HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 11 March 2003
(*Afternoon*)

Session 1

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CONTENTS

Tuesday 11 March 2003

HEALTH AND COMMUNITY CARE COMMITTEE
12th Meeting 2003, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Mr Tom McCabe (Hamilton South) (Lab)
Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Fergus Ewing (Inverness East, Nairn and Lochaber)
Mrs Mary Mulligan (Deputy Minister for Health and Community Care)

WITNESSES

Dr Martin Graham (Office of Fair Trading)
Mr Charles Whitworth (Office of Fair Trading)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Eliot

LOCATION

Chamber

Scottish Parliament

Health and Community Care Committee

Tuesday 11 March 2003

(*Afternoon*)

[THE CONVENER *opened the meeting at 14:12*]

Items in Private

The Convener (Mrs Margaret Smith): I ask the committee to consider discussing in private item 4, on the draft annual report, and item 5, on the draft legacy paper, to allow for a full discussion of the options. Is that agreed?

Members *indicated agreement.*

Subordinate Legislation

Draft General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003

The Convener: The draft General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 is an affirmative instrument. The minister is with us this afternoon to speak to us on the order.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): The order will establish a new independent body, the postgraduate medical education and training board, with responsibilities for the United Kingdom. The order will also provide a framework to improve the supervision of general and specialist training, leading to the award of a certificate of completion of training in both general and specialist practice. Further, it will establish a general practitioner register and a specialist register and require that a doctor working in the national health service anywhere in the UK as a consultant or general practitioner be included in the relevant register.

I hope that my remarks have been helpful; I am happy to answer any questions.

I move,

That the Health and Community Care Committee, in consideration of the draft General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003, recommends that the Order be approved.

The Convener: Various royal colleges seem to have had some concerns, but those concerns appear to have been allayed. The Subordinate Legislation Committee had nothing to report and no members' comments have been received.

Motion agreed to.

Feeding Stuffs (Scotland) Amendment Regulations 2003 (SSI 2003/101).

The Convener: The next instrument is the Feeding Stuffs (Scotland) Amendment Regulations 2003 (SSI 2003/101). The Subordinate Legislation Committee had no comments on the regulations, no members' comments have been received and no motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation on the instrument. Is that agreed?

Members *indicated agreement*.

Retail Pharmacies (Office of Fair Trading Report)

14:15

The Convener: Agenda item 3 is the Office of Fair Trading report, "The control of entry and retail pharmacy services in the UK". I welcome Mr Charles Whitworth and Dr Martin Graham, who are here on behalf of the OFT. After they have made a short opening statement, we will come back with some questions.

Dr Martin Graham (Office of Fair Trading): We are here today to be grilled by the committee on the OFT report, "The control of entry and retail pharmacy services in the UK". The report is an investigation under section 2 of the Fair Trading Act 1973 and is part of a series of market investigations that the director general of fair trading instituted in October 1991. I think that the report on pharmacies is the second or third such investigation to report.

Mr Charles Whitworth (Office of Fair Trading): The series of investigations was instituted in 2001.

Dr Graham: Sorry, it was in 2001.

The report deals with the United Kingdom as a whole, but we looked at England, Scotland, Wales and Northern Ireland separately, because each have slightly different regulations and slightly different markets. We assessed that and made our recommendations accordingly. The single recommendation that we make applies to the UK as a whole. The director general's view is that the control of entry regulations does not make the market work well for consumers and should be abandoned or dispensed with. [*Interruption.*]

The Convener: I am sorry, Dr Graham. I must stop you for a moment. We seem to be experiencing some difficulty with your microphone. I ask you to move one seat along and to budge up—to use a technical term—beside Mr Whitworth.

Dr Graham: The control of entry regulations were introduced in 1987, essentially as a stop-gap measure to control mushrooming costs at a time when too many small and costly pharmacies were entering the market to dispense NHS prescriptions. Our studies are evidence-based and we have published that evidence. Indeed, there are two volumes of detailed evidence and other materials behind the main report, which we are quite happy to disclose if members want to see them.

Our key findings are that abandonment of the control of entry regulations would give rise to competition benefits such as lower prices and better services. We would have a more competitive market, we would make savings in administrative costs and efficiency gains and business and the NHS would benefit. Although we have considered alternative remedies such as tendering contracts or tinkering with the regulations, we did not find any of them to be particularly attractive or viable.

As far as the next steps are concerned, I should perhaps look to my colleague to put the matter into a framework.

Mr Whitworth: This report is meant primarily for Government, rather than for the industry or pharmacy professionals. I am sure that MSPs are well aware that pharmacy matters are wholly devolved, which means that what happens with the OFT's recommendation is a matter for the devolved Administrations. Although there is a common process, as it were—we have already spoken to the National Assembly for Wales and engaged with the matter in England—the decision-making responsibilities lie with each of the devolved Governments.

The commitment to respond in 90 days, which is mentioned in our initial submission, was primarily made by the Department of Health in London. Whether it is followed in Wales, Scotland or Northern Ireland is a matter for those Administrations.

I know that members of the Scottish Executive health department have been involved in the technical working parties that have been set up following the report. However, the purpose behind our attendance at today's meeting is for OFT officials who are involved in the report to respond directly to MSPs' questions.

The Convener: You have anticipated my first question, which relates to where the power to make such decisions lies, and have made it clear that that power lies ultimately with the devolved Administrations, irrespective of the fact that consumer protection issues are reserved. Obviously, health matters are devolved to Scottish Executive ministers and, critically, to the Parliament.

You also said that abandoning the control of entry regulations would benefit business and mean administrative savings. However, our major concern centres on patients as patients, not on patients as consumers. My question is: why are you doing this? After all, patients as consumers do not seem to be making a large number of complaints about the existing level of services provided by community pharmacies in Scotland. Given that your report recognises that patients enjoy high-quality services to which they have easy access, will you confirm that the study was

driven by the larger supermarkets such as Asda and Superdrug, rather than by any dissatisfaction from patients at the grass roots in Scotland or elsewhere in the United Kingdom about the range of services that is available to them at their local community pharmacy?

Dr Graham: Examining regulatory issues is a new task for the Office of Fair Trading and is part of the market studies initiative that began in October 2001. In general, consumers or patients tend not to complain about a sub-optimal regulatory framework, because they do not have a reference point for comparison.

Our approach is twofold. We are aware of the framework and of the primacy of protecting and promoting the health of the people of the UK. However, we are competition specialists. Our initial remit was to ask whether the market works well for consumers and whether it could work better.

Mr Whitworth: The report will help with health outcomes, because we envisage that more innovation will be developed in a more liberalised or deregulated set-up. We see no incompatibility among the pharmacy strategies in Scotland, Wales and England, which we have carefully read and noted in the report; we see benefits to patients in wider access to over-the-counter medicines. The report focuses on that.

The Convener: Do you agree that the report was not the product of a groundswell of discontent among patients and consumers about how the system works? To paraphrase your words, the market appears to work well for consumers of the products.

Mr Whitworth: I can only repeat what my colleague Martin Graham said. The study was started on the office's initiative because the regulations are major and have a significant impact on the way in which an important market—the market for community pharmacy services—works. As far as we knew, no study across the board had been undertaken since 1987. The regulations have been in place for 15 years, but their impact on consumers and service development has not been analysed. That was the primary justification for our report.

Dr Graham: It might be significant that the regulations were not introduced in 1987 with any great desire to serve consumers, patients or people's health better. They were introduced as a fairly short-term, desperate measure to stop the national health service's mushrooming expenditure on such services, which was caused by the use of a cost-plus basis for the remuneration and reimbursement of pharmacists, which, interestingly, was amended in 1989 and has been adapted since. Our report quotes the permanent secretary at the Department of Health in 1989, who said that if the department had got its act together and moved away from the cost-plus reimbursement system sooner, it would not have been necessary to impose the regulations.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Will you describe your definition of the market? Are you talking about the totality of the individuals who frequent community pharmacies, or about people who do not go to such pharmacies for NHS prescription dispensing? How do you determine what a service is to such individuals?

Mr Whitworth: The services that community pharmacies deliver probably fall into three major areas of interest. Through the prescription dispensing service, medicines that are otherwise restricted under the Medicines Act 1968 are professionally delivered to individual consumers and patients. That is the bedrock of most community pharmacies' business activity and forms about 80 per cent of a typical community pharmacy's turnover.

Margaret Jamieson: Is that the figure for a typical pharmacy in the United Kingdom? Do you have different figures for the devolved areas?

14:30

Mr Whitworth: We did not find that there were significant differences in the ways in which community pharmacists do business throughout the UK; the situation is similar in Scotland, Wales and England. Obviously, the major exceptions are the very large high street pharmacy groups, particularly the Boots Group plc, in which prescription business forms a much smaller proportion of turnover.

The largest proportion of business in a typical community pharmacy is the prescribing and safe professional dispensing of medicines. Over-the-counter medicines are, however, becoming increasingly important because all health departments see the need to keep a lid on prescribing costs. There is therefore a general presumption that people should be encouraged to take responsibility for their own health where they can. Access to pharmacy-only medicines—or P medicines—is available only through pharmacists; that accounts for 10 per cent of the turnover of a typical community pharmacy.

The final part of what might be called the professional pharmacy business is the giving of pharmacy advice, which is obviously not paid for. If a person goes to their pharmacist and asks for advice there is, under the current professional and ethical rules, no separate charge for advice. People might not take that advice and might not, in the end, purchase anything.

Our study considered all three aspects—they are the core—of community pharmacy services. Some community pharmacies also carry out additional retail activities alongside those three.

Margaret Jamieson: You said that you are aware of "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland" and that you considered it in producing the OFT report. However, in that document, there is much emphasis on the partnership between the community pharmacist, the general practitioner and the patient. How did you measure that, given that you made no mention of it in your response?

Mr Whitworth: The aspects of pharmaceutical services in "The Right Medicine", which is the Scottish pharmacy policy document, are all matters that are being driven forward by the Scottish Executive health department. It is a matter for individual health departments, but some of those aspects will form the basis of new contractual arrangements with the pharmacists; some will be part of the general development of the profession. Nothing in our report undermines that or will make it more difficult. In a deregulated or liberalised pharmacy contract market, there should be no reason why the pharmacy strategies in "The Right Medicine" could not be implemented just as easily as under the current contracting arrangements. We see no particular difficulty with that at all.

Shona Robison (North-East Scotland) (SNP): In response to a question from Margaret Smith you said that the proposed changes would be helpful for health outcomes. How did you come to that conclusion? What evidence did you take in Scotland that led you to that conclusion? Will you outline how long you spent in Scotland and to whom you spoke?

Mr Whitworth: The inquiry was UK wide, so we spent time in all the parts of the UK. Our primary point of reference was the UK-wide consumer survey—in which Scotland was fully represented—which was a broadly based consumer survey of current use of pharmacies and of what is important to pharmacy consumers. We asked particularly about access and shopping patterns, and for consumers' views on the quality of advice. You will find that that is summarised in the main document, but it is included in full in the second volume of our report. That was the primary reference point in respect of consumers.

In respect of health policy in Scotland, we had a number of meetings with the Scottish Executive health department. We went through "The Right Medicine" document and the health strategies quite carefully with the department. We considered general matters that are common to pharmacy consumers in England, Wales, Scotland and Northern Ireland, particularly in relation to access to over-the-counter medicines. The issues were broadly similar throughout the UK, given that the pattern of commercial or community pharmacy provision in Scotland, and groups that serve community pharmacies, are in Scotland broadly similar to what exists in England and Wales.

Shona Robison: How many pharmacies did you visit in Scotland to take views?

Mr Whitworth: We had two separate meetings with pharmacy groups in Scotland. We also conducted a pharmacy survey, which a number of Scottish pharmacists completed. We had a proportionately greater response to the survey from Scottish pharmacists.

Shona Robison: Did you visit any pharmacies to see the work that they were doing?

Mr Whitworth: We visited pharmacies in England.

Shona Robison: But none in Scotland.

Mr Whitworth: We did not visit pharmacies in Scotland, but we met pharmacists.

Shona Robison: So the views that you got from pharmacies were from the survey alone, as far as pharmacists in Scotland are concerned.

Mr Whitworth: No. As I said, we had meetings with two professional groups of pharmacists. We had a two-hour meeting with the contractors group here in Edinburgh last August. We had a thorough discussion about all the matters that were of concern to that group. We also met one of the other pharmacy groups.

Dr Graham: It is also worth pointing out that the study was launched with a fair degree of publicity back in October 2001. There has been no shortage of pharmacists' views being put to us. We have invited them to express those views in a number of ways, such as through our website or by phone.

Shona Robison: For the record, will you tell us what the thrust and the flavour of the response was from the Scottish pharmacies that responded to your survey, in relation to the impact of the proposals on the national health service in Scotland?

Dr Graham: As far as I am aware—my colleague will confirm this—the Scottish response was similar to the response that we got from pharmacists in England, Wales and Northern Ireland.

Shona Robison: So the response was not particularly supportive of what you propose.

Dr Graham: Absolutely. It is undeniable that there is considerable fear and uncertainty about removal of the control of entry regulations.

The Convener: We have heard from two of the pharmacy organisations in Scotland—the Scottish Pharmaceutical Federation and the Scottish Pharmaceutical General Council. My understanding, from the meeting that I had with them, was that you had neither met them nor asked them for their points of view. Will you clarify who the contractors are and what body of pharmacists they represent?

Mr Whitworth: I am little surprised that the SPF and the SPGC said that; I suspect that there has been confusion. We made direct contact with the SPGC, which is the contractors body, early last year. We received a written submission from it in the middle of last year and, in August, we had a two-hour meeting with the SPGC in Edinburgh. At that meeting, we covered all the major areas of concern. As my colleague Martin Graham indicated, the SPGC did not support any proposals for deregulation, but we had not then formulated any direct proposals. However, we covered with the SPGC all the major issues that we have discussed this afternoon.

Mary Scanlon (Highlands and Islands) (Con): Can you define what you mean by "retail pharmacy services"?

Mr Whitworth: The term "retail pharmacy services" describes the parts of community pharmacy services that, broadly speaking, are provided by commercial contractors. Some pharmacy services are not provided by commercial contractors.

Mary Scanlon: Can you give an example of such services?

Mr Whitworth: Do you mean an example of services that are not provided by commercial contractors?

Mary Scanlon: No—I mean an example of a retail pharmacy service that is provided by a commercial contractor.

Mr Whitworth: I refer Mary Scanlon to a response that I gave earlier. Services that are provided by commercial contractors include dispensing services. Those are patient oriented, but they are also commercial because contractors are remunerated by the health departments under quite complicated remuneration arrangements. The sale of over-the-counter medicines—both pharmacy medicines and general sales-list medicines—is strictly commercial, because no additional remuneration is provided for those. Broadly speaking, the provision of advice is supported by fee payments that are made as part of the remuneration system. Within the pharmacy contract, all health departments require individual pharmacies to provide a certain amount of health promotion and support for particular health policies.

Mary Scanlon: Do you see medicines as normal retail commodities?

Mr Whitworth: We did not take a view on that. With over-the-counter medicines, a commercial transaction clearly takes place. There is a price for, and a volume of, such medicines. One must decide whether a medicine is suitable for treating a particular condition. The transaction takes place in a highly regulated and professionally controlled context, which we support.

Mary Scanlon: Are you happy that the code of ethics that applies to pharmacies will apply to supermarkets? With more competition, there will be a desire to sell more medicines. However, the code of ethics for pharmacists requires them to recommend and sell only the amount that is appropriate for patients' needs at the time of consultation. Is it in the interests of the patient or consumer for us to encourage people to take more medicines and supermarkets to sell more?

Dr Graham: Our report does not recommend free entry into the market—we are talking about registered pharmacists. One could say that we are discouraging restrictions on who owns pharmacy businesses, but to act as a pharmacist a person must be a qualified pharmacist, must comply with the regulations and must meet the professional standards of pharmacy.

Mary Scanlon: Do the findings of the UK study take account adequately of the more rural distribution of the Scottish population? Shona Robison asked about the consultation that you carried out. When last we inquired into that matter, we were told that you had spent half a day in Scotland and that you had spent that half day talking to officials. As a list member for the Highlands and Islands, I want to know whether you are aware of how dependent on the pharmacy structure people in that area are. In "The Right Medicine: A Strategy for Pharmaceutical Care in Scotland", pharmacies are encouraged to carry the NHS logo. Pharmacies are clear partners in the NHS, rather than commercial enterprises. Are you aware of the needs and wants of people in remote and rural areas?

14:45

Dr Graham: Yes. We are operating within the framework that is set out in "The Right Medicine". Obviously, there are issues about rural and less-populated areas, which are not confined to Scotland but also exist in Wales, England and elsewhere.

Mr Whitworth: Nothing in our proposals for deregulating and liberalising the market would impact adversely on the provision of pharmacy services in rural areas. At the moment, Scotland is unusual in the United Kingdom because pharmacists in Scotland are at liberty to establish

pharmacies in rural areas subject to the agreement of the local health board; there are no regulatory restrictions, as there are in England and Wales, where a pharmacy cannot be established in a rural district without regulatory permission. The regulations are not so severe in Scotland. We do not believe that anything in our proposals would undermine the provision of rural pharmacy services.

You expressed concern that our report is a hard-headed commercial report. We feel that the commercial provision of pharmacy services and broader social policy objectives are compatible and complementary. We do not see them as being in opposition to each other. I hope that the way in which we have written the report makes it clear that we validate the social objectives for community pharmacy that are made by all health departments throughout the UK. We do not think that our recommendations in any way undermine those social objectives.

Mary Scanlon: Despite the assurances that you are giving, I have received concerned e-mails and letters from chemists in Shetland, the Western Isles, the Orkney Islands and Inverary. A chemist in Nairn wrote to me last week saying that they had just invested £5,000 in consulting rooms for their business in order to adhere to the action points in the strategy, which pharmacists in Scotland are signed up to. They fear that you have destabilised that move forward; they are not reassured by your report. They do not know whether to invest in their businesses or even whether they will continue to have businesses and they feel threatened by your recommendations. Are they misunderstanding what you are saying? They are certainly not excited about the innovative prospects.

Dr Graham: There are two points to be made. We do not see our recommendations as being cataclysmic and we do not think that they will destabilise the retail pharmacy business in the way that pharmacists fear. Mary Scanlon questions whether we have spoken to enough people and spent enough time speaking to pharmacists in Scotland. Our research methodology is to undertake evidence-based studies and investigations, for which we use about 10 different methods. We are not, essentially, a body that goes round speaking to people and getting a consensual approach—we conduct analytical research. We are now into the consultation phase. That work is not being done for the Office of Fair Trading; it is being done by the Scottish Executive, the Department of Trade and Industry in England and so on. The Government is responsible for the consultation phase. Our responsibility was to produce an analytical report that included recommendations: we have attempted to do that.

Mr Whitworth: The other thing that I can say to Mary Scanlon's constituents, by way of reassurance, is that pharmacy is a growing market. Year on year, there is a real-terms increase of about 3 per cent in community pharmacy spending throughout the UK. The figure is obviously more or less in different parts of the UK. Therefore, we are not looking at a situation in which everybody will have to compete in either a static market or a smaller market, which means that there is room for new community pharmacy entrants to provide new types of services.

Supermarkets alone will not provide such services—there might be discount pharmacies or new independents on the high street. An Aberdeen constituent, who is also a young pharmacy graduate of the Robert Gordon University, wrote to us welcoming our report. He said that young graduate pharmacists have for the first time in 15 years been given the opportunity to set up businesses themselves without having to go through an existing contract or chain. That should be welcomed, because the current regulations mean that young pharmacists who wish to develop a commercial pharmacy business have difficulty because they are restricted.

Mary Scanlon: I am struggling to find a reason for the report, given that 94 per cent of people say that the chemist provides a nearby service and so on. What exactly is the objective of the report? Is it designed to save money or to increase consumer choice? What do you hope to get from it? Are you hoping to save the NHS or consumers money? According to my information from Boots Group plc, supermarkets do not sell medicines cheaper than do local pharmacies.

Dr Graham: Our objective is the same as in any market investigation—we need a prima facie case that markets might not be working well for consumers.

Mary Scanlon: That might be the case, but 80 per cent of community pharmacy work is in the NHS. I am a Tory—the authors of the internal market. Are you treating the NHS as a market like other markets?

Dr Graham: The NHS is not a market like others, but it has the characteristics of a market. The ability to dispense medicines under the NHS has largely been frozen since 1987. The market dynamics that one sees are about people selling existing businesses, one to another. In many ways the industry has been set in aspic since then.

Mary Scanlon: Consumers are happy.

Dr Graham: We believe that the market can work better without the entry controls.

Despite the reasons behind the study, restrictions on a market that stop new entrants

coming in are sometimes justified. We did not enter into our investigation with preconceived ideas. There is a prima facie case that the market will work better without the entry conditions and that is the basis on which the director general approved the study in October. It was, thereafter, a matter of collecting the evidence, balancing it and seeing whether a better regulation method could be devised. We contend that our proposal does that.

Bill Butler (Glasgow Anniesland) (Lab): I am a wee bit puzzled about some of the things that you have been saying, so perhaps you could help. Mr Whitworth said that the single recommendation of the report states that the control of entry regulations should be abolished. He also said that the report will "help with health outcomes". Dr Graham said that the studies and investigations were "evidence-based", and that an analytical approach was adopted. However, it seems that the evidence—I think that Mr Whitworth said something similar—is, by and large, against deregulation; patients are against it and pharmacists are overwhelmingly against it.

It seems that only you and some large supermarket chains support the proposed change. Are you saying, in an academic way, that deregulation is a good idea on paper and that the market will work better if it is freed up by deregulation? Have you heard the expression, "If it ain't broke, don't fix it"? Would you care to comment on that? I am mystified by what you are saying.

Dr Graham: I do not think that John Vickers, the director general of the OFT, subscribes to the "if it ain't broke, don't fix it" approach. The premise of the investigation was that there was something that was worth examining in this market. By and large, restrictions on the entry of firms into a market have problems and do not work; they tend to be associated with market failure.

Bill Butler: Does that happen in every market? You have just said that we are talking about a specialised market.

Dr Graham: Yes. We have taken 15 months to compile the report, and—

Bill Butler: But it could still be wrong.

Dr Graham: We did not merely start it in October and conclude in November that the regulations were not valid. A lot of evidence was used; we could not do our work by taking a straw poll and going around to every pharmacist—

Bill Butler: Indeed, but from where did you gather your evidence? You talked about a couple of meetings, and about extensive market surveys, but you do not seem to have gone out and talked to people at the sharp end—those who deliver and receive the service. That is astonishing.

If the changes go ahead—I certainly hope that they do not—what evidence is there that this would, I quote you, "help with health outcomes"?

Mr Whitworth: Can I respond?

Bill Butler: Yes, please.

Mr Whitworth: We were struck especially by two areas of evidence that arose from the research that we carried out. One was that freeing up the market will lead to wider access to low-priced over-the-counter—OTC—medicines, and—

Bill Butler: You said "will" rather than "may".

Mr Whitworth: Yes.

Bill Butler: That is very definite.

Mr Whitworth: There is no doubt that pharmacy-buying groups that could come from a variety of sources will establish lower-priced pharmacy outlets, to the benefit of consumers. As to price benefits, we estimate that the figure for a mixture of P medicines and general advice-related or sales list medicines will sit—

Bill Butler: Forget that. This seems to me to be what an old tutor of mine called "mere assertion" without an evidence base. You are saying "will, will, will", and "must, must, must", which seems to be most unscientific and lacking in analysis.

Mr Whitworth: It is not. We have set that out in the report, in particular in chapter 4. We talked with several pharmacy groups that told us that they wanted to open additional pharmacies but could not do so under the current restrictions.

Bill Butler: Do you think that you might be wrong in any way? I hope that there is at least some doubt in your mind.

Mr Whitworth: We do not take a long-term view about what is the ideal number of pharmacies in Scotland or Wales, for instance. However, we do believe that in the near term—in the two or three years after restrictions are removed—new pharmacy provision will come in and that some of it will provide lower-priced OTC medicines.

The—

Bill Butler: How do you know that?

Mr Whitworth: We have tried to reason it from the behaviour that we can already see in the market. In the past 10 years, there have been at least two major developments in pharmacy provision in the UK, namely supermarket provision and the development of new pharmacy chains by additional groups entering the market. We think that that would continue and probably be accelerated.

Bill Butler: As other members have mentioned and, I am sure, will mention, both constituency

MSPs and list MSPs on the committee have heard a great deal from pharmacists and patients who are concerned about the proposed deregulation. Pharmacists and patients fear that the proposal will lead to pharmacies being concentrated in out-of-town retail parks, which would be to the detriment of the disabled, the infirm, the poor and the elderly. As someone who represents a constituency with the second-largest concentration of retired people in the whole of Scotland, I obviously take those concerns on board. How does the OFT respond to those fears? Mr Whitworth's previous replies to my questions still seem to me to be too certain, too lacking in doubt and too full of mere assertion. How does the OFT respond to those real concerns?

15:00

Dr Graham: The modelling that we have done suggests that the removal of the controls of entry would not generate a dramatically different situation for small community pharmacies. In all probability, the availability of an outlet in an out-of-town shopping park will not knock out the pharmacy that is next to Bill Butler's constituency office if his office is in an inner-city area.

Bill Butler: There is more than one such pharmacy.

Dr Graham: The other thing to be said is that I am sorry if we come across as rather dogmatic, but the report is much more balanced than judgmental and argued. In these things, there is always a tendency for us to be perhaps too positive in our assertions to the contrary when we get a universally hostile response.

Bill Butler: At least you are used to it.

Dr Graham: There is a need to maintain a balance and to make a judgment call. We do not have a crystal ball to see the future. However, allowing for the fact that we did not adopt a consensual approach that involved speaking to everyone but tried to come up with a scientific, objective, research-based study, our interpretation of the material that we have collected is that the controls of entry should go.

The one caveat that I would make is that it is important that the remuneration package is balanced. The controls were introduced in 1987 when the remuneration basis was fairly ineffectual and inappropriate. That remuneration has subsequently been modified to the extent that the senior civil servant concerned thought that if the package were tweaked a little further, he would not need the controls of entry. In our view, that could be done, but I do not think that the controls of entry could be abandoned if we were to keep the present remuneration package frozen.

Bill Butler: In the friendliest way possible, as a former teacher of English, I would grade Dr Graham's ability to interpret as a C minus.

The Convener: On the back of that question from my colleague Bill Butler, let me say that it should come as no surprise that the Health and Community Care Committee's approach to the issue is from the point of view of the health of our constituents and our country. From the representations that we have received, that is clearly what most concerns our constituents.

On Bill Butler's point about access, the report itself assumes that between 400 and 500 supermarket pharmacies would open following market deregulation. The report says that such deregulation would have an impact on access to more localised pharmacies, and certainly to those that are around GP surgeries. The report also says that the vast majority of people currently access pharmacies after visiting their GP; they do not go straight from home. I think that all of us feel that those access issues would impact most on the elderly, the infirm and those who live in areas of deprivation, who are the very people who are key to improving the health of our country.

Your report estimates UK-wide consumer savings of approximately £30 million a year. That means that the figure for Scotland is approximately £3 million, which gives a ballpark figure of a saving of 60p or 70p for each Scot. Let us take the Scot who no longer has access to the pharmacy right beside their GP's surgery, who will have to take a bus to go to the supermarket, probably while infirm or elderly or ill. That one journey would obliterate any savings that might be made in a year. For that level of saving, why is it worth while obliterating a system that is an integrated part of the NHS in Scotland?

Your suggestions would have an impact on access, which would place other costs on patients and consumers, particularly those who do not have a car or access to a large supermarket. You seem to understand the price of some things, but you do not seem to know the value of anything. We are talking about the real value to our constituents of the community pharmacist. Bearing in mind the concerns that members have raised, is it worth while closing local pharmacies for a saving that is somewhere in the region of 60p per person per year? As I have said, certainly in Edinburgh, that saving would be obliterated by one journey.

Mr Whitworth: In producing the report, we spent a lot of time considering the access implications of deregulation, which is an important issue. It was not possible to model access at the detailed community-by-community level that we would have liked because we did not have access to pharmacists' business data, which are commercially confidential. Instead, we imagined

extreme scenarios and tried to consider their implications. For example, we imagined scenarios in which there was a lot of new entry to the market by supermarkets or by pharmacists in areas close to GP surgeries in which there were no pharmacies.

The general results were surprising—there were some implications for access, but they were not widespread or extreme. We also found that, on the whole, the access implications for those in vulnerable, low-income and elderly groups would be broadly the same as the implications for other people, because those groups are fairly well dispersed among the communities in which they live. Therefore, the impact on those groups would not be significantly differential.

We acknowledge that there might be access issues in some areas, but we strongly believe that health administrations have a number of levers at their disposal. My colleague Martin Graham mentioned the remuneration system—with a properly designed remuneration system, there could be support for community pharmacies. The essential small pharmacy scheme, which supports about 50 pharmacies in Scotland, is well tested and well established. We see no reason why that scheme could not be extended to cover urban areas or semi-rural areas in which there are pressures on local pharmacies. That would be a more effective way in which to meet the access concerns that the convener expressed than the general restriction on entry into the market, which has other effects that are harmful to consumers and possibly to health outcomes.

The Convener: Given your comments and the contents of the report itself, you seem to know the price of everything but the value of nothing very much. Anecdotal and other evidence and the representations that we have received from pharmacists and constituents suggest that individuals value their local community pharmacist. Your basket analogy—where you compared the cost of a basket of medicines from a supermarket with that from a local community pharmacy—misses out the advice role that is more prevalent within small local community pharmacies. Indeed, there seems to be anything up to 90 per cent consumer loyalty to those pharmacies, while supermarket pharmacies apparently have a high staff turnover rate and make greater use of locum pharmacists.

As a result, people seem more likely to get one-to-one care, which has a big part to play in health outcomes, at a smaller local community pharmacist than at a supermarket. That was certainly my experience when, after being told by a doctor that I had to take a certain amount of aspirin, I ran into a supermarket and grabbed some. It was two or three days later that I realised that I had taken the wrong strength of aspirin. If I had gone to a local community pharmacist, I would have been able to say, "This is what I need." Where does the role of such advice fall in your report?

Mr Whitworth: On the importance of the quality of pharmacy advice to community services, it is certainly true that—across the pitch—consumers value pharmacy advice. However, we did not find any significant differential that favoured one particular type of pharmacy outlet as against another. In other words, there was no consistent evidence that supermarkets were rated as giving poorer-quality pharmacy advice than community pharmacies. Instead, we found a mixed picture. When the matter was raised in discussions with health departments, they could not point to any significant work that they had undertaken that showed that the quality of advice was poorer in certain types of multiple pharmacy as against individual pharmacies. In fact, we heard some counter-arguments that people prefer the anonymity of the supermarket setting and perhaps prefer to access pharmacy advice in a slightly less sensitive environment. After all, such a visit might be combined with another shopping trip.

We found that the arguments played both ways and did not come to any view either way on what constituted the better outlet for community pharmacy advice provision. From my understanding, the health department feels that all the different approaches have their own strengths.

Shona Robison: I want to pick up on a point you made in response to the convener. Before regulations were introduced, did pharmacies not tend to cluster around GP surgeries to ensure that they were the first port of call? Therefore, given the balance of probabilities, is it not the case that the same situation will arise once the system is deregulated?

I am also astonished by your comment that remuneration schemes could be introduced to compensate for the fall-out of your proposals and to keep community pharmacies in areas where they are not profitable. Is it not bizarre to talk about schemes to sort out the problems that your proposals will cause? Is accepting that such schemes will be needed not an argument for not taking this approach in the first place?

Dr Graham: I would like to answer the second point. I apologise if I was misleading. Our view is that the remuneration package and the distribution of pharmacies are intimately linked. The 1987 regulations came in because of the cost-plus remuneration system that existed then. Those regulations have been adapted and we anticipate that they will have to be changed again if the controls are completely abandoned. I do not want to give the impression that that would be a

desperate, forced measure. It is natural that things should be in balance.

15:15

Mr Whitworth: I will respond on Ms Robison's other point, which was about clustering. We found evidence that life has moved on since 1987. That came through especially in the way in which consumers responded to our survey, which is dealt with in the second volume of our report. People are more mobile—they move around a lot more—and, in their minds, they have a wider range of possibilities for accessing pharmacy services.

The first of the three main access possibilities is the residential approach, which is based on where one lives. That is the 1987 approach. There is the work-based approach, which depends on where one works. It is a different matter if one is not out at work. The third possibility relates to where one shops. Our consumer survey gave us strong messages that all three points of access were important. We feel that that is where the 1987 arrangement fell down. It was very strong on the residential approach, but not so strong on the place-of-work and shopping approaches. A good proportion of the population both works and shops. In our view, the current system was not responding to that important aspect of consumer preferences at all.

How does that answer Shona Robison's point about clustering? If the existing controls were removed, which we believe should happen, not everyone would have such an overwhelming preference for getting their scripts dispensed as soon as they left the GP. We found that only about 50 per cent of people wanted a script dispensed as soon as they left the GP. The rest of the population was happy to get it at some other time. That is partly because many people have repeat prescriptions, which are not medically urgent. If one is on a course of treatment that runs for six months, it is just as convenient to get one's prescription at Boots on the high street in the town where one works, or as part of a shopping trip.

Shona Robison: Your response has confirmed that you are talking about two different types of population. The first type works and shops in out-of-town supermarkets. The proposals represent no problem for that population. We are concerned about members of the other population—the resident population—who are elderly, infirm and disabled. They will continue to use their traditional local pharmacy. Your response has confirmed that the proposals have not been designed to take account of their needs.

Dorothy-Grace Elder (Glasgow) (Ind): I wonder whether the witnesses are aware that car ownership in Scotland is still under 50 per cent, in spite of the great increase in car ownership that has taken place since 1987, which is the reason for the changed shopping patterns that they have identified. That increase in car ownership has affected mainly the affluent parts of Britain.

Mr Whitworth: We did not give specific consideration to the car ownership issue across different parts of the UK.

Dorothy-Grace Elder: Why not? That issue is vital to Scotland. In some of the housing estates in Glasgow, about 70 per cent of residents do not have access to a car, never mind owning one. The fact that you did not consider car ownership in Scotland answers my question.

I have a point of clarification. You said that, if your scheme were implemented, medicines would perhaps become cheaper in a few years. You did not specify the period. Surely you were referring to bulk buying, which would benefit only the supermarkets, not the smaller pharmacies.

Mr Whitworth: No. We do not consider that bulk buying is restricted to supermarkets. Some of the multiple pharmacies—the larger chains, such as Lloyds Pharmacy Ltd and E Moss Ltd—have considerable buying power. At the moment, for various reasons, they are not passing on the benefits of that buying power to those who buy over-the-counter medicines in their shops.

There are also schemes under which independent pharmacists are getting together to buy in large bulk. I think that the Vantage scheme is the best known. If such schemes develop over time, I have no doubt that there will be the opportunity to pass on the benefit of lower prices through those schemes.

However, we did not find that there was significant pressure—we go back to where we started—on the price of over-the-counter medicines because of the way that the restrictions effectively freeze competition for medicine prices. That was a major issue that we identified in the report. Freeing the market would put pressure on the large chains with buying power to pass on some of the reductions.

Margaret Jamieson: Paragraph 1.18 of your report states that you would expect an increase in the number of pharmacy outlets. We have been advised that the New Economics Foundation think-tank believes that if pharmacies were to follow the same decline as other high street retailers, which have declined at around 4 per cent per year, that would equate to one pharmacy per day being lost from the United Kingdom. Do you accept that view, or do you have another view?

Dr Graham: The New Economics Foundation's "Ghost Town Britain: A Lethal Prescription: The

impact of deregulation on community pharmacies" is an interesting report. It came out fairly promptly in response to our report. We reject quite a lot of the analysis in it. The New Economics Foundation has for some time been running a campaign about the decline of small retail outlets and what that does to local communities. We see retail pharmacy in a slightly different light. Bear in mind that 80 per cent of the typical retail pharmacy's business is dispensing and half of the other 20 per cent is medicine related.

It is interesting that the New Economics Foundation did not mention pharmacies when it produced its original report about the decline of retail outlets—"Ghost Town Britain: The threat from economic globalisation to livelihoods, liberty and local economic freedom"—which was only two or three months ago, just before we published our report.

"Ghost Town Britain: A Lethal Prescription" is an interesting read but, as far as I am concerned, there are no knockout blows in it.

Mr Whitworth: The issue is that pharmacies are in a special position because, throughout the UK, between 70 per cent and 80 per cent of their prescription business is not price related, because people are exempt from charges.

"Ghost Town Britain: A Lethal Prescription" says that local community pharmacies will survive only in the more affluent areas. That will just not happen under the present NHS remuneration arrangements, because the pharmacist's remuneration does not depend on whether the person who walks through the pharmacy door is wealthy; it depends on the actual value of the script to the pharmacist, which depends partly on the turnover of items that the pharmacist achieves. That is one part of the pharmacist's income. The major part of the turnover is the value of the drug that is dispensed. That is not related to the income of those who walk through the pharmacy door.

We are sceptical of that part of the NEF's report. The economics of community pharmacies are quite different from the economics of bakers, butchers and the other food-type high street outlets that have declined.

Margaret Jamieson: I will press you further on that, because that was not the view that you gave to us earlier, when you indicated that you had not considered the 80 per cent of the business that community pharmacies deal with, which was the NHS scripts. However, now, to talk down somebody else's contrary report, you say that that side of the business will allow community pharmacies to continue. It is a wee bit like having your cake and eating it.

Mr Whitworth: I suspect that there was probably a slight misunderstanding when I said that we did not look at the NHS prescribing business. We obviously looked at it in the round in considerable detail. We looked at the way in which pharmacies are remunerated, the percentages of scripts that are paid for or not paid for, and the split between repeat prescriptions and urgent prescriptions. Although we looked at all those things, we did not try to estimate what would happen to NHS business in the same formal way that we looked at over-the-counter medicines. I hope that it is possible to see that, undergirding our report, there is a clear understanding of how NHS dispensing sits alongside the other activities of community pharmacies.

Margaret Jamieson: I think that you would have found it more beneficial to have visited some of the constituencies that we represent. If you had done so, you would have found how vital the community pharmacy is to our constituents.

Time and again, patients, general practitioners and community pharmacists have raised the issue of the partnership that has been encouraged over the past few years in respect of the way in which the general practitioner transmits prescriptions to the community pharmacist. They have also raised the issue of the double-check mechanism. If the same pharmacist continually dispenses a person's script, errors that could take place are caught very quickly with no damage to the patient.

If a person takes their script to a different chemist every time, a greater margin of error exists. If someone does that, the chemist does not get to know the individual cocktail of medicines that a person can be on because of their various ill health problems. What price did you put on that?

Dr Graham: There is nothing in the report to suggest that those seeking to have a prescription filled will go to a tremendously wide and uncertain range of pharmacies.

Margaret Jamieson: If the community pharmacist had to close because there was insufficient money for them to continue, people would have to do that.

Dr Graham: I do not know that they would go to a succession of different pharmacies week after week.

Margaret Jamieson: They might well do and they would need to travel outwith their own communities to do that. The vast majority of people in my constituency do not live in the main town; they live outwith it. At the moment, we are fortunate to have at least one community pharmacist in each of the smaller towns. However, if their community pharmacy were no longer viable, people would have to travel 12 to 15 miles to have a prescription dispensed.

Dr Graham: The report is by no means intended to be an attack on pharmacists or an under-

valuation of the services that they provide. I said that we had only one recommendation, but we have two, although the second one does not affect Scotland. The second recommendation relates to doctors dispensing.

Essentially, our view is that the best way of delivering the service is for doctors to prescribe and for pharmacists to dispense. We believe that that is best done in a free-market commercial environment. Where that fails, the essential small pharmacy scheme can be used to make economic the provision by pharmacists. Where that scheme fails, one has to rely on doctors dispensing. If provision is viewed in terms of a pyramid, we see commercial provision by pharmacists as the best way of delivering the service, as that provision contains the very checks that the member mentioned.

15:30

Mr Whitworth: I will repeat what my colleague Martin Graham said a few minutes ago. The other point to make in this respect is that, even in a deregulated environment, the changes would not be particularly dramatic—they would be gradual over a period of time. We cannot envisage any possible scenario in which community pharmacy would melt down and disappear. Most community pharmacies are well supported by their local populations and that will continue if they continue to provide good and effective services.

The market is growing. We are talking about health care provision being uplifted, improved and increased. There should be room for everybody. There is no dog-eat-dog situation whereby if somebody comes in, somebody must go. We did quite detailed work in respect of new pharmacies in supermarkets and local community pharmacies, but we did not find the adverse business effects that community pharmacies are obviously telling members about and that they are certainly telling members' colleagues in England and Wales about, from what we have heard. We do not see such severe and drastic effects. On the other hand, we see a little more opportunity for new players to come in, more pressure to innovate, higher levels of quality and some other benefits that we have mentioned.

Margaret Jamieson: I am heartened by what you have said about everybody in Scotland and England singing from the same hymn sheet, which says to me that the OFT has got things wrong. The people whom you mentioned cannot all be wrong.

Mr Whitworth: We received one letter from a young man at the Robert Gordon University.

Margaret Jamieson: One letter—that is absolutely brilliant. I will remember that. Can we have his name so that we can write to him?

Mr John McAllion (Dundee East) (Lab): You admitted that your director general and the DTI have driven the deregulation agenda. In Scotland since 1999, successive ministers with responsibility for health have made it clear that they want to rid the NHS of the market mechanism and to dismantle completely the internal market. Community pharmacies are essentially part of the NHS and there are plans in Scotland to integrate them further into the NHS network of services. Given that, what weight did you give to the distinctive Scottish political situation in your report, and in making recommendations and drawing conclusions?

Dr Graham: I hope that I said that the director general is behind the report and that it reflects his views and commitment. We are certainly not working to a DTI agenda. The director general is appointed by the Secretary of State for Trade and Industry, but he is totally independent—he does not take orders from that secretary of state. He chooses topics for market investigation and is his own man. He is pretty much unfireable during his five-year term.

Mr McAllion: When you met Scottish ministers, was it made clear to you that the Scottish Parliament and the Scottish Executive had rejected market models for the delivery of NHS services?

Dr Graham: We do not see the study quite in that way. We are not carrying out some covert exercise to commoditise or marketise the health service—that is not what the study is about.

Mr McAllion: It sounds as if it is. This afternoon, you have talked consistently about customers, markets and deregulation. It sounds as though you are pursuing completely the opposite agenda to that which the Parliament is pursuing. Indeed, if we took you at your word and said that the services in question should be opened up to a free market for whoever wants to provide them, surely there would be a tendency towards monopoly, as there is in all free markets. Increasingly, the big national chains would become the main providers of services and the small community pharmacies would be knocked out of business. Such things happen in all markets. Why would they not happen in this case?

Dr Graham: The OFT has an anti-monopoly arm. We are one of the safeguards that ensures that competition does not end up at that extreme—

Mr McAllion: I can think of monopolies, or near-monopolies, in all sectors of the economy, with huge multinationals and national chains predominating and small retail outlets getting knocked out of the picture. If we listened to you, why would not that happen in this case?

Mr Whitworth: It would not happen partly because of the distinctive nature of community

pharmacy, which a number of your colleagues have mentioned. There is a relationship between the pharmacist and his or her team on the one hand, and those who use the pharmacy on the other hand.

Mr McAllion: You are now agreeing with us. You are now saying that the sector is not appropriate for market deregulation, which your report calls for.

Mr Whitworth: No—we are saying that both approaches can be pursued with mutual benefit. I know that some of your colleagues jibbed at what I said about improving health outcomes from a deregulated community pharmacy market, but that is the evidence that we found. In terms of access to medicines and the quality of pharmacy services, we found that there would be benefits in deregulation.

Mr McAllion: We, as a Scottish committee, have a problem because in an earlier answer to Bill Butler one of you accepted that your conclusions and recommendations were a judgment call based on little Scottish evidence. The Scottish NHS is distinctive—it has distinctive policies—but you are saying to us that we should follow a model that does not apply here and that nobody supports here. Why should we do that? Why should not we give more weight to the New Economics Foundation's report, rather than to your report, if you were just making a judgment call, as the NEF made?

Dr Graham: Ours is an evidence-based report.

Mr McAllion: So is the New Economics Foundation's report.

Dr Graham: No it is not—there is no new evidence in it. It is a good bit of polemic. It is a good read, and it has some good points, but I commend to you our report, which does stand up.

Mr McAllion: What was your evidence base in Scotland? It was minimal. Why should Scotland follow a model that is based on what is going on south of the border?

Mr Whitworth: If you look at our consumer survey in particular, you will see that the messages that we got from Scottish users of pharmacies—to use a more neutral term than "consumers"—were similar to messages that we got from throughout the rest of the UK. The sorts of things that Scottish users of pharmacies wanted were similar to what people in Wales, Northern Ireland and England wanted, as you would expect.

Mr McAllion: You are saying that Scotland is calling out for deregulation and the introduction of the market.

Mr Whitworth: No—that is not what we are saying.

Mr McAllion: That is what your report calls for.

Mr Whitworth: No. We did not ask questions about deregulation, as such.

Mr McAllion: So there is no support for the conclusions at which you have arrived.

Mr Whitworth: We asked questions about how people use their pharmacies, how important the availability and prices of medicines are, how important good quality pharmacy services are, and what advice was important and how they used it. At the end of the day, we felt that all that we heard supported the value and the benefit of deregulation to Scottish consumers. The report is evidence-based and it stands on all fours on that.

The Convener: How many Scottish consumers were involved?

Mr Whitworth: It was a UK-wide survey. I think that 1,500 households were canvassed; the Scottish weight was proportional to Scotland's proportion of the UK population, so 150 Scottish consumers were involved.

Mr McAllion: Was that use of the Barnett formula?

Mr Whitworth: I think the figure was 1,460 households, if you want to be precise.

Dr Graham: I will come back on that. "Regulation" is an emotive term. There is a simple recommendation in the report, which is that the control of entry regulations are not only unnecessary, but are undesirable and should be got rid of. Those regulations were introduced only in 1987 and, believe it or not, the world was turning before that; I am old enough to remember that pharmacy provision existed prior to 1987.

The Convener: However, we have also outlined in our comments that the world has moved on in terms of the role that we rightly expect professional pharmacists to play, through "The Right Medicine"—which is our strategy—and elsewhere in the United Kingdom. I do not think that anybody wants to go back to where we were in the 1980s with pharmacy services.

Fergus Ewing (Inverness East, Nairn and Lochaber) (SNP): Gentlemen, I am concerned about the impact that the recommendation would have on rural and sparsely populated areas. Perhaps I might explain briefly that I represent a constituency known as Inverness East, Nairn and Lochaber, which has a population of about 70,000 people, but is six times greater in area than greater London. We also have the highest mountain in Scotland, Ben Nevis, and the deepest loch in Scotland, Loch Morar, and if you live on the wrong side of the loch or the mountain it can be quite a long way to your local pharmacy as things stand, never mind under the new regime.

I want to go over a few points with you, if I may. The recommendation of the report is not borne out by your findings. First, paragraph 1.12 states:

"It is difficult to estimate precisely the potential benefits to consumers that would derive from deregulation".

The estimate that you make—for which you do not share with us the computation—is that there might be a saving of about £20 million on a market of £1,200 million, which is less than 2 per cent. That is highly speculative.

Secondly, paragraph 1.14 of your written statement says that none of the data that you have provided evidence of excess profitability. That contradicts directly your statement in oral evidence today that benefits have not been passed on to consumers. I presume that your written evidence takes precedence over your conflicting oral evidence. You say that your proposals would result in pharmacies closing down, but that that would be compensated for by an enlarged system of essential pharmacies. You do not say how many will close in Scotland or what the cost of the essential pharmacies would be. You do not say whether the costs would be greater than the estimated £3 million that the convener has correctly estimated as a ballpark figure of the notional putative savings that you say Scotland might make.

I have gone over those points briefly, but I would like to put one simple question to you. Do not you feel that the recommendation that you make is really not borne out by your own findings?

Dr Graham: I will probably have to ask Mr Whitworth to comment on that. He is the team leader and I was merely the branch director with overall responsibility. However, I think that I can address some of the issues. The estimate of benefits is transparent and it is all in the report. As we made clear, the figures that we come up with are minimum estimates so, on that basis, they are quite worthwhile. When we do a market study, our basic objective is to implement positive gains that would be greater than the cost of implementing them. The figure of £20 million or £30 million is therefore quite significant.

I am a little bit at sea—perhaps Mr Whitworth will be able to help me—on the conflict between statements that benefits are not necessarily passed on to consumers and the fact that we did not find evidence of high profitability. I do not find our conclusion on profitability to be at all extraordinary. In the NHS, there is a monopsony, or single buyer, that is in a position to extract any surplus rents from small pharmacies, and probably from large ones as well. That is certainly what the NHS is trying to do, so the fact that we do not find excess profits is not extraordinary, nor is it inconsistent with the view that it is not an optimal system and that further efficiency gains could be got out of it.

There is another point that is worth making. The really big gains from removing the entry controls are probably the dynamic ones. The figures that we come up with are fairly mechanical. Experience shows that, when you allow competition to develop in the market, the dynamic gains usually far outweigh the simple predictable or mechanical ones on which we provide the estimate.

Mr Whitworth: We did not find excess profits in the system. In a more liberalised and more deregulated community pharmacy environment, there would be more pressures to improve efficiency and therefore to deliver outcomes at lower cost. One of those pressures would obviously be increased pressure on the multiples to bring down the prices of their over-the-counter medicines, which would be beneficial to consumers.

As to whether the benefits are sufficient to outweigh possible costs, I can say only what we have said all afternoon: we had to make a judgment. We could not put hard and fast figures on all the costs and all the benefits, but we identified and quantified sufficient benefits, albeit at a conservative level.

15:45

The costs related largely to access; the detailed work that we undertook on access suggested that any losses would be local and restricted. We do not think that an area such as Mr Ewing's constituency would be significantly affected, because it is a rural area in Scotland and such areas are largely unaffected by the regulations. An existing system for supporting small essential pharmacies in urban and semi-urban areas could be targeted effectively on areas that have access problems.

Mr Ewing said that £3 million was a small amount for Scotland, but the total expenditure on the small pharmacies scheme in Scotland is only about £350,000 a year. Even if £3 million were set against a doubling of the value of that scheme to £700,000, a significant net gain would be made in terms of pounds and pence.

Fergus Ewing: I thought that the evidence was thin and what I have heard has not fattened it. You advocate removing regulation, so should the task of regulation in promoting and maintaining competition in an industry

"belong to the regulatory authority for that industry"?

Dr Graham: Regulation is a broad term in the subject under discussion. The OFT is the competition authority for the UK. The objective of market studies is to examine markets or regulatory

regimes and to work out whether they work well for consumers. I am sorry that you dislike our report, but we consider ourselves to be well placed to make such judgment calls. You will certainly not obtain a comparably objective view by approaching the professional bodies for pharmacists, doctors or dentists.

Fergus Ewing: I asked the question because I was not giving my view, but quoting the view that is expressed in the book called "Privatization: An Economic Analysis", which is by Mr John Vickers. His view is that regulatory authorities have a role. I note that you do not share that view; I hope that you do not get into trouble for that act of mutiny.

Dr Graham: I will probably be hung up by my thumbs when I return.

The Convener: That will save us the job.

Fergus Ewing: For my final question, I will stick with Mr Vickers. I gave the witnesses notice before the meeting and earlier today of what I planned to discuss. I understand that Mr Vickers admitted after the report was initiated that he had advised a supermarket or supermarkets.

Dr Graham: John Vickers is unique among directors general of fair trading. We have in the past had lawyers, accountants and administrators, but he is a professional economist and an academic economist. All academics do consultancy work and John Vickers has acted as a consultant to supermarkets. I understand that that related to supermarket mergers and acquisitions. That is not exactly shock news about a competition economist in his area—it is what would be expected. I believe—Mr Whitworth can say whether I am wrong—that John Vickers stood aside from considering the recent Safeway acquisition. The question is probably for Mr Vickers to answer, but the study was of pharmacies, and I see no conflict of interest.

The Convener: The matter is about pharmacies, but your report assumed that between 400 and 500 supermarket pharmacies will open, following market deregulation. All the information that we have heard from pharmacist organisations is that, in terms of the footprint of people entering supermarkets where there is a pharmacy—as opposed to those in which there is not—there would be an increase of about 1 per cent. The impact for supermarkets is not just about how much money they will make from their pharmacy sales; rather, it is about how much more money they will make when customers pick up apples, bread and milk, because they are in the supermarket getting a script filled. The issue is also fundamentally about supermarkets.

Dr Graham: Let us get the matter in perspective. When John Vickers becomes director general, he relinquishes his other interests, just as all his predecessors did. Gordon Borrie was a lawyer; if you look through his record you will probably find that he did work for Tesco in 1960 or something, before he became director general. I am not particularly competent to talk about this, but it seems that things have got a little out of perspective.

Janis Hughes (Glasgow Rutherglen) (Lab): I will pick up on a couple of points about access in your report. Your report says that if localised problems with access occur, they could be tackled through specific schemes. You cite the fact that the average independent pharmacy is open for about 50 hours a week, which provides limited access, whereas supermarkets allow for greater opening—for 80 hours a week, for example. On some of the evidence that you have been given about car ownership and access to cars, it would not matter whether access was increased to 24 hours, seven days a week. If someone cannot get to a supermarket on the edge of town or in another town, 24-hour access is not beneficial.

Your report covers the cost of the current system. You talk about administrative savings that might be made and you quote a figure of £10 million in NHS administration costs. I worked in the health service for 20 years; I trained as a nurse, so I feel that I am qualified in some way to make assertions about this. It is my belief that there would not be savings, because the detrimental effect on the health of people who would not be able to access pharmacies outwith their communities if community pharmacies closed would far outweigh any longer-term cost savings to the NHS. Will you comment on that?

Mr Whitworth: I will deal with the point about access. It has been said that it is all very well for supermarkets or new discount pharmacies to enter the market and to open for longer hours, but if they are not in the right places, people cannot get to them. We are not denying that that could be an issue. We are saying that access is a mixture of issues. It is not simply about whether there is a pharmacy sufficiently close to where people live.

There is also the question of the services that are provided by the pharmacy, its opening hours and issues of convenience. We are saying that the debate on access that takes place in the profession—and which took place around the time of introducing the regulations in 1997—needs to take into account more than just the physical location of a pharmacy. We are not saying that location is not important, because 50 per cent of people say that it is very important that when they leave their GP's surgery, they can get their script dispensed quickly and conveniently. We do not deny that and we can see that it is important.

We are not saying that the points that Janis Hughes raised on access are not important; rather

we are saying that there are mechanisms that are in the gift of the health departments for dealing with specific and local access issues. If there is not going to be a meltdown of community pharmacies—which we strongly believe there will not be—there can be only local access issues and we think that they can be addressed by the remuneration system and the essential small pharmacy scheme.

Martin Graham might want to comment on the question whether the administrative savings are outweighed by wider costs to community health. That is a judgment call that we, as an office, cannot easily make because we do not have expertise in all those areas.

Janis Hughes: Did you take advice from health professionals on that matter?

Mr Whitworth: We certainly shared our broad conclusions with health professionals, but we did not ask them to put values on individual scenarios for different health outcomes, which could move in several different ways, as we have tried to show during this discussion. There could be positive health outcomes, such as the ones that we have mentioned, and there could be negative outcomes if there were localised problems of access. However, we think that mechanisms exist that could deal with such problems.

Janis Hughes: I know that the OFT's role is not specifically to plan services, but surely the strategic planning of services for the future would be a vital factor to take into account when considering potential savings. I am sure that the OFT would not just narrow-mindedly focus on making savings of, for example, £10 million now or in the next five years but not care about what might happen in the next 10, 20 or 30 years. That would be a false economy in anyone's books.

Mr Whitworth: We can only agree. What the director general says on the first page of our report—and what we try to say throughout the report—is that, on balance, no clearly adverse health outcomes would arise from our deregulation recommendations. We believe that health departments have the tools and the ability to deal with any local access problems that might arise and that all other health outcomes would be broadly positive. However, we cannot put a value on how positive those outcomes would be because we are not specialists and cannot do the detailed valuations of health improvement scenarios that health departments are able to do. However, I am sure that part of the commentary that you will get from the Scottish Executive health department will be along those lines.

Dr Graham: The point has been made forcefully during the meeting that things have changed since 1987 and that one of the big changes is the commitment to a more integrated system and "The Right Medicine" strategy. However, our view is that the 1987 control of entry regulations are not needed to implement "The Right Medicine" strategy. Such a strategy could not have been run, for example, in 1985, when entry controls would not have been a condition of the programme.

Janis Hughes: It is a well documented fact that there is a shortage in the health sector of certain professional groups of staff, including pharmacists. Would not deregulation have an adverse affect on attracting skilled staff and on their availability, particularly in remote areas? Would not it be difficult to staff all the pharmacies that might set up if deregulation took place?

Mr Whitworth: We considered work-force issues in the third volume of our report, which has a long paper on work-force issues throughout England, Wales and Scotland. We did not do a separate study on Northern Ireland.

It is obvious that several important things are happening within the pharmacy work force. Members will be aware that there was the issue of the so-called fallow year south of the border, whereby all pharmacy students were required to stay on at university for an additional year. The total number of pharmacists who came into both the community sector and the hospital sector, which competes with the university sector, fell from 1200 to 150 because only Scottish graduates were available. That certainly put a lot of pressure on pharmacy recruitment throughout the UK. We had representations from Scottish pharmacy groups on that issue in particular. For example, we were told—not by Boots, but by another group—that, in Scotland, Boots is having difficulties such as it has never had previously in recruiting pharmacists.

16:00

We are well aware of pressures on the pharmacy work force. I have to say—I am pretty sure that the director general would say this, although he would probably say it better than I can because he is smarter—that we feel that the deregulation argument cuts both ways on work-force issues. In a deregulated set-up, there is a tendency for skilled professionals to be directed more forcibly or accurately to the areas where they are most useful. In so far as deregulation would sharpen up the issues around the work force, we think that that might be better for community pharmacy. It would mean that where community pharmacies were most valued by patients and consumers and the demand for their services was greater—that might be reflected in their wages, but it might not be; I do not have a view on that—pharmacists would be, as it were, directed to those areas. I do not think that deregulation is made

more difficult because there are work-force shortages. It is possible to argue the opposite: when resources are scarce, it is better that they go to the areas where they are most required.

Our view is that although the work-force issues are very important and must be thought about, they are not an argument for not deregulating, which is what some pharmacy groups have suggested to us. They have said that deregulation should not take place because there is already a shortage and deregulation will make it worse. We do not think that that will happen. Deregulation will mean that pharmacists will go to the areas where they are most valued.

Janis Hughes: Is that borne out by evidence that you took from professional bodies, or is it your own opinion?

Mr Whitworth: We talked about the future supply of pharmacists. I know that there are proposals for opening two more schools of pharmacy in the UK over the next 10 years. Another issue is to what extent it is possible to add to the number of domestically educated pharmacists by having pharmacists come in from outside the UK, in particular from other European Union countries. That is certainly happening in north Wales, where a significant number of EU pharmacists have arrived and provide a good service; they do not provide a substandard service.

We considered that issue. We did not think that the work-force issue was a fundamental issue that should stop us from recommending deregulation.

In practice, the changes following deregulation might happen fairly slowly. If someone wants to come in and open up a new pharmacy business or set of businesses, they would have to find pharmacists to staff them, which takes time. That might be a good thing, because it would mean that the changes would take place in a measured and gradual fashion. That would be helpful.

Mary Scanlon: I will raise a point that arose from your discussion with Bill Butler. I have evidence about the difference between prices in community pharmacies and those in Asda and Tesco for the top twenty analgesic cough and cold lines and gastro lines. I am surprised to see that many of the items are more expensive in Asda and Tesco. I do not have time to read through the lists, but in particular Nurofen and other ibuprofen products are more expensive. Very few medicines are much cheaper in Asda and Tesco.

The Deputy Convener: For the record, will you say from where the figures originate?

Mary Scanlon: The figures come from Boots. I am happy to pass the information to the witnesses.

Mr Whitworth: We have not seen that information, so it would be helpful to get it.

Mary Scanlon: Have you consulted the supermarkets to ask whether they will be willing to provide services to people who are on the methadone programme, the needle exchange programme or those on nicotine replacement therapy or who want emergency contraception and so on? Are the supermarkets more likely to cherry pick the more profitable services and ignore the advisory and other services that are based on need rather than profit?

Dr Graham: No. Our study did not address that issue, which is one of the accusations—if I may call it that—that is made in the New Economics Foundation's report. The issue is interesting, but I do not think that we picked it up in our report.

Mary Scanlon: Were the supermarkets consulted about whether they would be willing to provide the methadone programme and needle exchange. Did the OFT work with them?

Dr Graham: I do not think that we were aware of the precise issue that the New Economics Foundation has raised when we published our report.

Mr Whitworth: If I may put it like this without sounding silly, we took the view that our deregulation recommendations are colour-blind: that is, we did not consider who would come in and provide additional pharmacy services in a deregulated environment. It could be the young man from the Robert Gordon University—

Mary Scanlon: Who was the only person in Scotland who agreed with you.

Mr Whitworth: Good for him—perhaps one or two of his colleagues might join him. There is also a pharmacy school in Glasgow, so perhaps he could be joined by a colleague from Glasgow. There would then be two of them.

Perhaps a high street discount chain, such as Superdrug, could enter the market. Over the past 10 years, Superdrug has bought 200 pharmacies throughout the UK, including in Scotland, so Superdrug would be able to launch a discount chain of pharmacies. At the moment, Superdrug's prices are pretty much the same as any other chain's. Perhaps 300 or 400 supermarkets might enter the market. We do not take a view as to who will provide the additional pharmacy services.

Mary Scanlon: Mr Whitworth has not addressed my point. Under "The Right Medicine" and the action programme, which set out Scotland's pharmacy strategy until 2006, pharmacists are investing in their property to provide consulting rooms in which they can help people who are on the methadone programme or who require needle exchange or emergency contraception.

If the market is deregulated, will the supermarkets be able to cherry pick the profitable services, or will anyone who has a pharmacy licence be required to provide all those services? That is our concern.

Mr Whitworth: We were asked that question in Wales—

Mary Scanlon: The question comes not from the report but from the pharmacists themselves.

Mr Whitworth: I will say what we said to your colleagues in Wales. How services are organised, delivered and promoted is primarily a matter for health departments to decide on with contractors—after all, those relationships are contracts. A contract can either specify a lot of services or a few services. The health department can say that there is a core pharmacy service—

Mary Scanlon: Could the supermarkets cherry pick the profitable services and leave aside things such as the methadone programme, morning-after pill and needle exchange?

Mr Whitworth: Our office does not take a view on that. That would be a matter for health departments.

Mary Scanlon: But would it be possible?

Mr Whitworth: That is a matter for health departments. If everybody were contractually required to provide the whole range of services, we would not take a view on that either way, provided that everything was set out sensibly and understandably.

Mary Scanlon: Were the supermarkets asked whether they would participate in such programmes?

Mr Whitworth: We have not discussed cherry picking with supermarkets.

The Deputy Convener: It is interesting that we come to a close on that subject, which concerns what services would be provided if deregulation were to come about. The committee is as one in not wishing to see the OFT's report being implemented in Scotland. However, we will deliberate on that.

I thank the witnesses for coming to Scotland and for giving us a considerable amount of their time in explaining their report.

Mr Whitworth: Thank you. It has been a robust session, but I think that we both profited from it.

The Deputy Convener: I am sure that you enjoyed it.

16:08

Meeting suspended until 16:16 and continued in private thereafter until 16:24.

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