THE ROLE OF THE PHARMACIST IN THE PERSONALISED CARE OF PATIENTS :
CHALLENGES, RESPONSIBILITIES AND OPPORTUNITIES.
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EXECUTIVE SUMMARY

I Review of context

Ensuring the quality, effectiveness, accessibility and safety of the medicines prescribed and the pharmaceutical care dispensed, on the one hand, and on the other, enhancing the economic efficiency of pharmacotherapy, constitute the traditional central pillars of the role and function of the pharmacist.

The challenges linked to the changes in the population pyramid involve taking account of new prospects for the pharmacist's profession. The challenges linked to developments and applications in the information and communication society also prefigure significant modifications to the paradigm of the pharmacist's profession that has prevailed up until now.

To this end, modes of preparation, dispensation and administration of pharmaceutical care, as well as funding the application of personalised care, are crucial.
If questions relating to quality, budgets, economics, and practical matters are being highlighted, innovative solutions for personalised pharmaceutical care, combined with conclusive results and measurable improvements, are the subject of numerous initiatives in the interest of many players : patients, care-givers, doctors, pharmacists, the pharmaceutical industry, and the payers.

On the basis of this, UEPS (The European Union of Social Pharmacies) considers this an opportune moment to (re)visit the positioning and development of the roles and functions of the pharmacist in European pharmacies, amongst others, in terms of monitoring patients' adherence and persistence, in brief, compliance with pharmaceutical treatments and prevention of risks of complication.
This includes the fact that the pharmacist is expected, within a multidisciplinary and interdisciplinary context, to contribute to the detection and prevention of risks, and to make an early intervention with a view to minimising risk, especially with regard to polymedicated or chronic patients.

Current initiatives in this direction are focused on, for example, the field of vaccination (flu, shingles, pneumococcus, travel vaccinations), the care of drug users (collecting needles, methadone treatment), the pharmaceutical monitoring of patients suffering from chronic illnesses (asthma, diabetes, migraine, arterial hypertension (AHT)), and the pharmaceutical monitoring of polymedicated or chronic patients.
In this respect, the detection of AHT in the pharmacy, biological tests for blood sugar, cholesterol, and body mass index (BMI) also contribute to meeting the objective sought by **personalised pharmaceutical care, that is to say detecting problems and guiding the patient towards definitive solutions for complex problems**.

II The role of the pharmacist in the personalised care of patients : what does this involve ?

As with all the fields and questions dealt with during previous General Meetings of UEPS, the subject may once more appear to be technical. However, in fact, **this subject recalls all the major debates** surrounding the pharmacist's profession for the past quarter-century.

1° The definition of the pharmacist's profession and his role within the healthcare system.

In a changing market, it is clear that the **future position of the pharmacist** lies in a context of **multidisciplinary and interdisciplinary collaboration**.
The question arises, therefore, of the **relationship with, principally, prescribers**, the demarcation of each person's profession, and the collaboration between the various healthcare professionals.
Thus, **formularies and alternative practices** are two sensitive subjects, if ever there were, but a good level of communication and collaboration are the essential conditions for a pragmatic application in the interests of the patient.
In Belgium, the VIDIS project constitutes an **example of the future development of connected interdisciplinarity.** Within an innovative context of medico-pharmaceutical collaboration (MPC), the evaluation of current medicines in connection with the **medication regimen (eSdM = e-medication plan) and the prescribed treatment plan** will be possible.

2° Relationship with payers.

This medication plan, the pharmaceutical history, **the evaluation of the medication (medication review),** should be the rule for the **objectivation**, **measurement** and **traceability** of the **added value** of pharmaceutical care, in accordance with **pharmaco-economic procedures for measuring efficiency that are yet to be devised**.
It involves service activities provided by the pharmacist to patients that are very time-consuming, and in the absence of the incentive of compensation, economic and financial, there will be no motivation for the pharmacist.
It is unthinkable that the patient should bear the entire cost of this, or that the pharmacist should take it on.

3° Relationship with the pharmaceutical industry, production and presentation of medicines.

The appropriateness of commercial presentations, prescriptions and dispensing to the dosage and duration of a patient's treatment constitutes a significant dimension of the personalised care of the patient. Such a level of appropriateness leads to a prudent, objective and verifiable application of the pharmacotherapy, on the one hand at the time of dispensing provided for in the eSdM, and, on the other, during pharmaceutical monitoring of the correct use of medicines. Dispensing and pricing by unit of dosage are therefore the rule, for example, in the USA.

4° Relationship with the patient

The line of change in **pharmacist/patient/prescriber relationships** is deviating from the line of prefabricated boxes of medicines and is following that of **medicines that are available at the moment they are taken, accompanied by a medication plan**. The pharmacist must start with a **digital treatment plan** drawn up by the prescriber. In collaboration with the various prescribers, the pharmacist translates this treatment plan into dispensing, administration and invoicing plans.

The patient must be informed, educated and made aware in this sense, so he no should longer see the pharmacist as simply a **dispenser of products**, but also as an **adviser,** offering a range of **pharmaceutical care services, who is available throughout the treatment period to ensure the correct use of the medicine once dispensed**.

III Aspects of quality, effectiveness, safety.

Adherence and persistence (*compliance*) determine the effectiveness of a treatment and are all the more certain when the medicine is administered to the patient at the planned time, in accordance with the prescribed treatment plan, on the basis of **medicines available at the moment of being taken, accompanied by an analogue or digital eSdM**.

Two other arguments in terms of quality argue in this way for an eSdM and an historical pharmaceutical dossier, based at the patient's standard pharmacy and shared between disciplines :

- Minimisation of **risk** of error ;
- Advanced pharmaceutical monitoring, in particular by the detection of incompatibilities, contra-indications, duplicate medicines, and interactions between drugs sometimes prescribed by more than one doctor.

IV Budgetary and financial aspects

Should the method used to finance these **activities - dispensing, monitoring, and personalised patient care** by the pharmacist - be **disconnected** from the **pharmacist's purchase price** for the product and/or the **quantity of commercial packaging of pharmaceutical items being dispensed ?**

On the other hand, should this **funding method** be linked to the quantity of care, pharmaceutical monitoring and dosage unit or defined daily doses (DDD) dispensed to a patient for a given period ?
For example, in the Netherlands we may observe a **first pillar of flat-rate charges (Capitation)** for each patient and for each defined period.
A **second pillar of economic margin** linked to the units or DDD dispensed (quality: type of molecule ; quantity : number of DDD or dosage units). This pillar **takes account of the increase in operating costs due to the quality-related changes brought about by pharmaceutical care.**

This capitation fee covers the intellectual act of dispensing, and may, furthermore, be complemented by a **third pillar** linked to the additional services dispensed to the patient.
The prospect must be that the funding method covers the charges for dispensing the products and services mentioned above.

The economic aspects are linked to the rational use of medicines, which it is the pharmacist's role to promote. Thus, the saving must be shared with the pharmacist and the patient : incentives must be provided.

We must begin to rationalise the range of medicines dispensed to patients. This aim of this rationalisation is that doctors issue prescriptions within the framework of a pharmaco-therapeutic form drawn up using International Nonproprietary Names (INN) in Defined Daily Doses (DDD). The pharmacist is responsible for dispensing the medicine that is available within his range at the fairest price for the patient.