

# Community pharmacists should make local authorities their new best friends

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**P**rimarily care policy and service development, with the focus on improved access and choice, and the shift from hospital to community are increasingly as much about where services are provided as they are about what services are provided. Community pharmacy has always prided itself on its high street location, which makes it easy for patients to reach. But there are forces at work that will drive changes in the location of pharmacies — and perhaps not all for the good.

## One-stop centres

Traditionally, the rule of thumb has been that pharmacies do well when they are close to GP surgeries. Perhaps this is one of the reasons why the Government is so focused on there being pharmacies in every one-stop primary care centre,<sup>1</sup> of which there will be 750 by 2008. As well as more altruistic goals, like convenience, the Government knows that it can subsidise the building of these centres by charging community pharmacy and other contractors premium rents for space in them. Early experience from NHS Local Improvement Finance Trust projects has seen one pharmacy contractor being played off against another by private sector partners and primary care trusts alike. This is despite local pharmaceutical committees and pharmacy owners being willing to talk about service models like consortia, which will enable the continuation of a pharmacy service on the high street alongside that in the one-stop centre.

Ironically, with the introduction of the new general medical services (GMS) and new pharmaceutical services (PhS) contracts, one-stop pharmacies may find themselves with little dispensing to do and thus unable to meet premium rents. A recent survey of PCTs in England<sup>2</sup> found that 80 per cent were already commissioning, planned or wanted to commission a community pharmacy-based minor ailments service. With estimates that up to 30 per cent of GP workload consists of minor ailments that could be treated under such schemes, and GPs keen to reassign this work to community pharmacy, if such schemes become widespread, one-stop centres will see significant falls in people presenting for treatment of acute self-limiting illnesses.

When repeat dispensing is in place as an essential service within PhS, this, too, will change the way people access the pharmacy service. Once they no longer need to visit the surgery to collect their prescription every month, people will choose to access a dispensing service in a place convenient to their home or work. Studies of repeat dispensing

confirm that under such schemes prescriptions migrate away from pharmacies close to surgeries. With 70 per cent of NHS prescriptions classed as repeats, and estimates that as many as 80 per cent of these could be dispensed under the new arrangements, a large proportion of current health centre pharmacy business may disappear overnight.

However, both these changes will take time to bed down, and developing a technology infrastructure that supports information exchange between pharmacies and general practice is an important prerequisite.

In the meantime, the inevitable freeing of control of entry is likely to destabilise the existing pharmacy network. The question is, who will be the winners and who the losers?

## Gaps in service and regeneration

A barely acknowledged fact is that despite the existing controls to entry, there are already pharmacy deserts within the UK. Often in areas of deprivation and rural areas, the local population does not have access to the pharmacy service they deserve because the business case for a pharmacy in their neighbourhood cannot be made. The essential pharmacy scheme has not plugged these gaps. In some areas, PCTs are exploring the use of local pharmaceutical services (LPS) pilots to support pharmacies that would otherwise be non-viable, and this is perhaps one of the most positive uses of LPS to date.

But there is another facet to this agenda that is yet to be fully explored by pharmacy and the NHS — the link with regeneration and neighbourhood renewal.

The Welsh pharmacy strategy consultation paper<sup>3</sup> was the first to make this important link. It quoted the Department of Health's own research, which shows that there are three essential businesses needed to make a business community flourish — a general practice, a pharmacy and a source of cash (usually a post office). If any one of these businesses closes, it will have an impact on the local business economy. Ironically, in its rush to relocate GPs to more central premises, the NHS may inadvertently be destabilising the local economy that is so important to public health in its broader context. "Tackling health inequalities: a plan for action"<sup>4</sup> acknowledges this and encourages the NHS to act as a good corporate citizen when planning its estate and service provision so as to support neighbourhood renewal.

But in neighbourhoods where there is no pharmacy — or the viability of an existing business is threatened due to a GP surgery

relocating to a new one-stop centre — there is a case to be made to both the NHS and the local authority for support to develop and sustain a successful pharmacy business on grounds of regeneration alone. The model pharmacies in Scotland, funded by generic primary care premises improvement budgets, signal what such pharmacies might look like and how they could contribute to health improvement and increase footfall for their retail neighbours. With suites of consulting rooms where visiting health and social care professionals can run outreach clinics, pharmacy-based provision of drug misuse services, alongside minor ailments and repeat dispensing schemes, these pharmacies would, in effect, become the general practice of old, allowing GPs to concentrate on a more challenging case mix.

Cracking this nut will require pharmacy to engage with new partners, most notably local government, but unlike its experience with primary care organisations, community pharmacy may find it is pushing at an open door. Local authorities understand the importance of the business side of pharmacy, and that, in its own way, the pharmacy as a business contributes to public health by providing employment and supporting other retailers. This, and local government's increasing engagement with the NHS agenda, bodes well for community pharmacy in the future.

## Conclusion

There is not a pharmacy organisation that does not see continuation of an extensive pharmacy network that provides access to all as an important feature of the service. There are a number of threats to that network in the current policy environment. The challenge in 2004 will be to look beyond these threats to the opportunity community pharmacy has to contribute to public health in its broader context, in partnership with both the NHS and a new and increasingly vocal ally in health matters — the local authority.

## References

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