



House of Commons
Health Committee

The Control of Entry Regulations and Retail Pharmacy Services in the UK

Fifth Report of Session 2002–03



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*Report and formal minutes together with oral
and written evidence*

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Footnotes

In the footnotes of this Report, references to oral evidence are indicated by 'Q' followed by the question number. References to written evidence are indicated on the form 'Ev' followed by the page number.

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1 Introduction

1. In January 2003, the Office of Fair Trading (OFT) published a report entitled *The Control of Entry Regulations and Retail Pharmacy Services in the UK*. The remit of the investigation was to consider the effects of the Control of Entry Regulations on the service available to consumers, as well as the cost of this service. In doing so, the investigation applied a purely economic and consumer perspective, concluding that the Control of Entry Regulations for community pharmacies in the UK should be ended.¹ The report generated immediate controversy and public alarm, with its critics arguing that it sounded the “death knell” of smaller community pharmacy services.²

2. In the light of this controversy, we decided to conduct a rapid inquiry into the report. The inquiry was announced on 18 March 2003, and on 3 April 2003 we took oral evidence from the OFT, the Pharmaceutical Services Negotiating Committee, the Cooperative Pharmacy Community Technical Panel, and ASDA. We also received written evidence from the Patients’ Association, Boots, the Association of the British Pharmaceutical Industry, the Association of Town Centre Management, the Royal Pharmaceutical Society of Great Britain, the Company Chemists’ Association, the UK Public Health Association, Lloydspharmacy, the British Medical Association, and North East Derbyshire, Chesterfield and High Peaks and Dales PCT. We are very grateful to all those who submitted evidence to this inquiry. In addition, we are indebted to the Clerks’ Department Scrutiny Unit for their excellent research, briefing and drafting support.

1 Office of Fair Trading OFT609 (2003), para. 1.24 (hereafter, OFT 609 (2003))

2 Pharmaceutical Services Negotiating Committee, quoted by BBC News Online 17 January 2003, <http://news.bbc.co.uk/1/hi/health/2668031.stm>

2 Background

3. The current regulatory framework for pharmacies dates from 1987.³ Since then, this policy area has been devolved, but so far the regulations remain more or less the same throughout the UK. Under these regulations, it is possible to open a pharmacy anywhere, but the granting of contracts to dispense NHS prescriptions is regulated. Given that approximately 80% of the turnover of an average pharmacy tends to originate from NHS prescriptions, regulation of NHS contracts in practice amounts to full regulation of market entry. This is borne out by the fact that only 1% of all community pharmacies, some 130 pharmacies across the UK, operate without an NHS contract.⁴

4. Local Primary Care Trusts are responsible for granting contracts to dispense NHS prescriptions, and in doing so, they have to be satisfied that a pharmacy is '*necessary*' or '*desirable*' for a particular neighbourhood.⁵ As a result, a new pharmacy is not normally granted a contract if the area already has one or more pharmacies catering adequately for local needs.

5. There are approximately 12,250 community pharmacies dispensing NHS prescriptions in the UK.⁶ Pharmacies are currently fairly evenly distributed in the country, with 79% of the population in Great Britain living within one kilometre (0.62 Miles) of a pharmacy. Also, 98% of GPs' surgeries are within one kilometre of a pharmacy. Nonetheless, in the view of the Department of Health, the current distribution of pharmacies is not perfect.⁷

6. The current pharmacy framework is a constraint on change in the numbers and locations of pharmacies, and as a result, the net annual increase in the number of pharmacies has been four per year in the 1991-2001 period.⁸

3 OFT 609 (2003), para. 3.9

4 OFT 609 (2003), para. 1.5

5 OFT 609 (2003), para. 3.11

6 OFT 609 (2003), p. 1

7 See comments made by Lord Hunt of King's Heath, Parliamentary Under Secretary of State, Department of Health; HL Deb, 25 February, col 123

8 OFT609 (2003), para. 3.27

3 Potential effects of the OFT proposals for deregulation of pharmacies

7. The OFT report focused on consumer access (both geographical accessibility and opening hours), prices of over-the-counter (OTC) medicines (encompassing both pharmacy-only (P) medicines, and general sales list (GSL) medicines⁹), and also the cost of implementing the current regulations.

8. We received a large number of submissions, from a broad spectrum of interested parties ranging from the Patients' Association through organisations representing Community Pharmacists to large pharmacy chains, which were highly critical of the recommended deregulation of pharmacies. In the main, supermarkets have responded positively to the recommendations of the OFT, but only one company, ASDA, fully endorsed the proposals of the OFT report.

9. One of the key criticisms of the OFT analysis and proposals is that they are based on issues of competition but that they neglect the healthcare perspective. Several critics argued that it was inappropriate to treat pharmacy provision in the same manner as any other retail sector, as community pharmacies are part of the provision of healthcare through the NHS, and as such, fulfil a public service function.¹⁰ As the British Medical Association put it:

Other commercial outlets do not rely on 80% of their income flowing from what is, essentially, a state-funded public service. They do not educate the public and improve their health. Neither do they work with members of the local primary health care team to ensure the effective co-ordination of services to patients.¹¹

10. This view was echoed by several witnesses at our oral evidence session.¹²

11. Much of the debate generated by the OFT recommendation to scrap the control of entry regulations for pharmacies hinges on predictions about their likely impact on the structure of the pharmacy market. The OFT argued that deregulation would provide:

- Savings for consumers of £25-£30 million per annum (around £20-25 million on P-[Pharmacy-only] medicines, and a further £5 million on GSL [General Sales List] medicines).¹³

9 Pharmacy only—or P medicines—do not require a prescription but a pharmacist must supervise their sale. This can be because of the active ingredient involved, the strength of the drug, the instructions for use or its pack size. For example, Nurofen tablets (200 mg) are classified as 'P' in a pack of 24 but in a pack of 12 are available as a General Sales List medicine. Other P medicines include many of the stronger cold and flu medicines. General Sales List medicines are medicines that do not need to be sold in pharmacies but do need to be sold in a lockable shop. They are commonly found in supermarkets, convenience stores and petrol stations. GSLs are listed on 'The Medicines (Products other than Veterinary Drugs) (General Sale List) Order 1984' and include such medicaments as cough mixtures and paracetamols.

10 See for example comments by Lord Clement-Jones, HL Deb, 25 February 2003, col. 122; Ev 1-2 (Pharmaceutical Services Negotiating Committee); Ev 3 (National Pharmaceutical Association); Ev 54 (Lloydspharmacy)

11 Ev 57

12 Q94 (Mr D'Arcy); Q124 (Ms Colling)

13 OFT609 (2003), para. 1.12

- Savings for taxpayers of £26 million per annum (around £10 million in NHS administration costs, and nearly £16 million in compliance costs to business).¹⁴
- Improved service quality resulting from increased competition.¹⁵
- Improved access in terms of opening hours.¹⁶

12. The OFT maintained that the scrapping of entry regulations would not lead to a substantial overall reduction in the number of pharmacies, and that there would be zero impact in terms of access for the elderly and low income groups.¹⁷ However, this conclusion was strongly contested by the overwhelming majority of submissions and evidence put to us.

Closures of pharmacies

13. There was general agreement in our evidence that the numbers of pharmacies may *initially* increase following deregulation, but the majority of those who made submissions to us questioned the OFT conclusion that even in the long run, pharmacies in rural or deprived areas will not come under threat as a result of deregulation.¹⁸ Several witnesses suggested that many small pharmacies serving rural, isolated or deprived areas are likely to become unviable if the market is deregulated entirely, enabling any supermarket to open an in-store pharmacy. John D'Arcy of the National Pharmaceutical Association (NPA) argued that:

there will be an increase in openings first off but that increase will settle down because the market, as we have already established, is inelastic. It is not going to go in the way it is described. There will be a bigger shift towards the bigger, better resourced players.¹⁹

14. It is argued that pharmacies in rural or deprived areas may lose a proportion of their dispensing revenue to new pharmacies, located particularly in supermarkets because customers with easy access to big stores may find this more convenient. Such a shift in business would not benefit consumers in terms of price, since there is no price competition on prescription medicine. However, it might expose customers without easy access to transport by making smaller pharmacies unviable. Sue Sharpe, chief executive of the Pharmaceutical Services Negotiating Committee (PSNC) told us that:

geo-demographic modelling [...] shows that there are 858 pharmacies at present that are more than a mile already from a GP's surgery, so they are not the pharmacist next door. They are within the catchment areas of supermarkets that do not currently have pharmacies. All we need is a 10 to 15 per cent shift of business,

14 OFT609 (2003), para. 6.2 and 6.31

15 OFT609 (2003), para. 1.13

16 OFT609 (2003), para. 1.17 and 1.20

17 OFT609 (2003), para. 1.18 and 1.19

18 See, for example, Q110

19 Q50

convenience business, away from those pharmacies and we would expect the majority of them to move from viability to unviability.²⁰

15. Liz Colling from the Co-operative Pharmacy Community Technical Panel concurred:

I am particularly concerned that these small pharmacies serve very distinct socially deprived areas and it would not need many prescriptions to go elsewhere, as a result of out of town shopping or whatever, for the services which these pharmacies currently provide to be no longer viable. An exit from that area will then create a whole new problem about socially deprived people not having access to, not just pharmacy services, but any kind of health services in some situations.²¹

16. According to the National Pharmaceutical Association (NPA), the threats to local communities were being felt particularly keenly by “the elderly, the infirm, mothers with young children”.²²

17. Consequently, with the exception of supermarket pharmacies, in their evidence to us the majority of the pharmacy industry not only appeared to disagree with the OFT on the issue of whether deregulation would lead to closures of pharmacies in the longer term, they also indirectly questioned the validity of the OFT’s *worst-case-scenario model*. The model used by the OFT assumes that the two pharmacies closest to every new supermarket pharmacy close down. Given this assumption, and also given the extreme scenario that 2,127 supermarkets and 93 pharmacies currently without an NHS contract open fully fledged pharmacies, the OFT model showed that *on average* people would only have to travel 40 metres further to their nearest pharmacy. It also concluded that only 1% of the population would be more than one kilometre further away from their nearest pharmacy than they are at present.²³

18. However, the OFT’s own assertion that currently, nearly two thirds of pharmacies in Britain lie within 500 metres of another pharmacy seems to put into doubt the assumption that it is necessarily the pharmacies closest to new supermarket pharmacies that would close under the worst case scenario. As most submissions and much of the oral evidence pointed out, it is pharmacies in marginal communities that would be most threatened in a worst-case scenario model.

19. This Government has emphasised the crucial role of community pharmacies in delivering improvements in the NHS, a view which we support. The role of community pharmacies is not limited to dispensing prescriptions, but extends into providing NHS patients with free advice on medication and self-treatment, and can make a significant contribution to easing pressure on other NHS services. A policy which could lead to the closure of significant numbers of community pharmacies, or to less equitable distribution of community pharmacies dictated by commercial markets rather than the needs of patients, would therefore go against the best interests of the NHS. The issue of whether deregulation will result in significant closures of pharmacies, and in particular,

20 Q61

21 Q64

22 Q51

23 OFT609 (2003), paras. 5.40—5.49

pharmacies in rural or deprived areas is therefore crucial, and much of the evidence we have received indicates a strong likelihood of such closures.

Social impact of potential closures

20. The potential social impact of deregulation is twofold. First, if deregulation led to closures of pharmacies, this is likely to have a profound social impact on vulnerable groups who might effectively lose access to pharmacy services altogether.²⁴

21. Vulnerable groups tend to be the biggest users of prescription services, as shown by OFT research. People over the age of 71 cash on average 13 prescriptions per year, compared to an average of just 6.4 in the 16-34 age group. Likewise, social classes D and E cash an average of 12.3 prescriptions per year, as compared to 9.3 in social classes A and B.²⁵ The OFT survey data show that people living in villages cash almost 50% more prescriptions as a yearly average (12.2) than do town and city dwellers (8.5).²⁶

22. Ms Sharpe reminded us that:

We know in answer to a Parliamentary Question that was answered by the Minister responsible for pharmacy very recently, that 56 per cent of all prescriptions are for people over sixty. It seems to me to be self-evident that these are the high users of the local community pharmacy services, and therefore by definition these people [are those who] ... will be affected.²⁷

23. Furthermore, the OFT survey of pharmacy users clearly confirms that the closure of a local pharmacy would present a 'real problem' primarily to the elderly, women, the disabled, and the lower social classes. In their survey, 35% of disabled people and 35% of the 75+ age group responded that the closure of their local pharmacy would be a 'real problem' for them. While only 13% of social classes A and B felt it would be a 'real problem', the proportion rose to 30% of social classes D and E.²⁸ This skew in concern over potential closure of a local pharmacy is likely to be a reflection of access to private transport, as well as the fact that the elderly, the disabled, and the lower social classes are the groups who use pharmacies the most frequently.²⁹

24. Speaking recently in the House of Lords, Lord Borrie, the former Director of Fair Trading (1976-1992), expressed the view that:

At present, patients—especially elderly patients, with whom we must be concerned—have ready access to a spread of pharmacies throughout the country, which is most helpful to healthcare. If entry regulations disappear and there is complete de-control,

24 Note that the OFT view is that the scrapping of entry regulations would not lead to a substantial overall reduction in the number of pharmacies, and that the impact in terms of access would be no different among the elderly and low income groups. OFT609 (2003), para. 1.18 and 1.19

25 OFT609 (2003), Appendix D, pp. 98-99

26 OFT609 (2003), Appendix D, p. 98

27 Q135

28 OFT609 (2003), Appendix D, pp. 134-35

29 OFT609 (2003), Appendix D, p. 98

the ambition of supermarkets will be such that many pharmacies will be in difficulty and no longer viable, which will be seriously dangerous to people's health.”³⁰

25. If deregulation were to lead to some communities being left without access to local pharmacy services, the social impact among elderly and less privileged groups could be grave. This outcome would clearly run counter to other government initiatives expressly intended to redress the health inequalities between different groups in society.

26. The second area of social impact potentially arising from deregulation concerns the provision of services which may be time-consuming, unprofitable, or have social stigma attached to them. Much of our evidence expressed concern as to whether pharmacies in supermarkets would be happy to provide compliance aids and home delivery services or drugs for addicts, emergency contraception and sexual health advice on their premises. ASDA assured us that most of these services are provided in their supermarkets except home delivery, which one store does “quite a bit but not very much”.³¹ Mr Evans, in the same response, then changed the argument:

I think you are making the assumption that supermarkets would take over these roles from other pharmacies. I am not sure if I agree with that. I think that if the market were deregulated, more pharmacies would exist rather than less pharmacies, so that the current pharmacies out there would still be there.³²

27. Our evidence conflicts with that view. We believe that the willingness of all pharmacies, including supermarkets, to provide such services is a key issue, and one that is integral to the Government’s plan for extending the roles of community pharmacists. **Irrespective of issues concerning deregulation, the Government must ensure that local PCTs have sufficient levers at their disposal to oblige pharmacies to provide services such as emergency contraception and these essential extra services for the elderly, disabled, substance abusers and mentally ill wherever they are needed.**

The Essential Small Pharmacy Scheme and dispensing doctors

28. The OFT report argued that if deregulation were to cause localised problems, two schemes which already exist, the Essential Small Pharmacy Scheme (ESPS), and the system of allowing doctors to dispense prescriptions in rural areas, could be used to remedy the situation.³³

29. The Essential Small Pharmacy Scheme (ESPS) exists to protect small pharmacies which are considered essential for local communities, but which are not in themselves financially viable because of their location. There are 340 ESPS pharmacies across the UK³⁴ although the rules on eligibility and payments vary between England, Scotland, and Wales.³⁵

30 HL Deb, 25 February 2003, col123

31 Q25

32 Q25

33 OFT609 (2003), para. 1.21

34 These are distributed with 243 in England, 22 in Wales, 50 in Scotland, and 25 in Northern Ireland

35 OFT609 (2003), Appendix F

30. However, a number of witnesses argued that neither of these schemes is appropriate for such an increased role. As regards the ESPS, Mr D’Arcy of the NPA argued that:

The ESPS has been proposed as an alternative, but it is not a credible alternative or a way of solving the closure problem, because it is essentially a top-up payment, and it is not a particularly good one. It will keep a pharmacy afloat, but it does not turn it into a great pharmacy practice. If there were closures—and we have opined that there could be between 800-900 pharmacies at risk—if they were to be supported by an ESPS, it is untenable to suggest that the current arrangements, where the subsidy is taken from other pharmacy contractors’ remuneration—that is not tenable as an alternative.³⁶

31. A further measure to ensure provision of NHS prescription drugs in areas with poor access to pharmacies (particularly rural areas) consists of granting certain GP practices the right to dispense prescription medicines. In 2001, there were a total of 1,565 dispensing practices in the UK, staffed by more than 5,000 doctors. Of these, 1,242 were in England.³⁷ However, there are serious concerns about whether or not this *would*, or indeed *should*, become more widespread in a deregulated environment.

32. The British Medical Association emphasised the good service provided by dispensing doctors, whilst also acknowledging the delicate equilibrium between pharmacies and dispensing doctors.³⁸ On the other hand, the Chief Executive of the North Eastern Derbyshire Primary Care Trust argued that there was “a fundamental conflict of interest in the prescription and dispensing of medicines and we are opposed to total freedom being granted to GPs to provide both services.”³⁹

33. Quite apart from a possible conflict of interest between the role of a doctor and the role of dispensing prescription medication, there may be cost implications.⁴⁰ Even in the view of the OFT, dispensing doctors are not a universal option for remote, rural, or deprived areas. Matthew Johnson stated that: “Dispensing doctors should only come into play when there are real gaps where pharmacies cannot come in to the market, that is our view. The best thing is for pharmacists to dispense.”⁴¹

34. We recommend that the dispensing doctors scheme is retained only where a pharmacy is unviable, even with the support of the Essential Small Pharmacy Scheme. Dispensing doctors should not be seen as a solution to problems arising from potential deregulation of entry into the market.

Deregulation and the quality of service

35. One of the central arguments of the OFT report is that with increased competition, the quality of service and innovation in the pharmacy sector is likely to improve, and that

36 Q84

37 OFT609 (2003), para. 2.19 and Table 2.2

38 Ev 59

39 Ev 60

40 Q151

41 Q152

supermarket pharmacies have much to offer in this area. Jonathan May of the OFT explained:

We tried to look at quality of service with a series of proxies. One was the consultation area, the second one was opening hours and the third one was home delivery. If you look at the figures, you can see that the independents and the supermarkets score highest in terms of consultation areas, which is interesting if you compare with the multiples, for example—and consultation areas are clearly important for patients who may want to consult with their pharmacist. Supermarkets offer less, obviously, if you look at the chart we have there, in terms of home delivery, although it is worth noting that they probably offer a higher proportion than do multiples to patients in need. In terms of the third quality or service standard at which we looked, which is opening hours, clearly supermarkets would tend to be open longer.⁴²

36. Mr Johnson added that research showed that pharmacies were more likely to open before 9 am in areas where there were more pharmacies per GP, and that pharmacies were also more likely to offer a consultation area if there were more supermarket pharmacies in their area.⁴³

37. In some circumstances, increased competition may facilitate innovation and improvements in terms of the quality of service. However, it is difficult directly to transpose principles of competition onto the health care sector, which functions very differently from other sectors of industry, and we would only support competition within the pharmacy sector if it was clearly compatible with a planned provision of pharmacy services that ensured provision in deprived areas.

A shortage of pharmacists

38. There is currently a shortage of pharmacists in the UK, and the OFT along with witnesses from the industry acknowledge this.⁴⁴ However, whilst the OFT assumes that the effects of deregulation on the pharmacy labour market would be manageable, some argued that it is a key problem which, in a deregulated market, might increase the pressure in parts of the NHS. The Royal Pharmaceutical Society of Great Britain argued in their submission:

in the short term, the only readily available source of a substantial number of trained pharmacists and support staff would be NHS acute hospitals. Many hospitals are already experiencing staff shortages, and any net loss of staff would place additional pressures on the delivery of patient care and compromise plans for future developments in clinical services.⁴⁵

39. Lloydspharmacy, a pharmacy chain, made a similar point in their submission, adding that “workforce shortages resulting from a major expansion in the number of pharmacies

42 Q22

43 Q21

44 Q24

45 Ev 51 (Royal Pharmaceutical Society of Great Britain)

could easily result in costs to the NHS exceeding all the likely cost savings from deregulation.⁴⁶

40. Mr D’Arcy from the NPA added a further dimension to the debate, suggesting that the proposed changes would “lead to inconsistency in service provision, which will be limited by availability of a pharmacist.” He went on to argue:

But it must follow, if there are more pharmacy openings and thus more demand for pharmacists, that it will put pressure on the supply of existing pharmacists, and there will be attempts made to woo those pharmacists from existing positions. One has to go further and suggest that pharmacists who would be most affected would be those in less nice areas, who might be wooed to go to better areas, with the prospect of better working conditions and perhaps better money.⁴⁷

Potential cost implications

41. The OFT estimated that the current system of regulation costs £26 million per annum, consisting of £10 million in NHS administration costs, and nearly £16 million in compliance costs to business. These costs, it is argued, would be entirely eliminated with deregulation.⁴⁸ Furthermore, the report also suggested that the cost of over-the-counter medicines (OTC) will fall, resulting in “annual customer savings of around £20-25 million on P-medicines [Pharmacy-only medicines], and a further £5 million on GSL [General Sales List] medicines.”⁴⁹

42. However, some witnesses argued that the OFT’s estimates of potential savings were greatly inflated, whilst others maintained that they were simply unrealistic because costs would increase elsewhere. Both Boots and Lloydspharmacy attempted to replicate the OFT calculations of potential savings following from deregulation, and both reached considerably lower figures.⁵⁰ Boots provided a breakdown of their calculations, and estimated that the cost of the current regulatory system amounted to approximately £1.15 million per year for business, and £7.3 million per year for the NHS/the taxpayer, meaning that the recurrent system costs approximately £8.45 million in total per year, some £17 million less than the OFT’s estimates.⁵¹

43. Boots, along with other witnesses, also pointed out that the OFT had not provided comprehensive estimates of the additional costs likely to arise in connection with deregulation of entry into the retail pharmacy market. Boots argued that there was likely to be a range of costs, both direct and indirect, including increasing costs to support unviable pharmacies in remote areas, and wage costs, which would need to be taken into account in any assessment of overall cost implications.

46 Ev 56

47 Q80

48 OFT609 (2003), para. 6.2 and 6.31

49 OFT609 (2003), para. 1.12

50 Ev 42; Ev 56

51 Ev 42

44. Both the OFT and ASDA acknowledge that *some* small pharmacies will become unviable in a deregulated market, and propose that the Essential Small Pharmacies Scheme (ESPS) is the appropriate mechanism for ensuring the continued provision of pharmacy services in rural or deprived areas.⁵² Mr May of the OFT argued that even if doubling the cost of the ESPS, deregulation would still save money.⁵³ Others, however, argue that this scheme would need considerable expansion in a deregulated environment, which could end up costing as much as, and possibly even more than, any administrative and legal savings made through scrapping regulation.⁵⁴

45. Witnesses did agree that savings could be made in NHS administration costs by deregulation, but argued that equivalent or greater savings could be made by amending the existing scheme without this wholesale deregulation. This did not seem to have been examined by the OFT report, and the Government should consider this in responding to the OFT report. **We are not convinced that deregulation of retail pharmacy in the UK would lead to savings, either to the public purse, or to business. Indeed, there is some indication that (indirect) costs resulting from deregulation might in fact outweigh any savings made. We recommend that the Government develops a more robust set of models of potential costs and savings before relying on an economic argument to determine the fate of regulation of entry into the pharmacy market.**

52 Ev 6; OFT609 (2003), para. 1.21

53 Q88

54 Ev 50 (Association of Town Centre Management)

4 Pharmacy services within the wider framework of the NHS

46. The Department of Health in England, as well as the devolved authorities in Wales, Scotland and Northern Ireland, have all proposed major extensions to the role of community pharmacies within NHS healthcare provision. In England, the Department of Health's *Pharmacy in the Future—Implementing the NHS Plan* set out an ambitious programme for the role of modern pharmacies in meeting the diverse and changing needs of patients.⁵⁵ As Sue Colling of the Co-operative Pharmacy Community Technical Panel put it: “Increasingly, pharmacists are becoming part of the wider healthcare agenda and engaging in provision of primary care health rather than retailers.”⁵⁶ The question is how the current regulatory framework aids or hinders the objectives set out in these programmes.

47. Much of our written as well as our oral evidence expressed concern that deregulation of entry into the pharmacy market would jeopardize these programmes, in part because it would make it harder for Primary Care Trusts to *plan* the local provision of pharmacy services. As Mr D’Arcy of the NPA argued:

we are on the cusp of making great use of pharmacy and pharmacists’ skills, improving pharmacists’ input and improving patient care. That is the policy that is outlined in *Pharmacy in the Future* and the various other UK strategies. Therefore, pharmacy services, as part of overall NHS care, should be planned and managed.⁵⁷

48. We also heard that implementation of the proposals to involve pharmacists much further in primary care had the potential to save considerable amounts of money for the NHS, in particular in terms of doctors’ time. For example, Ms Sharpe from the Pharmaceutical Services Negotiating Committee (PSNC) told us it has been estimated that if pharmacists take on repeat dispensing from GPs, they could save 2.74 million GP hours.⁵⁸

49. However, countering these views, ASDA argued that it was precisely the requirements for change and adaptation to the needs of modern patients that made de-regulation necessary.⁵⁹

50. We support the objective of giving community pharmacies a greater role in the provision of primary care, including repeat prescribing. It is essential that all people, including those from rural and deprived areas, have access to pharmacies, and in order

55 Department of Health: NHS: *Pharmacy in the Future—Implementing the NHS Plan* (September 2000), pp. 3-4; See also Ev 10 (National Co-operative Chemists); Ev 1 (The Pharmaceutical Services Negotiating Committee)

56 Q124

57 Q117

58 Q7

59 Ev 5

to achieve this, it is crucial that Primary Care Trusts have the ability to plan the provision of pharmacy services.

5 Deregulation or reform of the current framework?

Reform—but with a planned provision of pharmacy services

51. Many witnesses argued that this debate should not be seen simply as a choice between the current system *or* total deregulation. None of our evidence suggested that the current system of controlled entry was perfect. Sue Sharpe (PSNC) contended that the NHS gets the “best value within a planned service” as opposed to an “increase in the numbers of pharmacies in unplanned localities,”⁶⁰ and summed up the argument:

it is very important not to characterise this as a debate between deregulation and the status quo. We have made proposals for change, proposals for improvement in the planning systems that operate under a revised scheme, and I think it is really important to identify the key issue here which is: do we have a planned pharmacy service or do we have an unplanned service that comes from deregulation? I do not think any of my colleagues here are supporters of the status quo.⁶¹

52. Mr D’Arcy of the NPA added that:

in moving forward we should be building on what we have got, recognising deficiencies, and dealing with those on the basis of health need in particular in the needy groups—the mothers with young children, the elderly, the infirm—particularly vulnerable groups—and building a modern, high-quality pharmacy service, which is flexible and adaptable and is actually patient-focused.⁶²

53. Mr D’Arcy further argued that the Government’s aim should be to “develop proposals that will give PCTs and primary care organisations throughout the UK greater flexibility in meeting local needs, that is something we are all supportive of and in essence deregulation is not necessary to achieve that.”⁶³

54. Most of those from whom we took evidence expressed support not only for reforms of the current system, but also for a model in which a national framework guarantees a degree of uniformity of standards but which is nonetheless sufficiently flexible to enable Primary Care Trusts to plan and tailor the provision of pharmacy services to the specific needs of their area.⁶⁴ However in their oral evidence to us, the OFT argued that the current system of regulation is only a negative planning tool in the sense that it allows PCTs to decide that there *should not* be a new pharmacy in a particular location, but that it does not allow them to decide that there *should* be one in a particular place.⁶⁵

60 Q37

61 Q40

62 Q117

63 Q51

64 Q117; Q159

65 Q57

The relationship between the regulatory reform and the remuneration system for pharmacy services

55. Several witnesses and submissions to the Committee mentioned the fact that reform of pharmacy provision and, in particular, the objective of increasing pharmacy involvement in primary care might be facilitated through changes to the system of remuneration of pharmacies. For example, ASDA argued that pharmacies could be paid on the basis of services other than just prescriptions:

Other services that could reasonably be linked to payment to encourage the pharmacy market to lift service standards include: the provision of emergency services; extended opening hours; repeat dispensing; supplementary prescribing; provision of private consulting rooms; sums for provision of methadone; blood pressure testing; diagnostic testing such as of cholesterol and diabetes; warfarin clinics; smoking cessation; emergency hormonal contraception (EHC); bone density testing; head lice management; asthma clinics; tests for drug addiction; flu vaccinations; time spent with GPs auditing high use patients' medication records; home delivery. It may be that some of these services would be valued more highly than others and remunerated accordingly.⁶⁶

6 Conclusion

56. Much of our evidence has suggested that the current system of control of entry regulations is overly inflexible and in need of reform. During this rapid inquiry, we have not been able to explore all possible options for future regulation, planning, and delivery of pharmacy services. However, it has become clear to us that the recommendations of the OFT report have the potential to make certain pharmacies unviable, potentially leaving some of the most vulnerable communities, who have the greatest health needs and are least able to travel long distances, without any local pharmacy provision, a situation which would be unacceptable.

57. We are not convinced by the economic and competition arguments relied upon by the OFT to support its recommendation, and while we would welcome measures that encouraged pharmacies to provide a higher quality service to patients, we feel that in order to deliver the best possible service to NHS patients, Primary Care Trusts must retain the ability to plan the provision of local pharmacy services, which play an integral part in the delivery of health care to local communities. Deregulation which allows the market to decide where to provide any dispensing of NHS prescriptions would necessarily reduce the finances available for PCTs to plan the remaining NHS dispensing. We would not, therefore, support such deregulation. Any reforms to the regulatory framework for the provision of pharmacy services should be in close concert with the negotiations for a new payment system for pharmacies currently being carried out by the Department, and must fully take account of the wider role of pharmacies within the 'bigger picture' of the NHS and of this country's health needs, something we feel the OFT report has singularly failed to do.

Conclusions and recommendations

1. This Government has emphasised the crucial role of community pharmacies in delivering improvements in the NHS, a view which we support. The role of community pharmacies is not limited to dispensing prescriptions, but extends into providing NHS patients with free advice on medication and self-treatment, and can make a significant contribution to easing pressure on other NHS services. A policy which could lead to the closure of significant numbers of community pharmacies, or to less equitable distribution of community pharmacies dictated by commercial markets rather than the needs of patients, would therefore go against the best interests of the NHS. The issue of whether deregulation will result in significant closures of pharmacies, and in particular, pharmacies in rural or deprived areas is therefore crucial, and much of the evidence we have received indicates a strong likelihood of such closures. (Paragraph 19)
2. If deregulation were to lead to some communities being left without access to local pharmacy services, the social impact among elderly and less privileged groups could be grave. This outcome would clearly run counter to other government initiatives expressly intended to redress the health inequalities between different groups in society. (Paragraph 25)
3. Irrespective of issues concerning deregulation, the Government must ensure that local PCTs have sufficient levers at their disposal to oblige pharmacies to provide services such as emergency contraception and these essential extra services for the elderly, disabled, substance abusers and mentally ill wherever they are needed. (Paragraph 27)
4. We recommend that the dispensing doctors scheme is retained only where a pharmacy is unviable, even with the support of the Essential Small Pharmacy Scheme. Dispensing doctors should not be seen as a solution to problems arising from potential deregulation of entry into the market. (Paragraph 34)
5. In some circumstances, increased competition may facilitate innovation and improvements in terms of the quality of service. However, it is difficult directly to transpose principles of competition onto the health care sector, which functions very differently from other sectors of industry, and we would only support competition within the pharmacy sector if it was clearly compatible with a planned provision of pharmacy services that ensured provision in deprived areas. (Paragraph 37)
6. We are not convinced that deregulation of retail pharmacy in the UK would lead to savings, either to the public purse, or to business. Indeed, there is some indication that (indirect) costs resulting from deregulation might in fact outweigh any savings made. We recommend that the Government develops a more robust set of models of potential costs and savings before relying on an economic argument to determine the fate of regulation of entry into the pharmacy market. (Paragraph 45)

Formal minutes

Thursday 5 June 2003

Members present:

Mr David Hinchliffe, in the Chair

Mr John Austin
Sandra Gidley

Dr Doug Naysmith
Dr Richard Taylor

The Committee deliberated.

Draft Report (*The Control of Entry Regulations and Retail Pharmacy Services in the UK*), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 57 read and agreed to.

Resolved, That the Report be the Fourth Report of the Committee to the House.

Ordered, That the provisions of Standing Order No. 134 (select committees (reports)) be added to the Report.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

[Adjourned till Thursday 12 June at 10 am.]

Witnesses

Thursday 3 April 2003

Page

Ms Sue Sharpe, Chief Executive, Pharmaceutical Services Negotiating Committee, **Ms Liz Colling**, NHS Business Development Manager, National Cooperative Chemists Ltd, **Mr John D'Arcy**, Chief Executive, National Pharmaceutical Association, **Mr John Evans**, Superintendent Pharmacist, ASDA Stores Ltd, **Mr Jonathan May**, Divisional Director and **Mr Matthew Johnson**, Economist, Office of Fair Trading

Ev 11

List of written evidence

1	Pharmaceutical Services Negotiating Committee	Ev 1
2	National Pharmaceutical Association	Ev 3
3	ASDA Stores Ltd	Ev 4, Ev 33, Ev 60
4	National Co-operative Chemists Limited	Ev 9
5	The Patients' Association	Ev 37
6	Boots	Ev 39
7	The Association of the British Pharmaceutical Industry	Ev 49
8	The Association of Town Centre Management	Ev 49
9	The Royal Pharmaceutical Society of Great Britain	Ev 50
10	The Company Chemists Association Limited	Ev 51
11	Pharmacy Health Link, and United Kingdom Public Health Association	Ev 51
12	Lloydspharmacy	Ev 53
13	British Medical Association	Ev 57
14	North Eastern Derbyshire, Chesterfield and High Peaks and Dales	Ev 59

Reports from the Health Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2002–03

First Report	The Work of the Health Committee	HC 261
Second Report	Foundation Trusts	HC 395
Third Report	Sexual Health	HC 69
Fourth Report	Provision of Maternity Services	HC 464

Session 2001–02

First Report	The Role of the Private Sector in the NHS	HC 308
Second Report	National Institute for Clinical Excellence	HC 515
Third Report	Delayed Discharges	HC 617