Dispensing Separation (DS) in Malaysia:

Challenges, Perceptions, and Benefits

The term DS refers to a practice in medicine and pharmacy in which the doctor who prescribes a medical item is separate from the pharmacist who fills the prescription. In Malaysia, DS was implemented in government hospitals and primary care clinics but was absent in private practices, including community practices [1-3]. However, the increasing number of pharmacists in recent years, coupled with a growing workforce in community settings, now qualifies them for exclusive dispensing rights, unlike the pre-independence era [1, 3, 4].

However, the debate over the DS for community pharmacists in Malaysia has persisted for decades, giving rise to numerous arguments [2, 5]. Efforts to promote DS have been ineffective due to strong opposition from the medical community, who heavily relies on medication sales for income. The argument is that DS is inconvenient to patients, who would need to visit both a general practitioner (GP) for a prescription and a pharmacy for dispensing. It was also claimed that DS could increase costs for consumers, and one of the frequently mentioned concerns is the shortage of pharmacists in Malaysia. Uneven distribution of retail pharmacies, concentrated in urban areas with few in rural areas, and the absence of 24-hour community pharmacy services are also reasons for DS opposition [3].

Not only GPs but the Malaysian public expressed opposition to the DS policy [1]. Both groups argued that having two professionals would increase medical costs and inconvenience to patients. They believed the current system was adequate and practical and that medication errors could still occur, even with pharmacists dispensing medications. Furthermore, they asserted that DS would not reduce overall medical costs when factoring in additional expenses like transportation, parking, and time costs.

Irrational prescribing was the main reason for the advocacy of DS in Malaysia [2]. Irrational prescribing, including uncontrolled antibiotic prescription, can increase the risk of adverse drug reactions (ADRs), especially in vulnerable groups like the elderly or those with multiple health conditions. It can lead to harmful drug interactions and antibiotic resistance. It may also contribute to drug dependence and waste limited healthcare resources, ultimately increasing treatment costs and medication expenses.

The high rate of medication errors by physicians was also the reason behind the promotion of DS in Malaysia [6]. Hence, having a pharmacist check the prescription prior to medication dispensing would reduce such harmful and costly errors. Of note, the separation of prescribing and dispensing activities is considered a safety mechanism to ensure an additional independent assessment of the proposed therapy before the patient begins treatment.

The separation of dispensing and prescribing of medicines in Taiwan effectively reduced drug expenditure and improved physician's prescription practices [7]. In Japan, the dispensing right reduced patient medicine costs by promoting generic drug use [8]. In Taiwan, the prohibition of physicians dispensing drugs reduced the number of antibiotics and inappropriate prescriptions for viral illnesses [9]. A study in Malaysia found that the public accepted and valued pharmacists' dispensing services due to the high cost of dispensing by physicians and excessive medicine markup [10].

Despite the growing number of pharmacists in Malaysia and strong public support for DS's benefits in reducing medical costs and improving healthcare quality, the policy remains a subject of debate between community pharmacists and general practitioners.

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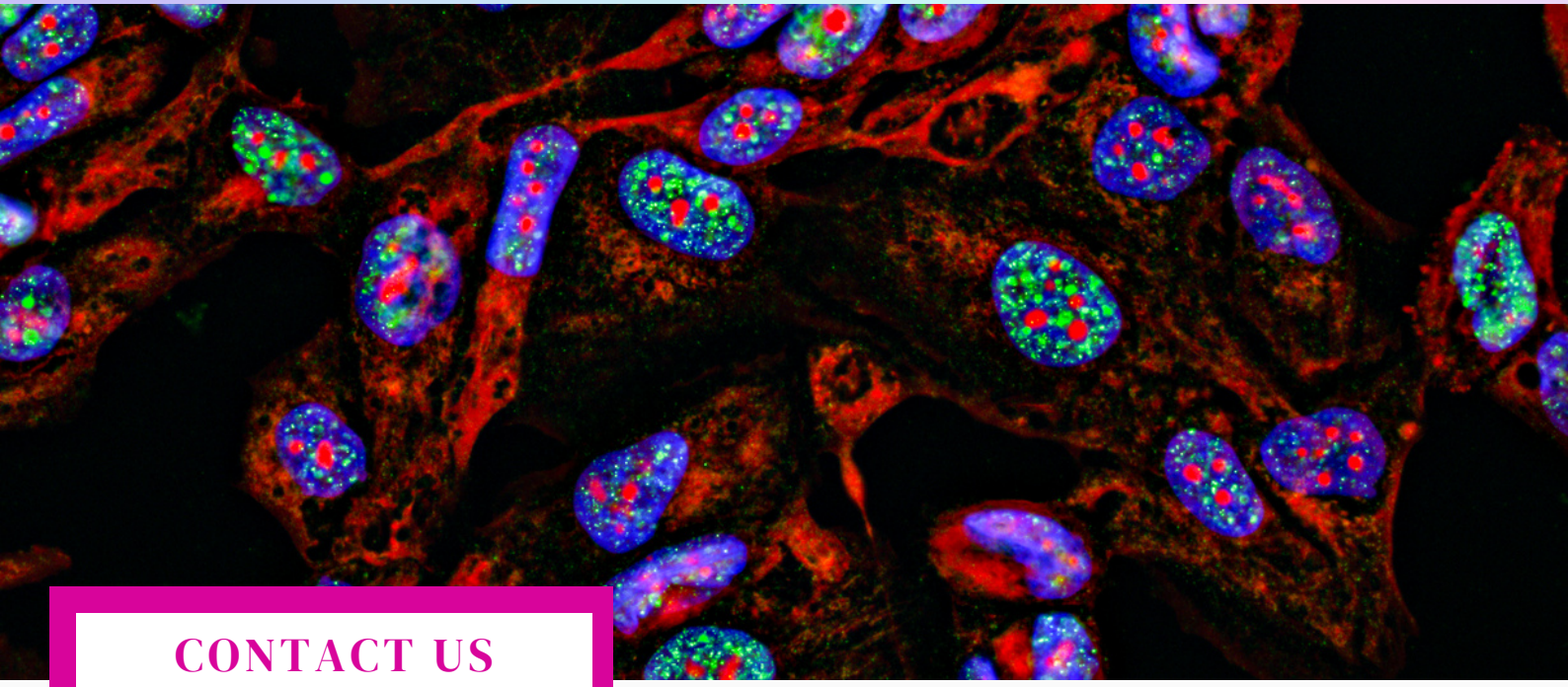

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