

Pharmacy contract negotiations raise concerns as GPs accept their contract

PHARMACISTS are waiting to hear how negotiations for a new community pharmacy contract are progressing now that general practitioners have accepted theirs. A series of roadshows (see Panel) starts next week at which the Pharmaceutical Services Negotiating Committee will set out what it has achieved so far.

GPs eventually accepted a new contract for providing medical services last week. Negotiations started in September 2001, with GP leaders having to overcome much opposition on the way. The GP contract is to be implemented in April 2004.

The conduct of the two sets of negotiations is markedly different and some PSNC members are concerned about the process being used for pharmacists. Pharmacy negotiations started early this spring with no known implementation date.

A key difference lies in the involvement of elected representatives. Pharmacy negotiations involve a three member team, only one of whom — the PSNC's chairman of contract planning Steve Williams — is an elected member. The other negotiators are the PSNC's chief executive Sue Sharpe and



Sue Sharpe: we will not be bounced

head of NHS services Alastair Buxton. The doctors' negotiating team comprised eight elected members, backed by BMA negotiators and key staff.

Criticism of the PSNC process has come from members who say that the negotiations have been behind closed doors. One said: "PSNC members have not been fully informed about what has been going on. Negotiations are far more advanced than we expected and have been without our involvement."

It has also been claimed that the committee is divided over whether the final outcome should be put to a vote of contractors or of local pharmaceutical committees. It has been suggested that a contractors' vote would accept a contract that an LPC vote would reject because of the block votes of pharmacy multiples. It has also been claimed that the Government wants to see a regional roll-out of the new contract.

Another PSNC member, who is less concerned about the alleged lack

of involvement of committee members, is concerned about the proposed new contract timetable. "It's a very tight timescale," he said. "April 2004 is still on the table. There is nothing to worry about yet, but it is reasonable to ask 'why so fast?'"

He added that the time pressure was not coming from the PSNC and that there were no signs of any internal split, although there was some internal questioning.

Mrs Sharpe said that a full report on progress is given to every meeting of the PSNC and every PSNC member is involved in working groups looking at aspects of the possible contract. She said that the most important thing is to get a clear steer from the committee. "The PSNC has a chairman of contract planning in whom they have faith and we are only negotiating principles at this stage," she said.

On the April 2004 target she said: "I believe the service framework should be achievable by then. It is too early to say how funding negotiations will go. We will not be rushed over any agreement on funding. Even when funding is agreed it may take the Government some time to find it. It is very optimistic to assume that all the funding will be agreed with mechanisms in place for full implementation by April 2004."

Mrs Sharpe denied that there were any signs of plans for regional roll-outs of new services, but she predicted phased implementation.

Addressing concerns that the new contract might lead to an independent-multiple division, Mrs Sharpe said: "We must be absolutely clear that there is no sectoral bias. We have fought the Office of Fair Trading over small pharmacies and it would be absurd to sell them down the river over the new contract. Our benchmark is that there should be fair funding for small, efficient, independent pharmacies."

New contract roadshow locations and dates

London, Holiday Inn, Bloomsbury	30 June
Newcastle, Holiday Inn, Washington	2 July
Bolton, Reebok Stadium	3 July
Leeds, Leeds United FC	7 July
Norwich, De Vere Dunstan Hall	9 July
Birmingham, Birmingham City FC	10 July
Cardiff, Holiday Inn, Cardiff North	14 July
Exeter, Exeter City FC	15 July
Southampton, Holiday Inn, Eastleigh	21 July

Overseas English test is too hard

OVERSEAS pharmacists wishing to register with the Royal Pharmaceutical Society have to reach a standard of English that is unfairly demanding.

Gareth Davies, course manager for English for academic and professional purposes at London's Westminster Adult Education Service, said that recent research, as yet unpublished, indicates that a majority of highly educated first-language English-speakers fail to achieve the standard required of overseas health professionals seeking registration in the United Kingdom. The research tested practising doctors and dentists and was carried out by Mr Davies' colleague Karl Hughes.

To achieve registration through the Royal Pharmaceutical Society's Adjudicating Committee procedure, non-European

overseas pharmacists must gain a minimum score of 7 in each test parameter of the International English Language Testing System (listening, reading, writing and speaking). European pharmacists seeking registration by the Society do not need to show proficiency in English.

The British Council, which oversees the tests, says that a score of 7 demonstrates "good use" with "operational command of the language, though with occasional inaccuracies, inappropriacies and misunderstanding in some situations; generally having complex language skills and understanding detailed reasoning."

Mr Davies said: "Getting straight sevens is extremely difficult; it is very easy to drop half a point in the test. Getting a seven in the reading test is particularly problematic."

England pharmacy minister confirmed

ROSIE Winterton has been confirmed as the minister responsible for pharmacy services at the Department of Health.

Her other responsibilities include emergency care, including A&E and ambulance services, NHS Direct, adult mental health services, clinical negligence, patient and public involvement, diabetes services, transplants and organ donation, and dentistry.

Rosie Winterton, MP for Doncaster Central since May 1997, was Parliamentary Secretary at the Lord Chancellor's Department from 2001 until her appointment as Minister of State for Health.

Lord Warner, Parliamentary Under-Secretary of State for Health in the House of Lords will be responsible for pharmaceutical industry issues.

New guidance recommends improved training in prescribing for doctors

NEW recommendations to improve prescribing training for medical students have been set out this week.

The recommendations follow changes to the structure of the medical undergraduate course in the 1990s. This resulted in increased emphasis on problem-based education. The authors of the recommendations — Dr Simon Maxwell, clinical pharmacology unit, University of Edinburgh, and Professor Tom Walley, department of pharmacology and therapeutics, University of Liverpool — believe that one consequence of this redesign was “the loss of single-discipline courses including basic pharmacology and clinical pharmacology and therapeutics”.

This view is backed by the British Pharmacological Society, which says that training in the basic principles of prescribing and therapeutics, drug action and basic knowledge about commonly used drugs is failing.

Dr Maxwell and Professor Walley suggest that:

- Prescribing and therapeutics should be identified as an important theme that runs vertically through the medical curriculum
- The factual burden should be eased by prioritising learning around a core list of commonly used drugs
- Core learning objectives should be set and robustly assessed

They go on to describe in detail what the medical curriculum should cover. The recommendations will be distributed to medical

schools and are published in the *British Journal of Clinical Pharmacology* (2003;55:496).

Commenting on the publication of the recommendations, the President of the Royal Pharmaceutical Society, Dr Gill Hawksworth, said: “These new recommendations can only be a good thing for patient safety and quality of patient care.”

Welsh assembly airs rural dispensing row

DISPUTES between rural doctors and pharmacists over dispensing rights have been given an airing in the National Assembly for Wales.

Carmel, Gorsedd, Milwr and Greenfield in the north Wales Delyn constituency have been reclassified as part of an urban, rather than rural, area, and 2,000 people have been told that they must have their prescriptions dispensed at a pharmacy instead of by their general practitioner.

Questioned in the assembly by Sandy Mewies (Labour, Delyn), First Minister Rhodri Morgan said that the reclassification had followed the proper procedures with a subsequent appeal. All the issues involved had been given full consideration. Mr Morgan reassured Ms Mewies that any patients who could not reach a pharmacy because of mobility problems would still be able to have their dispensing done by their doctor.

Centralised purchasing jeopardises Welsh health planning, says NPA

THE National Pharmaceutical Association has issued a warning that centralising medicine buying by the National Health Service in Wales will put health planning at risk.

Responding to a report by the auditor general for Wales, which said centralising medicines buying for primary care could save £50m a year (*Pf*, 29 March, p430), the NPA management board said that any moves that adversely affect pharmacy income and the profession's ability to invest in and fund services will frustrate pharmacy planning and thus overall health planning.

The report claimed that the money could be saved by centralising drug purchasing at hospital prices. It also said that pharmacists made profits to which they were not entitled by beating the discount clawback.

At their June meeting, members of the NPA board warned that the pharmacy network would not be financially viable if all discounts were recovered by the NHS.

Other matters considered at the meeting are reported below.

Omeprazole Concerns were expressed over the proposed POM-to-P reclassification of omeprazole (*Pf*, 24 May, p709). These included the drug's slow onset of action, which board members believed made it inappropriate for the immediate relief of reflux-like symptoms. It was more suitable for the relief of frequent heartburn. Also, omeprazole was not supported by any nationally recognised guidelines as a first-line single agent for the treatment of dys-

pepsia. Pharmacists could find themselves advising GPs to use H₂ antagonists and antacids as first-line treatments for a condition for which a non-prescription proton pump inhibitor was a first-line non-prescription treatment. Board members accepted that PPIs were an exciting new group of medicines for pharmacy supply, but believed that other PPIs, such as lansoprazole, were to be more suitable, with a better safety profile.

Nurse prescribing There was broad support for plans to extend the nurse prescribers' formulary to cover areas such as pain relief in midwifery and for patients with suspected myocardial infarction, and the treatment of emergencies, such as acute asthma attacks and hypoglycaemia. A proposal to permit extended formulary nurse prescribers to prescribe specific medicines for unlicensed indications in palliative care was supported, so long as the nurses are made aware of the implications for professional liability.

CD regulations The board approved Home Office proposals to allow computer generated prescriptions for Schedule 2 and 3 Controlled Drugs and for computer registers for Schedule 2 CDs.

Care homes The NPA is to develop closer links with the National Care Standards Commission to determine the resources members need to providing services to care homes.

BRIEFLY

New CDs

Remifentanyl and dihydroetorphine are to be made Schedule 2 Controlled Drugs on 1 July. Gamma hydroxybutyrate and zolpidem will become Schedule 4 Part I CDs on the same date. Four steroids become Schedule 4 part II CDs (see Law and Ethics Bulletin, p910).

Genetics strategy for the NHS set out

A PLAN setting out how genetics-based health care will be integrated into the National Health Service has been published this week by the Department of Health.

In a White Paper the Government sets out a £50m strategy, which it says will “harness the potential advances in genetics for the benefit of NHS patients” over the next three years. Much of the £50m — £18m — will be spent on upgrading NHS genetics laboratories to prepare them for the expected expansion in genetic testing. However, more than £7m will be spent on new initiatives to introduce genetics-based health care into mainstream clinical areas and into primary care.

In particular, the report says the DoH will invite bids for up to £2m start-up funding to explore ways of building up the expertise of doctors, nurses and pharmacists who may want to take a special interest in genetics.

The paper also notes that developments

Genetic testing

Access to genetic tests is discussed in the report, which says that individuals who want to take more direct responsibility for their health should not face “arbitrary barriers”. However, the Government seems to recognise that unfettered access to tests could cause problems and is therefore considering conclusions made in a Human Genetics Commission report published in April (*Pj*, 12 April, p508).

The White Paper also includes plans to make it an offence to test someone’s DNA without their consent (except as part of their medical treatment where consent is impossible to obtain, or in the lawful use by police and courts).

Reserve new statin for difficult to treat

ROSUVASTATIN (Crestor) should probably be reserved for patients with hypercholesterolaemia that is difficult to treat with existing drugs, according to the latest issue of *MeReC Extra*. Rosuvastatin should be used cautiously, with careful monitoring, it says.

MeReC Extra also considers whether ibuprofen should be avoided by patients taking low-dose aspirin because of suggestions that ibuprofen may reduce its cardioprotective effects. It concludes that more robust evidence is needed before a policy decision can be made. Other topics covered by *MeReC Extra* include new guidelines on the use of buprenorphine for opioid dependence and how and when to prescribe anti-obesity drugs.

A copy of *MeReC Extra* is included with this week’s issue of *The Journal* sent to pharmacists in England. It is also available via the National Prescribing Centre website (www.npc.co.uk) and via the NHSnet (www.npc.ppa.nhs.uk).

in pharmacogenetics could allow pharmacists to take on a greater role in prescribing. “A GP could make the diagnosis and discuss with the patient the general approach to treatment. But the selection of the genetically most favourable option could be undertaken by a pharmacist with the aid of genetic testing facilities,” the report states.

Plans are also laid out for the inclusion of genetics in training courses for health professionals. With this in mind, the DoH plans to set up an NHS genetics education and development centre to coordinate activity. In addition, a new university chair and department in pharmacogenetics will be set up and over £4m will be spent on pharmacogenetics research on commonly used drugs.

The report adds that new technologies will have to be proven clinically if they are to be used routinely in health care. And the DoH expects those involved in medicines management to judge whether or not a particular pharmacogenetic test is important for the safe use of medicines.

Dr Nicola Gray, chairman of the Royal Pharmaceutical Society’s science committee, said: “The promised investment in pharmacogenetics research will result in better targeted and more effective use of existing medicines, and the development of new

gene-based therapies. We also welcome the plans in the White Paper to ensure that ethical issues are addressed and to train health professionals to meet these new challenges.”

However, not everyone has welcomed the white paper so warmly. GeneWatch UK has warned that no legal safeguards are proposed to prevent employers or insurers abusing genetic test information.

The report — “Our inheritance, our future — realising the potential of genetics in the NHS” — is available via the *Pj Online* links page (www.pjonline.com/links/pj).

Polypill proposed for heart disease

RESEARCHERS this week propose that everyone over the age of 55 years should take a combination of drugs in a single pill to prevent cardiovascular disease. Described as a “polypill”, the proposed combination is three blood pressure lowering drugs each at half the standard dose, a statin, folic acid and aspirin (*BMJ* 2003;326:1419).

The polypill strategy has been outlined by Professor Nicholas Wald and Professor Malcolm Law from Barts and the London, Queen Mary’s School of Medicine and Dentistry, University of London. They estimated the efficacy and adverse effects of the combination using a number of meta-analyses. Using these data, they say the polypill would reduce ischaemic heart disease (IHD) events by 88 per cent and stroke by 80 per cent.

“One third of people taking this pill from age 55 would benefit, gaining on average about 11 years of life free from an IHD event or stroke,” they say. In addition to people aged over 55 years, they suggest that it is also given to everyone with known cardiovascular disease.

The polypill would cause adverse effects in between 8 and 15 per cent of people, the researchers estimate, and would be “acceptably safe”. “With widespread use, [the polypill] would have a greater impact on the prevention of disease in the Western world than any other single intervention,” they say.

While admitting that the strategy is radical, they comment: “It is time to discard the view that risk factors need to be measured

and treated individually if found to be ‘abnormal’. Instead it should be recognised that in Western Society the risk factors are high in us all, so everyone is at risk; that the diseases they cause are common and often fatal and that there is much to gain and little to lose by the wide-spread use of these drugs.”

Certain issues associated with such an approach are highlighted in an accompanying editorial (*ibid*, p1407). These include the controversy over extensive use of preventive medicines among people without symptoms and the fact that there are other ways to reduce risk of cardiovascular disease. In addition, routine use of a polypill might prevent tailoring of medication to individuals.

n Cholesterol tests at 50 Measuring the cholesterol of everyone aged 50 years and over would identify most people at high risk of developing heart disease, researchers say. They compared four screening strategies with the Framingham 10-year coronary heart disease risk equation.

A method that tailored cholesterol measurement on the basis of other known risk factors identified 99.91 per cent of people at 15 per cent or greater risk. However, this strategy required measurement of cholesterol in 73 per cent of the study population. Screening based on age required measurement of cholesterol in 46 per cent of the population and led to 93 per cent of those at 15 per cent or greater risk being identified (*BMJ* 2003;326:1436).

Both continuous and sequential HRT regimens increase breast cancer risk

THE risk of breast cancer in women who use combined hormone replacement therapy (HRT) is increased whether they follow a continuous or sequential regimen, new research suggests (*JAMA* 2003;289:3254).

The risk associated with continuous HRT use is already documented (*Pf*, 13 July 2002, p43) but the effects of sequential use — a regimen commonly used in the United Kingdom — are largely unknown.

Dr Christopher Li, Fred Hutchinson Cancer Research Centre, Seattle, Washington, and colleagues examined the relationship between duration and patterns of HRT use and breast cancer risk in more than 2,000 women aged 65 to 79 years. They

found that women who had taken combined HRT for longer than five years had double the risk of developing breast cancer and that risk increased with duration of use. “We found that both regimens [continuous and sequential] were associated with similar increases in breast-cancer risk. There does not seem to be any advantage to sequential progestin use compared with continuous progestin use with respect to reducing this risk,” says Dr Li.

The researchers also found that combined HRT did not increase the risk of oestrogen-receptor negative or progesterone-receptor negative breast cancers. “That the use of combined HRT only increased

the risk of hormonally-positive tumours points to the importance of progesterone in breast-cancer development. It appears that HRT must contain progesterone to promote breast-cancer growth and that it may act through stimulation of both oestrogen and progesterone receptors, not just one or the other,” explained Dr Li.

n Effect on mammography Another study published in *JAMA* (ibid, p3243) concludes that relatively short-term use of combined HRT stimulates breast cancer growth. Furthermore, such treatment increases the frequency of abnormal mammograms and if breast cancer is diagnosed it is at a more advanced stage of disease.

Survival in relapsed ovarian cancer improved with paclitaxel

WOMEN with relapsed ovarian cancer are likely to live longer if they are treated with platinum-based chemotherapy plus paclitaxel (Taxol) than if they receive conventional platinum-based treatment alone (*Lancet* 2003;361:2099).

This finding comes from research led by the Medical Research Council clinical trials unit, which involved 802 patients with relapsed cancer that was still sensitive to platinum-based treatment.

The researchers say there is no agreement on the best second-line treatment for relapsing disease but argue that their results, which come from two parallel trials, suggest an additive effect of platinum and paclitaxel.

“All women who relapse more than six months after the completion of previous platinum-based chemotherapy should be considered for combination chemotherapy with platinum and paclitaxel,” they say.

In the trials, known as ICON4 and AGO-OVAR-2.2, women were randomly assigned to one of two treatment regimens. The researchers found that more women

assigned to combination therapy than conventional platinum-based therapy were alive two years after the trial began (57 per cent versus 50 per cent). In addition, both median survival and progression-free survival were longer for patients who received paclitaxel (29 versus 24 months and 13 months versus 10 months, respectively).

Furthermore, combination treatment with paclitaxel was associated with less haematological toxic effects than conventional platinum-based chemotherapy. This result supports previous suggestions that paclitaxel may be myeloprotective, they say.

n Gene key to ovarian cancer A gene, known as OPCML, may provide the key to improved treatments for ovarian cancer. Researchers from Cancer Research UK's Edinburgh oncology unit have found that the gene is “switched off” in almost all ovarian tumour cells. Furthermore, they have shown that if functioning OPCML genes are inserted into human ovarian cancer cells, tumour growth is suppressed (*Nature Genetics* 2003;34:337).

Call for heart failure prescribing change

PRESCRIBING practice in relation to beta-blockers for treating heart failure should change, according to cardiologists at the European Society of Cardiology heart failure meeting in Strasbourg this week. Their call follows presentation of results from the longest and largest study in chronic heart failure (CHF).

Professor Philip Poole-Wilson from Imperial College, London, and Professor John Cleland, from the University of Hull, say that the non-selective beta-blocker, carvedilol (Eucardic), should be the beta-blocker of choice in CHF.

Results from COMET (carvedilol or metoprolol European trial), based on more than 14,000 patient years of follow up, show that patients treated with carvedilol gain a survival benefit of 17 per cent compared with the beta₁ selective beta-blocker, metoprolol ($P=0.0017$). This reduction in mortality was consistent in all sub-groups. The mean doses of carvedilol and metoprolol were 42mg and 85mg, respectively.

COMET is the first head-to-head survival study comparing two beta blocking agents in CHF. Professor Poole-Wilson, who chaired the COMET steering committee, said: “The survival benefit seen in this trial is as significant as the SOLVD trial.” SOLVD (studies of left ventricular dysfunction) assessed the effect of enalapril on mortality.

The trial, funded jointly by Roche and GlaxoSmithKline, was designed to compare the effects of carvedilol with those of metoprolol on the risk of death and hospital admission. Full results are due to be published in *The Lancet* next month.

COMET investigators said that the difference in mortality observed between the two treatment groups was due to pharmacological differences between carvedilol and metoprolol. Professor Poole-Wilson said that carvedilol's ability to block beta₂ receptors as well as beta₁ receptors probably accounted for the difference.

ROYAL PHARMACEUTICAL SOCIETY NEWS

Practice guidance

The Society has published new practice guidance on cholesterol testing and on medicines in care homes (p909).

New Charter

The annual general meeting of the Society's Scottish Department has carried a motion calling for devolution to be taken into account in a new or revised Charter (p911); a motion to the same effect is also to be debated at the Society's AGM for members in Wales (p909).

PJ Online

Pf Online contains the editorial contents of *Pf* publications.

British Pharmaceutical Conference

The conference programme is available as a PDF file, along with details of registration, fees and accommodation. www.pjonline.com/bpc

Pharmaceutical Journal letters

The letters page is available as a PDF file, on Thursday afternoon. The “What's new” page updates itself every 10 minutes. www.pjonline.com/whatsnew

New pharmacy-based asthma care service launched

IMPROVING treatment compliance among patients with asthma is the aim of a new pilot launched this month by Moss Pharmacy.

The service will be offered initially by eight of the company's pharmacies. It involves pharmacists developing an asthma action plan for patients, reviewing and educating the patient's inhaler technique, and monitoring the patient for six months.

Compliance problems, or difficulties with inhaler technique, will be tackled by the pharmacist but any issues that cannot be resolved will be referred to general practitioners. Patients found to have uncontrolled symptoms, drug interactions or a need for dose adjustment will also be referred to the GP. Any action taken by the pharmacist will be recorded in the patient's care plan.

Pharmacist salary agreement reached

AN agreement on national salary scales for this year has been reached by the Pharmaceutical Whitley Council and representatives of healthcare pharmacists.

In terms of national salary scales for 2003/04, an increase of 3.225 per cent will be introduced with effect from 1 April 2003. London allowances will be increased by 3.225 per cent, effective from the same date.

Agreement was also reached over increases to the emergency duty commitment allowance. It too will be increased by 3.225 per cent with effect from 1 April 2003.

A letter sent by the Department of Health to chief executives of trusts states that the agreements have been approved by the Secretary of State for Health.

BRIEFLY

Last SARS travel warning lifted

Travellers are no longer being advised to postpone travel to certain areas of the world in order to minimise the spread of severe acute respiratory syndrome. The World Health Organization lifted its recommendation that people should postpone all but essential travel to Beijing this week. Beijing was the last area in the world to which this advice still applied.

Moss reaches 800

Moss Pharmacy, Alliance Unichem's pharmacy chain, has acquired its 800th community pharmacy. The company recently completed the take-over of L.J. Tressler Pharmacy, Tile Hill, Coventry.

Downing Street petitions

PETITIONS and letters calling for the preservation of local pharmacy services have been delivered to Prime Minister Tony Blair at 10 Downing Street by representatives of pharmacists from Surrey and north east London.

One petition was delivered by Hugh Mullen and Hasmukh Patel from Egham, Surrey, accompanied by their member of Parliament, Philip Hammond (Con, Runnymede and Weybridge).

Mr Hammond has written to every one of his constituents who signed the petition expressing support for the campaign.

"While I would normally be sympathetic to a proposal to remove barriers to competition, this is a very special case," Mr Hammond said. "At the moment, the regulations surrounding the grant of contracts to dispense NHS prescriptions ensures that the NHS prescription business effectively cross-subsidises the many unpaid services (including the giving of advice) which local pharmacists perform. If pharmacies were deprived of their income from NHS dispensing those services would either have to be paid for or would have to be provided by other parts of the primary health care team. That would be a huge own goal for the NHS."

The other was delivered by Hemant Patel, secretary of North East London Local Pharmaceutical Committee. In an accompanying letter, Mr Patel, who is also chairman of the National Pharmaceutical Association, set out 11 points which he asked Mr Blair and the Government to consider before making a final decision about what to do about the Office of Fair Trading's call to abolish all restraints over the opening of community pharmacies.

Mr Patel drew a parallel between community pharmacies and local post offices, describing them as services which glue communities together. The closure of pharmacies in secondary shopping parades would lead to the collapse of other local businesses, creating a need for regenerative measures.

He said that it was not clear why the Government had adopted a different line for England from that taken by the devolved administrations for Scotland, Wales and



Hugh Mullen (left and Hasmukh Patel (right) with Philip Hammond

Northern Ireland. Mr Patel also asked why the Department for Trade and Industry was taking the lead on a health matter. "It seems inherently wrong that competition theory should dominate over health care planning," he wrote.

Community pharmacies should be planned as a network that provides a platform for the launch of new professional services, Mr Patel told the Prime Minister. So the proposed balanced package of measures should centre on giving primary care organisations greater flexibility in ensuring that patients get ready and easy access to high quality services. Any gaps in provision should be resolved by negotiations between LPCs and primary care trusts.

"It is vital that Ministers and health care planners recognise that the future of the community pharmacy sector is a crucial issue for local communities throughout England," Mr Patel concluded. "Without a compelling and demonstrated need to alter substantially the current market dynamics, they risk possible long-term unintended and unforeseen negative consequences which will jeopardise not only local healthcare provision, but the long-term objectives of the core consumer for NHS pharmacy services: the Department of Health itself."

Dentists to display lists of charges

DENTISTS are to be required to display tables of charges for private treatments and menus of treatments that they offer under the National Health Service.

Responding to an Office of Fair Trading report on private dental services published earlier this year, Secretary of State for Trade and Industry Patricia Hewitt said that consumers were unable to make informed dental choices because they did not have basic information on prices, the quality of services and what treatments were available on the NHS. As a result, dentists are to be required to display price lists, details of NHS services

and to give their patients written treatment plans and itemised bills.

If existing patients want NHS treatment which a dentist does not offer, there is to be a requirement to tell patients how they can access NHS services.

There are also to be regulatory changes through an amendment to the Dentists Act 1984 to give the General Dental Council new powers to implement a fitness to practice regime.

Private dentistry will be made subject to scrutiny by the Commission for Healthcare Audit and Inspection.