The Royal Australasian
College of Physicians

RACP Submission:
Competition Policy Review

November 2014

Executive Summary

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the Competition Policy Review Draft Report presented by the Competition Policy Review Panel ('the Panel'). We believe that good public policy involves striking the right balance between competition and regulation in order to meet community needs. No two markets are completely alike and the application of competition policy to markets which are part of or have impacts on the healthcare sector must be approached with particular caution. In some of these markets, health and other considerations may mean that the wider community interest justifies greater regulation. In others, less regulation may actually enhance the health of the community, by making certain services or products more easily accessible and affordable.

Community pharmacy

Current location and ownership restrictions in the community pharmacy sector unnecessarily restrict competition and bear no relevance to today's market and the needs of patients. Any call to support the retention of these anti-competitive restrictions must be supported with compelling evidence that their retention is in the public interest. The evidence from the liberalisation of the community pharmacy sector in Europe shows that it has not led to reduced professional standards of pharmacists, or reduced pharmacy services. We believe that an increased level of competition, facilitated by the removal of ownership and location restrictions, will lead to improvements in patient access to medicines and pharmacy services, especially in regions where there is currently a monopoly on these services. It is also likely to improve the affordability of those medicines that are only able to be sold by a pharmacist (S3 medicines). Accordingly, we **support** the Panel's recommendation that current pharmacy ownership and location rules should be removed

Liquor licensing

We believe that different considerations apply to the licensing of alcohol, which is no ordinary commodity and is causally linked to at least 60 different medical conditions and injuries. There is substantial evidence – both Australian and international – demonstrating that increased availability of alcohol, whether through an increased number of physical outlets selling alcohol or improved affordability of alcoholic drinks, leads to higher levels of both consumption and alcohol-related harm. Accordingly, we **strongly oppose** the Panel's recommendation that the government consider reviewing and removing current restrictions that prevent supermarkets from selling liquor. If anything, all levels of government in Australia should be striving to introduce measures to **further restrict** the availability of alcohol and reduce its affordability.

Enhancing competition in healthcare

The Panel has recommended the development of an intergovernmental agreement establishing choice and competition principles in the field of human services. We **cautiously support** this recommendation which is consistent with the idea that the government should be looking at more comprehensive and innovative ways to extract better value from healthcare. Improving the integration of healthcare services not only is a key area for efficiency gains (due to duplication and wastage), but will also drive quality improvements in the health system and prevent unnecessary downstream costs. We also recommend that Primary Health Networks, which have been given the remit of purchasing healthcare services on behalf of their local communities, should use their role to drive better integrated care.

1. Introduction

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the Competition Policy Review Draft Report presented by the Competition Policy Review Panel ('the Panel'). RACP Fellows have significant expertise and an ongoing interest in the health of the Australian population. In this submission, we will comment on the Panel findings and recommendations which would have policy implications on the health of the Australian population

We share the Panel's view of the important role that strengthening competition in markets can play in promoting the general welfare of the community by enhancing choice and diversity, increasing the affordability of goods and services, and promoting innovation. However, as also acknowledged, by the same token, increased competition and its impact can at times have a detrimental health impact.

In our review of the Panel's draft report, we have focused on the key sections of the review that have the most impact on health.

The RACP's submission is structured as follows:

- Section 2 discusses the Panel's recommendation that current pharmacy ownership and location rules should be removed. We **support** this recommendation, and indeed believe that it will enhance people's access to medicines and quality healthcare advice that is provided by pharmacists.

- Section 3 considers the Panel's recommendation that the government consider reviewing and removing current restrictions that prevent supermarkets from selling liquor. We **strongly oppose** this recommendation, as evidence clearly demonstrates that increased accessibility to alcohol (via more outlets and reduced price) increases the harms caused and associated costs.

- The Panel's recommendation for the development of an intergovernmental agreement establishing choice and competition principles in human services is discussed in Section 4. We are **broadly supportive** of this recommendation and the principles underlying it subject to some caveats. We also recommend that Primary Health Networks, which have been given the remit of purchasing healthcare services on behalf of their local communities, should use their role to drive better integrated care.

2. Competition in the community pharmacy sector

Since 1990, there has been a series of five-year Community Pharmacy Agreements (Agreements) between the Commonwealth government and the Pharmacy Guild of Australia. These Agreements set out a variety of terms and conditions specifying the level of funding provided to, location, and ownership of community pharmacies.

The current Agreement commenced on 1 July 2010 and is worth $15.4 billion over five years, with this funding distributed to around 5000 community pharmacies[1]. Given that this agreement terminates on 30 June 2015, we agree with the Panel's view that now is an appropriate time to critically evaluate the model, and to identify areas in which it can be improved.

A central component of the current and past Agreements is the Pharmacy Location Rules, which relate to the establishment of a new pharmacy or the relocation of an existing pharmacy. These Rules set out criteria which must be met before the Australian Community Pharmacy Authority (ACPA) can recommend approval of the opening of a pharmacist, or the relocation of an existing community pharmacy. There are also specific restrictions applicable to pharmacies opening in facilities such as shopping centres.

A further set of restrictions apply to the ownership of new pharmacies. These restrictions were introduced in the 1930s to prevent the British pharmacy chain Boots from entering the Australian marketplace and, subject to some exceptions, prohibit a person from owning, conducting or having a proprietary interest in a pharmacy business unless they are a registered pharmacist.

The conclusion by the Panel in their draft report was that the impact of the location and ownership restrictions is anti-competitive and recommends that the current pharmacy ownership and location rules be removed and replaced with regulations that do not unduly restrict competition but that instead focus on ensuring patients have appropriate access to pharmaceuticals and receive high quality health professional advice on their use and associated precautions.

The RACP supports the Panel's recommendations. Current location and ownership restrictions are unnecessary, and bear no relevance to today's market and the needs of patients. Any call to support the retention of these anti-competitive restrictions needs to be supported with compelling evidence demonstrating that their retention is in the public interest.

Broadly speaking there have been three kinds of objections made to the liberalisation of current ownership and/or location restrictions.

The first objection which tends to be made against liberalisation of ownership restrictions is that removal of these restrictions can undermine the professional standards of pharmacists in delivering controlled medications to the population.[2]

The College would like to emphasise that it wholeheartedly supports the important professional role played by pharmacists in dispensing controlled medications to the community and the maintenance of these professional standards. However, no evidence has been presented to suggest that removing current regulations on who can conduct or own a pharmacy business would undermine these professional standards. Whatever the ownership and location rules, the important role pharmacists play in providing health advice and guidance to patients must be supported.

[1] http://www.health.gov.au/internet/main/publishing.nsf/Content/fifth-community-pharmacy-agreement-copy
[2] This seems to be the implicit concern expressed in Pharmacy Guild of Australia 2014,'Community pharmacy: A trusted public-private partnership delivering accessible high quality healthcare for all Australians', Submission in response to the Competition Policy Review Issues Paper, p. 25, quoting the Wilkinson Review.

Enforcement of these professional standards would continue to be maintained through current restrictions that require practising pharmacists to satisfy legislative criteria including meeting core competencies. These would not be lessened by the removal of the ownership restrictions. It would not mean that non-pharmacists would be allowed to dispense controlled medications or that health advice would not be provided by anyone other than qualified pharmacists and pharmacy assistants.

It should be noted that in a very similar market, legislation does not stipulate that medical centres can only be owned by qualified doctors. There are separate and effective regulations in place that ensure that only registered doctors and appropriately qualified health professionals practice medicine, and it should not be simply assumed that professional standards would decline under liberalisation of ownership rules. This is confirmed by a study commissioned by European pharmacists comparing the more 'regulated' and 'deregulated' pharmacy sectors in Europe which concluded that:[3]

'The quality of the pharmacy services appears to be appropriate in all countries, including the deregulated ones. This is attributable to high professional standards among the pharmacists.'

A second, related objection which has been made against both ownership and location restrictions is that the increased competition caused by the abolition of these restrictions may lead to pharmacies 'cutting corners', for instance by reducing the range of services and support they provide.[4] This argument assumes that pharmacies would only compete by cutting costs. In fact, where there is competition, pharmacies compete vigorously on service dimensions such as waiting times, opening hours and quality of advice and service.[5]

There is also no evidence for the argument that liberalisation of the community pharmacy sector would lead to the reduction of services or the exit of pharmacies in areas that are difficult to service. While the liberalisation of ownership and location rules in Europe encouraged pharmacies to extend their opening hours[6] and encouraged the increased establishment of new pharmacies particularly in urban areas, this did not come at the expense of service reductions or closures in rural areas.[7]

Similarly, an evaluation of reforms allowing more entrants into the UK community pharmacy sector concluded that liberalisation delivered all the expected benefits of greater choice and access to medications but did not result in any net exits of pharmacies or service disruption.[8] Notably this evaluation also concluded that UK consumers benefited from liberalisation because of the significant reductions in travel time and waiting time for prescription collection facilitated by the entry of new pharmacies.[9]

[3] Vogler, S., D. Arts and K. Sandberger 2012, 'Impact of pharmacy deregulation and regulation in European countries', Commissioned by Danmarks Apotekerforening (Association of Danish Pharmacies).
[4] See for instance Pharmacy Guild of Australia submission, p. 39.
[5] Para 1.7 of UK Office of Fair Trading 2010, 'Evaluating the impact of the 2003 OFT study on the Control of Entry regulations in the retail pharmacies market'.
[6] Vogler, S. 2014, 'Competition issues in the distribution of pharmaceuticals', paper for OECD Global Forum on Competition.
[7] Vogler, S. 2014, 'Competition issues in the distribution of pharmaceuticals', paper for OECD Global Forum on Competition.
[8] UK Office of Fair Trading 2010, 'Evaluating the impact of the 2003 OFT study on the Control of Entry regulations in the retail pharmacies market'.
[9] UK Office of Fair Trading 2010, 'Evaluating the impact of the 2003 OFT study on the Control of Entry regulations in the retail pharmacies market'.

A third objection is that the removal of ownership and location restrictions can lead to consolidations in the sector, which can ultimately lead to anti-competitive impacts.[10] However this is no different from other industries which are as important as community pharmacy. Competition laws are already in place to prevent anti-competitive mergers and acquisitions. It does not make sense to argue to maintain current anti-competitive arrangements in order to prevent future anti-competitive developments.

Accordingly, we believe that an increased level of competition, facilitated by the removal of ownership and location restrictions, will lead to improvements in patient access to medicines, especially in regions where there is currently a monopoly on these services. Currently, in these locations, there is no incentive or drive for improvements to be made to aspects such as opening hours or customer service.

We also believe that more competition in this sector would improve the affordability of those medicines that are only able to be sold by a pharmacist (S3 medicines). Again, especially for people where there are few pharmacies in their area, there is no incentive for any price competition for these medicines to improve their affordability for patients.

Indeed, the College would go further and suggest that it is time for a broader consideration of the distribution of medicines, and that a review of best practice – including from international experience – should be undertaken.

[10] See for instance Pharmacy Guild of Australia submission, p. 38.

3. Alcohol – no ordinary commodity

Alcohol is no ordinary commodity. On the one hand, it is very much part of the social fabric of Australia, and is consumed by most adults to facilitate relaxation, conviviality and socialisation. On the other hand, it is also causally linked to at least 60 different medical conditions and injuries[1]. Evidence demonstrates the very clear link between the amount of alcohol consumed, either in the short or long term, and the level of harm that results both for individuals and societies.[2] It is for these reasons that alcohol policy is of great interest to the College and an area in which many of our Fellows, including our Public Health and Addiction Medicine Fellows, have significant expertise.

Accordingly we have significant concerns regarding those of the Panel's findings which would have an impact on the regulation of alcohol sales. **In particular**, **the College vigorously opposes the Panel's recommendation that the government prioritise the removal of current restrictions on alcohol sales in supermarkets as part of a proposed regulatory review.**

Alcohol-related harm and availability

There is substantial evidence – both Australian and international – demonstrating that increased availability of alcohol leads to higher levels of both consumption and alcohol-related harm.[11] This increased availability can result from both increased *financial* availability (that is, affordability through lower prices) and increased *physical* availability (namely, easier access to alcohol through a greater number of outlets selling alcoholic drinks). Although the Panel's comments on liquor licensing primarily relate to physical availability, there is also an indirect connection to financial availability, as is highlighted below.

Physical availability

Australian and international research shows that as the density of licensed outlets increases so too do levels of assault.[12] This applies to both 'on licence' outlets, such as bars or hotels, and 'off license' outlets, such as bottle shops or alcohol retailers. If anything, the relationship between outlet density and violence is strongest for 'off license' outlets while being more context dependent for on-license outlets [13]

There is evidence that 'preloading', that is drinking prior to going out, can reinforce the impacts of consumption at on-license outlets. For instance, a recent Australian study found that:[14]

- 57 per cent of all drinkers consume alcohol before going out to a pub, club or bar.
- People who are most likely to consume alcohol before going out are those who drink to get drunk (85%), Generation Y (76%) and regular drinkers (67%).

A recent Lancet review concluded that

> *"… an increased density of alcohol outlets is associated with increased amounts of alcohol consumption among young people, with increased numbers of assault, and with other harms such as homicide, child abuse and neglect, self-inflicted injury, and with less consistent evidence, road traffic accidents."*[15]

[11] P Anderson, D Chisholm and D C Fuhr 'Effectiveness and Cost-effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol' (2009) 373 *Lancet* 2234, at 2238.
[12] Chikritzhs, T. and P. Catalano 2007, 'Predicting alcohol-related harms from licensed outlet density: A feasibility study', National Drug Law Enforcement Research Fund.
[13] Gruenewald, P. et al 2006, 'Ecological models of alcohol outlets and violent assaults: crime potentials and geospatial analysis', *Addiction*, 101(5), 666–677.
[14] http://www.fare.org.au/research-development/community-polling/annual-alcohol-poll-2013/drinking-before-going-to-a-pub-club-or-bar-preloading/

How physical availability of alcohol also affects financial availability

At the same time, it is also well established that the increased physical availability of alcohol – through the licensing of more outlets including supermarkets – enhances its affordability due to the heightened competition between outlets. This competition leads to greater discounting of alcohol products[16], with the result that areas with a higher density of liquor outlets will have lower alcohol prices than those with a lower density of outlets.[17]

The increased alcohol consumption and its resulting harms – as a direct result of increased competition due to more licensed outlets – must be taken into consideration when balancing the costs and benefits of greater competition within the sector.

We strongly assert that the greater harms associated with higher alcohol consumption due to liberalising alcohol sales far outweigh the benefits to consumers from lower prices.

Alcohol is already too cheap

Alcohol is already too cheap, in the sense that its market price is below what its socially optimal price should be. The taxation revenue from alcohol sales brings in approximately $9 billion a year[18], compared to the $15 billion in social costs that have been estimated from alcohol-related harm. It should also be noted that this $15 billion figure is likely to be a conservative estimate, as it does not fully account for all the costs to non-drinkers.[19]

If anything, all levels of government in Australia should be striving to introduce measures to **further restrict** the availability of alcohol and reduce its affordability. Maintaining restrictions on the availability and affordability of alcohol is likely to lead to net savings in the long-term, through reductions in healthcare expenditure, not to mention expenditure by the policing and criminal justice system.

According to one estimate, an additional $1.3 billion in revenue per annum would be raised by even the relatively minimalist measure of replacing the misnamed Wine Equalisation Tax (which effectively places a lower tax burden on wine compared to other alcohol products) with a volumetric excise rate equal to the current excise tax rate for low-strength beer sold offsite. This measure would also lead to net savings of $820 million in lifetime healthcare costs for the population.[20] As these savings arise from, and are premised on, measures which effectively discourage alcohol consumption by making it more expensive, introducing measures to liberalise alcohol sales by making it cheaper and more readily available would be a retrograde step.

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[15] P Anderson, D Chisholm and D C Fuhr 'Effectiveness and Cost-effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol' (2009) 373 *Lancet* 2234, at 2238

[16] New Zealand Law Commission 2010, *Alcohol in our lives: Curbing the harm*, Final Report

[17] Cameron, M. et al 'The Spatial and Other Characteristics of Liquor Outlets in Manukau City', (Impact of Liquor Outlets Research Report No. 3, Population Studies Centre, University of Waikato, Hamilton, 2009).

[18] The exact figure is around $8.6 billion a year based on 2010 data as estimated by Doran, C. et al 2013, 'Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues', Medical Journal of Australia 199(9).

[19] This estimate from Collins, D. and H. Lapsley 2008, 'The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol', DoHA Monograph Series No. 70 is based on 2008 data and therefore the cost adjusted to 2010 figures may well be higher.

[20] Doran, C. et al 2013, 'Estimated impacts of alternative Australian alcohol taxation structures on consumption, public health and government revenues', Medical Journal of Australia 199(9).

4. Enhancing competition in healthcare

The Panel's Draft Recommendation 2 calls for the development of an intergovernmental agreement establishing choice and competition principles in the field of human services. The Panel has articulated a series of principles to guide the design and delivery of human services, namely:

- Placing user choice at the heart of service delivery;
- The separation of funding, regulation and service delivery;
- Encouraging a diversity of providers without crowding out community and voluntary services;
- Stimulating innovation in service provision.

In particular we note that:

- The Panel recognises that, in some cases, government may wish to retain some controls over service delivery while still encouraging increasing competition and a diversity of service providers.
- The Panel acknowledges that in commissioning healthcare services, it is better to rely on the broader notion of contestability than on strict competitive tender processes, because the appropriate provision of healthcare services requires cooperation between purchasers and providers.
- The Panel recognises that the principle of competition must be appropriately tailored to context and that the commissioning of healthcare services should be with an 'outcomes' focus rather than on a narrower 'value for money' basis.[21]

Thus, the College **cautiously supports** Recommendation 2 and associated Recommendations, as they are consistent with the idea that the government should be looking at more comprehensive and innovative ways to extract better value from healthcare. We believe that improving the integration of healthcare services not only is a key area for efficiency gains (due to duplication and wastage), but will also drive quality improvements in the health system and prevent unnecessary downstream costs.

However it is important to note that the human services market is one where market failure and the need for community service obligations (to ensure equity of access) are likely to be more common than in other markets. As such, the application of these principles, particularly in the healthcare sector, must be appropriately guided by an awareness of the various caveats and trade-offs associated with both the more general notion of competition and the more specific ideas of commissioning services in healthcare.

- There needs to be a constant awareness of the need to meet community service obligations through appropriate government subsidies or interventions where market forces are unable to meet such obligations.
- It needs to be recognised that while the commissioning of healthcare services can bring significant pro-competitive benefits, there are also significant transaction costs associated with commissioning, and it can sometimes requires a high level of resources and capacity to get a contract 'right'. This includes the specification of measurable outcomes from the commission. Realistically, it may not be possible to measures outcomes in all cases.

Bearing these caveats in mind, we a note that one of the aims for the new Primary Health Networks (PHNs) is to promote the greater use of commissioning of healthcare services, with PHNs purchasing healthcare services from third party providers rather than delivering the clinical services themselves.

[21] P. 160.

We believe that, if this is envisaged as a primary role of the PHNs, then they should use the opportunity to exercise their commissioning role to also promote and drive better integrated care. More specifically we recommend that the move to better integrated care should be central to the remit of PHNs, given this primary role as purchasers of healthcare.

[1] Babor, T. et al 2010, *Alcohol: No Ordinary Commodity - Research and Public Policy*. 2nd ed. Oxford: Oxford University Press.
[2] Babor, T. et al 2010, *Alcohol: No Ordinary Commodity - Research and Public Policy*. 2nd ed. Oxford: Oxford University Press