OFFICE OF FAIR TRADING

The control of entry regulations and retail pharmacy services in the UK

A report of an OFT market investigation

January 2003

This report was revised in March 2003 to take into account a number of small corrections and amendments. These in no way affect the OFT's final analysis in the report or conclusions.

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FOREWORD

This report concludes our investigation into the control of entry regulations in the community pharmacy sector – a sector worth £8.6 billion annually. It is the first study carried out by the OFT's new Markets and Policy Initiatives Division to focus on regulatory restrictions on markets. There will be more such studies.

There is no question about the importance of the provision of high quality pharmaceutical services to the community, and the industry's commitment and professionalism in providing them. The question is whether the regulations that currently control entry into the industry are unduly impeding the way that the market works – to the ultimate detriment of the public.

Our study leads us to conclude that the control of entry regulations should be lifted. They inhibit price competition. They stifle efficiency improvements and innovation. They limit the availability of pharmacy services. And they impose substantial regulatory burdens.

The evidence and analysis that supports our recommendation are set out in this report. It is now for the Government to decide what action, if any, to take in the light of our findings.

We are grateful to all those who have contributed to our analysis.

John Vickers
Director General of Fair Trading
17 January 2003

1 SUMMARY AND RECOMMENDATION

Introduction

1.1 This market investigation covers the provision of retail pharmaceutical services in the United Kingdom (UK). In particular, it examines whether the interests of consumers are best served by the current control of entry regulations[1]. These regulations place restrictions on how and where contracts to dispense National Health Service (NHS) prescriptions in the UK are awarded.

1.2 The investigation was launched by the Office of Fair Trading (OFT) in October 2001 and has been carried out under section 2 of the Fair Trading Act 1973. OFT market investigations are evidence-based studies that examine whether markets are working well for consumers, and in this case specifically whether the control of entry regulations are acting to prevent markets working well for consumers. The investigations are guided by the principle that competitive markets to which there are no barriers to entry generally serve best the interests of consumers. In formulating our recommendation, we have, however, remained mindful of the public policy objectives of health departments in the UK for community pharmacy (CP) and the supply of NHS prescription medicines.[2]

Why study pharmacies?

1.3 There are currently some 12,250 CPs in the UK and the markets they serve account for a sizeable share of consumer spending. CPs have an important role to play in the health of local populations through the distribution of prescription medicines, the sale of over-the-counter (OTC) medicines and the provision of professional advice.

1.4 The markets for NHS prescriptions and for OTC medicines alone were worth £8.6 billion in 2001. The vast majority (£6.8 billion) of this is accounted for by NHS prescription. Pharmacy-only (P) medicines (OTC medicines that can only be sold in a pharmacy) account for a further £0.9 billion, with General Sales List (GSL) medicines, that can be sold in any outlet, accounting for the remaining

[1] The control of entry regulations in England and Wales are contained in the National Health Service (Pharmaceutical Services) Regulations 1992; in Scotland in the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995; and in Northern Ireland in the Pharmaceutical Services Regulations (Northern Ireland) 1997. They are referred to as 'the control of entry regulations' in this report.

[2] CP is a devolved issue and hence our recommendations are directed to the administrations in England, Wales, Scotland and Northern Ireland.

£0.9 billion. There is also a small but significant market for private prescriptions of around £300m.

1.5 The control of entry regulations impact not only on NHS prescriptions, but also on sales of OTC medicines. It is extremely difficult for pharmacies to be viable without a contract to dispense NHS prescriptions. NHS dispensing accounts on average for 80 per cent of the business of the typical CP. Indeed only around 130 CPs (or just over one percent) dispense without such a contract.

1.6 Since 1987 the number and location of NHS contractor pharmacies in the UK have been restricted under the control of entry regulations. Typically, entry restrictions to any market result in prices being higher, innovation lower and quality of service poorer. This report examines whether the control of entry arrangements for community pharmacies have had such effects and, if so, whether their retention is nevertheless in the best interests of consumers.

The evidence we gathered

1.7 In addition to seeking the views of, and surveying, pharmacists, we consulted widely including representative and professional bodies, the owners of community pharmacies and pharmacy chains, supermarkets, consumer groups, the Department of Health and the devolved administrations in Scotland, Wales and Northern Ireland.[3] We undertook our own analysis of the regulations and how they work and of the markets for non-prescription or OTC medicines. We commissioned a wide range of quantitative and qualitative research, including:

- a consumer survey on the use of pharmacies
- national mapping of pharmacies
- modelling of pharmacy entry and exit
- study of the extent of price and non-price competition between pharmacies
- a report on the valuation of community pharmacies
- case studies of the local impact of the regulations
- a comparative study of pharmacy regulation abroad
- a report on pharmacy workforce issues.

The results of this research may be found in the annexes in volumes 2 and 3 of this report.

1.8 The following section outlines our main findings and our recommendation. Our report assesses the impact of these controls on the market and consumers in terms of prices, innovation, access and costs.

Findings

Competition and entry of new pharmacies

1.9 Since 1987, when the control of entry regulations were introduced, there has been very little change in the number of pharmacies as measured by either gross or net entry. In the ten years after 1990, the average annual net change in the number of NHS contractor pharmacies in England and Wales was four. By contrast, in the five years before1985 (two years before entry controls were introduced), the average annual net increase was 130 contractor pharmacies per year.

1.10 The structure of the pharmacy market has changed somewhat since 1987. While the share of the national market is not dominated by any one or two chains, existing national pharmacy chains and supermarkets have increased their share of the market significantly, and since 1990 one new national chain (Superdrug Ltd) has entered.

1.11 Nevertheless, the effect of the control of entry regulations has been to constrain such change. In particular, the regulations have acted to impede entry and expansion by pharmacies that offer consumers lower prices, more convenient opening times, or valued and innovative services. Moreover, by limiting the numbers and location of pharmacies in a local area, the regulations have restricted competition between pharmacies, in terms of both prices and quality of service.

1.12 It is difficult to estimate precisely the potential benefits to consumers that would derive from deregulation, in the form of increased price and quality competition. We note, though, that some of the national supermarket pharmacy chains offer substantial price savings on OTC medicines, of up to around 30 per cent. Currently, access to such low priced pharmacies is limited. However, with free entry into the market, we estimate that increased sales from such low priced supermarket pharmacies would lead to annual customer savings of around £20-25 million on P-medicines, and a further £5 million on GSL medicines.

1.13 If deregulation were to increase competition between pharmacies more generally, we would expect to see substantially higher customer savings from lower prices and also improvements in service quality. The charges (if any) that the consumer pays for NHS prescription medicines are fixed, and thus one would

[3] A list of the organisations consulted is in annexe I.

not expect to see immediate direct price benefits from entry deregulation in this area. However, any improvements in service quality would also benefit customers for NHS prescriptions, while in the longer term improvements in the efficiency of pharmacies might be expected to reduce the overall cost of the NHS prescription system to the taxpayer.

1.14 We reviewed published and other data for the three largest national chains, and also commissioned a valuation study of smaller pharmacies. None of this provided evidence of excess profitability in pharmacy activities. High prices are paid on occasion for NHS contracts, in particular by supermarkets, but these may reflect a variety of factors, of which profitability is but one, and as such cannot be taken as evidence of excessive profitability.

Access

1.15 The UK is currently well served geographically by pharmacies. Most people live within a short distance of a CP. Indeed, 79 per cent of people in Great Britain have a CP within one kilometre of their home and 47 per cent have a pharmacy within 500m. Furthermore, around nine out of ten people consider it easy to get to a pharmacy from their home and 86 per cent considers access to a pharmacy easy from their General Practitioner (GP). In practice, for at least half of the cases, prescriptions are picked up following a visit to a GP from a pharmacy near the surgery. Around 98 per cent of GPs have a community pharmacy within one kilometre and around 75 per cent have one within a short walk of 300 metres.

1.16 International comparisons show that the UK ranks only slightly above the average for the number of pharmacies per head. France, Ireland, Italy, Australia, Germany and Canada all have more pharmacies per head than does the UK.

1.17 Nevertheless, the picture across these various aspects of access is not uniformly strong. The location of UK community pharmacies has essentially been little changed since the control of entry system was introduced in 1987. This is despite changes in the distribution of where people live and changes in consumer habits. There are a number of areas where access could usefully be improved, particularly in opening hours.

1.18 Without entry controls we would expect to see more firms entering the market over time and offering a wider range of services and opening times. Over time, we would also expect some existing pharmacies to exit the market, as happens in any competitive market. However, we would not expect to see substantial *net* exit of pharmacies. Analysis of recent pharmacy entries and exits – and common sense support the view that entry into a given area tends to increase the total number of outlets in that area.

1.19 Moreover, empirical modelling of a variety of entry and exit scenarios shows that there would only be a limited reduction in local access even in an extreme scenario where pharmacies are opened in all medium to large supermarkets and, for each new entrant, the **two** nearest community pharmacies close as a result. This scenario modelling also found that impacts on access were broadly the same for low income groups and the elderly as for the general population.

1.20 There is, in any case, more to access than location. Opening hours, convenience and other services, such as home delivery, are also important. There is substantial room for improvement on these aspects of access. For example, the average independent pharmacy is open for around 50 hours per week. This provides relatively limited access compared to, for example, supermarket pharmacies which tend to be open for much longer hours – around 80 hours per week on average. We would expect the ending of entry controls to bring substantial benefits to consumers in terms of these other forms of access to pharmacies and their services. Consumers would use those pharmacies that are most convenient to them, and offer the services that they value most.

1.21 Overall, therefore, we believe that local access will improve following deregulation. Moreover, if localised problems do occur, other support mechanisms – such as the Essential Small Pharmacies Scheme (ESPS) – are much better targeted at problem areas than are universal control of entry regulations.

1.22 Moreover, in areas where there are no NHS dispensing pharmacies, dispensing by GPs offers a further mechanism to ensure appropriate access to prescribed medicines. We would expect this important safeguard to be maintained under deregulation of community pharmacies.

Costs of the current system

1.23 There are also substantial administrative savings to be made from deregulation of entry. Any estimate of the costs of administering the current system is necessarily approximate. Our central estimate of the annual costs to pharmacy businesses and taxpayers directly attributable to the control of entry system is around £26 million. This is made up of £10m in NHS administration costs and around £16m in compliance costs to business. These costs are borne by the taxpayer and by pharmacies and, indirectly, by their customers.

Alternative remedies

1.24 A variety of other potential remedies were put to us during the course of our investigation. However, changes that fall short of abolition of the control of entry regulations for community pharmacies would not, in our view, address the failings of the existing system and the costs it imposes on business and

consumers. More modest changes would add complexity to an already complex and time-consuming process.

Recommendation

1.25 We recommend that the control of entry regulations for community pharmacies in the UK should be ended. This would mean that all registered pharmacies with qualified staff may dispense NHS prescriptions.

2 INTRODUCTION AND OVERVIEW OF COMMUNITY PHARMACY IN THE UK

Introduction

2.1 This report presents the findings of the OFT's market investigation into the regulations that control entry to community pharmacy NHS dispensing in the UK. The investigation was launched on 3 October 2001 and has been carried out under section 2 of the Fair Trading Act 1973. It has been undertaken by the OFT's Markets and Policy Initiatives division (MPID). MPID's remit is to keep markets, practices and regulations under review with a view to making them work well for consumers.

2.2 A number of studies were commissioned for this investigation and they appear in the annexes in volumes 2 and 3.[4] These annexes are the responsibility of the authors concerned and any views expressed in them are those of the authors and not necessarily of the OFT. The OFT's views are expressed in this report, which has been written with the benefit of having seen these studies.

2.3 CPs (also known as retail pharmacies or chemists) play a primary role in the UK's healthcare system. They form an extensive network of outlets that allow the great majority of people to have their prescriptions dispensed conveniently. In addition, they provide other essential services to the community including retailing of non-prescription medicines and healthcare products, providing professional advice on safe and responsible use of medicines and basic medical testing. As the UK population continues to age and as health expectations rise, community pharmacies will continue to grow in their importance to the nation's health.

2.4 The most important service CPs provide is the dispensing of NHS prescriptions. In order to dispense NHS prescriptions, a pharmacy must have a contract with its local Primary Care Trust (PCT).[5] In 1987 regulations were introduced in the UK that placed restrictions on the award of NHS dispensing contracts and hence entry to the market. This report examines the evidence on whether the interests of consumers are best served by these regulations.

2.5 During the course of the investigation we consulted extensively with pharmacy owners and representative bodies (annexe I), surveyed consumers, analysed

[4] Annexes C, D, G, H, J, K, L, M, N & O.

[5] In England, from October 2002 PCTs took over responsibility for this (and other functions) from Health Authorities. This report sometimes refers to Health Authorities when describing these functions.

price and location data of pharmacies, undertook case studies, prepared international comparisons and modelled deregulation scenarios.

The report

2.6 The remainder of this chapter provides an overview of CP in the UK.

2.7 Chapter 3 outlines the regulations that govern the awarding of contracts to dispense NHS prescriptions to pharmacies and their impact on the industry. For example, they place restrictions on the opening and relocation of pharmacies.

2.8 Chapter 4 discusses the effect of these regulations on competition. These include effects on NHS dispensing and on the prices and availability of other medicines as well as on non-price factors such as how pharmacies compete on services.

2.9 The implications of removing the entry restrictions on consumer access to community pharmacies are explored in chapter 5. Good access is not just about having convenient geographical access to pharmacies but also about having convenient opening hours and after-hours services, access to valued services and to a range of low-priced pharmaceutical products.

2.10 While chapters 3 to 5 show how the entry regulations impact on consumers, chapter 6 discusses the administrative costs they impose on business and taxpayers.

Community pharmacies in the UK

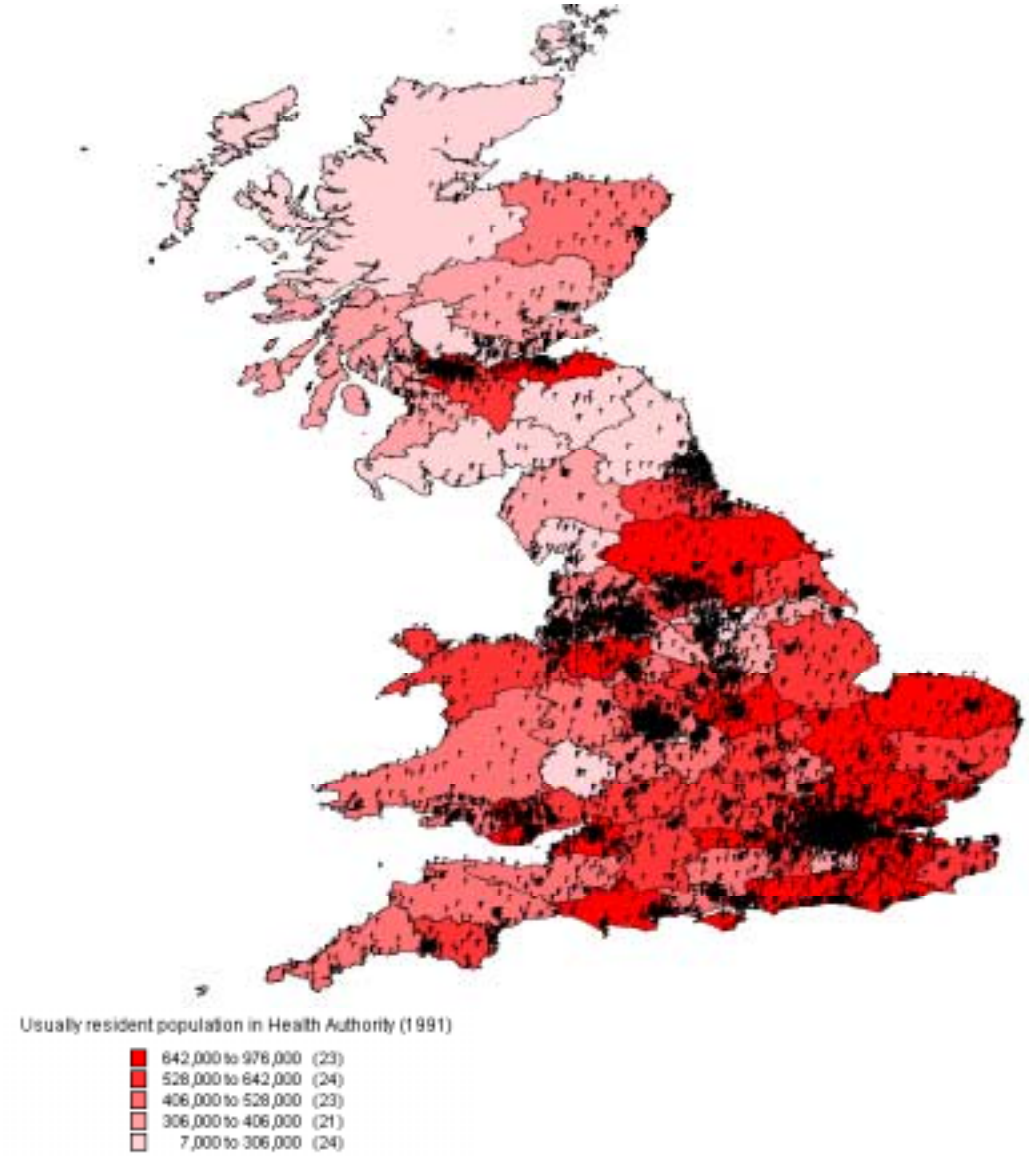
Market overview

2.11 Pharmacists work in a range of sectors, the largest of which is community pharmacy. They also work in hospital pharmacy, primary care and industrial pharmacy (drug manufacturers and wholesalers).

2.12 At the time of analysis there were some 12,124 CPs dispensing NHS prescriptions in the UK.[6] CPs employ over 22,300 pharmacists or 57 per cent of all registered pharmacists in Great Britain.[7] In Northern Ireland some 70 per cent of the 1,700 registered pharmacists work in community pharmacy.[8]

[6] Department of Health, Scottish Executive and DHSSPSNI. This figure differs slightly from the one presented in annexe J as different time periods were used.
[7] Hassell (annexe H).
[8] DHSSPSNI.

FIGURE 2.1: LOCATION OF COMMUNITY PHARMACIES IN GREAT BRITAIN



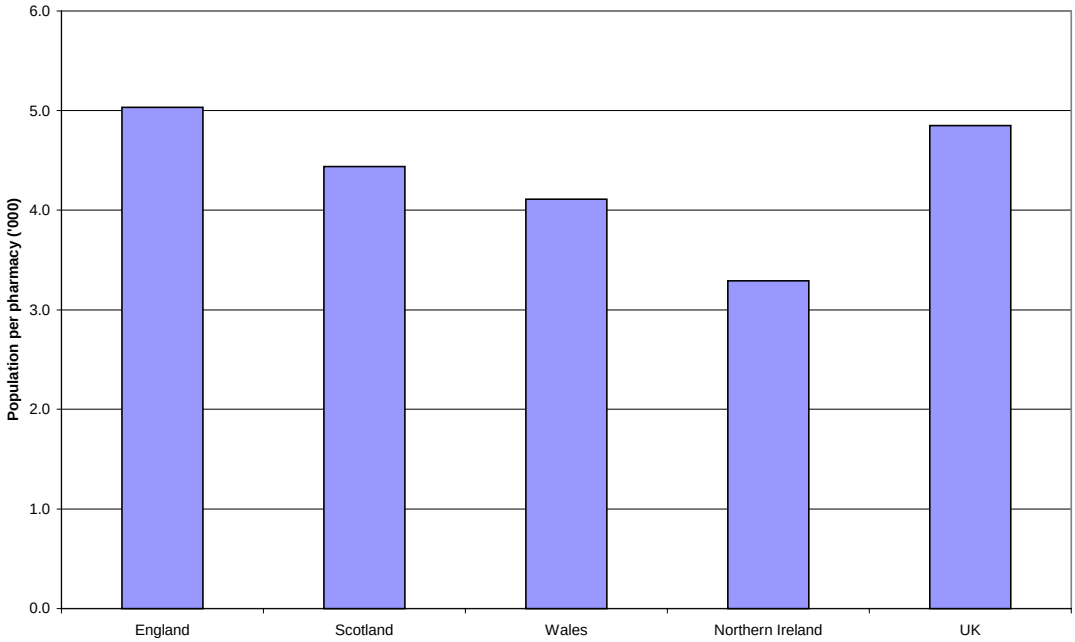
Source: Frontier Economics

2.13 At the time of analysis, there were 9,765 pharmacies in England with a contract to dispense NHS prescriptions, 1,141 in Scotland, 706 in Wales and 512 in Northern Ireland.[9]

2.14 England has 5,000 people for every NHS contractor pharmacy, Scotland has 4,400 people per pharmacy, Wales 4,100 people while Northern Ireland has 3,300 people for every pharmacy (figure 2.2). For the UK as a whole, there is one NHS contractor pharmacy for every 4,800 people.

[9] Department of Health, Scottish Executive and DHSSPSNI.

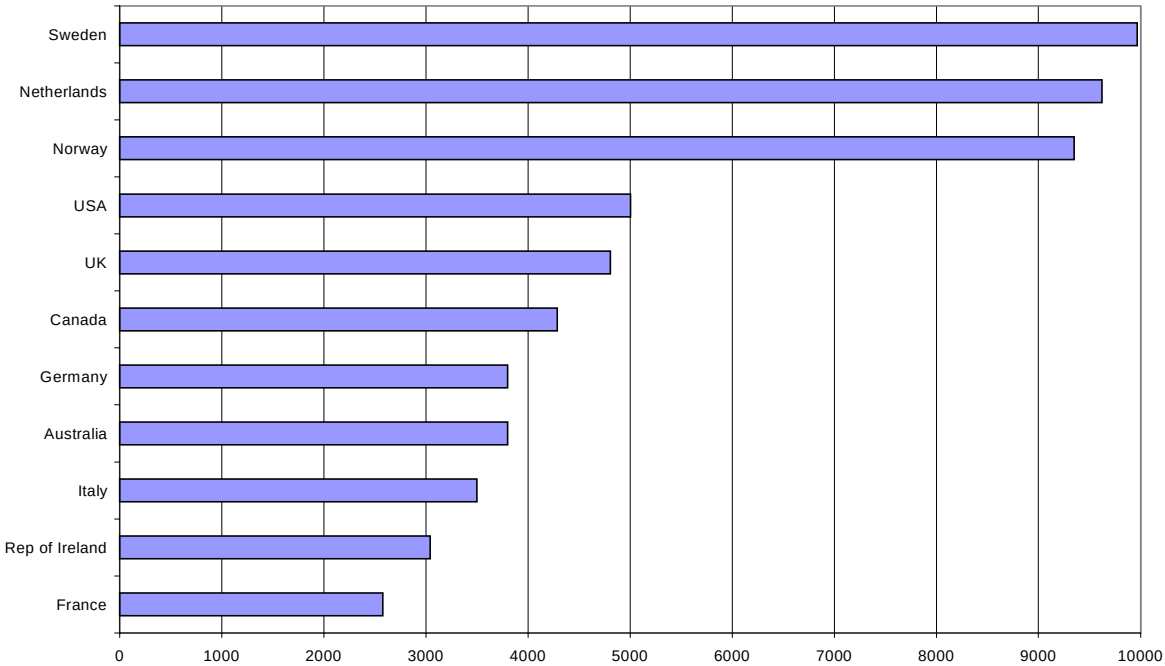
FIGURE 2.2: POPULATION PER NHS CONTRACTOR PHARMACY IN THE UK



Source: Department of Health, Common Services Agency (Scotland), DHSSPSNI and Office for National Statistics.

2.15 International comparisons show that the UK has a slighter greater than average number of community pharmacies per head of population (figure 2.3). France, Ireland, Italy, Australia, Germany and Canada all have more pharmacies per person than does the UK.

FIGURE 2.3: POPULATION PER COMMUNITY PHARMACY



Sources: Mossialos & Mrazek (annexe C) and AESGP (2001).

2.16 The national market has low market concentration. The top three chains account for just 27 per cent of all outlets (table 2.1). There is also a degree of vertical integration of firms. The three market leaders are vertically integrated with wholesalers – Boots the Chemists Ltd is owned by Boots Plc, Lloydspharmacy Ltd is owned by Gehe AG and E Moss Ltd is owned by Alliance Unichem.

TABLE 2.1: CONTRACTOR PHARMACIES IN THE UK, 2002

Pharmacy	**Number of outlets**	**Share of total outlets (%)**
Lloydspharmacy	1 321	10.9
Boots the Chemists	1 268	10.5
Moss Pharmacy	773	6.4
L Rowland & Co	300	2.5
National Co-operative Chemists	290	2.4
Superdrug	228	1.9
Tesco	210	1.7
Cohens Chemist Group	107	0.9
Sainsbury's	107	0.9
Safeway	105	0.9
Asda	80	0.6
Others	7 335	60.4
Total	**12 124**	**100.0**

Sources: Department of Health, The Independent, 21 November 2002.

2.17 There has been a substantial change in the structure of the market over the past decade. In this time, the proportion of pharmacies in chains of 5 or more has risen from a third to a half.[10] Superdrug Ltd, for example, has built up its number of NHS contractor pharmacies from nothing ten years ago to around 230 today. Another significant change in the market structure since 1990 has been the opening of some 450 supermarket pharmacies. There is one supermarket pharmacy in Northern Ireland.

2.18 There are relatively few legal barriers to opening a CP without an NHS dispensing contract, but in reality this rarely happens. Only one in a hundred pharmacies operate without such a contract (approximately 130 pharmacies in all).[11] With 94 non-contract pharmacies, Boots owns more than anyone else.

2.19 In rural areas where consumers have difficulties in accessing a pharmacy, GPs can dispense prescribed medicines. Since 1987, in England and Wales,

[10] Department of Health Bulletin 2001/3, December 2001.
[11] Although the number of NHS contractor pharmacies is known there is no central database of non-contract pharmacies.

arrangements for dispensing by doctors in these areas have also been subject to the 'prejudice test'. In Scotland, dispensing doctors are put in place by PCTs or NHS Boards. Table 2.2 shows that in 2001 there were 1,565 dispensing doctor practices in the UK.

TABLE 2.2: DISPENSING DOCTORS IN THE UK, 2001

	Number of practices	Number of doctors
England	1 242	4 455
Wales	91	317
Scotland	218	272
Northern Ireland	14	27
Total – UK	**1 565**	**5 071**

Source: Dispensing Doctors Association and UK departments of health.

The control of entry system

2.20 CPs operate under a range of regulations designed to protect public safety and professional standards.

2.21 In 1987 the departments of health introduced regulations that required any CP wishing to dispense NHS prescriptions to pass a local needs test. These regulations are commonly referred to as the 'control of entry regulations'.

2.22 The regulations determine that local Primary Care Trusts (or Health Boards) should consider applications for new pharmacy contracts on the basis of whether the proposed pharmacy is 'necessary or desirable' in order to ensure an adequate provision of pharmaceutical services in the 'neighbourhood'. Therefore, the choice of whether to open and where to locate an NHS dispensing pharmacy and where to locate it is not simply a commercial decision left to the discretion of the pharmacy owner. A more detailed discussion of the regulations and how they affect pharmacy entry is contained in chapter 3.

Pharmaceutical products

2.23 CPs in the UK typically provide a range of professional and retail services that includes selling over-the-counter medicines (OTCs), toiletries, skin care and hair care products, perfumes, cosmetics and baby care products. They also provide professional advice on medicines. The most important stream of income for CPs is derived from dispensing NHS prescriptions. For a typical CP, dispensing NHS prescriptions provides 80 per cent of its revenue – a proportion that has risen over time. [12,13]

[12] OFT Small Pharmacy Survey (annexe E) and Competition Commission (1999).
[13] 30 years ago the proportion was 40 per cent (Jones, 1998).

2.24 The pharmaceutical products commonly sold or dispensed in community pharmacies are regulated under The Medicines Act 1968. They are split into three broad categories:

- prescription only medicines (POM)
- pharmacy only medicines (P)
- general sales list medicines (GSL).

2.25 Prescription only medicines (POMs) are listed in The Prescription-Only Medicines (Human Use) Order 1997.[14] For pharmacy dispensing, only those with a contract with their local Primary Care Trust (or Health Board) can dispense NHS prescriptions and this must be done under the supervision of a registered pharmacist. Last year in the UK the market for NHS prescribed medicines was worth £6.8 billion. There is also a small but growing private prescriptions market worth around £300m annually.

2.26 Pharmacy only – or P medicines – do not require a prescription but a pharmacist must supervise their sale. This can be because of the active ingredient involved, the strength of the drug, the instructions for use or its pack size. For example, Nurofen tablets (200 mg) are classified as 'P' in a pack of 24 but in a pack of 12 are available as a GSL medicine. Other P medicines include many of the stronger cold and flu medicines. There is, however, no statutory list of pharmacy medicines as such. Instead, any medicine that is not listed as POM or GSL is, by default, a P medicine.[15]

2.27 GSL medicines are medicines that do not need to be sold in pharmacies but do need to be sold in a lockable shop. They are commonly found in supermarkets, convenience stores and petrol stations. GSLs are listed on 'The Medicines (Products other than Veterinary Drugs) (General Sale List) Order 1984' and include such medicaments as cough mixtures and paracetamols. Around 50 per cent of GSLs are sold in pharmacies.[16]

2.28 Together P medicines and GSLs are known as over-the-counter medicines (OTCs). Until recently, branded OTCs were subject by law to a minimum retail price, fixed by manufacturers or suppliers (the system was known as resale price maintenance or RPM). RPM was removed in May 2001. In 2001, OTCs had a market value of £1.83 billion – split evenly between P medicines and GSLs.[17]

[14] A similar list exists for veterinary drugs.
[15] Royal Pharmaceutical Society of Great Britain (RPSGB).
[16] AESGP (2001).
[17] Key Note (2002).

2.29 The combined annual market for all retail pharmaceutical products (POMs and OTCs) in 2001 was at least £8.6 billion.

Payments to pharmacies for NHS dispensing

2.30 Payments to contractor pharmacies have two components: [18]

- remuneration (payment for providing NHS pharmacy services)
- reimbursement (to reimburse for the costs of the drugs dispensed).

2.31 Details of the rules and rates of payments for the two components are contained in the 'NHS Drug Tariff' (published separately for England and Wales, Scotland and Northern Ireland).

2.32 Remuneration payments comprise dispensing fees and a professional allowance (for pharmacies that dispense over a minimum threshold amount). In England, CPs send prescription forms to the Prescription Pricing Authority who calculate the remuneration due and notify the relevant Health Authority who then pays the pharmacy. In Scotland, payments are calculated and paid by the Practitioner Services Division of the Common Services Agency. Additional payments are available to some pharmacies for the provision of additional services – e.g. providing advice to nursing homes.

2.33 The pool of money that is available for remuneration for the community pharmacy sector is known as the Global Sum and is set by the health departments each year. In 2001-02, the Global Sum was set at £806.6 million in England and Wales, and £83.6m in Scotland. By convention, over- or under-payments are taken into account when setting the next year's remuneration payment.

2.34 Reimbursement is by far the larger component of the two payments and covers the cost of the drugs dispensed, container costs and other costs related to dispensing. In 2001-02, £6 billion was made available for reimbursement.

2.35 To gauge the level of discount community pharmacies can obtain from their suppliers regular Discount Inquiries are held by health departments. In Scotland a separate Generics Discount Inquiry is also held (in England, both proprietary and

[18] The charges (if any) CPs receive from consumers who pay for their prescribed medicines are deducted from total payments due to CPs for that month. The charge for NHS prescription item is currently fixed at £6.20 in England, Scotland and N Ireland (£6.00 in Wales). Around half the population is exempt from paying at any one time (e.g. children under 16 and those aged 60 and over). This results in approximately 85 per cent of prescription items being dispensed without charge (around 90 per cent in Northern Ireland).

generic drugs are covered in the one Discount Inquiry). These are taken into account when the reimbursement is calculated.

2.36 The basis for reimbursing NHS contractor pharmacies is that pharmacies are reimbursed for the costs of drugs dispensed, less a discount shown in the Deduction Scale.

2.37 The Deduction Scale recognises that some pharmacies receive bigger wholesale discounts than others do when purchasing drugs. The Discount Scale ranges from 6.51 per cent for monthly totals dispensed of less than £125 to 13.1 per cent for monthly totals dispensed of more than £150,000. In Scotland, the discount rate is called the Net Ingredient Cost Scale and ranges from zero for monthly dispensing totals of less than £2,000 to 9.29 per cent for monthly totals of more than £150,000.

BOX 2.1: THE CONDUCT OF NHS DISCOUNT INQUIRIES

Boots the Chemist does not participate in the NHS Discount Inquiry in England or the NHS Proprietary Discount Inquiry in Scotland on the grounds that, as the Boots group does its own wholesaling, it is unable to provide reliable information on the actual level of discounts secured on its purchases.[19] Boots did, however, participate in the last generics discount inquiry held in Scotland.

To compensate, the discounts secured by the other large integrated retail pharmacy chains (such as Lloydspharmacy and Moss) are used as proxies for those that could be obtained by Boots. Such compensatory weighting may, however, fail to fully reflect the economies of scope and scale available to Boots. Provided Boots' internal transfer prices are supported by accurate cost data from the Boots group and any necessary adjustments in the light of these data were made, they could, and in our view should, be employed to make the findings of the NHS Discount Inquiries more robust.

Essential small pharmacy scheme

2.38 Besides standard remuneration and reimbursement payments, 340 community pharmacies in the UK currently receive additional payments under the Essential Small Pharmacy Scheme (ESPS).[20] ESPS payments provide financial assistance to pharmacies that are not economically viable because of their location but are considered vital to the provision of pharmaceutical services to their local community. The scheme, therefore, aims to ensure the proper provision of pharmaceutical services in areas that would otherwise have difficulty in attracting them. Payments are drawn from the Global Sum and in 2001-02, a

[19] Oxera (2001) and Scottish Executive.
[20] Department of Health, Scottish Executive, National Assembly for Wales & DHSSPSNI.

little over £4 million in England and Wales and around £380,000 in Scotland (or less than 0.5 per cent of the Global Sum in both countries).

Profitability of pharmacies

2.39 As a result of the changes to the payments system (both in 1989 and subsequently) gross margins on NHS dispensing have fallen for CPs of all sizes although the reduction has been proportionately greater for low volume pharmacies.[21]

2.40 As part of our investigation we reviewed available data on pharmacy profitability. Restrictions on the availability of NHS dispensing contracts may affect pharmacies' OTC sales, enabling them to earn profits above those which could be earned in a competitive market (excess profits). In addition, the NHS remuneration and reimbursement system may reward differentially the large pharmacy chain compared to small independent CPs.

2.41 We reviewed the last three years' published accounts of the three largest pharmacy chains, Boots the Chemist, Lloydspharmacy and E Moss Ltd., supplemented by additional financial information provided to us on a confidential basis. The available evidence, which is limited, did not lead us to conclude that any of these companies was earning excess profits on their retail pharmacy business. Due to the large number of pharmacies in the UK and the limited nature of the accounts they publish, it was not practicable to appraise the profitability of small CPs (the independents and small multiples) by examining their published accounts.

2.42 The profitability of small CPs can, however, be reflected in the prices paid for such businesses. We accordingly commissioned a report from Mr A R Townsend, National Business Sales Manager of Orridge Business Sales Ltd, a valuer and transfer agent of pharmacy businesses in the UK. This report (the Orridge report) is at annexe G.

2.43 Supermarket chains claim to have paid large sums to acquire independent pharmacy businesses (often to relocate these into their store). They attributed the high prices paid to the effects of the control of entry regulations and the need, in effect, to purchase an NHS dispensing contract. However, it is not possible to draw firm conclusions on profitability from the prices at which pharmacies close to supermarkets change hands. High values for some dispensing contracts may be driven by the supermarkets' desire to increase their footfall.

[21] Reference Sheet 86/10 for the National Health Service (Amendment) Bill 1985-86 and Department of Health Statistical Bulletin (various issues).

2.44 The valuation principles described in the Orridge report indicate that prices, while variable, depend on a multiple of adjusted earnings that is typically in the range 4.5 to 6. This does not, of itself, confirm the existence of excess profits.

2.45 Overall, we therefore found little direct evidence that pharmacy businesses are earning excess profits. High prices paid for some businesses may be due to a number of factors, of which profitability is but one.

3 THE CONTROL OF ENTRY REGULATIONS

Introduction

3.1 This chapter provides an overview of the control of entry regulations in the UK, including the background to their introduction and their administration.

NHS pharmacy strategies

3.2 Regulatory responsibility for NHS community pharmacies in the UK is a devolved matter. The Department of Health has responsibility for England, the Health Department (Scottish Executive) for Scotland, the Department for Health, Social Services and Public Safety (Northern Ireland Assembly) for Northern Ireland; and the Health Department (National Assembly for Wales) for Wales.

3.3 The English, Scottish, and Welsh administrations have each released strategies for community pharmacies in their jurisdictions.

3.4 *'Pharmacy in the Future – Implementing the NHS Plan'* sets out the Department of Health's vision for pharmacy in England. Among other things, it aims to:

- take fuller advantage of the professional skills and expertise of pharmacists in providing advice and medicines management
- promote Local Pharmaceutical Services (LPS) – an alternative to the existing national contract in providing and paying for local pharmacy needs
- create 500 one-stop primary care centres that house doctors, nurses, pharmacists and other health professionals, and
- promote electronic prescribing ('e-pharmacy').

3.5 The possible need to change or remove the control of entry regulations is acknowledged in the report where it states:

'The control of entry arrangements for community pharmacy will be changed if they block the development of better services for patients and where they are clearly inappropriate'.

3.6 *'The Right Medicine: A Strategy for Pharmaceutical Care in Scotland'* provides a corresponding community pharmacy plan for Scotland. The strategy is wide ranging and includes calls for:

- developing the health improvement role of pharmacists

- improved access to the Primary Care team in terms of pharmacies e.g. walk in centres, out of hours services linked to GP co-operatives and improved pharmaceutical services in areas of high deprivation and for rural and isolated communities, and

- better use of pharmacists' clinical skills and knowledge, through developments such as pharmacist prescribing, to improve the pharmaceutical care of patients.

3.7 Similarly wide-ranging, '*Remedies for Success: A Strategy for Pharmacy in Wales'* strives to:

- better utilise the expertise of pharmacists

- ensure everyone can easily obtain high-quality information on medication issues

- examine ways in which consumers can gain better after hours access to pharmacies

- to develop new models of service delivery, and

- overcome shortfalls in the workforce, equipment and technology.

The background to the control of entry regulations

3.8 Until 1989, pharmacies were reimbursed on a cost-plus basis for drug ingredient costs, pharmacists' wages and other overheads with a two-tier system which generously supported low volume pharmacies (those with less than around 16,000 prescriptions per year).[22] This form of reimbursement was introduced to address the decline in pharmacy numbers in the 1960s and 1970s but resulted in increasing number of entrants in the 1980s (figure 2.1) with a resulting increase in the cost of reimbursement to the Department of Health. This prompted a comment in *Pharmacy: A Report to the Nuffield Foundation* (1986) that:

'… under the terms of the existing contract higher payments are made to smaller pharmacies for each prescription dispensed than to larger ones. This has encouraged the opening of new pharmacies which in turn increases contractors' total costs and so the sums paid to pharmacy contractors by the NHS'.

[22] Reference Sheet 86/10 for the National Health Service (Amendment) Bill 1985-86.

3.9 The control of entry regulations were introduced in England and Wales, Scotland and Northern Ireland in 1987 in order to contain the escalating cost to the NHS. For England and Wales they are now contained in the National Health Service (Pharmaceutical Services) Regulations 1992; for Scotland, the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995; and, for Northern Ireland, the Pharmaceutical Services Regulations (Northern Ireland) 1997.

3.10 The cost-plus remuneration system held responsible by the 1986 Nuffield report for this escalation was replaced in 1989 by the current remuneration and reimbursement system. Sir Graham Hart, the then Permanent Secretary of the Department of Health, told the Public Accounts Committee in 1992 that the control of entry regulations had indeed been introduced to stem the rising cost of dispensing encouraged by the pre-1989 remuneration system. He acknowledged, however, the potential for the remuneration system to do this, commenting that:

'I think that if we manage to restructure the remuneration system then it may well be the case that entry controls are no longer needed'.[23]

3.11 Under the control of entry regulations, any pharmacy in the UK wishing to obtain an NHS contract to dispense NHS prescriptions must satisfy the relevant authority that it is either 'necessary' or 'desirable' to grant the application to secure the adequate provision of pharmaceutical services in a particular neighbourhood. Permission is also required for minor relocations and changes of ownership. Minor relocations cover pharmacies wishing to relocate over a short distance within the same neighbourhood. Changes of ownership are granted only if the same services will be provided as before, there is no interruption in service provision and no relocation involved.

3.12 Annexe A contains further information on the regulations in England, Wales and Scotland and how they are administered. The regulations in Northern Ireland are broadly similar in form and effect to those applying elsewhere in the UK.

Dispensing doctors

3.13 In England and Wales, GPs have long-standing rights to dispense medicines. Under the National Health Service (Pharmaceutical Services) Regulations 1992, some areas are deemed rural in character and are classified as 'controlled' areas'. Within these areas, GPs may apply to provide NHS dispensing services to patients who live more than one mile away from their nearest pharmacy.

[23] Committee of Public Accounts, 'Community Pharmacies in England', Minutes of Evidence, Wednesday 24 June 1992.

Dispensing doctors thus play an important role in ensuring access to NHS dispensing services in rural areas. Dispensing doctors do not, however, engage in the sale of non-prescription (OTC) pharmaceuticals. In relation to pharmacy applications in controlled areas, pharmacies which are not on the pharmaceutical list must pass the 'prejudice test' as well as the 'necessary' or 'desirable' test. Those pharmacies already on the pharmaceutical list need only satisfy the 'necessary' or 'desirable' test (except in minor relocation applications).

3.14 In Northern Ireland, the situation is similar. GPs may not dispense if there is a pharmacy within one kilometre of the surgery, but otherwise, they may dispense to patients, so long as the patient has 'serious difficulty' in getting to a pharmacy. In Scotland, no distinction is made between controlled and non-controlled areas, and there are no formal rights for GPs to dispense, and doctors cannot apply to dispense to patients. However, where a Health Board is satisfied that a patient has serious difficulty in obtaining drugs or appliances, the Health Board can require the patient's GP to supply the drug or the appliance.

3.15 In England, Wales and Scotland if a pharmacy is granted a NHS dispensing contract by the Health Authority or Board in a controlled area where a dispensing doctor is present, the dispensing doctor is required to cease dispensing and make way for the pharmacy. However, this is a gradual process allowing the dispensing doctor to phase out dispensing, normally over a period of 12 months. The length of the 'gradualisation' period is not prescribed by the regulations.

Further details on England, Wales and Scotland can be found in annexe A.

The essential small pharmacy scheme

3.16 Sir Graham Hart also told the Public Accounts Committee in 1992 that the control of entry regulations did not necessarily ensure pharmacies were located where they were most needed. He commented that:

'If we were convinced that there was a really serious problem of access we could certainly consider some kind of extension of the Essential Small Pharmacy Scheme or some other kind of incentive in order to support that objective'. [24]

3.17 The Essential Small Pharmacies Scheme (ESPS) currently provides financial support to pharmacies that are not economically viable because of their location but are considered vital to the provision of pharmaceutical services to the local community. It is available throughout the UK although differences exist in eligibility requirements and payments between England, Wales, Scotland and

[24] Committee of Public Accounts, 'Community Pharmacies in England', Minutes of Evidence, Wednesday 24 June 1992.

Northern Ireland. In all, there are 340 ESPS pharmacies in the UK. Further details are contained in annexe F.

How the regulations are administered

3.18 Decisions made by local health authorities in the UK can be taken to appeal. In England the Family Health Services Appeal Authority deals with applications, in Wales the National Assembly for Wales Office Committee deals with appeals and Scotland and Northern Ireland each have their own designated National Appeal Panel.

3.19 Appeals that are deemed frivolous or vexatious are dismissed without a hearing. Others are dealt with in an oral hearing where the parties concerned each present their case to an independent adjudicator.

3.20 The appeal authority notifies the decision to the parties in writing. There are no further avenues for appealing. Any party that wishes to take the matter further has to apply for permission to have the appeal body's decision judicially reviewed in a court of law. In England and Wales and Northern Ireland the High Court will deal with this issue and in Scotland it is the Court of Session.

3.21 There have been a number of judicial reviews in each jurisdiction since 1987. There is as a result less uncertainty over the requirements of the regulations. This has helped potential litigants to understand better what is expected.

3.22 Appeal statistics on the total amount of appeals are collated every year by the relevant authorities as well as the numbers on each type of appeal, whether it is for a new contract, minor relocation or change of premises. In the year 2000/2001 a total number of 362 appeals were received in the UK. Further details of the numbers and types of appeal are contained in annexe A.

Pharmacy regulation in other countries

3.23 The regulation of community pharmacies in other countries varies considerably. Table 3.1 below shows that, in each of the seven OECD countries, a licence or contract to dispense prescribed medicines is required. The UK, together with the USA, Canada and the Netherlands, has relatively liberal ownership regulations. In these countries, there is no restriction on how many pharmacies each pharmacy owner can own and there is no requirement to be a qualified pharmacist in order to own a pharmacy.[25]

[25] In the UK, if a non-pharmacist owns a pharmacy then a qualified pharmacist must be employed in the role of superintendent pharmacist.

3.24 However, a comparison of the UK and other European and North American countries on some of the other aspects of pharmacy regulation that affect competition, the UK is found to be relatively restrictive. For example, of the selected countries, only France and Norway place restrictions on where pharmacies can open and how many pharmacies can exist in any area.

3.25 Some price competition on prescribed medicines is allowed in some other countries – namely Canada, the Netherlands, France and Norway.[26] The conclusion we draw from this research is that restrictions on the location of new pharmacies are not an essential feature of effective pharmacy regulation. A study providing an overview of pharmacy regulations in these countries was commissioned as a part of this investigation and is in annexe C.

TABLE 3.1: REGULATION OF PHARMACIES IN SELECTED COUNTRIES

	UK	France	Germany	Netherlands	Norway	USA	Canada
Licence or contract required?	**Yes**	Yes	Yes	Yes	Yes	Yes	Yes
Location of new pharmacies restricted?	**Yes**	Yes	No	No	Yes	No	No
Ownership structure restricted?	**No**	Yes	Yes	No	No	No	No
Number of stores per owner restricted?	**No**	Yes	Yes	No	Yes	No	No
Freedom to reduce prescribed drug prices	**No**	Yes	No	Yes	Yes	No	Yes

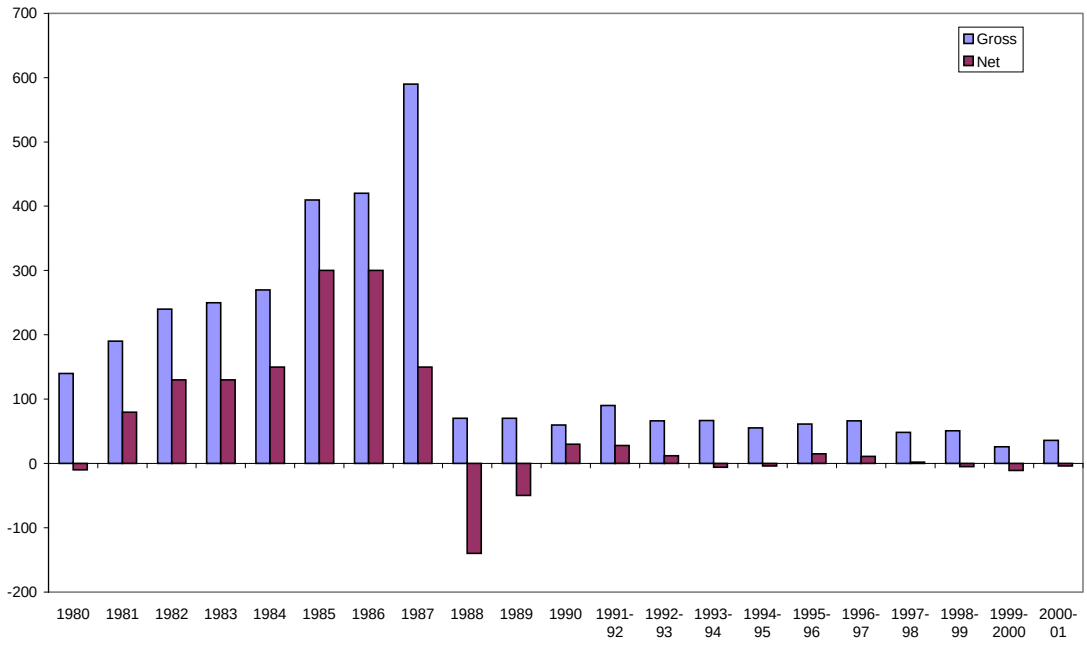
Source: Mossialos and Mrazek (annexe C).

The introduction of the control of entry regulations

3.26 The effect of the control of entry requirements on the number of pharmacies that opened (gross openings) and the increase in the total number of pharmacies (net openings, i.e. once pharmacy closures have been taken into account) in England and Wales was dramatic. See Figure 3.1 below.

[26] As annexe C explains, many other countries have a private health insurance system. Therefore, the fee the consumer pays for prescribed medicines may differ because of competition between insurers and not necessarily because of competition between pharmacies.

FIGURE 3.1: GROSS AND NET OPENINGS OF CONTRACTED PHARMACIES IN ENGLAND AND WALES, 1980 TO 2000-01



Source: Department of Health, *General Pharmaceutical Services in England and Wales* (various issues).

3.27 Under the control of entry regulations the number of NHS contracted pharmacies has been remarkably static. In the ten years from 1991-92 to 2000-01 the average annual net change in the number of such pharmacies in England and Wales was **four**. This represents an annual growth rate of about 0.04 per cent or four-hundredths of one per cent. By contrast, in the five years to 1985 the average annual net change was **one hundred and thirty**. Moreover, the absolute number of openings per year dropped precipitously when the regulations were introduced and has since declined further.

3.28 After the introduction of the control of entry regulations, businesses wishing to enter the market or expand their number of existing sites were effectively required to buy existing pharmacies. In the report by Mr A R Townsend, National Business Sales Manager of Orridge Business Sales Ltd, (the Orridge report) at annexe G around 300 pharmacies are reported as changing hands each year. As these figures represent a change in the ownership of a pharmacy rather than a change in the overall number of pharmacies, they are not reflected in figure 3.1.

3.29 The demand for existing pharmacy businesses since 1987 is said to have resulted in significant amounts being paid to acquire NHS dispensing contracts.

Asda estimated the average cost of buying a pharmacy contract in 2001 was £0.5 million and one even changed hands for around £1 million.[27]

3.30 These large payments can, however, simply reflect the value of sustainable earnings. Analysis in the Orridge report indicates that pharmacies are generally valued as a multiple of 4.5 to six times adjusted earnings, but, as could be expected, this varies significantly with the location of the pharmacy and the extent to which the pharmacy faces local competition. The Orridge report also notes that some supermarkets have paid 'over-inflated prices' to capture the benefits that they expect to receive in getting consumers into their store. However, the amounts being paid have fallen in line with those paid by other buyers more recently.

3.31 While **some** pharmacy contracts are of considerable market value, this is not uniformly the case. Some pharmacies attract little if any additional value because of their contract to dispense NHS prescriptions. Where pharmacy contracts have value, this may be for reasons not related to the control of entry regulations.

Entry and exits

3.32 As a part of this investigation, analysis of the areas in which new contracted pharmacies have entered was undertaken (annexe K Part 2). The results show that, for the period 1997-2001, in the majority of cases, a new entry in the local area did not result in another pharmacy closing, but rather an overall increase in the number of pharmacies in that area. Other areas saw one pharmacy exit for every one that entered. Net displacement (where more than one pharmacy exits for each one that enters) is very rare.

The control of entry regulations and the markets for P and GSL medicines

3.33 By law, a qualified pharmacist must be present when P medicines are sold. This does not necessarily have to be in a pharmacy with a NHS contract. Non-contract pharmacies are free to open, to dispense private prescriptions and to sell P medicines. However there are significant joint costs in supplying prescriptions and P medicines. Joint costs are those common costs that a pharmacy must bear whether or not it has an NHS contract.

3.34 The key joint costs are the cost of employing a pharmacist and the costs of setting up and maintaining a pharmacy to the standards required by the RPSGB, (or the Pharmaceutical Society of Northern Ireland). The illustration of small

[27] Asda News Release, 6 March 2002.

pharmacy costs in the Orridge report indicates that the cost of employing a pharmacist and/or locum can amount to some £42,000 per year.

3.35 The significance of these joint costs means that, in almost all cases, pharmacies selling P and GSL medicines cannot survive without also dispensing a significant volume of NHS prescriptions. Using financial information submitted by a number of large pharmacy chains and also the information on small pharmacy finance in the Orridge report, we carried out analysis on the commercial viability of non-contract pharmacies.[28] This found that, typically, pharmacies without revenue from dispensing NHS prescriptions are not commercially viable. This is irrespective of whether the pharmacy is a small independent or part of a large chain, although the Boots and Superdrug business model have both demonstrated the viability of health and beauty outlets without a pharmacy on offer.

3.36 This analysis is corroborated by the fact that in comparison to the 12,124 pharmacies in the UK which hold an NHS contract, only around 130 pharmacies – or around one percent – operate without a contract.

Summing up

3.37 In the 1980s, costs to NHS dispensing were rising. In order to address this, rather than change the remuneration system, regulations were introduced in 1987 that controlled entry to NHS dispensing. Since then, the number of NHS contracted pharmacies has remained static.

3.38 The regulations have a wide impact on pharmacy business decisions. They reduce entry to the market and distort business locations. The difficulties in obtaining a new contract to dispense NHS prescriptions have pushed up the value of some existing dispensing contracts, in some cases quite considerably.

3.39 Evidence of regulation in other countries suggests that restrictions on the location of new pharmacies are not an essential feature of effective pharmacy regulation. As Sir Graham Hart acknowledged in 1992, an appropriate remuneration system complemented by the Essential Small Pharmacy Scheme can represent a practical alternative to the control of entry regulations.

[28] See annexe G.

4 COMPETITION

Introduction

4.1 In this chapter we explore the impact of the control of entry regulations on both price competition (section 4.1) and competition in service quality (section 4.2). In section 4.1, the effect on prescription-only medicines (POM), pharmacy-only (P) medicines, and general sales list (GSL) medicines are discussed separately.

4.2 Although the control of entry does not relate directly to over-the-counter (OTC) medicines, it effectively results in entry being restricted not only into the dispensing of POMs, but also the sale of P-medicines, with implications too for GSLs. Where entry controls bite – i.e. where entry is lower than it would be in the absence of the regulations – this is likely to reduce competition in the market. This in turn will harm consumers, since in general, increasing the level of competition in a market benefits consumers by reducing prices, improving quality of service and encouraging innovation.

4.3 The sum of the evidence on price competition clearly points towards significant consumer savings following entry deregulation, in terms of access to lower prices for P-medicines and GSLs.

4.4 On non-price competition we present evidence which indicates that despite the concerns raised by some stakeholders, reductions in service quality following deregulation are unlikely. We also report evidence that in fact indicates a positive relationship between the level of local competition and some key aspects of service quality, such as opening hours.

Section 4.1: Price Competition

P-medicines

4.5 The obvious and immediate benefits of deregulation would be in the prices of P-medicines. This is because the regulations controlling the issuing of NHS dispensing contracts indirectly distort the market for P-medicines.

4.6 The evidence presented in chapter 3 describes how the significant joint costs in dispensing prescriptions and selling P-medicines mean that the control of entry system also restricts entry into the P-medicine market. Our financial analysis shows that, in general, a pharmacy selling P-medicines also needs to have an NHS dispensing contract in order to be commercially viable.

4.7 Aside from joint costs, there are other problems that affect non-contract pharmacies. One problem that has been raised by stakeholders is that the status of such outlets is confusing for customers. A customer cannot tell whether a pharmacy has an NHS contract or not until they try to get an NHS prescription dispensed. This can lead to confusion and annoyance for customers.

The empirical relationship between price and competition

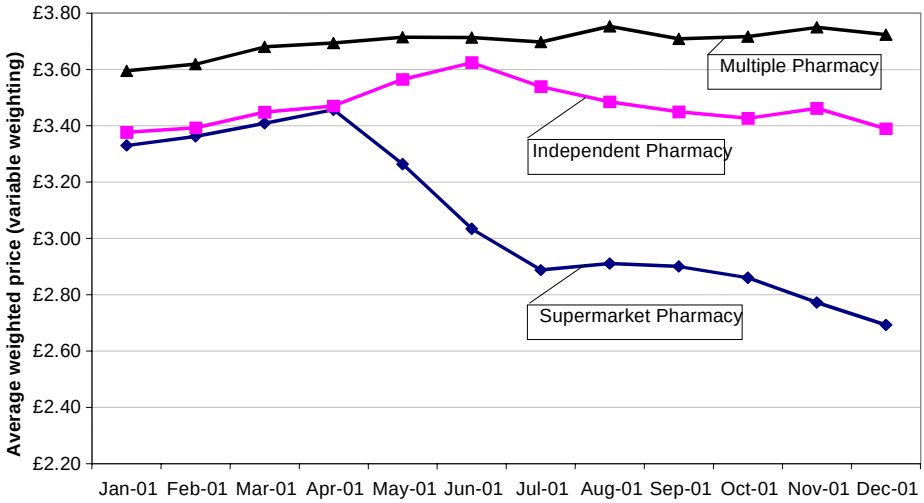
4.8 Removing the control of entry regulations would free up entry into the retailing of P-medicines. This can lead to consumer savings in two main ways:

- increasing the availability of low prices if more low-price supermarket pharmacies and discount pharmacies enter
- increasing price competition between pharmacies, which will lower prices in all types of pharmacies.

Increased availability of low priced P-medicines

4.9 Evidence on the first point comes from price data collected during 2001. Figure 4.1 below shows the average price for a basket of 27 products from a sample of 650 pharmacies (249 supermarket pharmacies, 169 multiple, and 232 independent) in Great Britain over 12 months from January to December 2001. (We did not collect data for Northern Ireland.) The data show that shortly after the ending of resale price maintenance (RPM), in May 2001, supermarket pharmacies reduced prices for a basket of P-medicines to levels up to 30 per cent lower than other pharmacies. The data shows no clear response to these price cuts from non-supermarket pharmacies. The price cuts in supermarket pharmacies were sustained.

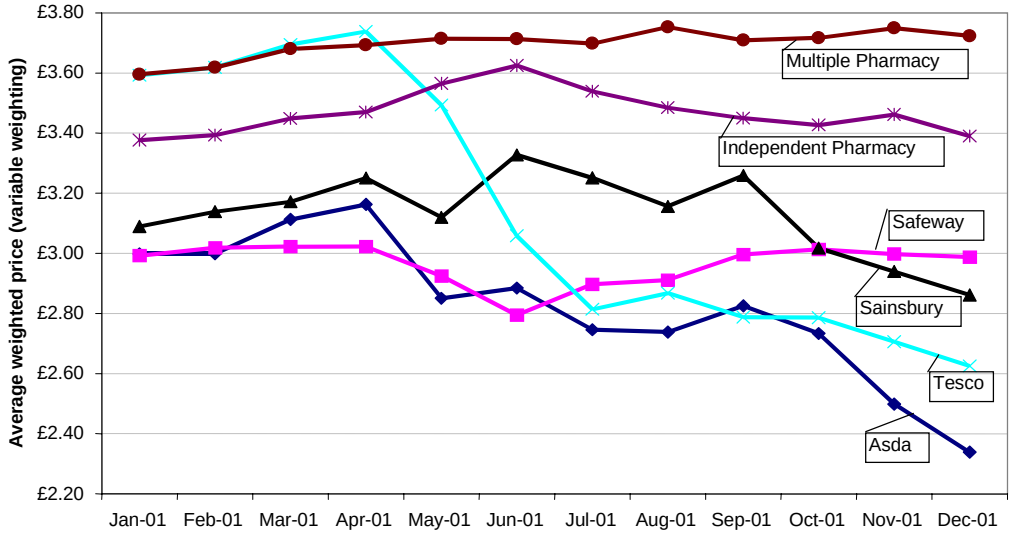
FIGURE 4.1: PRICE EVOLUTION INDEX FOR THE THREE MAIN PHARMACY TYPES BASED ON A BASKET OF P-MEDICINES[29]



Source: OFT analysis of IMS Health data

4.10 Figure 4.2 below shows the price index for certain supermarket pharmacies compared to specialist pharmacies. It shows that whilst supermarket pharmacies are in general cheaper than other types of pharmacy, there was a wide range of price responses to the ending of RPM from different supermarket chains.

FIGURE 4.2: PRICE EVOLUTION INDEX FOR SPECIFIC SUPERMARKET TYPES BASED ON A BASKET OF P-MEDICINES[30]



Source: OFT analysis of IMS Health data

[29] Prices are based on total value sold divided by total volume sold. The price indices shown in figures 4.1 and 4.2 are weighted according to the proportions of each product sold in each type of pharmacy.

[30] Prices are based on total value sold divided by total volume sold. The price indices shown in figures 4.1 and 4.2 are weighted according to the proportions of each product sold in each type of pharmacy.

4.11 The weighted average prices in Figure 4.1 and 4.2 are weighted according to the proportions of each product sold in each type of store. Clearly some of the average price differences in the above figure could be due to the mix of products stocked in different chains. To take account of this issue, Figure 4.3 below shows comparisons for P-medicines that are stocked in each of the pharmacy chains listed in the table.

4.12 Figure 4.3 uses the same IMS data to compare actual prices for seven individual P-medicines sold in all of the pharmacy chains listed.[31]

FIGURE 4.3: AVERAGE PRICES OF P-MEDICINES (DECEMBER 2001)

	Calpol Susp 6+ 250mg 100ml	Clarityn Allergy Tabs 10mg 7	Ibuleve Gel 5% 30g	Nurofen Tabs 200mg 24	Nytol Caplets OAN 50mg 16	Otex Ear Drops 5% 8ml	Piriton s.m Tabs 4mg 30	Weighted average price based on these seven items[32]	Percentage cheaper than the most expensive.
Asda	1.44	4.45	3.89	2.44	3.53	3.62	2.98	2.68	**29.6%**
Tesco	1.69	3.95	3.89	2.44	4.15	4.25	2.29	3.35	**11.7%**
Co-op pharmacy	3.39	4.45	3.89	3.15	4.15	4.25	2.99	3.60	**5.1%**
Sainsbury's	2.39	4.45	3.89	3.15	4.15	4.25	2.99	3.69	**2.9%**
Independent	3.25	4.40	3.88	3.10	4.15	4.25	2.94	3.74	**1.7%**
Safeway	3.39	4.45	3.89	3.15	4.15	4.25	2.99	3.75	**1.3%**
Lloyds	3.39	4.45	3.93	3.31	4.15	4.27	2.99	3.80	**0.0%**

Source: OFT analysis of IMS Health data

4.13 The evidence on prices that was collected on the OFT's behalf is supported by other published research. A report by the Consumers' Association (CA), that was based on data collected between 29 October and 9 November 2001, found differences of up to 30 per cent between the price of a basket of P and GSL medicines in low price supermarket pharmacies compared with prices in high price supermarkets and more traditional pharmacies. [33]

[31] We selected all the P-Medicines from our original basket that are sold in all of the pharmacy chains in the table.
[32] Weighting based on the total volumes for each product in each pharmacy chain in December 2001.
[33] Over-the-counter Medicines, Which? Magazine, February 2002.

4.14 The CA research was based on a limited basket of goods and a relatively small number of pharmacies were surveyed. As such the results should be treated with some caution. However the overall story is clear, and is in line with the findings of the OFT's own commissioned research.

4.15 Overall, the evidence on prices shows that some supermarket pharmacies are cheaper than the specialist pharmacies for a basket of pharmacy products, and that some (Tesco and Asda) have especially low prices. Allowing more supermarket pharmacies to open would therefore be expected to lead to consumer savings, by giving more consumers easier access to these low prices.

Increased price competition

4.16 Deregulation might also bring lower prices where increased competition causes prices to come down in all types of pharmacy, not just supermarkets. In order to test this proposition, consultants from Frontier Economics were commissioned to explore the empirical relationship between the prices charged by pharmacies and the conditions of local competition faced by those pharmacies. They were commissioned to carry out a modelling exercise using data on prices, pharmacy location, pharmacy type and measures of local competition. This analysis is presented in full at annexe K.

4.17 The analysis revealed no statistically observable relationship between the price level of a pharmacy and any measure of local concentration[34]. This result was robust to all changes in specification that were explored.

4.18 There are a number of possible explanations for this result:

- One reason may be inertia among pharmacies. Resale price maintenance on P-medicines and GSLs ended in May 2001. In other industries that have experienced similar deregulation, price competition has sometimes taken a long time to emerge. Moreover, as around 80 per cent of a typical pharmacy's turnover is price regulated, some independent pharmacies may not think competitively and may simply choose to price at the manufacturer's recommended retail price rather than taking account of local competition.

- Secondly, the data available for analysis came from pharmacies that are within the control of entry system. This system restricts competition by limiting entry from pharmacies that wish to set up business in competition with other pharmacies. This may explain why the data shows that the level of local concentration appears to have no effect on prices charged.

[34] Geographical concentration was used to proxy for the level of competitive pressure.

- Lastly, and perhaps most importantly, some pharmacy chains and all supermarket chains adopt national pricing policies. This means they choose not to respond to local competition by cutting prices in certain stores.

4.19 Taking account of these points we consider the results of the analysis are inconclusive. Notwithstanding the caveat about national pricing, the analysis is certainly consistent with the view that that the current control of entry regulations contributes to making the retail pharmacy market sluggish and unresponsive to local competition. We do not believe the results show that in the event of deregulation, pharmacies would not begin to compete more in terms of price. All they do show is that under the current control of entry system, pharmacies do not respond to local competition by lowering prices locally.

GSL Medicines

4.20 Unlike P-medicines, there are few legal restrictions on the sale of GSL medicines. GSL lines are widely available in the UK at most supermarkets and other retail outlets, including convenience stores and garage forecourts. This basic evidence might be expected to lead to the conclusion that the market for GSL medicines is not distorted by the control of entry regulations and prices should be expected to be competitive.

4.21 However, it is possible that competition in this market too might be affected by the control of entry. Currently, around half of GSL sales in the UK are made in pharmacies, where a pharmacist or member of trained pharmacy staff is present.[35]

4.22 The two main reasons for GSL sales taking place only where a pharmacist is present are:

- **The customer needs advice from the pharmacist or pharmacy staff:**

  When consumers buy GSL products they may require advice from a pharmacist. This may be for a number of reasons. For example:

  – the consumer may be aware that they have a medical problem but may not be aware of the specific product they need. This advice would be available in a pharmacy but not in a supermarket or convenience store without a pharmacy.

  – the consumer is already taking other medicines and requires advice about whether it is safe to take a certain combination of drugs.

[35] Based on information contained in The 'Economic and Legal Framework for Non-prescription Medicines', June 2001, Association of the European Self-Medication Industry (AESGP), Brussels.

- **The customer is confused between which drugs are P-medicines and which are GSLs:**

  – there is a clearly defined list of drugs which are classified as P-medicines and therefore can only be sold in pharmacies. However, consumers do not generally have easy access to this list and in some cases confusion arises about which medicines can only be sold in pharmacies and which are more widely available. The effect of this confusion is that in some cases customers will try to purchase P-medicines from non-pharmacy retailers and find they are not able to. Perhaps more significantly in terms of market distortion, some customers will buy GSL medicines from pharmacies because they are not aware they can buy them elsewhere. This is likely to be a particular problem in the case of GSL medicines which consumers tend to buy on an infrequent basis.

4.23 In either of these cases consumers are effectively restricted to purchasing from pharmacies. This means that the 'joint costs' problem, which distorts the market for P-medicines, may also affect some sales of GSLs.

4.24 New entry from low-priced supermarket pharmacies would mean that some of those consumers who are restricted to buying GSLs from a pharmacy could switch to buying their GSLs from a supermarket pharmacy. This would allow them to take advantage of the lower prices offered in these outlets.

Prescription medicines

4.25 The fee to the consumer for an NHS prescription (where charged) is fixed by law. Removing entry controls will not have any immediate effect on the price to consumers of NHS prescriptions. However, indirect positive effects might be expected to occur over time as increased competition rewards more efficient pharmacies at the expense of less efficient ones and some inefficient pharmacies may exit the market. Based on this, we would expect the efficiency of the sector to increase on average over time, which in the long term may allow the Department of Health to reduce the level of reimbursement to pharmacies. These savings could potentially be passed on in terms of reduced costs to taxpayers and/or lower prescription prices for consumers.

Calculating the likely consumer savings from deregulation

4.26 It is difficult to accurately quantify the likely level of consumer savings following entry deregulation. A number of key factors are hard to predict. These include the extent of entry from supermarkets and discount pharmacies, the price response of existing pharmacies to increased competition, and the increase in

total OTC sales that may result from lower prices. However, the following section uses basic market data to give broad-brush estimates of the likely magnitude of consumer savings that we expect to result from entry deregulation.

P-medicines

4.27 As stated above in paragraph 4.8, removing the control of entry regulations can lead to consumer savings in two main ways:

- increasing the availability of lower prices by allowing more low price supermarket and discount pharmacies to open
- increasing price competition between pharmacies, which will lower P-medicine prices in all types of pharmacies.

SAVINGS FROM INCREASED AVAILABILITY OF LOW PRICES

4.28 Evidence on the first point comes directly from the OFT analysis of the IMS price data. It is clear from the data presented that if more consumers buy their P-medicines from supermarkets they will save money. In order to quantify the consumer savings from allowing more supermarket pharmacies to open we require a number of key pieces of information. Firstly, the price difference between supermarket pharmacies and other pharmacies. This information comes from the comparisons based on the OFT analysis of the IMS price data set out in Figure 4.3. The difference in prices between low price supermarket pharmacies and others following the ending of RPM is between10 per cent and 30 per cent depending on the supermarket.

4.29 The second key piece of information is how many new supermarket pharmacies are likely to open following deregulation. Based on confidential information supplied to OFT by individual supermarket stakeholders, we expect supermarket entry to be in the region of 400-500 new pharmacies[36].

4.30 Finally we need to know the value of P-medicine sales per supermarket per year. Where available, this information has been taken from information that was sent to the OFT by some large pharmacy chains. Gaps in this information were supplemented with data supplied by IMS Health.

4.31 Combining these figures leads us to expect that the entry of new supermarket pharmacies will lead to consumer savings in the region of £20m-£25m per year

[36] These may not all enter within the first year. Entry will be constrained by the availability of qualified staff.

following deregulation.[37] This figure only covers savings that accrue within the extra supermarket pharmacies.[38]

CONSUMER SAVINGS FROM INCREASED PRICE COMPETITION

4.32 The second way in which entry deregulation can lead to consumer savings is if increased entry leads to increased price competition between existing pharmacies and lower prices in all types of pharmacy. Although we expect prices to come down in some multiple and independent pharmacies, we do not have firm evidence which we can use to accurately predict the likely level of consumer savings which would arise following entry deregulation.

4.33 The current size of the market for P-medicines is around £900m per year. The difference in prices between supermarket and non-supermarket pharmacies following the ending of RPM is up to 30 per cent, which gives an indication of the potential for price reductions from increased competition.[39] 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.

GSL medicines

4.34 In order to quantify the effect of the pharmacy entry controls on GSL medicine sales, we need to calculate the value of advice related sales and sales related to confusion between P and GSL medicines, as a proportion of the total sales of GSL medicines. The proportion is calculated as follows:

- published figures show that around half of GSL sales take place in pharmacies[40]
- the OFT consumer survey reports that of those customers who buy GSL medicines in pharmacies, the reason for doing so in 36 per cent, or approximately one third, of cases is so that the pharmacist or pharmacy staff can provide advice[41]

[37] For each chain where we expect consumer savings from entry to occur we calculated: (P-medicine sales per supermarket X number of new pharmacies X percentage savings over basket of goods).
[38] The figure does not take into account any growth in the market for p-medicines caused by the improved access and lower prices.
[39] Source: OFT analysis of IMS Health data.
[40] Based on information contained in the 'Economic and Legal Framework for Non-prescription Medicines', June 2001, Association of the European Self-medication Industry (AESGP), Brussels.
[41] See Section 2.5 of annexe D.

- combining these two figures, we can estimate that approximately one sixth of GSL sales are advice related.[42]

4.35 The total value of GSL sales is around £900m per year. Approximately one sixth of these sales are advice related and so require a pharmacist or member of pharmacy staff to be present. One sixth of the market is approximately £150m. Therefore, approximately £150m of GSL sales each year are indirectly affected by the pharmacy entry controls, because outlets without a pharmacy cannot compete for these 'advice related' GSL sales.[43]

4.36 Evidence from the Consumers' Association shows that low-priced supermarkets are up to 30 per cent cheaper for GSLs. Following deregulation, the increased number of supermarket pharmacies would give access to lower prices for some of those consumers who are constrained by issues of advice or confusion described above.[44]

4.37 We believe that following deregulation consumer savings will occur, as more supermarket pharmacies are able to open and compete for the significant proportion of GSL sales that are advice related or come from confusion over the categorisation of P-Medicines and GSLs.

4.38 If we assume that GSL sales in supermarkets with pharmacies are at least as high as P-medicine sales in these outlets we can apply the percentage savings on GSLs from the Consumer's Association report to the supermarket entry costing presented for P-medicines above. If we apply the figures for expected supermarket entry (400-500 new pharmacies) and the disaggregated figures for P-medicine sales per supermarket to the percentage savings on GSLs (disaggregated by supermarket chain), this results in expected consumer savings in the order of £5m per year.[45]

Overall savings

4.39 Consumer savings in P-medicines are likely to be in the region of £20m - £25m per year. We expect the savings from supermarket entry into advice related GSL sales to be at least in the order of £5m per year. Therefore, we expect total consumer savings on sales of OTC medicines to be in the region of £25m -

[42] 36 per cent of half the market equals 18 per cent, or around one sixth of the total market. Therefore we estimate that approximately one sixth of GSL sales are advice related.
[43] It is has not been possible to get information on the proportion of GSL sales that are affected by confusion over the categorisation of P medicines and GSLs. This problem is likely to have a further effect on competition. in GSL. This is likely to be a further source of consumer saving following deregulation.
[44] See paragraph 4.22 above.
[45] This figure is adjusted to take into account the fact that advice related sales make up only one sixth of total GSL sales.

£30m per year. This figure does not take into account any savings that would arise as a result of increased price competition in P-medicines. If over time price competition were to increase significantly, the resulting consumer savings could be substantial.

4.40 There are certain other basic assumptions underlying the figures for consumer savings. The key assumption is that in the counterfactual scenario where the regulations remain in place, price differences between supermarkets and other pharmacies will remain as they are currently. If this assumption does not hold and despite the entry controls, non-supermarket pharmacies eventually have to lower their prices in response to supermarket price-cutting, consumer savings from deregulation would be lower.

4.41 Our estimate for the likely consumer savings following entry deregulation is significantly more cautious than those quoted by those in favour of deregulation. Supermarket chain ASDA published figures which estimated that consumers are current paying £270m per year too much for OTC medicines.[46] On closer inspection, the figure is based on assumptions that in our view appear to be overly optimistic; for example, it implicitly assumes that in order to benefit from lower prices all consumers would use an ASDA supermarket or one that charged the same prices, for all their purchases of over-the-counter medicines. In contrast, our calculations do not assume price-cutting by all types of pharmacies but simply use the evidence we have received about new entry from low-price supermarket pharmacies following deregulation.

Local monopolies

4.42 During our investigation we observed evidence of high concentration of certain pharmacy chains in certain areas. Empirical analysis carried out on the geographical location of pharmacies confirms these observations. We believe these concentrations arise partly as a result of the fact that the pharmacy entry regulations do not take into account issues of competition. Furthermore, the right of local pharmacies to appeal decisions by Health Authorities will serve to bolster local concentration, since pharmacies are more likely to appeal against entry from other chains than entry from their own chain.

4.43 High local concentrations of certain chains might, in some cases, lead to local market power for some firms, which could in some cases reduce competition and lead to higher prices for consumers, lower quality of service, and almost certainty more limited choice. We have not attempted to collect evidence of

[46] Press release of 8 March 2002 entitled ‘ASDA calls on OFT to end pharmacy 'closed shop''.

higher prices or lower quality of service in these areas of high concentration. However if higher prices or lower quality do in fact result from local concentrations of particular firms, freeing up the entry control system could potentially reduce this detriment.

Summing up

4.44 This section has brought together evidence produced by consultants, external independent research, and information provided by the major players in the sector. The sum of the evidence clearly points towards significant consumer savings following entry deregulation, from lower prices for over-the-counter medicines.

Section 4.2: Non-Price Competition

Introduction

4.45 Increased competition between pharmacies following entry deregulation can benefit consumers in a number of ways. These include lower prices on OTC medicines, as described above in Section 4.1 and also improvements in service quality.

4.46 For non-prescription items, pharmacies can compete both in terms or price and quality of service. However, the price that consumers pay for a prescription is fixed and so competition on price cannot occur in this area. In this case we would expect pharmacies to compete more strongly on other areas that consumers value such as location and the quality of service following deregulation. By contrast, some stakeholders who are opposed to entry deregulation have argued that removing the entry restrictions would in fact lead to a lower quality of service.

4.47 In this section we explore in detail the likely effect of entry deregulation on aspects of non-price competition.

Aspects of non-price competition

4.48 As with any retail business, pharmacies compete with each other on many aspects of service quality. These include location, the quality of advice offered to consumers, the range of services offered, opening hours, speed of prescribing, quality of shop fixtures and fittings, and the range of products stocked. [47]

[47] Competition in terms of location is explored in more detail in chapter 5.

4.49 The Royal Pharmaceutical Society of Great Britain and the Pharmaceutical Society of Northern Ireland regulate certain minimum quality standards in retail pharmacies, but other aspects of service quality are determined by competition to provide for consumer preferences. Under the current system, the restrictions on pharmacy entry may mean that consumers find it less easy to switch from their current pharmacy to an alternative one and so there is less pressure on pharmacies to provide the services that consumers most value.

4.50 In order to assess empirically how these aspects of non-price competition would be affected following deregulation of entry, we commissioned an econometric study to quantify the way non-price indicators vary with local competitive pressures under the current entry control system. This evidence is presented later in this section. We also used evidence collected as part of our consumer survey to assess the importance to consumers of various aspects of non-price competition.

The importance of non-price competition for consumers

4.51 Evidence from our consumer survey shows that consumers put a higher value on some non-price aspects of the service that pharmacies provide than other aspects.

4.52 Figure 4.4 clearly shows that the most important factors for consumers when choosing a pharmacy for their NHS prescriptions are location and convenience. Convenience can take various forms including proximity to home, doctor's surgery or place of work, opening hours, or the ability to have a prescription dispensed at the same time as other activities, such as shopping.

FIGURE 4.4: REASONS FOR CHOICE OF OUTLET FOR NHS PRESCRIPTIONS[48]

(Base: All those cashing prescriptions with a usual chemist) Source: FDS International

Would removing the entry restrictions improve the quality of service?

4.53 Minimum standards for opening hours and quality of advice are regulated by Local Health Authorities and Professional Bodies respectively. The current entry regulations do not directly impact on the quality of service in retail pharmacies. Nevertheless the regulations do have an indirect impact on quality of service.

4.54 Stakeholders who support the current entry controls argue that the present system allows them to invest significantly and that allowing unrestricted entry will lead to greater uncertainty, reduced investment and a lower quality of service.

4.55 It is true that for some pharmacies, the control of entry regulations allow higher profits than would occur with free entry and therefore more money could be available to re-invest in the business. However competitive pressure is generally the most effective driver of service quality and innovation. Furthermore investment decisions are forward looking and depend on the balance between the marginal cost and the expected marginal benefit from investing.

4.56 In order to investigate empirically the concerns raised by those opposed to removing entry controls we commissioned a number of analyses designed to explore whether or not deregulation would lead to negative results for consumers in terms of service quality.

[48] This figure is reproduced from Section 2.4 of annexe D.

Empirical analysis

The relationship between competition and quality of service

4.57 Freeing-up the entry control regulations and increasing non-price competition can benefit consumers in two main ways:

- increasing the availability of stores that provide a high quality of service
- increasing the level of competition on non-price aspects of service.

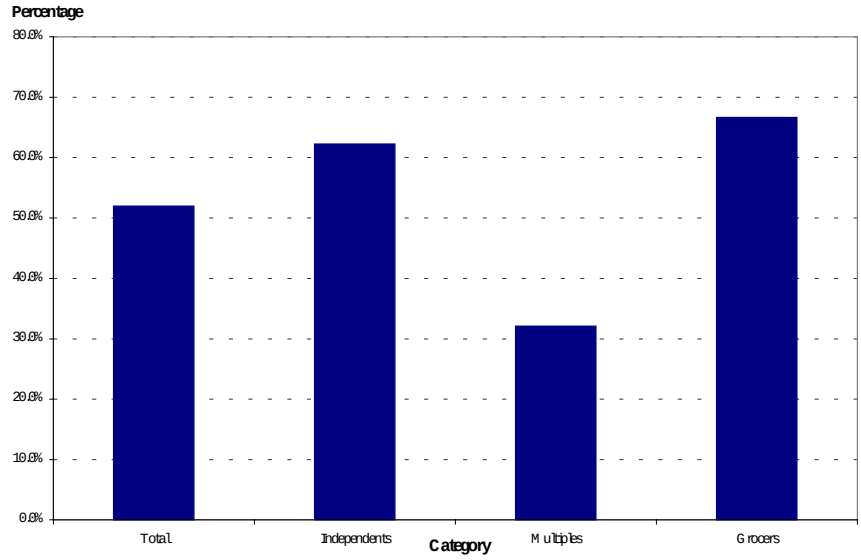
4.58 Non-price competition covers a wide range of variables. In order to empirically assess the relationship between non-price competition and local competitive pressure we require information on the key aspects of non-price competition. However some important aspects are difficult to quantify. For example, the quality of advice offered in pharmacies can be measured in basic terms such as whether or not correct advice is given, but more sophisticated classifications are more difficult to evaluate.

4.59 Having reviewed a number of possible variables, three were chosen to indicate quality of service. These were the existence of a private consultation area in the pharmacy, whether the pharmacy offered a collection and/or delivery service for prescriptions, and the number of hours that the pharmacy was open on different days of the week. The variables were chosen on the basis that they represent non-price competition variables that are important to consumers, and also that they are easily quantifiable.

4.60 The following charts show some basic differences between types of pharmacies on key measures of quality. The results are interesting, with different types of pharmacies relatively strong on different aspects of non-price competition.

4.61 Half of the pharmacies have a private consultation area, as shown in Figure 4.5. More than 60 per cent of both supermarkets and independents have a consultation area, whilst for multiples this percentage is lower at around 35 per cent.

FIGURE 4.5: PROPORTION OF PHARMACIES WITH A CONSULTATION AREA[49]

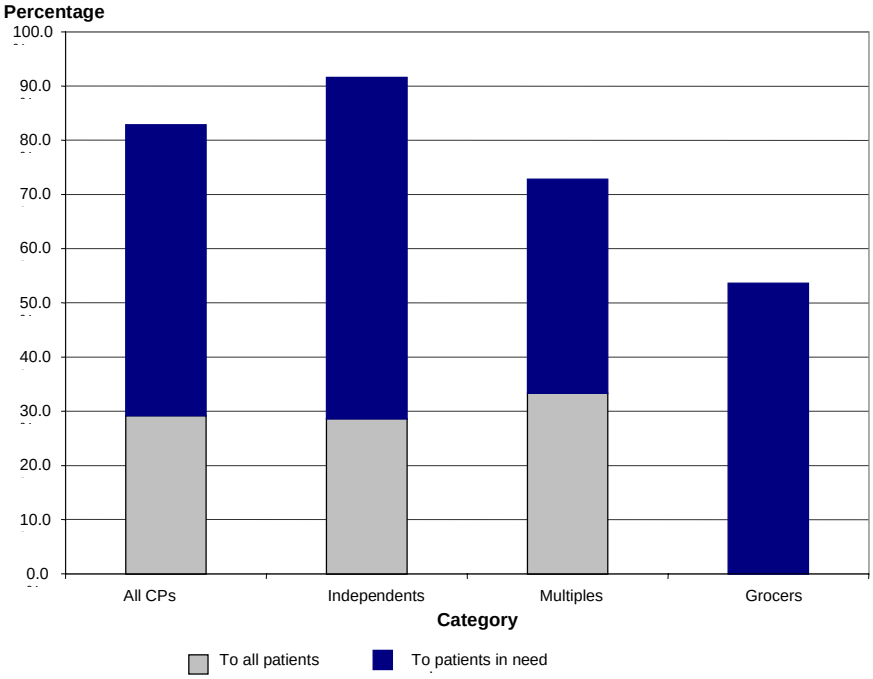


Source: Frontier Economics analysis of questionnaire responses

4.62 Many pharmacies offer a home delivery service (82 per cent) as shown in Figure 4.6. This percentage is higher for independents (92 per cent) and lower for supermarkets (33 per cent). The supermarket surveyed make this service available to patients in need only. In contrast, roughly a third of independents surveyed offer this service to all patients (i.e. regardless of genuine need) as do 45 per cent of multiples.

[49] This figure is reproduced from section 3 of annexe M.

FIGURE 4.6 PROPORTION OF PHARMACIES OFFERING A HOME DELIVERY SERVICE[50]



Source: Frontier Economics analysis of questionnaire responses

4.63 The survey also found that the number of opening hours per week varies between different types of outlet. The independent pharmacies in our survey opened for an average of 49 hours per week, multiple pharmacies 54 hours per week and supermarket pharmacies 79 hours per week. Further details on opening hours can be found in chapter 5.

4.64 The results on longer opening hours are strongly supported by aggregate evidence supplied by one large supermarket chain and anecdotal evidence from stakeholder meetings with supermarket chains. The number of supermarket pharmacies responding to the survey was low (nine responses or 3.6 per cent of those contacted) compared to independent pharmacies (143 or 61 per cent) and multiples (81 or 46 per cent). Overall this means that although the supermarkets surveyed may not be representative of supermarket pharmacies as a whole, the results tie-in closely with the other available evidence.

4.65 Although not a comprehensive review of services offered by pharmacies, it is clear that the overall coverage of services is very good. Furthermore, there is some variation in the type of pharmacies offering each type of service indicating that there are various mechanisms that pharmacies can use to compete.

[50] This figure is reproduced from section 3 of annexe M.

Results of the econometric modelling

4.66 Frontier Economics were asked to investigate the empirical relationship between quality of service indicators and measures of local competition. This work is presented in full at annexe M. The analysis found a clear systematic statistical relationship between some aspects of quality and some measures of local concentration. In particular:

- pharmacies are more likely to be open before 9am if they face a higher number of CPs per GP in their locality, or if they are the closest pharmacy to a GP
- pharmacies are more likely to offer a consultation area if there are more supermarket pharmacies in their locality, and
- when a pharmacy faced no other pharmacy within 5km, it was less likely to offer home delivery.[51]

4.67 These results were based on a reasonably small sample of pharmacies (233) and so the conclusions should be treated as indicative rather than providing precise results. This does not detract from the main message contained in the results, which is that there is a clear statistical relationship between some quality measures and local concentration[52]. Based on this we would expect more pharmacies to result in a higher quality of service.

Deregulation and leapfrogging and the quality of service

4.68 Some of the organisations we consulted who are opposed to the removal of the control of entry regulations claimed that deregulation would result in significant 'leapfrogging' (leapfrogging is where pharmacies locate between an existing pharmacy and a source of demand such as a GP's surgery). It is argued that would in turn result in reduced incentives to invest (for fear of being leapfrogged following the investment).

4.69 In order to investigate these arguments we commissioned a study to assess the theoretical arguments and consider whether we would expect deregulation to have a negative effect on investment due to leapfrogging. The study is published in full at annexe N.

4.70 The results of the study are ambiguous on the question of whether or not a more competitive environment will induce or impair investment. In each investment decision the choice of whether or not to invest will depend on the particular

[51] This result may be related to the rurality of the area where the pharmacy is located rather than the level of competition facing it.
[52] Geographical concentration was used to proxy for the level of competitive pressure.

circumstances, what the extra benefit to the pharmacy is, relative to the extra cost of investment.[53] One point to note is that many improvements in quality require increased costs as the service is being delivered (marginal costs), but relatively little fixed (or up-front) costs. The risk of leapfrogging would have no impact on such quality investments because arguments concerning leapfrogging relate only to its effect fixed cost investments. Examples of quality improvements that require few extra fixed costs are home delivery or increasing opening hours.

Local monopolies

4.71 As explained above (in paragraph 4.42) our investigation found evidence of high levels of geographical concentration for some pharmacy chains in some areas. Whilst we did not attempt to collect evidence on how these high concentrations of certain chains affect the quality of service offered, it is likely that the effect would be either neutral or potentially negative. If the effect on quality were negative, freeing up the control of entry system could potentially reduce this detriment.

Summing up

4.72 In this section we have presented evidence on the likely effect of entry deregulation on non-price aspects of competition and explored the question of whether increased competition will improve or worsen quality of service. The evidence presented shows that despite concerns raised by some stakeholders, deregulation is not likely to lead to reductions in service. We have also presented statistical evidence to indicate that increasing competition is likely to improve aspects of service quality, particularly opening hours.

[53] The business uncertainty that leapfrogging brings may discourage investment. However, in some circumstances leapfrogging may encourage investment – leapfrogged pharmacies may increase investment in qualities that will attract customers away from the second pharmacy that now has a superior location.

5 ACCESS

Introduction

5.1 Community pharmacies in the UK play a pivotal role in the healthcare of all UK citizens. Ensuring proper access to community pharmacy services and prescribed medicines is essential to the continued health of the population.

5.2 Good access takes many forms. It includes having a pharmacy within easy reach (usually from the doctor's surgery or from the home) – in this report measured by distance and drive times. Good access also incorporates having convenient opening hours and after-hours services, access to valued services (such as collection and delivery services, diabetes testing and private consultation areas) and to a range of low-priced pharmaceutical products.

5.3 We have explored the current state of access to pharmacies. The degree of local access to pharmacies in the UK is currently good, with the majority of consumers finding it easy to get to a pharmacy from their home and from their GP's surgery. Nevertheless, the picture is not uniformly strong. There are a number of locations where local access could usefully be improved as well as improving convenience of opening hours and certain other elements of access.

5.4 This chapter considers how removal of the current control of entry regulations is likely to affect access. Some have argued that access will deteriorate. The arguments for this include the potential for destructive leapfrogging behaviour by pharmacies and of supermarkets driving out small community pharmacies. These arguments, however, have only been presented to the OFT as theoretical possibilities. We have not seen evidence that measures the extent to which these effects would occur, or their impact on competition and consumers if they were to take place. In our view, new entry is likely to improve access to pharmacies, not reduce it.

5.5 In terms of having a pharmacy within easy reach, it is noteworthy that, under the control of entry regulations, local health authorities can only grant or refuse applications; they cannot determine that pharmacies open in particular areas. As such, any positive effect of the system on local access is at best indirect, and it is more likely in practice that the regulations act to limit the total number of pharmacies. Typically, markets without entry controls are more dynamic, exhibit greater innovation and focus more directly on what customers want in the way of access to outlets and services. In our view the pharmacy market is no exception.

5.6 Case studies and entry-exit analysis of recent pharmacy entry support the view that entry into a given area tends to increase the total number of outlets in that area. Indeed, historically, there has been a substantial exit of local pharmacies only when such exit has been specifically encouraged by using financial inducements. Moreover, empirical modelling of a variety of entry scenarios demonstrates that there would be only a limited reduction in local access (in terms of travel distance) even in an extreme scenario where pharmacies are opened in all medium to large supermarkets and, for each new entrant, the two nearest local community pharmacies close as a result.

5.7 Overall, therefore, we believe that local access will improve following deregulation. Moreover, if localised problems of access do occur, the Essential Small Pharmacies Scheme (ESPS) provides a readily available solution. The ESPS offers financial assistance to pharmacies that are not economically viable but are considered vital to the provision of pharmacy services to a local community. It plays an important role in safeguarding access, and since it is targeted directly at resolving problems of access, it is able to achieve this goal at substantially less cost to consumers and taxpayers than the broader control of entry regulations.

5.8 In addition, in predominately rural areas where there are no pharmacies, general practitioners can dispense prescribed medicines, and we would expect this to continue. However, the 'prejudice test' that applies in England and Wales, under which dispensing doctors may object to some entry by pharmacists, acts as a constraint on competitive supply. This should fall away together with the regulations establishing the controlled areas to which the test applies.

5.9 Entry should also improve other aspects of access, such as convenient opening hours and home delivery, as competition for consumers increases. This is supported by evidence on the opening hours offered by the most likely entrants into the market, and by case study evidence, as well as by the empirical relationship shown in chapter 4 between local competition and quality of service delivered.

5.10 Thus, while there are possible theoretical arguments that can be made against the natural proposition that freer entry will improve access (and customer service generally), the available empirical evidence supports our view that the most likely overall outcome would be an improvement in access, not a reduction.

The current state of access to pharmacies

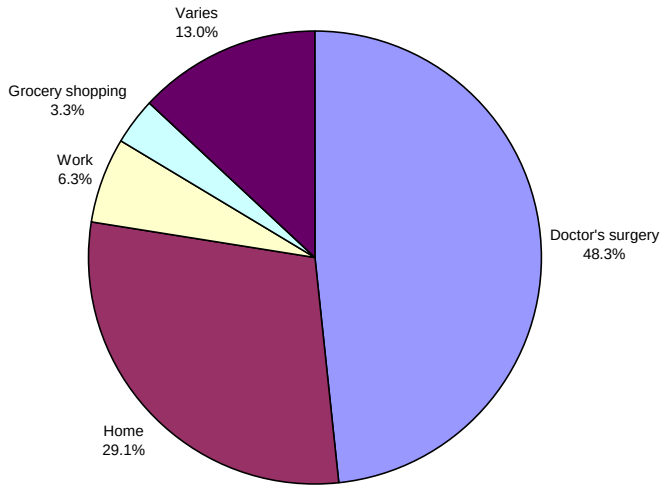
5.11 Consumers value many different aspects of access. In this section, we first review the current state of local access, in terms of distance and drive times required to reach a local pharmacy. We then examine certain other aspects of

access that are valued by consumers, such as convenient opening hours and after-hours services, access to valued services, and access to a range of low-priced pharmaceutical products.

Local access

5.12 Easy local access to a pharmacy is important to consumers. The OFT Consumer Survey found that 57 per cent of people wishing to have a prescription made up choose their pharmacy because of its location.[54] The most common point of departure when taking a prescription to a pharmacy is the doctor's surgery – around half of consumers come from there (Figure 5.1). Almost a third of people typically go to collect prescriptions from their home, making it the second most common departure point.

FIGURE 5.1: WHERE CONSUMERS NORMALLY COME FROM WHEN TAKING A PRESCRIPTION INTO A PHARMACY

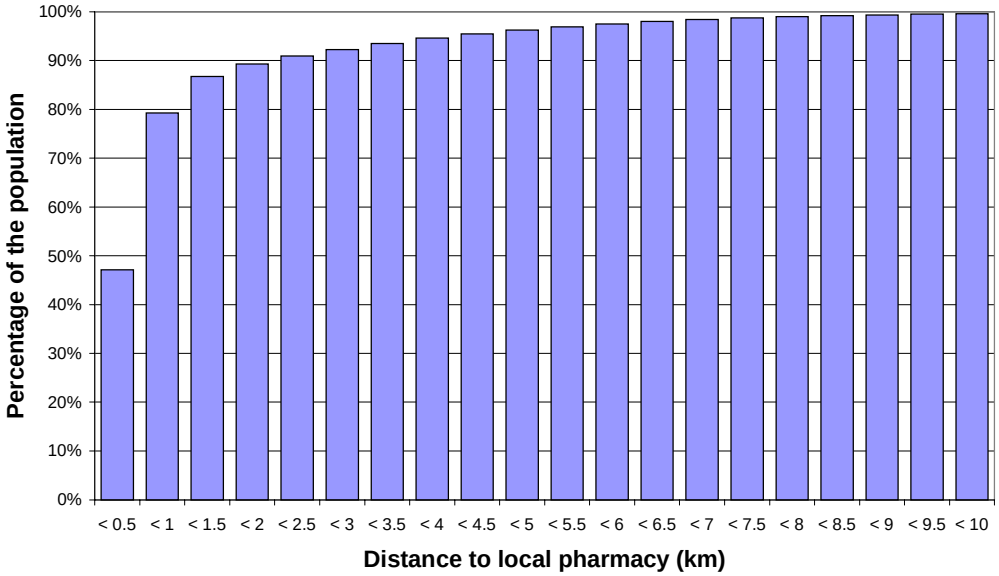


Source: FDS International (annexe D).

5.13 In practice, local access to pharmacies is currently good across much of Great Britain. As set out in chapter 2, there is around one pharmacy for every 4,800 people, a ratio that is only slightly above the average when compared with many other OECD countries. Analysis of pharmacy location by Frontier Economics (presented in Figure 5.2) shows that 79 per cent of people in Great Britain have a community pharmacy within one kilometre of their home, and 47 per cent have a pharmacy within 500 metres. Frontier Economics have also shown that around three-quarters of GPs have a community pharmacy within a short walk of

300 metres, 89 per cent of GPs have a pharmacy within 500 metres, and 98 per cent have one within one kilometre.[55]

FIGURE 5.2: DISTRIBUTION OF DISTANCES TO NEAREST LOCAL PHARMACY FROM HOME[56]



Source: Frontier Economics analysis using the electronic map (annexe J).

5.14 The OFT consumer survey also supports the view that local access is good – 89 per cent of respondents considered that their chosen pharmacy outlet was easy to get to from their home, while 86 per cent said that it was easy to get to a pharmacy from their GP's surgery.[57]

5.15 These various sources support the view that the vast majority of people find it easy to get to a NHS dispensing pharmacy – whether from their home or their doctor's surgery. However, the picture on local access is not uniformly strong. The Social Exclusion Unit (1998) expressed concern over the lack of access to pharmacy services in some of Britain's poorest neighbourhoods. Moreover, our consumer survey found that 11 per cent of respondents did not consider that their chosen pharmacy outlet was easy to get to from their home, while 14 per cent did not consider it easy to get to a pharmacy from their GP's surgery. This

[54] Carried out for the OFT by FDS International. Full survey results are provided in annexe D.
[55] This analysis was carried out using the electronic map (annexe J). It was not possible to include information for Northern Ireland for all the necessary datasets, and so the analysis was restricted to Great Britain.
[56] Distances are in fact measured from the 'population-weighted ward centroid' of the ward in which consumers live. See footnote 78 for a full discussion of this measure.
[57] FDS International (annexe D, section 3.5).

is in line with the Frontier Economics figures presented in Figure 5.2, which show that 11 per cent of the population has to travel more than two kilometres from their home to reach their nearest pharmacy.

5.16 Moreover, it is important to remember that the effect of the control of entry regulations on access is at best indirect. While the system can disallow a pharmacy from locating in a certain area, it cannot force a pharmacy to open in a poorly served area. It is up to the individual pharmacy concerned to identify an area in which it wishes to dispense NHS scripts and make an application to the relevant local authority. There is little scope under the current system to encourage pharmacies to open in areas where there is the greatest need.

5.17 Instead, the control of entry system produces a pharmacy network that is sluggish to respond to consumer demands on local access, by making it more difficult for pharmacies to open up in new areas or to change location.

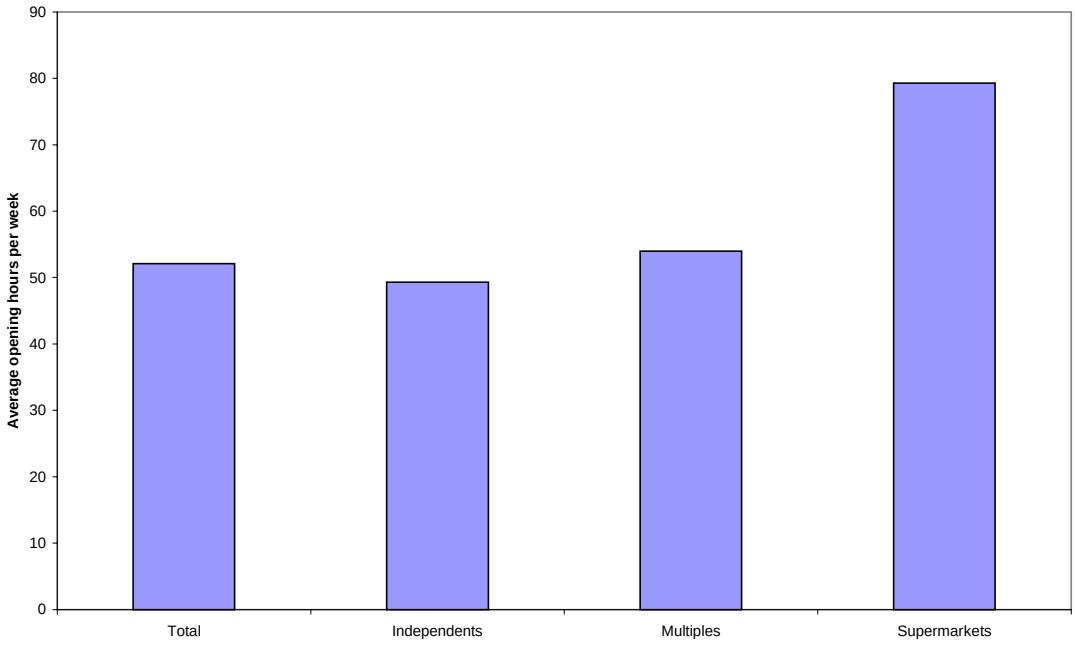
Other aspects of access

5.18 Another important aspect of pharmacy access is that pharmacies are open during convenient hours of the day. Survey evidence collected by the OFT found that independent pharmacies and small chains are most commonly open from 9am until 6pm during the week, although some do stay open later (around 15 per cent reported closing at 7pm). [58,59] On Saturdays almost half of small pharmacies have a pattern of opening that could loosely be described as half-day – typically from 9am until 1pm. The remaining 50 per cent stay open all day, albeit tending to close at 5pm or 5.30pm rather than 6pm or 6.30pm.

5.19 In all, the average independent pharmacy is open for around 49 hours per week, multiples (such as Lloyds) are open for 54 hours per week with the industry average (including supermarkets) being 52 hours per week (Figure 5.3).[60] Supermarket pharmacies, by contrast, tend to be open for much longer – 79 hours per week on average.[61] This finding was confirmed in our meetings with supermarkets.

[58] OFT survey of small pharmacies (annexe E).
[59] Around half of all pharmacies in the UK receive payments for additional agreed hours of service. In most instances this is for Sunday and Bank Holiday opening, but for around 20 per cent of pharmacies it also covers extended weekday opening hours.
[60] Source: IMS Health data, analysed by Frontier Economics.
[61] Source: IMS Health data, analysed by Frontier Economics.

FIGURE 5.3: AVERAGE WEEKLY OPENING HOURS FOR PHARMACIES



Source: IMS data analysed by Frontier Economics (annexe M).

5.20 This suggests that increased entry into the market by supermarkets and multiples would raise average opening hours. Moreover, analysis by Frontier Economics shows that pharmacies tend to be more likely to open early if there are more pharmacies (per GP surgery) in the local area.[62] Thus, increased local competition as a result of deregulation should act to increase opening hours, irrespective of what types of entrant are observed.

5.21 Chapter 4 discussed the Frontier Economics analysis of non-price competition, which shows that there is potential for improvement in other aspects of access, such as availability of home delivery or access to a private consultation area.[63] Indeed, these elements of access tend to be higher in areas of greater local competition (especially supermarket competition in the case of consultation area). Since deregulation of entry should facilitate increased competition, we would expect these elements of access to improve if the entry controls were removed.

5.22 We would also expect access to low-price pharmacies to increase following deregulation. As set out in chapter 4, only a few supermarkets currently offer low-priced P-medicines, and access to these is restricted by the control of entry regulations. With more entry from these supermarkets, access to low priced

[62] Frontier Economics (annexe M, section 4.3.1).
[63] The full Frontier Economics analysis is presented in annexe M.

pharmaceuticals should increase and indeed we might expect to observe increased price competition more generally.

Arguments against removing entry restrictions

5.23 We recognise that there are a variety of situations in which the free market may not produce the best outcomes for competition and consumers, and where regulations are an appropriate response. For example, consumers may find it difficult to develop information about the quality of the products that they are purchasing. In this instance, regulations that control the professional standards of those entering the market are an appropriate policy response. In the case of pharmacies, such considerations clearly justify ensuring a standard of professional ability amongst pharmacists. Professional standards are regulated directly by the RPSGB and the PSNI.

5.24 This report does not however consider these regulations of standards, but rather focuses on the control of entry regulations for pharmacies. One of the original rationales for the introduction of the entry controls was to ensure that the public had good access to pharmacies.[64] During the course of the OFT Pharmacy Investigation, we have been presented with a number of arguments as to why the current regulations are required in order to ensure good access, and why deregulation would therefore have a detrimental impact on access. In this section, we review the theoretical bases for these arguments. In the next section, we test them against empirical evidence.

Arguments against deregulation

5.25 **Increased access requires increased profitability**. The first argument put to us is that the entry controls are a prerequisite for delivering good access. The argument appears to be that the restrictions on entry increase pharmacy profitability and thus encourage pharmacies to locate in the community or in neighbourhood areas, in which pharmacies might not otherwise be viable.

5.26 In our view, this argument is not convincing. Other retail sectors, such as groceries, provide vital goods and services but are not the subject of regulations restricting their location (and effectively overall numbers) in order to provide good access, convenient opening hours and a high quality of service. On the contrary, in other retail businesses, good access is a direct result of firms' reacting to consumer demand. Moreover, even if this argument were valid, increasing profitability across the market – especially by impeding entry – would be a wasteful if not counterproductive way of achieving this aim. If access is

[64] Committee of Public Accounts (24 June 1992).

judged to be deficient in some areas, the solution is to encourage it in those areas, not to impede it in general.

5.27 **The net exit effect.** This argues that new entrants into the market would drive existing outlets out of the market. Where the potential entrants are supermarkets, each entrant may be expected to drive out more than one other outlet, leading to a reduction in total outlets. Moreover, supermarkets are often located out of town, and are less easily accessible than existing community pharmacies. Such a scenario would thus reduce access, so the argument goes.

5.28 Again, we are not convinced by this argument.

- First, there are a number of factors that might be expected to dampen any potential net exit effect. If consumers really do care about local convenience, as our consumer survey suggests, then this might be expected to limit the degree of switching away from local pharmacies in the face of entry by out-of-town supermarkets.[65] In addition, prescriptions account for around 80 per cent of revenues for a small community pharmacy and that 77 per cent of this prescription business involves repeat prescriptions.[66,67] Repeat prescription customers often have ongoing prescription collection arrangements with their local pharmacy, and thus would be relatively unlikely to switch away from their existing pharmacy. This will further dampen any effect leading to a net reduction in pharmacy numbers. In addition, where supermarkets are located a long way from existing pharmacies, it seems likely that the effect of any business-stealing would be dispersed across a variety of local pharmacies, making it less likely that any particular pharmacy would be driven out of business.

- Second, while supermarkets are not always quite as close to people's homes – or to GP surgeries – as other community pharmacies, they are still highly accessible. Indeed 99 per cent of households do their main grocery shopping at supermarkets, and 93 per cent visit a supermarket at least one a fortnight.[68] Moreover, as discussed above, supermarkets offer very convenient opening hours, which should improve overall accessibility.

[65] FDS International (annexe D, section 3.4).
[66] OFT Small Pharmacy Survey and Competition Commission (1999).
[67] FDS International (annexe D, section 3.3).
[68] According to the Competition Commission report on supermarkets (2000), 86 per cent of shoppers go to the supermarket weekly or more often. Another 7 per cent go fortnightly (Appendix 4.2 of the CCs report). Only one per cent of shoppers use smaller shops (than supermarkets) for their main shopping - i.e. virtually everyone uses a supermarket for their main shopping (See figure 4.6 of the CCs report). In addition, the average distance to a supermarket

Third, the strength of this argument effectively depends on there being a net decline in the number of pharmacies in the market. However, it is far from obvious that this is realistic, given that the current control of entry regulations appear to be limiting pharmacy numbers. This empirical question is analysed further in the following section.

- Lastly, it is important to consider the underlying causes of entry and exit (which are natural features of markets in general). Broadly speaking, entrants displace incumbents only if they are better at meeting consumer needs. Exits, to the extent that they occur, can therefore be part of the process by which consumers are served better, not a manifestation of poorer service. Moreover, firms will only have an incentive to provide what consumers want if they can gain (and lose) consumers as a result of satisfying (or failing to satisfy) these consumers' needs.

5.29 **The 'leapfrogging' argument.** A variant of the above argument is that abolishing the control of entry regulations would result in pharmacies 'leapfrogging' each other towards GP surgeries. Leapfrogging describes the process by which a pharmacy opens or relocates closer to a doctor's surgery than an existing pharmacy, thereby jumping over or 'leapfrogging' the existing pharmacy. It was a particular concern to the industry in the early 1980s. The argument is that a move towards GP surgeries would result in the closest pharmacy to the GP receiving the bulk of the surgery patients' custom, and that this would in turn force neighbourhood pharmacies to close. This would have a detrimental affect on those people in affected areas who do not go to their pharmacy from their GP's surgery.

5.30 There are a number of reasons why we do not consider this to be a convincing argument against deregulation. First, deregulation would allow pharmacies to locate in areas where consumers value them to the greatest extent. This is beneficial for access and for consumers. Second, pharmacies already congregate around GPs without any obvious detriment to consumers (and arguably reducing the potential for future leapfrogging). Indeed, as mentioned above, three quarters of all GPs have a community pharmacy within 300 metres.[69] Third, our consumer survey suggests that only around half of consumers travel to their pharmacy directly from their GP, suggesting that there is a considerable demand for pharmacies in other areas (Figure 5.1). This demand may be expected to sustain pharmacies located further away from GP surgeries. Fourth, the leapfrogging observed in the 1980s was at least partly a result of the structure of the payments system then, which encouraged low-volume entry. The

for those people living in Britain's 100 lowest-income postal sectors was 0.57 miles (Appendix 13.4 of the CCs report).

[69] Frontier Economics analysis, using the electronic map described in annexe J.

remuneration system today does not offer the same strong incentives for low-volume entry.[70]

5.31 **The 'theory of second best'.** A final argument that has been put to us is that in a heavily regulated market such as community pharmacy, different regulations may 'balance each other out', such that removing one restriction whilst leaving others in place will not necessarily benefit consumers. This argument, in a general form, is known as the 'theory of second best'.

5.32 Specifically, in this case, competition between community pharmacies is inhibited in two fundamental ways – (1) through the entry controls and (2) through the fixing of retail prices on prescription medicines. Removing entry restrictions would free up dimensions of competition between pharmacies to serve customers. However, this competition may be distorted by the fact that fees on NHS prescribed medicines would remain fixed. This may act to prevent pharmacies from locating in certain areas where consumers want them and indeed would be prepared to pay higher prices in return for extra convenience, if they were able.

5.33 In response to this argument, we note that there are clearly other ways in which pharmacies can compete, other than on price, as discussed in chapter 4. There would also seem to be more appropriate responses to the issue than controlling entry across the UK (for example, one possible response would be to free up the charges charged to consumers for NHS prescriptions). Overall, though, the 'theory of second best' primarily simply makes the point that one cannot simply argue from theory alone that removing a regulation will be good. This proposition needs to be examined empirically, as we do below.

5.34 It should also be noted that while the charges for (and the cost of) NHS dispensing may be fixed in the short run, prices and costs in the longer term will be influenced by incentives for improved efficiency over time. Deregulation should enhance those incentives – to the benefit of the public as consumers and taxpayers.

Conclusions

5.35 For these reasons we are not persuaded by the theoretical arguments that have been made against the natural proposition that greater freedom to supply will tend to improve customer service. But this is in the end an empirical issue. Consequently, the OFT commissioned three pieces of empirical research analyses in order to explore the relationship between entry and access. This empirical evidence is examined in the next section.

[70] The 'leapfrogging' argument is assessed in more detail in annexe N.

Empirical evidence on deregulation

5.36 We present three forms of empirical evidence on the relationship between entry and access below: case study analysis, exit-entry analysis, and scenario modelling. These generally support our view that the current level of good overall access will be improved rather than worsened under deregulation, and certainly that there are unlikely to be significant detrimental effects on access. The evidence also suggests that the impact of access changes is likely to be similar for demographic groups.

Case study analysis

5.37 Three case studies undertaken for this report provide some initial insight to the dynamics of competition in community pharmacy.[71] Case 1 considered the entry of an independent pharmacy in a semi-rural area where pharmaceutical services were provided in part by dispensing doctors. Case 2 considered the entry of a supermarket pharmacy in an edge of town location. Case 3 investigated the entry of an independent pharmacy in an urban area.

5.38 No pharmacies closed as a result of the new entry in any of the three studies. However, one study involved an entrant in a controlled neighbourhood that did not previously have a pharmacy but rather a dispensing doctor, and by law the dispensing doctor had to give up dispensing to some of his patients. In another study, the entering pharmacy was eventually sold to an existing pharmacy but did not close. Thus, in each case of entry, local access was improved. Two of the entrants examined also had longer opening hours than the existing pharmacies, further improving access.

5.39 It is arguable that the control of entry regulations cushion pharmacies from the forces of competition, and therefore reactions by existing outlets to the entering pharmacy may not have been as extensive in these case studies as might be expected under deregulation. However, where pharmacies did react to the new entrant, these reactions included increasing the services offered.[72] In each of the cases, it seems clear that access was increased as a result of entry, and consumer behaviour rewarded those pharmacies that offered convenience of location, longer opening hours and valued services.

[71] Frontier Economics (annexe K).

[72] Although in one case the reaction of an existing pharmacy was to reduce its opening hours, as a result of the inability to compete with the entrant's longer hours.

Exit-entry analysis

5.40 To build upon these case studies, Frontier Economics carried out an analysis of all pharmacy entries and exits in Great Britain over the period 1997-2001.[73] Specifically, they considered all instances of entry and examined how often local entry was followed by one local exit (such that there is one-for-one displacement) or larger scale exit (such that there is net exit).

5.41 In the vast majority of cases, there was found to be no exit, in that the new pharmacy entry straightforwardly increased the number of outlets in the local area. In a significant minority of cases, there was found to be one-for-one displacement. However, cases of net exit were extremely rare. These results were consistent across different definitions of local area. In fact, over the past 20 years, pharmacies have only exited on a large scale when financial inducements were offered to pharmacies to exit the market immediately following the introduction of the control of entry regulations.

5.42 Overall, then, this evidence supports the view that new entry will tend if anything to increase the number of outlets in a market, and is highly unlikely to reduce this number. This should be good for access.[74]

Scenario modelling

5.43 In order to gain a better picture of the possible impact of deregulation on access, we asked Frontier Economics to model a variety of entry and exit scenarios.[75] In order to test our views on access as fully as possible, we deliberately used scenarios involving large-scale entry, and then considered a variety of levels of consequent exit. This analysis was used to examine both the net exit argument set out above and the leapfrogging argument.

ANALYSIS OF THE NET EXIT ARGUMENT

5.44 To analyse the net exit argument, Frontier Economics considered three possible entry scenarios:

[73] Annexe K has details of this analysis.

[74] Again, an obvious caveat to this analysis is that the entry and exit examined occurred under the current control of entry system. Thus, it could be argued that this is not representative of the sorts of entry and exit that might occur with complete deregulation. Clearly, we are more likely to observe displacement as a result of entry as the pharmacy sector becomes saturated. However, this entry-exit analysis certainly seems to corroborate the view that removing the current entry controls would lead to net entry relative to the current situation. An average of 50 pharmacies have closed each year since 1990 in England and Wales (Department of Health, *General Pharmaceutical Services in England and Wales*, various issues).

[75] A detailed discussion of the modelling exercise is provided in annexe L.

- entry by 900 large (over 25 thousand square feet) supermarkets that are currently without an in-store pharmacy
- entry by the 2,127 medium to large (over ten thousand square feet) supermarkets currently without a pharmacy, and
- entry by these 2,127 supermarkets plus 93 currently non-contract pharmacies owned by Boots.[76]

5.45 Corresponding with each of these, they then also analysed the impact of three possible exit scenarios:

- no existing pharmacies exiting
- the closest pharmacy to the new entrant exiting
- the two closest pharmacies to the new entrant exiting.

5.46 The following table sets out the impact of entry on a measure of the average distance travelled by customers from ward centroids (a good proxy for where people live) to their nearest pharmacy under these nine different scenarios. The main points to notice in these results are (i) that the overall impact of entry on average distances travelled is neutral or positive so long as there is no net exit and (ii) that the overall impact on accessibility is in any case small (no more than 40 metres either way on average).

[76] As set out in chapter 2, there are around 130 non-contract pharmacies, including 94 Boots outlets. However, Frontier Economics only had sufficient information to model 93 Boots outlets.

TABLE 5.1: OVERALL IMPACT ON AVERAGE DISTANCE TRAVELLED FROM HOME (IN METRES)[77]

	No exit	Exit of nearest CP	Exit of 2 nearest CPs
Entry of 900 large supermarkets	-20	0	20
Entry of 2127 med-large supermarkets	-40	-20	40
Entry of 2127 supermarkets plus 93 non-contract pharmacies	-40	-20	40

Source: Frontier Economics (annexe L).

5.47 Clearly, the impact of these scenarios on average distances travelled potentially masks more substantial impacts in particular areas. However, even under the most extreme of these various entry and exit scenarios, this analysis shows that only four per cent of the population would have to travel more than 500 metres further to reach a community pharmacy from their home. And only one per cent of the population would have to travel more than one kilometre further. [78,79]

5.48 A primary reason for these results is that a large number of pharmacies are currently located close together. Almost two-thirds of pharmacies in Great Britain have at least one other pharmacy within 500 metres. In addition, each pharmacy has, on average, 78 other pharmacies within a 15 minute drive time, 30 within a ten minute drive time and six within a five minute drive time.[80] In this light, it is hardly surprising that the net gain or loss of one local pharmacy has little overall impact on local access.

5.49 Access implications for specific groups in society (e.g. the elderly, those with young children and those without a car) were also assessed. An argument has been presented that although the majority would be better off under deregulation, some groups may be worse off. However, there is no evidence that

[77] These distances are in practice measured from the 'population-weighted ward centroid' of the wards in which consumers live, because it is technically hard to calculate distances from people's actual homes. An electoral ward contains on average around 5,200 people, and the population-weighted centroid of the ward is the centre of the ward, as weighted by population. As such, it will tend to be closer to where people actually live than a genuine geographic mid point, and thus a fairly good proxy for the true distances people have to travel from their homes. Note that analysis was also carried out of the impact on distance from GP surgeries (for which precise location information could be used), and the results are similar. However, this case is arguably less relevant since local supermarket entry is in practice highly unlikely to displace the pharmacy that is most closely located to the local GP's surgery.

[78] The most extreme scenario is entry of 2127 supermarkets plus 93 non-contract pharmacies, plus two CP exits for every entrant.

[79] Frontier Economics analysis, from modelling exercise described in annexe K.

these groups fare significantly differently in terms of access in the modelled scenarios compared with the population as a whole.

ANALYSIS OF THE 'LEAPFROGGING' ARGUMENT

5.50 To analyse the 'leapfrogging' argument, Frontier Economics considered the impact of entry by 2,030 pharmacies at GPs where there is currently no pharmacy within a short walk of 300m. This entry scenario was then matched with the three possible exit scenarios set out above, and the overall impact on consumers' access to pharmacies from their homes was examined. In practice, the results are broadly similar to those for the other scenarios, as exemplified by Table 5.2.

5.51 This suggests that this entry scenario would tend to be beneficial to access, so long as there is no corresponding exit, and that the detrimental impact on access would be relatively small, even if each entrant were to drive out its two nearest pharmacy competitors.

TABLE 5.2: OVERALL IMPACT ON AVERAGE DISTANCE TRAVELLED FROM HOME (IN METRES)

	No exit	**Exit of nearest CP**	**Exit of 2 nearest CPs**
Entry by 2,030 pharmacies at GPs where there is no pharmacy within 300m	-40	-3	10

Source: Frontier Economics analysis, annexe L.

CONCLUSIONS FROM EMPIRICAL EVIDENCE

5.52 A precise estimate of the immediate and longer-term effects of ending the control of entry regulations is not possible. However, it seems likely that we will see entry from:

- existing non-contract pharmacies (the majority of which are owned by Boots)
- some independent pharmacists currently frustrated at the lack of opportunities to enter
- a substantial number of supermarkets,[81] and
- a few pharmacies entering (or moving) close to GP's surgeries.

[80] Frontier Economics (annexe J, section 5).

[81] For example, Asda has recently commented that it would add pharmacies to all its 246 stores at a rate of 50 a year. 'Supermarket groups bank on pharmacy deregulation as OFT inquiry concludes'. The Independent, 21 November 2002.

5.53 Overall, on the basis of this scenario modelling, combined with the results of the case study, we believe it is reasonable to expect that all types of new entrants will improve general access to pharmacy services – whether in terms of location, opening hours or access to low priced medicines. Moreover, even under the extreme scenario, where two pharmacies exit for every one that enters, access is not substantially worsened overall. As mentioned earlier, entrants generally only displace incumbents if they are better at meeting consumer needs, and so consumers are better off.

5.54 When considering the immediate effect of deregulation, it is also important to note that one restraint on large-scale expansion over the short term is the supply of available qualified staff, especially registered pharmacists. This issue is especially relevant for supermarket entry, since supermarkets tend to employ more staff than other community pharmacies to cope with their longer opening hours. Many pharmacies are currently experiencing difficulties in recruiting qualified staff, particularly in North Wales, East Anglia, the South West and in the north of England. Although pharmacists from overseas can help fill this demand, it is nonetheless rare – less than four per cent of registered pharmacists come from abroad (annexe H). Clearly, this issue need not constrain entry over the longer term, as new people enter the profession, but it may mean that the pace of entry is likely to be relatively constrained over the short term.

Safeguarding access

5.55 Overall, then, we believe that local access will improve following deregulation. However, we recognise that with deregulation – as with regulation – there might be access issues in some pockets of the country.

5.56 When asked about the consequences of their local pharmacy closing, 54 per cent of the people taking part in our consumer survey thought it would either not affect them personally or would not be a significant problem. A further 26 per cent considered it would be a nuisance but have alternatives. There were, however, some 19 per cent of respondents who thought it would be a significant problem if their local pharmacy closed.

5.57 More than half of this group reported regularly shopping (at least once a week) at one of a local parade of shops, in-town high street shops or shopping centre or out-of-town supermarket or shopping centre. For these customers, it is likely that they would be able to locate a convenient alternative pharmacy at the same location as their shopping trip.

5.58 It is nonetheless vital that effective safeguards against substantial loss of access are in place. This point is independent of deregulation and, as discussed above,

the control of entry regulations do not directly deliver this important policy objective anyway, as they impede rather than encourage entry. There are, however, alternative mechanisms for maintaining good access that are well targeted and effective, such as the Essential Small Pharmacies Scheme (ESPS).

5.59 The ESPS provides financial assistance to pharmacies that are not economically viable because of their location but are considered vital to the provision of pharmaceutical services to the local community. The scheme, therefore, aims to ensure the proper provision of pharmaceutical services to consumers in areas in which they would otherwise have difficulty in accessing them. There are currently 340 pharmacies in the UK receiving ESPS payments. annexe F provides further details about the ESPS.

5.60 The ESPS provides a safeguard selectively to ensure that appropriate levels of access are maintained. We do not believe access would be materially reduced under deregulation. Indeed, we expect it to improve. But if problems do occur in some areas, for whatever reason, we believe that the ESPS provides a better solution, and at substantially less cost to consumers and taxpayers than the control of entry regulations.

5.61 Dispensing doctors also provide an important service in those predominantly rural areas where there are no NHS dispensing pharmacies. We expect this important role to continue. It is not, however, a reason to prevent pharmacies from entering the market where they wish to do so. We therefore consider that the 'prejudice test', under which in England and Wales dispensing doctors may object to some entry by pharmacists should fall away together with the other regulations for controlled areas generally.

5.62 Arrangements under which GPs dispense are a matter for the relevant health departments.

Summing up

5.63 Having good access to pharmacy services means having a pharmacy within easy reach, usually from the doctor's surgery or the home. It also means having convenient opening hours and after-hours services, access to valued services, such as collection and delivery services and access to a range of low-priced pharmaceutical products.

5.64 The control of entry regulations do not, indeed cannot, ensure good access. In our view, arguments that the current control of entry system is good for access are not convincing. Instead the current system reduces consumer choice and generally reduces access to pharmacies and pharmacy services.

5.65 By removing the entry controls, new pharmacies would be free to enter the market and meet current unmet demands. This would involve them locating pharmacies in areas where consumers value them the most, offering opening hours at times best suited to consumers and offering valued services. Moreover, if there were areas that suffered access problems for whatever reason, we believe the current safeguards – the ESPS and dispensing doctors – have proved effective and provide a targeted solution.

6 THE COST OF ADMINISTERING THE CONTROL OF ENTRY REGULATIONS

Introduction

6.1 This chapter looks at the administrative costs associated with the control of entry regulations (subsequently referred to as 'The regulations'), all of which could be saved by moving to a deregulated entry system.[82] These costs are borne by the taxpayer and pharmacies and, indirectly, by their customers. These administrative savings are over and above other competition benefits resulting through deregulation, which are discussed in chapters 4 and 5 of this report.

6.2 The introduction of the control of entry system brought with it additional costs to both the taxpayer and the industry. The main purpose of the control of entry system in 1987 was to help stem the rising costs to the taxpayer of NHS reimbursement and remuneration of pharmacies. In turn, this was caused by the influx of small, inefficient, pharmacies into the market that the remuneration system favoured at that time. In this chapter we estimate the administrative costs that could be saved by moving to a deregulated entry system. Our central estimate of these costs is around **£26 million** per year. This comprises the following annual costs:

(i)	Administrative costs to business	£13 million
(ii)	Appeal costs to business	£2.5 million
(iii)	Legal costs to business	£0.2 million
	Total business costs	**£15.7 million**
(iv)	Cost to taxpayer of Health Authorities	£9 million
(v)	Cost to taxpayer of Appeal Authority	£1 million
	Total NHS administration costs	**£10 million**

6.3 Each of these costs are reviewed in more detail below.

Costs to business

Administrative costs of the regulations

6.4 All CPs have some dealings with the Health Authorities/ Health Boards, regardless of whether they are small independent pharmacies, large multiples or supermarket pharmacies. The regulations control all entry, minor relocations and

[82] National Health Service (Pharmaceutical Services) Regulations 1992.

change in ownership. A survey of some 200 small independent pharmacies confirmed that nearly 60 per cent of all CPs surveyed had spent some time and money contesting an application. [83]

6.5 The OFT Small Independent Pharmacy survey showed that 60 per cent of small pharmacy owners had contested an application one or more times. Some respondents may file objections to any application that falls within their neighbourhood making it difficult for competitors to enter the market.

6.6 Different costs fall on those pharmacies that are involved in the application process for a new contract or a minor relocation. The costs to business can increase significantly when a pharmacy applies for a new contract from the Health Authority or Health Board. The situation may be further exacerbated by what has been described as 'inconsistency' amongst the local health bodies, whereby mixed messages are given on the prospect of obtaining a new contract. [84] This can increase the costs to businesses. Further costs can arise due to long delays in the process.

6.7 Below is an example from one of the three case studies carried out for the OFT pharmacy investigation that illustrates the sorts of costs involved, as well as the complexities and delays that add further to the costs. [85]

BOX 6.1: EXTRACT FROM A CASE STUDY CARRIED OUT BY FRONTIER ECONOMICS FOR THE OFT IN RELATION TO PHARMACY APPLICATIONS AND PHARMACY MOVEMENTS WITHIN A LOCAL AREA

The example in this box (taken from a large town in the south east of England) illustrates the potential cost and complexity of the regulations in the event of a slight change in the market. In this example the change involved the relocation of a general practitioner's surgery. The surgery was based in one part of a town and decided to relocate to another, more deprived part (referred to as Area 2). Prior to the relocation, the surgery had a pharmacy next to it (known here simply as P1).

P1 decided to move with the surgery and made an application for a change of premises (unofficially referred to as a major relocation). Area 2 already had a pharmacy (referred to here as P2). P2 applied for a minor relocation to be nearer the relocated surgery and objected to the application by P1.

[83] The Small Independent Pharmacy Survey carried out by OFT and contained in annexe E.
[84] Views commonly expressed by pharmacy businesses in consultations with the OFT.
[85] This is a real example taken from case study notes and information given to the OFT by some pharmacy businesses.

A third application was made from another pharmacy (known here as P3) The local GP next to P3 was retiring and thus closing down the surgery. P3 made an

application for both minor and major relocation to be near the relocated surgery.

A fourth application was made by one of the major supermarket outlets (known here as P4): this was for a new contract. With the exception of the supermarket, the rest of the applications were for preliminary consent. Area 2 had no other medical centre and the health authority anticipated that the relocated surgery would serve not only its remaining loyal patients from where it had relocated, but also the residents in area 2. This meant that, in the opinion of the health authority, the patients from this new medical practice could be served by two pharmacies.

On this basis, the health authority accepted the minor relocation application of P2 and also the application of P1 on the grounds that P1 was the first to submit its major relocation application. P3's application was not considered to be a minor relocation and was rejected by the health authority. The supermarket's application was also rejected.

P1 started building its new pharmacy next to the new medical centre and P2 sought new premises. Both had obtained from the health authority an extension to their preliminary consent. At the end of the extension period P1's pharmacy was not in operation and, since the health authority could give only one extension to the preliminary consent, this location became available to all applicants.

Again, applications from P3, P1 and P4 were made but an application from a rival supermarket (known here as P5) was made in advance of the end of the extension period of the preliminary consent. In line with the entry control regulations and guidelines the health authority granted the NHS contract to P5.

P1 completed the construction of the new pharmacy site and operated as a non-NHS pharmacy. P1 then applied for a change of address to a town centre location; this application was granted. P1 traded for only one day before making yet another application for a minor relocation to its new non-dispensing premises in area 2. After appeal this application was granted.

6.8 As the above example shows, the current system of entry regulations can impose a heavy cost burden on pharmacy businesses. In this example, a unilateral decision by a medical practice to relocate to another part of the town triggered a sequence of activity amongst the local pharmacies. Pharmacy P1 had to relocate twice and trade for just one day in one location in order to get to its

chosen position. The businesses involved faced costs of management time, administration, time delays, legal costs and loss of revenue. The total could run into tens of thousands of pounds per pharmacy, much of which CPs would seek to pass on.

6.9 In the view of a number of pharmacy businesses consulted, the process of the entry control system is unwieldy, with applications and appeals taking anything between six and eighteen months. In one particular example, in South Wales, Asda have indicated that they submitted a minor relocation application in May 2001, six months before its new store was due to open (for an existing contract nearby to be relocated into the Asda store). It was approved at the health authority stage but Boots appealed and a local oral hearing was agreed. This was held by the health authority in January 2002, two months after the store opened. While members of the oral hearing panel recommended approval of the relocation application, the National Assembly for Wales (NAW) only released this information in September 2002, another nine months later. Despite the recommendation of the panel, the NAW rejected Asda's application.

6.10 The regulations affect CPs in many aspects of their business, from obtaining a new contract to relocating to another part of town. They also affect the sale of CPs to new owners. The entry control regulations impose upon the seller the obligation to apply for consent for a change of ownership. The financial costs of change in the industry can be significant.

6.11 Existing pharmacies have incentives to use the control of entry regulations to object or appeal against new contract applications, thereby blocking new entrants into their neighbourhood. Thus there are costs involved for all pharmacies as a direct result of the regulations.

6.12 In annexe B we present our estimate of the administrative costs to business from the system. This includes such factors as the management hours spent on the control of entry regulations and pure administrative costs to the business. However, we have not included any loss of revenue from time delays though these can be considerable. A separate assessment of legal and appeal costs is made below.

6.13 Taking the above factors into account, we estimate the cost to business of dealing with Health Authorities/Health Boards as a direct result of the control of entry regulations at around **£13 million** per year. [86]

[86] See paragraphs B.1 to B.6 of annexe B for a detailed breakdown of our assessment.

6.14 Our estimate is less than that of Superdrug in its response to the Government's review of pharmacy strategy in 1998.[87] Superdrug's analysis assesses costs to the industry to be in the region of £26.4 million. Its estimate does, however, include a significant element for the cost of delay, which is not reflected in our estimate.

Appeal costs

6.15 If the relevant Health Authority/Health Board refuses the initial application for a new pharmacy contract, it is open to the applicant to appeal against the decision to the NHS Appeals Authority (in England) the equivalent in Wales or Appeals Panel (in Scotland). Likewise, if the application is granted it is also open to other interested parties to appeal the decision of the health authority. The process can be lengthy and the approaches taken by the relevant authorities have been alleged not always to be consistent. [88] The system imposes costs on those pharmacies involved in the appeals process.

6.16 The cost to business will involve management time, over and above the time spent on the original application to the health authority/health board, as well as additional administration costs. The majority, if not all, of businesses involved in the appeal process tend to engage legal and other professional experts to help them through the appeal.

6.17 In the year 2000/2001 there were a total of 392 appeals in the UK. In England and Wales there were 362 appeals[89], in Scotland 18 appeals[90] and in Northern Ireland 12 appeals[91]. In the work done for Superdrug in 1998, McKinsey & Co estimated the cost of appeals to business at around £24.6 million, which includes those cases that went to an oral hearing. However, this analysis was based on 1996/1997 NHS Appeals Authority data that covered around 370 appeals and included appeals with oral hearings. Legal costs were not included in the analysis.

6.18 Taking into account the management and administrative costs to business of the appeal process and the number of appeals received in the UK for the year 2000/2001, we consider that the overall cost is probably less than the figures in the Superdrug analysis as their figures appear to incorporated a delay factor into the analysis. The cost to business is probably more in the region of £2.7 million

[87] Superdrug's paper, '*Modernising Community Pharmacy'* contained analysis by McKinsey & Co and NHS appeals authority data from 1996/1997 and looked into the cost to business of time delays caused by the current entry regulations.
[88] A number of supermarkets have alleged to the OFT that they have experienced inconsistencies in the system.
[89] Family Health Service Appeal Authority Annual Report, 1 April 2000 – 31 March 2001.
[90] Data from the Scottish Executive Health Department.
[91] Data from the Northern Ireland DHSSPNI.

(including the management and administrative cost of appeals £2.5 million plus legal costs of £0.2 million).[92]

6.19 This figure does not take into account the cost of those cases that were the subject of application for judicial review, which could also add tens of thousands of pounds to the costs. Pharmacy businesses have indicated that a single case can cost in the region of £20,000. Following the introduction of the entry control regulations, there was increased activity in the courts. This has, to a large extent, reduced due to judicial review in the early and mid 1990s which clarified a number of points of procedure and interpretation in the regulations. In 2001 there were around two to three judicial review cases in the whole of the UK which is a sharp decline since the mid 1990s.

Costs to taxpayers

Administering the control of entry system

6.20 As well as costs to business, the entry control system imposes costs on the health service, which in turn falls to taxpayers.

6.21 There are two elements to these costs: those of the Health Authorities and those of the Appeal Authority. These costs are incurred by the taxpayer as a direct result of the control of entry regulations. They are recurring.

6.22 In 1998, Superdrug, in a response to the government's review of pharmacy strategy, estimated the annual cost of health authorities to be in the region of £2.68 million. [93]

6.23 The OFT believe that the true figure may be higher, more in the region of around **£9.3 million**. [94]

Administering the appeal authority

6.24 The second element is the cost of the appeals system. In England and Wales there is a designated body set up to deal with all the appeals that arise from the decisions of all the health authorities. The body is known as the Family Health Services Appeal Authority (FHSAA) and is based in Harrogate. Its functions in Wales have been taken over by the National Assembly for Wales (NAFW). In Scotland a similar body exists**,** known as the National Appeals Panel (NAP). In Northern Ireland the National Appeals Panel deals with appeals.

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[92] See paragraphs B.7 and B.17 of annexe B for a more detailed analysis of appeal costs and legal costs.
[93] Superdrug Ltd, '*Modernising Community Pharmacy'* (1998). See paragraphs B.19 and B.20 of the annexe B for a breakdown of the figure.
[94] See paragraphs B.19 and B.20 of the annexe B for a detailed breakdown of this figure.

6.25 The total expenditure of the FHSAA in England and Wales in 2000/01 was **£755,000.** The resulting call on the Department of Health was only £525,000, as the FHSAA also supplemented its budget by running courses on the workings of the pharmacy regulations.[95] However, the higher figure is a better measure of avoidable cost as the courses run would have no value in a deregulated system. The FHSAA does not spend all its time dealing with pharmacy appeals: other functions include disciplinary hearings: It is, however, fair to say that the majority of its time is spent dealing with pharmacy appeals.

6.26 The NAP in Scotland cost £86,390[96] in 2001. In Northern Ireland the annual cost of the NAP between April 2001 and March 2002 was £6,500[97].

6.27 The annual cost to the taxpayer of running the appeals system in the UK is therefore:

£755,000 + £86,390 + £6,500 = **£847,890 or £0.8 million.**

6.28 The overall cost of administering the control of entry system in the UK is:

£9.3 million + £847,890 = £10.1 million or **£10 million**.

Summing up

6.29 The control of entry regulations places a heavy financial burden on both industry and taxpayer alike. The original intention of the regulations was to stem the influx of small independent pharmacies into the market which had led to a spiralling of the remuneration and reimbursement costs to the NHS. The influx resulted from the incentives of the remuneration system in place at the time.

6.30 The control of entry regulations sought to address this particular problem. It has, however, created other costs to the taxpayer and to business. These might have been avoided if the problem had been addressed by adjusting the levels of remuneration for dispensing, as was done in 1989.

6.31 Under a deregulated system the costs to industry and taxpayer highlighted in this chapter would be eliminated because they arise as a direct result of the control of entry regulations. At present the control of entry regulations is costing industry and the taxpayer around £26 million per year.

6.32 This chapter illustrates a wider point about entry control regulation. As well as restricting business activity and depriving consumers of benefits that they would enjoy under deregulation, the entry control regulations have substantial direct

[95] Family Health Services Appeal Authority Annual Report 1 April 2000 – 31 March 2001.
[96] Figure confirmed by Scottish Executive.

costs of administration. They also create unproductive incentives for businesses to invest time and money in influencing regulatory outcomes.

[97] Figure confirmed by DHSSPNI.

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8 GLOSSARY AND ABBREVIATIONS

Community pharmacy (CP): Retail pharmacies, also known as chemists. They are called community pharmacies to distinguish them from hospital pharmacies.

Controlled area: Areas that are rural in nature.

DHSSPSNI: Department of Health, Social Services and Public Safety, Northern Ireland.

Discount Inquiry: A survey of community pharmacies on prices paid for drugs that are dispensed under the NHS. This allows health departments across the UK to determine the average level of discount pharmacies of different sizes obtain from suppliers. This information is then taken into account when pharmacy reimbursement amounts are paid (e.g. through the Deduction Scale in England & Wales).

Essential Small Pharmacy Scheme (ESPS): A subsidy scheme available to pharmacies with low NHS prescription levels that operate in areas that would have difficulty accessing pharmacy services if those pharmacies were not there.

Global Sum: The fixed pool of money available for pharmacy remuneration. It includes dispensing fees and professional allowance. The Global Sum in negotiated annually.

GP: General practitioner.

GSL (General sales list): A classification of an over-the-counter medicine. GSLs can be sold from a wide range of outlets and do not require the supervision of a pharmacist when sold.

Leapfrogging: The process of pharmacies moving closer to a desirable location (usually a GPs surgery) by 'jumping over' another pharmacy.

Minor relocation: The act of relocating within the same defined neighbourhood.

NAW: National Assembly of Wales

OTC: Over-the-counter medicines. These are medicines that can be bought without a prescription and comprise 'P medicines' and GSLs.

P (Pharmacy-only) medicine: A classification of an over-the-counter medicine. P medicines can only be sold in a registered pharmacy under the supervision of a qualified pharmacist.

POM (Prescription only medicine): These require a prescription from a qualified doctor or dentist and can only be dispensed at a registered pharmacy by a registered pharmacist. To dispense prescriptions on the NHS, the pharmacy must have a contract to do so.

PSNC: Pharmaceutical Services Negotiating Committee.

PSNI: Pharmaceutical Society of Northern Ireland

Reimbursement: Payments to pharmacies to reimburse them for the costs of drugs, containers and other costs of dispensing medicines on the NHS.

Remuneration: Payments to pharmacies for providing NHS dispensing services, taken from the Global Sum. It comprises dispensing and practice fees, and a professional allowance.

RPM: Resale price maintenance. Minimum price fixing on branded OTCs from manufacturers and suppliers that was allowed to exist until May 2001.

RPSGB: Royal Pharmaceutical Society of Great Britain.

SPGC: Scottish Pharmaceutical General Council.