WHY THE OFT REPORT IS SO SERIOUSLY FLAWED

Allen Tweedie, MBA, FCIM, FRPharmS, chairman of the Leadership Group on Medicines Management, believes the Office of Fair Trading's report has engaged in contrived rationales in an attempt to discredit control of entry

Published on 17 January, the OFT report purports to investigate the entry regulations in the community pharmacy sector and establish whether they are "unduly impeding the way that the market works". Price competition is rightly a major issue because, in free market economies, price is held to be the essence of competition. It is a gross deficiency of the report, therefore, that 80 per cent of community pharmacy revenues (the NHS dispensing service) receive one paragraph of treatment. Community pharmacy NHS competition is thus dismissed in four confused sentences. This and other serious flaws in the report are discussed below.

ACCESS

Of location and access to pharmacy services, the OFT cites the following statistics:

- 47 per cent of the population are less than 500m from a pharmacy
- 79 per cent of the population are less than 1,000m from a pharmacy
- 86 per cent of the population consider access to a pharmacy from a general practitioner's surgery is easy
- 90 per cent of the population consider access to a pharmacy from their home is easy

In addition:

- 75 per cent of GP surgeries have a pharmacy within 300m
- 89 per cent of GP surgeries have a pharmacy within 500m
- 98 per cent of GP surgeries have a pharmacy within 1,000m

From patients' homes and GP surgeries 79.4 per cent of patients have easy access to the present entry-controlled pharmaceutical service. Further enhancing this access and convenience, 82 per cent of all pharmacies have a home delivery service and 92 per cent of independent pharmacies provide such a service.

The OFT also emphasises: "If there were areas that suffered access problems for whatever reason, we believe the current safeguards — the Essential Small Pharmacies Scheme and dispensing doctors — have proved effective and provide a targeted solution".

In its summary, the OFT reinforces its acknowledgement of these impressive market facilities by describing the community pharmacy service as "an extensive network of outlets that allow the great majority of people to have their prescriptions dispensed conveniently".

In spite of this acknowledged performance of the pharmacy service under control of entry, the OFT perversely concludes: "The control of entry regulations do not, indeed cannot, ensure good access . . . the current system generally reduces access to pharmacies and pharmacy services."

This is the first serious question mark over the credibility of the whole report.

EFFICIENCY IMPROVEMENT AND INNOVATION

Efficiency Turning to this important aspect of competition, the OFT concludes that control of entry regulations "stifle efficiency improvements and innovation".

Considering again the source of 80 per cent of community pharmacy revenues — which the report has failed to investigate for competitive effectiveness — some interesting facts emerge. By "control of entry" under the present regulations, pharmacy numbers have been limited, the global sum has been limited and prescription numbers have increased some 61.6 per cent since 1987. There have been both "economies of scale" and "returns to scale" under control of entry. In economic terminology, "X efficiency" has increased as has "productive efficiency". The cost of this increased production has been contained by a regulated global sum of remuneration.

Without controlled entry, the OFT's own speculative scenario of greatly increased pharmacy numbers could easily occur, where an extra 2,220 pharmacies enter contract, as happened previously under a free market in the mid-1960s (12,500 in England and Wales). In such a case both "X efficiency" and "productive efficiency" would be likely to drop, as global net ingredient cost (NIC) is divided between a greater number of pharmacies, accompanied by increased numbers of professional staff. Pressure on the global sum would increase, but if contained by controlled money supply, as at present, closure and opening of pharmacies would again be commonplace. This happened in the pre-1987 "de-controlled" era in an attempt to secure better location, greater prescription volume and fees.

This would be acceptable to economic theory, but seriously detrimental to patient care in the new cognitive pharmacy service now being introduced. Efficiency, under control of entry, is maximised especially in the new pharmacy service. It should be remembered, in any case, that in a deregulated health care market, as recommended by the OFT, full efficiency cannot be achieved. Supply and demand curves are not independent and the market cannot guarantee to work in a utility maximising way, as it would in a normal retail market.

Innovation The OFT asserts that innovation is stifled under control of entry. Since the introduction of control of entry, the most innovative initiative of the past 50 years has been developed in community pharmacy — medicines management. It is to the credit of the Secretary of State for Health and his officers that having studied the community pharmacy presentation on the potential of medicines management,

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£30m was allocated to development of this concept and £1.5m to commissioning pilot trials, preparatory to rolling out the service. The OFT is aware of medicines management but does not bother to investigate its genesis or impact.

Even before completion of these innovative projects, elements of medicines management services are already being introduced across the country, bringing both economic and health benefits of a high order to primary care. The medicines management service transforms the FP10 into a contract of patient care and crucially depends upon four prerequisites:

- Stability of the pharmacy network for building secure pharmacist-patient relationships to address patient needs
- Stable doctor-pharmacist partnerships in patient care, built upon mutual respect, trust and collaborative effort on behalf of patients
- Pharmacist confidence to invest in further premises and facilities development as the medicines management service expands
- Continuity of relationships in the pharmacist-patient new cognitive partnership, to guarantee seamless improvement in patient medicines-taking

None of these fundamental conditions can be guaranteed under deregulation. What would the OFT think of a situation where, to satisfy economic theory, GP practices were opening and closing on a regular basis? Opening and closure of pharmacies was a marked feature of the pre-1987 uncontrolled contract.

The prime issue is that this major innovation, which will in turn drive beneficial change in other parts of primary care, took place within a controlled entry contract, because of confidence in the future. The OFT's spurious claim that control of entry "stifles innovation" discredits its confusion.

Competition and competitive forces

Competition is a major issue, which the OFT avoids with regard to 80 per cent of community pharmacy activity in the NHS. The report devotes 11 pages to price competition generally and one paragraph to POMs within the NHS. This is remarkable when considering the relative importance of the three medicines markets and their size:

- POM — £6.8bn (one paragraph)
- P — £0.9bn + GSL — £0.9bn (eleven pages)

POM medicines Interestingly, the report says: "Removing entry controls will not have any immediate effect on the price to consumers of NHS medicines."

Contrarily it avoids saying what retention of control would mean to prices/costs of NHS medicines, which is the crux of the whole issue. However it does go on to say: "We would expect the efficiency of the sector to increase [under deregulation] 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 be potentially passed on in terms of reduced costs to taxpayers and/or prescription prices for consumers."

But this is happening now, under controlled entry. It is a paragraph of confusion and again fails to define "efficiency". The level of reimbursement is a function of three factors:

1. Manufacturers' prices
2. Disease driven global NIC
3. Pharmacy competitive activity for profit maximisation in the drug distribution chain, driving prices down

Discounts from wholesale drug suppliers were negotiated by individual pharmacies and groups as long ago as the 1950s. Local wholesaler discounts became widespread by the competitive buying activity of pharmacies and eventually a national wholesaler had to enter into competition or lose business. In the 10 years before limitation, the total discount achieved was 5.01 per cent. In the 10 years of controlled entry from 1987 the percentage rose to 8.43 per cent. It is now running at 10.28 per cent of global NIC. From 1987 to 2001 the quantum is £4.86bn. It makes the OFT computations of "administrative costs" of control of entry insignificant. (After all, it calls a £300m market small.)

Under control of entry, NIC increases for each pharmacy contractor, proportionate to disease driven increase in global NIC. Discount negotiating power is thus increased per contractor and discount is maximised. This is recovered by the Department of Health and the taxpayer gains.

In a deregulated situation the global NIC is divided between an increasing number of contractors and individual NIC decreases. In the OFT's own scenario of a maximal extra 2,220 pharmacies entering contract individual discount earning power would drop. A further downward pressure on wholesaler ability to give discount would also be the extra supply costs to another 2,220 pharmacies.

Under deregulation the likelihood is that both "X efficiency" and "distributive efficiency" would suffer badly. The taxpayer would lose, not gain. The OFT assertion that "typically, entry restrictions to any market result in prices being higher, innovation lower and quality of service poorer" is again incorrect.

P medicines It is argued in the report that distribution of pharmacy medicines is restricted because of joint costs, ie, a retailer of pharmacy medicines necessitates the employment of a pharmacist and this cost is normally shared with NHS dispensing activity. However, an NHS contract does not mean that pharmacy medicines can be sold more cheaply. It just means that other additional business makes it easier to cover the cost of a pharmacist. The opening of a non-contract pharmacy selling pharmacy medicines is a commercial decision. The fact that there are only 130 at present reflects a lack of innovation in beneficially changing the merchandising mix in a non-NHS pharmacy so as to recover more of the pharmacist's cost, through more profitable merchandise. It also reflects an unwillingness on the part of the multiples and supermarkets to absorb the difference in cost between a drug or beauty store manager and a pharmacist. Their much bigger margins would accommodate this difference. It would reduce profitability by a percentage, but if they are so concerned about patient care within the pharmacy medicine market, this is their route into pharmacy. As the OFT report states, larger national organisations have "economies of scope and scale".

Massive purchasing power is the legitimate competitive advantage of the multiples and supermarkets. They cannot expect protection of their margins from the OFT simply because they want an NHS contract. Other patient services could also be installed and charged — health checks, cholesterol and glucose testing and so on. The free market seems to lack the innovation that the OFT wrongly criticises the controlled market for.

In the OFT case for deregulation and more supermarket pharmacies set out in the report, it is noticeable that no cost-benefit studies have been undertaken and no mention of referred distribution costs, which the supermarkets pass to the consumer in extra distances travelled, customer vehicle depreciation and "opportunity costs".

Locating pharmacies in neighbourhoods reduces costs to the patient, provides convenience and a ready port of call for urgent and routine advice. The OFT approach to the issue of supermarket prices is superficial, to say the least.

The success of a pharmacy is portrayed by the OFT as being solely conditional upon an NHS contract, but in reality — like health food and herbal stores — is dependent upon other factors, not least of which is location, neighbourhood, novelty of services offered and new merchandise mix. Has the OFT researched these issues? The case of "joint costs" is contrived by the supermarkets and drug stores.

Despite the fact that resale price maintenance was terminated in 2001 and consequent lack of major price movement was discernible in the independent and multiple sectors of community pharmacy, the OFT cannot even demonstrate consistent universal price reductions across the full supermarket sector: "There was a wide range of price responses to the ending of RPM from different supermarket chains . . ."

Moreover, its sector comparisons are based upon 27 products, then reduced to seven products, sold in all outlets. It is common practice that supermarkets cut the price of well known brands, to give an illusion of good value. From a research perspective the data are seriously inadequate. One hundred products would give a realistic picture. The OFT admits that back-up data from The Consumers' Association "was based on a limited basket of goods and a relatively small number of pharmacies . . . surveyed". It is wholly unacceptable that a

report of this magnitude is reliant on such poor quality research.

Despite all the evidence of non-price competition of OTCs under deregulation, the OFT still clings to the belief (expressed as a double negative) that deregulation of the NHS contract would depress the price of OTC medicines: "We do not believe that results show that in the event of deregulation, pharmacies would not begin to compete more in terms of price."

As a declaration of faith, this is, of course, unassailable.

GSL medicines A tortuous rationale is employed by the OFT here, attempting to show that wholly unrestricted products (GSL medicines) with a long history of the widest possible distribution (in supermarkets, pharmacies, corner shops, newsagents, motorway service stations, general stores and garage forecourts) are still affected by control of pharmacy entry to the NHS. It speculates "the consumer may require advice from a pharmacist" and "the customer is confused between . . . drugs which are P medicines and which are GSLs" and are "not aware they can buy GSLs elsewhere".

Therefore, it argues, a proportion of consumers must go to a pharmacy to purchase GSL medicines and lose choice in other outlets. The two consequent implications of this rationale in deregulation are ignored by the OFT. In a deregulated market, the supposed "confused customer" situation remains and could not be resolved, unless there was a pharmacy in every one of the six additional types of outlet listed above. The concept is unsustainable. In any market, regulated or not, there are barriers to entry and thus legitimate "competitive advantage" with certain suppliers. To be a pharmacist is to have a legitimate competitive advantage, as is being a doctor or a nurse in their respective fields of practice.

The OFT proposition of deregulated entry solves neither of the contrived problems it presents. The same case could be argued for toiletries and cosmetics purchases as is argued for GSL medicines.

The OFT case on GSL medicines is short on research and marketing principles. The rationale on GSL is convoluted and contrived to explain away the failure of total price freedom in the OTC market. Consumers still support the neighbourhood pharmacy for its added value and not, as the report implies, because consumers are just confused people. Customers are intelligent learning people and are aware of good value. This comes from not only the "core" product, but the "tangible and augmented product" benefits. The OFT is seemingly unaware of these concepts, well known in marketing theory and practice.

Non-price competition The OFT claims that "competitive pressure is generally the most effective driver of service quality and innovation" and goes on to concede that under control of entry "pharmacies compete with each other on many aspects of service quality".

This effect will not change under deregulation. The new drive toward cognitive service under controlled entry will, for example, increase the number of consultation areas and collection and delivery services (two of the three quality markers investigated by the OFT). The third, opening hours, has no sound rationale for increasing under deregulation. It did not do so when there was no control of entry pre-1987.

Quality of service, which the OFT is rightly keen on, is not best achieved by open contract competition as it claims, but in a regulated profession, by benchmarking performance, clinical governance and audit — all of which are features introduced under control of entry. Its case is again contrived and unconvincing and dismissive of the experience of the past.

ADMINISTRATIVE COSTS OF REGULATED ENTRY INTO CONTRACT

Administrative costs of regulated entry into contract are portrayed by the OFT as being borne by the taxpayer, pharmacies and customers. Such costs are first, not borne by customers, whom the OFT lists separately from taxpayers. No additions are made to prices of prescriptions or POMs to patients or customers. In addition, all advice given by pharmacists, as well as collection and delivery services, are given free — issues not even commented upon in the report.

Yes, pharmacists pay — when they are involved in contract applications — as do the NHS and the taxpayer. The taxpayer also pays, directly or indirectly, for wine and spirits licences, television and vehicle licences and stamp duty when acquiring property. There are often taxpayer expenses for certain transactions in a free or regulated market. There is no good reason why NHS pharmacy should be different.

The immense savings generated by pharmacists on drug purchasing and through ever increasing schemes of prescribing advice and medicines management, reduce the administrative costs of regulation to inconsequential levels.

SUMMARY

The OFT report is guided by its principle that "competitive markets to which there are no barriers to entry, generally serve best, the interest of consumers . . .". It has failed to demonstrate this with respect to pharmacy.

The report confirms that 90 per cent of the population consider access to a community pharmacy from home is easy and 82 per cent of pharmacies have a home delivery service, and that pharmacies compete with each other on many aspects of service quality under control of entry.

Yet it has failed to acknowledge the tremendous competitive activity in the NHS sector which has delivered billions of pounds of savings to the taxpayer. It has failed to assess properly the impact of the development of the new cognitive pharmacy role and its necessary bases of stability, confidence arid continuity of patient and professional relationships. And it has failed to accept that deregulation of such devices as RPM has not delivered universal benefit in prices, nor has the widespread availability of GSL medicines.

Instead it has engaged in contrived rationales in an attempt to discredit control of entry. It is self-contradictory on crucial issues and lacking in quality research evidence on such matters as generalisation or price reduction comparisons in the OTC market. It has been shown to be wrong in its assertion that control of entry stifles efficiency and innovation.

All in all, an observer could be forgiven for concluding, as Jonathan Buisson neatly put it: "The OFT appears to have started with its conclusion and worked backwards in an attempt to justify it" (*PJ*, 25 January, p112).

Patient care seems to be a subordinate consideration and is not mentioned once in the report.

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