The Pharmacist Activist
Volume 19, No. 1 • January 2024

"Therefore, since we are surrounded by such a great cloud of witnesses, let us throw off everything that hinders and the sin that so easily entangles, and let us run with perseverance the race marked out for us." Hebrews 12:1

Editorial

How can Pharmacy Move Forward?

During the 18 years in which I have published *The Pharmacist Activist* my editorials have focused primarily on the problems and challenges facing our profession and, to a lesser extent, my recommendations as to how we can best address them. I consider the following to be the most important problems/challenges for which our profession must take action to move forward:

1. The dominant role that pharmacy benefit managers (PBMs) and health insurance companies have seized in making drug therapy decisions, and the nonnegotiable policies and abysmal compensation provided to pharmacies dispensing medications.

2. The understaffed, stressful, and error-prone workplace conditions in many chain pharmacies, and the significant decline in the number of patient-centered independent pharmacies which have historically provided the experience and motivation that have resulted in many young people choosing to pursue a career in pharmacy.

3. The failure of the profession of pharmacy to more effectively respond to the challenges that are the most important determinants of the future of pharmacy.

Although many pharmacists would agree that these challenges are very important, "solutions" and even credible and achievable recommendations have been elusive. Multiple options and combinations thereof must be identified and implemented.

PBMs

We can be encouraged that the Federal Trade Commission is investigating the anticompetitive and secretive programs and actions of the PBMs, and by the class-action lawsuits by pharmacists against several of the largest PBMs, the increased awareness and concerns on the part of legislators and other decision makers about the deceptive and abusive programs of the PBMs, and the increased activism of the National Community Pharmacists Association and the American Pharmacists Association in addressing the destructive impact of the PBMs on the scope and quality of pharmacists' services for patients and the financial survival of community pharmacies. However, benefits from these initiatives will likely take many years to accomplish, and the ability of the PBMs to legally or otherwise exploit loopholes or circumvent new laws or restrictions must not be underestimated. Individual pharmacists, including those with responsibilities not directly impacted by problems in community pharmacy practice, must be members and active participants in the pharmacy

Visit www.pharmacistactivist.com for a FREE subscription

associations that are advocates for our profession, and hold the leadership of these associations accountable to their membership.

Even if some of the above actions are successful, they may be too few and too late, and must be supplemented with additional strategies. Pharmacy and our associations do not come close to matching the financial resources of the PBMs and the influence those resources can buy. However, our profession does have tens of thousands of pharmacists who have the potential (but which is not yet activated) to locally and personally communicate with legislators, community leaders, and the corporate executives and union leaders who make the decisions regarding the prescription benefit programs to be provided for their employees/members.

Our profession and associations should construct a "model" prescription benefit program, document its value through pilot research studies with selected employers and government agencies, and to organize and mobilize pharmacists to publicize and promote the benefits and value of the model program in their communities. Pharmaceutical companies that develop and acquire approval for marketing their medications are among the victims of PBMs to which they provide large rebates in an adversarial working relationship. They should be natural allies (but are not at the present time) of community pharmacists in assuring optimal therapeutic outcomes with their medications. The pharmacy associations should request and expect collaboration of the pharmaceutical manufacturers in establishing and utilizing a model prescription benefit program for their thousands of employees with the expectation that there will be synergistic benefits that will also be recognized by other employers, government agencies, and communities.

The three largest PBMs, CVS Caremark, Express Scripts, and OptumRx "manage" about 80% of the prescriptions dispensed in community and mail-order pharmacies. The myth they perpetuate that they reduce the costs of drugs by negotiating rebates must be exposed and rejected. Employers and government agencies that utilize these PBMs must insist on full transparency of the financial and policy provisions of the contracts. Approximately five years ago the Auditor General in my state of Pennsylvania recognized the deception and lack of transparency on the part of the large PBMs which managed the prescription programs for numerous state and municipal employees, as well as the plans for many other employers in the state. He requested information regarding the financial and policy terms of the contracts of the prescription programs for state employees, but he was denied access to this information and was not supported by the state Attorney General at that time who is now the Governor. This situation is outrageous and must not be tolerated. It is insulting not only to the government officials and agencies that presumably have a right to know this information, but also to the citizens of the state whose taxes provide substantial financing for the prescription programs, but who are at risk of being victims of the programs that preclude the provision of counseling and other services pharmacists can provide that avoid harmful outcomes.

There are some smaller PBMs which administer prescription benefits transparently and equitably and also facilitate the provision of services that are of value for patients, pharmacists, and their communities. The experiences and collaboration of PBMs that have been successful in providing medications in a patient-centered and cost-effective manner should be utilized in the establishment of a model program.

Individual pharmacists should initiate and maintain communication with local elected, civic, and business leaders to urge their collaboration in addressing the egregious PBM programs that place patients at risk and result in closures of local pharmacies.

Community pharmacies

The financial pressures encountered in the operation of an independent pharmacy have resulted in the closures of many and the sale of others to large chains. Even the large chains with their economies of scale and abandonment of pharmacist communication with and services for patients are experiencing financial challenges. Rite Aid has filed for bankruptcy and is closing about 500 of its approximately 2000 stores during its reorganization. CVS and Walgreens have each announced that they will be closing hundreds of their stores. There are an increasing number of pharmacy deserts, primarily in rural areas and in inner cities, that have resulted in tens of thousands individuals having difficulty and inconvenience in

obtaining medications on a timely basis.

With isolated exceptions, our profession has not been successful in efforts to obtain equitable compensation for the application of our drug therapy expertise and the provision of patient counseling and related services. The abysmal compensation provided for the product (i.e., prescription medications) by those who have seized financial control of the drug distribution system makes the current community pharmacy system unsustainable. The public interest is best served by having continued access to community pharmacies, but pharmacists and our profession must be innovative in establishing professional and entrepreneurial practice models that integrate the provision of both medications and services. The following are identified as examples for consideration:

Concierge appointment-based practice that does not participate in prescription benefit programs, and for which patients pay membership fees plus the cost of medications; This practice model has been implemented successfully by some physicians and a small number of pharmacists. Although this strategy further widens the gap in access to medications and services between those who can afford to participate and those who can't, it provides a viable alternative in selected situations that will provide medication-related services for participants who otherwise may not have access to such in the current system.

Practice that is limited to the provision of medications that are available in less costly generic formulations: This practice model will reduce/avoid inventory of expensive medications that are still patent-protected, and can preclude the participation in prescription benefit programs. Many costly medications are already not available in local community pharmacies because of restricted distribution systems implemented by pharmaceutical companies and specialty pharmacies.

Compounding practices: The concept that "one size (dosage) doesn't fit all" is well understood and can be effectively promoted with the message that both the selection of medications and the best dosage should be personalized. Many compounding pharmacists have successfully extended their practices to include veterinary medications and services.

Medical equipment, supplies, and services: These products and the expertise/guidance in using them are often difficult to access, but represent a natural extension of a traditional pharmacy practice that provides medications.

Collaborative practice models: Many physicians, other prescribers, and practice groups that are not owned by health systems or investors are facing many of the same challenges that community pharmacists do. Collaborative working relationships will extend the scope of services provided and also the independence and strength of the practice model.

Self-care emphasis practice model: In addition to providing prescription medications and related services, pharmacists can establish their personal formulary (i.e., Pharmacist's Choice) of self-care and related products (e.g., nonprescription products, dietary supplements, natural products, nutrition products, cosmetics, complementary and alternative therapies) they can recommend and provide appropriate guidance for use. Consumers are often baffled in choosing among products that are not covered by insurance and they are personally purchasing, and the recommendations of pharmacists (who also have autonomy in determining the prices for these products) provide additional confidence in the benefits of the products and the value-added advice and services. The discontinuation of sale of oral phenylephrine-containing products and the recommendation of OTC/BTC (behind the counter) pseudoephedrine-containing products as a nasal decongestant provides a timely opportunity to provide such an emphasis as well as personal advice because of the BTC-only availability of pseudoephedrine.

Focused value-added healthcare products/services: There are numerous specialized/niche areas of health-related opportunities that would be value-added and financially-viable extensions of a traditional independent community pharmacy practice. These include, but are not limited to, immunization programs, travel medicine, diagnostic products, first-aid kits and medicine cabinet OTC products for which prompt access is beneficial, a hearing center, a vision center, and a skin-care center.

Health care navigator/referral services: Almost all consumers, as well as many health professionals, experience difficulty in understanding and choosing among very complex healthcare insurance programs and comparing their benefits, restrictions, and limitations. Although it may not involve the sale of a product, many individuals would be willing to pay for services provided by a pharmacist who would provide objective and trusted evaluations and recommendations regarding the available options.

The practice models identified above would be best implemented by pharmacists with the professional and entrepreneurial motivation to preserve and promote independent community pharmacy, for which I have been a strong advocate (please see the October 21, 2023 issue of *The Pharmacist Activist* and my editorial, "If Independent Pharmacies Do Not Survive, Our Profession Won't Either").

Some of the current challenges for community pharmacies are also being experienced by chain pharmacies. As CVS, Rite Aid, and Walgreens are closing hundreds of their stores, the pharmacists employed in those locations who are in a position to do so should explore purchasing the building, prescription files, and selected inventory of the store being closed. These pharmacists would have a head start toward establishment of a professional and profitable practice because they already know the community and some of the customers, the successes and failures of the operations now being abandoned by the parent company, and would be unencumbered by the inflexible corporate metrics and other policies promulgated by executives at remote company headquarters who do not care about the health of the customers but focus exclusively on the financial operations. Pharmacists who are currently or previously employed at the stores to be closed would need only a fraction of the space available to establish their own expanded pharmacy practice. The remaining space could be renovated and rented to individuals providing other health-care services or to businesses that would add attractiveness to the location as a shopping destination. If the chain that is closing the store is unable or unwilling to sell the location to its current pharmacists, these pharmacists should explore the purchase of a small property that is in as close proximity as possible to the store that is being closed.

The recent announcement by CVS that it will close dozens of its pharmacies in Target stores could also provide opportunities. I do not know the specifics of the agreement through which Target and CVS arranged for CVS to purchase or otherwise operate the pharmacies in Target stores. However, I can't imagine that Target is pleased with the announcement of closures by CVS. Pharmacists employed in these locations who are in a position to do so should approach Target management to explore favorable financial and operational terms that would permit them to purchase or be a franchisee who would independently manage the pharmacy. It is my understanding that CVS plans to close these stores between February and April, so it is important that these possibilities be explored quickly. If it is pharmacists rather than CVS management who are responsible for the operation of the pharmacy, I anticipate that the services of the pharmacy would be improved for the benefit of both the patients served and Target. The changes resulting from the exit of CVS could be sufficiently impressive that Target would terminate its working relationship with CVS in its other stores, and permit the pharmacists to purchase or operate the pharmacy as an independent franchisee.

In the next two issues of this newsletter I will provide my perspectives on the unionization of pharmacists and comment on what I consider to be the failures of the profession of pharmacy in responding to the important challenges identified.

Daniel A. Hussar
DanH@pharmacistactivist.com

Free Subscription
Go to www.pharmacistactivist.com
to sign-up for a FREE subscription.
The Pharmacist Activist will be provided FREE via e-mail to interested pharmacists and pharmacy students who request a complimentary subscription by signing-up online at:
www.pharmacistactivist.com

Author/Editor/Publisher – Daniel A. Hussar, Ph.D.
Dean Emeritus and Remington Professor Emeritus at
Philadelphia College of Pharmacy
Assistant Editor – Suzanne F. Hussar, B.Sc. (Pharmacy)

The Pharmacist Activist, 1 Boulder Creek Lane, Newtown Square, PA 19073
E-mail: info@pharmacistactivist.com

Distribution/Design Services provided by Jeff Zajac