



Dispensing Doctors' Association
2008 Patient survey

The Pharmacy White Paper

Dispensing Patients & Practice



Foreword

Rural areas present significant challenges for all aspects of healthcare delivery because of the sparse nature of the population, the local geography and the unique demographics of rural communities. The delivery of a patient's medication is a vital part of their care, and all patients deserve access to a service that is not only safe and efficient, but is convenient and stress free.

Doctors working in rural areas have been able to provide this service for their patients from well before the foundation of the NHS. Their patients have had a choice of provider and many have been able to choose to ask their doctor to dispense for them. In response practices have tailored their service to suit the needs of their local community and the geography of the area.

Dispensing by doctors is well liked by the patients who use it. It is safe and cost effective. It ensures that everybody, no matter where they live, has easy access to prescription medications. Over the years doctors and the dispensers who help provide this vital service have successfully improved the quality of care that is given to their patients. This is reflected in the results from the dispensary services quality scheme.

The Pharmacy White Paper threatens the existence of this service in many parts of the country. I would ask the government to consider carefully, the options that it has presented and then opt for "no change". If together we can create a stable environment for practices which dispense to their patients then we can concentrate on the much more important issue- working with pharmacists to deliver continued improvements to the patient journey and the overall quality of services we provide.

Dr Richard West
Chairman Dispensing Doctors Association

Expressions of Support

Mark Simmonds MP, Conservative Shadow Minister for Health

“Patients have expressed in large numbers their real and genuine concern regarding the impact of these proposals on their local dispensing surgery.

I cannot see the benefit of the Government’s proposals – if a patient receives a prescription from a dispensing GP’s practice now they are able to choose to have it filled at a local pharmacy if they wish. If dispensing practices lose the ability to dispense due to the location of a pharmacy nearby then many patients could lose access to their most convenient service. It is important that dispensing practices use the additional income to provide the maximum enhancement of services to patients.”

John Grogan MP, Chair of the Parliamentary Labour Party Departmental Committee for Health and Social Services

“There is an old saying much beloved in Yorkshire, ‘if it aint broke don’t fix it’. I know from representing the most rural Labour constituency in England that the dispensing doctors offer an essential service to many of my constituents, which should not in any way be threatened.”

Norman Lamb MP, Liberal Democrat Shadow Secretary of State for Health

“This report gives convincing evidence that patients, who should be the Government’s priority, are opposed to the changes being suggested in the Pharmacy White Paper.

Elderly and disabled patients have reported that they would find the journey to pharmacies difficult, and there is apprehension about the possibility that this will negatively affect their healthcare.

I fully support the Dispensing Doctors’ Association stance on this issue and commend them for producing such a persuasive piece of research.”

Sue Sharpe, Chief Executive of the Pharmaceutical Services Negotiating Committee (PSNC)

“PSNC did not seek and does not support changes to the regulations governing dispensing by doctors. The 2005 Regulations reflect agreement reached between the professions; any changes will inevitably destabilize relationships, and impair co-operation and collaborative working between the pharmacists and doctors affected.”

John Pole, Communications Manager, Action for Market Towns

“Action for Market Towns (AMT) is a national organisation with 400 small rural towns in membership. It is concerned with promoting the viability and vitality of small rural and market towns.

AMT is concerned that the proposals to alter the present dispensing system are likely to have a direct impact on many patients from rural areas, but, more significantly, will adversely impact the income of many market town dispensing practices, reducing the level of service which they will be able to provide to all patients, both those living within towns and those accessing the practices from the rural hinterland.

Both dispensing doctors’ and pharmacists’ national bodies are satisfied that the present system works well in our rural towns. The research undertaken by the Dispensing Doctors’ Association clearly demonstrates a patient preference to retain the present system.

Action for Market Towns would therefore support the Dispensing Doctors’ Association’s submission.”

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1. Executive Summary

Historically all doctors dispensed medicines to their patients, but at the start of the 20th Century pharmacists largely took over this role in urban areas. In rural areas and market towns 'dispensing doctors' continue to provide 4 million patients with a one-stop shop: patients who live more than a mile from the nearest chemist can visit their doctor, get a prescription and collect their medicines all at the same time, all in the same place.

In April 2008 the Government published its Pharmacy White Paper, 'Pharmacy in England building on strengths – delivering the future'. In the main Pharmacy in England focussed on supporting the development of an expanded professional role for pharmacists. However, amongst its proposals lay a radical and unexpected suggestion to change control of entry rules for dispensing doctors. If implemented, the proposals threatened to put an end to the majority of doctor dispensing, jeopardise the branch surgeries they provide and cause 5,000 redundancies.

To better understand how the proposals would affect patients, The Dispensing Doctors' Association (DDA), which represents the interests of the UK's six thousand dispensing doctors and promotes excellence in dispensing practice for the benefit of dispensing patients, embarked on a survey of thousands of patients across the country. More than six thousand patients responded, and this survey relays the findings for the first time key among them are that:

- Patients value the service provided by Dispensing Doctors
- Half of dispensing households include at least one person over 65
- One in six dispensing households include at least one disabled person
- 95% of surveyed dispensing patients would find it difficult or inconvenient if their surgery stopped dispensing
- Branch services are a vital part of rural services that patients do not want to lose
- 89% of patients asked want the choice to receive their medicines from their doctor

On 27th August the Government published a further consultation on dispensing doctors presenting four options for the future. Only option one ('no change') would ensure patients continue to receive the services they so value from their GP practice. The DDA hopes Government will heed patients' calls to keep its 'Hands off our prescriptions!' and will not take away their right to choose where they get their medicines, including from their own doctor.



2. Dispensing by Doctors

On the 25th of March 2008 there were 6,204 doctors working in 1,360 dispensing practices, providing NHS dispensing to nearly 4 million patients.

Patients must apply for the right to have their prescriptions dispensed by their GP, and must either live in a rural area more than a mile from a chemist or have clear difficulties accessing medicines in order to become a 'dispensing patient'.

This often means that not all patients at a dispensing practice are allowed to collect their medicines from their doctor. Besides the 4 million dispensing patients there are a further 5 million people who are patients of dispensing practices but live too close to chemists to be allowed to make use of the dispensing service. Any changes affecting dispensing doctors then impact on a large population - 9 million patients living in rural areas and market towns across the country.

The regulations which govern dispensing by doctors are laid down in the NHS (Pharmaceutical Services) Regulations 2005, as amended. Like other GPs, dispensing doctors are regulated in their medical practice by the General Medical Council, which also regulates their dispensing activity. Their practices have a 'dispensary', where trained staff fulfil prescriptions and dispense medicines to the patients of the practice; much as happens at a chemist's. Dispensers are additionally able to view patients' medical records to double-check that there are no contraindications and that the medicine being dispensed matches the medical history and is being taken properly.

The DDA, General Practice Committee of the British Medical Association, the Department of Health and NHS employers jointly introduced a dispensary services quality scheme to help with the process of continually improving performance and maintaining high standards.

The safety record of dispensing by doctors is as good as that of pharmacists. The number of dispensing errors is roughly the same for the two professions, both of whom have deployed staff training and improved systems and technologies to improve their performance in recent years.

As a result of the regulatory regime, dispensing practices are usually situated in market towns and rural areas. All patients who use their doctor to dispense their medications must live in a designated rural area.¹ People who live in rural areas often have different health needs to those in urban areas, and have greater distances to travel to access public services. Rural GP services are often shaped differently from those in cities and towns, in recognition that it can be particularly hard for the elderly, disabled

1. There is a rarely used exception that permits any patient to receive dispensing services from their doctor if they can satisfy their PCT that they have serious difficulty in obtaining drugs or appliances from a pharmacy through distance or lack of means of communication.



and those with young children to access medical care where distances are greater.

Many rural practices run 'branch surgeries' from second premises to bring their services closer to remote patients. Often the income from dispensing activity supports these additional rural services, and so any changes to one, risks affecting the other.

A recent survey of dispensing practices found that 62.5% were within one mile of a community pharmacy and so were at risk of redundancies and branch closures. With around 700 practices at risk of being affected, this would have an impact on the 5,500 plus staff working at these practices, dispensary jobs being particularly vulnerable .

The Dispensing Doctors' Association fears that, if implemented, the proposed changes could result in widespread redundancies and a reduction in branch surgeries and other rural primary care services. The proposals would also result in fewer patients having the choice of collecting their medicines at their general practice, seemingly at odds with the principle of increasing patient choice within the NHS.

The following are examples of the effects likely to ensue on specific practices from different areas across the country:

Lincolnshire

"The income from dispensing enables 3 of the doctors here, who are GPwSI's (General Practitioners with Special Interests), to work 'out of practice' for one day a week each, as we are able to fund an extra salaried practitioner for these 6 sessions though in fact we employ him full time to improve access for patients. We do of course receive income from the PCT as GPwSI's though this does not cover the full cost of employing GP's. If our dispensing income was lost then we could not afford the extra practitioner and we would probably have to work back in practice to ensure our own patients continued to receive an adequate service.



The knock on effect would be loss of duties carried out by the individual GPwSI's:

1. No Intermediate Care Diabetes Clinics down the East coast of Lincolnshire and all patients would have to go to secondary care for management. Not good for patients and not good for PBC budgets.
2. Leicestershire PCT would lose the development of COPD management in the Community as our third GPwSI is currently seconded to them, from Lincs PCT, to develop and roll out this service.

The loss of dispensing would most likely result in a reduction of service not only for our own patients but patients across the county.”

Wiltshire

“Our practice operates four small surgeries sites in the rural area between Bath and Bristol into Wiltshire. There are dispensaries in all four sites.

We are planning to build a new surgery at the smallest of these sites, and to improve the medical facilities from what is a very small surgery currently attached to the retired GP’s house, to a purpose-built 2 - 3 Doctor surgery with on-site dispensary with an improvement to local health facilities and a much-needed expansion of the surgery. The costings for this new build have factored in income from dispensing into the viability studies. If this thinking is taken out of the equation, the viability of the building project comes under threat, and it is quite possible that the development will not occur. It is much more likely that we would have to look to close 1 to 2 of our four surgery sites, which would leave two villages without a GP surgery.

We would probably have to look at the contraction of our practice area and list size, and not replace retiring GP partners to allow the practice to contract to contain further losses.”

Yorkshire

“Our branch surgery is dependent on the income from dispensing and if this were lost we would have to give very

The loss of dispensing would most likely result in a reduction of service not only for our own patients but patients across the county.

serious thought to closing and selling these premises and perhaps operating a satellite type system in the village hall on perhaps 2-3 days a week - thus hugely reducing the quality of service available to over 3000 of our patients."

North Yorkshire

"Out of a list of 5,807 patients, approximately 3,500 receive dispensing services. This translates to a figure of 5,813 items of medication dispensed per month to patients, many of whom live on farms or in isolated hamlets and villages. The practice provides a free home delivery service which provides patients with access to what is as an essential service, as well as enabling the doctors to keep in touch with often vulnerable patients.

If the Practice were to lose its dispensing status they would not only have to make redundant 3 dispensers and the free home delivery driver, they would also have to lose at least 1 whole time equivalent GP; at least 1 Practice Nurse; and at least one member of the non clinical support team (i.e. medical secretaries and receptionists). The impact on patients would be huge as the loss of a GP and a Practice Nurse would mean an immediate reduction of up to 300 appointments per week, not to mention a reduction in the capacity to attend home visits and to operate disease specific clinics as they do currently."

Bury St Edmunds

"It is possible that the practice may find it financially unable to continue to employ a salaried doctor to help provide services, as we currently do"

Lambourn Practice

"The loss of dispensing will lower the quality of nursing and medical care we are able to provide... there will be inevitable redundancies"

Chipping Surgery

"We would certainly lose 2 doctors from our practice"

Market Weighton practice

".... One nurse, healthcare assistant and a salaried doctor."

Caythorpe Practice

"Were the dispensing income stream to be removed this practice would cease to be viable in it's current format"

Battle practice

"In my own case this will lead to redundancies for eight dispensary staffour part time doctor is rethinking her career plans"

Bourn Surgery

"Services which are currently offered would be lost ... delivery of drug boxes to villages ...branch surgery would close"



3. Patient survey results

Doctors who provide a dispensing service to their patients often feel that their patients' decision to use that service is evidence of their support for it. Patients have to apply to become a dispensing patient, and can choose at any time to switch to receiving their medicines from the chemist, or indeed switch doctors, should they wish.

However, their support should not be taken for granted, and as the health service modernises and policy makers seek to improve patient choice, the DDA decided to test patient opinion through a large scale survey which amongst other things sought patients' views on dispensing practice, why some choose to be dispensing patients and the age and disability profile of patients' households.

A paper questionnaire (copy in Appendix) was distributed to 100 randomly selected dispensing surgeries, with the request that they be offered to all patients, both dispensing and non-dispensing, coming to the surgery or receiving medication between Monday 16th June and Friday 11th July 2008.

A large number (more than 6000) questionnaires were filled in from a wide geographical area. The results strongly support doctors' instinctive view that patients value the dispensing service provided at their surgery, and want choice over where they receive their medicines

A more detailed explanation of some of the important results of the survey now follow.

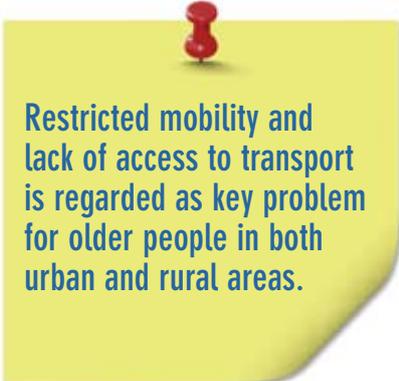
The demographics of dispensing patients

The first questions from the survey were aimed at giving an insight into the makeup of households served by dispensing practices and how long they had been using this service. The most important findings were:

- Of the 5000 patients who answered Question 2, 61% lived in a home which had at least one person also living there who was over 65.
- Over 20% lived in a home which had at least one person living there who was disabled
- 3378 of the patients surveyed have been dispensing patients for over 5 years –over 70% of respondents. Over 20% had been dispensing patients for over 10 years.

Whilst this survey cannot be considered a comprehensive review of the demographics of dispensing patients it reflects the findings of national studies examining the health and demographics of rural populations.

The results strongly support doctors' instinctive view that patients value the dispensing service provided at their surgery, and want choice over where they receive their medicines.



Restricted mobility and lack of access to transport is regarded as key problem for older people in both urban and rural areas.

This picture of an elderly population mirrors research conducted by the Commission for Rural Communities, which suggests that in the next 25 years the number of people age 65+ in rural areas of England will increase by 20 per cent more than the average for England as a whole [“Rural Disadvantage: Quality of life and disadvantage amongst older people – a pilot study”, Commission for Rural Communities, February 2006,]. The Rural Evidence Research Centre report, Rural England: Demographic Change and Projections 1991 – 2028, found that “rural districts have not only experienced the higher population increases over the period 1991-2001, they also have the highest rates of population ageing. Many of the ageing population increases are highest in rural areas presenting a number of challenges for rural development policy.”²

If this is considered along with the evidence that there is poor public transport in rural areas (the National Travel Survey 2005 survey found that only 54% of households in rural areas are within a 13 minutes’ walk of a bus stop with an hourly or better services. This is compared to 89% of households in urban areas³) then one can see how valuable dispensing practice is to certain patient groups. The potential for access problems is an issue that has been acknowledged by the Government before-the 2004 Rural Services review conducted by the Department for Environment, Food and Rural Affairs contained a quote from Institute for Rural Health, stating “**even when there are appointments available, access to services is a major challenge for rural people, especially for those without their own transport.**”⁴

Concerns over access to services are well established. In its 2006 report-Quality of Life & Disadvantage Amongst Older People-the Commission for Rural Communities states.

“Restricted mobility and lack of access to transport is regarded as key problem for older people in both urban and rural areas. However, in rural areas the greater distance between people’s homes and basic services may exacerbate such disadvantage. For example, 12 per cent of all rural households live more than four kilometres from a doctor’s surgery. Of the 800,000 households in question, 108,000 comprise a single pensioner.”⁵

And

2. The Rural Evidence Research Centre report, Rural England: Demographic Change and Projections 1991 – 2028, 2005. Pg 8
3. National Travel Survey, 2005, Transport statistics. Published 7th September 2006
4. Rural Services Review, 2004, DEFRA, Pg 15
5. Quality of Life & Disadvantage Amongst Older People-Commission for Rural Communities- 2006-Pg 12

“All respondents regarded physical access to resources and amenities as being dependent on health and mobility. Even if there was a good bus service, it was not always possible to use it if one had poor health.”⁶

Anything that can be done, such as removing the need for an additional journey to a pharmacist, can be seen as a contribution to the effort to reduce these problems for older people.

Why patients opt for doctor-dispensing

“It would take me all day to get from home to doctors to chemist and home again.”

“I can just walk to the doctor’s but one journey is enough for me.”

“There is only one bus a day, the branch surgery is a lifeline.”

“We can’t be ill by appointment.”

“When my children are ill it’s as much as I can do to get them to the surgery.”

“It’s hard for me to get out of the car, I can park near the surgery but it’s very difficult on the high street even with a disabled badge.”

Question 5 tackled prescriptions being dispensed from the surgery. Over 30% prioritised convenience and over 20% valued the advantage of being known by doctors and staff. Over 15% had difficulties accessing local public transport due to cost and availability. Comments added to the pages reflected the loyalty felt by patients to their doctor and the surgery staff, engendering trust and a sense of security. Little could be seen as a reason for change.

One patient highlighted the conflicts between environmental concerns and the extra journeys the loss of dispensing practice would require.

“At a time when the Government is putting pressure on us all to reduce CO2 emissions and unnecessary travel, it seems ironic

6 Ibid Pg 41

that they are forcing the sick and elderly to increase their travel to collect their medications from a location other than the surgery”

What impact would the proposals have on patients?

As suspected, dispensing patients were overwhelmingly of the view that it would be problematic for them if their doctors' dispensing service were to end.

95% of surveyed patients said it would be difficult or inconvenient if their doctor was no longer able to dispense to them.

Many added comments voicing fears for the future should they be less mobile or unable to afford additional journeys.

As mentioned above, one consequence of stopping dispensing by doctors could be branch surgery closures, as practices have used part of the income from dispensing to support branch surgeries, which bring services closer to patients who live farther away from the main practice.

Question 7 explored the impact of this service ending and found that just under half of the patients who use branch surgeries said that it would be “very difficult” for them if the branch surgery were to close. A further 28% said they would find it difficult but would manage. Fewer than 2% said they would be indifferent if their branch surgery closed. Convenience and ease of access to services is well supported by the Government agenda elsewhere-it should be supported through dispensing practice as well.

Patients gave examples of the additional journeys they would have to make if branch surgeries closed, with some saying they would have to travel 10 miles or more to access medical services, this being particularly difficult for the old and infirm or those with young children.



Margaret, a 34 year old lady with multiple sclerosis, who gets around in an electrically propelled wheelchair, lives in a village nearly 6 miles from the main surgery. She is proud of her independence and is able to attend the branch surgery in her village for medical care and any prescriptions.

The main surgery is just less than a mile (as the crow flies but not as the road twists) from a pharmacy in a neighbouring village, which is also 6 miles from her home but in a slightly different direction.

Loss of dispensing by this practice could mean closure of the branch surgery and a demoralising loss of independence for this disabled lady.

“When we get older, we’d have to move if the branch surgery closed.”

Patients want choice over where they receive their prescriptions

Recent Government initiatives - ‘Choose and Book’, extended GP opening hours, NHS Choices - have all had patient convenience and choice as their guiding principle. In our survey both dispensing and non-dispensing patients voiced overwhelming support for the option to receive their medicines from their doctor

89% of patients asked said they wanted the choice of being able to receive their medicines from their doctor.

Often this is for reasons of convenience, sometimes, in the case of the elderly, disabled and those with young children, patients face real difficulty in making a further journey on to a chemist. In all cases patients’ choice should be respected and upheld, and it is for this reason the DDA opposes the proposals to reduce doctor-dispensing, and calls on the Government to reassure all dispensing patients that their choice to receive medicines from their surgery will not be taken away.

Overall the picture is one of a settled patient population who want continuity of services and the choice to receive their medicines at a time and place of their convenience. Patients’ eagerness to participate in the survey can in itself be seen as a sign of support for their dispensing practices. A selection of comments taken from the survey, that the DDA feel help illuminate the issue, are included below.

“...you can get an immediate prescription and medication without further travel”

“Why, why, why must these changes happen when everyone is satisfied?”

“...it’s right by a bus stop and central to the village. There is a good car park for us older patients so no walking far”

“We live in a rural community where cars are our essential link to our local village and surgery, which is some two miles away. Without a dispensing facility my life would be made much more difficult”

“I would have to travel seven miles each way, find a parking space and wait”

“Those without their own transport need local branch surgeries. Public transport in most rural areas no longer exists”



4. Recent reviews of pharmaceutical services

In recent years pharmaceutical services have been the subject of a variety of reviews and policy papers aimed at increasing competition, lengthening opening hours and developing professional roles.

The 'control of entry' regime are the rules by which the NHS determines whether a pharmaceutical contractor (be they pharmacist or dispensing doctor) can provide NHS pharmaceutical services).

It has been scrutinised variously by the Health Select Committee, the Office of Fair Trading, and most recently through a review commissioned by the Government from Anne Galbraith, the former Chair of the Prescription Pricing Authority.

This year's Pharmacy White Paper: **Pharmacy in England Building on strengths – delivering the future** in April 2008 - combines their response to the Galbraith review with broader proposals for reforming pharmacy and dispensing.

The bulk of the White Paper is geared at modernising and developing the role of pharmacists to include independent diagnosis and management of patients. This expanded role is similar to the role that pharmacists play in many western European countries, and is a professional development broadly supported by the other professions, including the DDA, who welcome further opportunities to work in partnership with pharmacists.

“This White Paper sets out a reinvigorated vision of pharmacy’s potential to contribute further to a fair, personalised, safe and effective NHS. A vision that demonstrates how pharmacy can continue to expand its further role in an NHS that focuses as much on prevention as it does treating sick people, helping to reduce health inequalities, supporting healthy choices and promoting wellbeing for patients and public alike.”

As professional roles develop in general practice, pharmacy and nursing, so public understanding about who does what needs to keep pace. It is no longer the case for example that only doctors prescribe - in specified and particular situations both nurses and pharmacists can prescribe. Diagnostics and medicines reviews are other activities increasing carried out by all professions. The future of professional roles hinges on continuing and enhancing professional collaboration and ensuring these changes bring higher quality and more convenient services to patients.

This White Paper sets out a reinvigorated vision of pharmacy’s potential to contribute further to a fair, personalised, safe and effective NHS.

Here again change needs to follow the core guiding principles of patient safety, choice and convenience.

The DDA is therefore broadly supportive of the Pharmacy White Paper's various provisions to develop the role of pharmacists and is working hard through its members and at a national level to develop strong models of professional collaboration for the benefit of patients. It is only the provisions which relate to changing the control of entry regulations for dispensing doctors that we oppose.

Current Arrangements for dispensing practice

As mentioned previously, currently patients must apply for the right to have their prescriptions dispensed by their GP. The decision is based on the distance the patient must travel between home and the pharmacy. This means that patients registered at the same practice may or may not be dispensing patients depending on where they live.

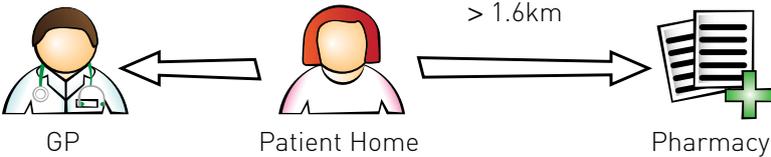
Entry to the market for pharmacists and dispensing doctors is governed by the NHS (Pharmaceutical Services) Regulation 2005. At present a pharmacy can open in a rural area only if it is deemed 'necessary or expedient' by the PCT, and does not prejudice existing medical or pharmaceutical services. There are a number of exceptions to this, for example if the pharmacy is open for 100 hours a week; they are exempt from the tests for control of entry.

Under the Regulations doctors may, in certain circumstances, provide medicine to their patients from their surgery rather than sending the patient to a chemist. Currently doctors may offer to dispense to patients who live more than one mile (1.6km) from a chemist – the patient must also apply to be dispensed medicine by their doctor. Note that the test is applied from the perspective of individual patients, not the GP Practice. The patient applies for the right to receive medicine from their GP. Along with the one mile rule there is a provision for patients to apply to receive medicine from their GP if it can be generally said that they would otherwise have difficulties obtaining medicine.

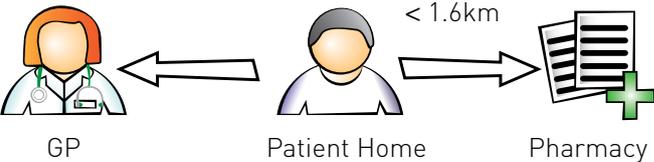


The diagram below helps illustrate the current rules. In Scenario

one, the nearest pharmacy is located over 1.6km from the patients home and so the patient can receive medicine from their GP. In Scenario 2, the patient's home is located within 1.6km of a pharmacy and so they cannot become a dispensing patient.



Scenario 1 Dispensing is allowed



Scenario 2 Dispensing not allowed

5. The proposed changes:

Pharmacy in England: Building on strengths-delivering the future

This April's Pharmacy White Paper highlighted a number of issues in relation to dispensing by doctors. It flagged in particular:

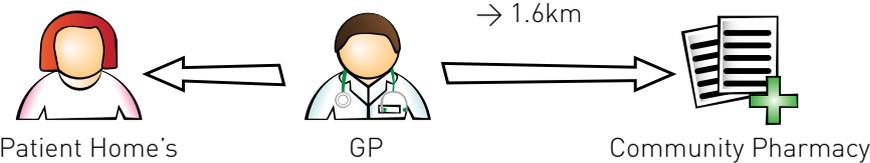
- a perceived inequitable provision of dispensing services
- close proximity of some dispensing practices to pharmacies
- a lack of transparency and logic
- a false perception that dispensing by doctors is more expensive

The Department of Health proposed that a change to the control of entry arrangements could 'resolve' these problems. The new proposals briefly summarised in the Pharmacy White Paper are as follows:

"Instead of the current considerations that take into account the locality and the distance between the individual patient's address and the nearest pharmacy, there could be a single condition relating simply to the distance between the surgery and the nearest pharmacy. This might appear more logical, as the person will usually travel to the surgery to see the GP. If a prescription is provided, they are likely to have it dispensed during that same trip.

8.71 If a dispensing practice met the new single criteria, then dispensing to all the practice's patients would be allowed. This would be far more transparent for patients and would facilitate other changes such as allowing patients to buy over-the-counter medicines from their dispensing practices (this would be unmanageable where only a proportion of patients could receive dispensing services)."

This new arrangement is illustrated in the diagrams below. The GP is now the central piece of the diagrams, no longer the patient as in the previous example, reflecting the change in legislation.



Scenario 1 Dispensing is allowed



Scenario 2 Dispensing not allowed

However, the department emphasised that this was only a proposed solution and that any changes to the regulation of dispensing doctors would be included as part of a wider consultation on the control of entry system.

The consultation process for the control of entry system began on the 27th August 2008 with the publication of the consultation document Pharmacy in England: Building on strengths – delivering the future – proposals for legislative change.

As promised, this document provides wide ranging proposals for the control of entry for both pharmacists and dispensing doctors. As will be covered further on, in some instances the possible changes are intertwined.

The proposals for control of entry for dispensing doctors have developed further from the proposals found in the Pharmacy White Paper. Below are the four possible suggested options for change (it is worth noting, that despite statements to the contrary, the consultation documents reveal that at one point a fifth option was considered-abolishing dispensing practice altogether⁷).

Option 1 is no change. This has the advantage of maintaining the status quo, does not remove services from patients and does not put any jobs at risk. It does not, however, address the financial issues or the inequities within the current system identified earlier and in particular, whether GP dispensing can be justified when there is a pharmacy in close proximity.

Option 2 is that whilst continuing with current arrangements where GP dispensing applies in controlled localities, the existing specific distance criteria would be removed. This would allow PCTs to determine the rural localities where GP dispensing is appropriate on the basis of their Pharmaceutical Needs Assessment (PNA). This option could address the current anomalies of a rigid national scheme and empowers local communities to make decisions appropriate to their needs. It aligns with the longer-term strategic direction for commissioning and pharmaceutical services generally, based on PNAs.

7. 5 of 8 Impact
Assessment of proposals
concerning legislative
arrangements governing
NHS dispensing doctors.
Department of Health. Pg7

Option 3 would mean that, instead of the distance between the patient's home and the pharmacy, the determining factor should be a distance between the dispensing surgery and the nearest community pharmacy. Such a distance could be put at less than the current 1.6 km, for example, at 500 m or at 1000 m. This removes the anomaly of a doctor dispensing to some of his/her patients where there is a community pharmacist in close proximity and also removes the question of a practice having dispensing and non-dispensing patients. Such a 'cliff edge' effect is less pronounced than under the current arrangements although there may still be such cut-offs where there are nearby practice boundaries.

Option 4 is a variation of Option 3. It would mean that a GP would not dispense where there is a pharmacy within 500 m or 1000 m of the GP practice and a second pharmacy within 1500 m. Those who are permitted to dispense may do so to all their registered patients regardless of the distance between their home and the surgery or pharmacy. This option maintains an element of choice for patients when having their drugs dispensed and has a less pronounced effect on GP dispensing.⁸



8. Pharmacy in England:
Building on strengths
– delivering the future –
proposals for legislative
change
Consultation Document.
Department of Health.
Pg36

6.DDA's response to the proposed changes

Since the publication of the Pharmacy White Paper the DDA has been clear that the changes proposed would have a wide ranging and significant impact on the provision of high quality and convenient medical services for patients in rural areas.

While superficially the changes proposed in the Pharmacy White Paper & related consultation document may appear to be only a minor alteration, the effect will be tremendous if implemented. The change to the one mile rule within Options 3 & 4 of the consultation document would essentially mean that wherever a surgery is currently within the specified distance (1000 or 500 m) of an existing pharmacy, all dispensing would have to cease. A recent practice survey conducted by the DDA found that this would apply to around 700 practices. The ability of the remaining doctors to continue dispensing would be totally dependant on whether or not a pharmacist decided to open shop within one mile of their surgery. The incentive for pharmacists to do so would be great as they would automatically inherit the doctors list of dispensing patients, both near & far.

The DDA maintain that the only way to ensure that there is continuity in the rural and dispensing services provided to rural patients is to choose Option 1-maintain the status quo. This chapter will illustrate the possible impact of changes in general and also lay out some general and specific criticism to the three options for change suggested by the DOH.

Threat to services, access & choice

Reduced patient choice – The majority of patients, when given the choice, elect to have their medicines dispensed at the doctor's surgery. Once they have made this proactive choice, they continue to be able to exercise choice in where they collect a prescription; their surgery or from a pharmacy. This provides added convenience, particularly to those who have mobility problems. Options 3 & 4 would result in fewer patients having this option in future, and millions⁹ of patients who currently exercise this choice having it taken away. This would seem to run against the aspiration of improving patient choice within the NHS. The addition of a need for two pharmacies to be in proximity to a patient is a nuance of Option 4 which could be perceived as a token attempt offer a form of choice in the shape of two chemists for current dispensing patients. While it may ensure a choice between pharmacy providers it does not allow for the choice that patients really want-whether to receive their medicine from their doctor or take an additional journey to the pharmacist.



The majority of patients, when given the choice, elect to have their medicines dispensed at the doctor's surgery.

9. Figure based on 700 practices out of 1135 likely to be affected with a total patient population of 8.9m.

Loss of integrated medical and pharmaceutical services -

Dispensing practices currently provide an integrated service – with dispensers working in practices alongside doctors, to deliver a joined-up comprehensive service to patients. Innovation in service delivery and joint working will be curtailed if dispensing doctors are prohibited from continuing in their practice.

Loss of medical services and possible surgery closures in rural areas -

If doctors were prevented from dispensing, the resulting loss of income for the practice will in many instances mean a reduction in patient services. Currently the income from dispensing subsidises other services (for example branch surgeries). Dispensing practices have examined the plans and foresee that they will have to close branch surgeries or make redundant salaried GPs. Where doctors are near retirement and sole practitioners, the prospect of surgery closures looms.

Staff Redundancies – It is estimated that between 5,000 and 7,000 staff employed in the dispensary and ancillary areas of dispensing practices will be made redundant. Many of these are staff who job share and the loss of their income would have a devastating effect on families across the country.

New inequities & anomalies?

As previously mentioned, the Pharmacy White Paper & related consultation document propose that changes are needed to the control of entry rules because of apparent inequities in service provision.

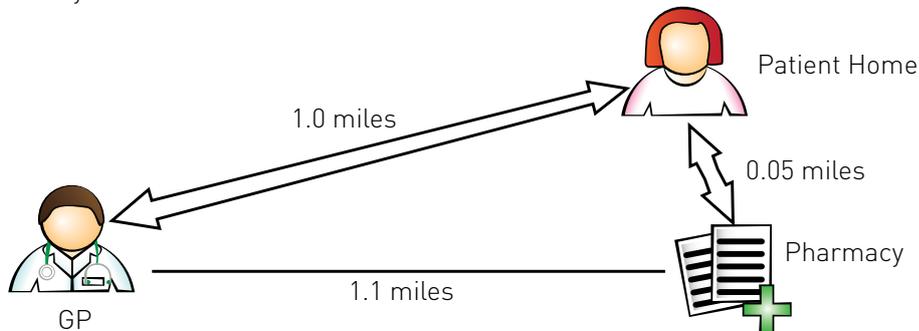
The DDA accepts that it may seem unfair that patients that live very close to each other have different services in regards to doctor dispensing.

However, the original proposal for change that has now become Options 3 & 4 in the consultation document, would only result in inequities of another kind & services disruption to patients. The following two scenarios demonstrate this.

In the first scenario, the new rules allow a patient to receive their prescriptions from their GP even though it adds little to their journey

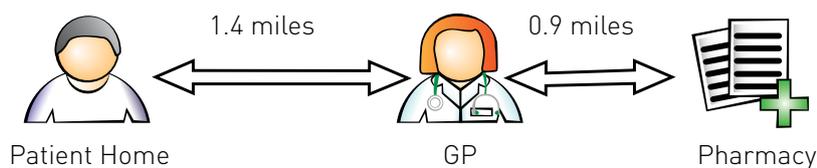


time to collect their prescription from their Pharmacy as they live nearby to one.



Scenario 1 Dispensing is allowed, distance travelled to obtain and collect prescription from pharmacist 2.1 miles

In scenario 2 at a different location the patient would not be allowed to collect their prescriptions from their GP even though they live a long way from their local pharmacy. Many prescriptions, approximately 80%, are repeat prescriptions and do not always need the patient to visit the doctor for them to be issued. With the introduction of the electronic prescription service they will go straight to the dispenser or may be requested by the dispenser and so the important distance for the patient is between their home and the pharmacy.



Scenario 2 Dispensing not allowed, distance travelled to obtain and collect prescription from pharmacist 4.6 miles

We would like to highlight the statement made in the Pharmacy White Paper in reference to the existing control of entry regulations (pg115 8.68).

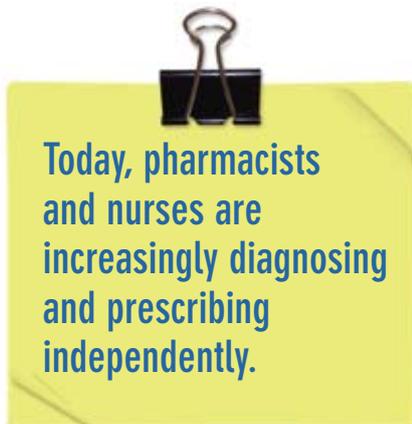
“This test can also fail to identify the actual distance a person has to travel when going from home to the GP and on to the nearest pharmacy.”

We would argue that the same criticism could be applied to all of the proposals now suggested by the DOH, whether option 3 or 4.

Doctors Dispense, Pharmacists Prescribe?

An assertion found in both the Pharmacy White Paper and accompanying consultation documents is that doctors prescribe and pharmacists dispense. For example, Pg 5 paragraph 5 of Impact Assessment of proposals concerning legislative arrangements governing NHS dispensing doctors states

“One of the founding principles of the NHS was to separate prescribing and dispensing services, with doctors mainly being responsible for prescribing and pharmacists for dispensing.”



The DDA is concerned that this assumption is being used as an argument to support a reduction in dispensing practice, but is based on an outdated view. Today, pharmacists and nurses are increasingly diagnosing and prescribing independently. Meanwhile doctor dispensing, which has in fact been practised for over 100 years to the satisfaction and convenience of patients, is being threatened. The guiding principle should be the drive to make services convenient for the patient without compromising safety, rather than a levelling down of the existing service.

Option 2-Pharmaceutical Needs Assessment

Option 2 is closely tied to a general reform of the control of entry for pharmacy provision through an increased use of the Pharmaceutical Needs Assessment (PNA) carried out by Primary Care Trusts. All Primary Care Trusts in England were required to carry out a PNA from 2005 onwards as part of their Joint Strategic Needs Assessment. As is standard when assessing health needs, the PNA should be used to consider broadly the populations ability to benefit from (pharmaceutical) health care. This includes everything from repeat dispensing and public health campaigns to minor ailment schemes and medicines use review. They would then make all decisions on market entry based on this assessment.

However, as noted in the consultation, “their consistency, breadth and depth are variable.”

Preliminary findings from a national survey of PCTs undertaken during 2007 found that at least 25% of PCTs had not revised

their PNAs since 2005 and they did not appear to influence commissioning.¹⁰

“The degree to which PCTs have used pharmaceutical needs assessments (PNAs) to assist their planning of service provisions appears mixed. We have heard that this can range from a simple map of the area with the providers denoted to a sophisticated assessment of current and future requirements and the role such services play in the promotion of better public health and prevention of disease.”¹¹

Therefore there would be a high degree of uncertainty as to what would happen to dispensing services if it were left for individual PCTs to decide and inevitably a degree of inconsistency would evolve, something which the Government has emphasised they are keen to avoid. We would highlight and agree with the statement made in the Pharmacy White Paper, Pg115.

8.67 Given the Government’s conclusion that commissioning development within PCTs is not yet at a stage where PCTs can be charged with full contractual responsibilities, there will remain a ‘control of entry’ regime.

If a move towards PNA based control of entry decisions were to be considered it would need to be coupled with strong safeguards within the PNA guidelines issued to PCTs to ensure the continued provision of existing dispensing services. The DDA supports the principle of local decision making within a framework of national guidance which maintains the existing level of service for rural patients.

Increased Cost of Dispensing Doctors

The Pharmacy White Paper contains some assertions that dispensing doctors are more expensive although this is not presented as a reason for change. Government figures show parity between the two. The DDA has explained the calculations confirming our finding to Department of Health officials but at the time of writing have yet to receive their response.

The DDA has looked at the figures from the Prescription Pricing

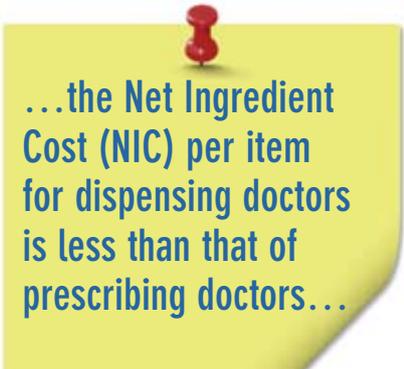


10. Celino & Blenkinsopp (2007) Preliminary findings from the Annual Survey of Pharmacy Development at PCTs in England. Personal Communication.

11. Review of NHS pharmaceutical contractual arrangements, Anne Galbraith, 2007 Pg34

Division¹² and found little difference between prescribing and dispensing practice in terms of total costs. Accurate comparison is made difficult since items personally administered by doctors are included only in dispensing practices' figures. What is certain is that the Net Ingredient Cost (NIC) per item for dispensing doctors is less than that of prescribing doctors but dispensing doctors prescribe more items, so overall there is little to choose between them.

There are 3,510,895 dispensing patients in England and 50,542,505 NHS patients. In the 12 months to June 2008 dispensing doctors dispensed 17.23 items per patient at an NIC of £148.68. In the same period pharmacists dispensed 15.66 items per patient at a NIC of £156.13.



...the Net Ingredient Cost (NIC) per item for dispensing doctors is less than that of prescribing doctors...

Thus in a year dispensing doctors are spending £7.45 less per patient than their prescribing colleagues. So on our patients each year, compared to prescribing doctor patients we are spending £26 million less on the basic cost of medicines.

The assertion that dispensing doctors are more expensive than pharmacists is harder still to understand since the fees that pharmacists receive from the NHS were raised by Government in October this year. A pharmacy now receives a headline figure that is only fractions of a penny different from the £2.13 per item paid per item to a dispensing practice. Because pharmacists also receive additional fees that dispensing doctors do not and because there are significant differences in discount levels clawed back by government, the average cost to the NHS per item for a pharmacy is £11.40 and for dispensing doctors is £9.79

Furthermore currently, dispensing doctors are prohibited by the NHS from selling any item privately so must provide many of the cheaper remedies on the NHS. This makes doctor dispensing more expensive than it needs to be.

12. The Prescription Pricing Division of the NHS Business Services Authority processes over two million prescription items per working day, determining reimbursement and remuneration levels through to payment.

6. Conclusion

This report has provided an overview of the current challenge faced by dispensing doctors and their patients. The DDA Patient survey provides for the first time, a clear insight into the views and preferences of the millions of patients currently served by dispensing practices. The findings deliver a powerful message to decision makers. Patients greatly value dispensing services and additional services provided by dispensing practices, such as home deliveries and branch surgeries, that support the provision of safe and effective healthcare in remote rural areas.

The potential effects of the proposals in the Pharmacy White Paper are serious and wide ranging. The report outlines undesirable consequences such as a reduction of choice and access to vital health services, the closure of branch surgeries, and a loss of dispensary jobs, and potential service reductions. The examples of patients and practices found throughout this document represent just a small handful of the many doctors, patients and dispensary staff who have expressed their concerns about the future of a service in which they hold a precious stake.

Dispensing by doctors is a safe and cost effective way to deliver medicines to patients. It worked well before the NHS was formed and has continued to work well throughout the significant reforms to the structure and delivery of healthcare over the past 100 years. This report is testimony to the fact that dispensing patients are clear in their view that this is one service that does not need to be reviewed. It is serving the communities who need it and will continue to do so whilst working with pharmacists to ensure safe and convenient access to medicines for all NHS patients.

As patients, doctors, politicians, pharmacists, rural and patient representatives have all commented, "if it ain't broke, don't fix it". Opting for 'no change' will ensure that rural healthcare will continue to be delivered with the patient and public interest at its heart.



7. Appendix- Patient Survey

Patient Survey about dispensing services

As a valued patient, we would be extremely grateful if you would take a few minutes to fill in this patient survey. It has been designed to give us an insight into the way you use our services to help us provide the service you want.

One person can fill a form for all the family

If you need help, please ask a relative or carer to fill this in for you.

Tick your answer against the options

ALL PATIENTS: please answer questions 1 ,2 and 3

Question 1. How many of our patients live at your address?

- 1
- 2-4
- 4 or more

Question 2. Tick one or more of these if any of our patients at your address are:

- under 10
- over 65
- disabled
- housebound

Question 3. Without a car how long does it take to travel:

From home to surgery?

- less than half an hour
- up to 1 hour
- 1-2 hrs
- 2 hrs or more

From surgery to pharmacy?

- less than half an hour
- up to 1 hour
- 1-2 hrs
- 2 hrs or more

From pharmacy to home?

- less than half an hour
- up to 1 hour
- 1-2 hrs
- 2 hrs or more

If your prescriptions are dispensed at our surgery, now please answer SECTION 1, Questions 4 to 7

If your prescriptions are NOT dispensed at our GP surgery, now please answer SECTION 2, Questions 8 to 10

SECTION 1 – FOR DISPENSING PATIENTS

Question 4. How long have you been a dispensing patient?

- Less than a year
- 1-5years
- 5-10 years
- More than 10 years

Question 5. Why do you have your prescriptions dispensed at the surgery?

- Getting medicines where I see the doctor is convenient
- I have difficulty getting about
- Making several journeys would be difficult without a car
- Public transport here is poor
- Public transport is expensive
- The local pharmacy has limited opening hours
- I prefer one journey because of children/other caring duties
- It's better where the doctors know me/my family and have my medical records
- Other reason

Question 6. How would you be affected if your doctor was no longer able to dispense to you?

- I would find it very difficult
- Very inconvenient but I would be able to cope
- Little or no difference

Question 7. If you use a branch surgery, how would you be affected if your doctor had to close it?

- It would be very difficult for me/my carer
- I would not like it but would manage
- it would not bother me
- I don't use a branch surgery

SECTION 2 – FOR NON-DISPENSING PATIENTS

Question 8. How long have you been a patient at this practice?

- Less than a year
- 1-5years
- 5-10 years
- More than 10 years

Question 9. Have you ever been a dispensing patient at any practice?

- yes
- no
- don't know

Question 10. Would you like to be able to choose where to have your medicines dispensed depending on where it's convenient at the time?

- yes
- no

