

# Rural dispensing — proposals for legislative change

**Richard Hough**, a practitioner in pharmacy law, looks at the regulations behind a professional dilemma



**C**ast your mind back to the mid-nineties. It was a time when very real divisions existed between two bodies of healthcare professionals: rural pharmacy contractors and dispensing doctors.

It was against this backdrop of divisiveness that the NHS (Pharmaceutical Services) Regulations 2005 (the 2005 Regulations) were introduced, which were perceived at the time as doing much to calm troubled waters.

Speaking in 2005, Stephen Lutener of the Pharmaceutical Services Negotiating Committee said that "the 2005 Regulations would improve access to rural patients to pharmaceutical services, remove the points of tension between the two professions, encourage a better service to patients and tidy up certain administrative procedures in the 1992 regulations." (PJ, April 23, 2005, p484). The 2005 Regulations, which are still in force, broadly state that:

1. Patients who are resident in areas which are rural in character, known as "controlled localities" and who live more than 1.6 km from the nearest pharmacy are entitled to get their prescriptions dispensed by their GP surgery, if that surgery is registered with its Primary Care Trust (PCT) as dispensing premises.

2. Applications by pharmacists for a dispensing contract and those currently on the PCT pharmaceutical list in a "controlled locality" must satisfy the "prejudice test", ie, the new service would not adversely affect the provision of local medical or pharmaceutical services. Upon satisfaction of the prejudice test, the PCT is obliged to consider whether an application is "necessary or desirable".

3. The PCT determines the merits of applications to dispense by doctors in accordance with the "prejudice test", though not currently the "necessary or desirable" test.

4. If a pharmacy opens in an area with fewer than 2,750 patients on its medical lists (a "reserved location"), patients living within 1.6 km of the pharmacy will not necessarily switch to receive dispensing services from the pharmacy but may continue to receive them from their doctor.

5. A GP's application for outline consent to dispense is to be refused if the doctor's premises are within 1.6km of an existing pharmacy.

The 2005 Regulations were widely perceived as bringing stability to rural dispensing services, from which patients have benefited greatly, but they are not without anomalies. For example, it

is possible that one person living on one side of a road is entitled to have his prescriptions dispensed at his surgery but another living on the other side of the road could not. It is also possible for someone eligible for doctor dispensing to pass their local pharmacy both on their way to the surgery and on their way home. But how many pharmacy contractors or patients are inconvenienced by these anomalies? And are these people sufficiently inconvenienced to warrant legislative change? The Department of Health (DH), after factoring in the higher costs associated with doctor dispensing and the questionable sustainability of some primary medical services, certainly thought so.

### Four options

Change to the rural control of entry regulations was proposed in the White Paper "Pharmacy in England: Building on strengths — delivering the future". Subsequently, a consultation document was published in which the DH set out four options:

Option 1 is no change. This maintains the status quo but fails to address any of the perceived inadequacies of the present legislation.

Option 2 is that, whilst continuing with current arrangements where GP dispensing applies in controlled localities, the existing specific distance criteria would be removed.

Option 3 is that, instead of the distance between the patient's home and the pharmacy, the determining factor would be the distance between the dispensing surgery and the nearest community pharmacy. Patients would have the right to have their prescriptions dispensed at their GP surgery only if the surgery was more than a specified distance from the nearest pharmacy. The White Paper gives 500m or 1,000m as examples.

Option 4 is a variation of Option 3. It would mean that a GP would not dispense where there is a pharmacy within 500m or 1,000m of the GP practice and another within 1,500m.

Option 3, the most pro-pharmacy option, appears to have caused the most consternation amongst dispensing doctors and their patients. On the face of it, the proposal that any patient who attends the dispensing premises could be dispensed to regardless of his registered home address seems logical and equitable. The patients on a surgery's list would all be treated consistently; all or none would be able to have their prescriptions dispensed by the surgery, depending on how close the nearest pharmacy

was to the surgery. As a large number of GP surgeries are located in towns or villages, the number of dispensing doctors in England and Wales would be expected to fall. This is partly because, out of the earnings of the average dispensing doctor (£127,000), the income derived from dispensing is typically £40,000 per annum, according to the *Independent*

(May 6). Dispensing doctors argue that patients will suffer because many doctors use this dispensing income to support other patient services. But is this really pharmacy's concern?

However, the PSNC, has backed Option 1. Its joint statement with the Dispensing Doctors' Association (DDA) says: "We are very concerned that the proposed changes to control of entry in the pharmacy White Paper threaten the stability we have achieved and will do untold harm to inter-professional relations, which could take decades to mend. Our joint view is that patients will be best served by a continuation of the status quo in rural areas and that wholesale imposed change is not helpful".

In deciding whether or not to abandon the hard-fought agreement reached between the PSNC and the DDA in 2000, the PSNC took into account the likely response of the Government in the face of a predictably strong and vociferous campaign by dispensing doctors and their patients, the potential damage to relationships between doctors and pharmacists and the impact of this on the delivery of the other White Paper policies. Pointedly, no mention is made of what might benefit rural pharmacy contractors. What surely will be determinative is whether the scale of any advantage secured for rural pharmacy contractors who might benefit from the implementation of Option 3 was worth the risk of re-creating a division between two groups of healthcare professionals.

I suspect the views of pharmacy contractor's will fall into two camps:

The PSNC should be criticised for having missed an opportunity to promote the interests of rural pharmacy contractors by refusing to endorse proposed legislative change which is unequivocally favourable to the cause of rural pharmacy contractors; or the PSNC should be applauded for displaying a light political touch and gaining kudos with a competing group of healthcare professionals by keeping its focus on the bigger picture of inter-professional harmony, which ultimately benefits patient care.

Responses to the consultation were due in by November 20, 2008.

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