

ALL-PARTY PHARMACY GROUP

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Control of entry in the pharmacy sector *A report to Health and Trade & Industry ministers*

Introduction & background

In its report published on 17 January 2003, the Office of Fair Trading recommended the abolition of all entry controls in the pharmacy sector in the UK. Those controls have been in place since 1987. They require anyone wishing to provide NHS pharmaceutical services to apply to the NHS locally for a contract. Contracts are granted on the basis of necessity or desirability. The OFT concluded that a de-regulated, free market would result in more pharmacies, improved services and more price competition in the sale of over-the-counter medicines. It also anticipated cost savings for the NHS and pharmacy businesses as a result of de-regulation.

The report's recommendation was welcomed by some, notably Asda, Tesco, Sainsbury and Superdrug. Most of these companies have long called for the removal of entry controls so that they may increase the number of pharmacies they operate. Others, especially those representing independent pharmacies, voiced concern that the OFT's recommendations would lead to reduced access to services and closure of neighbourhood pharmacies.

Ministers indicated that they would respond to the OFT within 90 days. The All-Party Pharmacy Group, which counts more than 100 MPs and peers in its membership, wishes to inform ministers of its views on the issues raised by the OFT. Our report is intended to assist ministers in evaluating the OFT's proposal and determining whether, and if so what, policy changes are justified.

Our deliberations

We met on 10 February 2003. Our guest speakers represented the two sides of the argument: John Evans, the superintendent pharmacist at Asda supported the OFT's recommendation; John D'Arcy, the chief executive of the National Pharmaceutical Association, opposed its proposal to de-regulate. Our invited audience of more than 100 people - included representatives from organisations representing pharmacists and pharmacies, PCTs, the medical profession, patient groups, pharmaceutical companies and the media.

During the course of our meeting, we examined a number of issues. The key points are summarised below.

Access

The OFT suggested that access to pharmacies would be enhanced by abolition of the current entry controls. John Evans agreed, arguing that the current regulations are restrictive. He told us that Asda customers wish to see pharmacies in more Asda stores. He referred to the Department of Health's strategy document, *Pharmacy in the Future*, and the pharmacy policy statements of the devolved UK governments, and argued that each of them had the objective of improving access to pharmacy services.

Access may be measured not simply by the number and location of pharmacies but also by the hours during which they are open. The OFT report claims that supermarket pharmacies are open for longer than high street and neighbourhood pharmacies. John Evans told us that increasing the number of supermarket pharmacies would therefore improve access.

John D'Arcy highlighted the OFT's own findings in relation to access. The vast majority of pharmacy users surveyed by the OFT - more than 90% - had no difficulty accessing pharmacies when they needed to do so. He told us that the current regulations had provided for a good distribution of pharmacies across the country, and that it was only those who wished to increase their market presence who supported the OFT's proposal. He suggested that it was commercial interests rather than patients or public concern that were driving proposals to remove the current regulations.

Doubts about supermarket pharmacy opening hours were raised by PCT representatives at our meeting. Experience in East Yorkshire and in Essex suggested that applications to open pharmacies in supermarkets often included plans to operate extended opening hours. However, it was suggested to us that once applications are granted these opening hours are reduced. In Essex, evidence suggests that the opening hours of neighbourhood pharmacies reflect surgery hours. Many pharmacies therefore remain open until at least 7pm. Out of hours rotas include a 24-hour on-call facility. Under this scheme a pharmacist is available at any time of day. Our understanding is that this scheme, open to all pharmacies, does not include any supermarket pharmacists.

We are concerned to hear that in-store pharmacies with particularly long opening hours seem to be unable to maintain those hours, since it is possible that their opening hours were a central element in the decision to grant them pharmacy contracts. This is not a matter that was investigated by the OFT, though its report did cite opening hours as an important measure of accessibility and supermarkets were considered to have longer opening hours. We recommend that further data is collected from PCTs to obtain a clearer picture on trends in opening hours.

On the wider issues relating to access, we take the view that those with mobility problems, the elderly, disabled, those without a car or with less good public transport provision, need to be able to access pharmacies near where they live. Generally those patients who rely most heavily on pharmacy services are those who suffer problems relating to mobility and social exclusion. For them, more out-of-town, or indeed edge-of-town, supermarket pharmacies are not especially helpful.

In fact, were such new pharmacies to drive local neighbourhood services out of business, they would have a positively damaging impact on access.

We are all aware of concerns about the decline of community services. Many local shops have disappeared in recent years, and sub-post offices have also come under threat. In many areas, both rural and inner city, the local pharmacy is an integral component in the local community. In many such locations the local pharmacy is one of the few remaining community services. We would be concerned at the knock-on effect in many communities were the local pharmacy to be under threat.

Competition

The OFT concluded that abolition of entry controls would enhance competition by encouraging the opening of more pharmacies. This was, in the OFT's view, likely to lead to service improvements and cheaper medicines.

Once again our speakers held opposing views on this issue. John Evans argued that the existing regulations had stultified competition and discouraged service innovation. He claimed that young pharmacists wishing to purchase a pharmacy were faced with costs of £500,000 or more, though this claim was refuted by a pharmacy sales agent at our meeting who claimed that pharmacies could change hands for as little as £75,000.

Mr Evans also told us that a de-regulated market would lead to more price competition on over-the-counter medicines. On this point Mr D'Arcy questioned the validity of the OFT's price basket calculations and was sceptical that more supermarket pharmacies would necessarily lead to cheaper medicines. Others we heard from, including the BMA, took the view that medicines should not be regarded as ordinary items of commerce, and purchase decisions should be made according to need rather than the level of discount available.

Mr D'Arcy also argued that any savings resulting from de-regulation would amount to no more than 0.4% of the total value of the pharmacy and OTC medicines market. He suggested that the OFT had not taken into account costs that could continue, and perhaps increase, following de-regulation. In particular, PCTs would still need to maintain pharmaceutical lists locally, and the remuneration paid to pharmacists by the NHS would likely increase if there were to be an increase in the number of pharmacies once the control of entry regulations were removed.

John D'Arcy believed that there was competition between pharmacies under the present arrangements and that service innovation was already under way, as set out in the government's policy document *Pharmacy in the Future*. He emphasised that the NHS was the biggest customer of pharmacy services since more than 80% of the turnover of an average pharmacy is derived from NHS work, and that NHS policy and patient need should dictate the location of pharmacies and the development of services.

In our view, competition amongst pharmacies is an important driver of quality, and we support quality improvements in community pharmacy. The question is not whether competition is a good thing, rather it is whether abolishing control of entry would have the desired effect in relation to quality and service improvements. We believe that here it is a matter of achieving a balance between the implementation of competition theory and the government's health planning requirements. Pharmacies operate in a planned NHS system. They are not like other retail outlets. Indeed we share the view expressed by the Health Secretary, speaking at the 2002 Labour party conference: "Pharmacists are clinicians, not shopkeepers". This means that health policy should be influential in determining the basis on which pharmacy services are provided. We agree with John D'Arcy's assertion that the OFT concentrated on competition policy considerations rather than the requirements of health policy. We look to ministers to achieve balance between the two; that is, ensuring good competition within the context of a planned (as opposed to free-market) service.

Innovation

Everyone in the debate over the OFT's proposals wishes to see innovation in pharmacy service provision. Much of our work over the past year or more has involved studying service developments, and exploring ways to increase the pace of change for the benefit of patients. We have not found pharmacists reluctant to innovate nor unwilling to move quickly towards new service arrangements.

Others too are beginning to recognise the potential in community pharmacy. The Regulatory Impact Unit in the Cabinet Office has calculated that transferring responsibility for repeat dispensing from GP surgeries to community pharmacies could save 2.74 million GP hours. In Scotland, pilot schemes in which community pharmacists have treated minor ailments have proved so successful that the service will soon be provided nationally. Estimates suggest that if one quarter of patients who currently consult their GP about minor ailments instead consulted a community pharmacist, the NHS could save £380million each year.

Service development and innovation is an issue closely linked to the discussions between the PSNC and the Department of Health on the structure of a new national pharmacy contract. Innovation is not wholly - we would argue, not mainly - contingent upon the retention or abolition of control of entry. Rather, it rests on altering the contractual arrangements under which pharmacies provide NHS services. The current contracts place emphasis on the dispensing of NHS prescriptions, and payments to contractors are heavily dependent on dispensing volumes.

We do not expect or wish to see dispensing overlooked in a new contract but we believe that emphasis also needs to be placed on additional services such as minor ailment schemes, medication review and medicines management. If so, the desire among pharmacists to develop these services can be harnessed and recognised, and quality improvements will be realised. At present, under the existing contract, progress is patchy and LPS arrangements have yet to have a significant effect on service development.

We have some concerns over the future of those service developments that have already taken place, were the OFT's recommendation to be implemented. Many such services, such as the supply of methadone to drugs misusers, the provision on the NHS of emergency contraception, and domiciliary oxygen therapy tend to be provided mainly by neighbourhood and high street pharmacies. If there were to be a growth in the number of supermarket pharmacies at the expense of existing providers, we would have some concerns as to the future of specialist services. How many supermarket pharmacies would provide oxygen therapy or counselling for drugs misusers? We are aware of a number of supermarket outlets that have chosen to withdraw from NHS provision of emergency contraception.

Doctor-owned pharmacies

One likely effect of de-regulation would be the growth of pharmacies set up and owned by GPs in their practice premises. Dr Peter Fellows, chairman of the prescribing committee of the BMA, told us that this was likely to happen and that it would be unwelcome for all concerned. He wished to see more partnership working between GPs and pharmacists, pointing out that GPs needed community pharmacists to help them if they were to successfully implement their own new contract. De-regulation would instead encourage GPs to establish pharmacies thus creating tensions and divisions between the two professions. Dr Fellows told us "it is a war we do not wish to fight".

We share the concerns raised by Dr Fellows. GP owned pharmacies would almost certainly be one consequence of implementing the OFT's recommendation. It is significant that none of the OFT's location modelling, or its calculations relating to possible pharmacy closures, factored in the effect of GP-owned pharmacies. The OFT assumed that no practice would open a pharmacy if there were an existing community pharmacy within 300 metres. We regard that as counter-intuitive, and it casts doubt on the validity of many of the OFT's assertions regarding access and pharmacy closures. We believe the effect of GP-owned pharmacies on existing service provision under the current contract (where volume of dispensing is crucial to economic viability) would be profound. We would expect many neighbourhood pharmacies to be under threat of closure if GPs were to open pharmacies.

Ironically, closure of such pharmacies and the proliferation of doctor-owned pharmacies could lead to less rather than more competition, especially in the OTC medicines market.

Bureaucracy

The control of entry system requires PCTs to consider applications to open pharmacies and to move pharmacies from one set of premises to another. These processes can be time-consuming for PCT managers, not least because frivolous applications are not unusual, and objections are often raised against new applications. Appeals against PCT decisions often take place. Nevertheless, it does not follow that abolition of the current system will remove the need for PCTs to manage community pharmacy provision locally. They will still need to maintain a list of pharmacies and they will inevitably wish to have some say in pharmacy locations since their own needs assessments are likely to require development of pharmacy services locally.

There are problems with the current arrangements. Even those who oppose the OFT's recommendation admit as much. The issue in our view is whether outright abolition of the system in favour of an unregulated market is an appropriate solution. We do not detect a desire amongst PCTs to see unregulated provision. Rather, we think they may prefer to see improvements made to the current arrangements. In this context we look to the Department of Health and representatives of community pharmacists and PCTs to work together to identify improvements.

Conclusions and recommendations

We support the development of pharmacy services in the community. We believe that *Pharmacy in the Future* set the right direction of travel though we have some concerns over the pace of change. Competition, innovation and quality improvements are important measures of progress. We are at one with the OFT in seeing these as desirable objectives. The question is whether abolishing the current control of entry regulations in favour of an unregulated market will be more conducive to achieving them.

Abolition would be a radical step. We are not convinced that it is the right way forward. We believe it would result in an increase in out-of-town supermarket pharmacies and in pharmacies owned by GPs and located practice premises. Neighbourhood pharmacies would be squeezed by these developments.

We are looking to policy makers to achieve the outcomes we all wish to see through a planned and managed service, since pharmacy is principally a frontline part of the NHS and should not be regarded simply as part of the retail sector.

We would expect a de-regulated market to lead to access problems for those who have to rely on neighbourhood services, and we would expect to see significant volatility in the pharmacy sector as pharmacists divert their attention to managing and anticipating location issues. We would prefer to see them continue to concentrate on service developments and patient needs. De-regulation would likely prove a distraction for PCTs and others (GPs in particular). We believe this is undesirable and unnecessary.

Stability also enhances patient care in that a pharmacist providing continuity of care is able to build a strong and positive relationship with patients. Constant change would disrupt this process. Likewise stability in the number of pharmacies helps in the management of pharmacist cover and service development.

However, we do not agree with those who believe the current arrangements cannot be improved. We believe changes can be made which would make community pharmacy more responsive to the needs of patients locally. We believe PCTs can be given greater discretion to ensure this happens. It is not our role, especially in view of the timescale, to set out precisely how that might happen. Rather, we expect to see all the stakeholders work together collaboratively to achieve this outcome.

Whatever the government decides to do in response to the OFT, we are concerned that the uncertainty and doubt it has created within the pharmacy sector is removed as quickly as possible. Pharmacists should be focusing their effort and energy on delivering and developing patient services, not on seeking to second guess whether there is about to be a major change to the rules governing the location of pharmacies.

The OFT in its report has sought ways of increasing access, choice, competition and quality. We have no dispute with these objectives, indeed we share them. If achieved, they would bring tangible benefits to patients. However, we are not convinced that outright de-regulation would achieve these outcomes.

We therefore recommend that the Department of Health works together with the NHS Confederation, on behalf of PCTs, and the PSNC, on behalf of the community pharmacy sector, to identify ways of achieving improved access, more choice, service development, competition, and quality improvements. We firmly believe that a collaborative effort between these parties, in consultation with relevant stakeholders (the BMA and patient organisations, for example), is required.

We also recommend that, as part of that collaborative process, problems caused by the current control of entry arrangements are identified and proposals developed for resolving them. As a part of this exercise, we recommend that **additional information is collected on the opening hours of supermarket pharmacies and others.**

We recommend that the collaborative efforts we have described, and consequent changes to control of entry, take place in the context of changes to the national contractual arrangements, since the issues are so closely linked. We also **recommend that the Department of Health commits itself to an implementation date for the new national contract,** so that all stakeholders are clear about the timescale and their role within it.

Finally, we recommend that ministers announce their decision as quickly as possible so as to remove the uncertainty and distraction within pharmacy.

We expect to return to this matter again once the government, working with others, has resolved a way forward.

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