The Pharmacy Guild of Australia

Submission to:

Senate Standing Committees on Community Affairs Inquiry:

Out-of-pocket costs in Australian healthcare

May 2014

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About The Pharmacy Guild of Australia

The Pharmacy Guild of Australia ('the Guild') is an employers' organisation servicing the needs of independent community pharmacies. It strives to promote, maintain and support community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicines management and related services.

Executive Summary

Co-payments and safety net arrangements have been part of the Pharmaceutical Benefits Scheme (PBS) for many years. Community pharmacies play a central role in managing the PBS, including the safety net, for government and consumers.

Australian Bureau of Statistics data shows that over the last 14 years out-of-pocket costs for pharmaceuticals have increased by just 2.1% per year, compared with the headline Consumer Price Index (CPI) rate of 2.8%. PBS Reforms were introduced in 2007-08, including a price disclosure mechanism that progressively reduces the Government price for off-patent PBS medicines, driven by market competition. While the bulk of the massive savings from this mechanism go to the Commonwealth Budget as a whole, some of the price reductions flow to consumers. Since 2007-08 the pharmaceuticals component of the CPI has increased by just 1.1% per year.

PBS co-payments have increased by about 4.4% per year over the same 14 year period, while safety net thresholds have increased by up to 6.0% per year.

Analysis of official data also shows that over the last 14 years the prices of pharmaceuticals which are open to competition amongst Australia's 5,350 community pharmacies have increased at a rate well below CPI, at about 1.7% per year.

Community pharmacies deliver a wide range of important services to consumers at no cost or at a price which is below the cost of provision. This has been made possible by PBS dispensing remuneration and additional trading terms on generic medicines. Both are now in rapid decline due to price disclosure. The outcome is that these cross-subsidised services will be discontinued or reduced, or additional out-of-pocket costs will apply.

Should a system of co-payments be introduced for GP consultations under the Medicare Benefits Scheme, this could result in some people deciding not to visit their doctor and may push more people towards community pharmacies for advice and treatment related to minor ailments. Community pharmacy is ideally placed to meet the needs of patients with relatively minor ailments, however with the impact of price disclosure they may not be able to do so without adequately structured remuneration arrangements, following the lead of other countries such as the United Kingdom and Canada. A GP co-payment could also potentially result in some people deciding not to have their prescriptions filled, particularly if it is accompanied by increases in the current PBS co-payments.

Background

PBS Co-payments and Safety Net

Mandatory co-payments have applied in relation to medicines dispensed under the Pharmaceutical Benefits Scheme (PBS) since 1960, when a 50 cent co-payment was introduced. A dual co-payment system has applied since 1983. Under this system, patients eligible for PBS benefits are split into two categories – concessional and general. The current co-payment levels are $6.00 for concessional beneficiaries and $36.90 for others. People eligible for concessional status include recipients of the age pension and other social security payments and allowances, and some self-funded retirees.

A PBS safety net arrangement has applied since 1986. Over the period from 2006 to 2009, eligibility for the concessional safety net was progressively increased from 52 co-payments to 60 co-payments (currently equivalent to $360.00). The general safety net was also increased over this period and in 2014 is set at $1,421.20. PBS safety nets apply for a family unit.

The concessional co-payment and associated safety net also applies to the Repatriation Pharmaceutical Benefits Scheme (RPBS).

Role of Community Pharmacy

Community pharmacies approved under section 90 of the National Health Act 1953 collect the PBS co-payment on behalf of the Commonwealth Government and submit claims to the Department of Human Services for the difference between the co-payment and the total cost of the prescription (this differential can vary from one cent to thousands of dollars). The full cost of the medicine is printed on the label affixed to the pack dispensed.

Community pharmacists and other community pharmacy staff also assist patients to monitor and record their progress towards their applicable safety net threshold throughout the calendar year. This is done through keeping computerised records (securely stored with other patient details in dispensing software systems) and on a Prescription Record Form (PRF). Community pharmacies also apply for and issue safety net cards for family units that have reached their applicable threshold.

By law, community pharmacies must not charge more than the applicable PBS co-payment[1]. Unlike almost any other business, and unlike other health care sectors such as general practice, community pharmacies are prohibited from increasing prices (on the 65% of sales represented by PBS subsidised prescriptions) on the products provided to consumers, even in response to increased business operating expenses or in response to unexpected changes to Government policy.

PBS Pricing & PBS Reforms

The total PBS price of a drug (the "dispensed price") is made up of:

- the approved ex-manufacturer price

[1] Plus any brand price premium, therapeutic group premium or special patient contribution that apply under the conditions of PBS listing for the particular drug or brand.

- wholesaler mark-up (usually 7.52%)
- pharmacy mark-up (varies based on price; current average is 9.7%)
- dispensing fee (currently $6.63)

When a drug is first listed on the PBS, the sponsor (usually the manufacturer) and the Commonwealth Government strike an agreement on the approved ex-manufacturer price of that drug. Under certain circumstances a manufacturer can apply for a price increase. When a second brand of a drug is listed on the PBS (for example, following the expiry of the drug's patent) an automatic 16% price reduction applies and the drug is subject to price disclosure, whereby all sponsors must provide sales data (revenue and volumes), and related information, to an agency appointed by the Department of Health (DoH). This market data is used to progressively reduce the PBS price of the drug, where the average market price is found to be significantly lower than the existing PBS list price.

Price disclosure arrangements have been in place since 2007. The Guild supports price disclosure as an appropriate mechanism to ensure that prices paid for PBS medicines reflect the competition in the market for those medicines. As a result of the price disclosure policy, expenditure on the PBS is now well contained[2] and the prices of many drugs have been reduced for consumers.

In addition to the acceleration of price disclosure negotiated in 2010, the Labor Government announced a further acceleration (referred to as Simplified Price Disclosure) in August 2013. This significant change takes effect from 1 October 2014 – before the end of the Fifth Community Pharmacy Agreement (5CPA). It was announced without consultation despite such consultation being expressly required under the conditions of the 5th Agreement.

PBS price disclosure will increase out-of-pocket costs for community pharmacy services

Further accelerating the effect of existing price disclosure arrangements, the changes will have a significant impact on the ability for community pharmacies to continue their current levels and range of services to consumers from 2014-15. This is because, unlike previous price disclosure arrangements, this latest change failed to take into account the flow-on impact on community pharmacy remuneration. As discussed later in this submission (under "Current Issues", **many services have been able to be provided to consumers free of charge or at a heavily discounted price, which will not be able to continue. This will increase out-of-pocket expenses for many consumers.**

[2] The Productivity Commission's *Report on Government Services 2014* confirmed that the PBS cost government less in 2012-13 than in any of the preceding four years in real terms. Forward estimates have been downgraded by more than $8.9 billion between the 2011-12 Commonwealth Budget and the 2013-14 Mid-Year Economic and Fiscal Outlook.

Under co-payment & private prescriptions

Approximately 72% of prescriptions for general patients have a dispensed price less than the general co-payment ($36.90)[3]. To provide certainty for consumers the www.pbs.gov.au website publishes a "Maximum price to consumer" for these items, which include the maximum allowable fees that a pharmacy can charge for the item. Although no government subsidy applies to these items they do count towards the safety net and www.pbs.gov.au also publishes the maximum value that can be added towards the safety net threshold for the item (if a lesser price is paid, only the price paid can be counted for safety net purposes). This sector of the market is open to competition amongst pharmacies and as a result many do not charge the allowable fees. Competition has intensified over the last decade with the expansion of a number of community pharmacy groups operating under a discount model, usually from locations with low rents and other reduced costs.

Items not available on the PBS, or for which an individual patient does not meet the requirements ("restrictions") for the item to be prescribed for them under the PBS, are dispensed as "private prescriptions". Like the under co-payment category the pricing of these prescriptions is deregulated and open to competition. The pricing of non-prescription medicines is also unregulated.

It is important to note that the 5,350 community pharmacies operating in Australia are independently owned and capitalised by over 4,000 individual community pharmacists, ensuring a competitive market for consumers.

[3] In financial year 2012-13 there were 62.0 million under co-payment prescriptions, compared with 23.7 million subsidised prescriptions for general patients.

Pharmaceuticals – out of pocket costs to consumers

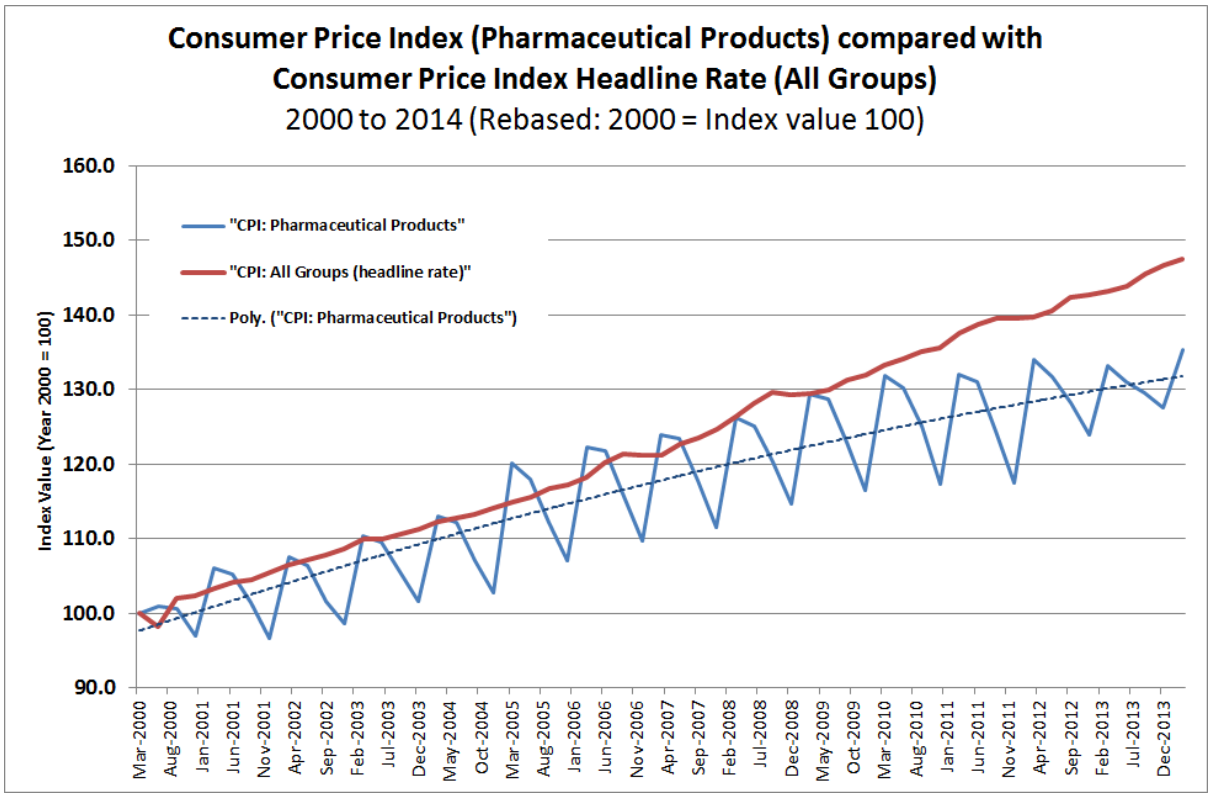
As shown in Figure 1 the cost of pharmaceuticals has increased since 2000, but at a significantly lower pace than overall inflation as measured by the Consumer Price Index (CPI). The CPI measures only prices paid by consumers (out-of-pocket costs including co-payments on PBS prescriptions). It does not include the cost of pharmaceuticals to the Government through the PBS.

The average annual increase in out of pocket costs for pharmaceuticals over the last 14 years has been 2.1%.

This compares with 2.8% for the entire CPI[4].

Notably, the pharmaceuticals index has increased by just 1.1% per year in the period since PBS Reforms (including price disclosure) were introduced in 2007-08.

Figure 1



Source of data: Consumer Price Index (catalogue 6401.0) Table 7, Australian Bureau of Statistics, 2014

NOTE: the jagged nature of the pharmaceuticals line in Figure 1 is a result of the seasonality caused by the safety net, which resets on 1 January each year.

[4] The period from September quarter 2000 has been used to derive these figures to avoid the distorting effect of the introduction of Goods and Services Tax (GST) on 1 July 2000.

Out-of-pocket costs – regulated prices component (PBS co-payments)

Table 1 below shows the change in PBS co-payments, safety net and average patient contribution per prescription (for subsidised prescriptions) over the same period shown in Figure 1 (2000 to 2014).

Table 1	2000	2014	Average annual % change
Concessional co-payment	$3.30	$6.00	4.4%
Concessional safety net threshold	$171.60	$360.00	5.4%
General co-payment	$20.60	$36.90	4.3%
General safety net threshold	$631.20	$1,421.20	6.0%

Out-of-pocket costs – unregulated prices component

The unregulated prices component of pharmaceutical out-of-pocket costs is made up of under co-payment PBS prescriptions, private prescriptions and over-the-counter medications.

There is no official measure of price movements on unregulated medicines alone. However, they are included within the CPI pharmaceuticals index, aggregated together with PBS co-payments. As the 2.1% annual increase in CPI (Figure 1) is well below the increases in the PBS co-payments and safety net thresholds over the same 14-year period (Table 1), the prices paid in the unregulated prices component must have increased at a rate **lower than 2.1%** over this period (as it is not possible for both the regulated and unregulated prices components of the CPI to both be below the aggregated CPI figure).

Data available from the Australian Institute of Health & Welfare (AIHW) can be used to derive an approximation for the actual increase by allocating weightings to the regulated and unregulated components (to approximate a separation of the CPI figure into these two components). According to the AIHW, in 2011-12 individuals outlaid $1,665 million on benefit-paid pharmaceuticals and $8,067 million on all other medications. Applying these weightings to the published movements in pharmaceuticals CPI and PBS co-payments derives an estimate of an increase in prices of just **1.7% per year** over the period from 2000 to 2014 for the unregulated prices component[5]. This is well below the 2.8%[6] CPI headline rate for the period.

This low rate of price inflation on the unregulated price component compared with economy-wide inflation is clear evidence that the community pharmacy sector is price-competitive and has delivered value to consumers over a long period despite the significant service element (and related business costs) associated with the safe and professional provision of pharmaceuticals to consumers.

[5] The impact of PBS co-payment increases over this period has meant that more, higher-priced drugs have moved from the regulated price component to the unregulated price component. For this reason a more detailed analysis using a consistent or adjusted basket of goods would derive a lower estimate than the 1.7 per cent shown here.

[6] The period from September quarter 2000 has been used to derive these figures to avoid the distorting effect of the introduction of Goods and Services Tax (GST) on 1 July 2000.

Current Issues

Impact of price disclosure on pharmacy services, including out-of-pocket costs

Over a long period, community pharmacies have contained price growth on privately-funded pharmaceuticals (see previous section). At the same time, in response to consumer demand and other factors, community pharmacies have been able to provide an increasing range of services. The provision of these services has in many cases been free to consumers, and in other cases provided well below the cost associated with delivering the service. This has been possible largely due to adequate remuneration for dispensing PBS prescriptions, and additional trading terms available on generic (off-patent) medicines. In effect, the services have been cross-subsidised by dispensing remuneration and trading terms. While this may not have been an ideal model of funding it has enabled these services to be available at low or no cost to consumers. Unfortunately price disclosure is now lowering remuneration levels and removing trading terms, to the extent that **the provision of these services under the existing model of no or low cost to consumers is becoming unviable**.

Three prime examples of these services are (1) the free advice community pharmacists provide in relation to minor ailments and other health issues, (2) the provision of dose administration aids and (3) provision of products and services under the National Diabetes Services Scheme.

- According to the ABS, 3.9 million Australians ask a pharmacist for health advice each year[7]. 79% of those people reported that the advice met their needs completely. Results presented recently from a PricewaterhouseCoopers project (for which the final report is soon to be released), show that 52% of people seek advice from their pharmacist in relation to minor ailments, chronic pain relief or chronic conditions, compared with 46% who consult their general practitioner (GP). The same study found that 89% of survey participants reported being satisfied with the interaction they had with their pharmacist in the last three visits. This model of free advice has served Australia well. Community pharmacists are highly accessible (without appointment) and highly trained. Unnecessary visits to GPs can be avoided as can associated out-of-pocket costs (where a bulk-billing GP is unavailable) and the associated cost to Medicare.

- More than 9 million[8] dose administration aid devices are provided by community pharmacies each year to Australians living in their own homes (many more than this are provided to residents of aged care facilities). These devices, usually provided once per week, ensure that patients take the right medicine at the right time – a vital service to reduce medication misadventure and keep people living independently at home rather than in aged care. The demand for this service continues to grow. An independent evaluation commissioned by the Department in June 2010 reported that 'the cost for a pharmacy to deliver a DAA service per patient/per week was $17.25[9]

[7] Australian Bureau of Statistics, *4839.0.55.001 - Health Services: Patient Experiences in Australia*, 2009

[8] Derived from data relating to the 5CPA Pharmacy Practice Incentives Programme

[9] Price Waterhouse Coopers, *Australian Department of Health and Ageing Evaluation of the DAA/PMP Programs*, June 2010.

This is also consistent with the difference of $17.62 determined between supplying medicines in a DAA as compared to original packs in an earlier research project.[10] A recent Guild survey has shown that the median price charged to consumers for this service is $5 per week. Current funding arrangements for DAAs under the 5CPA are incentive-based, linked to accreditation against relevant standards of quality. They are not fee for service and contribute only about $2 per week to the cost of the service. This leaves a gap of at least $10 per week, or more than $90 million per year across all community pharmacies at the current rate of demand for this service. Many of the people being provided with this service struggle to afford the existing cost of $5 per week and would be unlikely to be able to pay the full cost of this vital service.

- In 2011/12, the Australian Government spent almost $182 million on the National Diabetes Services Scheme (NDSS), ensuring over 1 million people have timely, reliable and affordable access to the products and services required to effectively self-manage their diabetes. For this period, there 4,050 NDSS Access Points across Australia for people to access the necessary products to self-manage their diabetes, the majority of which are community pharmacies.[11] While community pharmacies are the main supply agents for the NDSS, they receive no remuneration apart from a one-off payment of $2,800 to assist with the initial costs associated with becoming an Access Point.[12] A report commissioned by the Guild in 2010 found that the net loss associated with the NDSS averaged more than $7,000 per year per participating pharmacy.

These are just three examples of the services that may cost consumers more, or become unviable to be delivered at all, as price disclosure progresses.

In April 2014 the Guild conducted a member survey to determine the impact on services in the next financial year. One of the important findings was that home delivery services, currently offered by over 4,000 pharmacies, often for free or at a nominal cost, are expected to be heavily affected. Over 40 % of pharmacies indicated they were planning to discontinue the service, with a further 12 % reducing availability. Additionally **33% of pharmacies indicated they will reluctantly increase the cost of this service to patients**. Home delivery allows people to stay independent for longer, improving quality of life and reducing the burden on the health system and aged care facilities.

Pharmacist comments

"Currently we provide a free home delivery service, most of these services are done by myself at no cost to the patient after hours. Price Disclosure has impacted my business heavily and I have had to let go of staff and a pharmacist. **I will have to start charging for the home delivery service or on the other hand not offer the service at all**."

Pharmacy, NSW

[10] Effectiveness and cost-effectiveness of Dose Administration Aids; http://www.guild.org.au/services-programs/research-and-development/archive---third-agreement/2002-519

[11] Department of Health website – National Diabetes Services Scheme; https://www.health.gov.au/internet/main/publishing.nsf/Content/health-pbs-healthpro-supply-ndss.htm-copy2

[12] NDSS Access Point Guidelines 2011-2016; http://www.ndss.com.au/Global/Forms/Access%20Point%20Guidelines.pdf

Pharmacist comments

On Tuesday, an 85 year old customer raised concerns with me about her asthma worsening. In discussion she reported that her symptoms were not being relieved even when using a Spacer. Due to the urgency and the fact that she physically wasn't up to returning to the pharmacy, I visited her after hours that night. Her Spacer hadn't been cleaned or replaced in years and the valve clearly wasn't working. She was also taking her Ventolin at the same time as her Seretide and not PRN as it should have been. I went back to the pharmacy and returned with a new Spacer and reinforced the technique.

On the same day, the wife of a patient who is terminally ill with cancer came in quite upset that they were missing doses or potentially overdosing as he was now on 13 medications. Again, even though we were extremely busy at the pharmacy, we needed to immediately start him on a Dose Administration Aid. This was duly organised and I delivered this to him after work and spent 30 minutes with the family advising how to use the DAA, PRN medications etc.

These are the things we do on a regular basis because we are dealing with customers/friends with immediate and important health needs.

Pharmacy, VIC

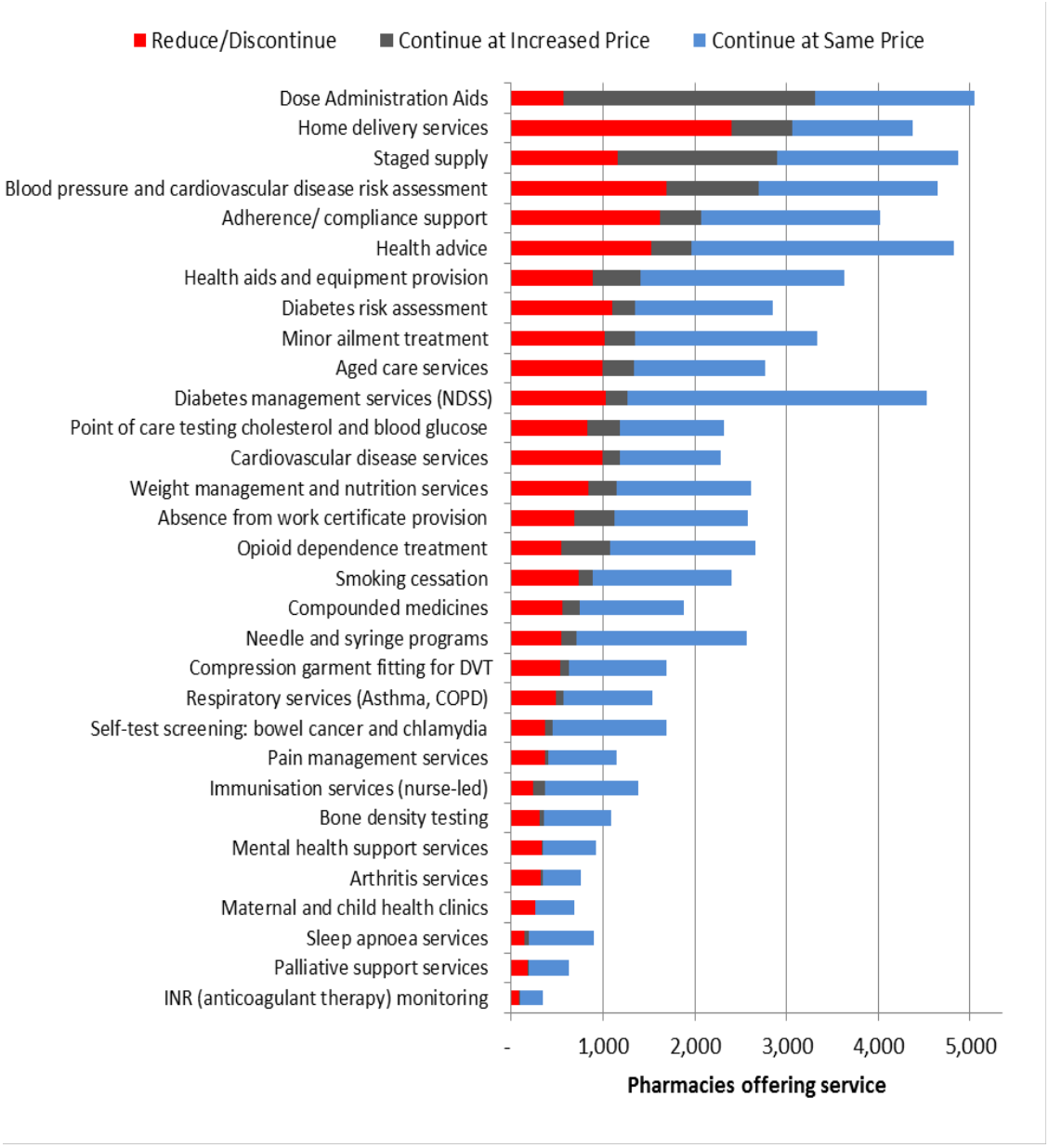
In the same survey about **60% of respondents in the survey indicated that they may be forced to increase the patient contribution to their DAAs service**. More than 30% of pharmacies stated that they would increase their fees for staged supply of medication. Staged supply is the process by which pharmacists supply medicine to a consumer in periodic instalments of less than the originally prescribed quantity, at agreed time intervals. The balance of the medicine is held by the pharmacy to fulfil subsequent instalments. The service is particularly important for some patients that suffer from mental health issues or have an addiction, who are some of the most vulnerable members of our society.

Increases in patient charges for services such as home deliveries, dose administration aids and staged supply would impact on patients in great need of the services, and recipients of these services are often also those least able to afford an increase in out of pocket expenses.

Figure 2 below provides a summary of the results of this survey. The RED bars indicate the number of pharmacies that stated that they will either discontinue or reduce each service. This is of relevance to the current Inquiry if it may force consumers to other, more costly, providers of a similar service (this is the case, for example, for health advice and minor

ailment treatment). The GREY bars, of direct relevance to this Inquiry, indicate the pharmacies which will continue to provide the service but at increased fees to patients.

Figure 2: Summary of April 2014 Pharmacy Services Expectations Survey results



Potential implications of co-payments for GP consultations

Many people visit their GP as the first line of treatment for what are relatively minor ailments. These doctor visits represent an inefficient allocation of our scarce health resources, including the time of busy GPs, whose skills would be better utilised addressing more complex medical problems. These minor ailment consultations are a major contributor to the fact that 23% of Australians in capital cities and 42% of Australians in other areas are forced to wait at least three days for a GP appointment[13].

A study commissioned by the Australian Self Medication Industry (ASMI) and conducted in 2008 by international health industry consultants IMS, found that 15% of all GP consultations involve the treatment of minor ailments, and 7% involve the treatment of minor ailments alone. When projected nationally, this equated to 25 million GP consultations annually, or approximately 96,000 consultations per day. A subsequent report commissioned by ASMI in 2009 showed that an 'augmented minor care initiative in pharmacy could contribute over time to an effective increase of between some 500 to 1,000 full-time equivalent (FTE) GPs, or some 3% to 7% of Australia's FTE GP workforce.[14]

Community pharmacy already provides advice, usually for free and with no structured program in place, in relation to many minor ailments such as coughs and colds, hay fever, headache, skin disorders, constipation, diarrhoea, haemorrhoids, ear aches, back pain, eczema, cold sores, conjunctivitis and many others.

As described in the previous section of this submission, **the ability of community pharmacy to continue to provide health and minor ailment advice for free is being severely impacted by price disclosure. The introduction of a mandatory co-payment for GP visits would likely push more people into community pharmacies for services such as these.**

A structured minor ailments scheme that included a consumer education campaign to raise the awareness of the choices available to consumers in relation to these minor ailments, together with appropriate remuneration that recognised community pharmacy's role, would ensure a better allocation of health resources. It would also provide greater convenience and more timely treatment for patients suffering from these ailments. Any such program would include protocols relating to the need for GP or emergency referral, with the pharmacy playing a triage role.

In implementing such a program Australia would be following the lead of other forward-thinking countries. A pharmacy-based National Health Service (NHS) Minor Ailments Scheme has already been implemented in Scotland (see the promotional material at Attachment 1), and programs also exist in some Canadian provinces. In January 2014 23 key health groups in the UK, including the Royal College of GPs, the Royal College of Nursing and the College of Emergency Medicine, wrote an open letter in The Times saying that one in seven GP appointments could be dealt with by pharmacists to take the burden off the National Health Service.

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[13] Menzies-Nous Australian Health Survey 2012

[14] ASMI Minor Ailments Report Sep 2009: The Potential Economic Impact of Expanded Access to Self-medication in Australia

It also needs to be recognised that introduction of a GP co-payment may potentially also result in some financially disadvantaged patients foregoing visits to their doctor when they are in need of diagnosis, treatment or medication that requires a GP intervention. In turn, this may result in patients not being prescribed their requisite medicines in a timely manner. It may also potentially have the flow- on impact of financially disadvantaged patients who do pay the GP co-payment then deciding not to have some or all of their prescriptions filled as they self-ration their out-of-pocket health care costs. This would mean that the role of the community pharmacist in encouraging patients to fill prescriptions they have been issued may become more important and potentially also more problematic.

Potential implications of increases in PBS co-payments

At the time of writing, there is speculation that the upcoming Federal Budget may include changes to existing PBS co-payments; including the possibility there may be changes to the eligibility for the PBS concessional co-payment for certain groups and changes to the concessional and general safety nets.

The Guild is not in a position to lend weight to this speculation as it has not been involved in these Budget deliberations. However, there is overwhelming evidence that current PBS expenditure is sustainable and is in fact rising at a rate significantly lower than the rest of the health system due to a combination of price disclosure and strong competition in the community pharmacy sector.

Such changes to PBS co-payments or safety nets could make it more difficult for some patients to afford the out-of-pocket costs of prescriptions. With the increasing prevalence of complex chronic conditions, it is not unusual for patients to be prescribed five or more PBS medications on an ongoing basis. Previously, when there have been increases in co-payments or changes to the PBS safety net, this has resulted in changes in patient behaviour with evidence of patients opting in larger numbers not to fill their original or repeat prescriptions.

There is a raft of evidence in Australia and internationally that medicine non-adherence is detrimental to patients' individual health. Any lessening of the responsible use of medicines results in higher costs across the wider health system through the combination of an increased demand for GPs and specialists, unnecessary hospitalisation and premature residential aged care admissions.

Accordingly, the Guild considers that any increases to the PBS co-payments and safety nets may discourage patients from purchasing their prescribed medicines because of an inability to afford any increased out-of-pocket costs. Equally it is important that price signals are accompanied by a greater commitment the funding of well-targeted medication management and community pharmacists support services, focused on those patients in greatest clinical need who have the highest risk of non-adherence to their medicines.

Attachment 1: NHS Scotland Minor Ailments Service – promotional material

More information: http://www.psd.scot.nhs.uk/docs/minor_ailment.pdf

Attachment 2: The Times (UK) article, 15 January 2014

Seeing the pharmacist not the GP 'key to survival of health service'

Chris Smyth Health Correspondent

Millions of patients should go to a high street pharmacist for minor ailments rather than bothering their GP, health leaders say today.

Pharmacists should be the first port of call for coughs, flu, aches, pains and common childhood sickness as part of efforts to ease the burden on the NHS, doctors, nurses, patients and managers say. Family doctors and A&E units are facing intolerable demands and the health service will collapse if patients do not agree to go elsewhere, they say.

One in seven GP appointments could be dealt with by pharmacists, who need to be seen as more than just prescription dispensers, say the heads of 23 key health groups, including the Royal College of GPs, the Royal College of Nursing and the College of Emergency Medicine. One in twelve emergency hospital visits could also be handled on the high street and patients need to think differently to help to solve the A&E crisis, the health-sector leaders write in a letter to *The Times*.

Local pharmacies "should be actively promoted as the first place of advice and treatment for common ailments. The NHS depends on community pharmacy, and it depends on people changing their behaviours for its very survival," they write.

Maureen Baker, chairwoman of the Royal College of GPs, said: "For coughs, colds, runny noses, problems of the eyes and skin, if people recognise they have a problem but don't feel very ill, it's reasonable to think 'maybe this is something the pharmacist can help with'. If people are thinking of the pharmacist, that's the first step. We're not trying to discourage people if they really want to see a GP, but we're saying it's an option. They can walk in and see the pharmacist very quickly, so it isn't dangerous."

Robert Darracott, of the professional association Pharmacy Voice, said: "We're talking about minor aches and pains, cold and flu symptoms, conditions where over-the-counter treatments can give relief. If you've got a cold, antibiotics are not what you need. You might need paracetamol, you might need cough medicine to make you feel a little bit better, but you don't need to go and bother your GP."

Pharmacists were the forgotten part of the health service and Britain needed to take a lead from other countries, where it was normal to turn to the high street first, he said. The bulk of pharmacists' earnings came from the NHS, which explicitly paid them to advise patients, yet relatively few people took advantange, he added.

A report by Professor Darracott's group estimates that 51 million GP visits could have been dealt with at a pharmacy, but "if you could shift just some of them that would make a huge difference to the system as a whole," he said. Many pharmacists were open at evenings and weekends when GP surgeries were shut, he pointed out.

GP consultations have almost doubled in the past two decades to about 340 million a year, while A&E attendance has gone up by more than 50 per cent in the same period, prompting an urgent search among health chiefs for alternatives to both. Sir Bruce Keogh, medical director of NHS England, said that more patients must be treated by pharmacists as part of his overhaul of urgent care services.

Roger Goss, of Patient Concern, said that pharmacists should not try to become "ersatz GPs", adding: "Many don't have the facilities to talk to you privately, and if you turn up at lunchtime the pharmacist is on a break.

"It's irresponsible to tell people to avoid their GP. We're constantly being told to go to the GP for potential cancer symptoms and it's muddled messaging. One of the reasons people go to a GP is they don't know if they're ill and want professional advice."

Professor Darracott said that pharmacists had five years' training in medicines and were able to spot "red flags" that indicated patients needed to see a doctor. "Day in, day out pharmacists are making these decisions and saying, 'If you're still not better there's something else that's going on and you need a GP.' If you're not sure about whether you should see a GP, you can get advice on that, too."

Michael Dixon, president of the GP group NHS Alliance, said: "There needs to be that shift in perceptions. It's about patients feeling able to ask a little more than 'can I have some paracetamol?' Having someone you can ask advice from first of all is important."

Leading article, page 24
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Help on the high street

High Street chemists have widened their remit beyond dispensing prescriptions and selling sunscreen, toothpaste, lipsalve and nit shampoo. Checks on blood pressure, cholesterol and blood glucose levels can be done in-store, while many offer pregnancy testing services and screening for allergies and sexually-transmitted infections. Smokers who want to quit and hernia patients in need of a truss can visit a pharmacist rather than their family doctor. Some pharmacists can even prescribe.