary General to Assistant Secretary DoHC [20 January 2010]

I wish to refer to your letter of 13 January and to thank you for the two enclosed reports.

At our meeting in October 2009, the Minister indicated that she intended tracking, on a monthly basis, the level of savings being achieved under the FEMPI Regulations. The Minister also indicated at that meeting, and publicly, that the Department and the HSE would share this analysis with the Union in the interest of transparency and, if the Union required further clarification, this would also be provided. The Department based its analysis of savings on forecasts for 2009 which have not to date been made available to the Union. The Union sees a benefit therefore in having a meeting between the Departments advisers, FGS and the Union's advisers, PwC to guarantee transparency and understanding on all data.

In the meantime, I would ask that you provide the information originally requested on 14 December and 23 December as soon as possible to enable the Union to make an informed submission to the Minister's Review.

The information requested is:

- Information showing the estimated amount being saved for each month by the HSE since the introductions of the cuts, including the calculations, methodology and underpinning computations; and
- Information on dispensing trends and payments over the past six months. (Jill Lyons sent two spreadsheets requesting both contract specific data and aggregate data by email on 23 December).

I look forward to hearing from you.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 2

From Secretary General to Assistant Secretary DoHC [11 February 2010]

I wish to refer to my previous letter of 20 January 2010 and would appreciate if you could arrange to provide the information originally requested on 14 December and 23 December as soon as possible. This information is vital to enable the Union to make an informed submission to the Minister's Review.

The information requested is:

- Information showing the estimated amount being saved for each month by the HSE since the introductions of the cuts, including the calculations, methodology and underpinning computations; and
- Information on dispensing trends and payments over the past six months. (An email containing two spreadsheets requesting both contract specific data and aggregate data was sent on 23 December).

Following receipt of your last letter and enclosed report, PwC has now reviewed the data and has written to the Union to outline some concerns they have in relation to the methodology and underpinning computations used in your calculations (copy attached).

I would appreciate if you could let me have the information previously requested and your views on the PwC analysis. It is important that both sides have a shared understanding of the data in advance of the Minister's consultation getting underway.

I look forward to hearing from you.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 3

From Secretary General to Minister for Health and Children [22 March 2010]

I wish to refer to our meetings in October 2009 and December 2009.

At both of the meetings, you indicated your intention to track, on a monthly basis, the level of savings being achieved under the FEMPI Regulations. You also indicated that the Department and the HSE would share this analysis with the Union in the interest of transparency and, if the Union required further clarification, this would also be provided.

The Union has written and/or emailed your Department and the HSE on the following occasions for information relating to the FEMPI Regulations:

- 14 December 2009
- 23 December 2009
- 20 January 2010
- 11 February 2010

The information requested was:

- The two Farrell Grant Sparks (FGS) Reports;
- Information showing the estimated amount being saved for each month by the HSE since the introduction of the cuts, including the calculations, methodology and underpinning computations; and
- Information on dispensing trends and payments over the past six months.

The Union has only received the FGS reports to date. We are still awaiting the other two pieces of information requested.

Arising from the FGS reports our advisers PwC have raised a number of issues around the forecasts for 2009 which the Department based its analysis of savings to be achieved from the cuts in payment. These issues were brought to the attention of the Department in a letter dated 11 February but to date no response has been received.

I would ask you to intervene as a matter of urgency to ensure that this information is provided as soon as possible. This information is vital in the interests of transparency but also in ensuring that the Union can make an informed submission to the Review that you will be conducting under the FEMPI Legislation.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 4

From Secretary General to Assistant Secretary DoHC [20 May 2010]

I wish to acknowledge your letter of 19 May in relation to the Minister's Review under the Financial Emergency Measures in the Public Interest Act 2009.

I wish to confirm that the Union will be making a submission to the Minister's Review. We would also welcome an opportunity to make an oral submission to the Department.

I also wish to acknowledge receipt of the report by Farrell Grant Sparks. However this does not contain the detailed data we had previously requested in our letters of:

14 December 2009; 23 December 2009; 20 January 2010; 11 February 2010; 23 March 2010

In summary, the information requested is:

- Information showing the estimated amount being saved for each month by the HSE since the introductions of the cuts, including the calculations, methodology and underpinning computations;
- Information on dispensing trends and payments over the past six months. (An email containing two spreadsheets requesting both contract specific data and aggregate data was sent on 23 December); and
- Clarification on the ongoing basis of the calculations (which is referred to in our letter of 11 February).

This information is now requested as a matter of urgency to ensure that the Union can make an informed submission to the Review.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 5

From PCRS Contract Manager to Assistant Secretary DoHC [21 December 2010]

I wish to refer to your letter of the 8 December 2010 regarding the Minister for Health and Children's review of payments to Pharmacy Contractors in respect of services they render to, or on behalf of, the Health Service Executive.

I wish to confirm that the Union will be making a submission and would also like to make an oral presentation. The Union would appreciate if we could be accommodated on the morning of Friday 7 January 2011 and would suggest 12 noon.

I look forward to hearing from you.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 6

From IPU President to Minister for Health and Children [11 January 2011]

I wish to write to you following a meeting with your officials last week regarding the FEMPI review. Our written submission (a copy of which is enclosed) together with our discussions last week are intended, as stated in the title of our document, to provide a basis for a new approach towards community pharmacy. This agenda would both save the Exchequer resources in the short term as well as better utilize the capacity of community pharmacy going forward.

Regarding the discussions at our recent meeting I wish to reiterate a few points that we made to your officials last week.

- According to the Department's own figures, pharmacists will have contributed €123m per year arising directly from the cuts that were made in July 2009.
- It is totally disingenuous to suggest, as happened at the meeting, that pharmacists are not taking a direct hit as a consequence of the reductions in the reimbursable price of medicines.
- The Union estimated that pharmacists will contribute another €30m on a full year basis as a direct result of recent agreements on the price of medicines based on 2008 data and taking into account the impact of the reduction on both the mark-up and the reimbursable price.
- Pharmacists will also contribute a significant element of the first month's €12m savings arising from the recent IPHA reductions as the failure to give pharmacists any reasonable notice of the price reductions left them holding significant stocks of medicines which will have devalued considerably.
- As pharmacists have seen a reduction of 32% in payments – or 45% of the CSO estimate of operating profit for 2007 – there is simply no scope for further arbitrary cuts.
- This is not to say that additional savings and efficiencies cannot be achieved through direct engagement with the Union on a change agenda within a tight timeframe.
- This can be done through a process similar to the one agreed with the Department and the HSE in April 2008.

I would welcome an opportunity to meet you to expand on our views on the appropriate way forward at this juncture. I hope that you will respond favourably to this proposal as it provides a focused and strategic basis for the future.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 7

From PCRS Contracts Manager to Assistant Principal Officer DoHC [21 January 2011]

I wish to refer to your telephone discussion with Seamus Feely about certain figures included in the Union's submission to the FEMPI Review.

At the outset, I want to reiterate that any reduction in the reimbursable price of medicines affects pharmacists directly and any savings that flow from these reductions comes directly from pharmacy. For example, in our submission and at the presentation with the Department of Health and Children on the 7 January, we stated that pharmacists will contribute nearly €20m on a full year basis from recent reduction to the price of medicines.

This figure comprises of the following:

- €14m from the decrease in the reimbursable price of medicines which directly affects the pharmacy; and
- €5.5m from the decrease in the mark up paid to pharmacists primarily on the DPS and LTI Schemes

I hope this clarifies matter and if you have any further questions, please do not hesitate to contact me.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 8

From Secretary General to Minister for Health [11 March 2011]

I wish to write to you regarding a review of payments to pharmacists that was commenced by former Minister Harney in December last year under the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI).

As part of that review, the Union made a detailed submission to the then Minister entitled "*Time for a New Approach*". In the submission, the Union highlighted that there is no scope for further unilateral and arbitrary cuts. Pharmacists have already suffered direct and indirect cuts of 32% or €153m which is more than that suffered by any other sector. Nevertheless we believe that additional efficiencies and savings can be achieved by adopting a new approach. This approach would involve a substantial and direct engagement with the Union within a defined period of time to review all existing, administrative, contractual and payment arrangements with a view to the realisation of pharmacy specific, system wide efficiencies and savings as well as addressing other aspects of Government policy including reference pricing and generic substitution.

Such engagement could get underway immediately under a process similar to that set out and agreed with the Health Service Executive and the Department in April 2008. This process envisages direct engagement on all matters including payment models under an independent chairperson.

The Union believes that this offers an orderly and efficient way to work together in bringing about real and lasting change and would welcome an opportunity to meet you to elaborate on our views.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 9

From Assistant Secretary DoH to Secretary General [31 March 2011]

I refer to the consultations under the above Act in regard to payments made to community pharmacy contractors under the General Medical Services and community drugs schemes.

I wish to inform you that the Minister for Health and Children, Dr. James Reilly T.D., has decided to make the following changes in payments:

A reduction to 8% in the wholesale mark-up on all drugs dispensed under the GMS and community drugs schemes

A reduction to 20% in the retail mark-up payable under the Long Term Illness Scheme and Drugs Payment Scheme for those items which currently attract a retail mark-up of 50%

A 50% reduction in the Patient Care Fee under the High-Tech Medicines Scheme for months when an item is not dispensed (Fee reduced from €60.52 to €30.26).

Regulations are required to give effect to these changes. The Minister has directed that these be drafted as soon as possible. I will let you know when the regulations have been signed.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 10

From PCRS Contracts Manager to Minister for Health [1 April 2011]

Re: FEMPI Announcement

I wish to refer to yesterday's announcement on reductions to pharmacy payments under the FEMPI Act.

The IPU is disappointed at the introduction of further reductions to payments. Only nine months ago it was accepted by the Department that pharmacists had taken a significant reduction in their payment and no further cuts should be implemented.

The IPU does not believe that any further reductions should be made. However, if the reductions are to be introduced the implementation date of the changes should allow sufficient time to update the IPU Product File and to allow IT vendors to amend pharmacy systems. Therefore we would request that any changes be delayed for a minimum period of six weeks to allow for the appropriate IT amendments to software systems to take place.

We sincerely hope that this is the last in a line of recent ad hoc and arbitrary cuts. The IPU welcomed your statement on Prime Time (28 March) where you outlined your intention to commence discussions on a new contract for pharmacists. The IPU continues to advocate for a new approach which would involve substantial and direct engagement with the Department of Health ('Department') and the Health Service Executive ('HSE').

A review of all existing administrative, contractual and payment arrangements, as well as discussion on other aspects of Government policy including reference pricing and generic substitution, could take place within a defined period of time. Such engagement could get underway immediately under a process similar to that set out and agreed with the HSE and the Department in April 2008. This process envisages direct engagement on all matters including payment models under an independent chairperson.

The IPU believes that this offers an orderly and efficient way to work together in bringing about real and lasting change, and would welcome an opportunity to meet you to elaborate on our views.

I look forward to hearing from you on the two matters highlighted in this letter.

Financial Emergency Measures in the Public Interest Act 2009 – Letter 11

From Minister for Health to PCRS Contract Manager [4 April 2011]

The Minister for Health, Dr James Reilly, TD, has asked me to thank you for your letter concerning the FEMPI Announcement and to let you know that it is receiving attention.

FEES FOR PHARMACISTS AND PHARMACIES

Fees for Pharmacists and Pharmacies – Letter 1

From Secretary General to Registrar & Chief Executive PSI [19 April 2010]

Re: IPU/PSI Meeting

I would like to thank you and your colleagues for taking the time to meet with the delegation from the Irish Pharmacy Union (IPU) on 30 March 2010 to discuss issues of mutual concern. I think we all found the meeting most productive and conducive to both our organisations working in collaboration in the future.

I thought it would be useful to highlight the points that were made during our discussion where further actions may be needed.

1. PSI Register

The issue was raised at the meeting that, if a pharmacist fails to re-register with the PSI when their current annual registration expires and their name has been off the register for more than six months, the Pharmacy Act 2007 does not prescribe a means for them to re-register with the PSI. We would ask that you seek to redress this anomaly in any forthcoming amendments to the Pharmacy Act that may be contemplated.

2. Electronic Invoices

We raised this issue in a previous letter prior to our meeting and we would ask that the PSI consider allowing electronic invoices to suffice for inspection purposes for the reasons we have outlined to you.

3. Charter for Inspections

It was agreed that the PSI and IPU would liaise to draw up a Charter for Inspections. Perhaps you could let us know who the contact person in the PSI will be for this. Our contact person will be Pamela Logan, Director of Pharmacy Services.

4. Proposed Prescription Charges

At the meeting, we reiterated the concerns highlighted in a previous letter to you about the proposed prescription charges. The PSI confirmed that you also had concerns in relation to the pharmacist's responsibility, under the Code of Conduct, of ensuring that patients get their medicines as required. We would ask that you continue to highlight these issues to the Minister.

5. Bankruptcy

We discussed the issue of pharmacists who have been declared as undischarged bankrupts being prohibited from registering with the PSI under Section 14(f) of the Pharmacy Act. In light of the current economic situation and the financial vulnerability of many independent pharmacy businesses following the drastic cuts in reimbursement in the last year, we

would ask that you seek to amend this part of the legislation in any forthcoming amendments to the Pharmacy Act.

Again, I would like to thank you and your colleagues for the meeting and look forward to continuing our dialogue with you on matters of mutual concern.

Fees for Pharmacists and Pharmacies – Letter 2

From Secretary General to National Director Integrated Services - Performance and Financial Management, HSE [25 June 2010]

Many thanks for your recent correspondence regarding the payments that are currently being withheld by the PCRS because of difficulties in reconciling the patient details on prescriptions with the PCRS patient records.

At the outset, I should point out that pharmacists are willing to co-operate with the HSE in resolving ongoing issues and it was precisely for this reason that we put forward our proposals on the 28th May last. We also expressed our strong concerns at that meeting and indeed at my meeting with you about the practice of withholding or rejecting claims or changing procedures without giving any advance notice to pharmacists or explaining why claims are being rejected. This practice is not acceptable and, as members of the public dealing with a public service organisation, surely pharmacists have a right to be informed in advance of any such decisions being taken. As late as last night, I had a call from a member whose advance payment was deducted from his payments this month again without any notice. These practices and concerns must be addressed if we are to build trust and confidence between contractors and the HSE. Equally, it is important that there is openness and transparency on the volume of claims that are being withheld or rejected and the reasons for so doing. In relation to the obligations mentioned in your correspondence, the first and most important obligation of all parties must be to the patients to ensure that they get their medication in a timely manner. The first clause of the pharmacy contract requires the pharmacist to "*supply, with reasonable promptness....such medicines as may be ordered.*"

The fundamental issue here relates to the HSE databases which are clearly not up to date and are grossly inaccurate. The databases held locally in HSE offices are not compatible with the PCRS list. We have a multitude of examples, including cases where the patient, according to the HSE records, is deceased but is alive and well and cases where, according to the local HSE office, the patient has a valid card but the PCRS system is showing the card to be invalid. Another case came to light recently where an 83 year old man has a valid card but the PCRS database is showing the card to have expired. No system will resolve these problems unless the base material is accurate and this is the first issue that must be tackled.

Section 14 (2) of the contract states that *“The pharmacy contractor shall co-operate with the chief executive officer and the General Medical Services (Payments) Board in the discharge of any statutory obligations imposed upon them including the obligation to establish the accuracy of claims.”* This does not place an obligation on pharmacists to verify the accuracy of prescription details but to co-operate insofar as they can in assisting the PCRS in the discharge of their obligations and we are anxious to do this in a practical manner.

Indeed, the Union has worked with the PCRS in previous years in relation to the Drugs Payment Scheme where it was evident that the datasets held in Local Health Offices and the PCRS did not match. The PCRS was legitimately concerned that some of these claims were invalid, however, it transpired that most of the claims related to patients that were eligible under the DPS Scheme but were *“unmatched”* by the PCRS to its database.

From the evidence given to the Union by its members, the Union is confident that the same situation is now arising in relation to the GMS Scheme and the majority of the claims in question are claims for eligible patients that are *“unmatched”* by the PCRS to its own database. This can arise for several reasons such as delays in the HSE in processing of medical card applications, as recently evidenced by the Oireachtas Committee on Health, and invalid data in the PCRS and Local Health Office datasets, for example where a death has been reported in error.

The Union is concerned that any change to current practice would have the effect of denying patients their entitlements under the Community Drug Schemes and this could, in some instances, lead to drastic consequences to the patient's health status. You will agree that this is a situation that should not and cannot be allowed to happen. Pharmacists must at all times consider their responsibility to their patients under the Code of Conduct of the Pharmaceutical Society while at the same time co-operating with the HSE in resolving administrative issues.

It was for all of these reasons that the Union offered to provide assistance to the HSE in resolving their current difficulties at the last meeting of the Joint Consultative Group on 28 May. Essentially, our proposal was that the HSE should apply a similar approach to medical card patients as they do to patients on the Long-Term Illness Scheme (LTI). I think it is important that I clarify our proposal which would involve:

1. The PCRS informing pharmacists in advance that the HSE will be left with little option but to withhold payments in specified cases unless the eligibility of the patients has been resolved to their satisfaction (see draft letter attached). This letter, specific to each case, would be sent at the same time as the pharmacy gets the detailed payment listing from the PCRS. Therefore, if a patient was dispensed a medicine on 6 January the pharmacy will receive notification from the PCRS in early March and, as I stated at our meeting, a further

dispensing will probably have been made by the time the notification is received.

2. The PCRS would provide an additional copy of this letter to the pharmacist, who would hand it to the patient when they next visit the pharmacy and advise the patient of the position and suggest to them that they contact the local HSE office to clarify their eligibility.
3. If the matter is not resolved within a reasonable period (to be discussed and agreed) from the first intervention by the pharmacist, then the pharmacist will act on the advice of the HSE and advise the patient that they must pay for their medicine. In other words, the pharmacy would be paid for that particular patient up to the end of the agreed period after which time the patient must pay for their medicines if their eligibility has not been clarified. One would hope, however, that once the letter has been handed to the patient by the pharmacist that the matter can be quickly resolved by the HSE directly with the patient. You can be assured that the Union will encourage our members to fully co-operate with this initiative.

The HSE databases must be reconciled, otherwise these problems will continue to arise and any new system developments will not resolve current problems. This is further evidenced by the fact that a patient will have already visited the GP and obtained a prescription before visiting a pharmacy and it is at that juncture that issues of this nature should come to light. I welcome your confirmation that the GPs are checking and confirming eligibility. The mere fact that these problems are not being resolved at this juncture again confirms that the source of the problems rests with the HSE's own records and delays in processing renewals and new applications. I understand that the HSE is obliged to keep the GPs informed of changes in client eligibility. You will also be aware that evidence was given to an Oireachtas Committee earlier this year that a survey of 60 GP practices showed that 645 patients either had cards or were entitled to a card, but they did not appear on the PCRS database.

In conclusion, the Union is open to discussing longer term solutions but it is important that we first address the root of the problem. You will also be aware that we put forward a proposal over a year ago on a process through which we could advance our respective IT agendas and we are happy to discuss this matter with you at any time. The Union's offer of assistance in resolving these issues is an attempt to assist the HSE in a practical and workable way to address the obvious problems you have with current systems and databases. Pharmacists will not lightly refuse medication to their patients and the HSE should accept that the first obligation of all parties is to ensure that patients get timely access to their medicines. The patient should be given adequate time to deal with any administrative issues before any entitlement is withdrawn.

In these circumstances, I would again ask that you reinstate the payments that are being withheld contrary to the terms of the pharmacy contract, consider the Union's offer of practical assistance and co-operation in resolving these issues, which we first made almost one month ago, that you give a commitment to advise pharmacists in advance of any claims being rejected or withheld and the reasons for so doing and provide figures on the total number of claims not being paid, for whatever reason, on an ongoing basis.

As we have a Contractors' Committee scheduled for early July, I would welcome an early response from you as we are anxious to move forward as quickly as possible. The Union is also available for a meeting if you think that would be helpful.

Draft Letter from PCRS to the Pharmacist

Dear pharmacist,

Re: Name and Address of Patient

I wish to refer to the claim received in respect of the above patient and to advise you that according to our records this patient

I would appreciate if you would bring the matter to the attention of the patient when they next visit your pharmacy and advise them that this matter must be resolved or they will no longer be able to avail of medicines under the community drugs scheme. Please advise the patient to contact the local HSE office for assistance.

You may wish to note this on your own records so that you will be aware that payments will not be paid after2010.

In this context, I enclose an additional copy of this letter for your records.

Fees for Pharmacists and Pharmacies – Letter 3

From Secretary General to Assistant Secretary DoHC [22 September 2010]

The Minister for Health and Children has indicated that it was her intention to obtain savings from the Agreement with the Association of Pharmaceutical Manufacturers (APMI) in September 2010 similar to the level of savings made under IPHA.

I have been asked by the Pharmacy Contractors' Committee (PCC) that the implementation of any price reductions should allow sufficient time to update our IT system and to allow pharmacists to try to dispense stock reimbursed at the higher price.

It is essential that there is continuity of supply for medicines for patients and that pharmacies are reimbursed at the old price for a two month transition period.

The Union would also request that members have access to the list of products well in advance of the implementation date to make sure that they are in a position to manage their stock while continuing to ensure that they retain an adequate supply for their patients. The HSE has informed us that there is no list at this time.

Fees for Pharmacists and Pharmacies – Letter 4

From Secretary General to Assistant Secretary DoHC [9 December 2010]

I wish to refer to the recent announcement, as part of Budget 2011, of price reductions and other measures which are expected to contribute up to €200m in savings.

I have been asked by the Pharmacy Contractors' Committee (PCC) that the implementation of date of any further price reductions should allow sufficient time to update our IT system and to allow pharmacists sufficient time to dispense stock reimbursed at the higher price.

As you are aware, January is the worst month of the year for such a change to be implemented because of the potential effects on both stock availability and, more critically, patient access to medicines. During the Christmas and New Year period there is increased hospital discharge rates, reduced access for patients to GP services, a reduced wholesaler delivery to pharmacies, an increased level of urgent prescriptions and unpredictable patterns of patient demand, which all routinely put pressure on the supply system.

It is essential that there is continuity of supply for medicines for patients during this critical time and any reductions arising from the agreement with IPHA should apply to medicines dispensed from 1 February 2011.

Fees for Pharmacists and Pharmacies – Letter 5

From PCRS Contract Manager to Assistant Secretary General DoHC [8 March 2011]

Re: Reductions in the Cost of Medicines

I wish to refer to the price reductions announced by the Department of Health and Children over the past 12 months, specifically the reductions which took place in:

- February 2010;
- September 2010;
- January 2011.

I have been asked by the Pharmacy Contractors' Committee (PCC) to highlight the significant loss experienced by pharmacy contractors due to the lack of notice provided

by the Department. The Union estimated in the recent Submission to the FEMPI Review in January 2011, that the average pharmacy lost in the order of €10,000 due to the overnight devaluation of their stock. While the Union welcomes the reduction of the cost of medicines to the patient, the manner in which the reductions were implemented is disgraceful.

The Committee have asked that, in future, when the Department intends to reduce the costs of medicines they should alert the Union and pharmacists well in advance of the implementation date. A minimum of 4 to 6 weeks' notice is necessary to allow sufficient time for the Union to update our IT system and to allow pharmacists adequate time to dispense stock reimbursed at the higher price.

The PCC is seeking a commitment from the Department to put arrangements in place with appropriate safeguards to give adequate notice of future reductions so as to prevent a loss of the scale experienced in January of this year from happening in the future.

Fees for Pharmacists and Pharmacies – Letter 6

From Assistant Secretary General DoHC to PCRS Contract Manager [10 March 2011]

I refer to your letter of 8 March concerning reductions in price of medicines in recent times, with particular reference to the reductions that took effect in January 2011.

As you will recall, this matter was raised by the IPU during its oral submission to the Department under the FEMPI process on 7 January last. On that occasion, I acknowledged the difficulties that the short notice of the price reductions had posed for pharmacists and other stakeholders. I explained that discussions between the Minister and the Irish Pharmaceutical Healthcare Association had concluded on 2 December. It was then a matter for the member companies of IPHA to notify the HSE of their new prices. These were received by the HSE during the month of December and were notified to the IPU without delay. Ideally, longer notice would have been given but, due to the serious financial challenges facing the HSE, the price cuts had to take effect from the earliest possible date in order to maximise savings in 2011.

I also pointed out that it was well known within the trade that further price reductions were under discussion between the Department, HSE and IPHA and that our understanding was that pharmacists ran down stock levels in December in anticipation of same. In addition, we were aware that IPHA companies had taken action to mitigate the level of stock loss when previous price cuts took effect and it seemed reasonable to conclude that the same would apply on this occasion.

The Department is not in a position to accept the validity of the claimed average stock loss of €10,000 per pharmacy due to the most recent price cuts as neither ourselves or the HSE have any means of assessing the levels of stock held by the pharmacy sector, the value of that stock, the actual price paid to suppliers or the mitigation measures that might have been negotiated by pharmacists.

Looking to the future, you can be assured that the Department will strive to give as much notice as possible in the event of further price reductions. However given the State's ongoing financial difficulties, it is not possible to give any commitment with regard to the length of any notice period.

PRESCRIPTION CHARGES

Prescription Charges – Letter 1

From Secretary General to Minister for Health and Children [26 March 2010]

I wish to refer to a discussion in the Dáil on 25 March 2010 about the introduction of prescription levy for medical card patients.

When questioned by Deputy Ó Caoláin about the implementation of the prescription levy, an Tánaiste stated that: *'The legislation is in draft form and will be brought as quickly as possible to the House.'*

In your letter, dated 5 January, you assured the Union that officials from the Department would consult with the Union when preparing the legislation for the implementation of the levy.

The Union would like to seek a meeting with officials from your Department to address our members many concerns about the introduction of the levy which we have previously brought to your attention.

Prescription Charges – Letter 2

From Secretary General to Minister for Health and Children [10 May 2010]

I wish to refer to our meeting on Thursday 29 April.

Prescription Levy

The Union believes that the issues of misuse and wastage can be addressed in other ways that may have less impact on patient welfare. However, if the levy is to be introduced the Union looks forward to discussing this matter with your officials as already agreed.

As discussed at the meeting, it would be helpful if the Department could provide a response to our letter of 17 December 2009 in advance of the meeting to discuss the draft legislation.

Review of FEMPI Act & Extent of the Cuts

We mentioned at the meeting that the Union has written and/or emailed your Department and the HSE on at least six occasions for information relating to the FEMPI Regulations.

The information requested was:

- Information showing the estimated amount being saved for each month by the HSE since the introduction of the cuts, including the calculations as is, methodology and underpinning computations; and
- Information on dispensing trends and payments over the past six months.

As highlighted during the meeting on Thursday, any further delay in getting these figures may interfere with the Union's ability to make an informed submission to the FEMPI Review.

The Union also wrote to the Department on 11 February 2010 highlighting concerns about information in the Farrell Grant Sparks report in relation to the projected calculation of the savings arising from last year's cuts. We would welcome a response to this letter as soon as possible.

Reference Pricing

Further to the discussion at the meeting, the Union looks forward to receiving a copy of the report by Mark Moran and his group. The introduction of a reference pricing system will have a significant effect on patient welfare and pharmacy income as we outlined at the meeting. It is our firm belief that this issue and other changes together with the long-term implications of increased medicine consumption on public expenditure can be best addressed in the context of a review of existing contractual arrangements for pharmacists. The Union looks forward to further engagement on these issues.

Competition Law

Any amendment to Competition law to facilitate any negotiations with other Representative Bodies should also be extended to the Union. The Union would welcome a formal response to our previous correspondence and legal advice submitted to the Department on this matter.

IPU AGM Motions

A further copy of the motions passed at the IPU AGM on 24 April is attached for your information and response in due course.

Prescription Charges – Letter 3**From Secretary General to Minister for Health and Children
[16 June 2010]**

I have been asked by the Pharmacy Contractors' Committee to refer to my letters dated 17 December, 29 March and 6 May and recent discussions with Department officials on the introduction of prescription charges for Medical Card patients.

The Union understands that the reason for introducing the charges is to deal with issues of underuse, overuse and misuse of medicines. The Union has advocated that the most appropriate way to deal with issues of this nature is through the introduction of medicine use reviews, which have been introduced in other jurisdictions. This approach would not compromise patient welfare and would not have the administrative difficulties associated with prescription charges.

The Union is extremely disappointed that the intention appears to be that pharmacists will be lumbered with the task of collecting these charges. This approach will fundamentally change both the nature of the relationship between a pharmacist and a patient and the contractual relationship between the pharmacist and the HSE. The burden and cost associated with the collection of these charges should not fall on pharmacists and the Union sees no reason why the HSE cannot collect these charges directly.

The introduction of such a charge for medical card patients will affect the most vulnerable patients in society. Community pharmacists will face many ethical dilemmas if these charges are forced upon them. Our understanding is that no process has been put in place to deal with situations where patients refuse, or cannot afford, to pay for their medication. This needs to be addressed before any charges are introduced.

The Union also has major concerns about patients on methadone and those who avail of the Psychiatric Scheme in the Eastern Region. As we understand it, the position is that these patients will have to pay the charge for all their medication, other than methadone. This is unworkable and will put a further strain on pharmacists and HSE clinics. These vulnerable patients should be exempted from these charges; otherwise they may not take their medication and end up in hospital care.

It is also important that homeless patients and patients in community and institutional care are exempt from these charges.

Certain patient cohorts can have their medicines changed on a weekly/daily basis (palliative care patients) and a mechanism will be required to address this situation. Issues will also arise in relation to imposing a charge for multi-preparation and combination packs and differing pack sizes, e.g. 1 x Zocor 60 mg (50 cent) versus 3 x Zocor 20mg (€1.50).

The definition of a “family” also needs to be addressed in the context of the intention to introduce a maximum charge.

In conclusion, the Union would ask that you reconsider your position on these charges and not proceed with them. The Union believes that these charges will have consequences for the health and wellbeing of vulnerable patients and will be an administrative and costly nightmare for those administering them and charged with their collection. If the proposal proceeds, it is vital that all the issues set out in this letter and in previous correspondence, as well as those discussed at various meetings, are adequately addressed in the legislation.

Prescription Charges – Letter 4

From Secretary General to Assistant Secretary DoHC [22 July 2010]

I have been asked by the Pharmacy Contractors’ Committee (PCC) to refer to the recent prescription levy legislation passed by the Oireachtas.

As you are aware, the PCC believes that there are more appropriate ways in which to deal with the issue of medicine wastage, however, now that the legislation has been passed, the PCC would request a further meeting to discuss the implementation and administration of the levy.

This introduction of the levy for medical card patients will fundamentally change the nature of the relationship between the pharmacist and their patient. The prescription levy will also place a significant administrative burden and cost on pharmacies and this needs to be addressed by the Department. The Committee is seeking the payment of an administrative fee which would be added to the dispensing fee to cover the cost to the pharmacy.

The PCC also has concerns and questions around the administrative difficulties associated with the prescription levy which need to be discussed well in advance of the introduction of the levy. Concerns raised previously with the Department include:

- Patients receiving treatment under the Methadone Treatment Scheme who are on other medicines;
- Patients receiving medicines under the Psychiatric Scheme in the Eastern Region;
- Homeless patients and patients in community who are not exempt from these charges;
- Certain patient cohorts who have their medicines changed on a weekly/daily basis including palliative care patients;

- The definition of a “family”;
- Situations where patients refuse, or cannot afford, to pay for their medication.

There are also a number of practical implementation issues that need to be considered and addressed before the levy is introduced.

I look forward to hearing from you on when the Department and HSE will be in a position to engage with the Union on these issues.

Prescription Charges – Letter 5

From Secretary General to Minister for Health and Children [2 December 2010]

The introduction of the prescription charges has given rise to considerable difficulties for some patients and also imposed a significant cost burden on community pharmacists who were handed the responsibility of collecting the charges. In particular, difficulties have arisen with certain patients and the Union believes that a relatively small number of patients should be exempted from these charges altogether. In particular, we would ask you to exempt the following patient cohorts from prescription charges:

- Patients in nursing homes;
- Patients receiving treatment under the Methadone Treatment Scheme in respect of other medication that they may be taken;
- Patients receiving psychiatric medicines;
- Homeless patients including those in homeless shelters;
- Patients who have their medicines changed on a weekly/daily basis including palliative care patients;
- There also needs to be some restrictive provision that would allow pharmacists to exercise their discretion to dispense medicines in situations where patients refuse, or cannot afford, to pay for their medication.

The Union appreciates the current budgetary constraints that the Government is facing but the cost associated with these exemptions would be very small in the overall context of the yield from the charges. Indeed the cost to health expenditure would be far greater if these patients did not take their medication as a consequence of the charges.

I would ask you therefore to consider amending the current regulations to exempt these patients.

Prescription Charges – Letter 6

From Assistant Secretary DoH to PCRS Contract Manager [4 March 2011]

I refer to your letter of 4 March concerning the provision in the Memorandum of Understanding between the Government and the EU-IMF relating to ensuring that the elimination of the 50% mark-up paid for medicines under the Drugs Payments Scheme is enforced.

As you are aware, in July 2009 the then Minister made regulations under the FEMPI legislation to reduce the retail mark-up paid to pharmacists by the Health Service Executive under the DPS from 50% to 20%. As you say, the lower mark-up is being applied where expenditure on drug purchases is met by the HSE. However, the reference in the MOU does not relate to the above but rather to the fact that many pharmacists are not passing on the mark-up reduction to patients whose expenditure is not met by the HSE e.g. where monthly expenditure by a person or family is below the €120 per month threshold under the DPS.

The relevant agencies are examining the actions that are required to ensure that the commitment in the MOU is implemented.

REJECTED CLAIMS

Rejected Claims – Letter 1

From Secretary General to National Director Integrated Services - Performance and Financial Management, HSE [10 May 2010]

We have been inundated with calls from members who have had a substantial number of their last month's claims rejected by the PCRS. When they contact the PCRS they are advised to write to Mr Paddy Burke and no one else there can offer any assistance to callers.

This situation is totally unacceptable and needs to be addressed urgently. Examples of cases where claims have been rejected are as follows:

- Claims have been rejected for patients who are recovering heroin addicts when the prescription is for a medication other than methadone. Certain medicines would be commonly prescribed for a recovering heroin addict to treat withdrawal symptoms. The pharmacist was informed yesterday that the HSE is refusing to pay for these additional medications. Many of these patients cannot afford to pay for the medicines themselves and the HSE gave no warning that they would no longer be paying for them. The pharmacist will no longer be able to provide these patients with their medicines unless this matter is resolved.
- Claims have been refused for medicines that a pharmacy dispensed to patients who are living in sheltered accommodation in Dublin's city centre. The

medical card that some of these patients have been using expired last May. Without warning the HSE are now refusing to pay for these medicines and these patients are not in a position to renew their cards.

- The HSE are refusing to pay for medicines dispensed to a patient as they claim the patient is dead. However the patient is alive and well and still requires her medication.
- The HSE are refusing to pay for medicines dispensed to a psychiatric patient. The patient is entitled to a medical card but his current card has expired. The patient does not understand what the HSE are writing to him about in terms of renewing his card, he does not understand that the card has expired and he would be unable to fill out the renewal forms. Neither is he in a position to pay for the medications.

There are thousands of other claims being rejected on the basis that the GMS numbers are incorrect. Other claims have been rejected in respect of patients who have valid cards in their possession. The responsibility for accuracy of medical card numbers does not rest with pharmacists – their responsibility is to ensure that patients get access to their medications when they need them.

This matter is now extremely urgent as the welfare and health of these patients is now at risk. In the circumstances please advise how you propose to deal with these issues and ensure that these patients, many of whom lack the capacity and resources to look after their own needs, are not put at risk.

I would welcome an immediate response to this letter as the Union has now no option but to highlight this intolerable approach in the interests of patients and their health and wellbeing.

I have tried unsuccessfully to talk to Mr Burke about these issues.

Rejected Claims – Letter 2

From Assistant National Director Finance Shared Services-PCRS to Secretary General [18 June 2010]

At our meeting (Joint Consultative Group) on Friday 28th May 2010, we agreed to draft a protocol, which could provide a solution in relation to the issue of incomplete claims.

To move this process forward in a way which ensures:

- that eligible persons have access to their drugs and medicines without disruption,
- pharmacists have certainty about payment for services they provide to eligible persons and

- the accountability responsibilities of the HSE are fully addressed,

I would suggest that the following protocol, which encompasses the proposal suggested by the IPU at the JCG, be considered at an early meeting of the Group:

- 1) Where a claim does not have the correct number of an eligible patient, it will be reported on the Pharmacists Detailed Payment Listing so that the pharmacists is alerted to the fact that the patient number is not correct. The pharmacist can then alert the client to regularise their medical card registration to continue to access the item(s) free of charge. The client will be assisted to do this by the HSE Local Health Office. The PCRS will process and pay this claim on a once off basis (for the first month), without prejudice, to allow the client to regularise their eligibility and registration on the national list.
- 2) I believe that it is important that pharmacists have access to the available software tools to support completion of claims and minimise error. Therefore, I will arrange to advise pharmacy system vendors to provide the patient identification tools to pharmacies and I will communicate with all pharmacists and advise them that these tools are now available to them. It is important that the IPU does not restrict pharmacist use of these tools.
- 3) As a matter of good practice both the IPU and the HSE will jointly advise pharmacists that incorrect claiming is not acceptable. The HSE will continue to closely monitor claims to identify if any additional measures are required.

The context allowing the HSE to propose this approach is very important. The HSE must ensure that all public monies are used to reimburse valid claims only. It cannot be agreed by the HSE to reimburse claims which cannot be verified on an ongoing basis. This protocol is proposed to operate through 31st December 2011 during which time the conjoint working of client, HSE and pharmacy will arrive at the point where eligibility confirmation at point of service is routine for all parties.

Further to our meeting on 28 May 2010, I have drafted an additional piece of correspondence which will issue to each individual pharmacist where reimbursement has been held, which I attach for your information and observations.

Subject to agreement and implementation of this new protocol, I would propose to issue this type of letter to pharmacists where there is a breach of faith in relation to operation of the protocol and in advance of ceasing reimbursement, in addition to the normal notification on the detailed payment listing.

I would like to take this opportunity to provide an overview regarding the processing of pharmacy claims in 2010 in response to concerns raised by the Irish Pharmaceutical

Union (IPU) and the background against which this solution is proposed.

I can confirm that the policy regarding the processing and treatment of pharmacy claims has not changed in any way. As an integral part of our function to process claims and make payments the PCRS is also charged with verification of the accuracy and reasonableness of all claims. A basic aspect of this verification is to ensure that where a pharmacy claims to have provided a service to a patient, the patient can be identified as eligible for the service. Where claims are identified, which raise concerns, reimbursement of these claims is held pending verification and the pharmacy is informed on their Detailed Payment Listing in the normal way. As soon as the pharmacist provides the required claim detail for any such claims these are paid in the next payment run. Nothing has changed in this regard.

While the policy has not changed, PCRS has identified a relatively small number of pharmacies that stand out from the norm. Under normal circumstances the pharmacist ensures that the patient is eligible under the Medical Card (GMS) Scheme as per his/her contract with the HSE. Once the dispensing is completed the pharmacist submits a claim for reimbursement providing the medical card number of the patient. A relatively small number of pharmacies (132, or 8.1%, in April 2010) do not appear to adhere to this process. These pharmacies submit large numbers of claims without providing the number of the eligible person to whom medicine was dispensed. Reimbursement of these claims has been withheld until the pharmacist furnishes the medical card number of the eligible person. The pharmacist is notified in each and every case on their monthly Detailed Payment Listing, and immediately the missing data is provided the held claim will be paid.

PCRS commenced holding claims from those pharmacies with unusually high levels of these claims, in the first instance, with the payment in February 2010 (January 2010 claims). Prior to holding any claims PCRS go through a rigorous procedure to ensure that only incomplete claims which require a pharmacist to provide additional information are held. Aside from the single case regarding Methadone Clinics/Sheltered Accommodation, about which we have already communicated and have resolved, no other systematic issues have been identified with this process. Therefore PCRS await hearing from the pharmacies concerned for details which can support the individual claims they have submitted in order to release payment for same.

In 2009 PCRS reimbursed Pharmacists more than €1.23bn (€244m fees) under the Medical Card Scheme, in respect of 51 million claim items.

The table below provides a summary of the claims which have been held over the months February 2010 through May 2010.

Month	Number of Pharmacies	Number of Claims Held	Value of Claims Held	Total Value of Pharmacy Claims	Number of Pharmacies Paid	Number of Claims
Feb 2010						
(Jan Claims)	80	813	€59,711	€98,371,621.64	1,615	1,388,682
Mar 2010 (Feb Claims)	77	654	€46,057	€86,912,340.43	1,625	1,313,440
Apr 2010 (Mar Claims)	132	3,698	€232,866	€101,250,622.17	1,627	1,540,575
May 2010 (Apr Claims)	171	3,047	€206,778	€89,839,434.56	1,500	1,415,408

Notes

- (1) The figures for May 2010 refer to early payment only since normal pay will issue in June 2010.
- (2) The value of claims held is a gross figure whereas the total value of pharmacy claims is a net figure.

An anomaly which has emerged in relation to the requirement for primary care professionals that have with contracts with the HSE to confirm client eligibility at the point of service, is the different approach taken by pharmacists as compared to the GP community. The following facts highlight this starkly.

- At least three vendors supplying software to GPs have integrated PCRS supplied tools to enable GPs to confirm client eligibility at the point of service. This suggests a level of demand for this function from GPs. Other GPs use the PCRS supplied internet browser and SMS based tools. Pharmacy software vendors consistently report that they can make this function available to their customers, however it has been reported to PCRS that the IPU has instructed that pharmacies should not have access to these tools to assist them.
- The number of times GPs confirm client eligibility at point of service currently ranges from 25,000 to 35,000 per day or over 6 million per year. GPs have incorporated these tools so that the checking of client eligibility is automated with action required on behalf of the GP only in exceptional circumstances. Because the process is effortless, GPs confirm client eligibility upon the setting of each appointment. In the case of pharmacies it would be sufficient to confirm client eligibility once per month per client. This check could be automated in pharmacy software with the pharmacy being alerted on an exceptional basis. The number of times pharmacists currently confirm client eligibility at point of service using the same tools that GPs use is practically zero.
- Some pharmacists also operate anomalous and inconsistent processes in relation to their acceptance of cards for payment purposes. PCRS understand that when bank cards (VISA, Laser, MasterCard etc) are accepted for payment that patient eligibility towards

reimbursement of the dispensing cost covered by that bank card is confirmed by the pharmacist in each and every case. However, it seems those same pharmacists will not confirm patient eligibility to have the dispensing cost covered by the medical card in any case.

I believe that the approach suggested by the IPU at the JCG which forms the basis for the proposal outlined above has a real potential for dealing with all of the issues and to deliver a solution in this area. I would welcome your comments.

Rejected Claims – Letter 3

From the Secretary General to National Director Integrated Services - Performance and Financial Management, HSE [22 July 2010]

At their recent meeting the Pharmacy Contractors' Committee (PCC) considered the payments that are currently being withheld by the PCRS because of difficulties in reconciling the patient details on prescriptions with the PCRS patient records. The Committee wishes to express their strong concern and annoyance about the delay in having these claims paid. The practice of withholding or rejecting claims or changing procedures without giving any advance notice to pharmacists setting out clearly in writing the legal or contractual reason why claims are being rejected is not acceptable.

The PCC noted that it has been five months since we first raised this matter with the PCRS yet there has been no progress made on the matter and claims continue to be arbitrarily rejected.

We have repeatedly stated that pharmacists are willing to co-operate with the PCRS in resolving ongoing issues and indeed in my letter dated 25 June we put forward an approach, based on a LTI circular from the PCRS that would help the HSE in dealing with this issue.

In a further effort to assist, the PCC wishes to put forward the following proposal to assist in resolving the matter. If the PCRS immediately stops rejecting GMS claims and pays all the outstanding rejected GMS claims for the 31 pharmacies involved. The PCC would be prepared to sit down with the HSE and agree the terms of reference for a six month pilot of the validation process with the pharmacies concerned whose claims have been rejected. The Union would expect that the HSE cease this arbitrary approach to the rejection of claims and pay all outstanding claims.

At the same time, the PCC would again request that the HSE review the accuracy of their database. The PCC has serious concerns about the reliability of the HSE databases which are clearly not up to date and are grossly inaccurate. The data bases held locally in local HSE offices are not compatible with the PCRS list. We have a multitude of

examples including cases where the patient according to the HSE records is deceased but is alive and well and cases where according to the local HSE office the patient has a valid card but the PCRS system is showing the card to be invalid. These cases have been raised with the PCRS on numerous occasions.

Recent developments around the LTI Scheme have also highlighted the lack of communication between the PCRS and the Local HSE offices. Pharmacists are being told they have approval to dispense medicines to patients with long term illnesses by the local HSE offices; however, these claims are subsequently rejected by the HSE. The PCRS refuses to accept the letter of authorisation from the pharmacist and insists that this is provided directly to them by the local office. Pharmacists are not responsible for the breakdown of communication within the HSE and should not be penalised by the arbitrary withholding of claims. This matter has been raised with the PCRS; however, they have failed to respond on the matter.

It is not acceptable for the PCRS to withhold or reject claims without prior explanation. It is unfair and unreasonable for the PCRS to change claiming procedures without giving any advance notice to pharmacists. Due to the lack of engagement by the PCRS, we are currently preparing a dossier on the 37 cases. If there is no progress on paying these currently withheld claims, the PCC believes it will be left with little option but to bring these cases to the attention of the Ombudsman for investigation. The Union has also been informed that the matter may also be pursued by individual pharmacists through the courts. The PCC would prefer to have these issues resolved through discussion and agreement however, due to a lack of engagement on the matter, the PCC cannot sit back and allow these practices to continue.

NEEDLE EXCHANGE PROGRAMME

Needle Exchange Programme – Letter 1

**From Secretary General to Assistant National Director
Finance Shared Services-PCRS
[11 June 2010]**

I wish to refer to your letter email of 27 April 2010 in response to the Union's submission from October 2009.

The Pharmacy Contractors' Committee noted your proposal at its meeting on 25 May and asked me to convey their comments on the proposal.

As discussed at the Joint Consultative Group meeting on 28 May, there is a considerable workload for community pharmacists involved in the operation of the Needle Exchange Programme. Factors to be taken into account when considering a pricing structure should include, but are not limited to:

- The impact on and risks to pharmacy staff;
- The impact on and risks to other pharmacy customers;
- Added administrative burden on community pharmacies providing the service;
- The training needed for pharmacy staff working in participating pharmacies;
- The extra time and counselling needed for this patient cohort;
- The labour-intensive nature of provision of Needle Exchange Programme.

The Committee feels that the HSE's proposal does not adequately address the issues raised in the Union's proposal.

A more reasonable approach, taking cognisance of the issues mentioned above would be either:

- Current dispensing fee of €3.50 for a pharmacy accepting dirty needles and €3.50 for the issuing of clean needles; Or
- Current dispensing fee of €7 for a patient transaction (accept dirty needles and issue clean needles).

The retainer of €1250 seems appropriate but should continue for three years. The associated costs, including increased security; time spent with this cohort of patient is continuous. These costs to the pharmacy will not decrease after year two. Where a new pharmacy joins the programme, this retainer should be offered to them.

The Union highlighted the need for a review of the operation of the Needle Exchange Programme after the initial roll out of the programme. Arrangements should be reviewed by the PCC and HSE following two years of operations. The Review should be completed and agreed between the parties before the end of the third year. The IPU would see this review taking cognisance of the following:

- Adequacy of the training course material (both face to face and distance learning);
- The work load for pharmacies providing Needle Exchange;
- The number of pharmacies providing Needle Exchange;
- The locations of the pharmacies providing Needle Exchange;
- The level of remuneration (the annual retainer and the transaction fee) for the provision of Needle Exchange Programme, if it is to continue after the three year period; and
- Input from the patients participating in the programme.

In its submission from October 2009 the Union agreed to support and advocate for the roll out of a Needle Exchange Programme based on the HSE's agreement to support pharmacists in a number of manners. As this aspect of our submission was not addressed in your response, we wish the HSE to confirm that it agrees to cover these services.

A commitment was given to appoint a National Pharmacy Liaison Officer. The Union believes that, in the interests of patients and providers of the service, a National Pharmacy Liaison Officer should be appointed, without further delay, to oversee the implementation of the Needle Exchange Programme and to provide training and back up to pharmacies participating in the provision of all addiction services, including the Methadone Scheme.

Once this appointment is made this will send a strong signal to pharmacy that unlike the Methadone Scheme, the HSE will be supporting pharmacies participating in the Needle Exchange Programme from day one. This support will ensure the participation of community pharmacists in the Programme and will help to attract new community pharmacists to join the Programme. This will be of benefit to every community in Ireland, and most importantly, to the patients themselves.

Needle Exchange Programme – Letter 2

From the Secretary General to Head of Addiction Service, HSE [4 November 2010]

I wish to refer to our discussions regarding the possible roll out of a needle exchange programme through pharmacy.

The matter was considered by the Pharmacy Contractors Committee (PCC) today and from our soundings, the roll out of this initiative is not feasible or viable for the fees currently on offer. We have explained previously in some detail the effort, risk and costs involved in delivering this service. The Committee had originally suggested a significantly higher fee than is currently on offer to cover the costs involved. The PCC believes that €5 is the minimum fee that should be offered for a service of this nature. Such a fee can be easily accommodated within the existing claiming arrangements by assigning a specific code to this service.

The Committee has also asked me to point out that the Regulations made by the Minister in 2009 did not set any precedent for determining payments for any new services nor did it create a "normal patient encounter fee". In addition, the training currently being provided by the ICCPE envisages a level of service and interaction with patients that will simply not be possible to deliver for a fee of €5.

In conclusion, this is an initiative that pharmacists are happy to explore with the HSE to see if it could be delivered through pharmacy. Discussions have dragged on for a very long time and I would ask you to review the HSE position on the matter again.

The Executive Committee is meeting on 10 November and I would welcome a response before then.

Needle Exchange Programme – Letter 3

From Assistant National Director Finance Shared Services-PCRS to Secretary General [9 November 2010]

It is disappointing that you consider that it is not feasible or viable to rollout this initiative for the fees on offer. The HSE conducted a comparison of Needle Exchange Programmes earlier in the year and consider that the arrangements proposed by the HSE compare favourably with other jurisdictions. The HSE considers that a review of all aspects of the service in one year allows an assessment with indigenous data of the particular demands of the Irish environment. Community Pharmacists would be availing of the generous retention fee during this timeframe and it is possible that some locations would have little demand for services in the initial stages.

You will be aware that the HSE has an agreement in place with the Elton John AIDS Foundation to financially support the roll out over 3 years – it will not be possible to continue with this initiative unless agreement is reached this month. The HSE is also ready to advertise the new post of Pharmacy Coordinator for Harm Reduction (outside of Dublin). As the primary focus of this post is the development of Needle Exchange services, it would not be possible to proceed in the absence of agreement on the service. This would be disappointing for all concerned. The interest of attendees at the ICCPE course was very encouraging and the HSE was arranging local integration with Addiction services as a support for participating pharmacies.

The development of a Needle Exchange Service opened up other possibilities in this environment. In proceeding within the current schedule of fees, the administrative burden for all involved would have been kept to a minimum. I would ask that the Executive Committee consider the matter carefully before making a final decision.

Needle Exchange Programme – Letter 4

From the Secretary General to Assistant Secretary, DoHC [23 December 2010]

We have been working with the HSE for some time to get a needle exchange scheme off the ground. The scheme will be funded for an initial three year period by the Elton John Foundation.

We have made very good progress on the matter however a problem has arisen over the level of fees being paid for the service which is now holding up its launch. The sides were considerably far apart on the matter but the Union's views on an appropriate level of fee for this service have been modified considerably. Essentially, the Union's bottom line on the matter now is that the fee for each transaction should be €5 while the HSE holds the view that the fee should fall within the current scaled fee structure for dispensing medicines.

As a profession and Union, we would like to be able to get behind this worthwhile project notwithstanding the obvious difficulties that will be involved in its implementation from our member's perspective. I would appreciate if you could review the matter and see if there is anything you can do to move this matter forward.

Needle Exchange Programme – Letter 5

From PCRS Contract Manager to Assistant National Director Finance Shared Services-PCRS [8 March 2011]

I wish to refer to the HSE's letter of 14 February on the Needle Exchange Programme.

The Pharmacy Contractors' Committee noted your recent proposal at its meeting on 2 March and asked me to convey their comments on the proposal.

As previously discussed, there is a considerable workload for community pharmacists involved in the operation of the Needle Exchange Programme. The Committee feels that the HSE's proposal does not adequately address the issues raised in the Union's previous proposal and that the fee on offer is inadequate. However, given the importance of this service to the people involved and to the wider community, the Committee is prepared to support and advocate for the roll out of a Needle Exchange Programme through community pharmacies on the basis that:

Service Outline

- The Needle Exchange Programme will be based on a simple transaction of exchanging dirty needles for clean needles;
- The Needle Exchange Group, with officials from the HSE and the IPU, will continue to meet to assess the progress of the programme and the locations of pharmacies participating in the programme;
- The position of National Pharmacy Coordinator will be filled by an appropriate candidate before the roll out of the programme;
- The HSE will provide support to all community pharmacy contractors providing Needle Exchange;
- The HSE will, through ICCPE, provide face-to-face training on Needle Exchange to all pharmacists participating in the programme;
- A distance learning pack will be provided by ICCPE to assist in the training of other pharmacy staff;
- The HSE will provide information for people participating in the programme;
- All staff working on the premises should be aware that a Needle Exchange Programme is being operated and should be covered for Hepatitis B immunisation by the HSE;

- The HSE will provide a protocol on the management of needle stick injuries;
- The HSE will provide stickers to be displayed in participating pharmacies;
- The HSE will provide clean injecting equipment locally and a safe disposal system for the return of used injecting equipment;
- The HSE will provide sharps bins and set up collection services for pharmacies providing the Needle Exchange Programme;
- The HSE will, in conjunction with the IPU in the Needle Exchange Group, address any areas of concern that arise for pharmacies participating in the programme in a timely manner.

Pricing Structure

- A needle exchange transaction will always attract a fee of not less than €5;
- The retainer of €1250 per pharmacy involved is guaranteed for three years. The associated costs, including increased security and time spent with this cohort of patient, are continuous. These costs to the pharmacy will not decrease after year one. Where a new pharmacy joins the programme, this retainer should be offered to them.

Review of the Needle Exchange Programme

- Arrangements should be reviewed by the PCC and HSE following one year of operation. The review should be completed and agreed between the parties before the end of the second year. The IPU would see this review taking cognisance of the following:
 - Adequacy of the training course material (both face to face and distance learning);
 - The work load for pharmacies providing Needle Exchange;
 - The number of pharmacies providing Needle Exchange;
 - The locations of the pharmacies providing Needle Exchange;

- The level of remuneration (the annual retainer and the transaction fee) for the provision of Needle Exchange Programme, if it is to continue after the three year period; and
- Input from the patients participating in the programme.

The Union is available immediately to discuss the roll out of the Needle Exchange Programme based on the above and looks forward to working with the HSE in the provision of this significant service.

I look forward to hearing from you or your colleagues on a date for the next meeting of the Needle Exchange Group.

Needle Exchange Programme – Letter 6

From Assistant National Director Finance Shared Services-PCRS to PCRS Contract Manager [8 March 2011]

I am writing to you in relation to your correspondence to the HSE of the 8th of March in relation to the Needle Exchange Project.

The HSE has reviewed the conditions outlined in your letter and is in agreement to meet with the documented conditions. It is now important that we should jointly proceed at haste on the basis set out and also on the condition that the terms of this once-off arrangement will not prejudice any other future arrangements or payments systems for other services and that we are in joint agreement that the pilot programme including the service and payment arrangements will be reviewed after one year. The details of the review will be arranged in due course between the respective parties.

A meeting of the Needle Exchange Group should now take place as soon as possible to progress the roll out of the Needle Exchange Project. As you are aware, the HSE membership of this group includes: Rory Keane, Joe Doyle, Denis O’Driscoll, Gretta Crowley, Kate Mulvenna and Rebecca Loughry. In this regard, I would appreciate if you would advise me of the nominated IPU representatives on the Needle Exchange Group. My colleague, Rebecca Loughry, Specialist Social Inclusion, will be in touch with you to follow up on this.

I wish to acknowledge the support of the IPU for the Needle Exchange Project and we look forward to now expediting the project with you.

HARDSHIP AND PSYCHIATRIC

Hardship and Psychiatric - Letter 1

From the Secretary General to the Minister for Health and Children [19 January 2010]

At our meeting in December, the Union raised the ongoing delay facing pharmacists participating in the Hardship and Psychiatric Schemes. Unfortunately the matter is still unresolved.

Many pharmacists have been supplying medicines to patients under both these schemes for over 6 months without payment. In some areas pharmacists have been paid the cost of the medicines but no fee or mark-up has been paid. Where there have been payments made pharmacists have not been given any paperwork and are unaware of what claims have or have not been paid. In other areas no payments at all have been made leaving pharmacists with unpaid claims of thousands of Euro.

Despite numerous requests, the HSE have failed to clarify the payment structures for these schemes. The Union has been requesting a meeting with the HSE to discuss the situation however to date a meeting has not taken place.

The situation is unacceptable and needs to be resolved without delay and we would ask you to intervene and raise the matter urgently with the HSE.

Hardship and Psychiatric - Letter 2

From the Secretary General to Assistant National Director Finance Shared Services-PCRS [25 January 2010]

I wish to refer to your letter of 21 January 2010.

I wish to express the Union’s disappointment that, despite commitments given by the HSE to revert to us on the Hardship and Psychiatric Schemes within a week of our meeting on 5 November 2009, it has taken the HSE over two months to respond. It is also disappointing that the fundamental issues raised at that meeting in relation to:

- changing scheme arrangements retrospectively;
- significant delays in making payments;
- inadequate payment levels;
- the lack of communications; and
- the lack of engagement;

have still not been addressed.

Hardship Arrangements

I welcome the HSE's intention to publish a list of medicines reimbursable under this arrangement; however, it is not clear whether this list will include codes and prices for these medicines.

The administration required for the Hardship arrangement is excessive and the proposed payments are completely inadequate. These issues need to be addressed immediately. It is unacceptable that pharmacists are still waiting to get full payment and, in some cases, any payments, months after they have dispensed medicines to patients. The PCRS list of Claims Paid is inadequate and it is not possible for pharmacists to reconcile payments being received with the claims they have submitted.

DPS Refund Claims

You will appreciate that it is a matter for each individual pharmacist to determine prices for their private patients and clients. It is not clear from your letter what precisely is being proposed or how it can be implemented on a practical basis. This issue needs to be discussed further.

HSE (Unified Claims Form) Receipts

It is not clear what is proposed in your letter in relation to the Unified Claim Form and how it differs from current arrangements. Again this issue requires further discussion and clarification.

Reimbursement for Psychiatric Drugs

The FEMPI Regulations did not cover this scheme or the Hardship Arrangements. It may be the desire of the HSE to bring payments under this scheme into line with the recent payment changes but this is not mandated by regulation. Furthermore, there was no communication from the HSE of their intention to change this scheme until November 2009, four months after the introduction of the regulations, and this communication was confusing and was not sent to every pharmacist.

As was raised at the JCG meeting in November, the HSE cannot implement price changes or administrative arrangements retrospectively. This issue is not addressed in your letter. Many pharmacists have not been submitting their claims, pending clarification from the Local HSE Offices, and many members have been told by HSE personnel that they do not know what payment arrangements will apply, or when payments will be made. This scheme applies to a very vulnerable cohort of patients and these issues should be resolved without any further delay.

The issues outlined above need to be resolved immediately and a meeting between the Union and the HSE is required urgently. The Union will make itself available on either Wednesday or Thursday of this week for such a meeting. It would be helpful if the issues set out in this letter are considered in advance of the meeting so that progress can be made on these matters.

Hardship and Psychiatric - Letter 3**From the Secretary General to National Director Integrated Services - Performance and Financial Management, HSE
[4 March 2010]**

I am writing to you on behalf of our members who participate in the Hardship and Psychiatric Schemes (*"the Schemes"*).

The reimbursement arrangements on these schemes were changed without notice to pharmacists and this has given rise to long delays in making payments. Following several meetings with HSE officials, some of these administrative issues are now being resolved.

The HSE has reported to reduce payments to pharmacists under the Schemes in line with the Health Professionals (Reduction of Payments to Community Pharmacy Contractors) Regulations 2009. However, these Regulations do not apply to the Schemes. In addition, the HSE is seeking to apply the reduction retroactively to claims as far back as July 2009 and all pharmacists were only officially notified of these changes in January of this year.

Firstly, as the Schemes are not affected by the Regulations, the HSE is not entitled to unilaterally reduce payments under the Schemes. Furthermore, payments to pharmacists under these Schemes are approved in advance by the local HSE office. In some instances this agreement is verbal, while in other cases a written form is issued by the HSE. In all instances however there is an agreement in place between the pharmacy and the HSE prior to the dispensing of the relevant products by the pharmacy. The pharmacy has reasonably relied upon the terms of this pre-approval in performing its part of the agreement and dispensing the respective product. The retroactive application of the reduction in payments is not only inappropriate, but the failure by the HSE to pay the agreed amount is a breach of the terms of the agreement between the pharmacy and HSE. This breach entitles the pharmacy to seek legal redress.

I would ask you to intervene to resolve this matter and I would welcome an early opportunity to meet to discuss these matters with you.

Hardship and Psychiatric - Letter 4**From the Secretary General to Assistant National Director Finance Shared Services-PCRS
[22 March 2010]**

I wish to refer to my letter of 4 March to Ms Laverne McGuinness about the ongoing problems pharmacists are encountering with payments relating to the Hardship Arrangements and the Psychiatric Scheme. To date, we have not had any response.

In May of last year An Tánaiste Mary Coughlan, T.D Minister for Enterprise, Trade and Employment, announced that the Government would reduce the payment period for Government Departments from 30 to 15 days. This new arrangement, established to ease the cash flow difficulties of small business, came into effect from 15 June 2009.

Many pharmacists are currently waiting on payments from the HSE dating back months. Many pharmacies have hundreds of thousands of Euro outstanding under the Psychiatric Scheme and Hardship Arrangements and, despite commitments given in January by the HSE, there are still significant payments outstanding to pharmacies.

The HSE's failure to pay in a timely manner is further adding to the worry and concern that pharmacists are experiencing with their business due to the economic downturn and the cuts imposed last year under the Financial Emergency Measures in the Public Interest regulations.

In the press release announcing the payment initiative in 2009, it also stated that Government Departments automatically include late payment interest where late payments are made after 30 days.

I would like you to clarify that the HSE are paying interest to pharmacy payments which are not made within 30 days.

I would also like you to clarify the amount of interest that has been paid out to pharmacists in each of the past three years.

DPS REIMBURSEMENT

DPS Reimbursement Letter 1

From Secretary General to National Director Integrated Services Performance and Financial Management, HSE [4 March 2010]

I wish to refer to previous correspondence on 11 December 2009, regarding DPS Reimbursement letters sent to patients [please see enclosed letter].

I have yet to receive a response to the matters raised in this letter. The Union has also been informed that patients continue to receive inaccurate letters from the HSE.

In order to avoid further action being taken by any pharmacies referred to, directly or indirectly, in the letter that HSE has sent, we require you to confirm immediately that the steps referred to in my previous letter have been carried out.

DPS Reimbursement Letter 2

From Secretary General to National Director Integrated Services Performance and Financial Management, HSE [8 October 2010]

Following up on our letter of 11 December 2009, we understand that the HSE is still contacting some patients who are due a refund under the DPS, with a letter which informs the patient that the pharmacy has not charged them the correct price. As stated in our previous letter to you, there is no "correct" price for products sold to private patients below the threshold (currently at €120). The statement that the pharmacist is charging incorrect amounts is not only inaccurate but is also damaging to the business and reputation of the pharmacist involved.

It has also come to our attention that the HSE continues to make reference to this so-called overcharging by pharmacists, which is inappropriately inflammatory and damaging to the business and reputation of the IPU and the pharmacists individually.

In order to avoid further damage to the business and reputation of any of our members we insist that you direct your employees to refrain from making or repeating such false accusations to the media.

Furthermore, in order to avoid further damage to the business and reputation of any of our members so referenced, directly or indirectly, in your letter, the IPU insists that you direct your local offices to:

1. Ensure that they have sent a copy of the first enclosed draft letter to all patients who have received a letter which included the language above or similar language;
2. Forward to this office a list of all patients to whom the local office has sent the original version of the letter so that the IPU can confirm among its members that their patients have received the corrected version; and
3. In the future, send the second enclosed draft letter to patients receiving a refund under the DPS.

In order to avoid legal action being taken by any of the pharmacies, including those referred to directly or indirectly in the letter the HSE has previously sent, we require your confirmation within fourteen (14) days of the date of this letter that the steps set out above have been or are in the process of being carried out.

MEMORANDUM OF UNDERSTANDING

Memorandum of Understanding Letter 1

From the PCRS Contract Manager to Assistant Secretary to the Department of Health [4 March 2011]

I am writing to you in relation to the Memorandum of Understanding between the IMF and the Irish Government.

There is only one action point that relates to pharmacy:

'Ensure the recent elimination of 50 per cent mark-up paid for medicines under the State's Drugs Payment Scheme is enforced.'

For the record, the Union wishes to confirm that the HSE PCRS has been paying pharmacy contractors in line with the FEMPI Regulations since 1 July 2009.

Memorandum of Understanding Letter 2

From Secretary General to Minister for Finance [12 April 2011]

I wish to refer to the proposal in the Memorandum of Understanding between the IMF and the Irish Government which states:

'Ensure the recent elimination of 50 per cent mark-up paid for medicines under the State's Drugs Payment Scheme is enforced.'

The IPU has been in correspondence with the Department of Health on this matter and is extremely concerned about the implications of this proposal.

The IPU would welcome an early opportunity to discuss this matter with you or your officials.

Memorandum of Understanding Letter 3

From Secretary General to Minister for Health [12 April 2011]

I wish to refer to ongoing correspondence between the Union and your Department in relation to the Memorandum of Understanding between the IMF and the Irish Government.

The Union is surprised that the Department has taken this view of this recommendation. The Union's position, supported by legal advice, is that a pharmacist's private business is entirely a matter between the pharmacist and the patient and the Union has no role to play in this matter. The normal rules of competition apply and the patients will go to the pharmacy where they achieve the best value in terms of price and service.

The Financial Emergency Measures in the Public Interest Act 2009 states that:

'the Minister for Health and Children may, with the consent of the Minister for Finance, by regulation, reduce, whether by formula or otherwise, amount or the rate of payment to be made to health professionals, or classes of health professionals, in respect of any services that they render to or on behalf of a health body' [emphasis added]

The Health Professionals (Reduction of Payments to Community Pharmacy Contractors) Regulations 2009 also refers to payments that are made to a community pharmacy contractor in respect of services rendered by the pharmacist on behalf of the State. This legislation only applies to services provided on behalf of the State under the various State schemes.

As confirmed in our previous letter, the PCRS now reimburses pharmacists a 20% mark up under certain State schemes however the relevant regulations are not applicable to private patients. Your letter suggests that an attempt may be made to force all pharmacists to apply the same mark-up as set out in the regulations to private patients. This is akin to forcing all GPs and Solicitors to charge the same for a consultation with a private customer as they are receiving for the delivery of services on behalf of the State. This makes no sense whatsoever. It flies in the face of Competition Law, would erode the capacity of small businesses to determine their own business strategies, and indeed their viability, and is not in the interests of patients, consumers or pharmacy employees.

There have been very significant reductions in the price of medicines over recent years and as far as the IPU is aware, all of these reductions have been passed on to patients and indeed acknowledged by many of them. However, pharmacists are private businesses that operate in one of the most competitive pharmacy markets in the EU and it is for each individual pharmacist to decide for themselves what price they charge to private patients, including sub threshold patients.

As this appears to be a consumer/ competition matter, the Union also intends pursuing this matter further with the Minister for Enterprise, Jobs and Innovation and the Minister of State for Small Business.

The IPU would welcome an opportunity to meet with you to discuss this matter further.

Memorandum of Understanding Letter 4

From Secretary General to Minister for Enterprise, Jobs and Innovation [12 April 2011]

I wish to refer to the proposal in the Memorandum of Understanding between the IMF and the Irish Government which states:

‘Ensure the recent elimination of 50 per cent mark-up paid for medicines under the State’s Drugs Payment Scheme is enforced’.

The IPU has been in correspondence with the Department of Health on this matter and is extremely concerned about the implications of this proposal and a copy of this correspondence is attached for your information.

As this is largely a consumer/ competition /employment issue, the IPU would welcome an early opportunity to discuss this matter with you.

IT ISSUES

From the Secretary General to Assistant National Director, Finance Shared Services-PCRS [15 November 2010]

We had some communication at the beginning of October on a number of IT issues. I gave you feedback from our IT Steering Group on each of your proposals but have not had any response from you to date. Hereunder are the issues we discussed.

1. Prescription Levy

The IT Steering Group reviewed and discussed your proposal on Prescription Charge per Item in which the itemised claims listing design was detailed to show how the prescription levy will be displayed on pharmacy itemised listings. The ITSG agreed that the proposed design was satisfactory but that it would be beneficial to members to receive the report in .xml format. This information was emailed to PCRS on 8 October but, to date, no response has been received. The IPU sent the proposal to system vendors on 8 October 2010. It would be useful if you could acknowledge if you can facilitate sending the report to pharmacies in .xml format.

It has also been reported to us that PCRS contacted a pharmacist who had indicated on their claims form that a medicine was not dispensed because the patient did not have the prescription levy. It is alleged that the PCRS suggested that medicines should be dispensed, regardless of whether the patient paid the levy or not. The Pharmaceutical Society of Ireland has recently reminded pharmacists that:

“From 01 October 2010, it is a legal requirement for a community pharmacy contractor to collect the levy of €0.50 per item dispensed under the Medical Card

Scheme. A failure to collect the prescription levy is a breach of this legislation and it should be noted that all pharmacists are obliged to comply with all relevant laws, regulations, rules, professional standards (Principle 3 of the Code of Conduct for Pharmacists) and also to practise within relevant legislative and professional regulatory guidance (Principle 4 of the Code of Conduct for Pharmacists). Any pharmacist who fails to collect this levy in accordance with this legislation may be subject to disciplinary process under Part 6 of the Pharmacy Act 2007.”

Perhaps you could clarify the position of PCRS in this matter.

2. 1st Generation Claiming Wind Down

At the IT Steering Group meeting of 5 October, the Group reviewed a letter sent from PCRS on 1 October, proposing that the 1st Generation Electronic Claiming Interface be wound down for claims submitted for December 2010. We replied to you on 9 October pointing out that we felt that a significant cost would be incurred by pharmacies moving from 1st to 2nd Generation software and that PCRS would benefit financially from this move year-on-year. Therefore, PCRS should incentivise pharmacies to make this move; otherwise the pharmacies may consider that a manual option would be better for them. In addition, we felt that asking any Retail Pharmacy Business to make a significant change to their operation over the busy Christmas period was impractical and proposed that the move be deferred. We would appreciate if you could confirm that you are agreeable to what we have proposed and we can discuss the matter further at the next meeting of the Joint Consultative Group.

3. Pharmacy Security Certificates

PCRS wrote to the Union on 8 October 2010, proposing that Pharmacy Security Certificates would be sent directly to pharmacists rather than system vendors. The Union replied on 9 October that, whilst in principle this would appear to be appropriate, it could create a significant workload for pharmacists and system vendors, especially if the timescales involved were tight. You replied on 11 October that you plan to commence renewing certificates directly before the end of the year and going forward as they fall due. Can you please let me have the up to date position on this matter and confirm if or when this has been communicated to all pharmacists and system vendors?

There was one other issue which you asked us to consider. On 30 September, you sent us a proposal on Approaches to Electronic Prescribing/Invoicing. The proposal was reviewed by the IT Steering Group and we proposed that a small working group should be set up to work with PCRS to further develop this proposal. I suggest that we discuss this further at the next Joint Consultative Group meeting.

I also emailed you about a couple of individual cases on 12 October, 1 November and 11 November to which I have received no response to date and would welcome a reply at this stage.

GENERIC SUBSTITUTION AND REFERENCE PRICING

From the Secretary General to Assistant Secretary DoHC [22 July 2010]

The Pharmacy Contractors' Committee (PCC) reviewed the recent report by the Reference Pricing Group on Reference Pricing and Generic Substitution and reaffirmed its commitment to work with the Department on the implementation of the initiative.

As acknowledged in the report, the introduction of a reference pricing system and generic substitution will have a significant impact on pharmacy. It would be imperative that further discussion on the recommendations of the report and on the implementation of the system take place between the Union and the Department. These discussions should commence in advance of drafting of the necessary legislation to ensure that there is a broad shared understanding of the issues involved and how they might be addressed. Perhaps you could let us know when the Department will be in a position to engage with the Union on the matter.

The PCC welcomed the establishment of the Committee on Interchangeable Medicines. It is important that stakeholders participate in the work of the Group and in this context the PCC requests the appointment of two nominees from the Union to the Group.

NEW SERVICES

From Secretary General to National Director, Quality and Clinical Care [4 May 2010]

I wish to refer to our discussion at the meeting between the Minister and the IPU last week. As agreed at that meeting the IPU would welcome the opportunity to meet with you to discuss pharmacist involvement in new services.

I would like to suggest the week beginning May 24 for such a meeting but if this week is not suitable perhaps could you indicate some alternative dates.

You might arrange to contact Roisin Molloy to arrange a mutually acceptable date.

METHADONE TREATMENT

From PCRS Contract Manager to Methadone Treatment Review Group, Department of Public Health and Primary Care [30 December 2010]

Pharmacies are not obliged to participate in the methadone treatment scheme under their contract with the HSE; they do so on a voluntary basis. The scheme has been very successful to date enabling those addicted to heroin to regain control of their lives, allowing them to re-enter employment or education, provide for their families and be positive contributors to society in general. Needless to say, methadone is only part of the solution; an ideal situation would be where patients would be free of addiction completely.

Delivering methadone treatment through community pharmacies is not only beneficial for the patient but it is also less conspicuous and more convenient for them to receive treatment from the local pharmacist than to travel to one of the methadone clinics. It has also been proven to be more cost effective for the State.

The IPU welcomed the opportunity to be involved in the recent review of the Methadone Treatment Protocol and broadly welcomes the recommendations in the recent published Opioid Treatment Protocol.

The Union believes that where issues of concern for community pharmacists are addressed then there is considerable scope to expand the numbers of pharmacies participating in methadone treatment scheme with a network of over 1,500 pharmacies across the country.

Pharmacists participating in the Methadone Treatment Scheme countrywide on a daily basis deal with the implementation of the Scheme, therefore it is imperative that a representative from community pharmacy be nominated to this group.

The Union wishes to nominate Mr Edward MacManus to the Group as the community pharmacy representative on this group.

Appendix X

A SELECTION OF PRESS RELEASES ISSUED TO THE NATIONAL MEDIA DURING THE YEAR ON VARIOUS MATTERS

1. PRESCRIPTION LEVY

23 April 2010

Pharmacists oppose new 50 cent prescription levy

On the eve of its Annual General Meeting, the Irish Pharmacy Union (IPU) has said that it is strongly opposed to the Government's plan to introduce a 50 cent prescription levy for medicines. The issue will be one of the matters debated at the AGM where it is anticipated that it will be strongly criticised.

Speaking today, Liz Hoctor, a pharmacist from Westmeath and outgoing President of the IPU, said the levy was little more than a "tax on sickness" which would cause additional hardship for the poorest in the community and would be extremely difficult to implement. She said; *"the amount being proposed may not appear much, but any disincentive for people particularly those on low incomes or seriously ill to take medicines should be avoided."* She warned also that the proposal may end up costing the Exchequer more as people would risk longer term medical complications if they did not comply strictly with their medicine regimes.

Ms Hoctor said *"This prescription levy will mean that some of the poorest patients, who have serious illnesses, will have to go without their medicines."*

Galway Pharmacist and Vice President of the IPU, Darragh O'Loughlin said *"While there is a need to tackle the problem of medicines being wasted, introducing a levy on prescriptions is not the answer and will damage patients' health and put increased pressure on hospitals."*

He argued that the international trend is to phase out prescription charges and said that the charges had been recently been abolished in Northern Ireland and Wales.

The IPU has approached the Minister for Health and Children on a number of occasions with alternative measures to reduce the overuse, inappropriate use and wastage of medicines. These proposals, which are already in place in other jurisdictions, include the introduction of Medicines Use Reviews to make sure patients are getting the full benefit from their medicines and to ensure patients are taking only those medicines which are clearly necessary for their treatment.

The Minister has committed to further discussions with the Union around the implementation of prescription charges. Mr O'Loughlin said there were still serious issues to be resolved: *"What about the patients who cannot afford to pay this levy on medicines? What about patients living in institutions, including nursing homes and prisons? What about patients with alcohol or drug addiction problems? Who is going to collect these charges and what is the cost of collecting them and more importantly what will be the costs, if some patients stop taking their medicines?"*

Pharmacists call for caution in introducing reference pricing for medicines as it could limit patients' access to medicines and further undermine the viability of pharmacies.

24 April 2010

Pharmacists call for equal treatment under new Competition Law

The Irish Pharmacy Union (IPU), the representative body for 1,800 pharmacists, has today called on the Government to ensure equal treatment for all healthcare professionals under competition law. The Government has committed to amending competition law to facilitate its negotiations with the Irish Medical Organisation (IMO), the body representing doctors. The IPU believes that any exemption in the legislation that is applied to doctors should also be applied to the representative bodies for other healthcare professionals. The call was made at the IPU's Annual General Meeting, which took place today [Saturday] in Mullingar.

Rory O'Donnell, Donegal Pharmacist and Vice-Chairperson of the Union's Community Pharmacy Committee put forward the motion: *"That this AGM calls on both the Minister for Enterprise, Trade and Innovation and the Minister for Health and Children to ensure that any exemption that may be granted in the new Competition Act to the Irish Medical Organisation should also apply to all representative bodies for healthcare professionals."*

The IPU has strong legal advice that there are no obstacles in competition law to Government negotiating fees with the IPU. However, any concerns that the Government may have in relation to this matter should be addressed in the new legislation and any changes introduced should be applied to all representative bodies, including the Irish Pharmacy Union.

The European Commission gave its opinion on this issue in July 2008. Mr. O'Donnell pointed out that this opinion vindicates the rights of pharmacists to be represented by their Union on all issues. The Union always believed that negotiating fees with the HSE was not a breach of competition law as the Minister for Health and Children always made the final decision in terms of setting pharmacists' fees. The Commission stated *"...the fixation of fees for pharmacy services would only be problematic from the point of view of EC competition law if it was not the Irish State which had the final word in fixing the price..."*

24 April 2010

AGM hears concerns about medicine shortages

The AGM of the Irish Pharmacy Union (IPU) has heard concerns that medicine shortages could follow the introduction of reference pricing for medicines in Ireland. The IPU said that the experience in the UK, had shown exactly this problem arising. The Minister for Health and Children has indicated her intention to introduce a system of reference pricing for medicines in 2011.

The IPU also warned that reference pricing could further undermine the viability of community pharmacies. The IPU called on the Minister to adopt a cautious approach in relation to reference pricing.

Speaking today, Noel Stenson, a pharmacist from Mayo and a member of the IPU's Pharmacy Contractors' Committee said *"In some countries reference pricing has led to a situation where patients cannot obtain certain medicines. For instance, in the UK, medicines such as Femara, a cancer treatment, and Cipralex, an antidepressant medicine, have been unavailable to patients in recent months. It has reached such critical proportions that the Department of Health in the UK called a major summit meeting of all stakeholders to try and resolve the supply crisis for certain fundamental drugs. This is not a situation we want in Ireland – this would be a bad situation for patients."*

Mr Stenson also pointed out that the impact of introducing the various models of reference pricing on community pharmacies would have to be assessed. He said: *"Pharmacists have already suffered a major blow due to cuts imposed by the Minister for Health and Children last year. 1,600 jobs have already been lost and patient services have been curtailed. This must be taken into account as part of any plan to introduce reference pricing."*

The Minister has indicated that in addition to reference pricing, she intends to introduce pharmacist-led generic substitution. Mr Stenson welcomed the Minister's decision to introduce pharmacist led-generic substitution, which he said *"is essential to reduce the cost of medicines."*

24 April 2010

Pharmacists' AGM hears of medical card chaos

At its AGM in Mullingar today, the IPU has warned that thousands of patients are being prevented from getting medical cards because of administrative problems at the HSE.

The AGM has called on the Minister for Health and Children and the HSE to urgently address the issues that are delaying the processing medical card applications to ensure that those who are entitled to medical cards get them as quickly and efficiently as possible. It is vitally important that the HSE streamlines its management structure so that patients and healthcare professionals know who in the HSE is responsible for these important decisions.

Speaking today, Joe Carroll a pharmacist from Galway, said elderly patients are amongst those experiencing major problems in having their medical cards renewed. *"One of my patients is in his early eighties and is hard of hearing. His medical card was cancelled by the HSE last year, even though he is entitled to a medical card. He reapplied, but he was waiting for months for the HSE to send him a new card."*

"What makes matters worse was that when he or his family called the central HSE office to find out what had happened to his application, they were left waiting on hold for ages. Since the HSE began centralising medical card applications, it has become extremely difficult to speak to a HSE official, if you have a query or problem," he said.

The Joint Committee on Health and Children recently recommended that the HSE should ensure that all medical card applications are dealt with in no more than 15 days. The IPU strongly supports this recommendation.

Pharmacists also criticised the HSE for not paying pharmacists for medicines, which they dispensed to patients in good faith. John Barry a pharmacist from Templeogue in Dublin said: *"The HSE is now suddenly refusing to pay for medicines which I have dispensed, on foot of medical card prescriptions written and signed by a GP, claiming they are somehow invalid. Most of the patients involved are over 70 and some have special needs. For the last 20 years, I have dispensed prescriptions in good faith to patients who need their medicines. It is unacceptable for the HSE to*

suddenly refuse to pay for these. This has gone on for three months and I'm facing the prospect of having to turn medical card patients away if they can't pay for their medicines. I'm fully convinced that the patients involved are eligible for free medicines having dealt with most of them over many years. It's incredulous that the organisation charged with caring for such patients could leave them in such a position. The HSE must begin to put the health and well being of patients first."

24 April 2010

Pharmacists AGM hears calls on Government to move quickly against Head Shops

The AGM of the IPU has called for the Government to immediately force the closure of the growing number of so-called "Head Shops" opening across the country, as they are a serious risk to public health.

Michelle Concannon, a pharmacist from Athlone, said: *"It is disturbing to see kids coming out of head shops with products, which could be lethal. There is no information on what the effects of these substances could be. In the UK, teenagers have died after taking mephadrone, a product which was bought in head shops. This product is now banned in the UK. However, there is no regulation on the sale of these products in Ireland and they are being handed out a casual, indiscriminate manner to young, naïve people."*

"As a pharmacist, I know the side-effects of the medicines I dispense and advice my patients on them. These medicines have been carefully tested and have been licensed by the Irish Medicines Board for the Irish market. People must understand that they are taking huge risks by using products from head shops."

Ms Concannon welcomed the growing realisation amongst Government and policy makers that was a real problem, but criticised the slowness to act *"there's talk of ban lists and increased Garda powers by the Summer but we need to act now. There's no time to waste."*

29 April 2010

Statement from the IPU on the Supreme Court Ruling in favour of the Department of Health and Children on the Advance Payments case

The IPU, the representative body for 1,800 pharmacists, said that it was disappointed with the outcome of today's Supreme Court ruling on the Advance Payments case, which ruled that Advance Payments do not form part of the pharmacy contract.

However, the Union welcomes confirmation from the Supreme Court that changes to the pharmacy contract should be brought about through agreement and, if this is not possible, through mediation.

The Union said that it will review the ruling and its impact, if any, on the terms of the contract between pharmacists and the Health Service Executive in consultation with its legal advisors. The IPU will be seeking a meeting with the Department of Health and Children to discuss the implications of the ruling.

Today's Ruling states:

"There is no question of any State party having a general inherent or residual power to alter or terminate binding contractual terms unless some unilateral power is agreed between the parties to such an arrangement..."

"the Minister is...in a position...to vary the terms of the pharmacy contracts, this does not place the Minister in a position in any way superior to the IPU in terms of such a change"

"I do not find therefore that this clause – which clearly vests power in the Minister to negotiate... with the IPU in respect of any term which may be agreed, and which may, after agreement, become pursuant to Clause 19(3) of the Pharmacy Contract, a future term of that amended pharmacy contract - adds anything to the respondent's case, or that by virtue of clause 19(5) "the Minister retained full control over any agreement to vary the terms of the individual contract," since equally, the IPU retained the same full control, on behalf of its members, over any agreement to vary the terms of the same.

Background

In July 2006, the IPU, along with four co-plaintiffs, lodged a claim in the High Court against the Department of Health and Children over its unilateral decision in 2002 to discontinue the payment of Advance Payments to new pharmacy contractors and to freeze payments to existing contractors. In an affidavit submitted by the IPU, it was estimated that pharmacists had suffered losses of €32 million in Advance Payments as a result of the unilateral decision to discontinue these payments.

The High Court ruled in July 2007 that the Advance Payments Scheme formed part of the contractual relations between individual pharmacists and the HSE and the decision to discontinue Advance Payments amounted to a unilateral variation in the contractual terms, which was not permissible.

This ruling was appealed to the Supreme Court by the Department of Health and Children.

The Advance Payment was introduced in 1971 as part of an agreement of the participation of community pharmacists in the reorganised General Medical Services (GMS) Scheme. The Advance Payment enables pharmacists to stock medicines to meet the requirements of medical card patients. It also compensates pharmacists for the delay in payment by the State for medicines and services provided by pharmacists to medical card patients. Advance Payments were paid to community pharmacy contractors from 1971 until December 2002, when the Minister unilaterally decided to alter their payment arrangements.

2. PRESCRIPTION LEVY

1 October 2010

- 50c Prescription Levy introduced today
- Pharmacists criticise HSE on lack of information on Levy
- Certain Patient Groups should be exempt
- Patients should continue to take their Medicines

Darragh O'Loughlin, President of the IPU has criticised the HSE for its failure to communicate to the public about the introduction of the new 50 cent levy on prescription medicines which comes into force from today. The IPU is the representative body for pharmacists in Ireland.

Under new legislation, a medical card patient must pay a 50 cent levy for each item on a prescription dispensed under the medical card scheme. This is subject to a cap of €10 per month per individual or family.

"This levy has faded from the public consciousness since it was first announced in last year's Budget. The HSE has not run an adequate public information campaign to ensure that medical card patients would be alerted to the imposition of this charge, something which we believe should have happened long before now."

"We agree with the Minister for Health and Children that the wastage of medicines is a problem; however, we don't believe that imposing a levy on prescription medicines for medical card holders is the best way to tackle it. Prescription charges have been abolished in many other jurisdictions, including Northern Ireland and Wales."

"This levy will cause hardship to many patients, particularly the homeless and those living in sheltered accommodation, and may even prevent certain patients from taking their medicines entirely. We would call on the Minister for Health and Children to exempt certain patient groups from paying the levy, including homeless patients, patients in sheltered accommodation and patients in nursing homes."

In terms of the implementation of the levy he said: *"Pharmacists are opposed to the levy; however, we are legally obliged to collect it on behalf of the HSE. We would encourage patients to continue taking their medicines as prescribed. If people have any questions on their medication, they should drop in to their local pharmacist for advice."*

16 March 2011

Pharmacists welcome commitment to abolish Prescription Levy

The Irish Pharmacy Union (IPU), the representative body for pharmacists, welcomes today's announcement by the Minister for Health, Dr James Reilly TD that he intends abolishing the prescription levy later this year. Pharmacists opposed the introduction of this levy as it hit the most vulnerable patients in the community. Pharmacy is increasingly a lifeline in hard times for accessing health advice and treatment.

Patients' reliance on community pharmacy comes just as the financial basis of pharmacies is under increasing stress. The IPU's submission of January 2011 to the Department of Health *"Time for a New Approach"* highlights how pharmacists suffered large and disproportionate cuts in payments since July 2009, when the former Minister for Health and Children introduced cuts under the Financial Emergency Measures in the Public Interest Act 2009.

The same document outlined how pharmacies are well placed to do much more in the cost effective delivery of primary health care. The IPU urged the Minister to engage with pharmacists in reviewing all contractual arrangements with a view to identifying how savings could be made without undermining pharmacy services in the community, especially for the most vulnerable patients whom the Minister rightly referred to today.

3. EMERGENCY CONTRACEPTION

30 August 2010

Pharmacists call for Morning After Pill to be made available without Prescription

In response to a call this morning from Choice Ireland, the Irish Pharmacy Union has reiterated its call for pharmacists to be enabled to provide Emergency Hormonal Contraception, also known as the Morning After Pill, to patients without a doctor's prescription. The Union said that pharmacists have the skills and competencies to dispense hormonal contraceptives and provide appropriate advice and counselling to such patients.

Meath pharmacist Kathy Maher said: *"It is important that patients get timely access to Emergency Hormonal Contraception and many often find it difficult to get a prescription at the weekend and come into pharmacies urgently looking for Emergency Hormonal Contraception. Pharmacists should be able to provide such a service and this could be done with appropriate advice, counselling and within agreed protocols. Emergency Hormonal Contraception should never be the only form of contraception used and pharmacists could also refer patients back to their GP, where appropriate, for a consultation on their contraceptive choices once the morning after pill has been dispensed."*

Pharmacists already provide advice to patients on sexual health and on sexually transmitted diseases. Campaigns have been organised throughout Irish pharmacies to raise awareness about contraception options and the dangers of sexually transmitted infections.

A study published in the British Medical Journal after patients in the UK were enabled to access Emergency Hormonal Contraception directly from pharmacists found that it did not appear to have led to an increase in its use or to a decrease in the use of other forms of contraception.

The Irish Pharmacy Union is the representative body for 1,800 community pharmacists across the country.

16 February 2011

Pharmacists welcome IMB Decision to make Emergency Hormonal Contraception available from the Pharmacist without Prescription

The Irish Pharmacy Union (IPU) today strongly welcomed the decision by the Irish Medicines Board (IMB) to allow Norlevo, one brand of Emergency Hormonal Contraception (EHC) to be made available from the pharmacist without a prescription. The IPU, on

behalf of community pharmacists, has repeatedly called for this step. This is a landmark decision for women and an important one for Irish pharmacy as a profession.

Kathy Maher, Meath-based pharmacist and member of the IPU's Executive Committee said: *"Women in Ireland will now have prompt access to Emergency Hormonal Contraception. Community pharmacists are healthcare professionals with the skills and competence to dispense this medicine to patients, where appropriate and to provide relevant advice. Patient safety and personal sensitivity are paramount. As a profession we are committed and capable of delivering appropriate care for our patients."*

Welcoming the announcement, IPU President, Darragh O'Loughlin, said: *"There are many medicines available from the pharmacist in other EU countries for which patients in Ireland currently require a prescription. These medicines have a good safety record and should be made available from pharmacists who are qualified health professionals."*

The medicines which pharmacists would like to see deregulated are:

- chloramphenicol for bacterial conjunctivitis
- oral fluconazole for thrush
- sumatriptan for migraine
- terbinafine and griseofulvin for fungal infections of the skin
- aspirin 75mg for prevention of heart disease and stroke
- statins for prevention of heart disease
- trimethoprim for urinary tract infections

The IPU is a key stakeholder on the Switch On to Self Care Working Group, along with representatives from the Irish College of General practitioners (ICGP), the pharmaceutical industry and Schools of Pharmacy, who published a paper last year on *"Self Care First"*, advocating that the range of medicines made available to patients should be expanded through switching or deregulation. Mr O'Loughlin said: *"I hope that this decision by the IMB on Norlevo will be a precedent that will allow Irish citizens the same access to medicines as their European counterparts."*

4. OTHER MATTERS

1 November 2010

Patients encouraged to ask about speaking to the pharmacist in private

Pharmacists are encouraging patients to seek a private consultation if they wish to discuss an issue with the pharmacist in private. From today, all pharmacies are obliged to have a private consultation area available to patients.

Rory O'Donnell, Donegal Pharmacist and Vice President of the IPU said *"This is a great facility and I would encourage patients to use it, especially if they feel uncomfortable about asking for advice across the counter of a pharmacy. Some patients may feel embarrassed to ask at the counter about certain health issues – such as thrush, contraception, sexually transmitted infections or headlice in children etc. Pharmacists are healthcare professionals and advise on these issues every day."*

He continued *"Pharmacists are now getting involved in providing new services such as blood pressure and cholesterol testing and testing for risk of diabetes. The private consultation area is the ideal location to provide such services."*

However, O'Donnell pointed out that the costs involved in installing a consultation area had presented a challenge for many pharmacists. *"There is an ever increasing burden of regulation on pharmacists. However, the private consultation area will enhance the experience of many patients in the pharmacy."*

2 December 2010

Community Pharmacists warn on Mixing Alcohol and Medicines in run up to Christmas

Community Pharmacists have today warned about the dangers of consuming alcohol while taking medicines or herbal remedies. Even moderate amounts of alcohol when mixed with certain medicines can lead to significant drowsiness and can impair judgment and the ability to drive. The warning comes at a time when many people are suffering from coughs, colds and flu and the Christmas party season will be shortly underway. Unfortunately, many people are unaware of the risks of mixing medicines and alcohol. Some medicines, including many cough, cold, flu and allergy treatments, commonly used pain relievers and even certain herbal remedies can interact with alcohol. People should always ask their pharmacist about the effects of taking alcohol with their medicine.

According to Darragh O'Loughlin, Galway Pharmacist and President of the Irish Pharmacy Union, *"Everyone has seen the warning about not consuming alcohol when taking certain medicines; it's important to take that warning seriously. Mixing alcohol with certain medications can be harmful and occasionally even dangerous."*

"Some medicines can increase the effects of alcohol on the body while, at the same time, alcohol can actually worsen the side-effects of certain medicines – leading to increased drowsiness, impaired judgment or loss of co-ordination and a risk of nausea, vomiting, headaches or fainting. People can put their personal safety and the safety of others at risk, often without even realising it."

"In addition to these dangers, alcohol can occasionally make medicines less effective or even useless, or it may potentially make some medicines harmful or toxic to the body. The message we want to give today is: before taking alcohol with any medicine, always ask your pharmacist whether it is safe to do so. Be safe and be certain when you are taking medication", Mr O'Loughlin said.

The warning from pharmacists applies to both prescription and non-prescription medicines and also to herbal remedies.

14 December 2010

Pharmacists welcome plans to enable them dispense cheaper generic medicines

The Joint Committee on Health and Children is today considering plans to introduce generic substitution and reference pricing.

Darragh O'Loughlin, President of the Irish Pharmacy Union (IPU), said: *"Generic substitution by pharmacists is standard practice in many other countries and will mean lower medicine prices for patients and considerable savings for the State. Generic substitution should be introduced without delay."*

However, in relation to the introduction of reference pricing, the IPU is recommending a cautious approach. O'Loughlin said: *"Reference pricing is a highly complicated mechanism and is not a quick fix. Careful consideration and engagement with key stakeholders is required to ensure that there is no disruption to supply. The impact that reference pricing will have on patients and pharmacists very much depends on the model of reference pricing that is introduced. In some countries, reference pricing has led to a shortage of certain medicines."*

The IPU is the representative body of pharmacists in Ireland.

Pharmacists also warned that some groups are at greater risk, particularly women and older people, and should exercise caution to avoid putting their health or safety at risk.

20 December 2010

Pharmacists welcome recommendation to expand methadone treatment services outside of Dublin

The IPU, the representative body for pharmacists in Ireland, has welcomed the “*Introduction of the Opioid Treatment Protocol*”, a report published today by the HSE. President of the IPU, Darragh O’Loughlin, said “*No part of the country has been spared the scourge of heroin addiction. The scale of the challenge is underlined by the fact that it is estimated there are over 20,000 opiate users in Ireland, only 8,551 of whom are receiving treatment. We welcome in particular the recommendation to expand methadone treatment services into areas outside Dublin. There is an urgent need to reach out and support people who wish to overcome addiction in more rural areas. To ensure this can happen, a national pharmacy co-ordinator should be appointed to support pharmacists who provide methadone treatment services in their local communities.*”

“Pharmacists have an important role to play but we need to be more integrated with other parts of addiction treatment services. Outside of Dublin and other cities we are too often left to deal with the issues of methadone treatment on our own, without other appropriate supports in place. Pharmacists are at the coalface in treating those who have an addiction to heroin, helping them to regain control of their lives. The Methadone Treatment Protocol has been very successful to date in enabling the patients involved to re-enter employment or education and to provide for their families. Needless to say, methadone is only part of the solution; an ideal situation would be where patients would be free of addiction completely. For this to happen, patients need other support services, such as addiction counselling.”

10 January 2011

The IPU strongly supports significant expansion of the role of pharmacists

The Irish Pharmacy Union (IPU) today re-stated its strong support for an expanded role for pharmacists in delivering primary healthcare to Irish patients. In response to the announcement by Boots that from 12 January its pharmacists will provide Emergency Hormonal Contraception to women, where appropriate, under a patient group direction (PGD) following a consultation, the IPU, as a representative organisation, stated that it has been to the fore in advocating an enhanced role for pharmacists. The IPU is working hard to ensure that pharmacists generally are in a position to provide a wider range of services to patients including those announced today.

Kathy Maher, Meath pharmacist and member of the IPU’s Executive Committee, said “*Pharmacists already provide advice to patients on sexual health and on sexually transmitted infections. Campaigns have been organised throughout Irish pharmacies to raise awareness about contraception options and the dangers of sexually transmitted infections.*”

The Irish Pharmacy Union is the representative body for over 1,600 community pharmacists across the country.

6 April 2011

Pharmacists respond to Centre for Ageing Research & Develop Ireland Research on long-term patients taking inappropriate medicines

The findings of this report are concerning. If patients are taking inappropriate medication their health may be at risk. The Irish Pharmacy Union calls on the Minister for Health to implement proposals to introduce pharmacist led Medicine Use Reviews for patients who are using multiple medications. The introduction of this initiative which has been advocated by the IPU in recent years will highlight problems in a patient’s medication regime and, lead to safer and more cost effective medicine use, better outcomes for patients and fewer hospital admissions.

Appendix XI

A SELECTION OF LETTERS PUBLISHED IN NEWSPAPERS

IRISH MEDICAL TIMES 3 DECEMBER 2010

A margin of error

The recent editorial in IMT, entitled *'Tough medicine for tougher times'* (November 19, see www.imt.ie/opinion/2010/11/toughmedicine-for-tougher-times.html), refers to a study, which claims that pharmacy margins in Ireland are around 43%. This figure bears no reality to pharmacy margins in Ireland.

Data in the 2008 report from the HSE's Primary Care Reimbursement Service is very clear. In 2008, of the total expenditure on medicines by the HSE, 24% comprised fees and mark-ups paid to pharmacies, which in effect represents the gross margin for pharmacies for supplying medicines and ensuring that patients' needs are looked after.

Secondly, a 2007 review of the sector by PricewaterhouseCoopers (PWC) found that the net profit margin of an average pharmacy in Ireland was 6.6%. However, the margin today is substantially lower as payments to pharmacists have since been cut by 30% by the Minister for Health from July of last year.

The editorial also refers to proposed measures to bring about the greater use of generic medicines. Offering patients the choice of cheaper generic medicines is a change that pharmacists have advocated for many years. We welcome the commitment of the Minister for Health to legislate for generic substitution next year.

A number of figures have been reported in the media recently as to the level of potential savings that could be made from generic medicines, including one of EUR300 million. However, no analysis has been published on how this figure has been calculated. The Irish Pharmacy Union believes that considerable savings can be generated from generics, but not necessarily the amount that is being reported.

The National Centre for Pharmacoeconomics carried out research in July 2009, which found that there was the potential at that time to generate savings of EUR77.7 million for the State from dispensing generic medicines, where a generic medicine is available, on the medical card scheme and the drugs payment scheme.

However, this does not take account of the fact that since then the price of 300 commonly used off-patent proprietary medicines was reduced by 40% and their generic equivalents were reduced by a similar amount. Therefore, the level of potential savings is likely to be lower than this figure.

Generic substitution has an important role to play in delivering cost savings for our healthcare system. However, the value of the proposal must be accurately costed in advance and effectively delivered thereafter.

Significant overestimation of what can be delivered is in nobody's interest, least of all the services and the patients dependent on the savings to be achieved.

Darragh O'Loughlin, MPSI, President, IPU.

[Editor notes: The report referred to above - comparing the price of medicines and margins in Norway with nine European countries - was compiled in 2008 by the Norwegian Institute for Research in Economics and Business Administration on behalf of the country's Minister for Health. To download English version visit www.regjeringen.no/en/dep/hod/Whats-new/News/2008/report-on-pharmaceutical-prices.]

IRISH TIMES 5 JANUARY 2011

Pharmacies offering vaccines

For the last number of weeks, your newspaper has carried reports on the increase in cases of swine flu, along with advice from the HSE that the best protection from this virus is the flu vaccine, which this year includes the swine flu strain. However, every article implies that the vaccine is available only from GPs.

My pharmacy has in fact been vaccinating patients since October of last year and for a lot of people, dropping into their local pharmacist is an alternative and sometimes more accessible and convenient way of getting their flu shot. Indeed in the US, in those states where pharmacist vaccination occurs, uptake of vaccines has been up to 50% greater than in those states where it is given by GPs alone.

At present, over 50 Boots pharmacies nationwide are authorised to provide the service with other pharmacies expected to follow in the coming year. Given the often negative press my profession has received in recent times, I think it's important initiatives such as this get due attention so that the public are aware of the broad range of sources from which clinical services can be obtained. I hope future articles will correct this undoubtedly unintended omission

David Carroll, MPSI, Boots, Grafton Street, Dublin 2.

IRISH TIMES 31 JANUARY 2011

Cherry-picking clinics and pharmacies

There is a sweet irony running through your recent correspondence from Dr Mel Bates (January 19). The biblical admonition about motes and planks cannot be far away. At the best of times, medical politics cannot be separated from doctors' income.

While the recent VHI increases are partially a testament to a rampant medical test industry, it would be fair to say that many patients would be seriously uncomfortable with the tenor of the debate that Dr Bates is stimulating. While it is obviously not his intention to denigrate his colleagues, he does make a valid point about the greed of many professionals.

In my own professional arena, community pharmacy faces many commercial threats, most of which have been well reported. What has not been made clear is the rapacious attitude of some of Dr Bates' colleagues towards my profession. The development of some primary care centres has been characterised by an extraordinary attempt to capitalise on the commercial prescribing power of groups of clinicians.

Indeed, the long-running saga of the Killarney primary care centre has been marked by an apparent unhealthy dependence of the whole project on the income to be generated from a pharmacy.

The parallels with Dr Bates' nightmare scenario are uncanny. Cherry-picking clinics or pharmacies are all faces of a common problem. In both situations the public end up on the losing end.

I welcome the call for a debate on the future of healthcare policy, although I fear that it is already much too late. The shelves are groaning under the weight of all the reports that have been prepared. What is missing is a vision where patient needs are central. Perhaps the minister-in-waiting will put the needs of the patient before the professional. In an era of unique events, another milestone could be achieved.

Jack Shanahan, MPSI, Church Street, Castleisland, Co Kerry.

IRISH TIMES 19 MARCH 2011

Dr James Reilly, our new Minister for Health, proposes that the prescription government levy which is 50c per item be discontinued. I would recommend hastening slowly on this point.

As a practising pharmacist, I have been surprised at the very low to non-existent level of opposition by medical card holders to this levy.

I had expected that many people would opt not to have their prescriptions dispensed because of the charge, and

that there would be a noticeable reduction in the number of prescriptions dispensed, but this has not been the case, in my limited experience.

That some would comment on the, "very good value" for the prescription levy, was something I had not expected.

However, my experience may not be that of other pharmacists.

I hope the Minister can quantify the number of prescriptions written but not dispensed, both before and after the introduction of the prescription levy, so as to quantify the effect of the levy in reducing patients' compliance with their prescribed treatments.

Richard J O'Rourke, MPSI, Drogheda Street, Monasterevin, Co Kildare.

IRISH TIMES 22 MARCH 2011

Scrapping prescription charges

The imposition of a tax on medical card patients receiving prescribed medication is fundamentally unfair. The whole idea of the medical card system is that it grants free medical care to those who require it. I find it interesting that Dr Niall Cawley GP (March 19) should seek to penalise the patient. Perhaps a proper medication review incorporating the patient's usage requirements would have been more appropriate in the circumstances. I wonder if Dr Cawley would be quite as enthusiastic about the tax were he obliged to collect it himself. An interesting anomaly in the system is that patients receiving medication from dispensing doctors are not required to pay the tax, while patients receiving medication from dispensing pharmacists must pay it. Go figure!

In relation to the comments by Richard J O'Rourke, pharmacist (March 19th), there is one point on which we agree - his views may not be shared by other pharmacists. The fact that there is little resistance to the tax does not mean that it is right. Irish people have shown themselves to be remarkably stoic in the face of inequities and unfairness in recent times.

One should not tax the vulnerable just because it is easy to do so. Mr O'Rourke obviously does not mind the role of unpaid tax collector eating into his contact time with patients - as a practising pharmacist, I do. Mr O'Rourke must not have the horrible administrative experience of trying to collect this prescription tax from vulnerable patients in nursing homes, residential care units and other institutions for whom no exception has been made.

It is right and proper that we should seek to minimise waste in prescribing and medication usage. But don't penalise the patient!

Conan Burke MPSI, Calry, Co Sligo.

IRISH TIMES 31 MARCH 2011

In your Editorial (March 29th) you rightly concluded that the Minister for Health, Dr James Reilly is correct to abolish the prescription charge, but that he must prioritise other means of tackling waste of unused medications.

Pharmacists have an important role ensuring patient safety and in tackling waste through medicines use reviews. There is a Medicines Use Reviews pilot programme currently being evaluated which we hope will eventually be fully rolled out. This will ensure better compliance, better quality of life for patients, reduced wastage and less admission to hospitals.

Gerard Howlin,

Head of Policy and Public Affairs, IPU.

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IRISH TIMES 25 APRIL 2011**Competition among pharmacies**

There has been much ill-informed comment recently about a supposed need to increase competition among Irish pharmacies. In fact, Ireland already has the most liberal and competitive pharmacy market in the EU. There are a higher proportion of pharmacies per head of population in Ireland than almost any other country in the EU with an average of 1:2,800 people compared to a European average of 1: 5,100. The previous restriction preventing foreign-trained pharmacists from establishing new pharmacies (which was not unique to Ireland and which remains a feature of regulation in several other EU member states, including Britain, France, Germany, Netherlands and Portugal) was abolished in 2007 with the passing of the new Pharmacy Act.

We are one of the few countries where there are no restrictions on who can establish or operate a pharmacy; in the majority of EU states only pharmacists can own a pharmacy and there are population or geographical criteria restricting the opening of new pharmacies.

In 2005, the European Free Trade Association (EFTA) completed a Europe-wide study of the regulation of professions, including pharmacists, and found that Ireland had the most de-regulated pharmacy market of all 25 EU member states. Similarly, a separate study, entitled Competition in Professional Services, published that same year by the European Commission, concluded that Ireland has the least regulated pharmacy market in Europe.

Of late, there have been substantial falls in the prices of hundreds of medicines, all of which have been passed on to patients by pharmacists who have themselves suffered dramatic cuts in their payments for providing medicines on behalf of the State.

The two main drivers of the national drugs bill at this stage are the increase in the number of medical cards (a by-product of soaring unemployment) and greater use of very expensive high-tech medicines, both of which schemes attract zero per cent mark-up for pharmacists.

Darragh J O'Loughlin, MPSI, President, IPU.