

# 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.

# 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.

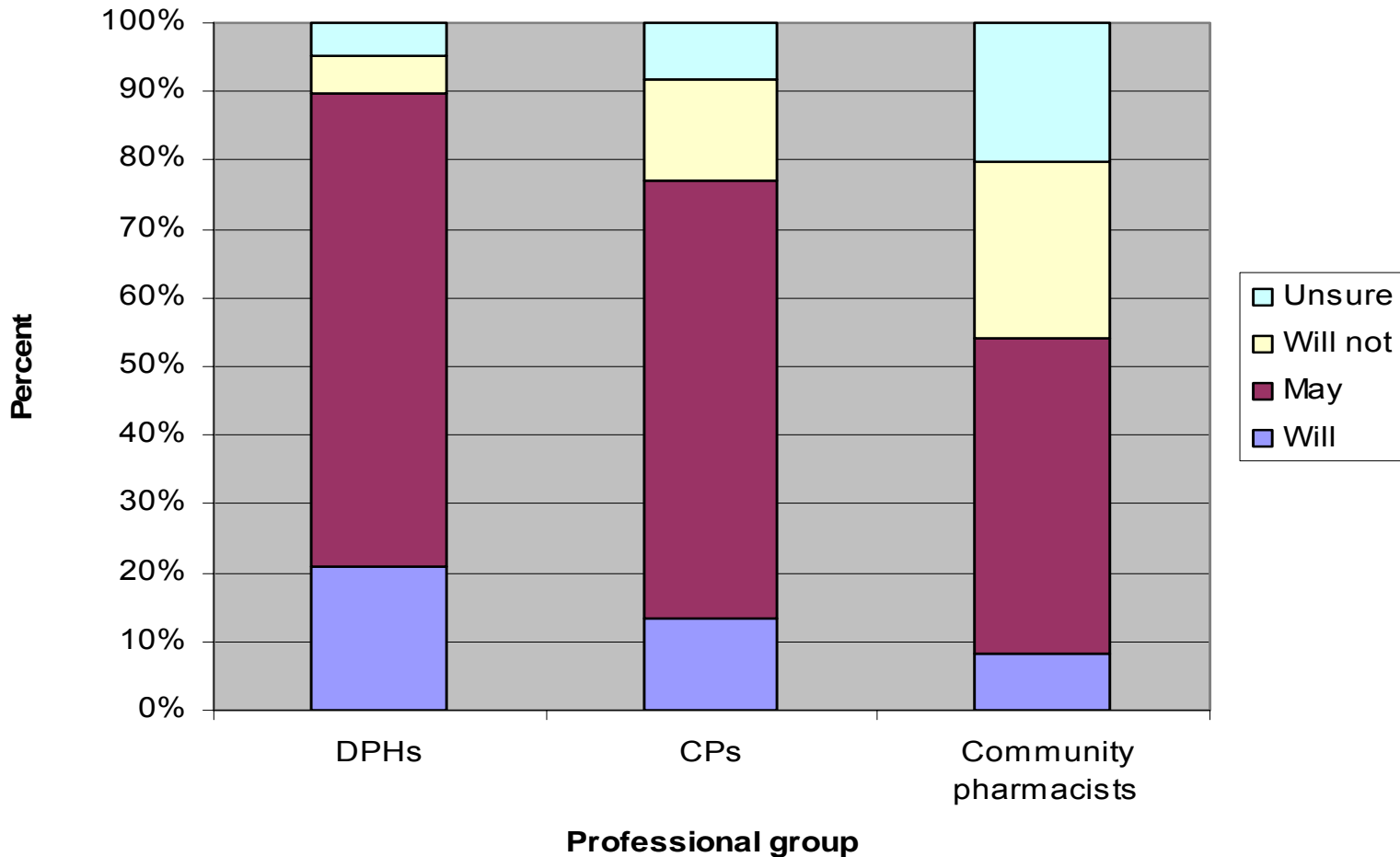
# Methodology

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

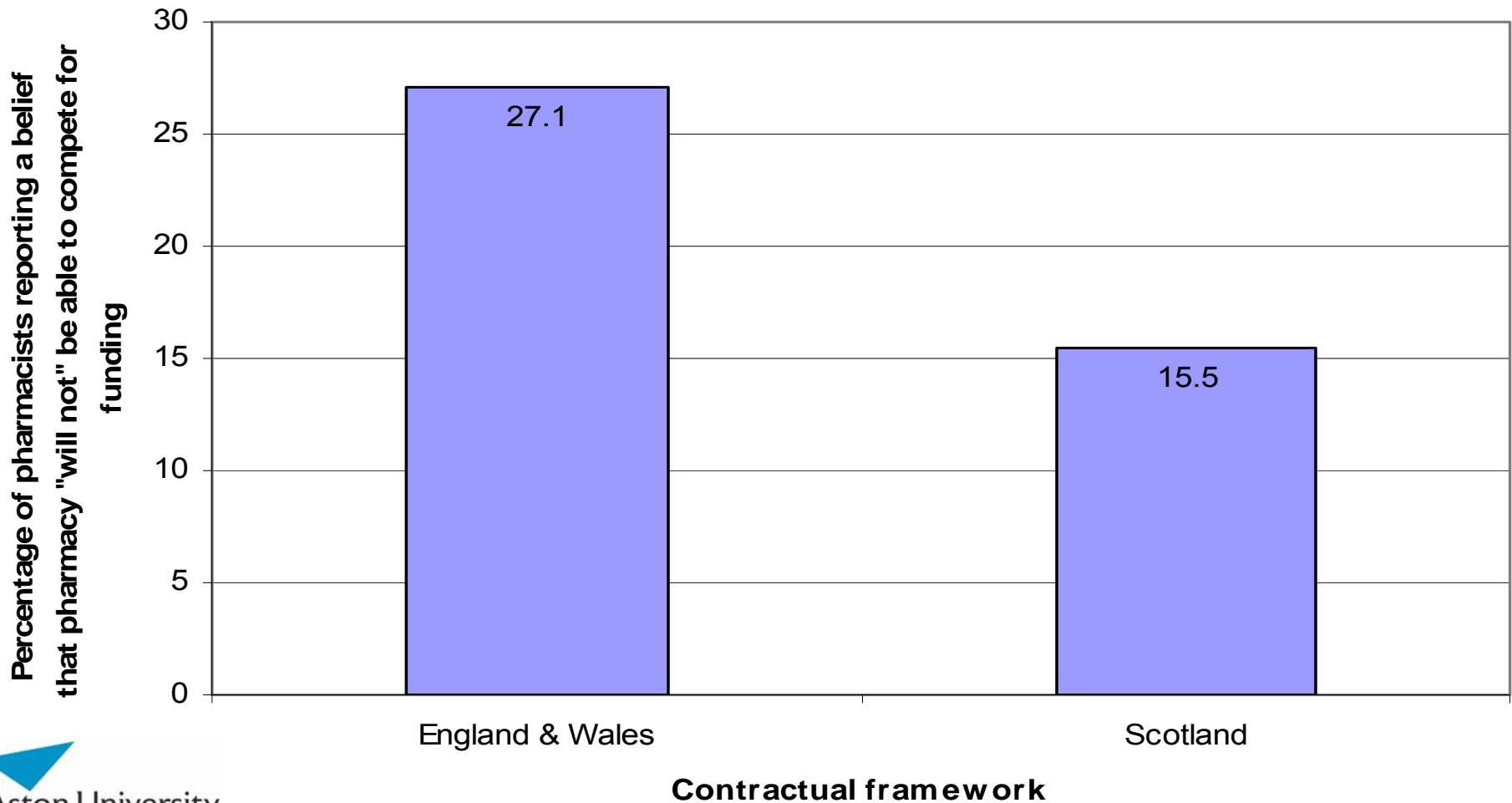
# Methodology (cont)

- ▶ 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:  $1023/1998 = 51\%$

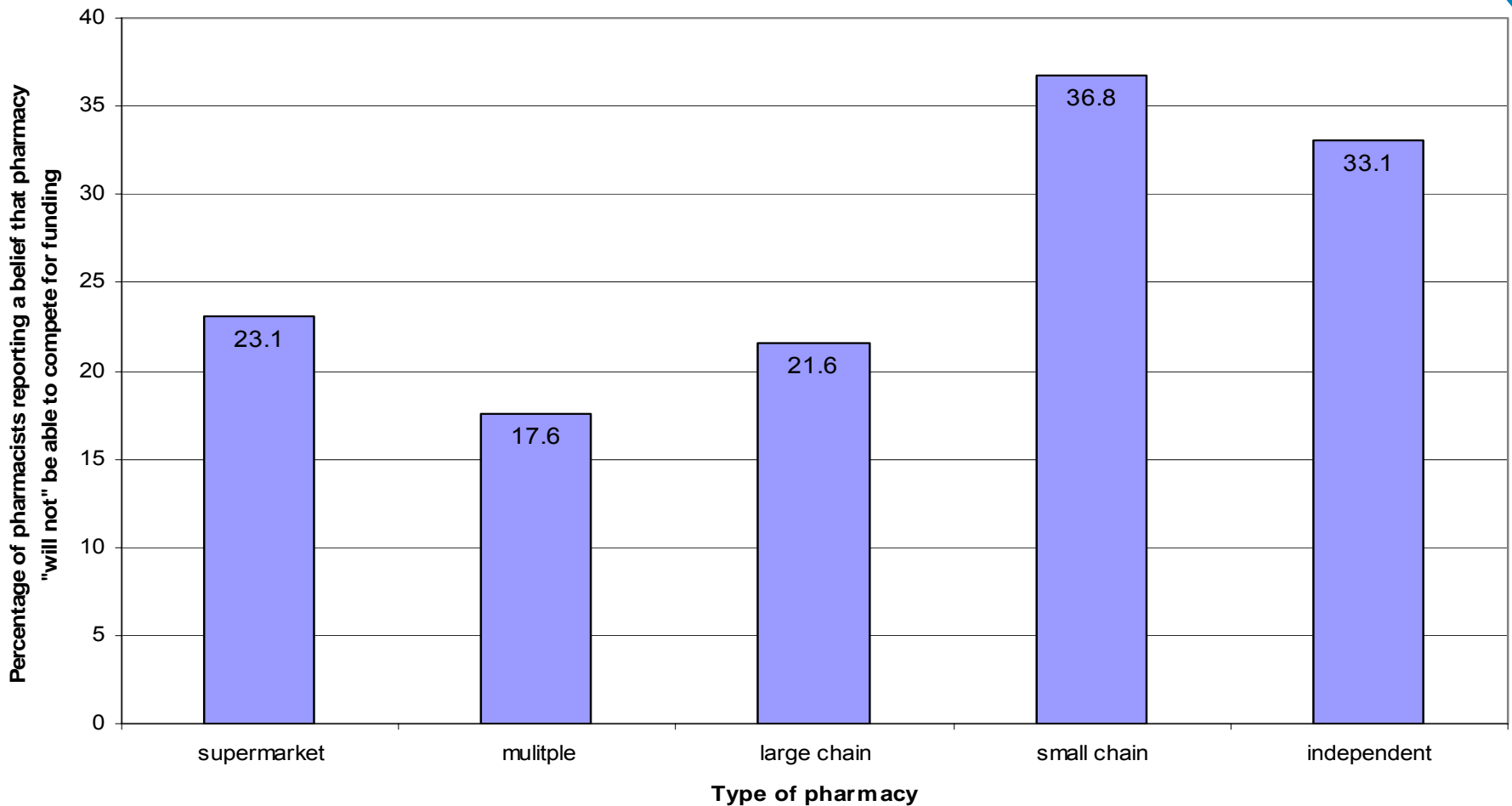
# Will community pharmacy be able to compete effectively for funding?



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



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

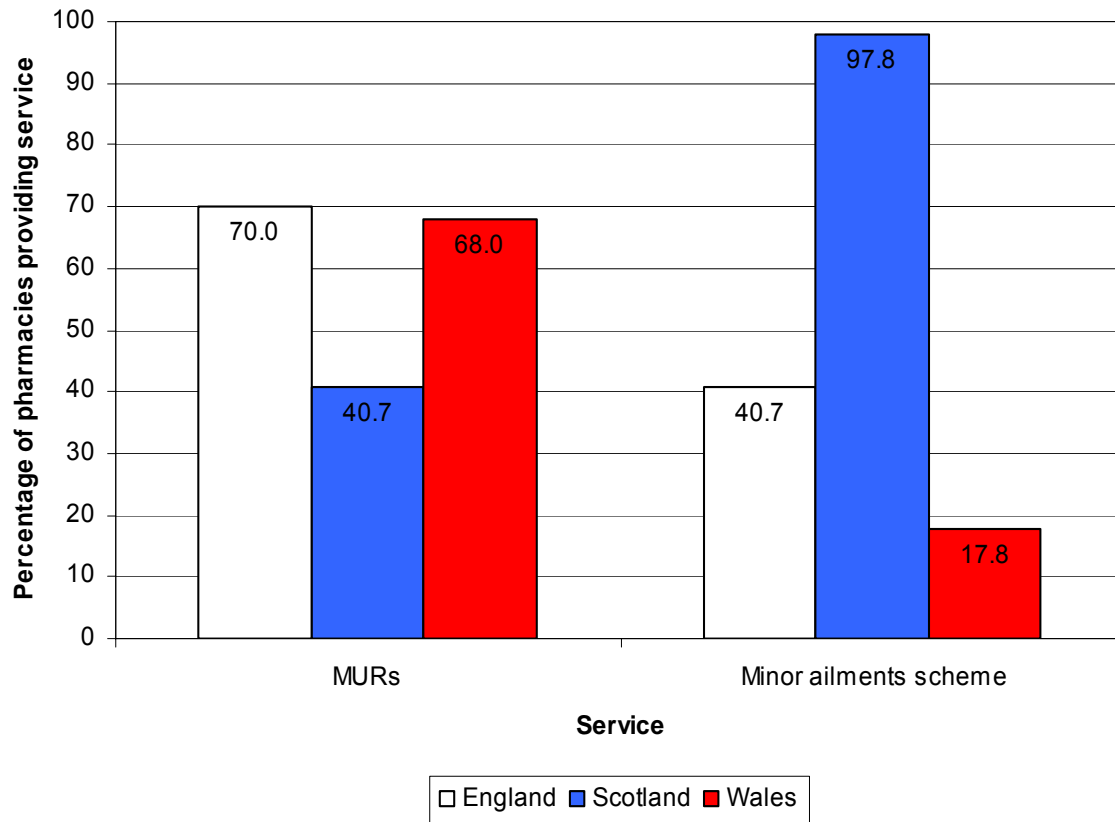


Multiple ( $n \geq 200$ ) Large chain ( $20 < n < 200$ ) Small chain ( $5 < n \leq 20$ ) Independent ( $n \leq 5$ ) – where  $n$  is the number of outlets

# 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

- ▶ 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

# 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 1000 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.

# 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)*

# 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?