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# REALISING THE POTENTIAL OF COMMUNITY PHARMACY: ASSURING PUBLIC ACCESS TO THE PHARMACY NETWORK

## OFFICE OF FAIR TRADING INQUIRY INTO PHARMACY SERVICES

**SUBMISSION BY:**
**THE NATIONAL PHARMACEUTICAL ASSOCIATION**

**JUNE 2002**

# Contents

# Executive summary

**1.** Community pharmacy's principal business is the provision of NHS pharmaceutical services and, in particular, the dispensing of NHS prescriptions. It is this, rather than retail activities, that the "Control of Entry" Regulations were introduced to regulate and upon which the Inquiry should focus.

**2.** The Regulations have worked well for consumers and have neither reduced supply nor increased prices. Rather they have benefited consumers through encouraging a more rational distribution of pharmacies and improving the range of products and breadth of services available from pharmacies. The relative stability afforded by the Regulations has given pharmacists the confidence to develop services and enhance the range of products offered to consumers. This has been particularly so in recent years, where pharmacists have made considerable headway in enhancing the range of professional services offered to patients.

**3.** Notwithstanding the Regulations, there is a high level of competition amongst pharmacies. Pharmacies compete with each other from a variety of "high street" settings, and in doing so, provide a range and level of service which goes way beyond that for which they are contracted to provide under the NHS and for which they are remunerated. And in accessing NHS pharmaceutical services, patients are not tied to a particular pharmacy. Patients 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.

**4.** The Regulations support a community pharmacy network. This network assures ready and easy access to NHS pharmaceutical services. The network also provides a platform from which to launch a range of additional pharmaceutical services, thereby increasing pharmacy's contribution to the provision of healthcare services – and assisting the Government in delivering healthcare policy and objectives as outlined in the NHS Plan.

**5.** Community pharmacy is an environment where a market free for all will not provide pharmacy's "consumers" (Government or patients) with the best deal. Pharmacists' principal focus is the provision of pharmaceutical services within the totality of NHS healthcare. Healthcare provision, and within this NHS pharmaceutical services, has to be planned and managed to ensure the best use is made of limited resources and that care is available to those in need at a time and place of their choosing. The free market cannot be relied upon to ensure this. Nor is it the best way for ensuring a consistent NHS pharmaceutical service. In conducting its inquiry therefore, the OFT needs to take full account of the Government's healthcare policies and objectives and the part to be played by pharmacy in this.

**6.** The Regulations provide the Government with a tried and trusted mechanism for delivering a rationally distributed pharmacy service and are an effective means by which it can discharge its statutory duty to ensure patients enjoy reasonable access to NHS pharmaceutical services. The continuance of the Regulations is necessary therefore not only to ensure the delivery of a managed pharmaceutical service, but also to ensure that there is some stability in the market as an incentive to pharmacy operators to invest their own capital in the development of enhanced NHS pharmaceutical services.

**7.** The need to enhance pharmacists' professional role in the delivery of healthcare services and to play a full part in delivering the vision of a modern NHS is recognised by Government. In its policy document Pharmacy in the Future – Implementing the NHS Plan, the Government sets out ways in which pharmacy can play an enhanced role in the delivery of healthcare services.

**8.** Pharmacy in the Future whilst giving tacit approval to the Regulations in the delivery of planned and managed healthcare services, is not by any means a charter for the status quo. It recognises that the healthcare and retail environment is changing and taking account of this, examines the possible ways pharmacy can adapt to give consumers the best possible service, whilst ensuring that those consumers enjoy a high level of access and choice.

**9.** One of the most exciting parts of the Pharmacy in the Future is the introduction of Local Pharmaceutical services (LPS) through which the Government wants to explore new ways for contracting for community pharmacy services. The lessons learned from LPS will be used to inform the discussions between the Department of Health and the pharmacists' negotiating body, the Pharmaceutical Services Negotiating Committee (PSNC) on the core components of a new contract for community pharmacy. LPS will provide the test bed for pharmaceutical services in the future and thus the ways in which the Government will get the best out of community pharmacy and patients will derive the best possible deal from pharmaceutical services. Against the background of LPS, now would seem an inappropriate time for any relaxation of the Regulations.

**10.** The Regulations work on the basis of granting an NHS dispensing contract where this is necessary or desirable for the adequate provision of pharmaceutical services in a given neighbourhood. Without the Regulations, openings of pharmacy would no longer be based on need but on a commercial imperative. In the absence of the Regulations there will be a proliferation of pharmacy openings in or adjacent to existing GP surgeries – given pharmacy's dependence upon NHS prescriptions. This will lead to the "clustering" of pharmacies in these locations. There will be a large number of new pharmacies opened in existing retail outlets which hitherto have not been able to demonstrate need for an NHS pharmacy contract.

**11.** Meanwhile, pharmacies in locations further away from GP surgeries will see a reduction in business. This will put at risk many smaller pharmacies which are providing a vital service to local communities but which are not very profitable

businesses. In terms of geographical location there will be, over time, a shift away from an even distribution of pharmacies to a situation where some areas have too many and others too few, if any, pharmacies. This situation will not be conducive to the Government's objective of achieving equity of access to healthcare services. It will at the same time not be conducive to pharmaceutical best practice. Pharmacy practice should be, in line with professional thinking and Government policy, about providing patients with the best possible care. In the absence of the Regulations we will see community pharmacists shifting their commitment away from patient care toward outmanoeuvring the competition.

**12.** The market will only support a limited number of pharmacies, so after a flurry of early activity there will be subsequent contraction. Those pharmacies forced into closure or to reducing the level or breadth of services will inevitably be the smaller pharmacies. Many of these will be located in socially deprived and inner city areas. One of the key drivers toward encouraging openings of pharmacies in such deprived areas is the current Regulations which place an emphasis on determining openings based on need for services. The fact that pharmacies exist in these communities is because they are needed. But their ability to survive commercially is because of the relative protection afforded by the Regulations. Where pharmacies close, they would deny local communities not only ready access to a full range of NHS pharmaceutical services, but also the undoubted contribution pharmacy makes to the social fabric of the community.

**13.** So, in effect, relaxation of the Regulations will play into the hands of the larger expansionist companies. No surprise therefore that a number of these companies have been so active in lobbying for the removal of the entry controls.

**14.** There is a shortage of pharmacists willing and able to take up community pharmacy positions. The current shortage will become even more acute should entry controls be relaxed. 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.

**15.** Those in favour of scrapping the Regulations suggest the essential small pharmacy scheme (esps), or a modification of it, will ensure at risk pharmacies are protected. This is to misunderstand the extent of the esps subsidy. Whilst the esps will keep a barely viable pharmacy open it will not turn a marginal pharmacy into a sound commercial proposition as evidenced by the difficulties associated with disposing of such businesses. Moreover, the subsidy is derived from the pharmacists' global sum, and so is funded by existing pharmacy contractors.

*June 2002*

# 1
# Introduction

1.1 This is the Submission of the National Pharmaceutical Association (NPA) to the Office of Fair Trading's (OFT) Inquiry into the "market for retail pharmacy services" launched in October 2001.

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.

1.3 We welcome the OFT's Inquiry and are confident that the OFT will find that the current regulations do provide a major public benefit by ensuring that consumers enjoy ready and easy access to a full NHS pharmaceutical service.

# 2
# The OFT Inquiry

*"The Regulations have encouraged a rational distribution of pharmacies and support a community pharmacy network. This network assures ready and easy access to NHS pharmaceutical services."*

2.1 The OFT's press release states that this Inquiry is to examine the UK market for retail pharmacy. The press release goes on to suggest that the overall turnover for the "retail pharmacy market" was £18.7 billion for 2001. We do not know how the OFT has arrived at this figure, but would query its accuracy. We estimate the average pharmacy turnover to be around £700,000. With around 12,700 pharmacies in the UK, the total turnover for the pharmacy sector is around £8.89 billion – well short of the figure quoted by the OFT. Of this, we believe the turnover for retail activity, as opposed to the provision of NHS pharmaceutical services, to be of the order of £1.78 billion.

2.2 We would submit that the OFT's market figure has been distorted by the retail turnover of the larger pharmacy players, particularly Boots and large grocery retailers. The larger operators are atypical when compared with other pharmacies in terms of the size of their retail activities. For example, in numerical terms, Boots owns around 12% of pharmacies in the UK, and their NHS market share is broadly in line with their numerical market share. However their share of the non-NHS retail component of the pharmacy sector is proportionally much higher. Grocery too has a substantial share of the retail healthcare market. Whilst figures for market share of general healthcare retail sales are unreliable, we rely on sales of over the counter medicines (OTCs) to make the point. For this segment of the market, BMRB figures indicate that supermarkets have 19% share (15% from "general shelves" and 4% from in-store pharmacies). This compares with Boots at 27%, Superdrug at 4% and other pharmacy at 38%[1].

2.3 It is not clear how the "retail pharmacy market" will be defined by the OFT and we assume that a market definition by which to scope the Inquiry will be drawn up as a preliminary step in the Inquiry. We are concerned, however, that the OFT may have over-estimated the importance of pharmacy's "over the counter" retail activity and under-estimated the significance of the provision of NHS pharmaceutical services on the overall pharmacy business. Pharmacies operate from a retail environment, but their principal business is healthcare, with the bulk of the pharmacy's turnover coming from the provision of NHS pharmaceutical services. The dependence upon NHS has been highlighted in a number of studies – one of which was a survey carried out by Taylor Nelson, on behalf of the OFT, which found that the main reason why consumers visited a pharmacy was to have a prescription dispensed. 62% of consumers said that the main reason was to have a prescription dispensed compared with only 16% who said that the main reason was to buy a non-prescription medicine[2].

2.4 It is the provision of NHS pharmaceutical services, and in particular the dispensing of NHS prescriptions, rather than retail, that the "Control of Entry" Regulations (the Regulations)[3] were introduced to regulate, and upon which the Inquiry should focus.

2.5 It is not the opening of pharmacies that is regulated through the Regulations. It is possible for anyone who is legally competent to own a pharmacy, to open a pharmacy wherever they like. However, only those pharmacies that are considered by health authorities, or boards, to be necessary or desirable are entitled to provide and be remunerated for NHS pharmaceutical services.

2.6 It is not clear from the press release or related documentation, why the OFT has reason to believe that consumers receive anything less than a square deal from pharmacies. The Inquiry detail suggests that *"barriers to entry tend to reduce supply and increase prices. There may, however, be benefits to set against such costs to consumers. We have an open mind."* We submit that the Regulations have neither reduced supply nor increased prices. Rather they have provided benefits to consumers through encouraging a more rational distribution of pharmacies and by improving the range of products and breadth of services available from pharmacies. The relative stability afforded by the Regulations has given pharmacists the confidence to develop services and enhance the range of products offered to consumers. This has been particularly so in recent years, where pharmacists have made considerable headway in enhancing the range of professional services offered to patients.

2.7 At first sight therefore, it is difficult to see any indication that the Regulations have adversely affected consumers in terms of reduced supply or higher prices. On the contrary, we would submit that they have delivered a major public benefit. The Regulations have encouraged a rational distribution of pharmacies and support a community pharmacy network. This network assures ready and easy access to NHS pharmaceutical services. The network also provides a platform from which to launch a range of additional pharmaceutical services, thereby increasing pharmacy's contribution to the provision of healthcare services, while also assisting the Government in delivering healthcare policy and objectives as outlined in the *NHS Plan*[4].

# 3
# The need for competition

*"...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" - Government or patients - with the best deal."*

3.1 In general terms, competition is a good thing. We fully appreciate the benefits competition brings to consumers by providing benefits of lower prices and better services tailored to their needs, and to business through improved effectiveness and efficiency. Conversely, if competition does not work, consumers will not get the goods and service they need and want – and inevitably prices will be unnecessarily high and variety and choice will be suppressed. In general, a totally free market will see prices driven downward and will see market participants competing with each other, not only on price, but also on range of service – in an attempt to achieve differentiation.

3.2 However, 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" – Government or patients – with the best deal. Pharmacists' principal focus is the provision of NHS pharmaceutical services within the totality of NHS healthcare. Healthcare provision has to be planned and managed; the free market cannot be relied upon to ensure that care is available to those in need at a time and place of their choosing. As part of overall healthcare provision, NHS pharmaceutical services also have to be planned and managed. Against this background, we would submit that in carrying out its inquiry, the OFT needs to take full account of the Government's policies and objectives in respect of healthcare planning generally – and the particular part to be played by pharmacy in this. The Regulations provide the Government with a tried and trusted mechanism for delivering a rationally distributed pharmacy service and are an effective means by which the Government can discharge its statutory duty, to ensure patients enjoy reasonable access to NHS pharmaceutical services.

3.3 The bulk of pharmacists' income comes from the dispensing of NHS prescriptions. A significant feature of the prescriptions "market" is the absence of price competition; most prescriptions are dispensed free of charge to patients and for those who pay there is a standardised levy. This means that the major potential benefit associated with a removal of control of entry – the lowering of prices – does not exist. Any new entrants to the market will survive economically 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 capture of business from other markets. The net result will therefore be over supply or, in economic terms, "excessive" entry to the market.

3.4 Notwithstanding the Regulations, there is a high level of competition amongst pharmacies. Pharmacies compete with each other from a variety of "high street" settings, and in doing so, provide a range and level of service which goes way beyond that for which they are contracted to provide under the NHS and for which they are remunerated. In accessing NHS pharmaceutical services, patients are not tied to a particular pharmacy. Patients 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 the position of some other healthcare professionals – most notably GPs – with whom patients register as a pre-requisite of service provision.

3.5 As there is no price competition in respect of NHS pharmaceutical services, price cannot be used by pharmacies on this core aspect of their business as a means of differentiating themselves from the competition. They therefore need to rely upon other factors, most notably added value services. In the case of NHS pharmaceutical services several "add-ons" have emerged in recent years. These include: information and advice on medicines and minor ailments; provision of prescribed medicines in monitored dosage systems; collection of patient prescriptions and delivery of dispensed medicines to the patient's home. 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.

3.6 As far as non-NHS turnover is concerned, pharmacies operate in a free market and compete with pharmacy and non pharmacy outlets not just on level of service, but also price.

# 4
# Pharmacy's contribution to healthcare – the Government's perspective

*"…Whilst we appreciate that the OFT will approach this Inquiry with an open mind, it is to be hoped that it will take full account of overall Government policy on healthcare planning and, in particular the provision of NHS pharmaceutical services. It is essential that Government policy on healthcare is fully "joined up" with competition policy."*

4.1 The need to enhance pharmacists' professional role in the delivery of healthcare services has been a professional aspiration for years. But the Government too sees the importance of pharmacists in playing a role in delivering the vision of a modern NHS. In its policy document *Pharmacy in the Future – Implementing the NHS Plan*, published in September 2000[5], the Government sets out ways in which pharmacy can play an enhanced role in the delivery of healthcare services.

4.2 The Pharmacy Programme recognises that pharmacists are highly qualified professionals, whose skills the NHS has been under-utilising for too long. It says that in the new NHS, pharmacists will spend more time focusing on the clinical needs of individual patients, helping them stay healthy, deal with minor illnesses, and get the most out of their medicines. It also describes ways in which the skills and expertise of pharmacists can be put to best effect within the NHS to meet the changing needs of patients by:

- Making sure that people can get the medicines or pharmaceutical advice easily and, as far as possible, in a way, at a time and at a place of their choosing
- Providing more support to people in using medicines to reduce both the rate of medicine related morbidity and the amount of medicine that is wasted

- Giving patients the confidence that they are getting good advice when they consult a pharmacist

4.3 To be at its most effective and to ensure that best use is made of limited resources, NHS services will have to be delivered in a managed way. An open market free for all is not the best means of achieving this. Nor is it the best way of ensuring a consistent NHS pharmaceutical service. The continuance of the Regulations are necessary therefore not only to ensure the delivery of a managed pharmaceutical service, but also to ensure that there is some stability in the market as an incentive to pharmacy operators to invest their own capital in the development of enhanced NHS pharmaceutical services.

4.4 The Pharmacy Programme gives tacit approval to the Regulations. It is made clear in the Programme that the regulations will not be allowed to get in the way of developments in "one stop" primary healthcare centres nor in the case of large retail parks. It should also be noted that in March 2001, Lord Hunt announced the Government would amend the Regulations to implement a compromise between the pharmacy and medical professions to reduce antagonism in rural areas when pharmacists and doctors are in competition to dispense for patients. This illustrates the Government's willingness to amend the Regulations on a piece-meal basis, if necessary, rather than introduce wholesale reform. It also illustrates Government's acceptance of the need for underpinning regulation in the delivery of planned and managed healthcare services.

4.5 But the Pharmacy Programme is not a charter for the status quo. It recognises that the healthcare and retail environment is changing and taking account of this, examines the possible ways pharmacy can adapt to give consumers the best possible service. So whilst The Programme suggests that the underlying principle is that the Regulations should remain in place, it does concede there may be a need for their relaxation in certain circumstances. This appears to flow from a desire to improve not only access to services but also choice.

4.6 The Pharmacy Programme examines other ways that pharmacy can take account of a changing world to improve access for patients. One of the suggestions in this area is the introduction of the electronic transmission of prescriptions. The Programme suggests that by 2004 prescriptions will be transferred electronically from GP surgery to pharmacy, thereby conveniencing patients and opening the door to "e-pharmacy". Pilots examining the feasibility of this are already underway.

4.7 The Government also wants to encourage medicine manufacturers to apply for over the counter status of their products where it is safe and appropriate to do so. The purpose behind this is to ensure that pharmacies have an increasing armamentarium of products to assist them in dealing with minor ailments presented in the pharmacy. This will in turn push people practising self-care away from traditional NHS services – particularly GP services – and thus ease the financial pressure on the NHS. There is price competition on sales of OTC medicines, and so medicine deregulation will increase competition not only between pharmacies but also non-pharmacy outlets.

4.8 Perhaps the most interesting component of *Pharmacy in the Future* is the Government's desire to explore new ways for contracting for community pharmacy services. It intends to do this through the introduction of Local Pharmaceutical Services (LPS) pilot schemes. It is expected that the first wave of these new services will start from July 2002. The lessons learned from LPS will be used to inform the discussions between the Department of Health and the pharmacists' negotiating body, the Pharmaceutical Services Negotiating Committee (PSNC) on the core components of a new contract for community pharmacy. LPS are clearly important to Government because they will provide the test bed for determining the shape of pharmaceutical services in the future – and thus the ways in which the Government will get the best out of community pharmacy. They will also enable patients to derive the best possible deal from pharmaceutical services. Against the background of LPS, now would seem an inappropriate time for any relaxation of the Regulations.

4.9 Whilst we appreciate that the OFT will approach this Inquiry with an open mind, it is to be hoped that it will take full account of overall Government policy on healthcare planning and, in particular the provision of NHS pharmaceutical services. On deciding upon future options, competition is relevant insofar as it contributes to achievement of the Government's healthcare objectives. Competition is therefore the means to the end but not the end in itself. It is essential that Government policy on healthcare is fully "joined up" with competition policy.

*"...the Government sees the importance of pharmacists in playing a role in delivering the vision of a modern NHS."*

# 5
# Pharmacy Ownership and Control of Entry

*"The OFT's own studies carried out in the course of the RPM case point to the Control of Entry Regulations contributing to improved consumer access."*

5.1 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.

5.2 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[6]. Since that time, the net openings and closures have, broadly speaking, balanced each other out.

5.3 The number of pharmacies in the UK has been relatively static since the Regulations were introduced. Ownership of pharmacies is restricted under the Medicines Act 1968 to individual pharmacists, partnerships of pharmacists or bodies corporate who have appointed a superintendent pharmacist. Those wishing to lawfully conduct a retail pharmacy business can open a pharmacy anywhere they choose. However, only those pharmacies included in a pharmaceutical list maintained by a health authority (shortly this role will be taken up by PCTs), or their equivalents

in Scotland or Northern Ireland, are entitled to dispense and be paid for NHS pharmaceutical services. The lion's share of a pharmacy's turnover comes from the provision of pharmaceutical services (principally the dispensing of NHS prescriptions).

5.4 A pharmacy without an NHS contract will be entitled to dispense private prescriptions and supply non-prescription medicines and traditional pharmacy goods. Private dispensing is generally small when compared to NHS dispensing and accounts for less than 1% of the turnover of a typical pharmacy. Moreover, sales of non-prescription medicines and "traditional" pharmacy goods on their own, and in quantities consistent with that of a "typical" NHS contracted pharmacy, will not be sufficient to secure the viability of a "non contract" pharmacy. Accordingly there are only a small number of non contract pharmacies; virtually all registered pharmacies in the UK are included in pharmaceutical lists and thus paid for the provision of NHS services. Whilst this is a narrow area of pharmacy business, it does illustrate the competitive nature of the pharmacy business.

5.5 Under the Regulations, pharmacies are admitted to a pharmaceutical list where it is necessary or desirable for the adequate provision of pharmaceutical service in the neighbourhood. It follows, therefore, that where services are less than adequate, a new pharmacy will meet the criteria for inclusion in a pharmaceutical list. The number and frequency of applications ensures that the adequacy of services – and thus the need or desirability of a new pharmacy in any given neighbourhood – is constantly under review. The inclusion in a pharmaceutical list has become known as the granting of an NHS contract. This is because those providing NHS pharmaceutical services do so as independent contractors to the NHS. There is not, however, any paper contract.

5.6 The Regulations go further than the granting of new contracts. They provide for the transfer of the "NHS Contract" from one contractor to another during the course of the sale of a pharmacy business. They also provide for a "minor relocation" of a contract under certain conditions. This allows an existing contractor to relocate the "NHS contract" a small distance, so long as service continues to be provided to the same localised population in the new location as in the old. The regulations also deal with the provision of pharmaceutical services by dispensing GPs.

5.7 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 to 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[7].

5.8 It is a well established principle that in considering whether or not a new contract or a minor relocation should be granted, it is the effect on services to patients that is at issue and not the effect on other contractors. Decisions on the granting of contracts, changes of ownership and minor relocations are taken in the first instance by health authorities, with appeals being handled by the Family Health Services Appeal Authority (FHSAA) in Harrogate (there are equivalent bodies in Scotland and Northern Ireland). The Appeal Authority decision panels include both pharmacist and lay members. The involvement of lay representation in decision making ensures a degree of consumer led objectivity.

5.9 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[8].

5.10 The OFT's own studies carried out in the course of the RPM case point to the Control of Entry Regulations contributing to improved consumer access. Included in the OFT's evidence prepared for the case was reference to studies carried out in a number of locations of pharmacies in 1970, 1988 and 1996. These studies indicated that in Gateshead and Lancashire a small decrease in the number of pharmacies was matched by improved access to pharmacies where the distance to the nearest pharmacy fell[2].

*"...there is evidence in favour of the Regulations creating a rational distribution of pharmacies."*

# 6
# Pharmacy economics

*"The falling NHS margin and the potential competition facing pharmacy in the post-RPM environment are likely to have a significant impact on pharmacy profitability."*

## 6.1 *Pharmacy Business Mix*

6.1.1 The provision of NHS pharmaceutical services – principally the dispensing of NHS prescriptions – accounts for around 80% of the typical pharmacy's turnover. Having said this, we estimate that the percentage rises to around 85% in the median pharmacy group. The remaining 20% of pharmacy turnover is derived from "over the counter" sales and is split, in broad terms, evenly between the sales of non-prescription medicines and other "traditional" goods sold by pharmacies. The non-prescription medicine segment is split between General Sales Medicines – which can be sold from any retail outlet, and Pharmacy medicines which, in the interest of patient safety, can only be sold from a pharmacy under the supervision of a pharmacist. In both cases, pharmacies and other retailers are at liberty to determine selling price at a level consistent with prevailing market conditions. This freedom on pricing of non-prescription medicines is, as the OFT will know, new and arose following the demise of RPM last year. We are already seeing price competition emerging in the non-prescription medicines market whether through direct price cuts or "buy one get one free" type offers. Competition in this area is likely to increase as players seek to capitalise on the opportunities associated with the freedom to set retail prices. Having said this, pharmacists' ability to get fully behind any promotional campaign will always be limited by their professional obligation to ensure that medicines are only supplied where it is appropriate to do so. In a large number of cases, pharmacists will advise consumers that no medication is necessary.

6.1.2 For non-medicinal over the counter business, pharmacies are already used to high levels of competition – particularly from grocery. There is no indication that the Regulations have contributed to higher prices to consumers. Nor is there any evidence to suggest that pharmacies, in general, are using geographical location or a local monopoly position as a means of charging higher prices. And it must not be forgotten that for the bulk of the products sold over the counter pharmacies are competing not only with each other, but also all other general retail outlets.

6.1.3 The high level of competition on the over the counter component of the pharmacy business is having an impact on profitability. The frequently asked questions section of the Pharmacy Inquiry Section of the OFT's web-site states that the OFT's resale price maintenance "initiative" has not damaged small pharmacies. It is far too early for the OFT to speculate upon the impact of the loss of RPM on community pharmacy. However, there is already evidence that larger grocery outlets are applying price cuts across a narrow range of fast moving non-prescription medicines. It is clear that selective price cuts are and will continue to be used as a means of attracting consumers. As the medicines market is inelastic, the increased share picked up by the grocery sector as a result of price cutting activity will be at the expense of those suffering the greatest difficulty in competing – smaller pharmacies. The erosion of pharmacy business has already been experienced by pharmacies in other markets, including toiletries and baby care.

6.1.4 Caution must be exercised in drawing parallels with the limitation of contract and RPM. The Regulations apply to NHS pharmaceutical services. There is no price competition associated with NHS pharmaceutical services and thus no link between this market and RPM.

### 6.2 *Pharmacy's dependence upon NHS pharmaceutical services*

6.2.1 The provision of NHS pharmaceutical services accounts for around 80% of a pharmacy's turnover. Pharmacy's dependence upon the NHS is increasing. Pharmacists act as sub-contractors to the NHS and are paid by the NHS for the services they provide. Virtually all of the pharmacist's NHS income is in respect of the dispensing of NHS prescriptions. For dispensing prescriptions, pharmacists are reimbursed the costs of any drugs and appliances supplied and paid a fee for dispensing the prescription. Pharmacists also receive a professional allowance which is paid on a graduated scale up to

a maximum linked to the volume of prescriptions dispensed. The terms and conditions and remuneration for NHS service provision are negotiated with the Government against a background of tight financial control and there is thus little flexibility in the arrangements. Pharmacists' ability to supplement the income received from the NHS is severely limited. Some pharmacists are able to secure small amounts of additional funding from their health authority or other localised healthcare grouping for a specific project. However, such opportunity and funding in respect of it is very limited and generally unsustainable. Notwithstanding this, pharmacists do attempt to enhance the range and depth of NHS pharmaceutical services they provide as a means of differentiating themselves from the competition. In general, the "add-ons" to NHS services are driven by the need to compete and are unremunerated. We shall return to this later.

6.2.2 Pharmacy's fee for NHS pharmaceutical service provision is therefore set by the Government. The Government monopoly on pharmacy remuneration is reflected in the margin for this segment of the business, which is falling sharply.

## 6.3 *Pharmacy profitability in the round*

6.3.1 The falling NHS margin and the potential competition facing pharmacy in the post-RPM environment are likely to have a significant impact on pharmacy profitability. The remuneration system for pharmacists takes no account of pharmacy overheads. Any increase in remuneration is dependent upon achieving a proportionally greater increase in prescription volume. To put this in context, this year pharmacists were awarded a 3.7% increase in overall remuneration. However, this increase is dependent upon achieving a 6% increase in prescription volume. In short, pharmacies are operating in a fiercely competitive market place.

# 7
# Factors affecting choice of pharmacy

*"Access to healthcare services is a strategic imperative for Government – and, as is confirmed in the NHS Plan, is one of the underpinning principles of the Government's strategy for the future delivery of healthcare."*

*"Access to healthcare services is particularly important in the case of pharmacy's high user groups: many of whom are elderly and unwilling or unable to travel anything other then short distances."*

7.1 A number of factors will affect the choice of pharmacy:

- Pricing of products and services
- Geographical location
- Range of products and services
- Level and quality of service

7.2 *Pricing of products and services*

7.2.1 The majority of patients are exempt from prescription charges and so receive their prescription medicines free from pharmacies. Around 58% of the population is exempt from prescription charges – but this translates to 85% of prescriptions dispensed. Non-exempt patients pay an NHS levy of £6.20 in respect of each prescription item dispensed. The levies collected by the pharmacist are deducted from pharmacists' monthly payment in respect of prescriptions dispensed. There is no price competition in respect of NHS pharmaceutical services, so it makes no difference to patients which pharmacy they use to access pharmacy services; the same arrangements will apply whether the pharmacy providing the service is an independent or larger multiple. So, whilst patient choice of pharmacy is an important factor in accessing

services, exercising this choice will be dependent upon factors other then price, including geographical location, product range and level and quality of service.

7.2.2 As we have already said, there is no price competition in respect of the major part of the pharmacy business – the provision of NHS pharmaceutical services. As far as the "over the counter" component is concerned, there is plenty of competition in the market place.

## 7.3 *Geographical location*

7.3.1 Geographical location is critically important both for ensuring convenient access for patients and for volume of pharmacy business. Given the dependence upon NHS dispensing to pharmacy turnover, proximity to a GP's surgery is a key feature in determining the profitability of a pharmacy. The most profitable pharmacies will be those located in or adjacent to GPs' surgeries. This does not mean however that pharmacies are only to be found in such locations. Pharmacies exist in a variety of settings – on High Streets, secondary and tertiary shopping sites, supermarkets and retail parks, including larger out of town developments. In some cases pharmacies will open in socially deprived areas considered "no go" areas by other healthcare professionals. In such cases pharmacies not only represent the only localised source of access to healthcare advice, information and service, but also provide an important social function in being part of the fabric of people's lives. In such areas there is a very low disposable income and thus high dependence upon NHS services.

7.3.2 Access to healthcare services is a strategic imperative for Government – and, as is confirmed in the *NHS Plan*, is one of the underpinning principles of the Government's strategy for the future delivery of healthcare. Access to healthcare services is not simply about numbers but as much about ensuring that points of delivery are in locations that allow local populations to gain convenient access to them. This is particularly important in the case of pharmacy's high user groups: many of whom are elderly and unwilling or unable to travel anything other then short distances. The same is true of those who are accessing a pharmacy for advice and/or product recommendation and purchase. Whilst some purchases will be "medicine chest" items, a much larger number will be those needed to deal with acute conditions. In such cases a long journey to an alternative pharmacy would be undesirable, if not, impracticable.

7.3.3 Of particular importance here is the distance between the doctor's surgery and the pharmacy. Patients receiving a prescription from their doctor will need to take it to a pharmacy to have it dispensed. For this reason it is important that the pharmacy and GP's surgery are not too far apart.

## 7.4 *Level and quality of service*

7.4.1 Pharmacists are healthcare professionals and as such are obliged to comply with a Code of Ethics and standards of professional practice as laid down by their professional body, the Royal Pharmaceutical Society of Great Britain (RPSGB)[9]. The RPSGB also engages a team of inspectors who carry out routine inspection of community pharmacies. As part of this inspection attention will be given to pharmacy operators' adherence to this Code. Moreover, pharmacists who provide NHS pharmaceutical services are obliged to comply with Terms of Service which stipulate a number of service standards to assure consistency and quality in the provision of services. The terms of service are set out as Appendix 2 to the NHS (Pharmaceutical Services) Regulations 1992. There is a political move to improve quality throughout the NHS through the implementation of clinical governance. Pharmacists will be required to meet clinical governance targets. The planned way in which pharmacy will engage in clinical governance has been set out in the recently published document *NHS Guidelines on Clinical Governance and Community Pharmacy*[10].

# 8
# Consumer attitudes to pharmacy

*"Research studies confirm that the pharmacist's popularity is growing steadily as a reliable source of information and advice about healthcare and medicines."*

8.1 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.

8.2 *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.

# 9
# What would be the impact of relaxation of the current regulations?

*"Where pharmacies close, local communities will be denied not only ready access to a full range of NHS pharmaceutical services, but also the undoubted contribution pharmacy makes to the social fabric of the community."*

9.1 It is clearly impossible to predict with any degree of accuracy what will be the overall effect of removing the Regulations, but a number of scenarios are more than likely. In a general sense it is reasonable to assume that there will be an immediate increase in the number of pharmacies, followed by contraction as the market readjusts.

9.2 Consumers already enjoy excellent access to NHS pharmaceutical services. The Regulations work on the basis of granting an NHS dispensing contract where this is necessary or desirable for the adequate provision of pharmaceutical services in a given neighbourhood. Without the Regulations, openings of pharmacy would no longer be based on need, but on a commercial imperative. Those advocating removal of entry controls are doing so because the Regulations are stifling expansion plans. The inclusion of a pharmacy within a retail outlet will be considered by consumers to add value and status to the retail business – the so-called "halo effect". It is therefore reasonable to assume that in the absence of any controls, larger retailers would seek to open pharmacies in existing outlets that do not currently host a pharmacy. We do not see how this would add any significant value or benefit to consumers. So, whilst increased openings may, in the short term, increase choice they will do little else. In the longer term, the market will move in favour of the larger better resourced players who will benefit from an ability to cross-subsidise pharmacy activities through revenue obtained from general retail activities. This will be at the expense of access.

9.3 In the absence of the Regulations there will be a large number of new pharmacies opened in or adjacent to existing GP surgeries – given pharmacy's dependence upon NHS prescriptions. Individual pharmacists would also seize the opportunity to open new pharmacies as removal of the Regulations would facilitate entry to the market. Openings close to GP surgeries will lead to the clustering of pharmacies in these locations. Meanwhile, pharmacy in locations further away from GP surgeries will see a reduction in business. This will put at risk many smaller pharmacies which are providing a much needed service to local communities. In terms of geographical location we will, over time, see a shift away from an even distribution of pharmacies to a situation where some areas have too many and others too few, if any, pharmacies. This situation will not be conducive to the Government's objective of achieving equity of access to healthcare services. It will at the same time not be conducive to pharmaceutical best practice. Pharmacy practice should be about providing patients with the best possible care. Current Government policy is aimed at making best use of pharmacist skills toward providing that care. In the absence of the Regulations we will see pharmacists shifting their commitment away from patient care towards outmanoeuvring the competition.

9.4 But the market will only support a limited number of pharmacies, so after a flurry of early activity there will be subsequent contraction. The new openings in the larger outlets and close to GP surgeries will remain. Consequently, those closing or reducing level or breadth of service offered to patients will be the smaller pharmacies located in secondary or tertiary sites. Many of these will be those located in socially deprived areas. Closures in these areas will be the particular disadvantage of socially deprived people and will cut across the Government's agenda for tackling health inequalities.

9.5 One of the key drivers toward encouraging openings of pharmacies in deprived areas is the current regulations which places an emphasis on determining openings based on need for services. The fact that pharmacies exist in these locations is because local communities need them. But their ability to survive commercially is because of the relative protection afforded by the Regulations. Where pharmacies close, local communities will be denied not only ready access to a full range of NHS pharmaceutical services, but also the undoubted contribution pharmacy makes to the social fabric of the community. There would also be a damaging "knock on" effect on the local business community. In many secondary and tertiary shopping parades, pharmacies are considered to be "anchor" tenants in the main, because of the footfall they attract on the back of the provision of NHS pharmaceutical services. The closure of a pharmacy in such sites would adversely affect other neighbouring businesses.

9.6 So, in effect, relaxation of the Regulations will play into the hands of the larger expansionist companies. No surprise therefore that a number of these companies have been so active in lobbying for the removal of the entry controls!

9.7 The Regulations currently limit dispensing doctor activity and the well-publicised compromise agreement between dispensing doctors and the pharmacy profession is indicative of a move toward the principle that doctors diagnose and pharmacists dispense. Removal of the Regulations would leave dispensing doctors in an uncontrolled environment in which they could immediately expand dispensing to all the patients on their lists. This would hand them a monopoly over supply of medicines and reduce patient choice, to say nothing of denying those patients access to proper pharmaceutical service under the supervision of a pharmacist. This would provide patients with a second class service with the dispensing of medicines being under the control of a receptionist or, at best, a technician rather than a pharmacist.

9.8 Bodies corporate owned by doctors already exist. Removal of the Regulations will lead to a proliferation of such companies. Doctor owned bodies corporate are a relatively new phenomenon and were not prevalent in the environment prior to the introduction of the Regulations in 1987. At that point, ethical guidance provided to GPs was against GPs having any interest in pharmacies. Whilst ethical guidance has now changed on this point, such an arrangement, where there is no separation between the prescriber and provider of medicines, is hardly in the best interests of probity.

*"Consumers already enjoy excellent access to NHS pharmaceutical services."*

# 10
# Pharmacist shortage

*"There is a shortage of pharmacists willing and able to take up community pharmacy positions."*

*"The current shortage will become even more acute should entry controls be relaxed."*

10.1 There is a shortage of pharmacists willing and able to take up community pharmacy positions. 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. 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. 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.

10.2 An analysis of Royal Pharmaceutical Society figures for undergraduate intake is not particularly helpful here. Between 1986 and 2000 the number of students entering Schools of Pharmacy in the UK has increased from 1250 to 1934, an increase of 55%. This compares with the numbers graduating over a similar period which have increased from 1110 to 1646 in 1999, an increase of 48% (there were only 322 graduates in 2000 because the pharmacy degree course changed from 3 to 4 years in 2000). In the same period the number of pharmacists on the pharmaceutical register increased from 30,770 to 38,392, an increase of 25%. It should be noted however that the number of pharmacists who declare to the RPSGB community pharmacy as their principal occupation has increased from 18,220 to 22,297, an increase of 22%.

10.3 These figures must be measured alongside the changes in community pharmacy ownership which is showing prolific multiple growth. In the same period, the split between independent/small chain owned pharmacies on the one hand and multiple/large chains on the other has shifted, in percentage terms, from a ratio of 75.4 : 24.6 in 1986 to 50.4 : 49.6 in 2000 (England and Wales). For these purposes a multiple is considered to be any chain of more than five pharmacies[7]. This trend is continuing. It should be noted that much of the multiple acquisition 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 will. This will result in an increase in demand for pharmacist cover. Other factors are contributing to the general shortage:

- The intake to School of Pharmacy and thus the pharmaceutical register is seeing an increase in the proportion of females. Royal Pharmaceutical Society figures indicate that in 1986, the proportion of females on the register was 34.7%. This increased to 47.7% in 2000. 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 creating a drift way from community pharmacy.

10.4 There are plans to open two new schools of pharmacy in England. This will ultimately lead to an increase the number of pharmacists upon 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.

10.5 Removal of the Regulations will undoubtedly create an increase in the number of pharmacy openings. It is our submission that there are insufficient pharmacists available to meet current demand, let alone any increase. We do not believe that the pharmacist shortage will deter existing players or new entrants from opening pharmacies. Therefore, increased openings will therefore lead to patchy service provision and uncertainty of access by patients to NHS pharmaceutical services.

# 11
# Essential Small Pharmacy Scheme

*"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."*

11.1 In response to suggestions that wholesale reform to the Regulations will lead to the closure of many smaller pharmacies, those in favour of scrapping the Regulations suggest the essential small pharmacy scheme (esps), or a modification of it, will ensure at risk pharmacies are protected. 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 who are eligible. Fewer than 300 pharmacies are involved in the scheme.

11.2 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.

11.3 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.

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