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Commerce Commission

Draft Determination

Note: This is a Draft Determination issued for the purpose of advancing the Commission's decisions on these matters. The conclusions reached are preliminary and take into account only the information provided to the Commission to date.

Draft Determination pursuant to the Commerce Act 1986 in the matter of an application for authorisation of restrictive trade practices. The application is made by:

THE PHARMACY GUILD OF NEW ZEALAND (INC)

The Commission: P R Rebstock
D R Bates
D F Curtin

Summary of Application: The Pharmacy Guild of New Zealand (Inc) (the Guild) has applied for authorisation to enter into or give effect to contracts, arrangements or understandings that are collectively described as Practice 1 and Practice 2

Date of Draft Determination: {26} April 2002

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THE APPLICATION

1. On 21 December 2001, the Commerce Commission (the Commission) received an Application from the Pharmacy Guild of New Zealand (Inc) ("the Guild") for an authorisation under section 58 of the Commerce Act 1986 ("the Act").[1]

2. On 25 March 2002, the Applicant amended its original Application. The references in the Draft Determination are to the original Application as amended.

3. Section 58 of the Act gives the Commission the power to authorise the entering into, or the giving effect to, contracts, arrangements or understandings which may be in breach of the restrictive trade practices provisions in the Act.

4. The Guild has sought authorisation of two groups of arrangements (collectively referred to as Practices 1 and 2). These are described below.

5. Although the Ministry of Health ("the Ministry") and the District Health Boards ("DHBs") are identified as parties to the arrangements described in Practices 1 and 2, they are not parties to the Application.

6. Under the heading Practice 1, the Guild seeks authorisation for the following arrangements:

   - the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between the Ministry on behalf of DHBs, and the Guild, on behalf of community pharmacies, as to any amount of monies payable to them by DHBs and associated terms, and as to the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services (Paragraph 2.7(a) of the Application);

   - the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between the DHBs and community pharmacies as to any amount of monies payable to them by DHBs and associated terms, and as to the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services (Paragraph 2.7(b) of the Application);

   - the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between community pharmacies as to what they (and/or the Guild on their behalf) may seek and/or accept from DHBs as to the amount of monies payable to them by DHBs and associated terms, in return for community pharmacies providing services or arranging for the provision of services (Paragraph 2.7(c) of the Application);

   - the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between community pharmacies as to what

[1] References to sections in this Draft Determination will be to sections of the Act unless otherwise stated.

they (and/or the Guild on their behalf) may seek and/or accept from DHBs as being the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services(Paragraph 2.7(d) of the Application); and

- the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between community pharmacies as to the amount of monies payable to them by DHBs and associated terms, and as to the amount of monies community pharmacies can charge patients and associated terms, that reflect and are constrained by the terms of agreements between the Guild and/or community pharmacies with the Ministry and/or DHBs (in relation to any amount of money DHBs will provide to community pharmacies and associated terms, and as to the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services) (Paragraph 2.7(e) of the Application).

7. Under the heading Practice 2, the Guild seeks authorisation for:

- the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between the Crown and/or DHBs and the Guild as to any amount of monies DHBs will provide to community pharmacy applicants and associated terms, and as to the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services (Paragraph 2.9(a) of the Application); and

- the entering into or giving effect to any contract or arrangement, or arriving at or giving effect to any understanding, between the Guild and community pharmacies as to the amount of monies community pharmacies can charge patients and associated terms, in return for community pharmacies providing services or arranging for the provision of services (Paragraph 2.9(b) of the Application).

8. Attached as Appendices 1 and 2 are diagrams prepared by the Commission outlining its understanding of the proposed practices.

COMMISSION PROCEDURES

9. The Application was registered by the Commission on 21 December 2001.

10. The Commission identified 38 parties likely to have an interest in the Application, and these parties were supplied with the material provided by the Guild in support of its Application. Interested parties were later advised of the amendments to the Application.

11. The Commission gave public notice of the Application in eight national newspapers on 11 January 2002. The Commission received no responses.

12. The Commission received initial submissions on the Application from the following parties:

- the Ministry of Health;
- Care Chemist Services Limited (Care Chemists);
- New Zealand College of Midwives (Inc);
- Pharmaceutical Society of New Zealand;
- Residential Care New Zealand Inc;
- New Zealand College of Pharmacists;
- IPA Council of New Zealand;
- Kentra Group Limited (Kentra);
- Pharmaceutical Management Agency (Pharmac); and
- New Zealand Medical Association.

13. The Commission proposes to hold a conference in Wellington in early June. The purpose of the conference is to enable the Commission to further consider the Application in light of any submissions received on this Draft Determination, and to test those submissions.

14. Submissions on the Draft Determination are due by Friday, 17 May 2002.

THE PARTIES

The Applicant

15. The Guild is an incorporated society that represents the interests of an estimated 80% of retail pharmacies in New Zealand. Its members have appointed the Guild to act as their agent for the pharmacy service contract negotiations with the Ministry.

Other Parties

The Minister of Health

16. The Minister of Health (the Minister) has overall responsibility for the health system. The Minister's role includes working in conjunction with the Ministry and other parties to:

- reach accountability arrangements with DHBs;
- determine health and disability strategies; and
- agree how the allocation of public money will be spent within the health system.

The Ministry of Health

17. The Ministry is the Crown's principal adviser on health and disability matters. It is responsible for:

- providing policy advice to the Minister of Health, including advice about the level and mix of public funding required for health;
- administering regulations on therapeutic products. This is carried out through New Zealand Medicines and the Medical Safety Devices Authority (Medsafe), a business unit of the Ministry. Medsafe administers the Medicines Act 1981, the Medicines Regulations 1984, parts of the Misuse of Drugs Act 1975, and the Medicines Regulations 1977;
- funding certain health and disability services, including negotiating or consulting with various provider groups in respect of funding of services provided by those groups to the public;
- processing claims from primary healthcare providers (including retail pharmacies) for subsidies which the Ministry has agreed to provide to these providers. This is undertaken through Health Benefits, a stand-alone business unit of the Ministry;
- providing a link between the Minister of Health and DHBs (and other health organisations). This includes the development and negotiation of funding agreements; and
- monitoring the performance of the health and disability sector.

District Health Boards

18. DHBs are Crown entities established by the New Zealand Public Health and Disability Act 2000 (the NZPHD Act). They have responsibility for the funding and provision of healthcare services to a geographically defined population. DHBs must assess the health and disability support needs of the people of their regions, and manage their resources within their allocated funding. Currently there are 21 DHBs.

19. The Government provides broad guidelines on what services the DHBs must provide and national priorities have been identified in the New Zealand Health Strategy. Services can be purchased from a range of providers. From 1 July 2001, DHBs assumed responsibility for the funding of many public healthcare services, including subsidised pharmacy services. As a result, DHBs are now parties to the contracts or section 88 Notices under the NZPHD Act for such services.[2]

[2] See paragraph 56 for an explanation of the contracting arrangements for the provision of subsidised healthcare services.

The Pharmaceutical Management Agency (Pharmac)

20. Pharmac is a Crown entity established by the NZPHD Act. It is directly accountable to the Minister. Pharmac's overall objective is to secure for "eligible persons"[3] in need of medicines, the best health outcomes that are reasonably achievable from pharmaceutical treatment, and from within the funding provided.

21. Pharmac is responsible for managing the New Zealand Pharmaceutical Schedule (the Pharmaceutical Schedule) for the Crown. The Pharmaceutical Schedule lists more than 3,000 pharmaceuticals and related products subsidised by the Government (see Paragraph 30 below for further details).

Retail Pharmacies

22. Retail pharmacies are independently owned businesses whose activities may be viewed as falling into three categories. These include the dispensing of pharmaceuticals prescribed by medical or other authorised practitioners, the sale of over-the-counter pharmaceutical products, and the sale of a wide range of other goods and services (e.g. beauty and healthcare products).

23. There are an estimated 940 retail pharmacies in New Zealand[4], the numbers having decreased over recent years. Of these, 785 retail pharmacies are members of the Guild.

24. The size, scale and scope of the operations of retail pharmacies vary. Some focus primarily on dispensing medicines, while others combine dispensing with the sale of a variety of other goods and services. The turnover generated from dispensing and retailing fluctuates between individual retail pharmacies.

25. Retail pharmacies have a statutory monopoly for the retail supply of many pharmaceutical products (see from Paragraph 40 below for details about the legislative environment).

THE PHARMACEUTICAL INDUSTRY

Subsidised Pharmacy Services

26. Practices 1 and 2 relate solely to the provision of subsidised[5] pharmacy services. These include:

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[3] An eligible person is defined as any individual who is in need of health services, and who is eligible to receive services funded under the NZPHD Act.

[4] Source: *Directory of Retail Pharmacy in New Zealand December 2001*, issued by the Guild.

[5] The term subsidised medicines incorporates both fully subsidised and partially subsidised medicines, unless otherwise specified.

- General Pharmaceutical Services: the dispensing of prescribed medicines that are either fully or partially subsidised to eligible people with appropriate advice and patient counselling;

- Pharmaceutical Review Services: review services to enhance and improve the cost-effectiveness of the use of prescribed medicines by targeted eligible people;

- Pharmacy Methadone Services: the dispensing of prescribed methadone to eligible people being treated for opioid dependence;

- Pharmacy Nicotine Replacement Therapy Services: the provision of subsidised Nicotine Replacement Therapy to eligible people with appropriate advice and patient counselling; and

- Other pharmaceutical services, as described in the schedules to the draft agreement between the Ministry and the Guild (e.g. the dispensing of Clozapine and Graseby pumps).

27. The Guild estimates that the number of individual subsidised pharmacy services, based on the number of prescriptions dispensed, is approximately 39 million per annum. This compares with an estimated 12 million unsubsidised pharmacy services supplied per annum.

28. The demand for most subsidised medicines is driven largely by what medical and other authorised practitioners prescribe for patients. Prescription-only medicines can be supplied by retail pharmacies only to persons holding a prescription from an authorised practitioner.

29. The Government funds certain pharmacy services to ensure the public have timely and affordable access to the medicines and medical devices that they require. The pharmacy services funded include dispensing of those medicines listed on the Pharmaceutical Schedule.

30. The decision whether or not a medicine will be subsidised rests with Pharmac. Pharmac manages the Pharmaceutical Schedule of medicines and related products that are subsidised by the Government under section 48 of the NZPHD Act. The Pharmaceutical Schedule lists the amount of the subsidy paid, as well as the manufacturer's price and any access conditions that may apply. Most medicines listed on the Pharmaceutical Schedule are fully subsidised. The remainder of medicines on the Pharmaceutical Schedule are partially subsidised (see Paragraphs 69 below for details).

31. Subsidised pharmacy services are provided by individual retail pharmacies under contract with the DHBs, or by way of a deemed contract under section 88 Notices[6] of the NZPHD Act (section 88 Notices). There are currently three contracts:

- the "Triple Region Contract" – which covers the three areas of the former Northern, Midland and Central Regional Health Authorities (RHAs);

[6] Paragraph 56 provides an explanation as to how section 88 Notices work.

- the "Southern Region Contract" – which covers the geographical area of the former Southern RHA ; and

- the "Care Chemist Contract".

32. In addition, some retail pharmacies not party to an individual contract in the form of either the Triple Region, Southern Region or Care Chemist Contracts, are bound by a deemed contract under a section 88 Notice of the NZPHD Act.

33. Appendix 3 contains a diagram showing the flow of information, medicines and transactions that currently occur in relation to the provision of subsidised pharmacy services.

Pharmacy Service Contract Negotiations

34. In January 2001, the Ministry and the Guild commenced discussions, and in April 2001 entered formal contract negotiations to develop a standard contract to replace the existing Triple Region and Southern Region Contracts. In these negotiations, the Ministry is acting as agent on behalf of the 21 DHBs, while the Guild is acting as agent for its members.

35. The Ministry and the Guild signed an agreed draft proposal on 7 November 2001 (the draft proposal). The draft proposal included:

- a summary of the services to be funded by the Ministry (via the DHBs) and provided by retail pharmacies;

- the amount of the dispensing fee for subsidised medicines, comprising a table of base dispensing fees and multipliers;

- the margin on the cost of subsidised medicines to cover stock holding and procurement costs;

- service specifications;

- quality standards;

- administration and efficiency issues; and

- the commencement date and duration of the proposed agreement.

36. The Ministry and the Guild require ratification of the draft proposal by both the DHBs and Guild members before signing by the DHBs and individual retail pharmacies. The Ministry is in the course of completing its ratification process with DHBs. The Guild is seeking authorisation for the Application from the Commission before it formally recommends the draft proposal to its members. It has, however, provided

members with a copy and asked for comments, and an indication as to whether the draft proposal is acceptable to them.

37. The overall objective is for the Ministry and the Guild to negotiate a "Template Agreement", which would form the basis for "Service Agreements" between DHBs and individual retail pharmacies in relation to specific subsidised services to be provided by retail pharmacies, and the price to be paid for those services. The draft proposal would, if agreed to by the parties, amount to a Template Agreement in terms of Practice 1

38. A Template Agreement will set the terms under which DHBs will fund, and pharmacies will agree to provide, subsidised pharmacy services to eligible persons, although there is scope for DHBs and individual retail pharmacies to negotiate amendments to the Template Agreement.

39. The Ministry stated in its submission that the Government was seeking to maintain continuity of subsidised services and is funding those services within strict budget limitations. In addition, the Government's approach was to promote national consistency in the price and content of subsidised health, but at the same time, to provide some scope for DHBs to procure services in such a way at a local or regional level to best meet the needs of their local communities.

LEGISLATIVE FRAMEWORK

Overview

40. The provision of pharmacy services is tightly controlled by legislation.[7] An overview of the major legislation is detailed below.

The New Zealand Public Health and Disability Act 2000

41. The purpose of the NZPHD Act is to provide for the funding of, and to ensure the provision to the public of, personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations (i.e. DHBs), to achieve certain health objectives.

42. A summary of the key provisions of the NZPHD Act relevant to the Application follows.

43. Section 3 provides, amongst other things, that the Crown and DHBs must endeavour to:

- promote the integration of all health services, especially primary and secondary services (section 3(4)); and

[7] When discussing particular pieces of legislation in this section, for convenience and ease of reading, references to sections will be references to sections of legislation under discussion, unless otherwise stated.

- provide for health services to be organised at either a local, regional, or national level depending on the optimum arrangement for the most effective delivery of properly coordinated health services (section 3(5)).

44. Section 10 makes provision for the Minister (on behalf of the Crown), or the Ministry (on the Minister's behalf), to enter into a Crown Funding Agreement with any person through which the Crown agrees to provide money in return for the provision of, or for arranging the provision of, services specified in the Crown Funding Agreement.

45. A Crown Funding Agreement provides the mechanism by which the Crown (and the Ministry on the Crown's behalf) makes funding available to DHBs for the provision of health services (including certain pharmaceutical services) in accordance with the service agreements and section 88 Notices.

46. Section 22 identifies the overall objectives for DHBs, while section 23 sets out the functions of DHBs for the purpose of pursuing their objectives. One of these functions is to "provide or arrange for the provision of services on behalf of the Crown" (section 23(l)).

47. The NZPHD Act provides methods by which a DHB may contract with retail pharmacies for the provision of services. These methods are:

- Service Agreements: Section 25 enables a DHB to make payment to a provider through a service agreement. A service agreement is an agreement between one or more DHBs and a service provider for the provision, or arranging for the provision, of services. It is proposed that the new pharmacy contracts would be entered into on this basis; and

- Section 88 Notices: Section 88 enables a DHB to give notice of the terms and conditions under which it will make payment for services. The Minister's consent is required in certain circumstances. Under section 88, acceptance by a provider of a payment made by a DHB constitutes acceptance of the terms and conditions of payment, by the provider.

48. Section 38 requires each DHB to determine a District Strategic Plan to achieve its objectives and functions for a five to 10 year period. In determining its District Strategic Plan, a DHB must consult with its resident population and obtain the Minister's consent.

49. Section 39 requires the Minister and each DHB to agree on an Annual Plan for that DHB for each financial year commencing on, or after, 1 July. The Annual Plan specifies amongst other things the expected performance for each DHB for that year and the dollar amount of funding allocated to that end. The Annual Plan must be consistent with the DHB's District Strategic Plan.

Medicines Act 1981 and Misuse of Drugs Act 1975

50. The sale and distribution of pharmaceuticals is controlled principally through the Medicines Act 1981 (the Medicines Act) and the Misuse of Drugs Act 1975, and associated regulations.

51. Section 3 of the Medicines Act defines three categories of medicines, which are declared by regulation or by a notice given under section 106. These categories are prescription medicines, restricted medicines and pharmacy-only medicines. A prescription medicine can be supplied only against a prescription issued by an authorised practitioner. Only a registered pharmacist can supply a restricted medicine, while only premises with a licence to sell medicines can supply a pharmacy-only medicine.

Pharmacy Act 1970

52. The Pharmacy Act 1970 (the Pharmacy Act) requires the registration of pharmacists with the Pharmaceutical Society of New Zealand (the Pharmaceutical Society). The Pharmaceutical Society provides the combined functions of a registration board and a professional body, including promoting quality and competence in the pharmacy profession.

53. In addition, all retail pharmacies must be registered with the Pharmaceutical Society. This process covers scrutiny of ownership, premises and equipment to ensure the retail pharmacy complies with the provisions of the Pharmacy Act.

54. The Pharmacy Act requires that a retail pharmacy is at least 75% owned by a pharmacist, and is under the supervision of a registered pharmacist. No company or any of its shareholders can have an interest in more than one retail pharmacy.

55. The Government plans to repeal the Pharmacy Act to allow appropriately qualified people who are not pharmacists to own retail pharmacies. These changes will be effected by amending the Medicines Act, consequent to the repealing of the Pharmacy Act, and the enactment of a Health Practitioners' Competence Assurance Bill. The Ministry anticipates that these legislative changes will be implemented next year.

Pricing of Subsidised Pharmacy Services

56. As noted earlier, the Application relates to the following subsidised pharmacy services:

- General Pharmaceutical Services;
- Pharmaceutical Review Services;
- Pharmacy Methadone Services;
- Pharmacy Nicotine Replacement Therapy Services; and
- Other Pharmaceutical Services.

57. Of these services, by far the bulk of the total subsidy is accounted for by General Pharmaceutical Services. The Commission understands that 97% of the total

dispensing fees paid to retail pharmacies derives from the provision of these services. Hence, the pricing of General Pharmaceutical Services is considered separately first, and all the other services together second.

General Pharmaceutical Services

58. General Pharmaceutical Services covers the dispensing by retail pharmacies of prescribed medicines to people eligible for subsidies with appropriate advice and patient counselling. The subsidies are complicated, but in broad terms there are two classes of medicines eligible for subsidy: those that are "fully subsidised", and those that are "partially subsidised". Although this terminology is useful, it should not be inferred that the "fully subsidised" medicines attract no payment from the consumer (although that is the case for some classes of consumers).

59. In considering price in a normal (i.e. unsubsidised) competitive market, the price paid by buyers is the same as the price received by suppliers. In a competitive market the subsidisation of the product drives a "wedge" between the price the supplier receives, and the price the buyer pays. This difference equals the size of the subsidy paid out on the good or service. Hence, because medicines are subsidised to different degrees, there are two different prices to be considered. In addition, the component services whose costs lie behind the supply price are set by Government regulation.

60. The pricing of fully subsidised and partially subsidised medicines will now be discussed in turn. Appendix 4 provides a breakdown of the individual components of the regulated supply and demand prices for fully subsidised medicines.

"Fully Subsidised" Medicines

61. The regulated supply price paid by the Government for a fully subsidised medicine within General Pharmaceutical Services is made up of the following elements:

- the cost of the medicine: this is determined by the outcome of negotiations between Pharmac and the manufacturer or supplier of the medicine. This cost is listed in the Pharmaceutical Schedule;

- a pharmacy margin: this is a margin on the cost of the medicine, which covers the cost to retail pharmacies of stock holding and procurement (currently set at 3.5% in the Triple Region Contract, and 5% in the Southern Region Contract); and

- a patient dispensing fee: this is a fee to cover the dispensing of the medicine to patients together with associated advisory services.

62. These three components together make up the cost of a fully subsidised medicine paid for by a DHB. On average, the medicine costs about $15, and the patient dispensing fee and margin about $5, making for an average cost per prescription of about $20. However, the average conceals a skewed distribution of medicine costs, with the bulk being less than $15, but some being more, or much more.

63. In contrast, the buyer price paid by the customer for fully subsidised medicines is determined by the size of the "prescription charge" or "co-payment" payable. This is defined in the Health Entitlement Card Regulations 1993, and is set out in the relevant Crown Funding Agreement. Currently, the maximum prescription charge for a three-month course for each prescribed item ranges from $0 to $15, depending upon patient status. These charges are shown in Table 1.

Table 1 Maximum Prescription Charges by Patient Status for "Fully Subsidised" Medicines

Patient Health Card(s)	Qualifier	Maximum Charge
No Card	Adult Child over six Child under six Contraceptives	$15 $10 $0 $3
Community Services Card (CSC)	No other card	$3
High Use Health Card (HUHC)	No other card	$3
Prescription Subsidy Card For families after first 20 prescriptions since previous February (except prescription with $0 charges)	No other card With HUHC only With CSC	$2 $2 $0

64. On the basis of information in a report prepared for the National Health Committee in 1999, it is estimated that CSC cardholders, who comprise by far the largest number of health card holders, account for around 50% of the population eligible for those cards.[8] However, the Commission understands that a small proportion of the population may use a disproportionate amount of the subsidy. For the average supply cost mentioned above, an adult would effectively pay for the cost of the medicine ($15), and receive the associated pharmacy services free of charge. Hence, the size of the Government subsidy is limited, even though the prescription is classified as being "fully subsidised".

65. A further consideration is that the subsidy varies considerably between different patient classes depending upon health card status, age and other factors. For example, a person holding a CSC or a HUHC would pay a $3 prescription charge, and receive a $17 subsidy for the average medicine. The size of the subsidy could be considerably greater for more expensive medicines.

66. On the other hand, for less expensive medicines it is possible for the regulated supply price (cost of medicine plus dispensing fee and margin) to be less than $15. The Commission is unclear at this time on what price is charged to customers in these

[8] Peter Crampton, *Third sector primary health care*, a report prepared for the National Health Committee, August 1999.

cases. While the spirit of the regulations, or possibly competition between retail pharmacies, might lead to an expectation that the retail pharmacy would charge the regulated price of less than $15, it has been suggested that certain retail pharmacies may sometimes charge the full $15, and take the difference as extra profit. The price charged to patients by retail pharmacies for medicines that are less than $15 provides the major scope for pricing competition under the current regulatory environment.

67. The scope for making additional charges to patients is limited by the Triple Region and/or Southern Region Contracts. These additional charges are confined to delivery charges, charges for dispensing medicines outside normal business hours, and any actual costs incurred in processing a prescription that are in addition to those specified in the contracts.

68. In summary, for fully subsidised medicines, customers in general pay a prescription charge that is less than the full cost of the prescription. This varies depending on whether the patient is eligible for a health card. The dispensing retail pharmacy is reimbursed by Health Benefits (on behalf of the DHB) for the cost of filling the prescription less the relevant prescription charge received from the customer.

"Partially subsidised" Medicines

69. The pricing for "partially subsidised" medicines within General Pharmaceutical Services is similar, but not identical, to that for "fully subsidised" medicines. The regulated supply price paid by the Government is made up of the following elements:

- the cost of the medicine: this is determined in part by the outcome of negotiations between Pharmac and the manufacturer, with the amount listed in the Pharmaceutical Schedule, plus a manufacturer's surcharge or premium borne by the patient, plus a pharmacy mark up (see Paragraphs 79-80 below);

- a pharmacy margin: this is a margin on the cost of the medicine, which covers the cost to retail pharmacies of stock holding and procurement (see Paragraph 70 above); and

- a patient dispensing fee: this covers the dispensing of the medicine and associated advisory services.

70. Hence, the only difference in the regulated supply price for partially subsidised as compared to fully subsidised medicines is the premium on the medicine, which in turn affects the price charged to the customer. This arises in the following way. When Pharmac negotiates with manufacturers over the price of medicines, it generally does so with respect to one medicine in a therapeutic sub-group, which becomes the fully subsidised medicine in that sub-group. Manufacturers are then free to sell other medicines in the same therapeutic sub-group at a non-regulated price, and hence at a price above that for the regulated item, with which they will compete. When the price for a partially subsidised medicine exceeds the price of a fully subsidised medicine within the same therapeutic sub-group in the Pharmaceutical Schedule, a retail pharmacy may recoup the difference (i.e. the manufacturers' premium) from the customer.

71. The prescription charge paid by the customer is, therefore, different for partially subsidised medicines as compared to fully subsidised ones. In addition to the prescription charge (i.e. $0-15), which is determined in exactly the same way, a product premium is added to cover the manufacturer's product premium (the product premium). For this reason, "partially subsidised" medicines will generally be more expensive for the consumer than their fully subsidised counterparts in the same therapeutic sub-group. They will tend not to be prescribed by GPs unless there is a significant offsetting advantage (e.g. lesser side-effects). In consequence, partially subsidised medicines make up less than 5% of all prescriptions issued.

72. The product premium that a customer will pay on top of the patient dispensing fee for a partially subsidised medicine can be estimated by taking the premium, and applying a retail pharmacy mark-up on the premium, plus other costs (e.g. tax). This particular mark-up is not regulated, and it appears that the software currently used by retail pharmacies to calculate prices may embody a standard mark-up of 86%.

Other Subsidised Pharmacy Services

73. As noted above, in addition to General Pharmacy Services, the other retail pharmacy services that are subsidised are:

- Pharmaceutical Review Services;
- Pharmacy Methadone Services;
- Pharmacy Nicotine Replacement Therapy Services; and
- Other Pharmaceutical Services.

74. These services are subject to separate service requirements and contracting arrangements. For some of these services, only a limited number of retail pharmacies may have either the expertise (as is the case with Pharmacy Review Services), or choose to carry out these services (e.g. Methadone Services).

75. The following is a summary of the pricing system used for some of these services:

- *Pharmaceutical Review Services*: a retail pharmacy currently receives a payment of $160 (excluding GST) for each individual review undertaken in accordance with the service specifications outlined in the contract. The total number of services to be provided annually is constrained by the Government funding available;

- *Nicotine Replacement Therapy Services (NRT)*: In return for providing services to those eligible (i.e. holders of an NRT Exchange Card), a retail pharmacy currently receives payment by way of a dispensing fee of $7.15 (GST exclusive), and a mark up of 5% on the Pharmaceutical Schedule cost of the NRT. A patient co-payment charge of $10 also applies in respect of the provision of NRT services. The annual amount of funding that the Government has made available for this programme is currently set at $5.49 million; and

- *Methadone Services*: the dispensing fee for these services is the same as that for General Pharmaceutical Services.

Question 1: The Commission seeks comments on its description of the pricing of fully subsidised and partially subsidised pharmacy services.

MARKET DEFINITION

Introduction

76. The purpose of defining a market is to provide a framework within which the competition implications, of the proposed practice can be analysed. The relevant markets are those in which competition may be affected by the practice being considered for authorisation. The reader is referred to the Commission's *Practice Note 4* for guidance on market definition principles.

77. The Act defines a market as:

> …a market in New Zealand for goods or services as well as other goods or services that, as a matter of fact and commercial common sense, are substitutable for them.

78. For the purpose of competition analysis, a relevant market is the smallest space within which a hypothetical, profit-maximising, sole supplier of a good or service, not constrained by the threat of entry, could impose at least a small yet significant and non-transitory increase in price, assuming all other terms of sale remain constant (the '*ssnip* test'). For the purpose of determining relevant markets, the Commission will generally consider a *ssnip* to involve a 5% increase in price for a period of one year, subject to the facts of each particular case.

79. The Commission seeks to define relevant markets in terms of four characteristics or dimensions:

- the goods or services supplied and purchased (the product dimension);
- the level in the production or distribution chain (the functional level);
- the geographic area from which the goods or services are obtained, or within which the goods or services are supplied (the geographic extent); and
- the temporal dimension of the market, if relevant (the timeframe).

80. The Commission seeks to define relevant markets in a way that best assists the analysis of the competitive impact of the authorisation under consideration. A relevant market will ultimately be determined, in the words of the Act, as a matter of fact and commercial common sense.

81. The Commission considers that the appropriate time period for assessing substitution possibilities is the longer term, but within the foreseeable future.[9] The Commission considers this to be a period of one year, which is the period customarily used internationally in applying the *ssnip* test to determine market boundaries. The Commission takes into account recent, and likely future, changes in products, relative prices and production technology.

82. The Application relates to the payments and service levels for dispensing services provided by retail pharmacies in respect of subsidised and certain unsubsidised medicines, and the payment for such services. This essentially involves the setting of fees and margins for the dispensing of subsidised medicines (whether fully or partially subsidised), and other services, and the setting of prices on certain unsubsidised medicines. It is the competition in these activities that is likely to be most affected, and hence the market definition will focus on these services.

The Guild's View of the Market

83. The Guild, in its application at paragraph 6.1, proposed that the market was that for "the provision of pharmacy services at the retail functional level" and, in particular, for the following subsidised services:

- General Pharmaceutical Services;
- Pharmaceutical Review Services;
- Pharmacy Methadone Services; and
- Pharmacy Nicotine Replacement Therapy Services.

84. With regard to the geographical scope of the market, the Guild submitted that "[c]ommunity pharmacies compete in local markets", and proposed that "the extent to which any one pharmacy is substitutable for another (is) dependent on the size of the city, town or suburb in which they are located and distance from, and modes of transport between, nearby cities, towns or suburbs".

<u>The Commission's View of the Market</u>

Product Market

85. The delineation of relevant markets as a basis for assessing the competitive effects of a restrictive trade practice begins with an examination of the goods or services offered by the parties to the practice. Both demand-side and supply-side factors are generally considered in defining market boundaries. Broadly speaking, a market includes products that are close substitutes in buyers' eyes on the demand-side, and suppliers

[9] In *Tru Tone Ltd v Festival Records Retail Marketing Ltd* [1988] 2 NZLR 351 Smellie J and the Court of Appeal on appeal approvingly quoted an earlier decision of the Commerce Commission in *Edmonds Food Ind Ltd v W F Tucker & Co Ltd* (Decision 21, June 1984) where the Commission said: "A market has been defined as a field of actual or potential transactions between buyers and sellers amongst whom there can be strong substitution, at least in the long run, if given a sufficient price incentive".

who produce, or are able easily to substitute to produce, those products on the supply-side.

86. The Commission proposes to examine the product market in terms of its supply–side and demand-side features.

Supply –Side Features

87. The Application relates to the retailing of the following pharmacy services:

- the dispensing of fully or partially subsidised medicines, and related advisory services. This incorporates general pharmaceutical services and specialised pharmaceutical services (e.g. Pharmacy Review Services);
- the dispensing of prescription–only unsubsidised medicines, and related services, where retail pharmacies have a statutory monopoly on the supply at retail of such medicines. This incorporates prescription –only medicines that are not listed on the Pharmaceutical Schedule (e.g. Viagra and Xenical), and those medicines where the full cost of the prescription is less than the relevant co-payment for subsidy purposes; and
- the dispensing of other prescription-only medicines, and related services, where retail pharmacies have a statutory monopoly on the supply at retail of such medicines.

88. The proposed practices for which authorisation is being sought will affect competition between retail pharmacies providing the services outlined above. All retail pharmacies supply all subsidised medicines[10] and pharmacy–only medicines, so there is uniformity in the physical product supplied. The product supplied is not differentiated (customers do not choose between retail pharmacies because of differences in product ranges), although the associated services are likely to be differentiated.

89. The predominant feature that characterises the supply-side of the affected market currently is the statutory monopoly held by retail pharmacies in the supply of all prescription medicines, and many non-prescription medicines. However, as noted in the background section, the Government is planning to make legislative changes that, if implemented, are likely to alter the regulatory environment under which pharmacy services will be provided.

90. Other supply-side features of the affected market are discussed below.

91. A feature of pharmacy operations is the apparent economies of scope between subsidised and non-subsidised medicines, and between those and the provision of other products. This would help to account for the joint supply of these products. The other products sold in retail pharmacies tend to be oriented toward health or personal use. These products fall into the following categories: babies, bathroom,

[10] It is the Commission's understanding that individual retail pharmacies can run out of particular medicines from time to time, or may not actually stock certain specialised medicines. However, they obtain these at short notice from other retail pharmacies, or from wholesalers. In other words, all essentially compete across the full product range.

beauty, cold remedies, eye care, first aid, gifts, hair care, natural health products, pain relief, photography, skin care, sports medicine, and toiletries.

92. Retail pharmacies appear to differ in the degree to which other goods are supplied. Commission staff were told that the proportion of sales of goods other than pharmacy-only medicines ranged between 20% and 90% for different retail pharmacies. The large variability appears to be, at least partly, by design, with some retail pharmacies choosing to specialise in dispensing medicines, and others the retailing of other products. This choice is usually associated with the physical location of the retail outlet. Specialist dispensing retail pharmacies, for instance, would normally be located near a doctor's surgery, while those located in shopping malls would likely sell more non-pharmaceutical products.

93. However, the obvious common factor across all retail pharmacies is the dispensing of medicines, and given the nature of the proposed practices, this suggests that a "pharmacy services" product market definition is the correct one. Nonetheless, the potential impact of the sale of other products must be kept in mind when the competition issues are being analysed. For example, there are likely to be common overhead costs to which all sales contribute.

Demand-Side Features

94. The demand for subsidised medicines and prescription-only non-subsidised medicines is closely associated with the demand for GP services. Generally speaking, a patient will choose to visit a GP in the event of illness, injury or a medical problem. After examining the patient, the GP may prescribe one or more medicines that can be sourced only from a retail pharmacy. In this situation, the demand for retail pharmacy services is a "derived demand", and GP's services are a "complementary product". In addition, consumers typically do not choose their medicine, but rather have it selected for them by their GP.

95. In some circumstances, a patient might substitute an alternative product or treatment for a pharmacy-only medicine. For example, a surgical procedure or a non-pharmacy product (e.g. herbal medicines) may provide a substitute for pharmacy –only medicines in some circumstances.

96. For a given customer, the demand for a medicine is very specific (for the particular medicine prescribed by their GP), yet a purely demand-side focus would result in an unduly narrow definition of the market. Nevertheless, all such transactions by customers on the demand-side are linked by the common source of supply - that of the pharmacies - and so it makes sense to aggregate on this basis in defining the market.

Rest Homes

97. It is conceivable that the provision of medicines to rest homes might form a discrete market. People in rest homes are significant consumers of medicines, and pharmacies often compete on service levels and price to supply them. In addition, the mode of supply to rest homes is different. Some firms, such as Kentra, specialise in supplying rest homes and other institutions. In other situations, a retail pharmacy might supply medicines to people in rest homes, in addition to supplying such products to the

general public. The Commission can see that there may be economies of scale (and possibly scope), and possibly higher profits, to be had in supplying to the residents of such institutions.

98. However the Commission considers that the service and price of pharmacy services for rest homes—being prescribed in such detail by statute, regulation, and contract—cannot be distinguished sufficiently from those of pharmacy services in general to warrant a separate market being used. Hence, the supply of medicines to rest homes is considered to be within the same market, for the purpose of this authorisation application.

Other Institutions

99. The Commission believes that the analysis on rest homes outlined above also applies to other institutional purchasers of medicines, such as prisons or private hospitals. Accordingly, the supply of medicines to these institutions is considered to fall within the same market in this authorisation application.

Question 2: The Commission seeks views on whether the supply of medicines to rest homes and other institutions is in the same product markets as retail pharmacies.

Conclusion on Product Market

100. The characteristics of the proposed practices suggest that the appropriate product market is one across all pharmacy–only medicines whether subsidised fully or partially subsidised, or unsubsidised. Abstracting from geographical factors, and given retail pharmacies' statutory monopoly over the dispensing of subsidised medicines, a *ssnip* would be unlikely to engender a significant response on either the demand- or supply-side once all such medicines are included. This naturally leads to all retail pharmacies being included in the one market definition.

101. The Commission concludes that the appropriate product market is one for "pharmacy–only medicines (subsidised whether fully or partially and unsubsidised) and related services".

The Geographic Market

102. The Commission will seek to define the geographical extent of a market to include all of the relevant, spatially dispersed, sources of supply to which buyers can turn should the prices of local sources of supply be raised. For each good or service combination, the overlapping geographic areas in which the parties operate are identified. These form initial markets to which a *ssnip* is applied. Additional geographic regions are added until the smallest area is determined within which the hypothetical monopolist could profitably impose a *ssnip*.

103. Generally, the higher the value of the product to be purchased, in absolute terms or relative to total buyer expenditure as appropriate, the more likely are buyers to travel and shop around for the best buy, and the wider the geographic extent of the market is likely to be.

104. Where transport costs are high relative to the final value of a product, a narrower geographic market is more likely to be appropriate. Where product perishability and other similar practical considerations limit the distance that a product may be transported, this may limit the geographic extent of the market. The timeliness of delivery from alternative geographic sources is similarly relevant.

105. Although buyers and sellers of a particular good or service may interact in markets that are apparently local or regional in extent, those markets may themselves overlap and interrelate so as to form a market covering a larger geographical area. In these situations, the larger market is likely to be the appropriate one for analysing competition.

106. As a general principle in geographic market definition, it is likely that the geographic market will be defined so that a small proportion of demand will come from people living outside the area, and a high proportion of demand will come from people living from within the area, with little draining outside. This is sometimes referred to as the LIFO, "little in from outside", and the LOFI, "little out from inside" model.[11].

107. The Commission considers that the geographic extent of the market is likely to be local, since from the demand-side perspective, customers are unlikely to travel far to gain access to services. Similarly, given the face-to-face nature of the service provided, supply is located in population centres close to demand.

108. In an earlier assessment of a merger proposal[12] involving two national supermarket chains, the Commission considered that, broadly speaking, it was appropriate to base the geographic markets on the assumption that the main source of the customers for each supermarket lies within a 5 km radius. Where the 'circles' defining the catchment areas for different supermarkets significantly overlapped, they would compete within the same geographic market. The decision states:

> In reaching a figure for this distance the Commission has had regard to the views of the supermarket chains and other retailers, the evidence of distance shoppers travel to supermarkets at present, the impact on supermarket shopping patterns of the opening of a new supermarket, and the economic model produced by NZIER.

109. In that decision, the Commission recognised that there is not a uniform size of market that applies to all areas, particularly in large urban areas; rather, there is a range of sizes that reflect a variety of factors influencing how far consumers are willing to travel to an alternative if faced with a small but significant local price increase. These factors include the presence of physical barriers to travel, the density of traffic on the roads, levels of car ownership, and the potential savings to be made, which would depend in part on the size of the transaction.

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[11] Elzinga and Hogarty, *Antitrust Bulletin*, Spring 1973

[12] Commerce Commission, Decision 438: *Progressive Enterprises Ltd/Woolworths (New Zealand) Ltd.*

110. A recent research paper on geographic markets in the retail pharmacy sector surveyed patterns of retail pharmacy patronage, using the patient databases of 12 retail pharmacies from different regions in New Zealand.[13] These were divided into three categories of retail pharmacies, classified by location ;a: rural, suburban and central city. Interviews were also carried out with 15 customers at each retail pharmacy who had just collected a prescription medicine. Differences were found in retail pharmacies' usage patterns corresponding to the different types of location:

- customers of central city retail pharmacies had a broad scattering of addresses throughout the city, and indicated that being close to work was the main reason for choosing a particular retail pharmacy in that location;

- customers of suburban retail pharmacies tend to live in that suburb or in neighbouring suburbs; and

- customers of provincial/rural retail pharmacies typically come from that township and its hinterland. The paper notes that "[i]n many cases a rural pharmacy may be the sole pharmacy serving a large community or district". In one case the next closest retail pharmacy was about 40 km away.

111. The survey of customers indicated that location is the most important factor in choice of retail pharmacy (mentioned by 82% of survey respondents) with a preference for retail pharmacies that, in descending order, were close to a GP (30%), home (20%), and work (13%). Choice of retail pharmacy was also influenced by loyalty and quality of service, with, in some cases, customers not using the closest retail pharmacy for these reasons.

112. The Commission believes that the following features may also influence the geographic scope of the market:

- some customers are likely to be unwell, and hence disinclined to travel far;

- the likely perception amongst customers that as the medicines sought are usually subsidised, prices will not differ between retail pharmacies, and hence there is no point in shopping around; and

- even if medicines can be purchased more cheaply by shopping around, only those with chronic or long-term conditions - and hence needing repeat prescriptions - may find it worthwhile to incur the necessary search costs, given the typical size of the transactions.[14]

[13] K. Ryan, G. Becket and P. Norris, "Who goes where and why? – the patronage of community pharmacies in New Zealand", *Australian Pharmacist*, January 2002.

[14] See: Dennis W. Carlton and Jeffrey M. Perloff, *Modern Industrial Organisation*, (1994), pp. 568. As the search cost "investment" need only be made once, or infrequently, for consumers making regular purchases the search costs per purchase will be low. In contrast, for those making single purchases, the cost of the search is likely to outweigh the benefit of any lower price discovered.

Conclusion on Geographic Market

113. The Commission has concluded that the relevant markets are likely to be local in extent. However, there are likely to be considerable variations across markets, with those in isolated population centres covering quite large areas, and those in the suburbs of urban areas having a quite restricted range. Nonetheless for ease of analysis, the Commission proposes to consider these local markets generically, although it recognises that there may be many differences between individual markets.

Question 3: The Commission seeks the views of interested parties on the geographic scope of the market.

Functional Market

114. The production, distribution and sale of a product typically occur through a series of functional levels – for example, the manufacturing/import level, the wholesale/distribution level and the retail level. It is often useful to identify the relevant functional level in describing a market, as the proposed practice may affect one horizontal level, but not others.[15] Alternatively, some practices, such as those involving transactions at different vertical levels, may raise issues related to vertical restrictions. Generally, the Commission will seek to identify separate relevant markets at each functional level affected by a practice and assess the impact of the practice on each.

115. The Commission considers that for the purpose of the authorisation the functional market definition is at the retailing level, between retail pharmacies and their customers.

Conclusion on Market Definition

116. The Commission has reached the preliminary conclusion that the relevant markets for the consideration of the Application are the local markets for the retail supply of pharmacy-only medicines (whether fully subsidised, or partially subsidised, or unsubsidised) and related services. While local markets will vary in terms of size and other characteristics, the Commission proposes to consider them in this Draft Determination on a generic basis.

[15] *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1991) 4 TCLR 473, 502 The High Court (Greig J, Shaw WJ, Prof M Brunt) noted: "If we ask what functional divisions are appropriate in any market definition exercise, the answer, …, must be whatever will best expose the play of market forces, actual and potential, upon buyers and sellers. Wherever successive stages of production and distribution can be co-ordinated by market transactions, there is no difficulty: there will be a series of markets linking actual and potential buyers and sellers at each stage. And again, where pronounced efficiencies of vertical integration dictate that successive stages of production and distribution must be co-ordinated by internal managerial processes, there can be no market."

Question 4: The Commission seeks the views of interested parties on the preliminary conclusion that the relevant markets are the local markets for the retail supply of pharmacy-only medicines (whether fully or partially subsidised and unsubsidised) and related services.

OVERVIEW OF THE PROPOSED ARRANGEMENTS

Practice 1

117. The Guild considers that Practice 1 will allow it to agree with the Ministry (on behalf of DHBs) on the amounts that DHBs will pay retail pharmacies for providing subsidised pharmacy services, on the amounts that retail pharmacies can charge patients for providing these services, and to arrive at a Template Agreement that specifies those payments, charges and associated terms. The Guild also considers that Practice 1 will allow DHBs and retail pharmacies to enter Service Agreements, under section 25 of the NZPHD Act, that reflect the Template Agreement.

118. Practice 1 is a continuing practice that the Guild intends adopting in its current negotiation of a draft proposal with the Ministry, and which it may adopt in future negotiations with the Ministry, or with DHBs. The Guild claims that any retail pharmacy (not just its members) will be able to take advantage of Practice 1. The Commission agrees with the Guild's description of Practice 1 in this respect.

119. The Commission has interpreted the individual arrangements within Practice 1 to mean:

- a contract, arrangement or understanding ("arrangement"), or Template Agreement, between the Ministry (as agent for DHBs) and the Guild (on behalf of its members) that will form the basis of Service Agreements between DHBs and Guild members (Paragraph 2.7(a) of the Application);

- Service Agreements between DHBs and Guild members (Paragraph 2.7(b) of the Application);

- arrangements between the Guild and its members about the payments that they will seek and/or accept from DHBs for providing certain pharmacy services, and the terms of these payments (Paragraph 2.7 (c) of the Application);

- arrangements between the Guild and its members about the amounts that they will charge patients for providing certain pharmacy services, and the terms of these charges that they will seek and/or accept from with DHBs (Paragraph 2.7(d) of the Application); and

- further arrangements between the Guild and its members about the amounts that they will charge patients (and associated terms), after arrangements under Paragraph 2.7(a) or Paragraph 2.7(b) of the Application have been concluded (Paragraph 2.7(e) of the Application).

120. These arrangements that would form Practice 1 can be divided into the following categories:

- Paragraphs 2.7(c) and (d): arrangements between the Guild and its members before or during negotiation of a Template Agreement;
- Paragraph 2.7(a): an arrangement between the Guild and the Ministry (a Template Agreement);
- Paragraph 2.7(b): arrangements between Guild members and DHBs (Service Agreements); and
- Paragraph 2.7(e): further arrangements between the Guild and its members (after the conclusion of a Template Agreement or Service Agreements).

121. These arrangements are considered likely to be given effect to in the sequence set out above.

Arrangements Between the Guild and its Members

122. The Application suggests that these arrangements are among Guild members themselves, and/or between Guild members and the Guild. This category of arrangements would enable Guild members and the Guild to arrive at a common position about what the Guild will seek, and what its members will accept, as the terms of a Template Agreement. These terms determine what a DHB will pay Guild members for providing subsidised pharmacy services and what Guild members can charge patients for providing these services.

123. In effect, these arrangements determine the subsidy amount (by way of DHB payment) that the Guild will seek from DHBs for its members in return for them providing subsidised pharmacy services to patients. The subsidy paid to retail pharmacies enables them to cover their costs in providing medicines and services at the reduced price to patients set by the Government. Clearly, the higher this subsidy is, the greater the likely profits for each retail pharmacy.

124. In terms of Paragraph 2.7(c) and (d), these arrangements need not relate only to charges for *subsidised* pharmacy services. Guild members could agree to seek payment from DHBs, and to seek (from the Ministry or DHBs) the ability to charge patients, for certain *non-subsidised* pharmacy services as well as subsidised pharmacy services. For example, the Guild and its members could agree that provision for a further patient charge over and above the current legislated prescription charge would be sought in negotiations with the Ministry. Legislation and other instruments largely prescribe patient charges for subsidised pharmacy services. This factor would be likely to limit the Guild's ability to negotiate additional patient charges with the Ministry or DHBs.

125. The terms of the Application would, if authorised, allow arrangements between the Guild and its members to occur at any point before or during negotiation of a

Template Agreement. For example, these arrangements would enable Guild members to ratify a Template Agreement.

Question 5: The Commission invites comment on its description of the arrangements between the Guild and its members. In particular, the Commission seeks comments on whether any of these arrangements are likely to extend to non-subsidised pharmacy services.

Template Agreement

126. Paragraph 2.7(a) of the Application anticipates negotiation of a Template Agreement between the Guild and the Ministry. A Template Agreement would form the basis of Service Agreements, which would be concluded between DHBs and individual Guild members at the next stage of Practice 1.

127. Some negotiation of a Template Agreement has already occurred in the current negotiating round between the Ministry and the Guild, although these negotiations have not yet been concluded. However, there is no indication that the negotiation that has occurred to date has been premised on arrangements between the Guild and its members as described above (Paragraphs 2.7(c) or (d) of the Application).

128. The purpose of a Template Agreement is to arrive at an arrangement relating to the amounts to be paid by DHBs to Guild members for providing *subsidised* pharmacy services, the terms under which they will provide these services, and the amounts that they can charge patients for providing these services. The scope of what can be agreed is constrained by legislation and by Government policy.

129. The Ministry considers that in its negotiations with the Guild to date, it is acting as the agent of the DHBs. However, the Ministry has advised that it does not *intend* to arrive at or enter a legally binding agreement with the Guild. It appears that an agency relationship between DHBs and the Ministry has been created by DHBs expressly agreeing to have the Ministry negotiate a Template Agreement with the Guild on their behalf, subject to being able to formally agree to the final version of this agreement[16]. The Ministry considers that in the context of distributing health funding, there is no distinction in practice between consulting and negotiating.[17]

130. The Guild considers that in negotiating with the Ministry it is acting on behalf of its members, and the Commission accepts that this is so.

131. Section 2(8)(a) of the Commerce Act provides that:

> (a) Any contract or arrangement entered into, or understanding arrived at by an association or body of persons, shall be deemed to have been entered into or arrived at by all the persons who are members of the association or body;

132. The Guild has sought authorisation to negotiate an arrangement on behalf of its members. If such an arrangement is reached then the application of section 2(8)(a) of

[16] Letter from DHBNZ to the Ministry of Health (19 July 2001).
[17] Submission by the Ministry of Health to the Commerce Commission (22 February 2002), 4.

the Act means that Guild members are deemed to have also entered into an arrangement with the Ministry. Therefore, the DHBs, the Guild and Guild members would be parties to the arrangement reached in relation to a Template Agreement.

133. The essential elements of an understanding are communication giving rise to a meeting of minds between the parties that embodies an expectation as to the future conduct of at least one of the parties, and that such party or parties be under some type of moral obligation to conduct themselves in the way which their communication has indicated.[18]

134. The Commission considers that negotiation between the Ministry and the Guild would amount (at least) to an understanding in terms of the Commerce Act in that each of the Ministry and the Guild understand that once concluded, the Template Agreement will be used by both the DHBs and Guild members as a basis for Service Agreements between them. This understanding about the terms of a Template Agreement would be between DHBs and the Guild (and Guild members). It is important to note that DHBs would not be obliged to incorporate the terms of a Template Agreement into Service Agreements.

135. The Commission has not been provided with a final version of a Template Agreement that has been proposed in the current negotiating round between the Ministry and the Guild ("the initial Template Agreement"). However, it has a draft version of this agreement, which is expected to be very similar to the final version.

136. It is very likely that DHBs will not deviate from the initial agreement significantly, given that they have asked the Ministry to negotiate on their behalf and that they will ratify the final version of this prior to it having effect. Section 25 does not allow the Ministry to be party to Service Agreements.

137. The draft version of the initial Template Agreement has been divided into sections. Paragraph 3.1 of Section A in the draft version states that:

> It is envisaged that this modular approach will enable significant amendments to be more readily incorporated into the Agreement

138. This indicates that it is anticipated that Service Agreements with individual retail pharmacies might deviate from the initial Template Agreement.

139. The draft version of the initial Template Agreement also includes agreement on the terms under which DHBs will fund, and retail pharmacies will provide, subsidised pharmacy services (although these terms are ultimately set by Service Agreements). Subsidised pharmacy services are:

- dispensing services (community);
- methadone and controlled drug dispensing and advice services;
- pharmaceutical review services; and

[18] Gault on Commercial Law, 27.07.

- other pharmacy services described in schedules of the base agreement.

140. The draft version of the initial Template Agreement indicates that negotiations between the Ministry and the Guild would relate only to costs for subsidised pharmacy services that are borne by DHBs. These costs are:

- the pharmacy margin, which contributes to the cost to retail pharmacies of stockholding and procurement, and is paid to retail pharmacies by DHBs as a reimbursement; and

- the patient dispensing fee, which comprises a base fee and multipliers that determine the fee for specialist services, and is paid to retail pharmacies by DHBs as a reimbursement.

141. The Pharmac medicine price, which is set by the Pharmaceutical Schedule and paid to retail pharmacies by Health Benefits, is also a cost borne by DHBs. This cost is determined by Pharmac's negotiations with medicine suppliers, and would not be negotiated under the Template Agreement.

142. The draft version of the initial Template Agreement does not include agreement on the costs for subsidised pharmacy services that are borne by consumers (i.e. the public) directly. These costs are largely set by legislation or other instruments, and are therefore beyond the scope of a Template Agreement. For example, the prescription charge (which varies between $0 and $15 and is payable by a patient to a retail pharmacy) is determined by the Crown Funding Agreement, the Pharmaceutical Schedule and by the Health Entitlement Cards Regulations 1993. Paragraph 4.4 of Section H in the draft version of the initial Template Agreement explicitly acknowledges the instruments governing prescription charges.

143. A Template Agreement that is concluded in future negotiating rounds between the Guild and the Ministry or DHBs is likely to have substantially similar content to the initial Template Agreement.

Question 6: The Commission invites comment on its description the Template Agreement between the Guild and the Ministry.

Service Agreements

144. Practice 1 anticipates that after a Template Agreement has been concluded between the Ministry and the Guild, DHBs and individual Guild members will enter Service Agreements that will substantially reflect the terms of the Template Agreement. Once executed, the arrangements between DHBs and individual Guild members will constitute Service Agreements in terms of section 25 of the NZPHD Act.

145. Service agreements would be the means by which DHBs would give effect to a Template Agreement negotiated. However, Service Agreements are possible irrespective of the other categories of arrangements included in Practice 1 (i.e. whether or not a Template Agreement is concluded).

146. The Guild expects that Service Agreements will substantially reflect a Template Agreement. However, there are a number of circumstances in which DHBs could enter Service Agreements that differ from this agreement.

147. The Application suggests that there could be scope within a Template Agreement for DHBs to enter Service Agreements with individual retail pharmacies that vary from this agreement, provided these variations are consistent with the District Annual Plan of the DHB and the "national consistency" goals of the NZPHD Act. The draft version of the initial Template Agreement indicates that this could be done through the addition or removal of schedules of a Template Agreement by individual DHBs, as provided for by Paragraph 3.1 of Section A in the draft version, or simply by varying the agreement by agreement with individual retail pharmacies.

148. Alternatively, DHBs could reject a Template Agreement negotiated by the Ministry and the Guild, and substitute an alternative Service Agreement of their own or use a section 88 Notice. In devising any alternative Service Agreement or a section 88 Notice, DHBs would be required to consult with individual pharmacies (possibly through the Guild), although the DHB could consult in a way that did not involve the Guild, such as through other provider groups or with individual retail pharmacies.

149. DHBs would not be required to *negotiate* the terms of an alternative Service Agreement with the Guild. However, given that DHBs have authorised the Ministry to act as their agent in negotiating a Template Agreement, and given the effort and resource required to negotiate an alternative agreement, the Commission considers it unlikely that this last situation would eventuate, at least not in relation to the present negotiating round, and that any changes are unlikely to be significant.

Question 7: The Commission invites comment on its description of Service Agreements. Specifically, the Commission seeks comment on the extent to which a Service Agreement may in fact differ from any Template Agreement as agreed between the Guild and the Ministry.

Further Arrangements Between the Guild and its Members

150. The Guild contemplates entering further arrangements with its members after it has negotiated a Template Agreement with the Ministry, or after its members have entered Service Agreements with DHBs.

151. Under the terms of Paragraph 2.7(e), further arrangements between the Guild and its members regarding DHB payments or patient charges would be possible provided that they were not inconsistent either with Service Agreements between Guild members and DHBs, or with a Template Agreement.

152. Arrangements between the Guild and its members that occur after these agreements will not be constrained by the terms of a Template Agreement or Service Agreements. However, within this constraint, Guild members would remain able to agree on aspects of price and service to the extent that this is not prohibited or restricted by

either a Template Agreement or Service Agreements. This means that Guild members could potentially retain the ability to agree on aspects of price.

Question 8: The Commission invites comment on its description of any arrangements between the Guild and its members after the completion of a Template Agreement or Service Agreements.

Practice 2

153. Practice 2 reflects the Guild's desire for the future evolution of Practice 1. The Guild states that although DHBs and retail pharmacies would enter Service Agreements under Practice 1, a number of its members have expressed a desire that the Guild enter into a Head Service Agreement with the Ministry (on behalf of DHBs) or with DHBs directly. If this happened, the Guild anticipates entering back-to-back service Sub-Agreements with retail pharmacies under which these retail pharmacies would provide services on behalf of the Guild (essentially as a sub-contractor).

154. As with Practice 1, the Guild claims that any retail pharmacy (not just its members) will be able to take advantage of Practice 2. To realise Practice 2 the Guild has sought authorisation for the following arrangements:

- a contract, arrangement or understanding ("arrangement") between the Guild and the Ministry (on behalf of DHBs), and/or between the Guild and DHBs directly, about the amounts that DHBs will pay retail pharmacies for pharmacy services, and the terms of these payments (Paragraph 2.9(a) of the Application); and

- arrangements between the Guild and pharmacies about the amounts that community pharmacies can charge patients for providing pharmacy services, and the terms of these charges (Paragraph 2.9(b) of the Application).

155. The Commission views Practice 2 as a bundle of arrangements that would enable the Guild to have a direct contracting relationship with the Crown, rather than a relationship as negotiator on behalf of its members. This would create a new role for the Guild, with it being a party to an arrangement with the Ministry or with DHBs in its own right. Under the Head Service Agreement ("the Head Agreement"), it is likely that payments by the Crown for providing pharmacy services would be made to retail pharmacies (i.e. Guild members) directly, rather than via the Guild. However, the Guild would be responsible for ensuring that pharmacy services are provided in accordance with the Head Agreement. It would do this by entering Sub-Agreements with its members. Guild members, rather than the Guild, would then provide the pharmacy services specified in the Head Agreement. A diagram which represents Practice 2 appears in Appendix 2.

156. The Ministry has stated in its submission (made on behalf of the Ministry *and* DHBs*)* that:

> Proposals involving the Guild holding head contracts on behalf of its members are extremely unlikely to eventuate under present approaches. The Guild is aware that the Ministry and DHBs do not propose to enter arrangements of this kind with the Guild.

157. The Commission notes the views of the Ministry and DHBs. Given these views, it appears unlikely that Practice 2 will proceed. The Commission also considers that Section 60(7) of the Commerce Act may apply to Practice 2, i.e. that the Commission could return Practice 2 to the Guild on the basis it was unlikely to proceed. However, for the purposes of the Draft Determination, the Commission considers that Practice 2 should be evaluated along with Practice 1.

158. The arrangements that would be included in Practice 2 fall into the following categories:

- the Head Agreement; and
- Sub-Agreements.

159. If authorised, these arrangements would be given effect to in the sequence outlined above.

Head Agreement

160. The Guild would negotiate a Head Agreement directly with either the Ministry or DHBs. Paragraph 2.9(a) of the Application indicates that the Guild would negotiate a Head Agreement with either of these parties. The Ministry would be able to enter a Head Agreement with the Guild as a health service provider under section 10 of the NZPHD Act. DHBs would be able to enter a Head Agreement with the Guild (in the form of a Service Agreement) under section 25 of the NZPHD Act.

161. The effect of Section 2(8)(a) of the Commerce Act means that Guild members would be deemed to be party to any arrangement entered into by the Guild. Therefore, a Head Agreement would be an arrangement between the Guild and either the Ministry or DHBs, and between Guild members and either the Ministry or DHBs.

Question 9: The Commission invites comment on its description of a possible Head Agreement between the Guild and either the Ministry or DHBs.

Sub-Agreements

162. The Application suggests that the Guild would enter Sub-Agreements with its members following the conclusion of a Head Agreement. These arrangements would have the purpose of giving effect to a Head Agreement.

163. Sub-Agreements would involve the Guild and its members agreeing about the amounts that retail pharmacies could charge patients for providing services and associated terms. It is likely that the Guild would enter a standard Sub-Agreement with its members, on terms that the majority of its members would be prepared to accept. Sub-Agreements would be likely to include standard terms relating to service specifications and quality standards. The Guild has stated that Sub-Agreements might also be signed by retail pharmacies that are not members of the Guild.

164. Under Paragraph 2.9(b) of the Application, the terms of these Sub-Agreements would not be constrained by a Head Agreement. This means that these arrangements would not be constrained or influenced in any way by what the Ministry or DHBs would be willing to agree to. The Application does not appear to identify or provide for any other constraints on the scope of Sub-Agreements. Therefore, Sub-Agreements could involve the Guild and its members having broad freedom to agree the amounts that its members would charge patients for services and the terms under which they would provide these services.

165. Sub-agreements might not be limited to *subsidised* pharmacy services. The Commission considers that the terms of Paragraph 2.9(e) are broad enough to allow the Guild and its members to agree on any *service* that is provided by retail pharmacies.

Question 10: The Commission invites comment on its description of possible Sub-Agreements between the Guild and retail pharmacies.

SECTION 30 OF THE COMMERCE ACT

Overview of Section 30

166. Section 30 of the Commerce Act prohibits any provision of a contract, arrangement or understanding between competitors that has the purpose, effect or likely effect of fixing, controlling or maintaining the price of goods or services. Such an arrangement is deemed to substantially lessen competition in terms of section 27 of the Commerce Act therefore a competitive assessment of whether it does in fact substantially lessen competition in terms of section 27 is not necessary. This approach was affirmed in two recent decisions in relation to section 30: *Commerce Commission v Taylor Preston Limited* [1998] 3 NZLR 498 and *Commerce Commission v Caltex New Zealand Limited* (1999) 9 TCLR 305.

167. To establish whether the arrangements in each Practice breach section 30 the following must be determined:

- whether the arrangements are between actual or potential competitors; and
- whether the arrangements have the purpose, effect or likely effect of fixing, controlling or maintaining prices.

Competition Between Guild Members

168. The Commission has defined the relevant markets as the local markets for the retail supply of pharmacy only medicines. These markets are geographically local markets though they may vary considerably in size. The Commission considers that the characteristics of these local markets do not differ significantly and has decided to treat them generically.

169. Within each local market, there is generally more than one pharmacy, particularly in the urban and city markets. However, the Commission is cognisant that in some markets, such as rural markets, there is likely to be only one pharmacy. The Applicant has given Waipukurau as an example where one pharmacy exists. The Commission has not separately identified each market where only one pharmacy might exist, but for the purposes of this analysis is treating all markets generically on the basis that generally, there is more than one pharmacy in each local market. In addition, because the Guild represents about 80 percent of pharmacies, it is also assumed that there is generally more than one Guild member in each local market.

170. Competition between Guild members tends to relate to service and location. Competition on price could also occur, although the extent to which it does in practice is unclear. Retail pharmacies are free to compete on various aspects of service. This competition takes various forms, such as the provision of information about medicine use, friendliness of staff, free delivery of medicines and so on. Retail pharmacies also compete on location. Pharmacies endeavour to be located near medical centres or shopping centres in order to attract customers. In major metropolitan areas, retail pharmacies may be located in close proximity to each other. While this may not be the case in smaller towns, in many instances patients would have access to more than one retail pharmacy in more than one location.

171. This indicates that Guild members compete in a general sense for the same actual or potential customers within each local market. Accordingly, a competitive relationship exists between Guild members.

Question 11: The Commission seeks comment on the extent to which Guild members currently compete with each other.

Assessment of Practice 1 Under Section 30

Arrangements Between the Guild and its Members

172. The Application indicates that Practice 1 involves the Guild and its members agreeing about patient charges and DHB payments that should be sought in negotiating a Template Agreement. A Template Agreement is in turn likely to form the basis of Service Agreements between DHBs and individual Guild members.

173. The subsidy that the DHBs would pay to the Guild members for providing subsidised pharmacy services is essentially the difference between the amount that the consumer pays for the prescription, as provided in regulations, and the actual cost borne by the Guild member for providing that service. There is clearly an information asymmetry between the Guild members and the Ministry about the level of these costs. Given that the level of subsidy will determine the profits of the Guild members, the latter have an incentive to ensure that the subsidy is as high as possible. Acting collectively and agreeing on the level of subsidy sought is therefore likely to achieve a better result for the Guild members.

174. Any agreement between the Guild members would be taken forward into the negotiations between the Guild and the Ministry about the terms and conditions of the

Template Agreement. These terms and conditions will then be reflected in the service agreements between DHBs and individual Guild members. Consequently, the arrangement between the Guild members as to the level of subsidy being sought, clearly has an influence over the final result. The issue to be considered by the Commission is whether this influence amounts to fixing, controlling or maintaining a price.

175. The meaning of "fixing, controlling or maintaining" was considered in *Radio 2UE Sydney Pty Ltd v Stereo FM Pty Ltd* (1982) 4 ATPR 43,912 and on appeal to the Federal Court (1983) 5 ATPR 44,398. At first instance Lockhart J adopted a dictionary meaning of "fix" and "maintain". His Honour commented on "fix" at page 43,921:

> The *Shorter Oxford Dictionary* defines the verb 'fix' as: 'To fasten, make firm or stable; … to attach firmly; ... settle permanently.' The *Macquarie Dictionary* defines the word as: '1. To make fast, firm, or stable. 2. To place definitely and more or less permanently. 3. To settle definitely; determine; *to fix a price*.

176. His Honour commented on "maintain" at page 42,921:

> The verb maintain is defined by the Shorter Oxford English Dictionary as: "to continue, persevere in; … continue, preserve, retain". The Macquarie Dictionary defines the word as "1. To keep in existence or continue; Preserve; retain …3. To keep in a specified state, position etc." In my view "maintain" where used in [the Australian equivalent of s 30], has a similar connotation to the verb 'fix' in that it involves some element of continuity, not merely being momentary or transitory. Generally, to maintain a price assumes that it was fixed beforehand.

177. The Commission considered s 30 in *Insurance Council of New Zealand (Inc) Decision 236* (1989) 2 NZBLC (Com) 99-522. There, the Commission adopted Lockhart J's definitions of 'fix' and 'maintain'. The Commission summarised the phrase 'fix, control or maintain' at page 104,482:

> In all of the cases noted above, the terms 'fix', 'control' and 'maintain' are synonymous with an interference with the settling of a price, as opposed to allowing such a price to be set in response to changes in the supply and demand for goods and services. Thus, in a technical sense any agreement by competitors in a market which has an influence on, or interferes with the setting of a price, amounts to 'price fixing'. However, following Lockhart J for that interference to have any significance in a competition sense, the price that is fixed must not be "instantaneous or merely ephemeral, momentary or transitory or be the result of arrangements which merely incidentally affect it".

178. A distinction between provisions which merely have an incidental affect on price rather than "fixing, controlling or maintaining" price was made in both the *Radio 2UE* and the *Insurance Council* decisions. In the *Insurance Council* decision, the Commission concluded that s 30 only applies to price fixing in a competition sense. The Commission observed at page 104,483:

> Thus while the Agreement might have influenced the price of insurance, the Council having itself stated that the price of insurance sold by a signatory is different to what it would have been in the absence of the Agreement, the Commission is not satisfied that this amounts to 'price fixing' in a competition sense. The effect of the Agreement is to remove the cost element from the price, the price minus that element then moves in response to normal competitive pressures. Accordingly, the Commission considers that the agreement does not constitute the 'fixing', 'controlling' or 'maintaining' of the price of motor vehicle insurance in terms of s 30 and cannot therefore be deemed to 'substantially lessen competition' in terms of s 27.

179. The issue of whether a provision must affect price in a 'competition sense' has been reviewed in two recent decisions. The decisions discuss the meaning of the word "control" in relation to s 30 (or its Australian equivalent). In *Australian Competition and Consumer Commission v CC (NSW) Pty Limited* (1999) ATPR 41-732 an understanding had been arrived at for the payment of a fee by the successful tenderer to each of the unsuccessful tenderers of a particular building project. The Federal Court of Australia was asked to consider whether this was likely to have the effect of controlling the price charged for the building project. Lindgren J found that the understanding would have the effect of 'controlling price' if it restrains a freedom that would otherwise exist as to the price to be charged. It was not necessary for there be some specificity as to price. Because of this, the understanding could fall within the terms of the Australian equivalent of section 30 (page 507):

> Concretes also submits that because the supposed UTF understanding left the tenderers with a great deal of freedom as to the price which they would charge, it did not have the effect of controlling price competition and therefore did not fall within the terms of [the Australian equivalent of s 30]. It seems to me, however, that putting to one side de minimis cases, the degree of control, although relevant to penalty, is not relevant to the issue of contravention. I do not consider the degree of control here to have been de minimis.

180. In *Commerce Commission v Caltex New Zealand Limited* [1998] 2 NZLR 78; (1998) 6 NZBLC 102,505, it was alleged that the simultaneous withdrawal of a free car wash offer by three petrol companies was a breach of s 27 of the Act by virtue of the s 30 deeming provision. On a strike out application, the High Court found that, in order to establish price fixing, it was not necessary for there to be certainty and agreement on what the new price levels would be. Elias J stated:

> If the Commission is correct in its contention that the promotion operated as an integral part of petrol or car-wash pricing or was a discount in relation to petrol or car-wash services (which seems to me to be a matter which can only be determined after hearing evidence), then an agreement to withdraw the promotion and increase the price or remove the discount seems to me to be within the scope of ss 27 and 30 irrespective of whether the companies are free to compete on price or discount in other ways in the future. *There is no authority for the proposition that in order to establish price fixing or impact upon competition it is necessary to establish a fixed price or agreed discount for the future.* I agree with the submission made by Mr Hansen QC that if that were so it would be easy to drive a coach and four through the Act. Nor do I think it can be said, in the absence of further agreement to fix prices, that the result is ephemeral. (emphasis added)

181. The above extract was later referred to by Salmon J in the substantive decision ((1999) 9 TCLR 305). Salmon J adopted the definition of 'control' in the *Shorter Oxford English Dictionary*: "To exercise restraint or direction upon the free action of" (at page 311). Salmon J agreed with the findings of Elias J that there was no need for certainty and agreement on price levels to establish price fixing.

182. Prices for pharmacy services are ultimately set by Service Agreements, which are concluded between DHBs and individual pharmacies. Under Practice 1, it is anticipated that these Service Agreements would be based on the form of a Template Agreement.

183. The Commission considers that arrangements between the Guild and its members would influence the terms of other arrangements that are included in Practice 1. The interrelationship between the arrangements that form Practice 1 means that

arrangements between the Guild and its members would ultimately influence the subsidy amounts that Guild members receive in return for providing subsidised pharmacy services. This influence comes from the role that arrangements between the Guild and its members have in determining the content of other arrangements that are included in Practice 1.

184. Since the monopsony purchasers (i.e. the Ministry and/or DHBs) in this instance controls the funding available, the outcome in terms of pricing and output may be likely to be closer to the end of the spectrum where these purchasers hold the preponderance of market power. Nevertheless, this market power would be mitigated to some extent by the influence the Guild under Practice 1 where it is able to exercise as a collective agent on behalf of Guild members.

185. What is not clear to the Commission is the extent to which the Ministry and DHBs might be influenced by other considerations in concluding agreements with health service providers, including the Guild or any other retail pharmacy group. Such considerations might include a strategy of not advancing a position that may damage the ongoing relationships with a health provider group.

Question 12: The Commission seeks comment on the extent to which the Ministry or DHBs would use market power to resist demands by health provider groups.

186. Although arrangements between the Guild and its members do not determine subsidies directly, they are agreements between competitors in a market that have the purpose, effect, or likely effect of influencing or interfering with price (being the price that DHBs pay Guild members by way of subsidies). The proposition that it is not necessary to show a fixed price to establish price fixing, and the definition of control ("to exercise restraint or direction upon the free action of") is also relevant to these arrangements.

187. For these reasons, the Commission considers that this category of arrangements falls within section 30 of the Commerce Act.

Question 13: The Commission invites comments on its assessment of arrangements between the Guild and its members in terms of section 30 of the Commerce Act.

Further Arrangements Between the Guild and its Members

188. The Application indicates that these arrangements would enable the Guild and its members to agree about patient charges and associated terms *after* the Guild has concluded a Template Agreement, or after its members have entered Service Agreements. Under Paragraph 2.9(e) of the Application, the terms of any arrangement must reflect and be consistent with either a Template Agreement or with Service Agreements.

189. As noted above at Paragraph 113, pharmacies compete within local geographic markets for the provision of pharmacy services.

190. Any arrangement under Paragraph 2.7(e), would have a direct effect on price when concluded between Guild members in the same way as arrangements under Paragraphs 2.7(c) and (d) of the Application. It is arguable that in the case of arrangements under Paragraph 2.7(e) the effect on price is even more immediate.

191. These arrangements are likely to have the purpose, effect or likely effect of fixing, controlling or maintaining prices relating to the provision of pharmacy services. Therefore this category of arrangements falls within section 30 of the Commerce Act**.**

Question 14: The Commission invites comments on its assessment of further arrangements between the Guild and its members in terms of section 30 of the Commerce Act.

Assessment of Practice 2 under Section 30

192. The analysis below considers whether the arrangements contained in Practice 2 fall within section 30. This has involved assessing the application of section 30 to each of the general categories of arrangements included in Practice 2 as set out in Paragraph 159.

193. The Application indicates that Practice 2 involves the Guild agreeing about patient charges and DHB payments directly with either the Ministry or DHBs. This agreement would result in a Head Agreement being concluded between these parties. A Head Agreement would form the basis of Sub - Agreements between DHBs and individual Guild members.

194. There is no competitive relationship between either the Ministry or DHBs and the Guild, or between the Ministry or DHBs and Guild members. For this reason, a Head Agreement would not of itself breach section 30 of the Commerce Act.

195. Negotiation of a Head Agreement is likely to be preceded by agreement between Guild members about the level of subsidy that the Guild will seek. As with Practice 1, any agreement between Guild members would be taken forward into the negotiation of the terms and conditions of a Head Agreement between the Guild and the Ministry. These terms and conditions will then be reflected in Sub-Agreements, which will give effect to the Head Agreement. Consequently, the arrangement between Guild members as to the level of subsidy being sought, clearly has an influence over the final result.

196. In the Commission's view, these arrangements are likely to have the purpose, effect or likely effect of fixing, controlling or maintaining prices relating to the provision of pharmacy services. Therefore this category of arrangements falls within section 30 of the Commerce Act**.**

Conclusion on Section 30

197. The Commission is satisfied that the following arrangements fall within the scope of section 30:

Practice 1

- arrangements between the Guild and its members (in conjunction with other arrangements included in Practice 1); and
- further arrangements between the Guild and its members (after the conclusion of a Template Agreement or Service Agreements);

Practice 2

- Sub-Agreements.

198. As these arrangements cannot be given effect to if severed from Practices 1 and 2, the Commission will consider their effect within these practices overall. Given that Practices 1 and 2 fall within the ambit of section 30, the Commission has jurisdiction under section 58 to consider whether the entering into of the arrangements included in Practices 1 and 2 should be authorised under section 58 of the Commerce Act.

Question 15: The Commission invites comment on its conclusion that Practices 1 and 2 fall within the ambit of section 30 the Commerce Act.

LESSENING OF COMPETITION

199. Under section 58 of the Commerce Act, a person may apply for an authorisation for contracts, arrangements or understandings that breach sections 27, 28, 29, 37 or 38. It cannot authorise Practices 1 or 2 as a whole, but can authorise the arrangements or provisions that are included in these practices.

200. For the Commission to authorise an arrangement that may fall within the scope of section 27 of the Commerce Act, it must be satisfied that this arrangement has the purpose, effect or likely effect of substantially lessening competition in a market.

201. Alternatively, the Commission may authorise an arrangement that results in a deemed lessening of competition in terms of section 27 (via section 30) of the Commerce Act.

202. Section 61(6) of the Commerce Act provides that the Commission shall not authorise an arrangement which the applicant believes might breach section 27 unless it is satisfied that that the public benefit which will in all circumstances result, or be likely to result, from the arrangement would outweigh the lessening of competition that would result or be likely to result from the arrangements or that is deemed to result.

203. Section 61(6A) provides that:

> For the purposes of subsection (6) of this section, a lessening of competition includes a lessening of competition that is not substantial

204. When assessing the competitive impact of the proposed arrangements to determine whether the Commission can grant an authorisation, the Commission assesses the difference in the competitive impact of Practice 1 and 2, and that of the Counterfactual.

205. Because the arrangements included in Practices 1 and 2 cannot be given effect to in isolation, with the exception of Service Agreements, the Commission has determined to assess the competitive impact of the practices as a whole. The competitive impact of Service Agreements has been considered within the Counterfactual.

THE COUNTERFACTUAL

Background

206. When considering an application under section 58, the Commission must assess the likely competitive effects of the proposed arrangement, and any public benefits or detriments likely to result. This requires the Commission to determine a benchmark against which to measure the likely competitive effects and public benefits. As the Commission has noted in previous decisions, the benchmark is the counterfactual; that is, the situation that would be likely to exist in the absence of the proposed arrangement. Thus it is a "with" and "without" comparison, rather than a "before" and "after" comparison.

207. The counterfactual is not necessarily the arrangement that might be preferred by the Commission or by others with an interest in the sector. The counterfactual is simply the Commission's assessment on the facts of each case of what is reasonably likely to occur in the absence of the proposed arrangement.

The Guild's View of the Counterfactual

208. The Guild has argued that the counterfactual involves the Ministry, and/or the DHBs, entering into Service Agreements with retail pharmacies, or issuing notices under the NZPHD Act ("section 88 Notices") to retail pharmacies, consistent with Government policy on primary healthcare services.

209. The Guild considers that in light of the Government's policy to ensure national consistency for service specifications and payment for those services, the Ministry would develop a standard agreement providing, amongst other things, for the amount of money to be paid to retail pharmacies for the provision of subsidised pharmacy services. The Guild also considers that such an agreement would form the basis for individual service contracts entered into by DHBs with retail pharmacies.

210. The Guild also considers that if the Ministry or DHBs were to issue section 88 Notices, this is likely to contravene section 27, section 36, and possibly section 30 of the Commerce Act. Below is the Commission's assessment of whether this view is correct.

The Commission's Counterfactual

Factors Affecting the Choice of the Counterfactual

211. The Commission considers that the following factors are relevant when assessing the appropriate counterfactual:

- the counterfactual must be one that is not likely to be in breach of the Act;
- the counterfactual must take into account the Government's policy and strategies on the delivery of public-funded health care services. This includes providing for subsidised services within tight budgetary constraints; achieving national consistency in respect of prices and service specifications; enabling DHBs to fund and provide for services to their local populations; and ensuring timely and equitable access for the public to a comprehensive range of health services, regardless of ability to pay;
- current health legislation as embodied in the NZPHD Act essentially provides scope for the Government to purchase pharmacy services under two mechanisms: a section 88 Notice or a section 25 Service Agreement;
- the Ministry and/or the DHBs, as the monopsony purchaser of subsidised pharmacy services, hold a high countervailing power when purchasing subsidised pharmacy services;
- the counterfactual must take into account the Crown's obligation to consult when deciding whether or not to contract or issue a section 88 Notice, and when deciding on the prices, terms and condition of the contract or notice; and
- the counterfactual must take account of any legislative or other changes that might alter the competitive environment. For example, the Government is planning to repeal the current rules on pharmacy ownership.

212. In light of the above factors, the Commission considers that the appropriate counterfactual would be as follows:

- the Ministry or DHBs issuing section 88 Notices; and/or
- Service Agreements under section 25 of the NZPHD Act (arrived at through consultation).

213. The Ministry and DHBs are obliged to consult with health providers before issuing section 88 Notices, and before entering into any contracts for providing services.

214. The Ministry has advised that it does not envisage negotiating with individual retail pharmacies as the transaction costs of doing so would be prohibitive. However, as demonstrated by similar situations the Ministry is likely to consult with the pharmaceutical industry.

215. This consultation is likely to involve the Ministry proposing draft terms and conditions under which DHBs would purchase, and pharmacies would provide, subsidised pharmacy services (under either section 88 Notices or Service Agreements).

216. In any consultation process, it is likely that the Ministry would receive submissions from individual retail pharmacies, retail pharmacy groups (e.g. Care Chemists) and the Guild. These submissions would provide the Ministry with information on which to base section 88 Notices or Service Agreements.

217. The role of retail pharmacy groups within any consultation process is likely to be limited to facilitating the flow of information between individual retail pharmacies and the Ministry. In effect, retail pharmacy groups would be providing information to the Ministry necessary to enable it to make a decision. Individual retail pharmacies could also provide information to the Ministry directly. This would be likely to result in the Ministry's decision making being influenced by a broader range of information and better quality information.

218. Consultation would not involve the Guild and its members agreeing to a common negotiating position (and therefore the range of information provided to the Ministry). Rather, the purpose of a consultation process would be to gather information and provide interested parties with the opportunity to present their views to the Ministry and/or DHBs. This is consistent with the manner in which the Ministry has consulted with other health provider groups (e.g. midwives and rest home operators). Any consultation process would need to be conducted in accordance with the provisions of section 30 and other Restrictive Trade Practice provisions of the Commerce Act.

Question 16: The Commission invites comment on the process likely to be used by the Ministry or DHBs to consult with individual retail pharmacies or pharmacy groups, absent the proposal.

219. At the completion of the consultative process, a generic draft agreement is likely to be produced. This generic agreement would provide nationally consistent base prices and terms for the provision of subsidised pharmacy services. The generic agreement is likely to form the basis of individual Service Agreements, or section 88 Notices issued by DHBs to individual retail pharmacies in their respective regions. These agreements might contain local variations to the generic document subject to the requirements of the NZPHD Act (refer sections 3 and 89 of the NZPHD Act). The Ministry or DHBs would either enter into section 25 Service Agreements, or those not willing to enter into these agreements would be issued with section 88 Notices on the same terms. Once a health service provider accepts payment made under a section 88 Notice, that provider is deemed to accept the terms and conditions of the Notice.

220. Section 88 Notices and section 25 Service Agreements provide alternative methods of funding health services providers. Both methods are constrained by the objectives and purposes of the NZPHD Act. The Commission considers that the functions, objectives and the purposes of a section 88 Notice and a section 25 Service Agreement are the same.

221. Other banner groups, such as Amcal or Unichem, or any other retail pharmacy group, might negotiate their own Service Agreement with the Ministry and/or DHBs. Unichem has told the Commission that it does not currently have the expertise or experience to negotiate its own arrangement and for that reason supports the Guild in the current process to develop a Template Agreement. However, should circumstances change in the future, Unichem considers that there might be scope for it to develop an alternative agreement with the Ministry or DHBs. It may be that such an agreement may in fact reflect any agreement that the Guild negotiates with the Ministry or DHBs.

Question 17: The Commission invites comment on its assessments of the ability of other retail pharmacy groups to develop an alternative agreement with the Ministry or DHBs, absent the proposal.

The Commission's Views on the Use of Section 88 Notices

222. As noted above, the Guild considers that use of section 88 Notices may be at risk under the Commerce Act. The Commission does not share the Applicant's views on the legality of using section 88 Notices. The reasons are set out below.

Section 27

223. With section 88 Notices, a contract is formed upon acceptance by an individual retail pharmacy of payment under the Notice. The Commission considers that section 88 Notices would not have the purpose of substantially lessening competition. Rather, their purpose is to facilitate the Crown's regulatory function of purchasing subsidised pharmacy services within the constraints of funding available. The material question then becomes whether the section 88 Notices, either taken individually, or when aggregated (under section 3(5) of the Act), would have the effect, or likely effect, of substantially lessening competition.

224. Section 88 Notices would determine various matters, including prices paid by DHBs for subsidised pharmacy services, and associated terms and conditions. Many other elements of the relevant market would be determined by legislation or other regulatory instruments (e.g. pharmacy ownership legislation, patient prescription regulations, etc). Accordingly, there is only limited opportunity for competition to take place in the relevant market outside the scope determined by section 88 Notices.

225. The Commission considers that, whatever the extent of competition (actual or potential) in the provision of subsidised pharmacy services, this would not be affected to any material extent by the Ministry or DHBs issuing section 88 Notices. In particular, the issuing of section 88 Notices is unlikely to affect:

- the existing state of competition, including those elements that are contestable (e.g. service competition, and pricing that is not covered by the regulated prescription charges);

- barriers to entry/expansion; and

- the countervailing power of the Crown.

226. For these reasons, the Commission considers that section 88 Notices would not have the purpose, or effect or likely effect, of substantially lessening competition for the purpose of section 27.

Section 30

227. An essential element of section 30 is that the goods or services be supplied or acquired by persons "in competition with each other". In this instance, neither the Ministry nor DHBs are in competition with retail pharmacies for the supply or acquisition of subsidised pharmacy services, and so section 88 Notices are not considered to breach section 30.

Section 36

228. Section 36 of the Act prohibits a party that has a substantial degree of power in a market from taking advantage of that market power for the purpose of restricting the entry of any person into any market; or preventing or deterring any person from competing in any market; or eliminating any person from any market.

229. As monopsony purchasers, the Ministry and DHBs would have a substantial degree of power in the purchase of subsidised pharmacy services. The issue is whether the Ministry or DHBs would be using market power for a proscribed purpose. The Commission considers that section 88 Notices issued for the purpose of facilitating the purchase of subsidised pharmacy services, in line with its regulatory function under section 36, would be unlikely to breach section 36.

Question 18: The Commission invites comment on whether on the use of section 88 Notices is likely to breach sections 27, 30 or 36 of the Commerce Act.

Conclusion on the Counterfactual

230. In summary, the Commission considers that the relevant counterfactual to the proposed arrangements is:

- the Ministry and/or DHBs consulting with groups in the pharmacy sector to reach a draft agreement; and

- this draft agreement being implemented through section 88 Notices and/or section 25 Service Agreements with individual retail pharmacies.

Question 19: The Commission seeks comments on the proposed Counterfactual as outlined above.

DIFFERENCES BETWEEN THE PROPOSED ARRANGEMENTS AND THE COUNTERFACTUAL

Counterfactual

231. Under the Counterfactual, there is likely to be a standard agreement developed by the Ministry/DHBs as a result of consultation under the Counterfactual that is similar to a Template Agreement developed under Practice 1. The Guild's ability to influence the terms of Service Agreements between individual DHBs and its members would be limited. Consequently, the Commission considers that the level of the subsidy paid by the DHBs to Guild members for the provision of subsidised pharmacy services would be lower under the counterfactual.

232. The Counterfactual, as with the Application, includes Service Agreements as a method by which DHBs and retail pharmacies (including Guild members) could agree on payment for subsidised pharmacy services (and associated terms). While the Application does not specifically include Section 88 Notices, the Ministry and DHBs would have the ability to issue such notices under both the Counterfactual and the Application.

Practice 1

233. The analysis below considers the difference between Practice 1 and the Counterfactual.

234. The overall effect of Practice 1 is that it would allow the Guild and its members to agree to a common negotiating position regarding DHB payments and patient charges, to advance this position in negotiating a Template Agreement, and to have this agreement given effect to in Service Agreements. Practice 1 would also allow the Guild and its members to arrive at further agreements *after* a Template Agreement or Service Agreements have been concluded.

235. One of the key differences between the Counterfactual and Practice 1 is the absence of agreements between Guild members about DHB payments or associated terms and conditions, under the Counterfactual. Rather, the Ministry would consult with the industry and consequently would have access to a wider range of, and arguably better quality, information on which to establish the terms and conditions of the Template Agreement. The information would be sought from the industry as a whole, and although the Guild could have a role in that process, the Counterfactual would not

[19] Section A, Draft Agreement for Provision of Pharmacy Services, 3.

result in the Template Arrangement being negotiated between the Guild and the Ministry.

236. The Guild anticipates making a recommendation to its members as to whether they should or should not enter into a Service Agreement in the form of the Template Agreement (if Practice 1 is authorised). This recommendation would not exist under the Counterfactual.

237. Another key difference between the Counterfactual and Practice 1 is presented by Paragraph 2.7(e) of the Application. This provision (if authorised) would allow Guild members to agree (within the constraints of a Template Agreement or a Service Agreement) on matters relating to subsidised pharmacy services such as the level of margin Guild members will charge consumers for partially subsidised medicines. This category of arrangements would not be present under the Counterfactual.

Practice 2

238. Practice 2 reflects the Guild's understanding of the possible future evolution of Practice 1. As such, it is difficult to predict the features of Practice 2 with complete certainty. The analysis below considers the difference between Practice 2 and the Counterfactual.

239. The overall effect of Practice 2 is that it would allow the Guild to enter a Head Agreement in its own right with the Ministry or DHBs. The Guild would then enter Sub-Agreements with its members, under which they would provide pharmacy services on the Guild's behalf. Sub-Agreements could include terms that are different to those contained in a Head Agreement. Neither the Head Agreement nor Sub-agreements would be present under the counterfactual. Therefore any benefits flowing on to the Guild and its members from this practice would also be absent from the counterfactual.

240. A Head Agreement is likely to reflect the interest of the "average" Guild member, which is not necessarily that of more innovative and entrepreneurial sections of the retail pharmacy sector. It is likely to contain agreement on DHBs and patient charges that are acceptable to the average Guild member, but not necessarily those that are appropriate to all retail pharmacies. This could result in retail pharmacies being paid amounts by DHBs or making charges to patients that do not accurately reflect their actual cost of doing business (i.e. being paid too much as a subsidy or charging too much).

241. This is likely to attract retail pharmacies that are not Guild members to the terms of a Head Agreement. Accordingly, a Head Agreement could make it more difficult for DHBs or the Ministry to enter agreements that do not reflect the terms of the Head Agreement with retail pharmacies (or pharmacy groups) that are not Guild members. In this way, the evolution of a Head Agreement could limit the scope for DHBs or the Ministry to negotiate alternative, and potentially more efficient or responsive, methods of delivering pharmacy services with retail pharmacies.

242. As a result, a Head Agreement might lead to subsidised pharmacy services being provided at an increased cost to patients, and to DHBs or the Ministry, with decreasing levels of service, innovation and efficiency.

243. Individual Sub-Agreements, which would be possible under Paragraph 2.9(b) of the Application would reflect the terms of a Head Agreement to the extent that this would be required under that Head Agreement. However, as Paragraph 2.9(b) is worded, Sub-Agreements could go beyond the terms of a Head Agreement. Sub-Agreements could allow collective price setting by retail pharmacies. For example, Sub-Agreements could allow Guild members to agree on the additional amounts they will charge consumers for providing any pharmacy service (e.g. dispensing of vitamins), not just *subsidised* pharmacy services. This could result in consumers bearing significant additional costs in respect of a number of "pharmacy only" services.

244. Sub-Agreements would not be present under the counterfactual. Rather Service Agreements under section 25, or Notices issued under section 88, of the NZPHD Act would be the method by which Guild members would be funded for providing pharmacy services. Under the Counterfactual, Service Agreements and section 88 Notices would limit the scope for collective price setting that exists under Sub-Agreements as any agreements between Guild members relating to subsidised pharmacy services would be governed by the terms of Service Agreements and Section 88 Notices. If the application were authorised, any collective agreement between retail pharmacies about anything other than subsidised pharmacy services would remain subject to the Commerce Act.

Question 20: The Commission seeks comment on its assessment of the impact that Sub-Agreements would have on competition in the relevant markets, compared to the Counterfactual.

Proposed Legislative Change

245. Parliament intends to introduce the HPCA Bill. The potential impact of the legislation would be present in each of the counterfactual and Practices 1 and 2. However, the Ministry considers that it is unlikely that this bill will be passed before the end of the year and the Commission accepts the Ministry's view.

246. The HPCA Bill provides for a licensing regime that, when implemented fully, would enable any person or entity to operate a retail pharmacy, subject to meeting certain licensing criteria.

247. The HPCA Bill has been given a Category 3 priority status in the 2002 Parliamentary legislative timetable, which means it is to be passed this year, if possible. At present, the Ministry is finalising its draft Cabinet paper, and Cabinet is scheduled to consider the matter in early May. If Cabinet approval is obtained, the HPCA Bill would be introduced into Parliament for its first reading, and the select committee process would follow shortly thereafter. The Ministry considers that it is unlikely that the HPCA Bill will be passed before the end of the year. Rather, it anticipates the proposed legislative changes will be enacted next year.

248. Assuming the HPCA Bill is enacted next year in its present form, it would be another two years before its provisions come into full force. In these circumstances, the Commission is unable to assess the full ramifications of the proposed legislative changes. In particular, it is unclear how, and to what extent, price and service competition will be affected.

249. At the minimum, the Commission considers that the proposed legislative changes are likely to have an immediate impact on the decision making and other market behaviour of existing and potential market participants, especially as new entrants prepare for the advent of the new legislation. Over the longer term, the Commission considers that rationalisation of retail pharmacy ownership is likely to accelerate as a result of the changes with supermarket and other retail chains operating a network of pharmacy outlets. This in turn is likely to have a major impact on price and service competition.

Question 21: The Commission seeks comment on how the proposed enactment of the Health Professionals' Competency Bill, with subsequent changes to various other legislation, might impact in competition terms on the relationship between the Guild and existing retail pharmacies, and the Ministry and DHBs.

250. Another change that may impact on the assessment of competition under the counterfactual is the proposed establishment of Primary Health Organisations (PHOs). PHOs form part of the Government's Primary Health Care Strategy, which was released in February 2001. They will be not-for profit organisations funded by DHBs to provide essential primary healthcare services to an enrolled population.

251. While it appears that retail pharmacies will be involved (either directly or indirectly) with PHOs, it is unclear at this stage how the proposed formation of PHOs will alter the existing competitive environment. They are, however, unlikely to materially alter the high countervailing power held by DHBs who will continue to fund and purchase subsidised pharmacy services.

Question 22: The Commission seeks comment on the competitive impact that the proposed establishment of Primary Health Organisations might have on the relationship between the Guild and existing retail pharmacies and the Ministry and DHBs.

Conclusion

Conclusion on Practice 1

252. The Guild has not provided any detailed comment on the competitive effects that it considers will flow from Practice 1.

253. Practice 1 will result in the subsidy paid by DHBs to Guild members for subsidised pharmacy services being higher than the price paid under the counterfactual. The level of the subsidies eventuating from Practice 1 would be influenced by whether the Ministry or DHBs could resist the inclusion of terms that would yield this result within a Template Agreement.

254. In addition, Practice 1 envisages additional arrangements between Guild members relating to charges that would be made to consumers for partially subsidised medicines. This second range of arrangements would not be present under the counterfactual.

255. The Commission considers that the following features of Practice 1 would have an adverse effect compared with the Counterfactual:

- arrangements under Paragraphs 2.7(c)and (d) of the Application; and
- arrangements under Paragraph 2.7(e) of the Application.

Conclusion on Practice 2

256. As with Practice 1, the Guild has not provided any detailed comment on the competitive effects that it considers will flow from Practice 2.

257. Practice 2 envisages the Guild essentially sub-contracting the provision of subsidised pharmacy services to its members. The resulting sub-agreements between the Guild and its members could include arrangements between Guild members as to the prices they will charge consumers for a wide range of services other than those for subsidised medicines. These sub-agreements would not be present under the counterfactual.

258. A Head Agreement might of itself result in a lessening of competition. This would occur if other retail pharmacies (or groups of retail pharmacies) seeking to negotiate arrangements with the Ministry or with DHBs as an alternative to a Head Agreement were deterred or prevented from doing so.

259. Sub-Agreements need not be constrained by a Head Agreement and are not required to reflect the terms of a Head Agreement. Accordingly, Sub-Agreements could relate to a wide range of products and services, not only *subsidised* pharmacy services.

260. The Commission considers that the following features of Practice 2 would have an adverse effect compared with the Counterfactual:

- an arrangement under Paragraph 2.9(a) of the Application; and
- arrangements under Paragraph 2.9(b) of the Application.

Question 23: The Commission seeks comment on the conclusion reached about the difference between the counterfactual and the proposed practices.

PUBLIC BENEFITS AND DETRIMENTS

Introduction

261. The authorisation procedure requires the Commission to identify and weigh the detriments likely to flow from the proposed practice in the relevant markets, and to balance those against the identified and weighed public benefits likely to flow from the practice. Only where the benefits outweigh the detriments can the Commission be satisfied that the proposed practice will result, or be likely to result, in such a benefit to the public that it should be permitted, and thus be able to grant an authorisation. Section 61(6) of the Act states that authorisation may be granted when the practice:

> … will in all the circumstances result, or be likely to result, in a benefit to the public which would outweigh the lessening in competition that would result, or would be likely to result or is deemed to result therefrom.

262. The various issues raised as to what constitutes a public benefit or a detriment have been discussed in a number of decisions by the Commission and the courts, in particular the Commission's decision in *New Zealand Rugby Football Union*, and the High Court's decision in *Ravensdown Corporation Limited v The Commerce Commission and Others*.[20] The interested reader is referred to those decisions, and to the Commission's outline of its approach in: *Guidelines to the Analysis of Public Benefits and Detriments in the Context of the Commerce Act*, a publication which it issued in 1994 and revised in 1997. In assessing both benefits and detriments the focus in decisions has increasingly been on economic efficiency. For example, the Court of Appeal stated in *Tru Tone Ltd v Festival Records*[21] that the Act:

> . . . is based on the premise that society's resources are best allocated in a competitive market where rivalry between firms ensures maximum efficiency in the use of resources.

263. As noted in its decision in *Goodman Fielder / Wattie* (Commerce Commission, 1987), the wording of the Act requires the Commission to assess detriment only in the market or markets in which competition is lessened, but to canvas for possible benefits to New Zealand both in that market and in all other markets in New Zealand which may be influenced by the arrangement.

264. The Commission considers that within the relevant markets, a public benefit is any gain, and a detriment is any loss, to the public of New Zealand, with an emphasis on gains and losses being measured in terms of economic efficiency. In contrast, changes in the distribution of income, where one group gains while another simultaneously loses, are generally not included because a change in efficiency is not involved. The Commission is also mindful of the observations of Richardson J in *Telecom*[22] on the Commission's responsibility to attempt to quantify benefits and detriments where and to the extent that it is feasible, rather than to rely purely on intuitive judgement. This is not to say that only those gains and losses which can be measured in dollar terms are to be included in the assessment; those of an intangible nature, which are not readily measured in monetary terms, must also be assessed.

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[20] Unreported, High Court Wellington, AP 168/96, 9 December 1996, Panckhurst J and Professor R G Lattimore.

[21] *Tru Tone Ltd v Festival Records Retail Marketing Ltd* (1988) 2 NZLR 351.

[22] *Telecom Corporation of New Zealand Ltd v Commerce Commission* (1992) 3 NZLR 429,447.

265. The benefits and detriments likely to flow from the proposed practice in the future have to be assessed against a counterfactual of what might otherwise happen in the future in the absence of the proposed practice. Thus, a comparison has to be made between two hypothetical future situations, one with the proposed practice and one without. The differences between these two scenarios can then be attributed to the impact of the proposed practice in question.

266. As discussed earlier, the Commission considers that the counterfactual in the current case is one where the Ministry/DHBs consult with the Guild and/or groups in the pharmacy sector on terms and conditions, with a view to reaching some consensus, where possible, on a proposed contract. A contract developed in this way would either be implemented as a section 88 Notice, or by service agreements with individual pharmacies, or as a combination of the two.

267. The Commission's preliminary view, as discussed earlier, is that the proposed arrangements under Practice 1(a)-(d), and Practice 2(a) are unlikely to result in significant effective loss of competition in comparison to the counterfactual scenario. This is based on the observation that the affected market would be subject to very similar significant legislative and regulatory controls in either case. Behind such controls is a degree of constraining monopsony power of the Crown in its capacity as sole purchaser of such services.

268. In respect of the proposed arrangements under Practice 1(e), and Practice 2(b), however, the Commission found that these might provide scope for the relatively free exercise of coordinated pricing and might limit the scope for parties other than the Guild to develop separate arrangements for the provision of subsidised pharmacy services to the DHBs' resident populations.

Detriments

269. The potential detriments are normally assessed under the following three headings, being allocative, productive and dynamic efficiency.

Allocative Efficiency

270. Subject to certain exceptions, the economy's scarce resources are allocated between alternative uses with maximum economic efficiency when, in any given market, the additional cost of producing the last unit of the good or service equals the price which a buyer is prepared to pay for that unit. Using economic theory, that optimum point is found where market demand equals market supply in a competitive market. Using the general market diagram shown in Figure 1, the intersection at point A of the competitive demand (D) and supply (S) curves for a particular product determines the optimum price and output of P_c and Q_c respectively.

271. An output higher than this, such as at Q_{high}, would be greater than is optimal since the social valuation of the good, as determined by the price consumers are prepared to pay for this quantity and indicated by the demand curve (at P_{low}), would be less than the sacrifice that society would make in producing that extra unit, as indicated by the supply curve. Similarly, at a less than optimal output, the reverse would apply; the social valuation of the good would exceed its social cost, indicating that more units should be produced.

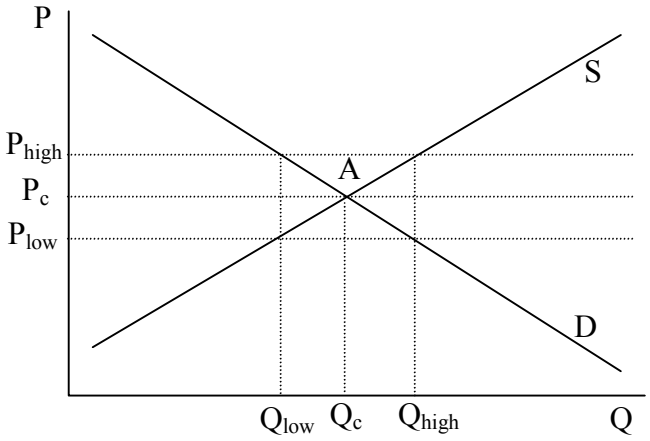

Figure 1
A Generalised Competitive Market Model

272. The market for pharmacy services is likely to be different, in a number of respects, to that shown in Figure 1. Its key differentiating feature is the fact that the product is subsidised. That accepted, there are two possible reasons for the subsidy:

- Medicines are a "merit" good; and / or
- Income distribution / equity.

273. Health services in general are commonly regarded as merit goods. The standard demand curve shown in Figure 1 represents private marginal benefit – that is, the benefit that each of the individuals consuming the goods concerned perceives that they gain. In contrast, merit goods are characterised as those where the social marginal benefit of a given quantity exceeds the marginal private benefit because a wider social good is being advanced, so that the resulting social demand curve lies above the private one shown in Figure 1. As a consequence, social welfare is not maximised at an output of Q_c, but at a larger level determined by the intersection of the social demand curve with the supply curve, in other words, from a social perspective, the free market results in too little of the good being demanded (and hence consumed) than is optimal. Given the above rationale, one possible reason for Government subsidisation and regulation may be an attempt to encourage an increase in consumption.

274. However, given that the demand for pharmacy services is likely to be highly unresponsive to price (see below) a subsidy intended to encourage consumption would have little effect. This suggests that there is an alternative motivation for the subsidy. The likely explanation is that the subsidy is distributional in nature. This seems to be reflected in the partially targeted nature of the subsidy, which results in all benefiting to some degree, but certain, apparently disadvantaged, groups (e.g. those on income support) benefiting more than others. With this interpretation there would be no difference between the private and social demand curves, and the impact of the subsidy would be to drive price to the consumer below, and quantity consumed above, the competitive levels shown in Figure 1. The government, it is assumed, would be willing to put up with the resulting small amount of allocative inefficiency

to achieve its distributional goals. The Commission concludes that the income distribution / equity explanation is likely to be the 'correct' one.

275. Hence, the standard market diagram shown in Figure 1 needs to be adjusted to reflect the special circumstances in the markets for pharmacy only medicines. The following need to be taken into account:

- the subsidisation of the service for many consumers;
- the fact that the overall price, and the price paid by consumers, are controlled; and
- the demand curve for pharmacy services is likely to be highly unresponsive to price (price inelastic).

276. A 'representative' market can be inferred from these peculiar features and some conclusions drawn regarding the overall national position. The Commission notes that this is an approximation to the rather more complicated real-life situation in which geographic markets may be highly heterogeneous depending on, for instance, the demographics of those in the catchment, location with respect to a doctor's surgery, etc. Also there will be variations between consumers and the medicines they require.

277. The demand price inelasticity is expected because the demand for medicines is determined primarily by the decisions made by GPs, who prescribe on behalf of their clients. This may be corroborated to some degree by a recent, consumer based, New Zealand study of demand for pharmacy services referred to earlier,[23] which found that price is of little importance, at least in choice of pharmacy used. However, it could be that this reflects a perception that as the services in question are subsidised, the price is not likely to vary between pharmacies.

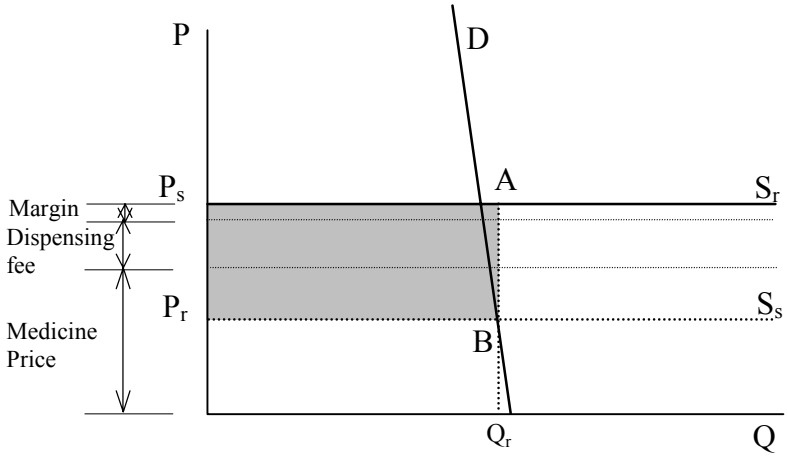

Figure 2
A Stylised Pharmacy Services Market

278. The situation that appears to apply in a typical local subsidised pharmacy services market is shown in Figure 2. The quantity of prescriptions issued per year is scaled on the horizontal axis, and the average price per prescription is shown on the vertical

[23] K. Ryan, G. Becket, and P. Norris, "Who goes where and why? – the patronage of community pharmacies in New Zealand", *Australian Pharmacist*, January 2002

axis. The regulated price, P_s, sets the position of the horizontal supply curve; S_r. For the typical fully subsidised medicine this total price is made up of the PHARMAC determined medicine price, plus the pharmacy dispensing fee, plus the pharmacy mark-up as indicated. The intersection of this regulated supply curve with the demand curve determines the quantity that would be demanded if that price were to apply. However, the consumer pays a lower price, P_r, set by the amount of the prescription charge, and hence the quantity demanded (Q_r) is somewhat larger. The subsidy paid in this market then equals the difference between these two prices (AB in Figure 2) multiplied by the number of prescriptions issued, Q_r.

279. As Figure 2 focuses on the typical subsidised prescription[24], it abstracts from variations between prescriptions, in terms of the degree of subsidisation for different classes of medicines, and also between different classes of consumers. In short, it is concerned with the 'average' position across all medicines and all consumers.

280. A possible refinement to the model is to recognise that pharmacies sell a wide range of products and services, and hence to incorporate the possibility that low fees and margins for subsidised medicines are being influenced by the high margins that may be available on other products sold. Thus, pharmacies may have an incentive to offer low margins, and therefore low prices, on subsidised medicines in order to draw more people into the store, where they may also buy other, high-margin goods. However, this would depend upon customers being responsive to prices for subsidised medicines which, it would seem, they are not. An alternative possibility might be advanced that the regulated margins allowed on subsidised medicines are too low, so that pharmacies are being forced to cross-subsidise from earnings on the sales of other products and, so, a rise in those margins would be beneficial. Given the very low marginal cost of dispensing, however, this seems unlikely.

281. If the proposed arrangements were to lead to an increase in fees, this increase would be unlikely to flow through to the price paid by consumers, and so would leave demand unaffected, i.e. in the graph S_r would rise but Ss would stay the same (unless the government responded by increasing these prices), hence *quantity demanded* would stay the same. The increase would, however, be felt in a rise in the margins earned by pharmacists. In terms of Figure 2, the regulated price would increase above P_s, but the price paid by consumers (P_c) would not.

282. It is unclear at this stage whether the increase in P_s would cause a loss of allocative efficiency, but even if it did, the loss would be negligible given the inelasticity of the demand curve. In any case allocative inefficiency in this market, determined using the standard demand curve, is arguably not relevant given the government's implicit determination that an unfettered market will not result in the optimal consumption of medicines, or that distributional goals outweigh such efficiencies.

283. However, there would be a significant transfer from the government, by way of the extra subsidy paid, to pharmacies. The social cost of this transfer would be likely to be significant, given the social cost attached to raising tax revenues. According to

[24] We do not deal here with medicines that cost less than the appropriate co-payment and, hence, have no subsidy paid for them.

Freebairn,[25] most studies of this issue put the marginal welfare cost (or deadweight welfare loss) of an extra dollar of taxation at 20 cents or more. This is not to say that taxes are generally bad, but rather that in order for an additional dollar of tax to be efficient, the subsequent use of such funds should generate social benefits that at least offset the additional dollar plus the marginal welfare cost involved in its collection. In the present case because the increased subsidy would be caused by the arrangement, and not reflect the government's intentions, it can reasonably be assumed that the additional tax would not generate a benefit of more than a dollar for every dollar raised.

284. The potential size of this loss can be estimated by assuming that the proposed arrangement has the effect of increasing the total subsidy by a certain percentage and multiplying the resulting dollar figure by the conservative figure of 20 cents. Information provided by the Ministry puts the total pharmacy budget at $678m, with $218m of this for the pharmacy services component. If this latter component is susceptible to growth because of the arrangement, then estimates of possible inefficiency effects can be made. The Commission is willing to make a rough estimate of the increase in the subsidy resulting from Practice 1(a-d) as between 1 and 3, percent or $2.18-6.54m. The resulting 20 percent welfare loss will therefore be between $0.44m and $1.31m.

285. Similar analysis for allocative detriment arising from Practice 1(1-d) can also be applied to that arising from Practice 2(a). It is likely however that, as outlined in the competition analysis, Practice 2 will result in greater market power for the Guild than under Practice 1. Because of this the Commission believes the likely resulting increase in subsidy to be greater and that an estimate of 5 to 10 percent is appropriate. This would translate to an increase in the subsidy of between $10.9m and $21.8m resulting in a welfare loss, from raising the additional taxation, of between $2.18m and $4.36m.

Question 24: The Commission seeks comment regarding the inclusion in its calculation of detriments, of a deadweight loss brought about by increases in taxation where arrangements are likely to result in increased Government expenditure?

286. Practices 1(e) and 2(b) raise another concern. In the competition analysis it was noted that if these clauses were given a wide reading, either might allow pharmacies to indulge in collusive behaviour that is not associated with the Guild's discussions and agreements with the Crown. Accordingly, the Commission sees the detriments associated with these practices as likely to be considerable.

Question 25: The Commission seeks comments on any allocative inefficiencies relating to non-subsidised medicines that may result from Practice 1.

[25] For a review of the literature see: John Freebairn, "Reconsidering the Marginal Welfare Cost of Taxation", *The Economic Record*, Vol 71, June 1995, pp 121-131.

287. Whereas other practices specified in the application are concerned with fully-subsidised medicines, an authorised Practice 1(e) or 2(b) might allow pharmacists to attempt to collectively set the price to patients for items in the additional following categories:

- Unsubsidised prescription medicines: this includes those items that would attract a subsidy but that the appropriate co-payment is greater than the item's cost and those items that are not subsidised;[26]

- Partially-subsidised medicines: in particular the component of the price charged to the customer over which a pharmacy has a discretion. (This is the manufacturer's premium and the pharmacy's mark-up on the premium);

- Pharmacy only products: this includes medicines that do not require a prescription but may only be purchased at a pharmacy under the terms of regulation.

288. Items in these categories are those that pharmacies only are able to supply and are, or have components that are, outside the effect of current or anticipated agreements with the Crown. Groups of firms in the same trade that contrive to raise prices collectively have been the subject of much economic research. In general they are more likely to be successful if the following conditions are true:[27]

- High seller concentration: reduces the number of firms whose actions need to be coordinated, and greater parity in sizes reduces the likelihood of there being a number of non-complying small firms;

- Undifferentiated product: makes it easier to reach agreement on the price, and avoids problems associated with variations in quality, changes over time in the nature of the product, and variations between firms in associated services;

- Speed of new entry: the longer the time needed to enter the market, the longer the coordinating firms can enjoy higher profits before they are eroded by entry;

- Lack of fringe competitors: the absence of fringe competitors avoids an often potent source of competition, or such firms may be present but unable to expand capacity readily;

- Price inelastic market demand: provides enhanced scope for a profitable rise in the price, and hence added incentive to collude;

- Industry's competition record under sections 27, 29 and 30: a record of price-fixing or other forms of collusion may indicate that market conditions are favourable to coordination; and

[26] This includes products such as Viagra and Xenical, which require a prescription but are not currently subsidised.

[27] Commerce Commission, *Practice Note: 4 The Commission's Approach to Adjudicating on Business Acquisitions Under the Changed Threshold in Section 27 – A Test of Substantially Lessening Competition*. See also Dennis W. Carlton, and Jeffrey M. Perloff, *Modern Industrial Organization* (2nd ed.), pp.180-189.

- Presence of industry associations/fora, or evidence of cooperative actions or attitudes among firms, which may enhance the possibility for coordination.

289. Applying these to the current case, an obvious defence against the likelihood of detrimental collective price fixing is that there are more pharmacies than the "few" firms envisaged under conditions of "high seller concentration". However, the market *is* determined primarily on location and, it could be argued, only a few compete in each local market[28]. In any event, one of the reasons why high seller concentration is seen as conducive to collusion is that it eases the practicalities of price coordination without detection by competition law authorities, if Practice 1(e) or 2(b) were to be authorised then this would not be an issue. Another reason for high seller concentration being advantageous to price collusion is that it enhances scope for "discipline" by participants of those cheating on any price fixing agreement. The need for such discipline will be obviated by the Guild having the ability to legally enforce contracts with its members regarding price.

290. Although pharmacies sell a variety of medicines and in varying quantities, the component of the price for which authorisation is sought is for dispensing services. Given the highly prescriptive nature of the regulations governing pharmacies' such services may reasonably be regarded as homogenous.

291. Fast and effective entry in retail markets can come in the form of existing outlets adding to their product lines. Current laws preclude existing, non-pharmacy, outlets adding prescription or pharmacy only medicines to their product lines. This may change to a degree with proposed law changes deregulating pharmacy ownership but the nature of the business will mean that requirements more stringent than for most retailing will still need to be met.

292. Probably the most important condition is that any group attempting to raise price for a good or service does in fact have the ability to profitably raise prices. This requires that they collectively face an inelastic demand. As discussed previously, the entire market demand for medicines is likely to be very inelastic, but the Guild and its members acting collectively may not face an inelastic *residual* demand if there were sufficient numbers of pharmacies outside the agreement. The Guild currently has in its membership approximately 80% of existing pharmacies – this, in any entity acting collectively, is well outside the Commission's safe harbours[29] relating to the exercise of unilateral market power and, prima facie, would suffice for the Guild to raise prices. Nevertheless, the distinctively local nature of the market would, even in the event of entry by retail chains such as the Warehouse (following proposed ownership law changes), ensure substantial market power in many localities.

293. The economic detriment brought about by successful collective price setting can be analysed in a similar way to that caused by a dominant firm supplier. The standard analysis of dominant firm behaviour, summarised in Figure 3, has the dominant firm setting its price or output in such a way that its revenue from the last item produced is equal to its marginal cost. Any output greater than this and the dominant firm would lose money on marginal output (since $MR - MC < 0$), and so would wish to produce

[28] Note that although such price fixing might be organised nationally, this does not preclude the possibility of different pricing strategies for different localities and competitive scenarios.
[29] *Practice Note 4* pp.28. See previous full reference.

less; any less, and the dominant firm would increase its profit by expanding its output (since MR – MC > 0).

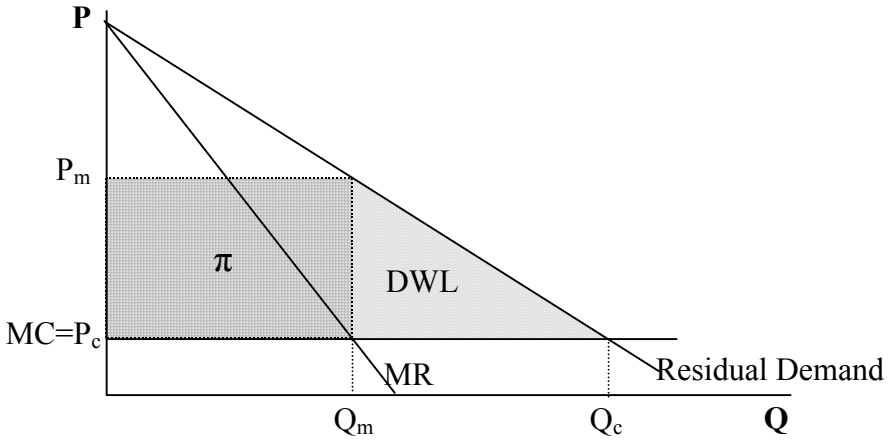

Figure 3 A Dominant Firm Supplier

294. The quantity produced by an industry with a dominant firm (shown in the graph as Q_m) is typically less than that produced in a competitive industry (Q_c), and the price (P_m) is higher. As a result, the dominant firm earns economic profits (represented by the area π) and there is a dead-weight loss of welfare shown by DWL. The dead-weight loss is the combined value that would accrue to consumers[30] had the good been priced at the competitive level (MC).

295. Revenues for items in categories causing concern under Practices 1(e) and 2(b) have been estimated by the Commission to be of the order of $170m per year, with most of this ($140-150m) coming from unsubsidised prescribed medicines. The Commission has attempted to estimate the aggregate demand and marginal cost for these goods based on the rather sketchy information available and some assumptions regarding market price elasticity of demand.

296. The Commission has estimated marginal cost using current prices; this is based on the strong assumption that this part of the market is competitive, as is claimed by the applicant, so that prices represent costs. Evidence from the Guild and others indicates that the average cost of a prescription may be about $15. If the distribution of prescription costs follows a normal distribution with an average of $15 and a standard deviation of $4[31] the average cost of an item under $15 will be between $11 and $12. Given that the estimate for items in other categories are lower, the Commission has opted to use an "average" marginal cost figure of $11. As indicated earlier, the Commission believes that market demand is very inelastic, however given the likelihood that not all pharmacies would participate in the Guild's scheme and the possibility of new entrants after the proposed law change, it is possible that the range

[30] Such a deadweight loss is the difference between the good's marginal cost, i.e. the competitive price, and consumers' respective reservation prices, i.e. the prices they would be willing to pay, summed over all consumers who would have bought at the competitive price but do not at the dominant firm price.

[31] The implication is that, for items under the co-payment, 68 percent of prescriptions are between $11 and $15, 95 percent are between $7 and $15, and 99.7 percent are between $3 and $15. In fact the distribution is probably skewed – this will not greatly affect this estimate since it is concerning one half of the distribution only.

of *residual* demand elasticities faced by Guild members might be as high as –0.5 to –1.0 at current price and output.

297. As discussed in preceding paragraphs, an unconstrained dominant firm will maximise profits by setting output where its marginal revenue equals its marginal cost. However, the prices so generated by the analysis ($16.40 – 19.00) are greater than the maximum pharmacies can charge. Including this ceiling constraint of $15[32] in the model suggests that pharmacies might increase the charge of their "average" under-$15 script from $11 to the maximum of $15.

298. Under these conditions, and the above assumptions, pharmacies will, under Practice 1(e) or 2(b), collectively take profits of between $39m and $50m. Such profits are not counted as efficiency losses since they are transferred from consumers to pharmacies. This is not the case however for the deadweight losses inflicted. The deadweight losses attributable to Practice 1(e) or 2(b) are calculated as being between $19m and $25m. These are summarised in the following table.

Table 2: Elasticities, Profits and Welfare Losses under Practices 1(e) and 2(b)

Elasticities	Profits	Welfare loss
-0.5	$50m	$25m
-1.0	$39m	$19m

Summary of Allocative Efficiency

299. Table 3 summarises transfers and allocative inefficiencies (welfare losses) arising from the proposed practices.

[32] This is true for items that are on the PHARMAC schedule but cost under the appropriate co-payment. For other unsubsidised prescription items there would be no such constraint.

Table 3 Transfers and Welfare Losses from Allocative Inefficiency

	Effects of	**Transfers (increase in pharmacy profits)**	**Deadweight welfare losses**
Practice 1	**Subsidy increase**	$2.18 - 6.54m	$0.44 - 1.31m
	Price increase	$39 – 50m	$19 - 25m
	Total practice	$41.18 – 56.54m	**$19.44 - 26.31m**
Practice 2	**Subsidy increase**	$10.9 – 21.8m	$2.18 – 4.36m
	Price increase	$39 – 50m	$19 - 25m
	Total practice	$49.9 – 71.8m	**$21.18m - $29.36m**

Productive Efficiency

300. For productive efficiency to be present in a given industry, its constituent firms should be operating on their lowest cost curves and at their minimum efficient scale. If the size of firms in the industry is reduced through non-market mechanisms then productive efficiency is likely to suffer. It has been suggested to the Commission that the average scale for a pharmacy is currently of the order of 30-35,000 prescriptions dispensed per year. It could be argued that an increase in dispensing fees will create economic "rents" for existing suppliers; this in turn will attract more pharmacies. The increase in the number of pharmacies competing in a local market for a share of the available demand will result in a reduced average scale, and hence lead to a higher unit cost of production. If this were a widespread phenomenon, the total cost of the dispensing function would then be higher. The increase in total cost would be a measure of the productive inefficiency caused by the rise in dispensing fees.

301. Consider the simple model of an individual pharmacy depicted in Figure 4. This assumes that the costs of the dispensing function are essentially fixed, so that the pharmacy's average cost curve (AC) slopes downward asymptotically as the number of prescriptions dispensed increases. The demand faced by the individual pharmacy (d) is more price elastic than that of the market, since typically it will face competition from other pharmacies. If it were to raise its dispensing fee (assuming an increase in the regulated fees) it would lose some but not all of its customers, as the services provided by pharmacies are differentiated to a degree by location and service, and some customers would continue to buy even at a higher fee because they prefer the service offered by that pharmacy.

302. Entry to the market is relatively easy and pharmacies compete on location and (to a degree) service since both price (and to a degree, service) are closely regulated.[33] The price for dispensing is set initially at P_c. At this price the pharmacy supplies Q_1

[33] Note that this model would be most realistic in an urban centre where the market is likely to be large enough to accommodate several pharmacies. In small provincial centres there often may be only one or two pharmacies in the relevant market

prescriptions and earns a normal profit, since AC equals demand. The price is then raised to P_1 due to the proposed practices. There is no demand-side price response since the rise is met by an increased subsidy, not by the consumer and so the pharmacy continues to supply Q_1 and earns economic profits shown as the shaded portion in Figure 4. However, the economic profits attract the entry of new pharmacies into the local market, and this causes the demand curve, faced by the incumbents, including the pharmacy depicted, to contract leftward. Such entry will continue until the excess profits are eliminated which occurs at that output where the new demand curve d' cuts the AC curve at the price P_1. The result is as follows: there are more pharmacies in the market; the average pharmacy will dispense fewer prescriptions (Q_2) at the higher price; and the average cost of dispensing medicines has risen accordingly by the amount of the price increase, P_cP_1.

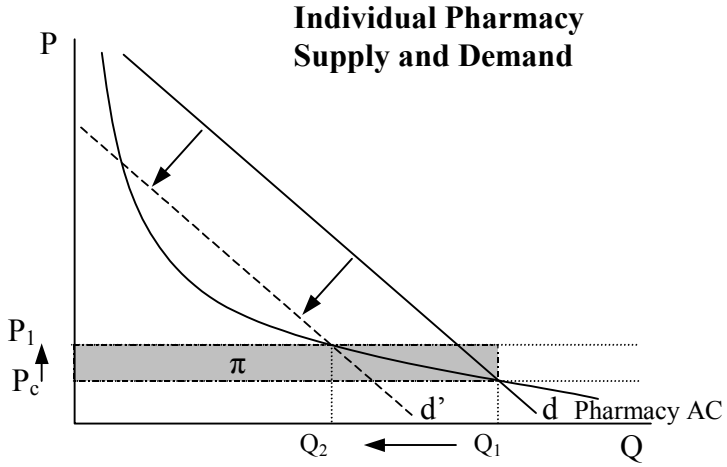

Figure 4 Individual Pharmacy Supply and Demand

303. Such a model may play out in the numerous markets across the whole country in the following way.[34] Currently, about 35 million prescriptions per year require filling. The costs of running a pharmacy are fixed at, say, $175,000[35] per year, and marginal costs are negligible. The price for filling a script is fixed outside the market, initially at $5[36]. Pharmacies are assumed on average to operate in a competitive environment (to the extent allowed by the regulations) and hence not to make (economic) profits, and given these assumptions, 1,000 pharmacies each supply 35,000 dispensing services, or $5 per prescription. However, if the dispensing fee were to increase by 10% to $5.50, pharmacies would (before entry) make economic profits of $17,500 each – a total of $17.5m. Entry then occurs until economic profits are competed away, at which point 1,100 pharmacies supply the prescriptions at 31,818 each. Pharmacies are now smaller, and therefore higher cost, and the total cost of supplying the same number of prescriptions has increased by $17.5 million.

304. Although in the above model a rise in the dispensing fee results ultimately in additional total dispensing costs, it seems likely that some additional value for consumers would be created. This might be expected to arise because firms compete

[34] Note that figures have been chosen to be illustrative rather than necessarily representative.
[35] This is probably on the low side compared to the actual fixed cost. 1995 figures received by the Commission late in its deliberations suggest that $275,000 per annum might be a more accurate figure.
[36] Note that this is close to the current actual figure of $4.97.

on location, and so an increase in the number of pharmacies in the market would serve to reduce the amount of travelling (and hence time) needed by the average consumer to gain access to a pharmacy. This could be particularly beneficial were it to enhance Government policy regarding access to the distribution of medicines. However, given the prospective size of the fee increase, this affect is likely to be small, and perhaps of little potential benefit in the CBDs of cities where pharmacies already tend to be relatively numerous. Moreover, a general fee increase is unlikely to advance such policy efficiently, again raising potential problems with the proposed practices setting a single price across all pharmacies.

Question 26: The Commission seeks comment on the model used to ascertain the productive inefficiencies arising from the proposed practices.

305. The likely rise in prices, and concomitant profits, discussed under allocative efficiency will feed into the process outlined in this section. By the arguments above any above normal profits will ultimately translate into increased costs. As discussed, the productive inefficiencies will be offset to a degree by an increased number of pharmacies, which provides some welfare gain to consumers. The size of this gain is difficult to estimate and the Commission considers that its effect is likely to be subsumed in the range of estimated losses in productive efficiency. Additionally in small geographic markets, for example those containing only one pharmacy, the increase in fees might not be sufficient to induce another to enter. In such a market, the operators would continue to earn excessive profits indefinitely. For this reason, the estimated losses in this section are maximums. The range of maximum productive losses is equal to the range of increase in profits estimated in the section on allocative efficiency. These are given in Table 4

Table 4 Maximum Welfare Losses from Productive Inefficiency

	Welfare losses
Practice 1	$41.18 - 56.54m
Practice 2	$49.9 - 71.8m

Question 27: The Commission seeks comments on the estimated welfare losses from productive inefficiencies.

Dynamic Efficiency

306. Dynamic efficiency is concerned with the speed with which an industry adopts superior new technology and produces improved new products. The first brings advances in productivity allowing costs of supply to be reduced, and the second brings the benefit of meeting buyer wants more fully. In terms of the graphical

analysis used above, product innovation would be reflected in a rightward shift of the demand curve, indicating a buyer switch to the improved products of the innovating company or industry, whilst the lower costs associated with production innovation would be revealed by a downward shift in the unit cost curve.

307. Competition is generally considered to act as a stimulus to dynamic efficiency, and market power and regulation as retardants. It is generally believed that in an industry which has at least a significant scope for technological advance, the potential losses associated with market power are likely to be greater in the longer term in respect of dynamic inefficiency than they are in respect of the static forms of inefficiency (namely, allocative and productive) considered above. This is because of the loss of the compounding effect of the improvements over time.

308. Commission staff found evidence of some incipient innovation within the industry in the approaches taken by Kentra Group and Care Chemists, although some of this has been encouraged by Ministry initiatives, such as the Pharmaceutical Review Services. It is notable that both of these operate outside the umbrella of the Guild. In their submissions, both object to the authorisation.

309. Kentra provides medicine-dispensing services in a manner unlike that of traditional pharmacies. They employ 14 pharmacists, but do not have any retail-style pharmacy outlets. They make heavy use of specialised software and combine this with a systematic approach to the logistics of providing medicines for patients in residential care. They typically serve the needs of institutional facilities in their entirety with medicines being packaged and delivered to the facility for each individual patient with the bulk of their business being with residential care facilities. In addition Kentra are currently the major supplier of Pharmaceutical Review Services.

310. Care Chemist banner group pharmacies specialise in dispensing and related services, and their pharmacists require a higher level of training than is typical of most pharmacies. Care Chemist negotiate their own contract with the Ministry and this contract, although based on that negotiated by the Guild, is tailored to target groups with specific health problems such as asthma, arthritis, diabetes, and heart disease.

311. Both Kentra and Care are concerned that their respective specialised offerings will be crowded out by the one-size-fits-all approach taken in the MOH-Guild contract. Currently the base contract used by Care is the standard contract, which is tailored to account for their specific offerings. On its own this does not seem to cause them difficulties and may indeed be of benefit, providing them with a thoroughly considered document that presumably covers many aspects of their offerings.

312. A key concern seems to be that the position of the Guild as bargaining agent will be strengthened by the authorisation, presumably resulting in their own positions, in negotiating subsequent variations, being weakened. Kentra's objections are unequivocal:

> We strongly oppose the Pharmacy Guild suggesting that, through their waning membership and historical negotiations with Government, they still represent the commercial thinking and positioning that they think is required in this market sector for the future. Like many representative (protectionist) groups before them they fail to see or accept the much required changes that the medication supply and service market sector in New Zealand requires.

313. The Ministry of Health echoes the concern that the Guild's position as pharmacy advocate / agent will be strengthened and that other groups representing pharmacies, such as Care Chemist, will be disadvantaged. Given that the current contract negotiated by the Guild provides a base for other, non-Guild pharmacies, the Commission surmises that the proposal may result in reduced flexibility in the proposals of other groups.

314. The school of economics that has innovation and market dynamics closest to its core theories is the Austrian school. A proponent of the Austrian school, Israel Kirzner, regards the process of innovation as the discovery of anomalies;[37] another, Joseph Schumpeter, considered the effect of innovation within a market to be "creative destruction".[38] Certainly, attempting to model the process and effect of innovation in order to ascertain meaningful quantified measures of detriment from a given practice is not likely to be fruitful. It will suffice to note the potential for innovation to increase welfare, and that the detriment from stifling such innovation is additional to the estimates given so far.

315. If the authorised practices were to damage Kentra's and Care's businesses (and other possible innovators), incipient innovation and dynamic efficiency would be harmed. In summary, the concerns expressed in various submissions about the impact of the proposed arrangement raise concerns that dynamic efficiency would sustain significant damage that would not occur in the counterfactual. This damage would be substantial under Practice 2 due to the Guild's increased and strengthened role in contract negotiations in that scenario.

Question 28: The Commission seeks comment on the scope for innovation in this industry, and how detriment of this nature would be quantified?

Preliminary Conclusion on Detriments

316. There has been no attempt in the application to quantify the detriments of the proposed arrangements as is encouraged in the *Guidelines*. The Commission, in conducting its own analysis, has made the estimates of detriments likely to result from Practice 1 and 2 that are summarised in Tables 5 and 6 respectively.

Table 5 Welfare Losses from Practice 1

	Welfare losses from Practice 1
Allocative	$19.44m - $26.31m
Productive	$41.18m - $56.54m
Dynamic	Significant

[37] Israel M. Kirzner, *How Markets Work*, 1997, pp.22.
[38] Joseph Schumpeter, *Capitalism, Socialism and Democracy* (New York: Harper, 1975) [orig. pub. 1942], pp. 82-85:

Table 6 Welfare Losses from Practice 2

	Welfare losses from Practice 2
Allocative	$21.18m - $29.36m
Productive	$49.9m - $71.8m
Dynamic	Substantial

Benefits

317. As explained in the Public Benefit Guidelines, to qualify as benefits under an authorisation, claimed benefits must exhibit the following characteristics:

- they must be efficiency gains;
- they must have a clear nexus with the proposal;
- they need not be restricted to the market directly affected by the proposal, but potentially could arise in any other market; and
- they must accrue to New Zealand residents

318. The Guild claims that the following benefits will arise from the proposed practices:

- Reduction in the cost of contract administration and management;
- Nationally consistent medicine subsidies and services;
- Community pharmacies able to delegate contract management;
- Countervailing monopoly power by the Guild;
- Further reduction in the cost of contract administration under Practice 2; and
- Greater national consistency for medicine subsidies and services under Practice 2.

Reduction in the cost of contract administration and management

319. The Guild claims such a benefit under paragraph 7.1 of the application. It includes a reduction in the burden of pharmacy contract administration for the relevant government agencies (7.1 a and c), and a reduction in the costs to the claims management agency of establishing and maintaining systems to manage the payment of claims (7.1 b).

320. The Commission acknowledges that these are likely to be realised under the proposed arrangement, but maintains that the counterfactual is likely to provide very similar benefits. This result is possibly due to the difference in view between the Commission and the applicant regarding the counterfactual.

321. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from this claim.

Nationally consistent medicine subsidies and services

322. Paragraph 7.3 of the application provides what seems to the Commission to be several different paraphrases (a to d) of a single benefit, namely national consistency in the delivery of health care. Patients' access to consistent services is claimed as a separate benefit by the Guild when it seems to the Commission to be integral to, and almost certainly the aim of, Government's drive toward national consistency. This also seems to be paraphrased in several places, namely paragraphs 7.4, 7.5 and 7.7. Paragraph 7.12 views this claimed benefit from yet another perspective: the point of view of DHBs and pharmacies in their dealings with mobile patients.

323. In general the Commission believes that the Guild is unnecessarily concerned that its absence from the negotiating table will result in national inconsistency in the delivery of medicines. The Commission believes that the government's policy of national consistency will be achieved as readily under the counterfactual.

324. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from this claim.

Community pharmacies able to delegate contract management

325. The Guild claims that under Practice 1, community pharmacies would benefit from being able to delegate the management of their relationship with their DHB to the Guild, leading to increased efficiency that would benefit patients (paragraph 7.8).

326. This possibly follows from the Guild's reasoning that the counterfactual has pharmacies negotiating their own contracts. Under the Commission's view of the counterfactual, it is envisaged that such benefits will follow without authorisation although the Guild may be the pharmacies' agent for the purposes of consultation rather than negotiation.

327. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from this claim.

Countervailing monopoly power by the Guild

328. The Guild claims at paragraph 7.9 that an asymmetry in bargaining power between pharmacies and the government will lead to a reduction in the number of pharmacies (and access to medicines for patients) and to increased cross-subsidisation within pharmacies. This claim seems to be predicated on the government forcing pharmacies, without the protection of the Guild, to agree to dispense medicines for a price below marginal cost.

329. If the scenario envisaged by the Guild above does indeed take place then this might weigh in favour of the practices. However, the government's policies of consistency of service and access to medicines and its persistent efforts to implement these, allow little credence for the possibility that they would disrupt the distribution of medicines in this way.

330. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from this claim.

Further reduction in the cost of contract administration under Practice 2

331. The public benefits claimed for Practice 2 by the Guild includes those claimed for Practice 1, and in addition further benefits are seen. Paragraph 7.2 submits that the burden of DHBs administering the community pharmacy contracts would be further reduced since some of this work would be taken over by the Guild as it manages the interface with individual pharmacies.

332. This claimed benefit will accrue to DHBs but will incur an expense of increased administrative costs for the Guild. This cost shifting does not translate to a freeing of scarce resources and subsequent reallocation to their next highest value use, leading to an efficiency gain, and so results in no net benefit.

333. The Commission accepts however that this approach may introduce some small net efficiencies. The Commission's estimate is based on the following:

- One third of a full time position may be saved at each of the 21 DHBs.
- Four additional full time positions will be required by the Guild.
- The total employment cost for each position above is $100,000 per annum.

334. Using the above figures, the Commission's estimate for benefits arising from this practice is $300,000 per annum.

Greater national consistency for medicine subsidies and services under Practice 2

335. The Guild claims at paragraph 7.7 that consistency for patients' service would be greater under Practice 2 than proposed in paragraphs 7.4 and 7.5. This additional benefit has been claimed without supporting arguments or information. The Commission does not see how Practice 2 would improve the outcome under Practice 1 or the counterfactual.

336. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from this claim.

Other claimed benefits

337. The benefits claimed under paragraphs 7.6, 7.10, and 7.11 of the application appear to recount benefits already claimed under paragraphs 7.2 and 7.8. Both 7.6 and 7.10 appear to the Commission to spend the costs saved under 7.2 on admittedly beneficial additional health services but this is double counting. The benefit under 7.11 at the contractual interface between pharmacies and DHBs seems inherent in benefits already been claimed under 7.2 and 7.8.

338. The Commission concludes that there will be no resulting gain in efficiency and therefore cannot allow any benefit from these claims.

Conclusion on Benefits

339. There has been no attempt in the application to quantify the detriments or the benefits of the proposed arrangements as is encouraged in the Guidelines. The Commission in turn can find scant grounds for attributing benefits to the proposed arrangements that would not accrue under the counterfactual.

340. The public benefits claimed for Practice 2 by the Guild at paragraph 7.2 submits that the burden of DHBs administering the community pharmacy contracts would be reduced. The Commission's estimate for benefits arising from this, and all, practices is $300,000 per annum.

Question 29: The Commission seeks comment on whether all double counting been identified and whether the benefits have been valued adequately with respect to the Counterfactual?

BALANCING

341. The Commission has made a preliminary assessment of the benefits to the public arising from the arrangements and the detriments caused by the loss of competition resulting from them.

Table 7 Summary of Net Benefits

		Net Benefits
Practice 1	**Detriments**	-$60.62 – 82.85m
	Benefits	Nil
	Total	**-$60.62 – 82.85m**[39]
Practice 2	**Detriments**	-$71.08 – 101.16m
	Benefits	$0.3m
	Total	**-$70.78 – 100.86m**[40]

342. On the information currently available, and for the reasons set out in the previous sections, the Commission is not satisfied that the public benefits outweigh the detriments and, accordingly, is not satisfied that the arrangements will in all the circumstances result, or be likely to result, in such a benefit to the public which would outweigh the lessening in competition which would result or would be likely to result

[39] This total does not include any allowance for the loss of dynamic efficiency which for Practice 1 was considered to be significant.
[40] This total does not include any allowance for the loss of dynamic efficiency which for Practice 2 was considered to be substantial.

therefrom; or will in all the circumstances result, or be likely to result, in such a benefit to the public that the arrangements should be permitted.

DRAFT DETERMINATION

343. If the Commission's preliminary assessments and conclusions are confirmed by submissions made on this Draft Determination {and during the conference that the Commission has determined to hold}, the Commission will determine to decline to grant an authorisation for the arrangements previously described.

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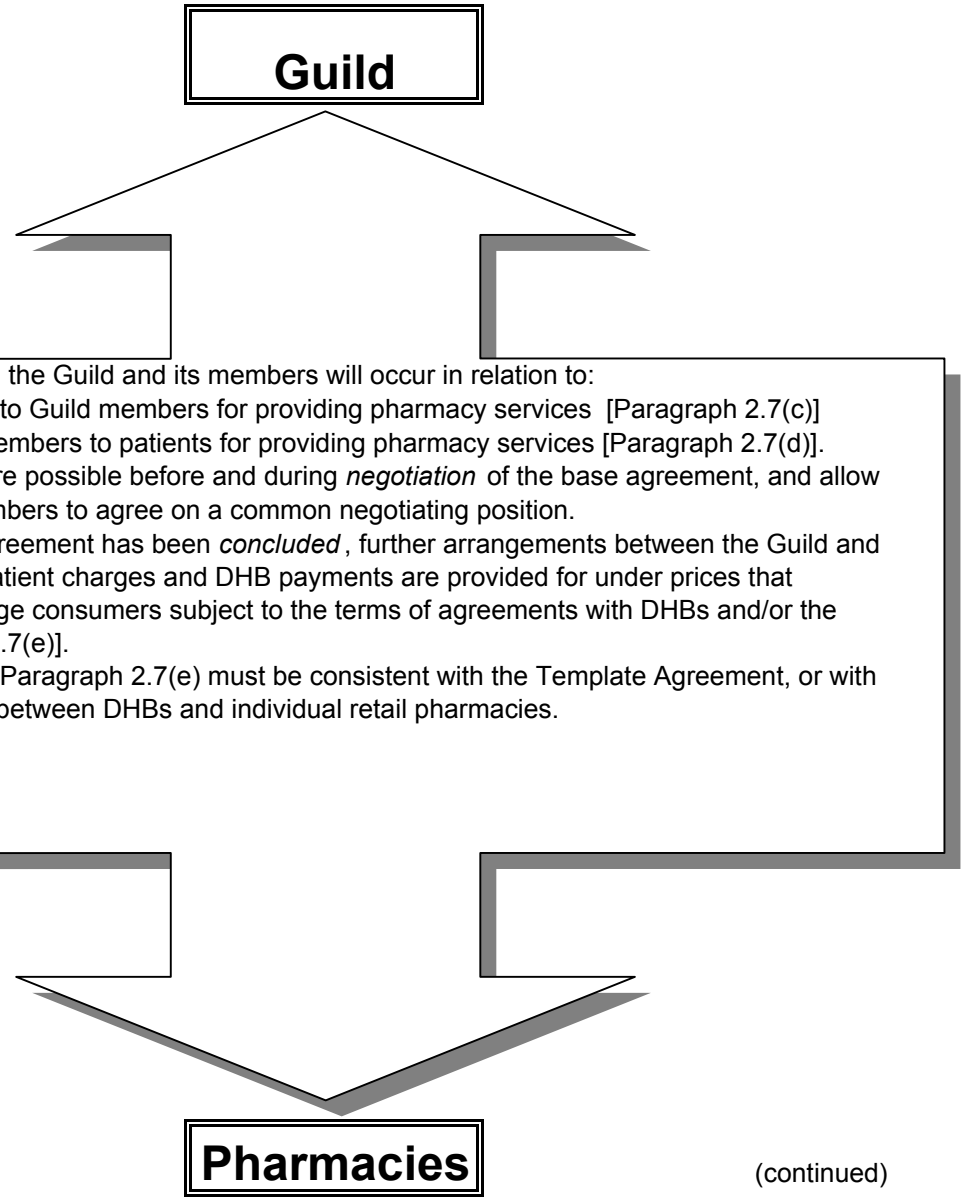
APPENDIX 1: Practice 1

(Revised Paragraphs 2.7(c)-(e) of the Guild's Application)



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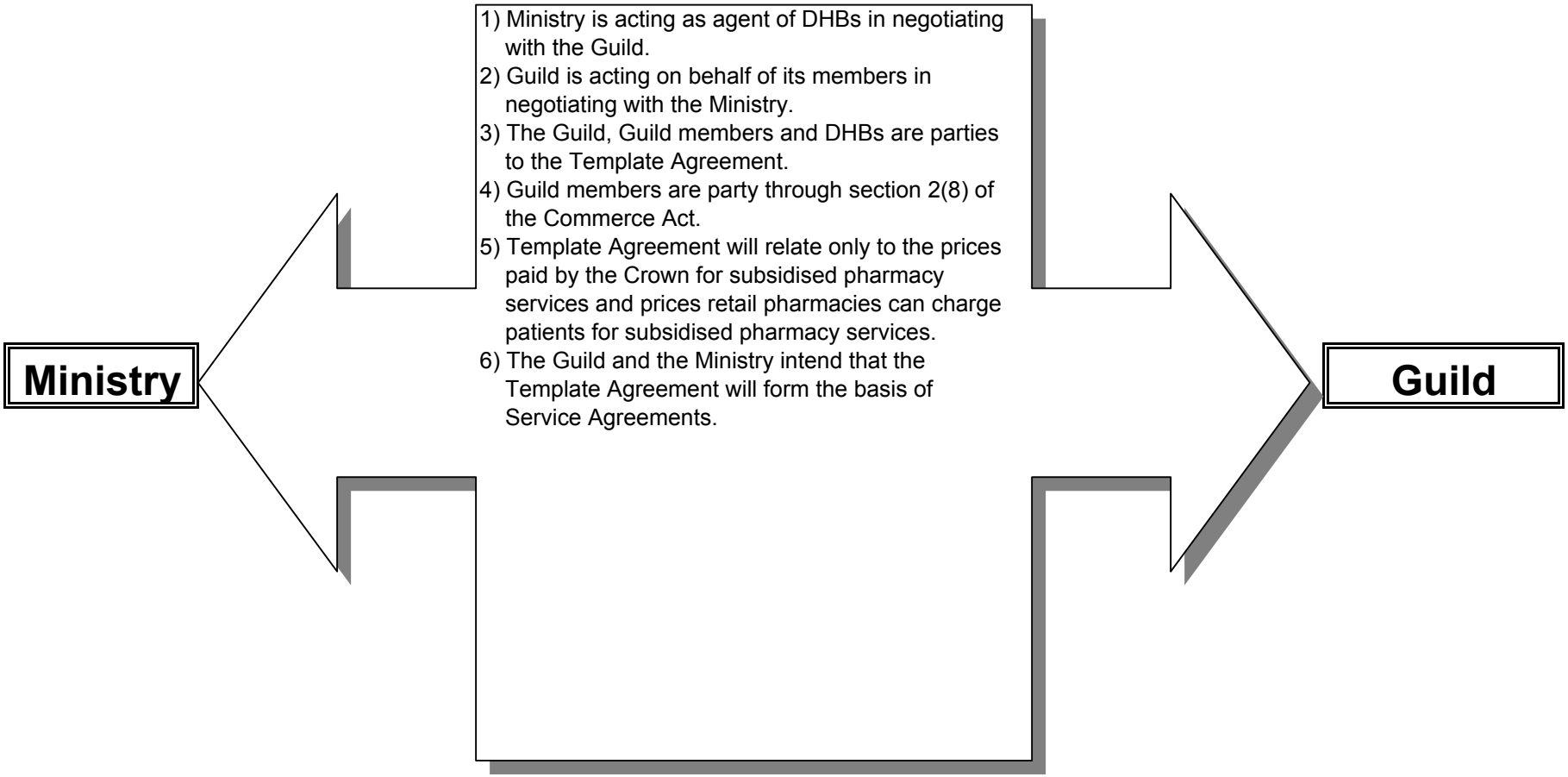
Template (or Base) Agreement (Revised Paragraph 2.7(a) of the Guild's Application)



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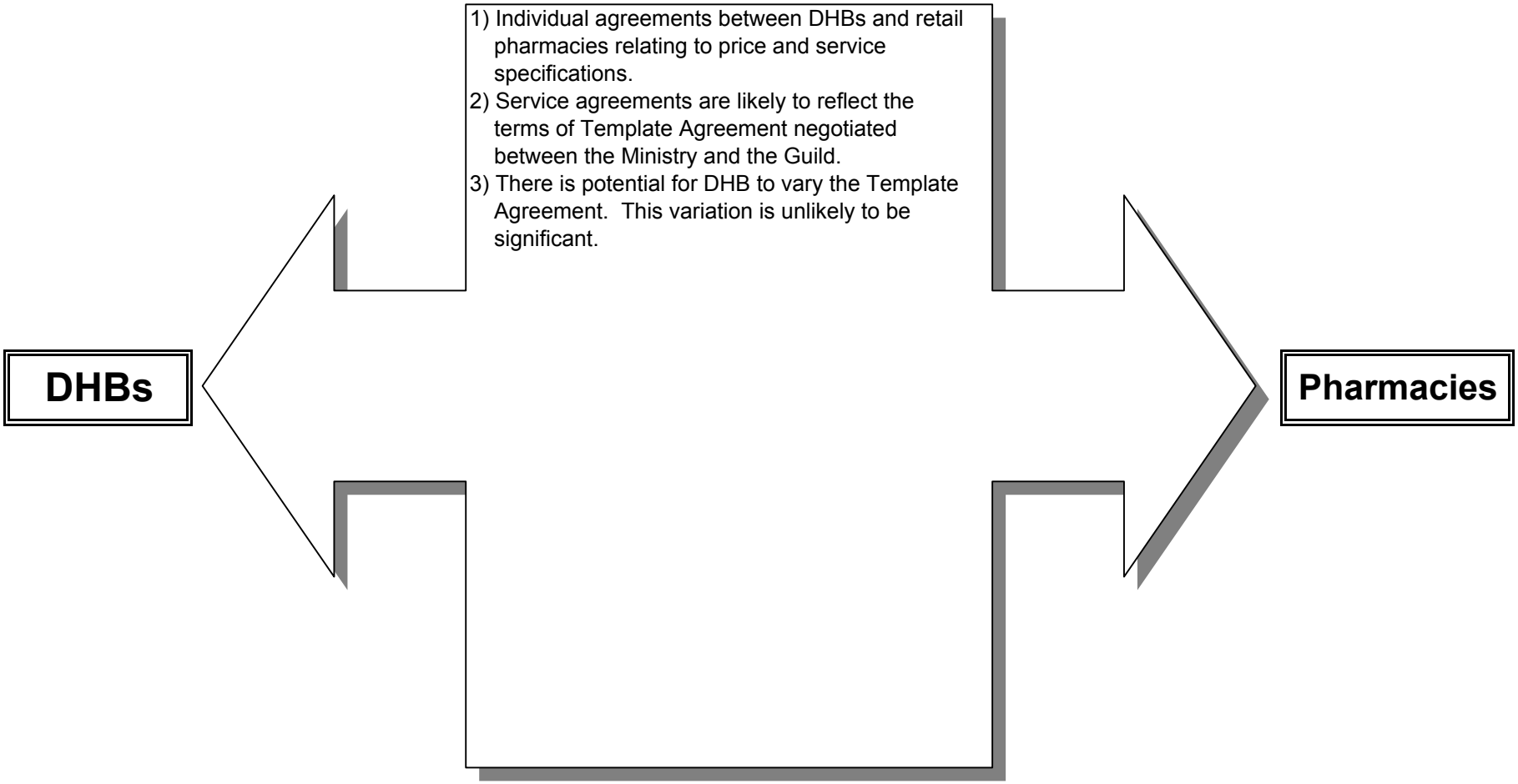
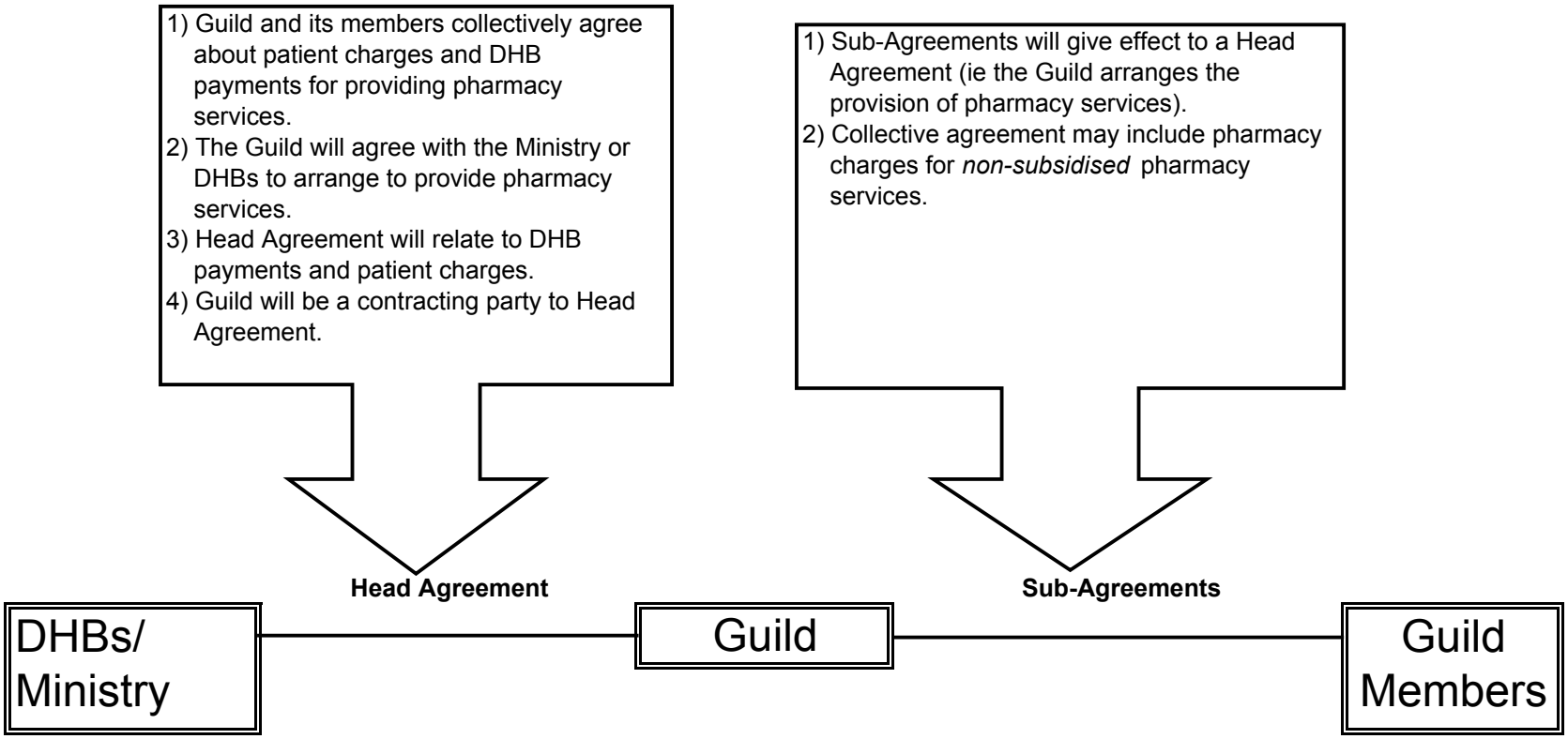
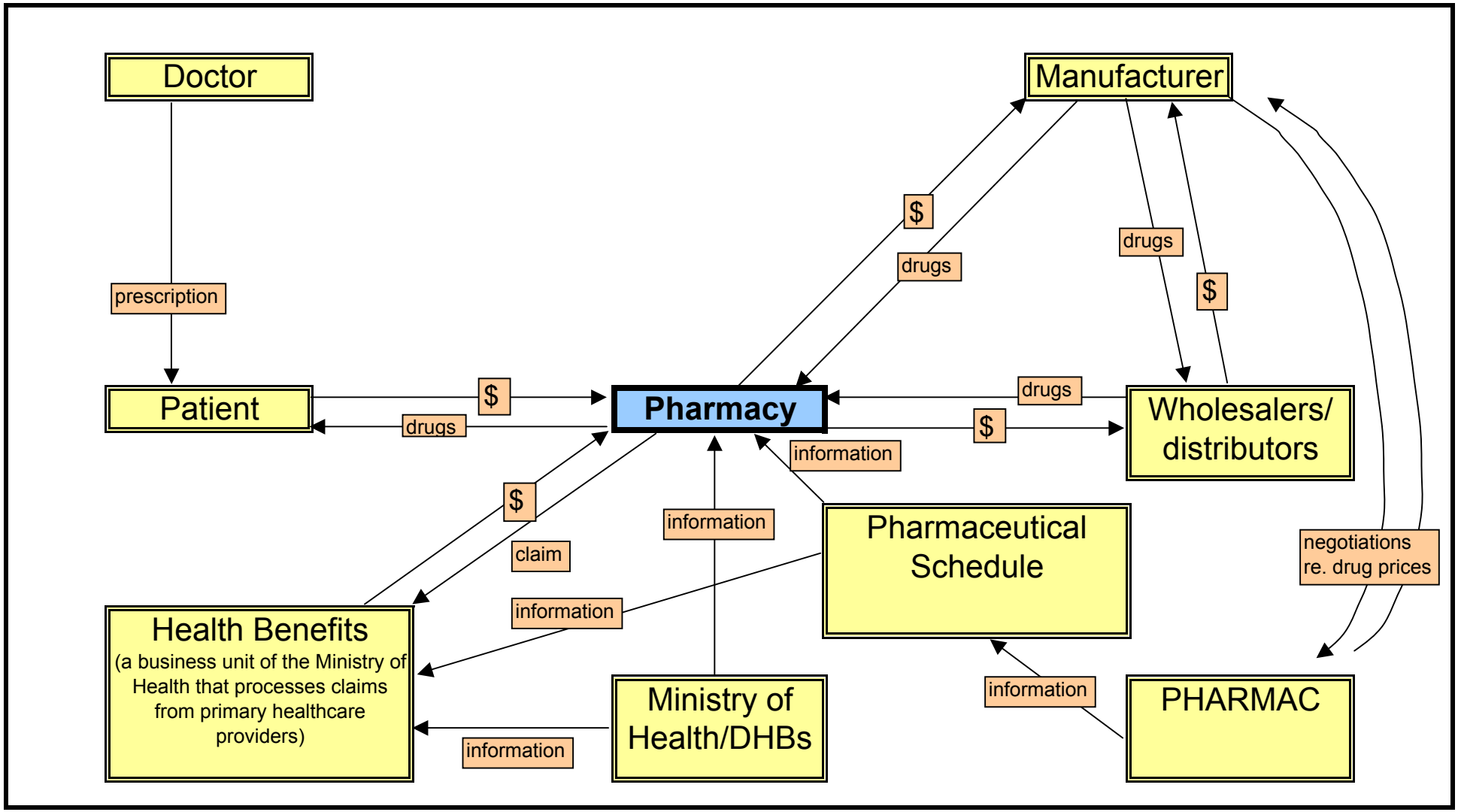
Service Agreements (Revised Paragraph 2.7(b) of the Guild's Application)



APPENDIX 2: Practice 2



APPENDIX 3: Industry Structure Diagram



APPENDIX 4: Breakdown of Costs in the Price of a Typical "Fully Subsidised" Medicine

Cost Breakdown for Regulated Price	Crown / Patient Share of Medicine Cost
Pharmacy Margin 1) Is negotiated by DHBs and pharmacies. 2) Contributes to the cost of stockholding and procurement. 3) Cost is to DHBs (DHBs pay margin to pharmacies as a reimbursement).	**Government Subsidy**
Patients Dispensing Fee 1) Is negotiated by DHBs and pharmacies. 2) Comprises a base fee and multipliers that are applied to the base fee to determine the fee for providing specialist services (eg Methadone dispensing). 3) Covers dispensing of medicine and associated pharmacy services. 4) Cost is to DHBs (DHBs pay dispensing fee to pharmacies as a reimbursement).	
PHARMAC Medicine Price 1) Is set by the PHARMAC schedule. 2) Cost is to DHBs (DHBs pay the PHARMAC medicine price).	**Prescription Charge** 1) Is determined by the Crown Funding Agreement, Pharmaceutical Schedule and Health Entitlement Cards Regulations 1993. 2) Cost ($0-$15) is to consumer (Consumer pays prescription charge to pharmacy).