

Sustainability of Pharmacy Services: Advancing Global Health

International overview of remuneration models for community and hospital pharmacy



Executive summary

Community and hospital pharmacies are a critical part of health system infrastructure. Pharmacy remuneration models aim to ensure the safe and responsible use of medicines. From a health systems' perspective, these models need to be cost-effective. For pharmacies, they must also provide adequate compensation to enable sustainable access to medicines and delivery of comprehensive pharmacy services, including important public health services.

This report provides insights into the variety of remuneration models for community and hospital pharmacies and the overarching trends in pharmacy remuneration on the global level. Key elements that may spark future changes in the way pharmacy services are remunerated are identified. Data were gathered in three ways: a survey, semi-structured interviews and document reviews.

Information is presented from 49 countries which responded to a survey sent to 129 member organisations of the International Pharmaceutical Federation (FIP). The survey was designed to look at three areas: (1) structure and regulation of the pharmacy and healthcare sector; (2) community pharmacy remuneration; and (3) hospital pharmacy remuneration. A glossary defining standard terminology accompanied the survey questionnaire.

The survey results are complemented by a series of six in-depth case studies, which give a more substantive understanding of how recent health system reforms have impacted pharmacy remuneration models. The case studies come from Australia, Canada (Ontario province), England, the Netherlands, South Africa and Switzerland — chosen with regards to income, geographical region and health system structure. Close attention was paid to contextual factors influencing health sector reform processes and outcomes. Stakeholders from different interest groups were also asked about the need for future changes within their respective remuneration models.

Thirty-four countries gave details of their third-party remuneration models. The most prevalent type of remuneration schemes are statutorily enforced, single-payer models, that are predominantly based on product remuneration, either through regressive margin percentages or mark-ups that are non-cumulative.

About one-third of countries that provided information (n=28) reported that their community pharmacy remuneration model is predominantly a fee-for-service one. The most frequently remunerated services by third-party payers relate to dispensing services, administrative and clinical review of prescriptions, compounding, and on-duty and emergency services.

Most of the countries stated that their dispensing fee relates to the prescribed product and includes the provision of information to patients or caregivers. Since this advice giving is not always acknowledged and remunerated as a service in its own right, financial incentives for pharmacies to provide such services are lacking. Furthermore, a series of pharmacy services related to dispensing are mandatory but without third-party remuneration; they are essentially being subsidised by the service providers, raising questions about the long-term financial viability.

The survey results also indicated that in around half of countries that provided information (n=28), pharmacies are required to provide a private consultation space to accommodate professional services. Less than half of the countries (n=13) responding to questions about mandatory space requirements have any regulation regarding this consultation space, such as space availability, quality and confidentiality requirements.

A majority of community pharmacy systems in responding countries (61%; n=19) are currently operating under voluntary discounts, rebates or clawback regulations. Only 13% (n=4) of responding countries have mandatory discounts, rebates or clawback in place. In addition, few responding countries (n=12) operate under a maximum remuneration model.

The large number of businesses permitted to sell over-the-counter medicines could decrease the size of the pharmacy market in many countries. However, in most responding countries (85%; n=39), pharmacies are the only source of dispensed prescription medicines. Few responding countries (16%; n=7) indicated that physicians share a significant role in the dispensing of prescription medicines.

Globally, there appear to be rapid changes in the ways individual countries structure their community pharmacy remuneration systems. Survey results showed a trend towards reforming product remuneration followed by adding more services that are reimbursable. These services are not just delivered to patients, but to other health professionals and sometimes to payers.

In a number of these countries (n=13), health insurers have taken a lead role in initiating and driving price and margin reductions to achieve budget control. This trend has intensified in recent years, within an overall economic crisis context, with an accelerated negative impact for pharmacies, which has resulted in decreasing opportunities for pharmacy associations to shape remuneration models.

The survey also provided responses on the number of hospital pharmacies per 100,000 inhabitants. Of the 31 member organisations that responded, Japan leads with a 6.7 hospital pharmacies ratio, Nigeria has the lowest ratio (0.06), while some high-income countries (Sweden, Switzerland, Israel, Germany and Singapore) showed a relatively low number of hospital pharmacies per 100,000 inhabitants.

The staffing ratio within hospitals is best stated as pharmacists (in full-time equivalent terms) per 100 beds, or even per 100 occupied beds. Nineteen member organisations provided information on hospital pharmacy staffing, out of which 14 reported having at least one full-time pharmacist (defined as more than 30 hours per week) per hospital pharmacy. The survey results also reveal remuneration models for hospital pharmacies distinct from those applied to community pharmacies and with different complexities.

A substantial number of countries (n=23) have hospital pharmacy remuneration models integrated with those for the hospital itself. Financing of the hospital pharmacy service may be included as a percentage of the global hospital budget, or be included in the daily charge for in-patient care and in time-based operating theatre charges. Hospital pharmacists all receive fixed salaries, and the activities they develop are remunerated along with other hospital services.

Only two responding countries confirmed the existence of hospital pharmacy remuneration systems which provided incentives for expanded services. Where hospital pharmacies are unable to charge for individual services, but are restricted to a fixed percentage of global hospital budgets or charges, this may be a barrier to expanding such services.

All of the case studies demonstrated that pharmacy incomes still depend largely on dispensing-related activities and less on other non-distributive services. Traditionally, third-party payers link their remuneration of pharmacies to the price of the products dispensed plus a margin (or sometimes a dispensing fee) that aims to include counselling and/or other related administration services. As prices of pharmaceutical products continue to decline in many countries, the net income of pharmacies is also declining.

The case studies also showed that, in general, stakeholders are interested in increasing the services offered by pharmacists. However, expanding the remuneration of these services is not without challenges. The countries studied vary widely in the number and types of services offered, as well as the degree to which pharmacies' incomes depend on them. Stakeholders identified several challenges in expanding non-dispensing-related services, including restrictive eligibility criteria that limit the frequency with which pharmacies are able to provide services, as well as the discontinuity of services offered due to annual or frequent (re)negotiations with insurers. Furthermore, stakeholders acknowledged that agreeing on how to measure the quality of the pharmacy services delivered as well as responsibilities for measuring is difficult. Finally, designing a remuneration scheme that incentivises quality use of medicines is also perceived as challenging.

A common concern among pharmacy associations worldwide was the long-term financial viability of community pharmacies. These concerns are first and foremost triggered by the impacts of successive price and margin cuts. Such cuts limit the ability of pharmacies to weather the vagaries of usual business cycles and pose significant threats to the long-term viability of pharmacies, independent pharmacies in particular. In addition, there is, in some settings, increased competition from non-pharmacy retail stores that sell medicines. Larger chain pharmacies appear to be more capable of absorbing the cost of lower dispensing fees with insurers than smaller pharmacies. This alone seems to have a substantial impact on the financial viability of independent pharmacies. Furthermore, countries vary in the way they support community pharmacy services in rural areas or pharmacies with low turn-over. These variations are largely influenced by geographical characteristics of the countries, among other factors.

Achieving new levels of price transparency is a common feature of many reform efforts.

This study has highlighted that, despite the philosophical shift towards a more service-focused model of care, community and hospital pharmacy remuneration models remain largely focused on products. This means there is little incentive for practice changes to become more widespread. Moreover, if the quantum of volume-based payments is decreasing, there is an urgent need to find other sources of revenue to support sustainable, quality, comprehensive pharmacy services.

This report does not present a “magic bullet”; no country’s system is the preferred model. However, a number of key elements were identified that could help to create a better functioning remuneration system for pharmacies, including:

- Remuneration based on pre-established transparent criteria, including measures of and incentives for quality;
- Greater communication — to allow others to better understand what pharmacists actually do; and
- Reduced complexity — to allow the system to be interpreted and communicated clearly to the public and political decision-makers.

All of the above will help build more credible, defensible and sustainable remuneration models for pharmacy. There is work to be done, since many of these factors were shown to be lacking in the countries that took part in this study. For example, there was limited evidence of quality measures being applied as part of pharmacy remuneration models, especially in community pharmacy. If pharmacy is to keep pace with other health professions, this will need to shift.

The survey results, combined with the case studies, shed light not only on the presence of large variations between remuneration models, but also on the contextual factors that shape them. The rapidly changing landscape of health service delivery and health system financing has profound effects on pharmacy remuneration models globally. This study provides information that can support FIP member organisations to develop remuneration models that promote the expanding role of pharmacies in providing health care and public health services, while maintaining the important infrastructure represented by community and hospital pharmacies.

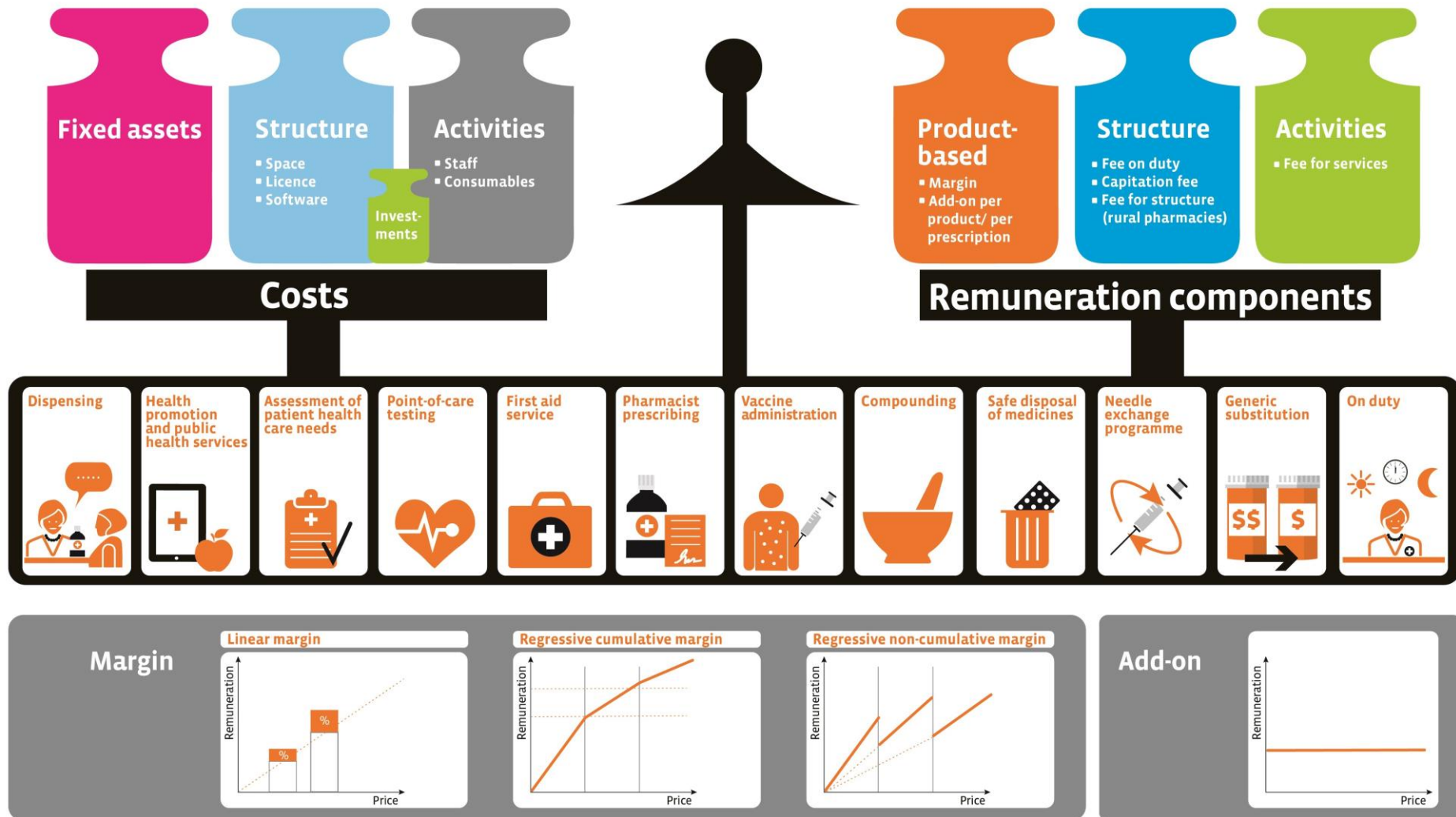
Notwithstanding these insights, the study identified a number of gaps in our collective understanding, which should be the focus of future work. First, it will be important to gain a better understanding of how remuneration models influence the implementation and sustainable delivery of basic and expanded pharmacy services. Secondly, it will be helpful to look at the extent to which pharmacy services are integrated into broader health system strategies and, therefore, funding plans. This may also mean expanding the focus of negotiations beyond the payers controlling medicines budgets, where traditionally it has been demonstrated that savings can be made, to areas such as primary care, aged care and public health. These are areas in which pharmacists can undoubtedly add value.

Healthcare systems around the world are in a state of change; it is clear that the pharmacy profession will need to be nimble in order to respond positively to these changes.

Key messages

- The viability of the pharmacy profession is an issue for the broader health sector and society as a whole. Pharmacists have a key role to play in delivering cost-effective solutions for payers and better health outcomes for people. This is particularly true for patients with multiple illnesses and those with chronic diseases who are taking several medicines.
- Pharmacy remuneration models must be founded on a social contract between pharmacies and society, under which:
 - pharmacies are given the responsibility to ensure universal and reliable patient access to medicines and relevant healthcare products; safe, responsible, effective and efficient use of medicines; and better population health outcomes according to the highest standards of practice; and
 - society gives appropriate recognition to these vital roles that pharmacists and pharmacies play in healthcare systems and, in doing so, helps to ensure the health infrastructure provided by pharmacists and pharmacies remains viable and sustainable into the future.
- Pharmacy remuneration models are moving towards an approach with a mixture of remuneration components:
 - Mark-up, dispensing fee or a combination of both to remunerate medicines supply and dispensing activities;
 - Incentives for efficiency and/or quality; and
 - Professional fees and/or capitation-based payments for pharmacy services.
- Pharmacy remuneration models need to value what pharmacies already bring to patients' use of medicines, public health, health systems and the economy, as well as to embrace extended roles and collaborative practices within primary health care and hospital care.
- It is important that additional services associated with medicines supply are strengthened, removing incentives to operate in an environment that largely rewards volume and is, instead, focused on patient need.
- Remuneration for medicines supply and dispensing activities must be based on pre-established, transparent criteria so that the important contribution pharmacists make to health is more visible to patients, payers and political decision-makers.
- Pharmacy remuneration for public health interventions needs to be built on an evidence-informed framework so that increased investments in pharmacy services can deliver effective and cost-effective solutions for society and better health outcomes for people.
- Pharmacy remuneration models must ensure the sustainability and profitability of pharmacies and the basic services they provide. Payments for additional services have to incorporate the resulting costs while providing the right incentives for the implementation of these new services.
- Finally, pharmacy remuneration models must include an evidence-based approach to implementation, because incentives and guidelines alone will not change practice. Investment is required in the areas that have been proven to be effective.

Key components of remuneration models for community pharmacy



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