

Key messages

- Major socioeconomic inequalities exist between ethnic groups in disadvantaged communities
- Despite these socioeconomic disparities, selected general practitioners equitably deliver preventive services for the major causes of premature death
- Recording of mammography and cervical cytology were important exceptions and these programmes require additional support at practice level

population or increased it among minority ethnic groups.

The study population experienced major socioeconomic inequity by ethnic group. In contrast, there was no substantive difference by ethnic or socioeconomic group in recording of preventive care for the major causes of death by selected general practitioners serving half the population in this inner London borough. However, ascertainment of risk is only a first step. Both white and minority ethnic groups in this borough are at high risk of premature death from preventable causes. Major obstacles remain to the delivery of appropriate preventive programmes promoting behavioural change,²⁹ and language, cultural, and additional material constraints of minority ethnic groups need to be addressed.

Mammography and possibly cervical cytology were the main exceptions to equitable recording of preventive care. Mammography was inequitably provided and was the only activity not supported by active recruitment or follow-up of non-respondents by general practice staff. Local programmes are now attempting to improve uptake of breast and cervical screening.³⁰

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General practitioners' views on over the counter sales by community pharmacists

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More over the counter medications have been made available recently. We carried out a survey of general practitioners' views on various drugs being dispensed by community pharmacists without a prescription to determine whether these views have changed since 1990.¹

Subjects, methods, and results

Details of 1301 general practices were obtained from eight family health service authorities throughout

England. All 250 fundholding practices were included in the study together with a random sample of 250 urban and 350 rural non-fundholding practices to permit comparisons between fundholding (mainly rural) and rural non-fundholding general practices and between urban and rural non-fundholding practices. The larger number of rural non-fundholding practices were included so as to increase the statistical power of the study.

In November 1994 a questionnaire was dispatched to one randomly selected doctor from each practice. It sought information on basic characteristics of the practice and the responding general practitioner. The section in Spencer and Edwards' questionnaire which was used to elicit general practitioners' attitudes to the provision of specific drugs by pharmacists in 14 clinical scenarios was reproduced.¹

The overall response rate was 61% (515/850)—69%

Table 1—Percentage (number) of general practitioners agreeing and disagreeing that drugs should be dispensed without prescription by community pharmacists. The 1990 survey had 744 respondents; the 1994 survey had 515 respondents. Not all respondents answered each question

Drug	Indication	Agree			Disagree		
		1990	1994	Difference (%)	1990	1994	Difference (%)
Prescription only at time of 1994 survey							
Chloramphenicol drops or ointment	Sticky red eye in children over 2 years	52 (370)	67 (349)	15	39 (278)	22 (116)	-17
Oral broad spectrum antibiotic (5 day course)	Productive cough in otherwise healthy adult	15 (106)	26 (133)	11	78 (559)	63 (325)	-15
Topical antibiotic	Weeping skin infection	30 (217)	40 (205)	10	59 (415)	46 (239)	-13
Morning after pill	Unprotected intercourse within previous 72 hours	27 (195)	53 (275)	26	64 (458)	35 (183)	-29
Trimethoprim (3 day course)	Frequency and dysuria in women	35 (250)	55 (285)	20	54 (382)	33 (171)	-21
Oral nystatin suspension	Oral candidosis in baby	63 (452)	80 (412)	17	28 (198)	13 (68)	-15
Co-dydramol (10 tablets)	Severe toothache at weekend	87 (619)	87 (447)	0	9 (67)	8 (43)	-1
Penicillin (5 day course)	Sore red throat in adult	17 (120)	27 (140)	10	76 (542)	62 (322)	-14
Propranolol (10x10 mg tablets)	Anxiety state in adult	11 (75)	19 (101)	8	81 (581)	68 (354)	-13
Rectal suppositories containing steroids*	Haemorrhoids	43 (305)	58 (300)	15	42 (300)	28 (145)	-14
Available over the counter at time of 1994 survey							
Cimetidine	Dyspepsia in adult under 45 years not responsive to antacids	11 (80)	54 (280)	43	82 (582)	31 (158)	-51
Nicotine chewing gum	Smoker wishing to stop	84 (607)	91 (471)	7	9 (64)	4 (23)	-5
Beclomethasone nasal spray	Allergic rhinitis not responsive to antihistamines	46 (328)	67 (347)	21	41 (292)	18 (94)	-23
Antifungal vaginal pessaries	Vaginal "thrush" in women	53 (381)	87 (447)	34	38 (269)	8 (41)	-30

*Became available over the counter shortly after completion of survey.

(172/250) for fundholding practices and 57% (343/600) for non-fundholding practices ($\chi^2=9.85$; $df=1$; $P<0.01$). The distribution of practice size, doctors' ages, and average list size did not differ significantly from that recorded in England in 1993.² The table compares our results with those of Spencer and Edwards in 1990.

Most respondents agreed that pharmacists should issue nicotine gum, oral nystatin, and co-dydramol. This is consistent with Spencer and Edwards' findings. In contrast to the earlier study, over 60% of respondents agreed that chloramphenicol eye drops and beclomethasone nasal spray should be available without prescription for the clinical indications cited. Across all categories the respondents to the 1994 study were more likely than respondents in the earlier study to agree that pharmacists should issue drugs without a doctor's prescription. In both studies, few supported the proposition that pharmacists should issue penicillin for a sore throat or propranolol for anxiety. The differences between the studies were significant at the 5% level (using two tailed Student's *t* test) for all scenarios except the prescription of co-dydramol for toothache.

Four of the drugs became available over the counter in the period between the two surveys and one became available shortly after completion of the 1994 survey. Between 1990 and 1994 the level of agreement increased significantly ($P<0.01$) for all five of these drugs.

For each of the 14 clinical scenarios no significant difference in response was found between fundholding and non-fundholding practices or between rural and urban practices. General practitioners from fundholding practices agreed to more scenarios than general practitioners from non-fundholding practices (mean 8.6 v 7.8; $P<0.02$).

Comment

There has been an overall increase in the level of approval among general practitioners for the provision

of a range of medications by community pharmacists. General practitioners from fundholding practices agreed to a slightly wider range of drugs being made available over the counter than practitioners from non-fundholding practices. Fundholding practices have been shown to have achieved significantly greater success in curbing increases in drug costs than non-fundholders.^{3,4} Some caution must be exercised in interpreting the results given the relatively low overall response rate of 60%. However, the more positive attitude of fundholders towards the over the counter availability of a range of drugs is consistent with a concern for containment of prescribing costs.

The increase in the proportion of general practitioners agreeing to drugs becoming available over the counter may reflect greater awareness of the cost of prescriptions to the NHS and the need for cost containment. Given the increasing pressures on their time, general practitioners may be more likely to encourage self-medication for relatively minor problems, more aware of the importance of the community pharmacists as part of a primary health care team⁵ and more supportive of pharmacists' extended role.

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