Bruce Annabel Business Time to challenge tradition

'If you're too adherent to tradition, then you tend to be a little bit less innovative. And there have been times when a reverence for the past has overwhelmed the need to be innovative.'[1]

During the past five years or so the traditional community pharmacy business model has survived on the back of generics and their generous attendant dispensary supplier discounts. Without these the traditional model would have been challenged some years ago rather than being deferred until now.

In my *AJP* articles from March to May 2013, I attempted to describe the resultant position community pharmacy owners now find themselves in: being 'too adherent to tradition' has led to bottom line maintenance and business viability which is now reliant on the next big patent expiry. On this point the 'saver' for pharmacy in 2014 was to be Nexium (about $260m dispensed value year ended 31 March 2013) patent expiry. However, after a successful legal defence by Astra Zeneca, it has been extended to 2015. This means that Nexium generic supplier discount dollars won't be there to help offset the various price cuts, including atorvastatin. This will negatively impact 2014 cashflow and net profit.

CONUNDRUM CONFIRMED

Confirmation of pharmacy's conundrum came with two key pieces of data released within the May 2013 budget papers. The first is the $2.7bn decrease to the PBS spend over four years (2013/14 to 2016/17) compared with last year's budget. The second identifies $5.3bn in forecast reductions coming from the general and concessional categories—the backbone of pharmacy dispensing—while the highly specialised drugs category (supply through hospitals) is forecast to grow by $2.6bn. These two pieces of data reflect the savage effects of price disclosure and the emphasis towards more new drugs being distributed to patients through the hospital sector. Both are bad news for community pharmacy and confirm that the sector will be giving up significant savings to the federal budget, taxpayers and health consumers.

A recent response has been a call for government in the next community pharmacy agreement to lift the dispensing fee sufficiently to compensate pharmacy owners for what they have and will be giving up. Whether that occurs, or does so in collaboration with other income sources such as health-outcome remunerated services, remains to be seen. Either way pharmacy owners who wish to remain viable have little choice other than to overhaul their business management practices and convert their competitive model (i.e. competing for customers and script business) from supply and product/price towards a customer health outcomes business model.

THE KEY TO SUCCESSFUL AND SUSTAINABLE COMMUNITY PHARMACIES IS TO BUILD A BUSINESS THAT IS CAPABLE OF SYSTEMATICALLY RESPONDING TO CHANGES

Put another way, the Guild will undoubtedly do a good job for its members in its negotiations with government. But responsibility for future business viability/success lies at the door of pharmacy owners, pharmacists and banner/marketing groups they may be a member of. The Guild can't and won't do it all for you.

WHAT DOES WORK?

The key to successful and sustainable community pharmacies is to build a business that is capable of systematically responding to changes. The fact is that the majority don't yet have that capability. But some have already made the changes and can state that their business model 'is capable of systematically responding to changes'.

When I review some of these pharmacies I have had the privilege of being involved with there seem to be three fundamentals common to all.[2]

1. **Better before cheap.**
2. **Revenue before cost.**
3. **There are no other rules, other than the application of both rules 1 and 2 which have delivered the best results.**

Here is a summary of how the successful pharmacies apply rules 1 and 2:

1. Better before cheap

The pharmacy offers value-adding health benefits in lieu of price discounting to enhance value, i.e. compete on differentiators other than price.

The key elements include:

a. location convenience;
b. offering customers a clear idea of the experience they can expect;
c. total seamless offer (dispensary health destination and retail health);
d. high % mix skilled (pharmacists) and specialist staff—who engage;
e. services, advice, health outcomes first;
f. rebalance merchandise;
g. market differentiators—local area marketing; and
h. being connected.

2. Revenue before cost

Prioritise increasing revenue over reducing costs. The key elements include:

a. selective discounting only, i.e. by customer not by product;
b. increase margin %/price in return for benefits;
c. build health initiatives benefits;
d. productivity—improve quality of staff mix, orient stock mix to health and away from general merchandise, and change physical store to resemble a health location; and
e. market the differentiators and benefits to customers, both existing and prospective, in the surrounding area.

Invest surplus generic largesse in business model reform now because it won't be there in two years' time.

Very rarely is cost leadership a driver of superior profitability in community pharmacy and there is only one group that can lay claim to that advantage.

In my next two *AJP* columns I will explain how the application of these rules by two innovative pharmacy owners, operating in different circumstances and in challenging traditional pharmacy practice markets, have transformed their pharmacies into growing and highly profitable businesses. ■

1. Bob Iger, Disney's CEO, on a More Modern Mouse. HBR IdeaCast, 16 June 2011.
2. Raynor & Ahmed. Three rules for making a company truly great. HBR April 2013: 108–17.

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