The Future of the Pharmacy Industry

"An independent perspective"

In response to a number of discussions on various social media forums about the "Future of the Pharmacy Industry" I was requested from a number of industry pharmacists to provide my thoughts on where I see this industry heading. Just where is the pharmacy industry heading and what is the Guild and other organisations doing to either hinder or enhance the industry. My response is independent and draws on a number of previously written papers, submissions and my own industry research. I am not aligned to or a member of any industry body.

Now it's not my position to espouse what pharmacists do. You know it much better than I do. I'm not a pharmacist I am an industry strategist (among other things). However I've researched enough to know what is right and what needs fixing. I've written this response from a societal value perspective and not from being a pharmacist, pharmacy owner or a member of the Pharmacy Guild (PG) or any other pharmacy body. However there are a few macro factors to consider:

- Pharmacy retail and dispensing is a $16 billion industry in Australia and its growth rate is less than 1%.
- There are roughly 5600 community pharmacies dispensing over 300 million prescriptions per annum.
- It is a "derived demand" industry, which means that no matter how much you advertise, the rate of dispensing of medicines is a function of the rate of illness, ailments and age – hence the low growth rate. Notwithstanding this the rate of PBS spend has increased disproportionate to the overall growth rate which since 2007 has resulted in the government trying to reign in that spend.
- Over 80% of all medicines dispensed are to those aged 65 or over, most of whom are pensioners or concession card holders. They represent about 15% of the population and by 2036 will represent 25% of the population. In economic terms this market is at the lower end of the financial and mobility spectrum.
- The "primary demand", or advertising sensitive side of the industry relates to non-prescription related product sales such us skin care, perfumes and other related health products. And yes advertising in this space makes sense because it creates an awareness and interest to impulse or desire purchase goods.

Growth of the likes of Chemist Warehouse (CW) are good examples of how primary demand works with over 230 stores nationally, from having grown 5 in 2005. They've been an industry disruptor by placing "supermarkets in pharmacies" as opposed to "pharmacies in supermarkets", which as we all know at present is not allowed. And they're about penetration, volume and price, pure and simple. While it might be a disorganised pharmaceutical shopping slum; it is cheap, serves its target market well and is successful. Some call it a category killer, but in reality I call it a consumer need filler. It is perhaps commoditisation by stealth but nobody can deny it is effective. Where it fails is the cheapening it does to the pharmacist profession itself, by virtue of its retail association and anecdotally it is the place ECP's[1] go to commence their careers, then leave in a hurry. Most pharmacists don't legitimately stay at CW to grow their careers, unless they're compensated well enough to do so.

This leads me on to the next thing, namely The Pharmacy Guild (PG) submission[2] to Government of January 2015 espousing the status quo of the industry and its location restriction strategy supporting pharmacy owners at the preclusion of major supermarket chains like Coles or Woolworths.

It is dumb.

Despite the rhetoric it does NOT serve the interests of the broader community. However let's be clear, this submission and any future submissions of the Guild will NEVER recommend the loosening of pharmacy location and ownership restrictions, because it goes directly against their charter[3]. It is their right to do so and if I was the leader of the Guild I would probably follow the same strategy, but I'm not and I won't.

However the Guild's self-interest should be viewed with caution and even scepticism from government representatives. In summary, their 2015 submission drew the following analogies and assumptions:

1) Guild claim the absence of location restrictions on medical GP's has not resulted in increased healthcare access in regional locations. The comparison is flawed. The reason this has occurred is "because of the simple fact that they are regional locations" and "the capital required to setup" (despite financial incentives), versus the returns available are just not there because of the low volume of demand. Secondly most people don't live in regional locations (but they are certainly no less important), so all things being equal, irrespective of the profession why would anybody choose to relocate away from friends and family? Put yourself in the shoes of a general practitioner. Despite your commitment and training to provide health care services, you still want to make money and be profitable. We don't need to over-engineer the uncomplicated. There is neither the lifestyle in it or money to be made and nobody would setup a presence in a location if it doesn't sustain a profitable ongoing return or suit their specific personal

[1] Early Career Pharmacists

[2] Community Pharmacy – Delivering Accessibility, Quality and Choice for all Australians

[3] See the Guild' website

circumstances. The Guild claim it is inherently problematic, I claim it's just plain lifestyle choice and the economics of supply and demand.

2) The Guild' second claim, from "empirical evidence", is that removing location and ownership restrictions carries significant risks in terms of accessibility of medicines. It did not happen in the USA and it won't happen here. And of course the PG would say that to protect their existing pharmacy owners and business model in accordance with their original and current charter. The very notion of "location restriction" is actually "supply constricting" and again it is plain economics. The PG fear the market power of the 2 major supermarket chains, and they should. But there is actually a greater power than the supermarkets; that is the common sense of consumer demand, lower prices and medicines availability and the government have been longing for that response also. Despite the PG fear, supermarkets and community pharmacies can peacefully coexist.

3) The efficiency and effectiveness rationale for ownership and location rules outlined by the Guild doesn't stack up. By their very admission they advocate limiting the supply and concentration of dispensing services. How does this generate a public or cost benefit? Limiting anything only increases price. Remember the taxi industry versus Uber. It is these prices that 15% of the community (age 65+) which constitutes 80% of the market demand has to bear.

4) The geospatial access analysis provided in the Guild submission was somewhat short on additional detail (I have considerable experience in this field). Firstly the Guild claim that the community pharmacy model provides a higher level of accessibility per head of population within a 2.5-5.0 kilometre radius within metropolitan or regional locations, and the simple fact is, that is absolutely correct. But when you look at the spread between supermarkets and pharmacies in terms of this access it is hardly compelling (87 v 83 at grade 1 level and 84 v 81 at grade 2 level). In simple terms the difference is negligible, however the fanfare and message proffered by the Guild is disproportionate to the supposed accessibility benefit. What they don't say is that of course the data would tell you this. The physical premises of community pharmacies are greater in number than the physical premises of supermarkets because they're a fraction of the size of a supermarket, so naturally their geospatial presence and thus penetration would be greater (and not much greater at that). Take a town like Raymond Terrace in NSW for example. Raymond Terrace has 2 Woolworths Stores and 1 Aldi store, however they have 5 pharmacies. If you were to re-measure the physical square meters of supermarkets per head of population what you will find is that availability and cumulative opening hours (not mentioned in the submission) is MUCH greater per head of population in these stores than community pharmacies. By and large "everybody" goes to the supermarket and what they offer is aggregated product convenience.

5) It was good to see that 89% of consumers trust the local pharmacist, and I note "local pharmacist" whom are often more representative of the local community pharmacy than the pharmacy owners themselves. However 64% of consumers is hardly a compelling number that supports the principle of professionals owning these businesses and this reaffirms the importance of the pharmacist's role and not the pharmacy owner's role (granted in some cases they are the same person, but increasingly less so). So it then draws a long bow when the Guild submission claims there is a level of distrust between supermarkets and pharmacies as to who is best to dispense medicines and that consumers remain unsupportive of supermarket chains doing so.

I fundamentally disagree.

That is like asking consumers of your local barber shop, do you trust them to do the dry-cleaning? Of course they wouldn't because there are no dry cleaners in the shop! However if the consumers surveyed were asked "if a registered, qualified and highly trained pharmacist who is subject to the ethical and professional standards all pharmacists are subject to, dispensed medicines from a specially configured portion of the store in a supermarket, would you trust them to do so?", I am quite certain most consumers would answer in the affirmative.

This leads me on to where to from here? What is in store for the pharmaceutical industry and pharmaceutical professionals?

Firstly, let us address the elephant in the room. Should the major supermarket chains be permitted to enter the pharmacy industry and dispense prescription medicines?

The overwhelming answer is "of course they should be".

Restricting the supply of anything only increases price which are inflicted on those least able to pay in the community. It perpetuates inefficiency and high government costs. With respect to Coles and Woolworths the combined penetration of the number of supermarkets in Australia is around 1750. Aldi have around 400 stores, making just over 2100 in total (excluding IGA, Foodworks etc…). The fear that the Guild have is that all full service supermarket locations will have pharmacies and this is simply highly unlikely, particularly in the regional areas as the demand is unlikely to generate the returns required to make that category profitable in some cases. However what the major chains will bring is a critical mass of working capital, buying power and most importantly innovation that no single chain in Australia can bring and this will lower prices for all consumers and most importantly lower the price of the $10 billion plus PBS medicines that the government reimburses for (i.e. societal value). Australia still pays the 2nd highest price for prescription medicines in the world which is manifestly unacceptable. One only has to look at the innovation Walmart has brought to the prescription medicine category in the USA because they have the capability, systems, information and execution expertise to do so.

A phased approach of supermarket transitioning to providing prescription medicines should be undertaken, whereby supermarkets offer to buy pharmacies that are strategically located within their existing shopping footprint. So those pharmacies adjacent to a supermarket would be most appealing to both the seller (pharmacy owner) and the buyer (supermarket chain). Neither should be compelled to act and both should have first and subsequent rights of refusal if they enter into a negotiation to transact a sale. I would note however that pharmacy owners should also have a right of refusal to sell if the price offered is not fair and reasonable and they should have a right of refusal for the supermarket to setup in store if that offer to buy was not reasonable to the seller. Similarly if the price offered by a supermarket for an adjacent pharmacy was fair and reasonable and a seller still refuses to sell then the supermarket should have the freedom to setup as they choose. If the pharmacy owner has no interest at all to sell, then a supermarket should be able to setup as they see fit.

There is no doubt some pharmacies will close but the overall reality is that net numbers of pharmacy outlets will increase and this is good for pharmacists, consumers and most importantly good for price. The downward pressure on the "supplied price" of medicines will also force suppliers and wholesalers to sharpen their pencils making it more appealing to all pharmacy owners, be they supermarkets or otherwise. If 1000 plus additional net outlets are available to dispense medicines to the community, with greater opening hours, then that must be a benefit to the whole community.

The rules which govern pharmacists and owners dispensing medicines should be adopted and adapted as appropriate for supermarkets. Most importantly all participating supermarkets should be required to have a secure, sectioned pharmacy category in store that is manned during their opening hours at all times by registered and qualified pharmacists. Given the extended opening hours of supermarkets this would typically mean 2 pharmacists per store as a minimum. The demand for pharmacists will go up and so will their salaries.

This leads me on to the pharmacists whom actually dispense the medicines. They are highly trained professionals who provide a critical service in the health care industry. And I wish to stress it is the pharmacist who does this not the pharmacy owners, whom anecdotally are dispensing less and less medicines. From my evidence pharmacists are woefully compensated for the training they undertake and the responsibilities they bear. Many have left the profession and continue to leave. Graduating pharmacists typically start on salaries of $39-45K per annum which let's face it is pathetic. And the average salaries of pharmacists is less than that of certain trades (those with cert 3 TAFE level qualifications), school teachers and other professions and absolutely NONE of those professions is responsible for human health care advice, sometimes which is critical. Base salaries above $100K for even the most experienced pharmacists are rare. It has to change.

See the problem stems from the fact that pharmacy outlets are now quasi retail outlets, thus shifting the managing pharmacist profession to a managing pharmacist retail profession, at the very expense of providing the necessary analysis and dispensing advice so important for the community. Increasingly newly hired managing pharmacists have to "grow the business" and "grow retail sales". Now this is a perfectly acceptable objective but the problem is that being aligned or associated with the retail profession has naturally lowered the salary growth that highly trained pharmacists should have received and diluted the health care services and advice they should provide.

My view is that all pharmacists whom have a minimum of 6 years' experience should be on a minimum salary (note the word 'salary' and not the words 'hourly rate') of $100K per annum for 40-45 hours week of work. There should be no penalty rates however all pharmacists should be entitled to 2 full contiguous days in a row off per week. Too many pharmacists work staggered weeks and have staggered breaks. For example some work Monday to Thursday, then have Friday and Sunday off. It is simply not enough to recharge. Others may work Monday to Friday then half a day Saturday. This is better but still only represents a 1.5 day break on the weekend.

What is interesting also is that under the current arrangement pharmacy owners benefit from the dispense reimbursement fee (around $7 per script), yet it is pharmacists who bear the risk to do so. The best result is that the pharmacist who actually dispensed the medicine are compensated $0.50 directly from the government for this fee while the owner is compensated the rest. For a busy outlet that dispenses say 200-250 scripts a day this is a $100+ fee that the pharmacist makes to uphold the professional training and advice they provide, usually at their own expense, and would provide them with additional compensation commensurate with the responsibilities they undertake. Because it is paid directly to the pharmacist as taxable income it would not hinder cash flow management in the existing business.

If supermarkets were allowed to enter the industry this would provide a more compelling career path for pharmacists beyond the current stale ownership model that now exists. It would also drive the up demand for qualified pharmacists. The only contentious issue would be that on average supermarket store managers earn between $80 and $120K per annum and the responsibility for whom is accountable for the whole store would have to be determined, but in the grand scheme of things this is a minor challenge.

With respect to how and whom represents pharmacists, this must change. Currently the situation is:

- The Pharmacy Guild (PG) represents pharmacy owners. By definition they have become the defacto body representing the whole profession at the expense of the PSA and the PPA. This has been allowed to happen because employee pharmacists have let it happen (defacto industry power). One only needs to read the vitriol on social media threads to see that.
- The Pharmaceutical Society of Australia (PSA) claim to be the peak national representative body for pharmacists in Australia. Their primary role is pharmacist training, professional and ethical standards and accreditation.
- Professional Pharmacists Australia (PPA) advocate for and on behalf of 'employee' pharmacists and legitimately make no secret of the inadequacy of current pay rates to pharmacists. Tension exists between the PPA and the PG.

At present it is reprehensible that the PG is advocating the continued low rate of pay for pharmacists and their recent MedsAssist fiasco is evidence of an organisation which is out of touch with the broader industry need. As a general rule I am not a supporter of unions, because primarily their main goal is all about membership dollars which support the very few in the top of these organisations. Having had considerable experience running some large union workforces and been directly exposed to the likes of militant union actions I know exactly what makes them tick. However equally, nothing is more ineffective than a series of professional bodies that are tepid in supporting the interests of the overwhelming majority of the very people whom are dispensing medicines, the pharmacists themselves. As pharmacists, it is simply no use complaining about outcomes if you haven't put your money or your voice to driving a change to them.

Put simply, all employee only pharmacists should, and I in fact implore them to, join the PPA to provide them the strength of voice and means to drive the outcomes you want. The government will certainly listen to 29,000 pharmacists equally and if not more so than the 5000 plus pharmacy owners whose representative body is constricting industry supply and the profession. The PPA needs to be online more often with each and every pharmacist where voices and opinions can be submitted, discussed and debated and final messages crafted. This would bring power to the PPA and thus power to the pharmacy profession.

The power and authority of the PPA should mirror that of the PG and there should be no single body that represents or submits the parameters of each 5 year community pharmacy agreement (CPA). In fact the notion of the CPA is flawed and we should call it for what it really is; the Pharmacy Owners Restriction and Penetration Agreement (or PORPA).

The very notion of a CPA should be dumped and be replaced with what I term "VABESMA", or the Value Based Efficient Supply of Medicines in Australia, which the Department of Health should ultimately be accountable for.

For those more academically inclined I'm reminded of esteemed Harvard academic Michael Porter's 5 forces model of industry competitiveness. He outlines that the force of industry competitiveness is dictated by the forces of supplier power, buyer power, threat of new entrants and the threat of (product) substitutes. What we have at present is the following:

1. **Supplier Power** – Pharmaceutical drug companies have disproportionate power that inflates price. This occurs because of the present restrictions in the number outlets allowed to dispense medicines as perpetuated by the PG in the present CPA model and the lack of available alternatives for supply from other international sources. The effect has been the continued rise in the PBS, through generic medicine pricing, the sustainment of inflated prices for long term PBS drugs and inflated new drug pricing all of which is out of sync with actual market demand. Remember we still pay some of the highest rates in the world for prescription medicines in Australia.
    a. **Response**: Remove medicine supply restrictions to consumers and increase the number of outlets able to supply. Allow major retail chains to enter the industry and wield their buying and negotiating capabilities to buy and supply medicines to consumers at cheaper prices. Further increase pricing transparency between buyers and sellers so that unnecessarily inflated drug prices are reduced, thus benefitting the consumer.
2. **Buyer Power** – As the market is highly fragmented buyer power is ostensibly low and high prices for medicines remain. We need neither a Phd in economics nor an MBA in strategy to draw this conclusion. Restricting the market's ability to supply anything only serves to strengthen the suppliers ability to maintain high prices which by definition must carry on to the consumer. This buying fragmentation perpetuates a weak negotiating position with suppliers.
    a. **Response**: Increase the number of buyers by adding in supermarkets and the sourcing of supply to include offshore alternatives.
3. **Threat of New Entrants** – In its present form, and I stress the word "present", the threat of new entrants is low at least until 2020 when hopefully a new VABESMA is introduced. The PG wishes to sustain this highly flawed supply constricting model and keep hitting up government for more inefficient financial reimbursement incentives. Furthermore online models of supply are still developing however the present buying demographic of 80% of the volume of prescription medicines has never grown up with the internet, so the growth of online models will continue to evolve over time.

   a. **Response**: As most of the readers of this document have grown up with the internet then it stands to reason that in 5 – 30+ years time a much higher proportion of prescription drugs will be purchased and supplied from online means and in doing so change the "need it now" behaviour and business processes so presently entrenched to "I'll accept it within 2 days or pickup" once the medicine is dispensed and the pharmacists advice is provided electronically (text, portal, email etc…). New entrants and business models should be embraced and not feared.
4. **Threat of Substitutes** – At the supplied drug level generics have made great in roads in being able to substitute the branded medicines for non branded or generic ones. This has occurred because the switching cost to do so is low, the prices are cheaper, the quality is the same and the benefits are the same. The problem is the PBS bill has still kept rising because of the inherent market inefficiency.
   a. **Response**: But what if the substitutes also came in the form of different and more efficient business models, dispensing methods and supply routes. The consumer would be better off and so would the tax payer.
5. **Industry Competitiveness** – All of which leads me, as it stands, to an industry whose competitiveness is quite low. Supply routes to consumers are restricted and prices are inflated. This costs the health system much more than it needs to pay and that by and large hurts all in society.
   a. **Response**: By simplifying the industry, increasing supply to consumers and allowing other sectors to enter the market (while never compromising standards) prices will naturally fall and buyer power through a strong retail presence will only increase.

In closing the pharmacy profession has 4 major threats at its door step, namely:

1. Poor pay considering the training and responsibilities involved to provide a service to the community. In fact I know of no other professional whereby you have to 1) grow the top retail line of the business and 2) ensure people don't die or are harmed in the process of undertaking your everyday duties. The PPA submission to Fair Work Australia is not enough. Industry change and not just pay scale is required to pay pharmacists what they're worth.
2. The continuation of the current owner based community pharmacy restrictions which limits opportunities and fair pay to employee pharmacists.
3. Weak representation of pharmacist professionals to government. Pharmacists need to be much more vocal and use the PPA to do so.
4. Large numbers of pharmacists leaving the profession because the pay and conditions are inadequate and a shortage of pharmacists joining the profession because there are more lucrative industries, working hours and pay elsewhere; some of which require less training.

However there are responses to the above points. Namely:

1. Once and for all, fix the pay for pharmacists and pay them what they're worth. My recommendations outline this in conjunction with and most importantly in addition to other measures such as a small dispensing fee paid directly to pharmacists and minimum rates of salary for minimum periods of experience. Pharmacists need to see themselves as salaried professionals and not hourly based wage earners. It is also about being fair and trading off certain things for certain outcomes. For example I don't support penalty rates for salaried professionals (hence the salary standards I've outlined), but like most professionals they work at least 40 hours a week and most of my colleagues are in the 0800 – 1800 range per day Monday to Friday or a minimum of 45 hours per week and are at least compensated for it. Sometimes they have to give more and sometimes they can give less but their rate of pay is consistent. Locum pharmacists, again as professionals, should be paid a daily rate (or proportion thereof) and not an hourly rate and again let the market determine where this is, however $600 a day sounds about right.
2. Supermarkets must be allowed to enter the pharmacy industry, pure and simple. The arguments outlined by the PG are restricting and do nothing to increase societal value for the whole community. It's not Chicken Little and the Sky Won't Fall Down.
3. Pharmacists unite behind the PPA and give them the voice of relevance you so desperately want them to have.
4. The pharmacy profession will grow if you fix point 1.

What of the Pharmacy Guild of Australia?

The Guild will continue to be a strong and relevant voice for community pharmacy owners, and they should be. But when it comes to representing all round societal value they fall far short of what the whole community actually deserves.

As a registered employers' organisation it has done an admirable job in its 89 year history of supporting pharmacy owners and the industry at large. But now they're fighting for relevance. In a digital age they're an analogue option and they don't need to be.

The PG should embrace change or over time their relevance and influence will both diminish and eventually cease. Like any organisation that perpetuates inefficiency, it eventually becomes extinct because market forces invariably drive change and most importantly the economic resources are not endless to sustain such inefficiency. For example the automotive manufacturing unions in Australia know full well what that means because they perpetuated unsustainably high wages and conditions against a global market whose currencies were actually higher, but where quality was better and manufacturing prices were in most cases 2/3rd cheaper. Come October 2017 there will be no more automotive manufacturing in Australia.

The Guild should consider changing its charter and embrace industry efficiency, societal value and increases in supply by supporting supermarkets to enter the medicine dispensing sector. It stands to simple economic reason that when you have monolithic drug companies whom frankly charge what they like to a highly fragmented market, prices will forever stay high. This goes against the purpose of societal value and maintains Australia as one of the highest priced places in the world for prescription medicines, thus further burgeoning the PBS system. It is just plain wrong. When supermarkets enter the market they will have the bargaining and buying power to reduce the price of supply of prescription medicines and this will flow on beyond just the supermarket sector.

If Guild considered that the likes of Woolworths and Coles would also be "pharmacy owners" then their united strength industry wide would only increase. Some of the existing community pharmacies won't make it and I have to say I am comfortable with that. Why? Because they wouldn't make it anyway in the long term and have neither the capital nor innovation means to drive change and efficiency in a market that so desperately needs it. However the overwhelming benefit is to the community because net dispensing outlets will actually increase. Those who fear supermarket power are also grossly overestimating their position. Yes they are powerful in negotiating low price supply agreements for their products (a good thing, especially against drug companies), but again consumer power is winning over as we see major chains dropping prices in order to compete. The likes of Aldi have further enhanced the market competitive position with consumers and as other international chains enter it will only get better for the consumer. My message here is to use the very power of the supermarket sector for the holistic consumer and community benefit of the prescription medicines sector. We are 2.5 years away from 2020 and a new CPA will come into place, from which parties will advocate their points of view. As I outlined earlier what is needed is a VABESMA not a CPA. Unless they change, it will be a given what the PG will submit, but that is not enough and pharmacists will be left high and dry, again. Does it need to be like this? I don't think so.

Instead of fighting the inevitable changes that will occur, embrace them and structure those changes for community pharmacies and supermarket pharmacies so they can peacefully co-exist. Yes there will be a reduction in community pharmacies (but an increase in overall pharmacy dispensing capability within the industry), but those remaining will be stronger, more profitable and more innovative and those that are struggling will be given the opportunity to sell up. Yes it is survival of the fittest for the value based benefit of the community. Furthermore if these changes are adopted pharmacists will also be paid what they're worth and what they're accountable for.

The rate of PBS growth or reimbursement (particularly for long term generic medicines) must reduce and funds re-directed to those drugs that are both genuinely expensive and beneficial to consumers. Restrictions should be removed from all pharmacy owners to source prescription drugs globally if those drug companies whom have a local presence fail to comply or move with the market forces. In a society so fundamentally capable and mature, Australia should as its core outcome strive to be in the bottom tier of pricing for prescription medicines. A lazy billion saved in the PBS could easily build a world class regional or suburban public hospital that truly benefits the community as a whole. And multiples of that would truly have incredible health benefits nationwide.

To all of you pharmacists, sign up and support the PPA and mobilise to drive the outcomes you want and that the industry needs.

Despite what ALL parties think there is actually a greater level of commonality than you realise, however each party must be prepared to trade off something to drive and strive for the greater good. This greater good comes in the form of:

- ✓ **Personal** – higher pay and higher standards to those actually advising and dispensing medicines for it is here where the work is actually done.
- ✓ **Business** – Increasing supply of prescription medicines and making those left even stronger and providing for those struggling an opportunity to sell up
- ✓ **Industry** – Introduce VABESMA; the Value Based Efficient Supply of Medicines in Australia to replace the current CPA. All parties to submit their VABESMA outcomes.
- ✓ **Economic** – Driving for the greater good and societal value ensuring we can live within our economic means into perpetuity.

Good luck to you all.

Michael Rhodes – April 2017
Dip Tech, MBA, MeCom, MPM
Director - Rhodes Management
mr@rhodesmanagement.com.au