IRISH PHARMACY UNION
The voice of community pharmacy

Submission under the Public Service Pay and Pensions Act, 2017

Irish Pharmacy Union

November 2019

Executive Summary

Introduction

1. Section 42(10) of the Public Service Pay and Pensions Act 2017 (the "Public Pay Act") permits the Minister for Health (the "Minister") to fix such amounts or rates by regulations that he considers to be fair and reasonable. The Minister shall in fixing such amounts/rates have regard to the matters which the Minister considers appropriate.

2. In this regard, the Minister has considered it appropriate to seek a submission from the Irish Pharmacy Union (the "IPU") under section 42(9) of the Public Pay Act.

3. The Department of Health (the "Department") held an initial meeting with representatives of the IPU on 24 October 2019. Following the meeting, in a letter dated 25 October, the Department outlined the proposed structural changes to pharmacy fees which would apply from 01 January 2020.

4. These proposed changes are as follows:

    - That the current phased dispensing fee per item be abolished and replaced with a monthly patient care fee of €45.00;
    - That the number of items paid at €5.00 be reduced from 1,667 to 1,000 per month;
    - That the High Tech patient care fee of €31.02 payable in months where no dispensing takes place be abolished.

The Consultation Process under Section 42(9) of the Public Pay Act

5. Pursuant to section 42(9) "*Prior to making a regulation under subsection (1), the Minister of the Government concerned, or, at that Minister's direction, the public service body concerned, shall engage in such consultations as that Minister considers appropriate.*"

6. The IPU has reviewed the content of the letter dated 25 October 2019 from the Department, in which the Minister is proposing further cuts to fees. The IPU has set out in detail in this submission why it is of the view that such cuts are not "fair and reasonable".

7. However, the IPU is of the view that the consultation process engaged by the Minister is not a valid consultation under section 42(9) of the Public Pay Act. Therefore, the IPU is engaging in the consultation process without prejudice to this view and without prejudice to its rights in this regard.

8. The reasons for this view are: first, the Department has not set out in its correspondence of 25 October or at all, any reasons or furnished the IPU with any economic analysis or reports, demonstrating the basis for the proposed structural changes or why the Minister is of the opinion that such further cuts are "fair and reasonable".

9. Second, the Department has not provided any reasons for reneging on the Government's commitments and the legitimate expectation which has arisen on the part of the IPU and its members on foot of those commitments.

10. Third, the Department has failed to furnish the IPU with any documents which are relevant to the Minister's consideration of the proposals.

11. Fourth, the Department has failed to identify the particular criteria relied upon or the factors considered by the Minister which have informed his approach to the fee proposals, including, but not limited to, any matters contained in section 42(10) of the Public Pay Act to which he has had regard.

12. Finally, in circumstances where such information has not been provided to the IPU and the IPU is unable to consult with the Minister in respect of the proposed structural changes, the time period of 30 days for the completion of the consultation process as set out in section 42(12) of the Act cannot be complied with by the Minister or the IPU.

13. Clearly, the above information is essential so that the IPU can address any issues or concerns on the part of the Department or the Minister. In the absence of such information, including the reasons and or the basis/calculations for the proposed fee restructuring and any supporting documentation, the IPU is not in a position to provide a meaningful submission in response to the proposed structural changes contained in the letter 25 October and, in effect, cannot engage in a consultation with the Minister under section 42(9) of the Public Pay Act.

14. Therefore, the IPU is of the view that this process cannot constitute a valid consultation under section 42(9). In those circumstances, the IPU reserves all of its rights to challenge the "consultation" process and regulations which may be promulgated by the Minister under Section 42(1) of the Public Pay Act.

15. Without prejudice to the foregoing, the IPU has attempted, in the absence of key information, to respond to the proposed changes as set out in the letter dated 25 October 2019.

The proposed changes in the letter of 25 October are not "fair and reasonable"

16. Pursuant to section 42(10) of the Public Pay Act "A regulation made under subsection (1) shall fix amounts or rates that the Minister of the Government concerned considers to be **fair and reasonable**……." [our emphasis]

17. In coming to this decision, the Minister shall have regard to matters which he shall consider appropriate, "including all or any of the following:

    a. the terms of any existing contractual arrangements or understandings with the service provider concerned;
    b. the terms of any circular, instrument, or document which apply to the service providers concerned;
    c. any submissions made and views expressed during the consultations under subsection (9);
    d. the nature of the services rendered by different classes of service providers and the general nature of expenses and commitments of the service providers providing those services;
    e. the obligation on the part of the State to have a prudent fiscal policy under the Stability and Growth Pact and the Fiscal Compact."

18. The IPU is firmly of the view that what is proposed by the Minister cannot be said to be "fair and reasonable" against the backdrop of previous Government commitments on fees and the unwinding of FEMPI, the sustainability of the pharmacy sector and the role of the pharmacy sector in primary health care. The cuts which are proposed are not only objectively unjustifiable, but will also impact disproportionately on pharmacies which dispense lower than average numbers of prescriptions, which are often the pharmacies serving rural, isolated or disadvantaged communities.

19. The proposed change to the fee bands is markedly regressive, having the greatest impact on pharmacies dispensing 2,500-3,000 items per month, for whom it would result in a crippling reduction in fee income of up to 9% (Figure 1). EY Economic Advisory Services analysis shows that these pharmacies cannot survive any further cut in their incomes, never mind one of this magnitude. With average margins as low as 4% in some cohorts, this cut will put their very survival in jeopardy.

Figure 1: Impact of proposed changes to Dispensing Fee bands

20. We have explained and evidenced in detail in this submission how fees proposed by the Department are unfair and unreasonable, disproportionate, inconsistent, inequitable and, indeed, irrational. The IPU is of the view that the Minister has failed to take into account the long-term impact, not only on the community pharmacy sector, but also on the primary health care sector as a whole. The IPU is of the view that the proposals are unsustainable and will, undoubtedly, adversely affect patients.

Unfulfilled Government commitments

a. FEMPI

21. As the Minister and the Department are aware, the Financial Emergency Measures in the Public Interest Act 2009 (FEMPI Act) and the regulations made under it were used to cut payment rates to pharmacists and other professionals, which, were it not for the emergency in the State's finances, would have been unlawful.

22. As of 1 January 2020, the rates imposed under FEMPI no longer apply. However, rather than the Minister unwinding FEMPI as the IPU and its members had been led to believe would happen, on the basis that previous Government commitments would be implemented, it is now proposed, without any explanation, reasons or justification, to impose further cuts on the pharmacy sector.

23. The clear understanding of the IPU and the pharmacy sector, on the basis of Government commitments, is that there would be an unwinding of FEMPI.

    a. The Taoiseach, Leo Varadkar TD, when he was Minister for Health, committed to commencing the unwinding of FEMPI for pharmacists but no unwinding ever occurred.

    b. The 2016 review carried out by the Department of Health under the FEMPI Act concluded with a recommendation to the Minister that changes to remuneration structures for community pharmacy contractors must be linked to Government priorities for the health service which, in the case of community pharmacy, included areas such as probity, piloting of a minor ailment service, vaccination, expansion of interchangeable medicine use and reference pricing, and electronic interface with the HSE PCRS. The IPU and community pharmacists have delivered on <u>all</u> of these.

    c. In 2016, the Department committed to the IPU to increase pharmacy remuneration by €2.5 million per annum. This has not happened.

    d. In a meeting with the IPU in March this year, the Minister clearly acknowledged the cuts that had been introduced to address the financial crisis and the resulting financial pain felt by pharmacists and expressed his intention to move pharmacy fees beyond FEMPI to a higher terrain.

    e. In his keynote address to the IPU National Pharmacy Conference in May this

year, the Minister made a clear commitment to start discussions on a new pharmacy contract, on moving beyond FEMPI and on a programme of investment. He again acknowledged the cuts that had been introduced to address the financial crisis and the effects on the pharmacy sector and reiterated his intention to move beyond FEMPI to a higher terrain.

24. It is not surprising, therefore, that the legitimate expectation of pharmacy contractors is that there would be a significant and immediate unwinding of FEMPI.

25. Further, it is understood by pharmacists that in unwinding FEMPI in its application to public servants, or to a specific class of health professionals, both the negotiation process and any actions taken in this regard must be applied equally to all others impacted by the now repealed legislation.

26. The Government has agreed to a 40% (€210 million) increase in investment in general practice over four years, with GPs to receive their restoration of FEMPI in four stages. Even without this fee restoration, fees paid to GPs have risen each year since 2014 and overall GP fees and average fees per GP are both higher than they were before the FEMPI cuts of 2009. As shown in Table 1, GPs were paid a total of €499.67m in 2009, an average of €187,634 to each of the 2,663 contracted GPs. By 2018, that had increased to €565.41m, giving each of the 2,914 contracted GPs an average payment of €193,567. Meanwhile, fees to community pharmacy contractors have remained significantly below those paid before FEMPI was introduced. This is a disproportionate, inequitable and unjustifiable difference in treatment between two essential, highly qualified, under-pressure health professions.

Table 1: Fees paid to GPs 2009 vs 2018 (ref. PCRS Annual Reports)

Year	GP Fees € m	GP Allowances € m	**Total GP Payments € m**	Change on 2009	**Number of GPs**	Change on 2009	**Fees & Allowances per GP**	Change on 2009
2009	357.80	141.87	**499.67**		**2,663**		**€187,634**	
2018	411.75	153.66	**565.41**	+13.2%	**2,921**	+9.7%	**€193,567**	+3.2%

27. The proposed further cuts in the fees paid to pharmacy contractors are disproportionate and inequitable, inconsistent and irrational, not only in circumstances where the economic crisis is over, but also where pharmacists are the only major contractor group to have had no fee restoration and, despite Government commitments, continue to bear a burden of austerity that has been lifted from other sectors.

b. Lack of official engagement on key proposals and reforms

28. The IPU has participated fully and constructively in all statutory consultation processes and has worked collaboratively with the Department of Health and the HSE in improving financial accountability and probity and in developing patient services. However, there has been limited engagement and no reciprocation by the HSE or the Department.

29. The Programme for a Partnership Government committed to prioritising safe, timely care, as close to patients' homes as possible and says that, within two years, the role of the community pharmacist will be expanded. The IPU has made numerous submissions and proposals aligned with the Government's health service reform agenda, none of which have received a substantive response.

30. The IPU has also engaged with the HSE and the Department of Health to improve the electronic interface between community pharmacy contractors and the HSE and to facilitate the HSE in fulfilling its obligations regarding financial accountability and probity.

31. In the face of massive cuts to their incomes, pharmacies have delivered excellent value for money to the State and a high quality, safe and valued service to the public. They have also have introduced innovative services such as vaccination and emergency hormonal contraception. Yet, the Department proposes to cut pharmacists' fees further when Irish pharmacists have continued to experience a decade-long decline in resources for providing services on behalf of the State while costs have increased significantly.

Decline in the pharmacy sector

a. Decade-long decline in the pharmacy sector

32. The effect of FEMPI on community pharmacy can be seen in the sector's decade-long decline. Between 2009 and 2018, the State extracted a total of approximately €3.8 billion from the community pharmacy sector in reduced medicine reimbursements and cuts to pharmacy fees. FEMPI cuts alone accounted for €1.5 billion of this total.

33. PCRS statistics show that pharmacy output and efficiency have increased since 2009 (Table 2). The cost of pharmacy medicines to the State has fallen by 37% while there has been a 18.5% cut in the average fee per item paid to pharmacies from €6.00 to €4.89 and the average annual fee income per pharmacy is down by 17.5%. Had the fee per item been index-linked since 2009, it would have been €6.25 in 2018 (28% higher than at present).

Table 2: Productivity and Efficiency Increases in Community Pharmacy 2009-2018

	2009	2018	Change 2009-2018	
Prescription items (000s)	67,826	77,546	+ 972	+ 14.3%
Medical Cards (000s)	1,479	1,565	+ 86	+ 5.8%
Total Pharmacy Fees (inc. High Tech) (€m)	420.96	398.56	–22.40	–5.3%
Average Fee per Item Dispensed (€)	6.00	4.89	–1.11	–18.5%
Average Total Remuneration per Pharmacy (€)	258,258	213,134	–45,124	–17.5%

34. The number of community pharmacies in Ireland grew by 5% over the five-year period 2015 to 2019, in line with Ireland's population growth, with 1,870 community pharmacies as of 31 December 2018. However, the annual number of pharmacy closures more than doubled in the same period, with many essential small pharmacies that exist on the edge of viability ultimately failing. Fitzgerald Power has estimated that approximately 250-300 pharmacies have turnovers of less than €650,000 and, as such, are vulnerable to closure.

b. Increased costs of doing business in Ireland

35. Pharmacy revenues have not benefited from the economic recovery, although the costs incurred by pharmacies to deliver their services have risen substantially. The costs of doing business in Ireland are much higher than in most other states in Europe and therefore, a higher gross profit is required to meet these costs.

36. The largest single cost borne by community pharmacies relates to wages and salaries. Upward pressure on staff costs has increased as a result of rising activity levels and wage growth in the economy. Average pharmacy expenditure on wages/salaries rose from €278,148 per pharmacy in 2015 to €290,860 in 2018, an increase of €12,712, with Irish labour costs increasing by a further 2.9% in the latest year according to the National Competitiveness Council in April 2019. As revenues continue to fall, rising employment costs account for a greater proportion of a pharmacy's turnover. In 2012, the average pharmacy spent 16.6% of turnover on wages and salaries; by 2018, this had increased to 20.7%. Altogether, since 2015, there has been an increase in annual wage cost across the pharmacy sector of €39.5 million.

37. Property costs and other overheads have also continued to increase year-on-year. After the cost of labour, the most significant drivers of business costs are increasing rents, very high insurance costs (including professional indemnity insurance) and heavy regulatory, registration and waste disposal costs. The National Competitiveness Council reported that the prices Irish businesses pay for services were increasing at the fourth fastest rate in the EU. For example, insurance costs for a typical Irish pharmacy have risen by over 90% since 2010, from €2,700 to €5,200, imposing an additional €4.7 million annual cost increase on the sector. Details of the expenses incurred in the pharmacy sector are set out in section 8 of this submission.

38. The HSE currently reimburses pharmacies for many medicines at less than the cost pharmacies pay: currently, the reimbursement rate is at 91.8% of invoice cost for most medicines, whether or not such discounts are available to pharmacies, and 95.2% on fridge medicines despite these products never being discounted by wholesalers. In this regard, the IPU has raised concerns previously about the wholesale medicine market and medicine shortages. The IPU is of the view that a mechanism for price modulation needs to be implemented to balance the legitimate desire of the HSE to achieve lower prices against the need to ensure continuity of supply for Irish patients.

39. Finally, as shown in Table 3 overleaf, persistent cuts to pharmacy payments throughout the last decade have resulted in community pharmacy funding as a percentage of non-capital health spending falling from an average of 2.92% in the years 2009-2013 to 2.45% in 2018, despite an increase in output. This is an unsustainable drop, particularly at a time when Government policy is to prioritise primary care and pharmacists have clearly demonstrated their support for the implementation of the Sláintecare programme.

Table 3: Trends in Health Spending and Fees and Mark-ups Paid to Pharmacists by the State 2009-2018

Year	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Govt. Health Spend (€m)	14,431	13,818	13,181	13,218	13,084	13,276	13,868	13,879	15,316	16,287
Prescription items (m)	67.826	69.251	72.023	75.718	74.379	72.716	73.542	75.176	75.763	77.546
Medical Cards (m)	1.479	1.616	1.694	1.854	1.849	1.769	1.735	1.684	1.610	1.565
Total Pharmacy Fees (€m)	420.96	372.99	386.63	403.86	393.93	381.07	389.74	397.44	397.91	398.56
% of Health Spending	2.92%	2.70%	2.93%	3.06%	3.01%	2.87%	2.81%	2.86%	2.60%	2.45%
Fees if at 2.92% (€m)	420.96	403.08	384.50	385.58	381.67	387.27	404.54	404.86	446.78	475.10

Source: Health in Ireland | Key Trends 2018 (Department of Health) and PCRS Annual Reports 2009-2018

c. 3.8 billon extracted from Pharmacy Sector

40. Since 2009, €3.8 billion has been extracted from the community pharmacy sector: €1.5 billion relates to FEMPI cuts, although €2.3 billion was not under FEMPI. For example, the savings achieved under reference pricing alone amounted to an extraordinary €1.145 billion by the end of September 2019.

41. The cost of the restoration of public pay under the Public Pay Act was €844 million up to September 2018. The new three-year agreement which is currently set to run from January 2018 until December 2020 will cost a further €887m. By 2020 more than 90% of public servants will be completely out of the FEMPI pay provisions. By comparison, the amount promised in 2016 to be restored to community pharmacists was miniscule and, even so, was inexcusably not delivered.

d. Increased spend on High Tech drugs by the State

42. Expenditure on High Tech medicines is a key factor in the HSE's medicines budget. The growth in medicines spending which has occurred in the last decade is due to increased spending on these medicines, which are hospital-initiated and prescribed, and are funded separately to other medicines.

43. Use of High Tech medicines increased from 336,996 items costing €315.3m in 2009 to 684,582 items costing €781.23m in 2018 – an overall increase of 103% in volume and 148% in value – which has inflated the primary care drugs bill but has not added to pharmacy turnover. No margin on drug cost is made on these High Tech items by pharmacists, nor do they add to pharmacy revenues as they are procured and paid for separately by the HSE.

44. Taking all of the above into account, the IPU's position is that no reasonable Minister, could consider proposed further cuts in fees in this sector to be "fair and reasonable".

Sector sustainability and patient accessibility

45. Community pharmacies are largely family owned businesses (89%) which are an integral part of local communities. Irish pharmacies are efficient and deliver exceptional value to the State and to their patients. Pharmacy is also the most accessible part of the health

service and pharmacists are the most accessible healthcare professionals.

46. Further, as set out in section 5**,** the pharmacy sector makes a substantial contribution to the national GDP, employment and the total tax benefit to the Exchequer. The EY Economic Advisory Services analysis for 2016 is set out in Table 4.

Table 4: Economic Impact of Community Pharmacy Sector 2016 (EY-DKM Economic Advisory)

Addition to National GDP	€2.046 billion
Employment supported	26,750
Exchequer revenue generated	€466 million

47. Given the dependence of many pharmacies on the dispensing fee as a source of income and the needs of the State to provide services cost-effectively, it is natural that the State would seek to determine value for money. However, considering the level of expertise required to dispense medication safely, and the legal obligations that must be adhered to, the costs associated with maintaining a pharmacy business are significant. It should also be noted that the additional services which are provided by the profession and the sector are often offered to the public voluntarily, without State remuneration, which suggests there is a substantial social value that must be accounted for in policy-making.

48. Between 2009 and 2018, the average turnover per pharmacy from the State schemes has decreased by 37%, in circumstances where the average community pharmacy relies on the State for approximately 55% of its turnover and rural pharmacies have a greater reliance. Now, instead of unwinding the FEMPI cuts, the Department proposes to further cut fees for pharmacies. This will render many pharmacy businesses unviable, particularly in rural areas, as well as damaging patient experience and reducing accessibility.

49. The IPU has, in previous submissions, provided clear evidence to the Department that current dispensing fees are inadequate. Analysis by Smith & Williamson found that pharmacy sales started to decline in the fourth quarter of 2007 and that the value of dispensary sales in pharmacy has reduced every year since then, beginning a decade of decline as the HSE has brought in a series of drug price and fee reductions over the years.

50. Further, EY Economic Advisory Services analysis established that the pharmacies with the lowest average turnovers and the weakest profitability are those located in areas of greatest social need, particularly in rural, outlying and disadvantaged areas. There is also less opportunity in rural areas for the retail business which is necessary to subsidise the income from State schemes, upon which rural pharmacies are thus utterly reliant.

51. Therefore, where a pharmacy is located impacts its profitability and, unless dispensing fees are increased, a significant number of non-urban pharmacies will ultimately close. This may well lead to future difficulties with patient access to medicines in those locations.

52. Any reimbursement model must be viable and realistic, providing a sustainable dispensing fee across all schemes, with appropriate professional and administrative allowances to cover State-imposed costs and supports for marginal pharmacies in disadvantaged, rural

or outlying communities. A meaningful increase in fees is urgently needed to restore funding for pharmacy services to a level which will meet the ever-increasing costs of providing the existing service and ensure the sustainability of community pharmacy.

53. The Department's proposals will not only damage the viability of the community pharmacy sector and its cohort of patients, there may also be significant knock-on consequences for health service more generally and of course the wider public. The solution to releasing additional capacity in more complex healthcare settings, such as General Practice and Emergency Departments, is the development of enhanced pharmacy-based services.

54. The policies of successive Governments have accepted that a radical change is needed in our approach to healthcare, with greater collaboration amongst a multi-disciplinary team of healthcare professionals, and the vast majority of care being delivered in the community. This is reflected in the commitment in the 2016 Programme for Government to expand the role of the community pharmacist.

55. The Sláintecare Action Plan for 2019 sets out the first steps in a ten-year plan to deliver health and social care services with the intent that the focus is on providing the right care, in the right place, at the right time in a way that is efficient, effective and sustainable. The Government has committed to a decisive shift towards primary care, but there are simply not enough GPs to deliver this. The Government, therefore, must utilise the network of 1,870 Irish community pharmacies.

56. Modest investment in pharmacy-based services would free up crucial capacity in GP surgeries and achieve cost efficient treatment across the continuum of care. This is set out in further detail in section 6 of the submission, and includes an analysis of advances made in the pharmacy sector in Canada for the Department's consideration.

57. In these circumstances, the further proposed cuts are not reasonable or rational; rather, it is clear that the State urgently needs to invest in enhanced pharmacy-based services, successful international and domestic implementation of which has demonstrated real benefits in terms of patient outcomes, reduced total care costs and, crucially, the additional capacity which can be released in more complex healthcare settings such as General Practice and Emergency Departments – thus meeting key elements of the Sláintecare action plan.

Obligation on the State to have a prudent fiscal policy

58. The economic crisis is long over and, having come through a very difficult period, the Irish economy has recovered strongly, which is having a very positive impact on all fiscal indicators. World Bank data shows that Irish Gross Domestic Product (GDP) expanded by 59% between 2009 and 2018, with the official data suggesting that GDP expanded by 8.2% in 2018 alone.

59. The majority of other Irish economic indicators have also evolved in a positive manner. Following the economic and fiscal recovery, the Government budgetary position moved

into surplus in 2018, a year ahead of forecast, while non-capital health spending was restored, reaching €16.287 billion.

Conclusion

60. The IPU's position is as follows:

61. That the "consultation" process is not a valid consultation under section 42(9) of the Act. Therefore, the IPU is engaging in this process without prejudice to this view and without prejudice to its rights in this regard.

62. The IPU's position on the proposed structural changes to pharmacy fees contained in the letter dated 25 October 2019 is that proposed further cuts to the pharmacy sector are not "fair and reasonable".

63. The approach adopted by the Department and set out in the letter dated 25 October, is contrary to previous Government commitments on the unwinding of FEMPI and pharmacists' legitimate expectation that funding would be restored for pharmacy services to a level which will meet the ever-increasing costs of providing the existing service. It is inconsistent, irrational, disproportionate, unfair and unjustifiable.

64. The Government should, instead of implementing further cuts, commence the unwinding of FEMPI by **immediately releasing the €10m owed to pharmacists** (€2.5 million per annum for the years 2016-2019) **and increasing all fees by 19.2% from 1 January 2020.** Such an increase is urgently needed to restore funding for pharmacy services to a level which will meet the ever-increasing costs of providing the existing service, ensure the sustainability of community pharmacy and allow pharmacists to deliver on their commitment to ongoing service development and reform. The IPU has provided a detailed breakdown of the proposed fee structure to achieve this in Appendix 1 of this document. The IPU has also previously provided the Department with the benefit of analysis from expert reports evidencing the basis for these proposed fees. If the Department requires copies of such reports, these can be furnished to the Department.

65. It is the view of the IPU that this fee increase should lead into a more detailed engagement process on broader reform of the pharmacy contract and improving patient outcomes through the development of accessible, high quality, cost effective pharmacy services.

1. Background

On 10 October 2019, the Department of Health Initiated a consultation process under the Public Pay Act with the IPU. Following an initial meeting, the Department wrote to the IPU on 25 October 2019 proposing that the fees currently payable to pharmacies should be restructured as follows:

1. That the current phased dispensing fee per item be abolished and replaced with a monthly patient care fee of €45.00.
2. That the number of items paid at €5.00 be reduced from 1,667 to 1000.
3. That the High Tech non-dispensing patient care fee of €31.02 be abolished.

The Department's letter of 25 October provides that the 'consultation' period under Section 42(9) of the Public Pay Act expires on 8 November. However, the Department has not provided the IPU will any reasons for the restructuring of fees or any analysis, reports or documentation explaining or justifying the position set out at the meeting and in the letter of 25 October. Therefore, the IPU in providing this submission to the Department is engaging in the consultation process without prejudice to this view and without prejudice to its rights in this regard.

The IPU has set out its views on the fees / rates which it would be fair and reasonable to pay pharmacy contractors with effect from 1 January 2020.

Under the Public Pay Act, the Minister can by regulation, fix amounts or rates he/she "considers to be fair and reasonable, having regard to the matters which that Minister considers appropriate, including any or all of the following:

a. The terms of any existing contractual arrangements or understandings with the service provider concerned;
b. The terms of any circular, instrument or document which apply to the service providers concerned;
c. Any submissions and views expressed during consultations under subsection (9);
d. The nature of the services rendered by different classes of service providers and the general nature of expenses and commitments of the service providers providing those services;
e. The obligation on the part of the State to have a prudent fiscal policy under the Stability and Growth pact and Fiscal Compact"

As we have explained and evidenced in detail below, it is clear that the fees now proposed by the Department are unfair and unreasonable, disproportionate, inconsistent and inequitable and indeed, irrational. The proposals are short-sighted and unsustainable and will undoubtedly adversely affect patients.

2. Department Letter of 25 October

As set out above, the Department has outlined in its letter dated 25 October 2019 to the IPU the following proposed structural changes to pharmacy fees:

- That the current phased dispensing fee be abolished and replaced with a monthly patient care fee of €45.00.
- That the number of items paid at €5.00 be reduced from 1,667 to 1000.
- That the High Tech non-dispensing patient care fee of €31.02 be abolished.

These changes would apply from 01 January 2020.

Not a valid consultation under section 42(9)

The IPU has reviewed the content of the letter dated 25 October 2019. However, the IPU is not in a position to provide a full and meaningful response to each of the proposed changes to the pharmacy fees. This is in circumstances where the consultation process engaged by the Minister is not a valid consultation under section 42(9) of the Public Pay Act for the following reasons:

i. The Department has not set out in its correspondence of 25 October or at all, any reasons or furnished the IPU with any economic analysis or reports demonstrating the basis for the proposed structural changes or why the Minister is of the opinion that such further cuts are "fair and reasonable".

ii. No reasons have been provided by the Department or the Minister for reneging on the Government's commitments and the legitimate expectation which has arisen on the part of the IPU and its members on foot of those commitments.

iii. The Department has failed to furnish the IPU with any documents which are relevant to the Minister's consideration of the proposals.

iv. The Department has failed to identify the particular criteria relied upon or the factors considered by the Minister and which informed his approach to the fee proposals, including, but not limited to, any matters contained in section 42(10) of the Public Pay Act to which he has had regard.

v. In circumstances where such information has not been provided to the IPU and the IPU is unable to consult with the Minister in respect of the proposed structural changes, the time period of 30 days for the completion of the consultation process as set out in section 42(12) of the Act cannot be complied with by the Minister or the IPU.

The above information is essential so that the IPU can address any issues or concerns on the part of the Department or the Minister. In the absence of such information, including the reasons and or the basis/calculations for the proposed fee restructuring and any supporting documentation, the IPU is not in a position to provide a meaningful submission in response

to the proposed structural changes contained in the letter 25 October and, in effect, cannot engage in a consultation with the Minister under section 42(9) of the Public Pay Act.

Therefore, the IPU in providing this submission to the Department is engaging in the consultation process without prejudice to this view and without prejudice to its rights in this regard.

The proposed fee changes in the letter of 25 October are not "fair and reasonable"

Pursuant to section 42(10) of the Public Pay Act "A regulation made under subsection shall fix amounts or rates that the Minister of the Government concerned considers to be **fair and reasonable**……." [our emphasis]

In coming to this decision, the Minister shall have regard to matters which he shall consider appropriate, "including all or any of the following:

a. the terms of any existing contractual arrangements or understandings with the service provider concerned;
b. the terms of any circular, instrument, or document which apply to the service providers concerned;
c. any submissions made and views expressed during the consultations under subsection (9);
d. the nature of the services rendered by different classes of service providers and the general nature of expenses and commitments of the service providers providing those services;
e. the obligation on the part of the State to have a prudent fiscal policy under the Stability and Growth Pact and the Fiscal Compact."

The IPU is firmly of the view that what is proposed by the Minister cannot be said to be "fair and reasonable" against the backdrop of previous Government commitments on fees and the unwinding of FEMPI, the sustainability of the pharmacy sector and the role of the pharmacy sector in primary health care. The cuts which are proposed are not only objectively unjustifiable but will also impact disproportionately on pharmacies which dispense lower than average numbers of prescriptions, which are often the pharmacies serving rural, isolated or disadvantaged communities. As shown in Figure 1, the proposed change to the dispensing fee bands is markedly regressive, having the greatest impact on pharmacies dispensing 2,500-3,000 items per month, for whom it would result in a crippling reduction in fee income of up to 9%. EY Economic Advisory Services analysis shows that these pharmacies cannot survive any further cut in their income, never mind one of this magnitude.

Figure 2: Impact of proposed changes to Dispensing Fee bands

3. Value for Money in Pharmacy and Unfairness of Further Cuts

Pharmacies are extraordinarily efficient and deliver exceptional value to the State and to their patients. A Behaviour and Attitudes survey in March 2019 found that 86% of the Irish public rates value for money in the pharmacy sector as good or very good. Instead of recognising this and securing this into the future by restoring the FEMPI cuts, the Department proposes to further cut fees which will undoubtedly render many essential small pharmacy businesses unviable, particularly in rural areas, as well as damaging patient experience and accessibility across the board. Fitzgerald Power has estimated that approximately 250-300 pharmacies have turnovers of less than €650,000 and, as such, are vulnerable to closure.

The Department's proposals are short-sighted in terms of the sustainability of the community pharmacy sector. Furthermore, the cuts proposed will make it impossible to deliver on enhanced pharmacy-based services which are the solution to releasing additional capacity in more complex healthcare settings such as General Practice and Emergency Departments. The proposals will not just damage the community pharmacy sector and its cohort of patients; there may be significant knock-on consequences for the health service more generally and of course the wider public.

Pharmacists are the only major contractor group to have had no fee restoration and not only do pharmacists continue to bear a burden of austerity that has been lifted from other groups, the Department now proposes to cut pharmacy fees even further at a time of sustained economic growth. It is inconsistent and unjustifiable, not to mention deeply unfair, to commence the unwinding of FEMPI for other professions but not pharmacy contractors.

Overall Cost to the Exchequer and Pharmacy Fees

The position is often advanced that the overall spend on medicines has increased in the period 2009-2018, despite the cuts. This is not the case. The cumulative amount of money paid to pharmacists by the PCRS under the State schemes depends on a variety of factors, primarily the number of medical cards in issue and the number of prescriptions issued by GPs, both of which have increased in line with population growth, along with the mix of medicines prescribed and the cost of those medicines. However, falling medicine prices and cuts to pharmacy remuneration have served to absorb the increased demand within existing budgets, which is no longer sustainable.

Between 2009 and 2018, measures imposed under FEMPI extracted approximately €1.5 billion from the community pharmacy sector in cuts to pharmacy fees. In terms of State fees and mark-up payments to pharmacists, the average remuneration per item has fallen from €6.00 in 2009 to €4.89 in 2018 – a reduction of 18.5%.

In their 2018 review of the pharmacy sector, Fitzgerald Power estimates that, due to the implementation of the Health (Pricing and Supply of Medical Goods) Act 2013 and the agreement between IPHA and the HSE regarding the supply and pricing of on-patent medicines, total State savings from medicine reimbursement reductions since 2009 stood at

approximately €3.2 billion as of 31 December 2018. In other words, the State and its citizens are getting much more for less.

Table 5: Pharmacy reimbursements 2009-2018 excl. High Tech (Ref. PCRS Annual Reports)

Year	No. of items dispensed	Change on 2009	Total drug payments € m	Change on 2009	Avg. drug cost per item	Change on 2009	Fees/mark-ups to pharmacies € m	Change on 2009	Avg. fee/mark -up per item	Change on 2009
2009	67,468,626		1,273.77		€18.88		405.02		€6.00	
2010	68,860,539	2.1%	1,191.88	-6.4%	€17.31	-8.3%	357.51	-11.7%	€5.19	-13.5%
2011	71,590,122	6.1%	1,114.61	-12.5%	€15.57	-17.5%	368.63	-9.0%	€5.15	-14.2%
2012	75,196,035	11.5%	1,161.46	-8.8%	€15.45	-18.2%	386.76	-4.5%	€5.14	-14.3%
2013	73,823,818	9.4%	1,053.29	-17.3%	€14.27	-24.4%	376.43	-7.1%	€5.10	-15.1%
2014	72,132,792	6.9%	979.01	-23.1%	€13.57	-28.1%	363.77	-10.2%	€5.04	-16.0%
2015	72,911,181	8.1%	956.75	-24.9%	€13.12	-30.5%	371.64	-8.2%	€5.10	-15.1%
2016	74,494,210	10.4%	945.90	-25.7%	€12.70	-32.7%	377.95	-6.7%	€5.07	-15.5%
2017	75,017,045	11.2%	915.24	-28.1%	€12.20	-35.4%	376.96	-6.92%	€5.02	-16.3%
2018	76,727,850	13.7%	919.07	-27.7%	€11.98	-36.6%	375.20	-7.36	€4.89	-18.5%

Excluding High Tech medicines (which will be dealt with separately), in 2009 – the year FEMPI was introduced – 67.5 million pharmacy medicine items were dispensed on State schemes at a total cost of €1.274 billion (Table 5). This equates to an average of €18.88 per item. In 2018, 76.7 million items were dispensed on State schemes at a total cost of €919.07 million, which equates to an average of €11.98 per item. In the last decade, the State has achieved an average price reduction of almost 37% per item, leading to a fall of 28% in total medicines expenditure, despite the number of items supplied to patients increasing by 13%.

Meanwhile, the average medicines turnover per pharmacy from the State schemes has decreased from €782,000 in 2009 to €495,000 in 2017, a 37% decline**.** The average pharmacy relies on the State for approximately 55% of its turnover[1].

Excluding High Tech, the total paid to pharmacists in dispensing fees and mark-ups under the State schemes in 2009 was €405 million, as against €375 million in 2018. This has resulted in an average dispensing fee drop per pharmacy of over 19% from €248,479 in 2009 to €200,642 in 2018, which has had a direct negative impact on viability.

In summary, PCRS statistics for 2009 to 2018 show that:

Pharmacy efficiency ↑ – In 2009, 67,825,991 items were dispensed by 1,630 pharmacies i.e. an average of 41,611 items dispensed per pharmacy. In 2018, 76,727,850 items were dispensed by 1,870 pharmacies i.e. an average of 41,030 items dispensed per pharmacy. Output per pharmacy dropped by only 1.4%, while the average pharmacy suffered a fall in payments of 19.3% (Table 6)**.**

[1] Smith & Williamson found that pharmacy chains rely more on over the counter and retail sales than PCRS reimbursements. Independents and smaller groups rely much more heavily on State disbursements.

Cost of medicines to State ↓ – The cost of medicines reimbursed in 2009 was €1,273.77 million for 67.5 million items; this equates to an average cost per item of €18.88. For 2018, PCRS paid €919.07 million for 76.7 million items; this equates to an average cost per item of €11.98, which is a 36% reduction.

Fees and mark-ups to pharmacies ↓ – In 2009, pharmacies were paid €405.02 million to dispense 67.5 million items, giving an average fee of €6.00 per item. In 2018 the figure was €375.20 million to dispense 76.7 million items, or an average of €4.89 per item. This represents a cut in fees per item of 18.5%.

Index Linked fee would be €6.25 – If the average fees and mark-up per item paid to pharmacies in 2009, i.e. €6.00, were index-linked using the Consumer Price Index (CPI) 2010-2018, the average fee per item in 2018 would have been €6.25, which is 28% higher than the €4.89 actually paid. Excluding fees for phased dispensing, which is a discrete service, the average fee payment per item in 2018 was only €3.90.

Average amount paid to each pharmacy ↓ – The average amount paid to each pharmacy has reduced. Excluding High Tech, dispensing fee and mark-up payments totaling €405.02 million were paid to 1,630 pharmacies in 2009, an average of €248,479 per pharmacy. In 2018, €375.20 million was paid to 1,870 pharmacies, an average of €200,642 per pharmacy, which is a reduction of 19.3%.

Table 6: Average pharmacy payments 2009-2018 (excl. High Tech) (Ref. PCRS Annual Reports)

Year	No of pharmacies	Change on 2019	Items per pharmacy	Change on 2009	Drug costs per pharmacy	Change on 2009	Dispensing fees/mark-ups per pharmacy	Change on 2009
2009	1,630		41,611		€781,454		€248,479	
2010	1,671	2.5%	41,443	-0.4%	€713,273	-8.7%	€213,950	-13.9%
2011	1,690	3.7%	42,617	2.4%	€659,533	-15.6%	€218,124	-12.2%
2012	1,713	5.1%	44,202	6.2%	€678,027	-13.2%	€225,779	-9.1%
2013	1,744	7.0%	42,648	2.5%	€603,951	-22.7%	€215,843	-13.1%
2014	1,778	9.1%	40,897	-1.7%	€550,624	-29.5%	€204,595	-17.7%
2015	1,801	10.5%	40,834	-1.9%	€531,233	-32.0%	€206,352	-17.0%
2016	1,830	12.3%	41,080	-1.3%	€516,885	-33.9%	€206,530	-16.9%
2017	1,849	13.4%	40,975	-1.5%	€494,991	-36.6%	€203,872	-17.9%
2018	1,870	14.7%	41,030	-1.4%	€491,818	-37.1%	€200,642	-19.3%

The FEMPI Act and the regulations made under it were used to cut payment rates to pharmacists and other professionals, which, if it were not for the emergency in the State's finances, would have been unlawful. Instead of reversing these cuts, as has been done for the public service and for other professions, the Department proposes to cut fees even further. Therefore, the fees proposed by the Department are clearly unfair and disproportionate, inconsistent and unjustifiable.

The approach adopted by the Department and set out in the letter dated 25 October is contrary to previous Government commitments on the unwinding of FEMPI and

pharmacists' legitimate expectation that funding for pharmacy services would be restored to a level which will meet the ever-increasing costs of providing the existing service, ensure the sustainability of community pharmacy and allow pharmacists to deliver on their commitment to ongoing service development and reform.

High Tech Medicines

The further cuts proposed to pharmacy fees are in stark contrast to the runaway spending on High Tech medicines (Figure 3), which are not pertinent in terms of the fees paid to pharmacies.

Table 7: High Tech Medicines Expenditure (Ref. PCRS Annual Reports)

Year	High Tech Items Dispensed	Change on 2009	HT Drug Costs € m	Change on 2009	Avg HT cost per item	Change on 2009	HT Fees to Pharmacies € m	Change on 2009
2009	336,996		315.36		€935.80		15.94	
2010	340,138	0.9%	345.76	9.6%	€1,016.53	8.6%	15.48	-2.9%
2011	361,419	7.2%	350.18	11.0%	€968.90	3.5%	18.00	12.9%
2012	443,981	31.7%	385.04	22.1%	€867.24	-7.3%	17.10	7.3%
2013	466,485	38.4%	442.27	40.2%	€948.09	1.3%	17.50	9.8%
2014	491,678	45.9%	484.71	53.7%	€985.83	5.3%	17.30	8.5%
2015	530,638	57.5%	544.19	72.6%	€1,025.54	9.6%	18.10	13.6%
2016	573,867	70.3%	611.74	94.0%	€1,066.00	13.9%	19.49	22.3%
2017	622,596	84.7%	664.22	110%	€1,066.86	14.0%	20.95	31.4%
2018	684,582	103.1%	781.23	148%	€1,141.18	21.9%	23.36	46.5%

High Tech medicines are initiated and prescribed in the hospital setting rather than in primary care and the number of High Tech items dispensed has increased from 336,996 in 2009 to 684,582 in 2018 (Table 7). The cost of these High Tech medicines in 2009 was €315.3 million; by 2018 it had increased 148% to €781.23 million. No margin on drug cost is made on these High Tech items by pharmacists, nor do they add to pharmacy revenues as they are procured and paid for separately by the HSE.

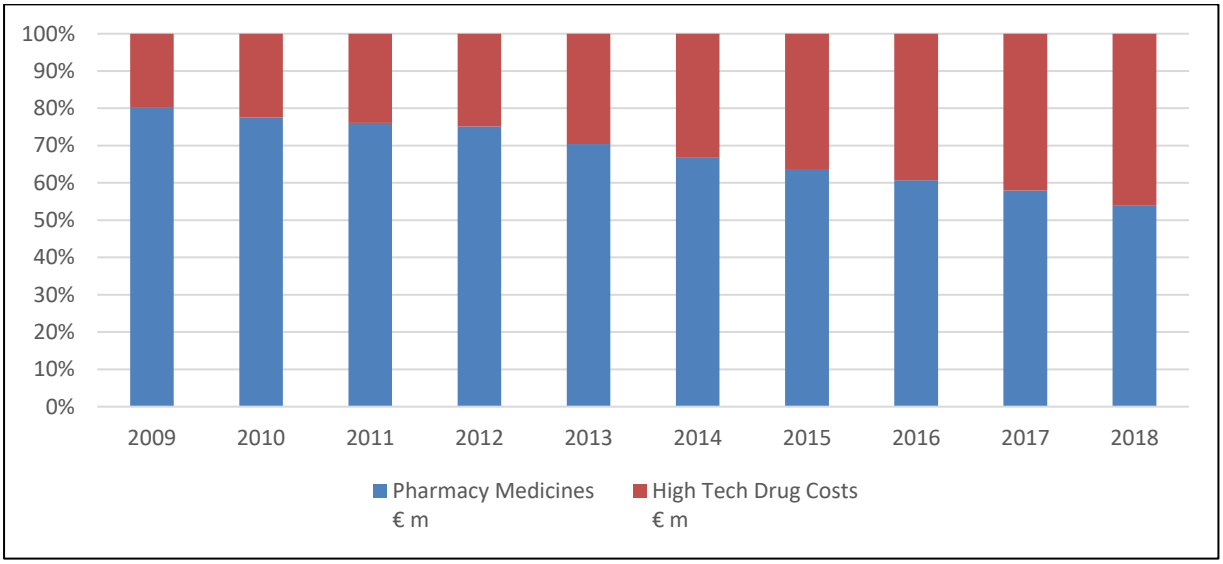
Table 8: High Tech Medicines Expenditure per Pharmacy (Ref. PCRS Annual Reports)

Year	High Tech Items Claimed	High Tech Items Dispensed	HT fees to Pharmacies € m	No. of Pharmacies	Avg. HT fees per pharmacy	Change on 2009	Avg. HT fees per Item Claimed	Change on 2009
2009	357,365	336,996	15.94	1,630	€9,779		44.60	
2010	390,838	340,138	15.48	1,671	€9,264	-5.3%	39.61	-11.2%
2011	433,139	361,419	18.00	1,690	€10,651	8.9%	41.56	-6.8%
2012	522,355	443,981	17.10	1,713	€9,982	2.1%	32.74	-26.6%
2013	554,686	466,485	17.50	1,744	€10,034	2.6%	31.55	-29.3%
2014	582,744	491,678	17.30	1,778	€9,730	-0.5%	29.69	-33.4%
2015	631,042	530,638	18.10	1,801	€10,050	2.8%	28.68	-35.7%
2016	681,631	573,867	19.49	1,830	€10,650	8.9%	28.59	-35.9%
2017	746,052	622,596	20.95	1,849	€11,330	15.9%	28.08	-37.0%
2018	818,114	684,582	23.36	1,870	€12,492	27.7%	28.55	-36.0%

The number of High Tech medicines dispensed has increased 148%, with pharmacy fees paid under the scheme only increasing 46.5% overall (Table 8). Average fees per pharmacy under the High Tech scheme have increased by 27.7% in the period in question, due to the increasing numbers of patients being treated, while average fees per item dispensed have fallen 35.9%. As such, there is no justification for the proposed changes to High Tech patient care fees.

The Department of Health should allow for community pharmacists to practise to their full scope. This approach would be more engaging and in the case of allowing for substitution of biological medicines for biosimilars, as the IPU has previously proposed, would have a more positive impact on the medicines budget than further unwarranted cuts to pharmacy fees.

Figure 3: Share of Drug Costs – High Tech vs Pharmacy Medicines 2009-2018 (Ref. PCRS Annual Reports)



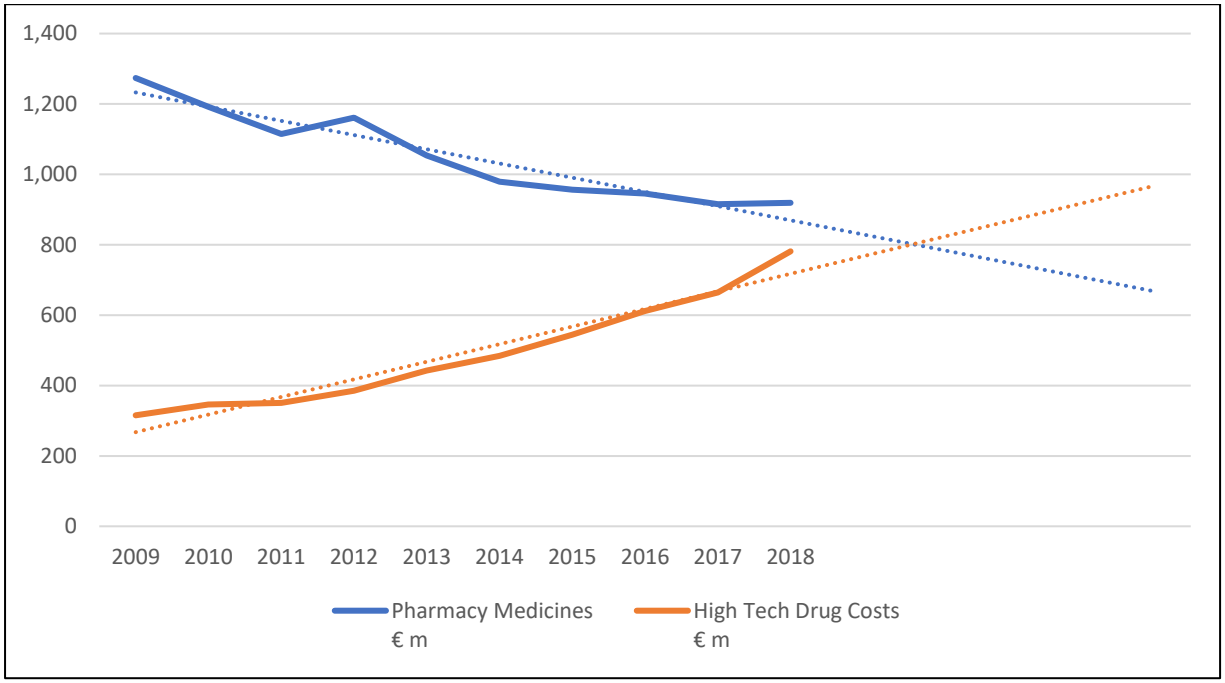
Within the expenditure on High Tech medicines, biological medicines containing tumour necrosis factor (TNF)-alpha inhibitors accounted for €224.65 million in 2017, meaning that these drugs alone accounted for 10.9% of total expenditure on medicines by the PCRS.[2]

The Medicines Management Programme (MMP) has a process to identify the best value biosimilars (BVB) and has developed guidance to support this initiative. They have recommended the BVB for the TNF alpha inhibitors adalimumab and etanercept, as these two biological medicines cost the state €193.4 million in 2017. The MMP guidance states that, as a benefit of switching to the BVB, "potential for savings will allow for more treatment with new medicines and therefore getting the best possible value for the medicines budget without impacting on patient safety".[3] The MMP has provided clear guidance to healthcare professionals and patients on this switch from a reference biological medicine to a biosimilar, and pharmacists are the ideal professionals to counsel patients on these products and make that switch.

[2] https://www.hse.ie/eng/about/who/cspd/ncps/medicines-management/best-value-biological-medicines/mmp%20report%20bvb%20medicines%20tnf%20alpha%20inhibitors%20may%202019.pdf
[3] file:///Z:/Irish%20Research/Biosimilars/biosimilar-medicines-in-the-irish-healthcare-setting.pdf

A change to the Health (Pricing and Supply of Medical Goods) Act 2013 to allow substitution by pharmacists of biologicals deemed appropriate by MMP under the BVB programme remains the most cost-effective way for the Department of Health to make budget reductions. This is the area of most rapid growth for the State's drug budget and, given that current trends in expenditure suggest the cost of High Tech medicines is likely soon to outstrip pharmacy medicines (see Figure 4), it would seem prudent that the Department work with the pharmacy sector on a biosimilar substitution policy, rather than undermining the sector through further cuts to pharmacy fees.

Figure 4: Trends in High Tech Drug Costs vs Pharmacy Medicines 2009-2018 (Ref. PCRS Annual Reports)



4. Accessibility, Patient Experience and Sector Sustainability

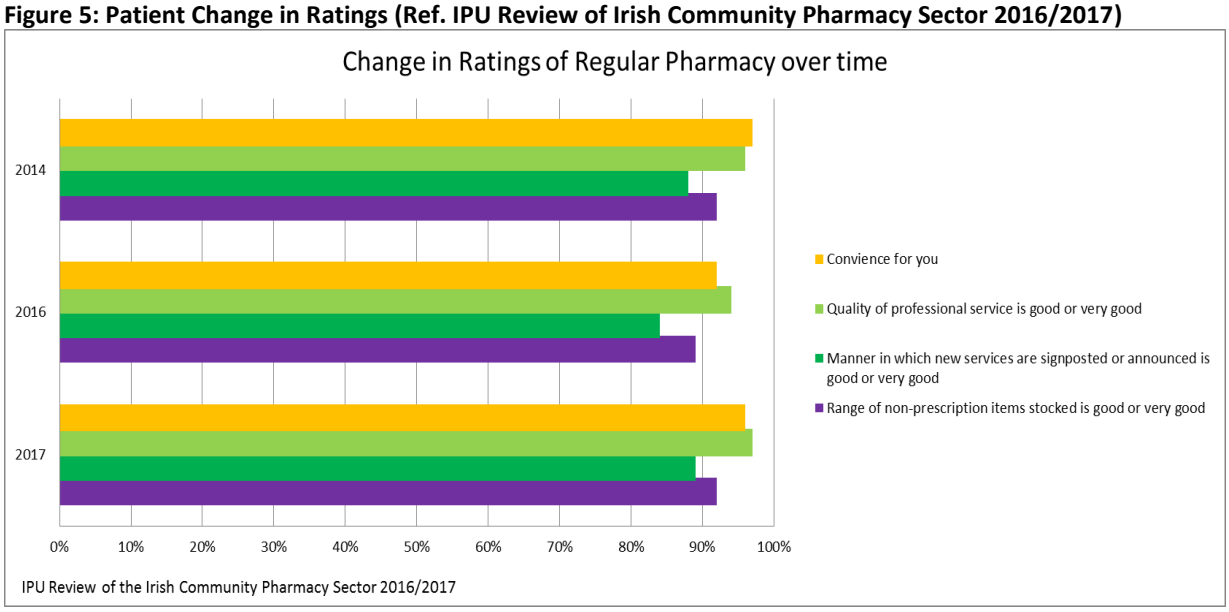
Accessibility and Patient Experience

Pharmacy is the most accessible part of the health service and pharmacists are the most accessible healthcare professionals. Patient access to medicines and to pharmacy advice, support and services in Ireland, regardless of geographic location, is excellent. For example, every pharmacy in the country has a consultation room, and pharmacies offer late night services, services at weekends and on bank holidays and access to an expansive list of medicines at short notice.

There are over 1.5 million visits to pharmacies by Irish people every week and half of the population lives within 1km of a pharmacy, 75% within 2km and 88% within 5km[4]. EY Economic Advisory Services in 2017 calculated that each month over 2.7 million adults visit a pharmacy, 6.2 million prescriptions are dispensed under State schemes and €54 million is added to Ireland's economic output.

Behaviour & Attitudes research on patient satisfaction (published by the PSI)[5] indicates that there is a 96% satisfaction rating with pharmacy services. Patients indicate that their primary reasons for attending a pharmacy for healthcare services are convenience of access and efficiency such as longer opening hours, no need for appointments etc. (Figure 5). 74% of respondents rated trust in the pharmacist as $^{9}/_{10}$ or $^{10}/_{10}$.

Figure 5: Patient Change in Ratings (Ref. IPU Review of Irish Community Pharmacy Sector 2016/2017)



Potential Improvements

Behaviour & Attitudes research in 2019 shows that the public wants more services from pharmacies, such as health screening – blood pressure (sought by 90%); cholesterol (89%); more medicines directly from the pharmacy without a prescription, i.e. Minor Ailment Scheme (94%).

[4] Both findings were made by a Behaviour & Attitudes survey in 2017.
[5] http://www.thepsi.ie/tns/news/latest-news/AttitudestoPharmacyinIreland.aspx

As many as 85% now indicate that they are open to the idea of asking to talk to the pharmacist in the private consultation area about a personal healthcare matter or to avail of a service or test and 70% say that they talk to their pharmacist first ahead of visiting the GP.

Those additional services which have been funded and rolled out have been exceptionally well received. The flu vaccination service has been a significant success, with constant year-on-year growth in numbers and exceptional patient satisfaction. A PSI review of pharmacy vaccination found that 79% of service users rated overall satisfaction as $^{10}/_{10}$, 93% rated overall satisfaction as $^{9}/_{10}$ or $^{10}/_{10}$ and 99% rated overall satisfaction as either $^{8}/_{10}$, $^{9}/_{10}$ or $^{10}/_{10}$.

Instead of seeking to improve patient experience by allowing pharmacies to provide a greater range of services under State schemes, the Department's proposals will jeopardise existing pharmacy services and fatally undermine the prospect of additional services being rolled out.

Patient Choice and Access

As set out in detail under 'Sector Sustainability', EY Economic Advisory Services analysis shows **there is an under-provision of services in rural areas**. In the absence of an increased dispensing fee and administrative allowances to cover State-imposed costs and supports for marginal pharmacies in disadvantaged, rural or outlying communities, the only choice many patients in rural areas may have is to travel to larger towns. Instead, quite irrationally, the Department proposes to cut fees and thus, undermine these essential small pharmacies.

Medicine Shortages

The IPU has consistently argued that, although lower medicine prices are important when healthcare resources are limited, setting prices excessively low in an open market can lead to medicine shortages. That point was acknowledged by the Oireachtas Joint Committee on Health and Children in its *Report on the Cost of Prescription Drugs in Ireland*, which recommended that the HSE and the Department "maintain strong surveillance on the impact of national drug price policy on the drug supply and should put in place a contingency plan for when drug shortages arise". Research conducted by the IPU in August 2019, confirmed that there is a significant level of medicine shortages, with 99% of pharmacists confirming that they have experienced medicine shortages in the last 12 months, 95% saying shortages have increased in the last year and over half believing that the health of their patients has been adversely affected or put at risk as a result of these medicine shortages. The IPU has highlighted this issue as an area of concern and believes it is necessary for an immediate review and an appropriate adjustment in reimbursement prices of affected products. The UK's NHS publishes a monthly list of "concession prices" to accommodate this situation. Although no shortages have yet been directly attributed to Brexit, there remains a risk that medicine supply may be adversely impacted when the UK ultimately withdraws from the EU.

Pharmacy service sustainability

Pharmacy services are provided by a sector that is heterogeneous and dynamic; there is no one 'typical' pharmacy. Pharmacies are located in cities, towns, and villages throughout the country, where local demographic and geographic factors make each pharmacy and customer base unique. Community pharmacies are largely family owned businesses (89%) and are part

of the fabric of the local communities they serve. They contribute to these communities by providing employment, supporting other local businesses and paying local authority rates and service charges.

A healthy retail sector is vital to the Irish economy and to the commercial life of our towns and cities. The importance of entrepreneurs in small businesses to Ireland's economy cannot be overstated. Irish retailers buy local and support Irish suppliers. Retail plays a crucial role in stimulating economic growth and enterprise, sustaining employment and supporting lively and vibrant communities across Ireland.

Where retail opportunities are available, such as in areas with high population density and/or footfall, pharmacies have a greater opportunity to generate revenue from other sources. This contrasts with pharmacies in smaller towns and villages, where these opportunities do not exist and State income can account for up to 65% of total turnover. In certain areas, retail turnover is needed to subsidise the pharmacy's healthcare operations, particularly where the costs are very high, and the number of private patients is low. Given the abolition of the mark-up and the reduction in dispensing remuneration, for some pharmacies it is impossible to depend on prescription-based income alone. With the Department now proposing an unprecedented further cut in fees, it is sounding the death-knell for many pharmacies.

EY Economic Advisory Services has considered pharmacies across three cohorts on the basis of dispensing fee income: an upper cohort, a middle cohort, and lower cohort, where each accounts for approximately a third of all pharmacies. The entry or exit point to each band varies by region and pharmacy type. The entry point to the lower cohort is lowest in Community Healthcare Organisation (CHO) Area 6 at circa €120,000 but highest in CHO Area 5 at €190,000. The entry-point to the upper cohort is lowest and highest in the same CHO Areas, respectively. The lower the entry point to a cohort, the higher will be the average dispensing fee income across the region or settlement pattern. Table 9 below presents the entry points to each dispensing fee income cohort by CHO.

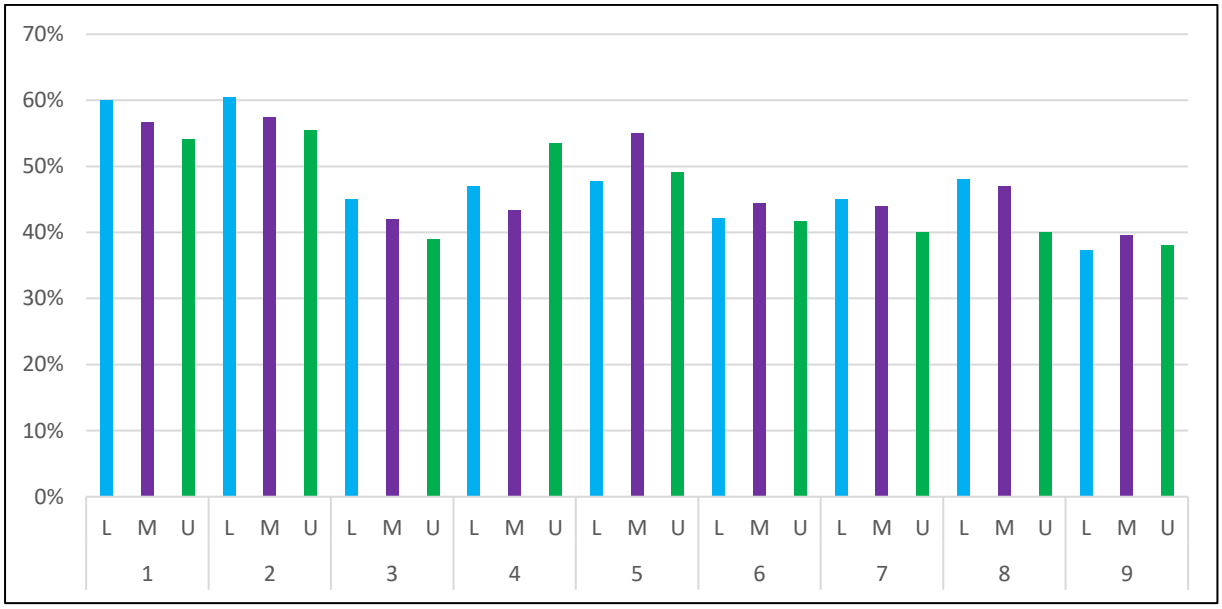
Table 9: Dispensing Fee Cohorts by 2016 fee income range and CHO (EY Economic Advisory Services Analysis)

CHO	Lower € 000s	Middle € 000s	Upper € 000s
1	<170	170-250	>250
2	<175	175-260	>260
3	<170	170-245	>245
4	<165	165-260	>260
5	<190	190-275	>275
6	<120	120-190	>190
7	<180	180-260	>260
8	<160	160-250	>250
9	<160	160-270	>270
National	**<160**	**160-260**	**>260**

Figure 4 presents the dependence of pharmacies on dispensing fee income as a proportion of total turnover across regions and cohorts. The heavy dependence on dispensing fee income

of pharmacies across all cohorts in CHO Areas 1 (north-western counties), CHO Area 2 (western counties), and CHO Area 5 (south-eastern counties) highlights the risks to pharmacies in these regions of any further negative changes to the existing dispensing fee structure.

Figure 6: Dependence on Dispensing Fee Income, by CHO, 2016 (% of Gross Profit) (EY Economic Advisory)



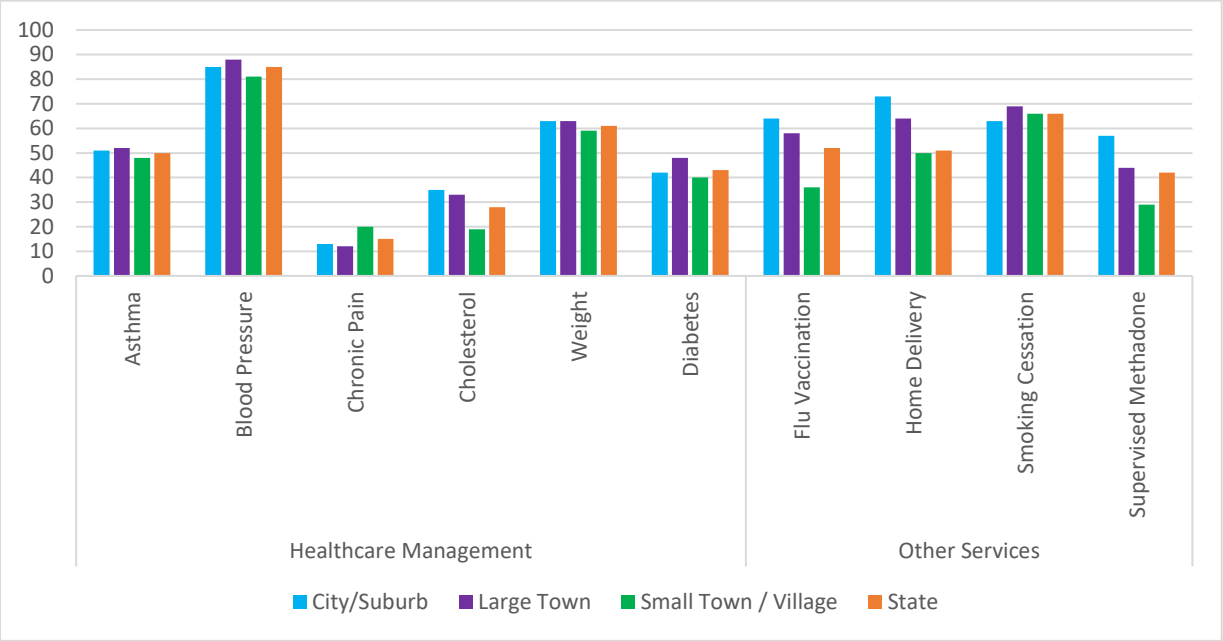
(L .. Lower; M .. Middle; U .. Upper Cohort)

EY Economic Advisory Services analysis calculated pharmacy operating profits at circa 5-10% of turnover nationally. Pharmacies located in western and northern counties were found to be under greatest financial pressure (CHO Areas 1 and 2), with average margins as low as 4% in some cohorts. With the proposed changes to dispensing fee bands representing a cut of up to 9% in dispensing fee income for pharmacies in the lower cohort (Figure 1), it is clear that their very survival will be put in jeopardy.

EY Economic Advisory Services found that there is a significant urban-rural split in relation to the accessibility and availability of services in Ireland. Services are more likely to be available in urban areas and in areas where pharmacies can subsidise the service through retail sales. Where those opportunities are not available, the opportunity to fund services is more dependent on income from public patients than income from private patients.

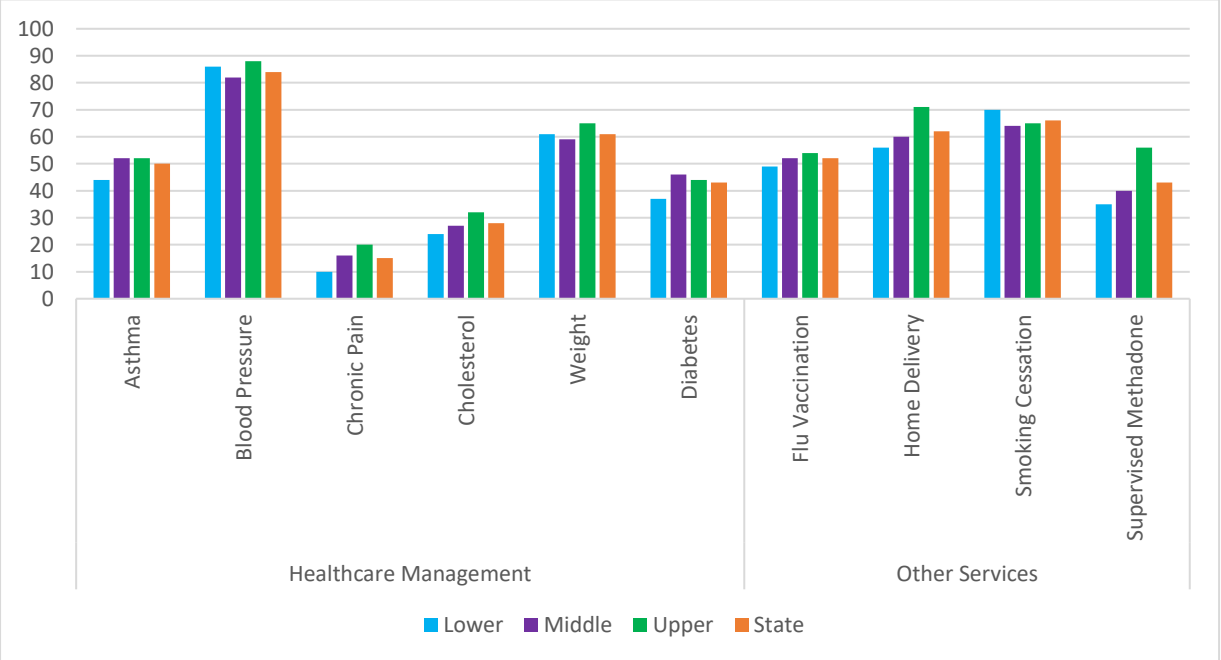
Further, in rural areas, where a larger proportion of the population is in receipt of a medical card, there may be greater need for pharmacy-led services. At the same time, lower GP densities in rural areas can also increase the need for pharmacy-led healthcare service. Thus, there is a circular challenge: there is an under-provision of services in rural areas where demand for those services is likely to be higher, driven by demographics (Figure 7).

Figure 7: Availability of Service by Settlement Pattern, 2016 (% of pharmacies) (EY Economic Advisory)



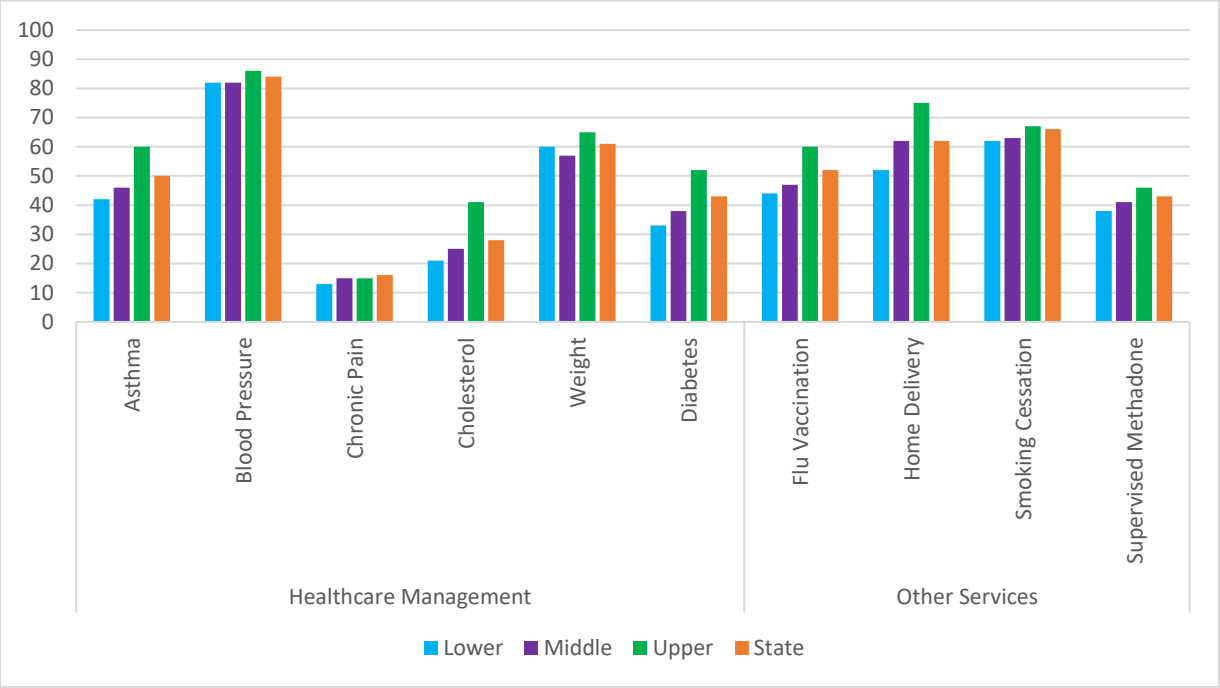
Dispensing fee income is positively correlated with the availability of services at a given pharmacy. As shown in Figure 8, pharmacies in the upper fee income cohort are more likely to provide services than those in the lower cohort. When other sources of income are considered (i.e. total turnover), pharmacies in the upper cohort appear to have a greater capacity to deliver services than those in the middle and lower categories.

Figure 8: Availability of services by dispensing fee range, 2016 (% of pharmacies) (EY Economic Advisory)



These figures imply that healthcare services in pharmacies are largely subsidised by other income and, therefore, in order for pharmacies to provide additional services to patients in areas of greater social or health need, a specific sustainable source of revenue is necessary.

Figure 9: Availability of services by turnover range, 2016 (% of pharmacies) (EY Economic Advisory)



Despite the availability of services to a significant share of the population, gaps remain between the public's demand for services and the sector's supply of services. Whereas 85%, 28% and 43% of pharmacies provide blood pressure management, cholesterol screening, and diabetes management service respectively, 90%, 88% and 86% of the population want these services available to them (Table 10).

Table 10: Gaps in Demand for and Supply of selected services (National, 2016, %) (EY Economic Advisory)

Service	Demand (Population)	Supply (Pharmacies)
Blood Pressure Management	90	85
Cholesterol Screening	88	28
Diabetes Management	86	43

In addition, many people want greater access to medicines from pharmacists, without the need to receive a prescription from their GP.

Asthma management services are provided by over 50% of pharmacies across Ireland. The greater the dispensing fee income and turnover, the more likely it is that this service will be provided.

On average, 85% of pharmacies provide blood pressure management; the rate is highest in Dublin – in some Local Health Office areas all pharmacies provide the service. The service is more likely to be available in large towns, cities, than small towns.

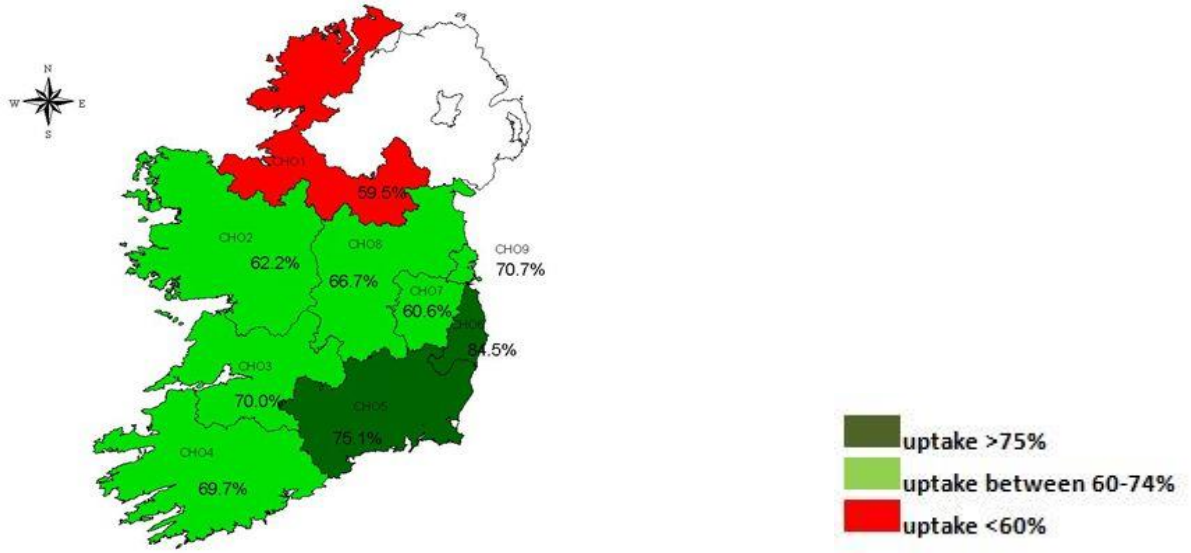
Chronic pain management services are provided by 15% of pharmacies, with the service most likely to be available in some parts of Dublin and Cork (>25%), and in small towns and villages (20%). In fee income terms, the service is less likely to be available to patients of pharmacies in the lower income range (9%) and more likely to be provided by pharmacies in the upper fee income range (19%). The need to expand the availability of this service is vital, especially to non-urban areas where more elderly populations can be supported by pharmacies and so that frontline services are supported.

Cholesterol screening is provided by 28% of pharmacies across the country. The rate of availability of the service in cities and suburbs (35%) is almost twice the rate in small towns and villages (19%). The service is sparsely available in some areas of the country whilst in some areas of Dublin more than half of all pharmacies provide the service. This disparity reflects a clear urban-rural divide, and may reflect relative access, or lack of access, to training and staff, respectively. Based on fee income, cholesterol screening is provided by 24% of pharmacies in the lower income range and 32% of pharmacies in the upper income range. This rises to 42% when total turnover is considered.

Diabetes screening is provided by an average of 43% of pharmacies. Its availability varies significantly by settlement type and is not particularly geographic-based. Screening is more likely to be available in large towns than elsewhere and is positively correlated with higher dispensing fee income and turnover. Given emerging indications that the prevalence of diabetes in the population could rise over coming years and decades, supporting pharmacies to expand these services could support healthcare management into the future.

The flu vaccination is made available by just over 50% of pharmacies. The rate is higher in cities and suburbs (64%) and lower in small towns and villages (36%). In western and northern counties, the rate of availability is circa 25%. HPSC data indicates that flu vaccine uptake among medical and GP visit card holders aged 65 years and older is lowest in CHO 1, demonstrating the need for service provision, while analysis has shown that the pharmacies in that region can least afford to subsidise unprofitable services such as vaccination.

Figure 10: Percentage seasonal influenza vaccine uptake in medical and GP visit card holders aged 65 years and older by CHO-Area, 2018/19



Home delivery of medicines can be a useful service to elderly individuals and others with challenging medical conditions. It is most likely to be available in cities and suburbs (73%) and from pharmacies in the upper fee income range and is less available in small towns and villages (50%) and in pharmacies at lower fee income levels.

Rather than seeking to address these issues and reduce these gaps, it seems the Department instead proposes to exacerbate the issues and render community pharmacy unviable in large swathes of Ireland, particularly in isolated, rural and disadvantaged areas.

Sustainability

The dispensing fee should be viewed from more than solely a financial perspective. The interaction between the pharmacist and the customer/patient requires awareness and empathy and an understanding of medicine, pharmacology, law, and public policy.

Given the dependence of many pharmacies on the dispensing fee as a source of income and the needs of the State to provide services cost-effectively, it is natural that the State would seek to determine value for money. However, considering the level of expertise required to dispense medication safely, and the legal obligations that must be adhered to, the costs associated with maintaining a pharmacy business are significant, as has been outlined. It should also be noted that the additional services which are provided by the profession and the sector are often offered to the public voluntarily, without State remuneration, which suggests **there is a substantial social value that must be accounted for in policy-making**.

Financial Sustainability

Analysis by Smith & Williamson found that pharmacy sales started to decline in the fourth quarter of 2007 and that the value of dispensary sales in pharmacy has reduced every year since then, beginning a decade of decline as the HSE has brought in a series of drug price and fee reductions over the years.

The medicines market is going through a period of substantial change. The use of generics is now widespread, which has radically altered the dispensing profile of the pharmacy sector in Ireland. Irish pharmacists have delivered on a public policy objective by driving an increase in the use of generic medicines from 17% to over 40%, generating a total of €1.145 billion in savings for the State since the introduction of reference pricing in 2013. Persistent downward pressure on State scheme medicine payments continues to depress pharmacy earnings. After a sustained period of turnover reductions, labour and property market pressures are becoming existential challenges.

Annual fee income per pharmacy declined again in 2018, which is evidenced in the 2018 PCRS Annual Report. With an increasing patient population served by a larger number of pharmacies in a growth-free market, there is less revenue per pharmacy, despite transaction volumes continuing to increase year on year. The market in Ireland is analogous to those of European peers, with much of the volume growth coming from low-value generic prescribing and dispensing. For the year 2018, generic medicines amounted to €228 million. *[source: hmR Ireland]*

Pharmacies have had to focus on increasing private dispensing revenues and over the counter medicine sales in order to survive. On average, dispensing turnover made up 67.7% of total pharmacy revenues in 2016 versus 68.7% in 2015, as the increase in the number of medicine items dispensed was not sufficient to offset the decrease in the value of those medicines. Fitzgerald Power found that there are approximately 250 to 300 pharmacies in the country with a turnover of €650,000 or less and which are therefore 'at-risk'. €650,000 is a significant watershed as it is the point below which a pharmacy business is loss-making if average gross profit margins and overhead expenditure levels are applied.

EY Economic Advisory Services analysis established that the pharmacies with the lowest average turnovers and the weakest profitability are those located in areas of greatest social need, particularly in rural, outlying and disadvantaged areas. Merely continuing payment of the existing fees may well lead to future difficulties with patient access to medicines in those locations. These vulnerable pharmacies urgently need a significant uplift in fees to reverse the declines of the last decade.

The existing professional fee of €5 per item or less does not reimburse a pharmacist for his or her cost of labour, overhead contribution and profit margin; it is an uneconomic level of fee for the service provided and the time taken to deliver it by a qualified professional with regulatory obligations and reporting requirements. Smith & Williamson calculated that, with PRSI and pension costs, an overhead contribution of 66% of salary (normally in professional services it is 100%) and a profit margin on top of these of 15% (again, normally it is 100%) are taken into account, this would point to a pharmacy dispensing fee of approximately €8 per item. Instead, the Department proposes to cut the number of dispensed items to which the €5 fee applies and impose additional cuts to current fees.

There is clear evidence that the current dispensing fees are inadequate. Pharmacies with higher reliance on dispensing fees are the least profitable, whereas those which can subsidise their core patient care function with retail activities are strongest. Instead of seeking to address this, the Department proposals will irreparably damage pharmacies outside of large towns.

5. Economic Contribution of Community Pharmacy

The National Contribution

EY Economic Advisory Services conducted an analysis of the contribution of the community pharmacy sector to the national economy. They found that the community pharmacy sector employed approximately 9,140 full time and 7,300 part-time pharmacy level staff members in 2016, equivalent to 11,600 whole time equivalents (WTE). This analysis excludes support staff. The pharmacy profession in Ireland is young, with more than 70% being under 45 years of age.

Contribution to National GDP

- Direct impacts, i.e. those that arise through the pharmacy sector's activity, are significant: total turnover in the sector is €1.915 billion, and in total the sector contributed €624 million to national GDP in 2016;
- Indirect impacts comprise €1.02 billion GDP, generated through the pharmacy sector's Irish supply chain;
- Induced impacts, as the direct and indirect wages are spent in the wider economy, are estimated to add a further €403 million to national GDP in 2016;
- In total, the direct, indirect and induced contribution of the sector to national GDP was €2.046 billion in 2016.

Employment Impacts

- Direct employment in the pharmacy sector is comprised of pharmacists, pharmaceutical assistants, technicians, and other retail and administrative staff. As of 2016, the total number of persons employed in the sector is 11,600 (WTE);
- Further indirect employment of 11,700 is generated in Irish firms that supply goods and services to the pharmacy sector, e.g. wholesalers and manufacturers and various business service providers;
- Induced employment impacts, i.e. additional employment as direct and indirect payroll is spent in the wider economy, is estimated at over 3,400;
- Thus the total direct, indirect and induced employment impact of the community pharmacy sector in 2016 is estimated at approximately 26,700 (WTE).

Exchequer Impacts

- The total tax benefit to the Exchequer from the above economic impacts is very substantial. The payroll, income and corporation taxes in 2016 are estimated to amount to €146 million, taking into account the direct impacts of the pharmacy sector itself;
- The Exchequer revenue from the indirect impact, back through the sector's Irish supply chain, is estimated at €196 million in 2016;
- The estimated Exchequer revenue from the induced impact is €124 million in 2016;
- Thus the total Exchequer revenues in 2016 are estimated at €466 million.

Taking into account the direct economic activity of the sector, along with the indirect impact generated by its purchase of goods and services from other sectors of the Irish economy, and

the induced impact as direct and indirect wages are spent in the wider economy, EY Economic Advisory Services estimates the following impacts in 2016:

Table 11: Economic impact of Community Pharmacy Sector 2016 (EY Economic Advisory)

Addition to National GDP	€2.046 billion
Employment Supported	26,750
Exchequer Revenue Generated	€466 million

It is should be noted that the Exchequer revenue generated (€466 million) exceeds the total fees paid to pharmacies by the State in the year (€397 million).

6. Existing Contractual Arrangements and Understandings

The "*terms of any existing contractual arrangements*" are the terms of the Community Pharmacy Contractor Agreement and the rates and fees set under it (i.e. the pre-FEMPI rates).

The following are the key points in relation to the understanding of pharmacy contractors:

1. The Taoiseach, Leo Varadkar TD, when he was Minister for Health, committed to commencing the unwinding of FEMPI for pharmacists but no unwinding ever occurred.

2. In 2016, the Department committed to the IPU that pharmacy remuneration would be increased by €2.5 million per annum. This remains unfulfilled, notwithstanding the funds having been identified to us by the Department of Health in December 2018 as still being "in the base", i.e. available for disbursement.

3. The 2016 review carried out by the Department of Health under the FEMPI Act concluded with a recommendation to the Minister that changes to remuneration structures for community pharmacy contractors must be linked to Government priorities for the health service which, in the case of community pharmacy, included areas such as probity, piloting of a minor ailment service, vaccination, expansion of interchangeable medicine use and reference pricing, and electronic interface with the HSE PCRS. The IPU and community pharmacists have delivered on all of these.

4. The understanding of pharmacy contractors arising from this and a variety of other statements from the Minister for Health, Simon Harris, and indeed other cabinet members, is that there would be a significant immediate unwinding of FEMPI. For example, in a meeting with the IPU in March this year, the Minister for Health clearly acknowledged the cuts that had been introduced to address the financial crisis and the resulting financial pain felt by pharmacists and expressed his intention to move pharmacy fees beyond FEMPI to a higher terrain.

5. Additionally, in his keynote address to the IPU National Pharmacy Conference in May this year, the Minister made a clear commitment to start discussions on a new pharmacy contract, on moving beyond FEMPI and on a programme of investment. He again acknowledged the cuts that had been introduced to address the financial crisis and the effects on the sector and reiterated his intention to move beyond FEMPI to a higher terrain.

Pharmacists, therefore, have a very clear understanding from the Government that fee cuts implemented under FEMPI would be unwound. It is understood by pharmacists that in unwinding FEMPI in its application to public servants, or to a specific class of health professionals, both the negotiation process and any actions taken in this regard must be applied equally to all others impacted by the now-repealed legislation. There must be parity of application and of process, and the unwinding must of course be fair, equitable and proportionate to each profession in terms of the cuts suffered by each.

However, despite the Minister's stated view that the IPU "has been a really constructive partner on Sláintecare and in coming up with ideas; it has also been an extraordinarily good partner on Brexit preparedness", pharmacists continue to bear a burden of austerity that has been lifted from other groups. It is inconsistent and unjustifiable to commence the unwinding of FEMPI for one contractor profession but not another.

The IPU and community pharmacists have delivered on all of their commitments and obligations but now, instead of the promised reversal of cuts to pharmacies' payments, the Department proposes to cut pharmacy fees even further.

7. Pharmacy Sector Contribution to Healthcare Reform

It has been acknowledged by the HSE that for a number of years the IPU has worked on a reform agenda in a productive and collaborative manner with the HSE PCRS and the Department of Health and has cooperated with new obligations for pharmacists. In the context of consistently falling pharmacy revenues and ongoing cuts to pharmacy fees, as well as a steadily increasing regulatory and administrative burden, pharmacists have delivered on a number of key initiatives which have brought benefit to the HSE while the effort and costs have been borne by pharmacists. We have facilitated new validation arrangements for the phased dispensing of prescribed medicines, which ensure greater probity and financial transparency to account for State spending. Pharmacists have also taken on the task of ensuring all GMS prescriptions are signed for at the point of collection. With over 58 million items dispensed on almost 20 million GMS prescriptions each year, this is a massive and time-consuming addition to the administrative workload of each community pharmacist, simply to satisfy PCRS demands for increased accountability – without reciprocation.

The ever-increasing administrative burden upon pharmacists also includes tasks such as confirming patient eligibility at the point of dispensing; implementing generic substitution and reference pricing; collecting and reconciling GMS prescription levies; implementation of the High Tech Ordering and Management Hub and the High Tech medicines stock take and audit; compliance with the complex hardship scheme, DOAC, fampridine and Versatis® application and approval processes, and other similar initiatives. Lastly, the IPU has engaged with the HSE PCRS and jointly developed a specification known as the PCRS-Pharmacy Interface Project (PPIP) which, among other benefits, would provide the PCRS with additional transparency on pharmacy reimbursement claims.

In the face of massive cuts to their incomes, pharmacies have delivered excellent value for money to the State and a high quality, safe and valued service to the public and have introduced innovative services such as vaccination and emergency hormonal contraception. Yet, the Department proposes to cut pharmacists' fees when every other profession has had or is having their FEMPI cuts unwound.

More Services – the untapped potential of community pharmacy

In September 2017, the Department undertook a public consultation as part of a review of health service capacity to the year 2030, which took into account factors such as current utilisation, unmet demand, demographic and non-demographic factors and future policy. This exercise aimed to quantify the scale of the shortfall of healthcare professionals given the projected requirements of the the ESRI study "Projections of Demand for Healthcare in Ireland 2015-2030" (Figure 10).

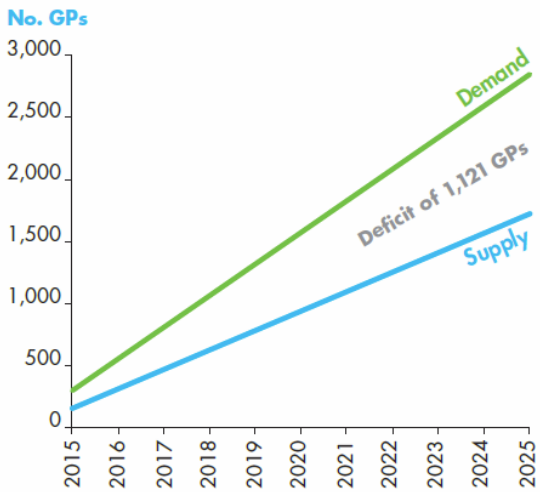


Figure 11: Deficit of GPs (Source: HSE, Medical Workforce Planning: Future Demand for GPs, 2015-2025)

Successive Governments have accepted that a radical change is needed in our approach to healthcare, with greater collaboration amongst a multi-disciplinary team of healthcare professionals, and the vast majority of care being delivered in the community. The Programme for Government committed to a decisive shift of the health service to primary care with the delivery of enhanced primary care in every community. If these policies are to be implemented, primary care will require significant expansion in the coming years. According to the OECD Health Data report, Ireland ranks among the lowest for GP numbers per population with only 5 GPs for every 10,000 people. Strain on GP services is increasing, largely caused by demand increases following the expansion of access to free GP care and capacity constraints within the profession caused by a changing GP workforce demographic.

A solution to this system-wide demand growth and constrained supply lies in the underutilised network of Irish community pharmacies. The network of 1,870 community pharmacies, each with its own consultation area, provides an unparalleled opportunity to meet Ireland's future healthcare demands within existing healthcare capacity and infrastructure. Pharmacists are highly trained, strictly regulated healthcare professionals who are trusted by the Irish public and have demonstrated success in providing new services such as the flu vaccination and other initiatives. They are experts in medicines, the most common healthcare intervention throughout the health system. The IPU has repeatedly sought to expand the range of services available under the State schemes and has made numerous submissions and proposals aligned with the Government's health service reform agenda (Table 12). However, there has been limited engagement by the HSE or the Department.

Table 12: Examples of Proposals submitted by IPU

Date	Subject of Proposal
December 2016	Proposal for expansion of pharmacy vaccination services to include additional vaccines
January 2017	Proposal for pharmacist-provided flu vaccination in Nursing Homes
April 2017	Expansion of vaccination service
May 2017	HPV vaccination in pharmacies in exceptional circumstances to improve uptake
July 2017	Offer to provide the existing ISO-certified SNOMED-compliant IPU Product File for use as a National Medicinal Product Catalogue on a non-commercial basis
July 2017	Proposal to allow GMS patients access smoking cessation services (counselling and nicotine replacement) from pharmacists
July 2017	Proposal to allow eligible patients receive pneumococcal vaccination in pharmacies
September 2017	Submission to consultation on Health Service Capacity, outlining the potential to utilise pharmacists' skills and pharmacy consultation rooms to deliver a greater range of primary healthcare services
September 2017	Submission to consultation on National Biosimilar Policy, which identified potential savings of €370m over three years
December 2017	Report on New Medicine Service (NMS) pilot study in which number of patients achieving optimal adherence levels increased from 68% to 77%
May 2018	Proposal to improve access to contraception

There is an as yet unfulfilled commitment in the Programme for Government to expand the role of the community pharmacist. The Sláintecare Action Plan 2019 sets out the first steps in a ten-year plan to deliver health and social care services with a focus on providing the right care, in the right place, at the right time in a way that is efficient, effective and sustainable. By expanding the services that pharmacists provide, many of the healthcare needs of patients can be addressed in the existing facilities and infrastructure already in place in pharmacies across the country. Modest investment in pharmacy-based services would free up crucial capacity in GP surgeries and achieve cost efficient treatment across the continuum of care.

It is worth considering where the pharmacy profession is today in Canada compared to ten years ago. From renewing prescriptions and delivering vaccinations to providing medication management services and prescribing for minor ailments and conditions, pharmacists in Canada are now playing an increasingly important role in the delivery of convenient, accessible and cost-effective primary healthcare.

Figure 9: Canadian Pharmacists' Scope of Practice 2005-2016 (Ref. Canadian Pharmacists Association)

Pharmacies in Canada have become highly accessible community health hubs with innovative services, including a growing range of wellness programmes and chronic disease management services. While the scope authorised to pharmacists varies by province, the trend is clear: increasingly, the Canadian government and its citizens are experiencing the added value pharmacies can bring to a sustainable healthcare system.

In Ireland, potential enhancements of the pharmacy service would include:

1. Improving equality of access to care;
2. Treating public patients for common ailments with Over the Counter medication;
3. Supporting better use of medicines for those newly starting a medicine for a long-term condition;
4. Supporting people with long-term conditions such as cardiovascular disease or asthma;
5. Improving the public's health through helping to deliver screening programmes as part of a national health promotion strategy;
6. Provision of smoking cessation services.

The report, *Future Pharmacy Practice in Ireland – Meeting Patients' Needs*, published by the PSI in November 2016, outlined the potential role of pharmacy practice in patient care. As part of the development of the report, PwC looked at the potential cost avoidance that could be realised with the introduction of two community pharmacy services. The services examined in the PSI report were New Medicine Service (NMS) for asthma patients and Medicine Use Review (MUR) for patients with five medicines or more in a nursing home setting.

The NMS involves a structured introduction to asthma medicine regime via three structured consultations with the pharmacist in the first three weeks of the regime. Based on UK experience and the findings of a pilot study carried out in Ireland, it was found that this would deliver an estimated €2.3 million net saving (after the cost of conducting the structured interventions) over a five-year period. An NHS evaluation of the service found that patients benefited by increased adherence, better disease control, fewer hospitalisations and improved mortality rates.

MUR is an annual multidisciplinary pharmacist-led structured medicine use review to identify and reduce inappropriate prescribing and limit associated potential adverse drug events. For every €1.00 spent on MURs, it has been estimated that €4.30 could be saved, with an estimated €2.74 million savings potential, due to a reduction in inappropriate prescribing and adverse drug events and resulting in potential reduced hospitalisations.

A Minor Ailment Scheme (MAS) allows medical card holders to treatments for non-serious conditions from a pharmacist without needing to attend their GP for a GMS prescription. Pharmacists have always managed minor ailments and self-limiting conditions for private patients attending the pharmacy and have the required knowledge and skillset to enable safe supply of treatment and advice. A study carried out by the Royal College of General Practice in London found that 18% of a GP's workload is spent dealing with minor ailments. A recent evaluation of the Scottish Minor Ailment Service found that 90% of participants rated the overall service $^{10}/_{10}$ for satisfaction and 60% of those who used the service said they would have gone to their GP if they could not have accessed this service at their community pharmacy. A British Journal of General Practice review[6] concluded that low re-consultation rates and high symptom resolution rates suggest that minor ailments are dealt with appropriately by pharmacies, that MAS consultations are less expensive than consultations with GPs, and that MAS provide a suitable alternative to general practice consultations.

Analysis of anonymised data from over 1,300 pharmacies by Health Market Research Ireland found that almost 950,000 GP consultations take place each year which result in a prescription for a medicine which is available without prescription. A roll-out of the Minor Ailment Scheme would alleviate under-pressure GP services by avoiding unnecessary consultations.

The IPU commissioned PwC to investigate the benefits that community pharmacy can deliver to patients and to the wider health system in Ireland, and to provide costed proposals in this regard. Outlined overleaf are summaries of five proposed services which could be implemented in Irish pharmacies.

[6] Br J Gen Pract 2013; DOI: 10.3399/bjgp13X669194

Table 13: IPU Pharmacy-based primary healthcare service proposals (PwC)

	Summary of proposed service	*Patient benefits of service*	*Health system benefits*
1. Health Promotion and Awareness	Pharmacists would provide structured health promotion and awareness campaigns e.g. a smoking cessation services available for both private and public patients.	• Patients 10-25% more likely to stop smoking. • Ensures greater capacity and utilisation of GP time. • Equitable access to healthcare for public and private patients.	35,780 GP hours saved per year. Significant long term savings due to reduction of smoking related illness.
2. Minor Ailment Scheme	Public patients would have direct access to medicines to treat minor ailments, as private patients currently do. Patients with minor ailments would consult a community pharmacist for and where necessary, be prescribed appropriate medicine. Patients would pay the standard €2.00 levy, without the need for a GP consultation.	• The public patient gains equal access to medicines for minor ailments as private patients • Public patients are no longer required to make and wait for GP appointments, saving up to five hours of wait time each time medicine is needed.	An estimated 947,806 GP consultations are saved throughout the health system as well as significant unnecessary ED attendances. Substantial GP capacity can be freed up – almost 100 GP WTE.
3.New Medicine Service	The service would involve a structured introduction to new medicine regimes for chronic diseases over two consultations with the pharmacist in the first two weeks of the regime at a cost of €30 per patient. System-wide cost estimated at €741,150 per year. Non-adherence is addressed through a collaborative approach between the pharmacist, the GP and other healthcare professionals.	• An increase likelihood of adherence to all medication regimes and thus better disease control. • Improved quality of life, and longer life expectancy. • Decreased adverse events and hospitalisations. • Reduction of medicines wastage.	Substantially reduced health costs over the lifetime of the patient due to improved adherence, decreased adverse events and fewer hospitalisations. Further cost savings as a result of identifying ineffective prescribed medicines and reducing medicine wastage. Gross savings of €1.24m per year and long term savings of up to €50 million
4. Chronic Disease Management	A pharmacist led blood pressure (BP) management service. The service is initiated by a GP and involves six visits over a 12 month period. The pharmacist assesses the patient; counsels on CV risk; monitors BP; reviews medication and adjusts dosage where necessary. This process is conducted in conjunction with the prescribing GP.	Decrease risk of hospitalisation and increased control of illness due to increased contact with a healthcare professional.	Avoidance of an estimated 71,600 cardiovascular events in Ireland over a 30 year period.
5. INR Testing	System wide drug cost reduction is achieved by supporting and managing new patients using warfarin, rather than a reliance on high cost NOACs. Patients prescribed warfarin would attend a clinic in their local pharmacy for testing and monitoring rather than in a hospital outpatient setting.	• Large, immediate cost reduction of patients being on Warfarin compared to NOACs. • Less invasive than venous blood test. • Limits any increased burden on already overcrowded hospitals. • Convenient and flexible access to testing in pharmacy.	An estimated net saving of €1.08 million per year for each new cohort of patients.

The Minister stated at the IPU Conference in May 2017 that the Future Pharmacy Practice report was “a key document for yourselves and for State policy. We are very keen, as I have said on more than one occasion, to expand community pharmacy services to our patients, particularly with the challenges we are facing, such as an aging population, the need for earlier hospital discharge and the increasing range of community-delivered treatment”.

At the IPU Conference in May 2019, the Minister said: “Expansion of community pharmacy services is an important part of primary care provision built around the foundation of your function as medicine experts.”

There is a very clear rationale for funding enhanced pharmacy-based services, based on successful international and domestic implementation of these services which have demonstrated benefits in terms of patient outcomes, reduced total care costs and, crucially, the additional capacity which can be released in more complex healthcare settings such as General Practice and Emergency Departments. Instead, the Department proposes to cut fees. When the Department was seeking to expand services and schemes delivered by GPs, did it start this process by cutting GP fees for existing services?

8. General Nature of Expenses and Commitments

Reimbursement Shortfalls

The HSE reimburses pharmacies for many medicines at less than the cost pharmacies pay: currently, the reimbursement rate is at 91.8% of invoice cost for most medicines and 95.2% on fridge medicines. There are now only two full-line pharmaceutical wholesalers remaining in Ireland. Typically, a pharmacy will have a preferred wholesaler and a secondary wholesaler, where the former generally offers a discount on the invoice price, bringing it to the level of the reimbursement price, while the latter does not. However, neither wholesaler carries all medicines, nor provides a discount on fridge medicines. This calls into question the sustainability of pharmacies supplying fridge medicines (e.g. insulin). In addition, due to the implementation of stringent pricing policies by both full-line wholesalers, neither now offers any discount on the first €2,000 of monthly purchases and thus both charge pharmacists 9% above the reimbursement price on at least €24,000 of purchases per year, such that each pharmacy is effectively subsidising the HSE to the tune of thousands of euro annually.

The impact of arrangements on the price of medications for the State (e.g. generic substitution levels and reference pricing)

An analysis by Health Market Research Ireland (hmR), using anonymised dispensing data from over 1,300 pharmacies, calculated that generic substitution by pharmacies has resulted in savings of over €1.145 billion since the introduction of reference pricing in 2013 (as against the originator pre-reference price). Generic penetration has risen from 17% to 40% in the period 2013-2019. This is driven by pharmacists engaging with affected patients on an individual basis, providing relevant information on generic medicines and personal reassurance to alleviate concerns. There is a cost to pharmacies in staff time and training, as well as IT developments to support the process – none of this was funded by HSE. In some other jurisdictions, such as Italy, a higher margin is paid for generic medicines, to reward the choice of the cheaper medicine (40.71% vs. 23.71% for brand).

Expenses

The costs incurred by pharmacies to deliver their services have risen very substantially. The largest single cost borne by community pharmacies relates to wages and salaries. Upward pressure on staff costs has increased as a result of rising activity levels and wage growth in the economy.

To attract and retain staff, community pharmacies have to compete with public salaries and other terms of employment. Average pharmacy expenditure on wages/salaries rose from €278,148 per pharmacy in 2015 to €290,860 in 2018, an increase of €12,712, with Irish labour costs increasing by a further 2.9% in the latest year according to the National Competitiveness Council in April 2019. As revenues continue to fall, rising employment costs account for a greater proportion of a pharmacy's turnover base. In 2012, the average pharmacy spent 16.6% of turnover on wages and salaries; by 2018, this had increased to 20.7%. Altogether, since 2015, there has been an increase in annual wage cost across the pharmacy sector of €39.5 million.

Property costs and other overheads have also continued to increase year-on-year. After the cost of labour, the most significant drivers of business costs are increasing rents, very high

insurance costs (including professional indemnity insurance) and heavy regulatory, registration and waste disposal costs. The National Competitiveness Council reported that the prices Irish businesses pay for services were increasing at the fourth fastest rate in the EU. For example, insurance costs for a typical Irish pharmacy have risen by over 90% since 2010, from €2,700 to €5,200, imposing an additional €4.7 million annual cost increase on the sector.

Waste charges for disposal of medicines, which require special collection and disposal services, are expensive. In terms of waste costs, the landfill charges have increased from €93 per tonne in 2010 to €113 in 2014 because of the increase in the landfill levy. Irish landfill costs are amongst the most expensive among the benchmarked countries/regions. The importance of thermal treatment (incineration) is growing in Ireland. Thermal treatment costs (gate fees) in Ireland are amongst the most expensive (€100+ per tonne) in the benchmarked countries/regions.

Excluding other business costs, which have also risen, increases in the pharmacy sector's annual payroll, regulatory and insurance costs alone amount to €69.9 million per year. A significant increase in funding is therefore urgently required to ensure the survival of the sector.

Compliance Costs

The IPU recognises the importance of effective and transparent regulation. However, the cost of complying with new regulations and guidelines has increased significantly in recent years and includes, for example, ongoing regulation costs, the cost of providing new consultation areas and, in general, compliance with the Pharmacy Act 2007 and regulations made under the Act as well as all other legislative requirements.

In their 2012 report, *A Review and Audit of Licences across Key Sectors of the Irish Economy*, Forfás, policy advisory board for enterprise, trade, science, technology and innovation, made the following recommendation 18:

> *Licensing authorities and bodies need to examine and seek to reduce licence fees in the sectors where the fees are considered to be most onerous. Fees in this category include the annual registration fees for pharmacies, Court Fees for Special Exemption Orders, Private Security Authority Licence fees and Table and Chairs Licence fee.*

Despite this, the cost of registration with the PSI remains out of line with international comparisons. The annual pharmacist registration fee is €380 (€540 on first registration) and each pharmacy must pay €2,135 per year to register (€3,325 on first registration). In the UK, the equivalent fees are £250 for a pharmacist (£356 on first registration) and £590 for a pharmacy premises (£831 on first registration).

Community pharmacists have fulfilled their obligations under the Falsified Medicines Directive (FMD) and the Delegated Regulation on Safety Features, with the IPU playing a key role in the establishment of the Irish Medicines Verification Organisation (IMVO) which is overseeing the implementation of medicines authentication. This has brought significant upfront and ongoing cost implications for pharmacists, necessitating the installation of additional software and scanners in pharmacies and a considerable investment in staff

training on the legislation and its implementation, as well as the ongoing resource and process implications of compliance with the Regulation. EY Economic Advisory Services conducted an analysis of the cost of complying with the Directive. The EY study, which has previously been shared with the Department of Health, found that the technology and training costs in an average pharmacy amount to €1,300 and that the inspection and scanning time costs amount to some €12,380 per pharmacy, equating to a total sector cost of €25.7 million in the first year.

The amount of time pharmacy owners spend on administrative tasks is increasing annually, with over three quarters (77%) of respondents to a recent IPU survey stating that new regulations and guidance issued by the Pharmaceutical Society of Ireland are overburdening their businesses. A study carried out by Tonic Consulting in 2017 found that the average annual cost of complying with pharmacy-specific legislation and with regulatory requirements was €20,088 per pharmacy. This includes completion of the mandatory PSI Pharmacy Self-Assessment and the time taken to complete all the regular tasks examined therein, and the provision and maintenance of equipment required by the PSI to be held, regardless of whether it is needed in practice. This equates to a regulatory compliance cost of €37.5m for the pharmacy sector and does not include the time taken to audit payments from the PCRS, which costs on average an additional €3,368 per pharmacy or €6.3m for the sector.

Present Challenges

As outlined above, pharmacies face excessive and increasing State-imposed legislative and regulatory costs. There are mandatory CPD requirements, ePortfolio reviews, pharmacy practice reviews, significant medicine waste charges and the recent increase in the minimum wage. All of this involves further increased costs on pharmacists. Tonic Consultancy estimated that pharmacies already spend an average of €4,250 on pharmacy-specific training each year. Pharmacists have now had a model of CPD and practice assessment imposed which is supposedly modelled on the system which applies in Ontario. One key difference is that in Ontario the regulator carries the full cost of participation in the practice assessments, whereas in Ireland the pharmacist must pay the cost of travel to the assessment venue in Dublin, and pharmacy owners carry the cost of having to provide alternative pharmacist cover to facilitate the process.

The perception of a career in community pharmacy among young pharmacists is deteriorating rapidly. This arises from the standard of HSE administration, the constant rule changes, the restrictions on reimbursement and their impact on patients, and the increased levels of regulation, inspection, audit, validation and administration. When combined with regular evening and weekend working, it is no surprise that there is now a shortage of pharmacy professionals (in addition to the shortage of GPs, nurses, occupational therapists and other health professionals).

It must be borne in mind that community pharmacy must compete with HSE pay rates and conditions, which are improving as a result of FEMPI unwinding; this combined with the attractiveness of permanent and pensionable posts means there is an emerging difficulty attracting full time and locum pharmacists and technicians. Further cuts to pharmacy fees will necessitate a reduction in employee rates of pay and this crisis will be exacerbated.

9. Obligation on the State to have a Prudent Fiscal Policy

In 2009, the Irish economy and its financial system were in a very difficult place. That year, gross domestic product (GDP) contracted by 5.6% and gross national product (GNP) contracted by 8%. Ireland's international reputation and, consequently, the ability of the Government to borrow at realistic borrowing costs were under serious pressure.

However, the economic crisis is long over and, having come through a very difficult period, the Irish economy continues to perform strongly in 2019. World Bank data shows that Irish Gross Domestic Product (GDP) expanded by 59% between 2009 and 2018 with the official data suggesting that GDP expanded by 8.2% in 2018 alone. This comprised growth of 3% in personal consumption expenditure; investment increased by 9.8%; and exports of goods and services expanded by 8.9%. The majority of Irish economic indicators have continued to evolve in a positive manner although consumer caution is still evident mainly due to the uncertainty around Brexit.

The medium-term forecasts for the economy are also projected to be strong. Between 2018 and 2022, real GDP growth is forecast to average 4.7% per annum and real GNP growth is forecast to average 4.3%. Employment is projected to reach 2.389 million by 2021 and the unemployment rate is projected to average 5.4% over the next three years.

The Exchequer finances continue to improve on the back of tax revenue buoyancy, reflecting the ongoing solid growth in the economy. Government revenues in Ireland increased to €16.541 billion in the second quarter of 2019 from €14.164 billion in the first quarter, having reached an all-time high of €19.214 billion in the fourth quarter of 2018. Following the strong economic and fiscal recovery, the Government budgetary position moved into surplus in 2018, a year ahead of forecast, while non-capital health spending was restored, reaching €16.287 billion. For the remainder of 2019, domestic activity is expected to remain quite vibrant. Although Brexit uncertainty and global economic uncertainties may take some toll, the economy is projected to expand by up to 4% in underlying terms in 2019.

There has been a monumental change in the finances of the State and the state of the economy, the disastrous state of which were of course the underlying rationale and justification for the cuts in the first instance. To impose further cuts is unfair and unreasonable, inequitable and disproportionate and will have a detrimental impact on the pharmacy sector into the future.

10. Equity of Treatment - Fairness and Reasonableness

Pharmacists are now the only major contractor group to have had no fee restoration since the FEMPI cuts.

The Lansdowne Road Agreement (2016-2018) was the first negotiated agreement which partially restored public sector pay and pensions following cuts made under FEMPI. The cost of this agreement was estimated by DPER at €844 million. The Public Service Stability Agreement (2018-2020) extends the terms of the Lansdowne Road Agreement. At a cost of €877 million, it will see pay restoration of between 6.2% and 7.4% for public servants (with up to 10% for new entrants), ensuring that by 2020 more than 90% of all public servants will be completely out of FEMPI pay provisions.

In May of this year, the Department of Health announced that the Government has agreed to a 40% (€210 million) increase in investment in General Practice over four years, with GPs to receive their restoration of FEMPI in four stages. The first increase of 20% in capitation fees paid to GPs for each of their GMS patients became effective on 1 July 2019, with further phased increases committed for 1 January 2020, 2021 and 2022. An additional planned €80m investment for chronic disease management was also reported.

Even without this fee restoration, fees paid to GPs have risen each year since 2014 and overall GP fees and average fees per GP are both higher than they were before the FEMPI cuts of 2009. In 2009, GPs were paid a total of €499.67m, an average of €187,634 to each of the 2,663 contracted GPs. By 2018, that had increased to €565.41m, giving each of the 2,914 contracted GPs an average payment of €193,567 (Table 14).

Meanwhile, fees to community pharmacy contractors have remained significantly below those paid before FEMPI was introduced. This is an unjustifiable and inequitable difference in treatment between two essential, highly qualified and under-pressure health professions.

Table 14: Fees paid to GPs 2009-2018 (ref. PCRS Annual Reports)

Year	GP Fees € m	GP Allowances € m	**Total GP Payments € m**	Year on Year %	Change on 2009	**Number of GPs**	Change on 2009	**Fees & Allowances per GP**	Change on 2009
2009	357.80	141.87	**499.67**			**2,663**		**€187,634**	
2010	348.13	145.70	**493.83**	-1.2%	-1.2%	**2,740**	2.9%	**€180,230**	-3.9%
2011	342.93	126.43	**469.36**	-5.2%	-6.1%	**2,758**	3.6%	**€170,181**	-9.3%
2012	351.09	132.05	**483.14**	2.9%	-3.3%	**2,832**	6.3%	**€170,600**	-9.1%
2013	343.41	136.26	**479.67**	-0.7%	-4.0%	**2,888**	8.4%	**€166,091**	-11.5%
2014	320.27	132.98	**453.25**	-5.8%	-9.3%	**2,870**	7.8%	**€157,927**	-15.8%
2015	348.03	141.66	**489.69**	7.4%	-2.0%	**2,889**	8.5%	**€169,502**	-9.7%
2016	394.80	148.33	**543.13**	9.8%	8.7%	**2,914**	9.4%	**€186,386**	-0.7%
2017	398.91	152.66	**551.57**	1.5%	10.4%	**2,928**	10.0%	**€188,378**	0.4%
2018	411.75	153.66	**565.41**	2.4%	13.2%	**2,921**	9.7%	**€193,567**	3.2%

Despite the Minister's stated view that the IPU "has been a really constructive partner on Sláintecare and in coming up with ideas; it has also been an extraordinarily good partner on Brexit preparedness", pharmacists continue to bear a burden of austerity that has been lifted from other groups. It is inconsistent and unjustifiable to commence the unwinding of FEMPI for one contractor profession but not another. To propose yet further cuts beggars belief.

11. Conclusion

The State has extracted disproportionate savings from pharmacies over many years, leading to a decade of decline for the sector. Pharmacies have delivered substantial productivity and efficiency gains, under a growing regulatory and administrative burden and in the face of increased demand and greatly reduced fees.

Overall fees to pharmacies and per-item dispensing fees have fallen significantly in both absolute terms and as a share of health spending, while activity and output have increased substantially since 2009. Average per item dispensing fees have fallen by 18.5% and average annual dispensing fees paid per pharmacy have fallen by 19.3%. Average pharmacy medicine prices have fallen by 36.6% and the overall pharmacy medicines bill has fallen 27.8%, despite an increase of 14.3% in items dispensed. At the same time, the High Tech medicines bill, over which pharmacists have no control and from which pharmacies do not benefit, has ballooned by 148%, consuming all of the savings delivered by the pharmacy sector.

Table 15: Productivity and Efficiency Increases in Community Pharmacy 2009-2018

	2009	2018	Change 2009-2018	
Government Non-Capital Health Spending (m)	14,431	16,287	+ 1,856	+ 12.9%
Prescription items (excl. High Tech) (000s)	67,826	77,546	+ 972	+ 14.3%
Medical Cards (000s)	1,479	1,565	+ 86	+ 5.8%
Total Pharmacy Fees (€m)	420.96	398.56	–22.40	–5.3%
% of Health Spending	2.92%	2.45%	–47 bps	–16.1%
Average Fee per Item Dispensed (€)	6.00	4.89	–1.11	–18.5%
Average Total Remuneration per Pharmacy (€)	258,258	213,134	–45,124	–17.5%

Behaviour and Attitudes research found that public trust in pharmacists is at 96%, that 86% rate value for money in the pharmacy sector as good or very good, and that there is a strong public appetite for a more extensive range of healthcare services to be provided through pharmacies. Pharmaceutical Society of Ireland research found that the public wants services such as health screening, minor ailment scheme, new medicine service, medicine use review and warfarin monitoring clinics provided in pharmacies. In their Future Pharmacy Practice report, the PSI identified additional services which, if provided by pharmacies, would improve patients' health outcomes and save on long term healthcare costs. The IPU has submitted numerous detailed costed proposals for service expansion aligned with Government health policy, the aims of Sláintecare, and public demand for enhanced access to healthcare and optimise patients' outcomes, without any real engagement on implementation.

EY Economic Advisory Services analysis found that pharmacies in areas of greatest social and healthcare need have lower revenues and operate on the thinnest margins; these pharmacies have the least resources to subsidise healthcare services and are the most vulnerable, and therefore need additional supports. Any viable and realistic reimbursement model must provide a sustainable dispensing fee across all schemes, with appropriate professional and administrative allowances to cover State-imposed costs and supports for marginal pharmacies in disadvantaged, rural or outlying communities. Where a pharmacy is located

impacts its profitability and, unless pharmacy fees are increased, a significant number of non-urban pharmacies will ultimately close.

The IPU has participated fully and constructively in all statutory consultation processes and has worked collaboratively with the Department of Health and the HSE in developing patient services and in improving financial accountability and probity. Despite this significant ongoing cooperation by the IPU and community pharmacists on initiatives which are of no direct material benefit to pharmacists or their patients but which meet the requirements of the HSE and the Department of Health to ensure that public funds and resources are managed to good effect, there continues to be an unexplained and unjustifiable failure to implement the long-overdue and previously committed unwinding of the reductions in payments to community pharmacy contractors which were implemented during a time of financial crisis.

A statutory review of payments to community pharmacy contractors carried out in February 2016 under section 9(13) of the FEMPI Act concluded with a recommendation that changes to remuneration structures for community pharmacy contractors must be linked to Government priorities for the health service which, in the case of community pharmacy, were identified as probity, piloting of a minor ailment service, vaccination, expansion of interchangeable medicine use and reference pricing, and electronic interface with the HSE PCRS – all areas in which the IPU and its members have already cooperated and delivered.

The Taoiseach, Leo Varadkar TD, when he was Minister for Health, committed to commencing the unwinding of FEMPI for pharmacists but no unwinding ever occurred. Public sector pay is being restored to pre-crisis levels and GPs have received increased funding while their contract negotiations are continuing. In that context, it would be unfair, disproportionate, inconsistent, irrational and inequitable for the Minister not to reverse the savage cuts that were imposed upon community pharmacy contractors at a time of financial crisis and still remain in place.

For the Department to propose further cuts to fees is entirely unjustified and will damage the excellent accessibility and patient service delivered by pharmacies, lead to a decrease in the range of services available to patients and make pharmacy unsustainable in large parts of Ireland, creating yet another crisis in the Irish health sector.

The IPU expects the Government to honour previous commitments and, in recognition of the contribution community pharmacy contractors have made to achieving significant savings for the State during and since the financial crisis, commence the unwinding of FEMPI by **immediately releasing the €10m owed to pharmacists** (€2.5 million per annum for the years 2016-2019) **and increasing all fees by 19.2% from 1 January 2020.** Such an increase is urgently needed to restore funding for pharmacy services to a level which will meet the ever-increasing costs of providing the existing service, ensure the sustainability of community pharmacy and allow pharmacists to deliver on their commitment to ongoing service development and reform.

This fee increase should lead into a more detailed engagement process on broader reform of the pharmacy contract and improving patient outcomes through the development of accessible, high quality, cost effective pharmacy services.

Appendix 1

Description	Current Fee	Proposed Fee
Dispensing fees payable under the GMS Scheme, DPS, LTI, EEA and HAA Schemes:		
For the first 1,667 items per month	€5.00	€5.96
For the next 833 items per month	€4.50	€5.36
For each other item dispensed per month	€3.50	€4.17
Other Amounts Payable on GMS Scheme:		
Phased Dispensing Fee	€3.27	€3.90
Non-Dispensing Fee	€3.27	€3.90
Extemporaneous Preparation of Oral Medication	€6.53	€7.78
Extemporaneous Dispensing and Compounding of:		
- Powder	€19.60	€23.36
- Ointment or Cream	€13.07	€15.58
Extemporaneous Fees - DPS, LTI, EEA and HAA Schemes:		
Eye Drops	€13.68	€16.31
Ear & Nasal Drops	€10.93	€13.03
Lotions		
- Up to 100ml	€10.89	€12.98
- 101ml to 200ml	€15.24	€18.17
- 201ml to 300ml	€17.12	€20.41
- 301ml to 500ml	€22.74	€27.11
Mixtures		
- Up to 100ml	€10.94	€13.04
- 101ml to 200ml	€14.97	€17.84
- 201ml to 300ml	€17.04	€20.31
- 301ml to 500ml	€22.53	€26.86
Ointments & Creams		
- Up to 90g	€13.76	€16.40
- 31g to 60g	€18.64	€22.22
- 61g to 120g	€23.97	€28.57
- 121g to 240g	€28.90	€34.45
- 241g & over	€34.27	€40.85
Powder		
- Up to 20 sachets	€20.44	€24.36
- Thereafter per 20 sachets pro rata	€12.26	€14.61

High Tech Medicines Scheme Fees:		
Patient Care Fee per month	€62.03	€73.94
Patient Care Fee (High Tech Meds not dispensed)	€31.02	€36.98
Description	**Current Fee**	**Proposed Fee**
Opioid Substitution Treatment Scheme Fees:		
Patient Care Fee (Higher)	€60.49	€72.10
Patient Care Fee (Lower)	€52.07	€62.07
Opioid Standard Dispensing Fee	€3.60	€4.29
M.D.A. Fee	€5.60	€6.68
Emergency Hormonal Contraception:		
79996 EHC Consultation (product supplied)	€11.50	€13.71
79997 EHC Consultation (product not supplied)	€11.50	€13.71
Influenza Vaccination:		
Supply and Administration of Influenza Vaccination	€15.00	€17.88