ASSURING AN ACCESSIBLE COMMUNITY PHARMACY SERVICE: DEREGULATION IS NOT THE ANSWER

Office of Fair Trading Report on the Control of Entry Regulations and Retail Pharmacy Services in the UK

Response by:

The National Pharmaceutical Association

February 2003

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Executive summary

1. The Office of Fair Trading does not believe that the best interests of consumers are served by Control of Entry. We do not agree, and believe that implementing the OFT's stark and radical recommendation could put at serious risk the current pharmacy network and frustrate Government healthcare planning and policy.

2. It is not clear what problem the OFT is trying to fix. Nor is it clear why pharmacy was selected for this investigation. Despite purporting to do so, the Report does not tell us! We are not aware of any strong consumer lobby for change. On the contrary, consumers like and value current pharmacy services. The Report acknowledges that there is currently an extensive network of pharmacy outlets and refers to surveys which show that consumers enjoy ready and easy access to pharmacy services from where they live or work or from their doctors' surgeries. And, through a diversity of pharmacy ownership, there is a high level of competition and consumer choice.

3. 80% of the typical pharmacy's turnover comes from the provision of NHS services, in particular the dispensing of NHS prescriptions. The fundamental flaw in this Report is that it misses the point by disregarding pharmacy's principal focus as a provider of NHS services. It also fails to take account of pharmacy's future enhanced role as a key player in primary healthcare delivery. But this is hardly surprising. The OFT is a body with expertise in competition and as it has itself acknowledged, has no expertise in healthcare. Lip service is paid in the Report to pharmacy's healthcare role. The OFT tells us that in formulating its recommendation, it has remained mindful of the public policy objectives of health departments in the UK for community pharmacy. It acknowledges that pharmacy plays a primary role in the UK's healthcare system; that there is an extensive pharmacy network providing convenient access to services; and that pharmacies will continue to grow in importance. But beyond these general statements, the OFT has not assessed whether the free market is the best approach to enhancing pharmacy's current and future healthcare contribution.

4. Whilst fully in favour of competition, we do not believe that community pharmacy is an environment where a market "free for all" will provide pharmacy's "consumers" – patients or Government – with the best deal. Healthcare provision has to be planned and managed; the free market cannot be relied upon to ensure that care is conveniently available to those in need. As part of overall healthcare provision, NHS pharmacy services also have to be planned and managed. This will be particularly important as PCTs and equivalents throughout the UK become increasingly responsible for localised healthcare planning.

5. There is, therefore, a fundamental incompatibility between the free market approach proposed by the OFT and the benefits associated with a managed network of pharmacies. In underpinning the pharmacy network, the regulations provide the Government with a tried and trusted mechanism for delivering a rationally distributed, easily accessible NHS pharmacy service. This network also provides a secure platform from which to launch many of the services listed in the pharmacy strategies throughout the UK. The OFT recommendation thus flies in the face of the Government's plans for pharmacy.

6. The OFT's main findings are equivocal. The Report states that the regulations have prevented the opening of pharmacies offering lower prices or innovative services and have restricted competition between pharmacies. In undertaking this inquiry, the OFT has adopted the general presumption that deregulation will benefit consumers. Indeed paragraph 5.5 of the Report states:

> *"Typically, markets without entry controls are more dynamic, exhibit greater innovation and focus more directly on what consumers want in the way of access to outlets and services. In our view the pharmacy market is no exception."*

But, in our view, the pharmacy market is an exception. We agree that, in general, unregulated markets work best due to the benefits of competition in terms of low prices and incentives for cost reduction and innovation. However, a key feature of the pharmacy market is that the product to which Control of Entry relates – the dispensing of NHS prescriptions – has no scope for price competition. Most prescriptions are dispensed free of charge to patients and for those who pay, there is a standardised levy. Therefore, the key component of competition, and thus the primary justification for deregulation, is absent. Accordingly, pharmacies are not typical of the retail sector at least in this key respect

7. To find price savings, the Report focuses on a narrow part of pharmacy business – the sale of non-prescription medicines. The Report is less than convincing about any of the financial savings which it suggests <u>could</u> result from its implementation.

8. The OFT suggests that because "some" of the national pharmacy supermarket chains offer <u>up to</u> 30% discount on a narrow range of OTC medicines an estimated saving of between £25-30 million could accrue. The OFT further suggests that the total cost associated with administering the regulations is around £10 million to the NHS and £16 million to business. Thus the total estimated saving to the consumer is around £51-56 million, or about £1 per head of population! Let us be clear; these figures are estimates – no more! But even if the savings in the Report are realised, these are insignificant when compared with the overall size of the market and total NHS Spend. Such savings, if realised, would represent only around 0.3% of the total market.

9. It is our view that to base a recommendation of deregulation, with all its attendant risk to service provision, on an estimate of such relative insignificance is disproportionate.

10. It is difficult to imagine a more inappropriate time for the publication of this Report!

- Government has announced that it wants to make better use of pharmacists in delivering its health policy objectives. Pharmacists have a key role to play in helping patients get the best from their medicines and to ensure that this expensive component of healthcare is used safely, appropriately and cost-effectively. If strategies towards making this happen are to be successful, there needs to be some stability in the market that will give stakeholders – particularly individual pharmacists – the confidence to invest in developing services. The regulations underpin this stability.

- The Pharmacy in the Future document highlighted the need for a new pharmacy contract and remuneration system. Negotiations have started with the Department of Health on this. Control of Entry, along with the outcome of the generics inquiry and, to a lesser extent, pharmacy workforce arrangements, are fundamental issues affecting the new contract and remuneration. Control of Entry should thus be considered in parallel with discussions on a new contract and decisions on the effectiveness or need for control, should not be taken in isolation.

- PCTs are getting to grips with their new structures, roles and responsibilities and will be "finding their feet" for a little while yet. Community pharmacy will be a key part of local health strategies. The instability and uncertainty associated with deregulation will not make planning of pharmacy services an easy job.

- There is a shortage of pharmacists. The OFT suggests that this will limit the number of new entrants into the de-regulated market. This will not stop new pharmacies opening; it will merely create widespread variation in service provision according to pharmacist availability.

- We are trying to test alternative models of pharmacy service – and thus are introducing new areas of competition – through Local Pharmaceutical Services.

11. Deregulation will create widespread instability in the marketplace, put a blight on pharmacy investment in premises and service development and will lead to reduced access to community-based, local pharmacy services.

12. At present, pharmacy contracts are awarded on the basis of need. Without the regulations, openings of pharmacies would no longer be based on need, but on a commercial imperative. Pharmacies will open close to GP surgeries and in areas of high customer footfall. This increase in number would not add any significant value or benefit to consumers; it will, in the short term, increase choice but do little else. And because the market will only support a limited number of pharmacies, after a flurry of early activity, there will be subsequent contraction in favour of the larger, better resourced players. This will put many smaller pharmacies that are providing a much needed service to local communities at risk. Closures, or reduced services, in these areas will disadvantage particularly the elderly, mothers with young children and socially deprived people and will cut across the Government's agenda for tackling health inequalities.

13. As the market adjusts to deregulation, there will be huge uncertainty and instability. Without the relative stability of the regulations, pharmacists will quite naturally feel less inclined to invest in improving patient care just when we have gained commitment from both the Government and the profession to an enhanced, professional role. This will inevitably slow down or even halt progress in a number of key areas of role development for pharmacists. This cannot be in the best interests of Government, the profession, healthcare commissioners and, most importantly of all, patients.

Summary

The current arrangements are by no means perfect but what system is? The important point is that the current system does work by underpinning a widespread pharmacy network. Deregulation is, therefore, not needed to enable pharmacy to play its part in helping the Government meet its health objectives. On the contrary, de-regulation will frustrate the Government's health policy objectives for pharmacy at a critical time. In summary, de-regulation:

- Cuts across healthcare policy and planning
- Creates unnecessary and untimely instability
- Is not necessary to ensure the delivery of improved healthcare services
- Will put local pharmacy services at risk

Removal of Control of Entry is not, therefore, the appropriate way forward for enhancing pharmacy's contribution to patient care.

1
Introduction

1.1 This is the response of the National Pharmaceutical Association (NPA) to the Office of Fair Trading's (OFT) Report on the control of entry regulations and retail pharmacy services in the UK.

1.2 The NPA represents the owners of around 11000 community pharmacies in the UK. We have, in voluntary membership, virtually all pharmacy owners except for Boots. Virtually all of our members contract with the NHS for the provision of NHS pharmaceutical services.

2
What is the problem that the OFT seeks to fix?

2.1 It has never been made clear why pharmacy was selected for this investigation and despite purporting to do so, the Report does not tell us. Paragraphs 1.3 to 1.6 follow the general question posed by the Report "why study pharmacies?" However, none of the paragraphs answer this question. Moreover the Report gives a number of significant examples of how the current arrangements work well for consumers. Paragraph 2.3 points out that there is currently an extensive network of pharmacy outlets and later in the Report reference is made to OFT surveys which show that consumers enjoy ready and easy access to pharmacy services from where they live or work or from their doctors' surgeries. Further, there is a substantial body of research indicating a high level of consumer satisfaction with pharmacy services (summary attached as Annex 1). It is our view that the Report fails to give sufficient weight to the current range and depth of pharmacy service provision. Whilst the current system cannot be said to be perfect, it has created a network which delivers good access and choice and serves as a platform from which to launch many of the new services envisaged by the various UK pharmacy strategies[1]. We believe it important to ask what problem the OFT seeks to fix. Further, we caution against implementing the OFT's stark recommendation which could put at serious risk the current pharmacy network and frustrate Government healthcare planning and policy.

2.2 It would appear that the principal drivers behind this investigation are the large expansionist companies – particularly Asda – who are frustrated with the regulations getting in the way of their expansion plans.

3
Pharmacy's principal business is healthcare not retail

3.1 The fundamental flaw in this Report is that it misses the point by disregarding pharmacy's principal focus as a provider of NHS services. The Report has placed an over-emphasis upon pharmacy's over the counter activity. This is probably not surprising given that as the Report acknowledges in paragraph 1.1, the investigation covered the provision of retail pharmacy services. The principal business for community pharmacy is the provision of NHS pharmaceutical services and, in particular, the dispensing of NHS prescriptions. Indeed, the Secretary of State for Health, Alan Milburn, acknowledged this when he said at a fringe meeting at last year's Labour Party Conference: "I see pharmacists as clinicians, not as shopkeepers".

3.2 It was in relation to community pharmacists' role as healthcare providers, rather than as retailers, that the Control of Entry Regulations were introduced and upon which the Report should have focused. The Report states at paragraph 1.2 that "the OFT has remained mindful of the public policy objectives of the health departments in the UK". Having made this statement, and listed the key objectives of the various UK pharmacy strategy documents, it fails to take account of pharmacy's current and future contribution to healthcare services. Even if the OFT claims it has taken this into account, the Report focuses merely upon pharmacy as it is now. It does not take account of how pharmacy may change in the future and whether the free market is the best way of facilitating these changes.

3.3 The OFT has compounded its omission in ignoring community pharmacy's role as a provider of healthcare services by focusing on the "consumer" as an individual. Pharmacy's principal "consumers" are patients in need of NHS pharmacy services. But the Department of Health is the principal consumer of pharmacy services (it pays for most of them). As such its views on the planning and management of pharmacy services are critical.

4
Pharmacy's healthcare role – planning of pharmacy services

4.1 The OFT tells us that in formulating its recommendation, it has remained mindful of the public policy objectives of health departments in the UK for community pharmacy. However, beyond this statement the Report pays lip service to pharmacy's healthcare role and to the fact that the Departments of Health in each of the UK countries have major plans for making better use of the skills of pharmacists in the delivery of their respective NHS plans. Many of these roles are predicated upon the existence of a robust pharmacy network from which to launch these services and through which access to pharmacy service can be assured. This network already exists and the regulations are instrumental in underpinning it. The OFT recommendation thus flies in the face of the governments' plans for pharmacy. Health and social care provision – and within this, NHS pharmacy services – need to be planned and managed. There is, therefore, a fundamental incompatibility between the free market approach proposed by the OFT and the benefits associated with a planned and managed network of pharmacies.

5
Is the OFT recommendation proportionate?

5.1 The Report focuses on a narrow part of pharmacy business and is less than emphatic about some of its conclusions particularly the financial savings which it suggests could result from its implementation.

5.2 We do have concerns about some of the estimates made by the OFT and we highlight these in a later section of this submission (Estimated savings from de-regulation). However, even if the estimates in the Report are accurate (and we would question this) the total estimated saving to the consumer is around £52-56 million, or around £1 per head of population!

5.3 It is our view that to base a recommendation of deregulation, with all its attendant risk and uncertainty, on a cost savings estimate of such relative insignificance is disproportionate. Moreover, we believe that the implementation of this recommendation against this background would be open to legal challenge by way of judicial review.

6
Price competition

6.1 The OFT recognises that there is no price competition on NHS services. However it does not give due weight in the Report to pharmacy's dependence upon NHS pharmacy service provision which accounts for around 80% of a typical pharmacy's turnover.

6.2 So the majority of pharmacies' business (and this will grow in the future as pharmacies become more dependent upon the NHS) is impervious to price competition. The Report focuses exclusively on pharmacy's role as a retailer and in keeping with other aspects of retail competition theory, suggests that the market will determine the best outcome for customers. Given pharmacy's increasing role as a provider of healthcare services, the question must be asked whether a conclusion based upon retail competition theory is appropriate?

6.3 The OFT's main findings are equivocal. The Report states that the regulations have prevented the opening of pharmacies offering lower prices or innovative services and have restricted competition between pharmacies. In undertaking this inquiry, the OFT has adopted the general presumption that deregulation will benefit consumers. Indeed paragraph 5.5 of the Report states:

> *"Typically, markets without entry controls are more dynamic, exhibit greater innovation and focus more directly on what consumers want in the way of access to outlets and services. In our view the pharmacy market is no exception."*

6.4 But in our view the pharmacy market is an exception. We agree that, in general, unregulated markets work best due to the benefits of competition in terms of low prices and incentives for cost reduction and innovation. However a key feature of the pharmacy market is that the product to which control of entry relates – the dispensing of NHS prescriptions – has no scope for price competition. Most prescriptions are dispensed free of charge to patients and for those who pay, there is a standardised levy. Therefore, the key component of competition, and thus the primary justification for deregulation, is absent. Accordingly pharmacies are not typical at least in this key respect.

6.5 There is price competition on the sale of non-prescription medicines and the OFT has studied this. The price comparison performed by the OFT is based on a basket of 27 products. This is further reduced to a basket of 7. This is a very small and non-representative sample. It is well known, that supermarkets will "cherry pick" and apply deep price cuts to a narrow range of fast moving products. This is borne out by the OFT's own research. Figure 4.3 in the Report reveals large price differentials but only between the heavily promoted brands (*Calpol, Nurofen* and *Nytol*). There is much less of a price differential on the other brands. The OFT is adamant that deregulation will see deep price cutting. But it is worth noting that this is what was predicted prior to the demise of RPM. Indeed Asda said there would be a consumer saving of £300 million when RPM went. All players, including supermarkets, can cut medicine prices now but they do not to any great extent. Indeed, Figure 4.3 in the Report indicates that whilst Asda have cut prices by 29.6%, on average, over the seven brands, the equivalent price cut from Tesco, for example, is well behind this at 11%. And what is the effect of these discounts if measured across the entire range of OTC products?

6.6 The OFT is very confident that the influx of more supermarket pharmacies into the market will drive prices down. Based on the post-RPM experience, this is unlikely. And even if it did happen, the cuts would probably be on a narrow range of fast moving, heavily promoted lines.

6.7 According to the OFT Report, the reasons why consumers are "restricted" to pharmacies for GSL medicines is because they need advice from the pharmacist or pharmacy staff on what product to take or whether a particular product is suitable for them given an existing medicine regime. However, some consumers will use the pharmacy on the grounds of convenience. If a medicine is needed for immediate use – a common scenario – it is unlikely that consumers (or a consumer representative) will travel to a supermarket located some distance away.

7
Inter pharmacy competition

7.1 The Report, at paragraph 4.19, says that the results of the inter-pharmacy competition analysis were inconclusive. However, the OFT goes on to say that notwithstanding this, there is nothing to suggest that in the event of deregulation there would not be more competition amongst pharmacies. This is pure supposition by the OFT. It is a weak conclusion that does not give sufficient weight to the fact that there is an absence of price competition from the lion's share of the pharmacy business – the provision of NHS services.

7.2 Notwithstanding Control of Entry, there is a high level of inter-pharmacy competition. Pharmacies compete with each other from a variety of "High Street" settings and, in doing so, provide a range and level of service going way beyond that for which they are contracted to provide under the NHS and for which they are remunerated. In assessing NHS pharmacy service, patients are not tied to any particular pharmacy and are therefore free to go to any pharmacy they like. This is a key feature for ensuring that pharmacies compete with each other on level and breadth of service offered. It also contrasts sharply with some other healthcare professionals – most notably GPs – with whom patients register as a pre-requisite of service provision.

7.3 As there is no price competition in respect of NHS pharmaceutical services, price cannot be used by pharmacies, on this core component of pharmacy business, as a means of differentiating themselves from the competition. Pharmacies therefore need to rely upon other factors, most notably "added value" services. In the case of NHS pharmacy services, several "add-ons" have emerged in recent years. These include information and advice on medicines and the treatment of minor ailments; provision of prescribed medicines in monitored dosage systems; collection of patient prescriptions and delivery of dispensed medicines to patients' homes. In virtually all cases, and in recognition of the high level of competition amongst pharmacies, these additional services are provided to patients free of charge.

7.4 As we have already said, the principal potential benefit associated with deregulation – the lowering of prices – is absent from the major part of pharmacy's business. Any new entrants to the market in the event of deregulation will survive only if they take business from existing players. Further, new entrants to the market are unlikely to contribute any additional

gain to consumers in terms of wider services or innovation. Consequently there will be no growth in the market, either through the development of new services or by the capture of business from other markets. The net result will therefore be over supply or, in economic terms, ‘excessive’ entry to the market.

8
Non price competition – quality of service and innovation

8.1 Paragraph 4.52 of the Report points out that the principal reasons for consumer choice of pharmacy are location and convenience. Taken together, these account for 86% of consumers surveyed. It is our view that both consumer choice and access under the existing arrangements are excellent. However, the Report has not commented on this. This seems to us to be a serious omission given that the OFT should be examining whether the market is working well for consumers.

8.2 Rather than focus on these areas the OFT has gone on to conduct a study to discredit the comments made by stakeholders that deregulation would have negative effects on consumers in terms of service quality. (Paragraph 4.56). In doing this, the OFT has picked on three variables which it suggests are indicators of quality; existence of a private consultation area, the provision of a collection and/or delivery service and pharmacy opening hours. Whilst these represent areas through which pharmacies may seek to differentiate themselves, they are not in themselves indicators of quality. For example, just because a pharmacy has a consultation area this is no indication that it is being used, or if it is, that it is being used well. Further, long opening hours in themselves mean nothing; pharmacies will always open in accordance with local need. In the main, these will be tailored to suit local surgery hours. However, where there is demand beyond these times, pharmacies will open to capitalise upon the business opportunity. Hours of opening are thus dependent upon locational and demand factors, neither of which appear to have been taken account of in this study.

8.3 The majority of quality indicators have been missed (although for some reason "diabetes testing" is mentioned in paragraph 5.2). Pharmacies provide a vast range of additional services which can be regarded both as quality indicators and as innovations. Twenty four examples are attached as **Annex 2**.

8.4 There is, in our opinion, no evidence to support the OFT's claim that Control of Entry Regulations stifle innovation. But there is evidence to demonstrate that innovation is strong within pharmacy, particularly in the independent sector. A recent survey of 178 pharmacists in North East London by the Kings Fund[2] showed that community pharmacists are keen

to expand the number of services they provide to patients, providing they have the resources to do so. It also shows that many pharmacies are already providing more services than required under their national contract. These services include nicotine replacement therapy, advice to care homes, health screening, providing advice to GPs and other primary care health professionals, medicines management and prescription collection and delivery.

8.5 The research carried out by the King's Fund highlights the fact that innovation is strongest in the independent sector. It is the independent sector of the pharmacy market which will be the most adversely affected in the wake of deregulation. So, rather than enhancing innovation, we would suggest that deregulation could stifle it.

8.6 Consideration must be given to the spread of extended services provided by the network of pharmacies. For example, many pharmacies provide services to drug misusers – an increasingly important part of localised healthcare. But it is also, for some, not an area that is popular. Accordingly there is a lack of equity of provision of this type of service amongst pharmacy providers. Similarly, with services such as EHC, some pharmacies are prepared to offer a more extensive service than others.

8.7 Whilst acknowledging that overall the "coverage of services is good", the Report goes on to outline an investigation of the empirical relationship between its so-called quality of service indicators and measures of local competition. The Report acknowledges that only a small sample was used and cautions against treating the results as being anything other than indicative. However, it suggests that the results demonstrate a clear link between some quality measures and local concentration. Given that the measures are not quality indicators we cannot see how this conclusion can be valid.

9
Access to services

9.1 The Report states at paragraph 5.1 that community pharmacies in the UK play a pivotal role in the healthcare of all UK citizens and that access to community pharmacy services is essential for the continued health of the population. Having explored access, the OFT concludes that access to pharmacies in the UK is good with the majority of consumers finding it easy to get to a pharmacy from their home and from their GP's surgery. The OFT's own survey showed 89% of respondents found that their chosen pharmacy outlet was easy to get to from their home and 86% said it was easy to get to a pharmacy from their GP's surgery. (The Report later contradicts itself at paragraph 5.63 by saying that "the Control of Entry Regulations do not, indeed cannot, ensure good access"!)

9.2 However the OFT goes on to say that "the picture is not uniformly strong" (paragraph 5.3). It is suggested that there are a number of areas where local access could be improved. Linked to this, the Report states at paragraph 5.5 that under the regulations, local health authorities can only grant or refuse applications; they cannot determine that pharmacies open in particular areas. The Report here implies that there is little activity at local level in terms of new pharmacies opening and that there is a high degree of unmet need in terms of pharmacy service provision. This is not the case. The principal reason why an area will not have a pharmacy is because there is no business case for one. And if this is so, this will be just as true in a free market environment. Indeed, the current regulations assess applications based on need. If an applicant applies for a new contract, where there is a need, one assumes the application will be granted. So it must follow that the regulations are not the cause of the problem. To suggest that deregulation will solve this problem is a *non sequitur*. Given that access is, by the OFT's own admission, good, what is the problem that the OFT is trying to fix?

10
Essential Small Pharmacy Scheme (ESPS)

10.1 The Report says at paragraph 5.7 that local access will improve in the event of deregulation. However, doubt about this is immediately expressed by a following statement that if localised access problems do occur, the ESPS provides a readily available solution. The ESPS is not a solution to this problem. Whilst the scheme does offer a subsidy for some pharmacies, its structure is such that it offers only very limited financial support to the small number of pharmacies that are eligible. Fewer than 300 pharmacies are involved in the scheme.

10.2 The ESPS subsidy is currently derived from overall contractors' remuneration. Pharmacy contractors are paid from a "global sum" which is negotiated on an annual basis between the UK Departments of Health and the pharmacists' negotiating bodies. The ESPS money is taken out of the global sum and so is actually paid by pharmacists rather than the Government. Thus any increase in ESPS subsidy would have the effect of reducing the payments to non-ESPS pharmacy contractors. Given the poor level of pharmacy remuneration, there is little prospect of increasing the ESPS subsidy above the current levels. There are essential small pharmacy schemes operating throughout the UK. Whilst the detail of the schemes varies, the overall principle remains the same.

10.3 As those pharmacists who currently receive ESPS and pharmacy business transfer agents will confirm, it is extremely difficult to sell an ESPS pharmacy. ESPS pharmacies are, by definition, small and virtually impossible to expand. They are not therefore a sound commercial proposition for either a pharmacist wishing to expand a business or for multiple acquisition.

11
Timing of the Report

11.1 It is difficult to imagine a more inappropriate time for the publication of this Report.

- The Government has started negotiations on a new contract and system of remuneration for pharmacists
- Community pharmacy has been identified as an important first access point to local healthcare services and is an important alternative to over-stretched GPs, particularly for minor ailments
- PCTs are going through a massive process of restructuring; they will be "finding their feet" for a little while yet
- Pharmacy contractor motivation is already at a low level but this will deteriorate markedly in a deregulated environment. Few contractors will be prepared to continue to invest in developing their healthcare role in the highly fluid and uncertain environment created by deregulation
- There is a shortage of pharmacists. This will not stop new pharmacies opening; it will merely create widespread variation in service provision according to pharmacist availability
- We are trying to test alternative models of pharmacy service – and thus are introducing new areas of competition – through Local Pharmaceutical Services

12
Pharmacist shortage

12.1 There is a shortage of pharmacists willing and able to take up community pharmacy positions. The Report makes little reference to this. The law requires that a pharmacist is in personal control of a pharmacy and available in that pharmacy at all times the pharmacy is open, to personally supervise the sale and supply of medicines – whether these are supplied over the counter or against NHS prescription.

12.2 A number of factors are contributing to this shortage.

- The number of multiple owned pharmacies is increasing. Most of the multiple growth is through take-over of independent pharmacies. In general terms, a multiple pharmacist manager will be employed on a contract requiring fewer hours than a proprietor. This will result in an increase in demand for pharmacist cover.

- There is an increasing feminisation of the pharmaceutical register. This is causing workforce problems because in general, for a variety of reasons, females are less willing and able to take up full time community pharmacy positions.

- In the last few years, a number of newer pharmacy positions are emerging in line with the changing role of the pharmacist and changing NHS. These newer positions such as pharmaceutical adviser, practice attached pharmacist and primary care pharmacist are causing a drift away from community pharmacy.

12.3 There are plans to open three new schools of pharmacy in England. This will ultimately lead to an increase the number of pharmacists on the register. However, with a four year degree course followed by a year's pre-registration training, any increase in pharmacists is a long way off. Even then it is impossible to predict how many of these new pharmacists will elect to work within the community pharmacy sector.

12.4 Some pharmacy companies are already experiencing difficulty in finding pharmacists to run the existing pharmacy network. The current shortage will become even more acute should entry controls be relaxed. Removal of the Regulations will undoubtedly create an increase in the number of pharmacy openings. We do not believe that the pharmacist shortage will deter existing players or new entrants from opening pharmacies. Therefore,

increased openings will exacerbate the current problems associated with the pharmacist shortage and therefore lead to patchy service provision and uncertainty of access by patients to NHS pharmaceutical services. There will not be enough pharmacists to go round and this will mean that there will inevitably be interruption of service provision in instances where a pharmacist is unavailable to run a pharmacy. To create an environment where such a state of affairs could exist would be doing patients a great disservice.

12.5 As part of its strategy to alleviate the shortage, community pharmacy will inevitably look to the hospital sector to plug the gap. This will come at a time when the hospital sector is already suffering from a pharmacy manpower shortage. The Audit Commission report on medicines management in NHS hospitals – "A Spoonful of Sugar"[3] – stated that 15% of hospital pharmacy posts are vacant. Attempts will be made to woo hospital pharmacists into community by offering attractive salary packages. If hospital is to retain its already depleted pharmacist workforce it will need to respond to this and will need to consider increases in pharmacists' salaries. This will put financial pressure on hospital pharmacy services and thus increase NHS costs. These increased costs will need to be offset against the estimated savings the OFT suggests may result from deregulation.

13
Entry and exits

13.1 Paragraph 3.32 of the Report summarise the results of an analysis of the areas in which new contractor pharmacies have entered the market between 1997 and 2001. The results indicate that, in the majority of cases, a new entry to the market did not result in another pharmacy closing, but rather an overall increase in the number of pharmacies in that area. This does not seem to us to be surprising given that the current controls to entry are based upon need. If a pharmacy is needed then it follows that there will not be net displacement.

13.2 The Regulations were introduced in 1987 to secure a rational distribution of pharmacies. The Secretary of State for Health has a duty under the NHS Act 1977 to ensure reasonable access to pharmaceutical services. Prior to 1987, there was a clear trend toward clustering of pharmacies around doctors' surgeries and shopping centres attracting a high customer flow. This was at the expense of outlying communities or areas of social deprivation whose residents were at risk of losing access to NHS pharmaceutical services.

13.3 An analysis of pharmacy openings for England and Wales (there is nothing to suggest any different trend for Scotland and Northern Ireland) prior to the introduction of the Regulations, shows the growth in openings prior to 1987. In 1980 and 1981 there were net openings of 90 pharmacies. Between 1982 and 1987 the total number of net openings was 960. In 1988 and 1989 there were net closures of 140 and 50 respectively[4]. Since that time, the net openings and closures have, broadly speaking, balanced each other out.

13.4 The market place is dynamic. This can be demonstrated by an analysis of decisions on applications relating to NHS pharmaceutical services. In England and Wales, figures for the four-year period between 31 March 1998 and 31 March 2002, show there were 1918, 1448, 1311 and 1278 applications respectively, decided by Health Authorities. Of these, 1112, 1022, 975 and 931 applications respectively, were granted, 529, 354, 284 and 291 respectively, were refused and 77, 72, 52 and 56 respectively, were withdrawn. These figures include both applications for new contracts and minor relocations (split figures are unavailable) and indicate clearly a high level of activity in the market place[5].

13.5 And there is evidence in favour of the Regulations creating a rational distribution of pharmacies. Since their introduction, more pharmacies have closed within 500m of their nearest competitor than have opened. At the same time, there have been more openings than closures over 1km from the next nearest pharmacy. The latest DoH Statistical Bulletin confirms this trend. In 2000-2001, 70% of pharmacies closing were within 500m of another pharmacy, but 67% of pharmacies opening were more than 1km from the nearest pharmacy[6].

14
Doctor dispensing

14.1 It is not clear exactly what the OFT is suggesting should happen with dispensing doctors. In so far as the Report appears to suggest they should be a "last resort", we would agree. The general principle should be that doctors diagnose and pharmacists dispense. In this way, the relative skills of the two professions will be used to best effect. However we are concerned at the two tier treatment suggested by the OFT for pharmacies on the one hand, and dispensing doctors on the other. For pharmacies the OFT recommends deregulation as the appropriate way forward. However paragraph 5.62 states that arrangements under which GPs dispense are a matter for the relevant health departments. It is illogical, not to say totally inequitable, to suggest such a duality of approach. We do however agree that it should be left to respective UK health departments, rather than the OFT, to make decisions on how healthcare services are planned and managed.

15
Estimated savings form deregulation

15.1 As paragraph 4.25 points out, accurately quantifying the likely level of consumer savings following deregulation is difficult because of the unpredictability of a number of factors. Accordingly, by the OFT's admission, the estimated savings are based on "broad-brush estimates". Paragraph 4.33 further highlights the weak ground upon which estimates are made. We are told that post RPM, the difference between supermarket and non-supermarket pharmacies is up to 30% (although this is in one supermarket and over a narrow range of products). Have these prices been checked since and are they regular price savings? Further, paragraph 4.33 concludes by saying:

> *"We do not have sufficient evidence to make accurate predictions about the likely savings to consumers from increased price competition following deregulation but we expect these savings to be substantial"*

15.2 This clearly indicates the unreliability of the estimates for cost savings put forward by the OFT. It should be noted that prior to the demise of RPM, huge claims were made about the savings that would accrue to consumers where RPM no longer applied. The extent of these claims has yet to be realised. Why will the situation be any different should control of entry go?

15.3 But even if the estimates are accurate, the predicted savings are very small when compared to the size of the market. Given that the existing arrangements are working reasonably well in ensuring patient access and choice to pharmacy services, it would seem to us to be taking a disproportionate risk to act upon these estimated savings.

15.4 The OFT's main findings are less than clear cut. Paragraph 1.11 states that the regulations have impeded entry by pharmacies offering lower prices or innovative services and have restricted competition between pharmacies. Having made this statement, the Report goes on to acknowledge the difficulty in estimating precisely the benefits that would accrue to consumers from deregulation. The Report suggests that by getting rid of control of entry there will be increased competition on OTC medicines (which account for around 10% of pharmacy turnover) and because "some" of the national pharmacy supermarket chains offer up to 30% discount on OTC medicines that an estimated saving of between £25-30 million could

accrue. The OFT describes these savings as "significant" (paragraph 4.44). Even if these savings are achieved, and the OFT Report does describe them as estimates, one has to say that a saving of £30 million on a market of around £9 billion is a small gain (around 0.3%) for the potential destabilisation that could result from a market free for all.

15.5 The OFT suggests that the costs associated with administering the Regulations are £15.7 million to business and £10 million to the NHS. Putting to one side the £15.7 million cost to business (which pharmacy funds from its own profits) this leaves £10 million costs to the taxpayer. We would query whether this figure is reasonable given that even in a deregulated environment, there will still be a need for PCTs (an there will be more of these than health authorities) to maintain and administer a pharmaceutical list. There will still be costs associated with this. Further, we would suggest that the OFT's estimates of costs associated with handling appeals are greatly exaggerated.

15.6 However, even if the £10million estimate is reasonable, these costs are being expended on ensuring ready access to services based on need and as such are a "legitimate" expense. Further, whilst £10 million is, in absolute terms, a huge sum of money, it is around 0.02% of total NHS spend. Adding this £10 million to the previous savings estimate of £25-30 million, we have a total projected saving of between £35-40 million. This is still only around 0.4% of the total pharmacy NHS and OTC medicine market. Against this background the OFT recommendation could be seen as a very large sledgehammer being used to crack a nut which does not need cracking in the first place!

15.7 The cost estimate is also incomplete in that it does not take account of pharmacists' remuneration. Pharmacists are presently remunerated from a global sum. The global sum is not directly related to the number of pharmacies providing pharmaceutical services. However where numbers are relatively static (as has been the case in recent years) the global sum and thus pharmacy remuneration are relatively easy to predict. As the Report acknowledges, there will be a proliferation in pharmacy openings in a deregulated environment. If this is not reflected in proportional increases in the global sum, this will lead to an overall reduction in pharmacy remuneration and massive financial vulnerability and thus instability in the market.

15.8 The Government claws back discount obtained on drug purchases by pharmacies on a scale related to volume. Deregulation will result in an initial increase in pharmacy numbers. As a result the prescription volume per pharmacy will fall. So will the discount obtained on purchases which will result in an overall reduction in the level of discount obtained by pharmacy and thus an increase in overall Government expenditure on medicines.

16
The impact of deregulation

16.1 The current arrangements are by no means perfect but what system is? The important point is that the current system does work and since the introduction of the regulations in 1987, there has been a move toward a rational distribution of pharmacies. As has already been said, since their introduction, more pharmacies have closed within 500m of their nearest competitor than have opened. At the same time, there have been more openings than closures over 1km from the next nearest pharmacy. The OFT Report acknowledges that patients currently enjoy good access to pharmacy services. The OFT recommendation of a complete free for all is likely to put at risk the health policy objectives for pharmacy at a critical time. Deregulation will create widespread instability in the marketplace, put a blight on pharmacy investment in premises and service development and will lead to reduced access to community based local pharmacy services.

16.2 The OFT has carried out a study to assess whether deregulation would be expected to have a negative effect upon investment due to "leapfrogging" by new or existing pharmacies. The results of this study are ambiguous on whether or not a more competitive environment will induce or impair investment. The Report later gives, in paragraph 5.30, a number of reasons why it does not consider that leapfrogging will occur. It is our view that the arguments used by the OFT are theoretical and seriously underestimate the dependence pharmacies have upon NHS dispensing for commercial viability and, therefore, the importance of proximity to a GP's surgery. Moreover, the OFT has ignored the fact that in a deregulated market we will see a proliferation of doctor-controlled pharmacies in or adjacent to GP surgeries. Having control of both the prescribing and dispensing of medicines will inevitably result in prescriptions directed toward the doctor-controlled pharmacy.

16.3 The proliferation of doctor-controlled pharmacies is something which has been recognised by the BMA. This was specifically referred to by the Chairman of the BMA's Prescribing Committee, Dr Peter Fellows, at a recent meeting of the All Party Pharmacy Group. Dr Fellows said that this development would be unwelcome for all concerned and would seriously undermine partnership working between GPs and pharmacists. Collaborative working between the two professions is essential if the new roles envisaged by the national pharmacy strategies throughout the UK are to happen and for the successful implementation of the new GP contract. Deregulation will thus lead to unwelcome and untimely tensions between

the two professions. In Dr Fellows' words, this "is a war we do not need to fight". It is significant that none of the OFT's location modelling, or its calculations on possible pharmacy closures, factored in the effect of pharmacies owned by GPs. The OFT makes the assumption that no practice would open a pharmacy if there was an existing pharmacy within 300 metres. This is unrealistic and counter-intuitive. It casts serious doubts upon many of the OFT's assertions regarding access and pharmacy closures. Given pharmacy's dependence upon NHS prescriptions for viability, the effect of the proliferation of doctor-controlled pharmacies on pharmacy service provision would be profound. Many neighbourhood pharmacies would be put under threat of closure if GPs were to open pharmacies. A proliferation of doctor-controlled pharmacies would, ironically, lead to less rather than more competition.

16.4 At present, pharmacy contracts are awarded on the basis of need. Without the regulations, openings of pharmacy would no longer be based on need, but on a commercial imperative. Pharmacies will open close to GP surgeries and in areas of high customer footfall. This increase in number would not add any significant value or benefit to consumers; it will, in the short term, increase choice but do little else. And because the market will only support a limited number of pharmacies, after a flurry of early activity there will be subsequent contraction in favour of the larger, better resourced players. This will put many smaller pharmacies which are providing a much needed service to local communities at risk. Closures, or reduced services, in these areas will disadvantage particularly the elderly, mothers with young children and socially deprived people and will cut across the Government's agenda for tackling health inequalities

16.5 As the market adjusts to deregulation, there will be huge uncertainty and instability. Without the relative stability of the Regulations, pharmacists will quite naturally feel less inclined to invest in improving patient care just when we have gained commitment from both the Government and the profession to an enhanced, professional role. This will inevitably slow down or even halt progress in a number of key areas of role development for pharmacists. This cannot be in the best interests of government, the profession, healthcare commissioners and most importantly of all, patients.

17
Is there room for improvement?

17.1 In advocating that control of entry is retained, we are not simply holding out for the status quo. We recognise fully that there is room for improvement. The Regulations should work to patients' advantage. We acknowledge the important and developing role of Primary Care Organisations (PCOs) in ensuring that local patient health needs are met. As part of this we believe that PCOs should have greater discretion to make the regulations more responsive to patient need. We know that the PSNC has told Health Minister, David Lammy, that it wants to work with the Department of Health and the NHS Confederation to identify any problems with pharmacy service provision resulting from the present controls and to work collaboratively on solutions that benefit patients and the NHS. We fully endorse this approach.

17.2 We have considered carefully whether there is any compromise between retaining control of entry on the one hand and deregulation on the other. We do not believe that there is any "half way house" or acceptable level of "partial deregulation". However, whilst remaining in favour of the need for regulation to allow for the planning and management of NHS pharmacy services, we recognise that problems exist with the current arrangements and believe that improvements could be made to the process. We recognise that processing applications under the current arrangements is time consuming for PCOs and Appeal Authorities. Efforts must be made to ease their burden and to streamline the process. For example, consideration could be given to making a charge for applications for inclusion in the pharmaceutical list as a means of cutting down the number of frivolous or vexatious applications. We also believe that PCOs should have the ability to identify areas of need for new or improved pharmacy services and, subject to the availability of necessary resources, have greater flexibility in implementing reasonable improvements to the range, depth and quality of services. We believe that improvements to the current system could be agreed between the Department of Health, representatives of PCOs and the pharmacy profession.

18
Summary

18.1 The current regulations have been in place since 1987 and since that time have worked well in ensuring that patients have enjoyed ready and easy access to pharmacy services. At the same time, the regulations have encouraged a more rational distribution of pharmacies. The regulations are not perfect, but they do support a pharmacy network which guarantees not only access but also provides a platform from which to launch the range of pharmacy services envisaged by the various pharmacy strategies for the UK countries. Deregulation is thus not necessary for maintaining ready and easy access to pharmacy services and for making best use of pharmacists' skills in delivering government health plans. The OFT's recommendation:

- Cuts across healthcare policy and planning
- Creates unnecessary and untimely instability
- Is not necessary to ensure the delivery of improved healthcare services
- Could put at risk local pharmacy services

18.2 Control of entry provides a tried and trusted mechanism for delivering pharmacy services and establishes a sound foundation upon which to build for the future. Deregulation might deliver the benefits stated in the Report, but there is no guarantee of this. Rather there is a considerable risk that we may replace a reliable service that is popular with patients with one that is inconsistent, unresponsive and driven totally by what offers the best commercial return rather than what is best for patients. It seems to us that to accept this recommendation the Government will be taking a significant and unnecessary risk to patient care.

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National Pharmaceutical Association, February 2003

ANNEX 1

Consumer attitudes to pharmacy

There is a high level of satisfaction amongst consumers about the services they receive from community pharmacies. Further, research studies confirm that the pharmacist's popularity is growing steadily as a reliable source of information and advice about healthcare and medicines.

Public perceptions of the pharmacist

- A 2002 Mintel Report on British Lifestyles revealed that pharmacists continue to be a growing source for medical advice – with the number of consumers seeking help from a pharmacist increasing by over 25% during the past 10 years. In that same period, there has been a 5% fall in the number who would consult a GP.

- A 1998 consumer survey – 'Everyday Health Study' – by The Proprietary Association of Great Britain [PAGB] showed that pharmacists are viewed by the majority of adults as being a convenient and appropriate source of advice – with 8 out of 10 adults (86%) endorsing this view.

- The same survey revealed that: pharmacists are twice as likely to be consulted for children's ailments than for adult complaints (19% : 10%) – and that over 50% of adults regard the pharmacist as a more convenient source of advice than the doctor – particularly because that advice can be obtained without an appointment.

- A 1997 British Market Research Bureau/Mintel market research study on OTC and prescription medicines retailing revealed that almost 50% of consumers were likely to self-medicate for minor ailments.

- PRISM (Progressive Research into Self-Medication) undertaken by Reader's Digest, consistently confirms that pharmacists are becoming a better-utilised resource for information on primary care. According to PRISM, almost 70% of those surveyed agreed with the statement 'Pharmacists are well enough qualified to recommend any medicines'. This indicates a high level of consumer trust and acknowledgement of the pharmacists' expertise.

- A 1998/99 study of the public's views of pharmacists/pharmacies as a primary healthcare resource, carried out on behalf of the Community Pharmacy Research Consortium, found that positive aspects included: ease of access, friendly, relaxed and approachable service, and the pharmacist's profile as a medicines expert.

- 2001 BRMB research into consumer attitudes showed that 86% of people regard the pharmacist as a good source of advice. 61% of people feel that more use should be made of the pharmacist for advice rather than bothering the doctor. 56% of people said that it is much more convenient to ask the pharmacist for advice than go to the doctor.

ANNEX 2

Innovation in community pharmacy

Examples of services, in addition to NHS dispensing, which are being developed and provided by community pharmacists:

- prescription collection and delivery
- smoking cessation
- health screening
- health promotion
- repeat dispensing
- advice to residential and nursing homes
- GP prescribing advice
- prescribing for minor ailments
- influenza vaccination
- anticoagulation clinics
- increasing aspirin usage by patients with ischaemic heart disease
- asthma management
- diabetes management
- supervised methadone treatment for heroin addicts
- domiciliary pharmaceutical services
- NHS supply of emergency hormonal contraception
- treatment of head lice
- hypertension management
- medication error reporting
- needle and syringe exchange for drug addicts
- palliative care
- hospital discharge liaison
- domiciliary oxygen supply
- medication review