Helpful advice and hidden expertise: pharmacy users' experiences of community pharmacy accessibility

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Abstract

Background

In recent years community pharmacies have emerged as strategically important settings to deliver services aimed at promoting public health. In order to develop evidence-based approaches to public health interventions that exploit the unique accessibility of community pharmacies, it is important to determine how people experience care in this context. This study, therefore, aimed to describe how care is perceived and experienced in community pharmacies with particular focus on community pharmacy access.

Methods

In-depth semi-structured interviews were used to explore the perceptions and experiences' of people using community pharmacies.

Results

A total of 30 participants were interviewed. Themes specifically emerged in relation to community pharmacy access; these fell into four main categories: relationships; time; lack of awareness; and empowerment.

Conclusions

The experience of developing a trusting relationship with the pharmacist is an important consideration in the context of community pharmacy accessibility. This could be an important consideration when a person uses a community pharmacy to access a public health service. There is also a perceived lack of awareness among the general public

about the extended role of community pharmacy; this is a potential barrier toward people using them.

Keywords: Community pharmacy, public health, healthcare access,

Background

Health inequalities represent a significant challenge to Western society:[1] for example, in the small borough of Stockton-on-Tees in the North of England, the gap in male life expectancy between the most affluent and deprived areas is 17 years.[2] This is comparable to the difference in life expectancy between the UK and Zimbabwe.[2] Beneath these figures lie significant differences in health behaviours: evidence shows smoking cigarettes, unhealthy eating and excessive alcohol consumption is more common in deprived communities, compared to more affluent ones.[3-5] As these behaviours are major risk factors within the aetiologies of certain diseases, individuals living in deprived areas are more likely to die from liver disease, cardiovascular disease and certain cancers. Providing universal healthcare – with strategic focus on health promotion and prevention activities – is thus seen as an effective way of reducing inequalities within a population.[1]

In view of this, community pharmacies have emerged as strategically important settings with potential to deliver services aimed at promoting public health.[6] Indeed, this has been acknowledged by the World Health Organisation who have described health promotion activities as a key activity of a community pharmacist;[7] in this context, a community pharmacy is considered a place in the community that is accessible to all and not based in a hospital, clinical or online. In England, this has been reflected in the community pharmacy contractual framework, whereby community pharmacists are now encouraged to move from purely pharmaceutical supply services to the delivery of patient focused public health services, including alcohol screening and brief intervention, smoking cessation and weight management clinics.[8] Given the challenges associated with health inequalities, this change in role is potentially significant: recent work has shown community pharmacists are the most accessible

primary care healthcare provider;[9] they also offer the advantage of being available without an appointment, often during the evenings and at weekends. Furthermore, another study has shown that, in contrast to the *Inverse Care Law*, as described by Tudor Hart in the 1970s,[10] access to community pharmacies is greatest in the most deprived areas – the so-called *Positive Pharmacy Care Law*.[11] These statistics are encouraging, but the scope of accessing healthcare or public health services in a community pharmacy extends beyond that of physical location: physical access (e.g. location), practical access (e.g. opening times), and professional access (e.g. having a private area to talk to a pharmacist) may all influence how someone experiences care in this context. Notwithstanding this, and given that access to primary healthcare is a well established social determinant of health,[12] using community pharmacies as a platform to provide public health services does have the potential to reach those that need it the most and thus impact on inequalities in health.

Despite this potential, there is a scarcity of literature exploring how people perceive or experience care provided by community pharmacies, or what facets of 'access' influence the experience within the community pharmacy. In order to develop evidence-based approaches to community pharmacy public health interventions that exploit the unique accessibility, and potentially impact on health inequalities, it is important to determine how people experience care in this context. This study, therefore, aimed to describe how care is perceived and experienced in community pharmacies with particular focus on community pharmacy accessibility.

Method

An exploratory qualitative study, using in-depth semi-structured interviews, was used to the perceptions and experiences of people accessing a community pharmacy.

Participants and recruitment

Participants were recruited from the North East region of England using posters advertising the study; posters were displayed in community centres, libraries, patient involvement groups and community pharmacies. Interested participants initially contracted the research team (LL) by telephone, while informed consent was taken face-to-face immediately before the interview. To be eligible for the study, participants had to be over 18 years of age and have the capacity to give informed consent. A purposive sampling framework was used to ensure there was maximum participant variation in deprivation. This was done by mapping participants postcodes to the Index of Multiple Deprivation (IMD) 2010 deprivation index:[13] each participant was categorised as living in an area of low, medium or high deprivation. Recruitment ended once theoretical data saturation was reached, *i.e.* when no new themes emerged, as assessed by two researchers (AT and LL).

Data collection

The interviews took place in the participant's homes or in a university setting. All participants were interviewed individually. Interviews took place between May 2014 and July 2015 and were undertaken by the same researcher (LL), lasting around 60 minutes. LL has expertise and previous experience at undertaking in-depth semi-structured interviews. At the start of the interview, participants were asked to describe

their main reason for using a community pharmacy and to give an indication of the frequency of use. Participants were then asked three open-ended questions:

- Why do you use a community pharmacy?
- What is it like to use a community pharmacy?
- Tell me about your last visit to a community pharmacy

Each question was followed up with probing questions to explore the participants' lived experience; examples included: the experience of using a community pharmacy compared to that of a GP; comparison of experiences between community pharmacies; services accessed when in the community pharmacy; and, barriers around using a community pharmacy.

Data analysis

Interviews were audio recorded, transcribed verbatim and analysed using a thematic approach. The analysis followed the six steps of thematic analysis: getting familiar with the data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes and producing written output.[14] The familiarisation and initial coding was done by one researcher (LL); the subsequent steps were undertaken jointly by two researchers (LL, AT). NVivo10 [QSR International, Melbourne] was used for managing the data coding. Any discrepancies were resolved through discussion (AT, LL) and if agreement was not reached, by consensus (AH). Emergent themes were tested using diverse accounts between cases, in order to challenge the integrity of the boundaries of themes. When using direct quotes from participants, pseudonyms were given to ensure confidentiality.

Ethical approval

The study complied with the 2013 Declaration of Helsinki; ethical approval was obtained from Durham University (ESC2/2014/02). All participants provided written informed consent prior to participating in the study.

Results

Participant details

Thirty participants were recruited to the study: ten for each level of deprivation (low, medium and high). Twenty participants were female (66%). The majority of participants were over 65 years of age (n=21); two were between 55-64 years; three between 45-54 years; one between 35-44 years and three between 25-34 years.

In the majority of cases, collecting repeat prescription medications was the primary experience of using a community pharmacy (n=25); for participants without chronic conditions requiring long-term medications, the main experience was obtaining healthcare advice or purchasing over-the-counter medication (n=5). Participants most commonly used a community pharmacy once or twice a month (n=17) or every couple of months (n=7). Three participants used one weekly, while two participants only used one once or twice a year; one participant was housebound and, as such, could not physically attend the community pharmacy; this participant communicated with the community pharmacy over the telephone or through their carers and relied on the delivery service to obtain medication.

Themes

From the interviews, themes specifically emerged in relation to community pharmacy access; these fell into four main categories: relationships; time; lack of awareness; and empowerment. These themes were observed across our sample; there were no apparent differences according to age, gender or deprivation.

Relationships

Participants perceived that the relationship they developed with the community pharmacist as important. The experience of developing this relationship made the participant more likely to visit a community pharmacist to gain certain healthcare advice, compared to other healthcare providers. Several participants described that, as a result of their relationship with the community pharmacist, they were more likely to be honest with them during a consultation.

> *I feel like a number in the doctor's. And it's different when you're coming somewhere like this* [the pharmacy] *and friendly you just think oh I can tell them everything. It's just more friendly, caring… I think with a pharmacist you'd be more honest with them. With the GP you tend to say to yourself should I tell him about this and that. I find pharmacies a lot easier places, more relaxed to talk about things. But just not the acute ailments, but more the major troubles and problems I have, yeah a lot easier to talk to them about that.*
>
> Steve, 55-64 years, high deprivation

Developing trust also appears to play a significant part in the overall process of developing a relationship with the community pharmacist; the majority of participants described this.

I only ever use that particular pharmacy, and have done for many years, for continuation really, just because they're, I trust them. I trust them to notify me if there's anything I need to know about any particular drugs, and they're always very helpful if I have any queries, any questions. It's just a pleasure to go on there.

Stephanie, >65 years, low deprivation

Participants described the relationship between themselves and the community pharmacist as 'different', when compared to the doctor / patient relationship. When consulting with a pharmacist, participants did not see themselves as 'patients'.

I don't feel like a patient as like a doctor patient to a pharmacist, it's totally different, because you are, they're providing you with a service.

Dorothy, >65 years, medium deprivation

Time

Participants described several experiences where they felt guilty about using the doctor for healthcare advice or to access a public health service, such as smoking cessation. In some cases, the sense of guilt or the perception that the doctor's time was being wasted appeared to be a barrier to people accessing these services. The experience of feeling as though a doctor's time is being wasted made participants more likely to access a healthcare service through a community pharmacy.

But to me that's [going to see a GP] *taking up valuable time that would be better used by somebody who, you know, maybe there might be somebody with an urgent complaint who needs that time, and you're sitting talking about giving up cigarettes.*

Barry, >65 years, medium deprivation

There was also the perception that community pharmacists appear to have more time to discuss certain things when compared to other healthcare providers. The context in which this experience was described was often in relation to public health advice.

Well yeah, I mean from what I could see she knew what she was talking about, and she said, just asked things like do you have a cigarette when you first wake up, then you'd probably want this patch overnight and things like that. And that was very helpful. I'm not sure doctors have got time for that kind of thing.

Ava, 55-64 years, high deprivation

Lack of awareness

Participants acknowledged there is a perceived lack of awareness by the general public in relation to community pharmacy; many participants described the experience of being surprised, or in some cases shocked, when discovering the patient focused role of the community pharmacist. This response, frequently given to the prompt around barriers to using a community pharmacy, was described for many facets of community pharmacy: the environment; how pharmacists are educated; and the healthcare and public health services they offer. For the environment, there was a distinct lack of

awareness that community pharmacies have consultation areas, so people can be consulted with in privacy.

> *They've got a little bit where you go and then there's a sort of more private area where they could actually ask if you needed help to understand the prescription. I think to let people know that you can do this. I think the accessibility seems fine, but a number of people I've spoken to don't know you can go.*
>
> Tom, >65 years, medium deprivation

In relation to education, many people did not appreciate the level of training a community pharmacist has undertaken; in many cases, there was no appreciation of multidisciplinary team working; instead participants described a perceived hierarchy of healthcare – with community pharmacists working somewhere in the middle of this. Participants were, however, happy for community pharmacists to offer patient focused services, provided they had sufficient training and were competent in undertaking them.

> *I think it is still a bit of a lack of knowledge of just how far their training has gone and what you can ask and what they know*
>
> Rory, 25-34 years, low deprivation

In relation to the services offered, several participants acknowledged many people are not aware that community pharmacies offer patient focused healthcare and public health services. Indeed, several participants described that people tend not to use community pharmacies for healthcare advice: in their experience, as a first port of call, the GP is used and, if an appointment cannot be made, advice would be obtained through Accident and Emergency services.

I think they would, there's a tendency, again this is from past experience, there's a tendency for them to go straight to the GP or if they're not satisfied with the time they have to wait, nip into casualty, which is a waste of resources. I think the general public tend not to know that the pharmacist has a decent knowledge to be tapped.

Gemma, >65 years, medium deprivation

Empowerment

As the community pharmacist could be consulted without an appointment, the interaction was described as being on the participants' terms. This appeared to cause the participant to feel a sense of empowerment when using a community pharmacy, as they were in charge of exactly when they received healthcare advice. Participants used phrases such as 'being in charge', 'decision is mine' and 'it's up to me' to describe this.

I can call in whenever I want. If I don't feel like going, I don't. Bottom line is – the decision is mine and that suits me fine. Often when I go to the doctors, I'm told when there is an appointment – when I can be seen; it's completely on their terms; when I go to the pharmacy it's up to me.

Caroline, 35-44 years, medium deprivation

One individual made specific reference to the smoking cessation service offered by the community pharmacy and being able to come in and get their carbon monoxide levels checked when they needed reassurance. This sense of empowerment, and the element of choice regarding access, improved the perceived accessibility of the

pharmacist and made participants more like to visit a community pharmacy for certain healthcare advice.

> *I was starting to have a wobble so I thought I'd pop in and check and reassure myself I'm doing the right thing and all of the hard work is worth it. The beauty of the chemist is I can do that. I know once I get that reassurance that my levels are low it will set me up for the week; if I have another wobble, I can just come back and see [the pharmacist] for another check – knowing I can do that gives me the confidence I need.*
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> Anne, >65 years, high deprivation

Discussion

Main finding of this study

The study highlighted that accessing healthcare services through community pharmacies is more complex than just considering how physically accessible the community pharmacy is. Indeed, just because a healthcare service is physically accessible does not necessarily mean that it will be used by the public as a means of healthcare advice. A number of themes emerged in relation to how people have experienced community pharmacy. Developing a relationship with the community pharmacist appears to be an important aspect in this context; participants described the experience of forming a trusting relationship with the community pharmacist that was different to a patient / doctor relationship. In many cases, this made participants more likely to use a community pharmacy for certain things, when compared to using a GP surgery; interventions related to public health, such as smoking cessation, were often given as examples in this context.

The perception of time was also considered important by participants in relation to healthcare access: participants described the experience of feeling guilty when consulting with a GP about certain things, as they felt it was not using their time appropriately; this was perceived as a barrier toward GP access. In contrast, however, participants perceived that community pharmacists had more time to speak about certain things – often those associated with unhealthy behaviours, such as smoking; the sense of guilt was not apparent when consulting with community pharmacists in this regard. Participants also felt that there was a lack of awareness around the role of the community pharmacist and this was a potential barrier toward accessing their services. Participants did, however, describe a sense of empowerment when accessing a community pharmacy for healthcare advice – as a pharmacist was available without an appointment, the interaction with the pharmacist was described as being on the participant's terms. In addition, participants did not see themselves as 'patients' but rather as an individual using a community pharmacy for healthcare advice – both of these factors meant they were likely to access a community pharmacy for certain things when compared to other healthcare providers.

What is already known on this topic

Several qualitative studies have explored the perception of service users in relation to public health services offered by community pharmacies. Bissell and Anderson, who explored the experiences of people obtaining emergency hormonal contraception via a community pharmacy, showed the users of the service valued it; in particular, users welcomed an absence of a judgmental attitude by pharmacy staff when accessing the service.[15] Another study, exploring the provision of 'flu vaccinations in primary care, showed that some people prefer using community pharmacy for

vaccination as the service was more convenient, owing to extended opening hours, pharmacy location and a preference for the pharmacy environment.[16] A further systematic review on pharmacist and consumer attitudes on public health in community pharmacy revealed the majority of pharmacy users did not expect to be offered public health services in this setting, although those that did were highly satisfied with the service.[17] The review also identified specific barriers toward delivering such services and included a perceived lack of pharmacist' ability and a lack of private space to undertake the delivery of such services. These barriers were also identified in our work under the theme lack of awareness. Participants acknowledged that there was a general lack of awareness around how a pharmacist is educated (and the subsequent level of competence associated with delivering services) and the environment in which public health services are delivered.

What this study adds

This is the first study to explore the lived experience in relation to community pharmacy accessibility. It is also the first study to describe the importance of the relationship between the pharmacy user and the pharmacist in the context of community pharmacy access and how this differs from the doctor patient relationship. The study also described how patients can experience a feeling of guilt, or may perceive they are wasting doctors' time in certain situations; smoking cessation was an example given in this context. In contrast, however, this was not reported when participants had experience of consulting with the community pharmacist. These findings are significant: future community pharmacy public health interventions should build on the finding that the public feel empowered as individuals rather than patients within the community pharmacy. This may be important as empowerment has been suggested as

an important factor, particularly in self-management and behaviour change.[18] We would urge commissioners to consider this when commissioning services in this regard. Another key finding to emerge from the study is that policymakers should do more to promote community pharmacy services to the general public. Indeed, a recent NHS England campaign promoting community pharmacy public health services portrayed a traditional image of a community pharmacist in a white coat standing behind a counter.[19] Given our findings, future campaigns should seek to modernize the public perception of community pharmacy and holistically promote the extended role. To make community pharmacies truly accessible, the general public needs to be aware of the healthcare and public health services available in this setting.

Limitations of this study

While we believe our results are robust and have important implications for the way in which community pharmacy public health services are designed, developed and commissioned we do acknowledge that the research was predominantly focused on a small sample of people in the North East of England: given that the majority of participants used a community pharmacy at least once or twice a month, we cannot rule out a degree of selection bias in our sample. In addition, ethnicity was not part of the sampling framework and all of our study participants appeared to be of White British origin. It is possible that people with different ethnicities may have different experiences of using community pharmacies – especially in relation to the more recent enhanced services, such as supplying emergency hormonal contraception. We also acknowledge that the differences in experience between people living in areas of low, medium and high deprivation regarding community pharmacy accessibility from an experiential viewpoint was not specifically explored. A larger questionnaire study,

together with further qualitative work, would be an avenue for future work to determine if there are any significant differences in terms of how community pharmacy public health services are experienced across deprivation levels; this will be essential to understand when designing services to impact on health inequalities. The findings of this study should therefore be interpreted with this in mind.

Conclusion

The experience of developing a trusting relationship with the community pharmacist is an important consideration in the context of community pharmacy accessibility. Such relationships were described as different to the patient / doctor relationship: people felt empowered as individuals and this appeared to increase the likelihood of a person using a community pharmacy to access a public health service. There was also a perceived lack of awareness among the general public about the extended role of community pharmacy; this could be a potential barrier toward people using these services, and would therefore be essential to address in any intervention targeting health promotion in this context.

Contributors

AT conceptualised and designed the study and was involved in study design methodological development, analysis and interpretation. LL undertook the interviews and was involved in data analysis and interpretation. AH, LS and JW were involved in the development of the methods and interpretation. AT led the drafting of the manuscript with input from all authors. All authors approved the final version, and AT has responsibility for its final content.

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