

Main obstacle to patient pack dispensing is “stick to the rules” attitude of the PPA

By John Wilson

As an occasional locum who can wield the scissors as well as anyone, I have followed *The Journal's* patient packs campaign with some interest. We have heard from representatives from “stakeholders” of various interest groups, all putting forward their views, which seem, at first glance, to be at variance with one another.

Community pharmacist Gerald Fox (*Pf*, 24 May, p721) makes a strong point that the integrity of a pack is compromised once snipping starts. General practitioner Dr Peter Fellows (*ibid*, p722) describes the “chaotic mismatch” of pack sizes. Representatives of two large patient organisations, for patients with epilepsy (*ibid*, p723) and Parkinson's disease (*ibid*, p624), describe what they regard as the deeply unsatisfactory nature of the present system but then wander off into other issues such as foreign-language labels and the problems of switching between brands and generics. The pharmaceutical industry, of course, is blameless (*Pf*, 17 May, p687).

My concern with the present campaign is that, like so many things in pharmacy, it seems to lack focus. A wide variety of issues has been bundled together under the campaign banner and, as usual, this tends to detract from the main issue. *The Journal's* website *Pf Online* includes, in addition to the articles published in the recent issues of *The Journal*, a website on patient packs which covers much ground but makes much of the differences in packaging policy between the pharmaceutical industry and others such as the food industry. In my opinion, by covering many side issues, the campaign runs the risk of missing the main point. Let us look at the reality of using patient packs.

The Patient Pack Initiative started many years ago. Although, as Dr Fellows points out, the “important final parts . . . were never agreed”, most packs are, in fact, not far from being standardised now. Most of the long-established medicines used for long-term therapy, such as digoxin, furosemide, allopurinol and atenolol, are in packs of 28. Few are in packs of 30 or multiples thereof — tamoxifen (30), ranitidine and cimetidine (each 60) spring to mind. The vast majority of newer drugs for conditions such as cardiovascular disease are in 28s. Only a few (for example, Coversyl and Seroxat) are in packs of 30. Most analgesics are in packs of 100. Quantities prescribed

are a far cry from those of yesteryear, when most tablets were in bulk packs. Prescriptions today tend to be for about one or two months' supply, not an odd number of days with all the items well out of sync.

In my view, and a point that seems not

to have been picked up elsewhere in the campaign, the biggest obstacle to patient pack dispensing is the “stick by the rules regardless” attitude of the Prescription Pricing Authority. If a pharmacist deviates even slightly from the requirements of a prescription (such as, for instance, using professional judgement when the prescriber cannot be contacted), then he or she will be penalised

by having the prescription referred back for countersigning by the doctor.

I therefore propose that the requirements for filling and endorsing prescriptions be relaxed, and that pharmacists be allowed to give the nearest appropriate quantity, usually a full pack, and be reimbursed for that. Here is an example. At a recent locum engagement that I carried out, there were several prescriptions for 30 thyroxine tablets (they are in 28s so I had to snip two from another pack and add them) and for 28 perindopril tablets (Coversyl are in 30s so I had to snip off two and put them in a split pack with all the other snipped off twos). When I spoke to the local doctor about this, he said that he was trying to use patient packs but thought that thyroxine were in 30s and Coversyl in 28s.

Prescriptions requiring tablets and capsules tend to be long-term (eg, thyroxine, cardiovascular drugs, etc) or short-term (antibiotics, short courses of steroids). I also propose that short-term prescriptions should state the exact number of dosage forms to be given (which will, admittedly, require some snipping unless one uses a bulk pack). After all, we should not be encouraging excessively long courses of antibiotics, and six tablets of trimethoprim 200mg are usually sufficient (and frequently prescribed) for simple cystitis requiring an antibiotic. Reducing courses of a steroids must be given as an exact number. Why not have bulk packs of such drugs? I have seen bulk packs of amoxicillin and penicillin V

with a number of patient information leaflets inside, each in a small cellophane envelope, so it can be done. Also, Delta-Cortril is packed in 100s.

For long-term medication (ie, most prescriptions) we should be permitted to supply an appropriate pack and endorse appropriately. Where the pack size does not match the amount prescribed we should endorse, say, “28pp” where the script called for 30 tablets, or “30pp” for those few preparations in 30s (such as Coversyl) where the prescriber orders 28 — “28pp” and “30pp” refer to a patient pack of 28 or 30. Prescriptions for, say, 224 co-codamol (which most of us would fill by pushing a strip of 10 plus two snipped off into the boxes of 100) would be filled by two boxes of 100 endorsed “2 x 100pp”. No more pregnant-looking boxes! For patients on long-term medication there would surely not be a problem if the quantities supplied did not exactly match the prescribed quantities.

Fears by the Treasury that patients would receive more medicines than prescribed could be allayed, since it is likely that far more patients prescribed 30 would receive 28 than of those prescribed 28 who would be getting 30. There would be no problems with package inserts — forget the photocopying saga — since only complete packs would be issued. Prescriptions for small quantities of such preparations as co-codamol and paracetamol could be filled with a counter pack of 32 and endorsed appropriately. For prescription-only analgesics, eg, co-codamol 30/500 and co-proxamol, it would be permissible to dispense, say, 50 or 60 from a pack of 100, but not under any circumstances to snip. However, even this pack splitting could be stopped if manufacturers could be persuaded to produce such drugs in packs of 50 and 100 and we were to dispense the nearest quantity. Some products come in different pack sizes from different manufacturers, for example, ibuprofen tablets in 100s or in 84s. However, we could endorse with the manufacturer's name in such cases to justify the quantity endorsed. Controlled Drugs would be the one exception to the “nearest quantity” rule. However, is it too much to expect general practitioner computer systems to have the pack sizes of such products as MST tablets available, so that the prescriber can select them rather than choosing either an arbitrary quantity or a quantity based on a number of days?

In spite of the various, sometimes gloomy, views that we have seen aired in this particular campaign, I believe that we are almost there in terms of availability of suitable original packs. All it should now take is the application of a little common sense.

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