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REPORT OF THE NATIONAL JOINT COMMITTEE OF THE
MEDICAL AND PHARMACEUTICAL PROFESSIONS ON THE
DISPENSING OF NHS PRESCRIPTIONS IN RURAL AREAS

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NOVEMBER 1977

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INTRODUCTION

The government of a civilized country may be viewed as a series of compromises in which personal liberty is balanced against community interest. So it has proved in the task remitted to us by the professional bodies on each side. In order to arrive at a scheme for sensible and fair regulation of rural dispensing in the interests of the community as a whole, some personal freedoms have had to be exchanged for common advantage. Our work may seem just a fragment in the complex mosaic of national administration. But it impinges directly on the man in the country lane who from time to time suffers an illness which medicine may relieve: and from us it has demanded an effort of goodwill and self-sacrifice as great for those concerned as if we had been prescribing for the nation. We therefore earnestly hope that those who read what follows, and whose goodwill is necessary for the implementation of our ideas, will read between the lines of our report the effort, goodwill and unselfishness which have gone into its making - and will value it accordingly.

C M CLOTHIER

Chairman

1. ORIGIN OF THE NATIONAL JOINT COMMITTEE, AND TERMS OF REFERENCE

1.1 The primary legislation covering the supply of prescription medicines under the NHS is Sections 41 to 43 of the NHS Act 1977 (formerly Sections 38 and 39 of the NHS Act 1946 as amended). The current arrangements under which doctors may regularly supply medicines to their patients are set out in Regulation 30 of the NHS (General Medical and Pharmaceutical Services) Regulations 1974, made under Section 43 of the 1977 Act. These provisions are reproduced in Appendix 1.

1.2 The following figures indicate the extent to which patients obtain medicines from doctors under these arrangements in England and Wales.

	Patients on dispensing lists	Percentage of all patients	Dispensing doctors	Percentage of all gp principals
October 1966	2,696,850	5.53	2543	12.43
October 1976	2,970,700	5.81	2748	12.41

Some doctors practising in rural areas do not supply medicines, and the patients concerned obtain medicines from a pharmacy.

1.3 The representatives of the pharmaceutical profession have long considered that the 'one-mile rule' contained in Regulation 30(1)(b) is out of date in the light of modern communication facilities and changes in doctors' practice arrangements; and that the operation of the rule adversely affects pharmacies in rural areas by limiting the number of prescriptions they could dispense. The pharmacists have on several occasions during the last twenty years asked for the regulation to be changed. For their part the representatives of the medical profession have long considered it unreasonable that a pharmacy may open in an area where a doctor dispenses and the regulations then prevent the doctor from dispensing within a mile of the new pharmacy. The doctors have objected repeatedly to this provision. Successive Ministers have taken the view that they should only consider changes which were agreed by both the medical and pharmaceutical professions and were in the interests of patients, and although several proposals have been considered none has been acceptable to both professions.

1.4 In October 1975, following an initiative by the then Minister of State (Health) Dr David Owen, the medical and pharmaceutical professions agreed between themselves that there should be a voluntary 'standstill' on changes in dispensing arrangements in rural areas while the two professions engaged in joint discussions under an independent chairman. The aim would be to find a solution which would secure sensible arrangements for the supply of prescription medicines in rural areas in the circumstances of each locality and would avoid sudden changes - with consequent effect on the incomes of existing doctors and pharmacists - in the arrangements on which patients relied. The text of the agreement between the General Medical Services Committee, the Council of the Pharmaceutical Society of Great Britain and the Pharmaceutical Services Negotiating Committee (formerly the Central NHS (Chemist Contractors) Committee) is set out in Appendix 2.

1.5. The voluntary 'standstill' has been extended to 10 April 1978, to allow time not only for the completion of this Report but for its consideration by both professions.

2. CONSTITUTION AND MEETINGS OF THE NATIONAL JOINT COMMITTEE

2.1 The Minister of State (Health) with the agreement of the two professions appointed Mr C M Clothier QC as Chairman of the Committee.

The representatives appointed by each profession were:-

General Medical Services Committee

Dr M A Wilson

Dr G Cormack

Dr D J D Farrow

Dr R J R Lewis

Dr A J Rowe

Pharmaceutical Society of Great Britain

Mr J P Bannerman

Mr R Dickinson

Mr G W Walker (from February 1976)

Pharmaceutical Services Negotiating Committee

Mr G T M David

Mr D L Coleman

Mr J Charlton (until January 1976)

2.2 Each profession also nominated an officer from its secretariat to act as an observer at each meeting. At the request of the professions the Department of Health and Social Security (DHSS) provided the Secretariat for the Committee.

2.3 The Committee met on 16 occasions between November 1975 and November 1977.

3. THE PROPOSALS OF THE PHARMACEUTICAL PROFESSION

3.1 The representatives of the pharmaceutical profession presented two papers to the Committee. The first paper put forward, as a basis for discussion, the proposal that dispensing in rural areas should be undertaken by pharmacists except where the patient would experience serious difficulty in having a prescription dispensed at a pharmacy or by means of a service supplied by a pharmacy; and that revised arrangements should in general be based on the proposals contained in the Third Report of the Joint

Discussions held in 1966 on the Family Doctor Service ('the 1966 proposals'). These proposals would have involved the removal of the one-mile rule and the designation of areas for dispensing by doctors where people would have serious difficulty of access to a pharmacy through distance or inadequate communications: with the proviso that a doctor who was required or authorised to dispense for patients in an area to which the serious difficulty criterion applied would have retained that right, subject to reconsideration only if there were a major change of circumstances in the area. Doctors who would have no longer dispensed would have had one year's notice of cessation; and there would have been a right of appeal by an interested party against the decision of an Executive Council (the predecessors of FPCs).

3.2 The pharmacists advanced the following main arguments in support of their proposal.

3.2.1 Whenever possible dispensing should be undertaken by pharmacists, since they were specifically trained for this; the potency of many modern medicines increased the importance of the role of the pharmacist.

3.2.2 Surgeries were in many instances in market towns and close to pharmacies, and the majority of consultations were at surgeries; but patients living more than one mile from the pharmacy were usually on the doctor's dispensing list and their prescriptions were not therefore dispensed by pharmacists.

3.2.3 Improved communications, particularly the availability of cars, made the one mile limit out of date.

3.2.4 It was in the public interest that the comprehensive pharmaceutical service supplied by pharmacies should be available as widely as possible, because it provided not only for the dispensing of prescriptions but for the sale of medicines and poisons and the giving of advice for the treatment of minor ailments and on medicines and other health matters generally.

3.2.5 NHS dispensing was important for the viability of rural pharmacies; the limitation of dispensing to those patients living within a mile discouraged the opening of new pharmacies and was often a major reason for closure of an existing one on retirement of the owner.

3.2.6 Rural pharmacies could provide improved services if their dispensing increased.

3.3 In their second paper the pharmacists outlined their views on how the proposal would operate.

3.3.1 The one mile limit would continue (a change from the 1966 proposals), because apart from exceptional individual circumstances people living within a mile radius of a pharmacy should not experience serious difficulty in having their prescriptions dispensed there; and retention of the limit would continue to provide some security for rural pharmacies.

3.3.2 Rural districts outside the one mile radius would be reviewed within a year, and doctor dispensing then be required only in those districts where patients would have serious difficulty in obtaining their medicines from a pharmacy because of distance or inadequate communications.

3.3.3 FPCs would establish dispensing committees to designate rural districts as pharmacist dispensing districts, taking account of the distribution of surgeries and pharmacies, pharmacy hours in relation to surgery hours, arrangements such as collection and delivery services, local shopping habits and transport facilities.

3.3.4 Districts would be reviewed if there were a major change of circumstances.

3.3.5 Doctors in districts designated for pharmacist dispensing would be given three months to cease dispensing, but there should be reasonable measures to compensate them for financial loss.

3.3.6 The FPC's dispensing committee would have a balanced membership of doctors, pharmacists and laymen so as to ensure that everyone interested would have confidence in the fairness of its decisions.

3.3.7 There would be provision for various appeals to the Secretary of State.

3.4 The pharmacists expressed concern about the way in which patients exercised their choice under the current arrangements for dispensing in rural areas. They felt that guidelines on this were needed.

4. VIEWS OF THE MEDICAL PROFESSION ON THE PHARMACEUTICAL PROFESSION'S PROPOSALS

4.1 The medical representatives pointed out that all doctors were entitled under the Medicines Act to supply medicines to their patients. Any alteration of this basic entitlement would affect the whole profession and was not acceptable.

4.2 The medical representatives drew attention to the terms of the agreement between the two professions in which it was stated "The aim (for the National Committee) should be to find a solution which will secure sensible arrangements for the supply of medicines etc on prescription in the circumstances of each locality and should avoid sudden changes - with consequent effect on income of existing doctors and existing pharmacists - in the arrangements on which patients have hitherto relied". The doctors could not accept that the pharmacists' proposal - that a patient would have to be in serious difficulty in obtaining medicines from a pharmacy before he would be permitted to obtain them from his doctor - was in the patient's interest. The doctors said that in their view the only sensible solution would be for the patient to have free choice as to whether he presented the prescription for dispensing to his dispensing doctor or to the pharmacy on each and every occasion when a prescription was issued.

4.3 In objecting to the principle that a patient must prove hardship in order to be allowed to obtain his medicines from the doctor, the medical representatives criticised the criterion of "serious difficulty" because

of the practical problem of implementation. A subjective criterion of this nature would inevitably be interpreted in a different manner from one area to another, which would provoke dissent and produce conflict between the two professions. These were the main reasons for the medical profession's rejection of the 1966 proposals.

4.4 In replying to the pharmacists' criticism of the one mile rule the medical representatives stated that in their view communication facilities, particularly public transport, had deteriorated in rural areas. The increase in car ownership was accepted but the car was normally used to take the working members of the family to work, leaving the elderly and the young mother with children with no means of transport.

4.5 In commenting on the pharmacists' view that the viability of rural pharmacies was affected by the one mile rule, the medical representatives gave their view that the main reasons for pharmacy closures were as follows.

4.5.1 A change in the method of remuneration of pharmacies in 1964 from a method which was favourable to small pharmacies to a method which was much more favourable to the large pharmacy.

4.5.2 The difficulties faced by all small retail businesses such as competition from supermarkets and soaring costs.

4.5.3 Doctors moving into new premises at an increased distance from the pharmacy.

4.6 In commenting on the pharmacists' opinion that rural pharmacies could provide improved services if their dispensing increased the medical representatives pointed out that this would obviously mean that dispensing doctors would do less dispensing, with a consequent effect on income. This could lead to some medical practices becoming uneconomic and the curtailment of medical services in other areas, such as the closure of branch surgeries.

4.7 The medical representatives produced figures to support their view that dispensing by doctors had not been a factor significantly affecting the number of pharmacy closures. These showed that the proportion of patients receiving their medicines from a dispensing doctor had only increased from 5.53% to 5.81% between 1966 and 1976 and that the proportion of all general practitioners who dispensed for their patients had actually fallen slightly from 12.43% to 12.41% over the same period.

4.8 In the view of the medical representatives any change from doctor to pharmacy dispensing was unlikely to ensure the viability of more than a few pharmacies, yet the habits and convenience of almost 3 million patients and the economics of some 2,750 doctors would be severely disrupted although neither those patients nor those doctors had expressed a wish for change.

5. THE PROPOSALS OF THE MEDICAL PROFESSION

5.1 The medical representatives presented a paper to the Committee which embodied a policy statement on dispensing in rural areas which had been approved by the General Medical Services Committee and the Conference of Local Medical Committees.

5.2 The medical representatives explained that the policy had been formulated recognising the different views of the two professions, in an endeavour to reconcile those differing views with the paramount interests of the patient.

5.3 The paper contained the following recommendations.

5.3.1 Each time a prescription was issued to a patient living in a rural area he should be able to choose whether it should be dispensed by his doctor or a pharmacist; the one mile rule would cease.

5.3.2 A doctor should be entitled to dispense for all his patients living in a rural area if at least fifty asked him to do so.

5.3.3 Having regard to the initial capital outlay and the need to ensure a reasonable return on this, to cover the running costs and leave a reasonable margin of profit, dispensing by doctors should not be liable to sudden change; once a doctor undertook a dispensing service he should retain the right to continue it.

5.3.4 A doctor who relinquished his right to dispense should receive compensation for loss of income.

5.4 The medical representatives advanced the following main arguments in support of their proposal.

5.4.1 It would safeguard the patient's interest and convenience in all instances, whether visiting the surgery, being visited at home, or being treated during the day or at night.

5.4.2 If there is a request for a service from patients and the doctor is willing to provide that service he should be allowed to do so.

5.4.3 The doctor should be protected from arbitrary change which would affect his income provided the patient retains the freedom of choice as to where his prescription is dispensed.

6. VIEWS OF THE PHARMACEUTICAL PROFESSION ON THE MEDICAL PROFESSION'S PROPOSALS

6.1 The pharmacists said that the proposal that patients in rural areas should decide on each occasion whether to obtain medicines from their doctor or from a pharmacist had been one considered during the 1969-1971 discussions with the medical profession and was unacceptable to the pharmacists.

6.2 The pharmacists appreciated the force of the doctors' objection to the risk of sudden change inherent in the present arrangements, by which a doctor has to cease dispensing for patients living within a mile of a pharmacy if one is opened in a rural area, and then has to resume dispensing for those patients if the pharmacy subsequently closes. Existing pharmacies operating in rural areas where doctors did not dispense similarly faced the risk of a sudden drop in income if doctors started to dispense. The pharmacists recognised the importance of dispensing income for the doctors concerned, and the doctors' view that loss of income on relinquishing a right to dispense merited compensation.

6.3 In reply to the doctors' view that doctor dispensing safeguarded the patient's interest and convenience the pharmacists emphasised that the dispensing service from pharmacies was available throughout the day and was supplemented by an out-of-hours service.

7. THE SEARCH FOR CRITERIA

7.1 Thus neither profession could accept the other's proposals, although both agreed that the present unregulated arrangements could result in sudden arbitrary changes which adversely affected patients, doctors or pharmacists. This threat is a fundamental disadvantage for doctors and pharmacists practising or envisaging practice in rural areas. We therefore considered whether agreement could be reached on new objective criteria which could be applied universally in deciding whether patients in rural areas should obtain medicines from pharmacists or from doctors. We examined whether instead of a rule based on the distance between a patient's home and a pharmacy there should be one based on the distance between the doctor's surgery and a pharmacy. The case for this was that most prescriptions are issued at surgeries and that most patients, if not obtaining medicines from the doctor, would wish to obtain them as soon as possible after visiting the surgery. There were a number of objections however.

7.1.1 It would not cater for patients whom the doctor visited: these would include an increasing number of elderly patients.

7.1.2 Sometimes there was more than one surgery which a patient might visit.

7.1.3 Pharmacies were sometimes closed before a patient could reach them after visiting the surgery.

7.1.4 Infrequent bus services can preclude a combined home-surgery-pharmacy-home journey.

7.1.5 Surgeries or pharmacies could be moved to gain advantage from such a rule.

7.2 Both professions had previously considered a surgery-pharmacy distance criterion. We came to the conclusion that while the present rule based on home to pharmacy distance produced obvious anomalies, one based only on surgery to pharmacy distance would result in others. Nor could we find other criteria which could be applied universally. Circumstances differ widely from one area to another. For example, there is the type of rural area where a market town is the centre on which people living in surrounding villages rely for shopping and other services and where the doctors' surgeries and the pharmacies are situated; and reasonable bus services link the villages to the town. Contrasting with this there is the type of area where there are a number of villages but no one town acting as a centre, and only sparse bus services. In addition there might be branch surgeries in one or two of the larger villages, but no pharmacy. Criteria which might prove suitable for one type of area could be inappropriate in another.

7.3 Apart from the difficulty in finding new objective criteria of distance we consider that other factors must also be taken into account in deciding the best arrangements for dispensing in each rural area. These should include the viability of pharmacies and the significance of dispensing income for the viability of medical practices; and it is essential to consider the effect on existing facilities provided by doctors and pharmacists (such as branch surgeries and the sale of non-prescribed medicines and other items relating to health care) of any proposal to change the arrangements on which patients have relied to obtain their medicines. If any changes did seem reasonable after examination of all the relevant factors there should be provision for these to be introduced over as long a period as was necessary to avoid inconvenience and hardship to patients and to avoid damaging either the pharmacy or the medical practice.

8. PROPOSAL TO REGULATE SIGNIFICANT CHANGES IN DISPENSING ARRANGEMENTS IN RURAL AREAS

8.1 We had thus reached the point where we agreed that certain elements of the present arrangements were unsatisfactory to both professions, but could not agree on either of the proposals put forward by the professions or on new objective criteria to decide whether pharmacists or doctors should dispense in individual rural areas. If progress was to be made both professions would clearly have to compromise. A method of avoiding sudden arbitrary changes and of resolving differences between members of the two professions was essential. The sensible solution therefore seemed to us to be that significant changes in dispensing arrangements in rural areas should be regulated, ie that such changes should require the approval of a body of people representing patients, doctors and pharmacists and whose task it would be to consider all the relevant factors before reaching their decision. We appreciate this will involve additional administrative work and the time of the people concerned. We believe however that the number of places in a year where significant changes in dispensing arrangements are proposed will in fact be small.

9. A NATIONAL STATUTORY BODY

9.1 We considered whether this task of regulating significant changes should be undertaken by the dispensing sub-committees of FPCs. However, there would be over sixty such committees and there would inevitably be variations between different areas in the factors taken into account in reaching decisions; and since we have ourselves been unable to agree on objective criteria it would clearly be difficult to give guidance to the dispensing sub-committees. Another difficulty in making decisions locally without objective criteria lies in ensuring complete impartiality in every case.

9.2 We therefore consider that such decisions should be taken by a national statutory body, independent of the DHSS. The advantages would be that there would then be a detached and impartial body of people who could draw up their own guidelines and build up "caselaw" so as to ensure a consistency in decisions yet produce the right solution for the individual circumstances of each locality and in the best interests of the patients, doctors and pharmacists concerned. Naturally this statutory body would

have to rely on detailed information on local circumstances provided by the dispensing sub-committee of the FPC; sometimes this would have to be supplemented by a visit to the place in question by officers or members of the body. The body would of course consider very carefully the views of the FPC's dispensing sub-committee, along with those of the Local Medical Committee and the Local Pharmaceutical Committee. The dispensing sub-committees of FPCs should in our view be responsible for deciding on certain changes which would not significantly disturb the local arrangements and which could take place without reference to the national statutory body. (see Paragraph 11.2).

10. MEMBERSHIP OF NATIONAL STATUTORY BODY

10.1 We consider that the statutory body should be composed of three doctors, three pharmacists, three people who are not members of the health professions and a chairman who is not a member of those professions. All members should be appointed by the Secretary of State but in the case of the doctors on the nomination of the General Medical Services Committee and in the case of the pharmacists on the joint nomination of the Pharmaceutical Society of Great Britain and the Pharmaceutical Services Negotiating Committee. This national joint committee is hereafter abbreviated to 'NJC'.

10.2 Provision should be made for deputies to be appointed at the same time as members. A tenure of office of three years would be appropriate for members and deputies, who would be eligible for re-appointment.

10.3 Six members or deputies would form a quorum, provided that there were present at least two doctors, two pharmacists and two lay members. Decisions would be by a majority vote of members present, with the chairman having a vote only in the event of an equality of votes.

10.4 The NJC must by virtue of authority and fairness command the respect of doctors and pharmacists practising in rural areas, and the chairman and members would need to be chosen on the basis of their ability to contribute to this aim.

11. THE EXTENT OF REGULATION IN RURAL AREAS

11.1 We consider that the following would always constitute significant changes in dispensing arrangements in a rural area, and should therefore require the approval of the NJC.

11.1.1 Any proposal to start NHS dispensing at a pharmacy.

11.1.2 Any proposal to start NHS dispensing by a medical practice (other than for patients qualifying under Regulation 30(1)(a) (serious difficulty)).

11.1.3 Any proposal by a dispensing medical practice to provide an NHS dispensing service (other than for patients qualifying under Regulation 30(1)(a)) in an area where the practice has not previously dispensed.

11.2 We discussed other changes in a rural area which might or might not, according to the circumstances of each case, be significant changes, and which we felt could best be considered by the FPC's dispensing sub-committee, whose membership would be prescribed in regulations (see

Paragraph 21). It would have power to approve those changes which seemed to have little significance and would refer to the NJC any proposals which in the view either of the dispensing sub-committee or of those members appointed by the Local Medical Committee or the Local Pharmaceutical Committee involved significant change. In particular we propose that the following changes should be considered by FPCs' dispensing sub-committees on this basis.

11.2.1 The relocation of a pharmacy on an FPC's pharmaceutical list near its present location.

11.2.2 The transfer of patients from the prescribing list of a medical practice to the dispensing list of the same or another practice without a change of patient's address.

11.3 Changes which we consider should take place without the approval of either the NJC or the FPC's dispensing sub-committee are as follows.

11.3.1 The inclusion in an FPC's pharmaceutical list of a new owner of an existing pharmacy.

11.3.2 Dispensing by a successor or a new partner in a medical practice for those patients already included in the practice's dispensing list.

11.3.3 The addition to the dispensing list of a medical practice of new patients who move into an area where the practice provides a dispensing service.

11.4 We think this division of changes which may arise in a rural area is sensible and will limit regulation to those proposals which are likely to have a significant effect on the services provided by doctors and pharmacy owners for people living in rural areas. We do not recommend that the NJC should have any power to initiate a change in dispensing arrangements in any area.

11.5 Whilst recognizing that in certain areas our recommendations might further limit patients' choice in determining from whom they receive their medicines, we hope that where a choice is available both professions will ensure that it is a free choice.

12. REVIEW OF WHETHER AN AREA IS STILL RURAL IN CHARACTER

12.1 Regulation 30(1)(b) operates only in areas which in the FPC's opinion are rural in character. The classification of areas for this purpose is therefore critical and a decision that an area has ceased to be rural in character for the purpose of Regulation 30(1)(b) may involve a significant change in dispensing arrangements, since patients will no longer be entitled to ask their doctor to dispense for them under the one-mile rule and will have to have their prescriptions dispensed at a pharmacy unless they qualify under Regulation 30(1)(a) (serious difficulty); doctors who dispense for patients living in the area must, subject to reasonable notice from the FPC, cease to do so except for patients who qualify under Regulation 30(1)(a).

12.2 The factors which an FPC takes into account in reviewing whether an area is still rural in character for the purpose of Regulation 30(1)(b) include the extent of building development, the density of population and the extent of services - commercial, public transport etc - available to the residents. In practice we believe that FPCs have frequently used the same areas for the purpose of Regulation 30(1)(b) as those in which additional payments are made to doctors from the Rural Practices Fund, and changes in the classification of areas have been infrequent.

12.3 We think that the question whether an area or part of an area (as appropriate) remains rural in character for the purpose of Regulation 30(1)(b) should be considered on its own merits, and the decision should not depend on the classification for the purpose of the Rural Practices Fund.

12.4 We consider that these decisions should continue to be taken by FPCs, but that in view of their importance in relation to dispensing arrangements and the system of regulation we are recommending there should be provision for the Local Medical Committee or the Local Pharmaceutical Committee to appeal to the NJC against the decision of an FPC on whether a locality is rural in character for the purpose of Regulation 30(1)(b).

13. FACTORS WHICH THE NJC WOULD TAKE INTO ACCOUNT IN REACHING DECISIONS ON APPLICATIONS TO START OR EXTEND DISPENSING

13.1 An application to the NJC would be made through the FPC by the doctor or practice of doctors or the pharmacy owner or prospective owner concerned. The applicant would have to state the reasons for the proposed change in dispensing arrangements and specify the areas of residence and the estimated numbers of patients likely to be affected.

13.2 The FPC should notify the Local Medical Committee, the Local Pharmaceutical Committee and all doctors and owners of pharmacies in the area in question of all proposals involving a significant change in dispensing arrangements. The applicant, the FPC, the Local Medical Committee and the Local Pharmaceutical Committee should have the right to give oral evidence to the NJC, and that right should be extended to any doctor or pharmacy owner who satisfies the NJC that he would be directly affected if the application were approved. The NJC should also have discretion to invite anyone else it considers necessary when dealing with any particular application. It would of course be open to anyone who considered he would be affected by a proposal to inform the NJC of his views.

13.3 The NJC would rely on the FPC's dispensing sub-committee to:-

- i. confirm estimates of patient numbers and details of areas of residence specified in the application;
- ii. describe the existing arrangements for patients to obtain prescription medicines, including the extent of any doctor dispensing areas and the factors governing accessibility to a pharmacy, and give the dispensing sub-committee's views on the likely effect on the general medical and pharmaceutical facilities in the area if the application were approved;

iii. comment on the views of the Local Representative Committees., *Taken out.*

13.4 Among the factors which the NJC would no doubt take into account would be the following.

13.4.1 The likely effect on the existing general medical and pharmaceutical facilities and the consequences for the patients, doctors and pharmacists concerned - the NJC would no doubt regard this as of critical importance.

13.4.2 Whether the patients covered by the application were with reasonable facility obtaining their prescription medicines from an existing pharmacy or dispensing practice.

13.4.3 Whether a proposed pharmacy would be viable.

13.5 The NJC would doubtless attach considerable weight to the views of the FPC's dispensing sub-committee and those of the Local Medical Committee and the Local Pharmaceutical Committee. We do not envisage that the NJC would be likely to approve an application which did not have the endorsement of the Local Representative Committee for the profession from which the application came, nor would it be likely to refuse one which carried the agreement of both the Local Medical Committee and the Local Pharmaceutical Committee, provided that the proposal was in patients' interests.

14. MODERATING THE EFFECT OF ANY CHANGE IN DISPENSING ARRANGEMENTS

14.1 Since one of the main disadvantages of the present unregulated arrangements is the risk of a sudden arbitrary change, we consider that if the NJC came to the conclusion that a proposal was in the public interest it should be able to make its approval conditional on any measures it thought necessary to ensure that the effect of the change would be gradual, so that there would not be difficulties for patients and the doctors or pharmacy owners concerned would not suffer a sudden loss of income.

14.2 This could be done by the NJC specifying an appropriate and temporary modification of the one-mile rule (in the case of a new pharmacy) or some form of limit on the rate at which patients were added to doctors' dispensing lists (in the case of doctors starting or extending their area of dispensing) or removed from dispensing lists (in the case of an area which had ceased to be rural in character).

14.3 Before reaching a decision on any proposal the NJC should be free - but only with the consent of the parties - to consult the DHSS on the effect the proposal would have on the NHS remuneration of any doctor or pharmacy owner who would be directly affected. We recommend that the DHSS should consider making appropriate provision for an adjustment of remuneration where this would facilitate a change in dispensing arrangements which the NJC considered desirable.

14.4 As an additional measure to preclude the risk of frequent changes we propose that once the NJC has reached a decision on an application, or on an appeal as to whether an area is rural in character, no further proposal relating to the same area and requiring to be referred to the NJC should be considered within five years of the NJC's decision, unless the NJC is

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satisfied that exceptional circumstances have arisen (such as the closure of a pharmacy or a proposed change in location of a surgery) which make it necessary for a proposal to be considered within that period. This "five year rule" would apply only to a proposal which had been referred to the NJC.

15. SCOPE OF APPROVALS BY THE NJC

15.1 An approval granted by the NJC should in the case of doctors be for a defined dispensing area and apply to the practice as a whole. It would thus be transferable not only to a doctor who succeeded an existing member of a practice but also to additional members of the practice. In the case of pharmacy owners or prospective owners the approval should relate to a specified pharmacy and be transferable to a new owner.

15.2 The area of residence in a rural area within which a patient would, in the absence of serious difficulty, have to obtain medicines from a pharmacy and not be able to ask his doctor to dispense would remain at the area of a circle of one mile radius centred on any pharmacy.

15.3 An approval from the NJC would of course be conditional on any necessary planning permission being obtained from the local authority and, in the case of pharmacies, registration of the premises under Section 75 of the Medicines Act 1968.

16. CHOOSING BETWEEN APPLICANTS

16.1 If there were more than one applicant for dispensing in the same area, the NJC would no doubt rely on advice from the Local Representative Committee in the case of a choice within the same profession and on its own assessment of the best interests of the patients in the area in the case of a choice between the professions.

17. APPEALS AGAINST DECISIONS OF THE NJC

17.1 The NJC would inform all those who had a right to give oral evidence, and the DHSS, of its decision, and advise the applicant and any directly affected doctor or pharmacy owner of their right of appeal against the decision. We do not think that anyone else should have a right of appeal. Appeals should be to the Secretary of State, within a prescribed time (which should be short), and it would be for him to decide whether an oral hearing was justified.

17.2 There would be no further right of appeal against the ruling of the NJC on an appeal against the decision of an FPC on whether an area is rural in character for the purpose of Regulation 30(1)(b).

18. SERVICING THE NJC

18.1 We recommend that the NJC should be serviced by officers of the DHSS, although these officers would naturally be precluded from dealing with appeals to the Secretary of State against decisions of the NJC.

19. RELATIONSHIP BETWEEN THE NJC AND OTHER BODIES

19.1 The Medical Practices Committee (MPC) established under Sections 7, 30, 33 and 34 of the NHS Act 1977 (formerly Section 34 of the NHS Act 1946) regulates entry to NHS medical lists, by classifying areas into designated, open, intermediate or restricted and considering applications for the filling of certain practice vacancies and the establishment of additional practices. We understand that the MPC takes into account, in considering applications relating to rural areas, whether the doctor will dispense for his patients. We do not however consider that the regulation of the start or extension of dispensing by doctors on the basis we recommend need clash with the consideration by the MPC of applications for entry to NHS medical lists, although it would clearly be desirable for the secretariats of the MPC and of the NJC to work in close liaison. In the event of a doctor seeking entry to the medical list as a dispensing doctor in respect of a new practice or an existing practice which did not dispense the MPC would need to obtain the advice of the NJC before proceeding in the matter.

19.2 If at any future date a body were to be established to regulate entry to NHS pharmaceutical lists on a national basis there would similarly be no need for any interference with the operation of the NJC, although close liaison would of course be desirable.

20. RESPONSIBILITY OF DISPENSING SUB-COMMITTEES OF FPCs

20.1 At present Regulation 30(5) provides that an FPC may, and on request by the Local Medical Committee or the Local Pharmaceutical Committee shall, establish a dispensing sub-committee to carry out the FPC's functions under Regulation 30, subject to such directions as the FPC may impose. We consider that the regulations should make clear that any FPC with these functions should establish a dispensing sub-committee with the prescribed membership to discharge them. Although the regulations would, as now, provide for this to be subject to any directions of the FPC, we envisage that having regard to the increased emphasis which we suggest should be given to the role of the dispensing sub-committee, FPCs would in fact delegate their functions relating to dispensing in rural areas to that sub-committee. We consider that the regulations should provide that if any particular function is not wholly delegated the FPC should consider the reports of the dispensing sub-committee relating to that function and accept as conclusive any findings of fact in those reports; and give the reasons if it does not adopt the recommendations of the sub-committee (in like manner to Regulation 10 of the Service Committees and Tribunal Regulations). All the information the dispensing sub-committee requires for the discharge of its functions would be provided by the FPC.

21. MEMBERSHIP OF DISPENSING SUB-COMMITTEES OF FPCs

21.1 In view of the important role to be played by FPCs' dispensing sub-committees we consider that their membership should be prescribed in the regulations. It would be necessary to discuss this with the representatives of FPCs, but we suggest that a dispensing sub-committee should be composed of three doctors appointed by the Local Medical Committee, three pharmacists appointed by the Local Pharmaceutical Committee, three lay persons appointed by the FPC and a lay chairman appointed by the FPC with the agreement of the Chairmen of the Local Medical and Local Pharmaceutical

Committees. We do not think that the chairman need necessarily be a member of the FPC, but if he is not he should have the right to attend and speak, but not to vote, at any meetings of the FPC at which a matter within the remit of the dispensing sub-committee is to be discussed. In appointing the lay members the FPC would naturally need to ensure that anyone who had a continuing personal interest in matters which could be the subject of adjudication by the dispensing sub-committee was not appointed. Any member who had a personal interest in any individual matter brought before the sub-committee would be expected to abstain from the proceedings of the sub-committee in that matter.

21.2 Deputies would need to be appointed. We think that a quorum should consist of the chairman and six members or deputies, including at least two doctors, two pharmacists and two lay members.

22. LEGAL IMPLICATIONS OF PROPOSALS FOR REGULATING SIGNIFICANT CHANGES

22.1 Our proposals would require primary and subordinate legislation. Primary legislation would be needed:-

22.1.1 to enable entry in a rural area to the pharmaceutical list of an FPC to be regulated - at present, by virtue of Section 42 of the NHS Act 1977 (formerly Section 38(2)(b) of the NHS Act 1946), there is no restriction on entry to the list by anyone who is entitled by law to sell or supply medicines and who undertakes to comply with the terms of service for chemists.

22.1.2 to enable the NJC to be established.

22.1.3 to empower the Secretary of State to prescribe in regulations the arrangements under which the NJC would operate.

23. TRANSFER OF DOCTOR'S OR PHARMACY OWNER'S DISPENSING FUNCTION IN RETURN FOR PAYMENT

23.1 In addition to considering a system of regulation we have considered the scope for agreed change in local dispensing arrangements and whether, to facilitate such arrangements, it should be possible for a part or the whole of a doctor's or pharmacist's dispensing function to be transferred to a member of the other profession in return for payment. Our recommendations are set out in Appendix 3.

24. VOLUNTARY 'STANDSTILL' AGREEMENT

24.1 Where any matters affecting the voluntary 'standstill' could not be resolved at local level and were referred to us our role was limited to considering the facts as presented by the local joint inter-professional committee and the FPC and offering advice on the application of the terms of the 'standstill' agreement, emphasising the desirability of the terms and spirit of the agreement being observed. We gave advice on three cases referred to us concerning dispensing arrangements at Tetbury (Gloucestershire), Llanberis (Gwynedd) and Sedbury (Gloucestershire). Informal advice on several other cases was given by individual members of the Committee and by the Secretariat. We shall remain in being until April 1978 for the sole purpose of giving advice to local joint inter-professional committees on the application of the terms of the standstill to a local proposal on which there is a difference of opinion within the local committee.

24.2 It is heartening that the 'gentleman's agreement' has been so successfully observed by both professions. Our proposals will of course take time to implement, and it is essential that the stability which has been established should be maintained. We recommend that the professions agree the terms of a voluntary agreement to operate until our proposals are implemented; that they form a central joint committee composed of representatives of both professions to give advice during this period to local joint inter-professional committees; and that these local committees should continue in existence to deal with any proposals to start or extend dispensing in a rural area, which we hope will be put forward only where a change of circumstances in an area suggests that an alteration in the existing arrangements for supplying medicines on prescription will be in the patient's interest.

25. CONCLUSION

25.1 Although the medical and pharmaceutical professions have long had differing views about the arrangements for dispensing in rural areas, in the majority of areas these arrangements operate smoothly and without disturbance, and amicable relations exist between the doctors and pharmacists concerned. It is only in a minority of areas that differences occur and then in the main when a change in arrangements is proposed. Under the existing regulations this can happen suddenly and arbitrarily; and it is this threat of sudden change which casts a shadow of uncertainty over the livelihood of doctors and pharmacists practising in rural areas. We have been unable to agree on new objective criteria which could be applied generally, but we consider that a method of avoiding sudden arbitrary changes and of resolving differences between members of the two professions is essential. We have therefore concluded that the sensible solution is to regulate significant changes in dispensing arrangements in rural areas through a national statutory body which would consider all the relevant circumstances of the individual area and decide on the right solution in the best interests of the particular patients, doctors and pharmacists concerned.

25.2 Our proposals are summarised below. We commend these to each profession and recommend that they make a joint approach to the Secretary of State for Social Services and the Secretary of State for Wales, requesting that the necessary legislation be submitted to Parliament.

25.3 We desire to acknowledge with gratitude the unfailing help and patience of our excellent Secretariat under the leadership of Alan Read.

SIGNED

C M CLOTHIER (CHAIRMAN)

J P BANNERMAN

D J D FARROW

D L COLEMAN

R J R LEWIS

G CORMACK

A J ROWE

G T M DAVID

G W WALKER

R DICKINSON

M A WILSON

10 NOVEMBER 1977

SUMMARY OF PROPOSALS OF NATIONAL JOINT COMMITTEE ON RURAL DISPENSING

1. A national statutory body (NJC) should be established to regulate significant changes in dispensing arrangements in rural areas. (Paragraph 9.2).
 2. The members of the NJC should be appointed by the Secretary of State for Social Services and should comprise three doctors nominated by the General Medical Services Committee, three pharmacists nominated jointly by the Pharmaceutical Society and the Pharmaceutical Services Negotiating Committee, three lay members and a lay chairman. (Paragraph 10.1).
 3. The following changes should always require the approval of the NJC.
 - 3.1 Any proposal to start NHS dispensing in a rural area at a pharmacy.
 - 3.2 Any proposal to start NHS dispensing in a rural area by a medical practice (other than for patients qualifying under Regulation 30(1)(a) (serious difficulty)).
 - 3.3 Any proposal by a dispensing medical practice to provide an NHS dispensing service (other than for serious difficulty patients) in an area where the practice has not previously dispensed.
 - 3.4 Any proposal referred to the NJC by the dispensing sub-committee of an FPC. (Paragraphs 11.1 and 11.2).
 4. FPCs should establish dispensing sub-committees, with a prescribed membership, to deal with matters relating to dispensing arrangements in rural areas. (Paragraphs 20 and 21).
 5. Changes which should initially be considered by the dispensing sub-committee of the FPC should include the following.
 - 5.1 Any proposal to re-locate a pharmacy on the FPC's pharmaceutical list near its present location.
 - 5.2 Any proposal to transfer patients from the prescribing list to the dispensing list of the same or another medical practice without a change of patient's address.
- If the dispensing sub-committee or the members appointed by the Local Medical Committee or the Local Pharmaceutical Committee consider the proposal would involve a significant change in dispensing arrangements the sub-committee should refer the proposal to the NJC. If the proposal is not considered to involve a significant change the matter would be for decision by the sub-committee. (Paragraph 11.2).
6. The following changes would not require the approval of the NJC or the FPC's dispensing sub-committee.
 - 6.1 The inclusion in an FPC's pharmaceutical list of a new owner of an existing pharmacy.
 - 6.2 Dispensing by a successor or a new partner in a medical practice for those patients already included in the practice's dispensing list.

- 6.3 The addition to the dispensing list of a medical practice of new patients who move into an area where the practice provides a dispensing service. (Paragraph 11.3).
7. There should be provision for the Local Medical Committee or the Local Pharmaceutical Committee to appeal to the NJC against the decision of an FPC on whether an area is rural in character for the purpose of Regulation 30(1)(b). (Paragraph 12.4).
8. The NJC should have wide power to enable any decision on a proposal or appeal to be conditional on measures to ensure that the effect of the change would be gradual. (Paragraph 14.1).
9. The DHSS should consider making appropriate provision for an adjustment of the NHS remuneration of a directly affected doctor or pharmacy owner where it would facilitate a change in dispensing arrangements which the NJC considered desirable. (Paragraph 14.3).
10. The NJC should not consider any further proposal or appeal relating to the same area within five years unless it is satisfied that exceptional circumstances have arisen. (Paragraph 14.4).
11. Approvals by the NJC should have the following scope.
- 11.1 In the case of doctors, be for a defined area, apply to the practice as a whole and be transferable to successors of existing members and to additional members of the practice;
- 11.2 In the case of pharmacies, apply to a specified pharmacy and be transferable to a new owner. (Paragraph 15.1).
12. The applicant and any doctor or pharmacy owner directly affected by the decision should have a right of appeal to the Secretary of State against a decision of the NJC. (Paragraph 17.1).
13. The professions should consider the possibility of payments between doctors and pharmacists being permitted for approved voluntary transfers of dispensing business from one to the other. (Paragraph 23.1 and Appendix 3).
14. To ensure stability until the NJC is established the professions should retain the local inter-professional committees and should agree a further voluntary standstill to be monitored by the local committees, with a central joint body for additional advice. (Paragraph 24.2).
15. The professions should jointly request the Secretary of State for Social Services and the Secretary of State for Wales to submit the necessary legislation to Parliament. (Paragraphs 22.1 and 25.2).

APPENDIX 1
(See Paragraph 1.1 of Report)

NATIONAL HEALTH SERVICE ACT 1977
(EXTRACT)

Pharmaceutical services

41. It is every Area Health Authority's duty, in accordance with regulations, to arrange as respects their area for the supply to persons who are in that area of -

(a) proper and sufficient drugs and medicines and listed appliances which are ordered for those persons by a medical practitioner in pursuance of his functions in the health service, the Scottish health service, the Northern Ireland health service or the armed forces of the Crown (excluding forces of a Commonwealth country and forces raised in a colony); and

(b) listed drugs and medicines which are ordered for those persons by a dental practitioner in pursuance of such functions.

The services so provided are in this Act referred to as "pharmaceutical services".

In this section -

"listed" means included in a list for the time being approved by the Secretary of State for the purposes of this section; and

"the Scottish health service" and "the Northern Ireland health service" mean respectively the health service established in pursuance of section 1 of the National Health Service (Scotland) Act 1947 or any service provided in pursuance of Article 4(a) of the Health and Personal Social Services (Northern Ireland) Order 1972.

42. Regulations may provide for securing that arrangements made under section 41 above will be such as to enable any person for whom they are ordered as mentioned in that section to receive the drugs, medicines and appliances there mentioned from any person with whom such arrangements have been made; and the regulations shall include provision -

(a) for the preparation and publication of lists of persons who undertake to provide pharmaceutical services;

(b) for conferring a right, subject to this Part of this Act relating to the disqualification of practitioners, on any person who wishes to be included in any such list to be so included for the purpose of supplying such drugs, medicines and appliances as that person is entitled by law to sell; and

(c) for the removal from the list of persons undertaking to provide pharmaceutical services for persons in any area of the name of any one in whose case it has been determined in such manner as may be prescribed that he has never provided, or has ceased to provide, such pharmaceutical services for persons in that area.

43. (1) No arrangements shall be made by an Area Health Authority (except as may be provided by regulations) with a medical practitioner or dental practitioner under which he is required or agrees to provide pharmaceutical services to any person to whom he is rendering general medical services or general dental services.

(2) No arrangements for the dispensing of medicines shall be made (except as may be provided by regulations) with persons other than persons who are registered pharmacists, or are persons lawfully conducting a retail pharmacy business in accordance with section 69 of the Medicines Act 1968 and who undertake that all medicines supplied by them under the arrangements made under this Part of the Act shall be dispensed either by or under the direct supervision of a registered pharmacist.

THE NATIONAL HEALTH SERVICE (GENERAL MEDICAL AND PHARMACEUTICAL SERVICES)
REGULATIONS 1974
(EXTRACT)

PART VIII

SUPPLY OF DRUGS, ETC BY DOCTORS

Arrangements for supply by doctors of drugs and appliances

30. (1) A person who -

(a) satisfies the Committee that he would have serious difficulty in obtaining any necessary drugs or appliances from a chemist by reason of distance or inadequacy of means of communication, or

(b) is resident in an area which in the Committee's opinion is rural in character, at a distance of more than one mile from the premises of any chemist,

may at any time request the doctor on whose list he is included to supply him with drugs and appliances.

(2) (a) If the doctor so requested indicates willingness to supply drugs and appliances, the Committee shall arrange with him to do so.

(b) If the doctor so requested does not indicate willingness to supply drugs and appliances, the Committee may require him to undertake such supply:

Provided that the Committee shall not require him to do so if he satisfies it or, on appeal, the Secretary of State that he does not normally supply drugs to his patients, or in the case of a person to whom paragraph (1)(b) of this regulation applies, that the person can with reasonable facility obtain drugs and appliances from a chemist.

(c) A doctor who under the provisions of the preceding subparagraphs supplies drugs and appliances to some or all of his patients may supply any necessary drugs and appliances to a person whom he has accepted as a temporary resident.

(3) A doctor shall be entitled to receive reasonable notice from the Committee that he is required to undertake the supply of drugs and appliances, or, where a person no longer satisfies the provisions of paragraph (1) of this regulation, that the supply is to be discontinued.

(4) Notwithstanding anything contained in this regulation, where a drug or an appliance is one for which a doctor is entitled to receive extra payment if he supplies it, he may, with the patient's consent, instead of supplying it himself, issue a prescription for that purpose.

(5) The Committee may, if it thinks fit, and shall if requested to do so by the Local Medical or Local Pharmaceutical Committee, constitute a sub-committee (in these regulations referred to as "the dispensing sub-committee"), and shall delegate to that sub-committee, subject to such conditions as it may impose, the functions conferred on the Committee by this regulation.

(6) The Committee may make, vary or revoke standing orders with regard to the terms of office of members of the dispensing sub-committee, the procedure of that sub-committee and the making of reports of their proceedings to the Committee.

(7) In this regulation, the word "drugs" shall include contraceptive substances and the word "appliances" shall include contraceptive appliances.

AGREEMENT MADE BETWEEN THE MEDICAL AND PHARMACEUTICAL PROFESSIONS IN
OCTOBER 1975

STANDSTILL ON DISPENSING IN RURAL AREAS -
MEMORANDUM OF GUIDANCE

Standstill

1. The standstill will be for a period of 12 months renewable if the discussions about a permanent solution are incomplete and appear to be progressing satisfactorily.
2. It will be a gentleman's agreement reached between and operated by the professions and will constitute an undertaking each to the other.
3. The Central NHS (Chemist Contractors) Committee and the Council of the Pharmaceutical Society give an undertaking to the General Medical Services Committee to do all they can to dissuade pharmacists from starting to dispense under the National Health Service where doctors already dispense; and the General Medical Services Committee give an undertaking to the Central NHS (Chemist Contractors) Committee and the Council of the Pharmaceutical Society to do all it can to dissuade doctors from starting to dispense in an area already served by a pharmacy. This latter undertaking would mean asking all doctors primarily not to transfer patients from their prescribing list to their dispensing list and secondly not to accept new patients on to their dispensing lists unless the patient has moved into, or has changed his address within, an area where a doctor already dispenses, or the patient wishes to change from one practice to another. The only exceptions to this standstill will be where there is local agreement between the two professions that an individual doctor or pharmacist should start or extend dispensing.
4. The professions will set up joint local committees in each Family Practitioner Committee area where there is, or is likely to be, dispensing by doctors under the existing Regulations. Each local committee will be composed of three pharmacists appointed by the Area Chemist Contractors Committee and three doctors appointed by the Local Medical Committee. The Chairman would be appointed by the local committee from among its membership. The Chairman will have a vote but not a second casting vote. There is nothing to prevent members of the joint local committee also being members of the Family Practitioner Committee or its Dispensing Subcommittee.
5. Each local committee will consider any case where a doctor wishes to start dispensing or to extend his dispensing list, or a pharmacist proposes to dispense under the National Health Service in an area where doctors already dispense. It will be their function to consider and offer advice on queries arising from the operation of the standstill and to promote an exchange of views between the professions at an early stage whenever a prospective change in existing dispensing arrangements becomes known. The committee will operate solely by professional influence and will seek to arrive at mutually acceptable solutions which avoid doctors or pharmacists taking up intransigent positions on Family Practitioner Committees and Dispensing Subcommittees.

6. The local committee may ask the National Joint Committee for advice where persuasion at local level is unsuccessful. Nevertheless the local and the national bodies can only use persuasion and both parties accept the possibility of individual doctors or pharmacists refusing to honour the undertaking given by the central bodies and as a consequence there may be isolated infringements for which neither can be held to blame. In these as in other cases the decisions and advice by Family Practitioner Committees, their Dispensing Subcommittees, and the Department will be based on the present Regulations if there is any conflict between this and the informal agreement between the professions.

7. The professions accept that there may be exceptional situations where a binding financial commitment, which might appear to breach the undertaking given by the central bodies, had been entered into by a doctor or a pharmacist before the standstill was announced on 11 October 1975.

National Joint Committee

8. A National Joint Committee will be established consisting of five representatives of each of the professions plus an independent lay Chairman appointed by the Minister of State. The Chairman will not have an arbitration function but will seek to be helpful to the two professions in arriving at agreed conclusions.

9. The aim should be to find a solution which will secure sensible arrangements for the supply of medicines etc on prescription in the circumstances of each locality and should avoid sudden changes - with consequent effect on income of existing doctors and existing pharmacists - in the arrangements on which patients have hitherto relied. As the circumstances will vary between different localities and in different cases it may be more profitable to look for a procedure which can be followed in each area than to seek to draw up rules for general application. Nevertheless if a solution to the dispute requires amendment of the regulations or of primary legislation, the Department would be prepared to consider a joint request by the professions.

10. The National Joint Committee will also consider difficult individual cases which are referred by local joint committees.

11. The professions have requested that the National Joint Committee issue a Progress Report after six meetings which it hopes will be by April 1976.

APPENDIX 3
(See Paragraph 23 of Report)

TRANSFER OF DOCTOR'S OR PHARMACY OWNER'S DISPENSING FUNCTION IN RETURN FOR PAYMENT

1. Situations could arise where it would be in the interests of both professions locally that the existing arrangements should be changed, and the possibility of "purchase" of the transferred dispensing business could enable the doctors and pharmacists concerned to reach an agreement satisfactory to themselves and in the interests of their patients. For example, a new development just outside the one mile limit on the outskirts of a market town might bring so much new work to the local medical practice that it would make sense for them to cease to dispense for patients from the parts of their practice with easy transport to the nearest pharmacy. The doctors might be satisfied that the change was not against their patients' interests, and the pharmacist be willing, in effect, to "purchase" the "business" the doctors were transferring on terms that were acceptable to the doctors. Similarly there could be situations where the transfer, with a payment, of business from pharmacists to medical practices could be advantageous to both parties. An example might be where a pharmacist in poor health, unable to sell his business to another pharmacist because it was too small to be viable, might be happy to sell his dispensing business to the local dispensing doctors to help finance his earlier retirement.
2. Payments of this kind would at present be incompatible with the ethical codes of the professions, and could be regarded as "the sale of goodwill" of a medical practice which is prohibited by existing NHS legislation. It would be necessary to amend this legislation. We are nevertheless convinced that there is scope for voluntary change in dispensing arrangements, and that this could be a useful supplement to the forms of change which the NJC would regulate; and that where the conditions for agreed change exist, agreement could more easily be reached if the "purchase" of transferred business were clearly permitted and seen as professionally correct and not unethical.
3. We recommend that the representative bodies of the professions, with the advice as necessary of the Medical Practices Committee (MPC) and of their own expert advisers, should give serious consideration to the suggestion that payments for the agreed transfer of dispensing business should be permitted and approved by both professions. Any agreed transfer would however require the prior approval of the NJC, who would be responsible for ensuring that patients' interests had been fully taken into account and would examine the effects of the transfer not just on the present viability of the medical practices or pharmacies in the area but on their continued viability, allowing for possible changes in circumstances when successors took over. The NJC might wish to consult the MPC when there was any doubt about the continued viability of a medical practice. If the professional bodies are convinced by our arguments appropriate recommendations could be included in their advice to the Secretary of State on this Committee's proposals.
4. We would emphasise that transactions involving money could only take place where both parties were willing and the price agreed between them. We would not wish the NJC to have power to require that payments should be made when there are other types of change in dispensing arrangements.

5. The terms for a purchase of dispensing rights would be a matter for local agreement between the doctors and pharmacists concerned, being determined essentially by "market forces" - a balance between the value of the change to the two parties. If the professions accept our recommendation they may wish to explore the possibility of working out a mutually acceptable formula for the calculation of reasonable payments, for the guidance of doctors and pharmacists. Such a formula would only be a starting point for negotiations, and it would be for the individuals concerned to decide whether they would use it.