COMMUNITY PHARMACY: SECTOR ANALYSIS 2018

GLOBAL TRENDS AND OPPORTUNITIES IN COMMUNITY PHARMACY

AUGUST 2018

worldpharmacycouncil.org

About this report

This is the inaugural World Pharmacy Council *Sector Analysis* report. The report provides an overview of community pharmacy issues and statistics in the seven member countries as at August 2018 – Australia, Canada, Ireland, New Zealand, South Africa, United Kingdom and United States of America.

The report will be updated and extended in future years.

Methodological note – currency conversion

Where figures in this report are stated in US Dollars, they have been converted from the local currency using the World Bank's published Purchasing Power Parities (PPPs) for 2016-17. PPPs are favoured over actual exchange rates as they are based on the number of units of a country's currency required to buy the same amount of goods and services in the domestic market as a US Dollar would buy in the USA. PPPs are less volatile than exchange rates, and are intended to reflect the worth of a currency in each country (for example, the PPP for Ireland is different to the PPP for Germany, even though both use the Euro as their local currency – this is due to price level differences within each country). PPPs can be viewed at http://data.worldbank.org/indicator/PA.NUS.PPP (accessed 29 June 2018).

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SECTION 1:
COMMUNITY PHARMACY TRENDS, ISSUES & OPPORTUNITIES

This section summarises some of the current issues facing community pharmacy in each WPC member country as at August 2018. This is intended as a brief, point-in-time overview. It is not intended to cover all issues in detail. It is intended to provide a brief summary of some of the most significant problems, opportunities, trends and changes.

1.1 COMMON COMMUNITY PHARMACY TRENDS IN WPC MEMBER COUNTRIES

While there are differences in the manner in which they manifest themselves in each market, the trends and issues that WPC member countries have in common include:

- independent community pharmacies facing increased competition from large (including multi-national) groups, and are reacting – in part – by seeking out their own niche, diversifying income streams into services and specialised niches, and by aggregating their market influence through forming or joining buying and marketing groups.
- pharmacies coping with the financial effects of reducing prices and margins on generic medicines, and in some cases reducing opening hours and eliminating unprofitable services as a result.
- pharmacists and their representative bodies continue to build the case and make progress for the full use of pharmacists' professional skills and scope of practice and broadened funding for both dispensing and non-dispensing services, often meeting with some resistance from other practitioners who feel that pharmacists are encroaching on their traditional (and often most lucrative) roles.
- some success has been made with increasing scope of funding and practice – including in the area of administering vaccinations, downscheduling of products from prescription-only, paid programs for medicines reviews, some minor ailments programs, limited prescribing rights (usually with additional certifications), and others.
- a focus on medication compliance/adherence, which is seen as a significant opportunity to provide both improved health outcomes and financial benefits for pharmacy and pharma companies.
- the establishment of programs and structures that promote collaborative, coordinated care, particularly for patients with chronic conditions. Examples include Health Care Homes (Australia), Primary Care Networks (England), Primary Care Clusters (Wales) and Community Pharmacy Enhanced Services Network (USA).
- the positioning of community pharmacies as destinations for health services, not only medicines.
- governments continue to deal with deficits and debt and are continuing to look at medicines and pharmacy as an area to save money rather than invest more.
- governments and insurers are also dealing with funding new, expensive medicines for conditions such as Hepatitis C, cancer and dementia, as well as developing pricing policies and regulations for biosimilars.
- the rise of corporate pharmacy, including the growth of multinational pharmacy giants, and the broader corporatisation of healthcare.
- the dichotomisation of pharmacy - the local, community-focused, independent pharmacy owner model which can provide more personalised care versus the centralised, mass-market corporate model that is perceived (by some) as less costly and more efficient.
- exclusion of, or discrimination against, some pharmacies from accessing some pharmaceutical products or payers as a result of exclusive dealing arrangements between payers, manufacturers, distributors and corporate pharmacies (an adverse outcome that is promoted by a trend toward vertical integration).

- abuse, misuse, diversion and deaths relating to prescription drugs (especially opioids), creating additional pressures and regulatory reforms, including stricter scheduling on codeine in Australia, Canada and New Zealand.
- the legalisation of cannabis products in several countries or jurisdictions.
- the positive and negative impact of technology, including online retailing, robotics, remote (or centralised, hub-and-spoke) dispensing, electronic prescriptions and shared health records.
- a growing consumer need for instant gratification (fast, convenient advice, service and delivery), which is often at odds with the best interests of patient care – a consequence of the information asymmetry that occurs in the provision of healthcare and medicines.
- education of politicians to change perceptions away from long-held, outdated views that community pharmacies are highly lucrative businesses.
- fighting against opinions that medicines can be treated like any other commodity and that the normal rules of economics can and should be applied to their supply.
- dealing with problems associated with drug shortages and interruptions to supply, brought on by price cuts, unforeseen demand, manufacturing problems or natural disasters. While some shortages are localised, others are global (eg. epinephrine, valsartan).
- in several countries, a transition to a more transparent dispensing remuneration mechanism relying more on direct fees and less on purchasing margin (due to survey-based and other methods of reimbursing at actual or average acquisition cost).
- the governments in both Canada and South Africa are exploring the introduction of nationalised health care systems.

1.2 COUNTRY-SPECIFIC DEVELOPMENTS

The following is a brief discussion of current issues specific to each WPC country, as at approximately July 2018.

AUSTRALIA

REVIEW OF COMMUNITY PHARMACY REMUNERATION & REGULATION

As part of the Sixth Community Pharmacy Agreement (6CPA), it was agreed that the government would conduct a review of the pharmacy sector, examining issues of regulation and remuneration. The final report was released by the Minister for Health in May 2018, concurrently with an official Government response to each of the Review's recommendations. The review process was problematic, not least of all due to the chair of the review panel being an economist who has previously been on public record advocating for the deregulation of community pharmacy.

The Review's recommendations were largely ideologically driven, especially with respect to financial and competition issues. The Final Report provided little in the way of evidence to justify its claims and preferred options for deregulation and reductions in remuneration. One of the more problematic areas was in relation to remuneration for dispensing, including a recommendation (by two out of three panel members) that pharmacies be forced to provide annual financial information to government from which an "efficient price" would be calculated and applied as a fee. The report did contain some worthwhile recommendations, including for the removal of the ability of pharmacies to discount the Pharmaceutical Benefits Scheme (PBS) co-payment by up to $1.

The Government's official response to the review was published in May 2018. It was for the most part supportive of pharmacy and simply "noted" most of the recommendations. In many cases the Government indicated that the recommendation would be considered in the context of negotiations for the 7th Community Pharmacy Agreement. The recommendation regarding the abolition of the $1 co-payment discount was rejected by the government, although it has committed to a separate review of that policy.

COMMUNITY PHARMACY 2025 (CP2025)

The Pharmacy Guild of Australia ('the Guild') commissioned a research project to determine what Australian community pharmacies will look like in 2025 and beyond. The findings of the project have been summarised at https://www.guild.org.au/news-events/news/forefront/v08n13/strategic-report-on-future-of-community-pharmacy. The research concluded that management of medicines as they increase in complexity and become customised for patients will assume an increasingly important role for pharmacies. Coupled with this, health literacy for patients will become a core specialty for community pharmacies. The report also suggests there will be a move to pharmacies becoming centralised health hubs. The research identified nine pathways that represent the best opportunities for community pharmacies to make the most of the changing operating environment (listed in the web page linked above).

CODEINE UP-SCHEDULING TO PRESCRIPTION-ONLY

From 1 February 2018, medicines that contain low-dose codeine have been available only on prescription. Previously, preparations containing less than 12mg of codeine per dosage unit had been available without prescription. This change required a major education campaign and a range of materials were prepared by the

Guild and the Pharmaceutical Society of Australia to help pharmacists and consumers[1]. The Guild had opposed the change, arguing that it will limit access to medicine for people with genuine need, and will put extra pressure on already overburdened doctors.

HEALTH CARE HOMES

Community pharmacy involvement in the Health Care Homes trial, agreed to last year under the Guild's Pharmacy Compact with the federal government, presents an opportunity for community pharmacists to expand their involvement in coordinated and integrated care which is tailored to patient needs. Health Care Homes are existing general (doctor/physician) practices or Aboriginal Community Controlled Health Services (ACCHS) which are providing better coordinated and more flexible care for up to 65,000 Australians living with chronic and complex conditions.

Currently nearly 200 general practices and ACCHS around Australia are providing Health Care Home services to these patients with the stage one trial that commenced on 1 October 2017 and runs till 30 November 2019. As part of this initiative, eligible Health Care Homes patients will benefit from patient-centred, coordinated medication management services delivered by their community pharmacy of choice in conjunction with their Health Care Home. These services will include an initial reconciliation of their medications and development of a collaborative Medication Management Plan (MMP).

HIGH COST MEDICINE REIMBURSEMENT & REBATE CHANGES

The federal government has announced that it will be changing the arrangements relating to some high cost drugs for which manufacturers pay the government a large rebate (after the pharmacy has paid, and been reimbursed on, a higher published price). The changes were originally scheduled to start on 1 July 2018, however after industry protests regarding the unworkability of the proposal this has been postponed until 1 July 2019 to allow time for consultation and refinement. The changes are likely to involve reimbursement for certain drugs (including hepatitis C drugs) directly from the government to the manufacturer based on their agreed (net) price. Pharmacies may acquire the products at no up-front cost but will still carry risk if the product is not dispensed within a certain timeframe. The price will remain confidential between the government and manufacturer and the culmination of the Special Pricing Arrangements will be an equivalent decline in both revenue and expenses in the government's budget.

OTHER SIGNIFICANT ISSUES

- **Shared electronic health records**: every Australian will be offered a My Health Record unless they choose not to have one during the three month opt out period that will run from 16 July to 15 October 2018. Pharmacists are being educated on when and how to access the prescribing and dispensing information available on the My Health Record.
- **Queensland Pharmacy Inquiry**: the government of the state of Queensland is conducting an inquiry into the establishment of a Pharmacy Council in that state, which may look at expanding the scope of practice for pharmacists.
- **Wholesaler review**: the federal Department of Health has begun a formal consultation on the wholesaler Community Service Obligation arrangements (which are funded through the 6CPA). They are seeking feedback on issues including direct supply and the implications for wholesalers of the new pricing arrangements for some high cost drugs (see above).

[1] https://www.guild.org.au/resources/codeine-upscheduling

- Three trials are in progress under the **Pharmacy Trial Programs** funding provided through the 6CPA. These are Diabetes Screening, an Indigenous Medication Review Feasibility Study, and an asthma management service. The trials and subsequent evaluations are being overseen by three universities.
- Following on from the funding commitments made by the Government in the 2017 Pharmacy Compact, **the scope of the Dose Administration Aids (DAA), Staged Supply and Medscheck programs have been increased**, including through the application of higher caps on service volumes.
- Also as committed under the Pharmacy Compact, legislation was passed to **remove a 30 June 2020 sunset clause on pharmacy location rules**.
- Legislation has been introduced to require manufacturers to **report all medicines shortages** to the drug regulator and, under a new classification system, all medicines shortages deemed to carry 'extreme' or 'high' patient impact would be mandatorily published on the public Medicines Shortages Information Initiative website (https://www.tga.gov.au/medicine-shortages-information-initiative), which is currently based on voluntary reporting.
- With changes in the regulatory environment, community pharmacies are becoming increasingly well-recognised providers of **vaccination services**, particularly the influenza vaccine, to the community. Some states are also examining an increase in the scope of pharmacist vaccination.
- The federal government has set a date of 10 October 2019 for the introduction of **paperless electronic prescribing**. This will enable prescribers to use clinical prescribing software to issue an electronic PBS prescription as a legal form of prescription for use in pharmacy. Consumer and prescriber participation will be optional.

CANADA

CONTINUED GENERIC PRICING REFORM

On behalf of participating federal, provincial, and territorial public drug plans, the pan-Canadian Pharmaceutical Alliance (pCPA), with the Canadian Generic Pharmaceutical Association (CGPA) developed a new five-year plan that further reduces the prices of prescription generic drugs for participating public drug plans and employee drug plans. As of April 1, 2018, the prices of nearly 70 of the most commonly prescribed drugs in Canada were reduced by 25% - 40%, resulting in overall discounts of up to 90% off the price of their brand-name equivalents. The pCPA did not engage the pharmacy sector in making this decision.

Previous pCPA initiatives have resulted in savings of over $1 billion to participating drug plans over the past five years, and will continue to save $250 million per year. The changes are estimated by the pCPA to save an additional $385 million in the first year, and up to $3 billion over the next five years through a combination of price reductions and the launch of new generic drugs.

The pCPA has stated that tendering will not be pursued by the participating drug plans over the five-year term.

Several provinces have increased dispensing fees over the past several years, in response to generic cuts. However, the impact these cuts have had and will continue to have cannot be accounted for by increasing dispensing fees. The Canadian Pharmacists Association (CPhA) has called for a portion of the resultant savings to be reinvested in improving clinical pharmacy services, and this has occurred in some cases.

In response to revenue reductions, some pharmacies began operating fewer hours, reducing staff or charging for delivery services. Depending on the province of practice, pharmacists are now remunerated for clinical services such as medication reviews, minor ailment prescribing or flu vaccination, as well as for prescription adaption. Canadian pharmacies now have access to a broader scope of services and funding than in most other countries, however this still represents a small proportion of income compared to dispensing.

DRUG SHORTAGES

Pharmacists in Canada continue to face drug shortages. Based on a recent report from C.D. Howe Institute[2], about 1,000 shortages are reported annually, affecting 1,250 products during a recent three-year period. The shortages seem to have affected at least 10% of all active drugs available in Canada.

Shortages this year included the significant EpiPen Auto-Injector and EpiPen Jr. shortages, as well as the valsartan recall; the full consequences of which have yet to be determined.

Reporting of shortages on the drugshortages.ca database became mandatory for manufacturers in the spring of 2017. However, analysts have criticized the database for a lack of robustness of data, including the lack of detail around the reasons for shortages.

CPhA has attempted to measure the effects of leading causes of drug shortages in Canada; assess the relative burden and costs of drug shortages across patients, pharmacists, payers, and health care systems; evaluate the impact of existing and potential new drug shortage interventions; and identify leading practices for drug shortage interventions. However, a major barrier to the research was the significant lack of data available both nationally and internationally.

[2] https://cdhowe.org/sites/default/files/attachments/research_papers/mixed/Commentary_515.pdf

CPhA will focus the next phase of our research on assessing the current impact of drug shortages on key stakeholders in Canada.

PHARMACARE

Pharmacare, or full population drug coverage, has been a major health policy agenda item over the last year. Under the current liberal government, it appears that Canadians are in favour of some form of pharmacare, but how this will be implemented and paid for is still being debated. A report was released in September 2017 by the Parliamentary Budget Officer estimating the costs of a national, public-payer pharmacare model.

The House of Commons Standing Committee on Health has put forward recommendations for a national public-payer pharmacare model.

In April 2018, the federal government established an Advisory Council on the Implementation of National Pharmacare. The Council is leading consultations with stakeholders across Canada to assess the best option for the implementation of pharmacare. It aims to publish recommendations in the fall of 2018, with implementation by 2020.

CANNABIS

Cannabis will become legal in Canada on October 17, 2018. Once recreational cannabis is legal, the federal government plans to impose an excise tax on both recreational and medical cannabis. CPhA and patient groups are advocating against this tax and are calling on the government to regulate the price of medical cannabis as it does other prescription drugs (though medical cannabis is currently authorized by a medical "document" from a prescriber, not a "prescription")

CPhA believes that Canadians requiring medical cannabis should be able to access cannabis in the same way as they all other medications, which would provide them the benefits associated with clinical oversight and support from a regulated health care professional at the time of dispensing.

OPIOIDS

The opioid crisis continues in Canada. CPhA is advocating for pharmacists to be included as "practitioners" in the Controlled Drugs and Substances Act (CDSA) as a first step to enabling pharmacists to adapt opioid prescriptions. Pharmacists with this authority could, where appropriate, reduce the dosage of opioids for patients; administer a patient's opioid tapering plan; and recommend and prescribe alternative therapies to opioids, such as non-steroidal anti-inflammatories.

E-PRESCRIBING

Canada Health Infoway, a not-for-profit organization funded by the federal government, is rolling out an e-prescribing service (Prescribe IT) across the country, beginning in a few select provinces.

While CPhA supports advances in health technology, we have voiced our opposition to the payment model, where pharmacies will be the only users of Prescribe IT who will be charged for the service.

IRELAND

MEDICINES PRICING AND REDUCED FUNDING

As of December 2017 the Irish government has extracted an estimated €3.14bn from the community pharmacy sector since 2009, largely through reduced medicine prices. Traditionally, the State paid pharmacists dispensing fees, mark-ups on medicines and medicine reimbursements. Changes to each of these payment mechanisms in recent years have resulted in reduced earnings for pharmacists (the mark-up component of remuneration was eliminated from 2013). Average mark-ups + fees per item have reduced by about €0.92 per item over this period, while the cost per item has reduced by an average of €6.08.

Ireland has not yet seen any significant reinvestment into community pharmacy from savings the government continues to generate from drug price reductions. As a result of these issues most pharmacies have seen reduced profitability, although the 2017 year was a period of relative stability.

In July 2016 the government announced a new four-year agreement with Irish Pharmaceutical Healthcare Association (IPHA) to further reduce the price of medicines, saving a further €600m+. The changes include an expansion of the reference basket used to set prices in Ireland from the previous nine to 14 countries, including for the first time Greece, Italy and Portugal. The agreement also includes, for the first time, an annual price realignment to ensure that the prices of medicines in Ireland reduce in line with price changes across the reference countries.

The Financial Emergency Measures in the Public Interest (FEMPI) Act, which started in 2009 as a result of an economic crisis, created massive cuts in most areas of Irish government spending with pharmacy disproportionately affected. The previous Minister committed to commence the unwinding of the savage reductions in payments to community pharmacy contractors. However, to date, pharmacies have not seen one cent returned.

PUSH FOR MORE PAID SERVICES, EXPANDED SCOPE & BIOSIMILAR SUBSTITUTION

A broad range of clinical services is available in Irish pharmacies and the number of these that are State reimbursed is slowly growing. These include vaccination for influenza, pneumococcal and herpes zoster. Notably, there was a 46% increase in the uptake of pharmacy influenza vaccination in the last year, reaching a total of 115,000 patients (refer https://ipu.ie/home/news/46-increase-uptake-flu-vaccine-pharmacies/).

Additionally, from 1 July 2017, a new government-funded emergency contraception service was implemented for medical card holders. A prescription is not required. A consultation fee of €11.50 is paid to the pharmacy by government (whether or not the product is supplied), in addition to a dispensing fee and reimbursement for the drug price.

Pharmacists identify “customer service and patient care” as the most important elements of their businesses and are calling for additional services to make full use of the skills of staff for the benefit of patients, and to diversify their income. Since 2016, when there was a change in power following an election, the IPU has been calling on the current Irish government to commit to the expansion of the role of pharmacists, including an extended vaccine service, a minor ailment scheme, health check service, a New Medicine Service and the reclassification of some medicines (refer https://ipu.ie/news/ipu-calls-on-new-government-to-commit-to-expansion-of-role-of-pharmacists-in-programme-for-government/). The IPU has also been lobbying for oral hormonal contraceptives to be made available from a pharmacy without a prescription.

These calls have continued into 2017 and 2018. The IPU, together with the HSE, successfully piloted a pharmacy-based minor ailment scheme in 2016 but it has not been implemented to date, even though 4 out of 5 members of the public have said they would welcome such an initiative.

Recently, the IPU has been highlighting the opportunities for government savings around biologics if they allowed pharmacists to substitute biosimilars. It has been estimated that this would release €800 million in potential savings over a five-year period. In the absence of specific steps being taken to improve biologic uptake, HSE spending on biologics is expected to reach €900 million annually by 2020 (refer to IPU release here - https://ipu.ie/home/news/government-ignoring-potential-e800-million-savings-health-budget/).

NEW ZEALAND

NEW INTEGRATED COMMUNITY PHARMACY SERVICES AGREEMENT FROM 1 OCTOBER 2018

It was announced on 30 July 2018 that the New Zealand Pharmacy Guild ('NZ Guild') had come to an agreement with the 20 District Health Boards (DHBs) on a new contract offer for pharmacies. The main points include:

- a new name: the "Integrated Community Pharmacy Services Agreement (ICPSA)" (previously CPSA).
- the Agreement has no end date but there will be a National Annual Agreement Review. This is a new process and will take place in the final quarter of each financial year.
- funding for 2018-19 is up 5.9% on the 2017-18 level, to about NZ$470m inclusive of wholesale margin.
- as with previous arrangements, for dispensing there are Handling Fees and Casemix Fees including "multipliers" for certain dispensing types such as extemporaneously prepared items, clozapine, controlled drugs, etc. All of these fees and levels are unchanged, including the additional $21 monthly fee per registered Long Term Conditions patient. The fee schedule is at https://tas.health.nz/assets/Uploads/ICPSA-Fees-and-Payments-from-1-Oct-2018-Fact-Sheet.pdf.
- the wholesaling margin receives a small uplift in the pack fee component from 23.8 cents to 25.3 cents per pack.
- apart from a 2.5% forecast increase due to prescription volume, most of the extra funding is in a new pool averaging about $8,000 per pharmacy per year in a "Professional Advisory Services Payment". This new payment recognises pharmacists' professional advisory services. It will be paid automatically to every pharmacy. The total pool for this payment will be distributed to pharmacies monthly based on market share and an "equity adjuster" (based on the pharmacy's number of Maori/Pacific Islander patients and the number of certain health card holders). Overall market share will be determined 85% by script volume and 15% by unique patient count. There is also an upfront lump sum averaging about $2,000 per pharmacy in this pool.
- services funding continues, primarily through the Community Pharmacy Anti-Coagulation Management Service (CPAMs) (NZ$45/patient/month) and influenza vaccine administration (NZ$19.57).

HEALTH AND DISABILITY SYSTEM REVIEW/PRIMARY CARE FEDERATION

On 29 May 2018 the Minister of Health, Dr David Clark, announced a wide-ranging ground up review of the health system with a final report due 31 January 2020. The NZ Guild looks forward to participating in this review to share our views and analysis of primary/secondary health funding inequities – and the associated adverse impacts on increased access to primary care services and financial sustainability. This is an opportunity for addressing structural complexity in our health system. Too many entities (20 District Health Boards) currently add layers and complexity – there is great opportunity to streamline and simplify.

The NZ Guild has become a member of Federation of Primary Health Aotearoa NZ. We see the federation as a useful primary care voice to influence policy and funding decisions in general – including the Health and Disability system review.

MEDICINAL CANNABIS

Ministry of Health are working to develop a Medicinal Cannabis Scheme. The aim is to allow domestic cultivation and manufacturing to produce more readily available medicinal cannabis products and help to remove barriers for access and provide prescribers with confidence in these products.

The NZ Guild has advocated for an alternate medicinal cannabis model of supply that would empower the role of pharmacists. The model is based on patients having better access to pharmaceutical grade medicinal cannabis products.

In 2017 there was an amendment to the Misuse of Drugs Regulations to allow some products containing cannabidiol (CBD) to be prescribed without ministerial approval and the removal of other restrictions. This allowed for CBD products to be prescribed by a doctor and when dispensed through a pharmacy it was exempt from all the usual controlled drug storage and recording requirements.

There is currently a bill going through Parliament that is looking to change CBD products from a controlled medicine to a prescription only medicine.

Currently there are no registered CBD products in New Zealand and are brought into New Zealand through section 29 of the Medicines Act. There are only a small selection of CBD products available for patients currently. Some pharmacies are importing CBD products for their patients from overseas. Only a small selection of CBD products are kept locally by wholesalers.

The end goal of medicinal cannabis is to align with the practices in Australia. In Australia, CBD products are prescription only equivalent and they have set guidelines for domestic cultivation and manufacturing of medicinal cannabis products.

MENTAL HEALTH AND ADDICTION INQUIRY

The Government has established an Inquiry to identify unmet needs and develop recommendations for a better mental health and addiction system for New Zealand. The NZ Guild sees the opportunity of the inquiry to help break down the stigma associated with mental health and to remove the barriers that the population have towards getting the required help.

The NZ Guild would like to see community pharmacy to be more involved with mental health and addiction. By harnessing the trust that our local communities have in the profession and through our accessibility to patients. There are opportunities for pharmacy to provide education, screening, provide referrals and work more closely with other health professionals to piece together the current gaps in the health system.

Further opportunities through medicines therapy assessments for patients to get better health outcomes from the medication that they take. The NZ Guild sees opportunities to improve on both methadone and clozapine services.

QUALITY SERVICE FOCUS

The quality of service provision, and goal of lifting performance standards across the sector, is an important focus. The NZ Guild will provide ongoing leadership and support to members for Medicines Control audits.

SOUTH AFRICA

NATIONAL HEALTH INSURANCE (NHI)

The health coverage of approximately 17% of the population of South Africa is taken care of via 82 "medical schemes". This is the so-called "private sector" and is where all community pharmacies are operating and are remunerated, i.e. there is no national one payer system. 83% of the population is dependent on the public sector (hospitals, clinics etc.) for their health needs. The SA Government has realised that it is time for the country to move to universal health coverage where everyone receives quality healthcare regardless of economic status. The universal health coverage is called National Health Insurance (NHI), a financing system designed to pool funds and actively purchase services (including from community pharmacies) to provide universal access quality health services for all. The intention is to do largely do away with most of the current medical schemes (the remuneration system of the private sector) so that they will be only supplementary to NHI.

The most recent developments relating to NHI in South Africa is the publication of a National Health Insurance Bill, 2018 by Government on 21 June 2018. A short summary of the Title of the Bill provides an indication of the purpose of the Bill and what Governments intentions are with NHI, namely: "to provide mandatory prepayment health care ion the Republic in pursuance of section 27 of the Constitution; to establish a National Health Insurance Fund and to set out the powers, functions and governance structures, to provide a framework for the active purchasing of health care services by the Fund on behalf of users"

This will be a long term process and represents a huge challenge and opportunity for community pharmacies.

MEDICAL SCHEMES/PAYMENT FOR SERVICES

The publication of the NHI Bill was complemented by the publication of the Medical Schemes Amendment Bill, 2018 by Government on 21 June 2018, as a further step towards an NHI Funded healthcare system in South Africa. The Bill concerned is a beginning in re-organising / re-emphasising the role of medical schemes against the background of the implementation of NHI and the funding of NHI.

HEALTH MARKET INQUIRY

The above-mentioned developments are further strengthened by the recent preliminary Report of The Competition Commission's Health Market Inquiry. The "initiation of this inquiry was motivated by high and increasing expenditure and costs of private healthcare in South Africa"

DESIGNATED SERVICE PROVIDERS AND CO-PAYMENTS

In the private system (where community pharmacy operates) the current remuneration system is via negotiations with 82 medical schemes. Pharmacy ownership has been deregulated since 2003 with limited conditions. Medical Schemes are allowed in terms of the Medical Schemes Act to negotiate fees (remuneration) with providers and enter into contracts with Designated (or preferred) Service Providers (DSPs), such as the larger pharmacy groups, at lower fees. Patients who do not wish to or cannot use a DSP must pay a co-payment (penalty) if they use a non-DSP provider.

Where such arrangements are transparent and available to any pharmacy that can meet reasonable requirements DSPs are not a problem. They are a way for medical schemes to manage their costs. However, over the years some medical schemes have selected DSPs in a discriminatory manner without considering applications to join the network from all interested service providers. This unfairly limits the number of selected pharmacies available to provide services.

CORPORATE COMPETITION / VERTICAL INTEGRATION

Corporatisation is a growing concern since the opening up of pharmacy ownership and the supermarket type pharmacy entering the market. This matter is aggravated by a new developing trend of vertical integration by some of these owners, meaning the same ownership of wholesaler, manufacturer and pharmacy.

DISPENSING FEE

The dispensing fee (per item on a prescription) is determined by way of a four tier system based on the Single Exit Price of the medicine (item) concerned. [SA has strict drug pricing arrangements and the government-regulated Single Exit Price (SEP) for each drug must be charged by suppliers to all pharmacies]. The fee is a maximum fee and determined by a Pricing Committee established in legislation. As indicated above, medical schemes pay a negotiated fee which in most cases is significantly lower than the prescribed maximum. The dispensing fee is supposed to be increased by CPI annually and the Association(s) could make submissions in this regard. Unfortunately, there has been disagreement on the application of the CPI due to the impact of the four tier level approach. A new Pricing Committee was appointed in July 2017 and it was agreed that a new methodology must be agreed on for determining an appropriate (maximum) dispensing fee for community pharmacists, in future.

UNITED KINGDOM

HIGH COURT APPEAL RE: COMMUNITY PHARMACY CONTRACTUAL FRAMEWORK (CPCF) FUNDING CUTS

On 20th October 2016, the Government imposed a two-year funding package on community pharmacy in England, with a £113 million reduction in funding in 2016/17. This took total funding to £2.687 billion for 2016/17, a reduction of 4% compared with the previous year, but it also meant that contractors saw their funding for December 2016 to March 2017 fall by an average of 12% compared with pre-December levels. This has been followed by a reduction in 2017/18 to £2.592 billion for the financial year, which has seen funding levels from April 2017 drop by around 7.5% compared with pre-December 2016 levels. The imposition, which was announced by minister David Mowat in Parliament, came after unanimous rejection of the package on 14th October 2016 by pharmacy.

A Single Activity Fee (SAF) has been introduced which incorporated and replaced the previously applicable Professional Fee, Practice Payments, Repeat Dispensing Fee and EPS Monthly Allowances. For December 2016 to March 2017 the SAF was set to £1.13 per item to meet the imposed budget. The SAF then rose in 2017/18 to a level of £1.25 per item. In addition, from April 2017 Establishment Payments have been reduced by 40% compared to 2015/16 levels. This alone is a £10,000 reduction on an annualised basis for most pharmacies.

The NPA and PSNC have both challenged the cuts through the High Court, arguing (amongst other issues) that the Department failed to base its decision on reliable information regarding the financial performance of community pharmacies. Hearings were held in May 2018 and a decision has not yet been passed down as at the date of this report.

CATEGORY M GENERICS PURCHASING MARGIN CLAWBACK

The NHS funding package includes £800m in retained buying margin each year. A Margins Survey is used to identify whether the delivery rate of margin to community pharmacy under or over delivers on the £800m

target, and the Government re-calibrates Category M Drug Tariff reimbursement prices to bring the margin delivery rate back on track. A reduction of £15 million per month was made to Category M reimbursement prices from August 2017 to begin to address a measured over-delivery of medicine margin for 2015/16 and 2016/17. Originally this reduction was agreed for twelve months, however the PSNC raised concerns about the impact of price reductions on contractors' cash flow. As a result, the Department of Health and Social Care (DHSC) is now increasing Category M reimbursement prices from August 2018. DHSC and PSNC continue to work to complete the medicine margin assessment for 2017/18 and finalise the outturn for 2016/17, to inform any further adjustments in 2018/19.

PHARMACISTS WORKING IN GENERAL PRACTICE

In April 2016 the NHS England "General Practice Forward View" (refer https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf) committed over £100m of investment to support an extra 1,500 clinical pharmacists to work in general practice by 2020/21. NHS England's programme to recruit and train pharmacists to work in general practices has continued and the latest figure from NHS England (July 2018 Board Papers) was that there were over 720 Full Time Equivalent pharmacists in post, with recruitment continuing.

In the last year, NHS England have also commenced the recruitment of pharmacists to work in integrated urgent care settings (NHS 111 call centres, GP out of hours services and some urgent care walk in centres). Money has also been made available for Clinical Commissioning Groups (CCGs) to implement a locally developed programme to recruit pharmacists and pharmacy technicians to undertake medicines optimisation work in care homes. It is possible that community pharmacy may be able to participate in this work in some areas, but many CCGs are blocking community pharmacy involvement, due to perceived conflicts of interest related to supply of medicines to care homes.

In June 2017 the Pharmacists' Defence Association (PDA) launched a survey after "a number" of GP pharmacists reported being "put under pressure" in their surgeries. They said "as a defence association, we are concerned about the lack of an adequate supervisory support structure for clinical pharmacists in GP practices in some parts of the UK, and we are trying to do something about it." (refer https://www.chemistanddruggist.co.uk/news/pda-number-gp-pharmacists-facing-workplace-pressure).

DEVELOPMENT OF PRIMARY CARE NETWORKS IN ENGLAND

NHS England is encouraging all general practices to work together in 'hubs' or networks working to support a combined patient population of 30-50k, known as Primary Care Networks. All practices should be a member of such a network by the end of March 2019. One model for Primary Care Networks – the Primary Care Home - has been developed by the National Association of Primary Care (NAPC). The networks provide an opportunity to improve collaborative working between community pharmacy and general practice, so work has been undertaken with NAPC to develop guidance on how pharmacy can get involved in the networks/primary care home sites: https://psnc.org.uk/our-news/community-pharmacy-integration-guidance-published-by-napc/

OTHER SIGNIFICANT ISSUES

- Potential Brexit impact on medicines supply chain: at this point it is unclear what the impact may be, but there are predictions of supply chain problems once Brexit occurs.
- Implementation of the Falsified Medicines Directive: this continues, but there is ongoing uncertainty about the longevity of the European system in the UK post-Brexit. It is however expected that a serialisation system for medicines will be introduced in the UK even if it is not part of the EU system.

- Medication safety: the former Secretary of State for Health and Social Care initiated work on medication safety and this is becoming a key priority for the NHS. It links to wider work that the World Health Organisation are undertaking. The report of a working group on this topic is available at https://www.gov.uk/government/publications/medication-errors-short-life-working-group-report
- NHS England Primary Care Prescribing guidance: during 2017 and 2018, NHS England have been undertaking work and several public consultations on restricting the prescribing of several products at NHS cost. This was initially focussed on medicines of "low clinical value", but it then moved on to recommend that there should be restrictions on the prescribing of OTC medicines to treat minor illnesses. Both these changes (and probably other factors, such as increasing the quantity of medicines prescribed on individual prescriptions) are starting to supress growth in prescription volume in England, which is hovering just above zero growth and it may move negative in due course.
- Evidence base for care planning in pharmacies: the Community Pharmacy Future II projects economic evaluation was published, demonstrating the cost effectiveness of the community pharmacy service: http://www.communitypharmacyfuture.org.uk/pages/pharmacy_care_plan_248975.cfm and https://www.sciencedirect.com/science/article/pii/S1551741117308380?via%3Dihub.

UNITED STATES

DIR FEES & CLAWBACKS

Direct and Indirect Remuneration (DIR) fees imposed on pharmacies participating in Medicare Part D networks by plan sponsors and their PBMs have exploded in recent years. The treatment of these pharmacy price concessions as pharmacy DIR rather than as reductions in the "negotiated price" of a drug has had a negative impact on patients, the government, and a crippling effect on community pharmacies. The retroactive nature of these fees means beneficiaries face higher cost-sharing for drugs and are accelerated into the coverage gap or "donut hole" phase of their benefit. What's more, beneficiaries reach the catastrophic phase faster of the benefit, for which health plans are able to shift cost responsibility to CMS which incurs approximately eighty percent of the cost. Finally, pharmacy DIR fees are taken back from community pharmacies months later rather than deducted from claims on a real-time basis. This reimbursement uncertainty makes it extremely difficult for community pharmacists to operate their small businesses. To help reference the magnitude of this issue, CMS reported that $83.3 billion has been paid in DIRs by pharmaceutical manufacturers and pharmacies between 2010 through 2015 and the annual trajectory is on the rise - DIR as a percentage of gross drug costs has risen steadily year over year, going from 11.3% in 2010 to 17.2% in 2015.

INTEREST IN CHANGING THE PHARMACY PAYMENT MODEL

The payment for prescriptions in the U.S. flows through PBMs. Pharmaceutical manufacturers must pay PBMs rebates to gain formulary access and pharmacies must accept PBM payment terms in order to access patients. Pharmacies have known for a long time that rather than control costs as PBMs claim, they are actually contributing to the higher cost of prescription drugs. In the last two years, the profile of PBMs and their practices has been elevated to consumers and legislators through media and lobbying. For example, the popular newsmagazine "60 Minutes" reported in a feature story that the largest PBMs quoted in court documents that it is not contractually obligated to control costs. The Wall Street Journal ran an editorial calling out the hundreds of millions of dollars that CVS Caremark has mismanaged for the state's indigent program. The National Community Pharmacists Association (NCPA) has testified at numerous Congressional hearings to explain why drugs cost so much. President Trump and Health and Human Services Secretary, Alex Azar both called out PBMs as contributors to the high cost of drugs in the U.S. in a White House press conference. Multiple signs are pointing toward an increased appetite for changing the current pharmacy payment scheme in the USA.

PBM FIDUCIARY DUTY

One solution gaining traction to both rebates and spread pricing is to require PBMs to have a fiduciary duty with respect to plan assets that they manage for other entities. A fiduciary duty would shed light on opaque PBMs' practices, including the PBM's incentive to charge the plan more than the pharmacy is reimbursed and keep the difference as profit, which ultimately raises consumer and taxpayer costs. Another solution is to force all price concessions such as rebates to the point of sale.

OPIOID EPIDEMIC

As part of Congress' ongoing efforts to combat the opioid epidemic, there was movement on two pieces of legislation that have been endorsed by NCPA, The Senate Finance Committee passed S. 2460, the Every Prescription Conveyed Securely Act, that would require electronic prescribing for Schedule II through V controlled substances prescriptions covered under Medicare Part D. Due to NCPA's advocacy efforts this legislation maintained provisions to exempt long-term care patients and to ensure that patients' choice of pharmacy is respected.

Also, the House of Representatives passed H.R. 4275, the Empowering Pharmacists in the Fight Against Opioid Abuse Act, will help pharmacists detect fraudulent prescriptions. H.R. 4275 was endorsed by NCPA and would require federal agencies develop and disseminate materials, giving pharmacists greater understanding and ability to decline to fill controlled substances when they suspect the prescriptions are fraudulent, forged, or appear to be for abuse or diversion.

COMMUNITY PHARMACY ENHANCED SERVICES NETWORK (CPESN)

In addition to dispensing critical medications to patients, many independent community pharmacies are joining clinically integrated networks of pharmacy providers known as CPESN, that coordinate patient care with physicians, care managers, and other patient care teams to provide medication optimization activities and enhanced services for high-risk patients. CPESN has grown rapidly and now has 43 networks in 40 states across the United States.

CPESN pharmacy providers see their complex patients 35 times a year, while physicians only see their patients 3.5 times a year. NCPA member pharmacies in this network work directly with payers to add enhanced services into contracts and lower drug costs. These clinically integrated network pharmacies are able to negotiate together as long as they are improving quality and lowering costs. The local networks negotiate with plans responsible for overall medical costs (rather than the PBMs who are siloed in prescription drug benefit).

PROGRESSIVE PHARMACY NICHES

Independent community pharmacies are rapidly expanding in various progressive niches. These niches are helping owners differentiate their pharmacies in local markets and become better integrated in the community's overall health care system. Thirty-five percent of pharmacists have a collaborative drug therapy agreement with a physician, and 23 percent have access to electronic medical records. Pharmacists are part of the health care team providing innovative services, transitions of care, and patient education.

SPECIALTY MEDICATIONS

PBMs (including CVS) and Walgreens are actively contracting with payers to steer high cost specialty prescriptions into their specialty pharmacies by denying patients the ability to fill these prescriptions at the pharmacy of their choice. Thirty-nine percent of independent community pharmacies dispense specialty medications and cash flow is vital as a small number of specialty patients could represent hundreds of thousands of dollars in accounts receivable awaiting payment. The top disease state specialty medications dispensed by these pharmacies include rheumatoid arthritis (85 percent), HIV (55 percent) and hepatitis C (45 percent). Community pharmacies provide high-touch care to the patients in their local communities who need these medications.

OTHER MERGERS

Two major proposed mergers are being considered by regulators at the time of writing:

- CVS Health is attempting to merge with Aetna, the nation's third largest health insurer. CVS is already the pharmacy benefits manager for Aetna, and independent pharmacies have been foreclosed from Aetna's Part D preferred networks for the last two years. Consolidation of the two companies will only strengthen their ability to steer patients to CVS/Aetna-owned retail or mail order pharmacies.
- Cigna, the fourth largest health insurer, has bid to acquire pharmacy benefit manager Express Scripts. Continued vertical health care consolidation could impede competition and foreclose any meaningful entry into the market, leading to fewer choices and higher health care costs. Rigorous antitrust scrutiny is critical to protect competition and ensure affordable patient access.

FEATURE: The USA experience

The NCPA provided the following summary of what successful independents are doing to counter the growing prevalence and dominance of chains, supermarkets and mail order in the USA.

- *For the past decade independent community pharmacy has struggled with below cost reimbursement from third-party contracts and government reimbursement programs.*

Combined with recent unpredictable DIR fees in Medicare Part D, profits have fallen and store closures have increased.

- *As a whole independent community pharmacy must continue to fight for fair reimbursement and the opportunity to expand beyond the role of dispensing medications by* ***taking on a more proactive role in the total health care of their patients****.*

- ***The most successful pharmacies are pioneering this transformation by crafting new and unique pharmacy services to address gaps in care in their communities.*** *Many independents are joining clinically integrated network of pharmacy providers known as CPESN. Pharmacies in these networks have strong relationships with the patient and the members of that patient's local health care team. They provide the* ***integrated care and enhanced services that have proven to improve the health of complex, chronically ill patients.*** *Other successful pharmacy owners are* ***playing a major role in the rapidly expanding specialty market by dispensing specialty medications for disease states such as rheumatoid arthritis and hepatitis C.***

- *Diversified revenues are not enough to distinguish successful pharmacies from unsuccessful pharmacies. In a world of low margins, controlling costs is crucial to the success of independent community pharmacy. Cost of goods sold and total operating expenses as a percentage of total sales revenue are much lower for the most profitable pharmacies relative to other pharmacies.* ***Purchasing labor saving technologies to control payroll expenses and buying goods at low cost is crucial to success.***

- *Given the complexities of reimbursement models,* ***successful pharmacies properly utilize data mining tools that transform accounting data into meaningful metrics and reports that allow owners to make wise business decisions.***

- *Finally* ***successful pharmacies get out from behind the counter and form relationships. Business does not simply come to successful pharmacies. Successful pharmacies go to and earn the respect of every customer they have.*** *Forming strong bonds within the community promotes brand image and is feature that distinguishes successful from unsuccessful pharmacy.*

SECTION 2: HEALTH SYSTEM STATISTICS & OUTCOMES

Unless otherwise noted, the statistics in this section come from (or are derived directly from) the OECD Health Statistics database (http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#). Secondary sources include the World Health Organisation's World Health Statistics publication (http://www.who.int/gho/publications/world_health_statistics/en/) and the World Bank (https://data.worldbank.org/indicator).

Comparisons of international health data can be problematic, largely because of differences in terminology, data collection, timing and health system structure. However, these sources represent the most reliable datasets of their kind. In coming years the WPC will be expanding the range of data it collects and monitors in relation to community pharmacy services and outcomes, and will be seeking to achieve improvements in data quality through applying more rigorous standards.

Colour coding is used in some of the tables below. GREEN indicates positive health system performance and RED indicates relatively poor performance (within the WPC member cohort).

LIFE EXPECTANCY AND AGE DISTRIBUTION

	AU	CAN	IRE	NZ	SAF	UK	USA	Year	Note
Life expectancy	82.5	81.7	81.5	81.7	57.4	81.0	78.8	2015	Total population, at birth
Share of population aged 65+ in 2000	12.5	12.6	11.1	11.8	3.4	15.8	12.4	2000	
Share of population aged 65+ in 2010	13.6	14.2	11.2	13.0	5.2	16.2	13.1	2010	
Share of population aged 65+ in 2016	15.3	16.5	13.2	14.9	5.2	17.9	15.2	2016	

MORTALITY

AVOIDABLE HOSPITAL ADMISSIONS

	AU	CAN	IRE	NZ	SAF	UK	USA	Year	Note
COPD hospital discharges	286	241	323	257	NA	251	230	2014-15 (USA 2010)	All hospital admission rates are age-standardised rates per 100,000 population
Heart failure discharges	220	179	132	188	NA	142	331	2014-15 (USA 2010)	
Hypertensive diseases hospital discharges	33	19	49	21	NA	17	158	2014-15 (USA 2010)	
Diabetes-related hospital discharges	137	102	95	136	NA	77	203	2014-15 (USA 2010)	

HEALTH RISK FACTORS

	AU	CAN	IRE	NZ	SAF	UK	USA	Year
Daily smoking in adults in 2000 (%)	20	22	33	25	24	27	19	2000
Daily smoking in adults, latest data (%)	12	14	19	14	19	19	11	2014-16
Daily smoking in adults - change 2000 to latest data	-40%	-36%	-42%	-44%	-21%	-30%	-42%	
Obesity among adults in 2000 (%)	20	22	NA	25	NA	21	31	2000
Obesity among adults, latest data (%)	28	26	NA	32	NA	27	38	2014-16
Obesity in adults - change 2000 to latest data	40%	18%	NA	28%	NA	29%	23%	

HEALTH & PHARMACEUTICAL EXPENDITURE

	AU	CAN	IRE	NZ	SAF	UK	USA	Note
Health expenditure as a % of GDP 2000	*7.6*	*8.3*	*5.9*	*7.5*	*8.1*	*6*	*12.5*	
Health expenditure as a % of GDP latest	9.1	10.4	7.1	9.0	8.2	9.7	17.2	OECD & World Bank
Health expenditure per capita (USD)	4543	4826	5447	3683	1086	4264	10209	OECD & World Bank
Expenditure on pharmaceuticals per capita (USD)	385	644	538	178	NA	403	1009	OECD, US CDC

PHARMACEUTICAL-RELATED STATISTICS

	AU	CAN	IRE	NZ	SAF	UK	USA	Note
Influenza vaccination coverage, % of people aged 65+	75	60	54	65	NA	71	69	Latest available data
Anti-hypertensive drugs consumption	7.9	2.3				13.7		Defined Daily Doses, per 1,000 people per day (2016-17)
Lipid-modifying agents consumption	133.8	113.1				141.8		Defined Daily Doses, per 1,000 people per day (2016-17)

PRESCRIPTION PHARMACEUTICAL USAGE

The table below is derived from statistics used elsewhere in this report (it is not from the OECD or WHO). This measure can be affected by a range of factors, including frequency of dispensing and dispensing quantities, so it is at best a rough proxy for prescription pharmaceutical usage per person.

	AUS	CAN	IRE	NZ	SAF	UK	USA*	*Average*
AVERAGE ANNUAL VOLUME OF PRESCRIPTION ITEMS DISPENSED PER PERSON	**12.9**	**18.7**	**22.2**	**14.5**	**15.7**	**18.8**	**11.2**	*16.3*
Difference to average	*-21%*	*15%*	*37%*	*-11%*	*-4%*	*15%*	*-31%*	

* To the extent that non-independent pharmacies may dispense more prescriptions on average than independent pharmacies, the USA volume is likely to be an understatement

APPENDIX 1: INTERNATIONAL TERMINOLOGY & ACRONYMS

This appendix contains definitions of some of the terms and acronyms that are used across some or all countries in WPC. Where applicable, the table includes relevant section numbers of this report where more information or context can be found.

Term	Definition
6CPA (AUS)	6th Community Pharmacy Agreement (Australia) Five-year agreement (2015 to 2020) between the Australian Government and The Pharmacy Guild of Australia with regard to pharmacy funding arrangements. Previous agreement (2010 – 2015) known as 5CPA.
AAC (mainly USA)	Actual Acquisition Cost
Adherence aid/pack	See *Compliance Aid*
ADR	Adverse Drug Reaction
APA (mainly CAN)	Additional prescribing authority (for pharmacists)
API	Active Pharmaceutical Ingredient
AUR	Appliance Use Review (a funded service in the UK)
AWP	Average Wholesale Price
CAM	Complementary and Alternative Medicine
CACP	Comprehensive Annual Care Plan (Alberta, Canada)
Close control (NZ)	A regulation in New Zealand that provided a mechanism for pharmacies to dispense more frequently to some patients. It has now been replaced by the Dispensing Frequency Rule.
Category M (UK)	The pricing of Category M (off-patent) drugs is adjusted quarterly based on a Margins Survey which examines the invoices from a sample of pharmacies. The Government re-calibrates Category M Drug Tariff prices to bring the margin delivery rate back on track. Similar to NADAC (USA) and Price Disclosure (AUS).
CMS (USA)	Centers for Medicare and Medicare Services (USA): The US government agency responsible for the overall management of Medicare programs and federal oversight of Medicaid funding.
Compliance Aid	A compartmentalised pack into which tablets/capsuled are packed according to timing of dosage, usually for seven days, to encourage the taking of medicines as directed by the prescriber or pharmacist. Also known by terms including: • Adherence aid • Adherence packaging • Blister packs • Compliance packaging • Dose Administration Aid (AUS) • Dosette box/pack • Monitored dosage systems • Multi-compartment compliance aids (MCAs) (UK) • Webster Pack (AUS)

Term	Definition
Co-payment (sometimes *co-insurance*):	Insured patient's contribution towards the cost of a medical service covered by the insurer. It can be expressed as a percentage of the total cost of the service (also known as co-insurance) or as a fixed amount.
CPCF (ENG)	Community Pharmacy Contractual Framework (England)
CPhA (CAN)	Canadian Pharmacists Association
CPSA (NZ)	Community Pharmacy Services Agreement (New Zealand)
CSO (AUS)	Community Service Obligation
DAA (AUS)	Dose Administration Aid See *Compliance Aid*. Also commonly referred to as a "Webster Pack" (a proprietary name in Australia).
Deductible	An initial amount required to be fully paid by the patient beyond which other arrangements apply.
DHB (NZ)	District Health Board There are 20 DHB areas in New Zealand. They are responsible for the health budget (including pharmaceuticals and pharmacy services) in their own region.
Dosette box/pack	See *Compliance Aid*
Drug Tariff (UK)	The NHS publication used as a reference for the payment and repayment of NHS prescription costs in the UK by pharmacists or doctors dispensing in primary care.
DSP (SAF)	Designated Service Provider South African medical aid schemes are allowed to limit entitlements to products and services provided though certain providers (designated service providers, or DSPs) – particular groups of hospitals, clinics, doctors and pharmacies.
DTC	Direct to Consumer (usually in relation to advertising)
EAC	Estimated Acquisition Cost
FUL (USA)	Federal Upper Limit
GDP	Gross Domestic Product (the most common measure of the size of a country's economy)
GMP	Good Manufacturing Practice
GSL (UK)	General Sales List Medicines that are allowed to be sold outside of pharmacy (i.e. through general retailers), without a prescription or pharmacist.
Guild (AUS, NZ)	Usual shortening of The Pharmacy Guild of Australia (also Pharmacy Guild of New Zealand)
HMR (AUS)	Home Medicines Review
ICPA (SAF)	Independent Community Pharmacy Association (South Africa)
INN	International Non-proprietary Name The internationally recognised generic name for a medicine.
IPU (IRE)	Irish Pharmacy Union
ISO	International Organisation of Standardisation

Term	Definition
LTC	Long Term Conditions (mainly New Zealand)
Mark-up	An amount (usually a percentage, but in some cases a fixed amount) that is added to the purchasing price to get to the selling price. Alternatively, it may be a percentage or amount added to an approved or listed ingredient price to arrive at a total reimbursement amount from a third-party payer.
MCA (UK)	Multi-compartment Compliance Aid See *Compliance Aid*
Medical Aid Schemes (SAF)	private medical insurers, including for pharmaceuticals.
Medscheck (AUS, CAN)	Another name for a Medicine Use Review, used in Australia and Ontario.
Monitored Dosage System	See *Compliance Aid*
MSP	Manufacturer Selling Price Also sometimes known as Manufacturer's List Price or simply Manufacturer's Price.
MUR	Medicines Use Review
NADAC (USA)	National Average Drug Acquisition Cost – an ongoing national market pricing survey commissioned by the USA's Centers for Medicare & Medicaid Services, which aims to determine the actual acquisition cost of medicines. Similar to Category M (UK) and Price Disclosure (AUS).
NCPA (USA)	National Community Pharmacists Association
NCE	New Chemical Entity (chemical molecule developed by the innovator company in the early discovery stage, which after undergoing clinical trials could translate into an approved and marketed pharmaceutical)
NGO	Non-Government Organisation
NHS (UK)	National Health Service The UK government's healthcare funding scheme, including for pharmaceuticals.
NMP	National Medicines Policy
NMS (UK)	New Medicine Service
NPA (UK)	National Pharmacy Association
Nursing home	Aged care facility
OPP	Out of Pocket Payments (including deductibles, co-payments and co-insurance)
Originator brand/innovator brand/brand	These terms are interchangeable and refer to a product that was first authorised worldwide for marketing (normally as a patented product) on the basis of the documentation of its efficacy, safety and quality, according to requirements at the time of authorisation. The originator product always has a brand name; this name may, however, vary across countries.
OTC	Over The Counter (non-prescription) medicine

Term	Definition
Parellel Import	Parallel or grey-market imports are not imports of counterfeit products or illegal copies. These are products marketed by the patent owner (or trademark-owner or copyright-owner, etc) or with the patent owner's permission in one country and imported into another country without the approval of the patent owner.
PBM (USA)	An organisation that provides administrative services in processing and analysing prescription claims for pharmacy benefit and coverage programs. Many PBMs also operate mail order pharmacies or have arrangements to include prescription availability through mail order pharmacies.
PBS (AUS)	Pharmaceutical Benefits Scheme (Australia) The federal government drug subsidy scheme in Australia.
PGNZ	Pharmacy Guild of New Zealand
PHARMAC (NZ)	New Zealand government agency responsible for pharmaceutical funding decisions.
Pharmacovigilance	The process and science of monitoring the safety of medicines and taking action to reduce risks and increase benefits from medicines
POM (UK)	Prescription Only Medicine (UK). Note: in some countries POM can refer to Pharmacist Only Medicine or Pharmacist Only Medicine.
Post-marketing surveillance	Assess the quality of medicines, therapeutic value and treatment strategies for medicines that have already been licensed for public use. Post-marketing surveillance studies are based on the product characteristics on which the marketing authorisation was granted.
Price Disclosure (AUS)	The policy in Australia under which sales information of off-patent medicines is collected and an average price is calculated, which usually becomes the new reimbursement price. Similar to NADAC (USA) and Category M (UK).
PSNC (UK)	Pharmaceutical Services Negotiating Committee
QCPP (AUS)	Quality Care Pharmacy Program Australia's pharmacy accreditation program.
QUM	Quality Use of Medicines
RACF (AUS)	Residential Aged Care Facility
Rational Use of Medicines	Rational use of medicines requires that patients receive medications appropriate to their clinical needs, in doses that meet their own individual requirements, for an adequate period of time, and at the lowest cost to them and their community.
Reimbursement list	The list of medicines which a third party payer pays in part or completely.
Reimbursement price	The amount which is paid to a pharmacy in relation to the dispensing of a medicine. May also refer to ingredient cost.
Rest Home (esp. NZ)	An aged care facility.
Return of Unwanted Medicines (RUM)	The safe disposal of medicines no longer needed by a consumer, usually through a pharmacy.
RPMA (AUS)	Rural Pharmacy Maintenance Allowance

Term	Definition
Schedule	This term is used to refer to the reimbursement list (see above) in some countries. Scheduling also refers to the regulation of the sale of registered medicines by different locations or professionals.
Staged supply (AUS)	The process by which pharmacists supply medicines to consumers in periodic instalments of less than the total required or prescribed quantity at agreed intervals, usually as requested by the prescriber.
Technician/tech	Terminology for technicians varies from country to country, and can indicate a difference in qualifications or formal registration/recognition. Terms include pharmaceutical technician, pharmaceutical assistant, dispensing technician, dispensary assistant, pharmacy assistant.
Third-party payer:	Any entity, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients of the coverage.
WAC	Wholesale Acquisition Cost