

# Community pharmacy in a commissioning-led NHS: Can pharmacy compete effectively?

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# Commissioning: policy context

- ▶ *“Commissioning is the process by which the health needs of a population are assessed, and responsibility is taken for ensuring that appropriate services are available which meet these needs”* (Mannion, 2005).
- ▶ *Shifting the balance of power within the NHS* (DH, 2001) made the commissioning of services a core responsibility of English PCTs from 2002.
- ▶ *Commissioning a patient-led NHS* (DH, 2005) moved the emphasis of PCTs from spending on services to investing in health and well-being outcomes.
- ▶ Commissioning function reinforced by new contracts across primary care – medicine, dentistry and pharmacy.

# New Labour – increasing private sector involvement

- ▶ Acheson (1988):
  - ▶ *“The science and art of preventing disease, prolonging life and promoting, protecting and improving health through organised efforts of society.”*
  
- ▶ Wanless (2004):
  - ▶ *“The science and art of preventing disease, prolonging life and promoting health through the organised efforts and **informed choices** of society, **organisation**, public and **private**, communities and **individuals**”*

# Darzi

- ▶ NHS Next-stage Review (Darzi; DH, 2008)
  - ▶ Heralded arrival of 'Polyclinics'/GP-led Health Centres.
- ▶ Post-Darzi
  - ▶ Virgin Healthcare (Virgin Group – revenues £10 billion+ in 2006) to access primary care sector in 2008
  - ▶ Furthermore Tesco (£50 billion+), Asda (Wal-mart – approx £194 billion), Boots and Lloydspharmacy rumoured to be looking to challenge traditional model.

# Devolution

- ▶ Since 1991 baseline of Thatcher's 'internal market', each system has taken a distinct path (Greer, 2003):
  - ▶ England: most market based with a focus on service provision rather than new public health
  - ▶ Scotland: near opposite – unitary NHS with commitment to new public health
  - ▶ Wales: reluctance to work with private sector with a strong commitment to new public health that shapes its service organisation.

# Pharmacy policy context - England

- ▶ The 'New' (2005) Pharmaceutical Services Contract introduced differing levels of service provision:
  - ▶ Essential Services
    - ▶ to be offered by all contractors
  - ▶ Advanced Services
    - ▶ optional and require accreditation (of both pharmacist and pharmacy premises)
  - ▶ Enhanced Services
    - ▶ commissioned locally by PCTs on the basis of need.

# Pharmacy policy context - Scotland

- ▶ New Scottish contractual framework
  - ▶ Structure different to its English equivalent
  - ▶ Four distinct core components rather than differing levels of service:
    - ▶ Acute Medication Service – ‘classic’ dispensing function
    - ▶ Chronic Medication Service – pharmaceutical management of long term conditions
    - ▶ Public Health Service
    - ▶ Minor Ailments Service
  - ▶ Plus ‘additional’ services
    - ▶ Similar to ‘enhanced’ service level of English contract.

# Methodology

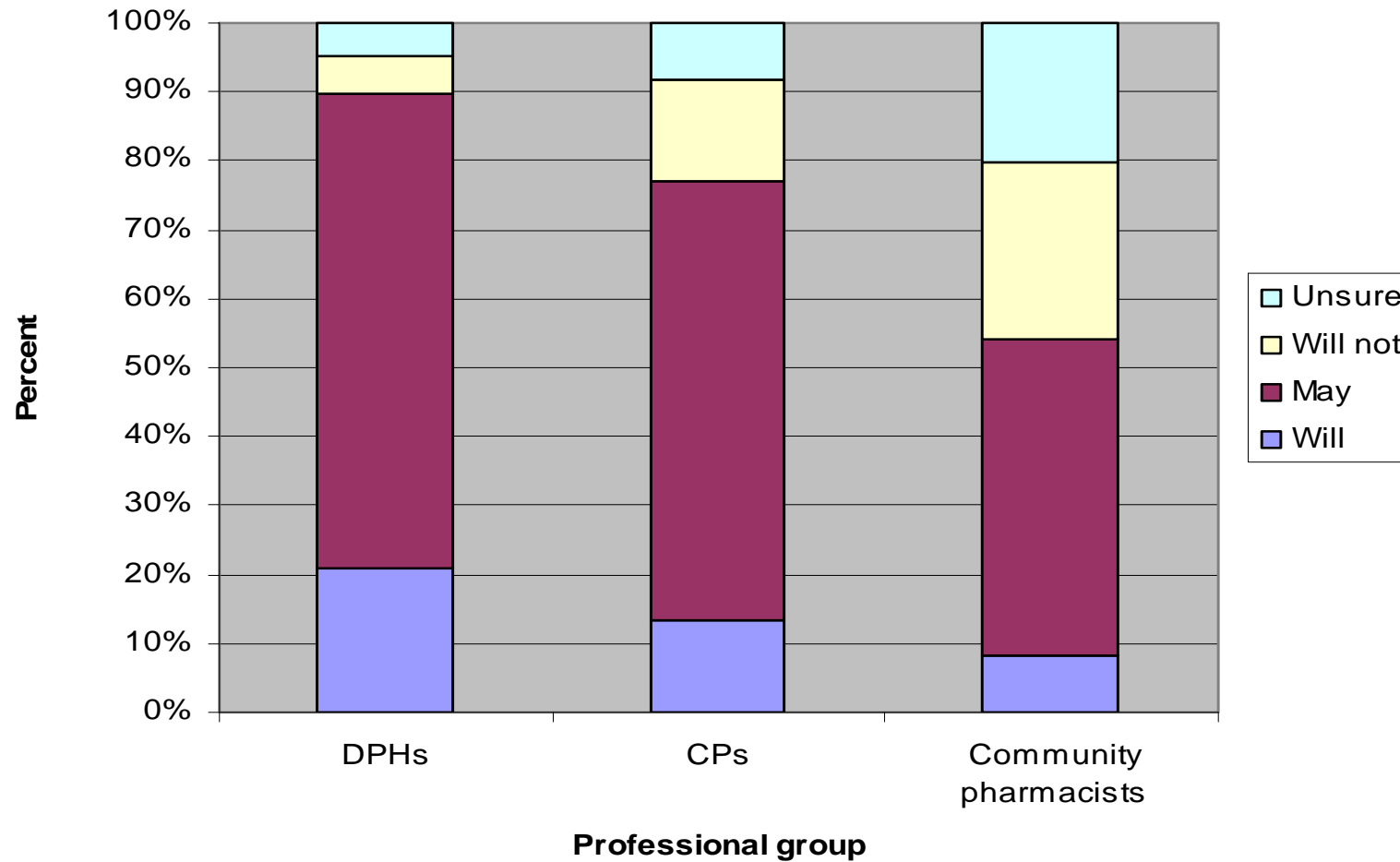
- ▶ Comprehensive literature review
  - ▶ Identification of purposive sample (n=6) for exploratory interviews
- ▶ Self completion postal questionnaire developed
  - ▶ Sample: Directors of Public Health and Chief Pharmacists across UK (response: 307/627 = 49%)
- ▶ Questionnaire adapted to reflect a community pharmacy audience
  - ▶ Pilot study



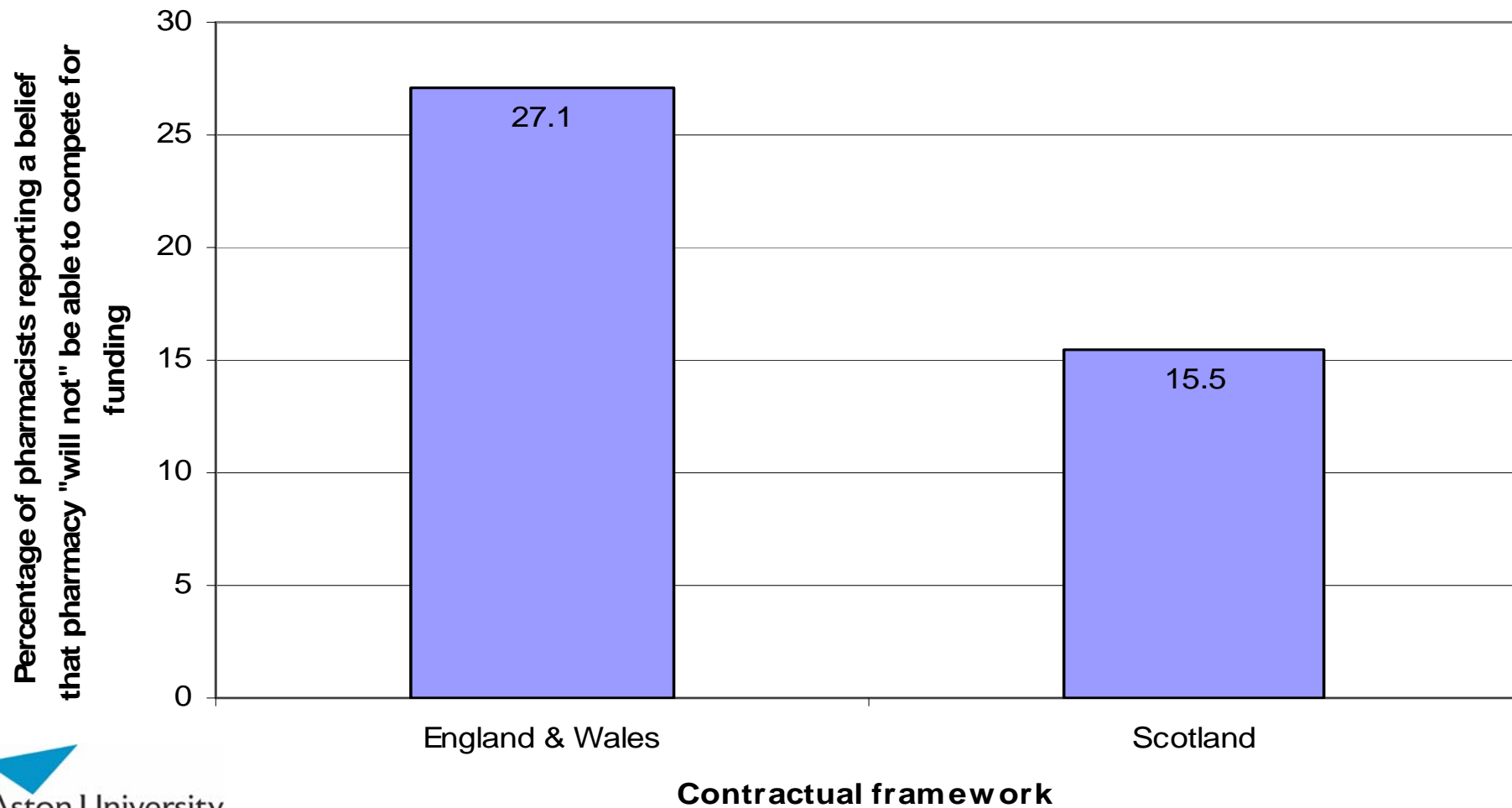
# Methodology (cont)

- ▶ Self-completion postal questionnaire
- ▶ Sample of 1998 practicing community pharmacists stratified for sex and country of residence (England, Scotland and Wales)
- ▶ Initial mailing – August 2006
  - ▶ Follow-up to non-responders at 4 weeks
- ▶ Response:  $1023/1998 = 51\%$

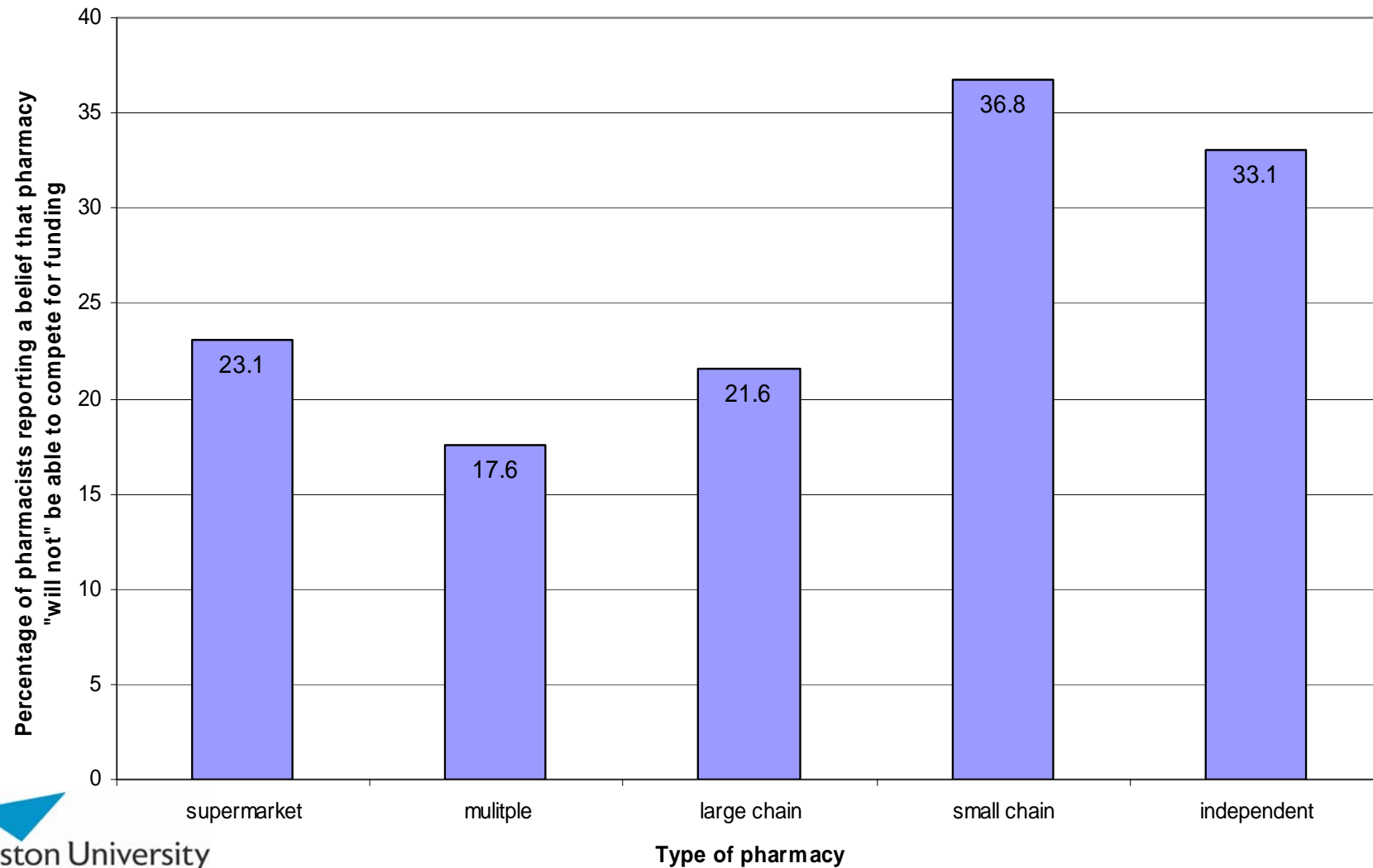
# Will community pharmacy be able to compete effectively for funding?



# “Will not” be able to compete by country of residence



# “Will not” be able to compete by type of employing pharmacy



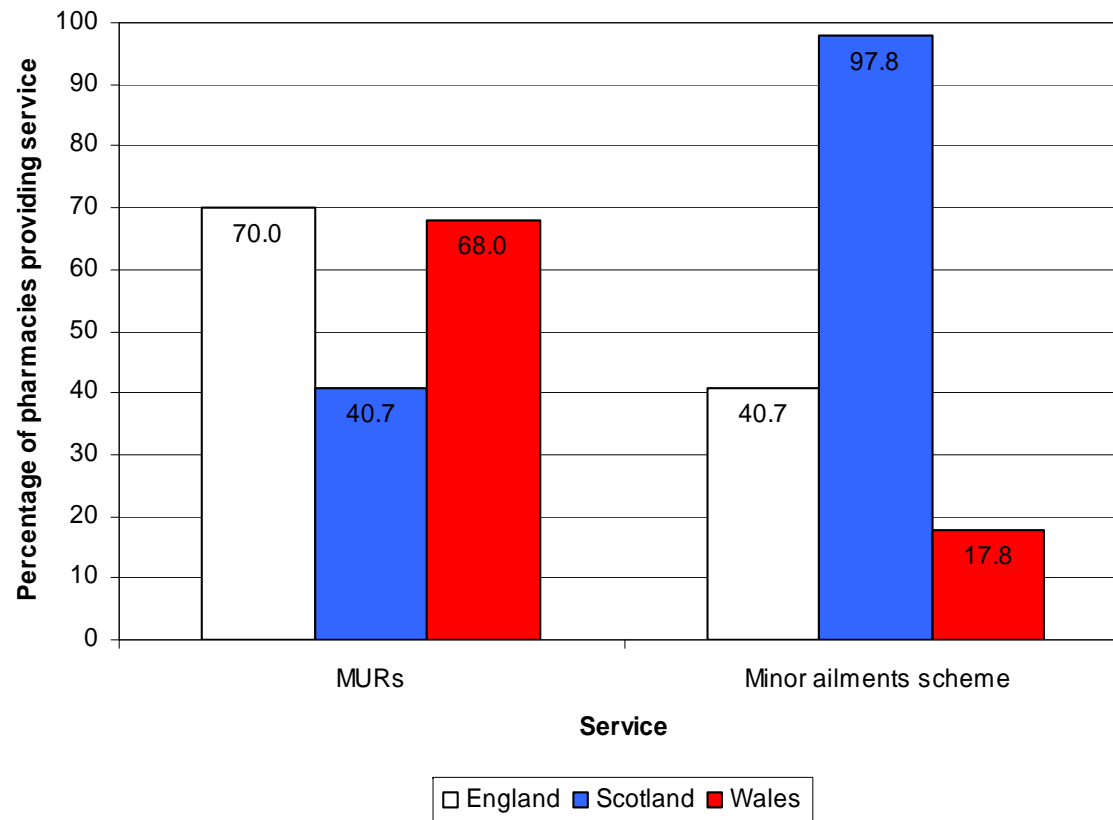
## Suggested reasons for the perceived inability of pharmacy to compete effectively

Reason	Number of respondents
Power of GP lobby	36
NHS financial constraints	35
Inability of the national pharmacy organisations to represent the interests of community pharmacy effectively	33
The failure of PCOs to recognise the potential of community pharmacy	24
Time constraints	18

## Suggested reasons for the perceived inability of pharmacy to compete effectively (cont)

- ▶ *“PCTs are run by GPs for the benefit of GPs”*
- ▶ *“PCT have no funds available to pay for extra services”*
- ▶ *“We do not have a national body with enough clout or backbone to fight for us”*
- ▶ *“PCTs don’t seem to value the importance of pharmacy”*
- ▶ *“Pharmacists don’t have time to eat lunch let alone develop services”.*

# Variations in service provision



- ▶ MURs
  - ▶ 'Advanced' level in England and Wales
  - ▶ Not included in Scottish framework (initially).
- ▶ Minor ailments
  - ▶ 'Enhanced' level in England and Wales
  - ▶ Core component in Scottish framework.

# Summary

- ▶ Community pharmacists less confident of pharmacy's ability to compete effectively for funding than Directors of Public Health and Chief Pharmacists
- ▶ Most community pharmacists employees of corporations and possess little professional autonomy
  - ▶ Little control over the decisions necessary to obtain funding



# Summary

- ▶ The devolvement of healthcare budgets to the national assemblies has led to the differential development of the public health function of community pharmacists across the UK
  - ▶ Scotland:
    - ▶ Public health enshrined as one of the four core components of the remuneration framework for community pharmacy
  - ▶ England:
    - ▶ Development of community pharmacy's public health function – in terms of the current, service-based approach – is dependent on the commissioning of local enhanced services by PCTs.

# Discussion

- ▶ Community pharmacists believe that the larger pharmacy chains and the supermarkets occupy a propitious position in terms of attracting finance to develop services.
- ▶ Inability of independents to attract funding may:
  - ▶ Hasten their demise
  - ▶ Stifle the development of community pharmacists employed within independent pharmacies

# The financial power of the multiples

Pharmacy Chain	Ownership	
	Company	Turnover (£ billion)
Lloydspharmacy	Celesio	16.4*
Boots	Alliance Boots	15.3
Rowlands	Phoenix	15.2*

*\*based on €-£ exchange rate at financial year end (31<sup>st</sup> December 2007)*

# Discussion (cont)

- ▶ Independent pharmacies may be limited in the range of services they can provide by the willingness of their local PCO to provide funding
  - ▶ Supermarkets and multiples may be able to operate outside of this restriction
    - ▶ E.g. Lloydspharmacy's diabetes testing programme
  - ▶ Why would a PCO fund pharmacy provision when some local pharmacies will provide it free of charge?
- ▶ Risk of corporate pharmacy chains becoming 'preferred providers' of services to PCOs.

# Discussion (cont)

- ▶ Multiples are attractive partners for Government because of their national scope
  - ▶ Much easier to organise provision of a service through a single partner provider with 100 outlets across the country than through 1000 independent pharmacies
    - ▶ Boots – Chlamydia testing.
  - ▶ Greater management capacity
    - ▶ Responsibility for negotiations does not fall on individual pharmacists
    - ▶ Professional development teams.

# Concluding remarks

- ▶ Viability of independents further threatened?
- ▶ Current economic climate favours large pharmacy chains and the concentration of pharmacies in areas of affluence at the expense of areas of economic deprivation
- ▶ May lead to inequities in access
  - ▶ An 'Inverse Care Law' in pharmaceutical services?