

Pharmacists will have to transform themselves into pharmacotherapists

This year's European Society of Clinical Pharmacy spring conference took place in Edinburgh. Tom Moberly reports

The challenge for pharmacists over the next 20 years will be to transform themselves into pharmacotherapists, Bill Scott, Scotland's chief pharmaceutical officer, believes.

Pharmaceutical care is, he stressed, not about medicines and not about medicines management. "It is about the provision of direct care to patients by pharmacists, using a systematic approach to practice where we seek to promote those actions which maximise the benefits of the medicine and eliminate problems in order to achieve optimal outcome," he said. Unless pharmacists are all focused on that they will not achieve equality of care for patients, he argued.

In bringing equality for patients to pharmaceutical care, there needs to be strong leadership to help plan strategies to improve the use of pharmaceutical skills, and divisions

between services will also need to be eroded, he said. Services also need to be based on need and community pharmacy contracts need to be based on clinical practice, quality and on maximising pharmacist prescribing, he added.

"It is important that we have integrated services, that we are not in silos — hospital versus community versus public health," he said.

"Most importantly, we must have, in our clinical care, a systematic approach to practice" he added. "This is not about dispensing, this is about the clinical care of patients and the contribution pharmacists make and, most importantly, those 1,100 community pharmacies [in Scotland] — they are a tremendous resource and that is where the majority of the patients experience pharmaceutical care."



Bill Scott: pharmaceutical care is about provision of direct care to patients

Significant proportion of pharmacists set to become prescribers

A significant proportion of pharmacists in Scotland will practise as independent prescribers in both community pharmacy and primary care, said Fiona Reid, who runs pharmacist-led clinics for patients with cardiovascular disease in general practices in Lothian.

Of the pharmacists currently working in Scotland, 17 per cent have trained or are in training as supplementary prescribers, with about 4 per cent currently practising, mainly in primary care, she said. "This number is likely to increase exponentially over the next few years as all our undergraduates will be trained to this level as of this summer," she added.

Independent prescribers in Scotland started training when the courses became available in March this year. "This will have a positive impact on the numbers of pharmacists prescribing in hospital, because supplementary prescribing is not ideally suited to this setting because of the acute and multifactorial nature of patients' [conditions]," Ms Reid added.

Community pharmacists can play a crucial role in early dementia

Community pharmacists can play an important role in identifying and providing information to patients early in the course of dementia, according to Gabriel Gold, chief of services in the department of rehabilitation and geriatrics at the University Hospitals of Geneva, Switzerland.

Early in the course of dementia, people often direct questions to close friends, family or informal contacts, he said. "One of the people they might be contacting would be their pharmacist," he said. That contact would often occur before anyone concerned about their memory would contact their GP, he added. "I think an understanding of that situation and of the need for evaluation is important," he said.

Later in the course of treatment, people will need treatment for their dementia and for any other conditions they have, the treatment of which will become more complicated if they have dementia, he said.

"There's room for a lot of interaction [with pharmacists], both when it comes to the choice of medication and the rhythms of prescriptions and to whether they are being taken correctly or incorrectly," he added.

Sube Banerjee, professor of mental health and ageing health services research at King's College London, also backed a role for com-

munity pharmacists in helping concerned patients find help early in the course of dementia.

"There's a [large] market in people seeking out all sorts of magic chemicals to help their memories, and a significant proportion of those people will have problems with dementia," he said. "If someone is buying ginkgo for themselves then one has to ask why."

He added: "If you were choosing just one question that might help you determine whether a person has a problem with their memory, it is 'Do you have a problem with your memory?'. If people come in and say 'I've got a problem with my memory — what should I take for it?', maybe the answer is 'Yes you can take the ginkgo, but maybe also you need to go to see your GP or go to the memory clinic,' because those things need to be sorted out."

Community pharmacists might also be able to spot early signs of dementia in patients, he said. One of the problems resulting from dementia is that it prevents patients complying with their medicines. So, he added, if patients are having problems with their medicines, one for the reasons for that might be dementia, so that is something community pharmacists need to look out for.

The European Society of Clinical Pharmacy's 7th Spring Conference on Clinical Pharmacy took place in Edinburgh from 16 to 19 May.

No medicine is ever inherently not cost effective

Medicines are only ever deemed to be not cost-effective because of the price charged for them, Andrew Walker of the Scottish Medicines Consortium insisted.

Professor Walker explained how the SMC assessed the clinical- and cost-effectiveness of new medicines, and the common problems with applications from pharmaceutical companies. "Sometimes the cost per QALY [quality-adjusted life year] is simply too high, often reflecting the fact that the company has set the price too high," he said. "No medicine is inherently not cost effective — it's only not cost-effective at the price the company chooses to charge."

Another problem is that the comparator is often carefully selected by the company and does not always reflect standard practice in Scotland, he said.

"The easiest thing to do if you have a new medicine which isn't very cost effective is to compare it against something that's even less cost effective, and then, by comparison, it looks good. So you have to be very careful with what it's being compared to."

Problems also arise from optimistic assumptions, failures to use QALYs and poor-quality indirect comparisons. The SMC's use of indirect comparisons is borne out of necessity, he explained. "There really isn't an alternative, because if we just rejected everything because it didn't have a comparison with what is current practice in Scotland, we'd reject quite a lot of medicines." However, companies sometimes submit applications in which one or two studies have been carefully selected from the literature to make the best case, he said.

Although manufacturers did sometimes submit applications with such problems, using this model has some advantages, he emphasised. "The really useful thing we find is it places the onus on the manufacturer. So we say to the manufacturer: 'You must prove to us that this is cost effective — that it's effective and cost effective, and if you can't do that, then we will say no.'"

He added: "Sometimes we have situations where a medicine has got a licence, so there seems to be an assumption that it must be used unless there is a good reason not to. This changes the thinking a bit and says



Andrew Walker: sometimes medicines prices are simply too high

"There is no previous assumption. We will only use what you can prove, from an evidence base, is good value for money."

Consistent approaches needed for new medicines

Health care systems need to develop consistent approaches to incorporating new medicines into patient care, Nils Wilking, an oncologist at the Karolinska Institute in Stockholm, Sweden, believes.

There needs to be recognition, he said, that, although the pharmaceutical industry is good at developing drugs, it is up to health care systems to develop new therapies. The health systems themselves need to integrate a new drug into the clinical practice, to see how valuable it is, and what added value it has as an addition to current treatment processes.

In addition, common views on the usefulness of new medicines need to be developed, he added. "It cannot be that a drug is considered effective in Scotland and not considered effective somewhere else in the UK or that there are huge differences across the European Union. That means that some who are using it should not be and that some that are not using it should be using it. There needs to be consensus, otherwise, from a patient point of view, it will cause confusion."

The review times for marketing authorisations need to be capped at a low level and assessments could be based on a hybrid model, he suggested. The Scottish Medicines Consortium could be taken as a model which would allow for conditional approval from a clinical point of view. A fuller evaluation on the same level as those carried out by the National Institute for Health and Clinical Excellence could then be conducted, a few years after the medicine had been launched.

Such a system would need to have appropriate funding, he said. It would also have to consider cost-effectiveness from a long-term perspective, he added, accounting for the fact that a drug is often launched for one indication and then is approved for wider indications.

Speaking in the same session, Andrew Walker, of the Scottish Medicines Consortium, said that, although he could see the potential benefits of having Europe-wide cost-effectiveness analyses, he believed that there were also problems with such an arrangement.

"We don't have the same current practice in all EU countries, so we have to compare the new medicine with current practice and that sometimes isn't even the same across Scotland, never mind across Europe," he said.

Another issue was, he said, the different levels of pricing across various national health care systems, which would mean that a drug could be affordable for rich countries, but if it were approved in other countries it would leave almost no funds for any other treatments.

In addition, local clinicians and patients may believe that decisions are being imposed upon them and they may not agree with those judgements, he said. "We have our own doctors on committees, so that when they go back to see the patients they know why the decision has come about," he said. "If it was a committee in Brussels or Paris or Germany, they would think 'Why have they made this decision?' but if they were actually on the committee, they would understand, so they



Nils Wilking: health care systems must develop new therapies

are more likely to put it into practice. So I understand the arguments for it, but I think there are factors against as well."

Professor Wilking replied that, although he recognised the importance of some local aspects of cost-effectiveness evaluations of medicines, he believed that some of the technical aspects of appraisals could be conducted at a supra-national or European level, in order to achieve cost savings and avoid duplicating efforts.