

Let us move towards a more logical and flexible approach to contract regulation

By Gerry Green

A little over 10 years ago, I moved my pharmacy into a supermarket. I was then persuaded to sell my pharmacy to the supermarket and then to seek to procure and relocate more pharmacies for the chain. About 30 acquisitions later, my client decided to conduct this work in-house although I continued, for several years afterwards, to represent my client at oral hearings, mainly established by the appeal authority. At that time, I also undertook similar work for a well-known chain that had decided to add pharmacies to its branches. In the same way I represented these and other clients at oral hearings.

I believe that in the main the health authorities that existed until 2002 and the Family Health Services Appeal Authority were fair and reasonable in their decision making process thus allowing a number of pharmacies to move to make their National Health Service services more accessible. This was especially so when a move into, or next to, a general practitioner's surgery was proposed. This was also true of many "changes of premises" where some sensible redistribution of existing pharmacies would provide better access to pharmaceutical services where these were deemed to be less than adequate.

However much support such proposals received from other health professionals, community health councils and other patient representative organisations, almost all the other pharmacy contractors would appeal against such decisions. All the major multiples and, in most cases, those supermarkets that had a contract were, in my experience, appellants insisting on the status quo, however reasonable many of the proposals to move might appear to the general public. Pharmacy owners often did little to enhance their own public image by the language of protest they employed in their letters of opposition, often misunderstanding the regulations governing minor relocation and usually, too obviously, putting the effect on their business ahead of quite genuine advantages to the members of the public who require pharmaceutical services.

What is certainly true is that most of those who sold contracts to supermarkets and other chains received a fair price for their business plus compensation for the property with which they were left and the stock the buyer did not choose to take. Only one supermarket chain believed such reasonable recompense to existing owners was not for them and so set about, instead, to

seek to lobby for the abolition of the regulations in order to save themselves money.

Most chain buyers that bought pharmacies had the benefit of an existing clientele who would usually follow the staff who had served them well in the past and an experienced pharmacist who knew the other primary health care staff. It was certainly my experience that the progress of such pharmacies under new ownership was significantly better than where, occasionally, I was able to persuade the relevant authorities to allow a new pharmacy to open.

Having said that, the one thing most of these "multiples" lost out on was their over-severe pruning of the pharmacy inventory of medical and surgical items, an opportunity usually taken up by independent rivals. (My own pharmacy had a solid business in veterinary medicines before it was sold, all of which was "delisted" by the new owner.)

The other negative was the loss of continuity. Careful staff planning over extended hours of operation, using some shift-work for experienced and publicly known staff, plus robust systems of record keeping and handover procedures, certainly allowed my pharmacy to succeed in those circumstances. But, in my experience, too often this is not the case in the majority of today's supermarket pharmacies.

There is, however, a genuine public demand which has allowed the major supermarkets to capture the lion's share of most retail markets for fast moving consumer goods. With almost three out of four prescriptions issued for repeat medication and the opportunity taken in the majority of these cases for the pharmacy to collect repeat prescriptions from surgeries, a pharmacy in a supermarket will often be the preferred choice of the public for such work. This is especially so for the "time poor" workers of both sexes requiring prescriptions for themselves or for family members. Home helps and other social workers also express preference whereby they are able to shop for those in their charge and collect their medication in a single "one shop" way.

Such is the groundswell of public opinion that I believe it would be unwise for pharmacy contractors to oppose all changes

in the regulations and so prevent a modest increase in pharmacy contractors, particularly in supermarkets and major shopping locations. What would be the most sensible way for all concerned would be if a greater degree of flexibility was permitted under Regulation 4(4) to allow existing pharmacy contractors to move from areas of limited demand, where other pharmacies would remain in the immediate proximity, to locations such as out or edge of town supermarkets or shopping centres, thus fulfilling this pent up demand for more convenient access.

Such greater flexibility is especially required in the regulations governing Scotland and Northern Ireland where, in my experience, the ability of pharmacies to move, even under minor relocation regulations, has been stifled to an excessive degree by the existing pharmacy contractors.

As a tax payer as well as a pharmacist, I am gravely concerned that deregulation would open the way for a huge influx of pharmacies owned by medical practitioners, a situation which would undoubtedly lead to a more costly prescribing out of the self-interest of the prescribers as well as the temptation for some to bend National Health Service rules. Little heed would be paid by such owners to the additional role services proposed to be the way forward for pharmacy, and the shortage of pharmacists might itself be dealt with by the typical unsupervised dispensing one sees in a dispensing doctor practice.

Too many new pharmacies would mean significant extra costs in "payment for additional services" or "practice allowance" (as most of us call it), a point ignored by the OFT. I estimate another £20m of such costs to the global sum if 1,000 new pharmacies were allowed to dispense NHS prescriptions. By contrast, the OFT sums on the costs to business of the present regulations were ludicrously overstated at 300 hours' work for each application and 200 hours' work for each appeal. I would have retired a long time ago had I been able to claim fees from my clients for anything like that amount of my time. Even one tenth of the OFT figures would rarely be needed by the now highly experienced executives of all the multiple and supermarket groups, as well as the handful of specialist consultants such as myself.

So, let pharmacy contractors' representatives attack the OFT proposals where they are blatantly wrong, where they have placed far too much emphasis on the sale price of OTC medicines and far too little on the breadth of services the present contractors offer which are well beyond those laid down in the regulations on the supply of medicines. But let us, please, not seek to argue this case on the effect on the pharmacy owners' wealth, but concentrate, instead, on the public good.

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