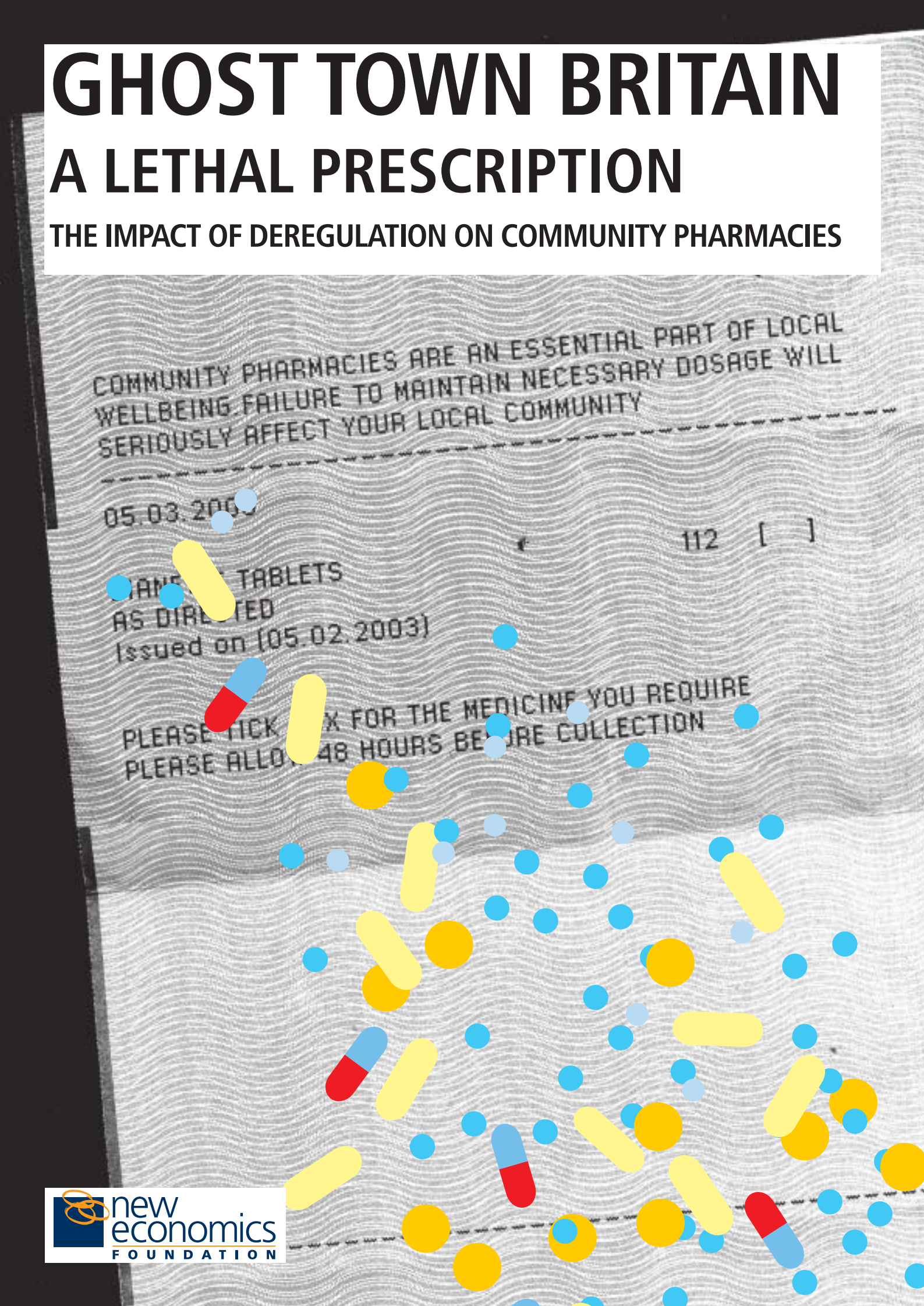
GHOST TOWN BRITAIN

A LETHAL PRESCRIPTION

THE IMPACT OF DEREGULATION ON COMMUNITY PHARMACIES



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Pharmac

CONTENTS

CONTEXT

In December 2002, the New Economics Foundation published a report – *Ghost Town Britain* – that underlined how fast our local services – including corner shops, grocers, banks, post offices and pubs – are disappearing. The change is happening most visibly in villages and market towns – but the picture is just as dramatic in many larger urban and suburban areas.

Between 1995 and 2000 we lost roughly one-fifth of these vital institutions – the fabric of our local economies. If current trends continue, we will lose a third more over the next ten years. The result is *Ghost Town Britain* – an increasing number of communities and neighbourhoods that lack easy access to local banks, post offices, pubs, corner shops and other services that provide the social glue that holds communities together.

Ghost Town Britain argued that many of the services in our communities are potentially reaching a 'tipping point' – rather than following the current steady rate of decline. When the number of local retail outlets falls below a critical mass, the quantity of money circulating in the local economy will suddenly plummet as people find there is no point in trying to do a full shop with an impoverished range of local outlets. This means a sudden, dramatic loss of services – leading to food and finance deserts.

The social and economic effects of this can be disastrous. The hardest hit by such economic and social decline are those with the least access to alternatives – the elderly, single parents and those without private transport. As a result our economy becomes more and more dependent on an alienating and unsustainable car culture as people are forced to drive further and further away from their homes and local areas to obtain their key comestibles and other supplies. We are half ghost and half gridlock Britain.

COMMUNITY PHARMACIES – THE MISSING LINK

Not discussed in *Ghost Town Britain* was the plight of local pharmacies. This is because, to date, the 12,250 community pharmacies on our high streets have been in relatively a protected position. Under regulations introduced in 1987 only those pharmacists who have satisfied health authority requirements that their services are 'necessary or desirable' for a local area are currently given dispensation to provide NHS prescriptions. These prescription rights are what make local pharmacies viable. Some 80 per cent of local pharmacy income is derived form NHS prescriptions – the sale of other cosmetic or bathroom products makes up for the remaining 20 per cent.

This policy of 'market regulation' has had the effect, according to the Office of Fair Trading (OFT) of blocking any new pharmacy businesses from being able to enter the market. Because the sorts of outlets that are allowed to dispense prescriptions has been controlled and licensed by the NHS, it argues, the opportunity for competition in the pharmacy market is artificially limited.

In January 2003, the OFT put forward a recommendation that restrictions should be removed from the community pharmacy market. It argued that liberalising the licensing scheme would give consumers more choice and access to pharmacy services. This briefing aims to examine that claim – in the light of what has happened to the rest of Britain's local services.

If the existing 12,250 community pharmacies were to follow the trend of the other local services investigated in *Ghost Town Britain*, an average decline of about 4 per cent a year would mean a loss of more than one pharmacy per day.

The OFT's modeling projects a possible 900 new pharmacies in the large supermarkets that currently don't have them, and a further 2,127 pharmacies in medium sized stores. This could make a potential 3,027 new supermarket-based pharmacies – which would present a grave threat to many of our local community pharmacies.

Research commissioned by Lloyds Pharmacy in January 2003 shows that at present 6,624 pharmacies are located within the catchment area of two or more supermarkets, which suggests that a very high number of pharmacies are under a potential threat. This could translate to as many as 145 pharmacies being lost in an urban area such as Birmingham.[1]

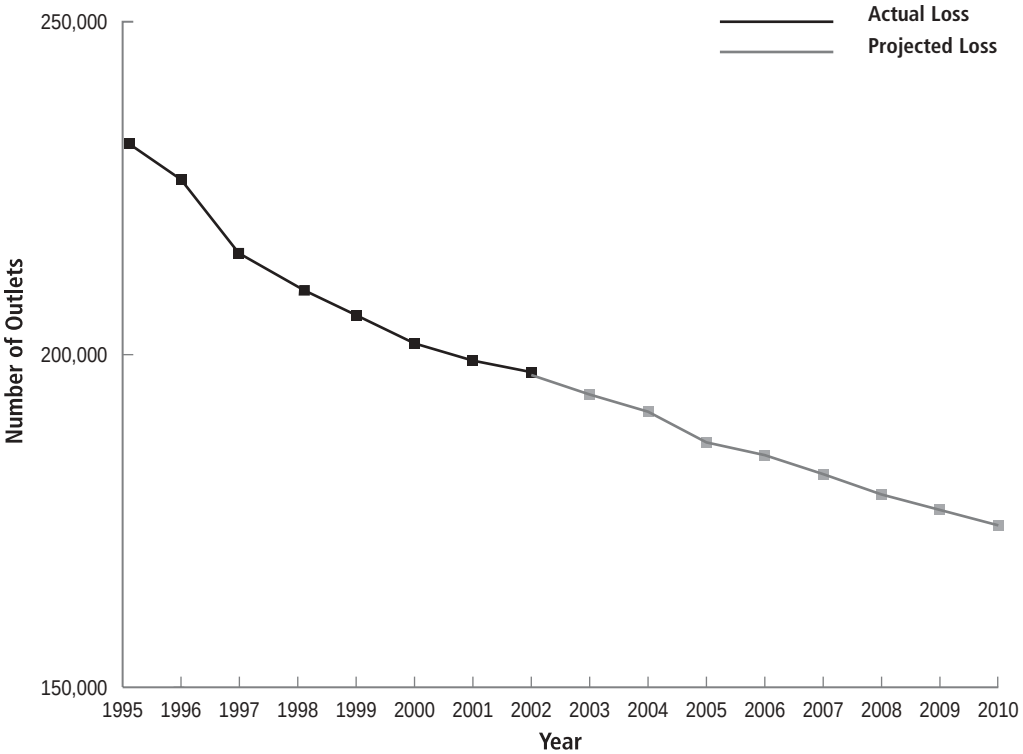

Figure 1: Ghost Town Britain – Loss of Local Retail 1995-2000 and projected to 2010

This graph is based on analysis of data from disparate sources combining trends over the last decade for five key local economic institutions: banks, post offices, pubs, grocers, and corner shops (confectioners, tobacconists and newsagents).

THE POTENTIAL EFFECTS OF DEREGULATION

'The ambitions of supermarkets to dispense prescriptions may have a seriously adverse effect on local pharmacies, to the detriment of the sick, in general, and the elderly sick, in particular, who find it hard to get to out-of-town supermarkets.'
Lord Borrie, former Head of the OFT [2]

No one opposes the widest possible range of consumer choice for any service, but is deregulation the best way to achieve it? Who are the winners and losers?

Amongst the most supportive voices of pharmacy deregulation are the supermarkets, some of which already have in-store pharmacies – especially in those areas that have no other local prescribing services. The benefit of deregulating pharmacies for them is that they will be able to offer all of the services currently available through the high street pharmacist. Along with selling newspapers, clothing ranges and large household items such as televisions and stereos, supermarkets would be able to offer prescriptions under the same roof as readily as all other groceries. It is the next step in their attempts to offer the one-stop shop.

For community pharmacies, supermarket sales of prescription drugs could signal the beginning of a decline similar to that experienced by independent food retailers over recent years. Studies have found that between 1995 – 2000 food specialists – fishmongers, butchers and so on – saw their sales drop by upwards of 40 per cent, as supermarkets consolidated their grip on these sectors.[3] Fifteen years ago there were 47,068 independent grocery retailers in Britain. Today that figure has been slashed to just 28,319.

Supermarkets have very successfully been able to undercut other retail providers. This is partly due to their cheaper overheads, the control they have over producers, and therefore pricing of goods, and the fact that they can offer so-called 'loss leaders' on products. This is the advantage that being part of a large, sometimes international, business affords.

As recent coverage of the possible take-over of Safeway supermarkets has indicated, the industry is becoming increasingly cutthroat. This is not just played out at boardroom level. It also means that the cost of certain goods are beaten further and further down. So it is fair to assume that in the short-term supermarket takeover of the pharmacy market might bring down the cost of some over the counter drugs, to some degree.

However in many areas where supermarkets have 'out-competed' local retailers through predatory pricing and loss-leader tactics, the cost of goods has risen again once the supermarkets have gained a monopoly position in the local area. Deregulation is therefore likely to lead to less, not greater, competition and consumer choice, and could restrict access to vital medicines amongst people unable to travel to the nearest supermarket.

There is also the frightening prospect of a 'Brave New World' of alliances between big supermarkets and the global pharmaceutical giants, ruled by shareholder profit and mutual self-interest. Pharmaceutical companies tend to be amongst the most heavily subsidised by government (for research and development purposes) of any industry in the world. They also enjoy unprecedented market protection under patent laws and regulatory requirements that make a mockery of the 'free market' that the OFT argues for in the case of community pharmacies.

Even in times of economic slowdown, the pharmaceutical industry regularly enjoys profit margins in excess of 30 per cent. This has been the case since the end of the Second World War, as the expansion in global healthcare demands, and an ageing population has provided a 'captive audience' for their products. A period of mergers amongst the big pharmaceutical giants over recent years has led to an industry that is almost unprecedented in the stranglehold enjoyed by a handful of companies.

The growing importance of the pharmaceutical industry gives it a powerful political influence. Not only have they cornered the market of drug production, they can also prevent any effective competition, both through the patent system and by their unrivalled ability to control supply and price.

Some interest groups, however, are less concerned about a decline in the numbers of local pharmacies, but rather fear that deregulation will lead to the re-location of these vital local services. The National Pharmaceutical Association, which represents around 11,000 community pharmacies, argues that range and choice of the current pharmacy network will be reduced as pharmacies cluster around GPs surgeries and profitable urban areas in order to survive. This will leave rural or deprived areas particularly vulnerable to becoming healthcare deserts of the future. NPA Chief Executive John D'Arcy argues that 'The only winners from (the OFT recommendations) will be the shareholders of the large, better-resourced players, whose main concern is profit rather than patients healthcare services.'

THE ROLE OF COMMUNITY PHARMACIES

Who visits a pharmacy?

Your local pharmacy serves, on average:

- **50 diabetics**
- **150 asthmatics**
- **500 hypertensives**
- **20 cancer patients**
- **10 mental health patients**
- **8 colostomy**
- **50 pregnant women**
- **750 older people**
- **500 under fives**
- **600 carers**
- **50 hospital discharged patients**

- **and pharmacists give free advice 2,500 times a month**

Community pharmacies fulfil a social function. To examine their role from the limited perspective of their retail potential alone, as the OFT remit demands, is to miss their central purpose. They not only provide accessible prescriptions services, but also act as the launch pad for many Department of Health initiatives. They provide a vital one-stop shop not only for emergency contraception and other health advice, but also for programmes such as stopping smoking, cardiac advice and controlled methadone distribution. It is unlikely that among the aisles of fresh, washed salad, blue cheese and Sunny Delight that these are roles supermarket pharmacies would like to take on.

High street pharmacies are a crucial lifeline in many communities especially for those who do not have easy access to a car and therefore to any large out-of-town shopping facilities. As in other parts of the ghost town, we are in danger of replicating many social problems when areas become a health-facilities desert.

Areas that lose any ready access to a vibrant local economy tend to be less attractive to live in. There is no 'social glue' that holds them together. People lose economic fluency. Entrepreneurs have no local economy to contribute to. The unemployed lose local routes back into work. As a result these can often be areas of higher crime – and the consequent insecurity that this leads to.

The loss of local, community pharmacies could have a bigger impact on the high street than has been acknowledged by the OFT. Unlike many other independent retail outlets, banks are very supportive in their lending practices towards pharmacies because they know that their service and supply and demand assessments are secure and ongoing. So the knock-on effect of community pharmacy loss to other outlets could be very significant. The Countryside Agency found that each post office closure, for example, caused an estimated 15 percent drop in trade for local shops in rural areas. And local traders report losses of between 10 and 30 per cent when the last local bank closes.[5]

Economically deprived areas are particularly vulnerable. The Department of Health's own studies[5] outline the strong links between socio-economics and community health. In her introduction to the Government consultation Tackling Health Inequalities, then Health Minister Yvette Cooper explicitly committed her Government to create better life-chances for all of our communities. As Ms Cooper underlined:

'What greater inequity can there be than to die younger and to suffer more illness throughout your life as a result of where you live, what job you do and how much your parents earned?' [6]

The harsh reality is that levels of illness are strongly determined by how wealthy you are and how economically viable and thriving your local area is.

As a result of this demands on health services in socially deprived areas tend to be much higher than in wealthier areas. According to the Office of National Statistics low income households have on average twice as many annual visits to the doctor as high- income 'professional' households. We can extrapolate from this that demand for primary care services is therefore twice as high in deprived as in affluent areas.

Whilst serious and ongoing medical conditions will always need the intervention of a GP, an ambulance or hospital visit, however, it is worth looking at how many GP appointments are absorbed by non-essential visits. Typical examples are repeat prescriptions and the ubiquitous winter sore throat or cold. Research published by London Ambulance Service NHS Trust indicated that 40 per cent of calls made to it were non-essential[7] – certainly not worthy of an ambulance or hospitalisation.

So with services already stretched to these sorts of levels it is worth considering the additional burden of those calls on medical assistance from those who will be unable to access a local pharmacy. On an average day, a pharmacist in a busy local high street might offer advice to many people who would otherwise be contacting their GP for advice.

And plans were outlined in the NHS Plan Our Healthier Nation to relax current prescriptions laws sufficiently to allow pharmacists to give repeat prescriptions. This would, it is estimated by the Cabinet Office, save an incredible 2,545,455 GP appointments a year[8]. But undermine community pharmacies and that burden-easing will be lost.

Community pharmacies are, by their very nature, rooted in the communities that they serve. A local pharmacist, as well as having an understanding of their area, is a trusted member of the community able to give frontline advice when necessary. They can also give advice anonymously, without the customer having to have a written record of their consultation – which is important for those not sure whether to book a GPs appointment or not, or with medical conditions they would rather not have on their patients notes.

A Community Pharmacist speaks:

Hemant Patel, Secretary of the North-East London Pharmaceutical Committee and past President of the Royal Pharmaceutical Society.

'Most people do a degree in pharmacy because they want to help the public. It is an idealistic job to do. When I qualified what I most looked forward to was working in the community – face-to-face contact with patients.

'Since World War II the emergence of big pharmacy chains – which now own 50 per cent of pharmacies – has resulted in an exodus from the pharmacy profession. I think there has been a consequent erosion of service too. A community pharmacist needs to be a trusted local figure, and one of the ways this happens is by continuous service.

'People tell me that supermarket pharmacies tend to be run by locums – as a result of which there isn't any continuity of service. Any sense of a face-to-face relationship is completely lost. Large chains also have profit-driven criteria for remaining in an area – not a commitment to the people that they serve.

'In Barking and Havering we've innovated lots of new practices through our community pharmacies – such as screening for osteoporosis to save people having to go to their GP.

'We're also trying to get a campaign called 'Warm Front' off the ground – which will ensure that older people get advice and assistance during the cold winter months. We wanted advice leaflets to be issued with prescriptions to our older customers – but none of the big chain pharmacies will agree to do this with us.'

Deregulation – and the consequential takeover of the pharmacy market by major multiple retailers – would mean the loss of this vital local lifeline for many members of our communities. Whilst the convenience of supermarkets for those with easy access to them and private transport is acknowledged, once again it leaves those with fewer alternative options – on the whole the most marginal and vulnerable in society – with a major service gap.

NHS Plan

In July 2000 the Government presented the NHS Plan, Our Healthier Nation, to Parliament. The core ethos of this document was to make the NHS more patient-focused and responsive and also to improve working conditions for those in the service. In relation to pharmacists one of its more far-reaching proposals was to give community pharmacies medicines management responsibilities and also allow them to do repeat prescriptions (for example for chronic conditions such as hypertension or diabetes). This would free up an enormous amount of non-essential GP contact time.

The NHS Plan was able to propose this scheme because the network of local pharmacies is so extensive and far-reaching, a real lifeline.

The present Government came to power arguing that it would not 'silo' policies and government departments but rather offer 'joined-up thinking'. It is unfortunate therefore that in this instance it would appear that the Department of Health and Department of Trade and Industry have such different approaches to offering choice in healthcare.

LOCAL ECONOMIC DOMINOES

The argument for local and community pharmacies runs deeper than just their role in maintaining an effective healthcare delivery and social service system, however. Pharmacies are part of the high street – and as every community knows, a thriving high street is good for business. The New Economics Foundation has developed an economic tool for actually measuring this fact. It is called Local Multiplier 3 (LM3) and it lets communities measure how money flows within their local area. Using this tool, communities can see how much of the money they spend locally is re-spent in the area, rather than going to the shareholders of big companies. So it is possible to see and measure the full effects of enterprise on the local economy.

In the case of local bank branch closures, Britain lost a quarter of its local network between 1990-2000 – some 4000 branches. This has left 25 per cent of households in the UK more than 5km from a bank. Not only has this left communities needing to travel further and further distances to access bank services – it also means they are far less likely to spend money in their local area, instead shopping where they use a bank.

The OFT points out that at present local pharmacies tend to be located near to each other – giving unprecedented local access to their services. Some two-thirds of pharmacies are within 500 metres of each other, with, on average, 78 other pharmacies within a 15 minutes drive time.[8] This means that the current levels of service are freely available and clearly economically viable enough to survive – even at such close proximity – which says a lot about high levels of local use and demand.

Pharmacies provide local employment – but they also provide an inducement to shop locally too. If people can service all their needs – banking, comestible, retail, medical – on one high street they will be more inclined to do all their shopping there. Furthermore a thriving and diversified high street economy means that local businesses are more likely to use one another's goods and services, and so keep money circulating within the community. Offering a wide variety of services in one place are a finely tuned mechanism – as soon as people have to travel out-of-town for one service, the rationale often follows that they will go out of town for all of them. This has been amply demonstrated by the closure of local banks.

SUMMARY

If the Government follows the OFT recommendations to deregulate pharmacies, the following will be a feature of our communities:

- Loss of local, accessible pharmacy services – as pharmacy numbers decline or cluster around supermarkets and GP surgeries, so people will have to travel further and further to access basic pharmacy services
- Decline in the variety and quality of services on our high streets – if pharmacies follow other service decline patterns, up to a quarter may be lost in the scramble for amalgamation
- Health facility deserts – especially in deprived areas which arguably have the most need for extensive pharmacy networks
- Increase in non-essential GP appointments, putting a further strain on services. This will undermine both developments to the pharmacists' career structure plans, but also clog up more primary care facilities
- Failure to deliver on key points of the NHS Plan – particularly those target health areas that rely on pharmacies as information and campaigning centres
- Loss of local, social capital. This will accelerate as people leave their local area as they are no longer able to service their needs on their high street
- Increase in the stranglehold of supermarkets over an essential service.

CONCLUSION – IF IT'S NOT BROKEN…

The OFT has attempted to find a solution to a problem that does not exist. By its own admission, 86 per cent of people are currently satisfied at the access they have to a pharmacy.[9] Government policy openly states that it wants to enhance the role of pharmacists in their clinical and community roles. If pharmacies are deregulated:

- We will have some areas that continue to be well-served by community pharmacies – generally those more affluent areas – and others – generally more deprived areas - that will become health facilities deserts

- The Government's own commitment to developing the role of community pharmacies – to extend to offering repeat prescriptions services, or osteoporosis screening for example – will be lost

- Radical new initiatives to increase participation by the local community in health services – as piloted by Time Banks in South East London for example, will be lost without the strong community health networks fostered by accessible community pharmacies

The problem with the OFT analysis of pharmacy regulation is that it only looks at one side of the coin, by falsely equating a free market with wider accessibility, and only accounting for one part of the economic argument – in this case the possibility of slightly cheaper over-the-counter drugs in the short-term. This fails to take into consideration the wider issues of social capital, local economic vitality and potential for inward investment that thriving local services provide, and appears to conflict with other stated government objectives.

The New Economics Foundation believes that local pharmacies should have a vibrant, enhanced future at the centre of their communities – as advice agencies and frontline health resources. This after all is part of the Government's stated aims, which we believe could be taken and developed even further. But the OFT recommendation will simply hasten the slow death of Britain's high streets – and the decline of our community life. It could be a lethal prescription for local services. Is that a cost we really want to swallow?

NOTES

1 Experian for Lloyds Pharmacy, January 2003
2 Hansard, Column 196, 5 February 2003
3 Ghost Town Britain, New Economics Foundation, 2002
4 Ghost Town Britain, New Economics Foundation, 2002
5 Tackling Health Inequalities, Department of Health, 2000
6 Tackling Health Inequalities, Department of Health, 2000
7 London Ambulance Service NHS Trust, 'Inappropriate Use' Campaign, December 2001, www.londonambulance.nhs.uk
8 Making a Difference: General Practitioners Report, Cabinet Office, June 2002
9 The Control of Entry Regulations and Retail Pharmacy Services in the UK, p.59, Office of Fair Trading, January 2003
10 The Control of Entry Regulations and Retail Pharmacy Services in the UK, p.59, Office of Fair Trading, January 2003


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The New Economics Foundation (NEF)

NEF works to construct a new economy centred on people and the environment. Founded in 1986, it is now one of Britain's most creative and effective independent think tanks, combining research, policy, training and practical action. Now the UK home of the international Jubilee debt campaign, NEF has a wide programme of work on economic globalisation ranging from corporate accountability to climate change.

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