Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Community Pharmacy

14 March 2012

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Community Pharmacy

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Samuel Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

Witnesses:

Ms Aileen Crossin	Community Pharmacy Northern Ireland
Mr Lindsay Gracey	Community Pharmacy Northern Ireland
Mr Gerard Greene	Community Pharmacy Northern Ireland
Mr James McCaughan	Community Pharmacy Northern Ireland

The Chairperson: I take the opportunity to welcome the members of Community Pharmacy to the meeting. We have Mr Gerard Greene, chief executive; Mr Lindsay Gracey, chairman; and Mr James McCaughan, a board member. Mr Paul Cooper, vice-chair, has been called away and sends his apologies. However, Aileen Crossin has stepped into his position. We are well aware of the issue of community pharmacy, and the Committee has looked at and had briefings on it. We have received substantial amounts of individual information and personal testimonies from pharmacists. You are aware that the Minister made a statement yesterday. I will hand over to you to make a presentation and then open it up for Committee members' questions or comments. You are more than welcome to the Committee. This is an issue that all Committee members have an interest in. We are well aware of the importance of community pharmacy in our communities. Gerard, I think that you are taking the lead on this.

Mr Gerard Greene (Community Pharmacy Northern Ireland): Lindsay, as chair, will start off, and I will come in afterwards.

Mr Lindsay Gracey (Community Pharmacy Northern Ireland): Madam Chairperson, ladies and gentlemen, thank you for your welcome and for the opportunity to address the Committee today. I introduce to you the Community Pharmacy Northern Ireland (CPNI) team: Aileen Crossin, a pharmacy owner from north Belfast; Gerard Greene, chief executive; and James McCaughan, a community pharmacist in Ballycastle and Armoy. I will shortly pass over to Gerard, who will take you through the briefing paper, but before I do so, I would like to cover a few points.

We welcome the Health Committee's continued interest in resolving the crisis that exists in community pharmacy. As the Committee knows, there have now been two judicial reviews (JRs), the second of which was essentially a sequel to the first. Both were caused by flawed departmental and board processes associated with consultation or the lack of it, particularly relating to the work that underpinned the new Northern Ireland drug tariff, which was introduced on 1 April last year. Both judicial reviews have been caused by the same underlying flaw: the Department and the boards' unlawful imposition of pricing arrangements from the drug tariffs in England and/or Scotland, without ensuring that they are fit for purpose in a Northern Ireland situation.

This is an evolving situation, and it is important to note that our briefing paper was written and submitted before the Minister made the statement in the Assembly late yesterday afternoon. It is also important to note that the funding proposal presented by the Minister yesterday differed from any of the previous proposals made to CPNI, and we were not given an opportunity to respond to it in any formal way. We are also extremely disappointed to learn of the Minister's decision to appeal. Given the clear conclusions of the judgment, we had hoped to avoid further legal constraints, instead moving forward to achieve the resolution much needed by pharmacy contractors. CPNI absolutely understands the challenges presented by the current difficult financial circumstances. We believe that to overcome those significant challenges, it is critical to ensure that all key skills and opportunities in the health service be fully realised in order to deliver improved patient outcomes, while achieving the best value for public funds. CPNI is fully committed to change.

Before I hand over to Gerard, I feel that I need to dispel a few myths that I know have existed in the Department for some considerable time. I would like to formally, absolutely and unequivocally address a number of those key points.

We understand and support the movement towards a more open, transparent system, particularly with regard to understanding the extent to which drug procurement margins subsidise the delivery of this service. Therefore, we support the development of a joint ongoing margins survey — I stress the two words "joint" and "ongoing" — and, in fact, have been working jointly with the board and departmental officials on that for almost one year. Although we continue to place value on our high-quality dispensing service — the core service of our profession — we also support the move towards a more service-based remuneration contract model, which will reward improved health outcomes.

Collaborative working lies at the heart of our preferred approach. Over the past year, CPNI has presented a number of compromised proposals to the Department, the first of which was submitted in May 2011. Those proposals centred on a compromise position, which we believe to be necessary to stabilise the network and to allow three key pieces of joint work to be carried out. The three pieces of joint work, which we first proposed last May, are a joint ongoing margins survey; a joint cost of service inquiry; and a joint pharmaceutical needs assessment, which we have had no response to during that 10-month period.

It is interesting to reflect on our proposed approach against that presented in the Minister's statement yesterday. The Minister proposed a parallel approach for the margins survey, with each side carrying out its own work. He also proposed that the board take control of the cost of service inquiry, with CPNI as an unequal partner. We believe that such an approach can only lead to a further dispute. If the aim is to reach a single view of the truth, that will be achieved only through collaborate approaches and agreement. It is also important to note that both margins surveys and cost surveys are carried out on a joint basis in all other UK regions.

CPNI has approached the entire process from a position of reasonableness. When it became clear that we had reached an impasse, we submitted a proposal based on compromise and joint work, and central to that was a compromise figure. In order to minimise risk to public moneys, we accepted that

should the compromise figure be in excess of that arrived at through an agreed cost of service figure, it could be clawed back from the pharmacy network, and I want to stress that point.

CPNI has also proposed consideration of some form of independent mediation, and that offer was also rejected by the Department. I hope that today we will show that CPNI is not the aggressive, commercially driven, truculent and secretive organisation portrayed by some in the Department. Rather, it is an organisation deeply concerned about the injustice to which, we believe, the community pharmacy network has been subjected. We wish, as always, to have patient care at the forefront of what we do, and we are working hard to do all that we can to support our contract members who are struggling to survive to provide those essential services to patients. I will now pass over to Gerard for the key points of the briefing. Thank you.

Mr Greene: Thank you, Madam Chair and Committee members. Ladies and gentlemen, community pharmacy functions at the closest level to local communities in Northern Ireland. It is often the first point of contact for people to the health service and it is also the last point of contact for those receiving prescribed medication. It offers unprecedented access to the health service for patients and offers commissioners a direct line to around 130,000 people in Northern Ireland on a daily basis without the need for an appointment. Positioned as it is, we believe that a fully engaged, enabled community pharmacy network would offer the single most cost-effective resource to a reprofiled health and social care system.

'Transforming Your Care' proposes an enhanced role for community pharmacy, and we have no doubt that community pharmacy will rise to that challenge. We know that innovative investment in community pharmacy services could now deliver improved outcomes for patients, reduced drug wastage, the reprofiling of GP and accident and emergency consultations, reductions in hospital admissions and better preventative healthcare and supported self-care in an enhanced community support network.

Negotiations between CPNI, the Department and the board to develop a new contract for community pharmacy were progressing steadily before the start of the most recent judicial review. Much good work has been done. Although a new contract must be affordable to the commissioner, it must, equally, deliver a clear and fair remuneration, reimbursement and investment framework for community pharmacy services in a way that meets safety, quality and efficacy requirements. Even with fair remuneration systems in place, community pharmacy services would remain the most cost-effective in the health service; no other provider can guarantee access to around 130,000 people a day.

The opportunity provided by that level of access is well illustrated by the smoking cessation services provided by community pharmacy, which is, by far, the largest provider of that service in Northern Ireland. It supported almost 23,000 people to quit smoking in 2010-11. Compare that with the 7,000 who went through GP practices.

Specific areas in which we know that investment will deliver long- and short-term savings include developing community pharmacies as public health resources, improving the use of medicines, improving access to the health service, and in these times, of course, implementing and prescribing efficiency interventions. We are all aware of the general perception in the board and Department that Northern Ireland has too many pharmacies per head of population. Before it is possible to reach a decision on the appropriate number in and distribution of the network of pharmacies, it is important to fully understand the local factors that influenced the current situation. Such factors include rurality and population dispersal; higher levels of health and social care needs; more prescriptions per head of population; and duplication of services, as a legacy of the Troubles. All those factors impacted on the current size and distribution of the community pharmacy network. Clearly, this is a complex issue that cannot be solved by a simple extrapolation from GB.

As Lindsay mentioned, to address that issue, last May, Community Pharmacy Northern Ireland proposed to our board and departmental colleagues a joint pharmaceutical needs assessment, which would have looked at the number and distribution of pharmacies. We believe that that work is important and needs to be carried out to ensure that local, and particularly rural or disadvantaged, communities are not deprived of an accessible health service resource. It would also ensure that other pharmacies are not faced with an unmanageable workload, as prescription demand will remain,

regardless of the number of pharmacies. We are keen to progress that work and would welcome further discussion of it.

CPNI remains committed to resolving this dispute. Indeed, it is our duty to do so to prevent the meltdown of community pharmacy services that will inevitably occur if this situation is allowed to develop further. CPNI remains acutely aware of the deepening impact that the funding reduction experienced by community pharmacy owners is having across the network, and with which Committee members will be familiar.

It is important to remind ourselves of why we are in this position. CPNI firmly believes community pharmacy has been subjected to unfair and unreasonable funding reductions. Flaws have been found in the departmental and board processes. We believe that those flaws have resulted in the current level of funding not being capable of providing fair and reasonable remuneration to pharmacy owners.

In summary, at present, CPNI's fundamental concerns are based on, first, an unworkable financial envelope. We remain resolute in our belief that the board's proposed financial envelope of £90 million, which was arrived at through a flawed process, is not sufficient to provide fair and reasonable remuneration for the existing community pharmacy network. That amount will simply not work, and will lead to the indiscriminate, uncontrolled closure of pharmacies. Many local communities will suffer if such an approach is allowed to continue.

Secondly, there is concern for the sustainability of the network. CPNI must reiterate our grave concern about the current situation. Many community pharmacies have tried to cut pharmacy overheads back to a bare minimum and scrambled together short-term funding in an attempt to remain open, hoping that a resolution can be found. These quick fixes have resulted in a reduced number of staff, the selling of assets, the cashing in of pensions, the taking out of short-term, high interest loans and the borrowing of money from family members. Community pharmacy contractors have been put in that position because of flawed departmental and board processes, and it is completely unacceptable and unjust that they have been forced to subsidise the provision of an essential healthcare service in this way. This is not expected of any other primary care provider, and these issues are substantiated in the results of our contractor survey, which was carried out last October.

There is also concern about the well-being of community pharmacy contractors. As this situation continues, CPNI is becoming increasingly worried about the health and well-being of pharmacy contractors and their staff. Our concerns extend to contractors right across the community pharmacy network, and we have relayed those serious concerns to the board.

Finally, in our experience, the fact that there have been two judicial reviews that have found against the Department cannot be understated. The second judicial review was, essentially, a sequel to the first and had an even more definitive judgement, yet the approach taken by the Department and board officials has not changed. For us, this is no surprise. Following the first judicial review, the Department did not move to reach an agreement until a number of contractors issued writs some five months after the judicial review ruling. The interim arrangements were eventually agreed in July 2010. CPNI's position and preference at all times is to reach agreement by engaging in active discussion and meaningful negotiation.

I will now take the opportunity to update you on recent events. Three without-prejudice meetings have taken place between Monday 20 February and Friday 2 March between us and board and departmental colleagues under the chairmanship of the permanent secretary, Dr Andrew McCormick. At the most recent meeting on 2 March, a new package of proposals was presented to CPNI, which, if accepted by CPNI, we understood would be recommended to the Minister. In spite of some pressure for an immediate answer, CPNI decided to call an emergency board meeting on the evening of Monday 5 March. At that meeting, the CPNI board reached a unanimous view on the proposal and unanimously agreed that it should report to the contractor network and seek their views on the proposal, given the implications that it would have on them. That contractor meeting took place on Thursday 8 March, 511 votes were cast, and the unanimous decision of all present was to reject the Department/board offer.

Given the confidential and without-prejudice nature of the discussions, we could not detail the nature of the proposal in our briefing document that was provided previously to you. However, it is important to

state that the proposal presented to us differed to that which the Minister presented yesterday. I can also state that our interpretation of the Department's offer did not amount to a funding envelope of £100 million approximately. In essence, the £90 million funding element that was proposed at the start of 2011-12 remains unchanged. Clearly, for an offer to be unanimously rejected by the CPNI board and the 511 contractors, there were firm grounds for that decision. The fundamental concerns that were expressed during those discussions were the completely unworkable funding envelope; the proposal's all-or-nothing approach; failure to reach a proposal based on meaningful negotiation; the differential payment models, leading to potential inequity; the linkage of immediate 2011-12 issues with medium-term investigative work streams; and the limited opportunity for a collaborative approach going forward. However, the fundamental reason why the proposal was rejected was that it was found to be unfair and unreasonable in that funding falls below what is needed to provide this essential, community pharmacy, front line healthcare service.

Now that we have come through both JRs, it is incumbent on all parties to reach a settlement that is sustainable, achievable and acceptable to all. We remain committed to finding solutions. CPNI believes that these solutions fall into two broad parts. First, there needs to be an immediate allocation of the underspend. There must be immediate respite in the form of allocating the underspend in the current Health and Social Care Board (HSCB) budget back into the system. We understand that the Minister has proposed a distribution model in his statement, but it is CPNI's view that the money should be distributed in a fair and equitable way across the network to reflect accurately the work that has been done over the past year and the level of impact that the funding changes have brought about.

Secondly, there must be agreement on an interim position. I will point out again that the £90 million referred to in the Assembly yesterday is essentially the same £90 million put to CPNI last April. We emphasise again that the £90 million that is on offer was arrived at through flawed analyses and is clearly inadequate to cover the cost of providing a community pharmacy service in Northern Ireland.

CPNI is keen to work with the Department and the board to carry out the necessary investigatory pieces of work; that is, the joint cost survey, the joint margins survey and a joint pharmaceutical needs assessment. That work will provide the evidence currently lacking to arrive at a financial envelope that is fair and reasonable.

Until that work is completed, there needs to be more than £90 million put into the system for 2011-12 and 2012-13. CPNI has proposed a compromise figure. That could be done without prejudice, and in order to minimise risk to public moneys, as Lindsay said, CPNI accepts that if there is an underpayment, money could be paid back to the network, and if there is an overpayment, that would be subject to clawback. Should the current dispute remain unresolved, CPNI will continue to seek other avenues for resolution, such as independent mediation or arbitration.

We have no doubt that failure to learn the lessons of what has gone wrong in the past and failure to stabilise the finances of community pharmacy immediately and in 2012-13 will result in the decimation of our once vibrant community pharmacy network.

There is a need for a managed transition, within a comprehensive heads of agreement, to reach our goal of achieving an accessible, effective, efficient community pharmacy network, remunerated at a fair and reasonable level, which is capable of delivering an enhanced role and of bringing many new important services to patients, as outlined in 'Transforming Your Care' and is capable of meeting the increasing needs and demands of a growing Northern Ireland population.

The Chairperson: Thanks very much for your presentation and for the paperwork that you sent us. A number of members have indicated that they want to speak. This is an issue that has been on the Committee radar for a while. I have a number of points to make and then we will move to questions. The Deputy Chair and I had a briefing with the Minister and his officials yesterday, and we had five minutes to get back into the Chamber prior to the statement being made. We raised some of the points with the Minister that you have raised. Did you get a briefing or was there any contact with the Department at any time prior to the Minister making the statement yesterday?

Mr Greene: There was no formal contact.

The Chairperson: So, you were aware that a statement was being made but you did not know what was in it.

Mr Greene: No, definitely not.

The Chairperson: With regard to the issue of the clawback, what is being said is that there could be an issue around the Comptroller and Auditor General on that and around the Public Accounts Committee. Do you have any view on that? It is being said that if the money was overpaid, there could be an issue where it could be clawed back.

Mr Greene: We are not aware of the processes that the Department and the board have to adhere to but we know that, in previous years, there has been accommodation across a number of financial years where adjustments needed to be made to payments.

The Chairperson: So, there is evidence that that has happened before anyway.

Mr Greene: Yes, in previous years, payments that have straddled a three- or four-year period have been made in one year.

The Chairperson: Has that not raised concern?

Mr Greene: Again, I do not know the internal machinations of the processes.

The Chairperson: You made a point about the joint margins survey, the cost of service and the issue of pharmacy needs. Can you give me any understanding of why you believe the Department is so against that being done jointly?

Mr Gracey: I, personally, cannot. The practice everywhere else in the UK is that it should be a joint piece of work. In England, the Pharmaceutical Services Negotiating Committee (PSNC), which is the equivalent of Community Pharmacy Northern Ireland, has a unit set up in their building. All the invoices are collected, and the methodology that has previously been jointly agreed is worked through. There is a level of validation that gives the Department comfort that the work that is being done on the margins survey is correct.

There are two key points with our margins survey. We have already accepted a level of validation that is significantly in excess of the validation that occurs in England and Wales. In addition, we have offered that, on a full-time basis, a member of departmental staff can be embedded in the margins survey unit. So, I struggle to see what the issue is and why we should be treated differently to our colleagues in England, Scotland and Wales.

The Chairperson: During the presentation and the statement yesterday, we heard that information is needed to show that there is a need for the additional money. I am struggling to find out why it cannot be done jointly and what the Department means by "parallel", because I am sure that youse are looking at the same evidence. It strikes me that, based on what you say Gerard, there is a need for a form of independent mediation. Can you elaborate on what you mean by that and why you say it?

Mr Greene: We might find ourselves in a situation where it does not look like there will be resolution. We are convinced that our position on the funding that is required for community pharmacy is absolutely justifiable, and we have brought in external experts to validate and produce that information for us. We are confident in our position. If we cannot reach agreement — as I said during my presentation, we want to do this collaboratively; it is the way to do it, we get buy-in from contractors. There are advantages all around.

The Chairperson: Could that be because there has been a breakdown in relationships between officials and yourselves?

Mr Greene: If there is a need for that information to be obtained going forward, and if both sides cannot do it, we are happy for that to be done externally by independent arbitration and mediation.

The Chairperson: OK. I am trying to tease out some stuff. I believe that there has been a breakdown and I am trying to get that out. Do not assume that my questions suggest that I do not support you. The issue of the flawed process has been mentioned a few times. Can you elaborate on what you mean by that?

Mr Gracey: There has been a change to the system for the way you remunerate people, the fees you pay, the amount that you pay for the drugs and the discount that you might assume that your customer is getting, which you might adjust. We have said all along that no proper regulatory impact assessment has been carried out on the changes that have been brought in here by the application of an English drug tariff. In April last year, we supplied the Department and the board with the work that had been carried out for us, based on 135 contractors, on the effect that the changes, which we knew were coming in April, would have. Very simply, those changes were a reduction in the ordinary and multiple dispensing fees and a change in the discount. There are two types of drug: generic drugs, which are off-patent, and patent-protected drugs. Historically, the Government took a 1% clawback from us against the price that was in the drug tariff for generic drugs, and on branded products, they took a discount of about 8%.That changed to a flat clawback of 10%. So, it was quite clear: you knew the value of the generic drugs and the branded drugs, so you knew how much additional money you were going to claw back.

On top of that, interim payments had been made in relation to the unlawful application of category M. We also knew the value of removing that. There was also a change in the minor ailments scheme, which we were able to quantify. So, we put before the Department and board a very clear view of what money would be removed. The only item that we could not absolutely clarify was the drug tariff, or the list that tells us what they will pay us for the various drugs. There was a substantial reduction in that in April, but when we were modelling our figures, we did not know how much money it would amount to because that is affected by prescribing patterns and we did not have the new prices.

Those things together were the impacts that the Department and the board should have looked at, and we provided substantial evidence to help them obtain that figure. They also have access to the business service organisation (BSO) figures.

The Chairperson: I accept that some of this topic is without prejudice and that you may not be able to answer all the questions.

I think it was you, Gerard, who said that CPNI submitted a compromise proposal to the Department. When was that? Was it this year or last year?

Mr Greene: We submitted a compromise proposal last May. We submitted another proposal in September. Both were submitted to prevent the judicial review going ahead. The first compromise proposal was to prevent the judicial review having to be applied for. The second one was —

The Chairperson: Can we see that proposal? Are we allowed to do so?

Mr Greene: If we can provide it, we will.

Going back to your point about the flaws, the judge was quite clear in his judgement that there were flaws in the processes around the failure to carry out a margins survey and a cost survey, which are key elements in arriving at fair and reasonable remuneration and funding for community pharmacy services. Part of our proposals in May and September last year was to do those joint pieces of work. So, we were quite clear in our minds that they needed to be done and that things had to be evidence-based.

Mr McCarthy: When is your next meeting with the Department? It seems to me that the gap is getting wider instead of narrower as regards reaching a settlement or agreement. In the meantime, you know better than I do that community pharmacies will be worse off by a long shot.

The Minister made his statement yesterday. I asked a question about the £38 million, and I do not know whether you picked up the Minister's response, but he laughed at it. His response was that I could not count and that the figure was closer to £6 million. There is a hell of a difference between £38 million and £6 million. Can you tell us what is going wrong? Does somebody in the Department not understand the situation?

Mr Greene: Returning to the court case, one of the things that was said in court was that somebody had got their figures wrong. We came up with the figure of £38 million last April and the changes that you could see coming out of the system for that amount. As the year has gone by, we have started to see the evidence coming through from the BSO figures to corroborate that level of funding cutback. We are also seeing from contractors, because they are effectively one year down the line since the changes were introduced, that this is starting to come through in their audited financial accounts information. That is in black and white and shows a situation in which funding has fallen off a cliff. That is impacting through contractors' accounts to the bottom line.

Many people are reporting losses overnight. As someone said, that does not happen just because there is a £6 million reduction in funding. We are confident in our figures and we still stand by them. In fact, some people tell us that they think that CPNI got its figures slightly wrong and that they are too low.

Mr McCarthy: How are we going to overcome this? The Minister said that he will appeal it. We do not know how long that will take. How can we get someone to accept these figures and do something about it?

The last time that the Department came to the Committee, I was quite annoyed, as I am sure all members were. There were two guys here. Joe talked about transparency, and the other guy talked about truth. It seemed to me that they were almost saying that they do not believe what you guys are saying. Is that what is going on?

Mr James McCaughan (Community Pharmacy Northern Ireland): I can show you the figures. I am here to represent rural pharmacy. We opened a small rural pharmacy in Armoy, which is six or seven miles from two larger towns in north Antrim. That happened after four, possibly five, years of the local community wanting a primary care facility in the heart of the village. For the first five months, we were paid under the straightforward regime that I had experienced during the previous 20 years of my pharmacy career. We have had these cuts imposed on us since April. As with any business initiative, we had to go to the bank. A series of projections were conducted to facilitate the overdraft and loan that would allow us to start the business. Private moneys were also put in to start the business.

We have had exceptional support from the local community. We can demonstrate that our footfall for what we call over-the-counter sales, which is a minimal amount, is up by 10% to 14%. This suggests that the facility is valued in the local community. Yet, when we use the figures that we had extrapolated due to our previous experience, I am actually 30% down. As a consequence, unless something serious happens between now and the end of the month, the bank will probably close the business.

Mr McCarthy: That applies to you, and it will apply to others across Northern Ireland.

Mr McCaughan: It will apply to many others. There is Armoy, Dunloy, Rasharkin, Clough Mills, Kells, Feeny — you name them. It affects every constituency, although I am not that familiar with certain parts of the Province. The same impact of the cuts is reflected in urban environments.

Mr McCarthy: Chair, is there any way that this evidence can be given to the Department or whoever is making the decisions? That is what we want to know.

The Chairperson: We will come to the steps that the Committee can take after we finish questions on the presentation.

Mr Wells: I have never come across a dispute in which the two sides seem to be so far apart. Indeed, the complex theory of thermodynamics seems to be nothing compared to working out how pharmacists are paid and how the retained profit issue works.

The Minister told us yesterday that, a year ago, he paid about £90 million to community pharmacy in Northern Ireland and everyone was happy. This year, he is paying £91 million to community pharmacists, yet everyone is falling off a cliff. Practically every pharmacist in South Down has told me, directly or indirectly, that this is an absolutely dire situation. If the Minister is paying the same amount, community pharmacy is still getting £90 million. If you are paying roughly the same amount for your drugs, where does the £28 million to £35 million loss come from?

Mr Gracey: It is complex, but try to bear with me. The pharmacy economy is funded by two things. First, there are fees, a professional allowance and dispensing fees. Secondly, as Lord Justice Morgan pointed out at the first judicial review, there is retained purchase profit — the difference between what pharmacists pay for drugs and the rate at which government reimburses them.

There are two ways in which we get money. We get a professional allowance for having the pharmacy practice there. We get dispensing fees. When you come in, there is a fee of £1·04 attached to dispensing your prescription, or 49p if the script is dispensed daily or weekly. In addition, there is a margin in the drugs. When you give your prescription to me, I get a dispensing fee and a potential profit in the drug that I supply you with. The reality is, and this is acknowledged by the Department, that if the drug is a branded, patent-protected drug, on almost every occasion I will have paid more for the drug than the Government pay me. That is created by the fact that the discount that I am given by the companies is substantially less — 2% to 3% less — than the clawback that the Government apply to the list price of that drug. On many occasions, big companies such as Pfizer, which supplies Lipitor — some of you may be on it —

The Chairperson: Is it for old age? *[Laughter.]*

Mr Gracey: It is to reduce cholesterol.

The Chairperson: I am on that.

Mr Gracey: When I dispense a box of Lipitor, and the Government get that prescription and pay me, they take just over 10% from the manufacturer's list price of the drug. So, if I make it simple and say that the manufacturer's price is £100, the Government will reimburse me at £90. They will remove 10% through discount clawback.

Mr McCallister: Do the Government know how much you are paying for that?

Mr Gracey: Yes, in that case, John. They know that I am getting around 6·5% or 7%.

Mr McCallister: That would be on the branded drug, but the Government do not know how much you are paying for the generic drug.

Mr Gracey: That is right. So, the situation is that if we look at a total drugs bill of, I think, £440 million, £350 million to £360 million of that is for branded drugs, so my colleagues and I carry a loss on that £360 million. We have dispensing fees to help to fund us, and we are then left with £80 million for generic drugs, which is the area where there is a margin. Lord Justice Morgan accepted, and it is universally accepted, that it is the retained purchase profit in generic drugs that allows the service to exist. Common sense tells you that if you dispense £360 million worth of drugs at a loss, there has to be profit in the remaining £80 million or it is all over.

Two things have happened that have adversely affected that this year. First, there was the movement of the discount clawback. I have just explained that the Government take 10% from me in discount on Lipitor, and I have 6·5% or 7%. The Government are also taking 10% off their list price for any generic drug. So, if you are on a fluid tablet, and it is £1 a box on the tariff, that is the price that they paid.

They are now clawing that back at 10%. They take 10% discount and they pay me 90p. Until April 2011, they would only have taken 1% back and would have paid me 99p: 9% has gone on that.

In addition, when we came to April, compared with March last year, they introduced part of the English drug tariff. The tariff that we had in place, which was the Scottish tariff, had prices for all drugs. To go back to the example of the fluid tablet, that tablet in the Scottish tariff last year might have been £1·20, but when the English tariff was introduced, the price was moved to, say, 90p. So, I have lost 30p in what I am being reimbursed, and I have had an additional 9% discount taken from me.

That is how the funding has been stripped out along with things such as the minor ailments service, which you are all familiar with. Whenever coughs, colds and hay fever were removed from the minor ailments scheme, it removed 80% of the consultations that were made on minor ailments. So, compared to 2010-11, that equates to a funding removal of £2·9 million. So, there was another loss.

In the settlement for 2010-11, there was an acceptance that category M was applied illegally in Northern Ireland. It was short-funding community pharmacy in Northern Ireland, so an annualised figure of £11 million was made in category M payments. That has been removed. I hope that I am making myself clear: I am trying to break down where the money has been stripped out.

I now turn to the issue of the £90 million, Jim. Colleagues can clarify for me if I do not make this clear.

Mr Wells: Keep going. You are doing well.

Mr Gracey: The £90 million includes a figure that the Government have assessed as retained profit on drug purchases. The figure that they assessed was £16·5 million. To make up the £90 million envelope that Jim talked about, the figure included £16·5 million of retained purchase profit, which is a combination, in their view correctly, of losses on branded medicine and profit on generic medicine. Now, the issue is that, in fact, no one knows what that retained purchase profit was. They have assumed that, in this year, that £16·5 million is remaining and they arrive at a figure that is very similar — £90·5 million or £91 million. I have just explained to you what has happened to the discount structure and to the reimbursed prices. That combination could not leave the same amount of money. If you take 9% additional discount on generics, 2% additional discount on branded products and you slash the reimbursement price of all the generic drugs, how could it conceivably be the same?

Mr Wells: That is the money that was given by the Department of Finance and Personnel to the Department of Health, which the Health Department has allocated to community pharmacy and which has come out. That £90 million has gone somewhere, and it has gone into 526 community pharmacies. However, what you are saying is that the clawback is money coming out much faster at the other end, as a result of the clawbacks, because of the increased discounts to tackle retained profits.

Mr Gracey: The discounts, the reduction in the tariff, the removal of the likes of the category M money, the change in the minor ailments, the new lower tariff prices — there is a combination of five or six factors, Jim.

Mr Wells: Where is that money? Where is that £28 million to £35 million?

Mr Gracey: It will show, primarily, in a reduced drugs bill to the Department of Health, I assume.

Mr Wells: So, the Department should be showing us a reduction in its drugs bill of about £28 million to £35 million.

Mr Gracey: It will show you more than that.

Mr Wells: So, that means that the overall pharmacy budget should be down by a good 7%?

Mr Gracey: You will always have issues with new, expensive drugs coming on to the market, which patients need and will add to the drug spend.

Mr McCallister: And that is growing.

Mr Gracey: It is growing by the fact that we have an ageing population.

Mr Greene: I think you are right, Jim. When we looked, quarter-on-quarter this year and last, you can clearly see a reduction in the amount that is being paid in totality.

Mr Wells: Lindsay, I think that every MLA should take this page out of the Hansard report and learn it. This is the first time that I have had the issue properly explained to me in a way that is digestible by an ordinary mortal, rather than by someone who has a PhD in maths. Excellent. At least now I know where I am going on this matter. However, the Minister said yesterday that you could be right, but that the problem is that there has been insufficient co-operation from the industry prior to this situation, which would have enabled the Department to have tied down exactly what community pharmacy's retained profit is. Therefore, the reason why we are at this crisis today is because, had you co-operated, they would have understood where you were coming from and maybe we would not be in the position that we are in today.

Mr Gracey: I have to say that the impact assessment that we gave them last April, Jim, clearly showed those factors and how they would kick in. They are not mysterious. We have just agreed that it is quite a simple —

Mr Wells: It is as simple as PR.

I accept what you are saying, but with all due respect, the figures produced by CPNI are not impartial or neutral. The Department is saying to us that had you co-operated with it about a year ago or 18 months ago by looking at your books to see what you were paying for drugs and cross-referenced that with the wholesalers to see what they were paying, it would have been able to get a very clear impression of exactly what the retained profit was and what impact any clawback would have. You refused to co-operate. The Department, admittedly, did not use the powers that it had to impose disclosure on the wholesalers, and I accept that. However, you did not co-operate, so the Department had to have a stab at it, and now you are saying that that stab in the dark has led to the carnage that we are facing today. To some extent, however, is that not your fault?

Mr Gracey: No. I want to make it quite clear that we have worked exceptionally hard on the methodology and the manner in which a margins survey needs to be done. In both our interim proposals, we have stated our absolute acceptance of the essential nature of a margins survey, a cost survey and a needs assessment. What we do not accept — and there is any amount of documentation to support our argument — is for someone to look at prices in a particular month and say that that represents, and accurately represents, the margin obtainable from drugs. Annualised figures from England, Scotland and Wales show significant variation from month to month. So, a one-month margins survey, rather than a rolling margins survey, proves absolutely nothing.

Mr Wells: So, you would have accepted a survey that had been spread over a year.

Mr Gracey: Yes. We have worked incredibly hard over the past year to agree methodologies and everything else. If you were in my position and this was being done to you, would you want a margins survey in operation to prove the amount of money that is being stripped out? With respect, I think that you would. Why would I run away from a margins survey when I am being kicked all over the park? This is common sense. Of course, I want a margins survey but I want one that is fair and accurate.

Mr Wells: Finally, we are in a recession, and the retail trade on the high street in villages is going badly. There is a view that some of this would have happened anyway, regardless of what clawback the Department invoked. Given the difficult financial conditions, some of your members would still be finding it tough had exactly the same funding regime as last year been in place this year.

Mr McCaughan: Not if the volume of work has increased in all pharmacies: we are dispensing more than we ever have.

Mr Wells: Are you still making money on shampoos, hair dyes and the other services that you provide?

Mr McCaughan: I just recounted an example of a rural pharmacy where the turnover on shampoos, and so forth, that you describe makes up less than 5% of the total turnover. I cannot even employ a Saturday girl.

Mr Gracey: That is equally true for me. I have two pharmacies in Ballykeel and Ballee in Ballymena. The NHS turnover constitutes over 95% of my turnover. Shop sales are almost irrelevant. We provide those things as a service to the public; it is not a commercial exercise.

Mr Wells: Do you accept that the Department has a right to clawback the savings that it makes when drugs go generic?

Mr Gracey: I accept that with a properly created financial envelope, there are savings for the Government through the move to generics. We accept that absolutely and we have supported the use of quality generic medications recommended by the National Institute for Health and Clinical Excellence. There is no issue with that. Why would I want to continue dispensing branded drugs when I lose money on every one that I dispense?

Mr Greene: From the figures from BSO, we know that the average cost of a branded medicine is something like £23 an item and that a generic drug costs £4·37. It makes sense for everybody. Lindsay says that he is losing money on £23. Why would you want to do that? If there is some margin on £4·37, the health service will benefit if £23 becomes £4. If you can switch to generics, there are cost savings straight away. Pharmacies depend on getting a margin from that small amount of £4·37. All we are saying is that we need some of that to keep us afloat and alive; do not strip it all out. The important point is that in England, Scotland and Wales, where prices are suppressed through the tariff arrangement, the money taken out of the system comes back in by way of fees. However, there has not been that shift of money here; the money taken out has not gone back into the system. Money has been taken out, with no compensatory money coming in. That is why we are in this situation now; it is a crisis. Too much has happened too quickly in one year, and people cannot cope with that.

Mr McCallister: We have been getting very heavily involved in the pharmacy industry over the past six or seven months. Jim mentioned the costs survey and how you get impartiality on your side. Presumably you would not count the Department as being completely impartial in this?

Mr Gracey: Would they consider me to be completely impartial if I did it?

Mr McCallister: Well, that is the point that I am making.

Mr Gracey: That is the point.

Mr McCallister: Lindsay, you said that you worked hard to get the methodology right for the margins survey, and that one cannot just take a snapshot.

Mr Gracey: Yes.

Mr McCallister: Presumably it would be like measuring traffic on a Sunday or something. It may not be entirely accurate.

Mr Gracey: That is right.

Mr McCallister: Your group commissioned a PricewaterhouseCoopers (PWC) survey a year or two ago.

Mr Greene: That was to do with the cost of providing pharmacy services.

Mr McCallister: Remind us of the figures.

Mr Greene: The PWC survey determined that the cost of providing pharmacy services in Northern Ireland was in the range of £123 million to £130 million.

Mr McCallister: The Department would not accept that?

Mr Greene: No. The Department did not accept the work of PWC, which is one of the world's leading experts in understanding pharmacy costs. It is also worth pointing out that the methodology used in our survey reflected that used in the current joint Department of Health in London and Pharmaceutical Services Negotiating Committee (PSNR) colleagues' survey in England. We have used the same methodology, and PWC has been involved in that. It has used the latest industry and economically accepted methodologies, and that was applied in Northern Ireland. The Department did not accept the findings.

Mr McCallister: Are you close to getting agreement as to how you do the margins survey and to getting it started?

Mr Greene: We are well down the road with getting the methodology for the margins survey. There have been absolutely no discussions about a cost survey.

Mr McCallister: For how long will you have to run the margins survey before you get to the point at which you can say that it is accurate?

Mr Greene: You need to look at it on an ongoing basis so that you get the full picture and not just a snapshot. As Lindsay says, there could be a particular time in the year when the figure would be depressed or elevated.

Mr McCallister: What will happen if other funding is not brought in quickly? As James said, the end of the month is only two and a half weeks away, which is not a long time. There was an announcement yesterday, but I am not sure that I found the Minister's tone to be particularly helpful. It did not sound as though he was handing out much of an olive branch to anyone yesterday. He talked about £8 million going into new services, but I am not quite sure which new services he was going to deliver in the last two and half weeks of the 2011-12 year. How do you see that working out? Is it going to be of some help?

We have had the Department here on several occasions, and it has been depressing, to put it mildly. We keep hearing the same thing; they say that they are working closely. Every excuse has been used, from the judicial review to waiting on remedies or on something else happening. They say that they cannot talk much about it or that they are meeting you guys on Friday. We have heard all that but we do not seem to be getting any closer to a resolution.

Mr Greene: The money will be welcomed. It has to go in straight away. However, people are concerned about the methodology that will be used to apportion the money to different pharmacies. Some will get a disproportionately higher amount than pharmacies in other locations. People are concerned that new criteria for dividing up the money have been brought in at the eleventh hour and imposed on us. We have had no real engagement or negotiation around the introduction of new criteria for the distribution of that money. People feel that because their funding is reduced as a result of the drug tariff changes that affected them and the work that they have done, that money should be distributed equitably across the network. This way, it will not be. We hope that some money will go into the system in the next couple of weeks because, as James said, people need it.

Mr McCallister: I hope that it gets —

Mr Greene: Fundamentally, it is not enough.

Mr McCaughan: All that we are doing is putting off the inevitable. It is just a Band-Aid; it will give a stay of execution to a lot of community pharmacies out there, but they will probably be back in the same position three months down the line. As I understand it, about £3 million a month is being taken out of the pharmacy economy.

The Chairperson: We are also coming to the end of the financial year, which is unfortunate.

Mr McCallister: It will be difficult because we will go into the next year without appearing to be any closer to a resolution. It is not as if we are sitting here today thinking that we have nearly turned the corner. I expect to have the Department back here in a month or six weeks' time or whatever going over the same old stuff again and saying that it is trying but it cannot agree the figures or get to that point.

Mr Dunne: I thank the panel for their contribution. It has been very informative. The last point that you mentioned was about new criteria. One of the criteria, as I understand it, looked more at the location of the various pharmacies. What is your attitude towards the location-based criteria? Surely, as we talked about before, there is an argument that a pharmacy that is located in somewhere like Helen's Bay is totally different to one that is located in the Bloomfield Shopping Centre, to use an example in my constituency of North Down. Surely there is quite a differential that needs to be recognised.

Your attitude to the cost and margins surveys has been fairly well covered. Are you happy to proceed with those in the new financial year?

Mr Greene: It was a joint margins survey. We had an option that reflected the methodology that was used across the water. It had been agreed, and it has the approval of the Department there, the representative bodies and the contractors. There is a slight moving away from that in Northern Ireland, and it is unfortunate that the Minister chose that option.

Mr Dunne: Is that still an issue?

Mr Greene: We need to get the margins survey done. At the end of the day, the Department has statutory powers. If it invokes that, it invokes that, which is unfortunate. We want to work collaboratively, and we think that there is still merit in the margins survey being operated by CPNI. As Lindsay said, the level of validation, the level of checks and the input that the Department's officials can have in a margins survey unit that CPNI would operate would be far in excess of what happens across the water.

Mr Dunne: It is important that good evidence is given to the Department to clarify the issue once and for all and for transparency. It obviously works both ways and in both interests. I am not sure whether we all followed the funding formula that Lindsay clarified to Jim. Is it true that the bottom line is that the clawback is roughly £28 million? Is that fair?

Mr Gracey: You have a twin funding track: you have dispensing fees and professional allowance and then you have the retained margin — the profit and acquisition. So, it is difficult to come up with an absolutely definitive figure. We calculated the £38 million. Remember that I mentioned the difference in the price list that occurred between March and April. We did not know what that would be, and that is also affected by what people prescribe. If you are asking whether £28 million is the amount of money that has been removed, the answer is no; that is very substantially below the amount of money that has been removed. Within two or three months, we will be in a position to have fully audited complete-year accounts from a very substantial number of pharmacies. Those accounts, which will no doubt be signed off by PwC and KPMG and all sorts of significant accountants and smaller independent accountants across the country, will fully prove the removal of funding from community pharmacy. Personally, I look forward to the day when the fully audited, full-year accounts are on the table showing the full effect.

Mr Dunne: I suppose that will play a part in the cost and margins surveys.

Mr Gracey: Yes, they will, because they will reflect people's costs more so maybe than the margins.

Gordon, you made a comment about Helen's Bay and Bloomfield Shopping Centre. Whether you live in Helen's Bay or in Bangor, if you go to the community pharmacy in Helen's Bay, you will expect to be treated by a professional person giving you quality advice, dispensing the right item correctly and fulfilling all the healthcare needs you have. If you chose to go to Bloomfield Shopping Centre because that is a frequent shopping venue for you or because you live in that part of Bangor, I would suggest that you expect exactly the same things. There are differences, such as the rent and rates in Helen's Bay will be somewhat less than for the 3,000 or 4,000 square feet unit that might be the pharmacy in Bloomfield Shopping Centre, but the professional service that you are being offered in either place has to be to the highest quality standard and providing that facility to a community or a neighbourhood of people. There are differences in the nature of the two businesses, but the quality output that you are seeking to achieve is the same.

Mr Dunne: The dispensing figures will be significantly different.

Mr Gracey: They may be. I worked for almost nine years in shopping centre pharmacies; three years in the old Clandeboye Shopping Centre in Bangor and six years at Connswater. Shopping centre pharmacies are a different kind of animal because you see a lot of people in the evening —

Mr Dunne: You have a lot of footfall.

Mr Gracey: There is a lot of footfall and different retailing. There tends to be a lot of retailing. However, dispensing people's medication and giving them appropriate healthcare advice are common to both. There are certainly differences in the business model and there are different costs attached to running those two types of operation.

Mr Dunne: Is it fair to assume that you are not keen on a location-based funding formula?

Mr Gracey: We have accepted fully the need for a joint needs assessment on the number and distribution of community pharmacies in Northern Ireland and a review of the workload undertaken by them. I will give a very simple example. In England, roughly 11% of the items dispensed are dispensed by dispensing doctors. There are very significant costs attached to that service that are not seen as part of the pharmacy envelope. In Northern Ireland, dispensing by dispensing GPs is under 1%, so there is a significant cost in England that is not present in Northern Ireland.

People in Northern Ireland, on average, are on much more medication. You can take any view you like on that but it is a fact. We have more medication used per head of population in Northern Ireland than the UK in general. You could go to specific areas of Glasgow or other areas across the country where you might find very high medication usage, but overall, if you compare Northern Ireland with England, Scotland or Wales, I think you will find that patients here use significantly more medication. With that, there is a workload. That is not my fault: I do not prescribe; I dispense. I have to have staff in place and stock on the shelf to fulfil that need for the patient.

The Chairperson: Two other members want to ask questions, but I am conscious that if we lose people soon, we will lose the quorum. It is Sam then Mickey.

Mr Gardiner: Thank you for your presentation or rather your information thus far. At the end of the day, it all comes down to money. What is the shortfall that you are asking for, bearing in mind that the Department will be listening in to these recordings?

Mr Gracey: That is quite all right.

Mr Gardiner: It will probably be looking at you, too.

Mr Gracey: Transparency is what we are about.

Mr Gardiner: We have talked around it but we have not got to the point.

Mr Greene: As I said earlier, PwC has shown that the cost of providing pharmacy services in Northern Ireland is somewhere between £123 million and £130 million. The Department and the board say that fair and reasonable funding will be provided at £90 million. So, there is obviously a substantial difference.

I have referred to two interim proposals that we put forward previously. Part of those proposals recognised the disparity in the two figures. To stabilise the system, we proposed a compromise figure somewhere in between for one year, which would allow stability in the system and for key pieces of work — the margins survey, the cost survey, the needs assessment, and so forth — to be carried out on a joint basis to inform proper meaningful discussions and negotiations. It is only when you have that information that you are able to determine what the funding needs to be.

We put forward the proposal. It represented a significant saving to the health service. In percentage terms, it was a saving over and above what other sections of the health service are being asked to make. Typically, people are being asked to take a funding cutback of 4%, 5% or 6%. Our proposal was that we would come back to somewhere in the region of the £110 million.

Mr Gardiner: That is £110 million compared to the £90 million that you are getting at the moment.

Mr Greene: That is what we feel is sufficient to stabilise the system.

Mr Gardiner: Is the Department considering that?

Mr Greene: The Department has had that proposal since May last year. I believe that we did not hear formally about it. We then submitted the proposal again just before the court case and it was not progressed.

Mr Gardiner: Madam Chair, it would be worthwhile following up with the Department on why pharmacists have not received a definite reply.

The Chairperson: Well, there have been negotiations. There are also issues that I will suggest at the end of the meeting.

Mr Gracey: The interim proposal was refused.

The Chairperson: Without getting into it, there have been negotiations. I say that without prejudice; we need to be careful in the stuff that is said.

I suggest that the Committee writes to the Minister for more information and to find out why the margins survey and the cost survey cannot be done jointly. I am still concerned about that and I have not had any evidence to tell me why it has not been done. It is important that the Committee gets information from the Minister on the reasons why he and the Department believe that it cannot be done.

I also want clarification from the Department and the Comptroller and Auditor General about the clawback exercise. The information that I have received is that the Comptroller and Auditor General has a concern about that. Lindsay, you made the point that it happened before. The Committee needs clarification on that before we decide. If we get that information, we can then look at where to go to next.

Mr Gracey: I will try to clarify this. The Department here states that its target for retained purchase profit is £16·5 million. Our workings clearly display that that is far too small a figure to fund the envelope correctly. However, under the model that operates in Scotland, for instance, they have a target for retained purchase profit. In other words, they aim at an amount of money as retained profit in the drugs for the pharmacies. They run the margins survey and get the results, which are always a little bit retrospective. If there has been an overpayment, the fees and discount structure are reset the following year so that you try to get back to your target figure. In a sense, that is the proof that that model is legal and fine.

Mr Brady: Thanks for the presentation. I thank Lindsay because he made a very complex subject relatively easy for even me to understand. You should give the presentation to the Department; you never know what effect it might have.

The Chairperson: You might get £200 million because you confused all of us. *[Laughter.]*

Mr Brady: The Department pays lip service to how essential a service community pharmacies provide. You provide an essential service. There is a lot of unanimity and solidarity in your own ranks. Some 511 went to an emergency meeting, which is 96% or something. To me, that is a good sign that you are sticking together. There is always value in numbers. As Gerard said, the money will be available before the end of the month, as the Minister mentioned yesterday. It seems to me that it will be doled in an almost arbitrary fashion and be distributed disproportionately.

Do you have any idea of the criteria that will be used? Obviously, we are all getting lobbied by our own rural pharmacies, and in my constituency, people have had to lay off staff and cut opening hours. That means that the business is in decline and may take a while to recover, even with the money that the pharmacies get. It seems that it will almost be given on an ad hoc basis, and that seems to me to be wrong because some pharmacies will be worse off than others. We have heard testimonies, some of which are quite harrowing, about the lengths that people were having to go to, including cashing in insurance. It just seems wrong.

You talked about the situation in England, Scotland and Wales, and when discussing matters to do with the Department for Social Development, we are constantly hit with the parity argument that what happens over there should happen here. In your case, that is not happening, so, obviously, there is no parity and a totally different system is being imposed here and a lot less money, by the sound of it. Have you any idea of the criteria that might be used?

Mr Greene: The figure of £8 million has been divided into three or four components, and we have been given broad-brush criteria. We do not yet know the detail on how that might translate down at a contractor level. I acknowledge that the Department is to provide us with that information by the end of the week, but as I am sure you can appreciate, contractors are ringing in to see what way that will work, and we just do not have the answers yet other than the very broad-brush headline apportionments.

Mr Brady: James made the point that it is a Band-Aid — a short-term solution for a very long-term problem.

Mr Greene: We want the foundation funding to be sorted for pharmacy services. We want to move on to simply providing services and not being before the Health Committee and having this unfortunate dialogue on an ongoing basis, because we know that pharmacies can bring a lot of benefits to patients in Northern Ireland and to the health service. We want to get the foundation sorted out and then use that as a platform to build for the future.

Mr Brady: The issue is of the long-term effect on rural communities in particular. If businesses go to the wall, it will entail a cost to provide a service for those communities. Presumably, that may well cost more in the long term. It seems to be a very blinkered kind of approach. You probably agree with that.

Mr Greene: We want a managed process going forward. Yes, there will be and has to be change. That is the nature of the environment and the times that we live in, but that change has to be managed. It is managed everywhere else, and we feel that pharmacy, because it does a lot in the health service, should have the same applied to it so that there is not a fracturing of that.

Mr Brady: When you look at the Compton report's recommendations on how the role of pharmacy will change in providing that community-based care and, certainly, primary care, you wonder at the lack of forethought. Those recommendations will be rolled out over the next five years, so, one way or the other, a solution will have to be found anyway.

The Chairperson: You would think that one of you beside me would have given me a wee tablet for my head cold. *[Laughter.]*

Mr Gracey: Not without checking whether you are on any other medication, Sue. *[Laughter.]*

The Chairperson: On behalf of the Committee, I think that the information that you sent us and the presentation have been quite useful. Sometimes, we get inundated with paperwork from everyone, including officials and Departments, and that is why we are doing this test. This is probably the Committee that gets the most paperwork, and we are now doing a test on trying to computerise a lot of it. I do not know whether that will work, but the Committee has agreed that we will get more information from the Minister and clarification on some of those points. We had the statement yesterday and only got the opportunity to ask questions based on it, and we want to get in writing why the joint margins survey on the cost of service cannot be done. Clarification on the issue of the clawback will answer some of the questions that we have and youse have. We will keep you in the loop. What we heard yesterday probably had to happen on the back of the end of the financial year, but I do not see this as the end of the issue of community pharmacy being discussed in the Committee. Hopefully, together, we can have a great working relationship and build up the relationship between the Departments and officials. Thank you very much.

Mr Greene: Thank you very much.