

What social capital is and why it is present in community pharmacy

In the second article in a series leading to a consultation among members about the Royal Pharmaceutical Society's Pharmacy 2020 project, Stephen Fishwick, head of NHS service development at the National Pharmacy Association, takes a look at social capital

Social capital refers to the institutions, relationships and norms that shape the quality and quantity of a society's social interactions. Most definitions of the concept refer to social capital being more than the sum of the institutions that underpin a society; in addition it is the "glue" that holds people together — involving a sense of belonging, an experience of social networks and shared values. It may be said of social capital that you know it when you see it and that you also sense when it is not there; in the case of the latter, trust decays and at a certain point this decay begins to manifest itself in serious social problems, such as crime and endemic poor health.

The existence of local facilities is one of the four elements of social capital as defined by Robert Putnam, professor at the Kennedy School of Government, Harvard University, and one of its main proponents; local facilities provide opportunity for interpersonal contact, thereby fulfilling a social function.

Community pharmacy plays a role in maintaining social cohesion (the "glue" of social capital) by providing a space for individuals to develop networks of trust and mutual support. For example, for many older people who live alone, a visit to a pharmacy constitutes valued social interaction. Community pharmacies are considered non-threatening environments where people are comfortable and patients frequently consult the community pharmacist with a variety of emotional and social problems.

In rural locations health professionals are often at the heart of networks within communities. In my own, semi-rural village, there are two park benches — one displaying a commemorative plaque to a long serving GP and the other dedicated to the village pharmacist. Pharmacy staff often know the social activities of regular pharmacy customers and exchange news about mutual acquaintances and local events. Researchers have even observed pharmacy support staff "delivering medicines to housebound customers on the way home from work and hanging out their washing to dry" (*PJ*, 4 April 2002, p610).

An ICM survey, commissioned by the National Pharmacy Association in March 2003, revealed that older people and people in social classes D and E are especially likely to see their pharmacist and pharmacy as being "at the heart of their local community" in a trusted role as "a family friend".

Pharmacies provide employment for local people and may also act as anchors for eco-



omic activity, thus helping sustain a commercially viable high street. According to the New Economics Foundation, if people can service all their needs — banking, comestible, retail, medical — on one high street they will be more inclined to do their shopping there. Where high street economies have expired, researchers note a growing sense of isolation, loss of community, higher crime and social exclusion.

Related concepts

Social responsibility and social enterprise are related concepts.

Social responsibility is a doctrine which claims that an entity, whether it is a government, business or individual, has a responsibility to society. Corporate social responsibility specifically concerns how businesses take account of their economic, social and environmental impact.

In an interview published in *Chemist and Druggist* on 9 June, Keith Ridge, the chief pharmaceutical officer for England, called on pharmacists to become "green leaders for their community" and promised educational materials to help contractors implement environmentally sustainable business practices. And the wider NHS has been urged by the Department of Health to behave as a "good corporate citizen". As a major landlord, employer and commissioner of services in most communities, the NHS exercises potentially huge influence over the economic, civic and social well-being of neighbourhoods, as well as over people's bodily health. (The NHS employs more than one million people and each year buys goods and services worth several billions of pounds. Its buildings and estates decisions impact significantly on local environments and economies. For example, hospitals are a major generator of travel and, therefore, air pollution.)

Social capital may be increased through socially responsible actions yet, as noted above, many pharmacies contribute to social capital by their mere presence and core activity, rather than through any consciously socially responsible actions on the part of the pharmacist or pharmacy staff.

A social enterprise is a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners. Social enterprises tackle a wide range of social and environmental issues and operate in all parts of the economy. Jamie Oliver's restaurant "Fifteen", *The Big Issue* magazine and Local Care Direct, which provides urgent health care services to people in West Yorkshire, are well known examples. There is no single legal model for social enterprise. They include companies limited by guarantee, industrial and provident societies, and companies limited by shares; some organisations are unincorporated and others are registered charities. A new form of legal model designed with social enterprise in mind is the (asset-locked) community interest company (CIC). The CIC legal form was specifically designed to provide a purpose-built legal framework and a "brand identity" for social enterprises that want to adopt the limited company form.

It is unlikely that many community pharmacists will wish to transform their whole business into a social enterprise. However, there could be specific schemes for which, possibly in conjunction with other local pharmacists, a social enterprise would be a desirable vehicle. Dealing with a social enterprise may be an attractive proposition for commissioning staff who want to ensure value for money and view social enterprise as an investment in the community. Furthermore, social enterprises can seek access to the Government's social enterprise fund and other funding streams via local authorities. CICs enjoy certain modest tax advantages that help them secure funding (see www.cicregulator.gov.uk/faq.shtml).

Community pharmacy

So how can social capital be maintained in community pharmacy?

Neighbourhood and high street-based community pharmacy is under pressure from a number of long-term factors, with the attendant risk of affected neighbourhoods seeping social capital.

The first range of factors concerns developments in the NHS estate. This includes the policy-driven trend towards co-located health facilities, seen as infrastructure needed to develop primary care and straddle community-acute care divisions. Unfortunately, due to a shortage of choice sites, many such one-stop



Marc Dietrich/Dreamstime.com

Social capital is the “glue” that holds people together. It involves a sense of belonging, an experience of social networks and shared values

health care facilities will locate out of close proximity to the people they serve and potentially dislocate existing accessible, community-based networks of care. In policy circles, a fashionable incarnation of the one-stop health centre is the polyclinic, which will consolidate GP practices and offer a range of other services, such as pharmacy and dentistry, also taking on much work that is currently undertaken by district general hospitals. NHS London’s “Healthcare for London: a framework for action” envisages most London GPs being based in polyclinics of up to 50,000 patients within 10 years. GP consolidation on such a scale would have an appreciable impact on the surrounding pharmacy network, particularly if the facility also contains a pharmacy.

Some community pharmacies might enter into consortium arrangements to secure their viability and the integrity of the network in the face of such developments. Commissioners, meanwhile, could ensure that frequently required, “access-critical” services — for example, management of minor ailments, screening for sexually transmitted infections and monitoring of long term conditions — can continue to be provided from the high street and close to patients by commissioning such services via the community pharmacy network. A “hub and spoke” model of provision, with the local community pharmacy network as the spokes, may be appropriate in many areas.

A second long-term pressure relates to the advance of models of “remote care” based on assistive technology such as telemedicine. A recent DoH report, “Research and development work relating to assistive technology 2006–07”, illustrates the range of the possibil-

ities being explored. Pharmacy needs to consider more urgently how technology can be harnessed to improve and augment, rather than replace, face-to-face care.

The principal opportunity to grow social capital may reside in the public health agenda. Indeed, public health initiatives and social capital can be symbiotic. Higher levels of social capital are believed to foster health maintenance. Meanwhile, certain current health improvement initiatives, such as the NHS Health Trainer programme, meld personal responsibility with social networking. (Community pharmacy staff may be ideally placed to become accredited health trainers.) Greenlight Pharmacy in Camden, London, provides another example of public health and social capital feeding into one another by organising community talks and guided walks to encourage exercise. The potential role of pharmacy in delivering public health targets was set out in “Choosing health through pharmacy”, published by the DoH in 2005. There is a relatively open field in public health provision (compared with, say, long-term conditions management) and a huge unfulfilled need that community pharmacy is ideally suited to satisfy.

Why it matters

We have seen why social capital in community pharmacies benefits local communities. Secure health infrastructure is important to maintain resilient communities. Pharmacies are, according to “A vision for pharmacy in the new NHS” published by the DoH, an “integral part of the NHS family” and a “vital local service” and “community facility”, according to Dr Ridge. Is any of this relevant, though, to community pharmacy’s bottom

line — providing excellent care, profitably? The answer, probably, is “yes”, provided that three groups acknowledge or at least sense the social capital emanating from the pharmacy: patients and public, commissioners, and local and national government.

Patients and public Nobel economist Milton Friedman explained that it may be in the long-run self interest of businesses to “devote resources to providing amenities to the community in order to generate goodwill” and thereby increase custom and profits. In his interview with *Chemist and Druggist*, Dr Ridge recently emphasised the “distinct commercial advantages of being at the heart of communities”. These relate primarily to the choices made by individual patients. In addition, social capital could cultivate support from patient and public representative groups, which are respected signposters to services and also have influence in relation to NHS commissioning decisions.

Commissioners Other things being equal, commissioners in England have been asked to give preference to providers, including social enterprises, which are willing to accept their broader social responsibilities. An overlap of social capital with social responsibility in community pharmacy may thus help gain a differentiating advantage in bids to access NHS funding. Such an overlap has certainly helped community pharmacy to attract service commissions from local authorities, sometimes supported by the Neighbourhood Renewal Fund.

Local and national Government Those government officials and elected representatives who acknowledge the presence of social capital in community pharmacy may be inclined to support the sector’s efforts to maintain and grow its presence in the heart of communities. Examples have begun to emerge during consultations on local health service reconfigurations, particularly those that involve proposals for changes in the NHS estate; an appreciation of the social value of the pharmacy network ensures thorough scrutiny of the implications to the sector.

Conclusion

Social capital may not be the most pressing matter in pharmacy’s in tray. Yet it would be a mistake to dismiss social capital as an academic construct that bears no relevance to “real lives”, to business or to healthcare. Such hard-nosed bodies as the World Bank have stated that “social cohesion is critical for societies to prosper economically and for development to be sustainable”.

Meanwhile, in certain circumstances, community pharmacists may find that the social glue that they generate also acts to bind them to communities in such a way as to secure a sustainable future for their pharmacies, in spite of certain pressures working against neighbourhood-based, “face and place” models of care.