The retail pharmacist

G. R. HABERFIELD
M.P.S.

Retail Practice, London

Summary

Though the exclusive use of approved names would simplify dispensing by a retail pharmacist, present standards of equivalence are not adequate to ensure that in these circumstances the patient would always receive the preparation best suited to his need. In the present situation, the decision about brands cannot be left to the retail pharmacist and doctors should therefore identify a particular product in their prescriptions by using the trade name.

THE question of whether doctors should prescribe by trade names or by approved names is a professional problem which has become enmeshed by political consideration.

There has been a great deal of activity in the past in support of generic prescribing, motivated almost entirely by economic factors. The Hinchliffe Report (1959) advocated the use of approved names, and the Sainsbury Committee (1967) went so far as to recommend the abolition of trade names. Doctors have been pressurized into prescribing habits by Health Department publications on the comparative costs of different brands of drugs, and the appointment of Regional Medical Officers requiring doctors to justify the expense of their prescribing. Likewise, pharmacists receive active encouragement from the National Health Service to supply 'cheaper' unbranded drugs by basing remuneration on the lowest cost available.

The evidence of therapeutic non-equivalence of drugs provides a powerful argument against prescribing by approved names. Sir Keith Joseph stated in a written Commons reply on 8 August 1972, that he 'was not satisfied that all chemically equivalent medicines had the same level of biological activity as the original product'. Doctors and pharmacists agree that the biological activity of chemically equivalent drugs is not self evident.

The retail pharmacist enjoys the challenge of commerce together with the professionalism of pharmaceuticals. His commercial sense provides him with an economic awareness which he applies to his dispensary as well as to his counter trade. With ever rising overheads, the retail pharmacist is forced to support and often subsidize his dispensary with his shop trade. The non viability of such dispensaries is

a contributing factor in the closure of pharmacies. The net closure of pharmacies during 1972 was 278.

Considering the national average, the proportion of return from National Health Service prescriptions is less than 38% of a pharmacy's turn over. The inclusion of private dispensing figures has little significance in the overall picture. Less than 5% of all prescriptions dispensed are private prescriptions, most of which are for oral contraceptives. The remainder of private prescriptions make up only 0.77% of all prescriptions dispensed (Institute of Pharmacy Management, 1973).

Approved name prescribing leaves the choice of the preparation to the pharmacist and, with National Health Service encouragement, he supplies what may be the 'best buy'. Subsequently, the preparation supplied may vary from time to time. It is possible that a patient may receive a preparation which varies in colour, or shape, or size, or flavour, or particularly, therapeutic efficacy, although the doctor has prescribed the same approved name on each prescription. These factors depend upon the pharmacy to which the patient takes the prescription, and within each pharmacy, the pharmacist's supplier.

The Pharmaceutical Society's Department of Pharmaceutical Sciences published a paper on bio-availability (1972) which was intended as a guide to pharmacists. This paper named groups of compounds where evidence of non-equivalence was particularly strong and went on to state: 'it is of particular importance that when a patient leaves hospital where he has been receiving maintenance therapy with a drug whose dosage needs careful control, the next supply of medicines he receives should be manufactured by the same manufacturer as before. Therefore the approved name only should not be given'.

In purchasing his supplies, the pharmacist must satisfy himself with the quality of his purchases and the continuity of supply. Discount inducements or bonus offers to buy a competitor's brand should be ignored. Where a pharmacist is able to give advice on maintaining and standardizing treatment, consultation with doctors should be encouraged.

The traditional pharmacy has about two thousand different packs of ethical proprietaries in stock and only 8% of these produce about 70% in value of

his dispensing (Report on the resale price maintenance hearing in the Restrictive Practices Court, 1970). The use of approved names would result in the retail pharmacist having to keep less stock. If every available brand of the tetracyclines, in their different formulations and different strengths were stocked by a dispensary, there would be more than two hundred different packs on the dispensary shelf for this one group. However, because most prescriptions tend to be from local surgeries where prescribing habits tend to rely on very few different brands, the average retail dispensary stocks only a proportion of these. Against this economic argument, is the point that generally, the prices of ethical proprietaries are higher than the corresponding approved name preparations, and therefore the National Health Service on cost yield is higher.

Doctors gain an impression of the chemical nature of a compound by the use of the approved name. These names are generally very long and less memorable than trade names. The use of the longer approved names could lead to abbreviation which in turn could lead to error. The easily remembered trade name identifies not only the chemical compound, but also the manufacturer. The manufacturer's reputation is therefore at stake, unlike the approved name manufacturer who can enjoy anonymity.

The Pharmacy Management Journal (Institute of Pharmacy Management, 1973) published a survey covering prescriptions dispensed between January and March 1973, which showed 72.9% of all prescriptions dispensed were prescribed by brand names. The survey divided the prescriptions into therapeutic groups and showed the percentage of each group prescribed by trade names. Tranquillizers had the highest percentage prescribed by trade names with 97.2%. Cardiovascular drugs had the lowest with 66.5%. Antibiotics showed 76.8% prescribed by trade names. Within this group, prescriptions for oxytetracycline BP showed that 53% were prescribed by the approved name.

Reliable details of the theoretical saving to the National Health Service, if approved name prescribing was the rule, are difficult to assess. In 1966-67, if unbranded equivalents had always been supplied, the saving to the National Health Service drug bill would have been about £720,000 (Committee of

Public Accounts, 1972/73). Dollery (1970) in a paper on generic prescribing estimated the saving to be about 1%. It can be assumed that the theoretical saving would be small but it cannot be assumed that the treatment given would be as effective as if brand names only had been used.

The use of trade names lends support to the Pharmaceutical Industry, the prosperity of which has brought considerable benefits to mankind. Prices of pharmaceuticals in the United Kingdom are often lower than any other developed country and expenditure on pharmaceutical services is not increasing as a proportion of the National Health Service (Committee of Public Accounts, 1972/73). With the political rumblings of nationalization, it should be remembered that no major drug discovery has come from any country with a nationalized pharmaceutical industry.

It is clear that present standards of equivalence are inadequate. Until standards of generically equivalent compounds give therapeutic equivalence, there should be no question of choice. This choice should not be left to the pharmacist. It should be made by the doctor, based on his experience of trade named drugs. He is in the best position to assess the value of his chosen brand.

The patient's requirements are of paramount importance. Only by the use of trade names can the doctor ensure the standardization essential to the patient's treatment.

References

- COMMITTEE OF PUBLIC ACCOUNTS (1972/73) *Fourth Report*. Her Majesty's Stationery Office, London.
- DOLLERY, C.T. (1970) Drug Names. *Prescribers Journal*, 9, 97.
- HINCHLIFFE, SIR H. (1959) *Final Report of the Committee on the Cost of Prescribing*. Her Majesty's Stationery Office, London.
- INSTITUTE OF PHARMACY MANAGEMENT (1973) Prescription survey. *Pharmacy Management Journal*, 13, 1384.
- REPORT ON THE RESALE PRICE MAINTENANCE HEARING IN THE RESTRICTIVE PRACTICES COURT (1970) *Pharmaceutical Journal*, 204, 656.
- SAINSBURY, LORD (1967) *Report on the Committee of Inquiry into the Relationship of the Pharmaceutical Industry with the National Health Service*. Her Majesty's Stationery Office, London.
- SCIENCE COMMITTEE OF PHARMACEUTICAL JOURNAL (1972) Biological availability. *Pharmaceutical Journal*, 209, 438.