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The apothecary's return? A brief look at pharmacy's future

David Taylor

This book has demonstrated that, in the past, the role of the pharmacist centred primarily on the correct preparation and safe supply of medicines. However, during the course of the 20th century, and in particular in the 50 years since the introduction of the NHS and its counterparts in North America and Europe, the profession's part in making medicines was for the most part lost to the pharmaceutical industry. Present developments in healthcare delivery and computer technology promise change in supply processes. They offer new ways of reducing the risks and assuring the safety of medicines taking, which may or may not continue directly to involve pharmacists.

The objective of this final chapter is to look forward, in the light of national and international health and social care developments, to the future of the profession. It is based on recent reviews of the available literature on the structure and evolution of pharmacy in Britain, other countries of Europe and in North America [1,2], and also on recent research into what younger community pharmacists are seeking for tomorrow [3]. It begins with a brief outline of present and likely future trends in health and healthcare. This is followed by an overview of current pharmaceutical sector policies and service structures. The forces driving continued change are discussed, and options for the future of pharmacy as a profession assessed.

Unresolved issues

The loss of pharmacy's historic position in relation to making medicines has to a degree been offset by the emergence of clinical pharmacy in secondary care. In the community setting, however, where across Europe as a whole well over 80% of practising pharmacists work (even in the UK, where hospital pharmacy is relatively well developed, almost

three-quarters of the profession's active members are community pharmacists) there has to date been less opportunity to innovate. In some respects the role of non-hospital pharmacists today is – despite the spectacular development of the pharmaceutical armamentarium since the end of the Second World War – less fulfilling than it was a century ago.

Many of the most important questions for the future of pharmacy relate to the community pharmacies and pharmacists of tomorrow, and how their clinical and/or managerial roles will evolve. In the next few decades a number of issues will need to be resolved, some of which are listed in Box 15.1. The terms of the new pharmacy contract agreed between community pharmacy contractors (pharmacy owners and their representatives) and the government at the end of 2004 will inevitably have a major impact on the development of pharmacy in Britain.

However in the longer term, and across the wider world, there is a considerable range of factors to be taken into account in looking at possible futures for pharmacy. These include the quality of the profession's leadership; the range and nature of the diagnostic and therapeutic

Box 15.1 Questions awaiting answers

- To what extent will public expectations of community pharmacy change?
 - Will more people come to see pharmaceutical care as a gateway, or an alternative, to medical care?
 - To what extent will pharmaceutical service users of all ages come to prefer using online services backed by the home delivery of medicines to the personal contact and advice offered in traditional pharmacies?
 - Will young pharmacists seek increasingly to work in premises shared with medical practitioners and other professionals?
 - Or will physically separate community pharmacies be preserved and be better linked by information and communications technology to other parts of the healthcare delivery system?
 - Within community pharmacy, will there emerge a growing divide between specialised clinical care providers and dispensing service and basic OTC medicine providers?
 - To what extent will regulatory and other policies permit or encourage the further growth of chain pharmacies and the vertical integration of the latter with wholesalers across regions such as Europe?
 - Will community and hospital pharmacy merge, to work in fully integrated care providers like those pioneered by Kaiser Permanente in the USA?
 - If so, will current professional boundaries remain, or will a new more unified body of health professionals evolve?
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innovations that will be developed and marketed; and the willingness and ability of health service users in differing communities and social positions to extend their self-care competencies, and to take a more central role as co-producers with professionals of personal and public health.

Pharmacy in the context of the public's health

Life expectancy in Britain increased markedly during the 19th and first half of the 20th centuries, well before most modern medicines and vaccines became available. From around 1850 better drains and water supplies combined with improvements in nutrition and housing to have a major impact on the public's health. By 1900 the average British baby could expect to live to about 50 years of age, although the chance of dying in the first year of life was still greater than 1 in 10. Today the equivalent figures are approaching 80 years, and 1 in 200.

Demographic changes

The processes of demographic and epidemiological transition associated with such changes include a fall in birth rates (as parents become better assured of their children's' survival they tend to have fewer babies); the ageing of the population; and a fall in the prevalence of infectious disease and premature deaths, balanced by increased chronic illness and disability rates.

The economic and social trends associated with such progress typically include increased industrialisation; increased education and status for women relative to men; more recognition of the importance of citizen and consumer rights and personal choice; and a greater emphasis on risk reduction, audit and public service quality in society in general and the healthcare context in particular.

One corollary of smaller family sizes and a general expectation of survival to old age is that death in childhood or earlier adulthood, when sadly it occurs, is even more of a tragedy than it was in previous eras. Such changes mean that public willingness to pay for more effective care and health protection rises exponentially, even while 'objective' indicators of health-related needs may fall. At the same time the status of professionals in universally educated populations becomes normalised in 'post-transitional' societies (that is, societies that have undergone demographic transition).

In the past the majority of people worked manually, and did not earn their livings by the use of a defined body of knowledge and technical

skills. Now most people are 'knowledge workers' in one way or another, and many policy-makers and members of the public appear to regard the special status of the traditional professions as increasingly anachronistic. This might help to explain why doctors, pharmacists and other healthcare providers may on occasions feel that more and more is being demanded of them, by people who treat them with less and less respect.

Worldwide, the most important health issues arguably relate to how communities that have yet to achieve average life expectancies of 70 years and over can best be helped to overcome the remaining barriers to such progress. In some sub-Saharan countries, such as Angola, a third of all children die before the end of their fifth year. This shocking figure underlines the fact that, just as the development of national health systems like the NHS was a major step in the 20th century, strengthening transnational systems of health resource transfer and provision is a key challenge for the 21st century.

This understanding has major ethical and practical implications for all the groups concerned with the supply of modern pharmaceuticals, from research-based and generic medicine manufacturers to pharmacists and other professionals responsible for their supply and appropriate use. However, there are also important opportunities for further public health gain in the 'rich world'. They relate in large part to improving the prevention and treatment of conditions most likely to affect people in later adult life.

Health improvement

Derek Wanless, in his reviews of healthcare funding and public health improvement [4,5], noted that the options for achieving further public health progress include enhancing access to effective medicines such as statins and anti-hypertensive treatments, and to interventions such as smoking cessation support. Tobacco use alone presently accounts for about half of the observed inequalities in longevity within the British community. These also include improving case management services for the minority of people with established diseases, who are at high risk of becoming unduly dependent on secondary care, and promoting self-care skills as and when this can contribute to better health outcomes for the majority of the population.

Growing governmental and professional understanding of the importance of appropriate medicines use and high quality chronic disease management has led in the UK to initiatives such as the Expert Patient Programme, and concepts such as 'concordance' and 'medicines

management' in the pharmaceutical sphere. There has been a range of attempts by the NHS to learn from the experience of organisations such as Kaiser and the United Health Group of Minnesota. Studies by independent groups such as the King's Fund have specifically highlighted the potential of pharmacists in promoting self-care and contributing to better chronic condition management [6]. From an objective standpoint, the economic evidence base underpinning claims that community pharmacists can move forward from their relatively limited dispensing role to enhancing medicines use in a cost-effective manner, and also to delivering health promotion and health protection services, requires further strengthening. Nevertheless, increased interest amongst governments across the world in the potential of disease management approaches to improve healthcare outcomes and contain its costs is an important signpost to the profession's future. So too is the fact that in the 21st century, post-transitional societies, the potential for environmental and lifestyle improvements alone to further increase life expectancy and reduce mental and physical morbidity is more limited than is sometimes suggested.

During the first 50 years of the NHS, average life expectancy in the UK increased by about 10 years. Medical care enhancements can reasonably claim about half this gain, and changes in lifestyle and environmental protection the other half [7]. Problems such as smoking and obesity should be addressed by further educational and protective interventions designed to influence behaviour. However as average life-spans reach 80 years, further progress is likely to demand the informed, early use of effective medicines coupled with other specific interventions based on an improved awareness of genetically mediated health risks.

Those seeking to divine pharmacy's future need to fully appreciate the significance of this conclusion. Whatever the strengths and weaknesses of the profession's contribution today, pharmacy has an important opportunity to be at the heart of attempts to further enhance public health tomorrow through an increasingly sophisticated, socially and psychologically appropriate application of pharmaceutical science-based innovations.

A vision for pharmacy?

Since the publication of the NHS Plan in 2000 [8], a number of official documents have provided a detailed picture of current policy directions relating to pharmacy in both hospital and community settings. They include *Pharmacy in the Future* (England) [9], *The Right Medicine*

(Scotland) [10] and *Remedies for Success* (Wales) [11]. In 2003 the Department of Health also published *A Vision for Pharmacy in the New NHS* [12]. This summarised plans for pharmacy's future in England and sought to stimulate discussion about their translation into reality. Key measures designed to allow the public better, more convenient access to modern pharmaceuticals and pharmaceutical care are listed in Box 15.2.

The implementation of these measures is being facilitated by programmes such as the Medicines Management Collaborative, and the Medicines Partnership. The latter is aimed at promoting better public understanding of medicines, and supporting self-management. Extending the role of technicians and other pharmaceutical care team members as dispensers and providers of services such as smoking cessation support is also an element in the overall set of policies aimed at liberating pharmacists from their traditional dispensing activities, and

Box 15.2 Measures to allow better access to modern pharmaceuticals

- New repeat dispensing arrangements, which should permit pharmacists to manage long-term medication programmes better and reduce unnecessary patient visits to GP practices to consult with their doctors, or their receptionists.
- Initiatives aimed at promoting direct pharmacist treatment of NHS patients with 'minor conditions'.
- The shift of medicinal products such as proton pump inhibitors and statins to Pharmacy status. If in future there is a similar reclassification of products such as anti-hypertensive medicines in the UK this could fundamentally revise the role of OTC products in preventing serious chronic illness, as opposed to alleviating transient acute distress.
- The development of supplementary prescribing and the use of NHS Patient Group Directives (or private PGDs) to allow pharmacists to take a more proactive role in supplying NHS (or private) patients with prescription medicines.
- The introduction of independent pharmacist prescribing, consultant pharmacists and pharmacists with a special interest in given disease areas, such as type 2 diabetes.
- Improved communication and collaboration between hospital and community pharmacy, aimed at allowing higher quality and more cost-effective processes of hospital admission and discharge.
- The establishment (in or before 2008) of integrated care records for all NHS patients, using systems with the technical potential to allow appropriate access to records in community pharmacies as well as in hospitals and GP surgeries.
- The development of pharmacists and pharmacies as 'public health' resources, providing health promotion, health improvement and harm reduction services.

allowing their time and skills to be used to make other contributions to the better use of medicines and increased health gain.

In the short term it remains to be demonstrated how successful such policies will be. Many British pharmacists presently report being heavily burdened by the volume of dispensing. The practical viability of extending their clinical roles may to some seem doubtful, and at present the strength of the evidence base in areas such as 'pharmaceutical public health' is limited [13]. Understandably, some community pharmacists also fear that if they lose their substantive role as dispensers in order to take on clinical tasks and/or 'community oriented pharmaceutical care', they will risk professional redundancy should the latter fail to prove to be economically sustainable.

Glimpses of the future

A weak community pharmacy future would be one in which the profession sinks during the next decade or two into a narrowly defined drug supply management role, with competitor groups such as medicine and nursing incorporating the more clinical aspects of pharmaceutical care into their roles, while less expensively qualified technicians and dispensers' assistants supply medicines to the public. However against this negative picture there are many other more positive scenarios for the future of community and hospital pharmacy in the UK. Some brief illustrative vignettes of what these 'pharmacy tomorrows' may be are now offered.

Scenario 1: Strengthened traditional practice

In this scenario, the current distinction between community and hospital pharmacy is, together with the physical separation of community pharmacies and general practice surgeries, preserved. However, better functional integration of NHS services is achieved via good IT links and improved approaches to service management and development within PCTs and their equivalents in Wales, Northern Ireland and Scotland. Patients and other pharmacy customers use both the Internet, backed by home delivery services, and personal visits to obtain advice, medicines and other pharmacy goods and services. Community pharmacies serve as 'walk-in health centres' for NHS and private users, and act as pharmaceutical care co-ordinating points for hospital admission and discharge and specialist outreach services.

A significant part of the future NHS community pharmacy role in this scenario is about ensuring that diseases diagnosed and initially

prescribed for by doctors are treated well in practice, and hence that high-quality medicines management is achieved. However, the availability of pharmacy-only (rather than prescription-only) medicines which permit the effective primary and secondary prevention of serious long-term illnesses, has also opened the way to a 'sea change' in responsible self-care.

The medical profession has welcomed strengthened traditional pharmacy practice. It is seen as reducing doctors' workloads without threatening precipitous change which could impair the delivery of 'serious medicine' and undermine medical authority. General medical practice has undergone a renaissance in this scenario. The extended commissioning powers and referral rights of general medical practitioners in an NHS economy based on primary care-supported patient choice and fixed Health Related Group payments for NHS Foundation Trusts have over time created a true primary care-led health service.

Scenario 2: Primary care (clinical) pharmacy, plus supermarket and other 'drug stores'

Primary care pharmacists work directly for or with family doctors, or in primary care organisations. Practice in this area has already been shown to be more flexible and varied than in traditional hospital and community roles [14]. In the scenario suggested here, dispensing remains located outside primary care practice. It takes place in either large high street community pharmacies, or centralised NHS dispensing units run directly by specialist medicines supply pharmacists employed by the Acute or Primary Care Trusts.

The work of primary care practice pharmacists has become almost entirely focused on their clinical role. Hospital pharmacy has also further developed its clinical and patient safety protection roles. Many younger pharmacists have welcomed this opportunity to use their skills. The public increasingly sees pharmacists as the professionals with legitimate control over the use of medicines. However, primary care pharmacists normally operate on an appointments-only basis: they are becoming almost as difficult to access as family doctors and senior nurse practitioners.

At the same time the number of independent and other pharmacies located in high street and other community settings has declined. Their business is concentrated on minimal cost dispensing and supply, based on the electronic transmission of prescriptions and increased volumes of home delivered medicines, supported by the high-volume sale of OTC

medicines. Some supermarket and other pharmacies offer health checks, but it has not in the main proved economically viable for the ‘shopping mall drug stores’ of 21st century Britain to develop specialist clinical services.

Scenario 3: Corporate pharmacy competition

Current estimates suggest that 75% of all NHS community pharmacies will be incorporated into chains of five or more stores by about 2015. In this scenario this trend proves more rapid than expected. A few large vertically integrated ‘company chemist’ pharmacy chains dominate the market. Competition between them has, however, driven significant improvements. These have been achieved via a combination of centrally funded, corporate, pharmaceutical and other health service research and development programmes, coupled with a greater devolution of the authority needed to deliver locally tailored services to the professionals working ‘at the coal face’.

Despite fears that care standards and professional independence would be undermined by the further corporatisation of UK pharmacy, informed NHS commissioning and sophisticated management practices (involving the franchising of company know-how, backed by good support services to individual pharmacists and pharmacy/professional partnerships with strong roots in their local communities) obviate this danger. By 2015 the integrated health companies that grew out of the pharmacy chains of the 20th century have in many instances become NHS-contracted ‘alternative primary care providers’, offering services to both publicly funded and private customers.

Community pharmacies are increasingly regarded as independent multi-professional health centres in a more plural healthcare system, which can be entered by several different types of ‘front door’. Despite the potential for conflict with other stakeholders in primary care, inter-professional rivalries and tensions have been managed.

Scenario 4: The new apothecary model (back to the future?)

This scenario is similar to scenario 3, but competing individual practitioners and partnerships of pharmacists (and other health professionals) have in an increasing range of therapeutic contexts established themselves as alternatives to NHS general practitioners, and have often been able to set up in self-employed practice. Pharmacists have moved on from medicines management to the independent provision of pharmaceutical

care. Amongst some sections of the community they have become 'the people's doctors', because of the convenience and customer responsiveness of the service provided.

This has caused significant inter-professional tension. However, UK policy-makers have for over a decade committed themselves to supporting choice and competition throughout the primary care sector. As in the case of dentistry at the end of the 20th century, they encourage patterns of pharmaceutical care that are jointly funded by the public purse (which is responsible for the provision of core, essential, services) and private individuals, who are free to purchase additional services directly. By 2015 it is widely accepted as inevitable and reasonable that people who are above agreed threshold levels of death or disability risk ought to be offered free NHS protection, while the large number of other people at 'low risk' should be actively encouraged to purchase additional protection on a personal basis.

Scenario 5: Integrated pharmacy in local NHS Health Maintenance Trusts

In this model PCTs and/or their equivalents develop their mixed commissioning plus indirect primary care provider roles to become fully integrated NHS primary and secondary service providers operating in discrete geographical localities. NHS pharmacy becomes a single salaried profession in these local managed care systems. Its members have been allocated a range of managerial and clinical roles, to be undertaken in various complementary settings. The distinction between hospital and community pharmacy is widely regarded as irrelevant, and practice is managed and co-ordinated in a unified system. A continuously increasing range of dispensing and patient support work is undertaken by assistants and technicians.

Boundaries between pharmacy, nursing and medicine practice (as with those between health and social care) still exist, but have become less significant and easier to cross than in the past. Standards of care for people with chronic illnesses and complex needs are said to have improved, although there are concerns about choice. Outside the NHS primary care centres there remain a limited number of private community pharmacies/drug stores. These offer varying services to their customers. In some areas they have good links with the NHS, but in others they are more isolated. Progress in this area is 'patchy'. Many professionals in mainstream NHS pharmacy express concern about the commercialism of the pharmacists practising in the residual private sector.

Scenario 6: Integrated pharmacy in competing healthcare companies

This scenario differs from that suggested above in that, without fixed geographical boundaries and with private ownership, there is competition between the alternative independent integrated care providers. As ‘for profit’ organisations they are strongly motivated to combine synergistically their publicly funded and private customer offers, and to make savings and introduce innovations as and where these improve their returns on capital.

This incentivises them to encourage vigorously and effectively self-care promotion and support, in part via agreements with independent community pharmacy chains and independents operating in supermarkets and other ‘high footfall’ sites. Surprisingly to some commentators, this competition and plurality leads to a well integrated overall system of pharmaceutical care delivery that appears to perform relatively well. However, there is continuing political controversy as to whether or not NHS principles have been fatally undermined through private ownership of the healthcare providers. Public service commissioning remains in the hands of regional health authorities, but these in total only employ a few thousand staff in 2020.

European and North American experience

These scenarios are not necessarily mutually exclusive. In reality the future for pharmacy in Britain, and other countries in Western Europe and North America, could well involve a mix of the possibilities described. With increasing social plurality and a growing emphasis on meeting differentiated healthcare consumer preferences and needs, almost the only thing that can be predicted with confidence is that the future of pharmacy (assuming the profession has the will to respond to new challenges, and the will to adapt to survive) is likely to be much more complex and varied than its past.

However, it is worth briefly considering some of the contrasting pharmaceutical experiences of Britain’s European partners, and the lessons to be learned from countries such as the USA and Canada. In the latter case, for instance, pharmacists already have extended IT-based access to medication and health records in some provinces. This has been well accepted by service users, and is an important global pointer to the future.

The USA

The USA has, like the UK, a relatively strong hospital pharmacy tradition (about a quarter of the 200,000 pharmacists in the USA work in

hospitals and nursing homes) and a community pharmacy system populated by both chain and independent pharmacies [15]. Increased use of prescription medicines, combined with extensions in the roles played by pharmacists, has led to a situation in which demand for members of the profession has outpaced supply. In comparison to Europe, America also has well-developed Internet pharmacy services. There is evidence that the latter offered some service users significant advantages.

Yet there is also evidence that independent community pharmacies tend to be preferred by significant sections of the public [1]. The lack of universal 'pharmaceutical benefits' in the USA, and the expense that older persons and individuals with long-term conditions needing treatment may consequently have to face, could well be a significant factor influencing consumer behaviour. Some medicine users are forced to put cost savings before the quality of their pharmaceutical care. The collective welfare service funding traditions of Western Europe may in fact have helped to preserve patterns of pharmacy service that may not be so technically efficient in distribution terms, but offer other less easily measured benefits.

Another important difference between the USA and the UK is that whereas Britain enjoys a regulatory system with three categories of medicines (prescription-only, pharmacy and general sales products), the USA has only two available (prescription-only and general sale). The message for the future is that, despite the competitiveness of the US market and the fact that prescription medicine advertising is permitted, this has inhibited extensions in the range of medicines available from pharmacies. The UK system offers greater flexibility for progress towards a wider range of self-care options.

Europe

The fact that in much of Europe there is no general sales classification (effectively, all medicines in countries such as, say, France and Spain have to be purchased through pharmacies) arguably represents another limitation on the development of the pharmaceutical marketplace. European debate about the potential costs and benefits of 'deregulating' the pharmaceutical sector and permitting more direct pharmaceutical company promotion of medicines to the public should be understood in the light of such concerns.

There is a wide variation in the number of community pharmacies in different European countries. Greece and Spain have one pharmacy for every 500–1000 people: this contrasts sharply with the 10,000 plus

people per pharmacy in the Scandinavian countries. Southern European countries allow much less delegation of dispensing and allied activities to non-technicians than is the case in Denmark and Sweden. Because of the way regulations restricting the sale of prescription medicines have been interpreted, it may also be the case that pharmacists in much of southern Europe have played more of a clinical practitioner role than the formal literature suggests. Other key points in the context of pharmacy in Europe are listed in Box 15.3.

Box 15.3 Pharmacy in Europe

- In the Netherlands, which has traditionally had large numbers of single-handed doctors in primary care, pharmacists have taken a more important part in guiding medical prescribing and managing patient care than has been the case in countries like the UK.
- At the same time they are not required to stay on their premises to supervise dispensing undertaken by qualified technicians, and when they are there they have private consulting areas in which to see clients.
- In most parts of Europe community pharmacists outnumber their hospital-based colleagues by between 10 : 1 (as in Belgium, for example) and 25 : 1 (in Spain and Germany); in the UK and Holland this ratio is in the order of 5 or 6 : 1.
- In most European countries only pharmacists can own pharmacies, and chain formation has not been allowed. This has led to major structural differences between countries such as France and the UK, which have similar-sized populations.
- France has over 50,000 community pharmacists, of whom some 27,000 are owners or co-owners; in Britain the equivalent figures are approaching 30,000, and a total of 4000 individual and corporate owners.
- The French community pharmacy system is relatively costly, but well respected.
- Volumes of medicines consumption in France are, per capita, twice or more than those in the UK.
- In countries such as Norway and Ireland, controls on pharmacy ownership and numbers have recently been lifted, along with other regulatory changes. The aim of this was to promote consumer interests by increased competition.
- Agencies such as the OFT in the UK have similarly called for deregulation.
- There is evidence from countries such as Portugal that excessive regulation can needlessly drive up overall pharmaceutical supply costs.
- However, there is a significant case for arguing in favour of healthcare systems such as the NHS being able to plan and direct their pharmacy services. Failures of markets in healthcare are the reason why public healthcare systems have been formed.

The economic incentives and powers available to pharmacists to promote the use of generic and other 'best value' medicines vary significantly across Europe, largely according to historical tradition. There is evidence that where pharmacists are appropriately supported and empowered they can play a significant part in containing medicine spending and improving the quality of pharmaceutical care, but where there are perverse financial incentives the opposite appears to be the case.

Although the structure of pharmacy has been relatively stable since the middle of the 20th century, pharmaceutical wholesaling has undergone significant change. It has become much more concentrated. If and when the rules on community pharmacy ownership are relaxed in Europe it is likely that major wholesalers such as Celesio (formerly Gehe), Phoenix and Alliance Unichem (together with internally integrated pharmacy chains like Boots) will extend their ownership of community pharmacies, and perhaps also extend offers to pharmacy service management in the hospital sector.

Choosing the future

Some historical events and trends are entirely outside the control of the individuals and institutions they affect. At a catastrophic level, wars and environmental disasters such as floods and earthquakes are often taken to fall into this category. Less dramatically, technical innovation frequently leads to redundancies, and revitalised economic and social orders. For example, the introduction of the H₂ antagonist medicines led in the 1980s to major reductions in the demand for gastric surgery. Surgeons could not prevent, and should arguably have welcomed, such progress.

Pharmacy and pharmacists are similarly in no position to turn back the tides of history. Superficially at least, the profession may be thought to be in the grip of social, technical and economic forces that make its future impossible to predict accurately, or control effectively. During the 21st century, for instance, further extensions in life expectancy and continuing changes in the incidence and prevalence of conditions such as the cancers and neurological disorders in later life should (barring unforeseen catastrophes) ultimately transform public expectations of pharmacy, medicine and nursing.

Beyond pharmacists' control

Advances in the pharmaceutical and biomedical sciences will also open up fundamentally new methods of diagnosing, preventing and treating

such illnesses. For instance, near-patient testing and more personalised therapeutic regimens could well in time revolutionise approaches to the delivery of pharmaceutical care in community and other settings. Many other factors independent of the profession itself are also likely to guide the evolution of pharmacy, some of which have been touched on in this chapter. They include those listed in Box 15.4.

However, the uncertainties facing pharmacy, and the extent to which its members are unable to influence their situation, should not be overstated. From a UK policy perspective the probable direction of community and hospital pharmacy development over the next 10–20 years is relatively clearly discernible. Furthermore, if divisions within pharmacy can be overcome and its internal stakeholders in governance, education and practice development can work effectively together, there seems little reason to doubt that the profession's own choices and preferences will be a significant influence on tomorrow's decisions.

Box 15.4 Exogenous factors guiding the evolution of pharmacy

- **Further advances in the power of computers and computer-based systems**

These will lead to new ways of informing prescribing and medicines use, and new opportunities to mechanise dispensing.

- **Revised political approaches to questions relating to safety, equity and access in the context of the medicines use**

The desire to deregulate and widen people's freedom to purchase and use protective and other medicines is likely to a degree to be counterbalanced by perceived interests in maintaining 'high standards' of patient safety, even if in reality greater health gains could be achieved by investments elsewhere. The extent to which the state (following events such as the Bristol inquiry and the Ledward incident, Chapter 14) will seek to replace further professional bodies as guardians of the public's well-being and health service quality is similarly debatable.

- **The attitudes of other health sector stakeholders to pharmacists**

In the UK the medical profession currently takes a relatively favourable view of proposed extensions to pharmacists' roles, and has in addition not been concerned to strongly defend GP dispensing.

In parts of southern Europe with an excess of medical manpower this has not been the case. Perhaps even more importantly, consumer attitudes towards and requirements of pharmacy and pharmacists also remain uncertain. Reported satisfaction rates with pharmaceutical services may be reassuring, but this could be – in the UK at least – a reflection of limited expectations.

Within pharmacists' control

Research has found considerable support amongst pharmacists under 50 for the modernisation agendas being pursued by the Department of Health and Health Department in Scotland [3]. For example, nine out of ten of 450 respondents agreed that the future of pharmacy lies more in clinical practice, and the delivery of better patient care. Over 90% also said that enabling community pharmacists to access and update patient treatment records will be a vital step in extending their clinical role, and that developing informed self-care skills amongst medicine users is a central part of their professional mission. About half the respondents would like to see GP practices and health centres having co-located pharmacy dispensaries in the next 10 years.

Currently a majority of younger community pharmacists in the UK do not believe that their profession has the status it deserves, or that they have the opportunities they need to use their professional skills to the full. The workload imposed by dispensing presently seems to leave little room for role extensions. Against this, however, there is evidence that job satisfaction levels amongst primary care and hospital pharmacists are relatively high, and that the policies outlined in government documents such as *A Vision for Pharmacy* are generally in line with the majority of younger pharmacists' aspirations for the future.

Conclusion

Arguably, the most enlightened way for pharmacy to address the future would be unequivocally to put meeting the public's concerns for better health at the top of the profession's agenda. This will demand individual and collective effort aimed at adapting existing skills, services and ways of working in order to meet the highest priority requirements of the profession's customers in progressively more efficient and effective ways. In Britain up until the 2020s, a pragmatic combination of the scenarios described earlier as 'strengthened traditional practice', 'primary care pharmacy' and 'corporate pharmacy competition' can reasonably be taken to represent the most probable pharmacy future capable of delivering such an end.

Notwithstanding achievements in the more distant past, pharmacy in the second half of the 20th century was commonly seen (particularly in the community setting) as a partial, and transitional, profession, which people too often entered as a second best to medicine. Its leadership has been described as divided and weak, and pharmacy in the UK

often appeared to be of lower status than pharmacy elsewhere. The opportunity for tomorrow is for pharmacy in this country to become a modernised, self-confident profession, which can offer its members greater fulfilment through maximising the health gain to be achieved through the application of existing and new medicines. In the UK the conditions needed for this progress to happen now appear to be in place. The challenge for the profession in Britain is to realise this promise, and in so doing to act as an example to the rest of the world.

References

1. Bond C M. *Evolution and Change in Community Pharmacy*. Department of General Practice and Primary Care and Department of Management Studies, University of Aberdeen. London: Royal Pharmaceutical Society of Great Britain, 2003.
2. Mossialos E, Mrazek M, Walley T. *Regulating Pharmaceuticals in Europe: Striving for Efficiency*. Maidenhead: Open University Press, 2004.
3. Taylor D G, Carter S L. *Realising the Promise. Community Pharmacy in the New NHS*. London: The School of Pharmacy, University of London, with the Social Market Foundation and the College of Health, 2002.
4. Wanless D. *Securing Our Future Health: Taking a Long-Term View*. London: The Treasury, 2002.
5. Wanless D. *Securing Good Health for the Whole Population*. London: The Treasury, 2004.
6. Lewis R, Dixon J. Rethinking management of chronic disease. *British Medical Journal* 2004; 328: 220–222.
7. Bunker J. *Medicine Matters After All*. London: The Stationery Office, 2002.
8. *The NHS Plan*. Command 4818–1. London: The Stationery Office, 2000.
9. Department of Health. *Pharmacy in the Future: Implementing the NHS Plan*. London: Department of Health, 2000.
10. Scottish Executive. *The Right Medicine: A Strategy for Pharmaceutical Care in Scotland*. Edinburgh: Scottish Executive, 2001.
11. NHS Wales. *Remedies for Success: A Strategy for Pharmacy in Wales*. Cardiff: Welsh Assembly, 2002.
12. Department of Health. *A Vision for Pharmacy in the New NHS*. London: Department of Health, 2003.
13. Royal Pharmaceutical Society of Great Britain. *The Contribution of Community Pharmacy to Improving the Public's Health – Report 1: Evidence from the Peer-reviewed Literature 1990–2001*. London: Pharmacy Health Link and the Royal Pharmaceutical Society of Great Britain, 2003.
14. Silcock J, Rayner D K, Petty D. The organisation and development of primary care pharmacy in the United Kingdom. *Health Policy* 2004; 67: 207–214.
15. Cooksey J A, Knapp K K, Walton S M, Cultace J M. Challenges to the pharmacist profession from escalating pharmaceutical demand. *Health Affairs* 2002; 21(5): 182–188.