

# Annexe C

Distribution of medicines in the UK

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## ANNEXE C

### DISTRIBUTION OF MEDICINES IN THE UK

#### Introduction

- This Annexe describes the market structure for the distribution of branded medicines to the primary care sector, and the nature of competition within this market. It describes how medicines have traditionally been distributed via full-line wholesalers, and how this changes under the direct to pharmacy (DTP) schemes.
- **Section A – Market structure:** covers the broad picture of UK branded medicines distribution in the primary care sector.
- **Section B – Manufacturers:** identifies the largest manufacturers and considers the nature of competition between manufacturers in the UK.
- **Section C - Pharmacies:** identifies the largest pharmacy chains and considers how pharmacies compete.
- **Section D – Wholesalers:** identifies the key wholesalers and describes the different types of wholesaling models which have emerged and the way in which this influences how they compete.
- **Section E – Barriers to entry in the wholesale sector:** describes the nature and extent of barriers to entry in the wholesale sector, as well as considering the features that may assist entry in this sector.
- **Section F – Pfizer’s DTP scheme:** describes Pfizer’s new arrangements and UniChem’s account of its performance so far. It considers how competition might take place under the DTP scheme.

## **SECTION A - Market overview**

### **Introduction**

- 1.1. This section describes the market structure in the distribution of branded medicines to primary care and considers various routes to market for branded medicines. It then identifies the key players at each level of the supply chain.

### **Market background**

- 1.2. In primary care, a patient generally takes a prescription written by a GP to a pharmacy. The pharmacy dispenses the medicine in question, with the patient either paying the flat prescription rate or, more commonly, no fee. Dispensing doctors, who typically practise in more remote areas, dispense the medicines they prescribe. Pharmacies are reimbursed by the NHS at prices determined by the PPRS (for branded medicines) or the Drug Tariff (for generics).<sup>1</sup>
- 1.3. Under the traditional wholesale model, pharmacies use several different channels to obtain branded medicines. They buy them from full-line wholesalers, and in some cases from short-line wholesalers, parallel traders or direct from the manufacturer. Full-line wholesalers account for the vast majority of sales to pharmacy and are so called because they are able to supply the entire range of branded medicines, around 12,000 lines.<sup>2</sup> Short-line wholesalers stock a smaller range of medicines, usually high volume medicines such as generics and parallel imports.
- 1.4. Many pharmacies typically have both a principal full-line wholesaler as well as a back-up (secondary) full-line wholesaler for situations when the principal wholesaler is unable to supply a particular medicine. Some also purchase medicines from short-line wholesalers when they are able to obtain better prices on particular medicines, such as generics and parallel imports. Other pharmacies, in contrast, particularly the larger chains and those vertically integrated with a wholesaler, choose to purchase all their medicines from their affiliated wholesaler.
- 1.5. About 90 per cent of prescription medicines are delivered to pharmacies and dispensing doctors by wholesalers. Approximately six per cent of this is by short-line wholesalers. The remaining ten per cent are either

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<sup>1</sup> See Annexe D for a more detailed description of pharmacy reimbursement.

<sup>2</sup> We recognise that since Pfizer implemented its DTP scheme, only UniChem has been able to distribute a full range of medicines.

self-supplied by the pharmacy or are supplied direct by the manufacturer.

- 1.6. The majority of manufacturers employ a pre-wholesaler (or contract logistics service provider) for the storage and transportation of medicines before they are sold to a wholesaler or direct to primary or secondary care. A few of the larger manufacturers operate these functions in-house.
- 1.7. NHS expenditure on prescription medicines<sup>3</sup> is allocated according to a system of discounts which has evolved in the traditional wholesale model. Some of the total expenditure on prescription medicines is retained by wholesalers and pharmacies, whilst the remainder goes to the manufacturer of the medicine. Pharmacy and wholesaler margins differ for branded medicines and for generics. This system of margins is described below.
- 1.8. Under the traditional wholesale model, the pricing through the supply chain for branded medicines is broadly as follows:
  - By custom and practice, manufacturers sell to wholesalers at a 12.5 per cent discount to list price.<sup>4</sup>
  - Wholesalers sell to pharmacies at discounts depending on volume, with wholesalers' discounts averaging at around 10 - 10.5 per cent.
  - Pharmacies are reimbursed by the NHS at list price less clawback (which averages 9.24 per cent of list price across all medicines including those on the Zero Discount list). Assuming pharmacies buy at 10.5 per cent below list price, this implies average pharmacy margin on medicines of around 1.26 per cent of list price.<sup>5</sup>
- 1.9. Figure C1 shows an estimate of the share of NHS expenditure on branded medicines accruing to the different parts of the distribution chain based on the above assumptions.

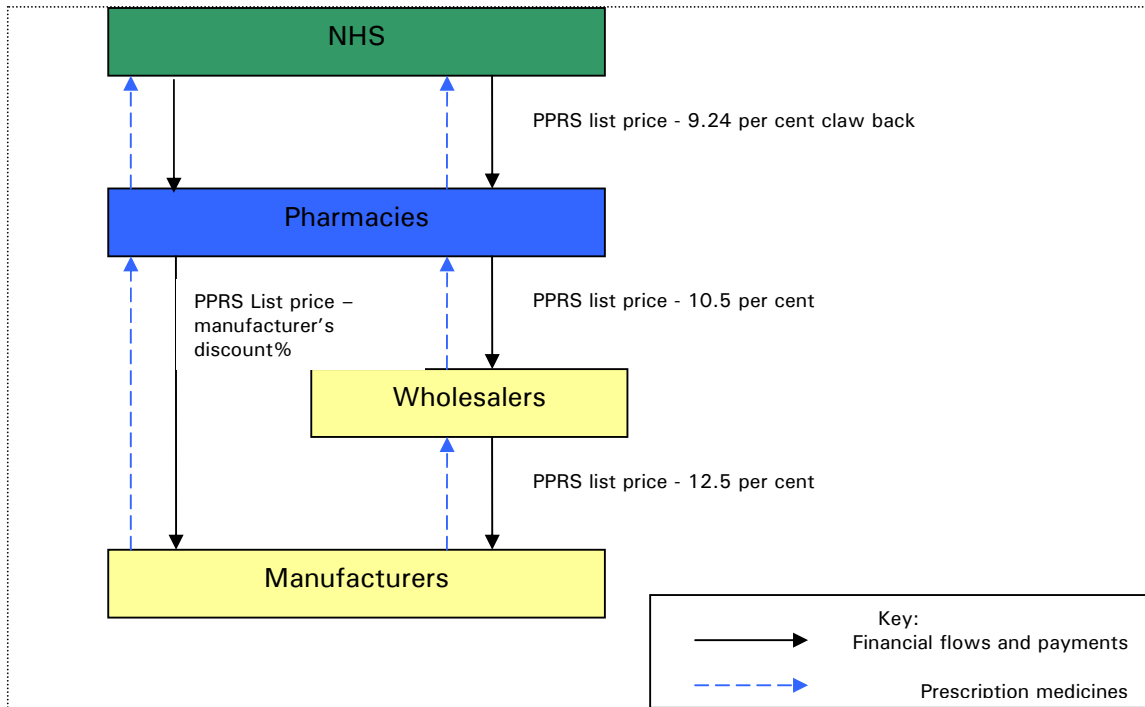
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<sup>3</sup> Annexe D describes the financial flows relating to NHS spending on branded and generic prescription medicines.

<sup>4</sup> The 12.5 per cent discount is also discussed in Chapter 3 and Annex D.

<sup>5</sup> Representing the difference between average pharmacy purchase price of around 10.5 per cent below list price and average pharmacy reimbursement at 9.24 per cent below list price.

**Figure C1: Allocation of NHS expenditure to the distribution of branded medicines**



- 1.10. Distribution margins for generics differ from those for branded medicines. Pharmacies are reimbursed for dispensing generic medicines according to Category M of the Drug Tariff which is adjusted to ensure the aggregate profit provision of the Pharmacy Contract is fulfilled.<sup>6</sup> Price competition between generics manufacturers tends to be vigorous, and consequently ex-manufacturer prices tend to be low. These prices form the basis for Category M reimbursement prices.
- 1.11. Whilst pharmacy reimbursement for generics is relatively transparent, the discounts that pharmacies receive from wholesalers are not. Short-line wholesalers tend to be more involved in the buying and selling of generics in bulk at discounted prices. Consequently, wholesaler and pharmacy margins on generics are relatively difficult to observe.

<sup>6</sup> See Annexe D for a more detailed description of pharmacy reimbursement regulations.

## SECTION B - MANUFACTURERS

1.12. The pharmaceutical industry is global in nature: multinational pharmaceutical companies with turnover of tens of billions of pounds operate across national boundaries. While the UK market is only a small part of a global industry, the relative sizes and importance of pharmaceutical manufacturers in the UK in general reflects their global positions. The UK market shares of the leading pharmaceutical manufacturers' sales to primary care are shown in Table C1 below.

**Table C1: UK pharmaceutical manufacturers' sales at list prices to primary care and market share, year to June 2007**

<b>Manufacturer</b>	<b>Sales to primary care (£m)</b>	<b>Market share %<sup>7</sup></b>
<b>Pfizer</b>	<b>957</b>	<b>10.0</b>
<b>GlaxoSmithKline</b>	<b>913</b>	<b>9.6</b>
<b>Sanofi Aventis</b>	<b>597</b>	<b>6.3</b>
<b>Astrazeneca</b>	<b>573</b>	<b>6.0</b>
<b>Novartis</b>	<b>341</b>	<b>3.6</b>
<b>Merck</b>	<b>320</b>	<b>3.4</b>
<b>Johnson &amp; Johnson</b>	<b>307</b>	<b>3.2</b>
<b>Wyeth</b>	<b>286</b>	<b>3.0</b>
<b>Eli Lilly</b>	<b>253</b>	<b>2.7</b>
<b>Roche</b>	<b>219</b>	<b>2.3</b>
<b>Boehringer Ingelheim</b>	<b>210</b>	<b>2.2</b>
<b>Novo Nordisk</b>	<b>194</b>	<b>2.0</b>
<b>Bayer</b>	<b>144</b>	<b>1.5</b>
<b>Servier</b>	<b>124</b>	<b>1.3</b>
<b>Mundi Int</b>	<b>100</b>	<b>1.0</b>

Source: ABPI

1.13. Table C1 shows the top fifteen pharmaceutical manufacturers, each with market shares of more than one per cent and sales to primary care

<sup>7</sup> Figures include OTC sales which are reimbursable under NHS. However, these OTC figures do not materially alter the market shares.

of more than £100 million. These make up just under sixty per cent of the market in total.

- 1.14. The larger manufacturers, with market shares of greater than five per cent, and who account for around a third of UK sales to primary care, have either already put new distribution arrangements in place or have publicly announced that they intend to implement changes. The changes are based on DTP and/or a reduction in the number of wholesalers that may distribute the manufacturer's medicines. The changes are summarised below.
- 1.15. Pfizer is the world's largest pharmaceutical company and the largest supplier of medicines to the NHS, supplying ten per cent of medicines to primary care. In March 2007 Pfizer implemented a new policy of supplying its medicines direct to pharmacies, dispensing doctors and hospitals in the UK. Pfizer appointed a single wholesaler, UniChem, to act as its sole agent in delivering its medicines to customers.
- 1.16. GSK is the second largest pharmaceutical manufacturer in the UK, supplying just under ten per cent of the medicines to primary care. GSK implemented a DTP scheme in 1991. It continued to use all full-line wholesalers as distributors but pharmacies operate an account with GSK itself rather than with the wholesalers appointed by GSK to deliver its medicines. Under its scheme, GSK sets the pharmacy discounts received on its products.
- 1.17. AstraZeneca is one of the larger pharmaceutical manufacturers, with a UK market share to primary care of approximately 6 per cent. In April 2007 AstraZeneca announced that it would be implementing a distribution system similar to that of Pfizer but with two agents, AAH Pharmaceuticals Limited (AAH) and UniChem.<sup>8</sup> This scheme is due to be implemented in February 2008.
- 1.18. Sanofi Aventis has a UK market share to primary care of approximately 6.3 per cent. Sanofi Aventis has, since 1 November 2007, restricted the number of wholesalers it uses to the three national players, AAH, UniChem and Phoenix Limited (Phoenix).

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<sup>8</sup> AstraZeneca does not consider that its arrangements comprise a DTP scheme. Its scheme does however fall within our definition of Direct to Pharmacy as Astra Zeneca sets the prices and service standards received by pharmacies, and retains ownership of its medicines until they are purchased by pharmacies. Any reference to DTP therefore applies to the new AstraZeneca model unless stated otherwise.

- 1.19. Napp Pharmaceuticals Limited (Napp) has also, from 1 October 2007, reduced the number of wholesalers who distribute its medicines to the same three wholesalers: AAH, UniChem and Phoenix.
- 1.20. From discussions with manufacturers it seems that others are currently considering revising their supply chain arrangements, but no other public announcements have been made.<sup>9</sup>

### **Competition among manufacturers**

- 1.21. In the longer term manufacturers compete through research and development to bring new medicines to market. In the shorter-term, they compete by seeking to have more of their medicines prescribed or dispensed.
- 1.22. Entry barriers into research and development of medicines are significant, reflecting the high fixed costs required to develop medicines. Manufacturers are often granted patents to protect their investments. The OFT's PPRS report found that pharmaceutical markets in the UK were highly concentrated.
- 1.23. Although large sunk-cost investments in R&D and patent protected innovations mean that competition is limited in the short run, dynamic competition may occur to a greater extent in the longer-term as new medicines enter markets and medicines lose their patents.
- 1.24. To treat a given condition, GPs may choose between medicines that are therapeutically substitutable. Manufacturers of therapeutically substitutable products will therefore compete with each other to influence GPs' prescribing behaviour. GPs will issue prescriptions to patients for the most suitable medicine, based on advice from a number of different bodies on the clinical effectiveness and cost effectiveness of the medicines available.
- 1.25. The patient's prescription is dispensed at a pharmacy. At this stage a pharmacist may have a choice of which medicine to dispense depending on whether the medicine is prescribed generically (i.e. using its chemical name) or as a brand. Competition to supply pharmacies can therefore be considered under two main scenarios:
  - when GPs write a prescription for a brand, or for the generic name but only a branded medicine is available, and

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<sup>9</sup> We are also aware that Astellas Pharma Ltd has, as of 26 November 2007, appointed UniChem exclusively as LSP for its two transplant medicines.

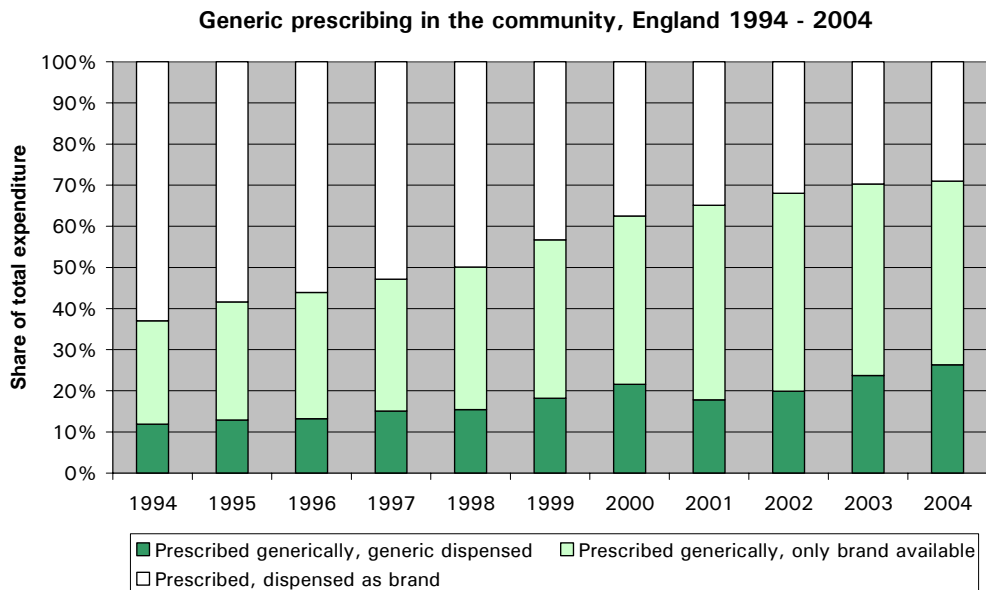
- when GPs write a prescription using the generic name and where, alternative medicines are available.

1.26. If a GP writes a prescription for a brand, or uses the generic name but no generic substitute is available,<sup>10</sup> the pharmacy is obliged to dispense the branded medicine, or a parallel imported version of the branded medicine and is reimbursed according to the manufacturer's list price as specified under the PPRS.

1.27. When the prescription uses the generic name, and there are generics available, the pharmacy can choose to dispense either a generic version or a branded version of the medicine. In this situation the pharmacy has a range of options available including the originator brand, all bioequivalent generics (including branded generics) and parallel imports. If the pharmacy dispenses a generic medicine it is reimbursed according to Category M of the Drug Tariff. The extent of generic competition is considered in the following section.

#### Branded and generic competition

**Figure C2: Generic and branded prescribing in the community in England, 1994 to 2004**



1.28. The figure above demonstrates that, by value, 25 per cent of prescriptions allow pharmacies some choice over which medicines to dispense. For the remaining 75 per cent of the expenditure, pharmacies

<sup>10</sup> For example, if the drug is on-patent.

are unable to choose between alternative medicines on receiving a prescription.

- 1.29. Where a pharmacy is unable to choose between alternative medicines, the constraint on the prices manufacturers offer to pharmacies is limited. When faced with a decreased discount on such medicines, pharmacies are unable to source alternative medicines except where they can obtain a cheaper, imported version of the same medicine.
- 1.30. Manufacturers of such brands therefore have an incentive to decrease discounts to pharmacies where possible. As outlined in the box below, we estimate that around £5 billion of primary care medicines expenditure therefore corresponds to medicines where either there are no alternative medicines available (other than parallel imports) or where pharmacies are unable to choose between substitutable medicines.

**Box C1 Expenditure relating to prescriptions against which pharmacies can dispense a single medicine**

Annual primary care expenditure on prescription medicines is around £9.3 billion annually (before the deduction of clawback).

Around 75 per cent of expenditure relates to prescriptions against which pharmacies are unable to choose between alternative medicines. Around £7 billion of this expenditure relates to such prescriptions. Around £1.25 billion of this is estimated to relate to expenditure on parallel imports. Over £5 billion of expenditure is therefore related to medicines sourced domestically and where pharmacies are unable to choose between alternative medicines.

Although a very basic estimate, this figure helps to establish the proportion of medicines expenditure where prices to pharmacies are not generally constrained by competition, and where manufacturers could potentially decrease pharmacy discounts without inducing significant switching to alternative medicines.

A one percentage point reduction in the discount to pharmacies on all such medicines would therefore raise NHS purchase costs by over £50 million, and a 10 per cent reduction would raise costs by over £500 million annually.

If we assumed that manufacturers accounting for half of branded sales adopted DTP, and that on average they lower discounts by 5 per cent, this would result in NHS cost increases of over £100 million per annum.

- 1.31. To consider the extent to which individual medicines in manufacturers' portfolios are open to competition, we examined Prescription Cost Data from 2005 for England for the top eight medicine manufacturers by size, Pfizer, GSK, Sanofi Aventis, AstraZeneca, Novartis, Merck, Johnson & Johnson and Wyeth. This considered exact matches between the medicine name and presentation between manufacturers'

medicine portfolios and generic medicines that were available at the time.

- 1.32. The following table shows the approximate percentage of their medicines that may be subject to competition in practice from equivalent generic medicines. This is analysed both as a percentage of the number of different medicines and presentations, and by the cost of reimbursement of the medicines.

**Table C2: Proportion of top eight manufacturers' medicine portfolios open to competition from generics in 2005**

<b>Manufacturer</b>	<b>Approximate percentage of portfolio open to competition (number of medicines)</b>	<b>Approximate percentage of total cost of medicines open to competition<sup>1</sup></b>
<b>Pfizer</b>	18	10
<b>GSK</b>	14	5
<b>Sanofi Aventis</b>	22	17
<b>Astra Zeneca</b>	19	31
<b>Novartis</b>	8	13
<b>Merck</b>	8	2
<b>Johnson &amp; Johnson</b>	5	62
<b>Wyeth</b>	17	47
<b>Simple Average<sup>2</sup></b>	<b>14</b>	<b>23</b>
<b>Value weighted average<sup>3</sup></b>	<b>-</b>	<b>11</b>

Source: OFT analysis of PCA data for England, 2005.

Note 1: This was calculated using the Net Ingredient Cost (NIC) of manufacturers' medicines.

Note 2: Unweighted simple mean.

Note 3: Mean calculated by value (NIC)

- 1.33. This analysis is intended to be indicative, rather than a detailed analysis of the extent to which generic medicines can compete with branded medicines. However, this does indicate that a number of manufacturers may have an incentive to reduce the discounts they offer on the vast majority of their medicines. For all of the companies considered, over 75 of their medicines were not subject to competition at the pharmacy level.

### **Parallel Imports**

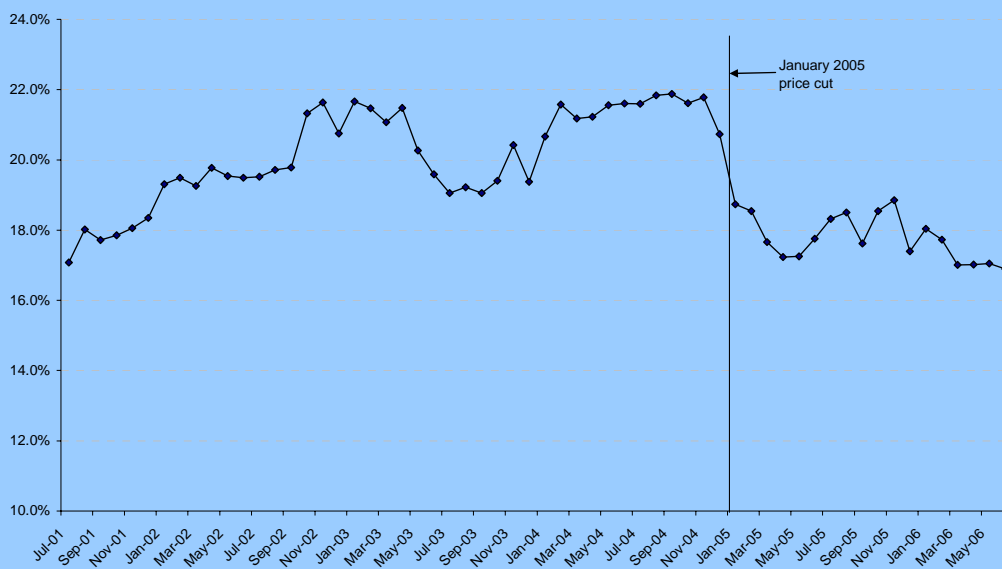
- 1.34. Manufacturers face another source of competition from parallel imports of their products. Pharmacies are reimbursed at list price (less clawback) whether they dispense a brand sourced from domestic suppliers or from parallel importers. Pharmacies therefore have a strong incentive to purchase parallel imports if they are available more cheaply

than supplies sourced directly from the manufacturer in the UK. The box below considers parallel imports in the UK.

**Box C2: Parallel Imports**

Parallel traders export branded medicines from lower-priced to higher-priced countries in the European Union. To sell parallel imports the UK parallel traders must be licensed by the MHRA. The chart below shows the penetration of parallel imports on brands in primary care between 2001 and 2006. In 2005, parallel imports accounted for around 18 per cent by value of branded drugs prescribed in UK primary care, or about £1.25 billion at list prices (see Figure C3).

**Figure C3: Parallel import penetration on brands in primary care in the UK, 2001-2006**



Source: IMS (supplied by ABPI)

Parallel traders arbitrate between countries in the EU as the prices vary for the same medicines. In some cases the price difference can be high due to the diversity of regulatory regimes among countries, diverse demand, currency fluctuations and manufacturers' commercial decisions about how to price in the light of these factors. UK prices are on average relatively high, making the UK a major destination for parallel trade. This activity can be volatile because opportunities shift as governments and manufacturers alter their pricing regulations and strategies. The chart above shows the drop in parallel trade in the UK that followed the seven per cent price cut following the 2005 re-negotiation of the PPRS.

Parallel trade is profitable when the difference between manufacturers' selling prices in the UK and in those other EU countries where supplies can be sourced for parallel trade exceeds the parallel traders' transaction costs. If there is competition from and between parallel traders, any potential profits may be shared with UK wholesalers, pharmacies and/or the NHS.

## SECTION C - PHARMACIES

1.35. There are approximately 12,600 community pharmacies in the UK. The top ten largest chains account for over half of UK retail pharmacy sales.

**Table C3: Retail pharmacies in the UK: market share by NHS revenue, 2006**

Pharmacy	Market Share %
Alliance Boots (UniChem)	20.8
Lloyds (Celesio (AAH))	13.3
Rowlands (Phoenix)	4.2
Co-operative Pharmacy (Sants)	2.8
Superdrug	2.2
Sainsbury	1.5
Tesco	1.4
Asda	0.9
Morrison	0.8
<b>Others</b>	<b>52.1</b>

Source: Verdict: The Retail Pharmacy Market 2006

1.36. Table C3 sets out the market shares by NHS revenue for the larger multiples for 2006. Vertically integrated wholesalers are shown in brackets. The two larger multiples (Boots and Lloyds) collectively account for approximately one third of the market. The next largest is Rowlands with just over 4 per cent of the market. In addition to the larger pharmacy chains are a large number of independent pharmacies.

1.37. Some independent pharmacies join buying groups to collectively negotiate for volume discounts and services with wholesalers and manufacturers. Some buying groups deal exclusively with one wholesaler whilst others may deal with several.

1.38. As well as pharmacies there are approximately 1,800 dispensing doctor practices which typically provide NHS dispensing services in remote rural areas to patients who live more than a mile away from their nearest pharmacy.

## Competition between pharmacies

1.39. Pharmacies compete locally in the provision of prescription medicines and 'over the counter' (OTC) medicines, as well as other goods and services.

### Market definition

1.40. The main product markets that a pharmacy operates in are:

- Prescription only medicines. Where patent protection applies, there is no demand side substitution within these or between prescription and non-prescription medicines.
- Over the counter (OTC) medicines, which fall into two categories:
  - P medicines (pharmacy only medicines) which can be retailed only under a pharmacist's supervision.
  - General Sales List (GSL) medicines which can be retailed in any outlet.

1.41. Prescription medicines are the main component of the pharmacy retail market, accounting for 77.3 per cent of retail pharmacy sales in 2005.<sup>11</sup>

1.42. Retail pharmacies also compete in the provision of services remunerated by the NHS. The NHS is now placing greater emphasis on pharmacies involvement in the prevention and diagnosis of illnesses. For example, pharmacies are now reimbursed for Medicine Use Reviews (MURs) carried out for patients.

1.43. In OFT merger investigations,<sup>12</sup> the relevant geographic market definition has been concluded to be a one mile radius around each relevant pharmacy. The OFT report on the control of entry regulations found that 78 per cent of consumers travel less than one mile to get to a pharmacy, and 96 per cent travel less than three miles.

1.44. Whilst it has acknowledged that there may be an element of national competition between the larger chains, the OFT has noted that the degree of competition between national chain in local areas may well be a factor in determining the extent to which they can influence each other's decision making at the national level, for example on pricing policies.

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<sup>11</sup> Verdict: The Retail Pharmacy Market 2006.

<sup>12</sup> Such as 'Anticipated acquisition by Boots of Alliance UniChem plc' February 2006.

## Competition

- 1.45. Pharmacies compete locally in the three main product markets and in the provision of NHS services. Competition between pharmacies has been considered in previous OFT work. This is summarised in Annexe B which includes a description of the OFT report on the control of entry regulations and retail pharmacy services in the UK and recent relevant merger decisions by the OFT. Competition between pharmacies is therefore not considered further here.

## SECTION D - WHOLESALERS

- 1.46. This section considers the distribution of branded medicines by wholesalers or logistic service providers (LSPs). Firstly, it identifies different methods by which medicines are supplied. It considers different types of wholesalers and then describes the various wholesale models. Finally, it considers the Pfizer DTP scheme in detail.
- 1.47. Branded medicines in the UK are supplied through a number of different channels. The vast majority are supplied through full-line wholesalers. Pharmacies also obtain supplies from short-line wholesalers, parallel imports, grey trade, direct from the manufacturer and through buying groups. At present these various supply arrangements, together with DTP, co-exist to supply pharmacies with their branded medicines.
- 1.48. **Full-line wholesalers:** these businesses hold the majority of medicines that may be required by pharmacies. The recent changes in distribution have limited the range of medicines available to all wholesalers. For example, Pfizer's decision to distribute exclusively through UniChem means that other full-line wholesalers do not have access to Pfizer's medicines (except as parallel imports). Similarly, Sanofi Aventis' and Napp's medicines are only available to UniChem, AAH and Phoenix.
- 1.49. Pharmacies typically have one principal full-line wholesaler offering a high quality, twice-daily delivery service. The discount structure offered by the wholesaler will tend to reward those pharmacies that place a substantial volume of purchases with it. In addition, many full-line wholesalers offer ancillary services to their customers including computerised ordering facilities, loan guarantees for improvements to pharmacies and product specific support services for pharmacists.
- 1.50. Full-line wholesalers in the UK, with the exception of UniChem, are members of the British Association of Pharmaceutical Wholesalers (BAPW). The BAPW describes its members and distribution practice as follows:

'Full line wholesalers act as a one-stop shop for almost all pharmaceutical products and services, playing a key role in the cost effective and safe distribution of a diverse range of healthcare products, all to exact orders on a same day basis.'<sup>13</sup>

- 1.51. Several full-line wholesalers have told us that it is necessary to hold a substantial volume of medicines and customers accounts to cover the full costs of supplying medicines on a twice-daily basis throughout either the UK or a particular region of the UK. Without such volume, the expensive supply model of full-line wholesaling is difficult to sustain. This is discussed further in Chapter 5.
- 1.52. There are eleven full-line wholesalers operating in the UK. Of these only the largest three, UniChem, AAH and Phoenix, operate at a national level. The remaining wholesalers are much smaller and operate on a regional basis.
- 1.53. Table C4 below gives the approximate market shares of 10 of the full-line wholesalers in the UK by volume, i.e. quantity of medicines distributed. This is based on the OFT's survey of full-line wholesalers and therefore does not indicate the market shares within the wider wholesale sector (as short-line wholesalers or parallel importers have not been included). The 2006 and 2007 figures represent the shares of full-line wholesalers before and after the Pfizer agreement was implemented. Further details of the wholesaler survey can be found in Annexe F. Pharmacy chains which share common ownership with a wholesaler are shown in brackets.

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<sup>13</sup> The BAPW Gold Standard – Good Distribution Practice by Pharmaceutical Wholesalers.

**Table C4: Volume based market shares of full-line wholesalers**

Wholesaler	2006 (%)	2007 (%)
UniChem (Alliance / Boots)	35	38
AAH (Lloyds)	39	38
Phoenix (Rowlands)	15	14
Mawdsley Brooks	3	3
Sants (Co-op)	2.7	2.6
Sangers NI	2.5	2.2
F Maltby	0.9	0.9
Sangers Maidstone (Paydens)	0.7	0.7
Norchem	0.5	0.6
Munro	0.2	0.3

Source: OFT calculations based on responses to the OFT wholesaler survey. Figures are for the months of May 2006 and May 2007. Figures do not sum to 100 per cent due to rounding errors. Figures do not include PIF Medical as it provided no response to the OFT survey. See Annex F for further details.

Notes:

- (1) UniChem has informed the OFT that, based on market data it receives from data provider IMS Health, it considers these estimates materially to overstate its share.
  - (2) These figures include branded and generic prescription medicines in the UK, and therefore exclude surgical products, OTC medicines and any other products supplied by full-line wholesalers to pharmacies.
  - (3) These figures include self-supply among vertically integrated wholesalers and pharmacies.
  - (4) These figures include volumes of GSK and Pfizer medicines.
  - (5) Figures for May 2006 are before Pfizer's DTP scheme came into operation, while figures for May 2007 are after Pfizer's DTP scheme came into operation.
- 1.54. Several of the full-line wholesalers, including those with national coverage, are vertically integrated with pharmacy chains. For example, UniChem is vertically integrated with Alliance Boots plc, AAH with Lloyds Pharmacy and Phoenix with Rowlands Pharmacies Limited.
- 1.55. **Short-line wholesalers:** As well as the full-line wholesalers, there are a large number of short-line wholesalers that supply a smaller range of prescription medicines focussing on the fast-moving, more profitable

parts of the supply chain, including generics and parallel imports. These medicines are also supplied by full-line wholesalers, many of which also trade in parallel imports and exports.

- 1.56. The number of medicines stocked by short-line wholesalers can vary substantially, with some holding a small number of medicines for distribution to a specific pharmacy or group of pharmacies while others hold close to the full-line range of products. Typically, short-line wholesalers might stock around 2,000 product lines, as opposed to the 12,000 typically stocked by full-line wholesalers.
- 1.57. Full-line and short-line wholesalers have essentially different business models. Full-line wholesalers compete for pharmacy accounts, while short-line wholesalers compete to supply a small range of individual product lines, and do not offer additional services to pharmacies. In previous decisions relating to the mergers of full-line wholesalers, the OFT has concluded that short-line wholesalers do not constitute a substantial competitive constraint on full-line wholesalers.<sup>14</sup>
- 1.58. Short-line wholesalers do not typically offer the same frequency of deliveries as full-line wholesalers, with deliveries offered on a next day or twice weekly basis being more typical, and with some such deliveries being carried out by couriers rather than a specialist medicine distribution fleet. Short-line wholesalers tend to supply a larger proportion of generic medicines as many of these are fast selling products that can be stocked in large quantities without incurring high working capital costs. Many short-line wholesalers also import branded medicines (parallel imports) and supply those in competition with manufacturers' own supplies in the UK
- 1.59. **DTP logistics service providers:** Under DTP a manufacturer appoints LSPs to deliver its medicines to pharmacies. The wholesaler does not sell the medicines to the pharmacy but acts as an agent with the level of service being determined by the manufacturer. While GSK has operated on this basis for some years, supplying all full-line wholesalers, the DTP model has become more high profile following the announcement of Pfizer's and AstraZeneca's schemes and their decision to appoint one and two LSPs respectively.
- 1.60. **Other supply channels:** parallel imports into the UK originate mainly from elsewhere within the European Union. The incentive for wholesalers to participate in parallel trade arises out of price

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<sup>14</sup> See 'Anticipated acquisition by Boots plc of Alliance UniChem plc', OFT merger decision of 6 February 2005.

differentials between different national markets and depends on factors such as the availability of sufficient supplies in the source country, market size in the destination country and the size of the price differential. Parallel trade in pharmaceuticals has existed in the UK since the beginning of the 1970s and now accounts for around 18 per cent of medicines sold in the UK.

- 1.61. 'Grey trade' refers to trade between pharmacies or wholesalers of medicines within the UK. This may occur, for example, when certain medicines are in short supply.
- 1.62. Vertically integrated chains are usually supplied by their group's wholesaler, for example Lloyds is supplied by AAH. In the case of shortages, however, vertically integrated chains may order from other sources. In some cases the pharmacy may buy directly from manufacturers.
- 1.63. Buying groups are groups of independent pharmacies who buy collectively as a means of negotiating better discounts from wholesalers and/or manufacturers than those obtainable by independent pharmacies negotiating alone.

### **Competition among wholesalers**

- 1.64. This section considers the level of competition under the traditional wholesale model where wholesalers compete for pharmacy accounts. It also considers DTP schemes where wholesalers first compete to become LSPs to the manufacturer concerned, and then compete for pharmacy business (unless the DTP contract is exclusive).

### **The traditional wholesale model**

- 1.65. This section looks at how branded medicines have been distributed under the traditional wholesale model. It considers features of distribution and how competition among wholesalers takes place under this model.
- 1.66. Under the traditional wholesale model, pharmacies obtain branded medicines through a number of different channels. They buy medicines from full-line wholesalers, from short-line wholesalers, from parallel traders or receive direct supply from the manufacturer. Figure C4 below

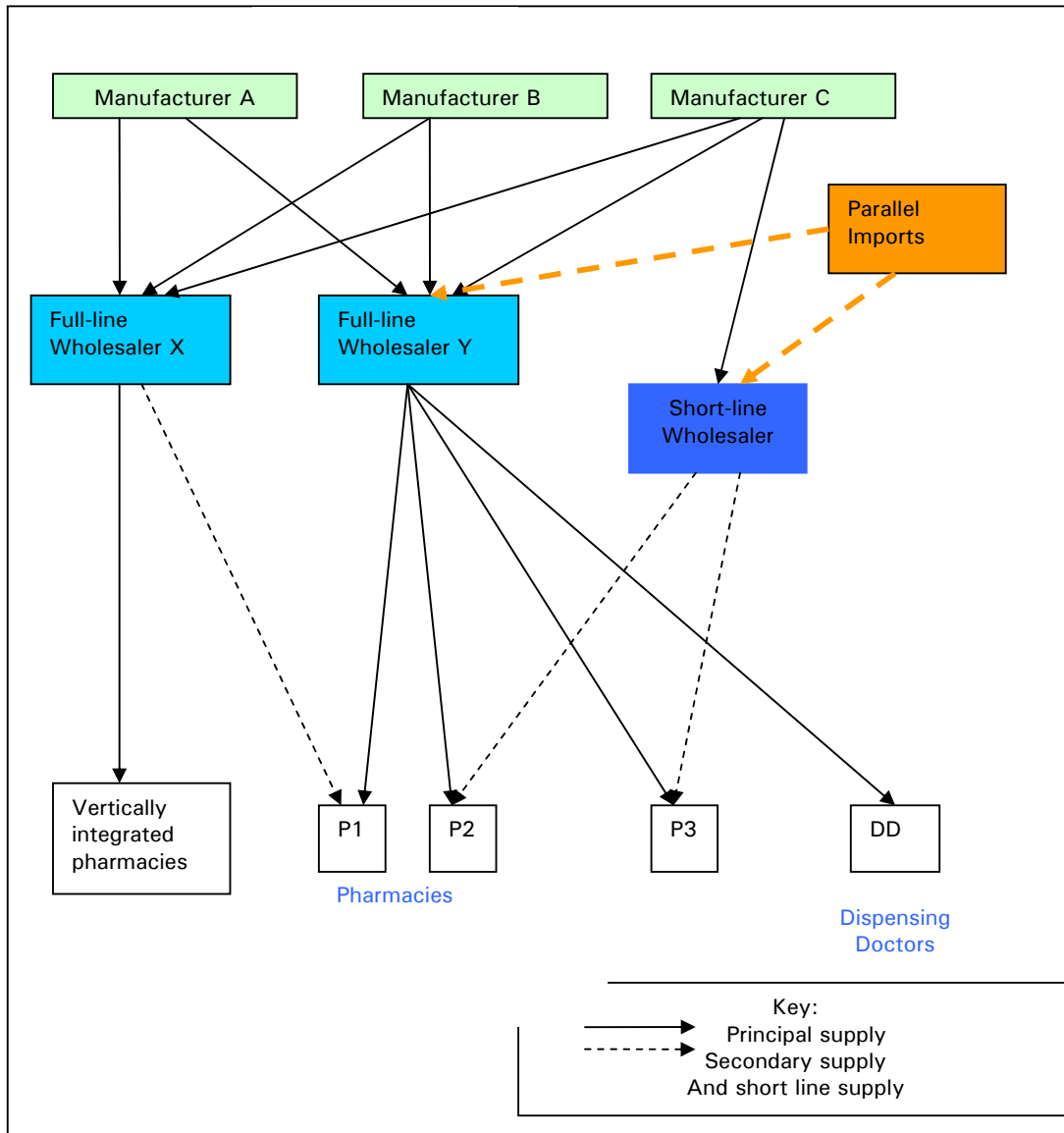
sets out some of the various types of distribution under the traditional wholesale model.<sup>15</sup>

- 1.67. Under the traditional wholesale model, prior to recent changes in distribution arrangements, manufacturers generally supplied all full-line wholesalers and some, but not all, supplied short-line wholesalers as well. Pfizer ceased supplying short-line wholesalers in 2004.
- 1.68. Independent pharmacies and dispensing doctors typically use a principal full-line wholesaler and also a secondary full-line wholesaler for cases when the principal wholesaler is out of stock of a particular product. They typically use short-line wholesalers for obtaining greater volume discounts on particular medicines, such as generics and parallel imports.

**Figure C4: Distribution of medicines under the traditional model in the primary care segment.**

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<sup>15</sup> When we refer to the term 'traditional wholesale model' we will generally be considering the interactions between manufacturers, full-line wholesalers and pharmacies.



### The cost of distribution

- 1.69. By custom and practice, manufacturers sell branded medicines to full-line wholesalers at a 12.5 per cent discount from list price under the traditional wholesale model. It is believed that this practice has been adhered to for approximately twenty five years.
- 1.70. The overall 12.5 per cent discount can be a straightforward 'off invoice' discount from the list price, or can sometimes be the outcome of a combination of components including discounts off invoice and discount linked to settlement terms. For example, 10 per cent off invoice with 2.86 per cent prompt payment terms, netting to 12.5 percent.

- 1.71. Wholesalers sell to pharmacies at discounts that vary according to volumes purchased. Wholesalers' discounts to pharmacies average approximately 10 - 10.5 per cent.
- 1.72. Manufacturers and wholesalers have told us that there has been general adherence to the 12.5 per cent discount under the traditional wholesale model. We have been informed that deviations from the standard 12.5 per cent discount have occurred only in exceptional circumstances or where companies have departed from the traditional wholesale model, as GSK did in 1991 when it introduced a DTP scheme

**Box C3: GSK's DTP scheme**

In 1991 GSK introduced an arrangement whereby it appoints agents to distribute its products to retail pharmacies. All full-line wholesalers currently act as GSK agents. The wholesaler is paid a management fee which is based on the value of the products sold and the number of packs supplied.

The discount structures applying to GSK medicines are determined by GSK, which negotiates terms directly with retailers. This restricts the scope for price competition among wholesalers in the supply of GSK medicines. As regards service aspects such as prompt delivery, the competitive position is no different from that with other manufacturers' medicines.

- 1.73. We found one further exception, which concerned Byetta (Eli Lilly) a Zero Discount product (see Box C4 below). Zero Discount products do not attract a discount when sold to pharmacies and dispensing doctors. Products may be added to the Zero Discount list by DH if the nature of the product warrants it or if the cost of the product is sufficiently high.<sup>16</sup>

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<sup>16</sup> For further information see the PSNC website: [www.psn.org.uk](http://www.psn.org.uk).

**Box C4: Eli Lilly distribution of Byetta.**

Eli Lilly supplies one medicine to wholesalers at a discount lower than 12.5 per cent. The product, Byetta P/F PEN 1.2ML, is a Zero Discount diabetes medicine supplied by cold chain. Its current list price is £68.24 and all wholesalers receive a discount of less than 12.5 per cent. Byetta is a new medicine and, given its high value, Eli Lilly considered the standard 12.5 per cent for distribution to be too high and therefore not warranted. It discussed the possibility of selling the medicine at a lower discount with certain wholesalers, who indicated that they would accept a lower discount. One wholesaler refused to take stocks initially but did so once it was satisfied that a given level of demand existed for the medicine.

Eli Lilly was confident that, given the cash margin offered, wholesalers would still be interested in supplying the medicine. Eli Lilly explained to OFT that, because Byetta is a Zero Discount medicine, its decision to offer a lower discount would not result in higher costs to DH.

**Features of full-line wholesale service**

- 1.74. Out of the 12,000 prescription medicines held by full-line wholesalers, only about 20 per cent (2,400 lines) are prescribed frequently. The remaining 80 per cent (9,600 lines) are required only infrequently. It is considered uneconomical by pharmacies to stock less frequently ordered medicines as this requires tying up money in stock and there is a risk that medicines may pass their shelf life. Storage capacity may be an issue for some pharmacies as well. As a result of these factors pharmacies favour frequent deliveries from their wholesalers to minimise their stock holding costs and risks.

**Delivery frequency and cut-off times**

- 1.75. Full-line wholesalers offer a twice daily delivery service on weekdays and a once daily at weekends to most of their pharmacies. Pharmacies in remote locations may not obtain the twice daily service and pharmacies in certain urban locations may receive more than two deliveries. Full-line wholesalers also offer an emergency service to meet urgent demands.
- 1.76. A pharmacy will generally place an order after receiving the prescriptions from the morning surgery (around noon) and will receive the deliveries during the afternoon (14.30 onwards). At the end of the day, (generally around closing time) the pharmacy will place a second order for delivery the following morning (generally around opening time).

Exact cut-off and delivery times vary across the country depending mainly on the distance from between the pharmacy and wholesaler's warehouse.

- 1.77. Delivery times of principal wholesalers are generally predictable because vans use the same routes every day and generally deliver to all pharmacies on their routes. However, the exact timing depends on factors such as weather and traffic conditions.
- 1.78. To some extent pharmacies are able to predict the level of demand for many medicines which are for, example, frequently prescribed or used for repeat prescriptions (although we were told that the ability to forecast demand from repeat prescriptions varied widely from pharmacy to pharmacy). Where demand cannot be fully predicted, the facility to order at short notice and obtain the required medicine within the same day enables a pharmacy to satisfy most patients' needs within a short timeframe and without the patient having to go elsewhere.
- 1.79. Short-line wholesalers generally operate a next day delivery service but a pharmacy may not have such deliveries every day and may use a number of short-line wholesalers. We found that some pharmacies could have a number of different deliveries on any given day depending on how active they are in purchasing medicines from sources other than their principal full-line wholesaler.

#### **Placing orders**

- 1.80. The majority of orders are placed electronically, though orders can also be placed by telephone or fax. Pharmacies generally have the opportunity to place orders twice per day with their principal full-line wholesaler and, depending on the pharmacy, they may also place other orders with manufacturers, short-line wholesalers and secondary full-line wholesalers. Smaller pharmacies, with fewer customers, may find that they need to order less frequently from their wholesalers depending on size of stock they are able to hold. Some pharmacies, for example, only order Pfizer medicines from UniChem every three weeks.
- 1.81. Many pharmacies operate a simple electronic ordering system whereby when the PMR<sup>17</sup> registers that a medicine is dispensed and an order is placed when the system automatically updates – around once an hour. Other pharmacies record and aggregate the individual medicines they need over the course of the morning or afternoon and then place the

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<sup>17</sup> Patient Medication Record

order. Most medicines ordered are for stock replacement, not in order to fulfil a prescription received that morning or afternoon.

### **Supply problems**

1.82. It is quite common for supply problems to exist for a wide variety of reasons and shortages could be either at manufacturer or at wholesale level. Wholesalers supply their customers with lists of out-of-stock medicines, which may be quite substantial and include medicines from a wide range of manufacturers

1.83. We have found some examples of supply problems:

- About three years ago Cardura XL (a Pfizer product) was in short supply as a number of batches encountered production difficulties and delays. This situation persisted for some time and some PCTs suggested that patients should be switched to alternative medication.
- In March 2007 Alliance Pharma Ltd experienced supply problems as the supplier of the Atarax active ingredient had a fire in its factory. An alternative supplier was found but the medicine required reformulation and renewed regulatory clearance. The factory is expected to reopen in 2008. Existing supplies were rationed and supplied to key customers only.

1.84. Alternative routes of supply are, in no particular order: secondary full-line wholesaler, short-line wholesaler, direct from the manufacturer or other local pharmacies.

1.85. We understand that many pharmacies have mutual supply arrangements with other pharmacies where they can source supply from each other if one is out of stock.

1.86. It is also possible for a pharmacy to ask the GP to change the prescription. We understand that this is often used as a last resort and can be time-consuming.

### **Ancillary services**

1.87. Wholesalers may offer other services to independent pharmacies which include:

- The provision of technical information on the medicines supplied as well as marketing and promotional assistance.
- The provision of financial support to customers. In particular, full-line wholesalers offer pharmacies loan guarantee schemes whereby

they guarantee a pharmacy's borrowing, often over a 10 year period in return for the pharmacy agreeing to purchase 70 – 80 per cent of its requirements from the wholesaler in question. This enables the pharmacy to borrow at favourable rates of interest and has become an important means for pharmacies to raise finance to acquire or refurbish premises.

- The provision of IT equipment to customers.

#### **Nature of competition between wholesalers**

- 1.88. Full-line wholesalers compete with each other in a number of ways to be a pharmacy's principal wholesaler. As noted above, it is common for a pharmacy to have accounts with two full-line wholesalers to ensure that its requirements will always be met. In such instances, one full-line wholesaler is used as the principal wholesaler and will be relied upon for the main part of a pharmacy's supplies. The secondary full-line wholesaler tends to be used primarily for items not immediately available from the principal wholesaler and hence generally represents only a small proportion of the pharmacy's supplies. Practice varies, however. Some pharmacies – including many of the very large chains - deal with only one full-line supplier; some of these also draw on short-line wholesalers and manufacturers for a proportion of their requirements.
- 1.89. Competition is focused on persuading a pharmacy to switch its principal account. One pharmacy group noted that the traditional way in which a wholesaler becomes established is to persuade pharmacies to open a secondary account with it. By providing a reliable service and building on such accounts, a new wholesaler could expect over time that some customers would shift more and more purchases to them until they became those customers' principal full-line wholesaler.
- 1.90. A pharmacy chooses its principal wholesaler on the basis of the discounts which are offered, the number of deliveries per day, the timing of these deliveries, order cut-off times and the ancillary services offered.

#### **Discounts**

- 1.91. Price competition between full-line wholesalers takes the form of discounts from list prices offered on the range of medicines supplied to pharmacies. As described above, the custom and practice under the PPRS of for manufacturers to sell branded medicines to wholesalers at a discount of 12.5 per cent to the list price. The wholesaler's price to

pharmacy will on average be at a discount to the list price of 10 – 10.5 per cent.

- 1.92. It is common practice for full-line wholesalers to publish standard discount terms, laying out the basis of discounts offered and the products which are eligible for discounting. Full-line wholesalers' standard terms tend to follow a common structure. They are based on the total monthly value of purchases of products eligible for discount. A minimum threshold is set for this figure below which no discounts are offered. Above the threshold a small number of discount rates (usually three or four) apply to set bands of the value of monthly purchases. Wholesalers may differ in their standard terms by virtue of the discount rates used, the monthly sales bands, and the range of products eligible for discount. In addition to these standard terms some wholesalers apply surcharges to customers whose purchases are below a certain level.
- 1.93. Not all pharmacies and buyer groups are covered by standard discount terms and full-line wholesalers may negotiate discounts on an individual basis with retail outlets or retail chains.

#### **Deliveries**

- 1.94. All full-line wholesalers offer twice daily delivery for a majority of their customers. Competition is therefore more likely to focus on order cut-off times and delivery times. Generally, the closer a pharmacy is to the wholesaler depot the better the cut-off and delivery times are. One would therefore expect the local wholesaler to have a competitive advantage on this factor.

#### **Ancillary services**

- 1.95. The ancillary services referred to in paragraph 1.87 above are also a feature of competition. A pharmacy which has been accepted a loan guarantee may then be unable to switch suppliers for a given period of time.

## **SECTION E – BARRIERS TO ENTRY IN THE WHOLESALER SECTOR**

### **Introduction**

- 1.96. This section considers the ease with which a new firm may enter the market for medicines distribution in the UK. It examines absolute barriers to entry and also considers the strategic advantages of incumbent wholesale firms which may deter entry. In addition, factors which may assist entry are considered in order to assess the overall attractiveness of the sector for a potential new entrant.
- 1.97. If barriers to entry are sufficiently low and timely entry is likely, an increase in market share on the part of a major incumbent, or a lessening of competition in the market, would be of less significance than if the barriers to entry are high.

### **Main barriers to entry**

- 1.98. There are a number of different factors that influence how easy it is to enter a market. We have considered the main barriers, represented by the following:
- wholesale dealer licences
  - DTP contracts
  - cost of entry
  - on-going cost of service
  - vertical integration
  - credibility of new entrants

#### **Wholesale dealer licences**

- 1.99. To become a pharmaceutical wholesaler or logistics service provider of prescription medicines in the EU<sup>18</sup> requires a wholesale dealer licence from the relevant regulatory body. In the UK this is the Medicines and Healthcare Regulatory Agency (MHRA).
- 1.100. Regulations 8 to 11 of The Medicines for Human Use (Manufacturing, Wholesale Dealing and Miscellaneous Amendments) Regulations 2005 establish standard provisions for licences required by wholesale dealers. Those regulations require, among other things, that the holder of a

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<sup>18</sup> That is, to sell, supply or procure medicinal products for any customer other than the end user.

wholesale licence (required for the sale or distribution of relevant medicinal products) shall:

'...ensure... the appropriate and continued supply of such relevant medicinal products to pharmacies and persons who may lawfully sell such products by retail or who may lawfully supply them in circumstance corresponding to retail sale so that the needs of patients in the United Kingdom are covered.'<sup>19</sup>

- 1.101. The regulations also require that licence holders comply with the principles and guidelines of good distribution practice.<sup>20</sup> Failure to do so to a material extent gives the MHRA the power, under section 28 of the Medicines Act, to vary, revoke or suspend the licence of the party in breach. Further details of the licensing regime for wholesalers can be found in Annexe E.
- 1.102. Given the nature of the regulations and the large number of wholesalers of different sizes and types in the UK, this does not appear to present a substantial barrier to entry.

#### **DTP contracts**

- 1.103. The moves to DTP and other supply restrictions may be seen to create an additional barrier to entry. In order to distribute the medicines of a manufacturer that restricts supply, wholesalers would need to have a supply contract with that manufacturer. Based on the current experience, tenders for LSP contracts under DTP are likely to arise only occasionally, lasting typically for a number of years.
- 1.104. The presence of restricted supply contracts has a knock-on effect on full-line wholesalers, as those without the full range of contracts would be unable to supply the full-range of medicines that customers may need. This in turn makes it more difficult for new full-line wholesalers to enter the market, as, while the costs of entry and operation are likely to remain unchanged, the overall revenue base is reduced as they would now be distributing fewer brands of medicines.

#### **The costs of entry**

- 1.105. The costs of entering the market as a wholesaler depend on the business model adopted. Entering to compete with the main full-line

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<sup>19</sup> Regulation 8(1)b, The Medicines for Human Use (Manufacturing, Wholesale Dealing and Miscellaneous Amendments) Regulations 2005.

<sup>20</sup> Guidelines on Good Distribution Practice of Medicinal Products for Human Use. These can be found at:

<http://ec.europa.eu/enterprise/pharmaceuticals/pharmacos/docs/doc2001/may/gdpguidelines1.pdf>

wholesalers across the UK would be a more costly operation than becoming a short-line wholesaler or being active in a limited geographical region in the UK. For example, the parties to a 2005 merger examined by the OFT considered the cost of establishing and stocking a single distribution depot to be up to £12 million.<sup>21</sup> It would take several such depots to provide UK-wide coverage.

- 1.106. The ease of entry as a logistics service provider under DTP would depend on the specifications of the contract by manufacturers in terms of the level of service specified and the level of competition from established full-line wholesalers. Where the service level required was similar to that currently provided by full-line wholesalers, such wholesalers are likely to have a cost advantage over new entrants given the number of customers they already serve and their established delivery network. These may be costly for a new entrant to reproduce.
- 1.107. More generally, a substantial proportion of the costs of entering the wholesale market as a significant supplier would be the fixed costs in establishing the business infrastructure. For example, investing in the storage facilities necessary, investing in systems for high level security and monitoring, the need for cold storage facilities, the distribution vehicles and the processing, picking, packing and other machinery necessary for efficient distribution of medicines.
- 1.108. Some of these costs would be specific to distribution activities and furthermore, some, particularly those in relation to temperature controlled storage and automated picking and packing, may be specific to medicines distribution. The more specific these investments are, the more difficult they may be to recover should a firm desire to leave the industry, and the greater the risks associated with entry.
- 1.109. Establishment as a short-line wholesaler would be significantly cheaper, as the operational requirement is in general lower (for example, reduced costs in holding medicines). A substantial short-line wholesaler will require appropriate storage facilities, distribution vehicles and computing equipment to enable the supply of the appropriate medicines to the appropriate customer. With short-line and other types of wholesale activity, entry costs would be lower where the entrant is already engaged in a related activity.

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<sup>21</sup> Anticipated acquisition by Phoenix Healthcare Distribution Limited of East Anglian Pharmaceuticals Limited. The OFT's decision of reference under section 33 (Enterprise Act 2002) given on 16 June 2005. Full text of decision published 29 June 2005.

### **On-going cost of service**

- 1.110. The model of high levels of service among full-line wholesalers may make it harder for potential entrants. This is because it may be difficult to establish sufficient numbers of customers and orders to cover the on-going costs of the relatively high service, high cost model.
- 1.111. For example, if an entrant was to try to fund the cost of entry by providing a similar service to existing customers with a lower price discount on medicines, it is likely that customers would be attracted to the established wholesalers as they provide the same service and a more favourable discount.
- 1.112. Entry as a DTP logistics service provider may be less costly where the manufacturer in question specifies a lower standard of service than the current full-line wholesalers. In this situation, new entrants may have a cost advantage over the incumbents because the current full-line wholesalers are set-up for delivery twice a day. If a manufacturer specified that it only needed delivery once a day, full-line wholesalers may not achieve particular cost savings while there may be other logistics companies able to provide a more attractively priced tender.
- 1.113. Against this, competing with established full-line wholesalers may be difficult where they already have a substantial business in medicines distribution and may be able to take on a limited amount of new business at closer to its incremental cost.
- 1.114. Entry as a DTP service provider may be more difficult where the tender specifies the need for national or near national coverage. This would be very costly for a new entrant to establish if it did not already have a national delivery network used for a related activity. However, it is uncertain whether DTP tenders in the future will make national coverage a necessary requirement on bidders.

### **Vertical integration**

- 1.115. The number of vertically integrated wholesale and retail pharmacy chains also makes it harder for new entrants to secure a significant customer base. Owing to the fixed costs of entering the wholesale market, a reasonable customer base is required to provide sufficient revenue. This may be more difficult to achieve where a large proportion of the market is vertically integrated and therefore unavailable to new entrants.
- 1.116. In the UK, the three largest full-line wholesalers are integrated with the three largest chains of pharmacies: UniChem with the Alliance and

Boots pharmacy chains, AAH with Lloyds Pharmacies and Phoenix with Rowlands Pharmacies. Together, these integrated businesses were estimated to account for almost 40 per cent of the retail pharmacy market in 2006.<sup>22</sup> There are other pharmacy chains in the market that self-supply some medicines, which would further restrict the possibility for a new full-line wholesaler to obtain customers. This structure implies that entry directly as a full-line wholesaler may be unlikely due to the difficulty in obtaining sufficient customers to justify the costs of entry.

#### **Credibility of new entrants**

- 1.117. Manufacturers and pharmacies may also be concerned about the level of service a new entrant would offer, as well as in its ability to meet any stated service level and its reliability and accuracy in terms of deliveries.
- 1.118. This concern might apply both to completely new entrants as well as to established logistics companies that operate in other sectors. The incumbent full-line wholesalers are viewed as reliable, with a good understanding of the particular requirements of working in the medicines sector.
- 1.119. The extent to which such issues constitute a significant barrier to entry depends on the nature of the entry in question. Issues of reputation and credibility are likely to be more important for full-line wholesalers and those companies seeking to become DTP LSPs than for short-line wholesalers. Competition between full-line wholesalers is more focused on service standards and reliability, whereas short-line wholesalers may be used on a more ad hoc basis such that less emphasis is placed upon on service quality and more on price.

#### **Incentives for new entry**

- 1.120. In considering the significance of any barriers to entry, it is also necessary to examine factors that may make entry easier or more attractive to potential entrants. These are the following:
  - market growth
  - phased entry
    - entry as a short-line wholesaler

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<sup>22</sup> Source: Estimated revenue figures for 2006 from Verdict: The Retail Pharmacy Market 2006.

- access to secondary full-line accounts
- acquisitions and mergers
- manufacturer-sponsored entry

### **Market growth**

1.121. One reason that the medicines distribution sector may be attractive for businesses is that there is a reasonable rate of growth in the use of, and demand for, medicines in the UK. The rate of growth in expenditure on medicines within the NHS from 2000 to 2005 is shown in the table below.

**Table C5 Growth of the community medicines bill in the UK, 2000 to 2005**

	England	Wales	Scotland	N Ireland
Average annual growth (nominal)	7.3 per cent	12.8 per cent	7.0 per cent	8.0 per cent

Source: prescriptions statistics<sup>23</sup> and OFT calculations.

- 1.122. Such sustained rates of growth could be sufficient to make entry attractive as there would be the expectation of growth in the market to accommodate the new entry profitably over time.
- 1.123. Conversely, the risk of this market shrinking in size and value appears lower than for other markets in the economy. This is supported by factors such as the growth and ageing of the UK population which increases the demand for medicines year on year. In such an environment, new entrants may accept the possibility of low margins given the low risk of decline and the potential for long-run growth.

### **Phased entry – Entry as a short-line wholesaler**

1.124. It is clear from the above analysis that entry as a full-line wholesaler or a DTP service provider is costly. One way in which these costs could be spread over time, and with less risk, is if the new entrant set up as a short-line wholesaler initially and gradually increases both the range of medicines supplied and the associated infrastructure. As the number of customers increases, it could expand in terms of the range of medicines

<sup>23</sup> Prescription cost analysis (PCA) data provided to the OFT by the Prescription Pricing Authority (England), Health Solutions Wales, the Information Services Division Scotland and the Central Services Agency (Northern Ireland).

supplied, and the standard of service, to then operate as a full-line wholesaler.

#### **Phased entry – Access to secondary full-line accounts**

- 1.125. One problem for a potential entrant is establishing a credible reputation for the service provided. This problem could potentially be overcome if a new entrant had sufficient funds to build up its customer base gradually.
- 1.126. One pharmacy group noted that the traditional way in which a wholesaler becomes established is to persuade pharmacies to open a secondary full-line account with the wholesaler. By providing a reliable service and building on such accounts, a new wholesaler could expect over time that some customers would shift more and more purchases to it until it became the customer's principal full-line wholesaler.

#### **Phased entry – Acquisitions and mergers**

- 1.127. Rather than establish a completely new wholesale business, the large number of wholesalers already in the market, particularly regional full-line wholesalers and short-line wholesalers means that there is the potential for a new entrant to seek funding to enter the market by acquiring one or a number of incumbent wholesalers. This may be particularly appealing where moves to DTP mean that fewer full-line wholesalers are able to distribute some medicines, necessitating consolidation in the sector.
- 1.128. One recent example of entry in the full-line wholesale sector is Phoenix Healthcare Distribution Limited. This company was established through the acquisition of existing regional wholesale companies, rather than through the establishment and organic growth of a new entrant. Phoenix was established in 1998 through a joint acquisition of two wholesale companies, L Rowland & Co. Limited and Philip Harris Medical Limited. The company made a number of subsequent acquisitions of regional wholesale companies and all were merged to form one medical wholesale company. While strictly speaking it may be argued that this does not represent new entry, Phoenix was able to enhance the competitive power of existing businesses within the market through the added resources it brought.

#### **Manufacturer sponsored entry**

- 1.129. The moves to DTP taking place in the industry may make entry easier in one respect. Where a manufacturer seeks to appoint a small number of distributors of its products, particularly where the costs tendered by the

incumbent companies are large, manufacturers may be willing to sponsor a new entrant to distribute its products. The manufacturers would not require the range of products and services of full-line wholesalers and with the support of a manufacturer to cover the initial investment, such entry may be effective.

### **Potential entrants**

1.130. Potential entrants in this sector as either full-line wholesalers or DTP logistics service providers include the following:

- businesses active in other medicines wholesaling activities – for example, pre-wholesalers
- distribution and logistics businesses active in other sectors of the economy
- expansion of existing short-line wholesalers and regional full-line wholesalers.

### **Pre-wholesalers**

1.131. A number of manufacturers use a pre-wholesaler to organise their stocks and deliver to the incumbent wholesalers in the UK. Such businesses may already make some deliveries (for example, to hospitals), and would be likely candidates for potential entry into wholesale distribution, with the advantage of an established reputation and a knowledge of the sector.

### **Distribution and logistics businesses**

1.132. Businesses active in similar logistics operations in other sectors of the economy – such as specialist storage, logistics and distribution companies, including parcel and postal companies could find entry into the medicines sector attractive. This may be the case particularly if DTP becomes more widespread, as tender opportunities would allow manufacturers to consider the benefits of alternative models of supply to those of the incumbent full-line wholesalers.

1.133. Many of these companies will have, as a result of their other activities, at least some of the infrastructure and knowledge needed to store and distribute medicines efficiently on a large scale. Furthermore, some of the distribution companies are already active in the distribution of medicines from manufacturers to hospitals. A move into distribution to pharmacies may therefore be a relatively easy form of expansion.

- 1.134. We are aware of one company that is actively considering entry. It would, however, be costly to enter the wholesale market for medicines (to pharmacies) as the level of service offered by full-line wholesalers is so high. Therefore, the company would only be attracted to enter if it was able to compete whilst offering a single daily delivery which was closer to the style of service it provides in its other logistics and distribution activities. The levels of investment in infrastructure required for a twice-daily delivery are too high in its view to support entry currently and are much higher than in the other parts of its business. Economies of scope would therefore be limited if it had to undertake a twice-daily medicines delivery service.
- 1.135. Consequently, where manufacturers are able to specify the level of service desired for their products via DTP, and where these are specified close enough to the capabilities of such potential entrants, they may well be attracted to enter the market. In this way, it can be seen how the setting service standards by manufacturers under DTP, rather than by competition among full-line wholesalers, may lead to a reduction in this barrier to entry.

**Expansion of existing short-line wholesalers and regional full-line wholesalers**

- 1.136. Existing short-line and regional full-line wholesalers are well placed to expand the range of medicines and the extent of the service they provide. This may be through a number of ways, such as investment and expansion of the business, collective bidding for DTP contracts, or through other working arrangements that would allow such businesses to engage in a wider range of wholesaling activities for medicines.

**Trends in medicines delivery**

- 1.137. In addition, there are trends in the sector that will affect the way medicines are delivered in the future. There may be more electronic sending of prescriptions to pharmacies, or even to the wholesale company to prepare the medicines and deliver them to the pharmacy. Alternatively, medicines could be increasingly delivered direct to patients. Such moves may have implications for the way wholesale companies are run. If a large quantity of prescription medicines was delivered direct to patients, it may be the case that the advantage of incumbent wholesalers would reduce in favour of companies that make a larger number of smaller deliveries on a daily basis, including parcel, postage and other distribution companies.

- 1.138. Developments such as these make it difficult to gauge the direction of change for barriers in the future. It is therefore difficult to predict with any accuracy whether the wholesale sector will become easier or more difficult to enter in the future.

## **Conclusion**

- 1.139. This section has identified a number of factors that could act as significant barriers to entry in this sector. These include the cost of establishing a new full-line business capable of providing the twice-daily, reliable service that pharmacies value, as well as obtaining sufficient customer revenue to cover these costs. The ability to obtain a viable customer base is impeded in this market by the prevalence of vertically integrated wholesalers and pharmacy chains. The licensing restrictions examined do not appear to be disproportionate and, given the large number of organisations in the UK that hold wholesale dealer licences, obtaining one would not appear to pose a significant barrier to entry in this sector.
- 1.140. There are some features of the sector that could assist potential entrants, including the current and likely future growth of the sector and the possibilities for entry on a smaller scale as a secondary full-line wholesaler or as a short-line wholesaler. Expansion appears possible as the number of customers and the entrant's reputation grow over time.
- 1.141. DTP may increase some barriers to entry by making it more difficult to enter the market as a full-line wholesaler, as the full range of products are not available to provide revenue to cover the cost of providing the levels of service currently offered by full-line wholesalers.
- 1.142. DTP may however also make entry as an LSP easier in some respects, because DTP manufacturers could to some extent sponsor entry of other businesses, including those active in other logistics or wholesaling activities.
- 1.143. Even without sponsored entry through DTP, there are a number of potential entrants in this sector, including other logistics, wholesale or delivery companies, as well as pre-wholesalers. There is also the possibility of expansion or mergers and acquisitions among regional full-line wholesalers and short-line wholesalers. Balanced against this is the fact that there has been little recent entry and more of a trend towards consolidation among wholesalers in recent years.
- 1.144. Overall, there do appear to be moderate, but not insurmountable, barriers to entry in this sector and, despite moves to DTP, some form of

entry appears to be a credible threat given the presence of the right incentives. It should be noted, however, that there has been no entry in recent years so the credibility of this threat remains to be tested.

## **SECTION F – PFIZER’S DTP SCHEME**

### **Introduction**

1.145. Section E describes the exclusive DTP model implemented by Pfizer. It covers the service level agreement between Pfizer and UniChem, and how this has affected pharmacies and UniChem’s account of its performance so far. It considers how competition might take place under the DTP model.

### **Background<sup>24</sup>**

- 1.146. Until 2004, Pfizer sold its prescription medicines to a wide variety of both full-line and short-line wholesalers. In 2004, Pfizer changed its distribution policy to limit its supply only to full-line wholesalers.
- 1.147. On 28 September 2006, Pfizer announced its intention to implement a new policy of selling its prescription medicines direct to pharmacies and dispensing doctors in the UK and to cease supplying Pfizer prescription medicines through full-line wholesalers. This policy was called direct to pharmacy (DTP). Following this announcement, five months’ notice of termination of the current supply arrangements was served on Pfizer’s wholesaler customers. One of the wholesalers, UniChem Limited, was appointed as a logistics services provider under DTP. The DTP arrangements commenced on 5 March 2007.

### **Appointment of UniChem as DTP wholesaler**

- 1.148. In March 2005 Pfizer launched a tender for the three-year appointment of one or more logistics service providers to support the DTP policy. In addition to the three main full-line wholesalers with which Pfizer then dealt (UniChem, AAH and Phoenix), Pfizer also invited a proposal from UTI, a pure logistics provider.
- 1.149. Pfizer received full written proposals from UniChem and from UTI and discussed the model at length with both AAH and Phoenix. Phoenix was unable to respond fully to Pfizer’s requirements. Pfizer sent AAH a request for proposal in March 2005 and later the heads of terms agreement<sup>25</sup> were signed. However, AAH subsequently withdrew from the talks at the beginning of 2006.

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<sup>24</sup> The following sections largely follow Pfizer’s own description of its arrangements in its submissions to the OFT.

<sup>25</sup> Open Letter by David Watson (Head of Trade, Pfizer) to pharmacies as printed in Pharmacy Business December 2006/January 2007.

- 1.150. Following lengthy discussions with the interested parties, spanning a period of 18 months, Pfizer decided to appoint UniChem as the only LSP able to perform the necessary services at an acceptable cost and within Pfizer's timescales. UniChem will remain the only logistics service provider for the first 18 months following launch of DTP. Thereafter Pfizer may choose to allow national organisations with their own captive pharmacy chains to provide these services to their own outlets (for example, AAH/Lloyds, Phoenix/Rowlands). After the first 24 months Pfizer may appoint further logistic services providers alongside UniChem.
- 1.151. Pfizer will have the opportunity to re-tender for the services at the end of the 3-year period.

### **Pfizer's DTP scheme**

#### **How it operates**

- 1.152. UK pharmacies and dispensing doctors purchase directly from Pfizer, with Pfizer's medicines delivered by UniChem. UniChem acts as a provider of logistics service to Pfizer, and no longer purchases from Pfizer as a wholesaler.
- 1.153. UK pharmacies and dispensing doctors transmit orders for Pfizer medicines to UniChem. Although UniChem delivers medicines under DTP, it does not do so as a traditional wholesaler or distributor. UniChem does not purchase and sell-on the medicines in its own right (although nothing in the agreement with UniChem prevents it from purchasing Pfizer medicines from other legitimate sources, for resale on its own account) and instead:
- the invoice is in Pfizer's name and Pfizer has full credit risk
  - UniChem is paid a contractual service fee as a logistics service provider
  - Pfizer has made some specific investments in order for UniChem to perform its logistics service provider role, such as the IT needed to support the model. UniChem has however had to invest in further transport and other infrastructure
  - Pfizer retains control over, and ownership of, its medicines at all stages up to the point of sale

- All pricing and other negotiations are direct between the pharmacy and Pfizer. UniChem has no authority to negotiate on behalf of Pfizer.

**Box C5: Service level agreement between Pfizer and UniChem**

The service level agreement, among other things, requires UniChem to:

1. make two deliveries a day where the customer was (prior to DTP) receiving two deliveries a day from its main supplier of Pfizer medicines;
2. ensure that no twice a day customer has a cut-off time earlier than 10 am for the afternoon delivery and earlier than 5 pm for the next morning delivery and no once a day customer has a cut-off time earlier than 10 am on the date prior to the delivery;
3. ensure that a minimum level of stock of Pfizer medicines is retained at any one time;
4. ensure that customers are invoiced correctly for the Pfizer medicines received; and
5. ensure that Pfizer medicines are delivered on time, in full and as notified to the customer.

**Rationale for DTP**

- 1.154. Pfizer believes that the DTP policy will enable it to manage the supply chain with greater efficiency and more secure medicine safety in the following ways:
  - Pfizer will be more responsive to stock-shortage or product recall situations and thus be able to increase the availability and safety of Pfizer medicines.
  - With regard to safety, the DTP policy will also allow Pfizer to reduce the risk of counterfeit medicines entering the supply chain and promote the physical integrity of packaging.
  - Pfizer will be better able to predict end-user demand accurately and to match the production and distribution processes with end-user demand. In Pfizer's view, wholesalers are not the best equipped to forecast end-user demand, as their views will be affected by their own stock levels.
- 1.155. Given its extensive inventory and, in particular, its globalised manufacturing strategy, Pfizer argues that the coordination of market demand and its manufacturing and supply strategy leads to more efficient use of its capacity and working capital.
- 1.156. Pfizer argues that another reason for adopting its DTP scheme is the increasing importance of the pharmacy as a provider of primary

healthcare services. The DTP policy will help to create a closer working relationship between Pfizer and the pharmacy to help the pharmacy's service provider role, with the potential for Pfizer to supply additional healthcare services in support.

### Discount structure to pharmacies

1.157. The discount structure is a function of the volume of products purchased and is not retroactive. For example, the 11.5 per cent discount in the table below will only apply to the excess of purchases over £416,667 per month, not to the total purchase. Discounts apply to purchases of eligible Pfizer medicines, excluding only the 18 Zero Discount products and two special-priced hospital-only lines (Sutent<sup>®</sup> and Campto<sup>®</sup>).<sup>26</sup> Discounts can be earned from the first £1 spent every month and there is no minimum order value and no minimum order quantity required to earn discount.

**Table C6: Discount structure for pharmacy customers**

Qualifying Pfizer purchases per year	Discount	Monthly spend (Annual divided by 12)
Up to £250,000	8.5%	Up to £20,833
£250,000 - £1 million	9.5%	£20,833-£83,333
Over £1 million, less than £5 million	10.5%	£83,333-£416,667
Over £5 million	11.5%	Above £416,667

Source: Pfizer letter to pharmacies – attached to email from David Marks, 4 Dec 2006.

- 1.158. Dispensing doctors get a flat discount of 10.5 percent on all purchases because clawback is higher for dispensing doctors (11.18 percent on average) than for pharmacies (9.5 percent on average). It applies nationally in line with current wholesaler practice.
- 1.159. As the system is based on treating individual businesses as separate purchasers, the discount scale is unavailable to buying groups, who are not recognised by Pfizer as eligible customers. Unlike the traditional wholesale model, therefore, individual pharmacies will not be able to obtain a higher discount by combining with others to form a buying group.

<sup>26</sup> Pfizer's OTC range is also excluded and distribution of these products is unaffected by the DTP arrangements.

- 1.160. Pfizer has stated that the discount structure will not impact on the list price of Pfizer medicines and will not cost the NHS additional money. Pfizer has stated that DTP is not a cost-saving exercise and Pfizer will incur additional costs in setting up and running its DTP scheme in order to implement more stringent tracking and auditing of its medicines.<sup>27</sup>

#### **Exclusivity**

- 1.161. One feature of Pfizer's arrangements is that it has appointed UniChem as its LSP on an exclusive basis. This issue is distinct from that of DTP itself: GSK for example operates DTP but not with an exclusive distributor; conversely, Sanofi Aventis and Napp have recently restricted the number of distributors they use, but have not switched to DTP and continue to sell their medicines to wholesalers for re-sale to pharmacies.
- 1.162. As noted above, Pfizer has indicated that it may consider whether to allow integrated pharmacy chains to distribute its medicines to their own stores in due course.

#### **UniChem's account of how DTP has operated**

##### **The new arrangements**

- 1.163. Since the implementation of Pfizer's DTP scheme, UniChem's customer account base has increased from 6,000 to over 15,000, with only a handful of dispensers not signing up. It invested in over 300 new vehicles and around 700 extra staff.
- 1.164. In cases where pharmacies do not use UniChem as their full-line wholesaler, but use a major wholesaler such as AAH, it is still possible to route orders for Pfizer medicines via the ordering system of their principal full-line wholesaler. As well as being convenient for the pharmacies, this gives the wholesaler the option of filling the Pfizer order using parallel imports and then transmitting any unfilled orders to UniChem.
- 1.165. UniChem typically offers each Pfizer-only pharmacy up to eleven deliveries per week except in remote areas such as the Highlands and Islands of Scotland, where the pharmacies typically receive one delivery per day.
- 1.166. UniChem uses a "hub-and-spoke" distribution system with each hub-and-spoke network covering a significant area. Large vans bring the

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<sup>27</sup> Pfizer letter to customers, November 2006

medicines to hubs and smaller vans then distribute the medicines to the individual pharmacies. For example, five to ten hubs for Pfizer-only deliveries operate in the area covered by the Letchworth depot.

- 1.167. Traditional routes for UniChem customers run at regular times and the pharmacy can know when to expect a delivery (referred to as 'bus routes'). Delivery times can however still be affected by factors such as weather and transport conditions. Some Pfizer-only customers are on dedicated routes, for example in certain densely populated urban areas and in rural areas not traditionally covered by UniChem. In other areas Pfizer-only customers have been added to existing UniChem routes, for example in rural areas. For UniChem's Letchworth depot, some Pfizer-only customers are included in the traditional UniChem full-line routes, while the remainder are served by dedicated routes.
- 1.168. The delivery pattern/schedule of the dedicated routes is less predictable and sees greater variation than the full-line routes for UniChem customers. This is because on average Pfizer-only customers mostly do not order every day and do not fully utilise the possible 11 orders they could make per week. Therefore the number of deliveries along the route will vary from day to day, whereas for UniChem full-line customers the driver typically makes deliveries to every customer.
- 1.169. UniChem tried to maintain its original network where possible and initially did not want to disrupt this by adding further Pfizer-only stops.

#### **Scope for discrimination against Pfizer-only customers**

- 1.170. UniChem argues that no discrimination is possible between its different customers as this would disrupt the efficiency of its operation. In particular, there is no scope for favouring its full-line customers (or Boots) against its Pfizer-only customers.
- 1.171. Route planning is part of the logistics process and UniChem uses computer software to set the route plan that maximises operational efficiency. Various parameters are inputted into the software, such as driver break times and no change in service to existing UniChem customers. This generates the best route plan applying those parameters and there is no scope to interfere with this configuration to favour full-line customers over Pfizer-only customers and at the same time to operate an efficient logistics operation.
- 1.172. In terms of processing orders, each order is put through the system depending on when the van is leaving rather than any other factor. Each route can contain a number of different customers, including chains and

independent pharmacies, so discrimination by customer is not likely to be possible. Furthermore, according to UniChem: (i) during the order picking and processing process the identity of the customer related to an individual order cannot readily be ascertained; (ii) a significant part of the process is automated; and (iii) the whole logistics model is based on ensuring the most efficient processes are operated to meet the tight deadlines for turnaround.

### **Summary of performance**

1.173. UniChem's view of its performance of its distribution of Pfizer products under DTP is summarised below:

- Its customer account base extended from 6,000 to over 15,000
- only a handful of accounts have not signed up
- product availability has never been higher
- courtesy calls have indicated that over 98 per cent of customers were totally satisfied with the service
- on-time deliveries achieved in excess of 99 per cent
- absolutely no preferential treatment for UniChem customers'

1.174. UniChem has commented that, in March, 45-55 per cent of Pfizer-only accounts had a morning cut-off time of 11 am or later. However, by July 65-75 per cent had a cut-off time of 11 am or later.

1.175. UniChem also stated that the average delivery times for its Pfizer only and full-line customers differed (for morning and afternoon deliveries) by around 15 minutes.

### **Pfizer's account of how DTP has operated**

1.176. Pfizer believes that the switch to DTP has been successful:

'DTP has been a success – Pfizer medicines have been delivered to the market with maximum efficiency and at least as efficiently as before DTP. Pfizer believes that its increased control over the supply chain has in some cases increased efficiency (this is for instance demonstrated by the recent out-of-stock situation [Champix]) ...Pfizer has at no stage seen any evidence from any party to contradict this view.

Robust service levels – UniChem Limited, Pfizer’s logistics service provider (the “LSP”), is obliged to meet challenging service levels as part of its agreement with Pfizer. Pfizer monitors these service levels, which include but are not limited to delivery and cut-off times, and has established that they are being met and often exceeded...

No reasonable complaints – Pfizer has received no substantive, grounded complaint concerning any aspect of DTP during the whole period since implementation. Pfizer has at no point seen any evidence – either from the Office or from any other party – to challenge its view that the operation of DTP has been successful'.

1.177. Pfizer submitted a detailed account of how it monitored the performance of UniChem:

'The Logistics Services Agreement between Pfizer and the LSP ... sets challenging service level requirements which Pfizer monitors rigorously and which Pfizer is confident the LSP is meeting. These are designed to ensure purchasing, delivery and related services are comparable to those existing before DTP....

In summary, on the basis of all the evidence available to it regarding the LSP’s performance of its logistics services and regarding the supply policy, Pfizer believes that DTP has operated successfully to date...

There are four ways in which Pfizer monitors the LSP’s provision of services:

3.1.1 On a monthly basis and in accordance with Clause 13.4 of the Agreement, operational managers from both parties meet to review the LSP’s performance of its service level obligations. At all such meetings to date, the LSP has provided Pfizer with spreadsheet evidence that it is meeting/exceeding these obligations.

3.1.2 Also on a monthly basis, a report is produced by the LSP of deliveries made to different customer channels (pharmacies/dispensing doctors/hospitals). In relation to service levels, these reports cover:

(a) the percentage of customers per channel who have received the order placed; and

(b) whether an order was received at the time of day (i.e. morning or afternoon) expected (by virtue of the customer having met the relevant evening or morning cut-off timer respectively).

For the period 5 March – 8 July 2007, aggregated across all channels, the LSP's success in relation to these levels of service was reported as (a) 99.41 per cent and (b) 99.86 per cent. Again... the delivery and on-time targets in the Agreement are 98 per cent (although these monthly reports are not meant to assess those targets as such).

3.1.3 A further report is prepared by the LSP which allows it to monitor the number of order lines properly fulfilled on a depot-by-depot basis. The report was initially weekly, but now it is produced on a monthly basis...

This reporting line contains a summary success rate for the month of June of 99.4 per cent aggregated across all the above service levels and across all depots.

3.1.4 Pfizer also routinely monitors the incidence and content of customer queries. Monitoring such queries led to the one-off review of cut-off times... Such queries have decreased.'

### **Competition under DTP**

1.178. This section considers the competitive model under DTP. Although this varies according to whether DTP is operated on an exclusive basis, with restricted number of distributors or on the basis of supplying all full-line wholesalers, the central feature is that the wholesaler has to agree with the manufacturer the terms on which it will distribute the manufacturer's medicines.

1.179. **Competition to obtain contracts:** Where DTP is exclusive, such as Pfizer's scheme, or with a restricted number of distributors, such as AstraZeneca's scheme, wholesalers must compete in order to obtain the manufacturer's contract to distribute its medicines.

1.180. Pfizer comments on the DTP system:

'DTP extends the range of options for the delivery of pharmaceuticals beyond the traditional wholesaler model and forces those wholesalers to compete more fiercely between each other and more broadly with other potential logistics providers.'

1.181. The competitive process takes place during the tendering process of the DTP contract. Both Pfizer and AstraZeneca have supplied accounts of the tendering process, and how different wholesalers dropped out at different stages. Pfizer commented:

'Following lengthy discussions with the interested parties, spanning a period of 18 months, Pfizer decided to appoint UniChem as the only logistics service provider able to perform the necessary services at an acceptable cost and with Pfizer's timescales.'

1.182. **Competition to supply pharmacies:** Where more than one LSP is appointed, those LSPs compete for pharmacy accounts. The intensity of this competition will be expected to increase with the number of LSPs appointed, the extent to which they overlap in geographical coverage and their ability to serve new areas.

1.183. During the contract term the manufacturer can monitor the LSP's performance against the service level agreement. This means that even within the period of a contract the LSP is subject to pressure in order to perform effectively. There may in fact be sanctions specified if the LSP does not perform to the required standard. In addition, the manufacturer may be in a position to appoint another LSP or terminate the contract.

1.184. The LSP of course also faces the constraint that in due course they will have to re-bid for the contract, and failure to perform under the initial contract could jeopardise their reputation and ability to bid for future contracts.