

What will happen when prescription medicines are treated like car parts

By **Bob Gartside**, a pharmacist from Gwynedd

It's fairly widely accepted that the pilot studies of electronic transfer of prescriptions (ETP) have not been an unqualified success. Certainly, there are no immediate plans to implement any system with the rapidity one would expect if the trials had been a striking success and had exceeded initial expectations. This is not, of course, surprising. If one deconstructs the concept it is a little difficult to see real, solid, practical advantages in ETP. The patient still has to visit his or her GP, who has to write a prescription, which the patient then has dispensed at a pharmacy. In at least one of the pilots it was found necessary to issue

patients with documents which identified them and authorised them to receive their medicines. Occam's razor suggests that one might as well have issued a prescription as normal and have done with the job.

Indeed, if e-prescriptions have to be each individually authorised by the GP this will involve them in more work than the present system requires. On the other hand, if the authorisation is not individual then you are handing prescribing to essentially unqualified receptionists or other ancillary staff. This is the real Achilles heel of e-prescribing and one which appears not yet to have been addressed.

What is equally surprising is that the NHS is so reluctant to carry out trials on electronic pricing of prescriptions despite the solid advantages in cost, accuracy and speed — not least because electronic pricing of prescriptions can provide prescribing data within a week of the prescriptions being issued rather than four months later as at present. There is little to be achieved by a prescribing adviser wishing to go through four-month-old prescriptions with a GP. More can be achieved with "hot", week-old data. Systems for electronic pricing of prescriptions are in widespread use in other countries. The systems development work has been done and the systems manufacturers are keen to get into the undeveloped British market. Yet it is obvious that the NHS wishes to have nothing done even though electronic pricing of prescriptions could be a natural lead into ETP, if one still wishes to pursue that chimera.

Another puzzle is the slow progress of trials of systems of repeat dispensing. Here is a

development desired by both patients and professionals and which promises substantial time and effort savings. It has the added and not inconsiderable merit that the pilot trials

showed cost savings of around 14 per cent — equivalent to £1,000m per year on a UK-wide basis if repeat dispensing were used for all maintenance therapy. Again, like electronic pricing of prescriptions, fully developed systems of repeat dispensing exist in other parts of the world, needing minimal adaptation to the British market. And again the NHS is dragging its feet. The excuse is that ETP will provide a repeat dispensing system. There is, however, no

intrinsic reason why it should do so automatically and no information on possible ways of working, just a vague reassurance that the black boxes will work their magic, perhaps just as they have done in so many other Government big computer projects.

Now let us consider automated dispensing in hospitals. Large sums are being spent on this system. Moreover, there is much "hidden" expenditure on major building alterations, which are not counted against the project cost. The machines are extremely large, extremely expensive and extremely slow. This may seem a sweeping statement, out of line with the spin but it is based on examination of systems in use.

Of course, with time and more money their speed will improve and it might, one day, be possible for the machines to be fully proficient and accurate so that they do not need the present army of human attendants. It is also worth bearing in mind that there are reports of a major near miss in the US involving almost 5,000 wrong dispensings, all of which had to be retrieved from patients.

When these machines go wrong they do so on a grand scale. Yet work on these expensive monsters is being pressed ahead in a way that contrasts strongly with the lackadaisical progress in repeat dispensing.

Finally, there is the strong growth of supply direct to the patient from the manufacturer and the recent announcement that new internet pharmacies will be exempt from the control of entry regulations. Direct supply is more expensive, cumbersome and inconvenient than supply via wholesalers and retailers — as many dot-com companies found to

their cost — and there seems no clear reason why new internet pharmacies should have special treatment.

So what is going on? One strong rumour is that the Treasury (not the Department of Health) has had a vision of a future medicines supply system that involves big, automated central dispensaries fed directly with e-prescriptions and posting medicines out to their customers. The major pharmacy multiple groups are also known to be carrying out market research into similar systems: much cheaper and far less messy than all those little community pharmacies.

We may call this the "motor car parts counter approach" because it treats medicines as mere articles of commerce, perhaps slightly complicated articles but no more so than motor car parts. Of course, as side effects of this system of supply, patients no longer receive advice with their dispensed medicines and community pharmacy ceases to exist — there is no gain without pain.

The drawback to this approach is that it misses the essential point: that medicines are not items of commerce as the term is normally used. They are literally life and death affairs for millions of people. If the lambda sensor for my BMW does not arrive until Thursday it is an inconvenience, perhaps a severe inconvenience, but not life threatening. In contrast, if my Ikorel and enalapril arrive three days late, I will likely have an angina attack, go into heart failure and will be lucky to survive long enough to be admitted to hospital. There is a degree of exaggeration here, but not much.

All practising community pharmacists know these things in their bones but it may be that as a profession we should begin to assemble an evidence base for community pharmacy. What are the proven, peer reviewed, reasons for having community pharmacy? Does it, overall, diminish morbidity and mortality to an extent that is distinct from the actions of the medicines which it provides? Is the large amount of unrecorded medicines management that quietly takes place having a beneficial effect and, if so, how large an effect? In the last analysis, can we justify the expense of community pharmacy?

In short, we should, perhaps, begin to prepare to justify the continued existence of community pharmacy to an increasingly sceptical government. General medical practice faced a similar need in the 1970s and facing and dealing with that need, produced profound, and beneficial, changes in general practice. We may need to do the same.

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