Appendix

Response to the OFT Report Sections

Chapter 1: Summary and recommendation

No specific comments that are not covered elsewhere

Chapter 2: Introduction and overview of community pharmacy in the UK

No specific comments other than:-

2.2 We note with interest the disclaimer for the evidence the OFT gathered.

2.4 We note the report examines whether consumers interests, as opposed to patients interests, are best served by the regulations

Chapter 3: Control of Entry Regulations.

3.7 Highlights the wide-ranging aspirations to use community pharmacist skills as set out in Remedies for Success: A Strategy for Pharmacy in Wales

3.16 –3.17 The OFT have failed to recognise that the funding of the ESPS came from the global sum and any extension to it would require extra funding.

3.23 to 3.25 We question the relevance to the UK of the information contained within the sections which dealt with the regulation of pharmacies in other countries. The OFT has not considered the fact that GPs are not allowed to own pharmacies in any of the countries featured within their illustrations. In Europe there is also a lack of corporately owned pharmacies, due to the restrictions placed upon pharmacy ownership.

3.26 to 3.31 These paragraphs and the graphs demonstrate that prior to 1987 there was uncontrolled growth of pharmacy numbers and that Government was right to be concerned about the cost of additional contracts. They also show that post 1987 the stability that was intended has been achieved.

The section ends with an analysis that the prices paid for pharmacies are not simply related to the control of entry regulations. It reinforces the point that supermarkets will pay over the odds to capture footfall for their store and related overall sales.

3.32 This deals with entry and exit of pharmacies from contracts. The data shows that within the current arrangements it is possible for pharmacies to open where there are existing pharmacies. In the majority of cases this results in both pharmacies remaining open with increased competition. The fact that there are relatively few such openings would suggest the market is saturated and that in most cases patient need is being met. Since the control of entry regulations require that existing services must be inadequate before a new contract is awarded, it is not surprising that new entries did not result in another pharmacy closing.

3.33 to 3.36 The OFT makes the case that the joint costs inhibit the opening of non-contract pharmacies and restrict the sale of P medicines and GSL medicines. They conveniently ignore the fact that increased competition in a

market which is not making excessive profit will, of itself, restrict the sale of P and GSL medicines by increasing joint costs and reducing revenue.

The non-contract pharmacy in supermarket model has not been tested whilst there is evidence to support the fact that such pharmacies do exist. The decision to open one or not is a commercial decision which may yet be affected by the loss of Resale Price Maintenance. To say they are unviable simply because of control of entry is actually proved not to be the case. It is clear that supermarkets are not made unviable by having a pharmacy, which does not have a contract. It might mean their profitability is marginally reduced.

Chapter 4: Competition

4.1 to 4.8 Much of the information in this section is based on assumptions about the way normal markets work and on empirical relationships between price and competition.

4.9 We do not dispute the data outputs from the exercise undertaken but we do dispute the inputs in respect of:

the premise on which they designed it

the validity of the time the study was undertaken,

the small scale, and representation, of the study and

the unrepresentative basket of medicines

Figures 4.1 and 4.2 Show the basket price movements for the various pharmacies. They show that the main protagonists for removal of Resale Price Maintenance (RPM) acted as expected to reduce pharmacy medicine prices.

Overall the estimated consumer savings on the OTC medicines market suggested only a 1.38% implied discount.

However, the data does not give details of price movements of other goods in supermarkets to counteract the lost margins on medicines. The consumer savings are implied rather than actual

Part of the data represented within the graphs related to 4 months when RPM was still present. Further data related to the period immediately after loss of RPM, when significant discounting activity was seen within the supermarket chains.

650 Pharmacies were sampled which is a small sample. There is a disproportionate weighting in favour of the supermarkets who are relatively minor in numbers. The weighting of multiple pharmacies is disproportionally small.

The basket of medicines is small and flawed in that it includes seasonal summer lines during the winter period and it relies on branded products, which gives the

results a pro supermarket bias. Many products used by independent and multiple pharmacies, as competitive lines, are generic or own brand.

4.15 The assertion that allowing more supermarkets to open will lead to reduced prices is not a safe conclusion

4.16 to 4.19 The OFT's research on the effect local concentration has on prices is, in their own words, inconclusive. They nevertheless go on to make assumptions based on this research

4.20 to 4.24 The section deals with sales of GSL Medicines. One reason that some GSL sales only take place in the presence of a pharmacist is that, as the pharmacist and his staff are trained, the law would expect a greater duty of care when selling a medicine than applies in a non-pharmacy outlet. The section shows appreciation for the advice and care of pharmacy staff, but does not expect the cost of this to be borne by the consumer. Rather it implies that purchase from a supermarket is superior because the price is lower – which we have shown may not be the case.

There is no evidence to support the statement that some customers will buy GSL medicines from pharmacies because they are not aware they can buy them elsewhere. Supermarkets display GSL medicines on open access shelving whereas in many pharmacies they are behind a counter together with Pharmacy Only medicines.

4.25 This paragraph is not based on any evidence. It is pure supposition. It also makes the mistake of measuring efficiency purely on the basis of the supply function and not on effective use of medicines by patients resulting in better health outcomes

4.28 to 4.31 The OFT have completely ignored the manpower issues affecting pharmacy. To open 500 new pharmacies will require approximately 1000 pharmacists and a similar number of support staff – both of which are in short supply. In the short term these would have to come from other community or hospital pharmacies. The shortage would increase salaries and the resulting increased cost would have to be passed on to the consumer. Retaining hospital pharmacies and increased costs in community pharmacy will be borne by the taxpayer. The savings of £20m - £25m are fiction as a result of the arguments made above.

4.32 to 4.33 Based on the inconclusive evidence they found earlier, their assumptions about increased price competition from concentration should not be allowed to predict substantial savings for consumers

4.34 to 4.38 The argument that GSL sales would result in £5m saving to consumers is a tiny discount on the cost to consumers of medicines and is accounted for by the care and advice patients receive from pharmacists and trained pharmacy staff.

4.39 to 4.41 Overall the expected savings to consumers presented is not based on good evidence, particularly as Resale Price Maintenance abolition had not worked through fully.

4.42 to 4.43 OFT admit they have not collected evidence for local monopolies and that the section is based on empirical thinking.

4.49 Changing from one pharmacy to another can represent an increased risk for some people, particularly those with chronic diseases, when reference to their medication record is relevant to their purchase of over the counter medicines.

4.52 Consumer scoring of locality and convenience as the most important non price competition issues confirms our view that pharmacies will tend to cluster closer to surgeries if there is deregulation

4.55 Competitive pressure exists and can be enhanced by contract development by Local Health Groups without the destructive aspects of deregulation

4.57 to 4.65 The empirical analysis is flawed by the small survey and the low response from supermarkets. One should question whether the respondents were chosen to present a better picture than the norm. All of the quality markers used could, and should, be developed as part of pharmacy contract restructuring against a quality matrix framework.

4.67 OFT admits the sample was small and results indicative only. We would argue that they are incorrect.

4.68 to 4.70 The report states that service development is delivered using marginal costs as opposed to fixed costs and that therefore the likelihood of investment being withheld would not occur to any great extent as a result of the threat of leapfrogging. This argument they admit is based on the study, which provided ambiguous results.

Chapter 5: Access

5.12 Sets out where consumers take their prescriptions but the figures are based on the current model and do not look at what might happen after deregulation. Nearly 50% of patients go immediately from surgery to pharmacy. This figure would move up significantly were GPs to open their own pharmacies or encourage pharmacies to locate within their surgeries. That the OFT report has not addressed this issue is a major flaw in its recommendation

The OFT models had also not addressed the opening of doctor owned pharmacies within surgeries and the likely script direction which would result because the doctors owned the pharmacy or alternatively because of clauses within any rental agreement held with tenant pharmacies. Even small surgeries, with perhaps only 2 GP partners, could support a viable health centre pharmacy.

The British Medical Association and Dispensing Doctors Association have said that doctor owned pharmacies are possibilities; however Dr Peter Fellows

(BMA), speaking at the All Party Pharmacy Group meeting on 10th February, had spoken strongly against de-regulation, while accepting that de-regulation may see pharmacies opened by doctors. He commented that the BMA wanted to see doctors and pharmacists working more closely together to help address many of the current problems within primary care and he stated that, "we don't want a war!" The DDA response to the report had been supportive of maintaining the current regulations, however if de-regulation were implemented, they would prefer a totally open market, where doctors could dispense in any location.

This will lead to a monopoly pharmacy structure close to or within GP surgeries and will reduce competition which is the opposite effect to that the OFT sought.

5.13 to 5.15 Support the view that access by distance to pharmacies for most patients in the UK is good with 87% of patients satisfied with access. We should not ignore the 13% who have problems but access can be improved by working with Local Health Boards.

5.16 to 5.17 Sluggish response to improve access by locating new pharmacies in response to consumer demand is not a result of the control of entry regulations. It is due to issues of viability. Again, contract negotiation between CPW and the Welsh Assembly Government can enable Local Health Boards to improve these issues. Deregulation will not make these areas viable.

5.18 to 5.21 The OFT were not appraised of the fact that Tesco have sought to reduce their hours to between 9:00 am and 5.30 pm across the UK which would bring into question all of the evidence for access in respect of opening hours. Also there is a disparity that sometimes occurs between supermarket pharmacies agreed opening hours and their actual opening hours.

Opening hours is another area that is within the scope of Local Health Boards to control as part of a quality matrix approach to contracts.

The OFT have completely brushed aside the manpower issues which we addressed earlier.

5.26 The use of the grocery sector to bolster the argument that regulation of entry is not required to create good access is surprising. Many less mobile people living in rural areas and town centres have less access to quality produce since the market concentrated into supermarkets. In reality people are forced into making journeys as local shops first lose the quality they had and finally close due to the false prospect of supermarket savings. The idea of encouragement in deficient areas is the wasteful and expensive option.

5.28 The analysis in this section relies on the marketplace behaving as it does currently under control of entry. The net effect argument opposition from the OFT does not work if community based pharmacies are squeezed between monopoly pharmacies at GP surgeries, and supermarkets.

5.30 Deregulation alone will not open pharmacies in rural areas and in urban estates where there are none at present.

75% of GP surgeries have a community pharmacy within 300 metres. This means that 25% do not. Also 300 metres is quite a distance in an issue where pharmacies will seek the position next door – or the ultimate of co-location.

As we have outlined above, where co-location involves GP ownership or a business interest in the lease, the potential exists to direct patients to that pharmacy. There is no question of neighbouring pharmacies competing in such a monopolistic environment.

5.31 to 5.34 The OFT seeks to discredit the theory of second best through concentrating on competition in the two areas of entry controls and Resale Price Maintenance. They ignore the fact that manpower, as a fixed cost, is controlled by legislation and ethical requirements in community pharmacy. Thus, the employment of staff is significantly restricted and regulated by law and ethics in a way which does not affect industries the OFT normally encounters. The costs of employment in such a regulated market are greater and deregulation would create manpower shortages, which will increase costs dramatically and negate the consumer benefits.

The references to prescription charges are inappropriate as they refer to an issue of taxation policy, which does not appear to be within the scope of this report and is speculation without evidence.

5.35 to 5.54 The scenarios and exit entry analysis are flawed. They only consider the marketplace adjusting along the lines of its current dynamics. The ability of GPs to enter the marketplace changes the picture radically.

5.55 to 5.61 ESPS is sometimes used as a safeguard when starting a pharmacy in an area where one is needed in anticipation of growth to viability – but that infers potential viability. It is also a lifeline to essential pharmacies that have lost volume as a result of local changes. The ESPS is paid for from the Global Sum for community pharmacy as a whole. Any enlargement of the scheme would result in reduced revenue for the majority of pharmacies and would imply a need to increase the global sum to compensate.

Chapter 6: Cost of Administering the Control of Entry

The figures quoted in the report for the time taken to make and process new contract applications are remarkably overstated. This also applies to the figures relating to Health Authorities (and therefore Local Health Boards) administration time and costs. The Welsh Assembly Government has indicated that they too are querying the LHB administration cost figures. Discussions between PSNC and numerous contractors lead us to believe that the cost to business in administering the regulations was massively overstated. In addition, there is an emerging view that costs would increase, not decrease in a free market.

This OFT view needs to be given the consideration it deserves as the OFT implies that the £26m could be better spent on patient care by the NHS and by pharmacy organisations. The actual figure is very small, potentially as low as £2m– £3m.