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Community Pharmacists' Remuneration in England and Wales - Background to the current dispute

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Summary

Recent reports by the NAO and PAC have suggested that, at least in some parts of the country, the number of community pharmacies could be reduced without compromising on access. The reports also stressed the desirability of widening the role of the pharmacist, a long standing aim of the Government and the profession.

Pharmacists are paid a fee as part of their remuneration system for dispensing which is higher per prescription up to 1700 items a month than it is thereafter. The NAO and PAC argued that this provides "indiscriminate" support to small pharmacies not judged essential. An "Essential Small Pharmacies Scheme" tops up the income of small pharmacies that are considered essential.

Government proposals made in March 1993 for the year from 1 April 1993 would:

- move towards a flat rate fee for dispensing (with the intention of completing the change in 1994-95) and make other changes to the remuneration system;

- introduce a "professional allowance" of £500 a month to pharmacies dispensing more than 2000 items a month who agree to widen their role.

The profession is concerned that the proposals do not sufficiently recognise the value of the small pharmacy and that many (perhaps a quarter) could close to the detriment of the public. A widening of the essential small pharmacies scheme has been promised but has not been negotiated in detail.

Introduction

The recent remuneration offer to community pharmacists has provoked widespread opposition amongst the profession with fears being expressed that many smaller pharmacies may close. Changes in the way pharmacists are paid for dispensing NHS prescriptions would lead to an end to the system which gives higher fees per prescription up to 1700 items a month and a lower fee thereafter. They would also pay a "professional allowance" for pharmacists providing an enhanced range of information and advice only to larger pharmacies. The existing support for "essential small pharmacies" would be broadened.

The dispute needs to be seen in the context of recent NAO and PAC reports which suggested that there was over provision of pharmacies in some areas and also of a long-standing desire on the part of the Government and the profession to develop an enhanced role for pharmacists.

The National Audit Office and Public Accounts Committee Reports

The National Audit Office Report Community Pharmacies in England was laid before the Commons on 28 May 1992 (HC 30). The report looked at:

- the changing role of the community pharmacist and the management of the service;
- the measures taken to secure an accessible community pharmaceutical service;
- the structure of community pharmacists' remuneration;
- the reimbursement of the cost of drugs dispensed by community pharmacists.

The Public Accounts Committee report following up the report was laid on 9 November 1992 (14th Report of 1992-93, HC 240). This report covered the following topics.

> 3. We examined the quality of service provided to the public; access to pharmacies and pharmacists' remuneration;the effectiveness of the scheme for reimbursing pharmacists for the cost of medicines dispensed; and the scope for extending the range of services provided by community pharmacists.

The Government response to the report was published in February 1993 (Cm 2145).

Accessibility of Pharmacists

The Department of Health Departmental objectives, published as Appendix 1 to the NAO report include ensuring that the public is provided with "reasonable access to a full range of pharmaceutical services". `Reasonable' is not defined and the Government has not thought it right to try to do so from the centre.

In 1987, following Government concern about the rise in the number of new pharmacies, entry controls were imposed, which meant that it was no longer possible to set up new pharmacies at will. This provision did not affect existing pharmacies, however. The NAO report argues that in many parts of the country there are pharmacies which make little contribution to accessibility:

> 14 The National Audit Office commissioned analyses of the distribution of pharmacies in Lancashire and Gateshead. These areas were chosen as being representative of shire county and metropolitan family health services authorities. The analyses showed that:
>
> - only 1.2 percent of the population of Lancashire and none of the population of Gateshead lived more than five kilometres from a pharmacist or a dispensing doctor;
>
> - most low volume pharmacies made little contribution to the accessibility of the service.
>
> (paragraphs 3.11 to 3.17)
>
> 15 The National Audit Office also noted that there are clusters of pharmacies which add little to patients' access to the service, particularly in London and in major conurbations. For example, an analysis of the distribution of community pharmacies in the Camden and Islington Family Health Services Authority area, showed that 55 pharmacies (46 per cent) were in clusters of three pharmacies within a radius of 300 metres. Fifty one per cent of pharmacies surveyed by the National Audit Office said there were three or more other pharmacies within a mile of their own premises. (paragraphs 3.18 and 3.19)

The report also quotes from consultants' research which they commissioned which showed that by encouraging more efficient higher volume pharmacies it could be possible in one area studies (Lancashire) to reduce the number of pharmacies by a quarter without seriously compromising access. They stress this is a "hypothetical model" and no such plan is recommended in the report, contrary to some suggestions.

The PAC was less forthright than the NAO but nonetheless noted that the present system gave "indiscriminate support" to low volume, high cost pharmacies.

The Remuneration System

The pharmacists' remuneration system is complex and has been subject to several changes in recent years. The main elements of the current (1992-93) systems are:

- Fees are calculated within a "global sum" set by the Department of Health.

- The fee structure was in three tiers until 1990-91, based on the number of prescription items dispensed. From 1991-92 the number of tiers was reduced to two. The fee is higher per item dispensed up to a fixed level (currently 1700 a month) than thereafter. Additional fees are payable in some circumstances.

- 2.5% "on-cost" is paid on the cost of the drugs dispensed. The on-cost was cut from 5% to 2.5% as part of the 1992-93 settlement.

- A separate scale of fees compensates pharmacists for "non core" services, that is, those other than dispensing prescriptions. These include providing a domiciliary oxygen service, urgent call outs and providing a rota service for opening outside normal hours.

The "Essential Small Pharmacies Scheme" tops up the income of pharmacies dispensing between 6,000 and 16,000 items a year which are more than 2 km from the nearest pharmacy. Those dispensing fewer than 6,000 items can be helped if the FHSA considers them to be essential. There were 150 pharmacies in the scheme in March 1992 [Memorandum from NHS Management Executive in PAC Report].

In 1990-91 total remuneration in England was £516m of which £501m was for core services [NAO Report para 4.1].

The scale of fees in the last three years was:

Year	**Number of items dispensed per month**	**Fee (p)**
1990-91	up to 1400	144.5
	1401-5250	66.5
	over 5250	73.5
1991-92	up to 1500	151.2
	over 1500	71.5
1992-93	up to 1700	159.0
	over 1700	80.5
Source: NAO Report Table 6. Pharmaceutical Journal 31.10.92		

The NAO Report argues as follows on the fee structure:

> 17 In the National Audit Office's view, entry controls have been successful in halting the growth in the number of pharmacies. But the controls leave existing pharmacies untouched, irrespective of their contribution to the accessibility of the service. And the two-tier structure provides indiscriminate support to many small pharmacies which make little contribution to accessibility -optimum fee structure to deal with this problem would be a single rate to cover all dispensing. In deciding whether to implement such a change, the Department would consider the scope for using any resources thereby released for the development mentioned in paragraph 8 above of the role of pharmacists in the enhancement of health services in the community. And the Department would need to take into account the implications of a shift in scale of operation for range and quality of services; that is, whether small, medium, or large pharmacies represent best value for money in other respects.

The Report was also critical of the continuation of the on-cost system which accounted for £105m of 1990-91 expenditure. It was introduced at a time when the Department did not pay pharmacists as promptly as now, and when they held higher stocks. It was also noted that the existence of the on-cost was a disincentive for pharmacists to recommend generic rather than proprietary drugs when consulted by doctors. The report noted that the Department was considering abolishing the on-cost. The reduction of on-cost from 5% to 2.5% was agreed as part of the 1992-93 package. It was also agreed it would be abolished in 1993-94.

The PAC recorded the Department's intention to move away from the two tier fee structure and urged progress "as quickly as practicable". The Committee also said:

(vii) We endorse the Department's intention to look into measures which ill reward pharmacists with high volume turnover without penalising those small pharmacies which provide a necessary service. We consider that the Department should use part of the money released by the proposed change in remuneration structure to develop the Essential Small Pharmacies Scheme to provide an improved service in disadvantaged and under-provided areas (paragraph 26).

(x) We note the Department's intention to discontinue the on-cost payment, and to pay the money thus released to community pharmacists through other mechanisms better designed to secure the Department's objectives. We expect the Department's negotiations with the profession to result in an early change to more effective arrangements (paragraph 28).

The Wider Role of Pharmacists

There has been concern in recent years about the need to develop a wider role for pharmacists. This has arisen in part because the skills of the profession are no longer fully used in compounding medicines with more medicines being supplied in manufacturers' original packs.

The most recent report on the subject was that of a joint working party between representatives of the Departments of Health and the Welsh Office and the profession published in March 1992 [Pharmaceutical Care: The Future for Community Pharmacy].

Some of the ideas in circulation for extending the role of the pharmacist are set out in Appendix 2 to the NAO Report Community Pharmacy in an Integrated National Health Service by David Taylor of the King's Fund Institute:

- giving community pharmacists wider freedom to substitute cheaper generic drugs for branded medicines prescribed by doctors;
- requiring community pharmacists to keep more comprehensive records of patients' medicine usage;
- extending the range of (currently prescription only) medicines available for purchase from pharmacies (that is, movement of drugs from prescription only to pharmacy status);

- increasing pharmacists' involvement in screening for health risk/early disease indicators, and providing health education;

- permitting telephone prescribing, so that doctors may call through to (and perhaps discuss with) pharmacists their instructions for therapy, and giving community pharmacists greater discretion regarding the dispensing of repeat prescriptions;

- further extending domiciliary and allied 'out-of-shop' services provided by the pharmacist, so that he or she advises and supports individuals in the administration of complex therapeutic regimes and ensures that institutions such as nursing homes store and utilise medications in an appropriate manner. (Some reforms towards this end were introduced via the 1987 White Paper 'Promoting Better Health');

- extending dispensing and allied "in-shop" services, including therapeutic drug monitoring (checking that the levels of medication in the patient are safe and effective) and enhancing drug contra-indication and side-effect surveillance; and

- reinforcing and improving the professional pharmacy advice available to family health services authorities through the employment of appropriately qualified pharmacists to, for example, interpret PACT (prescribing activity and cost) information and help doctors implement prescribing improvements. Family health services authority pharmacy advisers might also work to enhance the practice standards and premises of local community pharmacists and assist in family health services authority liaison with other relevant agencies in matters like establishing an even balance between family health services and hospital out-patient drug supply policies.

The NAO Report saw opportunities for using changes in the remuneration system to finance the development of the wider role and the PAC said that it looked to the Department to make progress quickly.

The 1993-94 Pay Offer

Pharmacists' pay is decided after negotiations between the Government and the Pharmaceutical Services Negotiating Committee (PSNC). A formal offer was made by the Government in a letter to the PSNC on 12 March released by the PSNC. The PSNC rejected it on 16 March. The details of the offer are:

- A 1.5% increase in the "global sum" to £640.6m.

- A "professional allowance" of £500 a month payable only to pharmacies dispensing more than 2000 items a month. In order to qualify pharmacies would have to produce a practice leaflet, display health promotion materials and offer advice and counselling as part of the dispensing process.

- Dispensing fees would be £1.51 for the first 1700 items and 97p per item thereafter. This is a cut in the fee for up to 1700 items but an increase in the over 1700 items fee and is intended as a step towards the introduction of a flat rate fee in 1994-95.

- Mark time payments to pharmacies dispensing between 1000 and 2000 items per month to top up income to 1992-93 levels. These payments would cease in March 1994.

- Introduction for 1994-95 of a revised essential small pharmacies scheme, details to be negotiated.

- Introduction of a new "expensive prescription" fee to compensate for the abolition of on-cost payments in cases where the net ingredient cost of the prescription is more than £100.

- Other fees subject to negotiation within the global sum.

[Information from Pharmaceutical Journal 20.3.93; Chemist and Druggist 20.3.93]

Reaction to the Offer

The reaction of the PSNC was to reject the offer completely. Their main area of concern has been the proposal that the professional allowance should be paid only to pharmacies dispensing more than 2000 items a month. Other criticisms were that accepting the offer meant accepting parts of a 1994-95 settlement without being clear what was on the table; that to introduce a flat rate dispensing fee for 1994-95 was to move too quickly, giving pharmacists insufficient time to reorder their financial affairs; they also argue that the 1.5% increase in the global sum does not take account of the increased costs which pharmacists have had to bear, arguing that this factor was taken account of in the settlement with GPs.

The most controversial aspect of the offer has been the arrangements for the professional allowance and the adverse effects on smaller contractors, especially when coupled with the proposed move to a flat rate fee, and the absence of a detailed agreement on a revised essential small pharmacies scheme.

According to PSNC evidence (published in the Pharmaceutical Journal of 27 March, 29% of pharmacies in England and 21% in Wales dispense fewer than 2000 items a month, about 2900 pharmacies in all. There are wide variations between FHSAs. In eight, all in London, half or more of pharmacies are in this position. In 4 10% or fewer of pharmacies dispense less than the threshold (Wakefield, Doncaster, Rochdale and Wigan). These figures have been behind claims that about a quarter of pharmacies could close.

Pharmacists are angry at what they see as the implication of the Government's offer that small pharmacists make no demonstrable contribution to NHS services. The offer letter to the PSNC is quoted as saying:

> "An important principle is the need to ensure that the allowance is targeted at those pharmacies which are sufficiently large to make a demonstrable contribution to NHS services. In our view this means not paying the allowance to pharmacies dispensing less than 2000 prescriptions a month."

[Quoted in Chemist and Druggist 20.3.93]

Evidence on which this statement is based has been sought. The Royal Pharmaceutical Society, for example, wrote to Dr Mawhinney requesting evidence for the statement on 19 March [Pharmaceutical Journal 27.3.93].

It has been noted that the proportion of pharmacies below the threshold is similar to that which the NAO report implied would be closed in some areas at least. This is despite the Civil Servant responsible being quoted as saying that the NAO "came out with an ill advised report which has not been signed up to by the PAC or DOH" [Chemist and Druggist, 20.3.93].

The PSNC has said it would accept a threshold of 1000 items provided there were adequate safeguards for small pharmacies.

Pharmacists would also argue that access is only one of the issues. Even if a substantial number of pharmacies could be closed without comprising access (which would be doubted) there would still be a loss of choice and a potential diminution in the quality of service.

It is also pointed out that immediate accessibility is valuable for many people (especially elderly people and those with young children) whether or not they are picking up an NHS prescription. They may be seeking the advice of the pharmacist or purchasing over the counter medicines.

The Royal Pharmaceutical Society has argued that reducing the number of small pharmacies would increase NHS costs. This is on the basis that, it is said, 1 million people a day asked the pharmacist for advice and that if a local pharmacy is not available some of them will go to their GPs instead.

Conclusion

Both the NAO and the PAC report argued that the present remuneration system gives indiscriminate support to small pharmacies, whether they are considered essential or not. It was clear that non-essential small pharmacies were likely to be put under pressure. There is also widespread agreement on the desirability of widening the pharmacists role so the principle of the new professional allowance would be generally welcomed.

What has proved controversial is the detailed arrangements. Given that the Government has been unwilling to put any new money into the allowance funding it was likely to prove controversial. Nonetheless the large number of pharmacies potentially disadvantaged by the single tier fee structure and the 2000 a month cut off point for entitlement to the professional allowances has led to widespread concern in the profession especially when the proposed changes to the essential small pharmacies scheme have not been agreed - although the Government has made it clear it expects an increase in the number of pharmacies being helped.