

Dispensing by the community pharmacist: an unstoppable decline?

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SUMMARY. *After posing the question 'Is your chemist really necessary?' this article demonstrates that the original role of the retail chemist — the preparation and safe dispensing of medicines — has become eroded. Furthermore, it is shown that the proposed new community roles are currently being carried out by other members of the primary care team. Finally, it is argued that the retail pharmacist may not give value for money and that doctor dispensing is a less expensive and safer alternative.*

Introduction

IN his speech at the British Pharmaceutical Conference in Manchester last year the chairman of the 1986 Nuffield report on pharmacy¹ is quoted as saying, 'The dispensing role of the community pharmacist is in unstoppable decline'.

The purpose of this paper is to discuss the present and future roles of the high street chemist and to determine whether or not these proposed new roles are unique to chemists or whether they are already being fulfilled by other agencies. It also seeks to indicate the cost-effectiveness or otherwise of high street dispensing and to suggest a logical alternative method of supplying patients with medication. In short, it is an attempt to answer the question 'Is your chemist really necessary?'

The disappearing role of the chemist

Currently the main role of the chemist is to supply medicines according to prescriptions written by the doctor. It is assumed that the doctor is aware of the effects of the medications he prescribes and it is, of course, the doctor who takes sole responsibility for inappropriate prescribing. In effect, the chemist acts rather like the chef in a kitchen, preparing the order as written on the piece of paper presented to him. Unlike the chef, however, he is not allowed to embellish it in any way. He is simply a supplier of goods, a storekeeper reaching for goods from a shelf. Industry has, furthermore, seen to it that those goods are pre-packed in standard boxes or containers. This is original pack dispensing which will account for upwards of 80% of dispensing within the next 12 months.

It has been said that by double-checking prescriptions the chemist has saved many a patient from the mistakes of doctors. That may be so but this role is rapidly being supplanted by computer technology in doctors' surgeries and dispensaries. Modern software includes essential cross-checks to improve the safety of dispensing, including a complete pharmacopoeia together with side-effects and interactions cross-referenced with the doctor's repeat prescription list and with a patient-disease register. This prevents patients receiving drugs which are inappropriate to either their current medication or their disease; for example, aspirin and warfarin or aspirin and duodenal ulcer. As the patient-disease register is confidential, the information can only be held by the doctor and never by the chemist. The back-up role of the chemist is thus disappearing.

The pestle and mortar days of preparing medicines have been overtaken by pharmaceutical industrial technology which accurately and aseptically produces complex medicines, pills and ointments. Only occasionally, following consultant directions, are complicated medicines made up in a pharmacy. The mixing role of the chemist has thus been eliminated.

Since the Nuffield report there has been much controversy over the question of the supervision of dispensing. Chemists employ well qualified dispensers whose job is to prepare the medicines for checking by the chemist himself who has, by law, to be present whenever dispensing takes place. A degree in pharmacy seems to be an over-qualification for reading a label on a box and comparing it with details on a prescription form. The qualified dispensary assistant is more than capable of this simple task — a fact recognized both by the Nuffield team and by chemists. The chemists' dilemma is that only compulsory supervision differentiates them from dispensing doctors, many of whom employ qualified staff who have left hospitals or high street chemists. The Dispensing Doctors' Association will shortly be sponsoring a staff training scheme equal to the National Pharmaceutical Association course. The supervisory role of the chemist has thus declined.

Future role of the chemist

Both the Nuffield report and chemists' representatives have suggested that simplifications in procedures for dispensing should release the chemist for community tasks. What are these tasks which chemists are seeking to undertake?

It has been suggested that chemists should supervise the medication of nursing home residents. However, this is the responsibility of the prescribing doctor and the matron of the home and involving the chemist could easily lead to confusion of advice and, consequently, an adverse effect on the patient.

Health education and advice is, at present, carried out by health visitors, practice nurses and doctors as well as some chemists, who may have literature for distribution in their shops. Non-dispensing chemists could equally well make such literature available. Chemists, however, are not currently trained to give advice about health and indeed, several surveys over the last few years have shown that the advice chemists do give is inappropriate and may even be dangerous.^{2,3} Better advice is given by practice nurses who have no subconscious temptation to sell over-the-counter remedies.

Some chemists have expressed a desire to visit the elderly in their homes to check on their medication. However, the sick elderly are likely to be on the visiting list of the doctor, district nurse, health visitor or social worker — if not all four — and any visit by a chemist would be condemned by most doctors as superfluous.

Far from being the unique providers of some new aspect of health care, the chemist in his new role, with no training in medicine, would perform identical tasks to appropriately trained members of the primary health care team, and would expect payment for these sinecures without a reduction in fees for the now less arduous dispensing role.

Cost-effectiveness

Does the National Health Service receive a cost-effective service from chemists in their present dispensing role?

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A recent article⁴ showed that the scale of dispensing fees of the chemist, according to the most recent drug tariff,⁵ ranges from £1.30 for the first 1400 items to £0.67 after 2200. But this is not the whole story since there are many additional fees such as £1.00 for special medicines, £2.00 for mixing ointments, up to £15.25 for urgent items after closing time.

The 'red book'⁶ lists the fees received by the dispensing doctor. The one simple scale ranges from 76.0p for the first 400 items to 59.7p after 4001. There are no 'urgent' or 'additional' fees. Considering that the tasks are identical there is a case for either reducing the chemists' or increasing the doctors' fees; in view of the fact that dispensing is now less arduous the former is more reasonable.

The Prescription Pricing Authority's figures for 1985-86⁷ and 1986-87⁸ both show that dispensing doctors made substantial savings for the NHS. The saving amounted to 25p per item or an overall £5.25 million in 1985-86⁹ and more the following year.¹⁰ A large proportion of the £5.25 million saved by dispensing doctors in 1985-86 was due to a lower net ingredient cost, probably because dispensing doctors are more frugal prescribers or more cost conscious as they pay for the medicines themselves in the first place.

All these figures emphasize that the service provided by chemists is much less cost effective than that of doctors. However, in considering the doctors' figures it must be emphasized that doctors pay value added tax to their wholesalers and chemists do not. The repayment of the doctors' VAT by the Department of Health distorts the doctors' figures leading to the impression that dispensing by chemists is cheaper. Comparing like with like doctor dispensing still costs 25p less per item.

A better alternative

Is dispensing by doctors a better alternative to high street dispensing and if so why?

First, computerized dispensing by doctors is safer, if only because the doctor's computer holds more information.

Secondly, patients prefer the convenience of obtaining their medicines at the surgery and are more inclined to ask questions about their medicines.

Thirdly, the dispenser has ready access to the doctor for queries and in the most up-to-date surgeries the doctor has a computer terminal in his room so the prescription may be dispensed by the time the patient reaches the dispensary.

Finally, the NHS gains from the savings made which would have amounted to around £90 million in 1985-86 had all general practitioners dispensed.

In summary, dispensing by the doctor is cheaper, safer and more convenient.

Free choice for patients?

The case against high street dispensing becomes stronger with the improving technology of dispensing. The chemist is following in the path of many other casualties of technology and is becoming redundant.

Only rural patients, however, may benefit from the development of dispensing by doctors because the much disputed Clothier regulations prohibit dispensing by doctors in towns. Abandoning the Clothier regulations and permitting complete freedom of choice for patients in town and country would be a first step in improving the dispensing service to both patient and NHS. Chemists say this would be the end of community pharmacy. If that is so then the case for doctor dispensing will have been made by those who matter most — our patients.

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