

SUBMISSION OF THE COMPETITION AUTHORITY TO THE PHARMACY REVIEW GROUP

A. PRELIMINARY

1. The Competition Authority welcomes the opportunity to comment on the current pharmacy regulations at this initial stage of the Pharmacy Review Group's proceedings. The Authority notes that the terms of reference for the Group encompass a wide range of issues regarding the effective delivery of a high quality, accessible and affordable community pharmacy service. As such, the Authority's general concern in making these comments is to test the hypothesis that the current regulations are actually achieving their purported aims, in a proportionate manner, without overly restricting competition.

2. It is sometimes argued that the health sector is unique, and that it is not appropriate to apply any competition policy concepts to it, particularly as regards the supply of professional services. That the consumers of pharmacy services and products frequently have imperfect information regarding their own needs, is typically cited as a reason for protecting pharmacists from competition. It is a fact, however, that many markets and sectors within an economy are characterised by such imperfect information. These markets are often subject to regulation but the key goal in such markets must be to correct for the imperfect information through the *minimum* level of regulation necessary to protect the consumers and suppliers of the service. Undoubtedly, the fact that consumers' health is involved (in addition, perhaps, to their financial or other interests) does raise special concerns as regards the quality of service supplied, and who may supply it. While emphasis should certainly be placed on ensuring quality and safety, however, this can be done, and should be done, in a way which does not disproportionately facilitate, or condone, anti-competitive markets. Otherwise, regulation is self-defeating as the costs to consumers from a lack of competition exceed the benefits achieved by regulation.

3. This document outlines the views of the Authority on the current pharmacy regulations. Part B outlines the economic reasoning relating to the regulation of professional services generally. Part C outlines the regulations governing the qualifications of pharmacists working in community pharmacies and the effect of the current regulations on the pharmacy market are examined. Part D outlines the regulations governing the obtaining of a community pharmacy contract and the elements which restrict competition in the provision of community pharmacy services. This part explains how these elements are restrictive and shows the effects of the restrictions on the provision of community pharmacy services. The justification for these restrictions are also examined in this Part. Part E looks at the OECD's recommendations and gives the Authority's conclusions on the current regulations.

B. ECONOMIC REASONS FOR REGULATING PROFESSIONAL SERVICES

4. From an economic point of view, the main reason for regulating professional services is to correct or prevent market failures that result in inadequate quality or safety. If consumers cannot evaluate the quality of the service, it is difficult for high-quality, high-cost practitioners to coexist, profitably, with their low-quality counterparts and the average quality of service can decline unacceptably. Related to this is deceptive over-treatment, when consumers have inadequate information about the options open to them and the likely range of outcomes and some practitioners take advantage of their ignorance to supply "too much" service. This is known as "supplier induced demand".
5. The regulatory response to ensure quality or safety often takes the form of registration rules requiring practitioners to be qualified to a certain level. Set standards and codes of conduct for professional services, coupled with disciplinary rules, are employed to help maintain quality and identify over-prescription. Many professional associations carry out some of these functions for their own members on a non-statutory basis.
6. But regulation often tends to, directly and/or indirectly, reduce competition unless adequate safeguards are put in place to prevent this, and there is a body of informed

literature, both in Ireland and elsewhere, which demonstrates that professional regulation can all too easily result in restrictions with adverse impacts.¹ For example, a system of regulation which allows for, or condones, limits on entry to a profession, the prevention of truthful advertising or the collective setting of fees can lead to higher priced services without improving quality. Such systems raise strong concerns about competition.

C. REGULATIONS GOVERNING THE RECOGNITION OF QUALIFICATIONS

Background

7. Under the provisions of the 1875 Pharmacy Act, as amended, an outlet for the 'dispensing or compounding of medical prescriptions' must be operated and personally supervised by a pharmacist who is registered with the Pharmaceutical Society of Ireland (PSI). Any new pharmacy must be operated by a pharmacist with at least three years post-qualification experience working in a community pharmacy.
8. To qualify as a pharmacist, one must earn a (four-year) Bachelor of Science (Pharmacy) degree in Ireland and complete one year of practical training under the supervision of a tutor pharmacist, or meet requirements for one's foreign education to be recognised. At present only Trinity College Dublin offers a pharmacy degree in Ireland that is recognised by the PSI. The number of places on this course rose from 50 to 70 in 1998. 540 Leaving Certificate points were required to enter the pharmacy course in 2000/01. This is equivalent to six honours A2s, considerably above the minimum requirements specified by Trinity. The high points show the high level of demand for places on this course. Indeed, 393 students put pharmacy as their first preference in their CAO applications in 1999. In August 2000 the Minister for Education and Science announced his decision to increase the annual intake of pharmacy undergraduates from 70 to 120 and in October 2001 it was announced that a new school of pharmacy will be set up in University College Cork to accommodate these 50 new places.

¹ For Example, *Competition in Professions*, the Office of Fair Trading in the UK

9. The recognition of UK qualifications, and all other Member States' qualifications, was spurred on by EU directives designed to facilitate the free movement of people within the EU. There are also similar arrangements between Ireland and Australia and New Zealand. Ireland availed of a derogation in the relevant EU Council Directive, however, which stipulates that pharmacists who are professionally trained in other EU and EFTA countries are prevented from ever managing or supervising a pharmacy that is not more than three years old. This "three year rule" effectively restricts an EU/EFTA national from ever opening their own pharmacy in Ireland. It includes Irish nationals who have gone to other EU States for their training because they could not obtain entry to the Trinity pharmacy degree course.

Effect of the Current Regulations

10. The limited number of places on the TCD pharmacy course, has led to a situation of under-supply of pharmacists in the State and many Irish students going to UK universities for their education. In fact, the largest part of recent additions to the PSI register were Irish students with qualifications from UK universities. The new school of pharmacy in UCC should go some way to improving the domestic supply of pharmacists in Ireland, and eventually facilitate an expansion in the number of pharmacists per outlet. The 50 extra places will not, however, make up the current shortfall. During the period 1991-97, only 38.5% of entrants to the PSI register were graduates of Trinity (around 50 graduates per annum) while 58% were graduates of UK universities (around 125 graduates per annum).²
11. The three year rule has negative effects on both the supply of pharmacists and the community pharmacy market in Ireland. It is particularly restrictive in a sector where there is already insufficient supply of labour. In the community pharmacy market, the three year rule restricts EU/EFTA qualified pharmacists from entering a market and providing a service for which they are qualified.

² *Assessing Supply in Relation to Prospective Demand for Pharmacists in Ireland, Report to the Higher Education Authority, Peter Bacon & Associates.*

12. The restriction has no positive object or effect and is generally defended on the grounds that it maintains a “level playing field” with EU and EFTA countries that may have similar restrictions. Such a level playing field only benefits the pharmacists operating existing pharmacies. Furthermore, it (a) discriminates against Irish people who, not being able to gain access to the only pharmacy qualification in Ireland, have studied abroad (b) is contrary to the principles of the EU internal market and (c) is ultimately harmful to consumers as it restricts the supply of pharmacists in Ireland.

D. THE HEALTH (COMMUNITY PHARMACY CONTRACTOR AGREEMENT) REGULATIONS 1996

Background

13. In 1996, the Minister for Health introduced the *Health (Community Pharmacy Contractor Agreement) Regulations, 1996* (“The Contractor Regulations”) which regulate the opening of new pharmacies in the State.³ These regulations in effect limit the number of General Medical Services (GMS) dispensing pharmacies i.e. pharmacies which will be reimbursed by the GMS for dispensing prescriptions to medical cardholders and other qualifying individuals. As a GMS contract represents close to half an average pharmacy’s revenue, relatively few pharmacies operate without a GMS contract. Indeed, it is not clear that it is appropriate to refer to a business as a *pharmacy* if it does not have a GMS contract because the balance/mix of its outputs would be drastically different from that which has been traditionally and commonly understood. Thus the regulations in essence govern the opening of all new pharmacies in Ireland.
14. The Contractor Regulations include a number of restrictions on where a new contract pharmacy may locate itself (“the location restrictions”). In urban areas, the distance between the new pharmacy and the nearest existing community pharmacy must be at least 250 metres door-to-door. In addition, the new pharmacy must identify a population of 4000 which is not served by the existing pharmacy. In rural areas, the

³ SI No. 152/1996.

corresponding minimum distance must be at least 5 kilometres. However, particularly in sparsely populated rural areas, the distance could be greater if a new entrant does not prove that there is an unserved population of 2500. Furthermore, the Contractor Regulations expressly state that a new pharmacy should “*not have an adverse impact on the viability of existing community pharmacies in the area.*”⁴ These criteria are a significant addition to the qualifications and capital costs requirements which new entrants must satisfy.

15. The Contractor Regulations also brought a new GMS contract for *all* contract pharmacies which includes increased public service requirements and accountability by pharmacists. Most of these new service requirements are held in Clause 9 of the contract.

Effects of the Regulations

16. The effect of these regulations has been to restrict the entry of new pharmacies into the market. They created a barrier to entry, in that new pharmacies incur a cost not faced by existing pharmacies in terms of restricted opportunity to obtain a GMS contract. This barrier to entry stems entirely from the location restrictions. A barrier to entry does not necessarily prevent *any* entry into a market, but it does hinder entry and in some cases prevents suppliers of a product or service from responding to demand.
17. GMS contract business accounts for, on average, 42% of a pharmacy’s turnover⁵; but the lack of a GMS contract is likely to restrict a pharmacy’s sales by an even greater amount, because a GMS contract brings other business with it. Private customers, i.e. non-medical card holders, may not know at the time of purchase whether their total expenditure on prescriptions that month will exceed the £42 per month threshold at which the Drug Payment Scheme applies. The excess is only refunded to customers through GMS contract pharmacies and so private customers are likely to behave exactly

⁴ *Health (Community Pharmacy Contractor Agreement) Regulations, 1996*, Section 2 (1).

⁵ *The Retail Pharmacy Sector in Ireland, A Sector Overview*, Brenson Lawlor.

like GMS customers and purchase their prescriptions only from a GMS contract pharmacy. Sales of private prescriptions are therefore likely to be lower in a non-contract outlet. Sales of over-the-counter medicines, cosmetics, toiletries etc. are also likely to be lower due to the lack of a GMS contract. A prescription customer, while waiting the several minutes it usually takes to make up a prescription, may make planned or impulse non-prescription purchases. Thus the reduction in revenue imposed by the lack of a GMS contract is likely to be considerably more than 42% of turnover. This reduction means that pharmacies without a GMS contract would probably not be viable, or at least not profitable enough to reward the pharmacists for their investment of eight years of study and training, and so they do not enter. Alternatively, if in fact non-contract pharmacies were viable this would suggest that contract pharmacies achieve extraordinarily high profits.

18. A barrier to entry has a negative effect on the competitiveness and efficiency of a market. Generally, as consumer demand increases new pharmacies cannot enter the market to serve the increased demand with increased supply and so the inefficiently small number of existing pharmacies face additional demand without threat of a corresponding increase in competition. This gives them the market power to charge prices considerably higher than cost, without fear of being undercut by new entrants, and therefore earn above normal profits. We thus have a situation where there are potential pharmacies willing to supply the same service to consumers, at prices which fall below the new market levels and which consumers are willing to pay, but are prevented from doing so. This is inefficient and hurts both consumers and excluded pharmacists. The higher profits and protection from competition yield what is known as “rents” to the pharmacies, and these rents are capitalised by the sale of the pharmacies. That is, protection from competition increases the value of a pharmacy outlet and this is reflected in the high price of pharmacies.
19. A related effect of this restriction is that inefficient pharmacies may not be challenged by more efficient entrants. In fact, this effect is inevitable from a regulation which

explicitly states that the viability of an existing pharmacy may not be threatened by a new pharmacy. This criterion takes does not take account of the possibility that the new pharmacy may be able to provide at least the same quality of service as the existing pharmacies yet at lower prices to consumers. Thus, if a pharmacy is operating inefficiently, a qualified pharmacist cannot open an outlet nearby and offer the same service to customers, at a lower cost to the pharmacy and lower prices to the consumers. As a result, there is no incentive for existing pharmacies to keep their costs to a minimum and so not only may pharmaceutical products be selling at unnecessarily high prices, the costs associated with selling the products may also be inefficiently high.

20. In addition, the lack of opportunity to compete against inefficient pharmacies promotes the acquisition of pharmacies. If a pharmacist or company can provide a better service more efficiently and at lower prices to consumers than an existing pharmacy, but is prevented from competing with the existing pharmacy, then an attractive alternative is to buy out the existing pharmacy. Furthermore, limited companies are generally in a better position, than sole traders or partners, to raise the capital required to purchase a pharmacy and so the restrictions on competition are likely to distort the ownership structure of the market in favour of chains and limited companies.
21. The protection from competition afforded by a barrier to entry can also protect pharmacies from striving to improve the quality of their service. With the regulations protecting their incomes and profits, the additional trade a pharmacy can attract by providing a better quality of service than other pharmacies is likely to be marginal. Pharmacies are therefore less likely to search for new, innovative, ways of improving their service.

Evidence of these Effects

22. Only 22 of Ireland's 1200 pharmacies operate without a GMS contract, despite the location restrictions. Opening a pharmacy without a GMS contract is generally not perceived as a viable option by either qualified pharmacists in Ireland or by any

corporate entity. The number of new pharmacies opening with community contracts has declined since the regulations have been introduced.⁶ Before the new regulations, from 1991-96, the growth in contract pharmacies was greater than the growth in population. Since 1996, the growth rate in the number of contract pharmacies has dropped below that of the population growth rate. This slow down is in marked contrast to the facts that (a) Irish people have become increasingly health conscious throughout this period, and (b) Ireland's population is aging and elderly people are generally higher users of pharmaceutical products and services. Ireland's increased health consciousness can be evidenced in the consistent rise in the proportion of the population covered by private health insurance during the past nine years. Thus we can see that the location restrictions are acting as a barrier to entry into this market and limiting the number of new pharmacy openings.

23. The retail margin on medicines in Ireland is higher than in any other EU country.⁷ For example, a 50% mark-up by retail pharmacies on private prescriptions is customary (in addition to a dispensing fee).⁸ This suggests that private customers are paying dearly for the lack of competition between pharmacies. The rates paid to pharmacists for dispensing medicines under State funded schemes are negotiated between the Department of Health and Children and the Irish Pharmaceutical Union, which represents pharmacies. The prices of medicines are also negotiated between the Department of Health and Children and the Irish Pharmaceutical Healthcare Association, which represents manufacturers of pharmaceutical products. It seems therefore that, as the State pays no pharmacy mark-up on medicines and a limited dispensing fee per transaction, those customers purchasing prescriptions without a medical card are to some extent directly cross-subsidising medical card holders. The location restrictions further increase the pharmacists power to increase prices and this is

⁶ *Community Pharmacy Openings: Initial Impact of the New Pharmacy Contract*, Fergal O'Nia and Owen Corrigan, School of Pharmacy TCD, The Irish Pharmacy Journal, October 2000.

⁷ *Assessing Supply in Relation to Prospective Demand for Pharmacists in Ireland, Report to the Higher Education Authority*, Peter Bacon & Associates.

⁸ *General Medical Service Report 1999*.

reflected in the high retail margin. The high retail margin is particularly burdensome on those private customers whose income falls just above the threshold for receiving a medical card. The average weekly expenditure on *prescription* medicines by average size households, of average age composition, in Ireland has trebled since the regulations were introduced. The average weekly expenditure on all medicines has doubled.⁹ This increase in expenditure represents a huge increase in the cost of medicines to households that cannot be explained away in terms of inflation, which was just 17% over the same period.

24. At present, the protection from competition provided through the Contractor Regulations are resulting in very high values for pharmacy outlets. This can be evidenced in the dramatic increase in the prices paid for pharmacies which are now being sold for prices far in excess of their non-medical retailing counterparts. Non-medical retail outlets typically sell at £1.00 per pound of turnover while pharmacies can fetch up to £2 per pound of turnover. Thus, for example, a pharmacy with a turnover of £500,000 may be valued at over £1,000,000 or 1.70 per pound of turnover. The pharmacy “licences” (GMS contracts), which are attached to a premises, are by themselves worth up to £500,000 in the current market.¹⁰ This situation is similar to Ireland’s taxi market before deregulation last year. The restrictions on the number of taxi licences and entry into the market led to a shortage of taxis and the licences were tradable at prices far higher than the intrinsic worth of a licence.

Justification for the Restrictions

25. It is not clear that any form of research, modelling, cost-benefit analysis, regulatory impact analysis or consultation was carried out before introducing the regulations. Indeed the reasons for implementing the regulations were only voiced after the regulations were challenged. As the OECD has pointed out, there is a need in Ireland

⁹ Source: CSO: Household Budget Survey, 1996 and 2001; Consumer Price Index.

¹⁰ *The Retail Pharmacy Sector in Ireland, A Sector Overview*. Brenson Lawlor, and the Sunday Business Post, 16 December 2001.

for higher quality regulation and a proper system of regulatory impact analysis. This review of the pharmacy regulations provides an opportunity for this issue to be addressed and a sound assessment of the aims of any regulation and the establishment of criteria for measuring the success of any regulation.

26. The main rationale behind the regulations was that by restricting the location (and effectively the number) of pharmacies, pharmacists' incomes would be protected and so they would be in a stronger position to develop the quality of their service and would have an incentive to do so, particularly in rural areas. The Minister has also stated that the regulations were introduced "with a view to bringing Ireland into line with other EU/EEA States where such controls exist in one form or another."¹¹ Another argument in favour of restricting entry, has been posited by others wishing to protect the ownership structure of the market on the grounds that locally-owned pharmacies are in the interests of society.¹²
27. The argument that standards can only be improved by restricting entry to the market is flawed. The idea that competition would force pharmacists to concentrate on promoting sales of products and neglect their professional duties does not stand up to scrutiny. Any public health/safety issues involved in the dispensing of drugs can be addressed by regulating for quality and safety, rather than artificially restricting the location of pharmacies. That is, it is not necessary to remove the public service requirements and accountability by pharmacists held in Clause 9 of the Contractor Regulations in order to remove the location restrictions. Rather, these service requirements can be regulated for, through the enforcement of quality requirements set out in GMS contracts, without restricting competition.
28. The extraordinarily high prices of pharmacy outlets are evidence that there is room for prices to fall, through competition, without any reduction in the number of pharmacies

¹¹ *Statement by the Minister for Health and Children on the Regulations for Pharmacies*, Press Office, Department of Health and Children, 1 February 2001.

¹² Hoban, J. *IPU Review*, January 1999.

or the standards of service being provided. Furthermore, as with many other professions, pharmacists rely on their professional reputation to succeed and the quality of service offered in Irish pharmacies is likely to be spurred on by competition. Many markets and sectors are subject to stringent standards and regulations which are fundamental to the Irish people's health and safety and yet coexist with competition between the market players. The current regulations are likely to be more effective in reducing the incentive to improve quality and lower prices than the "promoting access" or "improving standards" issues for which they were intended.

29. The location restrictions in the Contractor Regulations are not a proportionate or an effective way to ensure the delivery of a high quality pharmacy service in less populated areas. If a pharmacy service is not viable in some areas of Ireland, restricting competition will not make it viable in all those areas. The regulations may have gone some way towards achieving their narrow objective: of "redistributing" pharmacies by protecting the existing pharmacies and pushing new pharmacies to locate in areas with fewer pharmacies, rather than in areas where there are existing pharmacies. They have, however, done so at a very high price to consumers, as evidenced above, and without achieving their broader goal of providing a high quality pharmacy service in remote areas. To take one example already the subject of media comment, the people of Knock in Co. Mayo are being denied a pharmacy because it would allegedly affect the viability of pharmacies in neighbouring towns up to six miles away. The population of Knock plus the 1.5 million tourists and pilgrims visiting Knock every year, many of them in ill health, must travel to the neighbouring towns in an area badly served by public transport because there is not a single pharmacy in Knock. We have a situation where somebody wants to set up a pharmacy at Knock but has twice been prevented from doing so by the Western Health Board on the basis that "there is not a market for such a facility."¹³ This situation is inconsistent with the objective of promoting patient access to pharmacy services in rural Ireland. The location restrictions have simply

¹³ *The Examiner*, 22 February 2000; 4 December 2000.

served to create a protected monopoly which increases the incomes of all pharmacists and the values of all pharmacies.

30. Notably, the Health Board has the power to vary the population and distances specified in the granting of new contracts. These criteria are applied after the “catchment area” of a pharmacy has been identified. A catchment area is defined in the Contractor Regulations as being “the natural geographic area to which the community pharmacy at its location may reasonably be expected to provide its services to the population in that area”. It is difficult to see how this criterion could ever be transparently, fairly and effectively applied. In reality, the potential viability of a pharmacy is best assessed by the potential entrant.
31. The location restrictions reduce consumer choice. By limiting the number of pharmacies in a given area, consumers have less choice about which pharmacy they make purchases in. Though consumers of pharmaceutical services may not have as much information about pharmaceutical products as the pharmacists have, they are able to evaluate many aspects of the quality of service they receive for themselves. For example: the consistent availability of medicines for those on long term therapy, the manner of the advising pharmacist, etc. And of course, in some areas, due to the restrictions, the consumers may be denied having a pharmacy at all.
32. Similar controls on pharmacies in other EU/EEA States have been shown to be harmful to competition. For example, the OECD have reported that Danish regulations created geographic market divisions and reduced price competition and, as a result, prevented competition among retail pharmacies in Denmark.¹⁴ Strong pressure exists in many countries for the reform of these restrictive regulations; the Italian Competition Authority examined pharmacies in 1998 and “argued that guaranteeing a minimum level of service throughout the country could be attained more effectively by identifying indicators of service inadequacy and by providing for municipal pharmacies

¹⁴ *Regulatory Reform in Denmark*, OECD, 2000.

only where it was found that not enough privately owned pharmacies had entered the market to provide an adequate service.’¹⁵

33. It is not clear what economic benefits would accrue to society from protecting locally-owned pharmacies in general and, in fact, the regulations do not seem to have limited the growth of pharmacy chains. There now appear to be at least three chains controlling over twenty pharmacies each, compared to 1998 when only one chain owned over twenty pharmacies. It seems rather that the location restrictions have actually promoted multiple outlet ownership. The lack of competition between pharmacy outlets has greatly increased their value and limited companies are generally in a better position, than sole traders or partners, to raise the capital currently required to purchase a pharmacy. Also, for example, if one chain owned all the pharmacies in a locality they could significantly raise their prices without fear of attracting new competitors or losing trade to neighbouring pharmacies.

E. RECOMMENDATIONS

34. The OECD, in its report *Regulatory Reform in Ireland*, recommended the removal of the three year rule restriction on pharmacists trained in other EU/EFTA countries and the elimination of the location restrictions on pharmacies. The Authority concurs with these recommendations.
35. Ireland should lead the way by removing the restrictions on the free movement of qualified pharmacists rather than seeking to maintain them. The restrictions have no positive object or effect but have significant negative effects, both in Ireland and the EU. In the recent taxi case, Justice Roderick Murphy stated that previous case law¹⁶ cast doubt “*on the Constitutionality of any scheme which would have the effect of excluding persons from an industry for which they may be perfectly well qualified.*” Justice Murphy also judged that “*a quantitative restriction not alone affects the rights*

¹⁵ *Regulatory Reform in Italy*, OECD, 2001, p.235.

¹⁶ *O’Neill v. Minister for Agriculture and Food* (1998) 1IR 539.

of citizens to work in an industry for which they may be qualified but it also affects the right of the public to the services of taxis and, indeed, restricts the development of the taxi industry itself.” There may be strong parallels between this case and the current pharmacy regulations.

36. In the decision whether to award a contract, the potential viability of a pharmacy is best assessed by the applicant. Overall, the location restrictions (a) protect inefficient pharmacies from effective competition, (b) they act as a disincentive to any kind of restructuring in the sector, and (c) they represent an undue intrusion by the State into the community pharmacy market. The benefits to the community of retaining them are outweighed by their real costs.
37. The OECD further recommended that, once the location restrictions are removed, transparent subsidies be provided to pharmacies in areas where there is a genuine public need for a pharmacy but not sufficient demand to ensure its profitability. This is certainly an option worth exploring. Another option would be to have pharmacy services in multi-product retail outlets. For example, a local garage and shop could also have a pharmacy section and employ a fully qualified pharmacist to manage that pharmacy. These are but two possible options and, in any case, the regulation of quality and safety may be achieved through enforced GMS contract terms and conditions. It is not a question of abandoning all regulation in favour of free and open competition, but rather seeking effective regulation which does not overly restrict competition.
38. When regulating for quality and safety, it should be made clear what services pharmacists provide which cannot either be assessed by the consumer or regulated for through other existing regulations. Indeed, it is not clear what elements of quality of service, if any, are not already regulated for through other existing regulations. In addition, there does not seem to be any evidence of any surveys or monitoring of pharmacy services before or since the regulations were introduced. A recent survey by

RGDATA found that only 2% of pharmacies surveyed refused to sell the researcher an amount of paracetamol in excess of the legal limit of 24 tablets. Furthermore, only 14% of those pharmacies that sold more than the legal limit of paracetamol gave any spontaneous advice to their customer on taking paracetamol.¹⁷

39. In summary, the current regulations are causing substantive harm to the Irish consumer. As detailed above, they restrict consumer choice and, ultimately, raise the prices of medicines paid by the consumer, both directly and indirectly through the need for increased taxation to finance the cost of medicines to the State. There is no evidence that they lead to increased quality of service being offered to the consumer, or that any removal of the restrictions would lead to a lowering in service quality. The main beneficiaries of the regulations appear to be retail pharmacists already established in the market, who enjoy substantial rents which, if removed could be transferred to consumers in general. Thus the Authority concludes that removal of the restrictions would be of considerable benefit to the Irish consumer, and strongly recommends such action to the Review Group.
40. The Authority would welcome further opportunities to make submissions to the Group and to aid it in its task.

¹⁷ RGDATA, news release, 17 July 2001.