THE OFT HAS DROPPED A BOMBSHELL ON COMMUNITY PHARMACY

Kirit Patel, chief executive of Day Lewis Ltd, says that in the light of the report on control of entry from the Office of Fair Trading, community pharmacists should hope for the best but plan for the worst

On 17 January the Office of Fair Trading (OFT) dropped a bombshell on the community pharmacy sector. I was one of the stakeholders invited to the launch of the long-awaited report investigating control of entry. I do not believe that anybody present expected a total abolition of all regulations controlling entry. To quote John Vickers, Director General of Fair Trading: "There is no question about the importance of the provision of high quality pharmaceutical services to the community, and the industry's commitment and professionalism in providing them. The question is whether the regulations that currently control entry into the industry are unduly impeding the way that the market works — to the ultimate detriment of the public. Our study leads us to conclude that the control of entry regulations should be lifted. They inhibit price competition. They stifle efficiency improvements and innovation. They limit the availability of pharmacy services. And they impose substantial regulatory burdens."

MAJOR RECOMMENDATION

The report then goes on to make one major recommendation: that the control of entry regulations across the United Kingdom be ended, thus allowing all registered pharmacies to dispense National Health Service prescriptions. It also calls for an end to controlled area regulations for England and Wales and for arrangements covering dispensing doctors to be left to the Department of Health.

The OFT recommendation deals with pharmacy related issues only. While removing control of entry across the UK, the OFT has opted to leave the current requirement of registration of pharmacies and pharmacists as it is. It made it clear that all registered pharmacies may dispense NHS prescriptions.

Ending controlled area regulations unshackles all current requirements affecting dispensing doctors and pharmacies in rural areas. A dispensing doctor should not be prevented from providing pharmaceutical services to those within a one-mile radius even if there is a pharmacist in the neighbourhood. Neither will the presence of a dispensing doctor or pharmacy in a rural area prevent the others from providing full services. However, the OFT left arrangements for dispensing doctors to be a matter on which the DoH should take a view.

At the launch, I asked Martin Graham, who chaired the meeting, whether in deregulating one sector in favour of competition, the OFT was paving the way for the creation of a possible monopoly, in this case for in-surgery pharmacies owned by doctors. What was to stop all surgeries from setting up their own pharmacy corporate bodies in urban areas and dispensing doctor practices in rural areas?

Mr Graham responded that no evidence had been found that would lead to such a situation, which I find surprising. In Midhurst, Sussex, for example, doctors acquired the smallest of the three pharmacies in town and relocated it into the surgery, thereby killing off our shop and damaging the local branch of Boots The Chemists. The National Pharmaceutical Association has now amended its rules, making 51 per cent ownership by pharmacists a requirement for membership. This was done in the wake of a surge in membership applications from doctors.

One of the reasons stated at the meeting by Charles Whitworth, who headed the OFT inquiry, for the abolition of the control of entry was that it would help reduce the drugs bill. It is common knowledge that dispensing doctors' drug costs are much higher then those of GPs whose prescriptions are dispensed at community pharmacies. The Department of Health knows this, too. I believe that the OFT has got it wrong. I predict that doctors will divert the income stream from the pharmacy sector either by owning the pharmacy or by charging extortionate rents and premiums. Also the Government will play into the hands of doctors, thus making them far more powerful than they already are.

Under the NHS plan, 750 primary care centres are planned and a number of them are to have a pharmacy. It is the developers funding these projects through LIFT (local investment financial trust) and not the DoH that will decide who gets the contract. No amount of tendering from a multiple or independent contractor will be entertained if doctors decide upon owning the pharmacy.

According to the OFT, the abolition of resale price maintenance did not result in any significant reduction in the prices of pharmacy medicines. But by allowing supermarkets to have a pharmacy, they project a savings to public of £25m in P medicines and a further £5m in general sale list medicines. In a total market worth £1.8bn, this is a relatively small saving when one considers the quality of service and free advice that an independent community pharmacist provides while making a sale.

How can one compare health advice from a pharmacist in a local area to that provided impersonally at any major supermarket pharmacy? More likely than not, when the current restriction on the display of P medicines is changed, consumers will be able to pick up medicines from open display. This could prove to be detrimental to the patient's health in the long run, because medicines would be taken without proper advice. This would then contradict the OFT view that easy accessibility of over-the-counter medicines would improve public health, as suggested by Mr Whitworth at the stakeholder briefing. The reasoning for allowing supermarkets to have pharmacies in order to achieve this saving of £30m in OTC medicines market is short-term thinking. I predict that the cost in secondary care as a result of taking medicines without proper advice will negate this saving many times over.

CONSUMER SURVEY

The OFT quoted its own consumer survey, which found that not everyone preferred having their prescriptions dispensed in the in-surgery pharmacy. According to Mr Whitworth, only 46 per cent of consumers when questioned said that they preferred to do so. In reality, this is not the case. My experience shows that over 70 per cent of the prescriptions are dispensed within these pharmacies. The percentage is even higher when the doctors own the pharmacy. It is often the doctor's receptionist who has the greatest influence as to where the prescription is directed and hence dispensed.

The OFT stated that it wishes to encourage entry of more pharmacies at lower costs. I find this surprising considering the high premiums and rents currently charged by doctors and developers. The OFT, when questioned on its investigation into these extortionate rents, responded by stating that it was for the market to decide. I wonder which start-up pharmacy would have strong enough covenants, let alone the courage needed to sign up to the onerous term of leases offered to them. The OFT may well end up creating a monopoly where most pharmacies would be owned either by the national multiples, supermarkets or doctors. The Government will end up paying more for the pharmaceutical services, since any future cost of service inquiry will have to take into account the additional cost of premises. As if that were not enough, district valuers have been reappraising the rateable values of "in-surgery" pharmacies and this has resulted in substantial increases in the uniform business rate. Furthermore this would lead to the polarisation of services in or near surgeries, supermarkets and high streets.

The OFT recognised the pharmacy workforce shortage, but argued that the

availability of pharmacists would control the opening of new pharmacies. I believe there will be an influx of foreign pharmacists to fill the gap. The OFT is also of the opinion that pharmaceutical services in certain areas can be safeguarded through the current Essential Small Pharmacies Scheme and dispensing doctors.

One of the other reasons given for scrapping control of entry was the regulatory burden to NHS in the order of £10m to cover NHS tribunals, appeals authorities etc. If I may quote Charles Whitworth again: "High Court judges should not get involved in determining the provision of pharmacy services." Surely there is a better way of easing the complex regulation than bringing about an abolition and thus creating an unlevel playing field in the industry.

Many pharmacists consider the goodwill value of their business as their future pension. This has been destroyed overnight. If the Government wishes to encourage public-private partnerships, then surely it is not by taking away the very security the banks rely on in financing start-ups and acquisitions. What will the wholesalers do when their loan guarantees are called upon? Which entrepreneurial individual would risk his livelihood in a business start-up that offers no long-term security? To open any pharmacy from scratch would require a minimum of £100,000 to fund the legal costs of renting premises, fitting out costs, inventory costs, installation of all computers as well as funding the NHS debtors. The owner would also need to fund the negative cash flow generated until a breakeven point is reached. To raise this amount of money, a pharmacist would be required to give a personal guarantee to the bank and suppliers. When the business becomes successful and viable, what is to stop another individual from opening a new pharmacy next door, thus bankrupting the original retailer?

Flawed argument

I also believe that the OFT's argument that its recommendation will allow new entrants is flawed: it will only allow larger players and doctors at the expense of independent community pharmacists. The OFT made it clear at the hearing that the competitive tendering for a contract in the health centre was of no concern to it. I certainly hope that I am proved wrong and that the DoH can recognise the shortsighted thinking of the OFT and intervene. It should, if it wishes to implement the Government's health agenda successfully, influence the Department of Trade and Industry over the next three months. It should not fail to recognise the damage that will be done to the pharmacy infrastructure if doctors are to be allowed to own pharmacies in health centres and all supermarkets are allowed to dispense.

I have little doubt that the DoH will use the OFT's recommendations to drive through some harsh terms in the new pharmacy contract. Thus we must be prepared to do more for the same money. This is the price we will have to pay if we expect the DoH to help resist this change.

My advice to pharmacy owners is to check if they are situated in the best location and whether they are vulnerable. It is time to revert back to our core business. Competition from supermarkets and the high street is looming. I believe that we have nine months to a year to put our houses in order if we are to militate against losses in sales due to competitive prices. One should look to reduce unwanted overheads and make businesses leaner. One should reduce space allotted to toiletries and sundry items and increase the space allocated to medicines. We must revise staffing levels, especially at off-peak hours, and make some harsh decisions if need be. Leaving it until next year could be too late. Pharmacists thinking of selling their businesses may have left it too late, as the market is well down. Goodwill values have already fallen by 20 per cent and are likely to fall even more if the recommendation is accepted. Many national and regional multiples have suspended buying pharmacies and I can predict a surge in application for new contracts by supermarkets and the national multiples. Developers and doctors surgeries will be the first point of target. My advice is to hold back on unwanted capital expenditure not related to increasing sales. But check to see if the shop can be relocated to a better location. Plan for the worst and hope for the best!

Advertisement

THE OFT REPORT IS THE BEST THING THAT COULD HAVE HAPPENED

John Evans, superintendent pharmacist at Asda, explodes a few myths

Let us be very clear: the Office of Fair Trading report on the control of entry regulations and retail pharmacy services in the United Kingdom is not about supermarkets and small pharmacies. It is about the future of our profession. For too long, community pharmacy has been inward looking just trying to protect — an unsustainable position which benefits a few and restricts the majority of pharmacists.

What we should have been doing is moving with the times, challenging the status quo, ridding ourselves of Luddite practices, being innovative, improving our services and showing our true value to our communities. Rather than thinking about the patients, there are too many personal interests at stake. As a profession, we have cried wolf for so long and on so many occasions that we have now lost credibility. When we were battling to retain resale price maintenance, it was said that hundreds of pharmacies would close. Did it happen? No. And now more myths are being dreamt up to look after the few. Let me explain.

Myth 1 — Pharmacies will close resulting in a poor service to patients Relaxation of control of entry will result in more pharmacies not fewer, which will give a better not worse service to customers and patients, but do not take my word for it — read the OFT report. Pharmacies in rural areas or where they are considered essential should remain supported by the Essential Small Pharmacies Scheme and this should be better funded by increased contributions from the global sum.

Myth 2 — It will lead to the demise of the independent pharmacist On the contrary, keeping the current legislation will be the demise of independents in the next 20 years, resulting in only multiples owning pharmacies. The only independents who benefit from the current stagnation are the existing contractors who eventually sell their contracts to the highest bidder.

Let us consider this. Control of entry came in 16 years ago in 1987. The average pharmacist registers at 22 years of age. So any pharmacist who is 38 years old or younger (which is over 46 per cent of pharmacists) would only have been able to own and run their own pharmacy in three ways: (i) if they inherited one, (ii) if they were lucky enough to have successfully applied for, and been granted one of the few new contracts, or (iii) if they had been rich enough to pay hundreds of thousands of pounds for an existing contract.

This will continue to be the case until the "39 years and older" pharmacists retire. And to whom will they sell their pharmacies? Only the multiples can afford them. Even if every supermarket had a pharmacy, they would still be a minor player in terms of numbers.

Myth 3 — Young pharmacists will not want to risk opening a pharmacy when there is no protection to the business It will be much easier and cheaper for young pharmacists to open a pharmacy now because there is no contract to pay for and therefore less risk if it fails. It will enable pharmacists who have an idea to try it. Yes, a minority will fail, as they did before 1987, but many will succeed, bringing with them competition and a new way of pharmacy.

Here is more proof. The Young Pharmacists Group has a prospectus (which can be viewed at www.ypg.info/pharmacyproject/ypgprospectus.pdf) called "Investing in the future of pharmacy". The YPG believes "that the recent period of change within health care provision has provided some significant opportunities for those in pharmacy who are prepared to push forward the traditional boundaries" and that "many of the reforms will not only be a benefit to patients but also to the wider profession". It wants to open a pharmacy where it can trial new models of practice, but it cannot because it has not been able to acquire an adequate level of financial support to acquire a pharmacy. Yet again, innovation is being stifled.

Myths 4 — There are not enough pharmacists already, without having any more pharmacies First, we need more pharmacies. We have one for every 5,000 people in the UK, which is worse than many of our European neighbours including Germany, France, Ireland, Italy and Spain. The number of pharmacists will be a rate-limiting factor and it is possible that salaries will rise accordingly.

However, I believe that there will be a net increase of around 130 pharmacies each year (as in the five years to 1985) so we may need an extra 260 pharmacists. We have just survived the fallow year and the Register of Pharmaceutical Chemists shows that, normally, there is a net increase of 575 new pharmacists each year, even before the new schools of pharmacy come on stream. We just have to get better at keeping them in the profession. The current national contract encourages us to count tablets and type labels most of the day, and that would not make me want to stay.

Myth 5 — The goodwill value of my pharmacy will decrease overnight The price of buying a pharmacy business will decrease, but it will reflect the true goodwill value that it is worth as opposed to the inflated value that has resulted because of the scarcity of dispensing contracts. True goodwill values will be the same as with any other business. The Royal Pharmaceutical Society database shows that only 17 per cent of pharmacists are "pharmacist proprietors". I sympathise with those who have missed out on selling their businesses at a higher price, but this price was thanks to the extraordinary and unintended windfall given to them in 1987. Customers have not gained by this, but many ex-proprietors have.

We have an example where a contractor appealed against our application for a contract citing that his pharmacy was in the best location and there was no need for another, even though the application had huge community support. As soon as he won the appeal, he wrote to us asking if we would give him space in our store for his pharmacy, as he "would always appeal against any application" that we would make.

The truth is that pharmacies will always be where they were 16 years ago, frozen in time, irrespective of how things have changed unless these regulations change. Customers tell us that they want and expect to find pharmacies in an accessible and safe environment, at a time and place that they want. Sounds familiar? You will find that "Pharmacy in the future" in England and "The right medicine" in Scotland both want the same.

WHERE DO WE GO FROM HERE?

I wrote earlier about pharmacy always looking inwards, wasting our energy, time and money protecting things that we wrongly think are our given right, like price fixing of medicines, like limiting where the competition can compete. We must instigate changes and start swimming upstream. We are always on the back foot whinging and whining about being "done to". It is time that we stopped being victims and started taking the profession forward, and giving our young pharmacists a profession to be proud of, making them want to stay as pharmacists.

The first step is to get a new national contract that does not reward us for being dispensing machines and gets us away from being tied to the dispensing bench — let us leave that to technicians and robots.

It is about time that we stopped being subservient to general practitioners and started doing what we are trained to do. Let us take prescribing by the horns and really manage medicines from start to end. There is a lot to think through and it will not be easy. The big question is, do we have the bottle?

OFT REPORT HAS BEEN DRIVEN BY COST CONCERNS, NOT CONSUMER BENEFITS

Mahesh Shah, managing director of Nucare Plc, is disappointed by the conclusions of the Office of Fair Trading's report, which, he says, is inherently flawed

I am disappointed by the Office of Fair Trading's recommendation that the control of entry regulations for community pharmacies in the United Kingdom should be abolished. At the start of the OFT investigation, Nucare maintained that abolition was likely to have the greatest detrimental impact on the independent community pharmacist, hence our determination and lobbying of the OFT to present and highlight the views of the independents. We are disappointed that the ethos and methodology of the investigation did not reflect this.

The OFT report is inherently flawed because it concentrates only on competition and price issues. In addition, we are not operating in a truly open market; it is a distorted market dominated by one player — the National Health Service. If this report is accepted, we could see the emergence of pharmacies moving into or close to surgeries and contracts being given to those pharmacists with the deepest pockets, thus creating new and different barriers to entry.

What is more, there is no evidence to suggest that the present regulatory system does not work. Since its inception in 1987, hundreds of contracts have been awarded and there has been no suggestion that the public has had trouble in obtaining pharmaceutical services.

Set out below is my initial response to the recommendation and report:

The OFT report is flawed At the briefing to stakeholders, the OFT admitted that health care and health care policy were not the primary drivers of the report. The report focused on competition and retailing issues only. It was driven by cost considerations and "would not be worth anything if it results in increased costs of (essential small) pharmacies". In other words, the report's recommendation is driven by cost concerns rather than consumer benefits.

The OFT has not really taken any account of the structure for the provision of health care services Community pharmacy operates in a monopsony situation, where there is one predominant purchaser of prescription services — the Government. The source of prescriptions is via general practitioners, who do not have freedom to open surgeries wherever they like. GPs need permission from health authorities as to where they can operate and there are areas where they are not allowed to open. This is entirely sensible because it ensures rational distribution of medical services. Thus, it is inconsistent that consumers should not benefit from a policy that encourages rational distribution of pharmacies. The OFT proposals would leave it open to market forces to determine the fate of distribution of pharmacies.

Accepting the OFT recommendation will inevitably lead to pharmaceutical services becoming a commodity Here the focus is on absolute costs rather than a focus on cost-effective health care. It has been said that drug costs are already too high, but there is plenty of evidence to show that drug treatment is far more cost-effective than most other treatment options.

There is no evidence to suggest that the present regulatory system does not work. . . . hundreds of contracts have been awarded and there has been no suggestion that the public has had trouble in obtaining pharmaceutical services

The OFT report concedes that it is difficult to estimate the potential benefits that consumers would derive from deregulation There is no evidence at all that members of the public have had any difficulties in obtaining full pharmaceutical services and it is a high risk indeed to recommend the complete reversal of a system that has worked well to date. Since the new regulations have been introduced, hundreds of new contracts have been granted where they have been deemed necessary or desirable.

The OFT uses tenuous grounds of access, suggesting that the longer supermarket opening times are a benefit to consumers Pharmacists have long been providing rota services, and 24-hour emergency pharmaceutical services are available everywhere. It would be interesting to look at the evidence of whether or not there is a real need for pharmaceutical services late at night. The evidence from rota pharmacies suggests that such demand is low. However, if there is sufficient evidence to support the assertion that longer opening hours are required, this could be accommodated by existing pharmacies; indeed it already is where there is local demand.

The OFT estimates consumer benefits in the order of £30m per annum The extrapolations are based on many suppositions. In the United States, where there are no restrictions in the sale of over-the-counter medicines (ie, they can be purchased from any retail outlet, petrol forecourt, etc), the costs of such medicines is substantially higher. Secondly, the promotion of cut-price medicines may lead to excessive or inappropriate use of medicines. There is a danger that medicines will be purchased because of a "sale" rather than because their purchase is necessary or appropriate. This would easily negate the "savings" and may indeed lead to other costs, which would be an additional burden on the NHS.

The OFT contends that greater competition would lead to a better service In a survey conducted by Nucare, 82 per cent of independent pharmacy respondents said that they would reduce their investment in the business and only 3.5 per cent indicated that they would increase investment in training and development. Our results question the OFT findings.

An important element of service is the provision of a wide range of medicinal products to meet the individual needs of consumers, and facilitate patient choice. Our research shows that independents stock a much wider range than supermarkets. Supermarkets are interested in volume sales and tend to stock a narrow range of top brands.

CONCLUSION

It is estimated that pharmacists who are members of Nucare Plc made over 50 per cent of all returns to the OFT inquiry. The majority of Nucare members are located in the heart of local communities and our membership represents 10 per cent of the total pharmacy market and 20 per cent of the independent pharmacy market. As a group, it is estimated Nucare pharmacists deal with half a million patients and consumers a day and dispense over five million prescriptions a month.

Following publication of the OFT report, we are preparing to make representations to the Department of Health, including a detailed response about the profitability of a typical independent pharmacy. Plans are in place for us to conduct our own consumer survey in order to report its findings on consumer attitudes and benefits. The results will be made available at a future date.

THE OFT HAS NOT SERVED CONSUMERS WELL AND A PHONEY WAR MAY FOLLOW

Noel Baumber, an independent pharmacy proprietor from Lincolnshire, looks forward to less competition, longer queues and fewer services in the community

The good news is that the Office of Fair Trading report, "The control of entry regulations and retail pharmacy services in the UK", leaves action — or inaction — as an option for the Government. The report's conclusion, however, agrees with one of the principles of competitive markets: that a policy of no barriers to entry generally serves consumers' interests best. Without condemning service or access, the argument seems to be that the current system is not good for consumer choice. What happens next is the phoney war when all parties will be lobbying hard.

The bad news is what is not in the OFT report, since it lies in the realm of conjecture about what might follow from any Government action. It suggests relaxation of controls without providing alternatives or limiting any changes and it implies that the only threat comes from an extension of 500 new pharmacies opening in supermarkets and 130 or so non-contract pharmacies.

I could find no mention of the free-for-all back in the old days when leapfrogging reduced community pharmacy numbers from 15,000 to 8,000 and dispensing practices posed a real threat. Instead, we hear that it was the "bad old" cost-plus contract that was responsible for an increase in pharmacy numbers, not the two-year time lag in introducing the control of entry regulations. My memory must be fading.

INCONCLUSIVE RESEARCH

The report is full of assertions and inconclusive bits of commissioned research. Public detriment is not well defined but is mostly a whinge that we should all have reduced our prices more when resale price maintenance ceased. If we had, then they would not have had to consider wholesale slaughter to make a point. This is a sign of the times.

Interestingly, there is no evidence of excessive profits being made, and so the next objective is to decrease the costs to the taxpayer of dispensing NHS prescriptions and making applications for new contracts.

Having seen an Asda spokesman on the news suggest that pharmacy students could look forward to opening their own pharmacies, I thought the comment was particularly disingenuous. Individual pharmacists and especially students find it extremely hard to compete with the deep pockets of the multiples for the control of viable sites. In any case, supermarkets and new surgery developments will control their own sites, with or without the control of entry regulations.

No official research was done on the services we already provide as a result of healthy competition between contract pharmacies, which I estimate to be well over £100m per annum at little or no cost to consumers. Instead there is a presumption that there is no competition without deregulation.

We all know that manpower, time and contentment are in short supply. Here the OFT is predicting closures without financial compensation, greater ownership by pharmacy chains and longer hours.

There was no mention of the recent agreement between the Pharmaceutical Services Negotiating Committee and the General Practitioners' Committee over dispensing in rural areas but, if the OFT was serious about access and service, the report could have recommended the opening up of rural areas saving up to £100m a year from brand prescribing, or the introduction of patient-oriented services where pharmacies can make a big difference. The regulations are also about the divide between qualified and unsupervised dispensing, and about preventing the collapse of the pharmaceutical service through leapfrogging and monopoly. Here the OFT is protecting the rural GPs' monopoly, which is a vote for unsupervised dispensing and no competition in the place where it is most needed.

Competition clearly does not mean the same thing to the OFT, multiples and independent contractors. Why should the supermarkets drop prices any more than they do now that RPM has ended, when what they want is the freedom to undermine the competition anywhere without having to buy pharmacies and market share? Independents compete by providing patients with good services and good prices. All they want is stability and proper recompense for what they do. Theirs are the only assets at risk and they stand to be the losers, yet no one has looked at their viability or tried to assess what will be lost when they are driven out of business. I fear that the end result will be less competition, longer queues and fewer services in the community.

The Department of Health has been waiting for a fall in the numbers of pharmacies for years before it is alleged they will do something about the annual increase in funding. The OFT wants to oblige with an end to control of entry regulations, which can only mean a return to uncontrolled leapfrogging, bankruptcies and closures. In the short term there might be more pharmacies, but in the longer term the OFT appears content to accept possibly two closures per (undefined) locality and is looking for savings for the taxpayer. That is an appalling scenario for individuals who are contractor pharmacists. Never have independent contractors needed a body to represent their interests more than they do now, but the National Pharmaceutical Association cannot do it, the PSNC will not do it and ginger groups and internet talk shops are ineffective and unrepresentative.

The report highlights the point that the remuneration system could be restructured to remove the need for entry controls. I take issue with this. As I remember it, we received control of entry controls as a quid pro quo for losing the cost-plus contract. Furthermore, the cost-plus contract was lost partly because it was alleged that the increase in pharmacy numbers was due to front loading. In the words of the Nuffield report of 1986: " . . . under the terms of the existing contract higher payments are made to smaller pharmacies for each prescription dispensed than to larger ones."

DAMNING DOUBLETHINK

This clever and damning piece of doublethink ignores the point that any system with an eye to economies of scale and achieving savings through volume would exhibit the same symptoms. Add to that the initial increase of pharmacy numbers when the floodgates open and it will seem to justify the NHS not paying the professional allowance to all and sundry. Then, we could be down to a flat rate dispensing fee for recompense — a monstrous state of affairs when you know that we all share common costs unrelated to volume, which are at least three times in excess of the professional allowance. On the back of an envelope, this means that over £190m might be redistributed for other purposes within the global sum, roughly £140m of which currently comes to the half of community pharmacy comprising small and medium contractors. Putting that back into a dispensing fee would move an extra £45m per year to the top 25 per cent of contractors, an average gain of £18,500 each. That is what makes courting political influence so attractive, when there is no scope for increasing the global sum, and when "efficiency" is rewarded at the cost of the supposedly "ineffective".

The additional "savings" for the NHS will come from the resulting closures, first through the direct effects of leapfrogging but potentially from the restructuring of the contract. On the other hand, if the professional fee goes into funding new concepts of service in a new contract, then there will not be time or money around to provide all the services we were providing free of charge. We will all be busy studying, redesigning our pharmacies, or more likely deciding whom we will work for and whom we will not.