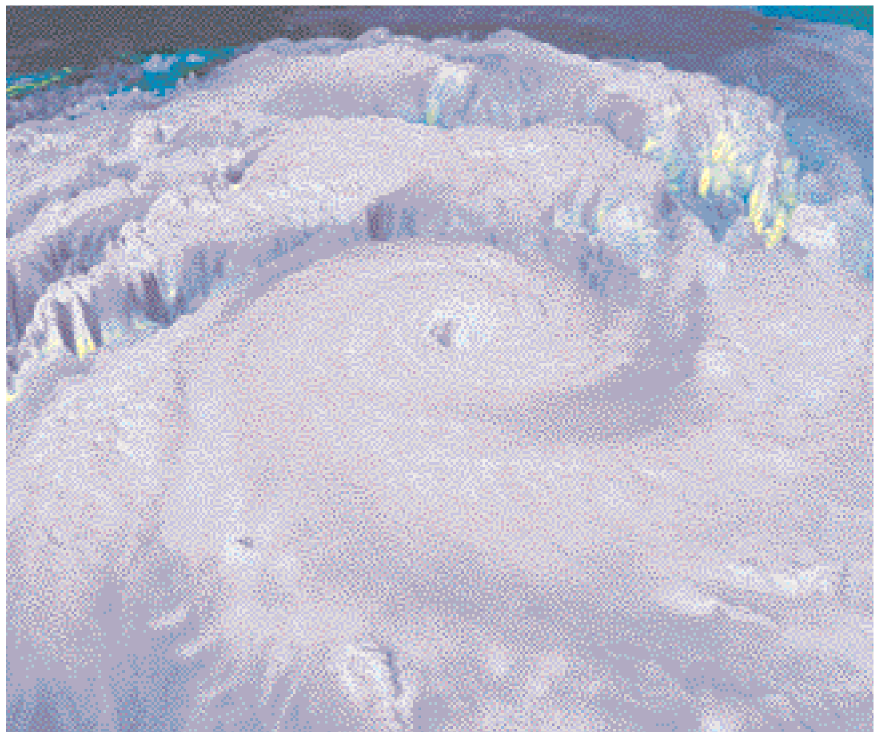
Storm clouds swirl around pharmacy

The whole of pharmacy — the individual sectors of the profession and the wider industry surrounding it — is moving through a time of rapid change and is facing many options. Jonathan Buisson takes a wide-ranging look at what is going on and imagines what pharmacy in the future, particularly the community sector, might look like when the storms have passed

ALL parts of the profession of pharmacy and the supporting industries that surround it are going through a period of major, and as yet unconcluded, change. Pharmacist are being forced to make a number of decisions about their future role and actions, while other decisions — with equally far-reaching consequences — appear to be being made for them. What can pharmacists expect to see in the future when all the storms have passed?



For pharmacy, the outlook seems stormy at present, but the future may be calmer and better

THE WORST OF ALL WORLDS

Perhaps the best way to look at the problems facing pharmacy is to imagine what might happen if all the decisions that could be taken by, or for, pharmacy were unfavourable. What is the worst possible outcome that might occur?

It is within community pharmacy, still by far the largest section of the profession, that some of the most far-reaching decisions are currently being considered and where the potential for the worst of all worlds might be seen.

One of the biggest areas of contention surrounds one of the decisions that is, currently, out of the hands of the profession. The Office of Fair Trading is examining the regulations governing control of entry into pharmacy contracts (which have now moved from health authorities to primary care trusts in England). Since the rules were put in place in 1987, they have given a degree of stability to the pharmacy market and have no doubt saved many smaller pharmacies from closure. However, they have to a great extent fossilised the distribution of pharmacies around the 1987 pattern, and provided a barrier to entry for companies, such as Asda and Superdrug, that were not particularly active in pharmacy at that time.

A complete loss of control of entry could be expected to lead to a free-for-all in the market with medium- and large-sized multiples dashing for growth while small multiples and independents find that one of their major assets (their dispensing contract) has been rendered worthless. Business closures and a much greater influence over pharmacy by the largest multiples would follow in this scenario.

The effect of such a decision would be magnified if several linked decisions were also unfavourable. Many community pharmacies today rely on competitive purchasing, particularly of generics, to supplement what is increasingly seen as an inadequate income from dispensing. The future arrangements for generics are also being studied by the Government.

Despite a long study of the area by Oxford Economic Research Associates (OXERA), which showed that the market for generics is complex, dynamic and difficult to predict, the Government would like more control over the prices being charged. Of the two options it is considering, the most radical for pharmacy would be centralised competitive tendering. If such a system was implemented, and control of it passed to local commissioning groups or strategic health authorities, the network of community pharmacies and the efficient distribution arrangements of pharmaceutical wholesalers might be at risk.

Then there is the new contract for pharmaceutical services. The current contract is widely seen as no longer offering adequate reward for the clinical work undertaken by community pharmacists. The worst outcome for them would be that instead of negotiating a new contract, the Government simply imposed an extension of the current arrangements, possibly on even worse terms.

Combining these negatives, it is easy to see why community pharmacy owners might not be sleeping well at night. In this scenario, many community pharmacy businesses might quickly become unviable.

Other things that might fail to turn out to the profession's advantage are: that pharmacists could lose influence with primary care trusts and other commissioning bodies; that new roles such as medicines management, repeat dispensing and pharmacist prescribing could fail due to lack of adequate funding and support; that recruitment and retention problems could continue in all sectors; and that modernisation elements such as continuing professional development and revalidation could drive pharmacists working outside the main areas of the profession off the pharmaceutical register. The loss of the pharmacy medicines category would add further insult to injury.

THE BEST OF ALL WORLDS

But it does not have to be this way. Things could also turn out in the best possible way for pharmacy.

For community pharmacy, the negotiations over the new contract offer a way to solve many of the problems currently affecting the sector. At the base would be a properly funded cost-of-service model that adequately rewards pharmacists for the work they do and the facilities they maintain to do it in. Funding would also be made available for improvements to premises to enable new roles to be undertaken.

The new contract could encourage community pharmacy to progress quickly through the transition stage it is in, moving from patient supply to patient support. New services such as medicines management,

repeat dispensing and supplying medicines under patient group directions (and soon by prescribing) and the shift of more POMs to the P category are pointing the way. The contract could accelerate the move away from simple volume-based payments towards more focused and targeted payments for supporting patients.

Supporting this would be the adoption of a benefit-sharing approach to the purchasing of generic medicines, rewarding pharmacists for competitive purchasing without undermining the market. On control of entry, only minor changes (in out-of-town shopping malls) would be made and procedures for the rational distribution of contracts, and exit from contract with compensation, could be developed.

Such positive outcomes would gradually transform pharmacy in the community. A move away from the economics of volume-based dispensing would probably lead to changes in the way that pharmacy is organised, with more pharmacists operating from a reduced number of well-spaced locations. Looking further ahead, the impact of new technology (such as electronic transmission of prescriptions, automation of dispensing, internet and mail order pharmacy, and electronic health records) and a greater use of technicians in dispensing and supply work will reshape the role of community pharmacists. Pharmacists will spend increasing amounts of time dealing with the ongoing management of individual patients' health.

Gloom and doom: the worse-case scenario

New contract Negotiations fail and existing contract is extended. No support for extended services such as medicines management.

Control of entry Complete free-for-all renders many businesses worthless.

Pharmacist prescribing Confined to hospitals.

Electronic records Electronic transfer of prescription models offer few benefits for pharmacists or patients. Community pharmacists excluded from accessing health records.

Primary care Only ad hoc representation of community pharmacists.

Professional Failure to achieve balance leads to forced split between regulatory and professional aspects of Royal Pharmaceutical Society. Many members leave profession.

PHARMACY VIEWS OF THE FUTURE

The concern over the future of community pharmacy and the effect that the new contract could have is shared by other observers of pharmacy.

Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee, says that the biggest threat to community pharmacy's future is "silo thinking" at the Department of Health.

"With the renegotiation of the contracts for pharmacists and general practitioners, there is a tremendous opportunity to deliver enhanced services around the supply of medicines and to take the burden of treating minor ailments away from GPs. The worst that could happen is that the Department continues with its silo thinking and misses the opportunity to integrate community pharmacy properly into primary care," Mrs Sharpe says.

This view is shared by hospital pharmacist Chris Cairns, director of pharmacy at University Hospital Lewisham in London. He says that despite the undoubted problems in hospital pharmacy, the biggest challenge for the profession is the remuneration and management of community pharmacy. "The worst outcome would be a continuation of the present contract with its perverse incentives that drive service provision for the wrong reasons and discourage innovation. If it continues, you might reach a point where one of the major multiples decides to withdraw from the pharmacy market for business reasons after all the independent pharmacies have withered on the vine. This would leave an unacceptably sparse service for patients."

James Semple, a proprietor community pharmacist from Gourock, Scotland, says that pharmacy can no longer rely on its core function of supply if it is to continue as a useful profession. Community pharmacy needs to embrace the wider role it has so often talked about, and do so in the community, not just in GP surgeries.

"The Scottish pharmaceutical care strategy, 'The right medicine', provides a firm basis for a brighter future," Mr Semple says. "Community pharmacies will become more integrated into the National Health Service providing repeat medication, medicines management, point-of-care testing and pharmacist prescribing. Most importantly, these take place in, and take advantage of the current network of local community pharmacies."

DEVOLUTION AND POSTCODES

Devolution of health care is already showing its effects on pharmacy. To date, three separate pharmacy strategies have been proposed for England, Scotland and Wales. In the future, there is the possibility of greater devolution within England, with regional assemblies being created for areas such as the North East or Devon and Cornwall. So far, no major changes in pharmaceutical services have been proposed by the devolved assemblies and the main differences have been in the speed of travel towards broadly similar goals and the amount of financial support being offered.

Under the terms of service of national contracts for pharmacy in England, Wales and Scotland, the service provided to patients has remained broadly similar across the country. There is a danger for pharmacy that devolution and the introduction of local pharmaceutical services contracts could lead to regional or even local variations and that "postcode pharmacy" could develop. A balance will need to be struck between wasteful duplication of specialist services and maintaining access for key customer groups, such as the elderly and mothers with young children for whom a long journey to an out-of-town shopping mall or a specialist clinic in a different town may not be an easy option.

PATIENT PACKS AND AUTOMATION

If pharmacy is to concentrate on patient support roles in the future, under a new contract, then there are a number of issues relating to the supply of medicines at present which could usefully be sorted out at the same time.

Top of this list must be the issue of patient packs. Pharmacists in the United Kingdom are now alone in Europe in their need to open carefully prepared and prepackaged medicines, snip off a few additional tablets, and present patients with the mangled remains, with or without an appropriate patient information leaflet.

This situation offers no benefits to patients and if medicines management and repeat dispensing schemes are to work effectively and efficiently then dispensing in complete patient packs will be necessary.

Greater standardisation of pack sizes, quantities and the use of barcoding would pave the way for increased automation in pharmacy. It would also smooth the way for more mail order or internet pharmacy schemes, in which patients may see more attraction than pharmacists do.

CARE IN HOSPITAL AND BEYOND

Clinical pharmacy services have become well established in hospitals, although some services are constrained by funding problems. For hospital pharmacy, the main issues to be addressed surround managing risk and ensuring effective use of medicines in hospitals and helping maintain continuity of care for patients when they leave hospital.

Both of these topics were covered in the Audit Commission's report, 'A spoonful of sugar', published at the end of last year. The report has given hospital pharmacy managers heavyweight backing in their quest to provide better services for patients. It is hoped that some of the extra funding being provided for the NHS will allow this to happen.

The role of pharmacy technicians is already well developed in most hospitals. The current reviews of workforce issues and skill mix, coupled with the formal registration of technicians, will allow greater development of their clinical roles as well as their

management roles, working alongside pharmacists on wards. Extending opening hours for hospital pharmacies, such as through early evening shifts, will increase the need for staffing in this area.

STAFFING AND SKILL MIX

A shortage of pharmacists and suitably qualified support staff has caused problems in both hospital and community pharmacy. The problems have arisen because new roles in primary care and longer opening hours in community pharmacy, coupled with perennial pay problems in hospital pharmacy, have led to increases in demand which have not been matched by increases in supply.

This unmet demand has been noticed and at least four new schools of pharmacy are expected to open their doors over the next two years.

In addition, new training standards for pharmacy technicians, at the Scottish/National Vocational Qualification level 3 should lead to more training schemes being offered. So, viewed over the medium-term, the problem is likely to abate partially.

For Steve Duncan, managing director of Moss Pharmacy, the issue of skill mix in pharmacy is a crucial one, but he sees it linked to the review of control of entry being undertaken by the OFT.

"We are beginning to see that we are making some headway on the aims of the pharmacy plan, with more patient-focused services. In order to provide these services, we are investing heavily in our staff and in premises. The OFT's review is causing uncertainty which might reduce our ability to invest," he says.

There is another underlying trend in the pharmacy workforce which is less visible and less talked about. The demands of running good community pharmacy businesses, and the viable alternative careers available in primary care, are leading many pharmacists to forsake the traditional career of managing or owning their own pharmacies. The number of pharmacy locums has increased, as can be seen from the increasing number of locum agencies offering their services. The new pharmacy contract, with an emphasis on clinically focused patient support roles rather than high-volume dispensing, may help bring some locums back into permanent employment.

In hospital, community and primary care pharmacy, a greater use of technicians and support staff is expected. Technician registration, which may start in 2005 (*PJ*, 26 October, p601), will reveal the number of technicians and allow more detailed profiling of the services they currently undertake and how these can be expanded.

Of all pharmacy's problems, it would appear that the workforce one is well on its way to solving itself (at least for a while).

SAME PROBLEMS, DIFFERENT ANSWERS

One of the problems facing pharmacy in seeking solutions to the many interlinked challenges it faces is that not all the different bodies, groups, companies, individuals and budget holders are agreed on what is the right solution to the same problem.

An example of this can be seen with electronic transmission of prescriptions (ETP). For the Department of Health, the solution is a lower-cost electronic version of the existing paper-based system. For pharmacists the solution is one that saves them time and effort in dispensing and allows new roles to be carried out. And, for patients, the solution is one where they avoid repeated treks first to the doctor and then to the pharmacy. It may not be possible to reconcile all of these in one acceptable solution.

Better and fitter: the best-case scenario

New contract A properly costed contract is agreed which supports a move to medicines management, repeat dispensing and pharmacist prescribing. Financial support is given for improving pharmacy premises.

Control of entry Only minor changes are made. Provision is made for contract exit with proper compensation. Rational distribution is recommended.

Medicines management Well developed and funded schemes are supported along with patient registration. Continued expansion of the areas covered by the schemes.

Pharmacist prescribing Pharmacists eventually take over the greater part of all prescribing in the community and routine and discharge prescribing in hospitals.

Electronic records Integrated health records, including prescription data, are introduced. Pharmacists have full access to the records.

Primary care Pharmacists at all levels of primary care management. Information technology allows continuity between primary and secondary care.

Professional Balance achieved between professional and regulatory aspects of Royal Pharmaceutical Society's work. Continuing professional development and revalidation introduced widely and successfully.

PROFESSIONAL MATTERS

The Royal Pharmaceutical Society's modernisation programme is a result of pressures from both inside and outside the profession. Its effects are likely to be positive for the profession in the long-term, but, as with every decision, there are potential negative outcomes. One problem could occur if the Society imposes requirements for continuing professional development and revalidation that are seen to be too onerous or irrelevant to pharmacists working outside the sectors of the profession that are linked directly to the National Health Service. Many pharmacists working in the pharmaceutical industry or academia and those in management, administration, publishing or consulting do not have direct patient contact. They could consider that they are outside the need for clinical governance and may no longer wish to pay an increasing fee for the privilege. If there is any significant reduction in the pharmacy register it will increase the costs on those who remain registered.

Idris Hughes, a community pharmacist from Trefriw, Wales, is among those pharmacists who believe that professional issues are the biggest challenge facing pharmacy at the moment. "An effective decision over the future role, or roles, of the Royal Pharmaceutical Society, and a wider separation of the regulatory and representational functions, is necessary," he says.

He fears that without a strong leadership role, the profession might not be able to advance against commercial pressures or Government wishes that might conflict with the desires of pharmacy.

FACING THE FUTURE

Of all the futures that pharmacy faces, it is likely that neither the most optimistic nor the most pessimistic scenarios will come to pass. The future will lie somewhere in between.

For community pharmacy, the negotiation of the new contract gives a once-in-a-generation chance to map out a new future. There will need to be compromises from all involved in the negotiations, but also a realisation that the current contract is no longer appropriate and new thinking is necessary. Few realistic options exist at present for the mass supply of medicines to the public with convenience and safety, other than via the community pharmacy network. Thus, this network must be maintained, more or less intact. That is not to say that some element of rational distribution and amalgamation of pharmacies should not be studied, for the society in which pharmacy operates is continually changing.

However, supply is no longer enough to justify the presence of pharmacists in the community. The move to a patient support role must be taken, for the sake of patients, pharmacists and the NHS as a whole.

Times of change are difficult for any individual or group to cope with. Pharmacy, which is clearly in the middle of a difficult transition period, is no exception. It is to be hoped that, when the storm has passed, calm will be restored.