General Pharmaceutical Services

Pharmaceutical services within the NHS

Pharmacists are trained, qualified and registered healthcare professionals who practise the art and science of pharmacy, i.e. the dispensing to patients of drugs/medicines and appliances.

Under the Medicines Act 1968 there are three legal categories of medicines:

- General Sales List (GSL) Medicines – which can be freely sold over-the-counter and are available in a wide range of retail outlets;
- Pharmacy-only (P) Medicines – which can be sold over-the-counter but may only be dispensed by, or under the supervision of, a registered pharmacist;
- Prescription-Only Medicines (POMs) – which must be prescribed for a named patient by an appropriately registered healthcare professional and dispensed by, or under the supervision of, a registered pharmacist.

In NHS hospitals, the dispensing role is fulfilled by hospital pharmacies, which are staffed by pharmacists working as salaried NHS staff. In NHS community services, it is mainly fulfilled by General Pharmaceutical Services, provided through independent contractors (community pharmacies), as has been the case since the inception of the NHS in 1948. The total number of NHS community pharmacies in England at 31 March 2006 was 9,872.

In certain designated (mainly rural) areas that lack easy access to a community pharmacy, GP practices can be permitted (subject to certain criteria) to dispense NHS prescriptions.

Prescriptions are written by doctors and dentists, and (since 2003) by some nurses and pharmacists who act as “supplementary prescribers” in respect of a limited range of medicines. Doctors and dentists are also able to administer drugs to patients at the time of treatment.

In *Pharmacy in the Future – Implementing the NHS Plan* (2000), the government envisaged a key role for pharmacy services in the new “high quality, patient-centred health service”, and committed itself to change and modernisation in various respects.

Prescription charges

Drugs, medicines and appliances that are dispensed in NHS hospitals are provided free-of-charge. This was initially also the case in respect of primary-care prescriptions. However, flat-rate, per-item patient charges were agreed in 1951 and introduced the following year, in order to raise revenue and limit demand (chiefly the latter).

Prescription charges have remained ever since in England and have risen every year since 1982. The current charge is £6:85 per item. Exemptions from charges apply to the following groups:

- children aged under 16;
- young people aged 16, 17 and 18 in full-time education;
- people with certain medical conditions;
- people aged 60 and over;
- women who are pregnant and those who have given birth within the past 12 months;
- people on benefits / a low income (as defined in regulations);
- war pensioners whose prescription is for their accepted disablement.

In addition, Prescription Pre-payment Certificates (a form of prescription "season ticket") help people who require multiple prescriptions to reduce the cost if they are not entitled to free prescriptions on other grounds.

Around 87% of prescription items in England are dispensed free-of-charge, a proportion that has remained fairly constant in recent years.

Prescription charges are expected to raise some £425 million for the NHS in 2007–8; this is, however, a very modest sum when set against the total cost of drugs provided by NHS community pharmacy services (see below).

In October 2006 the Department of Health announced an internal review of patient charges and exemption arrangements for the NHS in England, with a brief to consider "cost-neutral" options for reform of patient charges. This was in response to a report by the House of Commons Health Select Committee on patient charges that described current charging arrangements as "a complete mess". The outcome of the internal review is due to be reported to Parliament shortly.

The cost of drugs to the NHS

The "pharmaceutical revolution" of the 1950s and 1960s saw the development of more, and better, drug-based treatments than had hitherto been available. This led to a sharp increase in the NHS primary-care drugs bill, with the cost of community pharmaceutical services overtaking, and then significantly exceeding, the cost of General Medical Services (provided by GPs). The pace of pharmaceutical innovation has quickened ever since, with the consequent inexorable rise in drug costs posing a constantly escalating challenge to NHS finances.

This trend is now being exacerbated by the current growth in the population of older people, which adds significantly to the number of people with both acute and chronic conditions that are amenable to drug-based interventions.

Expenditure on drugs in primary care has increased by some 60% in real terms over the past decade, while the number of items dispensed has increased by 55%. The five years prior to 2005 saw average annual growth of 7.3% in the cost of community prescribing. The rising cost of drugs (in hospitals and in primary care) has absorbed a significant proportion of the additional money that has been put into the NHS by the government in recent years.

Some 752 million prescription items were dispensed in the community in England in 2006 (up 4.4% on the previous year). The cost of these items was £8.2 billion (equivalent to £22 million per day), representing a rise of 3.8% on the previous year.

While advances in pharmaceutical technology and demographic change both make it inevitable that NHS drug costs will continue to rise for the foreseeable future, it is evident that there is scope to blunt this trend somewhat by obtaining better value for money.

NICE guidance

The National Institute for Health and Clinical Excellence (NICE) produces guidance with the aim of ensuring that there is consistent prescribing of effective, and cost-effective, drugs throughout the NHS.

However, there is still perceived to be a "postcode lottery" in prescribing, driven by the different financial situations in which local NHS Primary Care Trusts find themselves. The provision of drugs prescribed by GPs does not have ring-fenced funding attached to it. Rather, it must be financed by PCTs from their "unified allocations", out of which hospital, community and primary-care medical services are also funded.

The situation is complicated by: the fact that NICE's findings are disputed by pharmaceutical companies; the time that it takes NICE to evaluate new drugs; and the trend towards litigation by some patients.

Other scope for savings

The latter part of 2005 and the first half of 2006 actually saw marginal falls in the cost of NHS prescribing in primary care. This one-off period of falling costs, against the long-term trend, has been attributed to the operation of the Pharmaceutical Price Regulation Scheme (PPRS) and greater use of generic drugs (chemical equivalents of expensive, heavily-advertised, brand-name products).

In February 2007, the Office of Fair Trading (OFT) published a report on the PPRS. The OFT recommended that the current "profit cap and price-cut" scheme be replaced with a value-based pricing scheme, in which the price paid by the NHS for medicines would reflect the therapeutic benefits they brought to patients. It was estimated that a value-based scheme could release over £600 million per year. The government is currently considering its response to the OFT report.

In May 2007, the National Audit Office (NAO) published a report on *Prescribing costs in primary care*. The NAO found that there was significant potential for achieving better value for money in primary-care prescribing. It was argued that PCTs could save more than £200 million, without affecting clinical outcomes, through more efficient prescribing.

Better prescribing, as already undertaken in a small number of PCTs, in respect of just four drug-therapies (statins, renin-angiotensin drugs, clopidogrel and proton

pump inhibitors – which together account for a fifth of the community prescribing bill) could have saved £227 million across England in 2006–7.

The NAO said that improving efficiency and effectiveness would entail changing the prescribing behaviour of some GPs. It was found that high-prescribing GPs tended to be strongly influenced by marketing messages directed at them by the pharmaceutical industry. The NAO noted that drug companies spent £850 million each year marketing their products to GPs. (A further complicating factor in future could be the advertising of drugs direct to the public. This is not currently permitted, but the European Union is reportedly looking at the possibility of relaxing restrictions on such advertising.)

The NAO report stated that Practice-based Commissioning (which involves giving GPs control over the healthcare budgets for their patients) could be a lever for improving value for money in drugs expenditure – although this potential had yet to be tested.

Drugs wastage (i.e. the dispensing of drugs that go unused by patients, for a variety of reasons) was identified by the NAO as a significant, but (to an extent) potentially avoidable, cost to the NHS.

It is hoped the data that will be produced by the Electronic Prescriptions Service (which is being implemented as part of the £12 billion NHS IT programme) will enable prescribing patterns to be analysed systematically and critically in future.

General Pharmaceutical Services contract

PCTs commission community pharmacy services from pharmacists and dispensing GP practices. These service providers are paid on behalf of PCTs by the Prescription Pricing Division of the NHS Business Services Authority (formerly the Prescription Pricing Authority). Providers are reimbursed for the cost of the drugs and appliances they supply (plus fees for each item dispensed and a professional allowance), according to rates set out in the monthly Drug Tariff.

Community pharmacies are contracted by PCTs to supply services in accordance with a statutory scheme, under terms of service that are set out in regulations.
Under current arrangements (introduced in 2005), services provided by community pharmacies are divided into three categories:

1) **“Essential Services”** must be provided by all community pharmacies. These include:

    - dispensing pharmaceuticals;
    - repeat dispensing (reducing the need for patients to visit their GP to obtain further prescriptions);
    - disposing of returned or unused medicines;
    - promotion of healthy lifestyles (particularly among at-risk groups, such as obese people);
    - advice on self-care for patients with minor or chronic illnesses;
    - “signposting” patients to other healthcare services.

2) **"Advanced Services"** require both the pharmacist and the pharmacy premises to be accredited for the provision of certain services. The first of these services that are being provided is the undertaking of "Medicines Use Reviews" (MURs). These are periodic discussions with patients to check their compliance with prescribed treatment and discuss any problems they have with their medication. The expected benefits of MURs include a reduction in drug wastage.

3) **"Enhanced Services"** can be commissioned by PCTs from community pharmacies to meet the needs of particular local populations. These services include the following:

    - Anticoagulant Monitoring;
    - Care-Home services;
    - Disease-Specific Medicines Management;
    - Gluten-Free Food Supply;
    - Home Delivery;
    - Language Access services for non-English speakers;
    - Medication Reviews;
    - Medicines Assessment and Compliance Support;
    - Minor Ailment Schemes;
    - Needle and Syringe Exchange for injecting substance-misusers;
    - On-Demand Availability of Specialist Drugs;
    - Out-of-Hours services;
    - Patient Group Directions (providing drugs to certain defined groups without individual prescriptions);
    - Prescriber Support (liaising with prescribers);
    - Schools services;
    - Screening for certain conditions;
    - Stop Smoking services;
    - Supervised Administration of certain drugs (e.g. the heroin substitute Methadone);
    - Supplementary Prescribing (over 500 pharmacists in England have now taken on the role of "supplementary prescriber").

These contract arrangements are intended to embody the principles set out by the Department of Health in *Choosing Health through Pharmacy* (2005). This set out a strategy whereby pharmacists in all sectors of the NHS (not just in the community) could help bring about the "health promoting NHS" referred to in the public-health White Paper *Choosing Health* (2004).

The new contract was welcomed by pharmacists for its recognition of their capacity to play a significantly enhanced role in the delivery of healthcare services. However, the Royal Pharmaceutical Society of Great Britain (RPSGB), which acts as the professional and regulatory body for pharmacists, is concerned that community pharmacists are finding it difficult to access funding from PCTs to provide extended (Advanced and Enhanced) services.

In addition to the national contractual arrangements, PCTs also have the option to commission under Local Pharmaceutical Services contracts, to provide certain services not traditionally associated with community pharmacies. There were said to

be around 270 such contracts in 2006, including some 230 under the Essential Small Pharmacies Scheme, providing additional financial support to pharmacies in areas where they might be unviable without subsidy.

"Control of entry" regulations

Originally, NHS community pharmaceutical services operated on an open-market basis. Pharmacies were able to provide services under contract to the NHS wherever they wished, meaning that community pharmacies were able to compete freely for NHS patients' business in a wholly unregulated environment.

However, the law governing the provision of community pharmaceutical services was changed in 1986. From the following year, the NHS had the ability to determine which "chemists" (a term covering both pharmacies and appliance contractors, who supply certain types of appliance) were given contracts to provide NHS services in each area.

This power to regulate NHS pharmacies through "control of entry" now resides with PCTs. In each case, the PCT must decide whether granting a pharmacy's application to supply NHS services is "necessary or desirable" in terms of securing adequate local provision of services.

In 2003, the OFT published a report, *The Control of Entry Regulations and Retail Pharmacy Services in the UK*, which recommended the total deregulation of NHS community pharmaceutical services. The OFT argued that restricted entry into the NHS pharmacy market acted as a restraint on competition, depriving consumers of choice and access.
According to the OFT, NHS dispensing accounted for 80% of a typical community pharmacy's revenues. There was a market for private prescriptions, but it was worth just £300 million a year across the whole UK, the OFT reported. Consequently, pharmacies without an NHS contract were seldom commercially viable – the OFT found that there were just 130 of these in the UK in 2003.

The OFT argued that deregulating NHS community pharmacies would lead to greater efficiency and innovation, as a result of more pharmacies opening and keener competition. In consequence, consumers would get better service and pay less for over-the-counter (GSL and P) medicines – and, ultimately, the NHS would get a better deal in the dispensing of POMs.

It was argued that the Essential Small Pharmacies Scheme and dispensing by rural GPs provided an adequate "safety net" for communities that might be poorly served by an unregulated market.

However, these conclusions were hotly disputed, not least by the RPSGB. Fears were expressed that complete deregulation would exacerbate the growing market strength of multiple pharmacy chains (see below), meaning that people living in less commercially attractive areas (such as deprived and rural areas) could suffer from reduced access to pharmacy services. This would particularly affect vulnerable people who were less able to travel, such as older people, socially excluded groups and people with chronic conditions.

It was argued that focusing on service-users as consumers, rather than as patients, would undermine the social function of community pharmacies – and cut across the government's aim to give pharmacies a greater role in health improvement, self-care and disease prevention.

A more competitive culture, it was argued, would undermine collaboration between pharmacists. This would cut across the government's aim for pharmacists to develop special interests and expertise, since pharmacists would be less inclined to refer patients to other pharmacists if they saw them chiefly as business rivals.

The government responded to the OFT report with what it called a "balanced package of reform measures". These were intended to open up the market and provide more convenient services through competition (as well as making regulation more business-friendly) – but without jeopardising the existing pharmacy network or causing widespread upheaval.

There were three strands to the government's reforms (which were introduced in 2005 – at the same time as the new General Pharmaceutical Services contract):

1) New criteria of choice and competition were introduced for the purposes of determining of whether it was "necessary or desirable" to grant an application for a contract.

2) Exemption from the "control of entry" requirements was granted for applications in respect of pharmacies that were:

    - located in shopping centres with over 15,000 sq metres of floorspace;
    - intending to open for more than 100 hours per week;
    - forming part of "one-stop" primary-care centres providing a range of NHS services;
    - wholly Internet or mail-order based (subject to the standard requirement to provide the full range of "Essential Services" under the NHS contract).

3) The operation of the regulatory system was reformed and modernised.

The rise of multiple pharmacy chains

There is a long-term trend of substantial growth in the proportion of community pharmacies within multiple chains (consisting of six or more pharmacies), which are owned by pharmacy companies and supermarkets. The proportion of community pharmacies in multiple chains increased from 38.6% in 1996–7 to 56.8% in 2005–6, with multiples exceeding independent pharmacies (single pharmacies and those in chains of up to five) for the first time in 2001–2.

The Department of Health stated in 2003 that the leading pharmacy chain (which was then Lloyds) held 10.9% of the market, while the top three companies (Lloyds, Boots and Moss) held 27.8% between them.

The merger of Boots with Alliance Unichem in 2006 led to the creation of a firm with a 17% share of the pharmacy market (dispensing 100 million NHS prescriptions each year), making it the new market leader. Alliance Boots is now the subject of a takeover bid by a private equity firm and concerns have been raised about the possible impact of this on NHS services.

Meanwhile, the government has given indications that it is keen to explore the idea of involving corporate High Street pharmacy chains in the delivery of a number of NHS services. In London, a pilot walk-in screening programme for the sexually-transmitted infection Chlamydia has been contracted out to 200 Boots stores. At Poole in Dorset, an NHS Healthcare Centre, providing a range of services, has been located by the local PCT in space rented within a Boots store. The Department of Health is keen to see similar arrangements elsewhere, involving Boots and also supermarket chains.

The future of community pharmaceutical services

In 2006, the government published a review of the impact of the revised "control of entry" regime. It showed that more than twice as many pharmacies had opened in 2005–6 than in any year in the period 1992–3 to 2004–5. The review found that deprived areas were neither significantly worse off nor significantly better off – although pharmacy closures in those areas were proportionally greater. PCTs with higher levels of social deprivation attracted proportionately more applications under the new exemptions, but evidence to show this would improve access was inconclusive.

Across the country, 99% of people were able to get to a pharmacy by car, walking or public transport within 20 minutes, including in deprived areas. There was evidence in some areas of pharmacies "leapfrogging" to secure the most advantageous commercial position. It was noted that there were more pharmacies near to GP surgeries than there had been in 2003.

The NHS had found the new regulations difficult to administer. It was stated that applications under the exemption provisions in particular had hampered efforts to plan strategically and commission more clinical services.

The government was sceptical about the suitability of the "control of entry" system as a means of enabling PCTs to play their commissioning role in respect of pharmaceutical services. It, therefore, announced a review to determine how to give PCTs "more powers to commission as is necessary to secure adequate service provision to meet local health needs, while ensuring that the opportunities to maximise choice and contestability within a reformed system are not lost".

Anne Galbraith, a lawyer and former chair of the Prescription Pricing Authority, was appointed to lead and chair the review. Her report will inform the government's next steps, which are expected to include a formal consultation.

The RPSGB has continued to oppose further deregulation, as well as expressing concern that the reforms already implemented (particularly the "control of entry" exemption for 100-hour pharmacies) are in danger of destabilising pharmacy services.

It has been suggested that further steps towards deregulation are inevitable, not least because of Article 14(5) of the proposed EU Services Directive, which is due to be implemented by 2010. This would have the effect of obliging the government to introduce complete deregulation of pharmaceutical services, in accordance with EU policy on free competition.

Provision of NHS community pharmacies in Kent and Medway / England, 2005–6

PCT area	Number of community pharmacies at 31 March 2006	Prescription items dispensed per month (000s), 2005–6	Population (000s), June 2003	Pharmacies per 100,000 population
Ashford	17	89	109	16
Canterbury and Coastal	30	174	167	18
Dartford, Gravesham and Swanley	42	236	223	19
East Kent Coastal	36	282	234	15
Maidstone Weald	33	234	239	14
Medway	47	258	262	18
Shepway	20	129	97	21
South West Kent	29	190	180	16
Swale	20	101	98	20
Totals:				
Kent and Medway	**274**	**1,692**	**1,610**	**17**
England	**9,872**	**54,914**	**50,093**	**20**

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies in receipt of Electronic Prescriptions Service (EPS) payments, Kent and Medway / England, 2005–6

	Number of community pharmacies at 31 March 2006	Number in receipt of EPS payments	Proportion in receipt of EPS payments
Kent and Medway	274	3	1.1%
England	9,872	406	4.1%

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

Mean and median prescription items dispensed per month per pharmacy by NHS community pharmacies in Kent and Medway / England, 2004–5 and 2005–6

PCT area	Number of community pharmacies at year end (31 March)		Mean items per pharmacy		Median items per pharmacy	
	2004–5	2005–6	2004–5	2005–6	2004–5	2005–6
Ashford	15	17	5,459	5,206	4,312	4,695
Canterbury and Coastal	30	30	5,438	5,785	4,301	4,621
Dartford, Gravesham and Swanley	42	42	5,294	5,608	5,134	5,628
East Kent Coastal	36	36	6,892	7,820	6,154	6,803
Maidstone Weald	33	33	6,517	7,095	6,584	7,236
Medway	44	47	5,617	5,498	5,256	4,847
Shepway	20	20	6,159	6,447	6,219	6,584
South West Kent	28	29	6,234	6,552	5,940	6,028
Swale	19	20	5,007	5,064	4,557	4,055
Totals:						
Kent and Medway	267	274	5,846	6,119	5,256	5,628
England	9,736	9,872	5,331	5,563	4,733	5,301

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies participating in scheme to collect and dispose of unwanted medicines, Kent and Medway / England, 2005–6

	Number of community pharmacies at 31 March 2006	Number in scheme	Proportion in scheme
Kent and Medway	274	273	99.6%
England	9,872	8,800	89.1%

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

NHS community pharmacies providing Medicine Use Reviews (MURs), Kent and Medway / England, 2005–6

PCT area	Number of community pharmacies at 31 March 2006	Number accredited to provide MURs	Proportion accredited to provide MURs	Number of MURs provided	Average number of MURs per accredited pharmacy
Ashford	17	7	41.2%	370	53
Canterbury and Coastal	30	13	43.3%	439	34
Dartford, Gravesham and Swanley	42	13	31.0%	339	26
East Kent Coastal	36	20	55.6%	260	13
Maidstone Weald	33	21	63.6%	720	34
Medway	47	13	27.7%	215	17
Shepway	20	9	45.0%	254	28
South West Kent	29	14	48.3%	488	35
Swale	20	5	25.0%	587	117
Totals:					
Kent and Medway	274	115	42.0%	3,672	32
England	9,872	3,842	38.9%	148,195	39

Source: NHS Information Centre, *General Pharmaceutical Services in England and Wales 1996-97 to 2005-06* (2006)

Potential savings through more efficient prescribing of statins, renin-angiotensin drugs, clopidogrel and proton pump inhibitors, Kent and Medway PCTs, 2006–7

Current PCT	Previous PCT (before October 2006)	Potential savings (£)
Eastern and Coastal Kent	Ashford	363,955
	Canterbury and Coastal	439,346
	East Kent Coastal	1,804,141
	Shepway	325,492
	Swale	413,987
Medway	Medway	867,830
West Kent	Dartford, Gravesham and Swanley	470,888
	Maidstone Weald	856,881
	South West Kent	1,301,914
Total:		**6,844,434**

Source: National Audit Office, *Prescribing costs in primary care* (2007)