The PHARMACY GUILD of AUSTRALIA
NATIONAL SECRETARIAT

NATIONAL COMPETITION POLICY AND PHARMACY

Submission to Productivity Commission Review of National Competition Policy Arrangements

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1. The Pharmacy Guild of Australia

1.1 The Pharmacy Guild of Australia was established in 1928 and registered under the then Conciliation and Arbitration Act (now Workplace Relations Act) as a national employers' organisation. The Guild's mission is to service the needs of its members, who are the pharmacist proprietors of some 4,500 independent community pharmacies, which are small retail businesses spread throughout Australia. Almost 90% of all pharmacist proprietors are Guild members.

1.2 Community pharmacy makes a significant contribution to the Australian economy with an annual turnover of $8 billion and $200 million in tax revenue, employing some 15,000 salaried pharmacists and 25,000 pharmacy assistants. Through the Pharmacy Assistant Training Scheme, the Pharmacy Guild provides a significant career path for young Australians, particularly young Australian women.

1.3 The Guild aims to maintain community pharmacies as the most appropriate primary providers of health care to the community through optimum therapeutic use of medicines, medicine management and related services.

2. Background to National Competition Policy and Pharmacy

2.1 Reviews of State and Territory Pharmacy Acts: The National Competition Council (NCC) as part of its 2003 review recommended the application of penalties to some States and Territories for outstanding or non-compliant reviews in a number of areas including pharmacy. The Federal Treasurer supported these recommendations, in a letter written to State and Territory Governments in December 2003, threatening suspensions of payments for non-compliance with NCC views.

2.2 At the time of writing, New South Wales was the only jurisdiction in which a compromise position had been reached to limit pharmacists to five pharmacies and friendly societies to six. Negotiations are continuing with other States and Territories. This only occurred as a result of the direct intervention by the Prime Minister who recognised that there was public benefit in retaining these restrictions so that large chains did not develop and undermine the current network of community pharmacy whose continuation he had committed his Government to support.

3. Pharmacy in Context

3.1 "Pharmacy is an important element of Australia's health care system." So began the National Competition Policy Review of Pharmacy (2000).

3.2 The document went on to sketch the social context of pharmacy in Australia in terms of both its familiarity and its own professional culture.

> The profession itself is remarkable for its superb ability to organise itself, develop an *esprit de corps* and common outlook among its members, and convert that professionalism into community influence.

3.3 That COAG review was carried out under National Competition Policy requirements in June 1999.

- Its final report in February 2000 found that there was a **public benefit** in retaining the requirement that pharmacy ownership be restricted to pharmacists.

- In August 2002, a Joint Government Response to the report was made public which supported this recommendation.

3.4 The overarching recommendation is designed to preserve what is arguably the world's best system of access to affordable medications for all Australians through the unique network of almost 5,000 community pharmacies.

3.5 Community pharmacy is the network of shopfront pharmacies that form the delivery platform for prescription and scheduled over the counter medicines as well as general pharmaceuticals to consumers. It occupies a unique position in the healthcare system in that it combines a retail function with health care services.

3.6 It is not as though pharmacy is an unreconstructed sector of the economy. The industry represents one of the best examples of successful micro-economic reform in the country.

Under agreements with government dating from 1990, almost 700 pharmacies have closed or have been amalgamated with others. The result is a smaller number of larger, well-located pharmacies better able to provide the quality advice and service consumers expect from community pharmacy.

3.7 Proponents of further deregulation argue that the dismantling of current ownership restrictions would introduce great competition into the sector, including retail prices.

3.8 In fact, only a small proportion of pharmacy sales would be potentially subject to greater competition in this way as about 63% of sales in the average pharmacy comes from pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS) which is subject to Commonwealth price regulation. Only 19% of the market is represented by drugs restricted under legislative scheduling and this is because their indiscriminate use is potentially health, or even life-threatening. For this reason they are not price promoted.

3.9 The noted US authority on markets and competitive behaviour, Michael E Porter, has drawn attention to the folly in the health care sector of focusing on price alone which, he says, "makes sense only in commodity businesses, where all sellers are more or less the same. Clearly that is not true in health care."[1]

3.10 The Pharmacy Guild of Australia has serious concerns with the National Competition Council's current agenda for the deregulation of the State and Territory Pharmacy Acts which, if carried through, will create large chains and will ultimately open up ownership for supermarkets and destroy the existing system of community pharmacy in Australia.

3.11 Deregulation has its place – that is, when a rigorous test of public benefit has been applied and found to be advantageous. To deregulate simply for the sake of deregulation is not only irrational, it can actively work against the public benefit it is purported to enhance.

3.12 Some aspects of the report from the review dilute the overarching recommendation on ownership and if implemented are contrary to giving full effect to it.

[1] Michael E. Porter & Elizabeth Olmsted Teisberg, "Redefining Competition in Health Care," *Harvard Business Review*, June 2004, p. 67.

3.13 One of COAG's recommendations is to remove the limit on the number of pharmacies a pharmacist may own and to allow unlimited expansion of friendly society pharmacies. This has the potential to change fundamentally the way pharmacy operates and to move it away from its current and growing focus on professional healthcare towards a corporate, retail model which emphasises product, turnover and profit – and tends to relegate professional healthcare to the backwaters.

3.14 Our concern is that in this process ideology has taken precedence over public interest.

3.15 The current limits on numbers, which apply in most jurisdictions, are based on the understanding that the public is best served by a practice which is owned and controlled by pharmacists who are personally responsible for its conduct and fully accountable to their respective pharmacy boards for the professional and responsible running of their pharmacies.

3.16 The development of large corporate chains and geographical monopolies will lead to an unacceptable corporatisation of pharmacy. The large and rapidly expanding friendly society chains are, in essence, corporate pharmacies, whose unlimited expansion in some jurisdictions is already threatening to change the nature of community pharmacy in ways that not only ignore but work against demonstrable public benefit.

3.17 The Friendly Society Medical Association Ltd, FSMA, trading as the National Pharmacies group, describes itself as being the largest retail pharmacy chain in Australia, owning 44 pharmacies in total—31 in South Australia, 18 in Victoria and one in New South Wales—and with further expansion earmarked, especially in Victoria. FSMA reported a turnover for the 2001 financial year of $153 million and had net assets of over $43 million. Its stated net profit was $3.87 million. One FSMA-owned pharmacy in South Australia is believed to have an annual turnover of approximately $19 million.

3.18 Community pharmacy is an integral part of each State and Territory's primary health-care infrastructure and is increasingly being used as a strategic partner by government to deliver an ever increasing range of health-care services, especially important with the growing demographic bulge of the ageing.

3.19 The Pharmacy Guild is strongly of the opinion that it is an exercise in sheer folly to look at pharmacy in isolation and outside the context of the healthcare system of which it forms such an integral part.

3.20 In the case of pharmacy, the deregulatory move could prove to be a costly mistake because the long-term health needs of Australians will suffer as a result. It would be neither rational nor economical.

3.21 Any further deregulation forced on reluctant States and Territories would see a move to a corporate supply-based model that would detract from the gains available to the Government through greater utilisation of community pharmacy in its health-care strategies.

3.22 In summary, a range of adverse impacts affecting service delivery, quality of heath care and government expenditure is likely to ensue if further progress down this track is forced without careful consideration of the public benefit arguments.

4. Possible Economic Impacts

4.1 Market failure is a major justification for regulation of markets, and that is imposed in social policy when evidence suggests that unregulated markets will not maximise social welfare which equates with public benefit. This is recognised in National Competition Policy.

4.2 Generally, market failure may be characterised by one or more of the following factors, each of which is applicable to pharmacy:

- Public goods: particular goods are not provided by the market alone, such as equity of access.

- Externalities: an activity or transaction provides benefits or costs not directly related to the activity.

- Natural monopolies: one firm or entity can exploit unfairly its market position.

- Information asymmetries: a seller has more knowledge of the product than the buyer, so that the buyer is dependent on the seller's expertise. In terms of pharmacy this is what economists call a "credence good" – a good whose quality cannot be fully assessed before or after consumption

4.3 Because patients do not know enough about pharmaceutical products to make an informed decision as to which best suits their needs, pharmacists play a crucial role in supplementing the role of prescribing doctors in addressing potential market failure caused by insufficient or inadequate information.

4.4 The pharmacist is no mere retailer or neutral intermediary between manufacturer and user; the maximisation of sales is not the prime mover in the transaction but rather it is a professional commitment to the quality use of medicines, and the healthcare professional relationship that exists.

4.5 The National Pharmacy Data Base Project (NPDBP) estimates that in addition to the compulsory information provided with the sale of certain medicines, approximately 78.2 million consultations occur annually in community pharmacies.

4.6 In comparison, in the heavily deregulated US pharmacy sector, it has been found that only 42% of US adults received any verbal advice about their medication, and in only 19% of cases did pharmacists advise on possible side effects.

4.7 In the US it has been estimated that $76 million is spent each year because of medication use problems and that the latter accounts for 8.7 million hospital admissions and 115 million physician visits. This is approximately twice the rate, proportionately, of Australia.

4.8 The NPDBP estimated that monitoring compliance with medicine usage instructions occurred about 14.4 million times per year. Around 45% of pharmacies used clinical testing devices to perform this monitoring, and in some instances this process resulted in the pharmacist declining to fill the prescription.

4.9 It is estimated that pharmacists' clinical intervention in Australia saves the health budget some $8 million dollars annually.

4.10 Regulation was originally intended to protect the integrity of the professional relationship between pharmacist and patient, and this remains so. The commitment to quality care and advice is underpinned by pharmacists being held personally accountable for every piece of advice and service delivered in their pharmacies.

4.11 By restricting ownership of pharmacies to qualified and accredited individuals, the potential loss to those individuals as a result of any professional misconduct or negligence is significant. An owner-pharmacist risks losing his or her entire livelihood and professional reputation if found guilty of misconduct. By contrast, a large corporate may incur a fine but would not necessarily be prevented from operating a pharmacy or suffering any serious impact to the greater part of its business.

4.12 Ownership restrictions, which currently limit the number of pharmacies that a pharmacist may own, serve to support the personal relationship that exists in Australia between pharmacist and patient.

4.13 A cornerstone of Australian health care policy is equity of access to affordable medicines and, under current arrangements, pharmacies across Australia are supplied on a daily basis with medicines at uniform wholesale prices by one of three independent wholesalers. If a sufficient volume of this business was acquired by large corporate owners, it is likely that they would acquire medicines directly from manufacturers, bypassing the existing distribution system and placing in jeopardy existing access to people, particularly in rural and remote locations.

4.14 Appropriate advice and after-sales service accompanying the supply of medicines is essential to address market failures associated with the use of medicines. If ownership restrictions were substantially altered then alternative means would have to be devised to ensure that adequate levels of pre- and after-sales pharmacy services were available top those patients most in need.

4.15 The Pharmacy Guild does not believe a similar level of service could or would be maintained in a supermarket environment where dollar return per square metre is the driving force. Corporate ownership by supermarket chains is a very real outcome for a deregulation scenario.

4.16 The stable and uniform ownership structure which currently exists provides the platform on which the Commonwealth enters into co-operative agreements with the industry to contain the costs of PBS outlays and to provide a framework in which community pharmacy participates in public health programs such as methadone and needle exchange, realising savings in the last two such agreements of some $200 million.

5. Overseas Experience

5.1 The most recent experiences of total deregulation in a market with some broad similarities are Ireland and Norway.

5.2 Ireland

5.2.1 Deregulation of the pharmacy sector in Ireland was introduced at the start of 2002, and within 18 months it was apparent that larger groups were moving to take over smaller, independent pharmacies. However, a fear of re-regulation inspired by some of the changes introduced uncertainty into the sector, dissuading many operators from investing in staff training and drug programs that required intensive staff input.[2]

5.2.2. The Irish experience has been reviewed intensively. An OECD study on the eve of deregulation predicted that revisions to pharmacy regulation in Ireland "could bring down prices without endangering safety or accessibility."[3]

5.2.3 A working group set up to respond to the OECD report (Mortell) expressed some disquiet about the arguments being used to drive deregulation and noted:

> Pharmacists are medicines experts, with knowledge few customers have. This directly affects the question of regulation of …pharmacy.[4]

5.2.4 The Mortell group reported that:

> Much of the material considered…including the OECD report, was grounded in economic or other policy theory and in opinion, and not based on evidence of how pharmacy markets operate.[5]

[2] *Sunday Business Post* (Dublin) 15 June 2003.
[3] *Regulatory Reform in Ireland*, OECD, 2001, 1.7.
[4] *Mortell Group Report*, Dublin, 2001, 2.13.6.
[5] *ibid.*, 4.3.3.

5.2.5 Mortell went on to question the assumptions in the OECD study, notably:

- there is insufficient evidence to indicate whether restrictions to the Irish pharmacy market would lead to lower consumer prices; and

- an ongoing open market could see the reduction or disappearance of single owner-operated local pharmacies.[6]

5.2.6 Consolidation of ownership, Mortell reported, took place rapidly. In 1998 the largest pharmacy chain controlled 19 pharmacies, and the month before deregulation this had climbed to 30. It now exceeds 50 and continues to grow.[7]

5.2.7 In its final report in January 2003, Mortell expressed concern in relation to vertical integration (a wholesaler or manufacturer-owned pharmacy, for example, stocking only the owner's products).[8]

5.2.8 While it found no chain was yet large enough to be a dominant force, there was concern about the possibility of local area monopolies and potential use of market power to lower service quality.[9]

5.2.9 Referring to deregulation in Norway, Mortell noted that "certain service types are vulnerable in a deregulated market….This gives rise to a significant public health issue"

5.2.10 Mortell warned that changes set in train were likely to be irreversible with adverse financial implications for the government, as an ongoing open market

> is likely to see the reduction or disappearance of some types of pharmacy services, in particular single-owner operated local outlets, and this would be a permanent change. There is insufficient evidence available to judge whether the consumer needs met by these service types would be catered for by the market. If they are not, then the State would be required to do so, with obvious resource implications.[10]

[6] 4.4.2.
[7] *2.12.2*,., 2.12.5.
[8] 2.12.2
[9] 2.12.6
[10] *ibid*., 4.3.3.

5.2.11 Its recommendations provided for a degree of re-regulation including a limit on the number of government health contracts held by each entity in a health board area, and legislative definitions of the role of pharmacists and pharmacy services and standards.[11]

5.3 Norway

5.3.1 The case in Norway represents a more extreme deregulation, both in its extent and in its effects.

5.3.2 Prior to deregulation in 2001, the ownership and operation of pharmacies were reserved for pharmacists, and the government controlled where pharmacies could be located, whether they could be moved or closed, and specified opening and closing times for individual pharmacies. Pharmacies with revenues under a certain level received subsidies, and wholesaling was a government monopoly.

5.3.3 By the time deregulation took effect, more than 70% of pharmacies in Norway had been pre-sold to three multi-national chains.

5.3.4 Change was as rapid as it was unexpected. A study by the Swedish Institute for Health Economics[12] reported:

> The rapid change took government by surprise and intervention was needed to prevent monopolies from emerging. Additional intervention to strengthen competition may be needed in the future to prevent unfavourable developments, and the tradition of maintaining equal access of services may prove more difficult to uphold. Experiences in both Norway and Iceland highlight the complexity if reforms that fundamentally influence competitive behaviour.

5.3.5 Vertical integration continued to the extent that a post-deregulation merger between two groups led to dominance of more than half the market and the competition authority intervened to rule that no pharmacy group could control more than 40% of the market and divesting was ordered.

5.3.6 During the year following deregulation, the number of pharmacies increased by 20% (from 370 to 445) while the average size of pharmacies decreased.

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[11] 4.4.2, 4..5.7.

[12] Anders Anell & Jonas Hjelmgren, "Implementing Competition in the Pharmacy sector: Lessons from Iceland and Norway," in *Applied Health Economics and Health Policy* 2002: 1 (3) 149-156.

5.3.7 Almost all of the new pharmacies opened in Oslo or in other highly populated areas, particularly in shopping-malls with liberal opening hours.

5.3.8 According to the Swedish study:

> As a consequence, access to pharmacies improved significantly in highly populated areas, but total revenues for the prescription market did not change proportionately, and average revenue per pharmacy decreased.

The study found no evidence of discounts to consumers and noted that three groups of equal size controlled 55% of the total number of pharmacies. By June 2004, this concentration among the three groups had reached 77%.

5.3.9 The legislation that was intended to bring about more competition in Norway in fact had the opposite effect in the creation of horizontal mergers and coalitions between pharmacies, and these emerging groups also integrated vertically with wholesalers.

5.3.10 As the Swedish study concludes:

> The number of individual decision-making units decreased, and the market for distribution of pharmaceuticals was rapidly transformed into an oligopoly.

5.3.11 By 2003 the situation had worsened to the extent that the Norwegian Competition Authority raided and confiscated documents and computer data from a number of pharmacy chains and wholesalers it suspected of involvement in price collusion. The investigation continues.[13]

[13] *Scrip*, World Pharmaceutical News, 12 Nov 2003, p. 4.

6. Conclusion

6.1. A series of five-year agreements with Australian governments, initiated by the Hawke Government in 1990, has seen pharmacy become a partner with Government in delivering community service obligations and health care benefits. Recent Agreements have seen pharmacy increasingly engaged in the delivery of professional services such as providing medication reviews to older Australians. The network of almost 5000 pharmacies, well distributed throughout the country, has become a platform for the delivery of health care services as part of a primary health care team. This investment by successive governments and by pharmacists will have been for nothing if the NCC is allowed to undermine the community pharmacy model upon which it has been built.

6.2 Community pharmacy is now a quality assured platform. The implementation of this program has, arising out of the Third Guild/Government Agreement, delivered remarkably quickly a situation in which 90% of pharmacies are now fully quality assured. Pharmacy has restructured at the behest of government. It has adopted and quickly applied a quality assurance program and it has moved with the encouragement of Government into the delivery of professional health care services.

6.3 Good public policy-making would suggest community pharmacy in Australia is entitled to benefit from a period of consolidation and a moratorium on NCC-driven change.

6.4. The spectre of Americanisation of Australia's heath care system is a very real one if a zealous approach to deregulation is allowed to prevail. A British Government report neatly encapsulated the distinction:

> In…countries with predominantly public systems, health care is considered a social good where health benefits are distributed according to need. This is in contrast to the USA where health care can essentially be considered a market commodity.[14]

[14] Elias Mossialos MD PhD & Monique Mrazek PhD, "The Regulation of Pharmacies in Six Countries", Report Prepared for the (UK) Office of Fair Trading, January 2003.