



ELSEVIER

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

'A smile is most important.' Why chains are not currently the answer to quality concerns in the Indian retail pharmacy sector



Rosalind Miller*, Eleanor Hutchinson, Catherine Goodman

Department of Global Health and Development, Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, 15-17 Tavistock Place, London, WC1H 9SH, UK

ARTICLE INFO

Keywords:

India
Pharmacies
Chain pharmacies
Private sector
Quality of care
Health sector regulation

ABSTRACT

Chain pharmacies are expanding in many low and middle-income countries (LMICs). Historically practices of independent pharmacies in these settings have been poor, and there is a need to understand how these new organisational arrangements are affecting the functioning of pharmacies, and the implications for public health. Drawing on economics literature, we develop a set of hypotheses as to how chains could address the quality failures that typify LMIC retail pharmacy markets, and explore these hypotheses using a set of 38 in-depth interviews, conducted in Bengaluru, India between 2014 and 2015. We look specifically at how being organised in a chain affects several key behaviours: employment of qualified staff; the ability of government authorities to focus regulation on central management structures; the propensity for firms to self-regulate; and the impact of the potentially lower-powered incentives faced by chain employees compared to independent owners. In practice, few differences were identified between chain and independent organisations in these areas. Not all chains were operating with a qualified pharmacist (akin to independent shops). Drug control authorities did not take advantage of the existing chain architecture to enforce regulation. Chains did heavily self-regulate but their focus was on customer service, rather than aspects of quality relevant to health outcomes. Additionally, widespread bribery in the sector was a barrier to effective drug control. Finally, the incentives faced by chain employees were not low-powered due to rewarding sales targets and pressure to increase sales. We observed that chains exerted strong influence over their staff but the potential to exploit this to improve quality of care is not currently being realised. A shift in focus from customer satisfaction to outcomes of public health concern is unlikely without either financial incentives or strengthened external regulation.

1. Introduction

Pharmacies and drug stores are the first point of care in many low and middle-income countries (LMICs) for a range of medical conditions, including respiratory infections, fever, malaria, injury, body and dental pains, skin infections, diarrhoea and sexually transmitted infections (Igun, 1987; Kamat and Nichter, 1998; Saradamma et al., 2000; Smith, 2009b; Francis N Wafula et al., 2012). Practice in these outlets is often characterised by deficient knowledge, poor adherence to treatment guidelines, inappropriate supply of medicines, and insufficient counselling (R. Miller and Goodman, 2016; Smith, 2009b; Francis N Wafula et al., 2012). In most LMICs, pharmacy retailing has traditionally been dominated by owner-run shops, but chain pharmacies are now a growing organisational arrangement for delivering pharmacy services in these settings. Given the limited evidence-based policy options to improve pharmacy practice in LMICs (R. Miller and Goodman, 2016; Smith, 2009a; F. N. Wafula and Goodman, 2010), chain pharmacies

may have potential to address quality challenges. Despite emerging interest amongst the global health community, empirical research on pharmacy chains in LMICs is scant (Lowe and Montagu, 2009). Work from high-income countries has explored the effect of pharmacy type on various outcomes (eg Fritsch and Lamp, 1997; Kalsekar et al., 2007) but is of limited applicability to LMICs given the strength of regulatory frameworks in these settings. With either established or growing corporate pharmacy retail sector in Mexico, Brazil, South Africa, Nigeria, Kenya, Uganda, India and The Philippines (Center for Health Market Innovations, 2014; IMS consulting group, 2014; Lowe and Montagu, 2009), there is a need to understand the effects of these new organisational forms on the functioning of pharmacies and the implications for public health.

Recent years have seen the steady growth of pharmacy chains in India. There are estimated to be around 800,000 medicine retailers, with chains accounting for 4% of these but growing at a rate of 25% per annum (IMS consulting group, 2014; Northbridge Capital, 2011).

* Corresponding author.

E-mail addresses: rosalind.miller@lshtm.ac.uk (R. Miller), eleanor.hutchinson@lshtm.ac.uk (E. Hutchinson), catherine.goodman@lshtm.ac.uk (C. Goodman).

Box 1

Classification of Prescription Only Medicines in India.

In India POMs are classified as either H, H1 or X. Under the Drugs and Cosmetic Rules 1945, Schedule H medicines should only be sold with a valid prescription from a doctor. In light of the high sales of these medicines in India without a prescription, Schedule H1 was introduced in 2013. The H1 list comprises of 46 medicines (mainly 3rd and 4th generation antibiotics and anti-tuberculosis medicines) and require that the identity of the patient, contact details of the prescriber and the name and dispensed quantity of the drug be recorded in a designated register. Schedule X comprises of a small number of narcotics and requires the pharmacy to retain the prescription for 2 years after dispensing.

The research presented in this paper comprises part of a broader mixed-methods study of Bengaluru's chain pharmacies which sought to understand the public health implications of this organisational arrangement. The quantitative component included a standardised patient (SP) study comparing the quality of management of two tracer conditions at chain and independent pharmacies (diarrhoea and suspected TB) (R. Miller and Goodman, 2017). The SP study showed that quality of care, as measured by adherence to treatment guidelines, was equally poor in chain and independent pharmacies. No shops managed the diarrhoea patient according to current guidelines and fewer than half for the tuberculosis (TB) case. However, chains sold significantly fewer harmful and prescription-only medicines (POMs) for the diarrhoea patient compared to independent shops (*ibid*). The survey also revealed that whilst overall sales of POMs were high, sales of the more restricted H1 (see [box 1](#)) subcategory were low, with chains not selling any of these medicines.

Drawing on a set of in depth interviews and insights from economics literature, the aim of this paper is to qualitatively explore how and why the organisational structure of pharmacy chains may affect the quality of service provision. Specifically, we investigate how the chain structure might influence the knowledge of pharmacy staff; the way in which they are regulated; and the profit motives faced by employees, in comparison to independent pharmacy owners.

1.1. Theoretical approach

Various bodies of theory provide insights into the study of pharmacy arrangements, such as those from neo-classical economics, industrial organisation and regulatory theory. Conventional economic analysis of pharmacy markets in LMIC typically focuses on the high likelihood of various market failures. Inappropriate prescribing of medicines can be associated with negative externalities (Laxminarayan, 2003) and information is highly imperfect (Mushkin, 1958). Further, the nature of information in health markets is asymmetric (Arrow, 1963). Within the agency relationship that results, it has been suggested that providers do not always act as perfect agents; rather they influence demand for their own self-interest, trading off income against patient welfare (McGuire, 2000; Morris et al., 2007). Fee for service (as in a pharmacy) is the provider payment system most associated with the resulting 'overserving' patients (Hennig-Schmidt et al., 2011; McGuire, 2000).

Drawing on theoretical insights, we develop a set of hypotheses as to how chains could address some of these market failures. A prior literature review of pharmacy practice in low-middle income Asian settings identified regulation, knowledge and profit motive as three key determinants of pharmacy provider behaviour (R. Miller and Goodman, 2016). [Fig. 1](#) presents a conceptual framework detailing how being organised as a chain may influence these determinants. Enforcing regulation is costly and logistically difficult due to the fragmented nature of pharmacy retail in India. Through consolidation (in chains) regulation could be improved. First, state regulation could be focussed on central management structures; essentially, the regulator could make firms take responsibility for their branches. Second, firms may self-regulate in order to preserve brand identity and image. This may, for example, lead to greater presence of qualified pharmacists at the point

of service delivery, who are currently often absent (Basak et al., 2009; Kamat and Nichter, 1998). Several authors have alluded to the potential of such 'market-based' regulatory mechanisms within pluralised, unregulated markets where traditional approaches have failed e.g. (Bloom et al., 2008; Ensor and Weinzierl, 2006). These reputation-based ways of delivering health care are argued to build trust and can, in theory, help to overcome the information asymmetry that characterises transactions in healthcare (*ibid*).

Another reason why quality may improve in a chain situation arises from the different incentive structures in place for pharmacy owners as opposed to managers. High-powered incentives exist when the profits of transactions flow directly to the parties involved (Frant, 1996). In the case of independent pharmacy owners, the potential for higher profits provides incentives to behave opportunistically. A hierarchical structure (as in a chain) can attenuate opportunism because the incentives faced by the personnel working in the pharmacy are low-powered (if salaried). While chain owners themselves will have incentives to maximise profits, these incentives may not be transmitted directly to their frontline staff. This could improve some aspects of treatment in public health terms, as a number of poor practices have been found to be linked to profit maximising strategies (which require effort), for example, the sale of medicines with high profit margins (R. Miller and Goodman, 2016). Other aspects of good practice, such as counselling, are effort intensive and these practices may worsen among employees of chain pharmacies with a tendency to shirk. Some economists suggest that incentive schemes are the key to overcoming these moral hazard problems (Harris and Raviv, 1979; Hölmstrom, 1979). Others argue that whilst incentives can improve efficiency, they do not necessarily maximise profits—the bonus required to induce high effort can be substantial and yield a lower expected profit than using a flat wage (G. J. Miller and Whitford, 2007).

2. Methods

Between 2014 and 2015 we conducted 38 in-depth interviews with pharmacy employees and other stakeholders in Bengaluru, the capital of Karnataka State, India. Bengaluru presents an appropriate setting for this research as a number of pharmacy chains are well established. We have used the interviews as a tool to explore the hypotheses laid out in the above conceptual framework, an approach advocated by Miles and Huberman (1994). The framework informed both the development of the interview guides and the analysis, although we were open to any new ideas or issues that arose.

The interviewees were selected as a sub-sample from the pharmacies in our SP survey (see R. Miller and Goodman, 2017 for more details). We used a list of all pharmacies in Bengaluru urban district, obtained from the Karnataka State Drug Control Department, as a sampling frame (validated through three neighbourhood censuses which found it to be 97% accurate). The list contained 5135 independents and 529 chain shops deriving from 13 chains. Chains were defined as organisations where two or more pharmacies were operating under the same name and the business used distinctive branding across all outlets. For the SP survey we then selected a random sample of pharmacies, stratified as either 'chain' or 'independent', including shops

Download English Version:

<https://daneshyari.com/en/article/7327181>

Download Persian Version:

<https://daneshyari.com/article/7327181>

[Daneshyari.com](https://daneshyari.com)