The 2014 Pharminterkom meeting was held on the South Island of New Zealand at Milbrook Golf Estate, a stunning venue in Queenstown. The surroundings were really beautiful and featured snow-capped mountains with glacier water filling the rivers and lakes. The meeting was attended by the seven English-speaking countries, namely Australia, New Zealand, the USA, Canada, England, Ireland and South Africa. South Africa was represented by Kobus le Roux and Jan du Toit. Many influential role players in pharmacy attended as representatives of their countries. It was a three-day formal meeting, but there was time for informal discussions with delegates and to share information on various projects.

The group has become like a family of pharmacists. Many representatives brought their families with them. As this was my third Pharminterkom meeting, I now know some of the members well, and they still talk about the bush experience that they had when the meeting was held in South Africa.

The topics discussed related to the practice of pharmacy and organisational matters, such as marketing the profession to members, as were retail issues and financial models.

There were many commonalities between the countries, and we were able to learn from one another. Country reports were circulated before the meeting, but only critical points were highlighted during the meeting. This was also an opportunity to benchmark your country against others. Statistical reports were prepared by the Pharmacy Guild of Australia, based on information provided by the participating members.

Communicating with members and providing them with information was a priority shared by members. We are on the right track with the modernisation and simplification of the PSSA membership management system which will facilitate communication with members, including CPS members.

An important issue was the need for a data-collection tool for Pharminterkom. It was agreed that participating countries will contribute to the establishment of a platform in order for a data-collection tool to be developed.

**Payment for pharmaceutical services**

Many governments and funders are willing to pay for services and consultations provided by pharmacists. The funding model is vastly different from country to country. Health care is predominantly government funded in most countries. Patients present at their local pharmacy, using a contracted price per medication. The contract is fixed for a term of five years and then renegotiated. Most if not all the governments have budgetary constraints and are under pressure to meet the healthcare needs of their countries. South Africa is the only country to have a diverse system of payers with several pharmacy benefit managers (PBMs) and medical insurers.

In South Africa, we need a programme that promotes the services provided by pharmacists. We also need a clinic programme for the service model that is envisaged for the future. Australia is willing to share its Pharmacy Guild Link programme with us. Member organisations are now approaching politicians and people in government to ensure that these models are implemented.

The expansion of community pharmacy is hampered by medical insurers and PBMs in many countries. Canada is currently drafting a document on health which will address payment issues in the future. Canadian medical insurers pay in full for certain services provided by pharmacists.

The dilemma of generic margins being driven down, and increased volumes and workloads in the pharmacy are also being addressed.

**Adding value to patients**

The UK has started with medicine reviews, and the evaluation is distributed to Dropbox on the Internet so that it can be accessed by other healthcare providers with the patients’ permission. There is a web-based referral system for patients who are discharged from hospital and then monitored by their pharmacist.

Ireland has a system where daily patient interventions are recorded on a clinical platform and regular weekly meetings are held with doctors. This system could be very useful for South Africa.

Health has become a political issue in all countries. Politicians do not recognise the value of pharmacists.

**Supply chain and reimbursement models**

Wholesalers receive a percentage payment for distribution and give a portion of this to pharmacies in most countries. Full-line wholesalers also provide other services, like financing and financial training, to pharmacists.
E-health

In Australia, the prescription issued by the doctor is stored via cloud computing, and may be accessed with the patient's permission via a barcode provided to the pharmacist. This is called an electronic health record. In some countries, the doctors' records and laboratory tests are also accessible, but issues with liability and confidentiality need to be resolved.

Organisational development

Most associations have developed tools to be used to communicate with their members and to give advice, continuing professional development (CPD) and training. Ireland has also developed a data-collection tool that is web based. The association owns the data, which is sold off for the benefit of its members.

Many countries provide CPD with online clinical models on various topics, such as diabetes and cardiovascular conditions.

In the USA, communication with members poses a challenge, and surprisingly, they have found that the best results are achieved through use of the facsimile.

Key points to be taken from Pharmintercom 2014

Key points to be taken from Pharmintercom 2014 are:

- The impact of decisions taken by government, PBM and medical insurers on the profession must be monitored, and if possible, informed
- Relationships at all levels are of utmost importance
- Leadership must be created in our organisation
- Innovation and improved functioning is needed, as is the involvement of members. Data collection is essential with regard to evidence of what pharmacists do
- Pharmaceutical care must be promoted
- Strategic alliances must be formed
- Financial issues and models are still a burning issue.

The flags of the countries around the table were different, but the issues were the same. The natural momentum in health care around the world is in favour of pharmacy, and members must take advantage of this opportunity by developing financial models, data models, consumer campaigns, patient-service models and by establishing long-term compensation models to secure the growth of pharmacy. It was agreed that Pharminterkom is an international support group for pharmacy and must be harnessed and utilised as such.

Visit to community pharmacies

Queenstown

Jan and I had the opportunity of visiting a community pharmacy in Queenstown, and were very impressed. Their community pharmacy functions like a hospital pharmacy, but with very good patient interaction and pharmaceutical care. Their clinic provides different services, including international normalised ratio, blood pressure, glucose and diabetic services, as well as compounding.

We also visited a brand new pharmacy in the town, which is run on a slightly different model, and with more of a focus on natural products. There is an automated dispensing unit with a revolving dispensary from which the products are collected. This only works if the stock is fairly stable, and the number of generics is limited to a fixed amount.

Singapore

Pharmacy in Singapore is very different to our system in South Africa. Hospital groups carry out most of the dispensing, and patients only fill the odd prescription from community pharmacies.

There are three categories of medicine in the pharmacy. The first category comprises general sales items, or over-the-counter medicine, which includes herbal and natural medicine. Secondly, pharmacy-only medicine may be sold under the supervision of the pharmacist, like our schedule 2 medicines. Thirdly, prescription-only medicine requires a script from the doctor. There is also an export category that enables tourists to buy scheduled medicine from pharmacies which they can take home. Many of the visitors do most of their shopping in Singapore, including medication, as some medicines are not always available in their home countries.

Most community pharmacies belong to one of the chains, i.e. the Guardian, Watson and Unity pharmacy groups. The independent pharmacy is very small in Singapore. The dispensaries are very small in the pharmacies, but there is an extensive front shop which stocks a large number of commodities.

I met a past president of the PSSA, who organised a visit to a Watson pharmacy. They use a very practical computer programme that is Windows® based. The system accommodates sales to a patient in a profile that is very useful for pharmaceutical care. Some features of this programme would be very useful for South Africa because data from the clinic could easily be incorporated into the system. Because it is Windows® based, it is easy to access information, when needed.

Pharmacies in Singapore also make extensive use of pharmacy assistants because there is a shortage of pharmacists in Singapore. Their CPD system requires pharmacists to attend CPD events and record learning outcomes.

Thank you

I would like to thank members for allowing Jan and I the opportunity of attending these meetings and learning from other pharmacists. It was a great learning experience, and it was very useful to make contacts which we can use in the future.