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26 November 2004

Mr Gary Banks
Chairman
Productivity Commission
PO Box 80
Belconnen ACT 2616

Dear Mr Banks

Review of NCP Reforms

On behalf of The Pharmacy Guild of Australia, I write to provide the following comments on the Productivity Commission's Discussion Draft for its Review of National Competition Policy Reforms.

The two specific issues on which I wish to make comment both relate to the current regulations which govern the operation of community pharmacy in Australia. The first concerns the requirements around pharmacist ownership contained in the State and Territory Pharmacy Acts; the second covers the location regulations which apply to pharmacies approved to dispense prescriptions under the Commonwealth's Pharmaceutical Benefits Scheme (PBS).

1. Pharmacist Ownership of Pharmacies

In 1999/2000 community pharmacy underwent a comprehensive national review conducted according to National Competition Policy guidelines under the auspices of the Council of Australian Governments (CoAG). The review found that there was a public benefit in the requirement that pharmacies be owned by pharmacists and the Joint Government response to the review, which was published in August 2002, supported this finding.

The Prime Minister, in his letter to pharmacists in September 2004, referred to this review process as follows: *"The major outcome of that review was agreement by all Governments that there are clear public benefits in retaining Australia's tradition of pharmacies owned and operated by pharmacists."*

He went on to say *"As indicated in my letter to you three years ago, this matter is now settled."*

Given this background, The Pharmacy Guild finds it puzzling that the Productivity Commission does not accept this position but again raises the issue of pharmacy ownership in its discussion paper. The Commission appears to take on the view of the National Competition Council (NCC) which, for some reason, chooses to oppose the findings of the CoAG pharmacy review and the Government's clearly stated position. The NCC has, in effect, set itself above the Government and CoAG. The Productivity Commission now appears to have followed that line without independent analysis.

We believe there is an inherent bias in the National Competition Council's handling of National Competition Policy, with specific regard to pharmacy, and I have attached to this letter a short paper outlining the Guild's concerns in this regard. (See Attachment A.)

Also attached is a detailed report on community pharmacy undertaken by an independent consultancy firm, NECG, which demonstrates the value provided to the community by the current system of pharmacist-owned pharmacies. (See Attachment B).

Community pharmacies, like all small businesses, need to have some business certainty with regard to the regulatory environment in which they operate. It is difficult to plan ahead to grow pharmacy businesses when regulations are under constant review. For almost ten years now, community pharmacy has been the subject of debate about NCP reviews and this has created a great deal of uncertainty for the sector with the result that young pharmacists have sometimes chosen not to go into community pharmacy. There is already a workforce shortage in community pharmacy and this uncertainty has exacerbated this situation.

It is time that the debate about further reviews for pharmacy ownership was brought to an end and acceptance given to the CoAG review and its major finding. This would allow the community pharmacy sector to be provided with some degree of certainty so that pharmacists could once again focus their attention on ensuring that they provide a high quality of health care service to the community instead of being concerned about the future viability of their business.

2. Location Rules for PBS-Approved Pharmacies

The Discussion Paper also referred to the need for a further review in regard to the location rules which apply to PBS-approved pharmacies. These rules were introduced in 1990 as part of the First Agreement between the Commonwealth and The Pharmacy Guild of Australia. This Agreement was the outcome of a most successful period of microeconomic reform of the pharmacy sector which involved rationalising the number of pharmacies existing at that time, in order to provide greater efficiencies.

Having reduced the number of pharmacies, the Agreement then placed an ongoing limit on the number of PBS approval numbers and regulated the location of approved pharmacies in order to ensure that there was equal access to pharmaceuticals and to pharmacy services in all areas of Australia – particularly in rural and regional areas.

These rules are subject to an ongoing review process and the next review is already underway. It will be finalised as part of the negotiations for the Fourth Guild/Government Agreement which must be signed prior to 30 June 2005.

The Pharmacy Guild therefore believes that the community pharmacy sector has already been, or is already, subject to a comprehensive review process in regard to National Competition Policy and should not, therefore, be subject to any further review through other mechanisms as is being advocated by the Productivity Commission and the National Competition Council (NCC).

Yours sincerely

Stephen Greenwood
Executive Director

cc: The Hon John Howard, Prime Minister

Productivity Commission Review of National Competition Policy

The Guild is concerned about what it sees as the inherent bias of the National Competition Council (NCC) in its handling of National Competition Policy (NCP) and the fact that the Productivity Commission (PC) appears to have accepted the views of the NCC without question and above other points of view.

Where pharmacy is concerned, the NCC has consistently demonstrated negative preconceptions about the industry. In its reports it has consistently assumed that the community would benefit from deregulation of pharmacy. It expressed this view even before CoAG had completed its review of pharmacy legislation and, once it had completed this review, it made it clear that it did not accept CoAG's recommendations and that it would continue to pursue pharmacy. In its 2003 NCP assessment it said "the Council considers that the review's conclusions that ownership provisions provide a net benefit to the community is based on questionable evidence"[1].

The Productivity Commission appears to have accepted the NCC's views without reservation or analysis, recommending that pharmacy legislation, along with other legislation which the NCC finds 'problematic', should be subject to second round reviews[2].

The Guild is concerned that throughout the review process it has faced difficulty in having its views taken seriously. The NCC has appeared unwilling to distinguish between the legitimate concerns of the industry and what it sees as industry self interest conveyed through the Guild. This problem may be far broader than the NCC's views on pharmacy. There appears to be innate bias against those industries targeted for reform, others having levelled the same complaints.[3]

There is considerable difficulty in 'proving beyond reasonable doubt' concerns about what will happen as a result of reforms, but this does not render such concerns baseless. This problem is particularly acute in the health sector, a sector focused largely on services, where there are many intangibles and where it is difficult to quantify legitimate concerns about the impact of change. It is acute in pharmacy, which is unique in that it is a professional health service provided in a retail setting.

In its submission to the Productivity Commission into Competition Policy, the Commonwealth Department of Health and Ageing identifies "a number of unique characteristics of the market for health services (which) make market failure a particular problem and (impose) limits of the extent of competition that is considered desirable".[4] These unique characteristics include:

- "an unequal balance of power and knowledge between patients and health professionals;
- potentially irreversible and serious, even life-threatening, consequences of wrong decisions or poor quality products;

[1] National Competition Council, 2003 NCP Assessment, Chapter 3
[2] See, for example p. XX1, final paragraph and p.XL1, dot point 2 of the Productivity Commission Discussion Draft
[3] See, for example Queensland Rail submission to PC Inquiry.
[4] Submission to PC Inquiry, Department of Health and Ageing, 2004.

- the need to address gaps where affordable and accessible services would not otherwise be available to all consumers, such as in rural areas or for low income earners;
- an expectation that health care will be accessible to everyone on the basis of medical need, irrespective of financial resources or consumer power; and
- the need to responsibly manage uncapped publicly-funded health care programs in the face of potentially unlimited demand."

While many of the Guild's arguments in support of the current system of community pharmacy are too detailed to include in this brief submission, the essential reality is that pharmacy is, and will continue to be, a highly-regulated industry, because it is dealing with dangerous drugs, many of which are heavily subsidised by Government. The Australian Government, for example, regulates the prices of medicines and the return to pharmacists through the Pharmaceutical Benefits Scheme, which represents over 65% of pharmacy trade. It also limits the number of pharmacies and regulates their location through the issue of approval numbers and the application of location rules. It does these things for social and health care reasons. In this context it is difficult to apply market theory to the industry in any meaningful way. Pharmacy is quite different from other industries.

It is also important to note that, while open competition sounds fine in theory, there are potential costs such as, for example, the impact of this model on the distribution system for pharmaceuticals and the impact of this on rural and regional areas. The fact that these are difficult to quantify with certainty does not render the concerns baseless.

The community pharmacy network is a delicately balanced distribution system, unique in the world, in which community pharmacies, spread uniformly throughout the country, are serviced by three wholesalers who make at least daily, often more frequent, deliveries of sometimes quite small quantities of pharmaceuticals at normal cost, guaranteeing prompt supply to customers of a huge range of medications even including those which are rarely used or quite obscure. In addition to providing medications, these pharmacists provide health-related education, professional care and advice and an increasing range of professional services reflecting the changing role of pharmacy.

Any development which leads to large, corporatised chain ownership with the eventual capacity to bypass wholesalers and make bulk purchases directly from manufacturers will damage the distribution network with an immediate impact on the supply of these services to rural and regional centres. It has very little bearing on price, since over 65% of pharmacy business is covered by the PBS, whose prices are fixed.

This was a central concern of the Department of Health and Ageing in its submission to the CoAg Review when it said:

"Access: The Commonwealth's principal concern is that changes to the ownership of pharmacies could lead to a shift in the mode of delivery from traditional community based arrangements to arrangements more heavily focussed towards retail objectives."[5]

In its analysis of the pharmacy industry, the NCC dismisses the Guild's concerns by deriding them as special pleading by the pharmacy industry. Of course there is some self interest in the retention of the current system of pharmacy. Guild members have invested much in their businesses and, if the NCC had its way, many would lose considerable value overnight,

[5] Submission by Department of Health and Ageing to CoAG Review. #151

threatening property values and retirement incomes. This is self interest, but it is also a legitimate concern which should be heeded.

More important than this, though, is the potential threat to the health care model of pharmacy which stands up well against the supermarket-style supply-based model, notably in the USA, but also increasingly evident elsewhere. There is a very real danger that any move towards the deregulated model favoured by the NCC will fundamentally change the nature of pharmacy as currently practiced. In our view, this would not only be bad for health care, but would be contrary to the policies of most governments, which are investing heavily in expanding the role of pharmacy into areas of professional health care, based on the fact that there is a ready-made network of professionals well distributed around the country, who are perhaps under-utilised and should be brought into the primary health care team. This is why governments at both State/Territory and Commonwealth levels sought an acceptable compromise, which increased competition whilst retaining a system of pharmacy that works well and is capable of so much more that is useful for both governments and the community.

Nor, in its zeal to deregulate pharmacy, does the NCC voice any concern about the possibility of oligopolistic control over the industry by the two major grocery chains, which between them control over 70% of the retail grocery market and now a substantial share of liquor and petrol and have made it clear that they want to include pharmacy in their supermarket operations. None of this may mean much to the NCC, but it means a lot to pharmacists, to the community and to governments.

The NCC bases its entrenched views on pharmacy on its claim that a deregulated model would lead to larger, better-managed pharmacies, with improved levels of innovation, able to take advantage of economies of scale and thus able to reduce costs and prices to consumers. The NCC has made the twin mistakes of basing its analysis on purely economic considerations and also on flawed assumptions drawn from discredited research. In its analysis, it has shown little understanding of the complexities of pharmacy – a health care service in a retail setting – nor of the social and health consequences of its reforming zeal. It appears to have taken no notice whatever of the Guild's expensive and professional commissioned rebuttals of many of its arguments.

CONFIDENTIAL

Ownership Restrictions applying to Pharmacies

Assessment of case for retaining restrictions

PREPARED FOR
PHARMACY GUILD OF AUSTRALIA

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Executive Summary

This report provides an economic rationale for the maintenance of current ownership arrangements in the community pharmacy sector, the principal effect of which is to effectively restrict ownership of pharmacies to registered pharmacists.

The central tenet of this report is that the services provided by pharmacists are an effective way to address market failures associated with medicine usage. Those services tend to be under-valued by consumers and it is not easy to prevent free-riding on their provision. Hence, in an unregulated market, there would tend to be too little consumption of pharmacy services. This provides a rationale for government intervention to promote the provision and consumption of pharmacy services above levels that would otherwise prevail. The report argues that the existing ownership arrangements are an effective way to promote this outcome.

Under State and Territory (hereafter, 'State') legislation, ownership and effective control of pharmacies is confined to registered pharmacists with certain limited exceptions mainly relating to friendly society dispensaries (FSDs). In most jurisdictions, new FSDs are prohibited or made subject to special ministerial approval before they can be established.

Existing arrangements were reviewed in 2000 as part of the National Competition Policy (NCP) review of legislation. The Council of Australian Governments (CoAG) subsequently proposed a limited reform package to remove restrictions on the number of pharmacies a pharmacist may own, expand permissible ownership structures and to allow FSDs to enter new jurisdictions.

Since then, there have been a number of developments that may alter the implications of the CoAG reforms:

- The expansion of FSDs beyond ownership limits that apply to registered pharmacists;
- Exploitation of the FSD structure to circumvent ownership limits; and
- The stated desire of national supermarket chains to enter the pharmacy sector.

Thus, current ownership arrangements are under considerable threat, particularly from large corporates including grocery retailers who have signalled their interest in entering the pharmacy sector. However, this report argues that changes to existing arrangements are likely to be detrimental to society.

The existing ownership arrangements may restrict competition by limiting ownership of pharmacies to registered pharmacists. Restrictions on competition usually result in lower levels of output, lower quality of service or higher prices. However, a large part of the sales volume of pharmacies is demand-driven and depends on the general health of the

public and the prescribing practices of doctors. Thus it seems unlikely that the existing ownership arrangements substantially constrain 'output'. Similarly, only 19 per cent of pharmacy sales, representing scheduled over-the-counter (OTC) and private prescriptions, are potentially subject to greater price competition than is currently the case.

In addition, current high levels of concentration in Australian grocery retailing cast doubt on whether short-term price competition by large retailers entering the pharmacy sector would be sustained in the longer run. There is therefore a possibility that the ultimate outcome for consumers of removing existing ownership arrangements could be a lower service offering and potentially similar (or not substantially lower) prices than currently prevail.

In relation to service quality, this report argues that the existing ownership arrangements facilitate higher levels of service than would prevail if ownership were more deregulated. Indeed it is this outcome that provides one of the key rationales for retaining existing ownership arrangements as pharmacy services are important in managing the externalities and other market failures associated with the consumption of pharmaceutical products.

Pharmacy services are valued by consumers but are not easily sold on a stand-alone basis because there is some potential for 'free-riding' on the supply of those services, particularly in relation to OTC medicines which are subject to repeat purchasing. Furthermore, it may not be desirable for pharmacy services to be provided on a stand-alone basis because of the positive externalities that are associated with the consumption of pharmacy services.

As well as addressing market failures, the existing ownership arrangements facilitate:

- Nation-wide distribution of pharmacy services to all Australians regardless of where they live, consistent with government health policies and objectives; and
- An effective regulatory system that helps to ensure that pharmacies operate according to professionally acceptable standards.

Market Failure

High levels of pharmacy services are desirable because they help to address market failures associated with the use of medicines. Market failure occurs when unregulated markets do not efficiently allocate resources. NCP recognises that regulation or government intervention may be justified if there is market failure.

There are a number of potential sources of market failure in the pharmacy sector:

- Imperfect information;
- Externalities;

- Moral hazard leading to over-consumption of medicines; and
- Principal-agent problems.

Imperfect Information

Most consumers do not know enough about pharmaceutical products to make a decision that best meets their health requirements. Pharmacists play a crucial role, supplementing the role of doctors, in addressing this source of market failure, by providing pharmacy services which help to ensure that medicines consumers purchase are appropriate for their medical condition.

Externalities

There are externalities (or 'spill-over effects') associated with the production and consumption of medicines. In this report, the focus is on consumption externalities.

Inappropriate consumption of medicines generates negative externalities by imposing health-related costs on the wider community. These may include reduced efficacy of medicines and increased rates of substance addiction.

It follows that well-managed consumption of medicines can generate positive externalities in the form of better health outcomes and associated lower public expenditure on health and pharmaceuticals.

Pharmacy services can promote appropriate usage of medicines and hence net positive externalities by:

- Reducing adverse medicine interactions by checking the range of medicines that patients take;
- Enhancing the effectiveness of medicine therapy and reducing the incidence of medicine overdose by advising patients how to safely comply with their medicine therapy;
- Minimising prescription errors by checking doctors' prescriptions;
- Improving health outcomes by comprehensively assessing whether changes in patients' health conditions warrant a review of their usual medication; and
- Minimising unauthorised drug usage and treating drug addiction.

Furthermore, to the extent that consumers do value pharmacy services there is scope for free-riding particularly in relation to OTC medicines.

Moral hazard leading to over-consumption of pharmaceutical products

Moral hazard is highly relevant to the pharmacy sector because of the impact of health insurance (both private and Medicare) and the Pharmaceuticals Benefits Scheme (PBS) and Repatriation Pharmaceuticals Benefits Scheme (RPBS) on the behaviour of consumers of medicines. Specifically, the provision of health insurance and subsidised medicines create a 'moral hazard' problem insofar as they change consumers' incentives to take preventative actions to avoid having to purchase medicines in the first place, or to economise on purchases of medicines. Moral hazard is thus likely to promote over-consumption of medicines. This may have adverse consequences for society as a whole. In other words, moral hazard may exacerbate the externality problems associated with the mis-use of medicines.

The provision of pharmacy services can facilitate a reduction in the negative consequences of moral hazard by helping to ensure that consumption of medicines is necessary and appropriate for the patient's medical condition. This reduces the need to resort to the use of expensive medicines and can increase the effectiveness of medicines that are consumed.

The need for a prescription in order to obtain most PBS and RPBS items also helps to address the problem created by moral hazard. However, as doctors do not face the full cost of over-consumption of medicines, they may not have sufficient incentives to minimise over-consumption of pharmaceuticals or doctor shopping by patients. The pharmacists' role in providing pharmacy services provides an additional check on the potential for over-consumption as a result of subsidised medicines.

Principal-agent effects

Principal-agent problems may exist in health care markets because consumers do not know what treatment or medication will generate the greatest improvements to their health and must rely on health professionals to advise them. Principal-agents effects can give rise to market failure because the principal's lack of information enables the agent to violate, or in other ways exploit, the implicit or explicit contract that exists between the two parties.

Doctor-patient relationship

The relationship between doctor and patient is that of principal (patient)-agent (doctor). In this relationship, principal-agent problems, if they arise, may either take the form of over-prescription of drugs (and over-servicing in general) or under-prescription of drugs (and general under-servicing).

Adherence to professional ethics and the enforcement of professional standards help to limit the extent of principal-agent (and moral hazard) problems between doctors and patients that may lead to over-consumption of medicines. However, pharmacists serve as

an additional check on the prescribing practices of doctors. In relation to over-prescription, pharmacists may provide some degree of mitigation by helping to ensure that the prescription is reasonable. If the problem is under-prescription and under-servicing, pharmacists may be able to detect inappropriate prescriptions or inadequate access to medicines. Detecting such instances and correcting them can obviously yield significant gains to the community.

Pharmacist-patient relationship

There is also a principal-agent relationship between pharmacists and consumers and the potential for pharmacists to act in their own interests to the detriment of consumers. It is expected that most pharmacists would act ethically in the best interests of their customers. However, regulation to ensure compliance with professional standards is also necessary to sanction those who do not.

The current ownership arrangements help to address such principal-agent problems between pharmacists and their customers by facilitating an effective and relatively low-cost regulatory regime.

Role of Medical Practitioners

Doctors also address market failures and generate net positive externalities associated with appropriate usage of medicines. However, pharmacists supplement that role by filling in the gaps in that relationship and helping to address some of the potential principal-agent problems between doctors and their patients. Furthermore, pharmacy services can be a substitute for more costly medical services in relation to minor ailments and are generally more convenient for consumers to obtain. If the pharmacist is able to assist a patient who would not have initially sought medical attention but may have ultimately required medical or even hospital services if those pharmacy services were not provided, then the provision of the pharmacy service can result in savings to the community as a result of avoided expenditure on health care.

How existing ownership restrictions help to address market failures

Existing ownership restrictions provide greater incentives for pharmacists to provide pharmacy services compared with more deregulated arrangements. Those pharmacy services, in turn, help to address the various sources of market failure associated with the use of medicines.

Non-pharmacist owners have fewer incentives to provide pharmacy services compared with owner-pharmacists because:

- Non-pharmacist owners are more likely to engage in price competition rather than service-based competition. Thus, non-pharmacist owners are likely to offer a lower level of service than owner-pharmacists because:
  - Corporate owners would typically face more commercial pressures to maximise financial profits than owner-pharmacists. Thus corporate owners are less likely to provide services that contribute to society's well-being but do not contribute directly to profits;
  - By contrast, an owner-pharmacist will probably not place as much value on narrow pecuniary benefits as shareholders of public companies. This is because owner-pharmacists are better able to capture the non-pecuniary benefits of operating their pharmacies (e.g. being highly regarded and respected in their local community) than would shareholders in a corporate pharmacy; and
  - Pharmacists are educated in professional ethics and obligations as part of their training and socialisation into the profession. Those social obligations include the provision of services that may not be immediately profitable.
- Externalities associated with consumption of pharmacy services mean that consumers are likely to choose a low price-low service option rather than a high price-high service option. This will add further impetus to focus on price competition to the detriment of service-based competition in a more deregulated ownership environment.

Ownership restrictions encourage the growth of good-will which is built up by developing long-term customer relationships cultivated by the provision of pharmacy services. An owner-pharmacist has a greater incentive to build up this good-will than an employee-pharmacist because the latter would have less of a stake in any goodwill built up by the business.

In a deregulated ownership environment, these factors will tend to reinforce each other in reducing the level of pharmacy services.

Of course, non-pharmacist owned pharmacies would continue to have some incentive to provide pharmacy services if ownership restrictions were removed. However, as there would be less incentive it follows that there would be less service overall.

Even requiring a non-pharmacist owner to employ a pharmacist to run the pharmacy does not create the same incentives to supply pharmacy services as existing arrangements. While there is no *a priori* reason that a pharmacist-employee would not wish to adhere to the same professional standards and ethics as a pharmacist-employer there are also likely to be incentives for a pharmacist-employee to act in the interests of his or her employer. As noted above, the incentives confronting a non-pharmacist owner to provide pharmacy services are likely to be less than that of an owner-pharmacist. These conflicting incentives make it likely that a pharmacist-employee would deliver fewer pharmacy

services when employed by a non-pharmacist owner than when employed by an owner-pharmacist. This assertion appears to be supported by overseas evidence.

Distributional outcomes - Encouraging equitable access for rural and regional Australia

As well as addressing market failures, current ownership arrangements have an important role in achieving government's health policies and associated distributional outcomes.

Current arrangements facilitate a wide network of community pharmacists that provide a relatively uniform level of service nation-wide, consistent with the National Medicines Policy. Relaxation of ownership restrictions may reduce some Australians' access to medicines and pharmacy services, in particular the availability of low volume prescription drugs.

Under existing wholesale arrangements, wholesalers have historically adopted a geographically uniform wholesale pricing policy. This helps to achieve the Australian Government's health objectives and underpins the community pharmacy network. However, it creates a situation whereby wholesalers are achieving varying returns across products and geographical locations.

If corporate owners acquire a sufficient volume of business then it is likely that existing threats to the sustainability of the current wholesale system and community pharmacy network would be exacerbated. Large corporate owners may initially 'cherry-pick' profitable segments and encourage wholesalers to reduce margins or else enter into direct distribution. In turn, this could increase costs for smaller community pharmacies and especially those in rural and remote areas. This would increase pressure on the viability of those pharmacies; indeed, absent direct, and potentially inefficient, public subsidies, some may be forced to close. This could reduce access to pharmacy services and medicines for consumers in those areas, contrary to government's policies. It may also have flow-on economic effects in those regions.

Ensuring accountability without excessive administrative and compliance costs

Finally, current ownership arrangements help to ensure pharmacists comply with their professional obligations without the need for high administrative and compliance costs to be incurred.

The existing ownership restrictions facilitate an efficient regulatory system for a number of reasons:

- By restricting ownership to qualified individual pharmacists, lines of professional accountability to regulators are simplified. This makes it easier to monitor conduct and enforce appropriate penalties for misconduct. Because of the lower cost and risk of sanction, corporate owners may have greater incentives to interfere in the running of a pharmacy to the detriment of the quality use of medicines;
- A non-pharmacist owner arguably would not be as easy to deal with in terms of a regulatory authority's supervision of professional activity within a pharmacy; and
- By restricting ownership of pharmacies to pharmacists, the potential loss from professional misconduct is high. An owner-pharmacist risks losing his or her entire livelihood and professional reputation if he or she is convicted of misconduct and is consequently suspended or deregistered. By contrast, a large corporation may have sufficiently deep pockets to pay a fine and would not risk losing its ability to run a business under existing disciplinary arrangements. Consequently, it might not be as motivated to ensure that its pharmacist-employees were not convicted of misconduct.

In effect, this means existing ownership restrictions can substantially increase the effective magnitude of penalties for breach of professional standards. Therefore, the regulatory system can maintain a substantially high deterrent effect without unrealistically high standards of policing (in effect the pharmacist is self-policing because it is strongly in his or her rational self-interest to do so) or unrealistically high fines. With more diverse ownership arrangements, it is likely that regulatory systems would have to be redesigned. This would entail legislative and administrative resources to implement as well as the likely need to review the effectiveness of the arrangements at a later date.

Costs of current ownership restrictions

As noted, existing ownership arrangements essentially restrict ownership of pharmacies to registered pharmacists. This may impose costs on society. Proponents of deregulation argue that current ownership restrictions can deter pharmacies from achieving cost-minimising scale and permit pharmacists to earn sustainable excessive profits.

Loss of economies of scale and scope

The economies of scale argument is based on now outdated work by the Bureau of Industry Economics (BIE) nearly 20 years ago.

Since then there have been a number of changes to the community pharmacy sector that have impacted on the scale and efficiency of its participants. These changes alone cast doubts on the applicability of the BIE's research to today's community pharmacy sector.

In addition, the data underlying the BIE's work no longer exists. Thus it is impossible to test the accuracy of its findings.

Furthermore, most of the economies of scale in pharmacy are pecuniary, rather than technological. Community pharmacies are already able to take advantage of pecuniary economies of scale by joining banner groups and other group buying ventures entered into with one of the full-line wholesalers. Hence it seems unlikely that substantial efficiencies would be realised if ownership restrictions were removed.

Furthermore, economies of scale in dispensing seem to be exhausted at annual prescription volumes of around 25,000. Around 70 per cent of community pharmacies are already operating at this volume or greater, implying that economies of scale are typically being exhausted under current industry structures.

Economic rents

The argument that pharmacy returns would be significantly lower if more diverse ownership arrangements (particularly large corporate ownership) were permitted is also debatable:

- It is inappropriate, to compare margins earned by general retailers with margins earned by professional pharmacists who have made substantial investments in human capital and ongoing professional development; and
- A large part of pharmacists' income is derived from prescribing price-regulated medicines. Per-unit remuneration, and implicitly margins, for prescribing is set by the Australian Government under agreements negotiated between it and the PGA. There would seem to be little scope for competition to *lower* the margin built into dispensing fees. Rather, competition would primarily occur for the *share* of the total dispensing remuneration.

Are there equally effective and viable alternatives to existing arrangements?

Current ownership arrangements are an effective way to promote high levels of pharmacy services. More diverse ownership arrangements are likely to reduce incentives to provide pharmacy services; therefore, it is possible that under alternative arrangements the level of such services would not be sufficient to address market failures and to deliver outcomes consistent with government health policies. Consequently, some kind of subsidy would have to be provided to either consumers or pharmacists to induce appropriate supply and consumption of such services. However, even with a subsidy paid to consumers there would tend to be under-consumption of pharmacy services because of the positive externality associated with pharmacy services.

Providing a subsidy to pharmacies would also be problematic because there is an element of free-riding associated with pharmacy services; in a more price-focused competitive environment, this free-riding provides an incentive to reduce pharmacy services. Thus, there would not only be a direct monetary cost associated with the provision of subsidies to pharmacists, but also costs associated with monitoring such subsidies to ensure that they are used to achieve the desired outcomes.

Further, as noted above, deregulating ownership arrangements would be likely to impact particularly on rural and regional areas. Changing ownership arrangements may exacerbate the existing difficulties in attracting pharmacy services to those areas by making it more difficult for pharmacies to remain viable in those areas. This may increase the need for government programmes and expenditure to ensure desired health outcomes are achieved.

In addition, deregulating ownership arrangements would likely necessitate the redesign of the pharmacy regulatory regimes. As well as the one-off legislative costs associated with regulatory change it seems likely that ongoing regulatory costs would be higher under alternative ownership arrangements than under current ownership rules. These additional costs might be incurred because the costs of detecting, deterring and enforcing regulatory rules could be higher under alternative ownership arrangements than under owner-pharmacist arrangements. The task would be made even more difficult because there would be more parties to regulate and less clear lines of accountability, as well as possibly greater litigation costs.

Thus it seems unlikely that there are viable alternatives to existing ownership arrangements that would deliver the same benefits to society without the need for increased government spending to induce higher levels of pharmacy services, achieve desired distributional outcomes and provide an effective regulatory regime.

1 Introduction

Community pharmacy is the network of approximately 5,000 shopfront pharmacies that are the main vehicle for providing prescription and scheduled OTC medicines to consumers. In addition, community pharmacy supplies other medicines, such as aspirin and paracetamol, in competition with general retailers.

Community pharmacy occupies a unique position in the health services sector in that it combines a retail function with the delivery of health care services. In particular, it is a key participant in the quality use of medicines that underpins the Australian Government's National Medicines Policy[1] by providing extensive before and after sales service to accompany the sale of medicines. These services, hereafter referred to as 'pharmacy services', include the provision of counselling, advice (including advising consumers against acquiring drugs), monitoring the use of medicines and medication reviews. Pharmacy services are essential to ensure that the medicines consumers purchase are not only appropriate for their medical condition but safe for them to use. In addition, community pharmacists provide services as part of public health campaigns including baby and maternal health services, screening and care-management programmes, methadone or buprenorphine dosing, needle exchange and participation in 'quit smoking' programmes.

These services are often provided at no direct charge to consumers. For example, it has been estimated that 38.3 per cent of Australian community pharmacists do not charge for

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[1] The National Medicines Policy is an Australian Government policy that aims to improve health outcomes for all Australians through their access to and use of medicines. It is based on four key objectives:

- timely access to medicines that Australians need, at a cost individuals and the community can afford;
- medicines meeting appropriate standards of quality, safety and efficacy;
- the quality use of medicines; and
- maintenance of a responsible and viable medical industry.

The Pharmaceutical Health and Rational Use of Medicines (PHARM) Committee – which provides expert advice to the Minister and Department of Health and Ageing on the quality use of medicines – recognises that to achieve quality use of medicines, consumers must be provided with the most appropriate treatment and have the knowledge and skills to use medicines to their best effect. Quality use of medicines is implemented through a partnership approach that recognises that doctors, pharmacists, nurses and consumers each have an important role in ensuring that medicines are used appropriately.

This footnote is based on information taken from www.nnp.health.gov.au, accessed June 2004.

the provision of asthma services, 38.1 per cent do not charge for provision of diabetes-related services and 36.2 per cent do not charge for hypertension-related services. [2]

It has also been estimated that in addition to the information that must be provided with the sale of certain medicines, approximately 78.2 million consultations occurred annually in community pharmacies.[3] Monitoring compliance with medicine usage instructions was also estimated to have occurred approximately 14.4 million times per year.[4] Around 45 per cent of pharmacies used clinical testing devices to perform this monitoring.[5] In some instances, monitoring resulted in the pharmacist declining a prescription.[6]

The Quality Care Pharmacy Program (QCPP) demonstrates the commitment of owner-pharmacists to improving service standards. The QCPP has been developed by the PGA in conjunction with other stakeholders. It seeks to raise standards of customer service in individual pharmacies across Australia and provides an industry-wide guarantee of retail service quality and professional practice. In recognition of the value of pharmacy services, and the role of the QCCP in developing those services, the Australian Government has made available $50m to encourage pharmacies to gain accreditation under the program.

There have been numerous attempts in the clinical literature to quantify the economic value of pharmacy services.[7] While many of the studies reviewed have been inconclusive, others have quantified clear economic benefits from provision of pharmacists' services in a range of areas. For instance:

- One study of 56 patients over a 6 month period found that the cost of drugs fell in the intervention group that received a pharmacotherapy consultation and increased in the control group that did not.[8] Similarly, an Australian study of 362 patients that compared various models of provision of domiciliary-based medication review found that average medication costs were significantly greater in the model that only included

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2 Berbatis C. G., V. B. Sunderland, C. R. Mills and M. Bulsara, *National Pharmacy Database Project,* School of Pharmacy, Curtin University of Technology of Western Australia, June 2003, p.35.

3 ibid, p. 6.

4 ibid, p. 6.

5 ibid, p. 43.

6 It was estimated that pharmacists declined to dispense around 1.08 million prescriptions per year due to dosage interaction, adverse effects or other problems.

7 Some of this literature is summarised in Roughhead, L., S. Semple and A. Vitry 2003, The value of pharmacist professional services in the community setting - A systemic review of the literature 1990-2002, available at http://www.guild.org.au/public/researchdocs/reportvalueservices.pdf (accessed June 2004).

8 Jameson, J., G. VanNoord and K. Vanderwound 1995, 'The impact of pharmacotherapy consultation on the cost and outcome of medical therapy', *Journal of Family Practice*, vol. 41, no. 5, pp. 469-472.

medication review compared with the model that included clinical audit by a pharmacist as well as medication review;[9]

- Randomised controlled trials in 99 patients in rural and remote areas of Australia found that the total increase in PBS and Medicare costs for the intervention group was lower than that for the control group, leading to annual net cost savings of $87.21 per patient;[10]
- A randomised controlled trial which assessed the effectiveness of a pharmacist reviewing repeat prescriptions in the UK found that though monthly drug costs rose in both groups, the rise was lower in the intervention group.[11] This finding was replicated by another UK study of the value of pharmacist review. It was found that 66 per cent of patients in the intervention group did not need the full quota of prescribed drugs. This represented a saving of 18 per cent of the total prescribed cost;[12]
- A randomised controlled trial conducted in the UK assessed the impact of pharmacist medication review in nursing homes on use of health care resources over two 4-month periods, one before and the other after intervention. Medication reviews were associated with a significant reduction in total costs.[13] Similarly a randomised trial that assessed a clinical pharmacy intervention in 52 nursing homes in Australia found a 14.8 per cent reduction in drug use in the intervention group relative to the control group. This was associated with a fall in PBS drug costs of $64 per resident over one year;[14]

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[9] Bennett, A., C. Smith, T. Chen, S. Johnsen and R. Hurst 2000, 'A comparative study of two collaborative models for the provision of domiciliary based medication reviews', Final report, University of Sydney and St George Division of General Practice.

[10] Nissen, L., and S. Tett, 2001, 'Pharmacists assisting general practitioners and the health care team in the integration of care for complex needs patients in rural and remote areas', Final report, University of Queensland.

[11] Zermansky, A. G., D. R. Petty, D. K. Raynor, N. Freemantle, A. Vail and C. J. Lowe 2001, 'Randomised controlled trial of clinical medication review by a pharmacist of elderly patients receiving repeat prescriptions in general practice', *British Medical Journal,* vol. 323, pp. 1340-1343.

[12] Bond, C., C. Matheson, S. Williams, P. Williams and P. Donnan 2000, 'Repeat prescribing: a role for community pharmacists in controlling and monitoring repeat prescriptions', *British Journal of General Practice*, vol. 50, pp. 271-275.

[13] Furniss L., A. Burns, S. K. L. Craig, S. Scobie, J. Cooke and B. Farragher 2000, 'Effects of a pharmacist's medication review in nursing homes. Randomised controlled trial', *British Journal of Psychiatry*, vol. 176, pp. 563-567; Burns A., L. Furniss, J. Cooke, S. Lloyd Craig and S. Scobie 2000, 'Pharmacist medication review in nursing homes: A cost analysis', *International Journal of Geriatric Psychopharmacology*, vol. 2, pp. 137-141.

[14] Bonner C. and M. S. Roberts 1995, *Project to optimise the quality of drug use in the elderly in long term care facilities in Australia* - final report to the Commonwealth, Departments of Medicine, Pharmacy and Social and Preventative Medicine, University of Queensland; Roberts M. S., J. A. Stokes, M. A. King, C. J. Bonner, T. A. Lynne, D. M. Purdie, P. P. Glasziou, D. A.

- A randomised controlled trial assessed the impact of medication review performed by a clinical pharmacist in a general medicine clinic. It found that the net result of a single medication review was a fall of 0.69 prescriptions per patient representing a monthly medication cost saving of $3.91;[15] and
- A randomised controlled trial assessed the impact of academic detailing on cost of antibiotic prescriptions in WA. It found that the increase in prescriptions was smaller in the intervention group ($16,130 for 3 months savings). These lower prescribing rates accounted for 82 per cent of overall savings.[16]

This report is organised as follows:

- Section 2 reviews current ownership arrangements, the outcome of the NCP review of those arrangements and legislative responses to that review and other developments;
- Section 3 discusses the economics of the pharmacy sector and the various sources of market failure associated with the use of medicines;
- Section 4 considers how existing ownership arrangements help to address those market failures;
- Section 5 discusses the distributional benefits of the existing ownership arrangements;
- Section 6 discusses how the existing arrangements facilitate an effective regulatory regime;
- Section 7 considers the costs of the current ownership arrangements;
- Section 8 discusses whether there are viable alternatives to the current arrangements; and
- Section 9 concludes.

2 Overview of current ownership restrictions

Under State legislation[17], ownership and effective control of pharmacies is confined to registered pharmacists, with certain very limited exceptions.

J. Wilson, S. T. McCarthy, G. E. Brooks, F. J. de Looze and C. B. Del Mar 2001, 'Outcomes of a randomised controlled trial of a clinical pharmacy intervention in 52 nursing homes', *British Journal of Clinical Pharmacology*, vol. 51, pp. 259-268.

[15] Britton, M. and P. Lurvey 1991, 'Impact of medication profile review on prescribing in a general medicine clinic', *American Journal of Hospital Pharmacy*, vol. 48, pp. 265-270.

[16] Ilett K. F., S. Johnson, G. Greenhill, L. Mullen, J. Brockis, C. L. Golledge and D. B. Reid 2000, 'Modification of general practitioner prescribing of antibiotics by use of a therapeutics adviser', *British Journal of Clinical Pharmacology*, vol. 49, pp. 168-173.

[17] The relevant legislation is as follows: *Pharmacy Act 1931* (Australian Capital Territory); *Pharmacy Act 1964* (New South Wales); *Pharmacy Act 1936* (Northern Territory); *Pharmacists*

Existing ownership restrictions take the following forms:

- Restrictions on who can own pharmacies;
- Restrictions on the numbers of pharmacies in which a registered pharmacist may have a proprietary interest;
- Restrictions on the ownership structures of pharmacy businesses; and
- Pecuniary interest measures to prevent persons and corporations other than registered pharmacists having an indirect interest in a pharmacy business.

The Pharmacy Acts require that a pharmacy must be supervised and managed by a registered pharmacist. By implication rather than formal definition, Pharmacy Acts characterise 'ownership' as, at minimum, the holding by a pharmacist or pharmacists of the effective and undisputed control of the decision-making of a pharmacy business. Other than transitional arrangements for bankrupt businesses and deceased estates, the only statutory exceptions to this general rule are for pharmacies owned and operated by friendly societies, known as FSDs, and for those pre-existing pharmacies that were owned by non-pharmacist corporations or individuals before present ownership restrictions came into force.

In some jurisdictions, new FSDs are also prohibited, or are made subject to special ministerial approval processes before they can be established. Table 1 summarises the current position with respect to FSDs.[18]

Registration Act 2001 (Queensland); *Pharmacists Act 1991* (South Australia); *Pharmacists Registration Act 2001* (Tasmania); *Pharmacists Act 1974* (Victoria); and *Pharmacy Act 1964* (Western Australia). This legislation is referred to hereafter as 'Pharmacy Acts'.

[18] Section 2.5.3 examines changes that are likely to occur with respect to FSD ownership in the near future.

Table 1: Summary of ownership restrictions applicable to Friendly Society Dispensaries

State	Restrictions
Australian Capital Territory (ACT)	▪ FSDs are prohibited from owning pharmacies. ▪ However, the *Pharmacy Amendment Bill 2004 (No.2),* which is currently before the Territory parliament, would allow FSDs to register a pharmacy that operated under the supervision of a registered individual pharmacist.
New South Wales (NSW)	▪ FSDs that owned a pharmacy prior to the relevant legislation being enacted can only move their pharmacies within one mile of the original place of business. ▪ Each new FSD requires approval by the NSW Minister for Health and is limited to owning six pharmacies.
Northern Territory (NT)	▪ FSDs are typically prohibited from owning a pharmacy, with some exceptions, for example those relating to Aboriginal health services. ▪ Additionally, the Minister is able to grant an exception to the above rule, if he or she is satisfied that health services will be improved by granting the exemption.[19]
Queensland (Qld)	▪ FSDs that existed when the legislative restrictions came into place may continue to exist. ▪ An FSD can only purchase a pharmacy that is owned by another FSD.
South Australia (SA)	• Only two existing FSDs can operate in this jurisdiction, with no new FSD players allowed into the market. • While one FSD is able to own 31 pharmacy outlets, it is limited to this amount.
Tasmania (Tas)	▪ FSDs are restricted to owning a maximum of two pharmacies.
Victoria (Vic)	▪ Only FSDs that were registered under the Victorian Friendly Society Code on 1 July 1999 can own pharmacies. There is no restriction on the number of outlets that an existing FSD can own.
Western Australia (WA)	▪ Only one FSD is allowed to operate in this state and no interstate FSDs are allowed the right of cross border ownership. ▪ The single FSD that currently operates in WA is only allowed to do so provided it remains in the same location in which it operated when the legislation came into force.

Finally, Pharmacy Acts require owner-pharmacists to be registered in the State in which they own a pharmacy. The Western Australian legislation also requires that the proprietor be a resident of that State.

[19] The provisions outlined here have been passed but not yet commenced.

2.1 Restrictions on ownership structures

Jurisdictions also impose limitations on the permissible persons and bodies corporate that can control a pharmacy business.

These combinations are:

- Sole trading pharmacists;
- Partnerships of two or more pharmacists;
- Limited partnerships between a practising pharmacist or pharmacists and external sources of capital, provided that those persons are also pharmacists;
- Bodies corporate, in which all the shareholders and directors are pharmacists; and
- Bodies corporate, in which pharmacists hold the majority of shares, with the balance held as non-voting shares by specified relatives of the pharmacist.

2.2 Restrictions on the numbers of pharmacies in which a registered pharmacist may have a proprietary interest

Each State except for the NT and ACT has restrictions on the number of pharmacies that can be owned by an individual owner-pharmacist.

By State, the current numerical restrictions on pharmacies in which pharmacists may have a proprietary interest are[20]:

- Two: WA and Tas;
- Three: Vic;
- Four: Qld and SA; and
- Five: NSW.

2.3 Pecuniary interest measures

Except for SA and the NT, all Pharmacy Acts provide in some form that no-one apart from a registered pharmacist may have a direct or indirect pecuniary interest in a pharmacy. The Victorian *Pharmacists Act 1974* extends this to include a proprietary interest.

Regulatory authorities and the profession generally construe these provisions to mean that no-one other than a pharmacist (and in some cases their immediate family members) can hold a share in a pharmacy business, or profit from the transactions of that business.

[20] Section 2.5.3 examines changes that are likely to occur with respect to numerical restrictions on pharmacy ownership in the near future.

Several Acts also provide that particular matters such as leases and rents, bills of sale, mortgages or securities on a pharmacy business must not carry specific conditions implying the control of, or interference with, a pharmacy's business decision making by a person other than a pharmacist.

2.4 Terminology used in this report

Throughout this report, the term 'ownership restrictions' is used to refer to the various categories of ownership restrictions that are identified above. In addition, the implications of allowing more 'corporate' ownership of pharmacies are discussed below. Unless otherwise indicated, the term 'corporate ownership' refers to ownership of pharmacies by shareholders or other owners who are neither registered pharmacists nor their family members.

2.5 Legislative review of ownership restrictions

The NCP Review of Pharmacy, (the Wilkinson Review)[21] was commissioned by CoAG to examine Acts and regulations relating to pharmacy, and to determine:

- whether these impose restrictions on competition;
- the net public benefits of the restrictions, and
- whether the objectives of the legislation can be achieved only by restricting competition.

Its Terms of Reference required, amongst other things, the examination of restrictions imposed by legislation on three specific areas of pharmacy practice, namely:

- ownership of pharmacies;
- location of pharmacies to dispense benefits under the PBS; and
- the registration of pharmacists.[22]

The Wilkinson Review reported in February 2000. It recommended that a range of existing restrictions on ownership largely be retained as these restrictions were considered to provide a net public benefit to the community through improved professional quality and network performance.

The Wilkinson Review did, however, make the following recommendations in connection with the regulation of ownership:

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[21] *National Competition Policy Review of Pharmacy*: Final Report, February 2000, (Wilkinson Review) available at http://www.health.gov.au/haf/pharmrev/final.htm (accessed June 2004)

[22] ibid, pp. 4-5.

- that restrictions be removed on the number of pharmacies a pharmacist may own or have an interest in;
- that permissible ownership structures be expanded to include sole traders, pharmacist partnerships and corporations comprised of pharmacist shareholders;
- that due to risks of possible conflicts of interest and the difficulties in determining the extent to which minority shareholders may compromise control of pharmacy operations, corporations with non-pharmacist minority shareholding (and by implication, majority shareholdings) should not be permitted;
- that existing exemptions to current restrictions, permitting pre-existing FSDs and corporations to operate pharmacies, should remain in place. However, FSDs should be prevented from entering new jurisdictions in which they were not already present; and
- that restrictions on direct pecuniary interests by non-pharmacists in pharmacies remain in place. However, restrictions on indirect interests (such as other lawfully permitted commercial relationships) be eased.

2.5.1 Council of Australian Governments' response

CoAG endorsed the Wilkinson Review's recommendations relating to removing restrictions on the number of pharmacies that a pharmacist may own. However, it rejected the Wilkinson Review's recommendation to prevent FSDs operating pharmacies in jurisdictions in which they were not already present. CoAG noted that further deregulation of ownership in the short term could be significantly disruptive to the industry.

2.5.2 National Competition Council assessment

In December 2003, the National Competition Council (NCC) released its annual assessment of governments' progress in implementing NCP reforms.[23] In relation to pharmacies, the NCC reviewed governments' progress against the CoAG recommendations described above.

The NCC considered that as at August 2003, no State had met its obligations under the Competition Principles Agreement (CPA)[24] in relation to pharmacy. It noted, however,

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[23] National Competition Council, 2003, *Assessment of governments' progress in implementing the National Competition Policy and related reforms: 2003*.

[24] The CPA is one of various intergovernmental agreements underpinning the NCP. The CPA sets out the various government's obligations in relation to prices oversight of government owned enterprises, competitive neutrality, structural reform of public monopolies and legislative review and reform.

that a number of jurisdictions had indicated that relevant legislation was either in the process of being drafted or before the relevant State Parliament.

States that do not meet their NCP obligations risk having their competition payments with-held.[25]

2.5.3 Recent changes to legislation

No State has passed legislation to bring about the CoAG reforms.

Earlier this year, NSW introduced draft legislation to Parliament which, amongst other things, sought to lift all licence caps. After receiving an assurance from the Australian Government[26] that NSW would receive payments to neutralise any possible NCC fines for failure to comply with its CPA obligations, NSW withdrew that legislation and instead passed legislation that increased ownership limits for:

- individual pharmacists: from three to five outlets; and
- FSDs: up to six pharmacies.

The Victorian Parliament is currently considering the *Pharmacy Practice Bill 2004* that repeals existing legislation and introduces similar reforms as New South Wales. At this stage, however, it is not clear how the NSW legislation will be adapted to apply to the Victorian market, where FSDs are not restricted in the number of pharmacies they may own. [27]

The ACT presented the *Pharmacy Amendment Bill 2004 (No 2)* on 14 May 2004. The Bill proposes reforms that would allow for the entry of FSDs to the market, as is required to meet the ACT's CPA obligations. A separate Act, the *Pharmacy Amendment Act 2004*,

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[25] The Commonwealth Government makes NCP payments to States if they achieve satisfactory progress against NCP reform obligations. The NCC advises the Federal Treasurer on whether satisfactory progress has been made. This information is reported in the NCC's NCP assessments.

[26] Prime Minister John Howard 2004, Pharmacy and Competition Policy, http://www.pm.gov.au/news/media_releases/media_Release848.html.

[27] As currently proposed the *Pharmacy Practice Bill 2004*, does not restrict FSD ownership, but caps individual and pharmacist-run company ownership at five. It is unknown at this stage if the Victorian legislation will limit the number of pharmacies FSDs will be permitted to operate. To limit existing FSD ownership to six outlets, as per the NSW legislation, could prove difficult in a state where certain FSDs currently own in excess of this number. It is unclear if the legislation will require divesture of excess pharmacies, or allow for grandfathering exceptions. . See also: L. Wood, 'Skirmish over chemist reforms', *The Age*, 12 June 2004, p. 3.

was passed on 23 June 2004.[28] The purpose of the latter Act is to ensure that pharmacists operate out of their own premises and not as sub-lessees of supermarkets.

The NT has enacted the *Health Practitioners Act 2004*. This contains limited reforms to pharmacy ownership. The relevant sections of this Act had not commenced as at 30 June 2004.[29]

There is an expectation that the other States shall likewise change current numerical ownership restrictions on pharmacies.[30] Thus the regulatory landscape in regard to pharmacies is still under review and remains fluid.

2.6 Changes to the competitive environment since the Wilkinson Review

Since the Wilkinson Review, there have been a number of changes to the industry which may alter the implications of its recommendations and the basis on which those recommendations were formed. First, FSDs have continued to expand in States where they are permitted to do so. In Victoria alone there are now at least four FSDs which own between five and 25 outlets.[31] The largest of these, Friendly Society Medical Association Limited (trading as 'National Pharmacies'), was initially a South Australian based FSD. However, it now operates pharmacies in SA, NSW and Victoria and is continually expanding.[32]

Second, recent developments in Victoria have highlighted how the FSD structure might be exploited to circumvent ownership restrictions. The PGA has informed NECG of an example of a friendly society being used as a shell by a group of pharmacists who then demutualised it to create a private company, undermining the spirit, if not the letter, of the relevant legislation. That company now controls 44 store pharmacies trading under a common moniker in apparent contradiction of ownership restrictions.

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[28] This bill was notified on 7 July 2004. On commencement of its amending provisions, it was automatically repealed by s.89 of the Legislation Act 2001.

[29] The *Health Practitioners Act 2004* allows for unlimited ownership numbers and a variety of ownership structures. Friendly societies are only permitted to own pharmacies upon the granting of an exemption from the restrictions by the Minister.

[30] PGA has advised NECG that Tas and WA are likely to enact changes to legislation allowing ownership of four pharmacies for individuals, and four for FSDs. Qld and SA are likely to follow the numerical changes made in NSW. It is likely that legislation to this effect will be presented to each State parliament before the end of the year.

[31] Information provided to NECG by PGA.

[32] Information provided to NECG by PGA.

Third, in recent months major national supermarket chains and other large retailers have signaled that they are considering entering the pharmacy market by establishing pharmacies within their stores.[33]

These trends, together with threats from the NCC to withhold payments to States who do not enact CoAG reforms, indicate that the current ownership structure of pharmacies is under considerable threat. The likely detrimental effects of these developments on social welfare are discussed below.

3 The economics of the pharmacy sector

The existing ownership arrangements are said to restrict competition by limiting the ownership of pharmacies to registered pharmacists. Restrictions on competition usually result in lower levels of output, lower quality of service and/or higher prices. Community pharmacists' main role is the dispensing of PBS-listed medicines. This role is essentially demand driven. In turn, the demand for PBS-listed medicines is derived from the general health of the public and the prescribing practices of medical practitioners. To NECG's knowledge, the sector currently meets the demand for dispensing.[34] Hence it seems unlikely that existing ownership arrangements constrain 'output' of PBS-medicines.

Furthermore, only a small portion of pharmacy sales would be potentially subject to greater price competition as a result of more diverse ownership arrangements. Approximately 63 per cent of the $9.3 billion retail pharmacy industry is accounted for by pharmaceuticals provided under either the Pharmaceutical Benefits Scheme (PBS)[35] or the Repatriation Pharmaceuticals Benefits Scheme (RPBS)[36] and is subject to substantial price regulation. 'Front of shop' products, such as cosmetics and hair treatments, represent a further 17 per cent and are already subject to effective competition from general retailers. Thus, only 19 per cent of sales, comprising Schedule 2 and Schedule 3 OTC products[37] as

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[33] 'Woolworth's pharmacy bid blocked in ACT', *The Canberra Times*, 24 October 2003.

[34] The exceptions would be when pharmacists consider prescriptions to be fraudulent, incorrect or otherwise not in the best interests of the patient.

[35] Discussed in more detail in Appendix 1.

[36] The RPBS is administered by the Department of Veterans Affairs. It covers all of the drugs included in the PBS as well as a range of pharmaceutical items specifically to cater for veterans' needs. Repatriation Health and Pharmaceuticals cards are issued to eligible veterans and their dependants. Card-holders are entitled to free pharmaceuticals under the RPBS.

[37] Schedule 2 medicines can only be sold in pharmacies. Schedule 3 medicines can only be sold in pharmacies and their sale must be accompanied by advice from a pharmacist.

well as private prescriptions for medicines not covered by the PBS, are potentially subject to greater competition than is presently the case.[38]

Finally, in relation to levels of service, it is this report's contention that the existing ownership arrangements facilitate *higher* levels of service than would prevail if ownership arrangements were deregulated. Indeed, it is this outcome that provides one of the key justifications for maintenance of the existing ownership arrangements. High levels of service are desirable in the pharmacy sector as those services help to address market failures associated with the use of medicines (see discussion below).

Market failure is a key reason for regulation of markets. It occurs when unregulated markets do not efficiently allocate resources. NCP recognises that regulation or government intervention may be justified if there is market failure.

In the pharmacy sector there are a number of features that imply that removal of existing ownership restrictions will not necessarily improve social welfare. This is because the restrictions help to correct market failure associated with the use of medicines. In the absence of regulation, market failure may arise in the pharmacy sector as a result of:

- Imperfect information;
- Externalities;
- Moral hazard leading to over-consumption of pharmaceutical products; and
- Principal-agent problems.

These factors interact with and reinforce the effects of each other. However, for ease of exposition each is considered separately below.

3.1 Imperfect Information

Most consumers of pharmaceutical products do not know enough about those products to make a decision that best meets their health requirements. Pharmacists play a crucial role, supplementing the role of prescribing doctors, in addressing the market failure caused by imperfect information by providing pre-sales service which helps to ensure that the medicines consumers purchase are appropriate for their medical condition. Pharmacists also provide post-sales services by responding to further queries and in some cases

[38] Figures provided by the PGA and correct as at 30 June 2003. Data may contain small rounding errors. This limited scope for price competition in the pharmacy sector is examined in more detail in Appendix 1 of this report

monitoring and managing the long-term drug consumption of their customers.[39] Without this service, the goal of quality use of medicine would be undermined.

Some of the information problems can be alleviated by information supplied with medicines by manufacturers, made available on websites or provided by public health campaigns. However, these measures cannot fully solve the problems because consumers lack sufficient expertise to locate and evaluate the information.

The potential for market failure arising from imperfect information is one of the main reasons that community pharmacists are not only retailers of pharmaceutical products but also neutral intermediaries between manufacturers and buyers, guiding the purchases of relatively less informed consumers. It is in acknowledgement of this latter role that pharmacists are licensed and subject to training requirements.

Of course, medical practitioners also have an important role in addressing information problems associated with consumption of medicines.[40] However, many medicines can be purchased without a doctor's prescription and, therefore, without the consumer having first consulted a medical practitioner. The requirement that pharmacists' counseling must accompany the sale of many of these OTC medicines is an important way to address information problems associated with the broad range of non-prescription medicines.

3.2 Externalities associated with medicine usage

The nature of medicines means that there are externalities associated with both their production and consumption.

Externalities are spill-over effects on third parties arising from production or consumption for which appropriate compensation is not paid. Externalities create a divergence between the private costs and benefits of consumption or production and the associated social costs or benefits. Externalities may be positive, whereby the social benefits exceed the private benefits; i.e. there are positive spill-over effects. Alternatively, externalities may be negative if the social costs of production or consumption exceed the associated private costs; i.e. there are negative spill-over effects. The presence of externalities can result in

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[39] For instance, Rupp, M., M. De Young and S. Schindelmeyer 1992, 'Prescribing problems and pharmacist intervention in community practice', *Medical Care, vol.* 30, no. 10, pp. 926-40 studied pharmacist interventions by 89 community pharmacists in 5 states in the US. They found that in 20.6 per cent of cases where pharmacists intervened (due to incomplete prescription, inappropriate dosage, drug interactions and other reasons), lack of intervention could have resulted in adverse consequences to the patient.

[40] In addition, pharmacists also have a role in addressing any principal-agent issues that may exist between doctor and patient.

inefficiently high or low production and/or consumption of the relevant product and thus market failure. The following discussion primarily focuses on consumption externalities.

Inappropriate consumption of medicines can generate negative externalities. For example, health-related costs may be imposed on the wider community as a result of:

- Reduced efficacy of medicines, particularly antibiotics, in the longer term and hence increased duration and spread of infectious disease. This raises the general risk of the public suffering health problems and incurring costs associated with losses in productivity; and
- Increased rates of substance addiction arising from excessive and unauthorised usage of potentially dangerous prescription drugs, such as morphine, pethidine, Panadeine Forte and benzodiazepines.

Just as inappropriate usage of medicines can lead to negative externalities, it follows that well-managed consumption of medicines can lead to positive externalities; that is, there are benefits to the general public from appropriately administered consumption of medicines, both in terms of better health outcomes and reduced expenditures on health and pharmaceuticals.

Pharmacy services can promote appropriate usage of medicines and hence create positive externalities by:

- Reducing adverse medicine interactions by checking the range of medicines that patients take;
- Enhancing the effectiveness of medicine therapy and reducing the incidence of medicine overdose by advising patients how to safely comply with their medicine therapy;
- Minimising prescription errors by checking doctors' prescriptions;
- Improving health outcomes by comprehensively assessing whether changes in patients' health conditions warrant a review of their usual medication; [41] and
- Minimising unauthorised drug usage[42] and treating drug addiction. [43]

Pharmacy services are valued by consumers[44] but are not easily sold on a stand-alone basis because there is some potential for 'free-riding' on the supply of those services,

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[41] For example, just over 50 per cent of community pharmacies are approved for domiciliary medication management reviews. Furthermore, it has been estimated that at least 4,600 patients receive a medication review by community pharmacists each month. Berbatis et al, op.cit, p.6.

[42] Community pharmacies play an important role in detecting forged prescriptions and 'doctor shopping'. It has been estimated that suspected misuse of s2 and s3 medicines leads to supply being refused around 0.6 million times annually. Berbatis et al, op. cit, p. 6.

[43] ibid, p. 7.

particularly in relation to OTC medicines which are subject to repeat purchasing. For example, it is not easy to prevent a consumer from obtaining advice about appropriate cough medicines from one pharmacist and then purchasing the medicine from another pharmacist.[45] Consumer research supports this contention; while 74 per cent of consumers surveyed were concerned about products like Nurofen or Panadeine being taken without appropriate advice, consumers conceded that once information was obtained repeat purchases would often be made at the most convenient outlet.[46] Furthermore, it may not be desirable for pharmacy services to be provided on a stand-alone basis because of the positive externalities that are associated with the consumption of pharmacy services; that is, the private benefits from consuming pharmacy services tend to be less than the associated public benefits arising from reduced public expenditure on health and medicines, as well as the benefits of better public health outcomes in general. If pharmacy services were sold on a stand-alone basis there would tend to be less consumption than is socially desirable.

Inappropriate usage of medicines arising from under-consumption of pharmacy services would place added burden on taxpayers who would be required to fund associated higher health costs. For instance, it has been estimated that 2.4 to 3.6 per cent of Australian hospital admissions are pharmaceutical related. In contrast, in the US, the misuse of pharmaceuticals has been estimated to cause 11 to 28 per cent of all hospital admissions.[47] A recent study by KPMG concluded that Australia's lower comparable admission rate, and the quantifiable savings per foregone hospital admission and other cost offsets (such as workplace absenteeism and sick leave costs) could be attributed directly to differences between the pharmacist-owned Australian system and the largely chain dominated US

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[44] NECG has been provided with a copy of a report entitled *Pharmacy Report-Industry Overview, Australian and International Markets 2003* prepared by Coles Myer Research. In that report, reference is made to consumer research conducted by Roy Morgan Research. The research findings are based on data collected via Roy Morgan's self-completion questionnaires with an annual sample of around 25,000 nationwide. The report contains a chart entitled 'Important factors when visiting a pharmacy (By Age)'. The chart indicates that 'good service/helpful staff' is important to around 70 per cent of the surveyed population. This is the highest overall percentage for any of the factors listed in the chart. There is some variation according to age with around 62 per cent of 14-24 year olds and 72 per cent of 35-49 year olds considering 'good service/helpful staff' to be important. Other age categories fall within the 62 to 72 per cent range.

[45] This argument generally does not hold as strongly for prescription medicines because in many instances the pharmacy services are provided at the time the medicine is dispensed.

[46] Crosby|Textor Research Strategy Results, *Qualitative & Quantitative Research: Consumer Motivations & Buying Patterns*, prepared for Pharmacy Guild of Australia, 16 February 2004, p.21.

[47] Roughhead E, A. Gilbert, J. Primrose and L. Sansom, 'Drug-Related Hospital Admissions: A Review of Australian Studies Published 1988-1996', *Medical Journal of Australia*, Vol 168, 20 April 1998.

pharmacy industry. KPMG concluded that these annual quantifiable benefits were in the range of $640-1,365 million. In comparison, the quantifiable costs of the Australian ownership restrictions in terms of foregone efficiencies and foregone price reductions were estimated to be around $93 million.[48]

In addition, if medicines are used inappropriately, there is likely to be greater demand for medicines in general, including PBS-subsidised medicines, because general health outcomes would be poorer than if medicines were used appropriately. Thus, government outlays on PBS medicines would rise. This would have flow-on effects for the revenue requirements of the Australian Government's budget and increase the burden of taxation generally in the economy.

Doctors also have a role in addressing market failures and generating net positive externalities associated with appropriate usage of medicines. However, as discussed elsewhere, pharmacists supplement that role by filling in the gaps in that relationship and helping to address some of the potential principal-agent problems between doctors and their patients.[49]

Furthermore, pharmacy services can be a substitute for more costly medical services in relation to minor ailments and are generally more convenient for consumers to obtain. For example, pharmacists can provide on-the-spot advice for such ailments, thus helping to reduce demand for, and cost to the community of, medical services, while referring more complex medical problems to medical practitioners.[50] In some instances patients may consider a pharmacist to be more approachable than medical practitioners.[51] If the pharmacist is able to assist a patient who would not have initially sought medical attention but may have ultimately required medical or even hospital services if those pharmacy services were not provided, then the provision of the pharmacy service can result in savings to the community as a result of avoided expenditure on health care.[52] The Wilkinson review recognised that pharmacist intervention can result in savings to the health care system through reduced or avoided outlays on medical or hospital services. The review considered that pharmacist ownership promotes a culture in community

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[48] This research is discussed in Volume 1 of the Pharmacy Guild of Australia's Submission to the National Competition Policy Review of Legislation 1999.

[49] That is, pharmacists' services provide an additional layer of supervision that patients' best interests are being met. See section 3.4. for further details on the principal-agent problem.

[50] See for example, D Andalo 2004, 'Vision for Pharmacy', *Pharmaceutical Journal*, vol. 272, no. 7296, p.510 available at http://www.pjonline.com/Editorial/20040424/vision/vision.html (accessed June 2004).

[51] ibid.

[52] Examples may include providing advice on mens' health or how to quit smoking.

pharmacy that encourages pharmacist and staff commitment to professional care and service.[53]

3.3 Moral hazard leading to over-consumption of pharmaceutical products

Moral hazard occurs when a contract exists between two parties and it is possible for one of the parties to change their behaviour to the detriment of the other party once the contract has been entered into.[54] As the party changing its behaviour does not face the full consequences associated with that change, moral hazard involves a form of externality.

The existence of insurance is associated with moral hazard on the demand side because once an insurance contract is purchased it is likely that the insured will change his or her behaviour compared with that engaged in prior to, or without, the contract. For example, the insured party may take fewer steps to prevent illness than he or she may previously have done, because the cost of illness is effectively lower with insurance than without it. Furthermore, once ill, the insured party may take fewer steps to reduce the costs of treatment because the cost is borne by the insurer, not the insured. Both actions increase the risk that the insurer will have to pay the insured an amount in excess of the insurer's assessment of that risk at the time the contract was entered into. The actions may also increase the demand for medical and health services compared with the situation where no insurance is held.

Moral hazard is highly relevant to the pharmacy sector because of the impact of health insurance (both private and Medicare) and the PBS and RPBS on the behaviour of consumers of medicines. For the insured party, health insurance effectively reduces the cost of illness and in some cases reduces the prices of medications purchased. This gives rise to a 'moral hazard' problem insofar as it changes the insured party's incentives to take preventative actions to avoid having to purchase medicines in the first place, or to economise on purchases of medicines (for example, by using medicines more sparingly or taking steps to maximise the effectiveness of the medicines' use). Moral hazard is thus likely to promote over-consumption of medicines. As discussed above, such over-consumption may have adverse consequences for society as a whole.

The provision of pharmacy services can facilitate a reduction in the negative consequences of demand side moral hazard by helping to ensure that consumption of medicines is necessary and appropriate for the patient's medical condition. This reduces the need to

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[53] Wilkinson report, op., cit, p. 38.

[54] It is important to note that, despite its name, moral hazard is consistent with rational economic behaviour and does not necessarily imply any fraudulent or immoral intent on the part of insureds. See, Pauly, M. V. 1968, 'The economics of Moral Hazard: Comment', *American Economic Review*, vol. 58, pp. 531-7.

resort to the use of expensive medicines and can increase the effectiveness of medicines that are consumed.

The PBS and RPBS have the same effect as health insurance in reducing insured parties' incentives to economise on the use of medicines or to maximise the effectiveness of their use. This is because users of RPBS or PBS-subsidised medicines do not pay the full costs associated with the production of the medicine; this is borne by taxpayers in general. As with health insurance, this can lead to over-consumption of medicines. In other words, moral hazard may exacerbate the externality problems associated with the mis-use of medicines that were previously discussed. The need for a prescription in order to obtain most PBS items helps to address this problem. However, as doctors do not face the full cost of over-consumption of medicines either, they may not have sufficient incentives to minimise over-consumption of pharmaceuticals or doctor shopping by patients. The pharmacists' role in providing pharmacy services provides an additional check on the potential for over-consumption as a result of subsidised medicines.

It is possible that linking pharmacist's remuneration to dispensing, as occurs under the current remuneration for pharmacists under the PBS, may reduce pharmacists' incentives to address over-prescription by doctors. Nonetheless, as is argued later in this report, the existing ownership arrangements provide greater incentives to provide pharmacy services compared with alternatives and less focus on narrow pecuniary benefits. Thus, there is likely to be *more* incentive for pharmacists to address over-prescription with current ownership arrangements compared with more deregulated alternatives.

More specifically, it is likely to be a feature of the current arrangements that on average, payments to pharmacists for each act of dispensing exceed the marginal cost of that act. This will be the case if there are fixed costs to operating a pharmacy, the marginal cost of dispensing does not rise with volume, and remuneration under the PBS makes a contribution to fixed costs. To the extent to which these conditions are met, pharmacists' remuneration through dispensing will reflect (though likely be less than) average costs, which will exceed marginal costs. This can create an incentive to over-dispense.

However, some gap between the remuneration and marginal costs is likely to arise in *any* workable scheme of paying pharmacists for dispensing. As a result, the issue is how the incentives created by that gap interact with other features of the environment in which pharmacists operate to determine their behaviour. For reasons set out below, it is likely that the current arrangements mitigate, if they do not entirely offset, the incentives to over-dispense in a way that would not occur in a more deregulated environment.

3.4 Principal-agent effects

Principal-agent effects arise when one party ('the agent') is appointed to act in the best interests of another party ('the principal'), but:

- the principal and agent have different incentives; and
- the agent has an informational advantage over the principal.

Because of this information asymmetry, the principal is not able to efficiently monitor the agent's performance, and specifically does not know if the agent has acted in the principal's best interests.

Principal-agents effects can give rise to market failure because the principal's lack of information enables the agent to violate, or in other ways exploit, the implicit or explicit contract that exists between the two parties.

Principal-agent problems may exist in health care markets, because consumers do not know what treatment or medication will generate greatest improvements to their health and must rely on health professionals to advise them.

3.4.1 Doctor-patient relationship

The relationship between doctors and patients is that of principal (patient)-agent (doctor). The information asymmetries between the doctor and patients provide the means for doctors to pursue their own self-interest to the detriment of patients as patients are usually not able to assess whether the doctor is acting in their best interest.[55] This may either take the form of over-prescription of drugs (and over-servicing in general) or under-prescription of drugs (and general under-servicing). In the economics literature, the former outcome is known as 'supplier-induced demand'.[56] Although the concept of supplier-induced demand is controversial[57], there is evidence of it occurring in practice.[58] In contrast, an outcome where doctors deliver fewer medical services than an informed

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[55] In addition, because of the 'moral hazard' identified above, consumers may not fully scrutinise the performance of their doctors even if they had the necessary information to do so.

[56] Monday, I. 2002, 'Supplier induced demand: its nature, extent and some policy implications' in Productivity Commission and Melbourne Institute of Applied Economic and Social Research 2002, *Health Policy Roundtable,* Conference Proceedings, AusInfo, Canberra.

[57] See for instance, Paterson, J. 1995, 'A new look at the National Medical workforce Strategy, in Harris A. ed. *Economics and Health: 1994 Proceedings of the 16th Australian Conference of Health Economists*, School of Health Services Management, UNSW.

[58] For example, Monday 2002 op. cit, has estimated that in 1998-99, health services to the value of $8.1 billion were in areas where consumers were unlikely to have sufficient information and knowledge to make good choices.

consumer would like has been termed 'stinting'.[59] Stinting may result in either over or under-prescription of medicines.[60]

Adherence to professional ethics and the enforcement of professional standards do go some way to addressing the principal-agent (and moral hazard) problems between doctors and patients that may lead to over-consumption of medicines. However, as discussed above, pharmacists serve as an additional check on the prescribing practices of doctors.

Where the major concern is with 'supplier-induced demand' for medicines, the manner in which pharmacists provide some degree of mitigation is simply by ensuring that the prescription is reasonable. However, the services provided by pharmacists are no less important when the major problem is stinting, as can occur in insurance schemes in which doctors are remunerated on a capitation basis. In these instances, stinting, and the associated under-provision of attention to patients, can result in either inappropriate prescriptions or simply inadequate access to medicines. Detecting such instances and correcting them can obviously yield significant gains to the community.

3.4.2 Pharmacist-patient relationship

As discussed above, pharmacists have a role in guiding the purchase decisions of less informed consumers. Thus, there is also a principal-agent relationship between pharmacists and consumers and the potential for pharmacists to act in their own interests to the detriment of consumers. It is expected that most pharmacists would act ethically in the best interests of their customers. However, regulation to ensure compliance with professional standards is also necessary to sanction those who do not.

The current ownership arrangements help to address such principal-agent problems between pharmacists and their customers. The reasons why are discussed in the next section.

4 How current ownership restrictions address market failures

This section discusses how current ownership restrictions address the market failures and principal-agent issues discussed above.

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[59] Newhouse, Joseph P. *Pricing the Priceless, A Health Care Conundrum*, The MIT Press, 2002.

[60] For example, a doctor may prescribe medicines to a patient rather than an alternative medical service which may require greater consultation. Such an outcome may be facilitated by the presence of moral hazard.

The central tenet is that pharmacy services are an effective way to address market failures associated with medicine usage. However, these services tend to be under-valued by consumers and it is not easy to prevent free-riding on the provision of those services. Hence, in an unregulated market, there would tend to be too little consumption of pharmacy services. This provides a rationale for government intervention to promote the provision and consumption of pharmacy services above levels that would otherwise prevail. This section of the report argues that the existing ownership arrangements are an effective, though not necessarily perfect, way to promote this outcome.[61]

4.1 Encouraging pharmacy services

Existing ownership restrictions provide greater incentives for pharmacists to provide pharmacy service compared with the corporate-ownership model. The reasons for this are discussed in this section.

4.1.1 Corporate owners have fewer incentives to provide pharmacy services compared with owner-pharmacists

Removal of ownership restrictions would enable pharmacies to be owned by companies who do not have pharmacists as majority shareholders. Such owners are likely to have different incentives to pharmacist-owners. In particular, non-pharmacist owners would have more incentive, and thus be more likely, to engage in price competition rather than service-based competition. Related to this, non-pharmacist owners are likely to offer a lower level of pharmacy services than owner-pharmacists.

More specifically, owner-pharmacists are likely to be more focussed on service-based competition compared with non-pharmacist owners because the former face less demanding commercial pressures to maximise financial profits compared with ownership by shareholders. There are three main reasons for this:

- Shareholders own shares not as a lifestyle choice, but because they want to earn high dividends and/or achieve a high share price.[62] Thus, pharmacies that are owned by corporates may be less likely to provide services that, although contributing to society's well-being, do not contribute directly to profits;

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[61] The market imperfections at issue here cannot be "perfectly" cured by any policy scheme – if they could, they would not be as serious as they are. Rather, any solutions will inevitably be "second best" and the issue is that of selecting the remedy that most cost-effectively addresses the underlying problem.

[62] This applies even when the individual concerned is not actively involved in managing shares but has those shares managed on his or her behalf by a fund or investment company since these firms are themselves subject to competitive pressures to maximise returns from their portfolios.

- By contrast, a pharmacist who runs his or her own business will probably not place as much value on narrow pecuniary benefits as shareholders of public companies. This is not because pharmacist-owners are necessarily altruistic but simply because as owner-operators they are better able to capture the non-pecuniary benefits of operating their pharmacies (e.g. being highly regarded and respected in their local community) than would shareholders in a corporate pharmacy. This does not mean that corporate pharmacies would not capture any non-pecuniary benefits resulting from their operating decisions. For instance, a good reputation in the community can lead to greater custom and, therefore, greater profits regardless of ownership. However, compared with an individual owner-operator, corporate pharmacies would be likely to capture fewer benefits that could not be directly translated into higher profits. This means that corporate pharmacies would be less likely than owner-pharmacists to make operating decisions that lead to 'non-pecuniary income' for the pharmacist-manager but which generated less 'pecuniary income' for the business as a whole. It follows that such corporate pharmacies will be likely to provide a lower level of services that confer wider benefits to the community than would individually owned and operated pharmacies; and
- Pharmacists are educated in professional ethics as part of their training and socialisation into the profession. Thus, pharmacists would tend to consider themselves as professionals with particular social obligations, not merely retailers of medicines. Those social obligations include the provision of services that may not be immediately profitable (for example free advice) or declining to dispense a prescription because the pharmacist considers it is not in the best interest of the consumer even though such action will directly reduce pharmacists' income.

It could be argued that as a corporate pharmacy would be required to have an employee-pharmacist run the store, it does not matter that corporate owners have fewer incentives to provide pharmacy services. Indeed, there is no *a priori* reason to not expect a pharmacist-employee to wish to adhere to the same professional standards and ethics as a pharmacist-employer and thus have similar incentives to provide pharmacy services. However, there are also likely to be incentives for an employee-pharmacist to act in the interests of his or her employer and, as noted above, the incentives confronting a corporate owner to provide pharmacy services are likely to be lower than those of an owner-pharmacist. These conflicting incentives make it likely that an employee-pharmacist would deliver fewer pharmacy services when employed by a corporate owner than when employed by an

owner-pharmacist.[63] This assertion seems to be supported by overseas evidence (see below).[64]

4.1.2 Ownership restrictions encourage non-price competition

It is widely claimed that entry by non-pharmacist owners would lead to more price-competition for OTC medicines, particularly by large grocery retailers, than is currently the case. For example, it has been suggested that prices for some pharmaceutical products could fall by as much as 25 per cent.[65]

Existing pharmacists are likely to respond to price competition by also reducing prices and cutting back on services provided because, as noted above, services cannot easily be supplied on a stand-alone basis and are subject to a degree of free-riding. In addition, externalities associated with pharmacy services suggest that if offered a choice between a bundle of lower priced medication and reduced services and a bundle of higher priced medicines and higher levels of services the consumer will be more likely to choose the first bundle than the second, particularly if they do not personally need higher levels of service, or value it at as much as its value to society. For similar reasons, new entrants

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[63] This argument does not require it to be assumed that employee-pharmacists act in an unethical way. It simply means that employee-pharmacists may have incentives to spend less time delivering pharmacy services compared with activities that contribute directly to profits.

[64] An analogy can be drawn with an article by John Shelton (Shelton John P, 1967. 'Allocative Efficiency vs, "X-Efficiency": Comment', The American Economic Review, December, pp. 1252-1258.) which considered the impact of management arrangements on the operating performance of a number of franchised restaurants. The franchisor provided a great deal of direction to franchisees; menus and recipes as well as restaurant service were standardised. Generally, each of the restaurant outlets was operated by a franchisee-owner. However, from time to time the franchisor found it necessary to operate a franchise outlet itself. At such times, a manager was appointed who had worked with the franchisor for many years and was familiar with the operations of the restaurant chain. Over time, the franchisor developed an accurate record of the performance of each restaurant during periods of franchisee-ownership or franchisor-management control. Because of the highly standardised nature of the franchise arrangements, any differences in performance between the two operating models could be attributed to the different motivations of the franchise-owner compared with the franchisor-manager. Shelton found that of the 22 restaurants where the type of management changed, the franchisor-manager model resulted in lower margins than the franchisee-owner model. Similarly, franchisee-owners achieved higher weekly sales than franchisor managers. Shelton concluded that despite detailed supervision which would seem to minimise opportunities for managerial initiative, restaurants operated by independent franchisee-owners outperformed those supervised by company managers, even though the company managers were paid on a basis that involved some incentive compensation for achieving profits. This was attributed to the franchisee-owner's motivation arising from his or her investment in the business and the need to generate income in the form of profits.

[65] This estimate is attributed to Roger Corbett, Chief Executive of Woolworths Limited according to a briefing note entitled 'Operating Margins and Profits' prepared by the PGA in May 2004.

would have little incentive to compete by providing the same or higher levels of services as incumbents.

For example, consumer research suggests that, while in theory consumers believe they would continue to visit their local pharmacy if supermarket chains were allowed to own and operate pharmacies, in reality many (particularly younger consumers) would opt for the most convenient outlet.[66] In many instances, the most convenient outlet would be a supermarket as this would allow consumers to combine the purchase of medicines with other household items. Thus consumer behaviour, and the reduced incentives of non-pharmacist owners to supply pharmacy services, will lead to a reduction in the overall level of pharmacy services provided compared with current pharmacist-owner arrangements. For example, in the more deregulated US pharmacy sector it was found that only 42 per cent of US adults received any verbal advice about their medication and in only 19 per cent of cases did pharmacists provide advice on possible side effects.[67]

Current high levels of concentration in Australian grocery retailing cast doubt on whether short-term price competition by large retailers would be sustained in the longer run.[68] If not, the ultimate outcome for consumers of removing existing ownership arrangements could be a lower service offering and potentially similar (or not substantially lower) prices than currently prevail.

4.1.3 Ownership restrictions encourage the cultivation of good-will

Long-term customer relationships cultivated by the provision of pharmacy services allow pharmacies to build up good-will. An owner-pharmacist has a greater incentive to build up this good-will than an employee-pharmacist because the latter would have less of a stake in any goodwill built up by the business. Corporate owners may be able to design incentive schemes to encourage their employees to capture good-will, but these schemes will come at a cost that is not incurred under the owner-operator model. Furthermore, as argued previously, corporate owners would have fewer incentives to encourage existing levels of service-based competition anyway because such services cannot easily be sold on a stand-alone basis and do not necessarily contribute to profits. Thus corporate owners would have fewer incentives to build up good-will by providing pharmacy services.

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[66] Crosby|Textor Research Strategy Results, *Qualitative & Quantitative Research: Consumer Motivations & Buying Patterns*, prepared for Pharmacy Guild of Australia, 16 February 2004, p.20.

[67] Morris L., E. Tabak and K. Gondek 1997, 'Counselling patients about prescribed medication 12 year trends', *Medical Care*, vol. 35, no. 10, pp 996-1007.

[68] Concentration is the extent to which sales in a sector are accounted for by a given number of firms. If concentration is high, that is, if a few firms account for a large portion of sales, then each firm may have some degree of market power. Such market power may include the ability to raise prices substantially and sustainably above competitive levels.

4.1.4 Conclusion on likely effect of deregulating ownership arrangements

Each of the organisational and competitive effects of removing existing ownership restrictions will tend to reinforce each other in reducing the level of pharmacy services. As discussed, these services are necessary to help manage the externalities and market failures associated with consumption of pharmaceutical products.

Of course, community and corporate pharmacies would continue to have *some* incentive to provide pharmacy services if ownership restrictions were removed. However, as there would be *less* incentive it follows that there would be less service overall.

4.1.5 Overseas evidence

There is substantial empirical evidence from overseas jurisdictions that allow corporate ownership of pharmacies to support the predictions and contentions presented so far. This evidence relies on comparisons between the conduct of individually owned pharmacies with chain pharmacies.

Evidence from the US indicates that independent pharmacies (i.e. pharmacies that are not members of large chains) offer a higher level of pharmaceutical care than chain pharmacies.

For instance, a 1997 US study[69] in Missouri found that pharmacists in independent pharmacies counselled a significantly higher percentage of patients than pharmacists in chain pharmacies (44 per cent versus 11 per cent). Thirty per cent of independent pharmacists reported that counselling required more than two minutes, while all chain pharmacists' interactions took less than two minutes. The study concluded that '… independent pharmacists counselled more frequently and thoroughly than did the chain pharmacists'. In addition, US, 'chain' pharmacies have higher dispensing rates than individually owned pharmacies[70] which may imply less time spent on counseling.[71]

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[69] Fritsch, M. and K. Lamp 1997, 'Low pharmacist counselling rates in the Kansas City, Missouri, metropolitan area', *The Annals of Pharmacotherapy*, vol. 31, pp. 984-991.

[70] ibid.

[71] Rupp., M, et. al, op. cit., found that 'pharmacists' willingness or ability to intervene in problematic new prescription orders decreases as the volume of prescriptions they dispense per hour increases'. They found that the average rate of pharmacist intervention at high volume pharmacies was 1.7 per cent, compared to a rate of 2.4 per cent in low volume pharmacies.

Another US study[72] found that patients rated the technical and explanatory skills of staff in independent pharmacies more highly than in chain pharmacies. In particular it concluded that:

> By a wide margin, independent pharmacies received higher satisfaction ratings than chains in the urban setting of Philadelphia County. Most respondents gave independent pharmacies an excellent or very good rating for each of the eight areas of service and for the global assessment. In contrast chain pharmacies received excellent or very good ratings from most respondents only for pharmacy location and telephone access.

The table from the study on consumer satisfaction is reproduced below.

Table 2. Satisfaction with independent and chain pharmacies, Philadelphia, USA

	% of respondents rating satisfaction with service as excellent or very good	
	Independent pharmacy	**Chain pharmacy**
Pharmacy location	70.6	65.0
Time kept waiting before seeing the pharmacist	63.5	36.0
Accessibility by telephone	71.8	42.0
Did staff spend enough time with you?	67.7	34.0
Time waiting to get script filled	61.3	38.0
Explanatory skills of staff	63.5	40.4
Technical skills of staff	71.5	43.8
Personal skills of staff	69.2	49.0
Overall visit	65.4	37.0

Source: Briesacher, B., and Corey, R., 1997, *Patient satisfaction with pharmaceutical services at independent and chain pharmacies*, American Journal of Health Systems Pharmacy, March 54:5.

Evidence on the influence of ownership structures on servicing incentives is also available from the UK where 'a body corporate registered by the registrar' is allowed to own pharmacies. Despite requirements that to satisfy a registrar the body corporate must have a pharmacist on the board of directors, a recent survey found that that UK pharmacists were

[72] Briesacher, B. and R. Corey 1997, 'Patient satisfaction with pharmaceutical services at independent and chain pharmacies', *American Journal of Health Systems Pharmacy*, vol. 54, no. 5, pp. 1079-2082.

frustrated at the limited time they had available for professional activities relative to pharmacists in Europe where ownership was generally more heavily regulated.[73]

A recent UK study has examined the impact on professionalised work in the UK and Germany, including pharmacy, of rises in intra- and inter-professional competition, technological change, EU regulation and internationalisation of business, more demanding clients and new forms of service provision.[74] The study found that these developments have had different effects in Britain and Germany because of differences in their institutional and regulatory environments.

The report notes that in the UK there are no restrictions on the number of pharmacies than an individual may own. As a result, single proprietorship has declined and dispensing of prescription drugs in supermarkets is common. Between 1990-91 and 1999-2000, the number of independent pharmacies declined by 20 per cent and by 1999-2000 the proportion of pharmacies in chains of five or more was 46 per cent.[75] In comparison, the German pharmacy sector is highly regulated. Owning more than one pharmacy, or dispensing in a non-pharmacy setting is prohibited. This regulation has prevented the formation of chains and dispensing in supermarkets or department stores. Consequently, small pharmacies employing fewer than 10 employees are the dominant arrangement and 44 per cent of pharmacists are self-employed.[76]

One aspect of professionalised work that was examined in the report was professional interests and loyalties. The report recognised that many professional services are no longer provided by independent professional practices. Furthermore, as the size of organisations increase and become more hierarchical, different interest groupings develop, including those of managers, employees and colleagues.

To explore the relative importance of these different interest groupings, the report's authors asked respondents where their greatest loyalties lie. The results are summarised in Table 3.

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[73] Cancrinus-Matthijsse A. M., S. M. Lindenberg, A. Bakker and P. P. Groenewegen 1996, 'The quality of the professional practice of community pharmacists: what can still be improved in Europe?', *Pharmacy World and Science*, vol. 18, pp. 217-228.

[74] Lane C., Wilkinson F., Littek W., Heisig U., Browne J., Burchell B., Mankelow R., Potton M. and R. Tutscher 2004., *The Future of Professionalised Work. UK and Germany Compared*, Anglo-German Foundation for the Study of Industrial Society,; and Lane C., Wilkinson F., Littek W., Heisig U., Browne J., Burchell B., Mankelow R., Potton M. and R. Tutscher 2003, *The Future of Professionalised Work in Britain and Germany, Pharmacists*, Anglo-German Foundation for the Study of Industrial Society.

[75] Lane, et. al., 2003, op. cit., p. 18.

[76] ibid, p. 19.

Table 3 Greatest Loyalties, UK and German Pharmacists (%)

Most Loyalty to:	UK	Germany
My clients	30.2	47.3
Myself	24.8	16.8
My colleagues	12.6	1.8
The people who work for me	9.4	3
My profession	11.9	1.8
My employer	6.8	23.4
My supervisor	1.4	1.2
The organisation which uses my services	2.5	1.8
Others	0.4	2

Source: Taken from Tables 3.1a and Table 3.1b on pp. 8-9 of Lane et al. 2003, op.cit.

While loyalty to clients was the most important category for both British and German pharmacists, the report indicated that German pharmacists were far more likely to prioritise their clients' needs over their own needs. The report noted that inter-country differences in the pattern of loyalties could, to some extent, be related to the differences in the size of employing organisations and to differing employment status. In particular, in Britain, where organisations employing pharmacists are larger, more complex and consequently have a wider range of possible interest groupings, the pattern of loyalties is more diverse.[77] There was also evidence that German firms have a stronger client focus and, because of their small size, have managed to stay closer to them.[78]

Other overseas experience with deregulation also provides some guidance as to possible structural outcomes in Australia resulting from deregulation.[79] For example, the pharmacy sector has been deregulated in both Norway and Iceland over the past few years with the specific intention of introducing more competition into the delivery of pharmaceuticals. Prior to deregulation, the ownership and control of pharmacies in those countries was

[77] ibid, p. 10 and Lane et. al. 2004, op.cit., p. 24.

[78] ibid, p. 28.

[79] Of course, when examining overseas evidence it is important to bear in mind the differences in regulatory, economic and cultural environments between Australia and overseas. Overseas experience can provide useful guidance but should not be taken as definitive evidence of likely outcomes of deregulation in Australia.

reserved for qualified pharmacists. Pharmacy location and drug prices were also substantially regulated.[80]

The pharmacy sector was deregulated in Iceland in 1996. As a result, while only a pharmacist can run a pharmacy, ownership and financial operation of a pharmacy is unconstrained.[81] Similarly, since March 2001, the ownership and financial operation of Norwegian pharmacies is largely unrestricted although a licensed pharmacist must manage a pharmacy.[82]

One of the immediate effects of deregulation in both Iceland and Norway was a rise in the number of pharmacies. In Iceland, within two years of deregulation the number of pharmacies increased by 67 per cent in metropolitan areas and by 17 per cent in other areas. This was accompanied by strong price competition mainly in metropolitan areas to gain and maintain market share.[83] In Norway, in the year following deregulation, the number of pharmacies increased by 20 per cent, mainly in metropolitan areas.[84] However, contrary to the Icelandic experience there was little evidence of price competition. Rather, between 1999 and 2002 the price of non-prescription drugs increased by 27 per cent.[85]

Regardless, in both countries the demand for pharmaceutical products did not match supply-side growth and consequently in the short term the average size of pharmacies and average revenue per pharmacy declined in both countries. Consequently, by March 2002, three groups of fairly similar size controlled approximately 65 per cent of the total number

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[80] The discussion in the remainder of this section is based on Anell A and Hjelmgren J, 2002,'Implementing competition in the pharmacy sector: lessons from Iceland and Norway', *Applied Health Economics and Health Policy*, I(3), pp. 149-156.

[81] Other features of Iceland's pharmacy regulatory framework are that approval of new licences is subject to recommendation by municipal councils and, like Australia, the price of OTC medicines is unregulated. Prices of prescription drugs are subject to a price ceiling.

[82] Prescribing physicians and the pharmaceutical industry are prevented from owning pharmacies under Norwegian legislation.

[83] Anell and Hjelmgren (2002), op. cit., p. 151.

[84] ibid, p. 154.

[85] This was one of the findings of a report by Ragnar Frisch Centre for Economic Research and the Bl Norwegian School of Management, commissioned by the Norwegian Competition Authority and published in May 2003. The finding was reported in the Norwegian Competition Authority's 2002-03 Annual Report available from http://www.knokurransetilsynet.no/archive/internett/publikasjoner/aasrapport/annual_report_2003.pdf [accessed 21 July 2004]. The Annual Report did not provide a reason for why the prices of non-prescription drugs had increased to the extent reported.

of pharmacies in Norway. [86] In Iceland, independent pharmacists increasingly incorporated into groups and by the end of the 1990s, three pharmacy groups dominated the market.[87]

Anell and Hjelmgren note that:[88]

> New legislation in both Iceland and Norway intended to bring about more competition created horizontal mergers and coalitions between pharmacies and in Norway these emerging groups also integrated vertically with wholesalers. The number of individual decision making units decreased and the market for the distribution of pharmaceuticals was rapidly transformed into an oligopoly.

Furthermore, Anell and Hjelmgren note that in both countries ad hoc government interventions have been necessary to prevent developments that were not consistent with government expectations.[89] For example, in Norway, further reforms to allow non-prescription OTC drugs to be sold in non-pharmacy outlets were introduced in 2003 in an attempt to contain rising OTC drug prices. Despite these reforms, the Norwegian Competition Authority has indicated that it 'is not quite satisfied' with developments in the market for pharmaceutical products and expressed the view that 'we feel that competition develops too slowly'.[90]

In addition, the experience in Iceland and Norway suggests that it may be difficult for deregulated markets to produce outcomes that are consistent with desired distributional objectives. For instance, in Iceland it seems that any benefits from reform have been largely focussed on metropolitan customers with rural customers gaining little. In Norway it seems likely that at least some of the benefits of reform have been captured by the oligopolistic pharmacy chains.

The next section argues that distributional issues associated with deregulation of pharmacy ownership are also likely to be important in Australia.

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[86] Norwegian Competition Authority, Annual Report 2001-02, available at http://www.knokurransetilsynet.no/archive/internett/publikasjoner/aasrapport/annual_report_2002.pdf [accessed 21 July 2004].

[87] Anell et. al. 2002, op. cit., p. 152. The authors do not provide an estimate of the extent of the industry domination. However, Table 2 on p. 152 of their paper suggests that in 2001, pharmacists incorporated in groups represented 73.5 per cent of the total number of dispensing units.

[88] ibid, p. 154.

[89] Anell and Hjelmgren did not comment on either of the respective governments expectations about the impact of reforms on the level of pharmacy services, or the actual impact of the reforms on such services.

[90] Norwegian Competition Authority, Annual Report 2002-03, op.cit., p. 23.

5 Distributional effects - Encouraging equitable access for rural and regional Australia

As has been demonstrated, existing ownership arrangements help to address market failure associated with the use of medicines by facilitating higher levels of pharmacy services than a less regulated environment. In addition, current ownership arrangements have an important role in achieving government's health policies and associated distributional outcomes.

Current arrangements facilitate a wide network of community pharmacies that provide a relatively uniform level of service nation-wide. Thus, one key objective of the National Medicines Policy that is facilitated by the community pharmacy model is widespread community access to the services provided by pharmacies (including the timely access to medicines at affordable prices).[91] Relaxation of ownership restrictions may reduce some Australians' access to medicines and pharmacy services, in particular the availability of low volume prescription drugs.

Currently, most pharmacies across Australia are supplied on at least a daily basis with medicines at uniform wholesale prices by one of three independent full-line wholesalers. In large metropolitan centres like Sydney and Melbourne, deliveries are made twice daily.[92] The physical characteristics of many medications, in particular, their short shelf life, mean that only under this type of distribution system is it possible for a small rural pharmacy to acquire a supply of such drugs as required, even for very low volumes.

Under the PBS, prices charged to pharmacies by wholesalers cannot exceed the price set under the PBS. This price assumes a 10 per cent wholesale margin. For other products provided by wholesalers, such a pricing restriction does not apply, however historically wholesalers have adopted a geographically uniform wholesale pricing policy. This helps to achieve the Australian Government's health objectives, although it creates a situation whereby wholesalers are achieving varying returns across products and geographical locations.

The full-line pharmaceutical wholesale sector is already facing strong competition from buying groups, direct distribution from manufacturers and short-line wholesalers who 'cherry-pick' profitable products and customers. As a result, wholesalers have claimed

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[91] This objective is similar to Objective 4(2)(b) of the Third Community Pharmacy Agreement between the Commonwealth Government and the PGA which is to increase access to community pharmacies for persons in rural and remote regions in Australia.

[92] NECG, Final Economic Report for API/Sigma, July 2002, p. 7.

that the current extent and level of their services may be unsustainable.[93] NECG has previously estimated that in the year ended 30 June 2001, uneconomic, low contribution products represented around 44 per cent of PBS units sold.[94]

If corporate owners acquire a sufficient volume of business then it is likely that threats to the sustainability of the current system would be exacerbated. Large corporate owners would initially focus on areas where high volumes and/or high margins were being achieved and may be able to build up market power in these retail market segments. This market power might be used to force wholesalers to reduce margins in these areas, or else risk being bypassed by direct distribution.[95] The margins currently being earned in these areas are being used to implicitly cross-subsidise wholesale distribution to less profitable segments, particularly rural and regional areas. This 'cherry-picking behaviour' by large retailers has the potential to undermine the current full-line wholesale distribution system which supplies often uneconomic small and remote pharmacies. In turn, this could be expected to lead to increased costs for smaller community pharmacies and especially those in rural and remote areas. This would place increased pressure on the viability of those pharmacies; indeed, absent direct and potentially inefficient public subsidies, some may be forced to close. This could reduce access to pharmacy services and medicines for consumers in those areas contrary to government's policies. It may also have flow-on economic effects in those regions.

6 Ensuring accountability without excessive administrative and compliance costs

Finally, current ownership arrangements help to ensure pharmacists comply with their professional obligations without the need for high administrative and compliance costs to be incurred.

Regulatory checks and balances are needed to ensure that registered pharmacists comply with their obligations under the various regulations applicable to pharmacy practice. As discussed above, pharmacies are not only businesses but also part of a principal-agent relationship, and may have some incentive to act in their own best interest to the detriment of consumers.

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93 ACCC 2002, Application for Authorisation – Australian Pharmaceutical Industries Limited, p. 55

94 ibid.

95 This threat of by-pass may be particularly credible if issued by a supermarket chain that already uses a direct distribution channel.

The existing ownership restrictions facilitate an efficient regulatory system for a number of reasons:

First, by restricting ownership to qualified individual pharmacists, lines of professional accountability to regulators are simplified. This makes it easier to monitor conduct and enforce appropriate penalties for misconduct. An owner-pharmacist can be held liable, not only for his or her conduct, but also for staff working under his or her professional direction. Such lines of accountability are likely to be blurred under corporate or non-pharmacist ownership. For example, most Pharmacy Acts impose disciplinary procedures and penalties on the registered pharmacist. By implication, under current ownership arrangements, this is typically the owner of the pharmacy. However, if the registered pharmacist is not the owner, as would increasingly occur under more deregulated ownership arrangements, then the possibility would increasingly arise that the pharmacist would be penalised for conduct that he or she may not have been directly responsible for. It follows, that the owner, or person responsible for the conduct, may not be penalised at all in such circumstances.

Because of the lower cost and risk of sanction, corporate owners may have greater incentives to interfere in the running of a pharmacy to the detriment of the quality use of medicines. For example, in 1974 the Pharmacy Board in Victoria launched an inquiry into the operation of pharmacies operated in four Victorian Kmart stores. Evidence was presented, amongst other things, that shelf stock and pricing had to conform to Kmart requirements which often conflicted with good pharmacy practice. Although the conduct was instigated by Kmart management, it was ultimately the registered pharmacists who incurred the penalties; the case ultimately led to the deregistration of one pharmacist and the suspension of another.[96]

The example in Box 1 below shows how it has become increasingly difficult to enforce certain aspects of professional conduct in the pathology sector as a result of the pathologist being increasingly responsible for outcomes over which he or she may have little control. This provides a useful example of the arguments presented in this section. The example highlights how the ownership structure of the Australian pathology sector has changed over the last twenty years from predominantly pathologist-owned to largely corporate-owned. Consequently, many pathologists are now employees in a corporate-owned laboratory rather than the owner of that laboratory. One consequence of this change is that it is now more difficult to detect illegal arrangements and agreements between pathologists and medical practitioners as those agreements may be entered into by corporate owners who are not directly accountable for the arrangements. This has reduced the effectiveness of legislation intended to prevent such arrangements.

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[96] Summary information about this case was provided to NECG by the PGA.

Box 1: Implications of Corporatisation for Enforcement of Pathology Regulations

The current regulatory arrangements applying to the provision of pathology services were introduced in 1986. Prior to that time, most private pathology practitioners were owned and operated by specialist pathologists. However, around 75 per cent of pathology services are now provided by company-owned Approved Pathology Authorities (APAs) who receive a similar share of Medicare benefits paid.[97] Medicare payments can only be made in relation to services provided by or on behalf of an Approved Pathology Practitioner (APP) in an Accredited Pathology Laboratory (APL) owned by an APA.

The APA scheme and eligibility requirements were intended to introduce new controls over the provision of pathology services and reduce the capacity for fraud or over-servicing in pathology by providing effective measures to control abuses.[98] To become an APP and hence receive Medicare benefits for services provided, pathology providers must undertake to abide by a set of practices which relate to personal supervision, agreements and arrangements with interested parties, multiple pathology services, excessive pathology services, accounts, receipts and assignment of Medicare benefits, advertising, supply of information, offences, persons acting on their behalf and notices.[99]

In the Final Report of Review of Commonwealth Legislation for pathology arrangements under Medicare, the Review Committee noted that many aspects of the current scheme should, in theory, be working effectively to prevent fraud and other illegal practices. However, it noted that some of the offence provisions in the scheme are not effective due, among other things, to changes in pathology business structures and the inability of the legislation to keep pace with these changes.[100]

For instance, the review committee noted that despite improvements since 1986, the enforcement of prohibitions on agreements and arrangements between pathologists and medical practitioners continues to be difficult. Since the scheme was introduced, corporatisation of pathology practices has meant that the role of many pathologists has changed and that many have gone from owner or partner of a practice to a contracted employee. This means that many APPs are likely to be removed from business and marketing decisions taken by APAs that may be encouraging agreements and arrangements between pathologists and referring medical practitioners. However, under the terms of the undertaking, APPs are accountable for such practices and for reporting them if they become aware of them. Despite anecdotal evidence of their existence, the Health Insurance Commission advised the review committee that it is very rare for APPs to report agreements or arrangements.[101]

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97 *Review of Commonwealth legislation for pathology arrangements under Medicare,* Background – July 2002, p.66, available at http://www.health.gov.au/haf/branch/dtb/pathreview.pdf (accessed June 2004),

98 ibid.

99 ibid, p.44.

100 *Review of Commonwealth legislation for pathology arrangements under Medicare,* Final report, December 2002, p.30, available at http://www.health.gov.au/pathology/pdf/review.pdf (accessed June 2004).

101 *Review of Commonwealth legislation for pathology arrangements under Medicare,* Background – July 2002, p.50.

Secondly, a non-pharmacist individual or corporation arguably would not be as easy to deal with in terms of a regulatory authority's supervision of professional activity within a pharmacy. This is especially so given that the relevant authorities are generally either self-funding or have limited resources.[102] In addition, a well-resourced corporation that was dissatisfied with a regulatory outcome would possibly be more financially able than the regulatory authority to expend resources on litigation to challenge the decision if it was found to be liable for conduct (which may not currently be the case).[103]

Finally, there is always the potential in any system, no matter how well designed or resourced, for some misconduct to occur. However any shortfall in apprehension and conviction could be adjusted for by ensuring the magnitude of penalties incurred if a particular case of misconduct were apprehended was sufficiently high to deter misconduct. This helps to ensure that the regulatory system continues to achieve an appropriate 'deterrence level'. By restricting ownership of pharmacies to pharmacists, the potential loss from professional misconduct is high. An owner-pharmacist risks losing his or her entire livelihood and professional reputation if he or she is convicted of misconduct and is consequently suspended or deregistered.[104] In such a situation, the pharmacist would lose the ability to own and run a pharmacy. By contrast, a corporation would probably have sufficiently deep pockets to pay a fine and would not risk losing its ability to run a business under existing disciplinary arrangements. Consequently, it might not be as motivated to ensure that its pharmacist-employees were not convicted of misconduct.

To achieve the same deterrent effect if ownership restrictions were liberalised to allow corporations to own pharmacies, higher fines may have to be levied. However a dilemma then arises. The penalty that would have to be levied to induce the same deterrent effect on a corporation would seem disproportionately harsh if applied to a pharmacist-owner. However, a penalty that might deter a pharmacist-owner from misconduct would be inadequate to deter a corporation. Levying different fines for each organisational structure might be considered discriminatory and therefore not politically viable.105 Alternatively,

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[102] National Competition Policy Review of Pharmacy: Final Report, op. cit, p. 42.

[103] ibid, p.43. Of course, review of decisions by regulatory authorities is often desirable and helps reduce the risk of regulatory error.

[104] Each of the Pharmacy Acts contain penalties of varying severity for conviction of professional misconduct by a registered pharmacist. For example, s.20 of the Pharmacy Act 1964 (NSW) lists the potential penalties for misconduct by a registered pharmacist in that jurisdiction. Among other things, these a caution or reprimand, the imposition of a fine, the suspension of registration, or deregistration. The Victorian legislation contains similar penalties.

[105] Moreover, even if very high fines were allowed for corporations, high fines (like other very harsh penalties) themselves can have undesirable effects. For example, they increase the cost of regulatory error, may induce wasteful investment in litigation (so as to avoid having to pay the fine) and may induce behaviour that is excessively risk-averse.

a higher rate of apprehension of misconduct would have to be achieved. However, this would require more resources, and hence higher costs.

In effect, these reasons mean existing ownership restrictions can substantially increase the effective magnitude of penalties for breach of professional standards. Therefore, the regulatory system can maintain a substantially high deterrent effect without unrealistically high standards of policing (in effect the pharmacist is self-policing because it is strongly in his or her rational self-interest to do so) or unrealistically high fines. With more diverse ownership arrangements, it is likely that regulatory systems would have to be redesigned. This would entail legislative and administrative resources to implement as well as the likely need to review the effectiveness of the arrangements at a later date.

7 Costs of current ownership restrictions

As noted, existing ownership arrangements essentially restrict ownership of pharmacies to registered pharmacists. This may impose costs on society. Proponents of deregulation argue that current ownership restrictions can deter pharmacies from achieving cost-minimising scale. It is also argued that general ownership restrictions, by restricting entry, permit pharmacists to earn sustainable excessive profits. It is claimed that both problems would be corrected by allowing more diverse ownership arrangements and larger scale pharmacies.

7.1 Loss of economies of scale and scope

The argument that current arrangements promote inefficiently small scale operations which prevent the realisation of economies of scale and hence impede efficiency is based on now outdated work by the Bureau of Industry Economics (BIE) nearly 20 years ago.[106]

Since then there have been a number of changes to the community pharmacy sector which have impacted on its structure and the efficiency of its participants[107]:

- The number of community pharmacies has fallen from a peak of 5,625 in 1989-90 to around 5,000 currently. This was achieved partly because approximately 700 small community pharmacies accepted government-funded redundancy packages designed to encourage the closure of small establishments;

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[106] Bureau of Industry Economics 1985, *Retail pharmacy in Australia — an economic appraisal*, Research report 17, AusInfo, Canberra.

[107] Pharmacy Guild of Australia and Pharmaceutical Society of Australia, Submission to the National Competition Policy Review of Legislation, Volume 7, Assessing the cost of legislation: economies of scale in retail pharmacy, July 1999, p.18.

- Community expenditure on pharmaceuticals has grown by at least 60 per cent in real terms; and
- The introduction of computers has streamlined the dispensing process.

A further concern with the BIE study is that the data forming the basis of this work no longer exists, making it impossible to test the accuracy of its findings.

Econometric research conducted by KPMG[108] in 1999 raised serious doubts about whether current arrangements prevent the realization of economies of scale. Importantly, most of the economies of scale in pharmacy are pecuniary, rather than technological. Pecuniary economies of scale, emanating from the greater purchasing power provided by large-scale operations, allow larger businesses to negotiate volume discounts with suppliers and hence obtain some inputs more cheaply than smaller businesses. They do not imply that existing labour and capital resources are being used inefficiently or that associated resource savings could be realised if the scale of the business was expanded. Community pharmacies are already able to take advantage of pecuniary economies of scale by joining banner groups and other group buying ventures entered into with one of the full-line wholesalers.[109] [110] Hence it seems unlikely that substantial efficiencies would be realised if ownership restrictions were removed.

Furthermore, KPMG found that economies of scale in dispensing are exhausted at annual prescription volumes of around 25,000. Around 70 per cent of community pharmacies are already operating at this volume or greater, implying that economies of scale are typically being exhausted under current industry structures.

7.2 Economic rents

Opponents of current ownership restrictions have argued that pharmacists earn margins that exceed the average return of other retailing businesses. There are at least two problems with this argument.

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[108] KPMG was commissioned by the PGA and Pharmaceutical Society of Australia (PSA) to undertake this research as part of the PGA and PSA's joint submission to the NCP Review of Legislation. The results of the KPMG research are reported in *Volume 7: Assessing the Costs of Legislation: Economies of Scale* of that joint submission.

[109] For example, Sigma Pharmaceuticals has arrangements with Guardian and AMCAL stores, API Pharmacy has arrangements with Soul Pattinson, API Healthcare Chemist, Chemworld and Pharmacist Advice stores and Mayne Group has arrangements with Chemmart, Healthsense, and The Medicine Shoppe.

[110] These arrangements do not undermine the implicit price subsidies contained in geographically uniform pricing policies because under current PBS arrangements the government negotiates the approved price to pharmacists on the basis that wholesalers will supply all pharmacists at a uniform price.

- To become a registered pharmacist and thus qualify for ownership of a pharmacy, a student must undertake prerequisite tertiary training over several years.[111] Profits earned by pharmacist-owners overall will generally need to include a return on this human capital in order to induce the entry of persons into the profession. General retailers as a group, in contrast, have probably not made large investments in human capital or participate in ongoing professional development. Thus it is inappropriate, to compare margins earned by general retailers with margins earned by professional pharmacists.
- A large part of pharmacists' income is derived from prescribing price-regulated medicines.[112] Per-unit remuneration, and implicitly margins, for prescribing is funded by the Australian Government under agreements negotiated between the Government and the PGA.[113] The total remuneration earned by pharmacists for dispensing is essentially derived from the prescribing practices of doctors and the general demand for medical services; there is little scope, therefore, for the total remuneration available to pharmacists as a group to be affected by competition.[114] As it seems unlikely that the manner of remunerating pharmacists would substantially change under alternative ownership arrangements, there would seem to be little scope for competition to *lower* the margin built into dispensing fees. Rather, competition would primarily occur for the *share* of the total dispensing remuneration.

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[111] Of course, prerequisite training also helps to ensure that pharmacists meet specified minimum standards.

[112] According to the Wilkinson report (p.5), about two-thirds of turnover is underpinned by government-funded remuneration and the fixed retail prices of subsidised medicines dispensed on the PBS.

[113] The Government has an incentive to contain the costs of the PBS while the PGA has an incentive to maximise remuneration for its members. These combined incentives may mean that per unit dispensing fees include an element of reimbursement above cost in recognition of the value of pharmacy services to the community as a way to address market failures. Under alternative ownership arrangements, where incentives to provide such services would be generally less, the value to pharmacy owners of dispensing fees may be even higher if there would need to be a greater economic rent component than is currently the case. This could be the case (1) if there was a greater information asymmetry or asymmetry of bargaining power between future owners of pharmacies and the Commonwealth than is currently the case (say because the industry was more concentrated) or (2) because risk averse corporate owners needed to be compensated for the risk created by exposure to potentially substantial fines.

[114] Obviously, if deregulation reduced the level of costs, say because fewer services were being provided, the direct financial cost to the Commonwealth of dispensing could fall. However, this would not make the community better off if it simply reflected inefficiently low levels of service provision. Additionally, if the Commonwealth then wanted to induce pharmacies in such an environment to provide a higher level of service, it would need to make offsetting payments. There is no reason to think that those payments would be any lower than the implicit payments being made under the current arrangements.

On this basis, it seems difficult to accept arguments that pharmacy returns would be significantly lower if more diverse ownership arrangements are permitted.

8 Are there equally effective and viable alternatives to existing arrangements?

If the ownership arrangements are deregulated it is likely that some kind of subsidy would have to be provided to either consumers or pharmacists to induce appropriate supply and consumption of pharmacy services. However, because an externality is involved in the consumption of pharmacy services, the mere provision of a 'cashed out' subsidy to consumers would not lead to adequate consumption of such services. This is because consumers would only consider the private benefits, and not the larger public benefits, associated with consumption of pharmacy services when deciding how much of those services to buy. Thus, even with a subsidy to consumers there would tend to be under-consumption of pharmacy services.

Providing a subsidy to pharmacies would also be problematic because, deregulating ownership arrangements is likely to change the nature of competition from largely non-price to price-based. Therefore, a subsidy may not be effective in inducing higher levels of pharmacy services because, as noted above, there is an element of free-riding associated with pharmacy services. Thus, there would not only be a direct monetary cost associated with the provision of subsidies to pharmacists, but also costs associated with monitoring such subsidies to ensure that they are used to achieve the desired outcomes.[115]

Further, as noted above, deregulating ownership arrangements would be likely to impact particularly on rural and regional areas. There are already difficulties in attracting adequate health services, including pharmacy services, to those areas. Thus, changing ownership arrangements may exacerbate those difficulties, by making it more difficult for pharmacies to remain viable in those areas, and be contrary to governments' health

[115] Indeed, conventional economics suggests that to induce corporate pharmacies to provide a higher level of service, the Commonwealth would need to find a way to remunerate directly the services at issue (say, through a separate fee-for-service arrangement). However, it is not clear how such an arrangement would work, much less how efficient it would be. Alternatively, the Commonwealth might provide a subsidy to dispensing but limit price competition between dispensers, on the basis that the subsidy would then be dissipated in non-price competition: as in the standard economic model of retail price maintenance – see Lester G Telser 1960, 'Why Should Manufacturers Want Fair Trade?' *Journal of Law and Economics* Vol. 3, pp. 86-105. However, that model assumes that consumers correctly value the service at issue (so that retailers can seek to attract consumers by means of its provision): where that assumption does not hold (as is the case here), this mechanism will not correct the under-provision of service.

policies. This could necessitate increased government programmes and expenditure to ensure that desired distributional outcomes are achieved.

It has been noted that the existing ownership arrangements facilitate effective regulatory regimes. Changing these arrangements would likely necessitate the redesign of the pharmacy regulatory regimes. As well as the one-off legislative costs associated with regulatory change it seems likely that alternative regulatory arrangements would not induce compliance as effectively as the existing arrangements. Thus overall, regulatory costs would be likely to be higher under alternative ownership arrangements than under current ownership rules. These additional costs might be incurred because the costs of detecting, deterring and enforcing regulatory rules could be higher under alternative ownership arrangements than under owner-pharmacist arrangements.

Under alternative ownership structures more resources would have be devoted to policing conduct in order to increase the rate of apprehension/conviction of misconduct. The task would be made even more difficult because there would be more parties to regulate and less clear lines of accountability, as well as possibly greater litigation costs.

9 Conclusion

As has been demonstrated, existing ownership restrictions confer three major benefits on society by facilitating:

- Higher levels of investment in pharmacy services than would occur if more diverse ownership arrangements were permitted. The provision of such services is important in managing the externalities and other market failures associated with the consumption of pharmaceutical products;
- Nationwide distribution of pharmacy services to all Australians regardless of where they live, consistent with government health policies and objectives; and
- A regulatory system that helps to ensure that pharmacies operate according to professionally acceptable standards. More deregulated ownership arrangements are likely to impose higher regulatory costs because of the need for more resources to detect and deter professional misconduct. It may also be necessary to redesign the regulatory system in order to ensure that those responsible for conduct that leads to professional misconduct are ultimately held accountable for that conduct.

It is worth noting that there is a regulatory economy of scope being captured by current arrangements because the three major benefits outlined above are delivered by one set of ownership restrictions, occasionally in combination with other regulations.

It has been demonstrated that the costs of existing restrictions are probably not as large as is sometimes claimed. This necessarily implies that the magnitude of alleged net benefits flowing from the removal of these restrictions would not be as large as has been suggested.

Alternative ownership structures reduce incentives to provide pharmacy services. It is possible therefore that under alternative arrangements the level of such services would not be sufficient to address market failures and to deliver outcomes consistent with government health policies. Similarly, it is likely that certain government health policies that aim to achieve desired distributional outcomes could not be delivered without increased government expenditure. Finally, changing ownership arrangements would probably necessitate the redesign of regulatory arrangements to ensure that pharmacists meet expected professional standards. Such arrangements are likely to be more costly than existing ones.

Thus there is a strong economic case for retaining existing ownership arrangements.

Appendix 1: Current price regulation in pharmacy sector

The PBS currently operates so as to limit the scope for price competition in respect of most prescription pharmaceuticals. Price regulation is imposed by the Australian Government in order to effect the two goals of the PBS:

- to ensure all Australian have access to a wide range of necessary medicines at an affordable price; and
- to ensure that the social costs of the purchase of medications is minimised.

At the consumer level the main components of the PBS are:

- a scheme for general patients and another scheme for pensioners both of which subsidise the price of PBS listed medications[116]; and
- a patient co-payment (explained further below) to provide some incentive for patients to limit their expenditure.[117]

PBS-listed products must be prescribed by a registered medical practitioner, or for certain medicines, a registered dentist. Similarly, PBS-listed medicines must be dispensed by an approved pharmacist except in limited cases.

The Australian Government negotiates a price for medicines with the supplier of the product and controls the mark-ups applied by wholesalers (the approved price to pharmacists) and dispensers. From 1 January 2004 the maximum retail price for a pharmaceutical benefit item on the PBS has been set at $23.70 for general patients and $3.80 for concessional patients.[118] The difference between the agreed price and the patient co-payment is met by the Australian Government.[119]

In order to effect the Government's secondary goal of containing costs, the PBS regulates the prices which:

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[116] To be listed on the PBS a drug must go through an evaluation and bargaining process which largely focuses on whether the drug is cost-effective.

[117] The economics of the PBS is discussed more in the section on 'Moral hazard leading to over-consumption of pharmaceutical products' at 3.3.

[118] These payments are adjusted annually on 1 January to reflect changes in the Consumer Price Index: http://www.health.gov.au/pbs/general/howmuch.htm. (accessed June 2004) These co-payments are expected to increase to $28.60 for general patients and $4.60 for concessional patients on 1 January 2005 following Labor's decision to support increases to co-payments in addition to the CPI increase.

[119] Note that for Commonwealth prices below the maximum patient co-payment, the difference will be zero and therefore the Commonwealth makes no contribution towards meeting the cost to consumers of these prescriptions.

- pharmaceutical companies receive for the drugs they produce which are listed on the PBS; and
- the amount by which wholesalers and pharmacies can in turn mark-up those prices.

Remuneration to pharmacists for dispensing pharmaceuticals that are listed on the PBS is set via the Third Australian Community Pharmacy Agreement between the PGA and the Australian Government which applies from 1 July 2000 to 30 June 2005. Under this agreement the remuneration paid to dispensing pharmacists, known as the Commonwealth price, is based on the following components established for the 2000-01 year:

- For ready prepared (RP) items, the sum of:
  - (i) A dispensing fee of $4.40;
  - (ii) A separate mark up of 10 per cent on the approved price to pharmacists[120] for RP items ('the mark up component'), except where the approved price to pharmacists is $180 or more in which case the mark up component is $18 per item until the approved price to pharmacists reaches $450 in which case the mark up component is 4 per cent of the approved price to pharmacists; and
  - (iii) The approved price to pharmacists;
- For extemporaneously prepared (EP) and related EP items, the sum of:
  - (i) A dispensing fee of $6.28; and
  - (ii) A separate mark up of 10 per cent on the approved price to pharmacists for EP items ('the mark up component), except where the basic wholesale price is $180 or more in which case the mark up component will be $18 per item until the basic wholesale price reaches $450 in which case the mark up component is 4 per cent of the basic wholesale price; and
  - (iii) The basic wholesale price.

Prescription-based remuneration for 2001-02 to 2004-05 is determined in the same manner as for 2000-01 except the dispensing fee is indexed annually to take account of inflation.

If RP and EP items are priced below the maximum patient co-payment, pharmacists are permitted to add a range of additional charges at their discretion. In such cases the price to the patient may consist of:

- (i) The Commonwealth price;
- (ii) An additional patient charge which when combined with the Commonwealth price equals the list or agreed price; and
- (iii) A further additional patient charge amounting to 10 per cent of the maximum general patient contribution plus 50 cents.

[120] The approved price to pharmacists is the price agreed between manufacturers and the Australian Government.

With the exception of (ii) these additional patient charges cannot be recorded on the prescription record form ("PRF") to accumulate towards the patient's Safety Net Entitlement.

The PBS directly limits the extent to which price competition can occur at all levels, but most relevantly for the purpose of this report at the retail level in the following ways:

- There is some scope for price competition at the retail level for medicines where the Commonwealth price is less than the maximum patient co-payment. For these prescriptions, pharmacists are able to impose fees additional to the Commonwealth price at their discretion (up to the maximum allowable or the maximum patient co-payment, whichever is less), and the ability to waive some or all of these fees allows for some price competition.
- For Commonwealth prices in excess of the maximum patient co-payment, there is no scope for competition as remuneration for dispensing is fixed as discussed above. Furthermore, pharmacists are not able to discount the co-payment contribution payable by consumers.

The above analysis implies that any changes to the competitive environment in the retail pharmaceutical market are unlikely to lead to significant reduction in prices of PBS medications for consumers, or cost savings for Government. Only Schedule 2 and Schedule 3 OTC products as well as private prescriptions are potentially subject to greater competition than is presently the case.