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Section 4 – Strategic Options for Pharmacy Research Results

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Section 4: Chapter 1

1 Analysis of Current and Future Service Offerings

1.1 Introduction

This chapter focuses on assessing and understanding current and future service offerings for pharmacies. It specifically addresses the Tender Objective of evaluating community pharmacy's ability to deliver the various services that form part of the agreements between the Government and the Guild. Three questions are addressed:

- What services are currently being offered by pharmacies, their perceived profitability and level of satisfaction?
- What services are planned for the future?
- What factors influence the ability to deliver?

The analyses for the first two questions come from section 3 of the mail survey "The Shape of Our Future" which deals with services offered. In the survey, 33 enhanced services were listed, ranging from services remunerated under the Third Agreement, potential service for the Fourth Agreement to complementary therapies. Complete details of the survey methodology is provided in section 3: 2.2 with a copy of the survey and survey results in appendices 2 & 3.

To address the first question of what services are currently being offered by pharmacies, we provide the results from the survey of the number of pharmacies currently offering enhanced services. We also provide analysis and discussion for the four specific cognitive pharmacy services negotiated under the Third Community Pharmacy Agreement (The Department of Health and Ageing 2000). We then report the survey results for additional services which have been suggested as possible candidates for the Fourth Community Pharmacy Agreement. We also provide supporting data from the survey to give an overall assessment of community pharmacy's ability to deliver these services.

1.1.1 Defining "Ability to Deliver"

Implementing professional services requires a fundamental shift in the role of the pharmacist and changes in practice (Odedina et al. 1995). In this section of the report we have interpreted a pharmacist's ability to deliver professional services as a combination of the services they are actually providing now, their intention to deliver in the future and their overall attitudes toward managing change in the pharmacy.

1.2 Assessment of Current Service Delivery

1.2.1 Enhanced services Offered by Community Pharmacies

Table 4.1 shows the mail survey results (total 575 responses) of the number of pharmacies offering enhanced services, from highest to lowest. CMLs were the enhanced service with the highest percentage offering with 98.4% respondents indicating they provided the service. A definition of enhanced services was stated in the mail survey. This was adapted from the survey conducted for Berbatis et al. (2003) to maintain consistency with previous surveys conducted in Australia.

Packaging for unit/multi-dose dispensing (dose administration aids) was the second highest, with 82.4% respondents indicating they offered the service.

From the pharmacies surveyed there is also a high number offering disease state management services:

- Smoking cessation: 67.3% offer
- Asthma management: 49.5% offer
- Weight management: 47.4% offer
- Diabetes management: 35.7% offer

For the natural and alternate therapies, herbal medicines/nutritional supplement counselling was mentioned as being offered by the most pharmacies (56.5% offering). The offerings of other related services were much lower:

- Aromatherapy: 18.1% offer
- Naturotherapy: 16.1% offer
- Homeopathy: 13.3% offer
- Iridology: 10.7% offer
- Massage: 5.6% offer
- Reflexology: 0.9% offer

Table 4.1: Enhanced Services Offered by Pharmacies

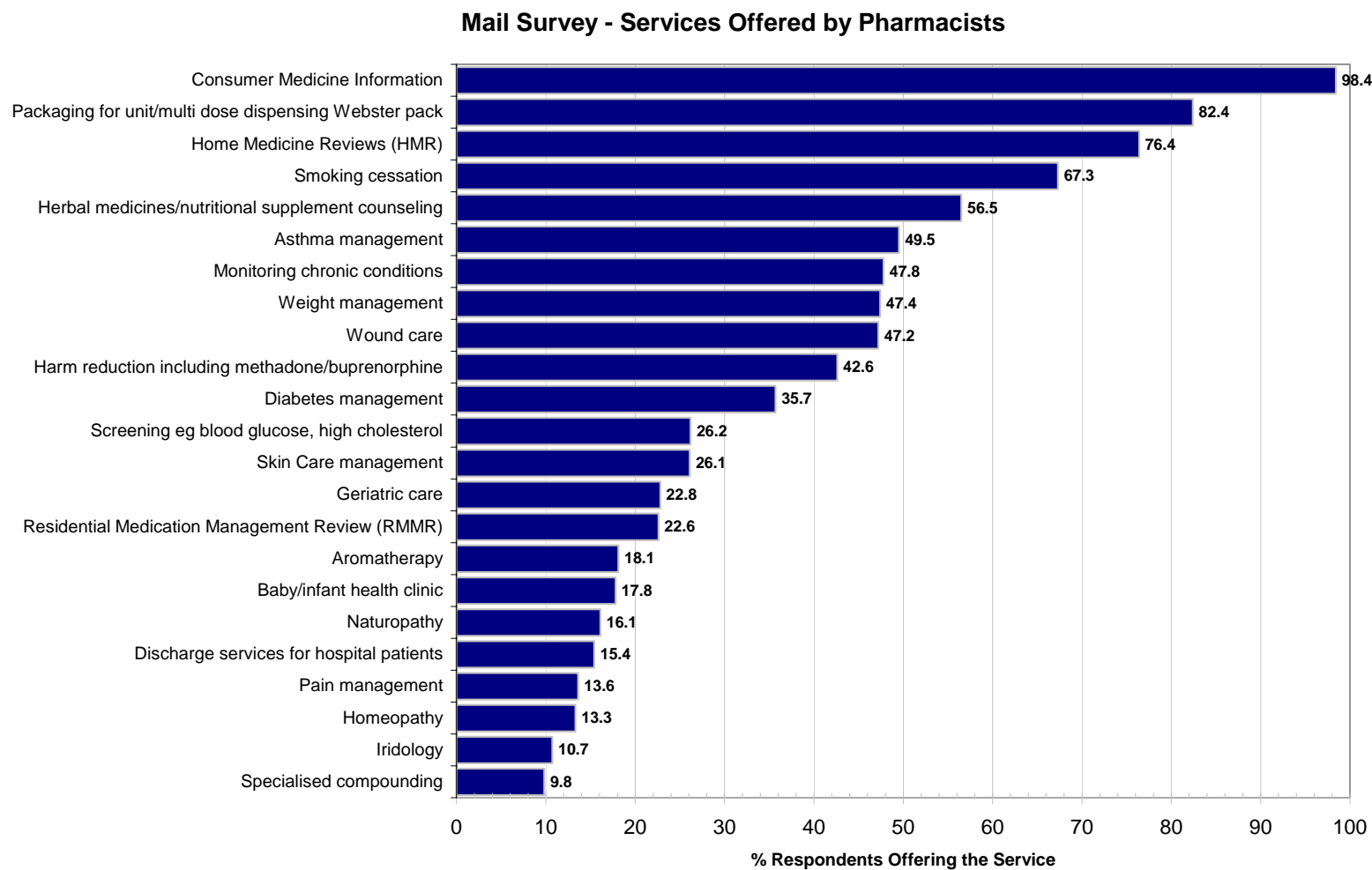
Service	Total responses	No. who offer	% offering
Consumer Medicine Information	570	561	98.4
Packaging for unit/multi dose dispensing Webster pack	562	463	82.4
Home Medicine Reviews (HMR)	560	428	76.4
Smoking cessation	556	374	67.3
Herbal medicines/nutritional supplement counseling	547	309	56.5
Asthma management	546	270	49.5
Monitoring chronic conditions	558	267	47.8
Weight management	548	260	47.4
Wound care	551	260	47.2
Harm reduction including methadone/buprenorphine	554	236	42.6
Diabetes management	543	194	35.7
Screening eg blood glucose, high cholesterol	553	145	26.2
Skin Care management	536	140	26.1
Geriatric care	540	123	22.8
Residential Medication Management Review (RMMR)	549	124	22.6
Aromatherapy	546	99	18.1
Baby/infant health clinic	544	97	17.8
Naturopathy	546	88	16.1
Discharge services for hospital patients	546	84	15.4
Pain management	538	73	13.6
Homeopathy	543	72	13.3
Iridology	542	58	10.7
Specialised compounding	482	47	9.8
Community clinic services with nurse	542	37	6.8
Nutritional support	486	33	6.8
Massage	539	30	5.6
Aboriginal health services	543	24	4.4
Drug level monitoring/kinetic dosing	541	21	3.9
Mail order or web based prescriptions	542	18	3.3
Chemotherapy preparation	536	6	1.1
Reflexology	540	5	0.9
Acupuncture	543	3	0.6

Notes:

1. These services are not mutually exclusive. For example: Herbal medicines/nutritional supplement counselling can also be considered as part of nutritional support.
2. Although respondents have indicated they offer the services, this does not mean that they actually provide these services in large numbers or in any depth. There may have been a response bias by participants in answering this question in the positive. However the case studies do provide more detailed insights into what these offerings mean in practice.
3. * indicates current Third Agreement services.

The distribution of these service offerings is shown graphically in figure 4.1.

Figure 4.1: Services Offered by Pharmacies



1.2.2 Assessment of Third Agreement Service Offerings

Table 4.2 below shows a summary of results from the mail survey showing the percentage of respondents who indicated they currently offer Third Agreement services. For more information on these services refer section 3: 1.5.3.1.

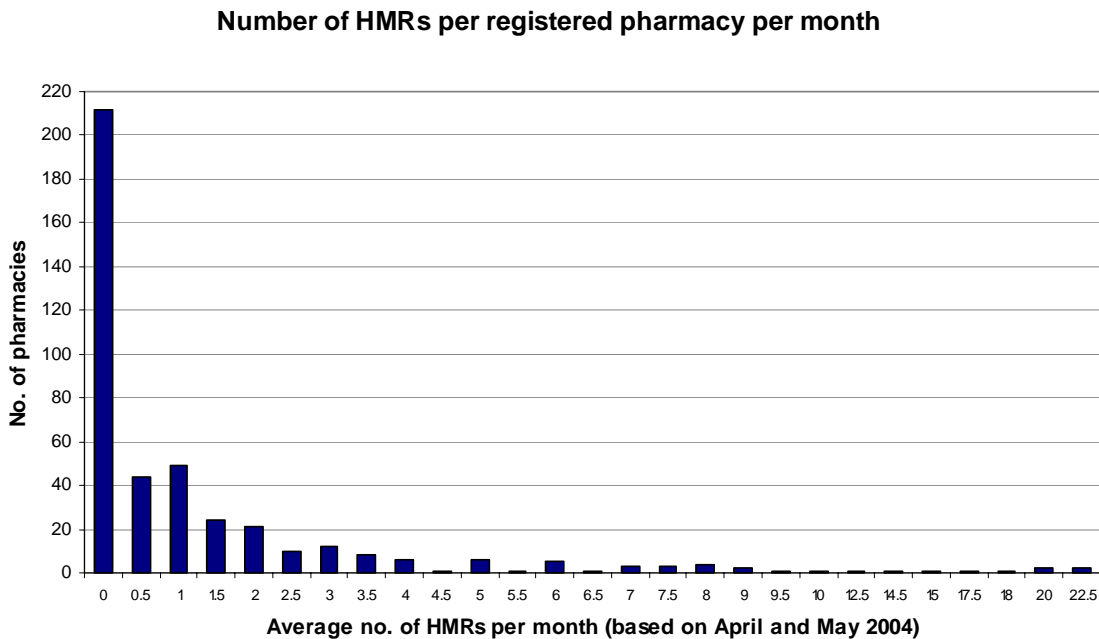
Table 4.2: Number of pharmacies offering/planning to offer Third Agreement services

Service	Total responses	Currently Offer		Not Currently Offering	
		No. offering service	% of total respondents	No. planning to adopt	% of total respondents
Consumer Medicine Information (CMI)	570	561	98.4	3	0.5
Home Medicine Reviews (HMR)	560	428	76.4	43	7.7
Residential Medication Management Reviews (RMMR)	549	124	22.6	29	5.3
Aboriginal Health Services (AHS)	543	24	4.4	4	0.7

CMIs were offered by almost all respondents (98.4%), with HMRs offered by 76.4% of respondents. The HMR figure is lower than the published figure for pharmacies offering HMRs¹. We compared these figures with the survey data from Roberts et al (2004) as shown in figure 4.2. This illustrates that even though a large proportion of pharmacies offer HMRs, the number of HMRs actually conducted per pharmacy is minimal. Over 60% of this survey's respondents were carrying out less than one HMR per month.

¹ As at 20 October 04, 4,564 pharmacies were registered to conduct HMRs, representing approximately 93% of registered pharmacies. However, being registered may not be the same as actually offering the service.

Figure 4.2: Number of HMRs conducted per registered pharmacy per month



Source: Roberts et al. (2004)

The response for those pharmacies offering RMMRs appears relatively low at 22.6%. However, this figure is similar to the 25% found in the survey by Roberts et al. (2004). The relatively low figure could be due to the same service being delivered through consulting companies that deliver RMMRs independently of community pharmacies but it should also be noted that the total market for this service is limited by the number of available residential care facilities. The remuneration for these services is through a pharmacist, rather than the pharmacy. From Guild sources, we understand there are approximately 500 contracts nationally for 140,000 people in aged care facilities. Half of the reviews (70,000) are undertaken by only about 20 service providers.

Sixteen survey respondents indicated they were offering AHS. While this represents 4.4% of the total responses received, it is not representative of the percentage that actually provide this service. Discussions with the Guild and other sources indicated that whilst approximately 40 pharmacies are registered to provide the services, only about 20 are currently offering them. In interpreting the figures for AHS it should be kept in mind that, under the government agreement, there are only approximately 40 pharmacies potentially able to provide this service.

1.2.2.1 Third Agreement Services Planned for Future Adoption

Table 4.2 also shows the response rates of those planning to adopt Third Agreement services in the next 12 months. As a measure of future adoption, these figures may be conservative, since there may be other pharmacists planning to adopt beyond the next 12 months. For those planning to adopt a service, HMRs had the highest response (7.7% of total respondents). This is shown in figure 4.3 which shows the number of pharmacies currently offering and those planning to adopt Third Agreement services. Despite the general view in the industry that the adoption has been low, these figures show a significant penetration of pharmacies in these areas.

Figure 4.3: Number of pharmacies currently offering and those planning to adopt Third Agreement services

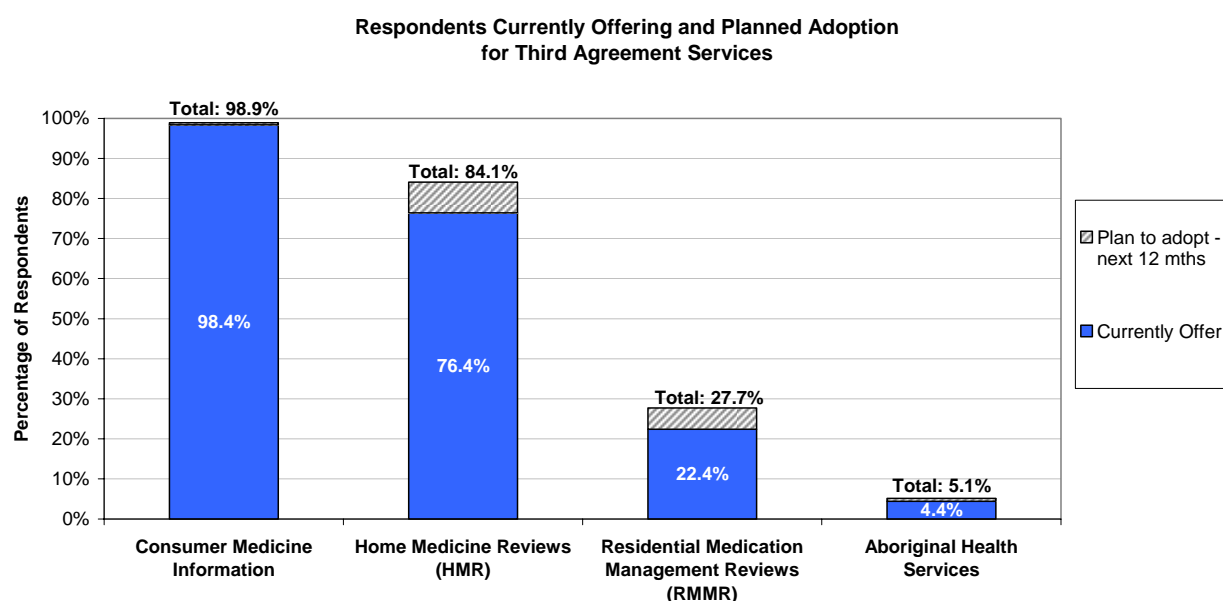


Table 4.3 shows the percentages and means for the four remunerated services under the Third Agreement.

Table 4.3: Factors influencing delivery of current Third Agreement services offered

Service	No. offering service	Specially trained or accredited pharmacist or staff member providing service		Pharmacist satisfaction with service ²		Perceived profitability ³		Perception of customer take-up ⁴	
		N	%	Mean	Median	Mean	Median	Mean	Median
Consumer Medicine Information (CMI)	561	284	61.9	4.1	4	1.8	1	3.5	3
Home Medicine Reviews (HMR)	428	327	85.2 ⁵	3.5	4	2.2	2	2.3	2
Residential Medication Management Reviews	124	95	74.8 ²	3.6	4	2.2	2	3.1	3
Aboriginal Health Services	24	11	14.5	3.5	4	2.3	2	2.6	3

Each of the means for Third Agreement services are plotted in figure 4.4. The means show that the level of satisfaction for CMIs is higher (mean 4.1, median 4) than for RMMRs (mean 3.6, median 4) and than HMRs and AHS (mean 3.5, median 4).

² on a scale of 1 to 5, where 1=very dissatisfied and 5=very satisfied

³ on a scale of 1 to 5, where 1=low profitability and 5=high profitability

⁴ on a scale of 1 to 5, where 1=very dissatisfied and 5=very satisfied

⁵ It should be noted that for HMRs and RMMRs fully accredited pharmacists are required. The discrepancy may be due to a consultant pharmacist being used.

Respondents seem consistently satisfied with the services they offer but perceive them as not particularly profitable. The perceived profitability is low for each, with means ranging from 1.8 for CMI to 2.3 for AHS, with mean profitability for RMMRs and HMRs at 2.2. For HMRs 14% of respondents rate the profitability as high as 4 or 5 on the five-point scale and this could come from pharmacists who are providing large numbers of HMRs.

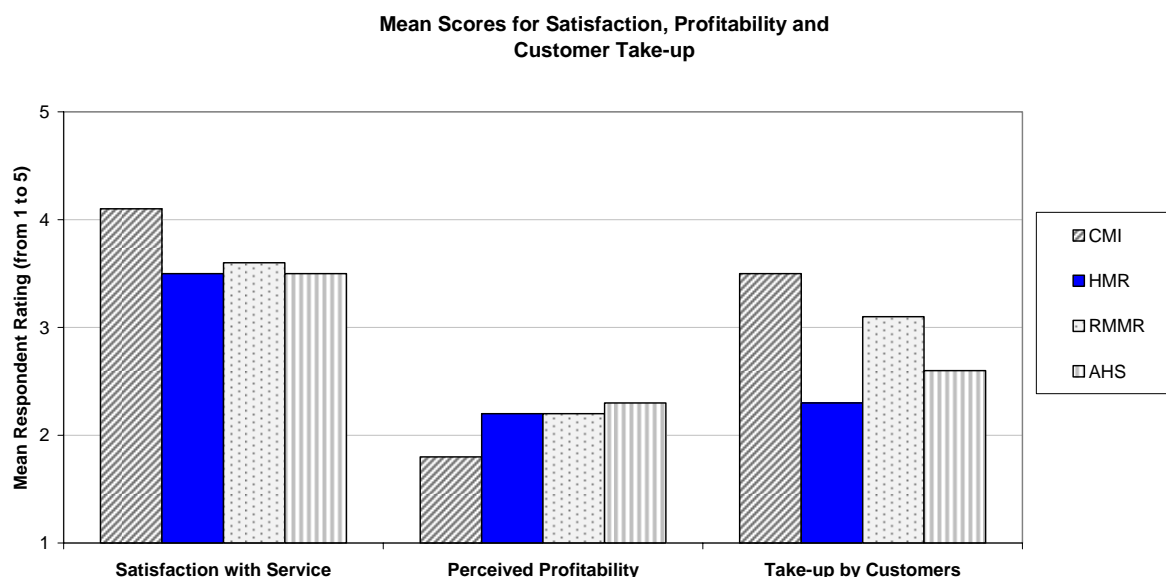
CMI can be considered straightforward and relatively easy to deliver and this is reflected in the high offering. The high offering may also reflect the time it takes for the pharmacy network as a whole to implement a new service.

Recommendation: As the majority of pharmacists perceive that service provision has low profitability, the Guild should demonstrate how to enhance the potential profitability of existing and future services. (Recommendation 62)

Where services have been negotiated through the agreement, there has been a relatively high take-up rate by customers as perceived by respondents. Perception of customer take-up by respondents was highest for CMIs (mean 3.5, median 3) and lowest for HMRs (mean 2.3, median 2). Given that this represents a departure from the existing pharmacy role, to reach this point over four years is a significant achievement. There are new pharmacists entering the profession, and new owners who may not have been part of the Guild's initial launch. Ongoing support and stimulation are required to ensure the gains are consolidated on a continuing basis so they are not lost.

Recommendation: In relation to existing current service offerings, the Guild should work to ensure that the current level of adoption is extended and deepened. It is important to continue to consolidate the changes already introduced. (Recommendation 27)

Figure 4.4: Satisfaction with Service, Profitability and Take-up by Customers for Third Agreement Services



1.2.2.2 Possible future services for Community Pharmacy Agreements

A number of future services have been canvassed in the literature. A selection of these was included in the survey. As can be seen in table 4.4, there already is currently a very high percentage of survey respondents offering dose administration aids (at 82.4%), with substantial customer take-up for the other services also. More than one-third to over half of respondents currently offer services for diabetes management, harm reduction and asthma management.

The table also shows the responses for those planning to adopt potential Fourth Agreement services. These figures are probably conservative in estimating future adoption rates, since they are based on respondents specifically indicating if they plan to adopt the service in the next 12 months only. Asthma Management had the highest response of those planning to adopt the service with 13.9% of all respondents indicating they planned to adopt. This is shown graphically in figure 4.5.

Table 4.4: Response rates for possible Fourth Agreement services

Service	Total responses	Currently Offer		Not currently offering	
		N	% of those offering	No. planning to adopt	% of total respondents
Asthma Management	546	270	49.5	76	13.9
Diabetes Management	543	194	35.7	60	11.0
Harm reduction - methadone/buprenorphine	554	236	42.6	9	1.6
Dose Administration Aids (DAA)	562	463	82.4	12	2.1

Figure 4.5: Response rates for those currently offering and those planning to adopt selected services

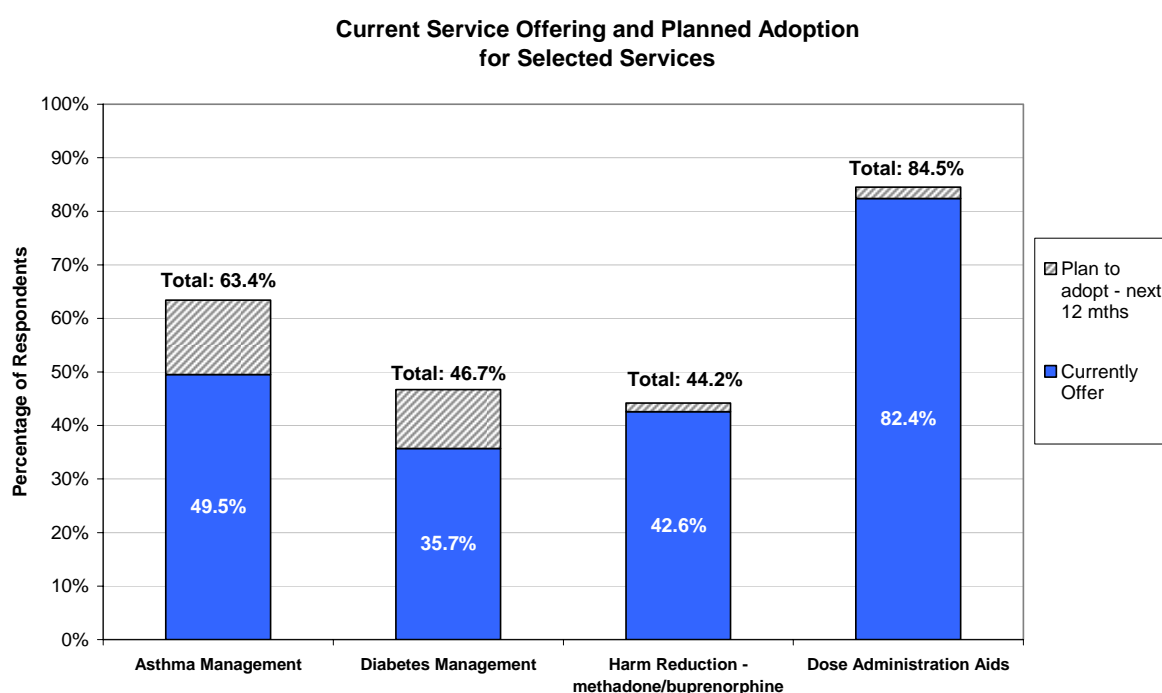


Table 4.5 shows the percentage of customers charged for the service, whether a specially trained or accredited pharmacist is available for the services, the mean scores for perceptions of satisfaction with the service, profitability of the service and customer take-up rate. Interestingly, for both harm reduction and dose administration aids a high percentage of consumers are charged while for asthma and diabetes a minimal number are being charged (1-2%). There appears to be no significant relationship (tested using Cramer's V) between the customer take-up and charging for the four services previously mentioned.

Table 4.5: Factors influencing delivery of possible candidates for Fourth Agreement Services

Service	No. offering service	Customers charged for this service		Specially trained or accredited pharmacist or staff member available for service		Pharmacist satisfaction with service ⁶		Perceived profitability ⁷		Perception of customer take-up ⁸	
		N	%	N	%	Mean	Median	Mean	Median	Mean	Median
Asthma Management	270	11	4.1	143	53.0	3.2	3	2.0	2	2.3	2
Diabetes Management	194	7	3.6	115	59.3	3.5	4	1.9	1	3.4	4
Harm reduction - methadone/buprenorphine	236	207	87.7	169	71.6	3.9	4	3.2	3	3.2	3
Dose Administration Aids	463	364	78.6	291	62.9	3.9	4	2.4	2	3.0	3

Table 4.5 and figure 4.6 show the satisfaction with the service as perceived by the pharmacist is comparatively high (mean 3.9, median 4 for harm reduction and dose administration aids). 73% of respondents rated harm reduction either a 4 or 5 on the five-point scale for satisfaction and 70% of respondents rated unit dose dispensing with a satisfaction score of 4 or 5 where 5 equals high satisfaction.

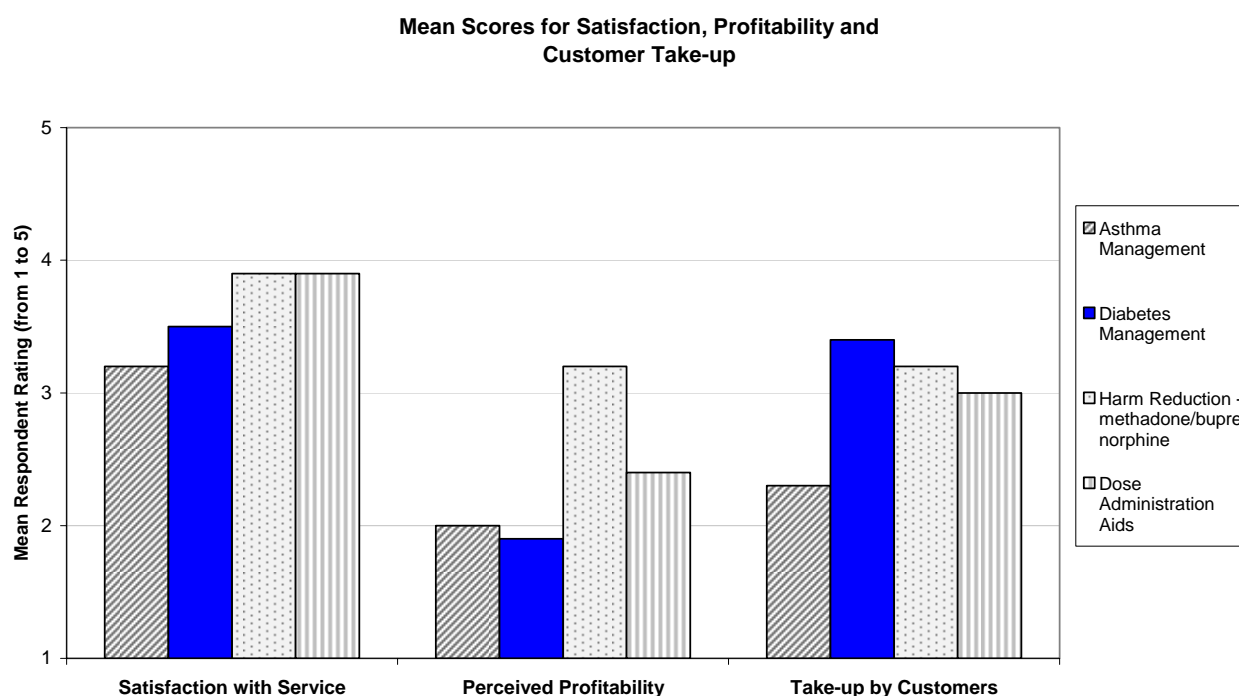
The high percentage of respondents indicating they had a specially trained or accredited pharmacist or staff member available for the service indicates that pharmacies are investing in trained personnel to provide these services.

⁶ on a scale of 1 to 5, where 1=very dissatisfied and 5=very satisfied

⁷ on a scale of 1 to 5, where 1=low profitability and 5=high profitability

⁸ on a scale of 1 to 5, where 1=low take-up and 5=high take-up rate

Figure 4.6: Responses to Service, Profitability and Customer Take-up of Possible Future Agreement Services



However, the perceived profitability of these services is relatively low, with harm reduction having the highest mean of 3.2. Harm reduction scored highest on the individual ratings, with 42% of respondents respectively scoring it a 4 or 5 on the five-point scale, where 5 equals high profitability. It is interesting to note that there does not appear to be a significant relationship between charging for the service, perceived profitability of the service and the satisfaction of the pharmacist. The only exception to this was a significant relationship (tested using Cramer's V) between charging and profitability for harm reduction. This is consistent with the qualitative findings of this report and Roberts et al. (2003).

From the chart it can also be seen that there is a perception of a relatively strong take-up of these services with the exception of asthma management (mean 2.3). Only 16% of respondents marked a 4 or 5 on the five-point scale, where 5 equals high customer take-up.

1.2.2.3 Conclusion

The results from the survey for possible Fourth Agreement services are encouraging, since they highlight the progress already being made by community pharmacy toward offering these professional services despite lack of government funding. It highlights the commencement of building capability within the profession, and signals an early notification to the marketplace. The proportion intending to offer in the next year, if they do act, would bring the total proportion these services in the range of 98.9% (CMIIs) to 44.2% (Harm reduction)⁹. The lower figures would no doubt be strengthened if a substantially revised reward system (government or fee-for-service) were introduced.

⁹ These figures do not include RMMR and Aboriginal Health Services.

1.3 Pharmacy Characteristics Influencing the Ability to Deliver

We also examined pharmacy characteristics to see whether they might explain differences in service offerings. We examined differences in service provision between: PhARIA zones; networked and non-networked pharmacies, and pharmacies of different size and with different dispensing volumes. Comparisons are discussed below.

1.3.1 Comparison of Services Offered by PhARIA¹⁰ categorisation

The following graph (figure 4.7) outlines the number of services offered by PhARIA. Pharmacies in PhARIA 1 dominated the responses, with 79% of surveys returned coming from pharmacies in PhARIA 1¹¹. The mean number of services offered by PhARIA is shown in table 4.6.

Table 4.6: Responses by PhARIA

PhARIA	Number of Responses	Mean Number of Services Offered	Standard Deviation	Median
1	445	8.6	4.0	8.0
2	26	10.2	4.5	9.5
3	45	7.4	3.4	7.0
4	23	8.5	3.6	9.0
5 and 6	25	9.3	5.6	7.0

Due to the small number of responses for PhARIA categories 2 to 6 (23 to 45 responses) compared with PhARIA 1 (445 responses) the means have not been compared. From the graph, over three-quarters of pharmacies in PhARIA 1 offer between 5 to 14 services, compared with 52% of pharmacies in PhARIA 5 and 6.

¹⁰ The index results, ranging from 0 (high accessibility) to 12 (high remoteness), have been divided into a 6 category classification system as follows:

- Category 1: Highly accessible
- Category 2: Accessible (Group A)
- Category 3: Accessible (Group B)
- Category 4: Moderately Accessible
- Category 5: Remote
- Category 6: Very Remote

¹¹ The PhARIA response rates is consistent with Berbatis et al. (2003) where 81% of pharmacies were in PhARIA 1.

Figure 4.7: Service offering as categorised by PhARIA

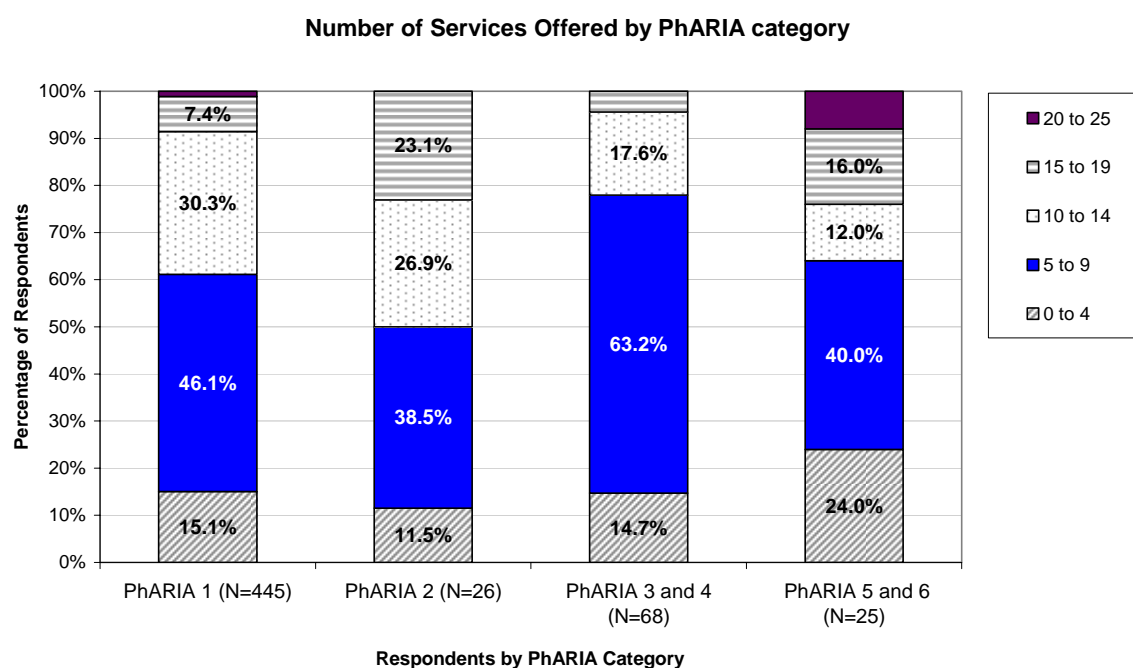


Table 4.7 shows the number of mail survey respondents offering services as grouped by PhARIA.

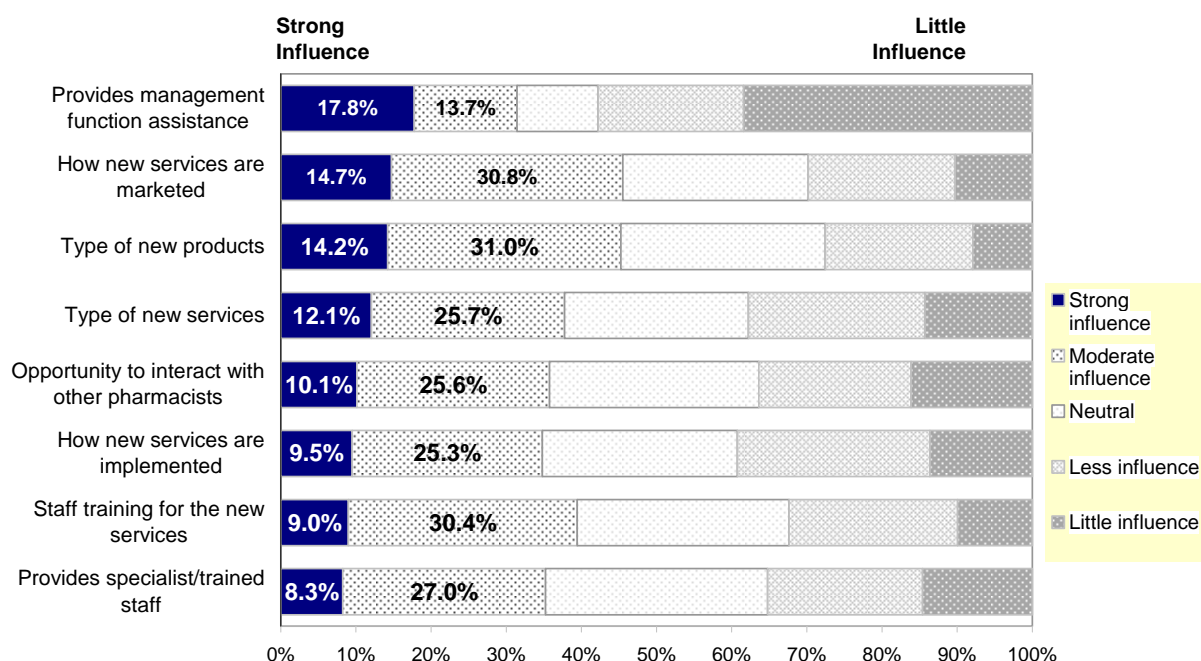
Table 4.7: Number of respondents offering services as grouped by PhARIA

PhARIA	Number of Responses	0 to 4	5 to 9	10 to 14	15 to 19	20 to 25
1	445	67	205	135	33	5
2	26	3	10	7	6	0
3	45	7	30	6	2	0
4	23	3	13	6	1	0
5 and 6	25	6	10	3	4	2

1.3.2 Comparison of Pharmacy Networks

The mail survey also asked respondents to rate the influence of their network which includes banner groups and informal networks and/or family groups. The results are shown in figure 4.8. This graph highlights the strong influence of networks in providing assistance in management functions (31.5% reported being strongly and moderately influenced). Networks are also reported as having strong influence in how new services are marketed (45.5% reported being strongly and moderately influenced) and the types of new products that are introduced (45.2% reported being strongly and moderately influenced).

Figure 4.8: Responses for network influence (N ranges from 312 to 316)



In figure 4.9 and table 4.8 there is an analysis of those pharmacies that indicated they are in a network group and those that are not in a group by the number of services they offer. Networked pharmacies tend to offer more services.

Figure 4.9: Service offering compared against Network or Non-Network Pharmacies

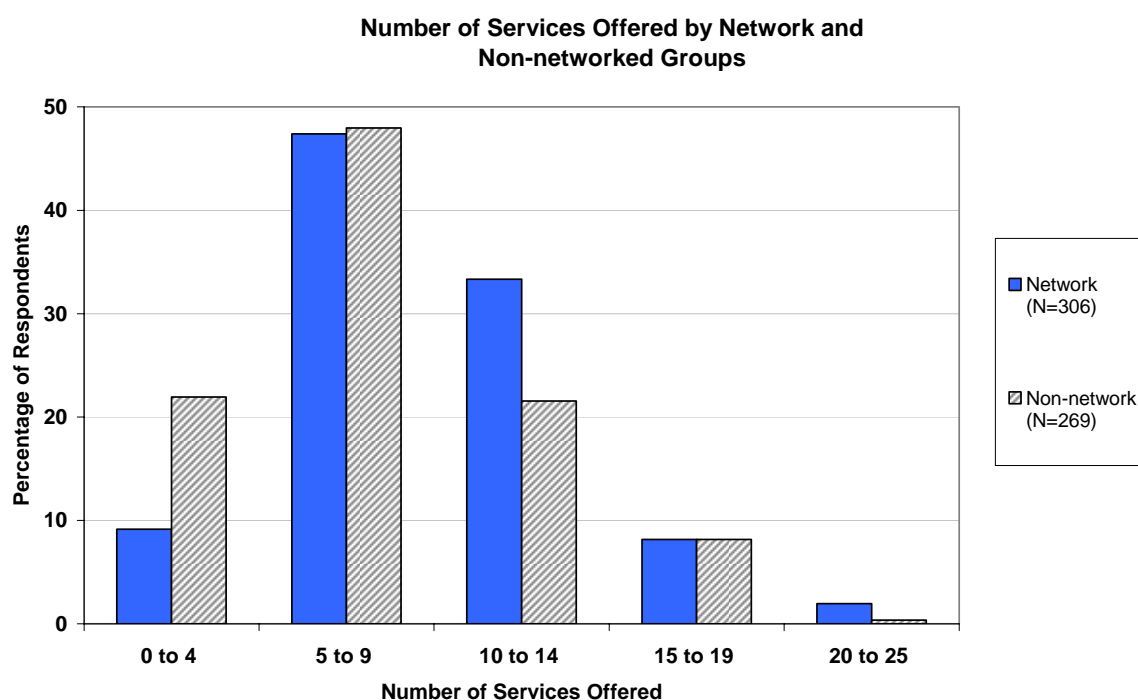


Table 4.8: Survey responses by Non-network and Network

	Number of Responses	Mean Number of Services Offered	Standard Deviation	Median
Non-networked	269	7.8	4.1	7
Networked	306	9.3	3.9	9

It appears that there may be a positive relationship between the number of services being offered and network membership, particularly between the range of 10-14 services (21.6% for non-networked, 33.3% for networked). This relationship would warrant further analysis to determine how networks could be used to accelerate change and the adoption of services.

Recommendation: The Guild should further investigate how network membership impacts on the rate of service adoption. (Recommendation 26)

1.3.3 Number of Services and Pharmacy Size

Figure 4.10 and table 4.9 outline the number of services offered by pharmacy size. Smaller pharmacies (less than 130 sqm) offer a lower number of services than larger pharmacies (more than 241sqm).

The Guild may need to accept that many smaller pharmacies may be unable to offer a full range of services. Elsewhere in this report, we discuss the time and other pressures faced by small pharmacies that limit their potential for service delivery. This has implications for the Guild's negotiations with government.

Figure 4.10: Service offering by Pharmacy Size

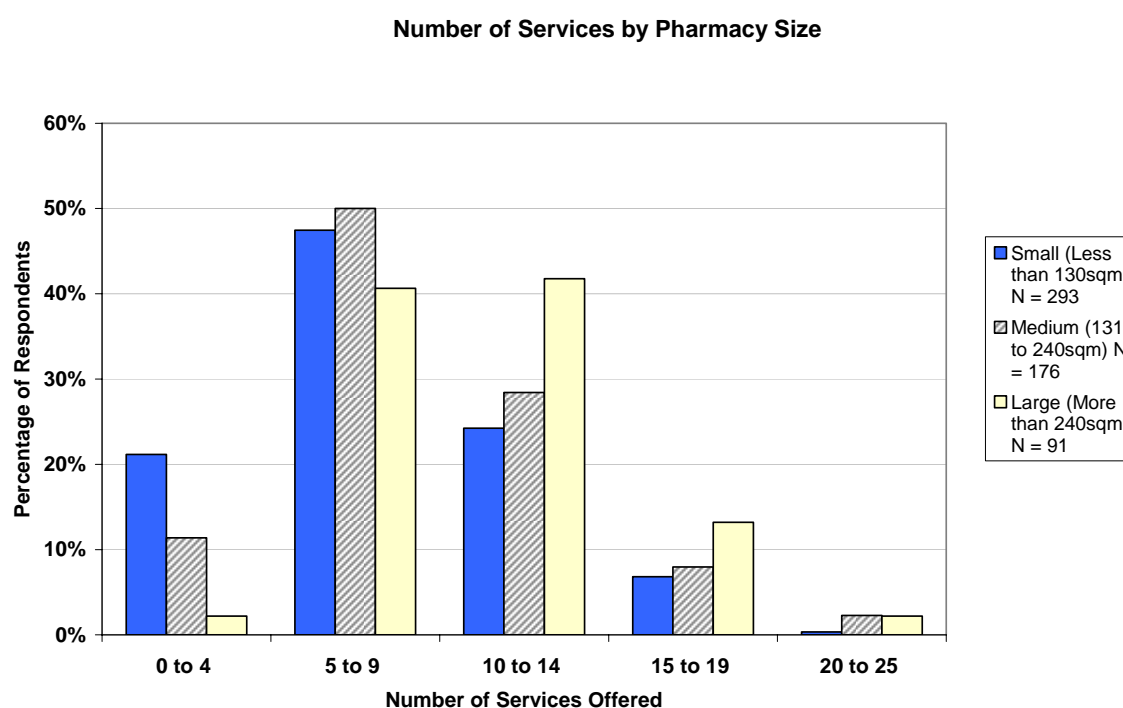


Table 4.9: Responses by Pharmacy Size

	Number of Responses	Mean Number of Services Offered	Standard Deviation	Median
Small (Less than 130 sqm)	293	7.9	3.9	7
Medium (131 to 240sqm)	176	8.9	4.1	8
Large (More than 240sqm)	91	10.7	3.8	11

1.3.4 Number of Services and Dispensing Volume

The following data (figure 4.11 and table 4.10) show the number of services offered by dispensing volume. The pharmacies with a high dispensing volume (more than 65,000 per annum) offer a higher number of services than pharmacies with a lower dispensing volume (those dispensing up to 65,000 scripts). This point highlights that a “product to service continuum” may not reflect the reality of how pharmacies operate or it may reflect that larger turnover pharmacies are providing a higher number of services. However, respondents may have interpreted service in a limited way. Pharmacy services are mostly product related and it seems that increasing the number of prescriptions increases the number of associated services offered.

Figure 4.11: Service offering compared against Dispensing Volume

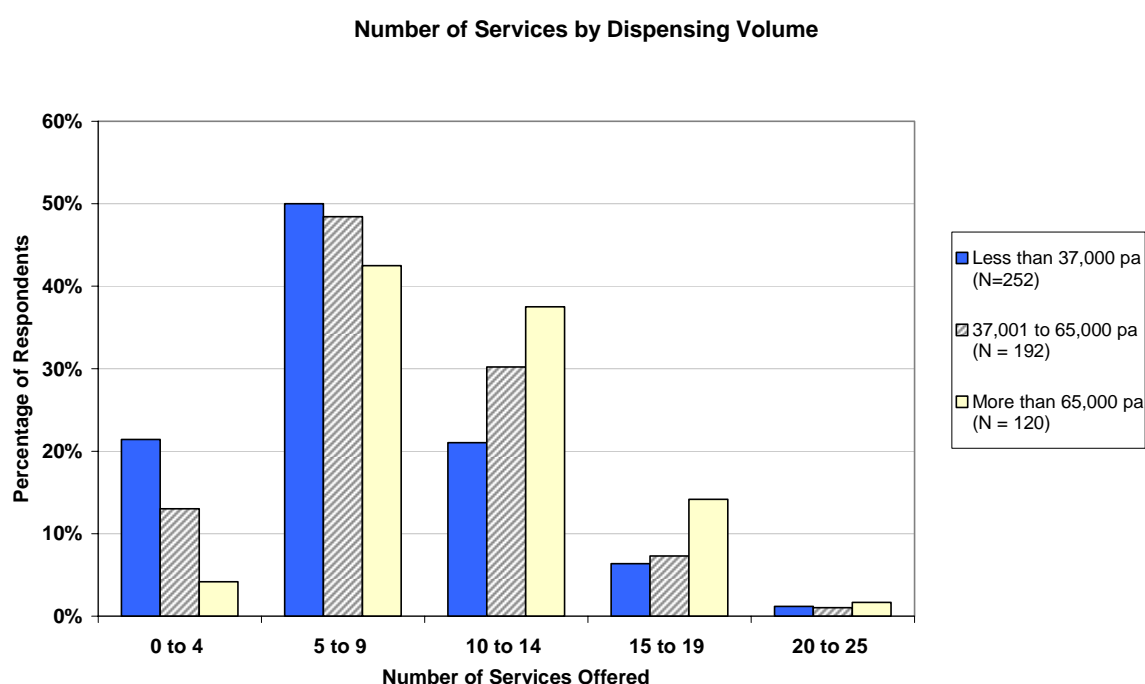


Table 4.10: Survey responses by Dispensing Volume

	Number of Responses	Mean Number of Services Offered	Standard Deviation	Median
Less than 37,000	252	7.8	4.1	7
37,001 to 65,000	192	8.6	3.9	8
More than 65,000	120	10.4	3.8	10

Recommendation: The Guild needs to emphasise to pharmacists and other stakeholders that products can be a nexus around which related services can be developed with mutual benefit in sales of both (where the services are charged for). (Recommendation 44)

1.4 People Related Factors Influencing the Ability to Deliver

The pharmacy's ability to deliver will depend on turning the intent to introduce services into action and the response of their staff and other people to change. The mail survey asked pharmacists to respond to a number of questions related to this:

- Whether a specially trained or accredited pharmacist was available to deliver the service
- Assessing pharmacists' "readiness for change" - attitudes toward new ideas and change in the pharmacy
- What information assisted in making the decision for change

1.4.1 Specially trained staff available to deliver the service

Table 4.11 below shows the correlation coefficient (Cramer's V) for current remunerated services, and for the possible candidates for services.

Table 4.11: Relationship between service take-up by consumers and having a specially trained person for Third Agreement programs and potential candidates for Fourth Agreement.

Service	Cramer's V
Aboriginal Health Management	.494
RMMR	.336
Diabetes Management	.369
Packaging for unit/multi dose dispensing	.214
Asthma Management	.226
Home Medicine Review (HMR)	.175
Harm Reduction (methadone/buprenorphine)	.156
CMI	.100

These results highlight that currently take-up of services by consumers is not highly dependent on having a trained person in all cases. The services where take-up was highly correlated to having a specially trained person were: Community Clinic Service & Nurse (0.652), Naturopathy (0.563) and Specialised Compounding (0.464). Clearly some services demand more specialised knowledge and skills than others. It also takes significant time to train and qualify pharmacists for new services.

Recommendation: The Guild should work with the educational providers to ensure that there are sufficient trained and/or accredited personnel to deliver new services. (Recommendation 56)

Recommendation: The Guild should work with the PSA to set standards of excellence for service delivery. (Recommendation 50)

Recommendation: The Guild should work with the PSA to develop professional qualifications for pharmacists or pharmacy staff offering services (Recommendation 51)

1.4.2 Readiness for Change

Readiness for change is defined as an organisation's plan for change and its ability to execute it. It also refers to the organization's history of change and its success or failure in it (Narine and Persaud 2003). While readiness for change is an attractive construct when considering change management, there is relatively little research around the actual construct (Eby et al. 2000). These authors suggest an employee's perception of readiness for change is a major factor in understanding large scale resistance to change, in that it represents the precursor behaviours of resistance to, or support for, a change effort.

An organisation's ability to successfully implement large scale change has been shown to be directly related to its 'readiness for change' or 'capacity for action' (Greenwood and Hingis 1996; Ingersoll et al. 2000). This readiness however, begins with an individual's perception of the benefits of change, the risks of failing to change or the demands of externally imposed changes (Cunningham et al. 2002).

The survey (section 2, part C) included 30 statements about attitudes to change and asked respondents to indicate the extent they agreed or disagreed with the statement. These constructs around attitudes were developed from previous studies and assessed attitudes toward innovation, attitudes toward change initiatives in community pharmacy, clarity of vision, resources and skills and for change and support of change initiatives in the pharmacy. Detailed results are provided in appendix 3.

Overall, pharmacists indicated they were open to new ideas and changes in the workplace and there appear to be a high proportion of pharmacies ready to change. However, while the attitudes are positive, comparing these with other factors shows that it is only about one-third who are adopting and supporting change in a proactive way. For example, while 88.5% of respondents agreed/strongly agreed they were open to new ideas and change in the workplace, only 36.4% of respondents agreed/strongly agreed that they were generally the first to try a new idea. The latter statement is consistent with the strategy questions (see table 4.11) where 31.2% indicated they were "Prospectors", i.e. innovators willing to take the necessary risks of providing new products and services. Similarly 35.7% of respondents were classified in the Defender¹² category, with 16.1% in Reactor category, yet they see themselves as open to change. Simply reacting to change (Reactor) is non-strategic and a Defender strategy represents a very conservative approach to change adoption. This indicates that over half of respondents will not change unless triggered by some type of threat, such as the entry of supermarkets. This confirms the views expressed by stakeholders, such as wholesalers, that many pharmacists are conservative regarding change.

¹² As per the Miles and Snow strategy categories of Defender (We stick to what we know how to do and do it as well as or better than anyone else), Prospector (We are innovators and are willing to take the necessary risks of providing new products and services), Analyser (We do not want to be first in our industry to offer an un-proven product or service, but we try to be close behind with a similar product or service that is competitive), and Reactor (We do not follow a specific program or plan for making us more competitive, although when we are faced with strong threats, we definitely make changes).

Table 4.12: Responses to Miles and Snow strategy questions

	N = 571	%
Defender: We stick to what we know how to do and do it well as or better than anyone else	204	35.7
Prospector: We are innovators and are willing to take the necessary risks of providing new products and services	178	31.2
Analyzer: We do not want to be first in our industry to offer an un-proven product or service, but we try to be close behind with a similar product or service that its competitive	97	17.0
Reactor: We do not follow a specific program or plan for making us more competitive, although, when we are faced with strong threats, we definitely make changes	92	16.1

Recommendation: The Guild continues to conduct environmental scans and use appropriate channels to update pharmacists on emerging challenges and opportunities for the industry. (Recommendation 18)

1.4.3 Mobilising the change

When moving from contemplation to action, the decision to proceed will vary for individuals depending on their personal motivation and business strategy. 71.7% of survey respondents agreed/strongly agreed that they only introduce enhanced services that fit the pharmacy's business strategy (statement 4). We regard this as an appropriate position from a business perspective. This also highlights the importance for the Guild to promote business strategies, such as the PVM or similar models, emphasise the importance of strategic action in the industry.

Figure 4.12 shows the relative importance of various factors to pharmacists in their decision to implement a new service. A clear understanding of the benefits of a new service was the most important factor in deciding whether to implement a new service, with 93.7% of respondents considering this important or very important.

Pharmacy staff support was considered the next most important factor in the decision to implement a new service, with 86.9% considering this important or very important. If pharmacy employees are not supporting the new product/service it is difficult to get any initiative underway.

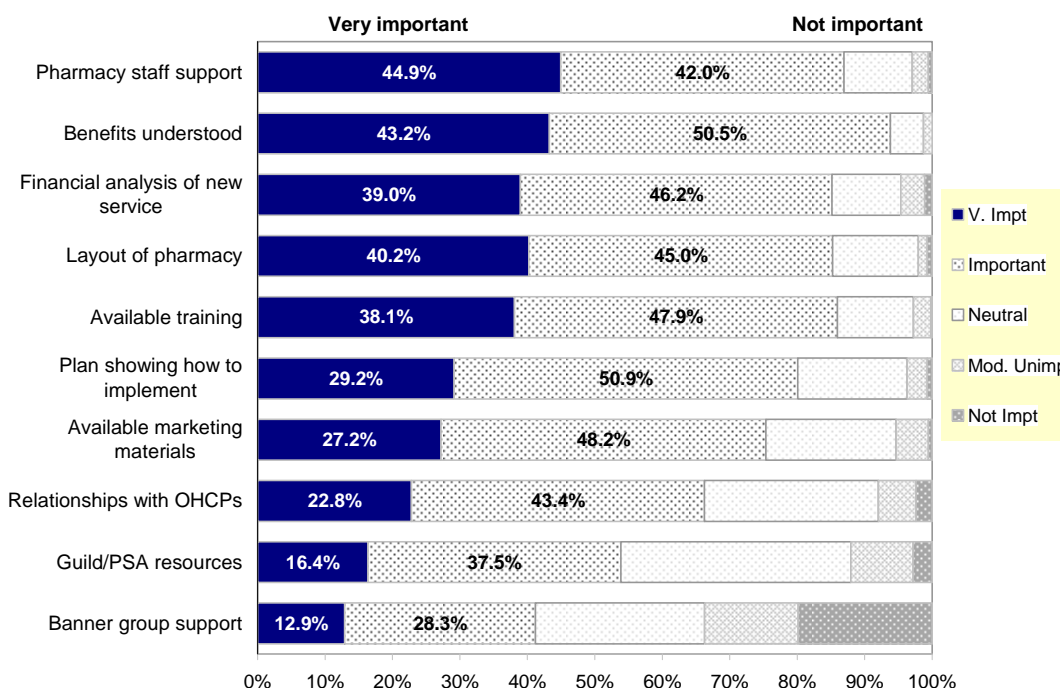
Other items considered very important were:

- Financial analysis and costing of the new service
- Layout of the pharmacy and
- Available training

This information is useful when considering pharmacists' ability to deliver services and in designing strategies for service implementation and change diffusion. These issues are dealt with in section 5 which outlines the PharmInd, Pharmacy Change Readiness and Change Implementation Wheels.

Recommendation: The Guild should make the Pharmacy Change Readiness and Pharmacy Change Implementation Wheels available to pharmacists (see later recommended communication strategy). (Recommendation 25)

Figure 4.12: Summary of survey responses regarding importance of factors influencing decision to implement a new service



Other results in this figure show the importance of establishing pilot programs that can be “showcased” and provide a model for other pharmacies. There should be clear business and service evaluation criteria with transparent monitoring and publishing of conclusions.

Recommendation: The Guild should identify and work with pharmacy owners/managers who appear more open to change and more innovative to establish working prototypes of new initiatives. (Recommendation 68)

1.5 Support and role of Guild

The Guild needs to play a strong role in putting change on the agenda for pharmacists. 87.4% of respondents (strongly agree/agree) with community pharmacy introducing enhanced services (statement 2) and indicate a compelling need for community pharmacy to introduce these services (statement 26 – 69.7% agree/strongly agree with statement). However 37.3% of respondents strongly agree/agree that there had been too much change imposed on community pharmacy in recent years (statement 13).

Respondents recognised the business impact of the negotiations by the Guild on their behalf. 76.9% of survey respondents strongly agreed or agreed with the statement “the outcome of the Guild/Government negotiations strongly impacts on my business”. Translating these negotiations into practical programs is however seen as an issue as shown in responses to the survey statements “the Guild has a realistic understanding of the practical issues when implementing new services” where 41.6% agree/strongly agree, and “the Guild has a realistic understanding of the financial implications when implementing new services” where only 34.4% agree/strongly agree.

Recommendation: The Guild should place more emphasis on developing implementation plans and financial reward structures when introducing new services. (Recommendation 22)

Recommendation: The Guild should demonstrate to its members that it has a realistic understanding of the practical issues and financial implications of implementing new services at a pharmacy level. (Recommendation 60)

1.6 Conclusion

Overall, pharmacists are developing their capacity to deliver enhanced or professional services. Since the introduction of the Third Agreement program, pharmacists have expanded their role through increasing their offerings of patient-focused services. However the financial returns for offering many of these services are seen as low.

Recommendation: The Guild should address a number of factors needed to help increase service implementation, such as producing a clear benefits statement of the proposed services which addresses the business, professional and personal considerations involved. (Recommendation 24)

Section 4: Chapter 2

2 Pharmacy Viability Matrix

2.1 Strategy and Change Framework

"Most Australian pharmacy businesses are bereft of a clear strategy"
(The Pharmacy Practice Foundation 2004, p. 8)

We have reviewed the overall results from the mail survey which relate to the provision of services. The mail survey also included questions relating to the Pharmacy Viability Matrix which we will now introduce in some detail. This section of the report considers how strategic choices made by pharmacy owners affect the provision of services. The Pharmacy Viability Matrix was developed by the research team in the early stages of the fieldwork, particularly in response to issues raised by participants in focus groups with pharmacists. It also builds on earlier work carried out by the Pharmacy Practice Foundation.

At a report on the results of a seminar session in 2004, The Pharmacy Practice Foundation noted in relation to a syndicate group session: "the groups also recommended the development of strategic thinking as an overarching skill along with understanding consumer behaviour and change" (The Pharmacy Practice Foundation 2004, p. 17)

The aim in developing the Pharmacy Viability Matrix was to take up this challenge and to develop a model which would assist pharmacists to examine key strategic choices available to them in developing their businesses and to examine the actual and potential impacts of these strategic choices on service provision

2.1.1 PPF Pharmacy Matrix

Figure 4.13: PPF Pharmacy Matrix

		COST COMPETITION	VALUE ADDING
M A R K E T	BROAD	Cost Leadership, wide product range	Multi-segment appeal, products and services
	NARROW	Low cost specialised products	Highly specialised products and services

The Request for Tender outlined the need for a comprehensive set of viable business strategies for the pharmacy industry and a comprehensive proposal for implementing these strategies with the assistance of the Guild and the Government. In the original tender submission, four basic business strategies were identified from previous work in the area (The Pharmacy Practice Foundation 2004). These strategies were derived from the work of Porter (Porter 1998a; Porter 1998b) and are shown positioned within the matrix seen in figure 4.13 (adapted from The Pharmacy Practice Foundation 2003). This framework anticipated that the significant change to the industry would involve a change from a more product driven business model to one that increases the provision of services, that is, from left to right on the matrix above.

The four strategies proposed are determined by two factors: the market being targeted (broad or narrow); and competition based on lower cost or value adding. The business model adopted by a particular pharmacy was envisaged to be primarily one, or a blend of two, of these strategies differentiated for the different market circumstances faced by the particular pharmacy.

2.2 Pharmacy Viability Matrix

Since the commencement of the empirical research into the provision of services in community pharmacy, the PPF pharmacy matrix has undergone progressive development. For example, the emerging data from the focus groups highlighted the commitment many pharmacists have to their local community and the extent to which they will tailor their range of products and/or services to meet the needs of their local community. However it also became clear that some pharmacies were extending their community catchment area beyond the confines of their immediate community and attracting consumers from broader geographical areas. Others were growing their business by expanding the range of products and services they offered while still remaining localised. Some were expanding the range of product and service offerings while also expanding their community base. Expansion on these dimensions of community scope and product/service choice represents change away from the Traditional Pharmacy with its relatively narrow range of products and services tailored to local community needs. Additionally, this model applies both to **health** and **non-health** related products and services, this includes non-health specialty services.

As we listened to pharmacists talk about their strategies, we realised that we were picking up strategic choices that were defining emerging business models which might have important implications for future service provision. The PPF model captured one of the key dimensions – market scope – but did not capture the theme of expanding the community base of the pharmacy. Pharmacies would serve their local community market and a market based on an extended community definition.

The resulting framework was developed to capture the essence of these emerging strategies. The Pharmacy Viability Matrix (PVM), as shown in figure 4.14, offers four strategic business models for pharmacy. Within each model is a product/service mix that will vary from pharmacy to pharmacy. The matrix acknowledges that all four strategies have and will continue to have a core product and/or service offering. Traditional pharmacies add to this core an additional relatively narrow set of products and services tailored to the needs of their local community. Each of the other three business models (Expanded Pharmacy, Focused Specialty and Multi Specialty) also shares the core but adds to the core in ways that differ from the Traditional pharmacy and from each other.

The labels for the four models are defined by the two dimensions. The terms should not be taken at face value, they should be defined only through the two axis in the matrix. By definition a traditional pharmacy has a narrow product and/or service range and only caters to their local market. The other three models are similarly defined according to the axes. It is important to note two points in relation to the PVM. Firstly, it is important to clarify that the definition of specialty includes both health and non-health related products and services. Secondly, the two dimensions of the matrix that differentiate the models are in fact on a continuum and the division between one model and another is not specifically defined.¹³

¹³ In the mail survey conducted for this project respondents were given two sets of questions to establish where they lay in the PVM. Respondents were self-categorised into the four PVM business models. For further analysis see Chapter 3 of this section.

Previous research in change management and community pharmacy has compiled detailed information on issues pertinent to community pharmacy but has lacked a systematic framework in the area of business strategic change. By bringing together the community scope of a pharmacy and the range of products and/or services that are offered, the Pharmacy Viability Matrix aims to demonstrate some strategically different business models available to pharmacists and to outline some of the important consequences of these strategic choices.

The emphasis of the matrix is on mapping important alternative strategic choices for the future market positioning of pharmacies, examining consequences of these strategic choices and so clarifying for pharmacists the major strategic options available to them

The PPF matrix addressed the variables of cost competition and value adding which have not been overlooked in the PVM, they can be a way of differentiating a pharmacy within any of the PVM strategies. For example, an Expanded Pharmacy can either concentrate on cost competition (see Case Study 8) or on adding value to their product and service offering (see Case Study 7). The two variables we have chosen to emphasise in the PVM are not the only way pharmacies can differentiate themselves in the market – the competitive advantage of a pharmacy can lie in a combination of the variables in the model or other variables not captured in this model (such as mode of service delivery). All classification systems of this kind are necessarily simplistic models of a much more complex world. However they can be useful tools that help owners and managers understand more fully the implications of some of the strategic choices they are making.

The unit of analysis in the matrix can be either an individual pharmacy or a network of pharmacies. (Network pharmacies include pharmacies with membership to groups such as: banner groups, informal networks, family groups, and corporate groups.) The prime strategic focus of either the sole pharmacy or the network can be represented by their position in one of the quadrants in the matrix below.

Figure 4.14: Pharmacy Viability Matrix

		PRODUCT/SERVICE CHOICE	
		NARROW	BROAD
C O M M U N I T Y S C O P E	EXTENDED	Focused Specialty	Multi Specialty
	LOCAL	Traditional Pharmacy	Expanded Pharmacy
		Core Pharmacy Product and Service Offering	

The Pharmacy Viability Matrix defines pharmacies by two variables: the community scope (vertical axis), that is, their market focus within their local community or extended across their local community boundaries; and the degree of product/service choice (horizontal axis) they offer to their customers. We now deal with these variables in more detail.

The actual product/service mix of the pharmacy can be different within any of the four models. Each of the models has the potential to change the product/service mix in the direction of a higher service offering both in health and non-health related areas. These newer strategic options also provide options for increased service delivery and, as we shall show when we review the research results, empirically the emerging models offer more services than most traditional pharmacies. The newer models are therefore critical to understanding how service delivery can be extended.

This matrix does not suggest that there is one viable model pharmacy of the future but rather that a pharmacy or network of pharmacies can be viable by adopting any of these models. The framework includes a strategic option for remaining in the same quadrant which can be a financially viable strategy for the future in the current pharmacy reward structure

The Pharmacy Viability Matrix feeds into our eventual recommendations for pharmacy change by defining major paths pharmacies can take in changing to survive and thrive.

2.2.1 Community Scope Characteristics

The community scope variable represents a continuum, beginning at a local level and extending, at its opposing extreme, potentially to a global level. Some e-pharmacies abroad are currently operating on a global level (by definition an e-pharmacy must be either a Focused or Multi Specialty pharmacy). Within the community pharmacy industry in Australia, it seems unlikely that pharmacies will provide products and/or services to a global market in the near future but selected e-pharmacy operations already work on a national basis.

A pharmacy can change the scope of the community it serves. That is, by reassessing the community that the pharmacy is servicing, it is possible to grow the business by focusing on a concentrated pool of potential customers (in say a disease state management area) by attracting customers from a wider catchment area, i.e. accessing a niche market. In most cases, the local area will not provide a large enough reservoir of customers who need the service so, to build sufficient customer numbers to justify the investment, the catchment area will need to be extended. This, of course, has implications for marketing.

A local community scope is representative of pharmacies that focus their business on servicing the community in a limited geographical area surrounding their pharmacy and adapt their product/service range to the demographics of the local area. Their mix of products and/or services, however, will differ - some may primarily supply products while others may supplement products with services.

An extended community scope is illustrated by pharmacies that concentrate their business on a community that goes beyond their local area – their customers are made up of people from an extended area. Generally a pharmacy with this characteristic focuses on servicing one or more niche markets with specialised health care needs. Their range of products and/or services also differs depending on their position along the product/service choice axis.

2.2.2 Product/Service Choice Characteristics

The level and viability of product/service choice is dependent on the actual or potential demand of the community the pharmacy serves. In either a local or extended market the range of products and/or services will be determined largely by demographic factors, consumer demand and disease patterns in the community the pharmacy serves. A movement from left to right along the narrow/broad axis signals an increase in the range of products and/or services offered. The mix between products and services, however, varies on an individual pharmacy basis.

A narrow product/service choice exists when the pharmacy provides a more limited range of products and/or services than other pharmacies – the actual mix will depend on the needs of the pharmacy's market.

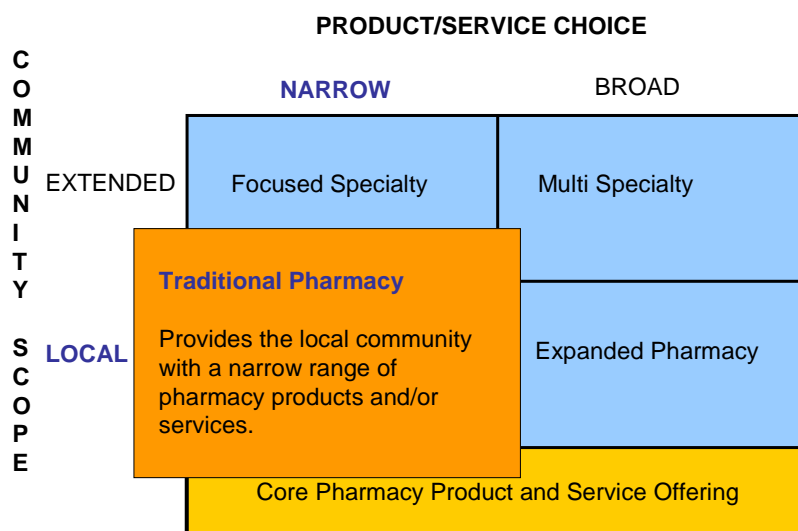
A broad product/service choice represents an offering of a larger and more diverse range of products and/or services to the community.

We now examine each business model in the PVM.

2.2.3 Strategic Focus for Each Model

2.2.3.1 Traditional Pharmacy

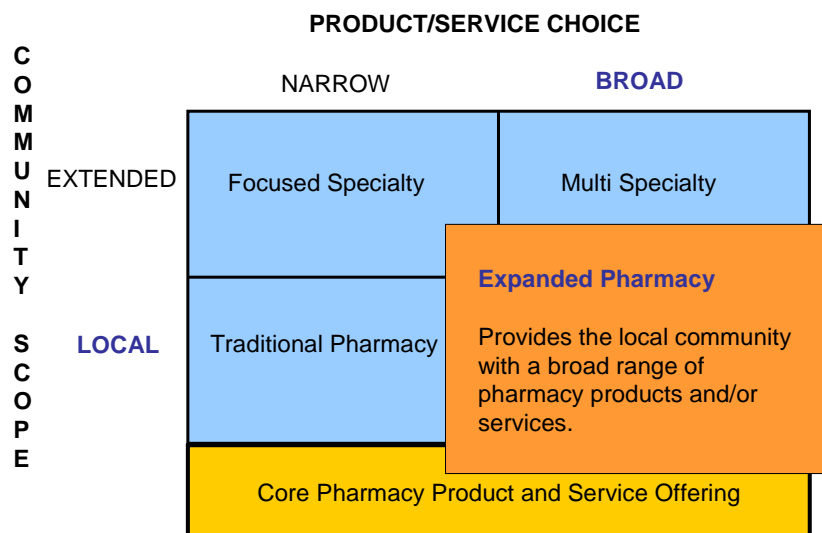
Figure 4.15: Traditional Pharmacy



The strategic focus for this model is on providing the local community with a narrow range of pharmacy products and/or services related to local community needs. A Traditional Pharmacy does not have a broad and diverse range of products and/or services and does not have the capacity to service a wider geographic area. For examples see case studies 1,2,3,4 and 5.

2.2.3.2 Expanded Pharmacy

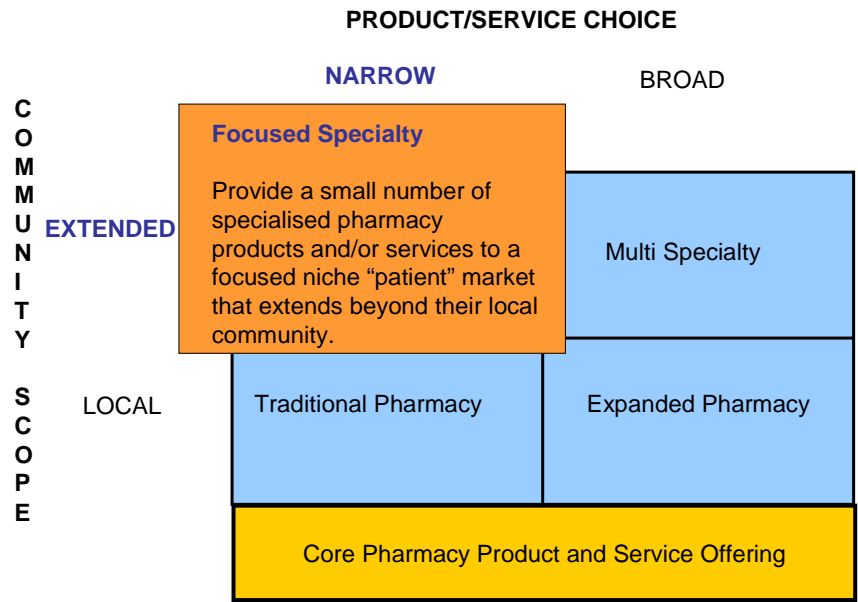
Figure 4.16: Expanded Pharmacy



The strategic focus for this model is on providing the local community with a broad range of pharmacy products and/or services. These pharmacies do not service consumers from a wide geographic area but focus on the needs of the local community and cater to their product and service needs. They differ from the Traditional pharmacy in offering a broader range of products and services. For examples see case studies 6, 7, 8, 9 and 10.

2.2.3.3 Focused Specialty

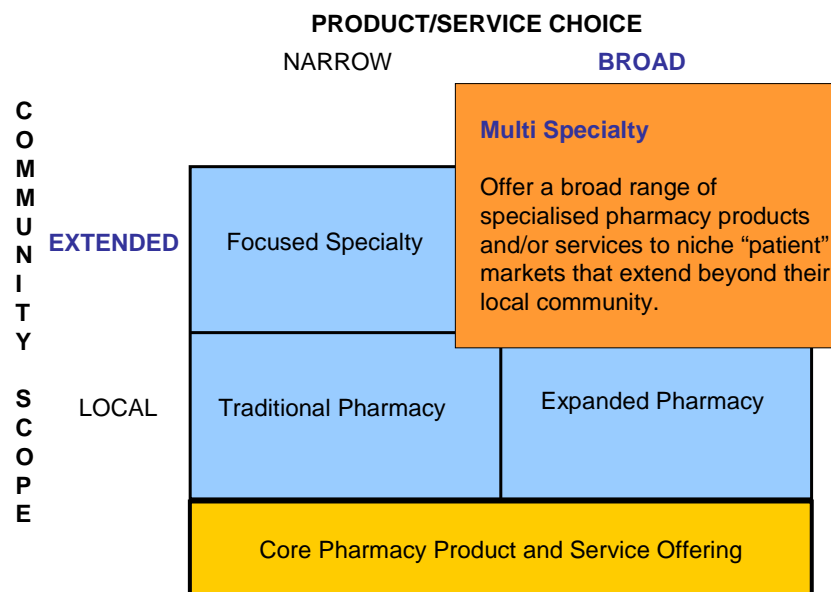
Figure 4.17: Focused Specialty



Their strategic focus is on providing specialised products and or/services to a niche market that extends beyond their local community. Because of their 'in depth' specialised knowledge, they are also able to attract consumers from a larger geographical area than the immediate local community. Customers are willing to travel further to access the more specialised products and services they need. For examples see case studies 11, 12, 13, 14 and 15.

2.2.3.4 Multi Specialty

Figure 4.18: Multi Specialty



The strategic focus here is on offering a broad range of specialised products and /or services. These specialised offerings attract consumers from a broader geographical base who are willing to travel to obtain these products and services, which are not generally available locally. A Multi Specialty pharmacy does not focus its business purely on the local consumers but looks beyond them to a range of targeted niche markets. For examples see case studies 16, 17, 18, 19, 20, 21, 22, 23 and 24.

2.3 Application of the Pharmacy Viability Matrix

The Pharmacy Viability Matrix provides a means of organising much of the data we have gathered using various research methods and also provides a clear connection to change theories.

For example, the PVM legitimises the continuing strategic importance of the Traditional Pharmacy, defined here as a pharmacy with a narrow range of products and services serving the local community, and directs attention to how its viability may be strengthened by the addition of new services and products to their existing range while still concentrating on their local community. Enriching service offerings at the pharmacy's physical location would be an example of incremental change and the characteristics of this kind of change have been well documented in the literature (see, for example, Stace and Dunphy 2001). Incremental change in this case would probably involve, for example, hiring of additional support staff with new skills to support the more labour intensive service offerings and upskilling of existing support staff.

One way to achieve movement beyond Traditional Pharmacy would be to expand the market size for the new service by extending the geographical area from which the pharmacy draws its clients. This would move the pharmacy away from a Traditional Pharmacy strategy toward Focused Specialty or a Multi Specialty strategy – an example of transformative change.

The change management literature addresses both incremental and transformational change in detail and can be adapted to the needs of pharmacies making such an expansion (see Nadler and Tushman 1999; Stace and Dunphy 2001; Burke 2002; Dunphy, Griffiths and Benn 2003). Examples of the models are illustrated in the case studies and analysed in chapter 4. Change may occur for a pharmacy within any of the models e.g. a shift in the proportion or mix of products and services; or between models e.g. when a pharmacy adopts a different business strategy.

These are only examples of how change management strategies can be used to investigate alternate strategic business models that represent potential optional paths to growing a pharmacy business. From this we have developed concrete change strategies to help pharmacists plan and implement the change programs needed to adopt the strategy of their choice (see section 5).

Recommendation: The Guild should map the current structure of the industry using the Pharmacy Viability Matrix (PVM) and support further research into appropriate service groupings related to the PVM strategy types. This will facilitate the development of policies for increased service provision for pharmacy in the future. (Recommendation 11)

Recommendation: The Guild should work with leading pharmacies that are using these strategies to increase service provision related to the PVM strategic types; evaluate and document the success of these programs for increased service provision and then support the diffusion of this new knowledge through the industry (Recommendation 12)

2.3.1 Application of the PVM in relation to the Characterising Opportunity Filter (COF)

Earlier in this report (see section 2: 4.2) we introduced the Characterising Opportunity Filter which is mainly designed for the Guild to use in developing and selecting new services. However the COF can also be used by individual pharmacies or networks to develop any of the four generic PVM strategies so that the options are more clearly specified. With reference to the seven dimensions of COF, a pharmacist may, for example perceive an opportunity in the disease state management in asthma. Let us assume that the pharmacy is located in an area which has a high incidence of asthmatic patients and there is a clear need for providing asthma-related services. From a strategic business perspective, the pharmacy would offer this service not only to the local area but to an extended area. This would mean that the business strategy has moved from a Traditional Pharmacy strategy toward becoming a Focused Specialty. They can then proceed systematically through the seven stages of the COF, in order to give this new strategic option more specificity. The first option is to consider where in the spectrum of health care the service should be offered – from prevention through to palliation. The pharmacist may decide for example to concentrate initially on early detection and diagnosis and assessment and extend later into treatment, rehabilitation and palliation. Similarly they may decide, on reviewing the second stage of the filter, to emphasise customer self management and provide professional care delivery later as the number of customers increases and staff training has been carried out. This process of progressively increasing strategic specification can be continued through all seven stages of the COF so that the generic strategy becomes increasingly clarified and differentiated for the pharmacy's specific situation. This process also fleshes out some important characteristics of the change program as it suggests what aspects of the service can be introduced first and what other aspects of the service can be phased in later.

So, in this example, the strategic opportunity is taken up initially in the areas of early detection and treatment. It involves self-management by the patient and then the addition of some professional pharmacy services. It is primarily service-oriented, but involves the sale of products (e.g. medications, spacers). Remuneration could be primarily through patient payment, with a PBS subsidy for some products. The pharmacist would be either providing a novel service, supplementing or substituting for a service provided by GPs. The service would be delivered in the pharmacy premises or through other relevant modes. Some training would be needed to enable the pharmacist to deliver appropriate services, and this should be linked to continuing education. Infrastructural development would also be needed, so that the pharmacist could have confidential discussions with patients. Incentives for the investment in training, continuing education and infrastructure would arise from the sales of relevant products and the development of relationships with the community (a fuller working through of the Asthma example is given in section 5, chapter 4).

Locating a pharmacy in the Matrix could also be based on the spectrum of health care rather than the disease itself. For example, If we take the example above of the pharmacy moving from a Traditional Pharmacy strategy to position itself as a Focused Specialty in the area of asthma screening. It has moved on to provide early detection services in the area of asthma, but could then extend its offering to early detection in diabetes. Alternatively, if the focus was initially on one disease but across many parts of the spectrum, i.e. from early detection to treatment; the pharmacy could shift to a Multi Specialty, offering the same services for other diseases such as diabetes and heart disease. This latter example raises the concept of "bundling" services, where a capacity has been built in a particular

spectrum of health care that can be extended to a number of related diseases. Different approaches to the 'bundling' of existing interests and new opportunities are described in section 4.6.

2.3.2 PVM in the real world

The PVM framework has the inherent limitations of any simplified model. As with any two dimensional model not all elements of a pharmacy's operations are represented within it. For example, within each box there will be different mixes of product and service offerings. As we have noted above, in all four strategic approaches it is possible to move to greater service provision. The particular set of services provided may, however, differ for each strategic position.

Each quadrant represents a Weberian "ideal" type model (Henderson and Parsons 1947); in practice some pharmacies may be combining two business strategies. Notwithstanding this, there is likely to be a dominant, but not necessarily exclusive strategy from the four quadrants which best represents the strategic direction adopted by any particular pharmacy. None of the proposed models are fixed in their definition, they are open to change and further development.

We now move on to examine the empirical findings from this research about the empirically derived characteristics of the four models and the consequences of choosing these business strategies. We also examine how these models affect service offerings in practice. We begin our discussion with results drawn from the mail survey and move on subsequently to review the findings from the case studies.

Section 4: Chapter 3

3 Analysis of Pharmacy Viability Matrix (PVM) using Mail Survey results

3.1 Demographics basis of PVM business strategies

Overall response rates from the mail survey were from two questions in the Business Strategy section of the survey form. There was a forced choice selection between:

- A1. This pharmacy provides a narrow range of products and/or services compared to most other pharmacies; or
 A2. This pharmacy provides a broad range of products and/or services compared to most other pharmacies.

AND

- B1. This pharmacy provides products and/or services to predominantly cater for the local community; or
 B2. This pharmacy provides products and/or services to cater for a market that extends beyond the local community.

The responses were coded as follows:

- A1+B1 = Traditional Pharmacy
 A1+B2 = Focused Specialty pharmacy
 A2+B1 = Expanded Pharmacy
 A2+B2 = Multi Specialty pharmacy.

A summary of responses coded in this way is shown in table 4.13.

Table 4.13: Breakdown of pharmacies responding for PVM

	N = 565	%
Traditional Pharmacy	169	29.4
Expanded Pharmacy	275	47.8
Multi Specialty	101	17.6
Focused Specialty	20	3.5

Table 4.13 shows that almost half of respondents classified themselves into the Expanded Pharmacy category; almost one-third in the Traditional Pharmacy category, and 17.6% in Multi Specialty. There were only 20 cases in the Focused Specialty category (3.5%). Because of the small number of Focused Specialty pharmacies in the mail survey sample, we have not generalised any of the results but they are presented in the diagrams below.

3.1.1 Demographic Differences between Pharmacies Using the PVM Business Strategies

Demographic analysis was completed for the four PVM strategies on a number of variables.

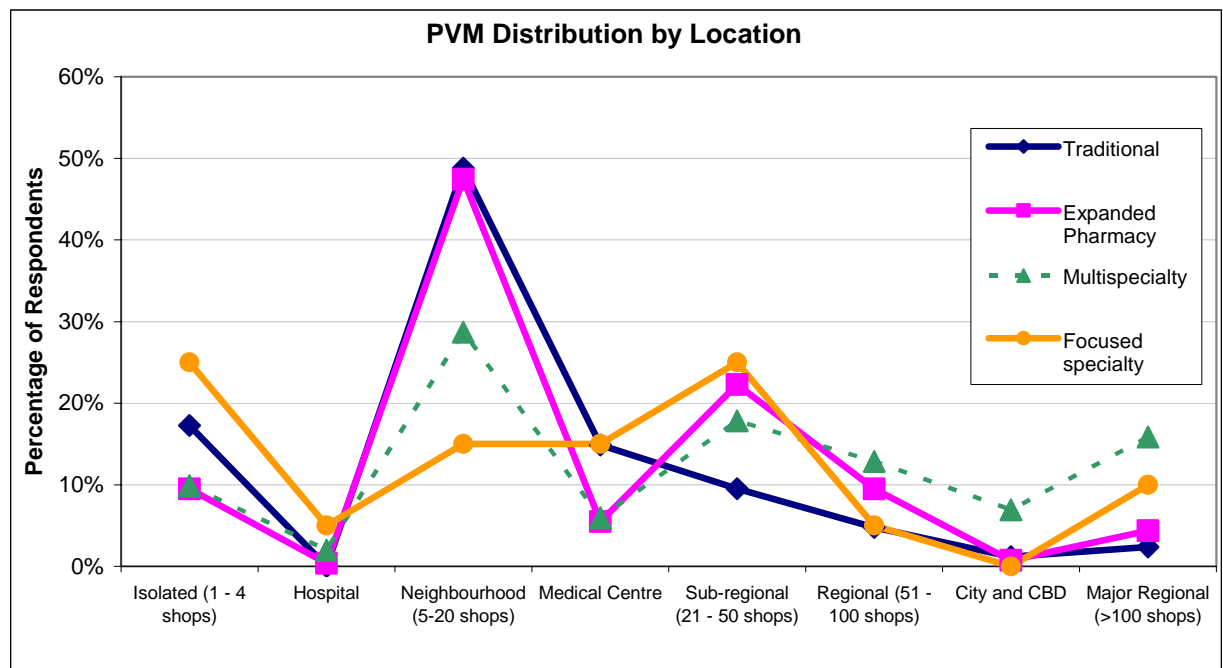
The major differences between the categories are discussed below.

3.1.1.1 Location

As shown in figure 4.19:

- Traditional Pharmacies are more likely to be local or neighbourhood based, with 66.1% located in an area with 20 shops or less.
- Expanded Pharmacies are similar to Traditional Pharmacies for location, but more strongly reported in sub-regional areas (that is, 21-50 stores)
- Multi Specialty pharmacies are much more highly represented in areas where there is a higher concentration of other stores, such as large shopping centres.

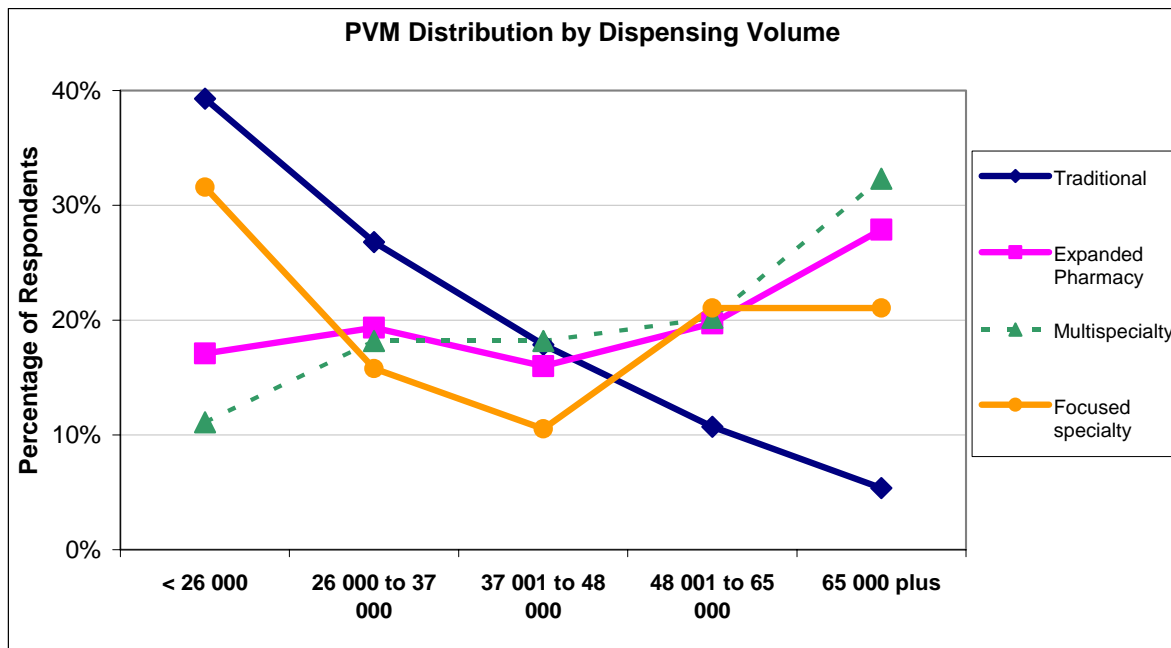
Figure 4.19: PVM Distribution by Location



3.1.1.2 Dispensing Volume

The Traditional Pharmacies have the lowest dispensing volume from the mail survey with Multi Specialty dispensing the highest number. Expanded Pharmacies were in between these (see figure 4.20).

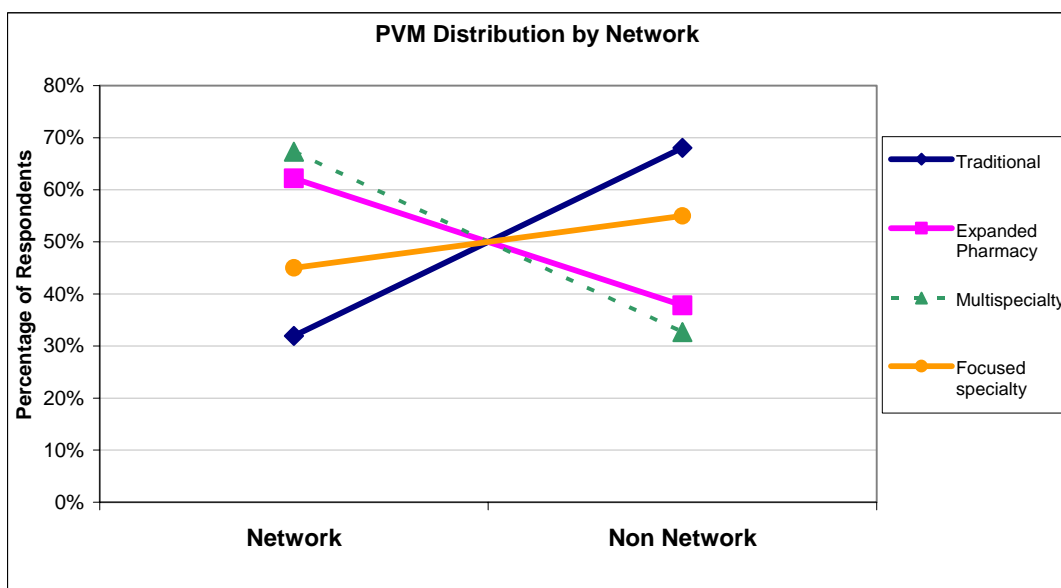
Figure 4.20: PVM Distribution by Annual Dispensing Volume



3.1.1.3 Network

Traditional Pharmacies are less likely to be in a network, whereas Multi Specialty and Expanded Pharmacies are more likely to be networked (figure 4.21).

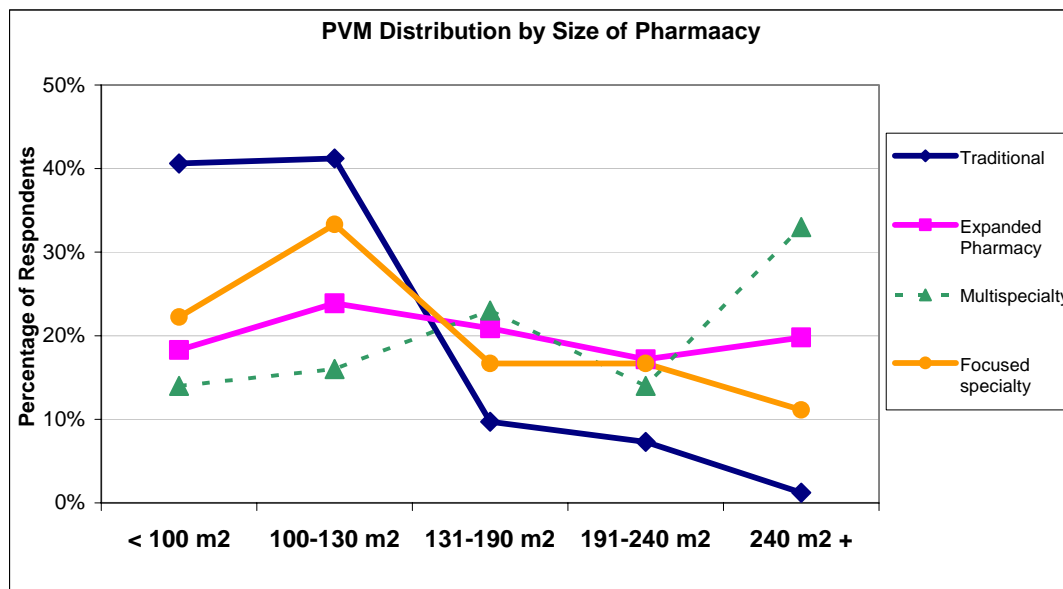
Figure 4.21: PVM distribution by Network



3.1.1.4 Size of Pharmacy

Traditional Pharmacies were smallest, with 81.8% having premises less than 130sqm whereas Multi Specialty pharmacies were the largest, with almost one-third larger than 240sqm. The Expanded Pharmacies are more evenly distributed by size (figure 4.22).

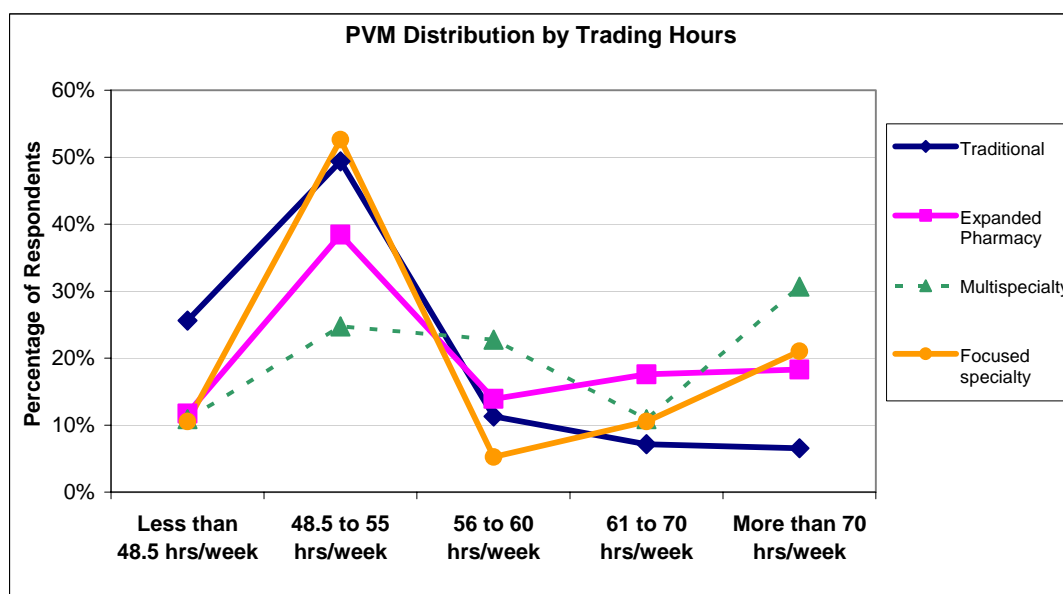
Figure 4.22: PVM distribution by Size of Pharmacy



3.1.1.5 Trading Hours

As shown in figure 4.23, most Traditional Pharmacies and Expanded Pharmacies open shorter hours, whereas Multi Specialty pharmacies open longer hours.

Figure 4.23: PVM distribution by Trading Hours



3.2 Attitudes to Change

Factor scores were developed to assess respondents' attitudes towards change and innovation within the pharmacy (see table 4.14). These were based on:

- **Attitudes towards innovation** (6 statements): how innovation and new ways of doing things were viewed within the pharmacy;
- **Support of change initiatives in the pharmacy** (6 statements): how initiatives were supported and resourced within the pharmacy;
- **Clarity of vision for the pharmacy** (3 statements): how clear the vision for the future is as perceived by the respondent;
- **Attitudes towards change** (7 statements): how change is perceived by staff and how change is implemented in the pharmacy;
- **Resources and skills for change** (5 statements): the perception of available resources and support to facilitate change;
- **Support of change initiatives in community pharmacy** (2 statements): the perception of the need for change and introduction of enhanced services in community pharmacy.

The individual statements for each of the factor scores are included in appendix 3. The six factor scores were computed from the responses to individual questions. Items were summed and averaged. For the factor scores, 5 represents a positive view. The factors were validated using principal axis factor analysis with direct oblimum rotation.

Table 4.14 shows the number of responses, means and standard deviations for each of the six combined factor scores for each PVM classification. The variance accounted for from the factor analysis is shown in brackets, as well as Cronbach's alpha, the reliability coefficient.

The factor scores were then analysed using one-way ANOVA and comparison of means using Bonferroni to identify any significant differences.

In almost all cases, Traditional Pharmacy scored the lowest for the factor scores. In only one case, "Attitudes towards change" the mean for the calculated factor score for Traditional was marginally higher than the responses for Focused Specialty. However, the response numbers for Focused Specialty is low (16 responses) compared to the other scores.

The ANOVA analysis identified significant differences in responses across the four Pharmacy Viability Matrix types:

- For all factor scores there is a significant difference in mean responses between Traditional Pharmacy and Multi Specialty. Traditional Pharmacy scores lower on these items indicating attitudes less supportive of change.
- There are significant differences for mean responses between Traditional Pharmacy and Expanded Pharmacies for the factor scores of **1. Attitudes towards innovation** and **4. Attitudes towards change**. The mean score for Traditional Pharmacy is lowest.

- There are significant differences in responses between Expanded Pharmacies and Multi Specialty for **1. Attitudes towards innovation** and **5. Resources and skills for change**. Expanded Pharmacies scores are lower than Multi Specialty for this factor score.

Table 4.14: Analysis of Change Questions

	1. Traditional	2. Expanded Pharmacy	3. Multi specialty	4. Focused specialty	Overall	F	Sig
1. Attitudes towards Innovation (6 statements accounting for 51.9% variance; Chronbach alpha = 0.82)							
N	149	235	89	19	492		
Mean	3.41 ^{ab}	3.73 ^{ac}	4.00 ^{bc}	3.71	3.68		
Std. Deviation	0.55	0.56	0.46	0.70	0.58	21.76	0.000
2. Support of change initiatives in this pharmacy (6 statements accounting for 39% variance; Chronbach alpha = 0.65)							
N	164	269	97	20	550		
Mean	3.57 ^{ab}	3.71 ^a	3.79 ^b	3.61	3.68		
Std. Deviation	0.68	0.48	0.49	0.49	0.55	4.05	0.007
3. Clarity of vision (3 statements accounting for 72.2% variance; Chronbach alpha = 0.81)							
N	168	269	99	20	556		
Mean	3.69 ^{ab}	3.93 ^a	4.10 ^b	3.87	3.89		
Std. Deviation	0.65	0.64	0.59	0.70	0.65	9.13	0.000
4. Attitudes towards change (7 statements accounting for 44.4% variance; Chronbach alpha = 0.77)							
N	163	271	97	19	550		
Mean	3.66 ^{ab}	3.83 ^{ac}	4.06 ^{bcd}	3.58 ^d	3.81		
Std. Deviation	0.53	0.57	0.50	0.69	0.57	11.67	0.000
5. Resources and skills for change (5 statements accounting for 41.0% variance; Chronbach alpha = 0.64)							
N	164	270	97	20	551		
Mean	3.61 ^b	3.74 ^c	3.97 ^{bc}	3.71	3.74		
Std. Deviation	0.51	0.51	0.47	0.61	0.52	10.56	0.000
6. Support of change initiatives for community pharmacy (2 statements accounting for 80.6% variance; = 0.74)							
N	167	267	98	20	552		
Mean	3.60 ^b	3.71	3.83 ^b	3.75	3.70		
Std. Deviation	0.55	0.52	0.52	0.54	0.54	4.09	0.007

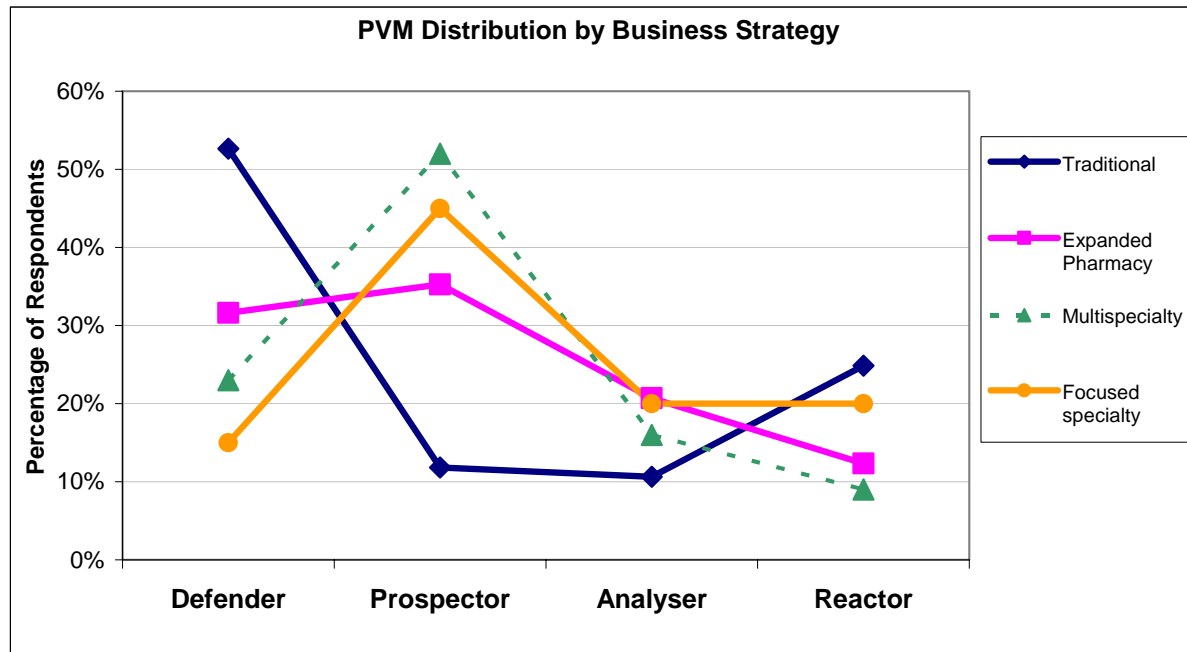
Notes:

- a indicates there is a significant difference at the 0.05 level between Traditional Pharmacy and Expanded Pharmacy for this factor score
- b indicates there is a significant difference at the 0.05 level between Traditional Pharmacy and Multispecialty for this factor score
- c indicates there is a significant at the 0.05 level difference between Expanded Pharmacy and Multispecialty for this factor score
- d indicates there is a significant at the 0.05 level difference between Focused Specialty and Multispecialty for this factor score

3.3 PVM and Miles and Snow Business Strategies

In the previous section we discussed pharmacists' attitudes to change as shown on the survey and specifically where they scored on the Miles and Snow business strategies (Miles and Snow 1978). We now examine how pharmacists in our four strategic types categorised their businesses into one of the Miles and Snow business strategies (figure 4.24).

Figure 4.24: PVM distribution by Miles and Snow Business Strategy



The questions from the mail survey relating to each of the Miles and Snow Business Strategies are:

- **Defender:** We stick to what we know how to do and do it well as or better than anyone else
- **Prospector:** We are innovators and are willing to take the necessary risks of providing new products and services
- **Analyser:** We do not want to be first in our industry to offer an unproven product or service, but we try to be close behind with a similar product or service that is competitive
- **Reactor:** We do not follow a specific program or plan for making us more competitive, although, when we are faced with strong threats, we definitely make changes

Traditional Pharmacies have the highest scores on the Defender and Reactor strategies indicating less willingness to change. Multi Specialty pharmacies are more likely to be Prospectors i.e. willing to innovate and to take more risks in changing. Expanded Pharmacy are split between Defender and Prospector strategies.

3.4 Service Offering

Table 4.15 outlines the percentages, from highest to lowest of services offered by pharmacies under each of the PVM categories. The highest ranking score for each enhanced service is shaded and the key findings of this table show that:

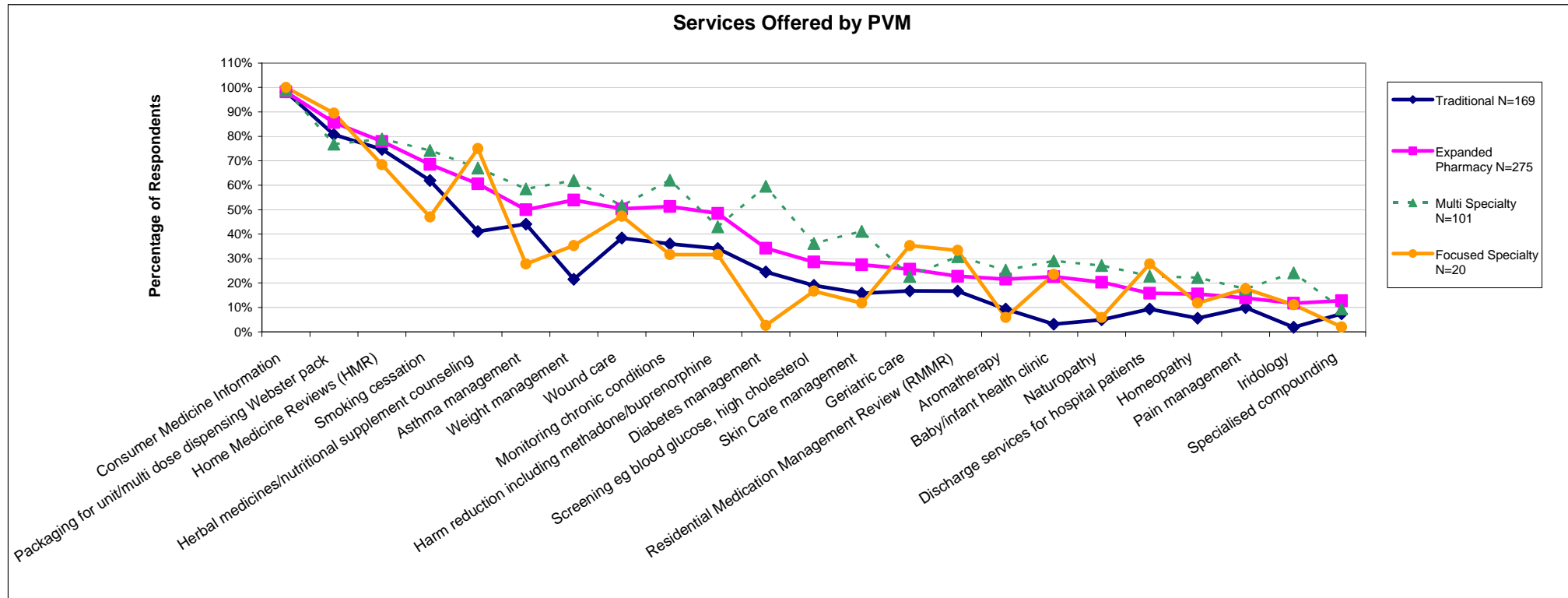
- Traditional pharmacies consistently offer the lowest percentage of enhanced services, compared to the other three categories; Expanded Pharmacies have the second lowest rate
- Multi Specialty pharmacies offer the most services – these services are more product-based or related to natural therapies
- Multi Specialty pharmacies and Focused Specialty pharmacies offer more services for ongoing disease state management services and for continuing care.

In many other areas of the survey there are only minor or insignificant differences between the four PVM strategy types. Figure 4.25 graphs the major services – those under the Third Agreement, potential candidates for Fourth Agreement and other major services.

Table 4.15: Service offering by PVM category

	No. offering Service	Overall %	Traditional N=169	Expanded Pharmacy N=275	Multi Specialty N=101	Focused Specialty N=20
Consumer Medicine Information	560	98.4%	98.2%	98.2%	99.0%	100.0%
Packaging for unit/multi dose dispensing Webster pack	552	82.8%	80.7%	85.7%	76.8%	89.5%
Home Medicine Reviews (HMR)	550	77.1%	74.7%	77.9%	78.9%	68.4%
Smoking cessation	547	66.9%	62.0%	68.5%	74.2%	47.1%
Herbal medicines/nutritional supplement counseling	537	56.2%	41.1%	60.6%	67.0%	75.0%
Asthma management	537	49.2%	44.1%	50.0%	58.5%	27.8%
Weight management	539	47.5%	21.5%	53.9%	62.0%	35.3%
Wound care	543	47.0%	38.4%	50.4%	51.6%	47.4%
Monitoring chronic conditions	549	47.9%	36.0%	51.3%	62.1%	31.6%
Harm reduction including methadone/buprenorphine	544	42.6%	34.1%	48.5%	43.0%	31.6%
Diabetes management	535	35.5%	24.5%	34.2%	59.6%	2.6%
Screening eg blood glucose, high cholesterol	544	26.7%	19.0%	28.6%	36.2%	16.7%
Skin Care management	527	25.8%	15.8%	27.5%	41.1%	11.8%
Geriatric care	531	22.8%	16.8%	25.7%	22.7%	35.3%
Residential Medication Management Review (RMMR)	539	22.6%	16.7%	22.8%	30.8%	33.3%
Aromatherapy	537	18.1%	9.4%	21.6%	25.3%	5.9%
Baby/infant health clinic	535	17.9%	3.1%	22.6%	29.0%	23.5%
Naturopathy	537	16.4%	4.9%	20.3%	27.2%	5.9%
Discharge services for hospital patients	537	15.5%	9.3%	15.8%	22.8%	27.8%
Homeopathy	534	13.5%	5.6%	15.5%	22.2%	11.8%
Pain management	529	13.4%	9.9%	13.8%	17.6%	17.6%
Iridology	533	10.9%	1.9%	11.7%	24.2%	11.1%
Specialised compounding	474	9.9%	7.4%	12.8%	9.4%	2.0%
Nutritional support	478	6.5%	2.0%	7.3%	11.0%	13.3%
Community clinic services with nurse	533	6.8%	2.7%	9.1%	12.2%	6.7%
Massage	530	5.7%	2.5%	5.7%	11.4%	5.9%
Aboriginal health services	533	4.3%	1.9%	5.6%	4.4%	5.9%
Drug level monitoring/kinetic dosing	532	3.9%	3.7%	3.0%	7.9%	0.0%
Mail order or web based prescriptions	534	3.4%	4.9%	1.5%	6.7%	0.0%
Reflexology	531	0.9%	0.0%	0.8%	3.3%	0.0%
Chemotherapy preparation	527	1.1%	0.6%	0.0%	4.5%	5.6%
Acupuncture	534	0.6%	0.0%	1.1%	0.0%	0.0%

Figure 4.25: Services Offered by PVM Category



We now turn to a financial analysis of the PVM strategy types.

3.5 Differences in Financial Performance between the Strategy Types (Medici Capital)

The following is drawn from the Medici Capital reports and summarises the financial results relating to the four PVM strategy types (see table 4.16).

Multi Specialty, Expanded Pharmacy and Focused Specialty pharmacies (in that order) outperform Traditional Pharmacies financially (i.e. on financial performance). Note that all three also outperform Traditional Pharmacies in the case study sample although, in that small sample, the order was Expanded Pharmacy, Multi Specialty and Focused Specialty (using means).

The Focused Specialty pharmacies in the mail survey had the lowest risk score. The level of risk increased progressively for Traditional Pharmacy, Expanded Pharmacy and Multi Specialty (which had the highest Risk score). Note that in the case study sample, Focused Specialty pharmacies also had the lowest risk score and the Multi Specialty pharmacies also had the highest risk score.

Traditional Pharmacies had the lowest cost index, followed closely by Expanded Pharmacies. There was a material difference in costs for Multi Specialty and Focused Specialty pharmacies.

Table 4.16: Pharmacy Viability Matrix Categorised Results

	Traditional Pharmacy	Expanded Pharmacy	Focused Specialty	Multi Specialty	Overall Mail Survey Sample Average
Means					
Financial Performance ¹⁴	51.41	72.20	70.03	82.15	67.68
Risk Score ¹⁵	85.13	85.72	81.36	95.49	87.13
Cost Index ¹⁶	97.92	98.43	102.13	100.21	98.75
Indicative Valuation ¹⁷	106.70	104.86	87.30	95.66	103.04
Number of cases	118	189	16	71	394

¹⁴ **Financial Performance:** The financial performance score is based on a model that uses turnover and prescription sales as key variables.

¹⁵ **Risk:** Risk comprises Business and Operating risk. Business risk takes account of Prescription Numbers, Prescription Percent (of turnover), Sales Growth and Sales Variability (an inverse relationship); Operating risk takes account of Prescription Numbers, Size of premises, Staff Hours and Trading hours.

¹⁶ **Cost Index:** The cost index is a composite of Cost of Goods Sold, Salaries and Rent as a percentage of turnover.

¹⁷ **Indicative Value :** The expected business value assuming normal operating ratio, given the measured contribution margin expressed as a percentage of Turnover.

Table 4.16 presents the scores for the Mail Survey participants belonging to each category in the Pharmacy Viability Matrix for the four key indices: Financial Performance, Risk, Cost, and Value.

On indicative valuation (i.e. value relative to turnover) Traditional Pharmacies were highest, closely followed by Expanded Pharmacies, then Multi Specialty pharmacies with Focused Specialty pharmacies having the lowest indicative valuation.

Based on the results of the mail survey, Multi Specialty pharmacies are larger in size and sales. Multi Specialty pharmacies are also achieving the highest contribution. In other words, Multi Specialty pharmacies are achieving the best contribution per square metre of shop space but they perform only slightly better than Traditional Pharmacy and Expanded Pharmacies.

Table 4.17: Financial Results and Business Measures by Category

	Traditional Pharmacy	Expanded Pharmacy	Focused Specialty	Multi Specialty	All Groups (Total Sample) Average
Means					
Size	123.75	185.79	170.67	214.06	171.69
Sales	\$1,588,699	\$2,385,187	\$2,454,496	\$2,910,423	\$2,244,109
Contribution	\$289,060	\$426,484	\$315,594	\$455,527	\$386,057
Sales psm	\$13,301.77	\$13,703.23	\$14,377.02	\$14,701.24	\$13,790.20
Contribution psm	\$2,463.20	\$2,455.84	\$2,062.80	\$2,472.49	\$2,445.09

So on Medici Capital figures, when compared to Traditional Pharmacies, Multi Specialty pharmacies and Expanded Pharmacies achieve almost identical the financial return per square metre (Contribution psm) despite their size and sales volume (table 4.17). Focused Specialty pharmacies have the lowest financial return psm but this may be a consequence of the small sub-sample.

Medici Capital conclude that the mail survey results indicate dramatic differences in the underlying business models. Financial performance is significantly different for all quadrants in the Pharmacy Viability Matrix. The only exception is for Focused Specialty pharmacies; however this specific result is probably an artefact of the relatively small sub sample of Focused Specialty pharmacies. Therefore the four business strategies identified by the research team lead to very different financial results and there are substantive and significant differences between the strategies on most of the Medici Capital financial measures.

3.5.1 Overall Summary

Traditional Pharmacies (30.9% responses):

- Are more likely to be local neighbourhood-based or isolated (1-4 shops together)
- Are more likely to be smaller in size
- Are more likely to have restricted opening hours
- Are more likely to be non-networked
- Are more likely to use defensive and reactive strategies
- Offer the lowest number of professional services
- Have lower financial performance
- Have the lowest cost index
- Have the highest indicative valuation (ie value relative to turnover)

Expanded Pharmacies (48.5% responses):

- Are more likely to be local neighbourhood based or isolated (1-4 shops together) but have more in sub-regional (that is, 21-50 stores) than traditional pharmacies
- They dispense many more prescriptions than Traditional Pharmacies, but less than Multi Specialty pharmacies
- They vary greatly in size
- They open for longer hours than traditional pharmacies, but substantially less than Multi Specialty pharmacies
- Their strategies are split between Defender and Prospector.
- 63% are networked
- They outperform Traditional Pharmacy and Focused Specialty pharmacies financially
- They have a higher risk score than Traditional Pharmacies
- They have a relatively low cost index
- They are second to Traditional Pharmacies on indicative valuation

Multi Specialty (18.2% responses):

- Are more likely located in areas of higher concentration of other stores, such as large shopping centres
- Are larger
- Dispense the highest number of prescriptions
- Open longer hours
- Are more likely to use a Prospector strategy; are more innovative
- 66.7% are networked
- Financially outperform all other pharmacy categories
- Have the highest risk score

- Have the lowest indicative valuation
- Achieve the best contribution of square metre per shop space

3.6 Conclusion

The Pharmacy Viability Matrix strategies represent distinctively different strategies, with very different profiles on a number of important indicators from the mailed survey. They represent strategic choices with varying consequences. All four strategies are economically viable under the present regulated environment of the Pharmacy industry.

Traditional Pharmacies tend to be more conservative in attitudes to change than those pharmacies following other strategies. This may be a reflection of so many of them being strongly embedded in local and remote communities. Their reluctance to change could also be a reflection of the fact that, on Medici Capital measures, they retain their resale value, ie they have the highest indicative value.

There are clear differences between the strategies in the extent to which the different strategy types deliver professional services (as services are measured in the Change Management and Community Pharmacy Survey) and in the range of services they deliver. Multi Specialty pharmacies deliver more services and a wider range of services than other strategy types. Their responses indicate that they are, on the average, more open to change and more innovative than other pharmacy types and therefore represent a lead opportunity for accelerating further increases in service provision.

Traditional pharmacies tend to offer fewer services. This relates to the recurrent theme, in many of our interviews with pharmacists from smaller pharmacies, that the pressures on pharmacists in these circumstances make it difficult to add further activities when the pharmacist's time is already fully occupied. There are clear implications here for the Guild's negotiations with the Government. The Guild needs to consider whether it can expect smaller pharmacies to offer a range of services when they may not have the resources to do so. To date, the Guild has expected all or most pharmacies to take up government supported services. Alternatively the Guild could try to negotiate increased resources to encourage and enable smaller pharmacies to extend their service offerings.

Because of the small number of Focused Specialty pharmacies we have refrained from making generalisations from the available limited mail survey data. It seems clear Focused Specialty pharmacy is an opportunity still largely waiting to happen. Offering specialised services usually requires prior and ongoing investment in technology and human resources and unless there is the opportunity to charge a fee for service, this strategy is unlikely to attract many pharmacy owners. Given a change of pharmacy policy and practice to in toward fee for service, however, this could become a much more strategically appealing option.

It is important to realise that our characterisations of these strategy types are generalisations only, and that there are specific pharmacies within each quadrant of the PVM which depart from most of these generalisations.

Section 4: Chapter 4

4 Case Study Reports

In this section we will examine the 24 case studies that were researched and written for this project. As outlined in section 3: 2.4, the case studies were undertaken across Australia and represent a sample of community pharmacies from different states selected also to cover rural/regional versus urban and banner versus independent. Each case study was classified by the principal interviewer and the research team into one of the four business strategy models as shown below (see chapter 2 in this section for a detailed discussion of the PVM strategy types and table 4.18 for classifications).

Table 4.18: Case Study Classifications

	Sample n =	Rural/ Regional	Urban	Banner	Independent
Traditional Pharmacy	5	3	2	3	2
Expanded Pharmacy	5	2	3	3	2
Focused Specialty	5	2	3	1	4
Multi Specialty	9	5	4	6	3
Total	24	12	12	13	11

The focus of the case study analysis was on providing practical examples of service implementation within each of the PVM business strategy types. We also included eight pharmacies which were in addition classified as innovative.

The case study pharmacies were analysed for similarities within each of the four models and the results are summarised below.

4.1 Traditional Pharmacy

Traditional pharmacies focus on their role in their local community and provide a limited range of pharmacy products and/or services. In this model the focus can vary from the supply function of pharmacy to the provider of a specific value added services to the local community. Typical characteristics of the case study pharmacies in this model are outlined below:

- They are limited in size and growth by their tendency to maintain a limited market share in the local community.
- Their financial performance is often strongly affected by outside influences such as other local health care professionals and competitive pressures from other competitors.
- They differentiate themselves according to the needs of their customers e.g. convenience (case study 2), specialised service through forward pharmacy (case study 5) or sports related products for gym members (case study 4).
- They are usually located in declining or stable markets. This increases the cautious of pharmacy owners when introducing new products or services and explains their strong focus on servicing their local customer base in a way that maintains customer loyalty.

- They have more limited in-house capacity and resources than most pharmacies using other strategies and are more likely to initiate the provision of services through outsourcing.
- They are likely to be quite constricted in pursuing some options due to the current shortage of skilled labour in the market – this, however, is not exclusive to this group.

4.2 Expanded Pharmacy

The Expanded Pharmacy provides local consumers with a broad range of products and/or services. Like the Traditional pharmacy, they are committed to serving their local community but with convenient location and broad range being central to their business image. Typical characteristics from the case study pharmacies in this model are outlined below:

- Pharmacy owners generally have highly developed business skills that they apply to their pharmacy. Therefore, they have more developed internal business systems. This is also due to their larger size and their available resources.
- They generally have a higher staff to customer ratio and have a well developed understanding of how to effectively use staff.
- They have a high product and service offering which helps them to compete with supermarkets and department stores.
- There is a tendency for them to leverage from government policies and services negotiated through the Community Pharmacy Agreements
- The motivation of Expanded Pharmacy owners/pharmacists varies greatly some focus on servicing their local community, while others focus on increasing financial returns from the business; others try to balance these objectives.

4.3 Focused Specialty

Focused Specialty pharmacies offer a narrow range of specialised products and/or services to an extended community. They generally focus their business on a niche market within the community that extends beyond their immediate local area. This model of pharmacy focuses on a particular market segment over a long term period. Ideal characteristics from the case study pharmacies in this model are outlined below:

- They tend to have a good understanding of the niche market that they are servicing and develop their product and service offering to meet the health care needs of the niche market customers. The area of specialty chosen is generally independent of services negotiated through the Community Pharmacy Agreement (with the exception of Case Study 14 whose focus area is Aboriginal Health Services)
- The pharmacy owner generally leverages from their own personal capabilities, technical expertise and experience when selecting a niche market – they are motivated to work in this area and service this market because of a personal conviction or commitment to the particular service specialty they have chosen.
- The pharmacy staff are generally also highly skilled in the focus area.

- They assemble highly focused and specialised resources to deliver the product or service.
- Within the pharmacy there is generally a well-established collaborative environment. The pharmacy staff learn from each other.
- All of the pharmacy's business practices are co-ordinated to meet the specific needs of the niche market
- The business risk of pharmacies in this model is higher than the Australian average due to the degree of specialisation
- They generally have well established relationships with health professionals and community groups that specialise in their "niche" area
- There are fewer competitors in their specialised area so they can monitor competitor activity more readily.

4.4 Multi Specialty

Multi Specialty pharmacies offer a broad range of specialised products and/or services to an extended community. This type of pharmacy is resource intensive and generally able to leverage the benefits of services and collaborative relationships to encourage the use of more specialised products and/or services. Typical characteristics from the case study pharmacies in this model are outlined below:

- They generally understand and use their extended geographic environment and community characteristics to their advantage by aligning product and service offerings with a broad range of consumer groups.
- They tend to have a clear vision for the future. (A notable exception to this, however, is when the pharmacist is close to retirement)
- These pharmacies are generally "future thinking" and have diversified their product and service offering in anticipation of future change to the industry.
- Services are generally provided at a higher volume due to the extended community.
- There is usually a higher ratio of staff to customers. The exception was when the pharmacy was a sole proprietorship.
- Pharmacy staff are well trained and focused on the pharmacy's goals and objectives.
- The pharmacist in charge/ pharmacy owner carefully plans for new services and alters workflow to help their implementation.
- There is a tendency to leverage from government policies and services negotiated through the Agreement.
- The pharmacy owners support their staff through mentoring and career development programs.
- The pharmacy environment promotes learning and professional development.

4.5 Other pharmacy characteristics that can affect the adoption of business strategies

The discussion that follows is based solely on the case study pharmacies that were interviewed. In some instances these findings may not reflect the findings of the mail survey data but they are given to add espoused views by pharmacists based on the following characteristics:

- Rural/regional vs. urban pharmacies; and
- Banner group vs. independent Pharmacies

4.5.1 Rural/Regional vs. Urban Pharmacies

As outlined in the project tender, the case study pharmacies have also been analysed as either rural/regional or urban pharmacies¹⁸ and banner or independent pharmacies. The following two tables (table 4.19 and 4.20) represent the predominant characteristics of these two differentiating factors.

Table 4.19: Rural/Regional vs. Urban Pharmacies from Case Studies

Rural/Regional pharmacies	Urban pharmacies
These pharmacies generally have a broader range of conventional products and/or services	These pharmacists have easy access to continuing education and other support resources in urban areas
They feel more pressured into providing products and services by the community regardless of financial rewards	Urban pharmacies have fewer problems with locum cover compared to rural/regional pharmacies
The pharmacy has stronger ties to the local community as they live and work in the same area. Customers are loyal and known to the pharmacy staff to a greater degree than in the metropolitan areas	There is less requirement to focus on the professional role of pharmacy in metropolitan areas – there is a greater need to maintain the role as the supplier of medicines
Although rural/regional pharmacists have close ties with local health care professionals, they are more dependent on a small pool of them and must manage this relationship carefully	
They are more likely to suffer from the labour force shortage	
Rural and regional pharmacies do not generally have problems with high support staff turnover	

¹⁸ This classification was determined by the principal interviewer

4.5.1.1 Implications

The location of a pharmacy has obvious implications in relation to the accessibility of resources and professional development programs for pharmacists. From the case studies, however, location does not appear to be related to the pharmacy owner's ability to use any of the four business strategies outlined in the matrix. Although rural/regional pharmacies tend to have stronger ties to their community and other health care professionals this does not imply that they cannot cater to the needs of consumers beyond their local community. The case study pharmacies in rural/regional areas were not particularly restricted by their location. The urban pharmacies were equally able to provide services and cater to broader communities if they desired. This indicates that the models within the PVM do not prejudice non-urban pharmacies and can apply to a variety of locations.

4.5.2 Banner Group vs Independent pharmacies

Table 4.20: Banner Group vs. Independent Pharmacies from Case Studies

Banner group pharmacies	Independent pharmacies
Membership of a banner group can provide assistance through the provision of centralised support services	Independent pharmacies are likely to be involved in informal networks to increase buying power or reduce the feeling of isolation
Banner group head offices provide clear guidelines that pharmacists can use in the pharmacy	Independent pharmacies are more reliant on the personal capabilities of the pharmacy owner or staff to achieve internal efficiencies
Staff training is provided through banner groups	

4.5.2.1 Implications

Affiliation with banner groups did not greatly influence the business strategy choices of the case study pharmacies. There appeared, however, to be a predisposition for independent pharmacies to rely on personal capabilities and interests which saw the many of independent pharmacies classed as Focused Specialty and Multi Specialty. Many banner group pharmacies were classified as Multi Specialty, these banner pharmacies appeared to use their membership of banner groups as a point of differentiation between themselves and competitors. This shows that independent pharmacies are not all by Traditional Pharmacies and they can adopt other emerging models in pharmacy.

We now turn to the financial analysis of the differences between these strategy types based on the case study pharmacies.

4.6 Financial Analysis: Case Study Results for the four Business Strategies (Pharmacy Viability Matrix)

Table 4.21 shows the scores for pharmacies belonging to each category in the Pharmacy Viability Matrix for the four measures of impact: Financial Performance, Risk, Cost, and Value.

Table 4.21: Pharmacy Viability Matrix Categorised Results

	Traditional Pharmacy	Expanded Pharmacy	Focused Specialty	Multi Specialty	Overall Sample (20 Cases) Average	Australian Average
Means						
Financial Performance ¹⁹	62.14	131.13	67.78	127.67	100	63.03
Risk Score ²⁰	98.74	96.28	92.54	107.29	100	74.67
Cost Index ²¹	99.00	100.10	98.60	101.45	100	96.99
Indicative Valuation ²²	106.58	107.31	105.92	87.74	100	133.59
Medians						
Financial Performance	70.41	129.44	50.59	126.55	110.60	
Risk Score	92.53	94.14	75.74	101.55	94.44	
Cost Index	101.13	101.79	99.08	98.87	100.83	
Indicative Valuation	95.20	93.39	111.37	99.47	103.25	

Number of cases 5 4 4 7 20

Note Case Scores are indexed to the sample average where the Sample = 100

Note: While the mean score has been provided for completeness, the size of the sample does not warrant the use of mean scores. For these reasons, our comments will focus on the median scores.

Expanded Pharmacies and Multi Specialty pharmacies achieved higher financial performance than Traditional Pharmacies and Focused Specialty pharmacies.

The lowest risk score was for Focused Specialty pharmacies, then in order of increasing risk, Traditional Pharmacies and Expanded Pharmacies, with Multi Specialty pharmacies having the highest risk score.

Multi Specialty pharmacies and Focused Specialty pharmacies had lower cost structures than Traditional Pharmacies and Expanded Pharmacies. (Note that these results differ from those in the Mail Survey sample).

¹⁹ **Financial Performance:** The financial performance score is based on a model that uses turnover and prescription sales as key variables

²⁰ **Risk:** Risk comprises Business and Operating risk. Business risk takes account of Prescription Numbers, Prescription Percent (of turnover), Sales Growth and Sales Variability (an inverse relationship); Operating risk takes account of Prescription Numbers, Size of premises, Staff Hours and Trading hours.

²¹ **Cost Index:** The cost index is a composite of Cost of Goods Sold, Salaries and Rent as a percentage of turnover.

²² **Indicative Value :** The expected business value assuming normal operating ratio, given the measured contribution margin expressed as a percentage of Turnover.

Focused Specialty pharmacies outperformed other strategy types in terms of value relative to turnover (indicative value). They were followed by Multi Specialty pharmacies, Traditional Pharmacies and, in the lowest position, Expanded Pharmacies.

Table 4.22 below presents the financial results and business measures for each category in the Pharmacy Viability Matrix. The sales and contribution (as previously defined) are presented in both gross and per square metre (psm) terms. We completed this analysis to test whether there are any significant differences between the categories within the Matrix.

Table 4.22: Financial Results and Business Measures by Category

	Traditional Pharmacy	Expanded Pharmacy	Focused Specialty	Multi Specialty	Overall Sample (20 Cases) Median	Australian Average
Medians						
Size	160.50	361.41	288.45	215.50	215.50	140.00
Sales	\$1,850,000	\$4,754,437	\$2,237,501	\$4,400,000	\$3,100,001	\$2,070,307
Contribution	\$307,015.15	\$722,457.01	\$453,407.07	\$635,582.38	\$479,465.71	\$312,552.95
Sales psm	\$13,528.14	\$13,155.29	\$11,769.06	\$19,314.64	\$13,155.29	\$10,323.40
Contribution psm	\$1,912.87	\$1,999.00	\$2,002.32	\$2,157.19	\$1,999.00	\$2,084.31
Abnormal performance	-22.71%	5.46%	-11.50%	-25.90%	-20.11%	

While the relative indices highlight comparative differences compared to the overall sample, the business results in dollar terms provide another insight.

The “Abnormal Performance” measures the level of under (negative) or over (positive) performance relative to the expected results given the key operating resources of each pharmacy. To assess this, firstly the expected sales were determined using a Medici Capital Sales Forecasting Model based upon pharmacy shop size, trading hours per week, and staff hours per week (including owners). The expected sales were then compared to the actual sales (based upon categorised data or actual reported sales) and the difference measured as a percentage deviation from the expected.

Hence, Expanded Pharmacies achieved actual sales above the expected sales by approximately 5.46% (median deviation). Whereas, Multi Specialty pharmacies achieved sales below the expected sales by approximately 25.9% (median deviation). These categories are respectively over and under the expected sales.

Relative to the overall sample, the index scores highlight noteworthy differences between the quadrants of the pharmacy viability matrix.

Expanded Pharmacies are the largest in size and sales but not contribution. These pharmacies are defined as servicing the local community with a broad customer product or service choice (see figure 4.26).

Figure 4.26: Analysis of Variables for the PVM models

COMMUNITY SCOPE	Focused Specialty	Multi Specialty	
Extended	Large	Medium	Shop Size
	Medium	Large	Sales
	Very Good	Highest	Profitability (contribution)
	Traditional Pharmacy	Expanded Pharmacy	
Local	Small	Largest	Shop Size
	Small	Largest	Sales
	Moderate	Good	Profitability (contribution)
	Narrow	Broad	PRODUCT FOCUS

The economic and financial analysis (for the case study sample) highlights that Expanded Pharmacies and Multi Specialty pharmacies are achieving the best financial results but are riskier and consequently are 'penalised' in terms of their value. (Note that Medici Capital uses a risk adjusted required rate of return to assess value for each pharmacy).

4.6.1 Medici Capital conclusions on the bias of the case study sample relative to the mail survey sample

Overall the case study pharmacists reported higher financial performance, higher risk and higher cost and slightly higher indicative turnover (value relative to turnover) than the mail survey pharmacies. In particular, the case study Multi Specialty pharmacies reported considerably higher financial performance, higher risk and decreased costs leading to higher indicative value scores (value relative to turnover).

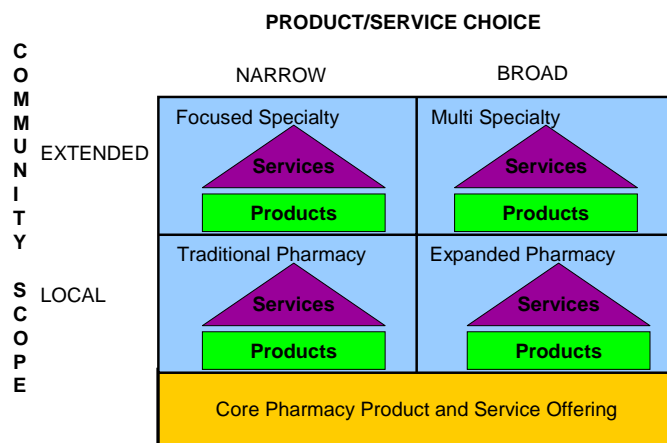
These results indicate that, overall, the case study sample of 20 pharmacies, when compared to the larger mail survey sample of 403 pharmacies, was biased toward higher financial performance, i.e. the case studies are closer to 'best practice' than the average survey pharmacy. (This appears not to be true however for Traditional Pharmacies where the averages are relatively close between the two surveys). This means that the case studies for the three "emergent" business strategy types (Expanded Pharmacy, Focused Specialty and Multi Specialty) have proved to be positive examples of their type, worth the detailed and closer study we gave them in this research in order to understand in more detail the implications of making these strategic choices. This is also true for those pharmacies classified as Innovative.

Recommendation: The Guild should fund further research, building on the financial analyses from this Report, to determine a reasonable rate of return for service provision which can be used to negotiate with government to extend support for funded services. (Recommendation: 67)

4.7 Transition within the Matrix

The following series of figures outlines the variety of product/service mix options in each model of the Pharmacy Viability Matrix. Figure 4.27 represents an equal product/service mix in all of the four matrix quadrants.

Figure 4.27: Equal Product/Service Mix



The following figures use the Traditional Pharmacy as the example of a transitioning model. That is, figures 4.28-4.31 illustrate that a Traditional Pharmacy could increase the provision of services and has the potential, through this increase, to move into any of the other quadrants.

Figure 4.28: Traditional Pharmacy increasing service provision

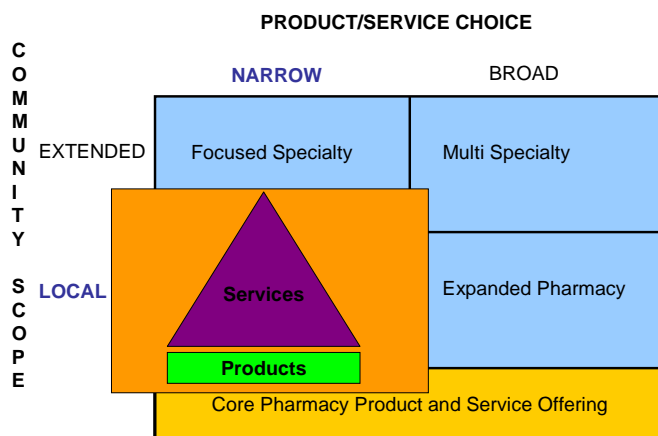


Figure 4.29: Traditional Pharmacy increasing service provision and moving to Focused Specialty

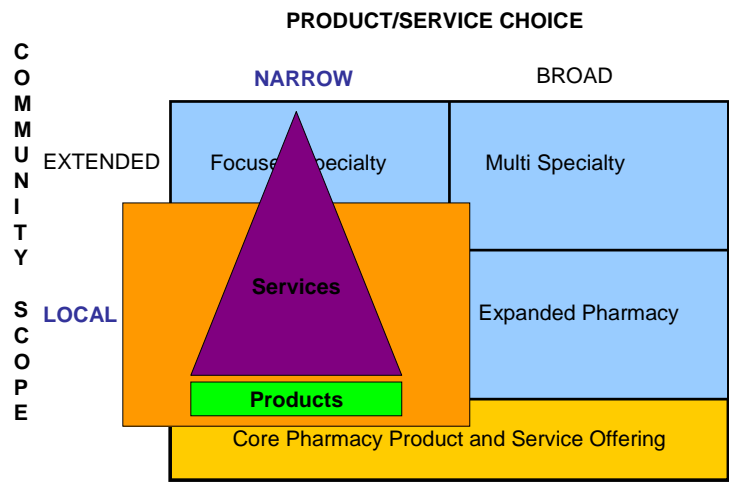


Figure 4.30: Traditional Pharmacy increasing service provision and moving to Multi Specialty

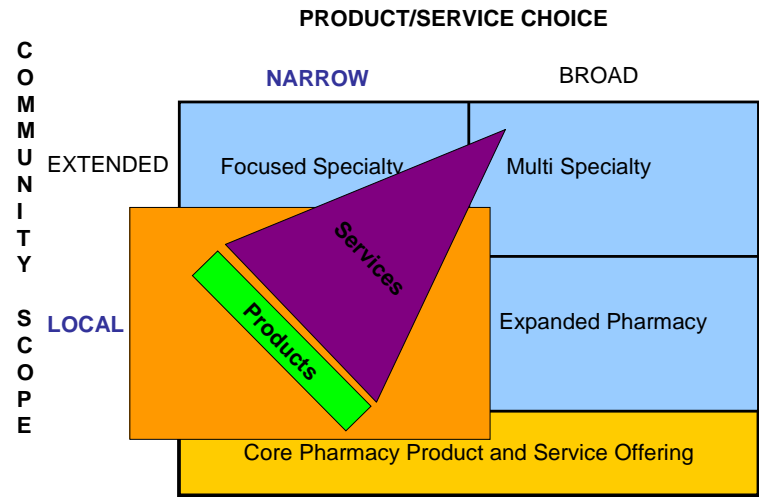
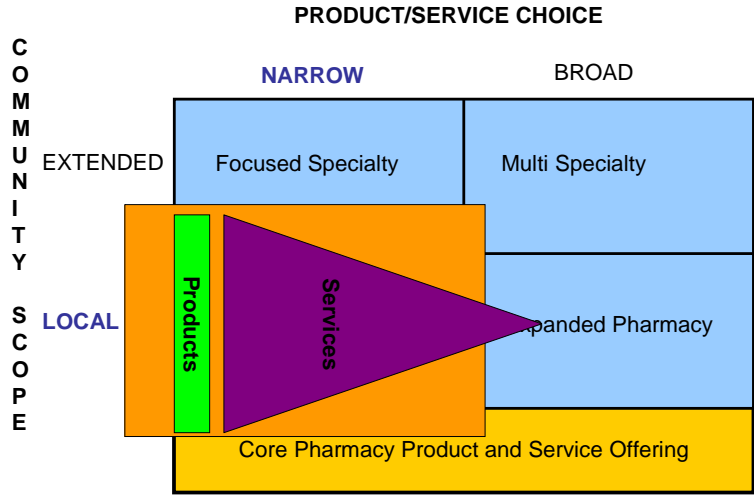


Figure 4.31: Traditional Pharmacy increasing service provision and moving to Expanded Pharmacy



The next set of figures show the same series of movements for a Traditional Pharmacy. This transition, however, is influenced by an increase in products with little change to the pharmacy's level of service provision.

Figure 4.32: Traditional Pharmacy increasing product provision

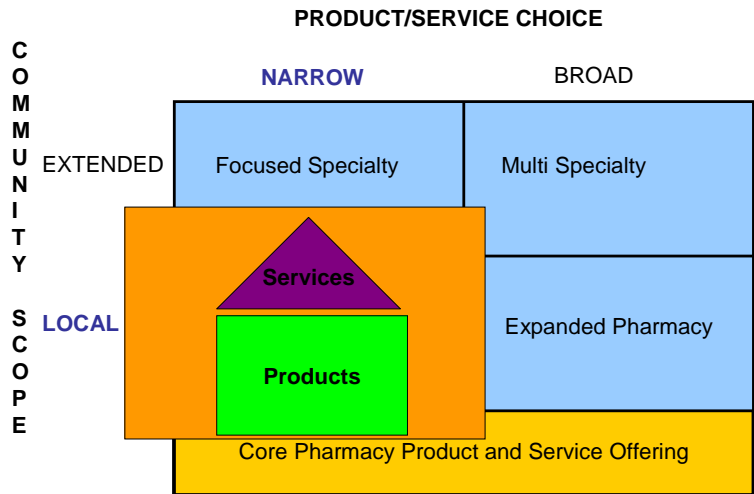


Figure 4.33: Traditional Pharmacy increasing product provision and moving to Focused Specialty

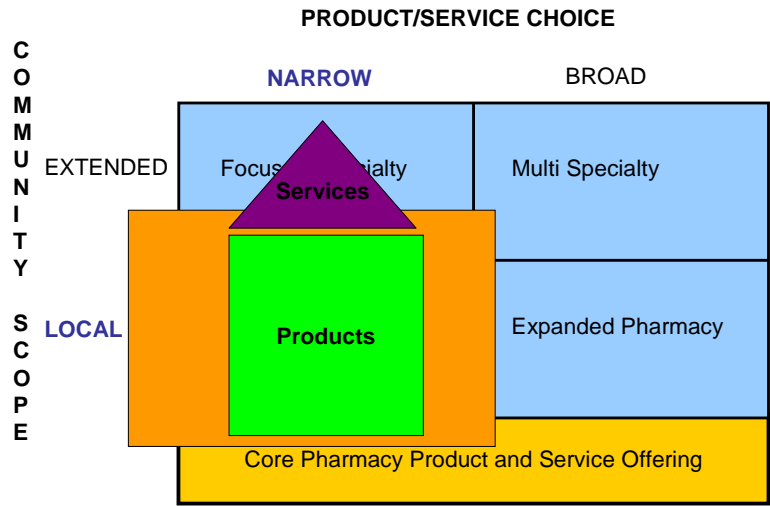


Figure 4.34: Traditional Pharmacy increasing product provision and moving to Multi Specialty

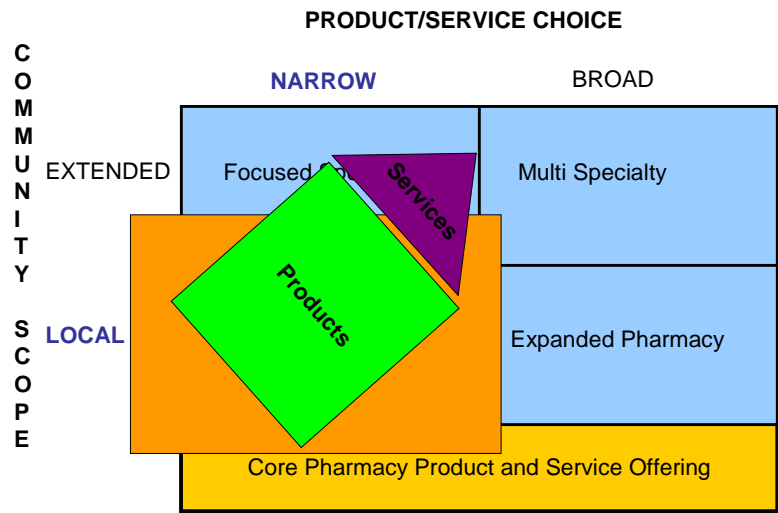
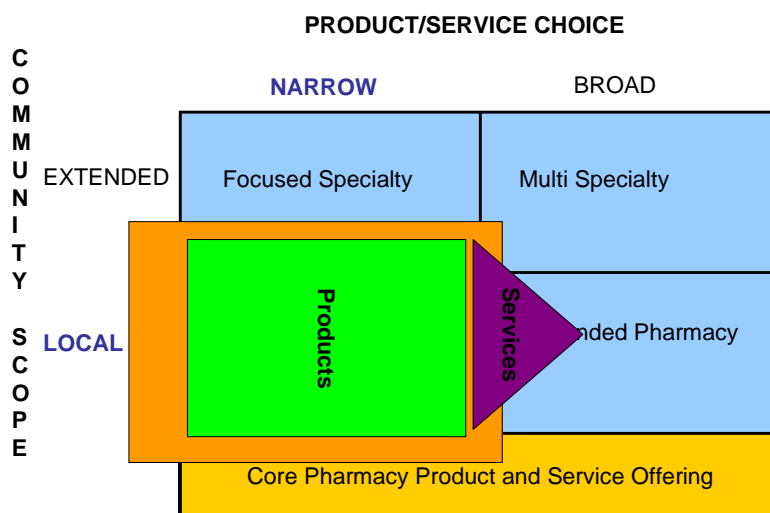


Figure 4.35: Traditional Pharmacy increasing product provision and moving to Expanded Pharmacy



A review of the changes above raises the issue of what costs are associated with making transitions of the kinds illustrated on the diagrams above. An attempt was made by Medici Capital to estimate these costs by following up on the case studies. We now present the results of that project.

4.8 Medici Capital conclusions relating to Multi Year Longitudinal Study and Transitional Costs

Medici Capital undertook a follow up study of the case study pharmacies to assess the transitional costs associated with moving from one strategy to another. The sample for this study was limited, for various reasons (mainly low response rate and poor data quality), to 13 of the 24 case studies chosen by the research team. The study did not produce substantive results. However Medici Capital also analysed the growth rates of the 13 case studies for the period studied. Their growth rates were above the market average which suggests that any transition costs had been successfully absorbed.

We can conclude therefore that, on the basis of the case studies, all the pharmacies represented viable business strategies in both professional and financial terms. We can also conclude that each of the four strategy types has a distinctively different profile when compared to other strategy types studied. This supports the general conclusions reached on the basis of the mail survey analysis. While there are some differences in the financial profiles of the PVM categories for the mail survey and the cases, there are stronger similarities so that the qualitative data and quantitative data are largely mutually confirming.

On the basis of an analysis of some aspects of the mail survey, Medici Capital concluded that moving from a narrow product/service focus to a broad focus (e.g. from Traditional Pharmacy to Expanded Pharmacy) would involve additional operating costs and also that moving from a local community focus to an extended community focus would involve

additional operating costs. But information on the capital costs needed to make such changes was not available.

Similarly they concluded that movement from one business strategy to another could also demand the ability to fund the investment and (new) knowledge and skills. However they were not able to estimate the transition costs associated with such changes in business strategy from the responses received.

There is clearly a need for more research to be undertaken in this area to obtain a systematic way of costing a strategic move from one strategic option to another

Recommendation: The Guild should fund further research, building on the financial analyses from this Report, to determine a reasonable rate of return for service provision which can be used to negotiate with government to extend support for funded services. (Recommendation 67)

4.9 Case Study Narratives

The 24 case study reports follow below. The methodology for this stage of the research is outlined in section 3: 2.4 and the protocols used in conducting case study interviews can be found in appendix 6.

The case studies are reported under the following headings as outlined in section 3: 2.4:

- Background Information
- Customer Demographics²³
- Pharmacy Strategy
- Pharmacy Processes and Systems
- Pharmacy Product and Service Offering
- New Products and Services and the Implementation of Change
- Potential Limitations for Change Management
- Key Learnings
- Financial Information²⁴

The financial analysis of the case studies was only completed for 20 of the 24 case studies (one of these case studies has been withheld on request of the participating pharmacy owner). Where applicable the financial information is reported in the case study.

²³ Australian Bureau of Statistics (ABS) demographics data for the area of the pharmacy's location were analysed to determine population trends potentially influencing the pharmacy. The most recent figures that could be standardised for all areas from were from the 2001 Census.

²⁴ This component of the case studies was completed by Medici Capital.