UNICHEM CONVENTION

Driver for ETP may be cost savings rather than patient convenience

Unichem's 2002 convention, attended by more than 340 participants, was held in Mauritius from 21 to 28 September. Our coverage this week includes contributions on electronic transfer of prescriptions and other developments in pharmacy services

Are pharmacists being manipulated into using some technologies for the sake of political agendas? That question was put to the convention by Ian Shepherd, group head of information and strategy, Royal Pharmaceutical Society.

He suggested that electronic transfer of prescriptions (ETP) is not about sharing information: the aim of the pilots is to replicate the existing prescription system in an electronic form. For ETP to be a vehicle towards electronic health records, common standards of nomenclature and structure of the information must be adhered to, he said. "There will a significant cost in ensuring that any pharmacy messaging is commensurate with technical standards applied elsewhere in the NHS. These are only just emerging and I forecast they will take some years before they can be universally adopted."

Much of the scope of the ETP projects was concerned with providing data for reimbursement and statistical analysis. "Providing the data in electronic format saves the enormous keying operation [at the Prescription Pricing Authority] — saving significant costs within the process." Perhaps this was the driver for change, he suggested.

Although the public might agree with the savings achieved through better management of medicine costs and reduced costs of calculating pharmacy reimbursement claims, as soon as they become patients the costs become less important to the individual. "[As patients] the public require quick access to the complete range of medicines, the choice by their prescriber of the most effective treatment for their condition."

Mr Shepherd pointed out that only two of the pilots offered patients freedom to choose their pharmacy up to the point of dispensing. The others required selection of the pharmacy before or as the prescription was written. "While it may be argued that the issue of patient registration with pharmacies is long overdue for resolution, it remains the stated objective of these pilots to replicate the existing system — which should surely include this element of free choice," he said.

Ian Shepherd: frustration for companies in ETP pilots

In addition, any change to the present system should not impact on the ability of patients to obtain quick access to medicines. "What happens if an electronic prescription arrives at the patient's choice of pharmacy and that pharmacy is either closed or is temporarily out of stock of an urgently required medicine," he asked.

Mr Shepherd suggested that this was why several of the pilots concentrated on repeat prescriptions, since it could be argued that these were not so time dependent. But this was not acceptable, again, because the pilots should completely replicate the present paper system. "The technological solution must not so fundamentally force change to the patient's behaviour," he said. And any systems that locked patients into a particular mechanism must be avoided until the full extent of the impact is known.

Mr Shepherd commented that repeat dispensing was the source of much frustration by companies involved in the ETP pilot systems. They all wanted to evaluate mechanisms to increase the ease with which patients were able to order and receive repeat medication. But to date this had been resisted by the project sponsors. The invitations to take part in medicines management pilots funded by the Department of Health had explicitly excluded bids employing ETP. The reasons behind this were unclear.

He added that opportunities to share information had so far been thwarted by requirements to keep the ETP pilots insular.

In an interactive debate, conference participants were asked what they believed was the main driver for the Government's enthusiasm for ETP. Most (72 per cent) thought it was to reduced cost. The integration of pharmacists into the primary health care team and patient convenience were cited by 12 per cent of participants as the reason behind the Government's enthusiasm.

Wholesalers' service level depends on customer loyalty

If independent pharmacists fail to support their main wholesaler by continuing to select the cheapest prices, thereby diluting the mix of business they give to it, wholesalers will have to reconsider the level of service they provide, warned Martyn Ward, UniChem's marketing director.

"We will at some point have to consider the options available to us to maintain our profitability. These could include such actions as reducing our service, not stocking the slowest selling products, not offering discount on the slowest selling products, or removing all added-value support". UniChem had no intention of carrying out any of these actions but its customers were urged to do more to support the company.

Recent developments within pharmacy, and pressures such as the generics review, the Office of Fair Trading enquiry into contract limitation and new contract negotiations, had evoked a reaction among independent pharmacists that Mr Ward found disappointing. "The overriding reaction has not been to improve the retailing skills, deliver added value via medicines management and local services, but to work tirelessly to save that extra two pence on a pack of fluoxetine."

He acknowledged that the business being transferred to short-line wholesalers was not UniChem's by right but warned that pharmacists would need to consider the consequences of taking the more profitable business away from full-line wholesalers.

The conference participants were probably some of the most compliant and supportive of UniChem's customers but only about 60 per cent of the available spend was given over to UniChem. If customers did not give UniChem enough business to warrant a twice-a-day service then it would have to reconsider its current service profile or implement minimum order values.

"What if you continue to demand retail support schemes from UniChem, utilise our expertise and support material, then purchase products from a different wholesaler? Well, quite simply, we will cease our marketing support and the results will be lower sales for everybody except the supermarkets who, I am sure, will welcome the additional spend with open arms."

Mr Ward concluded that it was up to UniChem to ensure that what it offered its customers was irresistible, but concluded that pharmacists must be supportive if both they and UniChem were to be successful in the future.

Development of pharmacy services obstructed by DoH

Within the Department of Health is an institutional scepticism about community pharmacy and a solid barrier of obstruction to developing pharmacy services, according to Barry Andrews, chairman of the Pharmaceutical Services Negotiating Committee. Positive and encouraging words from ministers are not being translated into positive and encouraging actions from officials.

Barry Andrews: offer of £50 a month is ludicrous

Mr Andrews told the UniChem convention that the Government estimated that repeat dispensing could save 2.7 million GP hours — a cost saving of more than £400m. The Department should work with the profession to develop a good repeat dispensing service, properly funded. The £50 per pharmacy per month that had been offered was unacceptable for any service and ludicrous when one considered the gains that could be delivered.

"What policy maker can possibly have even contemplated such a pitiful proposal? Only one who is so obsessed with minimising costs that he cannot accommodate the concept of fair reward and fair funding." By sharing a percentage of the savings achieved elsewhere within community pharmacy, the Government would produce disproportionately large returns.

Mr Andrews also pointed out that primary care centres or one-stop shops, perhaps meeting some perceived patient convenience on the occasion of a visit to the surgery, could damage fundamentally the network of pharmacies in the locality. "This is perverse. Far from building services around patients, which is the Government's stated objective, they would achieve precisely the opposite and build services around NHS centres."

Mr Andrews went on to explain that the basic service level suggested in the proposed two-tier pharmacy contract was very much a formalisation of the current service. "Many pharmacies will be fulfilling many of the criteria now. In my view, this basic level of service that will be demanded is not unreasonable in a fully funded service."

The second tier could include services such as:

- Regular reviews of patients' repeat medication
- appropriate consultation facilities (not necessarily private)
- premises that convey a professional appearance
- appropriate supplementary prescribing services
- verifiable audit and monitoring systems and ongoing quality reviews
- participation, which may be multidisciplinary, in audit and training, including clinical governance requirements for other services

Mr Andrews asked if these standards sounded intimidating. "How many pharmacies are doing some of these services right now? How many would like to, given the correct funding?"

The big question was whether the new roles would be nationally or locally negotiated. "Our view is that without new funding at national level, we cannot deliver the investment needed to offer the services."

If the services were beneficial to patients, or groups of patients across Britain, then the Government policy of reducing health inequalities strongly suggested that all patients should have access to them. Contracting for services year by year within a primary care trust, subject to the risk of changing priorities and budget pressures, was a poor basis for real, substantial progress.

Government wants hands-on approach to patient care

The pharmacy strategy documents in place for England and Scotland put major emphasis on medicines management, John D'Arcy, chief executive of the National Pharmaceutical Association, told the UniChem convention.

"The message is clear," he said. "Respective Governments want pharmacists to adopt a hands-on approach to patient care and expect measurable clinical outcomes from pharmacist intervention. It is equally clear that Governments are less than convinced about the intrinsic value of a straightforward supply role."

However, Mr D'Arcy added that the profession had to ask where the costed business plan associated with implementing the strategy documents was. "The programme conveys a huge mixed message. On the one hand is an apparent keenness to bring community pharmacy closer to the heart of primary care. But on the other, the Department of Health is waging a war of financial attrition against pharmacists," he said.

Mr D'Arcy pointed out that the "Pharmacy in the future" document made it clear that new roles might not be the exclusive domain of community pharmacy. "It suggests that consumers will want to rely on e-pharmacy, it talks about putting pharmacies into one-stop primary care centres and proposes local pharmaceutical services being run by pharmacists in competition with pharmacy owners."

Mr D'Arcy warned that the pharmacy network and thus the value of a pharmacy service located within local communities could be lost if the current arrangements were changed. "Can we afford to retain both the pharmacy network with all its benefits — in particular ready patient access — alongside the raft of alternatives envisaged by the Government," he asked.

However, pharmacists need to be flexible. They need to focus on the opportunities and threats inherent in the pharmacy strategies and adapt professional practices accordingly.

Mr D'Arcy went on to describe the importance of the supply element of pharmaceutical services. "It is easy to be dismissive of the supply element as a mechanistic process," he said, "but the principal reason for its importance is that it brings patients into contact with pharmacists and thus provides the opportunity for face-to-face contact between health professional and patient."

However, he added that concentrating solely on a supply role was over-focusing on the wrong part of the process. He pointed out that there was evidence of attempts to marginalise the supply role undertaken by pharmacists. "We have walk-in centres, with nurses supplying patients their medicines and we are likely to see proposals for out-of-hours arrangements where patients are provided with full courses of treatments." He added that the pharmaceutical industry also appeared keen to involve itself in direct supply to patients.

John D'Arcy: measurable clinical outcomes expected

Mr D'Arcy said that pharmacists had to rethink the ways in which they worked if they were to take on new roles successfully. "As a minimum, we must do more to delegate the mechanical aspects of the dispensing function to appropriately trained staff."

He told the conference that it was essential that pharmacists impressed upon local health commissioners the value of including community pharmacy in their localised health planning. "Do not assume they know who you are or what you do," he said.

He also warned that medicines management was not the exclusive domain of the pharmacist and that the Government would not hesitate to hand over responsibility to someone else if pharmacists did not prove willing and capable of doing the job.