Independent Body on Pharmacy Contract Pricing

Report

June 2008
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**Appendix 1 – Reference Material**  

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Chapter 1

Introduction

1.1 On 18 February 2008 the Minister for Health and Children announced the appointment of an Independent Body to recommend a new, interim community pharmacy dispensing fee for the General Medical Service (GMS), Drugs Payment Scheme (DPS) and other community drug schemes.

1.2 The Terms of Reference for the Independent Body on Pharmacy Contract Pricing are as follows:

“To advise the Minister for Health and Children on the appropriate level of dispensing fee to be paid to community pharmacists for existing services provided under the GMS and community drug schemes having regard to:

(i) the overall public interest including the issues of patient safety and continuity of supply;
(ii) the fee of €5 per item which has already been offered;
(iii) the reasonable costs incurred by pharmacists in providing services under the schemes and the value of the professional service of dispensing; and
(iv) the statutory obligation on the Health Service Executive (HSE) to use the resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public;

and to submit a report on the matter to the Minister for Health and Children.”

1.3 Along with the terms of reference, the Minister set out a proposed mode of operation as follows:

- both the HSE as the contracting body and the Irish Pharmacy Union (IPU) as the representative organisation for community pharmacists, along with other stakeholders, will be entitled to make submissions addressing whatever factors and issues are of concern to them.

- the Independent Body will also be entitled to engage whatever outside expertise it requires to assist it with its task.

- based on its consideration of submissions received and its own independent evaluation, the Independent Body will recommend an appropriate dispensing fee to the Minister that would, in its view, represent a fair and reasonable price to be paid for the pharmaceutical service currently being provided by community pharmacists to the HSE under the GMS and community drug schemes.
each pharmacist will have three options: to avail of the interim contract immediately; to accept the interim contract upon the report of the Independent Body; or to stay with the existing retail fee structure until the agreement of a substantive new contract.

1.4 This Report sets out the findings and conclusions of the Body. In considering the issues before us we consulted with and received submissions from interested parties. A total of 76 submissions were received, by far the greater number of which were from, or on behalf of, community pharmacists. The Independent Body heard evidence from HSE, IPU, the Pharmaceutical Distributors Federation (PDF) and a group of pharmacists represented by a firm of Chartered Accountants. We also reviewed both published and unpublished materials deemed relevant to the matter [these are referenced in Appendix 1].

1.5 The Body engaged Grant Thornton Chartered Accountants to assist us in analysing data arising from submissions received and to support us in evaluating the various financial and other issues that required consideration.

1.6 The Independent Body met formally on 12 occasions between February and June 2008 and also engaged informally between meetings.

1.7 We received full cooperation from all from whom we sought help. We wish to acknowledge the participation of all those who submitted information or documentation and who met with us. We received all the assistance we would have wished for from the Department of Health and Children. We especially thank Nuala O’Reilly, Secretary to the Body, for her unstinting and ever-helpful support.

Sean Dorgan (Chairman)
Mark Moran
Mary O’Dea

19 June 2008
Chapter 2

Background and Context

Health Service Executive’s Role

2.1 The Health Service Executive (HSE) is responsible for the provision of health and personal social services for everyone living in the Republic of Ireland. The HSE was established under the Health Act, 2004, which states that the objective of the HSE is to provide services that improve, promote and protect the health and welfare of the public. The HSE is the contracting body for pharmacy services under the General Medical Service (GMS) and other public schemes that provide subsidised medicines for the public.

Role of the Community Pharmacist

2.2 A community pharmacist is a pharmacist who has a contract with the HSE (or its predecessor Health Boards) ‘to keep open shop’ for the safe provision of medicinal products to the public. Practically all retail pharmacists have such contracts. The pharmacist’s role is a professional one, which involves making judgments on the appropriateness and safety of every drug, complementary to the role of the medical profession in the prescribing of such products. The provision of advice in the area of medicinal products is central to the pharmacist’s role.

2.3 The Irish Pharmacy Union (IPU) states that members of the Union aim to provide the best possible professional pharmaceutical service to patients and all members of the public. They are committed to delivering a quality, accessible, personal and professional service that puts the patient first and has as its primary goal the optimisation of the health and well-being of society.

2.4 Prior to the enactment of the Pharmacy Act 2007, many of the provisions governing the delivery of pharmacy services to eligible patients were specified in the community pharmacy contract, rather than in legislation. It is the stated intention of the HSE to negotiate a new community pharmacy contract to cater for evolving public health needs and the new legislative context.

Description of Community Drugs Schemes

General Medical Services (GMS)

2.5 Persons who are unable without undue hardship to arrange general practitioner medical and surgical services for themselves and their dependants, and all persons aged 70 years and over, receive free general medical services. There are currently 1.30 million GMS cardholders. Drugs, medicines and appliances supplied under the scheme are provided through community pharmacies. In most cases the doctor gives a completed prescription form to a patient,
who takes it to any community pharmacy. In rural areas the doctor may dispense for those persons who opt to have their medicines dispensed by him/her. All GMS claims are processed and paid by the Primary Care Reimbursement Service (PCRS).

2.6 Under the current (June 2008) reimbursement arrangements pharmacies are paid the reimbursement price of the item (ex-factory + 8%) and a dispensing fee of €3.59 upwards per item. The dispensing fee for patients aged 70 or over is €4.54 upwards per item. The average dispensing fee per item was €4.03 in 2006, and it was €4.39 in 2007; it is likely to be higher again in 2008 because of increases implemented with effect from 1 March 2008, when the base rate rose from €3.26 to €3.59.

**Drugs Payment Scheme (DPS)**

2.7 Under the Drugs Payment Scheme persons, who are ordinarily resident in the State and who do not qualify for GMS, can benefit if their spend on approved drugs, medicines and appliances for themselves or their family exceeds a monthly threshold (currently €90). In order to benefit under this scheme a person must register themselves and their dependants with their Local Health Office. 1.61 million people are so registered. DPS replaced the Drug Cost Subsidisation and Drug Refund Schemes (which required the patient to submit claims) in 1999. DPS claims are submitted by the community pharmacist and processed and paid by the PCRS.

2.8 Under the current reimbursement arrangements pharmacies are paid the reimbursement price of the item (ex-factory + 8%) plus a 50% mark-up on that price and a dispensing fee of €3.16 upwards per item; this revised fee also applies with effect from 1 March last.

**Long Term Illness Scheme (LTI)**

2.9 On approval by HSE, persons who suffer from one or more of a schedule of illnesses are entitled to obtain, without charge and irrespective of income, necessary drugs, medicines and appliances under the LTI. All LTI claims are submitted by pharmacists for processing and payment by the PCRS.

2.10 Under the current reimbursement arrangements pharmacies are paid the reimbursement price of the item (ex-factory + 8%) plus a 50% mark-up on that price and a dispensing fee of €3.16 upwards per item. This is similar to the arrangements for DPS.

**European Economic Area (EEA)**

2.11 Residents from one of the other states of the European Economic Area, with established eligibility, who require emergency general practitioner services while on a temporary visit to the State are entitled to receive from a General Practitioner a GMS prescription form for necessary medication and to have such medication dispensed in a pharmacy that has entered into an agreement with the HSE within the State. Students, posted workers and their dependants are entitled to full services on presentation of a valid form E128. EEA claims are paid by the PCRS on the same reimbursement basis as DPS and LTI (i.e. reimbursement price plus 50% mark-up and dispensing fee).
High Tech Drugs (HTD)

2.12 Arrangements are in place for the supply and dispensing of High Tech medicines through community pharmacies. Such medicines are generally prescribed or initiated in hospitals, and include items such as anti-rejection drugs for transplant patients or medicines used in conjunction with chemotherapy or growth hormones. The medicines are purchased by HSE and supplied through community pharmacies for which pharmacists are paid a patient care fee. Under current arrangements a patient care fee of €60.52 per patient per month is paid to pharmacies for this scheme.

Scope of our review

2.13 As the EEA scheme is relatively small in its coverage (giving rise to a total spend of €2.3m in 2007) and is treated in a similar manner to DPS and LTI, and as the High Tech scheme is remunerated on a separate basis, we will not deal further with them in this report. Similarly, we do not need to give specific consideration to other incidental and supplemental fees, which are paid to pharmacists related to community drug schemes.

HSE reviews of pharmaceutical procurement

2.14 The Department of Health and Children and HSE have been reviewing the pharmaceutical supply chain with a view to seeking better value for money in the State’s drugs bill, in order to better fund existing and innovative therapies without compromising patient safety or continuity of supply.

2.15 The HSE completed new four-year agreements in 2006 with the Irish Pharmaceutical Healthcare Association (IPHA) and the Association of Pharmaceutical Manufacturers of Ireland (APMI). These agreements, which provide for a revised basis for the pricing of drugs, including international comparators and particularly for substitutable or generic drugs, are intended to achieve savings of €250m over four years.

2.16 Following the completion of these new agreements with the manufacturers, the HSE commenced a review of wholesale pricing. Based on legal advice, it concluded that it could not negotiate directly with wholesalers; it then commenced a public consultation and it commissioned an analysis of wholesale margins from INDECON economic consultants. HSE announced in September 2007 that it wished to pay a fair, reasonable and transparent price to all segments of the pharmaceutical supply chain, but it considered that the current arrangements in respect of wholesale/distribution were not transparent. In particular, “a situation where the majority of the 15% gross margin given to wholesalers for the distribution of medicines to community pharmacy ends up in retail pharmacy is not an appropriate model”, and “retail pharmacy should be paid properly but separately for the services it provides”.

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2.17 HSE announced that it would reduce the reimbursement price from the ex-factory price plus 17.67% then effective to ex-factory price plus 8% from 1 January 2008 and ex-factory price plus 7% from 1 January 2009. This was intended to halve the wholesale margin. After considerable controversy, including the suspension of Methadone services by some pharmacies, this reduction was deferred and the first phase was implemented from 1 March 2008.

2.18 The reduction in reimbursement price by HSE has resulted in a number of legal actions against it by individual pharmacists, and mediation has been ordered by the High Court in relation to the issues involved. Injunctions have been granted in a few cases pending the hearing of the substantive actions.

Interim Community Pharmacy Contract offered by HSE

2.19 An interim contract was offered by the HSE to community pharmacists pending the finalisation of a new pharmacy contract. It offers a flat fee of not less than €5 for GMS, DPS and LTI dispensing schemes, in place of the previous basic fee (as at February 2008) of €3.26 for GMS (or €4.20 for those aged over 70) and of €2.86 (plus 50% mark-up) for DPS and LTI. Under this interim contract offer the mark ups on items dispensed under the DPS and the LTI are eliminated.

2.20 This interim contract offer is described as voluntary – all pharmacists who wish to retain the existing contract can do so. Each pharmacist has been given three options:

   i. avail of the interim contract immediately,

   ii. accept the interim contract upon the report of the Independent Body, or

   iii. remain with the existing contract until the agreement of a substantive new pharmacy contract.

2.21 We understand that no interim contracts have been taken up to date.
Chapter 3

Growing and evolving Pharmacy profession and market

The professional service of pharmacy

3.1 Community pharmacy has many facets: it is a professional service and is regulated accordingly, it is an essential public activity, it is a significant part of an extensive and growing public health system, and it is a commercial business operating both within and outside that system.

3.2 The Pharmaceutical Society of Ireland (PSI) was established under legislation in 1875 with responsibility for the education, training and registration of pharmaceutical chemists. The Society has been recently reconstituted under the Pharmacy Act 2007, with a range of functions and responsibilities, including the protection of patients and the public interest, maintaining registers of pharmacists, and maintaining high standards throughout pharmacy in Ireland. Under the 2007 Act, the Society will be bringing more demanding professional requirements into force over the next year or more. The Society is also currently engaged in developing a blueprint for the future of pharmacy practice and services. The Society, IPU and HSE share the ambition to increase the contribution of community pharmacy to the health of the public.

3.3 The public role of pharmacy has extended as the state’s involvement in healthcare has grown. With the introduction of the GMS in 1971, pharmacies could apply to local health boards for a contract to dispense medicines to GMS patients. At the same time, a scheme to refund the cost of drugs above a certain threshold was introduced for non-GMS patients – this later evolved into the Drugs Payment Scheme (DPS). In 1996 agreement was reached between the Department of Health and the IPU on a contract for community pharmacy services, which was intended to improve and standardise previous arrangements. This is still the basic contract in operation today.

Overview of growth in pharmacy

3.4 The number and cost of drugs on each of the main community drug schemes, and hence the HSE spend on the schemes, has been growing rapidly in recent years as Table 3.1 following shows.
### Table 3.1 GMS, DPS and LTI Drug Claim Reimbursements 2000, 2006 & 2007

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2006</th>
<th>2007</th>
<th>Increase 2000 to 2007</th>
<th>Average Annual Increase</th>
</tr>
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<tbody>
<tr>
<td><strong>GMS Drug Claims</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total items prescribed (000s)</td>
<td>22,882</td>
<td>40,157</td>
<td>43,633</td>
<td>91%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Ingredient costs* €m</td>
<td>263</td>
<td>744</td>
<td>838</td>
<td>219%</td>
<td>18.0%</td>
</tr>
<tr>
<td>HSE spend €m</td>
<td>328</td>
<td>925</td>
<td>1,049</td>
<td>220%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Average cost per item €</td>
<td>13.98</td>
<td>22.80</td>
<td>24.05</td>
<td>72%</td>
<td>8.1%</td>
</tr>
<tr>
<td><strong>DPS Drug Claims</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total items prescribed (000s)</td>
<td>7,776</td>
<td>11,872</td>
<td>12,942</td>
<td>66%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Ingredient costs* €m</td>
<td>84</td>
<td>170</td>
<td>185</td>
<td>120%</td>
<td>11.9%</td>
</tr>
<tr>
<td>HSE spend €m</td>
<td>141</td>
<td>283</td>
<td>307</td>
<td>118%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Average cost per item^ €</td>
<td>27.27</td>
<td>37.31</td>
<td>37.95</td>
<td>39%</td>
<td>4.8%</td>
</tr>
<tr>
<td><strong>LTI Drug Claims</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total items prescribed (000s)</td>
<td>988</td>
<td>2,165</td>
<td>2,315</td>
<td>134%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Ingredient costs* €m</td>
<td>24</td>
<td>67</td>
<td>73</td>
<td>203%</td>
<td>17.2%</td>
</tr>
<tr>
<td>HSE spend €m</td>
<td>42</td>
<td>115</td>
<td>126</td>
<td>201%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Average cost per item €</td>
<td>41.55</td>
<td>53.32</td>
<td>54.36</td>
<td>31%</td>
<td>3.9%</td>
</tr>
<tr>
<td><strong>Total GMS, DPS and LTI Drug Claims</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total items prescribed (000s)</td>
<td>31,646</td>
<td>54,194</td>
<td>58,890</td>
<td>86%</td>
<td>9.3%</td>
</tr>
<tr>
<td>Ingredient costs* €m</td>
<td>371</td>
<td>981</td>
<td>1096</td>
<td>195%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Total HSE spend €m</td>
<td>511</td>
<td>1323</td>
<td>1482</td>
<td>190%</td>
<td>16.4%</td>
</tr>
</tbody>
</table>

*Ingredient costs are at ex-wholesale invoice prices.

^DPS cost per item is gross, i.e. averaged for all items including those below the HSE reimbursement threshold.

3.5 Table 3.1 shows data only in respect of the three main community drug schemes. It does not include data in respect of (a) private prescriptions where drugs are purchased and no claim is made under the DPS or other schemes – see paragraph 3.12, (b) drugs under other HSE schemes (High Tech, Methadone, EEA, Health Amendment Act), or (c) drugs under hardship arrangements, funded by local health offices. We were informed that hardship payments (which are not routed through PCRS) cost HSE a further €152m in 2007, of which about €50m was paid in dispensing fees and mark-up to community pharmacists.

3.6 Table 3.1 shows the prime drivers in the growing cost of community drug schemes. Over the seven-year period 2000 to 2007, the number of drugs prescribed under the three schemes has almost doubled, with an annual growth rate of over 9%. The average cost per item has increased by about 8% a year in the GMS, 5% in the DPS and 4% in the LTI. The combined effect of these volume and price increases has close to tripled HSE spending on drug reimbursements on these schemes in the seven years, from €511m in 2000 to €1482m in 2007. In addition, HSE paid a further €413m in 2007 for drugs under other schemes – High Tech, Methadone, EEA, Health Amendment Act, and local health office hardship cases.

3.7 The average number of drug items per prescription has increased steadily over recent years, from 2.35 items per GMS prescription in 2000 to 2.91 in 2006. In the latter year, only 38.3% of GMS prescription forms had a single item prescribed, a further 39.3% had between two and four items, and 22.4% had five or more items. Broadly similar multiple item dispensing is evident in the DPS and LTI schemes.

3.8 Reflecting the growth in the market, and demographic and urban development, the number of pharmacy outlets grew from 1,180 in 2000, to 1530 in 2006 and to 1,592 in 2007 (based on PCRS data). The average number of GMS items dispensed per outlet increased from 19,392 items in 2000 to 27,400 in 2007, and the average of DPS & LTI items increased from 7,427 to 9,580 in the same period.

3.9 Medicines account for 10.9% of healthcare expenditure in Ireland. Data from OECD shows that Ireland had the highest annual average growth rate in pharmaceutical spending per capita between 1995 and 2005, 7.6% compared with an OECD average of 4.6%. (Health at a Glance 2007, OECD).

3.10 There are several reasons for these increases, according to HSE, including the following:
- New, more expensive therapies being developed,
- More patients being treated,
- An ageing population with more chronic illness,
- Life expectancy has increased,
- Medicines being used in preference to invasive treatments,
- Extension of the medical card scheme to the over 70’s,
- Specific strategies, such as for cancer and cardiovascular, which focus on the use of preventative medicines.
These various drivers of increased spending seem likely to continue. HSE is projecting a growth in total items prescribed under GMS, DPS and LTI from 59m in 2007 to 68m in 2008 and 77m in 2009. Growth at this rate will have implications for HSE spending, for pharmaceutical revenue at industry and wholesale levels, and for retail pharmacy.

**Private Prescriptions**

As noted in paragraph 3.5, HSE expenditure data does not generally incorporate information on prescriptions that do not give rise to a claim on the community drug schemes. An exception is data relating to drugs for DPS cardholders below the reimbursement threshold, where the private co-payment forms a base (€85 up to end-2007 and €90 at present) for reimbursement. As an example, if an individual or family obtains prescription drugs worth €150 in a month, €90 is paid to the pharmacist, who recovers the balance of €60 from HSE. The total of these co-payments and HSE reimbursements are reported in PCRS annual reports as the gross cost of the DPS, with reimbursements as the net cost. We were informed that, in 2007, the total gross cost was €491m and the net cost was €307m; the difference of €184m represents private payments for drugs to pharmacists, below the reimbursement threshold, which are not reimbursed by HSE. (By way of comparison, in 2000, the gross was €212m and the net was €141m.)

The survey of community pharmacy conducted by PwC for IPU estimates the total turnover of the retail pharmacy sector in 2005 at €2173m, as shown in Table 3.2.

**Table 3.2 Pharmacy Turnover 2005**

<table>
<thead>
<tr>
<th>Category of Turnover</th>
<th>€m</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Prescriptions</td>
<td>1179</td>
<td>54</td>
</tr>
<tr>
<td>Private Prescriptions (including DPS co-payments)</td>
<td>283</td>
<td>13</td>
</tr>
<tr>
<td>Over the Counter (OTC) Medicines</td>
<td>300</td>
<td>14</td>
</tr>
<tr>
<td>Other Sales (Front of Shop etc)</td>
<td>411</td>
<td>19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2173</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The market for private prescriptions is of some significance to our considerations; we will return to the issue in Chapter 5.

**Some other aspects of the pharmacy market**

The wholesale market in drug supply is dominated by three principal full-line wholesalers (United Drug, Uniphar and Cahill May Roberts), accounting between them for 90% or more of sales. There is a significant degree of vertical integration between wholesale and retail pharmacy. Uniphar is wholly owned by about 450 retail pharmacists, and operates the Independent Pharmacy
Ownership Scheme (IPOS), which supports the purchase or setting up of pharmacies. Cahill May Roberts, which is itself owned by Celesio AG, owns the Unicare chain of retail pharmacies with 60 outlets. United Drug states that 800 pharmacists are among its shareholders, and it operates Catalyst – supports for purchase or sale of retail pharmacies, which include guarantees of borrowings. The strong links between wholesale and retail were underlined by an arrangement that we became aware of under which shares in a wholesaler were granted to a retail pharmacist as a loyalty bonus for business placed with it.

3.16 The profitability of retail pharmacy has benefited from the growth of the market, of volume and of drug prices over recent years. The PwC Review of Community Pharmacy in Ireland 2005 (conducted on behalf of IPU and published in February 2007) estimates that the average pharmacy had a turnover of €1.52m in that year, with a gross profit margin of 35% and a net profit of €84,000 or 6%. The CSO Annual Services Inquiry for the same year was largely consistent with this, but showed a net profit margin of 9.7%. PwC, on behalf of IPU, updated their estimates for 2006, showing an average turnover of €1.75m, and a net profit before tax in a semi-urban medium-size outlet at 8%. There are variances in pharmacy profitability depending on location and business mix.

3.17 We see the rapid growth in the number of pharmacies and the high multiples of revenue that have been paid for retail outlets as evidence of profitability, and of expectations of growing profitability. Purchase multiples of 1.4 to 2 times turnover (or sometimes more where factors such as property value may be included) have been reported as standard, which – based on the profitability data submitted to us – equate to 12 to 18 times EBITDA (earnings before interest, tax, depreciation and amortisation). These are very high multiples for an acquisition, compared to a current norm of the order of 5 to 8 times EBITDA for private businesses.

3.18 Statements by international chains such as Celesio and Boots on the profitability of their Irish operations, and expansion plans announced by them, also point to the profitability of pharmacy in Ireland. We understand that there have been some falls in purchase multiples recently, probably reflecting the recent pricing steps taken by HSE and the general economic outlook, but one large chain was recently reported as paying 1.7 times turnover for a pharmacy in the South East “compared with multiples of 2.7 times at the height of takeover activity in the sector” (Sunday Business Post 25 May 2008).

3.19 There is a wide diversity of community pharmacies, from large urban to smaller urban or rural, individually owned or leased, or part of small chains (of two to twelve outlets), or the larger ‘multiple’ chains such as Unicare or Boots. Table 3.3 shows that half of all outlets are operated by single pharmacists, while just over a quarter (27%) are part of small chains and just under a quarter (23%) are in the larger chains.
Table 3.3 Pharmacy Contractors by Number of Outlets

<table>
<thead>
<tr>
<th>Number of Contractors</th>
<th>Number of Outlets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single outlet</td>
<td>797</td>
</tr>
<tr>
<td>2 – 5 outlets</td>
<td>129</td>
</tr>
<tr>
<td>6 – 12 outlets</td>
<td>10</td>
</tr>
<tr>
<td>&gt; 12 outlets</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>945</td>
</tr>
</tbody>
</table>

Source: HSE; data as at 31 March 2008

3.20 There is also diversity in the business mix evident in pharmacies. Some have a high reliance on community pharmacy schemes (GMS, DPS and LTI), accounting for 65% or more of their revenues, while in others a third of revenue or less comes from HSE schemes. This diversity creates difficulty, both in predicting the effects of radical change in reimbursement models and in recommending an appropriate dispensing fee, as has been requested of us. We return to these issues in Chapter 6.

3.21 Other factors that came to our notice included the increasing tendency for hospitals, often because of budgetary pressures, to transfer the dispensing of drugs, which they previously provided to patients on discharge, to community pharmacists. Given the considerably more favourable terms on which drugs are available to hospitals, this clearly has negative financial implications overall for HSE.
Chapter 4

Submissions

Submissions received

4.1 The Independent Body received 76 submissions in response to public advertisements and letters to interested parties. All submissions were considered and the issues raised formed the basis for much of our work.

4.2 The major or common issues raised during the process are summarised in the following paragraphs. This summary is not intended to be an exhaustive list of the issues raised, or of the considerations of the Body; we elaborate on the key issues in Chapter 5.

HSE

4.3 HSE says it has a major responsibility to use its funds to deliver the highest quality and volume of health and social services possible. It must make sure that what it pays for all products and services are within commercially acceptable norms and use all possible value for money opportunities. It has therefore targeted procurement processes and methods to obtain better value, not only in pharmaceuticals, to yield savings that are redirected to front line services. It considers that, based on facts and international comparison, HSE is paying above what is commercially necessary for pharmaceutical supplies. In 2007 HSE paid €1.1bn for drugs and an additional €600m to wholesalers and pharmacists for the distribution and dispensing of these drugs to patients (total €1.7bn); it considers this situation – of paying more than 50% of material costs for distribution and dispensing – as unreasonable and unsustainable.

4.4 HSE considers the current remuneration structure for community drug schemes unbalanced in that it allows a much higher payment for exactly the same service to non-GMS as to GMS patients. It is strongly of the view that the professional fees paid to contractors should be decoupled from the ingredient price of medicines dispensed and it states that there would be considerable advantages for contractors, the state and patients in this. These advantages would include greater transparency, certainty, protection from variations in product price, focus on the professional role of pharmacists, and a more patient centred service.

4.5 HSE provided extensive data on the growth of community drug schemes and the related escalation in costs; this data is referred to in Chapter 3 and elsewhere in this report.
4.6  HSE stated that it wished to have a realistic, fair, transparent, and affordable professional fee to be payable on a flat fee basis to contractors. It had regard to the fact that costs were being driven by the increasing ingredient cost of new innovative therapies and by the increasing number of items under the schemes.

4.7  HSE explained that it had commissioned economic analysis on what an interim flat dispensing fee should be. Using data on the volumes and types of items under each scheme in 2007, and the relevant fee and mark-up applying to each category of item for all pharmacists, the analysis indicated an interim fee of €5.93 per item. A scenario under which pharmacists ‘cherry-picked’ between the extant fee structure and the proposed interim fee was then considered (i.e. where only those pharmacists who would gain opted for the proposed interim fee); it was estimated that this could result in a 12 month exposure for HSE of €373.6m, or a rise of €33.6m on the actual fee and mark-up spend. Accordingly, HSE “in the interest of prudence and its obligation to stay within its approved Vote”, set the flat rate dispensing fee at €5.00. [The Body comments on this matter in Chapter 6.]

4.8  HSE stated that it had been unable to receive unambiguous assurances from IPU that there would be adherence to the terms of national agreements under which general round increases arise. Given this, and that a new substantive contract is to be negotiated, HSE recommended to the Body that the flat rate dispensing fee for the interim contract should continue to be set at €5.00.

**Irish Pharmacy Union**

4.9  In its submission the Irish Pharmacy Union (IPU) states that the community pharmacist undertakes a range of primary healthcare roles that are not directly remunerated by Government or service users, and that result in major savings elsewhere in the healthcare system. The HSE proposals on the community pharmacy sector dictate that changes in the accessibility and quality of pharmacy service will be inevitable and will have a direct impact on patients. The changes will also compromise the scope for the future development of the role of the pharmacist in the management and prevention of chronic ailments. The IPU argues that undermining the capacity of pharmacists to continue the current level of care provided to patients is completely contrary to the vision of care in the community.

4.10 IPU maintains that the HSE and the Department of Health and Children have no appreciation of the implications of their proposals, which seek to eliminate discounts, mark up and other payments, for the financial performance of the sector in its entirety. The IPU also states that the HSE is abusing its dominant position by interfering with the right of pharmacists to negotiate discounts with their suppliers for efficiencies achieved between the two parties in their business relationship.
4.11 The IPU estimates a loss of €102.7m to the pharmacy sector from the HSE’s €5 flat fee proposal, arising from the elimination of margins (the 50% retail mark-up) on the DPS and LTI schemes, equivalent to €67,118 from the net profit margins of every pharmacy outlet. In addition, it estimates that the reductions in the reimbursement price from 1 March 2008 and 1 January 2009 (the ‘cut in the wholesale margin’) will reduce pharmacy earnings by a further €99.7m or €65,137 per pharmacy. The cumulative impact of the HSE’s proposals, therefore, based on 2006 volumes, would be a reduction of €202m in earnings for the sector or €132,255 in the bottom line of the average pharmacy outlet.

4.12 IPU says that pharmacists may earn a rebate on ingredient cost for a number of reasons including bulk buying and electronic ordering, but HSE proposes to deduct 8.2% from the invoiced ingredient cost as a means of clawing back this rebate, irrespective of the actual rebate earned by individual pharmacists. According to IPU such a deduction in payments in based on a false premise, namely that the pharmacy can economically stock and supply products at a zero margin on cost price, and below cost price for items not attracting any rebate.

4.13 The IPU argues that a fixed fee model of remuneration can only be justified in a situation where there are fixed costs. As costs are not fixed in the pharmacy situation, a fixed fee model cannot be justified. It states that the current level of payments on the Medical Card Scheme (GMS) is grossly below the economic value of that service and it is being cross-subsidised by private patients. The only viable and realistic model, according to the IPU, is one that contains both a fee and a mark up across all schemes with appropriate professional and administrative allowances. The IPU suggests a variety of models for consideration by the Body.

4.14 In its submission the IPU adverts to a number of outstanding issues on previous contract negotiations, provides information on the costs incurred in pharmacy and dispensing, offers comments on matters the Body should take into account in fulfilling its terms of reference, and suggests how expanded use of pharmacy services could provide better healthcare and greater value for money for the state.

4.15 It petitions that any proposals from the Body must ensure that patient needs can be met by the pharmacy sector now and in the future. Proposals must preserve and build on the current situation where services are readily available and where prescriptions are dispensed promptly, competently and safely.

Other submissions

4.16 Of the 76 submissions received, 26 stated that the IPU, as the representative body for pharmacists, would be making a submission on their behalf. Many of the submissions made by or on behalf of pharmacists reinforced points made by IPU in relation to the adverse impacts of cuts in reimbursement and of disallowing mark-ups in DPS and LTI, and in relation to the inappropriateness of a flat fee remuneration structure. A significant number of submissions
provided details of revenue from community drug schemes to illustrate the impact on their business of both the reimbursement cut and the proposed fee structure and, in some cases, the impact of the new manufacturers’ agreement (see paragraph 2.15). These submissions generally set out the level of fee that would be necessary to restore revenue in individual pharmacies to that obtaining before changes were made; these estimates varied between €6.05 and €12.69, with half within the range of €8 to €10 and an average marginally over €9.

4.17 Among further points made in pharmacist submissions were:
- The Independent Body and its terms of reference were unsatisfactory as there was no consultation with IPU prior to its establishment and it had no pharmacy expertise,
- Changes in the fee structure should be implemented over a period to allow pharmacists to adjust, particularly as significant investment decisions and borrowings were undertaken on the basis of previous conditions,
- A proportionate mark-up should be continued as working capital is tied up in stocks, and any fee should be index-linked,
- The Body should consider a graduated fee where the amount per item is weighted towards assisting smaller pharmacies in marginal locations,
- If pharmacists are to be paid purely on fee basis there should be allowances for advanced services,
- A flat fee model will delay patient initiation on treatment because expensive items will not be stocked routinely.

4.18 The Irish Pharmaceutical Healthcare Association (IPHA), which represents international drug companies responsible for developing, manufacturing and marketing pharmaceuticals, informed the Body that it is strongly supportive of moving from a margin based system of remuneration to a fee per item of service. It states that levels of payment should be directly linked to the professional service provided rather than to the value of the product being dispensed, although differential payments may be justified based on the provision of particular services.
Chapter 5

Consideration of Issues

5.1 In considering the various issues before us, the Body adopted the following overarching principles in its deliberations:

- It is in the overall public interest to provide an efficient, reliable and appropriately accessible supply of medicines to patients in the community;
- It is an obligation on the HSE to use resources available to it in the most beneficial, effective and efficient manner to improve, promote and protect the health and welfare of the public;
- Community pharmacies play an essential role in the provision of pharmacy related services to the population;
- A determination on price should be fair, which can be defined as the rate that might reasonably pertain under a competitive market.

5.2 In its deliberations, the Body also had regard to the following considerations:

- An assessment of the impact of changes on the market and the timing of such impacts is an important consideration, especially in concluding a long-term sustainable agreement between the HSE and the community pharmacy sector;
- Changes should not adversely impact on consumers. Quality service, price transparency and ease of use at the consumer point of contact are key considerations;
- The implementation of changes should, where possible, promote an effective socio-economic outcome in the overall market, e.g.:
  - Minimisation of total system costs, including stock costs,
  - Maintenance of essential rural services.
- Reimbursement to a supplier should not be lower than cost;
- The reimbursement system should be as simple as possible to minimise the burden and costs of administration.

The control of spending

5.3 The recent changes in drugs reimbursement, and the proposals for further changes, have been prompted by the rapid escalation of costs in the health service generally and in medicines in particular, as set out in Chapter 3. The HSE is rightly determined to bring new disciplines to procurement processes and to divert all possible savings to frontline public and patient services. Given the lengthy accretion of schemes, processes and practices, and entrenched interests, this will inevitably meet resistance and be difficult. We believe that the public interest in effective and efficient health services demands that steps to achieve necessary progress are supported. A corollary requirement is, of course, that such steps are well planned and that key stakeholders are brought to support the necessary changes, without any group being allowed a veto on change.
5.4 It is clear from Table 3.1 that the prime factors driving the escalating cost of community drug schemes are (a) the rapid growth in the number of drugs prescribed and (b) the increase in the ingredient cost of these drugs. Revenues in the wholesale and retail sectors have grown with these increases, but these sectors are not the prime cause of cost escalations.

5.5 On reviewing the changes implemented and proposed for drug reimbursement, we were struck by the immediate financial impact on community pharmacy. Two aspects, in particular, bear heavily on retail pharmacies and we deal with these in subsequent paragraphs – the cut in the wholesale margin, and the disallowance of a retail mark-up.

**Cut in the Wholesale Margin**

5.6 As stated in paragraph 2.17, the HSE announced in September 2007 its intention to reduce the wholesale margin on drugs, which it would reimburse, from 17.67% then obtaining to 8% with effect from 1 January 2008 (later deferred to 1 March 2008) and to 7% with effect from 1 January 2009. HSE stated that the new margins would be more in line with European norms and would introduce transparency into the price being paid for different parts of the distribution chain.

5.7 The reduction in the wholesale margin for drugs reimbursed by HSE does not form part of the remit of the Independent Body. Nevertheless, we need to consider its impact given the effect that the reduction of HSE reimbursement to retail community pharmacists in respect of this element has on their revenue and business models.

5.8 HSE data indicates that €201 million of reimbursements from PCRS for 2007 were in respect of the wholesale margin. Given that it is accepted by all parties that half of this amount was rebated by wholesalers to retail pharmacists, it can be estimated that, if no other change occurs, revenue of up to €100 million would be ‘lost’ to retail pharmacists as a result of the reduction in the wholesale margin. However, we believe that some other changes will occur which will reduce this ‘loss’, as set out in the following paragraphs.

5.9 We were informed that rebates or discounts to retailers are variable, depending on a number of factors such as loyalty, volume of purchases, electronic ordering and payment, credit terms, delivery scheduling and reduced returns. We understand that, in practice, discounts / rebates can be as little as 2% or as much as 14% of monthly accounts, with the largest chains benefiting most. These arrangements are longstanding and similar practices are common elsewhere in the commercial sector, although HSE is of the view that they were never intended to apply in the community drug schemes.
It was the view of all parties that the wholesale drugs market is competitive. The Competition Authority came to this view in 2004 when considering the takeover of Ammado Ltd by Uniphar. PDF, the wholesalers’ federation, informed us that there is substantial competition between their members based particularly on the discounts and other terms offered to retailers, and that there have been significant market share switches between wholesalers in recent years. We were also informed that some retail chains invite tenders from wholesalers for the retailer’s business. Given this competition, and the significant vertical integration between wholesale and retail (noted in paragraph 3.15), we believe that a number of dynamic and inherently unpredictable factors will determine how the effects of reductions in the reimbursement for the wholesale margin will be borne as between wholesalers and retailers.

The IPU case, and the assumption implicit in many submissions made to us on behalf of retail pharmacists, was that all of the reduction in reimbursement would fall on their members and that they should be fully compensated for this. The PDF accepted that competitive forces would cause some rebates to continue, but they stated that their 2% operating surpluses would severely limit the potential for burden sharing. HSE informed us that they could not say what the final effects would be – they were primarily concerned to achieve the greatest possible transparency in their payments – but they did not demur from our view that the greater part of the €100 million reduction could fall on the retail sector.

There are two other mitigating factors in relation to the impact of this reduction on retail pharmacists. Firstly, HSE decided in April 2008 that the reduction in reimbursement would not apply to controlled drugs or fridge items, in respect of which no rebates or discounts are provided by the wholesalers; HSE informed us that this concession will cost €9m in a full year. Secondly, PDF informed us that, although wholesalers have not to date made any change in the invoice price of drugs to retail pharmacists, they would ensure that, in the aggregate for any individual pharmacy that is a primary wholesale customer, the monthly accounts for payment would not seek payment greater than was being reimbursed by HSE.

Regardless of where the impact of the reduction in wholesale margins will fall, it is likely that one consequence will be a reassessment of the service levels provided by wholesalers to retail pharmacists. In this regard, we found it difficult to reconcile twice daily deliveries to most pharmacies with the 6 to 8 weeks stocks we were informed that pharmacies carry.

We are drawing no definitive conclusions on the matter of what financial impact will fall on retail community pharmacists from the reduction in the wholesale margin imposed by HSE. The incidence of this will depend on the operation of competitive market forces, as discussed above, and the rebate and discount arrangements in the sector. Rather than draw tentative conclusions, we will rely on other aspects to come to our recommendations in Chapter 6.
Disallowance of retail mark-up

5.15 In proposing a flat fee for dispensing under the GMS and Community Drug Schemes, HSE is proposing not to allow in its reimbursement any retail mark-up on the wholesale price of drugs, which has been a longstanding feature of the pricing model for privately prescribed drugs (as opposed to GMS prescriptions). The HSE rationale for this approach is set out in paragraph 4.4 above. HSE says that it is willing to pay the same in dispensing fees to community pharmacists as it would have previously through the dispensing fees and mark-ups; this would make no allowance for the separate reduction in the reimbursement price (the cut in the wholesale margin) or the elimination of the margin on private prescriptions.

5.16 We understand that the current retail pricing model, i.e. invoice price plus 50% mark-up and dispensing fee, applies for all private prescription drugs, whether or not reimbursed by HSE. HSE informed us that they would expect that all DPS cardholders would purchase their medicines on the basis of the proposed new pricing model i.e. with a fixed dispensing fee and without any retail mark-up. This would be logical for all DPS cardholders, as some at least will reach the €90 monthly threshold and generate a claim on HSE. Elimination of the mark-up as proposed should reduce the incidence of DPS claims, as more drugs could be purchased before the €90 threshold is reached.

5.17 The disallowance of a retail mark-up would have an impact in retail pharmacies beyond what is funded through HSE reimbursements. The IPU submission to us estimated that, in 2006, pharmacists earned revenue of €172.7m in retail margins under the DPS and LTI schemes (including DPS patient co-payments). In the IPU view, any proposed dispensing fee should compensate for the loss of this revenue and the proposed fee of €5 per item would fall far short of doing so – to the extent of €102.7m they estimate.

5.18 As noted in paragraph 3.12, private co-payments for drugs under the DPS came to €184m in 2007. We estimate (based on CSO and PwC data) that at least a further €140m was spent on other privately purchased drugs, i.e. prescription drugs not generating a claim under DPS. This gives total private market revenue exceeding €320m in 2007, equivalent to one-sixth of dispensing sales, or 12% of total retail pharmacy revenue. Based on a mark-up of 50%, and allowing for dispensing fees and VAT, this revenue would have contributed a margin for retail pharmacies of the order of €100m in 2007. This analysis supports the IPU estimate; the impact, of course, will vary from one pharmacy to another, depending on business mix.

5.19 While our terms of reference extend only to the GMS and Community Drug Schemes, the ability of community pharmacists to provide services to the public is dependent on a satisfactory business model, which extends beyond publicly funded schemes. As we have stated, there is a significant interplay between public
schemes and private prescriptions. It appears to us that this interplay may not have been adequately considered in the proposals for a flat dispensing fee.

5.20 We noted a study dated March 2005 by the National Centre for Pharmacoeconomics, on Pharmaceutical Pricing and Reimbursement Strategies in 15 European countries. This showed that both the UK and the Netherlands have a flat dispensing fee for retail pharmacy; significant discounts from suppliers to supplement pharmacy income are noted in both countries. The other 13 states allow margins or mark-ups, and some are supplemented by dispensing fees; the margins are frequently capped or are regressive, in that, for example, generic or cheaper drugs attract a higher margin.

Recompense for Revenue Losses

5.21 While many pharmacists made submissions to us seeking a dispensing fee that would fully compensate pharmacies for revenue losses, we believe that this would be inappropriate for a number of reasons:

- Pharmacy is a dynamic business with a growing volume throughput; we believe it would be wrong in principle to set a remuneration model for this business based on revenue earned at a particular point in time,
- We believe that HSE is right to seek to achieve savings in public expenditure on community drug schemes; full compensation would imply that pharmacy income should be guaranteed, which would also be wrong in principle;
- A number of submissions asked that pharmacies be compensated for loss of mark-up revenue resulting from the prospective savings from HSE agreements with drug manufacturers (paragraph 2.15 above); we regard suggestions for compensation for price reductions as being without merit;
- We take the view that the resource and cost factors that should pertain in a competitive market are a more appropriate basis for fee setting than a revenue target;
- In practical terms, it would be impossible to design a fee system that replicated revenue for the current diversity of pharmacies on an effective, economical and equitable basis,
- A significant part of the revenue losses for which recompense is sought would involve previously private co-payments under the DPS (paragraphs 5.17 and 5.18 above); we do not believe it was ever intended that these payments should be transferred to the public purse, nor should they transfer in our view.
- Finally, the fee setting task we have been asked to undertake is in respect of an interim contract (for which there has not yet been any take up, as we previously noted) pending the settlement of a new contract; in these circumstances also, we do not consider that full recompense would be appropriate.
Conclusions on Pricing Issues

5.22 We considered whether, in the light of these circumstances, we should seek to price pharmacy services on the basis of some alternative reimbursement models that might achieve the aims of being fair and transparent, would present a satisfactory business proposition for community pharmacists, and yet would curtail the escalation of public spending that is inherent in the current model. We have concluded that we should not attempt this for a few reasons. Firstly, the issues involved are complex and are not capable of being fully examined in the short timescale available to us. Secondly, we believe that agreement on the scope of services to be provided by community pharmacists under a substantive new contract should form the foundation for new pricing arrangements. Thirdly, the grounding principles of a new pricing model should be discussed and, if possible agreed, between the HSE and IPU, representing pharmacists; even if an agreement on principles is not possible, a statement on points of disagreement would form a better basis for adjudicating on the issues than a detached attempt to design an appropriate model.
Conclusions and Recommendations

The need for change

6.1 The current arrangements for remunerating community pharmacy have developed in a piecemeal way over an extended period as the state’s involvement has grown, to the point where about five euro in every six spent on prescription drugs in Ireland is paid by HSE. The arrangements have a number of clear disadvantages, particularly from the point of view of patients, the public generally and HSE. These include differing payments for the same service (as between GMS and other schemes), continuing growth in costs and spending, and inadequate recognition of the professional role of pharmacists.

6.2 We have been troubled throughout our review by the dichotomy between a remuneration model built around drug dispensing and a service provision model that is, or needs to be, built around wider professional, retail and advice services in the community pharmacy. Community pharmacists today provide extensive and valuable services, but there is an apparent disconnect with the remuneration model. It is not clear to us that a flat dispensing fee, particularly for a short-term interim contract, adequately addresses this dichotomy.

6.3 It is also our view that the current reimbursement model, while profitable from the point of view of pharmacists, is not sustainable. If change is both necessary and inevitable, as we believe it is, then the form of that change needs to be shaped to achieve a better future model for the provision of community pharmacy services. The Pharmaceutical Society of Ireland is currently developing a blueprint for the future of pharmacy practice and services. HSE has initiated work on a new contract for services. IPU has stated a strong willingness to engage in discussions to shape these services.

6.4 The timing of change will be critical. Escalation of costs and spending demands early change, but a transition period will be needed to avoid damaging disruption in pharmacy services and in the market. A clear strategic view of the desired best outcome, and of the key steps needed to get there, are essential. We strongly urge the parties to work constructively on the new contract negotiations, and on the grounding principles for remuneration as we propose in paragraph 5.22. We believe that a substantive new contract addressing all aspects of community pharmacy, rather than interim contract arrangements, is the best way forward.
The Interim Contract

6.5 We understand that the Interim Community Pharmacy Contract (paragraph 2.19) was intended by HSE as a bridge to new payment arrangements, particularly for pharmacists with a high proportion of GMS business, in circumstances where a radical change was being made in reimbursements. It appears that the totality of this change was not fully evaluated, in relation to both the cut in wholesale margins and the loss of margins on private prescriptions. The economic analysis commissioned by HSE (paragraph 4.7) excluded both these factors in assessing the impact on individual pharmacies, and set a lower dispensing fee than was indicated by the analysis in any event (€5 as opposed to €5.93).

6.6 It will be a matter for individual community pharmacies to decide whether they will take up the Interim Contracts that are on offer. We now turn to recommending a dispensing fee, as has been requested, as a basis for them doing so. We do so with considerable caution, because it is intended only as a stop-gap and for the other reasons already stated.

Appropriate Dispensing Fees

6.7 Based on the considerations we have set out in Chapter 5, we propose to use the best available information on the resources and costs necessary to provide dispensing services as the basis for recommending the appropriate fee. In doing so, we will have regard to the specific aspects set out in our terms of reference and two additional factors, which we believe to be of particular importance:

- The fee recommended should, as far as possible, reflect and underpin continuing growth and dynamic change in the market for retail pharmacy, and
- The fee should also facilitate, and not discourage, the necessary discussions on the future contract for pharmacy services.

6.8 We received considerable financial information in submissions made to us by, and behalf of, community pharmacists. While we cannot say that this information was representative of all pharmacies, it appeared to us to be consistent and reliable for the outlets described. Nevertheless, there are likely to be differences between pharmacies, which are not evident in financial statements, in the treatment of owners’ earnings and pension costs, of the separation of business and property ownership and remuneration, and of interest and borrowings. We are also cognisant that costs that may be justified when income is buoyant can be curtailed in the medium term when placed under competitive or other pressures.

6.9 Based on the information provided to us by IPU and pharmacists, the single flat dispensing fee per item necessary to maintain revenue and profitability at 2007 levels would be €8.67 in the case of an average semi-urban medium-size outlet and €7.82 in the case of an average small rural pharmacy. Applying the lower fee (€7.82) to the former medium-size outlet would still maintain a rate of net
profit before tax on sales of 6.8% in such an outlet. This analysis disregards all of the structural issues and dynamic effects referred to earlier. Moreover, as we stated in Chapter 5, we do not agree that there should be full recompense for ‘lost’ revenue, not least because it would involve the transfer of further private expenditure on drugs to the public purse, which already bears about five-sixths of all prescription drugs expenditure.

6.10 A related assessment to that dealt with in paragraph 6.9 has been undertaken based on the professional costs of the pharmacist, as the prime resource in pharmacy, to which are added other staff and overhead (including financial) costs. The flat fee assessed in this approach varies between €4.72 and €8.45 per item depending on the different sizes and characteristics of pharmacies. A unit cost approach on a somewhat similar basis suggests a flat fee of between €6.39 and €7.22 per item, or €7.13 to €7.96 if a somewhat lower average dispensing throughput is allowed. Each of these estimates is subject to a high degree of sensitivity in relation to the underlying assumptions; as a result, they cannot be precise. In addition, they have the same limitations of static analysis as we referred to in previous paragraphs. Nevertheless, the estimates serve to establish a range of possible cost-based assessments.

6.11 The cost of provision of pharmacy services is not the only criterion to be considered. We also need to have regard to the impact on HSE expenditure and the efficient use of public resources.

6.12 All of our analysis pointed up one substantial issue in setting a dispensing fee – the wide variation in size, financial standing and business composition of pharmacies. A single flat fee would have quite different effects for different pharmacies. A suitable fee structure can incentivise more efficient business activities, but a balance has to be achieved with the maintenance of essential public services. Larger pharmacies with a diverse business base (often in more prosperous locations) could adjust more readily to a relatively low dispensing fee than smaller outlets in less advantaged areas. We therefore propose a tiered fee, as set out in Table 5.1 and discussed in the following paragraphs.

<table>
<thead>
<tr>
<th>Number of items dispensed per annum</th>
<th>Fee per item</th>
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<tr>
<td>Up to 20,000 items</td>
<td>€7.00</td>
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<tr>
<td>20,001 to 30,000 items</td>
<td>€6.50</td>
</tr>
<tr>
<td>Over 30,000 items</td>
<td>€6.00</td>
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6.13 We recognise that the fees proposed in Table 5.1 may be attractive in some cases but may be below the cost of provision of services (including necessary profit) for other pharmacies. In setting these rates, we are mindful that the rates set should prompt efficiency gains, that they are in respect of an interim contract, that they will not prompt universal take-up (fee rates that achieved that would be far too costly), and we must have regard to HSE expenditure.
6.14 We postulate our fee proposals on a total of 64m reimbursed items in 2008 and 72m reimbursed items in 2009; these are somewhat lower than the corresponding HSE estimates of 68m and 77m respectively, because the elimination of retail mark-up would reduce the number of drugs reimbursed under DPS. We believe that the cost to HSE of the proposals, if applied to all reimbursable drugs, is likely to be in line with the cost under the current arrangements, adjusted for recent concessions to pharmacists in relation to national pay agreements and controlled drugs and fridge items (5.12 above).

6.15 We were informed that mediation is pending between HSE and IPU in relation to the interpretation of an agreement in 2001 for compensation to pharmacists, arising out of the extension of GMS eligibility to all persons over 70 years of age. It is for the parties and the Department of Health and Children to deal with any retrospective issue of this nature. Our recommendation on the fair and appropriate fees is determined on the basis of current costs and circumstances, and should not be subject to any adjustment for prior events.

6.16 We note that regular upward adjustments have been made under the previous reimbursement arrangements. We do not think that any such increases should apply to our recommendation, given the basis on which we have arrived at it and the growing market. In any event, we believe that our recommendation on fees should apply for a limited time, say for one year to 30 June 2009, because of our strong view that a new contract is required urgently and that the parties should move to achieve that.

6.17 We recommend the dispensing fees proposed in Table 5.1.
Appendix 1 – Reference material

1. Tilson L, Barry M. European Pharmaceutical Pricing and Reimbursement Strategies: National Centre for Pharmacoeconomics, 2005
2. Purcell D. Competition and Regulation in the Retail Pharmacy Market: The Policy Institute 2004
11. Presentation by the Irish Pharmacy Union to the Joint Committee on Health and Children: Irish Pharmacy Union 2008
14. Ryan M. Report on payment to pharmacists under the GMS, Drug Payments and Long Term Illness Schemes: National Centre for Pharmacoeconomics, 2004
20. Pharmaceutical Society of Ireland. Codes of Ethics & Practice for Pharmacists, 2005