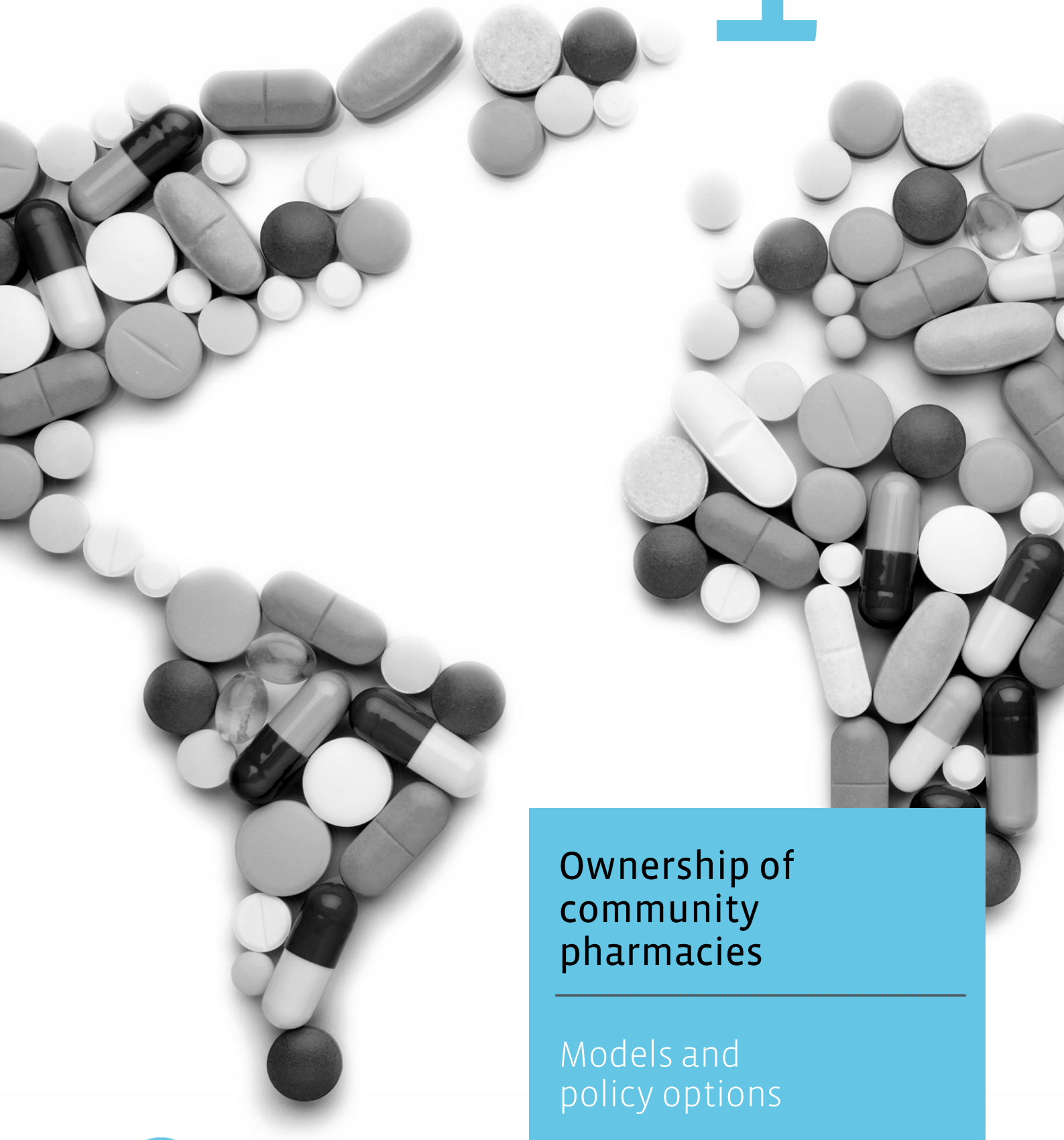
Policy Briefings 1



# Ownership of community pharmacies

## Models and policy options

2016

fip International Pharmaceutical Federation

# Colophon



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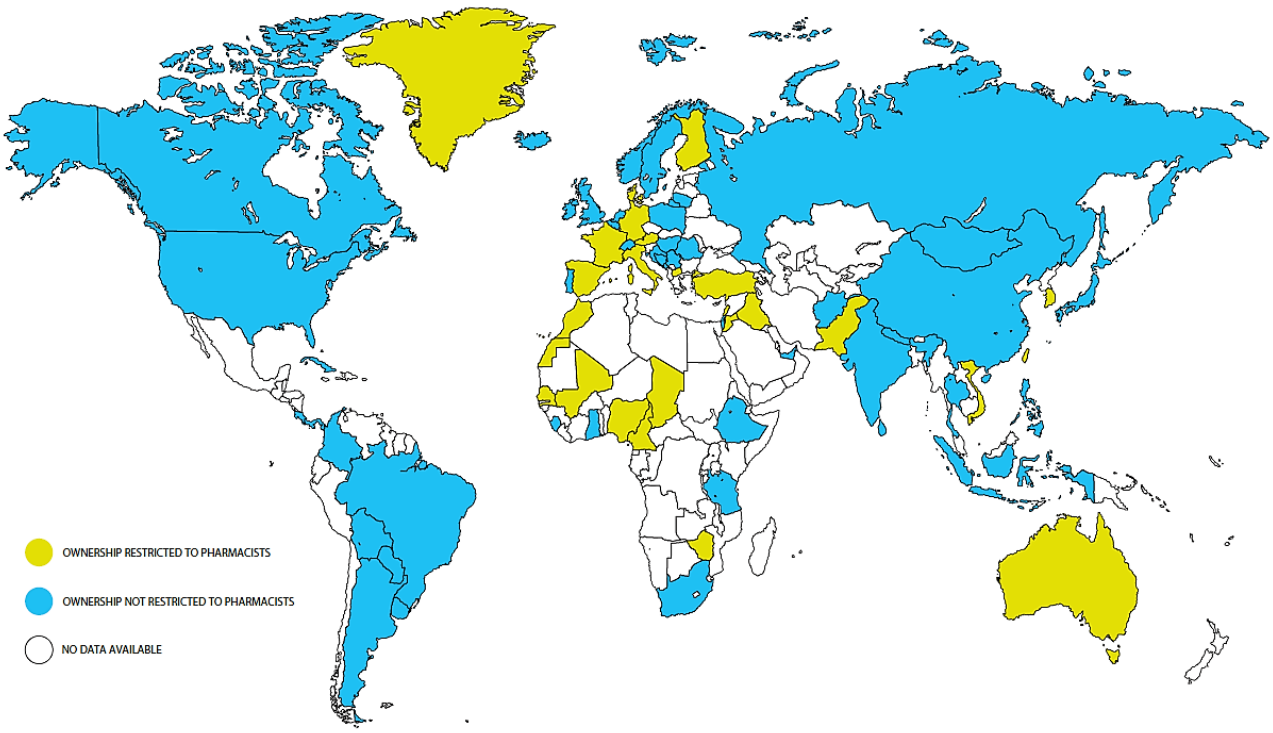
# Contents

# 1 Introduction

The issue of ownership of community pharmacies is at the crossroads between professional accountability, professional autonomy and economic policy. The weight and priority given to each of these elements in any given jurisdiction determine their policy in terms of who can or cannot own community pharmacies, and the roles of the state and the market in regulating the sector.

According to a survey conducted by FIP in 2015 (1), with responses from 71 countries and territories covering approximately 80% of the world's population, in 24 jurisdictions (34%) pharmacy ownership is exclusively restricted to pharmacists. In the remaining 47 jurisdictions (66%), pharmacy ownership is not exclusive to pharmacists, and includes several ownership scenarios, ranging from a state monopoly to fully liberalised ownership. The figure below provides an overview of pharmacy ownership regulation in the surveyed countries and territories as of June 2015.

Global overview of community pharmacy ownership restrictions to pharmacists (n=71)




In some cases, pharmacy ownership models may be determined by workforce capacity, as the number of pharmacists available in a given country may not be sufficient to cover all pharmacies if these were to be owned (and usually managed) only by pharmacists.

Whichever model is in place in any given jurisdiction, the following positions should be safeguarded:

a. The professional autonomy of community pharmacists must be preserved in all cases, regardless of the ownership of the pharmacy in which they practice. The pharmacy profession must use both regulation and ethical standards in building a culture of professionalism that is necessary for the preservation of the financial and clinical autonomy of practitioners (2).

b. The social accountability of pharmacists and pharmacies should not be overridden by the economic interests associated with pharmacy ownership or by market forces and competition rules that may be in place in a given jurisdiction.

Jurisdictions may also establish additional restrictions or regulations in relation to pharmacy ownership. This can be done through the establishment of either positive or negative lists of who is entitled or not to own a

pharmacy. The most prevalent restriction to ownership is for medical doctors and other prescribers (1), which contrasts with the existence of dispensing doctors in several countries and territories.

Other frequent exclusions are pharmaceutical wholesalers and/or manufacturers —several jurisdictions ban vertical integration in the medicines supply chain, and sometimes also limit horizontal integration (that is, the number of pharmacies owned by the same individual or corporation), to avoid the effects of dominant positons and control of a significant part of the supply chain.

This document offers a summary of the most frequent scenarios in terms of community pharmacy ownership and some of the main arguments used for or against each model.

# 2 Ownership restricted to pharmacists

## Key principles and arguments

In jurisdictions where pharmacies must be owned by pharmacists (individually or in companies either formed exclusively by pharmacists or in which pharmacists have majority shares/ votes), there is usually an understanding that community pharmacies are an extension of the health care system, and although they are privately owned, they provide an essential public service.

As such, it is understood that the management and ultimate decision-making in a pharmacy must be based on, or guided by, the professional judgement and ethics of the pharmacist. Such decisions may be related to the individual care of patients, or to broader strategies associated with the quality or appropriateness of medicines procurement, the dispensing of generic medicines, the availability of less profitable (but necessary) medicines or products, the confidentiality of patient data or the protection of dispensing data, among others. Oftentimes the right decision — from a clinical and an ethical point of view — may not be in line with a view of the pharmacy as a business or corporation, whose ultimate goal is to deliver economic results to its owner or shareholders. Examples of such decisions could include situations when not supplying a medicine is the right option, simplifying a patient's medication by stopping redundant treatments, or dispensing medicines and other health products of the lowest possible cost for the patient and third-party payers.

In jurisdictions where pharmacy ownership is restricted to pharmacists, it is considered that the professional autonomy of the pharmacist in charge of a pharmacy can only be fully safeguarded if she or he is not subject to the authority of an owner who may establish directions based primarily on business principles and possibly in contradiction with public health interests.

Furthermore, in such a model, it is considered that any decisions that may place profitability ahead of professional ethics may lead to sanctions or even to disqualification to practise, which in turn would compromise the business viability of the pharmacy.

## International distribution of regulated models

According to the 2015 FIP study (1), regulated models exist to a considerable extent in Africa, the Eastern Mediterranean and Europe, as well as Australia, but are largely absent in the Americas and most of Asia (with the exceptions of China Taiwan, the Republic of Korea and Vietnam).

In countries with a federal structure, such models may exist in certain subnational jurisdictions — although this was not captured by the FIP study, which was based on the dominant models at country-level. That is the case, for example, of North Dakota – the only state in the USA where only a licensed pharmacist or a group of licensed pharmacists may own and operate a community pharmacy. Although being part of a country where freedom of enterprise is generally deeply rooted in political culture, and in spite of several attempts promoted by large pharmacy chains to have this law changed (including a referendum in 2014), North Dakotans still prefer the independent, pharmacist-owned pharmacy model that was introduced by law in 1963. A report published in 2014 provides details of the documented advantages in terms of access to pharmacies, quality of care and price competitiveness associated with this model (3). Namely, the authors of the report found that:

1. Prescription medicines' prices in North Dakota are among the lowest in the country;
2. Independent pharmacies consistently outperform pharmacies operated by chains and big boxes[a], providing more one-on-one interaction with the pharmacist, shorter wait times, fewer out-of-stock medicines, and more health advice and screening;
3. Compared with neighbouring states and the rest of the USA, pharmacies are more plentiful in North Dakota and more broadly distributed.

Several of the countries where only a pharmacist or group of pharmacists may own a pharmacy are members of the European Union, where the principles of freedom of movement and establishment of people, goods and capitals are considered pillars of its common market economy. Yet a variety of national legislations exists in terms of pharmacy ownership, which is interpreted by some as a paradox. This led to two lawsuits that challenged German and Italian legislation for restricting such freedoms. The European Court of Justice has determined that the ownership and operation of pharmacies can be restricted to pharmacists alone and that

[a] "Big box" is a designation used chiefly in North America. "A big-box store (also supercenter, superstore, or megastore) is a physically large retail establishment, usually part of a chain. The term sometimes also refers, by extension, to the company that operates the store. The store may sell general dry goods in which case it is a department store, or may be limited to a particular specialty (...) or may also sell groceries, in which case some countries (mostly in Europe) use the term hypermarket." (18)

"Italian and German legislation laying down such a rule is justified by the objective of ensuring that the provision of medicinal products to the public is reliable and of good quality". In its judgement, the court stated:

> *It is undeniable that a pharmacist, like other persons, pursues the objective of making a profit. However, as a pharmacist by profession, he is presumed to operate the pharmacy not with a purely economic objective, but also from a professional viewpoint. His private interest connected with the making of a profit is thus tempered by his training, by his professional experience and by the responsibility which he owes, given that any breach of the rules of law or professional conduct undermines not only the value of his investment but also his own professional existence.*
>
> *Unlike pharmacists, non-pharmacists by definition lack training, experience and responsibility equivalent to those of pharmacists. Accordingly, they do not provide the same safeguards as pharmacists.*
>
> *A Member State may therefore take the view, in the exercise of its discretion, that the operation of a pharmacy by a non-pharmacist may represent a risk to public health, in particular to the reliability and quality of the supply of medicinal products at retail level.*
>
> *(...) The Court concludes that the freedom of establishment and the free movement of capital do not preclude national legislation which prevents persons not having the status of pharmacist from owning and operating pharmacies.* (4)

## From deregulated to regulated models

In spite of a trend towards liberalised ownership models across Europe over the past two decades, two European countries have recently returned to a regulated ownership model for pharmacies, after a period of liberalisation: Hungary (in 2009) and Estonia (in 2015, with a transition period until 2020). In Hungary, liberalisation (2006-10) was perceived to have a number of negatives including that the professional independence of pharmacists was not guaranteed; the pharmaceutical supply of rural areas did not improve, 20% of the new pharmacies were located in city centres and the increased capacity in towns absorbed patients from rural pharmacies; there was a growing number of pharmacies that were financially unviable; and there were permanent stock problems. Estonia observed similar effects (5) during the period of liberalised ownership (1991-2015), and gradually re-introduced restrictions to the establishment of pharmacies (2005), to vertical integration (2013) and to pharmacy ownership (2015) (6).

## Impact of deregulation

A study from 2012 (7) analysed the impact of pharmacy deregulation and regulation in nine European countries - five with a largely deregulated community pharmacy sector (England, Ireland, the Netherlands, Norway, and Sweden), and four with regulated models (Austria, Denmark, Finland, and Spain). The scope of the study was broader than the deregulation of pharmacy ownership, but in this regard, the authors concluded that:

- Wholesalers are often the winners of deregulation in the community pharmacy sector (due to vertical and horizontal integration).
- Independent pharmacists have seen a loss in their professional independence following deregulation
- Employed pharmacists and pharmacy staff might experience an increased workload and less work satisfaction in a deregulated environment
- Consumer satisfaction has not necessarily increased after deregulation

The 2015 FIP survey showed that it is not accurate that innovation is correlated with deregulated models: some of the countries that were most innovative in terms of pharmacy services, or offered a wider range of such services had ownership models restricted to pharmacists — as was the case of Australia, France, Finland, Germany or Spain. In fact, the Minister of Health of Australia, Sussan Ley, defended the regulated ownership model by addressing pharmacists at the 2016 Australian Pharmacy Professional Conference & Trade Exhibition in the following terms: "*What shines through — leaving aside the excellent clinical practice which of course is vital for your communities — is that the business model that you present just ticks all the boxes. Because of your ownership of your pharmacies, you have skin in the game as investors but you also have front and centre the need to look after people who walk in your door.*" (8)

## Franchise pharmacies

It should also be noted that there has been a steady increase in frequency at global level (1) of franchise pharmacies or independent partnership pharmacies, where independent community pharmacies are individually owned by pharmacists but they share a common brand name and image, and receive the advantages of large scale economies, such as favourable procurement conditions, staff development, marketing strategies, management, etc., in exchange for a payment. This system has been growing in jurisdictions where pharmacy ownership is restricted to pharmacists, as it has given the opportunity to multinational and local corporations to develop business operations even if the legal framework does not allow them to own community pharmacies directly.

## Examples of regulated models

Annex 1 lists examples of countries with regulated ownership models, providing some insight of the specific aspects of each jurisdiction. This list is not exhaustive, but is a collation of cases based on the FIP study (1) and online research of the legislation of different countries.

# 3 Ownership models not restricted to pharmacists

## Key principles and arguments

In the majority of the world's countries and territories, pharmacy ownership is open to non-pharmacists. This can exist via a number of different models, including ownership by the state (either in monopoly or in combination with private ownership), by non-governmental organisations and charities, by universities, by hospitals or — and most commonly — by individual entrepreneurs or corporations.

Detractors of limiting pharmacy ownership to pharmacists may argue that the accountability for the clinical and healthcare-related decisions made at a pharmacy should lie with the managing pharmacist, but believe that this does not imply that the pharmacist must be the owner of the pharmacy. A further argument is that a pharmacist who owns a pharmacy will necessarily be a business person who seeks profitability, which generates potential conflicts of interests.

Other arguments include that pharmacists may not have the necessary knowledge, skills or time to manage a pharmacy effectively and to optimise its business processes, including marketing strategies, innovation and competitiveness.

## Different models

A particular (but frequent) case of ownership by non-pharmacists is that of limited companies or corporations, often taking the format of chains of community pharmacies with a common brand. Such chains use the potential of scale economies to streamline processes and reduce costs of, for example, procuring medicines and other products. Likewise, by centralising the development of marketing strategies, service planning, staff professional development and training, and other processes, pharmacy chains may be able to provide more innovative services and lower prices for their customers.

Additionally, in jurisdictions where vertical integration is allowed (i.e., the ownership by the same company of community pharmacies and pharmaceutical wholesaling and/or manufacturing operations), the streamlining of costs is further optimised by eliminating middlemen and controlling a significant part of the medicines supply chain, and giving such companies an influential market position in the definition of prices. This could challenge the viability of many independent community pharmacies who cannot compete with large scale economies.

Even in such liberal economic scenarios, there may be limitations to the operations of such companies. Aside from the above-mentioned legal limitation to vertical integration, states may limit the market share (of the whole national market or regions, for example) of pharmacy chains, the distance between pharmacies of the same owner or the number thereof.

Community pharmacy chains are present in 54 of the survey's 71 (76%) countries and territories, but to varying degrees. Chains represent more than 50% of all pharmacies in 13 (18.3%) of the responding countries and territories (1). Nevertheless, independent community pharmacies represent more than 50% of all pharmacies in at least two thirds of the responding countries and territories. This means that the independent pharmacy is still the largely dominant ownership model around the world.

Other ownership models exist, although less widely implemented. One of them is ownership by social economy entities, such as non-governmental organisations, charities, religious or humanitarian organisations or other similar entities. Such pharmacies — often called "social pharmacies" — are usually established to cover the needs of special populations that may not have access to medicines in the same conditions as the general population. They may also exist for historical reasons. Such social pharmacies existed in 20 countries and territories (28%) out of 71 respondents to the 2015 FIP survey (1).

Likewise, some governments have developed state-owned community pharmacies in areas where private pharmacies are not established because of a lack of profitability, or to distribute medicines that are covered by public health insurance programmes. A total of 32 countries or territories (45.1% of the sample) indicated the existence of state-owned community pharmacies in the FIP survey (1).

A renowned example comes from Brazil. The programme "*Farmácias Populares do Brasil*" (Popular Pharmacies of Brazil) was launched in 2004. Municipalities own the pharmacy premises and employ pharmacists to work

there. Such pharmacies only dispense medicines on the List of Essential Medicines (112 medicines plus male condoms).

Until 2009, Sweden had a state monopoly for community pharmacies, and pharmacies were for the most part considered to be effective and to provide high-quality services by highly-educated staff. In 2009 the pharmacy system was *reregulated*, that is, many of the aspects that were part of the contract between the state and the National Corporation of Pharmacies (Apoteket AB), were transformed into laws or regulations. Ownership of pharmacies was liberalised and two-thirds of the pharmacies were sold to private owners. Apoteket AB had been operating all pharmacies since 1971. One reason for the monopolisation of the Swedish pharmacies was to facilitate better collaboration and coordination between the pharmacy sector and other parts of the health care sector. The increased governmental control was seen as a factor that made it easier to obtain the desired health effects. The sector today consists of big chains as well as smaller units with one or a few pharmacies per owner (9).

In some jurisdictions, certain hospitals may have community pharmacies, or provide medicines to out-patients. This may be the case in certain public health systems where medicines that are reimbursed by the state are distributed directly to patients by the pharmacy services of public hospitals or clinics. In this scenario, private community pharmacies mostly attend to patients who use private health services, or dispense medicines that are not reimbursed by the state. This is the case of China, for example. Due to its former planned economy system, hospitals are still the main distributors of pharmaceuticals: Huang, cited by Philipsen (10), states that nearly 80% of patients obtain their medication from hospitals, while Fang et al, also cited in (10) indicate that less than 10% of pharmacists work in community pharmacies.

In other cases, hospitals may dispense only certain medicines to outpatients. This was (and still is) often the case with several medicines for HIV, cancer, hepatitis C and multiple sclerosis — usually high-cost medicines.

In some jurisdictions, certain health insurers or third-party payers may also own pharmacies. This is largely applicable to mutual/cooperative health insurers or those specific to certain professional corporations, but it may also include public or private health insurers. Such pharmacies generally serve individuals covered by their insurance plans, but they may also serve other people, possibly with different conditions or benefits. An example of this model can be found in France, where miners have a centuries-old social security subsystem that still runs a few pharmacies that are for the exclusive use of miners and their families (11).

Finally, in some countries, universities may also own community pharmacies. These are usually associated with pharmacy schools, and may play a dual role as community pharmacies and experiential education centres for student pharmacists at different stages of their education. Nonetheless, they are open to the public and function as any other community pharmacy.

### Dispensing doctors

Also, according to the 2015 FIP survey, the existence of dispensing doctors is reported in 25 countries or territories, but their proportion in each country varies greatly (1). Although their activities as dispensing doctors does not imply ownership of a separate community pharmacy, their activities cover part of the ones from a community pharmacy.

However, in many of these countries, dispensing doctors either exist only in remote areas to offer access to medicines where there are no pharmacies available, or they exist due to centuries-old traditions — as in some Asian countries. Yet, in several of these countries, the separation between the two activities has been steadily progressing, supported by legislation, public policies and social awareness campaigns.

### International distribution and examples of non-regulated models

Several European countries have fully liberalised community pharmacy ownership. Countries such as Bulgaria, the Czech Republic, Ireland, Lithuania, FYR Macedonia, Montenegro, Norway, the Netherlands, Poland, Russian Federation, Serbia, Slovakia, Sweden and Switzerland apply no restrictions to the ownership of community pharmacies.

Non-regulated models are also the most common rule in other parts of the world, such as North America — where Canada, Mexico and the USA apply no restrictions to pharmacy ownership or location (except for the state of North Dakota, as mentioned above) —, China, India, Indonesia, Israel, Japan, New Zealand, the Philippines (where 90% of community pharmacies belong to chains), the United Arab Emirates. Also in Africa, countries such as Kenya, Nigeria, South Africa and Tanzania have pharmacy ownership models that are open to corporations.

Annex 2 gives examples of countries or territories with pharmacy ownership models that are not restricted to pharmacists, but have some sort of regulation or limitations in place, or have had recent developments or changes in their pharmacy ownership laws. Unless otherwise indicated, information was extracted from the survey to FIP member organisations from 2015, or provided by member organisations through correspondence.

# 3 Policy options

The main policy options for community pharmacy ownership can be summarised as follows:

<table>
<tr><td rowspan="2">Ownership restricted to pharmacists</td><td colspan="3">As individuals who are professionally accountable for a pharmacy</td></tr>
<tr><td colspan="3">As registered companies or partnerships of pharmacists only, or where pharmacists have a majority of shares or votes</td></tr>
<tr><td rowspan="9">Ownership not restricted to pharmacists</td><td rowspan="2">Individuals (non-pharmacists)</td><td>Unrestricted</td><td rowspan="9">Additional regulations may apply:<br>- Maximum number of pharmacies that an individual, corporation or organisation may own in total or in a given territory<br>- Establishment of branch pharmacies.</td></tr>
<tr><td>With exclusions (e.g., prescribers, non-nationals, civil servants…)</td></tr>
<tr><td rowspan="2">Corporations</td><td>Vertical integration allowed (e.g., with wholesalers and/or manufacturers)</td></tr>
<tr><td>Vertical integration not allowed</td></tr>
<tr><td>NGOs or charities</td><td rowspan="4"></td></tr>
<tr><td>Universities</td></tr>
<tr><td>Hospitals</td></tr>
<tr><td>Health insurers</td></tr>
<tr><td rowspan="3">The state</td><td>As a monopoly</td><td rowspan="3"></td></tr>
<tr><td>As a public network in parallel with the private network</td></tr>
<tr><td>In exceptional cases</td></tr>
</table>

Naturally, whether ownership is restricted or not to pharmacists, the various options indicated for each model can coexist, and often do (although not all scenarios may exist in one given jurisdiction). Likewise, in several jurisdictions where ownership is generally restricted to pharmacists, certain exceptions may exist, such as pharmacies owned by the state, NGOs or charities or universities.

The policy defined in each jurisdiction will depend on historical factors, overall economic policies, national and/or international pressures, market forces and the advocacy work of the involved stakeholders.

Notwithstanding, all ownership models must be compatible with a clinically-focused, patient-centred pharmacy practice that promotes the responsible use of medicines and participates in health promotion and disease prevention strategies, as long as the appropriate workforce is available and effectively offers their services at community pharmacies. Likewise, all models should allow and ideally facilitate an effective participation of pharmacies in health care systems, professional innovation, expanded scopes of health services and the highest performance standards for pharmacists. The cornerstone of all models must be to ensure the highest level of professional autonomy and competence of community pharmacists, who must be able to practise and make decisions with the best interest of the patient and the health care system in mind.

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# Annex 1. Jurisdictions with regulated models

| | |
|---|---|
| Australia | Pharmacy ownership is restricted to pharmacists, with the maximum number of pharmacies per pharmacist varying between four and six in the different states, and having no number limitation in the two territories. |
| Austria | Pharmacy ownership is restricted to pharmacists, and the license constitutes a personal right which cannot be transferred to another pharmacist. The premises of a pharmacy may be sold or inherited, but the new owner must apply for a new licence. The main dispensaries of prescription-only medicines are community pharmacies (approx. 1,300), but there are also dispensing doctors (940). Five of the 46 hospital pharmacies also act as community pharmacies. Each pharmacy is allowed to run at least one branch pharmacy (in total there are 23 branch pharmacies). Internet pharmacies are not allowed and there is a small list of non-prescription medicines that may be sold outside pharmacies. |
| Cameroon | The ownership of community pharmacies is limited to individual pharmacists or partnerships of pharmacists. Pharmacy branches and chains are not allowed. |
| Chad | Pharmacy ownership is restricted to pharmacists and regulated through the issuing of licences by the Ministry of Health. Such licences are not transferrable, and they do not they need to be renewed periodically. |
| Denmark | When the Danish Health and Medicines Authority issues a licence for a new pharmacy, only pharmacists may apply. Ownership of multiple pharmacies is not permitted but regulatory changes introduced in 2015 allow a pharmacy owner to have up to seven branch pharmacies with access to prescription medicines within a radius of 75km from the main pharmacy. Licences expire at the death of the owner or completion of 70 years of age, or can be suspended for other reasons. They cannot be sold or inherited. |
| Finland | Pharmacy ownership is restricted to pharmacists, and neither multiple ownership nor vertical integration is allowed. 98% of community pharmacies are privately owned. The other pharmacies are owned by universities. Pharmacies may have up to three branches, usually in underserved areas, but if a branch pharmacy's turnover exceeds 50% of the average pharmacy turnover, it becomes an independent pharmacy. (12). Pharmacy licences are not transferrable and expire when the owner reaches the age of 68 years. |
| France | Since 2013, holdings of pharmacists have been allowed. Such a holding may own up to three professional companies. Employed pharmacists may now have shares in pharmacies (up to 10%). Notwithstanding, pharmacy ownership is still restricted to pharmacists. |
| Germany | Community pharmacy ownership is restricted to pharmacists. A pharmacist may also operate up to three branch pharmacies besides the main pharmacy. Notwithstanding, the German Pharmacy Law contains the possibility for municipalities to open a *Notapotheke* if this is ultimately necessary to avoid a state of emergency because no pharmacist is willing to establish a pharmacy in a certain region. In such cases, the municipality would have to apply for the licence (instead of a pharmacist), and employ a responsible pharmacist. This provision, however, has never been exercised. |

| | |
|---|---|
| Iran | Private community pharmacies belong to pharmacists who are allowed to establish their pharmacy under district regulation and legislation of the Ministry of Health. They are responsible for providing medicines on the National Drug List (NDL) to all patients. Chain pharmacies and investment in multiple pharmacies are not allowed. (13) |
| Iraq | Community pharmacies may only be owned by individual pharmacists. Branch pharmacies and chains are not allowed. Licences must be renewed yearly and are transferrable, i.e., they can be sold or inherited. |
| Jordan | Community pharmacies can only be owned by pharmacists. However, in 2013, ownership regulations were amended, updating the previous law from 2001 that already allowed the establishment of pharmacy chains as long as all owners are pharmacists. With the new amendment, more than one pharmacist can take part in owning more than one pharmacy on the condition that the number of partners equals the number of pharmacies owned and that the share of any partner is not less than 2.5% nor more than 30% of the total shares. Partners may not participate in other chains. (1) |
| Korea, Republic of | Pharmacy ownership is restricted to pharmacists and chains are not allowed. The Ministry of Health and Welfare grants pharmacy licences to pharmacists, which are not transferrable. |
| Lebanon | Pharmacy ownership is restricted to pharmacists, and branches or chains are prohibited. |
| Macedonia | Recent legislation (2014) restricts ownership to pharmacists and prohibits vertical integration. Owners of wholesale companies and their close relatives may not own pharmacies or have any corporate or managerial relations to pharmacies owned by close relatives. Employees of the Ministry of Health, the Bureau for Medicines or the Health Insurance Fund and their close relatives also may not own pharmacies or wholesale companies. (1) |
| Oman | Royal Decree 35/2015 (the “Pharmacy Law”) introduced a number of measures designed to prevent the formation of monopolies in the pharmaceutical sector. Such measures include limiting the number of pharmacies an individual may open to one, restricting the number of branches that any given pharmacy may open, and stipulating the minimum distance between pharmacies. Article 11 provides that either the owner of any pharmaceutical establishment or one of his partners must be an Omani citizen. The Minister of Health may waive the requirement for a pharmaceutical qualification in areas where pharmaceutical services are scarce. (14) |
| Senegal | Ownership is restricted to individual pharmacists or pharmacist partnerships. Branch pharmacies and chains are not allowed, nor is vertical integration of community pharmacies with pharmaceutical wholesalers or manufacturers. |
| Spain | Pharmacy ownership is restricted to pharmacists and the ownership of multiple pharmacies is not allowed. There are no branch pharmacies, but small dispensaries may be established in remote locations, under the supervision of a pharmacy. |
| Turkey | Pharmacy ownership is restricted to individual pharmacists and branches are not allowed. |

# Annex 2. Jurisdictions with non-regulated models

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| **Bolivia** | Pharmacy ownership is open to any individual or corporation. Bolivia has one of the highest rates of pharmacies per 10,000 inhabitants among the responding countries and territories (4.37), and about 20% of all pharmacies belong to chains. |
| **Greece** | Ownership restrictions to pharmacists were removed in 2014 as part of the conditions imposed for the country's bailout by the European Commission, the European Central Bank and the International Monetary Fund. |
| **Italy** | In 2016, pharmacy ownership was open to non-pharmacists and corporations (including pharmacy chains), with a limitation by which the number of pharmacies per corporation cannot exceed 20% of the total number of pharmacies in any of the regions. Notwithstanding, establishment restrictions (territorial and demographic planning) remained in place. |
| **Kenya** | Pharmacy ownership is open to non-pharmacists and corporations, but a superintendent pharmacist will be accountable for each pharmacy. Furthermore, pharmacy licences must be renewed every year. (15) |
| **Nigeria** | Although the majority of pharmacies are owned by pharmacists, ownership is not strictly limited to pharmacists. Chains are also allowed. However, each individual pharmacy (even those belonging to chains) must be registered under the licence of an individual pharmacist, who will be fully accountable for that pharmacy. |
| **Portugal** | In 2007, pharmacy ownership restrictions were lifted, but large chains are still banned, as a maximum of four pharmacies may be owned by the same person or company. |
| **Romania** | Ownership is liberalised, but a chief pharmacist must be in charge of every pharmacy. |
| **Saudi Arabia** | Community pharmacies are privately owned (liberal ownership) but must be managed by registered pharmacists. Although there are no large multiples, there are plenty of chains of up to five pharmacies, some of which, like hospital pharmacies, open 24 hours a day (16). |
| **South Africa** | Pharmacy ownership is liberalised and chains are allowed. |
| **Tanzania** | Pharmacy ownership is open to pharmacists or to persons associated with a pharmacist, or to licensed corporations, who must hire a pharmacist as superintendent. |
| **United Kingdom** | No restrictions apply in terms of pharmacy ownership — pharmacies may be owned by independent pharmacists, non-pharmacists or companies — and pharmacy chains have existed for many years. Yet, for a pharmacy to dispense medicines under the National Health Services Prescriptions (which amount to approximately 80% of the turnover of an average pharmacy), the owner must obtain a contract with a local NHS Primary Care Organisation, which will determine if a new contract is necessary to adequately meet the needs of that local community. |
| **Uruguay** | Pharmacy ownership is open to any individual or company, and generally, no establishment rules are in place. Yet, since 2013, there must be a minimum distance of 1km between two pharmacies of the same owner. Pharmacy chains are also restricted to a maximum of 15 pharmacies. This rule did not apply retrospectively to the larger chains existing in 2013, but banned them (or new chains) from opening new pharmacies. |

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