AN ECONOMIC ANALYSIS OF THE IRISH RETAIL PHARMACY MARKET WITH A FOCUS ON COMPETITION POLICY ISSUES

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This essay by David Power provides a comprehensive analysis of the Irish retail pharmacy market. The author, starting from a brief market overview, proceeds to scrutinize the market structure, nature of the competition and existing barriers to entry. The paper is concluded by the critique of existing regulation in the market and suggestion of several reforms that would benefit Irish consumers.

Introduction

This study covers the provision of retail pharmaceutical services in Ireland. In particular, it examines whether the interests of consumers are best served by the current control of entry regulations. These regulations place restrictions on how and where contracts to dispense 'pharmacy-only' medicines in Ireland are awarded. The sector is clearly over-regulated, and entry is restricted to protect the profits of the incumbents. In this essay, I propose to demonstrate that deregulation will serve consumers interests, thus refuting the claim that restrictions are necessary to protect the markets and incomes of pharmacy owners.

The structure of this essay is to first, describe the retail pharmacy sector in Ireland and then to undertake an economic analysis of this market. The latter forms the core of this study and will involve a look at the nature of competition within in the sector, as well as the entry barriers that currently exist. The arguments for entry barriers will be discussed and rejected, and finally I will offer some suggested reforms to deregulate and then conclude.

The Competition Authority (2002) has recently investigated the regulatory situation in Ireland with respect of retail pharmacies and found that margins on private prescriptions in Ireland are the highest in the EU. The margins for a typical pharmacy outlet are 45% on private prescriptions, over double the margins of 19% on prescription medicines dispensed under General Medical Services (GMS). Bacon (1999) has shown that in a European context, these figures are even more staggering. Irish pharmacy margins on medicines, at 33%, were just under 1.5 times the EU

average (23.2%), and nearly 5 times the corresponding figure for the UK (7.5%). The reasons for such wide differences should be investigated in terms of regulation, competition policy and entry barriers.

Market Description

The continuing development of Irish retail pharmacy chains, the arrival of UK multiples, economies of scale, professional marketing techniques, and cost effective purchasing power has combined to put pressure on the traditional pharmacist to become increasingly commercially focused in their approach to community pharmacy.

Product Market

A retail pharmacy provides services in respect of four main categories of products:

1) Prescription medicines, i.e. a doctor's prescription is required for purchase;
2) Pharmacy-only Over-The-Counter (OTC) medicines;
3) Unrestricted OTC medicines;
4) A range of non-medicinal products; often referred to as cosmetic, toiletries and sundries (CTS).

Table 1 shows that estimates of nationwide turnover figures for each of the four categories indicate that the dispensing of prescription medicines forms the core business of pharmacies (61% of sales).

Table 1: Retail Pharmacy Sales in Ireland by Product Type

Category	Product Type	Sales €m 2001	Sales %
Pharmacy-only medicines	Dispensed medicines	702	61 %
	Pharmacy-only OTC medicines	179	16 %
Retail products	Unrestricted OTC medicines	18	2 %
	Cosmetics, toiletries and sundries	253	22 %
	Total	1,152	100%

Source: The Competition Authority (2002)

Pharmacy-only medicines distinguish a pharmacy from other retail outlets. The Pharmacy Act (Ireland) 1875 prohibits non-pharmacy retail outlets from dispensing prescription medicines. Unrestricted OTC medicines may be sold in any

type of retail outlet. However, only 10% of OTC medicines fall into this category. The total turnover of retail pharmacies in 2001 is estimated by at €1,152 million; for pharmacy-only medicines the corresponding estimate is €881 million.

Geographic Market

Demand from pharmacy customers tends to be local in nature. A number of factors influence the consumer's choice of retail pharmacy, including its location, price competitiveness, product range, and quality of service. This market is therefore hard to generalise, as it depends on location and varies in size and scope for each pharmacy. However, work by Hoban (1999), presented in Table 2, identifies three groups of pharmacies separated according to profitability.

Table 2: Types of Pharmacies in Ireland 1996

Class	Location	Net Profit Margin	Turnover	Number of outlets	% of Total Profits
A	Prime retail locations	15% +	£700,000 +	250	50%
B	Cities/ Large towns	7-15%	£400-700,000	550	40%
C	Rural	0-7%	£0-400,000	400	10%

Source: Hoban (1999)

The first, Group A, includes pharmacies in prime retail locations where economies of scale have enabled the net profit margin to grow to over 15% of turnover. They account for a disproportionate amount of total industry profits (50%), and are thus very attractive as commercial entities. Group B is the most numerous category and are generally located in large towns or cities or are the sole trader in smaller towns. Class C earn low or zero profits, and in effect provides a social service and a cost efficient distribution method for the Department of Health and Children.

Market Structure

As at March 2001, there were 241 hospital pharmacies and 1,202 retail pharmacies in Ireland (TCA, 2002). Retail pharmacies have traditionally been small, independent, single-location operations, but chains of pharmacies are becoming a more prominent feature of the Irish market. In 2001, 32% of retail pharmacies in Ireland belonged to a chain of two or more outlets. Most outlets (90.4%) are owned by pharmacists (Bacon & Associates, 1999).

Table 3: Ratios of Community Pharmacists in Europe (1993)

Country	Inhabitants per Community Pharmacy	Inhabitants per Community Pharmacist	Pharmacists per Pharmacy
Austria	8,000	2,224	3.6
Denmark	17,000	4,525	3.8
Ireland	3,070	2,800	1.1
Sweden	11,600	11,600	1.0
United Kingdom	4,810	2,741	1.8

Source: Based on MacArthur, D. (1995) *The Growing Influence of the Pharmacist in Europe: opportunities in a changing market*. Table 1.3. London: Financial Times Publishing

Concentration

Table 3 shows that concentration of pharmacies varies throughout Europe. The result is that Ireland ranks 5th in Europe in terms of the number of pharmacies per head, meaning that access is relatively good for consumers. Concentration levels are low, with the largest chain holding 4.3% of the total market. However, this figure is not particularly important, as it is the local market and not the national market that is the relevant focus.

Economic Analysis

It is clear that regulations restrict who may operate a retail pharmacy and where the pharmacy may locate. Adopting the approach of the Office of Fair Trading (1997) in the UK, this investigation is guided by the principal that competitive markets to which there are no barriers to entry generally serve best the interests of consumers. Therefore, I will consider whether consumers will be better served if the highly regulated and closed shop pharmacy sector was to be deregulated. However, I will also remain mindful of the public policy objectives of the government.

The Nature of Competition

Price competition and location competition between retail pharmacies has been regulated to a very large extent, therefore non-price competition is strong. Four dimensions of competition are usually identified (Ibid):

1) Pricing
2) Geographical location
3) Product selection
4) Level and quality of retailer service

Price Competition

Normal forces of supply and demand do not apply. 61% of sales come from dispensed medicine, which requires a doctor's prescription. Also, the GMS scheme set prices at wholesale levels. However, private customers are charged the wholesale price with a 50% mark-up rule plus the dispensing fee. This horizontal agreement is not explicit and so may vary, however pharmacists implicitly collude through the Irish Pharmaceutical Union (IPU) to agree to this general mark-up rule.

Location Competition

As outlined earlier, demand from pharmacy customers tends to be local in nature, as customers are generally not willing to travel long distances to obtain medicines. While there is no location restriction preventing a registered pharmacist from opening a pharmacy without a GMS contract, most pharmacies would consider a GMS contract essential. The 1996, 'location restrictions' effectively capped the number of pharmacists in each locality. In 2002, their removal was welcomed.

Product Selection

In recent years, the range of products available has increased dramatically, as cheaper generic substitutes for prescription medicines have entered the market. Secondly, the increasing entry of European wholesalers such as Gehe has provided access to a larger distribution system of more products. Thirdly, there is also a trend away from semi-ethical prescription medicines towards OTC self-medication medicines. This widens consumer choice, and also favours the broadening of distribution outlets at retail level to include supermarkets, etc. thus forcing manufacturers to become more customer-focused.

Quality Competition

Quality of care is an important aspect of the service that pharmacists provide as community health care professionals. Customers' value has come from a strong pharmacist-patient relationship that has been effectively provided by independent Class C pharmacies up to now. However, the entry of new chain retailers such as Boots has not resulted in reduced level of service, as they recognise the importance of quality competition in the market. Indeed, it could be argued that they have increased dynamic efficiency by introducing new innovations such as late evening and weekend opening hours.

Entry Barriers

Typically, entry restrictions to any market result in prices being higher, innovation lower and quality of service poorer. A considerable body of regulation surrounds the education, registration, employment and professional practice of pharmacy in Ireland. This regulatory framework began with the Pharmacy Act (Ireland) 1875, which set out that only Pharmaceutical Society of Ireland (PSI) registered pharmacists would dispense prescriptions. The Health (Community Pharmacy Contractor Agreement) Regulations (1996), '1996 Regulations', further restricted competition in the sector, by effectively limiting the number of GMS dispensing pharmacies through 'location restrictions'.

There are two main arguments the IPU and others advance in support of regulation. However from a competition policy perspective these restrictions are detrimental to consumer welfare.

(a) The 'Quality of Care' Argument

The main rationale put forward for the restrictions on competition introduced in the 1996 reforms was that it is necessary to protect the markets and incomes of pharmacy owners. This is expressly stated in Regulation 2(1): a new pharmacy should "not have an adverse impact on the viability of existing community pharmacies in the area." The aim of this legislation was to allow pharmacists to develop the quality of the service they offer as community health care professionals, in accordance with the long-term strategy of the Department of Health and Children. However, it does not follow that quality will be improved by ensuring that there is no local competition. Bacon (1999) proposed that the most appropriate way in this case to improve quality is not by restricting competition but to regulate for quality.

From a competition policy perspective, regulating for quality is appropriate as it can deter 'free-riding' by pharmacies that fail to meet the Department of Health and Children's requirements for pharmacies to deliver a quality service as community health care professionals. Pharmacists that fail to provide these pre-sale services could increase profits by free-riding on the quality certification that the other pharmacists would confer on OTC medicines and CTS products. A community pharmacist is providing a service, not just a product. Thus, pharmacies must provide a whole range of advisory services on a daily basis, as well as delivering the various GMS schemes, and not just dispense medicines. It is difficult to regulate for quality, but one possible way is to grant or renew contracts subject to an inspection or audit of services provided. This would help achieve the National Health Strategy goal that a close on-going relationship between providers and users of primary health care services is important.

Another reason why services may not be reduced is that competition among pharmacies is not price driven, but focuses on non-price competition. Of vital importance to this is the level and quality of services available. Therefore, as Gehe have outlined (TCA, 2002), service levels at multiples may in fact be higher. Rigorous staff training in customer care was provided, and considering that over 90% of managers were pharmacists in Gehe pharmacies, the level of care is not compromised. Secondly, the entry of multiples and resultant increase in competition improves dynamic efficiency. It has served as a catalyst to improving service and introducing innovations. Longer opening hours, weekend opening and home deliveries are some examples of innovative measures that have improved customer service.

(b) The 'Protecting Strategic Interests' Argument

A second argument identifies an interest of society in general arising from the protection of the ownership structure currently existing (Hoban, 1999). Basically, this relies on an argument that locally owned pharmacies are in the interests of society. However, this argument does not make economic sense and has not been proven. It is not clear, what, or how great, the benefits from having profits accruing to shareholders of smaller businesses (i.e. independent pharmacists or small chains) rather than shareholders in larger companies (i.e. larger multiples), will actually be. The fear is that larger pharmacies will fall into the hands of highly efficient operators and will crowd out smaller operations.

However, the 1996 regulations have only served to make the already viable pharmacies even more valuable. The IPU's argument that smaller 'Class C' pharmacies in more rural areas would be under threat and possibly disappear is unfounded, since no one would wish to start up a pharmacy to compete in such a locality anyway. They seem to present 'Class C' pharmacies as providing a social service to customers and operating at a loss, whereas it is clear that no business would continue to operate at a loss in any area. In fact, it has been the larger 'Class A' pharmacies that have become even more profitable, because competitive entry was restricted. So, despite the restrictive entry barriers, multiples will be attracted, rather than deterred, to the market, due to these high profits.

Principal-agent concerns are also relevant in this case. Opponents of deregulation would also argue that restrictions should be retained, as the growth of multiples will result in services being reduced. Small, independent, pharmacist-owned and run pharmacies have a long-term commitment to the locality, whereas financially motivated multiples may not demonstrate this concern. I believe there is merit in this argument as employees in multiples may be faced with principal-agent issues. Since they do not own the pharmacy, there is less of an incentive to develop strong client-customer relationships and there is likely to be a higher turnover of

professional staff. However, I believe that a partial solution to this problem is to place limits on ownership to maintain local ownership by pharmacists.

The Consumers Association of Ireland (CAI, 2000) challenged the 1996 regulations, by showing that while they may have been well intentioned, they have had the opposite effect. The regulations introduced unnecessary barriers to entry and resulted in a closed shop. They created monopoly power for incumbents, which I believe is anti-competitive and protectionist at its worst, as it is not in the best interests of consumers. On foot of the CAI's challenge, the regulations were finally dropped in January 2002.

Suggested Reforms

To improve the competitive situation of the market, I believe the government could adopt a number of measures. Firstly, the market should be opened up to competition. As has been shown with the failed 1996 regulations, placing restrictions on entry and thus limiting the number of pharmacies is detrimental, as it increases monopoly power of the incumbents and excludes competition. The granting of public service state contracts to new pharmacies should be open to all qualified pharmacists. If there is a sufficient population to grant a new contract then surely this is sufficient evidence of viability and the adverse effects on existing pharmacies should not be considered. Otherwise, inefficient pharmacies will be protected from direct competition, and the deadweight loss to consumers will be greater.

Secondly, limits on ownership should be introduced to ensure pharmacy services are kept localised. This measure may not necessarily be economically efficient, however wider social goals regarding access to pharmacy services take priority. The CAI suggests limiting ownership to two or three pharmacies. At present a review group is drafting a new regulatory system that is considering capping ownership at 10% of pharmacy contracts in each health board area (The Pharmaceutical Journal, 2002).

Thirdly, subsidisation could be introduced in order to meet the government's wider social goals for pharmacy services. The long-term strategy of the Department of Health and Children wants pharmacists to deliver a quality service as community health care professionals. This service is, in essence, a public good. Central to this idea is equal service to all; therefore, a subsidised system of financial support for pharmacists operating in remote and poorer areas would ensure the preservation of pharmacy services in these areas.

Fourthly, the supply of pharmacists should be increased. The Bacon report (1999) has analysed the labour market for pharmacists and concluded that the profession has been experiencing excess demand against a background of restricted supply. Recent moves by UCC and RCSI to introduce pharmacy degree programmes,

along with TCD's existing programmes, have more than doubled supply to 170 graduates per year (The Irish Times, 2001). Restricted supply also results in a misallocation of talent as entry requirements are high, which is costly from a societal point of view. Fingleton (1994) see this as a resource allocation problem, as pharmacists are involved in rent seeking because their talents are being under-utilised.

None of this is an argument for a free market in the pharmacy sector. This is not possible for a number of reasons and indeed many of the regulations are beneficial. For example, the system whereby the Department of Health and Children negotiates wholesale prices with the manufacturers appears to be a very effective means of counteracting the extreme market power that the drug companies would otherwise enjoy in negotiations with individual pharmacists.

Effects of Deregulation

The Office of Fair Trading (1997) in the UK admits that it is difficult to estimate precisely the potential benefits to consumers that would derive from deregulation, in the form of increased price and quality competition. However, they do point out that prices may drop, and cite the example of some national supermarket pharmacy chains that offer substantial price savings on OTC medicines of up to 30%.

While direct price benefits would not accrue to customers under the GMS scheme, private customers of pharmacy-only medicine would surely see price competition reduce prices, which would reduce excessive profitability among many pharmacies, and would result in longer-term improvements in the efficiency of pharmacies. This could further fuel cost savings, which would benefit pharmacies and could also be shared with consumers.

Conclusion

Returning to the introduction, The Competition Authority (2002) has shown that margins for a typical pharmacy outlet in Ireland are 45% on private prescriptions and 33% on all medicines. This is just under 1.5 times the European average. In this essay, I have attempted to analyse the reasons for these large profits in terms of regulation, competition policy, and entry barriers.

Typically, entry restrictions to any market result in prices being higher, innovation lower and quality of service poorer. The Irish retail pharmacy market is heavily regulated. As mentioned, I advocate the principle that competitive markets to which there are no barriers to entry generally serve best the interests of consumers. Two main arguments are offered in support of regulation, the 'quality of care' and

the 'protecting strategic interests' arguments. However, I have shown that both these arguments fail to benefit consumers and are only advanced to protect the interests of incumbents by restricting competition. Reforms could be introduced to help speed up deregulation: opening up the market to competition, limiting ownership, subsidising less profitable pharmacies to meet wider social goals and increasing the supply of pharmacists.

Regulation is not always bad, but the onus lies with the government to present conclusive arguments in favour of restrictive legislation, such as the 1996 regulations. Otherwise, legislation risks favouring particular groups, to the overall detriment of society.

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