Community pharmacy: moving from dispensing to diagnosis and treatment

Changes to the NHS community pharmacy contract have meant a shift of services from NHS primary care to the for profit community pharmacy sector. Elizabeth Richardson and Allyson M Pollock look at the extent of the changes to community pharmacy in the UK, and explain the implications.

Deregulation and changes to the NHS community pharmacy contract in England and Wales have allowed for the shift of clinical services from NHS primary care to the for profit community pharmacy sector. In 2005 the UK government implemented reforms to the organisation and delivery of community pharmacy services and the rules governing market entry in England. The government argues that expanding the range of services provided by community pharmacies will increase access and patient choice, reduce general practitioner workload, and lower costs to the NHS. Whereas the 2003 Health and Social Care Act enabled primary care organisations to contract with the private sector for the provision of primary care services, the 2005 NHS (pharmaceutical services) regulations allow community pharmacies in England and Wales to provide a new range of services to the NHS, some of which were once the reserve of general practitioners.

Changes to the UK community pharmacy sector

The community pharmacy market
Community pharmacies have been independent contractors to the NHS since 1948. A pharmacy can only dispense NHS prescriptions under contract with a primary care organisation. By law, a pharmacy must be owned by a pharmacist or a company that employs a designated superintendent pharmacist. No limits are placed on how many pharmacies one company may own.

There are three classes of drugs in the United Kingdom: prescription, pharmacy (sold without prescription but under the general supervision of a pharmacist), and general sales list. The first two can be provided only in a pharmacy, but general sales list drugs may be sold in any retail outlet. The range and availability of over the counter drugs—that is, pharmacy and general sales list—is increasing; since 2002, the government has authorised the switch of 69 substances from prescription to over the counter status, lifted advertising restrictions on many over the counter drugs, and eliminated resale price maintenance on branded generics.

Competition on non-prescription items has increased dependence on NHS funding; pharmacies now derive at least 80% of their income from the NHS. The structure of the pharmacy market is also changing. Between 1998 and 2008, pharmacies in England and Wales comprising five or fewer outlets declined from 57% to 39%. Across the United Kingdom, large chains (>30 outlets) now own 51% of all 12 974 pharmacies and employ 54% of all community pharmacists.

Extending the range of NHS pharmaceutical services
Of the 41 768 practising pharmacists registered in the United Kingdom, 71% work in the for profit community pharmacy sector—that is, as either a salaried employee of a company owning multiple pharmacies, such as Boots, often referred to as “multiples”; or as an owner or employee in an independent pharmacy. The industrialisation of pharmaceutical manufacturing and the development of new dispensing technologies largely eliminated the traditional compounding and dispensing roles of community pharmacists, and pharmacists have responded by expanding the range of professional services provided to the NHS.

These services included smoking cessation, needle exchange, and supervised methadone administration, and were typically arranged through service level agreements with primary care organisations. Government policy towards pharmacy services began to change with the publication of the NHS plan in 2000 (see table 1 for a list of key policy developments). In 2005, the statutory provisions governing pharmaceutical services supplied to the NHS were restructured, and a new pharmacy contract was introduced which incorporated a range of new services. As with primary care services provided to the NHS under the UK general medical services contract, pharmacy services in England and Wales are now divided into three categories: essential, advanced, and enhanced. Every contracting pharmacy must offer seven “essential” pharmacy services. Advanced and enhanced services are optional, and they require additional certification for the pharmacist and a private consultation area for patient use. Currently one “advanced” service—the Medicines Use Review and Prescription Intervention—is nationally agreed. The statute lists 19 “enhanced” services, which are defined and commissioned by local trusts (see table 2 on bmj.com). The government has announced an additional service category—directed enhanced services—which will be mandatory and nationally funded, but it has yet to determine which services will be designated under this category.

NHS funding for pharmaceutical services
Essential and advanced services are funded nationally. For 2008-9, total central funding was about £2.2bn (€2.54bn; $3.35bn). Central funding for 2009-10 will increase to £2.3bn, a 3.9% rise in total funding. This figure covers an agreed national capitation payment known as the global sum, which is allocated through dispensing fees and payments tied to dispensing levels. It also covers some payments that are allocated through primary care trust budgets, such as the fee for medicine use reviews; and an agreed level of profit paid to pharmacies for the generic drugs they procure on behalf of the NHS, known as retained purchase profit (see table 3).
Enhanced services are negotiated locally with trusts in competition with other healthcare contractors, and are funded from local budgets.

**Changes to control of entry regulation**

Since 1987, control of entry regulations have governed supply of pharmacies across the country. However, in 2005, England—but not Scotland or Wales—partially deregulated the market in response to an Office of Fair Trading report, which argued that control of entry regulations impeded fair competition and service innovation.8

In England, a pharmacy contractor is exempt from the control of entry test if it is established in a large retail area (15 000 m² or more); internet based; established within a one stop primary care centre; or open more than 100 hours a week. These criteria favour chain and supermarket pharmacies. The Health Act 2009 was a partial response to concerns that deregulation had impeded primary care trust planning and led to a clustering of pharmacies in some areas.16

Under the act, primary care trusts will be required to conduct a Pharmaceutical Needs Assessment, which will replace control of entry as the basis for granting pharmacy contracts.3 Draft regulations are expected shortly, to be implemented by April 2011.17

**Implications for primary care and pharmacists**

**Fragmentation of NHS primary care services**

The 2003 general medical services contract and 2005 community pharmacy contract are complementary reforms. The unbundling of primary care under the general medical services contract allows services to be contracted out to alternative providers, whereas the pharmacy contract permits pharmacies to undertake some of these services. The two contracts, however, are treated in isolation from each other, with little consideration of how continuity of care, quality, and patient safety will be managed and regulated. Few mechanisms exist to encourage interprofessional communication and collaboration between pharmacists and other health professionals,11 and there is a risk of fragmentation of services, which could lead to duplication of efforts, the undermining of access, and increased cost through inefficiencies.

For example, the National Audit Office evaluation of the National Chlamydia Screening Programme found that local commissioning of opportunistic screening in general practices, family planning clinics, and pharmacies had led to duplication of efforts and costs, and that primary care trusts were not meeting targets for testing and treatment follow-up.18 Costs varied widely between trusts, ranging from £21 to £255 per test. A survey of primary care trust commissioners also found that pharmacy screening was the least effective in achieving screening targets.19

**Expanding pharmacy services: accountability, data, and evidence**

By 2007-8, the number of enhanced services commissioned by the NHS in England had increased from 17 745 in 2005-6 to 25 229,21 a 42% increase. Most fall into five categories: smoking cessation (18.8%), methadone administration (17.9%), patient group directions (11.4%), minor ailment schemes (10.9%), and drug review (9.5%).19 Distribution of these services both across and within NHS trusts is uneven; in 2007-8 the highest service commission rate within one trust was 575 services, and the lowest was 10.20 A 2006 survey of primary care trusts showed that 216 had commissioned at least one enhanced service, whereas the median number of commissioned services was six.21 Another survey of 31 trusts found that more than 40% of pharmacies are providing three or more enhanced services, whereas 13% are not providing any.22 Most services predate the implementation of the contract; only an estimated 20% of enhanced services were established after the contract.22

Data on the specification, funding, and monitoring of enhanced pharmacy services are not centrally collected by the Department of Health, making it difficult to draw general conclusions about their effectiveness and efficiency. Value for money is also difficult to determine, because the true costs of providing pharmaceutical services are obscure, especially in relation to premises and staff.

Good evidence supports the provision of some extended services, like smoking cessation and emergency hormone contraception supply,22 and early evidence suggests that asthma targeted Medicine Use Reviews are beneficial.23 However, the evidence base on value for money and effectiveness of more complex services—such as screening and minor ailment clinics—is limited and more research is needed.22,24

**Commercial conflicts of interest**

The effects of deregulation and changes in ownership structure on access, coverage, and provision are not clear. Although service provision does seem to vary by ownership,17 these variations may

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**Table 1 | Policy milestones for pharmacy in England**

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<th>Milestone</th>
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<td>Supplementary and independent prescribing rights extended to pharmacists, 2003 and 2006 respectively</td>
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<td>Health Act 2009</td>
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**Table 2 | Policy milestones for primary care in England**

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**Table 3 | Central funding for pharmaceutical services, 2008-9**

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<th>Type of funding</th>
<th>Amount (£m)*</th>
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</thead>
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<tr>
<td>Fees and allowances:</td>
<td></td>
</tr>
<tr>
<td>Global sum (dispensing fees and item fees, establishment payments)</td>
<td>1648</td>
</tr>
<tr>
<td>Payments allocated through primary care trust budgets (practice payments and advanced services)</td>
<td></td>
</tr>
<tr>
<td>Retained purchase profit</td>
<td>500</td>
</tr>
<tr>
<td>Pneumococcal vaccination grants</td>
<td>18</td>
</tr>
<tr>
<td>Total funding</td>
<td>2231</td>
</tr>
</tbody>
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| Adapted from PSNC. | 
| £1 = €1.15 = $1.53. |
have multiple explanations, including willingness
and ability of the contractor to provide them, as well
as their appropriateness for a given location. Bush and colleagues suggest that corporate chains are
likely to attract a greater proportion of com-
misisioning income.24 This has implications for
accountability, because service contracts between
the NHS and the private sector are often confidenti-
Al. For example, Boots, the UK’s second largest chain,
was chosen to operate a two year chlamydia screening
plot project in 2005, as part of the National Chlamydia Screening
Programme. Both the contract value and the final econ-
omic evaluation of the service were deemed commercially sensitive and were not made pub-
licly available.25

Corporations also have obligations to sharehold-
ers that can conflict with public health priorities. In 2002 Tesco withdrew an emergency contracep-
tive service after criticism from prolife groups.26 In
2008 a review of the Medicines Use Review service
found that chains had implemented the service more rapidly, but it also noted a weak, negative
association between levels of provision and levels
of deprivation and long term illness.27 Reports also
suggest that chain pharmacies pressure employees
to conduct as many reviews as possible.28 The gov-
ernment’s evaluation showed that the number of
reviews conducted was highest in the final month of
the fiscal year, partial evidence that provision is
being driven by profit rather than patient need.3
Further research is needed to determine the rela-
tion between ownership, service provision, patient
access, and quality of care.

All practising pharmacists and all pharmacy
premises must be registered with the Royal
Pharmaceutical Society of Great Britain, which is
the professional and regulatory body—regulatory oversight will be passed to a new body, the General
Pharmaceutical Council in 2010. The society has limited jurisdiction over the terms and condi-
tions of employing pharmacists, an area for concern in a workforce that increasingly comprises salaried employees of corporate chains. As the sector becomes more corporate, some are concerned that professional autonomy may be constrained, and that pharmacists may become deskilled and lose their professional status.29 30 31

The new pharmacy contract was intended to
shift pharmacy’s focus to services, but funding is
still tied primarily to dispensing and drug margins,
rather than service quality or clinical outcomes.32
A full cost of service inquiry is being conducted,
the results of which are expected to inform new
funding mechanisms.

Conclusion
Together with the UK general medical services
contract, the new pharmacy contract allows a shift
of NHS services from general practice to private
for profit community pharmacies in England. This
reflects broader government policy to incorporate
the private sector into the provision of NHS care,
and transfer tasks away from general practition-
ers.3 As more services are contracted out, the
boundaries between private and public funding and
provision may become blurred and difficult
to monitor and regulate.
The role of the pharmacist is changing, as is seen by
the extension of prescribing rights to pharmacists
and other alternative providers,33 referrals from NHS Direct,34 and the progressive deregulation
of the pharmaceutical and pharmacy markets.
Market competition and reform of control of
entry have allowed the dominance of large corpo-
rate providers, which has implications for service
provision that are not well understood in the UK,
and which could undermine attempts at expand-
ing pharmacists’ professional role. As the health
systems of Scotland, England, and Wales diverge
it will be important to monitor these changes and
their implications for the NHS. The absence of
national data, central monitoring, and research
into these changes means that the effectiveness,
equity, efficiency, value for money, and above all
the implications for access, safety, and quality of
patient care are not known.35

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ships with commercial entities that might have an interest in
the submitted work; (3) No spouses, partners, or children
with relationships with commercial entities that might have an
interest in the submitted work; (4) No non-financial interests
that may be relevant to the submitted work.
Provenance and peer review: Not commissioned, externally peer reviewed.
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