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International Series: Integration of community pharmacy in primary health care

Primary Health Care and Community Pharmacy in Ireland: a lot of visions but little progress

Martin C. HENMAN 

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Abstract

Ireland is small country with a population of 4.8M which spent 6.9% of its gross domestic product on healthcare in 2018. Health services are provided through a twin track approach – all public services are largely free to those eligible (32.44% in 2019) and private patients pay for most services. Most of the expenditure on medicines is paid by the government while visits to General Practitioners (GPs) are an out-of-pocket expense for private patients under 70 years of age, and private health insurance provides cover for most hospital services. Healthcare professionals in the primary care sector contract to provide public services with the Health Services Executive (HSE) which is responsible for the day-to-day running of the service. Primary care teams began to be formed in 2001 to try to link and integrate the provision of care but since these are led by GPs neither community pharmacists nor dentists joined these teams. The focus of policy remained the primary care team until a proposal to create a public health service to provide universal health coverage called Sláintecare was agreed in 2017. However, implementation of Sláintecare has been slow and piecemeal. The government regularly devises policies to control prescribing and the HSE, together with other regulators has implemented generic substitution and preferred drugs and limited access to expensive drugs through schemes for particular patient groups. A programme called Healthy Ireland has taken on the health promotion policies but pharmacists have been excluded from most programmes although some campaigns have included them. Community pharmacy organisations have tried to develop pharmacy services and while a few which are targeted at specified patient groups, such as opioid substitution, emergency administration of certain drugs, emergency hormonal contraception and seasonal influenza vaccination have been remunerated for public patients by the HSE, other services have not. GP organisations defend their members' scope of practice and seek to influence policy makers to channel schemes and services through general practice. There is no professional body to represent pharmacists that is independent of any trade union responsibilities and this has weakened the profession's advocacy. Pharmacists are one of the most trusted group of professionals in Ireland and have maintained their practices throughout periods of recession and declining income from government. Whether pharmacists can argue that the optimisation of a patient's medicines depends upon their contribution and will benefit the health service remains an open question.

Keywords

Pharmacies; Primary Health Care; Delivery of Health Care, Integrated; Ambulatory Care; Community Health Services; Pharmacists; Community Pharmacy Services; Professional Practice; Ireland

IRELAND AND ITS HEALTH SERVICE

Ireland has a growing and ageing population estimated to be 4.8 million in April of 2020.¹ Healthcare spending in 2018 was EUR 22.5 billion (6.9% of GDP vs 8.8% Organisation for Economic Co-operation and Development - OECD average) with 37% spent in hospitals and 18% in long-term residential facilities and 20% in out-patient providers (mainly general practitioners - GPs and dentists).² Of the overall healthcare expenditure the Government covered 74% of spending in 2018, voluntary health expenditure (mainly insurance) 14% and household out-of-pocket expenses accounted for 12%.²

Health care is provided in a mixed system with public and private practice in both primary and hospital care. All healthcare (including medicines) is provided mainly free-of-charge with some small co-payments to some eligible groups – 32.44% in 2019, the largest of which is those with low income (means tested), while all children under 6 years of age everyone aged 70 and over have an automatic entitlement to free GP services.³ People with certain conditions, such as diabetes or epilepsy, are also entitled to receive medicines and other goods for the treatment or

alleviation of their condition free of charge – 6.1% of the national population were eligible in 2019.

For the rest of the population private health insurance provides cover for most of the costs of hospital care and a small proportion of other healthcare costs – a visit to a GP costs a private patient from EUR 50 to EUR 70 and for medicines the individual/family must pay up to EUR 114 per month before the Government pays any excess; in 2019 only 20.1% of the eligible population exceeded this threshold.³ The Government also pays for the cost of some oncology and hepatitis drugs and it pays pharmaceutical wholesalers for certain expensive hospital prescribed drugs that are supplied through pharmacies for which the pharmacist receives a fee. In 2019, community pharmacies received a total of EUR 1.35 billion from the government medicines schemes.³

Responsibility for policy and strategy rests with the Department of Health while the day-to-day running of Government funded health services (and some social care services) is carried out by the Health Service Executive (HSE).⁴ In primary care the policies and operation of the public health service are determined at a national level and then administered through regional offices. The health service is considered to be hospital-oriented with most of the public expenditure and public servants in the acute

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hospitals while primary care receives less funding and comprises mainly private contractors.⁵

There has been a consensus among all groups in society, including politicians, that there should be Universal Health Coverage (UHC) and that the service should be more preventative rather than treatment focussed. A policy called *Sláintecare* has been agreed with a 10-year implementation period.⁵ This policy does not mention community pharmacy but does accept that pharmacists, among others in Primary Care can play a part in integrated care. However, despite agreement by all the political parties and the publication of a strategy to move to UHC, progress has been slow and even the commitment to UHC by the designated reform group has been questioned.⁶ Meanwhile, piecemeal reform, rising consultation rates and rising costs create frequent crises that the Department and the HSE must attempt to manage.

PRIMARY CARE

In Ireland, patients may access primary care providers through the public health service or from a private provider. GPs, dentists and community pharmacists contract with the HSE to provide its services to public patients but they may simultaneously provide private services. In this way private practice is prevalent throughout primary care and successive governments have wrestled with the problems of providing resources to extend and improve the practices of health professionals without these resources being used for private instead of public patients. Private practice also offers opportunities for health professionals to induce demand among their patients.⁷ Contract negotiations are usually difficult and protracted as each side tries to gain advantages and as each professional group protects its members interests against the activities of other professionals which they view as encroaching upon their domain. For example, GPs compete to assess and treat private patients with hospitals and community pharmacists.

In a national population survey, 84% perceive their health to be very good or good and 32% report that they currently have a long-standing illness or health condition such as, high blood pressure (13%), high cholesterol (10%) and arthritis (10%).⁸ Public patients visit GPs more than twice as often as private patients and 27% of those reported affordability issues compared to 6% of public patients.⁸

GPs wield considerable influence as they are the gatekeepers of the public health service which means they determine who needs to visit a specialist in hospital or is entitled to certain health and social care services. General practice evolved in Ireland with many single-handed practices which increasingly lacked the capacity to respond to the rising prevalence of multi-morbidity and the need for sophisticated investigations. GPs who hold contracts with the State (2,974 in 2019) receive a capitation fee for treating public patients and are operate fee-for-service with their private patients.³ Community pharmacists are reimbursed for prescription products and are paid a dispensing fee for public patients and for private patients charge for the cost of the medicine plus a dispensing fee – there are no mark ups on the cost of medicines.

Pharmacists may substitute a generic medicine and are only paid for a generic irrespective of what is dispensed under a government scheme or for private patients unless they wish to pay for a particular brand. Value added tax must be charged on some items. In 2019, 79,269,467 items were claimed for by community pharmacies.

Community pharmacists sought to develop patient medication records to be able to follow up patients and to monitor prescription medicines usage, at first using record cards. The health service wanted accurate and timely data on its medicines schemes volumes and costs resulting from claims and wholesalers wanted to track their pharmacy clients' orders. These two factors propelled computerisation in community pharmacy earlier and more profoundly than in other professional groups in Ireland.⁹

Since 2001 the HSE has sought to organise GPs into primary care teams to serve populations of 7,000-10,000 and to co-locate other professionals such as physiotherapy, practice nurses and speech and language therapists with them in health centres to increase the integration of the care provided.¹⁰ During the development and implementation of this policy neither community pharmacists nor dentists wanted to join these teams arguing that their practice populations did not coincide with those of the team and because GPs were likely to be the de facto team leaders. Primary Care Networks were also proposed as looser linked groups in which dentists and community pharmacists would take part, but these were never implemented.¹⁰ Initially the health centres were all government funded but recently public-private partnerships and other approaches have become acceptable. In 2019 the new GP contract provided significant additional funding for general practice and placed the topic of medicines optimisation on the agenda for development in the near-to-mid-term which links with the GPs' proposals for 'clinical pharmacists' working under their direction.¹¹

As in other countries, successive Irish governments have frequently attempted to influence prescribing in primary care through a variety of methods; in order to promote the prescribing of generics the Health Products Regulatory Agency (HPRA; Medicines Regulator) regularly publishes lists of interchangeable medicines; while in frequently prescribed and costly therapeutic areas particular drugs are designated as 'Preferred Drugs' and they determine which products will be reimbursed and for which indications in the different medicines schemes.¹²⁻¹⁴ The resulting complex framework of schemes, differing eligibility and controls of access to medicines causes confusion amongst prescribers and patients and together with an increase in the prevalence of medicines shortages that has been exacerbated by disruption due to preparations for Brexit and the Covid-19 pandemic, all of this has added to the workload of the community pharmacist explaining and advising patients and prescribers about who is entitled and to what they are entitled.

Prescribing in primary care is heavily influenced by hospital prescribing policies particularly in those patients with multiple morbidity who represent a growing segment of the Irish population. Hospital prescriptions must be transcribed onto a prescription appropriate for the government scheme in Primary Care in order for the

patient to receive the medicines without additional costs. GPs complain that communication with hospital prescribers can be difficult and not all of them are prepared to question or intervene if these prescriptions contain anomalies or potentially conflict with other prescriptions that the patient has been given. Since the pharmacist must assure themselves that the prescription is 'in the patient's best interest' it is left to them to intervene and notably, pharmacists may refuse to dispense such a prescription for public patient and will still be remunerated.¹⁵

The organisation of care in residential homes for elderly and disabled people ranges from substantial in-house provision to periodic visits from contracted medical and nursing staff while community pharmacies provide the medicines usually in a manual monitored dosage system. However, despite guidance about patient counselling and the need for regular interdisciplinary meetings to review patient's medicines, these aspects of the care process are poorly monitored and enforced.^{16,17}

One area of practice in which there is a significant degree of collaborative practice is that of addiction services.¹⁸ Clinical guidelines for opioid substitution are based on a service in which users must register with participating prescribers and pharmacies to receive their medicines and the roles and responsibilities of all the participants are clearly set out. The HSE employs Liaison pharmacists to assist with the organisation and to support GPs and pharmacists in the operation of the scheme.

COMMUNITY PHARMACY

Community pharmacies are regulated under the title of retail pharmacies by a regulator, the Pharmaceutical Society of Ireland (PSI), with the power to make regulations, issue guidance, inspect premises, publish a code of conduct and assess the fitness-to-practice of a pharmacist working in a retail pharmacy business and to apply a range of sanctions.¹⁹ It is the most frequently consulted organisation in the pharmacy sector and its perspective is that of a State regulatory body. However, the regulator is limited to pharmacies that contract to provide medicines under government funded schemes and so the care of hospital inpatients is not within its remit. Since the formation of the pharmacy regulator there has been no professional body to represent pharmacists which diminishes the voice of the profession and hampers its development.²⁰ The Irish Pharmacy Union (IPU) represents the majority of pharmacy owners (~95%) both chains and individuals and some employees.²¹ They negotiate the contract with the HSE and advocate on behalf of community pharmacy. The IPU has developed resources, applications and cloud services for use by community pharmacies. They have sought to introduce new services and they support the continuing professional development of pharmacists and pharmacy technicians through education and meetings.

In October of 2020 there were 1,891 community pharmacies and 3,804 pharmacists registered as community practitioners with the pharmacy regulator in 2020.²² Community pharmacies can be owned by individuals or by limited companies and there is no limit on

the number that may be owned. A pharmacist must be appointed to supervise the day-to-day running of a pharmacy (supervising pharmacist) and where there is more than one pharmacy a superintendent pharmacist must be given the responsibility and resources to supervise the supervising pharmacists.²³ Pharmacy Technicians may assist in dispensing and the provision of non-prescription medicines under the supervision of the pharmacist but may not substitute for the pharmacist. Consequently, there are large and small chains as well as individual pharmacies in Ireland and since there are no criteria to regulate the distribution of pharmacies Ireland has one of the lowest populations per pharmacy figures in the world, 2,538 in 2020. Recently, a discount medicine supply pharmacy group has been established and another is considering entering the sector. There is significant competition between chains, discount providers and independents especially around the price of frequently used prescription and non-prescription medicines and additional, potentially fee-bearing services such as the provision of manual monitored dose systems.

Prescription medicines may not be promoted to the public and can only be obtained from pharmacies - mail order and internet supply are not allowed. Non-prescription medicines are classified as either pharmacy-only or general/open sale ('grocery outlets' only) and these may be promoted to the public. Some can also be provided by internet suppliers entitled to use the EU common logo; in 2020 there were 112 pharmacies and 80 other suppliers registered.²⁴ However, some classes of non-prescription medicine may not be available for self-selection in pharmacies – this guidance, from the Pharmacy Regulator not the Medicines Regulator, applies to codeine-containing non-prescription medicines and to domperidone, and is enforced via the pharmacy regulator's inspectors.²⁵

Services

All pharmacies in Ireland are required to have a consultation area which must be maintained in a fit state for pharmacist-patient consultations based on the regulations, the PSI guidance and the report of the PSI's inspectors.²³ This has become valuable for pharmacists providing services. The HSE approves some services for public patients targeting at risk groups (e.g. vaccination) or for patients authorised to receive specialist, high cost medicines who are living in the community (e.g. Pre-exposure prophylaxis for HIV). Private patients pay out-of-pocket costs for some services (e.g. vaccination, emergency hormonal contraception) and for others the pharmacist decides whether to charge or not.

Services remunerated for public patients

Vaccination

Although not the first service to be remunerated, it was the first that was made available to most of the population. Seasonal influenza vaccination by pharmacists began in 2011 and in the 2016/2017 season 78,935 people were vaccinated by pharmacists and this is now estimated to be approximately 16% of the total for Ireland.²⁶ In 2019, pharmacists claimed for 67,860 vaccinations of public patients at a total cost to the HSE of EUR 1,017,585.²⁶

Pharmacists were trained and certified through the work of the Irish Institute of Pharmacy, a training and Continuing Professional Development body attached to the pharmacy regulator.²⁷ Research by the Pharmacy Regulator indicated a high level of public satisfaction with the service – 99% said they would be likely to go to the pharmacy again to receive the vaccination.²⁸ During the Covid-19 pandemic, amended regulations allowed pharmacists to vaccinate people outside the pharmacy e.g. in their cars. In 2020, children from 2 years of age became eligible for seasonal influenza vaccination, funded by the government, through pharmacies and additional vaccines, those for Herpes Zoster and Pneumococcal Polysaccharide for at risk groups, were added recently.²⁹ Pharmacists must train specifically to provide each type of vaccination.

Emergency administration of medicines

Following a tragic death due to anaphylaxis when a patient's relative could not obtain adrenaline, legislation to allow trained non-medical people to administer certain medicines in an emergency was swiftly enacted in 2018. Pharmacists may administer adrenaline by injection for anaphylaxis, salbutamol by inhalation for acute asthma and other medicines in emergency situations such as, hypoglycaemia (glucagon injection), angina attack (glyceryl trinitrate aerosol) and opioid overdose (naloxone).²⁹

Emergency Hormonal Contraception

In 2005 the provision of levonorgestrel without a prescription to female public patients began and pharmacists receive the product cost and a professional fee (EUR 11.50 in 2017).³⁰ They may also receive the fee if they exercise their professional judgement not to prescribe a product. The scheme has since been extended to include ulipristal and pharmacists make a declaration when claiming the fee: "I confirm that I have counselled the patient and provided the service and/or product listed in compliance with the relevant protocol".

There is little data available on the usage of this service but in 2010, a total of 4% of 18-24-year olds had used emergency contraception from both GPs and pharmacists and this was double the usage in 2006.³¹

Services that not remunerated

Medicines Use Review

Although a pilot study in 2012 suggested that such a service would be workable, the HSE did not proceed with any further evaluation or development.³² Consequently, pharmacists offer the service themselves and while there is supporting documentation available from the IPU, there has been no review of the extent of the provision of this service or of the quality of the service.

Health Screening

Blood pressure monitoring is widely available in pharmacies (87% in 2016) and to a lesser extent, blood glucose monitoring (38% in 2016) and blood cholesterol are also available and lengthy guidance documents from different regulators have been published but have not encouraged pharmacists to offer these services.³³ In some instances, patients pay a fee set by the pharmacy and in others there

is no charge. More recently, ambulatory blood pressure monitoring has become more accepted with the pharmacy supplying and advising about the use of the monitor to a patient recommended by the GP and then providing the GP with the data. However, acceptance of this joint service varies considerably across the country, and the acceptability of screening services in general, is low among GPs.

The IPU carried out a pilot of a hypertension and atrial fibrillation screening service in 2018 in those over 50 years of age with potential hypertension detected in 319/1,194 people and an irregular pulse in 66/1,194.³⁴ Unfortunately, of those people who were referred for further assessment a high proportion were lost to follow up so that the outcomes data collected was incomplete and the impact of the service could not be fully evaluated but was underestimated. The HSE has not shown any interest in further investigating this type of service.

Smoking cessation

The IPU and some of the large pharmacy chains have developed smoking cessation programmes (56% of pharmacies in 2016).³³ However, material support for these has not been provided although mention of the pharmacist as well as the GP as providers of advice and support has been included in some government Health Promotion campaigns.

Health Promotion

Health Promotion is led by a division of the Department of Health through the Healthy Ireland strategy.³⁵ Health Promotion strategies have been coloured by the large private patient segment in Primary Care and by concerns among policy makers that community pharmacies might be influenced by suppliers of medicines or screening tests.³⁶ The consequence of this has been reluctance by the HSE to recommend to the public that they should consult a community pharmacy. They also have concerns about the reaction of GP organisations since these are prompted by members worried at the potential loss of private patient consultations and the reiterated suggestions of the vested interests of pharmacists. Until recently, this was apparent in the documents and campaigns of Healthy Ireland and in those of the HSE. However, there has been the development of a minor illness website advising the public about how to care for themselves, particularly concerning cough and cold symptoms, in order to reduce inappropriate antibiotic prescribing. This was developed in consultation with the Irish Pharmacy Union and it advises people to consult their pharmacist about some issues.³⁷ Interestingly, some patient support groups and charities, such as the Irish Heart Foundation and Irish Cancer Society, have collaborated with the Irish Pharmacy Union or with chain pharmacy groups to deliver some of their campaigns.

FUTURE

Health authorities' perspective

The Department of Health and the HSE now have two urgent demands to meet; firstly, to respond to the Covid-19 pandemic, and secondly, to increase the pace of

implementation of Sláintecare, including UHC which had slowed and then almost stopped during the pandemic.

In response to the pandemic there was increased use of a secure email communication platform (developed to enable GP-hospital communication by the HSE) between GP practices and community pharmacies, which will undoubtedly speed up the process of introducing e prescriptions which is part of the eHealth strategy, as both pharmacists and GPs found it valuable.

When vaccines become available for Covid-19, sufficient capacity to vaccinate those considered at risk will be required. It would be surprising if community pharmacists were not involved, given the success of their contribution so far.

The Government, which came into power in June of 2020, published its programme picking some element of Sláintecare for implementation and not surprisingly its choice and priorities were criticised by the opposition parties, and it remains to be seen what detail lies behind its stated objectives; for example, it plans to 'retain access to private health services'.³⁸ It also proposes to help communities that are disadvantaged through a separately funded programme to focus on health outcomes which will involve 'GP practices, community pharmacies and public health staff', the details of which have not yet been published.

As part of Sláintecare, there is to continued development of Community health networks which will deliver primary health care services to an average population of 50,000 working with 4-6 primary care teams in 96 areas around the country.³⁹ These networks 'will manage specified primary care team staff and enable collaborative multi-disciplinary team working' and will involve general practice in 'the planning and delivery of services in a structured way'. Whether and how community pharmacy might be included in these Networks is not discussed.

Instead, in the government's programme, there is a new proposal to influence prescribing with the formation of a 'National Medicines Agency' to promote 'national prescribing to reduce the cost of medicines, including via generic prescription, where appropriate, and to set a fair price for drug reimbursement'.³⁸ Clearly, the structure and remit of this body will be of great importance to community pharmacy.

Community pharmacy's concern about the intentions of the health authorities can be illustrated by, on the one hand the commitment of the government in its programme to agree a new contract with 'enhancement of their role in the delivery of healthcare in the community, including via e-prescribing and issuance of repeat prescriptions' and on the other, by the Minister's proposal to cut certain dispensing and other fees in the public medicines schemes.³⁹

The HSE commissioned research from the providers, users and stakeholders of General Practice in preparation for contract negotiations with GPs and further reform of Primary Care.⁴⁰ Some of this research, which included consultations with two pharmacy bodies (no detail is given but presumably the IPU and PSI), formed the basis of a

report.⁴¹ Notably, in the report's recommendations and comments relating to pharmacy it focuses on the provision of medicines, the importance of the separation of prescribing and dispensing, the potential vested interest of the 'dispenser' and the need for pharmacists to provide 'safe medicines at a reasonable price' to maintain their high level of public trust. It also proposes the introduction of 'clinical pharmacists' into GP practices, similar to primary care pharmacists in the UK, paid for by the health service, as a potentially valuable addition to general practice and one that would 'avoid any perceived conflicts of interest' for pharmacists.⁴¹ These themes were incorporated into a pre-budget submission to government in 2020 by the representative body for GPs and reflect an approach noted in the Sláintecare report of 2017 that medical organisations think the focus of policy 'should be on expanding capacity in general practice instead of allocating GP tasks to allied healthcare professionals'.^{5,43}

Nowhere in any document from the Department of Health or from the HSE is there any mention of reforming the way in which community pharmacists are paid in order to promote their delivery of services and of patient care, nor to supporting communication between GPs or primary care teams and community pharmacies, nor to facilitating the integration of community pharmacies with other Primary Care initiatives. This contrasts with the extensive discussion of the future development of General Practice.

Pharmacy perspective

In 2016 the pharmacy regulator set out its recommendations for the future of pharmacy practice in an extensive report for the Minister of Health.⁴⁴ Its system-level recommendation was, 'policy makers should consider the role that pharmacists...could play as part of an integrated solution to patient and healthcare demands.' The tone of the document emphasises that changes to pharmacist's roles should be considered and explored and if a recommendation is more concrete it is qualified by phrases such as 'where appropriate'. Throughout, the document refers to medicines management and although it highlights the pharmacist's duty to review a patient's medicines and to offer to provide counselling, it does not mention the shared duty of care with respect to medicines, nor the requirement to refuse to dispense a prescription that is 'not in the patient's best interests'. In short, while the document discusses and refers to many possibilities, it does not recommend that the pharmacist act as, and be recognised as, a provider of care.

The Irish Pharmacy Union has several objectives and strategies but has concentrated its aim on increasing the number of remunerated services that community pharmacies can provide to public patients.^{33,45} To support this aim, it has carried out demonstration projects and developed cloud-based solutions to allow the recording and verification of patient and management data.⁴⁶ The services that are remunerated at present, such as vaccination, have been seen as a success and have reinforced the IPU's contention that community pharmacies are easily accessible sites for healthcare.

Public and patient attitudes

Public trust in health professionals is high and in 2020 pharmacists were the second most trusted profession 96%, in between GPs (95%) and Nurses (97%).⁴⁷

The IPU conducts regular surveys to determine the public's views, and usage of pharmacies, and in 2020, 80% of the most recent visits were for medicines and 74% rated their experience of pharmacies as very good and 98% agreed that they trusted the advice and care they received from pharmacists.⁴⁸ Of those who had visited a pharmacy in the last 6 months, 63% said they would be happy to use the consultation area and 16% said they had used it.⁴⁸ Convenience remains an important factor determining the public's choice of community pharmacy and 71% of the population live within 2 km of a pharmacy.⁴⁸ The HSE only surveys hospital inpatient's experiences.

CONCLUDING REMARKS

For both community pharmacy and primary care the health service's mixed public-private system results in increased costs, fragmentation of service provision and competition for private patients.⁴⁹ At the system level, primary care is treated as a collection of appointment-based services and very little data is collected routinely to monitor the usage of these services by private as well as public patients. Community pharmacy is neither included in reviews of the system nor when data is collected. As a consequence, because policy makers have an incomplete understanding of how patients perceive and respond to their health concerns and how they view and use medicines, they cannot begin to deliver Sláintecare's aim of right care, right place, right time. The central focus of the Department and of the HSE remains on tracking and accounting for the cost of medicines and the operation of the medicines schemes with the result that community pharmacy is treated as a supply service and the defects in the medicines use process are undetected and unrecognised. The government therefore approaches the use of medicines as a prescribing problem and gives no thought to bringing together the stakeholders and services to formulate a national medicines policy for Ireland.⁵⁰ To implement Sláintecare will require an increase in the proportion of GDP committed to health expenditure, whether, and when, this might happen, now that the Covid-19 pandemic has created additional demands for expenditure and decreased government revenue, is unclear.

In a comprehensive review of the reform process it has been argued that because a definition of the term 'integration' has not been agreed by stakeholders as the health service attempts to reform, that this acts as a barrier to the process.⁵¹ This, together with the existing organisational culture of separation and lack of collaboration impedes interprofessional contacts and disrupts the provision of care. Medical dominance persists with health service managers deferring to the medical organisations in the nature and extent of integration. GPs have defended their scope of practice from what they see

as encroachment and are trying to add a pharmacist funded by the HSE to their practice team since this will increase their capability. There have been no substantive moves to include community pharmacy in integration, or to establish communication mechanisms in primary care. Unless the eHealth strategy gives pharmacists access to, and the authority to contribute to, the national electronic patient summary, then community pharmacy will be limited to informal and uninformed interventions to optimise patient's medications.

Pharmacies and pharmacists retain the trust of the public and have utilised digital technology effectively to support their practices. However, community pharmacists have concentrated on delivering services when and where they can and they have been unable to alter the perception of them as managers of medicines rather than as providers of care. The HSE's and the pharmacy regulator's terminology and approach has reinforced and perpetuated this perception. The lack of a professional body that is independent of any trade representative function has contributed to the weakness of the pharmacists' position. Since the income of community pharmacy derives mainly from the medicines schemes and each government reduces that income, pharmacists have had to gain volume and increase turnover to ensure the commercial viability of their practices with less time and resources to commit to individual patient care and service development. The policies and reforms of the Department of Health and of the HSE, under pressure from the medical organisations, has helped to drive this change in pharmacy practice. While this outcome may have been unintended, it was not unpredictable.

Pharmacy is more highly regulated in Ireland than any other health profession and operates to a very high standard. While it can be held accountable, it has only limited authority to enable it to meet its obligations and this frustrates many and demoralises some within the profession and this combined with the horizontal and vertical consolidation within the pharmacy sector may deter those who wish to care for patients from entering community pharmacy and encourage the departure of those who are trying to do so at the moment.⁵²

The optimisation of the use of medicines by individuals and within the health service depends upon the pharmacist establishing a therapeutic relationship and upon a comprehensive national medicines policy. In Ireland, as elsewhere, commitment by pharmacists to the provision of pharmaceutical care will deliver this optimisation for the benefit of their patients and their health service.⁵³

CONFLICT OF INTEREST

None.

FUNDING

None.

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