

# Community pharmacy needs magical thinkers to help secure its future?

Health economist **Darrin L. Baines** argues that, without organisational reform and an injection of new thinking into how pharmacy services will be managed in future, pharmacists will fail to realise their potential in the new NHS, just as they have failed to do for the past 55 years

**A**ncedotal evidence from around England suggests that the economic incentives embodied in the new pharmacy contract are now beginning to take effect.<sup>1</sup> Some pharmacists have moved to larger premises, and others are squeezing consultation rooms into their existing sites. Similarly, training courses are being attended, IT systems introduced, and innovations in services planned.

Until the statistics are collected, the full extent of the changes afoot will be unknown. Nevertheless, it is clear that the contract contains incentives strong enough to promote the provision of essential and advanced services. Although commendable, services provided under these headings do not promote the Government's long-term aim of fully integrating pharmacy and other primary care services.<sup>2</sup>

To integrate community pharmacy fully into primary care, a range of reforms such as joint IT systems, shared premises, unified budgets, joint working and shared care plans may be necessary. From experience, it is unlikely that such reforms will be achieved through incentives alone, but they will require the physical reorganisation of local services. Consequently, community pharmacists may soon have to move beyond their short-term focus on new contract implementation, if the Government's longer-term objectives for the pharmacy profession are to be delivered.

To achieve this end, the management literature suggests that pharmacists may need help from individuals capable of effecting change in difficult situations, whom organisational theorists call "magicians".<sup>3</sup> Without the help of this magical breed of change agents, community pharmacists may remain outsiders in primary care, providing essential and enhanced services but still failing to be fully part of the NHS.

## Selection bias

The new contract is the first major reform to community pharmacy since the inception of the NHS. Although local pharmaceutical services and medicines management projects were launched with great fanfare at the beginning of this decade, their impact has been relatively insignificant.

If we look back in history, the situation facing community pharmacists today is simi-

lar to that which faced GPs before the introduction of fundholding in 1991.<sup>4</sup> At that time, GPs had not experienced any major reform of their working arrangements, apart from some minor tinkering with their original NHS contract. Although fundholding was abolished by the Labour government for political reasons, much was written about it before its disappearance during the late 1990s.

In the current context, one study from Lincolnshire is interesting because it suggests that a form of "selection bias" existed during the recruitment of fundholding practices during their annual "waves" of membership.<sup>5</sup> According to the study, practices that joined the scheme during the first three waves (referred to "early wave fundholders") differed in their characteristics from those that joined in later waves.

Compared with non-members of the scheme, early wave fundholders tended to be better organised, larger practices that were more able to meet Government targets for primary care. Later wave fundholders, on the other hand, tended to have younger patients, lower hospital referrals and more practice management resources.

## Implications

Because fundholding was prematurely abolished, the importance of the differences between fundholders and non-fundholders, and different fundholding waves, was never fully explored. However, the Lincolnshire study implies that there is likely to be a selection bias in terms of the types of pharmacies that provide services under the new contract and those that do not. For instance, the new contract will ensure that only pharmacies able to perform clinical governance, offer repeat dispensing and provide new services will stay in business. To add to this selection effect, we may see differences emerging between pharmacies under the new arrangements, similar to those we see today between multiples and independents.

Table 1 shows that, under the new arrangements "repeat dispensing-focused" (RDF) pharmacies may emerge, which are large and well organised, have sophisticated IT systems, and specialise in repeat dispensing, with the majority of work being done by technicians. On the other hand, smaller, less affluent pharmacies may become "patient service-focused" (PSF), specialising in providing services, using the pharmacist as their main asset.

Using a framework suggested by Rooke, RDF and PSF pharmacists could follow different business strategies because their world views differ, with the former believing that medicines are the future and the latter believing patient services to be the way ahead.<sup>6</sup> Because they see the market differently, RDF pharmacies are likely to believe that their larger, well-organised pharmacies should be used to gain more of the local repeat dispensing business. Smaller, PSF pharmacies, on the other hand, are likely to believe that local practices and their primary care trusts should support what they see as the valuable clinical work performed by their incumbent pharmacists.

## Limits to growth

Although RDF and PSF pharmacies may follow different development paths, both are likely to experience limits to their growth. For instance, RDFs may become frustrated at their inability to exert control over local prescribing patterns.

Once electronic transmission of prescriptions is rolled out nationally and repeat dispensing systems provide data on local prescribing behaviour, RDFs will have more information on their potential markets. In this situation, there will be increasing demands for better co-ordination and integration of repeat dispensing, and it may be eventually be viewed as a separate service just like community nursing or out-of-hours cover. Therefore, the move towards RDF pharmacies will create the need for the local reorganisations of pharmacy outlets to facilitate the growth of this new service.

In the longer-term, the incentives embodied in the new contract will not have the power required to achieve this end without the reorganisation of prescribing and dispensing within the NHS. To promote this outcome, the Government has already implied that, within the next three years, the new contract is likely to be replaced with locally negotiated contracts between PCTs and pharmacy providers.<sup>2</sup>

As repeat dispensing emerges as a potentially separate PCT-funded service, PSF pharmacies may find their dispensing income diminishing. In response, they may demand the reform of general practice and pharmacy funding, so that they receive payment for their skills at working with patients not dispensing drugs. In other words, a situation similar to that envisaged by Linda Strand's

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**Table 1: Two types of pharmacy after the new contract**

Pharmacy type	Characteristics	Activities	Future
Repeat dispensing focused	Large, well-organised, many technicians with pharmacy manager and good IT system	Primary focus on repeat dispensing; consultations a secondary activity	Grows larger as invests in repeat dispensing IT systems
Patient service focused	Pharmacy organised around pharmacist, with direct personal involvement in patient care decisions	Primary focus on patient services; dispensing necessary to attract patients	Growth limited by pharmacist's time; merger with local practice when dispensing volumes drop significantly

**Table 1: Two types of pharmacy after the new contract**

Manager type	Characteristics	Strengths	Weaknesses
Conventional	Follows normal operating procedures working in a stable environment	Good at delivering results in predictable situations	Lacks capability to deal with uncertainty, instability or the unknown
Magician	Deals with the unconventional, the unstable and the unknown	Seeks inclusion and mutuality by seeing different world views	Loses interest when situation becomes stable and loses magic in the longer term

version of pharmaceutical care will become apparent, with pharmacists losing their dispensing role in order to concentrate on patient services.<sup>7</sup>

Before these changes occur, PCTs and others may have to draw the logical conclusion that, to be truly effective, medicine review pharmacists must work in the same building as the rest of the primary care team. Since the new contract does not embody the incentives required to secure integration between doctors and pharmacists, PCTs may be forced to examine how and where they fund medicine reviews.

In response, NHS managers may eventually decide to devolve pharmaceutical care budgets to local practices, allowing them to decide when, where and how this type of service should be provided. However, this move will not happen automatically and will require a transition beyond the current stage of new contract implementation into an era of radical pharmaceutical service reform.

### Organisational reform

Fundholding tried to improve performance in general practice through better practice management and the correct use of economic incentives. Although successful in parts, the scheme was abolished because the Labour government realised that fundholding alone could not create the required improvements in cash-limited NHS services. As a result, primary care groups and, later, PCTs were launched in 1997, and major reforms of primary care were announced in the national plan in 2000.

Although this process of change seems inevitable in retrospect, the process of reforming general practice was sporadic and slow until 1989 when the Conservative government introduced family practitioner commit-

tees. This attempt to manage (rather than administer) general medical services was the catalyst for over 15 years of continual and radical reform, recently resulting in a new contract for family doctors.

If a similar path is followed in pharmacy, the next 15 years will be a period of rapid and ongoing transformation of the ways in which NHS pharmaceutical services are funded, organised and delivered. For instance, the Government has already signalled its long-term desire for PCTs separately to fund large, local dispensing factories that supply medicines at rates lower than the national dispensing fee.<sup>2</sup>

Similarly, the launch of pharmacist prescribing at a time when medicines management has achieved acceptance as a new model for pharmacy practice may result in new ideas for organising NHS medicine services.<sup>7</sup>

Although the need for organisational reforms may soon become apparent, NHS policy-makers, PCT managers and pharmacy leaders may also discover the complexities and the uncertainties that such transformations create. For instance, creating new dispensing factories could destabilise existing supplier networks, while integrating pharmacists into primary care will be a journey into the unknown. Consequently, community pharmacists may remain stuck at the current stage in their evolution unless they actively seek the unknown, the uncertain and the complex that accompanies widespread organisational reform.

### New vision

Given the instabilities and the uncertainties ahead, community pharmacists may need guidance from individuals able to effect change in such difficult situations, ie, the "magicians" referred to earlier.

As Table 2 shows, conventional managers who follow normal operating procedures often lack the capabilities required to take their organisations successfully through periods of unstable, unpredictable change — unlike the "magicians".

In the current context, it could be argued that most pharmacy managers are conventional because they follow standard procedures and work in stable environments, delivering predictable results. Magicians, on the other hand, have the ability to see situations differently, to create unforeseen solutions that steer organisations to success.

According to Rooke, these magical individuals have the ability for advanced "meaning-making", which means their "broad and fundamental capacity" to see "each person's world view or view-of-the-world-outside-of-me".<sup>6</sup> As our view of things is framed by one of many possible different meaning-making structures, magicians have the fundamental capacity to realise that our world views change if we look at things differently. Based upon this realisation, magicians can often solve problems by seeing situations afresh and can achieve success by considering the views of all participants during the decision-making process.

In relation to community pharmacy, it could be argued that the Government's vision document shows many of the characteristics of a magician at work because of its unorthodox plans for the future of pharmacy. As a result of the document's unconventional contents, pharmacists have largely ignored it, although its thinking clearly outlines the new direction for the profession.

### A warning

Given this situation, it can be concluded that pharmacy will only begin the process of organisational reform when conventional thinking is put aside, and magicians are allowed to reframe the way the profession sees the world. However, be warned! If magicians are blocked by traditional thinkers within the profession, community pharmacists may spend the next 55 years (just like the past 55) failing to realise their full potential within the NHS.

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