

The impact of politics on UK pharmacy and the economics of medicines supply

In this seventh article in a series leading to a consultation among members about the Royal Pharmaceutical Society's Pharmacy 2020 project

David Taylor, professor of pharmaceutical and public health policy at the School of Pharmacy, University of London, discusses the effect of politics

Political processes involve the use of power in societies, and the ways in which social order is maintained and economic resources are allocated. Politicians — elected and otherwise — play central parts in defining the laws and regulations through which communities are governed, and in raising taxes and deciding patterns of public spending and action. A fundamental achievement of modern Western democracies such as the UK is that the conflicting desires of individuals and groups are normally balanced against each other through procedures which involve little physical violence, and which most people — at least for most of the time — judge to be reasonably fair.

Pharmacy, although a relatively small profession, is politically complex. It exists both to regulate and ensure the supply of medicines, and to enforce rules that have over time been made to promote the safe and appropriate preparation and use of drugs. Historically, the role of the profession in the UK has developed in a little over a century from being both the primary producer and distributor of medicines (and a key controller of poisons supply) to, in the NHS era, dispensing prescriptions and selling over-the-counter treatments in the community. Pharmacy has also developed as the facilitator of optimally cost-effective pharmaceutical care in hospital and allied clinic settings.

Internal divisions

Tensions between the business model(s) underpinning community pharmacy and the service goals of hospital pharmacy have been an important factor in the internal politics of pharmacy throughout the lifetime of the NHS. Notwithstanding recent, largely government-led moves to change patterns of professional regulation and extend the clinical and “public health” element of community pharmacy practice (see, for instance, Department of Health papers such as “Choosing health through pharmacy” and the Scottish Executive’s “The right medicine”), it seems likely that perceived conflicts between “private business as opposed to public service” approaches to health service provision will continue to be important themes in pharmacy’s story throughout the foreseeable future.

Other key determinants of the politics of pharmacy in this country relate to the changing needs of the public in an age of longevity and relative affluence, the wider dynamics of the NHS and its special place in British soci-



ety, the sometimes conflicted interests of the medical profession (given the latter's divided identity, based on both the traditions of surgery and specialised hospital medicine, and also those of the GPs and their apothecary progenitors), and the ongoing evolution of the pharmaceutical industry and the fundamental scientific and economic forces driving medicines innovation today.

Consumer demands

The most important — and diverse — stakeholder group in the pharmacy arena is the public. As populations age and individuals gain increased expectations of good health throughout their lifetimes, people tend to become more questioning of traditional professional authority, and to seek new forms of service from pharmacists and other care providers. At the same time treatment safety becomes an assumed universal right and any form of iatrogenic illness a potential scandal. Younger individuals may well require convenient and relatively impersonal access to risk factor monitoring and preventive interventions, as well as to sexual health and family planning services. Older service users seeking to live well with long-term conditions may also value convenience, coupled with more personalised care and support in medicines taking.

One in large part political issue facing community pharmacy (and also citizens seeking to use pharmacy services more fully) now and in the future relates to the extent to which members of the profession can (with appropriate patient permission) gain read/write access to individual medical records. As analyses such as the recent All Party Pharmacy Group's report “The future of pharmacy” have emphasised, a key determinant of the ability of pharmacists to provide clinical care in independently sited premises will be whether or not the new computerised NHS care record systems currently being established will be flexible enough in practice to deliver this requirement. A vital message for the profession to communicate to the voting public is that it will be a sad waste of money and effort if this is not the case.

Political legitimacy and the NHS

Until the end of the 1939–45 war the US and UK health care systems had much more in common with each other than is currently the case. The creation of the NHS marked a fundamental divide between the British and American approaches, with the former rejecting market mechanisms in favour of a publicly funded system of universal care. From a political perspective one reason for this divergence was the UK establishment's collective need to gain fresh credibility with its electorate, in the face of the costs of war and the loss of empire which began during the 1940s.

Seemingly conflicting modern attempts to support consumer choice and make the NHS more competitive and “customer responsive” on the one hand, but also to retain a ministerially led system with politically guaranteed standards of care and safety on the other, should be understood against this background. From a professional perspective, pharmacy's leaders need to understand in depth governments' mixed public interest-oriented and sectional party political goals, if they are to be able to negotiate systems of regulation and NHS pharmacy service funding which will allow the effective pursuit of a strong long-term future for pharmacy. A second vital message to transmit is that the variable “post code” rationing of pharmaceutical care encouraged by present local payment structures is undermining genuine consumer choice and confidence in the NHS.

The medical profession and pharmacy

To achieve their institutional objectives and serve patients well, medicine and pharmacy must work together effectively. The relatively limited number of doctors trained and employed in the NHS as opposed to many other European systems is a factor that has helped to create new opportunities for pharmacists to extend their clinical work. Further, service managers and policy makers may on occasions wish to use pharmacy as a lever against medical power and authority. But to be professionally successful, pharmacists should always seek to ensure that their efforts to improve patient care constructively complement doctors' services, where this is in line with service users' best interests, rather than compete destructively with the medical profession.

Many observers believe that pharmacists working in British hospitals, and also those employed by primary care organisations as ad-

visers in general practice settings, have already demonstrated their ability cost-effectively to improve pharmaceutical care standards. As experts in particular therapeutic fields it is politically uncontroversial to suggest that they should, wherever possible, seek to reduce needless expenditures on costly pharmaceutical products, while at the same time making sure that National Institute of Health and Clinical Excellence and other central guidance on therapeutic quality is followed.

However, managerial and governmental support for pharmacists might be less forthcoming in circumstances where, as health professionals, they seek to defend individual patient's interests in being able to access what is for them personally the best quality (but relatively costly) treatment. It may also be politically challenging for community pharmacy to develop further NHS or private business models (such as those based on "advanced" — nationally guaranteed as opposed to locally determined — service payments) that would allow them to build new primary care services outside medically led or directly managed controlled environments. Yet if the public loses faith in pharmacy's commitment to defending individual treatment quality or its ability to deliver faster, better care in the community, then the profession's popular support will over time erode.

Significant questions for the future relate to the extent to which (and at what levels) pharmacists and doctors can and should work together as allies in such fields, or are destined to remain locked in partial conflict. The danger of the latter is that the two professions' power and capacity to influence political decisions may be cancelled out, so that vital health policy decisions are left to groups with less substantive knowledge of patient needs and the realities of care provision.

Political economics of medicines supply

Similar political dilemmas are reflected in the relationships between pharmacists and the generic and research-based arms of the pharmaceutical industry. The latter is in many ways the inheritor of late 19th/early 20th century pharmacy's investments in pharmaceutical science. It is the ongoing source of new medicines and diagnostic and allied techniques likely to be at the heart of future pharmacy practice. As such it could seem to be the profession's natural political partner. Yet often the relationship between pharmacy and the pharmaceutical industry has been poor, and torn by conflict.

The reasons for this range from perceived rivalries as to which group should act as the provider of medicines-related information to prescribers and the public, through to more overt clashes of economic interest. Put bluntly, many pharmacists see their NHS role as centrally focused on the rational limitation of medicine use and costs. At the same time pharmaceutical industry employees are legitimately focused on promoting the most extensive reasonable (safe and effective) use of innovative (patent-protected) products.

It is a fact that across much of the world community pharmacists' incomes are in part dependent on (overt or hidden) discounts on both generic and patented medicines. Even in European countries the actual returns made on, say, parallel-traded medicines can be two or three times those allowed for by the claw-back mechanism embedded in current UK community pharmacy payments systems. Seen from this perspective claims that the pharmaceutical industry is unduly profit motivated as compared to pharmaceutical service providers may appear disingenuous, given that pharmacy incomes are to a degree concealed in headline drug prices.

Such issues have considerable political implications. It would be inappropriate to explore them in depth in this brief article. However, a core point to stress is that as the current business model underpinning private sector-funded pharmaceutical research and innovation is exposed to greater stress, companies seeking to survive are likely to change further their pharmaceutical product supply chain arrangements.

Across Europe the pharmaceutical wholesaling system is likely to undergo further rationalisation. At the same time governments and health care providers will also press for still greater medicines and pharmaceutical service price transparency. Key policy questions facing pharmacy leaders relate in this context to the extent to which those sections of the profession negatively affected by such trends should seek to cope with the resultant pressures in partnership with pharmaceutical companies, and especially those working to develop new direct-to-consumer health maintenance and disease management services.

Towards the 21st century apothecary?

After many decades of relative stability, pharmacy in the UK and — albeit to a lesser extent — elsewhere in the industrialised world is facing significant change. Established clinical and advisory pharmacists can look forward with reasonable certainty to a continuing role, albeit they will sometimes have to face hard choices between enhancing the true cost-effectiveness of pharmaceutical care and the realpolitik of making local cash savings. But those currently working in "traditional" — dispensing focused — community pharmacy businesses face greater levels of uncertainty.



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For instance, as other contributors to this series have noted, the advent of electronic prescription transmission and the creation of large, highly automated, dispensing centres could in time lead to drastic reductions in high street pharmacy numbers. A positive alternative is that current developments in this field will simply moderate community pharmacists' present levels of reliance on dispensing income streams, while opening the way to better funding for more broadly defined community oriented pharmaceutical care. Yet pharmacy's critics may argue (at least in private) that our society should eventually opt for fully integrated "polyclinics" at the first level of primary care, and that this will (along with innovations such as new home and allied prescription delivery systems) eliminate the need for traditional community pharmacies in future years.

However, for those whose judgement is that separately located community pharmacies can and should still have something vital to offer Britain in 2020, the political reality to grasp is that they will need to be able to convince not only politicians of their case, but also a majority of the public together with key stakeholders such as GPs and innovative pharmaceutical companies. Perhaps the most important final conclusion to draw is that the greater the number of informed friends and allies that any health profession doing a useful job for the community has, the less likely its members are — individually or collectively — to fall victim of either ill-founded bureaucratic intervention, or the misuse of political power by those seeking electoral profit at the expense of true public welfare.