



## **Pharmacy in England Building on strengths – delivering the future**

### **1. Introduction**

1.1 The Commission for Rural Communities (CRC) is the statutory voice for England's rural people, businesses and communities, providing well informed, independent advice to government and ensuring policies reflect the needs of people living and working in rural England, with a particular focus on disadvantage. Its key functions are to act as :

- Rural advocate – the voice for rural people, businesses and communities
- Expert adviser – giving evidence based, objective advice to government (central regional and local) in taking account of rural needs and circumstances
- Independent watchdog – monitoring and reporting on delivery of policies nationally regionally and locally

1.2 CRC has a long standing interest in and knowledge of the delivery of healthcare services in rural areas. Most recently we have worked closely with the Department of Health to ensure a rural dimension to the recent NHS Review led by Lord Darzi.

1.3 The CRC Chief Executive, Graham Garbutt, was invited to join the Rural Issues group at the Department of Health, which was established as part of the NHS Review. CRC has also been invited to participate in the setting up of a North East Rural Health Commission led by the Chairman of the Strategic Health Authority and the Chief Executive of a local Primary Care Trust, to identify and tackle inequality of access to health services in rural areas.

1.4. The CRC wishes to express concern that such an important policy affecting the future of a valuable community service has not been rural proofed at an earlier stage, and does not take into account the contribution that such services can make towards sustainable rural communities. The CRC would like to see a more proactive approach to rural proofing such policies and taking forward their implementation, and we are willing to provide support and expertise to this effect.

### **2. Rural populations, access to pharmacies and preventative health – specific issues**

2.1 Within rural areas those in poverty and at risk of poor health outcomes are likely to be dispersed across a community, which is often geographically sparse, whilst living side by side with affluent neighbours so that the real needs of individuals are hidden.

2.2 Rural people on low incomes or with disabilities who do not have access to their own transport are much more likely to experience difficulty in accessing services.

2.3 In this submission we identify two main areas where proposals contained in the White Paper could have a significant and disproportionate impact in rural areas. These are:

- More pharmacy services supporting healthy living and better care (Chapter 4)
- Structural enablers and levers (Chapter 8)

2.4 This submission focuses on each of these proposals in turn drawing on our research, analysis and knowledge of the sector together with the wider health policy landscape. However, we also have a number of general issues to raise in support of the positive role that rural GP's can play in contributing to sustainable rural economies. Consequently, any policy which might undermine the viability of rural GP's could lead to a negative impact upon rural residents.

### **3. Pharmacy services supporting healthy living and better care**

3.1 Proposed future service developments include pharmacies as centres promoting and supporting healthy living and health literacy, offering healthy lifestyle advice and support on self care.

3.2 Preventative health interventions, such as smoking cessation and sexual health/contraception services, are particularly important for disadvantaged individuals and communities who are more likely to experience unhealthy lifestyles and poor health outcomes. However ease of accessibility at a very local level in rural areas determines whether people will use preventative services. Whilst people in all areas will try hard to access health services in the event of a medical crisis, people are much less likely to access preventative services unless they are reasonably easy to get to.

3.3 The experience of Directors of Public Health in rural areas such as Cambridgeshire and the Fens, for example, indicates that unless rural accessibility at a very local level is factored into the planning, commissioning and monitoring of preventative services, such services tend to end up concentrated in a small number of usually urban locations with unrealistic expectations that rural patients will travel to them. Transport costs are invariably higher in rural areas. Households in rural settlements spend on average, £74.50 on transport each week, compared with £57.10 in urban areas.<sup>1</sup>

3.4 Prescribers are (commendably) under pressure to reduce waste by prescribing only a one month supply of medicines, but this does not take into account the indirect costs to people – particularly those who live remotely, exist on low incomes and are without public transport – of travelling to a pharmacy further away.

The Department of Health Impact Assessment suggests that dispensing by Doctors costs more than dispensing by Pharmacists. However, an analysis of the Impact Assessment, presented by the Dispensing Doctors' Association suggests that this is an untrue assumption.<sup>2</sup>

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<sup>1</sup> (SOC, pg 27) Department for Transport (2007) National Transport Survey.

<sup>2</sup> [www.dispensingdoctor.org](http://www.dispensingdoctor.org), evidence submitted by Dr Allan Tennant, presented by Dr Philip Koopowitz for Dispensing Doctors' Association, October 2008

## 4. Structural enablers and levers

4.1 Proposals for changing the current structure of provision include refocusing commissioning away from dispensing services and changes to contractual arrangements for pharmaceutical services.

4.2 Specific proposals include that dispensing GP practices would have to cease dispensing to all patients if a pharmacy opens/exists within one mile (1.6km) of the surgery. However, we believe that this proposal does not reflect the specific access needs of rural areas.

4.3 The CRC is concerned that the issue of cross subsidy has not been given more prominence as part of the evidence put forward by the Department of health. Many rural GP's rely considerably upon income from their dispensary services to offset the provision of other services. Where dispensary income is lost, services and staffing would have to be reappraised in light of a reduced budget. Potentially, this could lead to the closure of dispensary services within many rural doctors practices, with a detrimental effect on access to pharmacy services particularly for those people who do not have their own transport. Evidence submitted directly to the CRC and to the Dispensing Doctors' Association indicates clearly that a negative financial impact may be experienced by rural dispensing GP's, who currently rely upon the cross subsidy of dispensing services, consequently, threatening the viability of the GP surgery itself. The analysis of practice finances from one GP practice in a wholly rural area of Lincolnshire demonstrates that earnings from the medical practice alone are approximately 40% below comparable urban General Medical Surgery practices, and that the operations of the medical practice are heavily subsidised by the income stream from dispensing. The conclusion from this practice is that ..... *'were the dispensing income stream to be removed, this practice would cease to be viable in its current format'*. In many communities, the balance of the local economy is fragile and the loss of this service has real implications for the viability of many rural communities in general.<sup>3</sup>

4.4 The current measure of eligibility to receive dispensing services from a GP, is based on the distance between a person's home and the nearest community pharmacy. Although there are some anomalies associated with this system which the White Paper seeks to address, the effect on patients who rely solely on their GP for dispensing medication and who would have difficulty accessing relocated services has not, we believe, been fully taken into account. Nor has the impact of loss of a key service in a rural community where many services are already under threat been fully considered, particularly in relation to addressing the needs of sustainable rural communities.

4.5 The loss of dispensing services is also likely to have an impact on the provision of additional services such as blood tests, minor surgery and Warfarin monitoring. For example a GP practice in Market Rasen reports that ..... *'profits from our dispensary are re-invested in the practice and directly fund many additional services to patients in our surgery which we would not otherwise be able to provide..... If we lose the dispensary we will no longer be able to provide these services and patients will have to travel to a larger town or city for basic routine tests..... a minimum of 13 miles.'*

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<sup>3</sup> [www.dispensingdoctor.org](http://www.dispensingdoctor.org), evidence submitted by practitioners.

## **5. Sustainable Communities**

5.1 Our analysis of rural trends (see State of the Countryside 2007) indicates that it is likely that in the foreseeable future (say 5-10 years) many people will continue to be attracted to rural areas as pleasant, tranquil places to live and work. For these and other reasons we challenge the often held notion that small rural communities are inherently 'unsustainable'. Rather, the decline in rural services, such as dispensing GP's surgeries, like restrictive planning policies, will make villages less sustainable and worsen, rather than improve, the situation. Instead, we should encourage and promote the ways and means by which rural communities, along with urban ones, can be made more sustainable. The delivery of local services such as dispensing GP surgeries, will be a critical part of this approach, exploiting where possible the socio-economic and technological changes taking place in rural communities. For a fuller discussion of these issues see CRC's recent publication 'The Big Picture'.<sup>4</sup>

5.2 In addition, Appendix 1 and 2 of this response, illustrate the distribution and sparsity of existing rural dispensing GP services. These clearly show that the proportion of dispensing GP's surgeries in smaller, sparse rural settlements is very significant, thus any negative change to this will have a significant impact upon rural G.P surgeries overall.

## **6. Rural Economies**

6.1 Our concerns with regard to the loss of the dispensary from rural GPs surgeries would be the impact in terms of the loss of jobs - both professionally qualified pharmacists and associated support staff. Well paid professional jobs are in short supply in many rural areas. Secondly the loss of another service has an effect on the viability and critical mass required to retain many other services in rural areas e.g. GP surgery may use business services provided by the local post office; if the surgery closes because it is no longer viable due to loss of dispensary, there is a knock on effect at the post office.

## **7. Recommendations**

7.1 Where pharmacies are leading the drive to improve preventative health care services the commitment to rural accessibility at a very local level must be built into the planning and commissioning of these services. New technology alongside innovative delivery mechanisms can help to support this. The CRC, with the Institute of public policy research is currently examining innovative service delivery mechanisms for a series of Major Life events such as Cancer care, Stroke and Maternity services. For more information visit our website at [www.ruralcommunities.gov.uk](http://www.ruralcommunities.gov.uk). We welcome the opportunity to share these findings in order to illustrate how a flexible and innovative approach to service delivery can be achieved, for the benefit of rural communities.

7.2 The integration of pharmacists within existing health care teams in rural areas would be a positive step forward. This would allow pharmacists to become more directly involved in the public health agenda, coordinating and providing preventative services and screening services such as risk factors for coronary heart disease.

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<sup>4</sup> <http://www.ruralcommunities.gov.uk/items/3119>, CRC 73, Planning for Sustainable Rural Communities, the Big Picture.

7.3 In order to deliver a flexible service that is responsive of the needs of vulnerable people in rural areas, rural GP practices should be encouraged to continue dispensing and selling over the counter medications, thereby giving all patients the option of leaving the surgery with their medication and maintaining patient choice, which is at the cornerstone of Lord Darzi's NHS review.

7.4 The CRC shares the joint view of the DDA and PSNC<sup>5</sup> which emphasises the negative impact of the proposed changes to Control of Entry as set out in the Pharmacy White Paper, specifically,

.... ' that patients will be best served by a continuation of the status quo in rural areas and that wholesale imposed change is not helpful'

7.5 The CRC wishes to see such policies rural proofed from the outset with more flexibility built in when implementing these policies locally. We are happy to offer expertise in this regard. This proactive approach to rural proofing is the only way to take account of the contribution that rural dispensing GP's can make towards supporting sustainable rural communities.

In particular, we would wish to see the following measures:

- If Pharmaceutical Needs Assessments (P NAs) are introduced, Primary Care Trusts should be actively encouraged to undertake PNAs and consider commissioning, based upon their assessment of discrete localities. This would better represent the needs of rural areas, where the needs of vulnerable communities are often only identified at this local level.
- The issue of cross subsidy is a very important aspect which highlights how one service can support another and it should be taken into greater account when reviewing the evidence in support of the options presented.
- The commitment to rural proofing by the Department of Health should be backed up with a definitive action plan so that any future chosen option takes into consideration the needs of rural communities. The CRC is willing to offer support and expertise to rural proof the options presented and any recommendations that emerge from the consultation.

**Commission for Rural Communities  
October 2008**

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<sup>5</sup> <http://www.dispensingdoctor.org/content.php?id=340>, Joint statement by the Dispensing Doctors' Association and the Pharmaceutical Services Negotiating Committee, July 2008.

## Appendix 1

### Distribution of GP practices with dispensing facilities, 2008



Source: Binleys, 2008. GP practices database edition 26.

## Appendix 2

### Number of GP practices with dispensing facilities 2008

Area definition		Number of practices	Number of practices dispensing	% of all practices dispensing
Less Sparse	Hamlet & Isolated Dwellings	68	40	59%
	Village	452	367	81%
	Town & Fringe	1,230	624	51%
	Urban >10K	8,169	319	4%
Sparse	Hamlet & Isolated Dwelling	12	9	75%
	Village	71	61	86%
	Town & Fringe	84	47	56%
	Urban >10k	18	7	39%
	Rural	1,917	1,148	60%
	Urban >10K	8,187	326	4%
	<b>England</b>	<b>10,104</b>	<b>1,474</b>	<b>15%</b>