

SECTION 1: INTRODUCTION

- Research Objectives
- Actual vs Desired Outcomes



SECTION 2: FUTURE CERTAINTIES IN HEALTH

- Examination of social trends to identify future opportunities for the provision of cognitive services through community pharmacies
- Introduction of **Characterising Opportunities Filter**



SECTION 5: CLOSING THE GAP

- Integrates research results from all sources to show how gap can be closed between current service delivery and desired future service delivery
- Introduction of **Pharmind Wheel**: implementing change in context of the health and pharmacy industry
- Introduction of **Pharmacy Change Readiness Wheel**: a practical tool for pharmacists to use to check whether their pharmacy is ready to introduce a change in service provision
- Introduction of **Pharmacy Implementation Wheel**: a tool to help pharmacists design and implement change for their pharmacy
- Practical application of the five introduced tools



Section 5 – Closing the Gap

Pharmind Wheel

Pharmacist Change Readiness Wheel

Pharmacist Change Implementation Wheel

Practical Applications: A Pharmacy Change
Management Program – Delivering Asthma
Management Services

Section 5: Chapter 1

The change management program that should be followed is outlined in this section. This chapter deals with industry level change and is designed to be utilised by the Guild. The Pharmacy Change Readiness and Change Implementation Wheels that are presented in chapters 2 and 3 of this section are designed to be used by pharmacists on an individual basis. For this reason the three Wheels are written in different styles, according to the audience they are directed at. This section then ends with the practical application of these Wheels for Asthma Management Services and a business case financial analysis of Diabetes Management Services.

1 Pharmlnd Wheel

1.1 Introduction

The Pharmlnd Wheel presents a summary of key change issues for the health industry, and for pharmacy in particular, with corresponding recommendations for action to be taken by the Guild. It is clear from the data presented in the report to this point that the health industry faces major changes and that these changes represent both challenges and opportunities for the Pharmacy Profession and for the business of Pharmacy. So what actions should those who have carriage of the profession's future take to ensure that the profession has a strong future?

1.1.1 Why change?

There is no option than to change – if changes in the profession are not initiated by the profession, then the profession will be subjected to significant change by outside forces anyway. It is generally better to have some influence over one's own future than to have external forces simply determine your future, particularly when they fail to take your interests and motivation into account.

The reasons for initiating change described to this point can be summarised here as:

- Demographic changes such as the increasing size of the Australian population and the increasing number and changing proportions in differing age brackets mean that the demand for pharmaceutical products and services will increase and the demand mix will change significantly. The increasing availability of health and illness related information is already creating a consumer group with rising and distinctive expectations, much greater knowledge of what is potentially available to them and a propensity to exercise choices around what they want. Much of what they want is increased services. The shift from an emphasis on treating episodic illness to treating chronic illness will also transform consumer demand, by raising expectations around long term self management. The rising costs of drugs and the escalation of costs associated with the PBS and other medical support provided by governments will lead to "rationing" of health care provision to contain costs to

governments¹. The rise of a variety of business competitors and the possibility of some industry deregulation also threatens traditional sources of profitability.

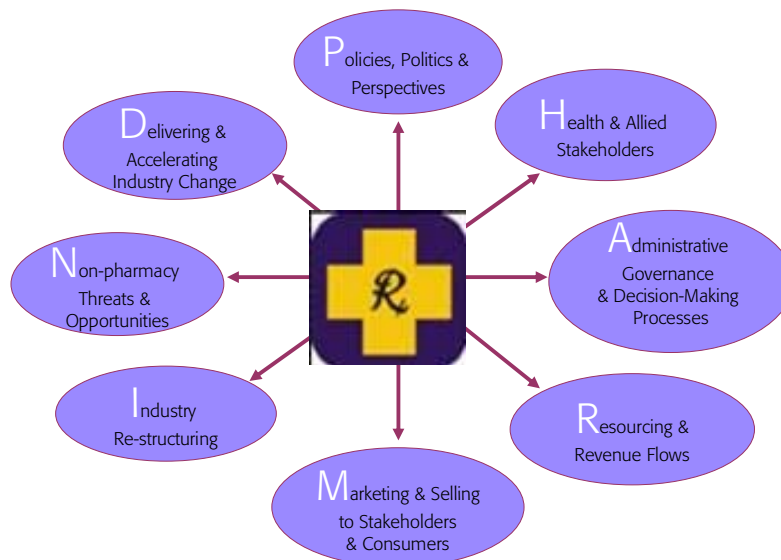
These and other social trends mean that Pharmacy cannot continue to conduct business as usual. Adopting a purely defensive, reactive stance is seldom a solution to system change of this magnitude; it is more likely to result in erosion of rewards and sidelining of the profession as other, more proactive organisations and professions pursue their advantages in a more fluid world.

The mail survey results (section 4 chapters 1 & 2) indicate community pharmacists do support the introduction of enhanced services (87.4% respondents agree/strongly agree to the survey statement) and that there is a compelling need to introduce enhanced services (combined 69.7% agree/strongly agree). However, 37.1% of respondents agree/strongly agree that there has been too much change imposed in community pharmacy.

The respondents recognised the impact of the Community Pharmacy Agreement on their business with over three-quarters agreeing/strongly agreeing with the statement. 41.6% agreed/strongly agreed that the Guild had a good understanding of practical issues when implementing new services and only 34.4% agreed/strongly agreed the Guild has a realistic understanding of the financial implications when implementing new services.

Recommendation: It is important that the Guild addresses the issue that a significant number of their members believe that the Guild does not have a good understanding of the practical implementation of new services. (Recommendation 59)

Figure 5.1: PharmInd Wheel



¹ "Aging and technological change will put more pressure on health funding and will bring about explicit rationing. The challenge is to recognise that rationing choices are fair, ethically sound and realistic." - Philip Davies, Deputy Secretary, Department of Health and Ageing, address to Pharmacy Australia Congress, Adelaide, 15-17 October 2004

The Pharmlnd Wheel (figure 5.1) summarises the issues, challenges and opportunities for pharmacy in eight categories. The issues we discuss have been identified through a qualitative analysis of interviews, forums and case analyses using a computer based coding approach known as NVivo. This approach facilitates the identification of themes raised in these various data sets. We begin now with the first: Policies, Politics and Perspectives.

1.2 Policies, Politics and Perspectives



1.2.1 Consolidating the base:

The core of pharmacy today is the dispensing of prescriptions and sale of PBS listed drugs. We have already indicated (see future certainties) that there will be a sustained increase in demand in this area. As the situation stands most pharmacies are heavily dependent on government funded revenue from these activities and this dependence has increased. The average ratio of prescription to non-prescription sales stands at 70:30 (The Pharmacy Guild of Australia 2004e). Pharmacists themselves realise that substantially increasing this dependency is not a likely (nor necessarily a positive) scenario and that, to the contrary, governments may take steps to deregulate the industry to limit or reduce this dependency. The latter path, whether limited or radical in character, would put many pharmacies in a difficult financial situation.

Australian governments will be trying to restrict rather than significantly increase the scope of “essential” health provision. This is the emerging thrust of the recent ‘Intergenerational Report 2002’ and ‘Productivity Commission Report 2004’. The latter predicts the possibility of health spending nearly doubling over 40 years – escalating from about 5.7% of gross domestic profit to 10.8% by 2045 unless the health care system is made more efficient (Wade 2004a; Wade 2004b). This is estimated to leave a cumulative gap between tax income and costs of \$2200 billion over 40 years (Metherell 2004).

Recommendation: The Guild needs to ensure that the high proportion of pharmacies now accredited for the Quality Care Pharmacy Program deliver a drug distribution system which underpins service provision to a high standard. (Recommendation 29)

Recommendation: The Guild needs to ensure that its competitive advantage of being sole provider of prescriptions funded by the Government is maintained on the basis that it provides sound advice to patients and other health professionals on the safe and effective use of medicines. (Recommendation 30)

Recommendation: The Guild needs to ensure it has widespread community support for the continuing provision of drug distribution through pharmacies as points of convenient access to the general community. (Recommendation 28)

Recommendation: The Guild needs to ensure that governments, the public and consumer organisations are aware of the quality standards achieved. (Recommendation 45)

1.2.2 Expanding from the base

The shrinking margins on front-of-shop retail products and the potential limitations on further substantial expansion of subsidies for prescribed drugs suggest that any major expansion in the business of pharmacy must come from changing the product/service mix. There is an increasing shift within the commercial world generally from product to service orientation with greater profitability associated with the provision of services rather than products.

We have already traced the increasing emphasis, led by the Guild and some innovative pharmacies and networks, on pharmacies offering professional services. We have provided data on the range of services currently provided and on the percentage of pharmacies offering these services. We have also put forward a list of potential service opportunities in section 2 for the Guild to review and select from for further development and possible negotiation. It seems appropriate for the Guild to take forward some selected professional services into the 4th Agreement negotiations with a view to advocating their inclusion as part of the future definition of the “essential” product/service mix that is subsidised by the government because of its importance for the health of all Australians.

A critical point is that these proposals will need to be accompanied by **realistic implementation plans** and **credible reward structures** to indicate that the adoption of service offerings by pharmacies will be sufficiently widespread and rapid enough to justify the expenditure. Where possible, arguments need to be presented that the provision of professional services through pharmacies solely or in partnership with other health professionals will reduce government expenditure in the medium to long term.

Changing the product/service mix offered through pharmacies represents a significant shift in the mindset of many pharmacists and of the government. However there seems to be a growing awareness and acceptance of the value of doing this.

Recommendation: The Guild should continue encourage pharmacists to move the product/service mix in the direction of increasing the professional service component. (Recommendation 31)

1.2.3 Grouping services to facilitate implementation

In the past the Guild has tended to consider services on a one-off basis. We have argued that, now that the provision of individual services has been trialled, it is more efficient to consider services in related groups of associated services which have similar characteristics. For example, the move to the Multi Specialty pharmacy involves putting a group of services together. These specialty health services will appear diverse but are likely to be linked by a common dependence on investment in a skilled workforce, an up-to-date IT system and

flexible delivery systems. The services that are grouped together can be in either health or non-health related areas, depending on consumer demand and the strategic direction of the pharmacy.

Recommendation: The Guild needs to collaborate with education and training providers such as PSA and the universities, to construct professional service training packages that prepare pharmacists and pharmacy personnel to operate across groups of services. (Recommendation 46)

Recommendation: The Guild should group services for more efficient implementation and maintenance. (Recommendation 34)

1.2.4 Supporting integrated health care delivery

The provision of a range of value-added services demands a place within an integrated framework for primary health service delivery. In moving forward into the service delivery area, the Guild needs the cooperation and active support of other key stakeholders, particularly the bodies representing other health care professionals who also have a stake in service provision. Achieving negotiated solutions which facilitate integrated health care delivery will not be easy and has to take place on several levels from national peak bodies to state bodies to local communities. However any solutions negotiated and achieved strengthen the Guild's support in gaining government assistance in providing services.

Recommendation: The Guild should collaborate with other health service delivery providers to move toward more integrated service delivery as part of primary health care provision at the community level. (Recommendation 42)

1.2.5 Ensuring adequate funding for service provision

A critical issue raised in every forum where we gathered data is the question of how service provision is to be funded. Pharmacists operate businesses and ultimately some party has to pay for services offered. We found many examples of pharmacists cross subsidising service offerings out of personal commitment to community health, or offering services as an investment in future "goodwill" which they hoped would influence customer loyalty. Nevertheless the provision of services on a substantial and continuing scale requires investment in capital, equipment and people and should be considered as an investment which will yield a return. Otherwise service delivery can endanger the financial viability and sustainability of the pharmacy.

There is a need for the Guild to explore with third party payers, such as health funds, the possibility of further subsidies on the basis of reduced health costs.

Nevertheless it appears that there will be a need in any case to fund many services on a "fee-for-service" basis. This represents a major turnaround in the thinking of both pharmacists, many of whom are reluctant to charge, and the public which is used to receiving free consultations and other services. The number of older people is increasing and many of them collectively hold a large proportion of the nation's wealth; they have significant discretionary expenditure and are predicted to significantly increase spending on pharmaceuticals.

Recommendation: The Guild should encourage the introduction of fee-for-service for value-added professional services not subsidised by governments or third party payers. (Recommendation 64)

Recommendation: The Guild needs to develop a strategy for assisting pharmacists to make a cultural change towards charging for service provision. (Recommendation 63)

We take up this issue in more detail in section 4 below – ‘Resourcing and Revenue Flow’.

1.2.6 Supporting equity in access to service provision

The introduction of a fee for some value-added services accentuates the need to ensure that services regarded as “essential” are made available to disadvantaged groups such as consumers in rural and remote areas, indigenous groups and low and no income earners. A proposal to the government to endorse fee-for-service and/or an autonomous move on the part of the profession to initiate fee-for-service needs to be accompanied by proposals to ensure that essential services are still provided free or subsidised for these groups.

Recommendation: In the interests of equity, the Guild should propose continuing and extended special financial provision by governments for ‘essential’ services to disadvantaged groups (Recommendation 36)

Recommendation: The Guild should take steps to “map” areas of disadvantage where special services are needed and advocate increased government funded service delivery in these areas. (Recommendation 37)

1.2.7 Reorganising for service provision

In the past, the Guild has espoused 100% adoption of services by pharmacies. The differentiation of pharmacies which we have discussed suggests that, beyond some essential services, this is unlikely to occur. Rather what we will see, particularly for services paid for by the consumer, is the use of service provision by pharmacies as a basis for differentiation among themselves designed to achieve relative competitive advantage. This seems appropriate given the increasing choice demanded by more affluent and informed consumers with discretionary expenditure. The role of the Guild and PSA in facilitating this change will be to ensure that high quality professional education and training is available for pharmacists and pharmacy personnel and that quality assurance standards are in place. Additionally, practice support and resources to support the behaviour changes needs to be provided, for example, mentoring and coaching support that is currently provided by the PSA encourage behaviour change. The initiative and choice about adoption of these discretionary services will be made by the pharmacy owners as a business decision.

The Guild and the PSA have a particular responsibility for monitoring and supporting the quality of product and service delivery of the core or specialty health services offered by pharmacies, some of which (the Traditional Pharmacies) will only offer these core product/services.

Recommendation: The Guild should advocate a two tier service delivery system consisting of core services and specialty health services. This must be done in such a way so as to ensure access for all Australians to the core service offering in community pharmacy, while allowing for differentiation in areas of specific need and/or demand. (Recommendation 32)

Recommendation: The Guild should ensure the provision of appropriate education and training to support service delivery and to maintain of service quality. (Recommendation 52)

1.2.8 Integrating Guild and PSA activities

It is imperative that the Guild and PSA “sing the same song”. They have different but overlapping constituencies and somewhat different interests. However, what the two organisations have in common, and the advantages of cooperation, far outweigh other differences in interest. Interviewees from several states reported high levels of collaboration at the branch level in their states but recognised that this was not true of all states or at the national level. Where there are high levels of trust and collaboration, the critical variable seemed to be interchange of representatives across the two organisations – some individual pharmacists had played key roles in both organisations.

Recommendation: The Guild should pursue all possible means to integrate the policy positions and continuing collaboration between the Guild and PSA. (Recommendation 8)

1.2.9 Identifying and closing the critical implementation gap

A critical gap to date in the policy area appears to have arisen from an assumption that policy change equals practice change. The gap arises from a failure to realise that changing policies does not necessarily result in change in practice – that implementation of policy changes requires change strategies, time, resources and skilled personnel. Proposals for policy change, on the part of government or elsewhere need therefore to be accompanied by implementation plans and estimated transition times and costs.

Recommendation: In making submissions for government funding, particularly for the 4th Agreement, the Guild should ensure that policy proposals are accompanied by implementation plans with time horizons and resourcing estimates (for examples see section 5 chapter 4). (Recommendation 23)

1.2.10 Defining the Value Proposition

While recognising that the Guild has written a value proposition, when making submissions for government funding the following value proposition can add to the current position of community pharmacy:

- The pharmacy network represents a unique national delivery system to local communities for the provision of health care products and readily accessible associated services.
- Pharmacists have strong public recognition for their professional honesty and ethics – trust is a vital component in effective service delivery.

- If the pharmacy network is linked by an “IT superhighway”, it will be even more powerful in terms of delivery of a variety of health related services.
- The Guild and PSA can jointly provide a level of quality assurance and advice that minimises risk and maximises benefit more effectively than alternate distribution systems (such as supermarket chains).
- A nationally agreed definition of “essential (for all Australians) products and related services” can be negotiated with government and effective and economical delivery guaranteed to communities where pharmacies operate around Australia.
- In addition, many pharmacies will offer a variety of extended professional services on a fee-for-service basis which will improve the health care options available to consumers with discretionary expenditure.
- Relationships with other stakeholders, particularly health care professionals and consumer organisations representing consumers with chronic health problems, will link the provision of services by pharmacies into a more unified primary health care system at the community level.

1.3 Health and Allied Stakeholders



This section of the PharmInd Wheel explores relationships with health and allied stakeholders in more detail and is based on 51 interviews. This analysis draws on the theoretical model of interorganisational collaboration as outlined below.

1.3.1 Theory – Interorganisational Collaboration

“The Guild tends to ignore other stakeholders in their decision making – they have not learnt from past mistakes”

The relationships between associations representing health care professionals are important to the delivery of health care services to the Australian population. The Guild has a number of stakeholders with which it works on specific projects. Generally these relationships have been built on project-specific bases. However, for long term sustainability a more systematic approach is needed to build trust between organisations and collaborative efforts. Interorganisational collaboration, involving combined endeavours between one or more stakeholders for a common purpose, promotes joint problem solving and promotes productive working relationships between organisations. If used appropriately, this form of alliance would be beneficial to the Australian health care system.

Collaboration is “the pooling of appreciations and/or tangible resources, by two or more stakeholders, to solve a set of problems which neither can solve individually” (Gray 1985). Collaboration has already begun to take place in the health care industry with the increasing presence of multi-disciplinary teams and projects for services specific to the community pharmacy industry. For example, Home Medicine Reviews promote collaboration between pharmacists and general practitioners but this program has not been without its challenges. More effective means of collaborating need to be identified for future programs that run across health care profession boundaries.

Interorganisational collaboration has been used internationally in the health care industry to promote networking infrastructure and partnerships between organisations across the globe (Sylvia 2003). In this trial, issues of trust and control were identified as areas that could bring about the failure of the collaborative process. The formation of an organisation’s image, or identity, can also be challenged during the collaboration process (Beech and Huxham 2003). Organisations such as the Guild and the Australian Medical Association have strong identities and when collaborative efforts are pursued, these identities and trust between organisations must be carefully addressed.

Gray (1985) argues that interorganisational collaboration is only justified in certain circumstances. The criteria for using this method of problem solving are (1) when traditional methods of problem solving are ineffective, (2) when the problems are beyond the capacity of one single organisation to solve; and (3) there is increasing instability in the environment. The health care needs of the Australian population can not be adequately addressed by one single group of health care professionals and their representative organisation.

To develop this collaborative environment Gray (1985) proposes a three-phase model which highlights and recognises the interdependencies of stakeholders. This model has the following stages:

- *Problem-Setting*: Problem-setting is concerned with identification of the stakeholders within a domain and mutual acknowledgement of the issue which joins them... Through [this] process, then, stakeholders negotiate issues of legitimacy and come to appreciate the interdependence which exists among themselves;
- *Direction-Setting*: [The] stakeholders articulate the values which guide their individual pursuits and begin to identify and appreciate a sense of common purpose;
- *Structuring*: When the stakeholders create long-term structures to support and sustain their collective appreciation and problem-solving activities.

The Guild could well build on the problem solving base that has been established with some stakeholder groups and increase involvement in direction setting and structuring. This could enhance the contextual support for new service introduction and implementation.

1.3.2 Interview Analysis

One of the most critical areas of future change in developed societies will be what is referred to by leading sociologist (Beck 1992) as the “sub-political arena”. This is the area of society which lies between governments on the one hand and organisations on the other — it is the world of inter-organisational relationships. In many areas of society change

is critical and there is a need to generate coordinated action in this arena to solve social and ecological problems and create innovative action to pursue new opportunities. However, this is an area where there are few, if any, established forms of governance and often a lack of established communication channels among interested parties. The health field is no exception.

In our study we identified the major players in the political and sub-political arenas of the health field whose actions can affect solutions adopted by Pharmacy. These stakeholder groups are listed below:

- Pharmacy Organisations
- Pharmacy Schools
- Wholesalers
- Retail Competitors
- Consumers and Consumer Groups
- Patient Support Organisations
- Other Health Care Professional Organisations
- Rural Associations and Pharmacists
- Regulatory and other Industry Bodies
- The number of interviews completed in each group can be seen in table 5.1.

Not included in this list, but still an important stakeholder group, is emerging stakeholders. These may be specific to a specialty health service area or may result from a change in the external environment, i.e. population demographics etc. It is important that these emerging stakeholders are continually evaluated and assessed by the Guild.

Table 5.1: Stakeholder Interview Summary 1

Stakeholder Group	Number of Interviews Completed
Pharmacy Organisations	19
Pharmacy Schools	3
Wholesalers	5
Retail Competitors	0
Consumers and Consumer Groups ²	3
Patient Support Organisations	4
Other Health Care Professional Organisations	5
Rural Associations and Pharmacists	8
Regulatory and other Industry Bodies	4

The attitudes and actions of these stakeholder groups will have a significant effect on the future shape of the health system as a whole and on the degree to which Pharmacy community pharmacy can take up the opportunities we have identified.

In interviewing stakeholder health professionals, we found a high degree of awareness in most cases of the initiatives taken by the Guild in redefining the nature of Pharmacy and also detailed knowledge in some cases of PSA initiatives. The proactive stance of the Guild in relating to government and securing political support was widely recognised, generally respected as an achievement, but not universally admired. Some stakeholders

² This analysis also used the data from Consumer Forums. Seven of these were conducted

also recognised the existence of tensions and occasional areas of conflict between the Guild and the PSA. Given the ethical commitment we have to protect the privacy of those we interviewed, we cannot name either the respondents themselves or their specific organisation. We can, however, summarise the issues raised and, where there are some shared attitudes within key stakeholder categories, we can discuss these.

1.3.3 Pharmacy Organisations

Pharmacy organisations are the bodies across Australia that represent and work with pharmacy in a variety of capacities. This discussion of pharmacy organisations highlights the relevant views of the profession. They are not, however, exhaustive but they represent the diversity of ways in which the people within the profession see themselves.

Professional organisations are placing an increasing emphasis on the advice-driven market. Pharmacists are viewed as suffering from the “four-wall syndrome” and are being urged to move out from the dispensary and into the advice-driven market. Pharmacy has begun to evolve into a provider of cognitive pharmacy services over and above its “conventional” role of supplying medicines. Many participants see this as a natural progression in response to changes in consumer demand. Interviewees believe that the organisations and pharmacists are becoming increasingly interested in the areas of health promotion and wellbeing. This is said to represent a major change in the product/service mix of the pharmacy and requires a significant change in attitudes and perceptions inside and outside community pharmacies. Thus there is an increased need for comprehensive change management strategies to facilitate this evolution within pharmacies and in the industry as a whole.

The provision of some pharmacy services is resented by other health care professional organisations but participants from pharmacy organisations believe that nevertheless this is the most viable future strategy for pharmacy. Interviewees believe that the boundaries previously separating various areas of health care are beginning to blur and other health care professional organisations are believed to be concerned that the role of pharmacists will be enlarged at the expense of their own profession’s role. Interviewees believed that alliances of health care professionals could be used to facilitate the sharing of valuable knowledge in providing improved patient care and to overcome the issue of professional boundaries.

Interviewees from pharmacy organisations support the implementation of services and are beginning to develop practice benchmarks or standards to guide pharmacies which may wish to move in this direction. These quality standards need to be developed by a professional body for community pharmacy, to set consumer expectation standards and to ensure quality service delivery to other stakeholders. Interviewees believe that disease state management services that are currently being researched for delivery through community pharmacy require specific protocols to address stakeholders’ concerns that the service to their constituents is consistent and of high quality.

To facilitate the increased uptake of services in community pharmacy there has been a call to modify the remuneration system, which still relies on the dispensing of PBS medication. Many interviewees believe that the current system does not adequately recognise the value-added services that pharmacies are already providing, let alone those they may provide in the future. It was claimed that some pharmacists used the remuneration from PBS medicines to cover any losses accrued through providing non-profitable services. The PBS margin, however, does not cover all such costs. If the cost is not passed on to the consumer, pharmacies become more dependent on government remuneration. It is

claimed by some interviewees that costs to consumers will be accepted if consumer awareness is raised.

Awareness of pharmacy services is claimed to be high within the profession but outside the profession there is, in some cases, a perceived lack of acknowledgement and acceptance of pharmacy-based programs and cognitive pharmacy services. Many services are promoted by the individual pharmacy in their local community. Although pharmacists are trusted members of the community, on the whole consumers are seen as unwilling to pay for cognitive services.

An interviewee expressed the view that:

"[the] government has encouraged people to believe that their health should be free... people aren't generally prepared to pay for services in pharmacies".

This is a major barrier for pharmacy. A possible change in consumer attitude to charging is also thought to be linked to the public's lack of knowledge in regards to the potential benefits of pharmacy-based services.

"The idea of actually paying for a service requires consumer education as much as anything else. It's bringing the consumer to the party at the same time as the pharmacist saying: 'Well, look, here's something that we can offer you that you really can't get anywhere else as well as you can get it from us and you should pay for it.'"

The management of change in pharmacy can be illustrated through recent industry changes and the implementation of new services. The Home Medicine Review (HMR) program was an evolutionary program for community pharmacy; one pharmacist describes its implementation:

"It was a big change for pharmacy. We underestimated the change that needed to happen for our profession to embrace HMRs, and deliver them in a sufficient quantity and quality. We didn't have the business model, or the implementation plan to tell people how they could implement it within their pharmacy. To actually integrate it into your pharmacy - day to day community pharmacy - was a big change and we didn't give people any help in telling them how to do that. The dream was to have an accredited pharmacist in every pharmacy delivering the service throughout Australia. You can debate is that a realistic goal, an achievable goal? It's very much a long term goal, and perhaps we should have had some short, medium and long term goals in place."

There was also a lack of infrastructure within the profession to support and maintain the new service when it was first implemented. Interviewees highlight the need for change management implementation plans in community pharmacy. (Section 5 of this report addresses this issue.)

Some participants from pharmacy associations have reservations about the quality of graduates being produced from some pharmacy schools in Australia. Some pharmacists are perceived to lack the management and communication skills necessary to implement change. These management and communication skills are becoming more vital with the

increasing importance of cognitive services and the need to manage the pharmacy business more effectively in the face of increased competitive pressures.

Although pharmacists are usually perceived as struggling to introduce change, some change programs in pharmacy have seen positive change implementation on the part of the community pharmacists involved. The manager of one such program involving pharmacies stated:

"We've had extraordinary goodwill from the pharmacies and we have encroached on their time and we have forced changes on them which they're not particularly happy about. They persevered with it which has been fantastic so in that sense of willingness to step beyond their traditional roles. I think they've really been amazing."

Pharmacies are seen as an ideal outlet for providing extended health care services to the community. As one interviewee stated:

"I think the area that currently gets more focus is new service delivery and I believe pharmacies are in a sensational position to do that and to make that delivery. We're accessible, we're well spread out, we're trusted, we're non-threatening, we are organised. To survive we have to be modest, you know, reasonably regimented and structured in the way we offer in this service that we offer and therefore, for lots of the things that Government need to be delivered to the public, pharmacies actually already are well situated."

However, it is said by some in the profession that pharmacists can also misjudge their local community needs and a greater emphasis on understanding and meeting consumer demand would make them a more effective point of delivery.

There is currently some tension between the two main representative groups for pharmacy, the Guild and the Pharmaceutical Society of Australia (PSA) and this is a matter of concern for many of those interviewed. A united front between these bodies could consolidate the voice of the pharmacy profession. The roles of these two integral organisations, however, are not clear even to members and overlap in some areas.

"I think they need to... communicate as a group and they need to consolidate their services and support or give clear definition about what they are all doing".

This relationship is currently being addressed. There appears to be a notable difference in the degree of cooperation between the organisations in different states and, for most states, more cooperation at the state level than at the national level.

1.3.4 Pharmacy Schools

The attitude of pharmacy schools to the implementation of services in pharmacy is positive. The representatives of various pharmacy schools that were interviewed indicated their support for this move within the profession. The need for adequate remuneration structures to support the implementation of new services was also noted as a crucial issue by these interviewees. It is also seen as imperative that remuneration reflects the level of commitment and the resources required to implement and sustain the service.

The provision of services requires highly qualified and experienced personnel. For services such as HMRs, pharmacy students are only eligible for the accreditation program two years after graduation. Some participants from pharmacy schools are in favour of this process as they believe experience as a pharmacist is essential to providing cognitive services. One participant stated:

"I think there is a need for a bit more worldliness and experience of real situations. If you're at university and you do a case study and a review, it's not a matter of life and death... when you go out into the real world you need a bit more confidence and experience."

The counselling role pharmacists provide is seen as one way to maintain positive attitudes towards their role in the health care system. One interviewee expressed this view by saying:

"They have to head more down the counselling approach and interaction with other health practitioners whether its doctors or physios or whoever – community nurses. Because that's the bit that shows that they're unique and they're worth having."

The shortage of pharmacists is said to be a barrier to implementing enhanced services in pharmacy. In Australia this workforce shortage has become a crucial issue. With government support many of the pharmacy schools have increased their intake of students and a number of new schools are opening across the country. These measures are designed to alleviate the problem. The more established schools, however, are concerned about the standard of education being lowered as there is a limited pool of qualified educators in this area.

Cognitive pharmacy services are considered "a welcome addition to community pharmacies" by pharmacy schools. The interviewees also indicated a number of areas of cognitive which community pharmacists could emphasise if properly remunerated. These include mental health support and community education, especially in rural communities.

It was suggested that approval for new services needs to come from the stakeholders who are affected by or affect the services as well as within the profession. In particular, other health care professionals can either 'make or break' enhanced services and they can initiate 'turf wars' according to interviewees. By highlighting the benefits of the services and the added value they can provide, pharmacy could potentially be better integrated into the health care system. Newer pharmacy schools have concentrated on helping pharmacy students to establish these relationships early on. They promote the integration of cohorts of pharmacy and other health care students at the university level. This allows them to establish working relationships with other health care professionals early in their careers.

Although awareness of cognitive pharmacy services is high within the profession, pharmacy school representatives believe that the low level of consumer awareness needs to be addressed. Pharmacy must highlight to consumers the value that can be provided to them through pharmacy services. Interviewees do believe that a fee-for-service model can be used for appropriate services but this will only be accepted once the value of services is reinforced to the community.

Many pharmacists are seen as not being fully equipped to offer cognitive services. Pharmacy students generally leave university with a high quality of clinical knowledge. Pharmacy schools are beginning to offer courses in underdeveloped areas namely communication skills and business management skills to complement their clinical knowledge. Interviewees believe that these are important elements of the pharmacist's education but some schools rely primarily on field experience. Other schools offer postgraduate courses or elective streams in these areas.

According to the interviewees, pharmacy has shown evidence of being effective in a dispensing role. Their role is described as:

"the custodian of the drugs. [They're] not a gatekeeper, but the second checkpoint on drug therapy. It's always dangerous to ignore their importance, as in some countries where they have dispensing doctors. The doctors write the prescription, then they dispense it themselves so there's no check in that on whether they've given the right dose or on the interactions."

As part of the health care community, pharmacists can also save valuable time for GPs by performing certain services, such as blood pressure checks, allowing GPs to focus on higher need patients.

It was suggested that the profession provides a flexible and adaptable career option for female pharmacists. This is important as there has been an increased feminisation of the workforce, which requires a more flexible approach to staff resourcing issues. The influx of women demands more flexibility in the workplace, which becomes a fundamental issue when implementing cognitive services as they require a significant time commitment. These workforce issues are currently being evaluated by the Guild.

1.3.5 Wholesalers

Wholesalers are an important link in the ethical drug distribution chain. There are three major wholesalers in Australia which compete with each other. The profitability of their businesses depends on the volume of drugs they are able to move and the efficiency of their warehousing and delivery systems ("delivering stock in full and on time"). Volume is dependent on the number of pharmacies they supply and the success of the pharmacies in attracting customers. By setting up banner groups for pharmacies, they create loyalty and support from pharmacists and influence the success of their pharmacies. The wholesaler can amass more buying power to obtain lower prices from manufacturers than individual pharmacies. Consequently the three wholesalers are also competing to recruit pharmacies to their banner groups.

While they are keen to maintain and grow their market share, wholesalers believe that they face four major threats to their operations. One threat is from the manufacturers who want to bypass them and market directly to pharmacies. A second threat is from pharmacy owners who secede from banner groups and set up smaller independent networks or act individually often buying direct from manufacturers, thus collaborating in bypassing the wholesalers. A third threat is from major supermarket chains who have tried, so far unsuccessfully, to move into the industry. If they did they would deal directly with manufacturers and compete directly with the wholesalers. A fourth threat is from government which is increasingly attempting to reduce the distribution costs of medicines.

As a result of these pressures, in their view, “wholesalers are being squeezed to the limit and we need to get volumes to sustain the business.”

‘Revolution’ and other similar words were used by a number of respondents and applied to major threats to the way that the supply chain is currently constructed.

One wholesaler pointed to the drop off of many pharmacy members of banner groups over the past two decades and there was general concern among wholesalers interviewed of the impact of falling banner group membership in reducing the ability of banner groups to supply services to pharmacies and to attract lower prices from manufacturers. In addition, they expressed concern at independent pharmacies and networks ‘cherry picking’, taking cheaper product deals where they could get them and developing their own infrastructures. They saw this as weakening the power of wholesalers and ultimately undermining the collective bargaining power of the pharmacies as a whole.

Wholesalers have a strong stake in the business success of the pharmacies they are linked to, particularly with those in their banner group. Consequently they provide pharmacies with a suite of services around retailing, property management, IT systems, business management, staff training and development, advertising and retail brand development. They provide this advice in an attempt to ensure that the pharmacies remain viable businesses.

“We provide services to pharmacies. Why? It is about getting volume and throughput and up selling, cross selling, complementary selling by the pharmacist or their assistant to the consumer.” (Senior Executive, Wholesaler)

Wholesalers see the provision of quality advice and care by pharmacists as the distinct competitive advantage that pharmacy has to keep supermarkets out of the industry. They are aware of the initiatives taken by the Guild and PSA in this area and strongly support these initiatives.

There is strong support amongst all wholesalers for the provision of such services by pharmacists. A typical response was:

“I am a strong advocate of service delivery by pharmacists”.

“What the community values in a pharmacy is service, advice, recognition and to feel comfortable. Now supermarkets don’t offer that, they’re just saying: “Well, we’ll get you a better price.”

An executive put it succinctly:

“The wholesaler strategy is around retail development, brand management and picking up on the unique position of the pharmacist to offer quality service and advice in a professional manner.”

Interviewees, however, expressed reservations about pharmacists’ capabilities in three key areas. The first is in the area of business management, particularly in the retail area of the pharmacy. The second is in the pharmacists’ understanding of the retail market. The third is the ability of pharmacists to manage change. They point to the dearth of effective business training that pharmacists receive.

"Can they communicate? Can they relate to customers? Let alone can they understand retail and the dynamics of a competitive industry? ...We send them to a school which gives them no training in business management, change management, staff training and education development or how to run retail or front of shop."

Similarly they perceive many pharmacists and others in the industry, as out of touch with consumers. They also see a substantial proportion of pharmacists as unwilling to adapt to change.

"My observation is that pharmacists are not heavily equipped to deal with change and in fact in many ways I think it would be quite fair to characterise the recruitment, the people who are attracted into pharmacies, as detailed, liking to keep things in order...But when it comes to change, that's not an area where they are going to excel..."

They pointed to the age structure of pharmacy and the implications for meeting the challenges of what they foresaw as significant imminent industry change:

"Right now we've got a group of pharmacists who've built up a large amount of equity and are steering the business in the rear vision mirror, hoping that the wall in front of them is far enough away so they can get out of the car before they get there. The revolution that's going to happen over the next 5-10 years is going to be major. We have to behave today as though the change is already on us or if we don't, it will be too late."

The wholesalers saw a clear role for the Guild in maintaining and improving professional standards in the industry and adopting a 'holistic approach' to pharmacy. They saw the need for the Guild to continue to use its power to 'lead the way' for the industry but to be less concerned with defensively protecting pharmacists from perceived threats and more proactively supporting delivery of a wider range of services related to changing social and economic demographics.

When asked by the interviewer to comment on the Guild's efforts to increase the service provision within pharmacies, one interviewee replied:

"Ten out of ten from me for that! From our point of view the more we can assist pharmacy to be successful, everyone will benefit from it. If sales and floor traffic go to grocery then the viability and sustainability of 5,000 distribution sites Australia wide becomes more and more vulnerable. So the more we can, as a community, direct and channel people into a pharmacy to maintain that support base, the better it is for everyone involved in the industry and for the community too."

1.3.6 Retail Competitors

Despite repeated requests no representatives of pharmacy's main retail competitors were available for interview for this project.

1.3.7 Consumers and Consumer Groups³

Although consumers and consumer groups believe consumers have a high level of trust in pharmacists as ethical health care professionals, there is also a degree of scepticism from consumers about pharmacists being in the business of giving advice and then saying: "here is the medication" while operating in a retail environment where the pharmacist stands to benefit from the transaction.

The interviewees view the core functions of pharmacy as related to medication dispensing and advice. Pharmacists were seen as the first port of call for people who could not afford doctors. High level pharmacy users are dependent on positive ongoing relationships with their pharmacist. Drug interactions and medication safety are the big issues for these consumers. They place greater emphasis on the development and expansion of this function of community pharmacy than on the implementation of novel services. Overall there was low awareness of services currently offered by pharmacies. However some interviewees knew about such programs/services through their work as carers. Concern was expressed about introducing consumer payment for services as this would impact on those consumers who are the most vulnerable and often unable to pay.

Consumers and consumer groups generally want to see pharmacists offer core functions more consistently such as: CMI leaflets supplied every time medication is issued, Safety Net information offered, cheaper generic brands offered, patient files kept. Pharmacists are not seen as using their clinical knowledge to assist in a range of areas particularly in the area of complementary therapies. Pharmacies sell the products, consumers are using them, but there is concern about how and where consumers get information about complementary medicines. This gap was highlighted in the recent Choice magazine survey (Choice Magazine 2004) where the quality of advice about conventional and alternative remedies, given in the pharmacies visited by "mystery shoppers", was viewed as poor.

Research participants from consumer representative groups did not appear to have particularly strong on-going relationships with the pharmacy profession. There has been some contact around specific projects in the past but little feedback. Unlike their relationship with GP organisations, there is limited involvement at the national level so that consumer groups are not influencing ways the profession works and how it impacts on consumers.

Participants argue that community pharmacy in Australia already offers community assistance and has a high profile, by and large, as a body of trusted health professionals. It offers even greater potential as an accessible point of contact, support and up-to-date information source – an enhancement of its current role. As a delivery point for health care information it offers the great advantage of face to face delivery. Interviewees believe that it is necessary to raise awareness of consumer health issues with pharmacists as well as consumers. They see pharmacies as more accessible than GPs and their "shopfront" nature offers a "place to talk". A lack of privacy and, at times, a lack of sensitivity shown to consumers by pharmacy staff, are perceived as drawbacks when services are offered in community pharmacies.

"With [my pharmacy], there's no privacy and especially if it's special tablets and they start talking, to me. I say, "Excuse me, could you lower your voice a bit""

³ The material in this section comes from both stakeholder interviews and consumer forums

Consumers and consumer groups can be critical of the pharmacy profession as with other industries also but it is an important part of their role to evaluate the effectiveness of service delivery to consumers. This can be uncomfortable for the profession but it does offer an excellent opportunity for more cooperation with these groups in ensuring the maintenance of high standards of service delivery. It is in the interest of the community pharmacy industry to have a transparent auditing system to assure the quality of standards for service delivery. Community pharmacy's claim to offer professional expertise which is not available in supermarkets needs to be convincingly demonstrated or community pharmacy risks diluting its professional reputation for integrity and professionalism.

"It doesn't matter how many times I have the same prescription, the pharmacist never misses coming out and going over the same thing which he's told me on a number of occasions before. Just to be absolutely sure."

1.3.8 Patient Support Organisations

Patient support organisations generally have a very positive attitude towards pharmacy as the central distribution point for information and other referral services for disease states. These referrals are to allied health professionals in the community and the representative bodies themselves. The organisations generally see pharmacies as an efficient and relatively cost-effective delivery point for their constituents. Their constituents use pharmacies on a regular basis and rely on pharmacists for correct information regarding the use of medications and aids. It was noted by the interviewees that pharmacists "want to get it right". There is some scepticism over various tests used by pharmacists for screening. Stakeholders in this area also fear that there is inconsistency in delivery because of limited or no accreditation standards. In these cases they generally refer patients to a GP instead of the pharmacy.

Noted advantages of the pharmacy as a delivery point are ease of access to the pharmacist, "free" advice and effectively providing follow-up assistance. However, lack of privacy was an issue highlighted in a number of discussions.

Community pharmacy is well placed to deliver services at both the state and national level. The organisations interviewed were both national and state based, and the Guild's own structure can accommodate this dual level of organisation. Tensions can exist for these organisations to implement at both these levels, and sometimes causes delays or inconsistent messages. In some cases, the Guild has initiated and provided a pharmacy representative to these organisations. This is highly valued as it provides the organisation with greater information and understanding of the potential role of pharmacists in the management of the disease state.

"Pharmacies are very, very public and people feel very insecure about that..."

The patient support organisations operate through boards, committees and working parties which include representatives from other health care professions. It is important for pharmacy to gain the support from these professionals and their associated organisations. From the interviews it appears some individuals and organisations have views which suggest that the pharmacist's role in the delivery of professional services is limited. This can potentially reduce the impact of pharmacists in service delivery.

“Doctors diagnose and prescribe and they regard the pharmacist very often as... just the one that fills a prescription and they forget the intensive training pharmacists have in drugs and drug interaction.”

In principle the patient support organisations supported community pharmacy providing services. However getting their specific disease state on the agenda for Government is a political process. There is often a long lead time for gaining government approved funding and eventual rollout of the resulting service in the community. Community pharmacy may not be initially seen as part of the central strategy by the patient support organisations. Therefore, it is in the interests of the Guild to have its own policy of disease state management in order for community pharmacy to be included by these stakeholders as a key health service delivery member. Collaborative relationships with the representative organisations, as well as articulating a clear role for community pharmacy will support pharmacy's expanding role in these health management services.

Some of the patient support organisations have highly developed consultative processes for their programs which already include as a key member of the health team. Examples of this include: having pharmacist representatives as a national advisory working group who provide pharmacy-specific advice for the management of the disease state, preparing joint publications and education modules, and conducting collaborative research with University pharmacy schools.

The interviewees' awareness of services offered in community pharmacy was generally limited to the specific disease state they had an interest in. Some organisations already have a formal and structured approach for providing educational information to pharmacists about their services.

One of the key issues for patient support organisations is to ensure that pharmacists and relevant staff are appropriately and adequately trained to meet the needs of their constituents. This may also include additional accreditation to provide appropriate advice and being able to direct consumers to the right source for further education, information or products. Being able to disseminate information quickly and provide consistency in protocols is important and a key to effective implementation.

The levels of education and accreditation for pharmacists can include modules prepared co-operatively and endorsed by the organisation and related health professionals. Interviewees mentioned there is a need to ensure that pharmacists are adequately trained in providing these services, with continuing professional development. For one organisation where they had evaluated the training, they found that, after their training, all the pharmacists involved noted that they felt more confident in being able to deliver the service.

1.3.9 Other Health Care Professional Organisations

A range of other health care professional organisations were interviewed for the project. While there was considerable variation in the views from one organisation to another, many of these key stakeholders expressed concern about community pharmacy implementing enhanced professional services. Pharmacy bodies believe that community pharmacy is ideally placed to provide primary health care services with its access to S2/S3 medicines and a consumer acceptance of the pharmacy as a health care setting. However, on the whole, other health care professionals did not agree.

Issues raised about pharmacy services included:

- Concern about the quality of services provided, eg baby health clinics in pharmacies not using trained Child and Family Health nurses.
- An open-space pharmacy environment not being conducive to positive health interactions, eg talking about sexuality, contraception, breast feeding.
- Health care advice given by relatively untrained and sometimes inexperienced pharmacy assistants rather than by pharmacists.
- Concern that because a pharmacy needs to make a profit, it may not be selling the most appropriate product even if providing an appropriate service.
- Pharmacy encroaching on other health professionals' territory without prior cooperative consultation or communication.
- The Guild accessing Government money to promote their own interests or the interests of pharmacy owners rather than the money being used to inform or provide the most appropriate effective health care for the community.
- Pharmacists sometimes bypassing or duplicating an already existing community health network rather than linking in to it.

The organisations interviewed saw community pharmacists' role as being limited to dispensing and advising on pharmaceuticals and medicines, eg. managing how many drugs people are on, monitoring interactions. However while they acknowledge this is an important service for the community, this is based on the assumption that health care is best managed by pharmaceutical intervention.

Interviewees were not comfortable about community pharmacists doing health checks. Other health care practitioners believe that they have a better claim to be able to manage those health checks. While pharmacy's push into primary care services is based on their community accessibility and existing infrastructure, other health professions believe that they also offer these advantages. An exception was seen to be the provision by pharmacies of services in rural and remote communities in circumstances where other health professionals were not available.

Community health education and promotion were mentioned as benefiting from the training, specifically in the areas of medications:

"The benefit of pharmacist training is that you pick up a lot more things based on the drug side. Unless someone deals with drugs day in and day out, and with normal clinical disease states and having to interpret them, then you are not going to be as effective in determining if the drugs are doing the job they are meant to for the individual at the time."

It was stated that training the pharmacists to build up their confidence in being able to manage queries and be an educator in the pharmacy would benefit consumers but other health care professionals saw a problem with making it cost-effective as a service from community pharmacy.

- Much of the tension between community pharmacy and other health care professional organisations around the implementation of enhanced services relates to a perceived lack of communication and consultation.
- Most stakeholders have a reasonably good relationship with the Guild but "we don't hear about their bright ideas until the government has funded them and we have to live with them."

- In general, other health care professional organisations do not see themselves as having a close working relationship with pharmacists; links are mainly informal. Some smaller 'players' did have a link to the Guild which they saw as getting them 'into the game'.
- Sharing and communication are seen to be critical at a local level but many pharmacists 'go it alone'.
- Pharmacists are seen as often establishing themselves in competition with other health care professionals rather than working with them.
- Some organisations are distrusting of pharmacists' motives in this area.

Interviewees believe that collaboration and communication are required between all health care professional bodies and organisations to plan and deliver integrated primary health care in the future.

1.3.10 Rural Associations and Pharmacists

Throughout Australia, pharmacists are faced with increasing problems associated with a shortage of skilled pharmacists and pharmacy staff particularly in rural communities. Rural and remote pharmacies have unique issues due to their isolated locations. The Guild introduced a new program that provides locum cover in the event of an emergency in rural and remote pharmacies⁴. Rural pharmacists interviewed in various stages of this project appeared to have low awareness of this program.

The shortage of locum cover and the costs of travel and accommodation also prevent rural pharmacists from attending many continuing education sessions and conducting cognitive pharmaceutical services that take them outside the pharmacy premises (such as HMRs). Training has been highlighted in every interview as necessary to effectively carry out cognitive services, particularly for mental health programs. To reduce the adverse effects of limited resources for training in these areas, it has been suggested that education be carried out in collaboration with other groups, such as combined training sessions for pharmacists and pharmacy assistants, with hospital pharmacists, nurses and GPs.

There have been a number of initiatives in Australia to enhance cooperative work between pharmacists in rural areas and other professional bodies. These alliances have been influential in supporting pharmacy services in these locations. On-line distance learning modules can help fill the training gap for rural and remote pharmacy personnel experiencing difficulty attending training programs. These programs exist, but in some cases are not being used due to technological shortfalls in telecommunications in remote areas.

Many rural and remote pharmacies work with Indigenous communities through the Aboriginal Health Service (AHS) centres across remote Australia. This support service is acknowledged and remunerated by the Department of Health and Ageing. This was established under Section 100 of the National Health Act (1953) that allocates an allowance to pharmacies that supply medicines to remote area AHS. Aboriginal communities, however, are very diverse groups, with different cultural values, very wide educational differences and understandings and these needs to be taken into account when servicing these communities. The AHS program has developed a multi-disciplinary approach to health care with a number of health care professionals and pharmacists

⁴ This program is outlined on <http://www.els.com.au/>

closely involved in medicines management. This promotes a co-operative outlook between professional groups where information exchange is already established due to the close professional relationships. There is much to be learned from these programs.

1.3.11 Regulatory and Other Industry Bodies

Some of the organisations in this area include:

- The Australian Government Department of Health and Ageing
- The Australian National Audit Office
- The Health Insurance Commission
- Medicines Australia
- The Generic Medicines Industry Association
- State Pharmacy Boards

Unfortunately two issues severely limit our discussion of the attitudes of these stakeholders, particularly those on which they hold views which could identify them. These organisations are so distinctively different that identifying views on some issues where they differ would almost certainly reveal the personal identity of the interviewee or their organisational affiliation. The other issue was the timing of these interviews which in most cases coincided with the Federal election campaign. Particularly in the case of government officials, their comments at this time were necessarily highly constrained. They could talk about procedural matters but were necessarily silent on any policy matters.

We can however report that there was a consensus on the importance of Pharmacy providing cognitive services of the kind already offered. There was also a high level of knowledge and acceptance of the Guild's activities in the area and recognition of the actual and potential importance of the role of the community pharmacy network in health care delivery. For example:

"I think that pharmacists have an essential role in communication about medicines. That role is consistent with the objective about the quality use of medicine because medicines aren't going to work unless the person takes them appropriately."

There was also awareness of the current limitations of the current health care system as a whole:

"At the moment I think the system is extraordinarily crude. We have a large health care industry that beavers away producing outputs in terms of treated patients but we've got no idea of what the outcomes are that are associated with those outputs – either in terms of beneficial health outcomes or toxicity. Or what the economic outcomes are. We've no idea of patterns of utilisation, of even the distribution of common conditions. We know that even for very common drug therapies and common medical therapies, there is huge variation from region to region, often between adjacent regions, you know. So there is a big potential for having really good managed care using clinical guidelines and education that can improve the quality of health care and thus optimise the health and economic gain from it. Pharmacies need to be having a role in that system... I

think in Australia we really have to be a bit more innovative in how we look at health care funding."

One issue raised was the time and resources involved in bringing about the implementation of changes once they were agreed between the Guild and the government. For example:

"The Guild and the Department of Health can get agreement on the business rules to make it happen (i.e. new service provision) but the thing that causes the problem is then making it operational from the Health Insurance Commission because a significant programme brings risk of leakage of taxpayer funds. That is really difficult."

There was also awareness of the gap that often exists between developing policies and putting them into effect.

"I think that there is a big lack of perception that what happens in Canberra in terms of legislative intent is a lot different from what happens at the grassroots. And I don't think we'll ever come to terms with it."

In addition, there were questions raised about how the effectiveness of service delivery programs could be evaluated – of how to determine whether proposed changes had been implemented and whether the change had produced the desired outcomes.

Although there was evidence of some interaction between some of the regulatory bodies, there appeared to be little awareness of the need for coordination between them and for consistency in policies put forward by the various bodies.

1.3.12 Conclusion

As Mattingly has pointed out, socio-political stakeholder relations are vital for the survival of organisations and organisations therefore need to develop relational strategies with the organisations on which their continuing performance depends (Mattingly 2004).

Mattingly outlines four potential strategies: cooptation, negotiation, avoidance and compliance. In the case of most of the stakeholder groups we have discussed, the most appropriate strategy is negotiation. We have suggested that the Guild review the key stakeholder categories from those covered here, identify the relative salience of these stakeholders for the negotiation and delivery of new services, and where possible, negotiate collaborative relationships which will support an expansion of service delivery through pharmacies as part of an integrated approach to community health care. Without stakeholder support, change initiatives can founder and eventually fail.

Recommendation: The Guild should ensure that any training or accreditation processes are endorsed and supported by the appropriate patient support organisation. (Recommendation 57)

Recommendation: The Guild should conduct a stakeholder mapping exercise when proposing and implementing new services as a basis for increasing stakeholder involvement and support. (Recommendation 41)

1.4 Administrative Governance and Decision-Making Processes



There is no unified governance at the industry level in health generally and Pharmacy in particular. This is true of most industries but health is particularly fragmented and disorganised. To the extent that it has governance, it is achieved through:

- a combination of regulation and funding on the part of both Federal and State governments which are often at odds with each other about how the system should work and who should pay
- the independent actions of professional health providers and their representatives such as the AMA, the Guild and the Australian Nurses Association
- the independent actions of various groups that represent the interests of patient groups such as the Cancer Council of Australia and Diabetes Australia
- shifting coalitions of some of the last two sets of actors above.

Achieving effective health service delivery in this rather chaotic world poses major problems.

It is here that Pharmacy represents a potential opportunity (see value proposition in section 1.2.10).

"I think that one of the areas in the future (in order) for pharmacy to be a strong and viable profession is the continued development of what I call the cognitive services; they are things like the introduction of the Home Medicines Review, all things that pharmacists can be paid for, the clinical skills that they have and (can) continue to develop because I think they are really important. I think we need more of these sorts of aims to the profession besides our traditional supply function. The supply function is still core to pharmacy at this point in time and this is the sort of majority of remuneration, but as we go along...already there are cases overseas where you have robots that can dispense. So if you're going to think that the future of our profession is going to be dispensing, I think this is sad and narrow. So it is the development of these other sorts of services that pharmacists have a key role in, that they are paid to do too. We need to become what I would call genuine members of the health care team, primary health care producers."

Pharmacy's distinctive advantage in achieving this position, where pharmacies are "genuine members of the health care team, primary health care producers", rests on the potential of the national network of pharmacies to deliver high quality, integrated services at the

community level. This is a combination of 'tight/loose' organisation: it is tight enough, through pharmacists' membership in Guild and PSA, to assure safe, reliable delivery of products and services and loose enough to provide flexibility in adaptation to local conditions as well as innovation and experimentation with the offering of new services.

Our respondents however raised issues around the current operation of the overall administrative governance in the area:

1.4.1 Governmental delays and complex procedures

(On dealing with the Federal Government) "Everybody has enormous goodwill. You know they are not bad people but the system is set up to frustrate just because of all the steps in it and we certainly need to find an alternative mechanism for next time (i.e., for the 4th Agreement negotiations)"

Respondents who had been involved in the negotiations outlined a series of issues. Some are due to the various administrative levels in the government involved in the negotiations. Currently negotiation on the most important policy issues are dealt with at ministerial level with lesser issues dealt with by officials with delegated authority from the Minister. The result is said to be that "as it goes down the line the message gets so mixed up..." and there are significant time delays as communication issues get sorted out.

Even when an Agreement is signed off after a negotiation process

"Of about 12 months, there is a big time lag ...to actually put things in place to make it happen. The budget wasn't included in the Agreement and only became available through additional estimates, so there was a delay of six months there [then there was a further delay involving] the establishment of an Agreement Management Committee to actually manage the development of proposals and implementation of proposals."

But then its proposals had to be "signed off", that is, go back to the Minister for approval through the departmental channels and the Minister sometimes disagrees with the decisions of the Committee. Then, when the Minister does agree, the proposal has to be translated into 'business rules' to go on to the Health Insurance Commission so that it can be eventually audited by the Australian National Audit Office.

This tortuous process is frustrating to all concerned and means that there are lengthy delays in moving from policy change to implementation plans and many points of slippage in between where changes can be made to the original agreement, deliberately or through misinterpretation or lack of information, which change the substance of the original agreement and delay implementation.

"From a change point of view, there is quite a significant time period that needs to be allowed between the Agreement and 'going live'."

Recommendation: As part of the process of negotiations relating to the 4th Community Pharmacy Agreement, the Guild should negotiate with Australian Government to streamline the translation of negotiated new policy into implementation plans. (Recommendation 10)

1.4.2 The importance of pharmacy networks

Another part of the administrative governance system of Pharmacy is the grouping of pharmacies into networks such as banner groups. Fifty per cent of pharmacies are part of some pharmacy network which has some influence over the activities of constituent pharmacies.

Traditionally most banner groups were attempts by suppliers to ensure that they had effective distribution networks or by pharmacies to ensure that they had buying leverage with suppliers of pharmacy products through the numbers of pharmacies involved in the network.

"Originally banners were perceived as means of buying loyalty to support your wholesaling business, primarily."

"With the big banners, I believe that the influence of them is entirely focused on product...I don't see them having a major desire to embark into the service delivery."

Recently there have been defections from some large banner groups – "a decline of nearly 1,732 banner group members since 1996" which can be interpreted as "the wholesale driven model in Australia is suffering from deep structural problems" (Sher 2004). However there does seem to be a move toward pharmacies creating a newer kind of network that is more consumer and potentially service delivery focused as evidenced by comments made in focus groups and interviews but this needs further information. Clearly there is a business advantage in belonging to a network.

"I think that these sorts of amalgamations of pharmacies are probably the future coming thing; larger groups of pharmacies, looking at buying power, employment, administrative sort of stuff being taken out of individual pharmacists' hands and being managed in a professional way. I think that's coming and changing and will change the shape of pharmacies to some degree. I think the solo guys are a bit of a dying breed..."

What are the characteristics of the "new networks"? We did not make a study of the various forms of networks but gained evidence of some changes in their character which deserve further investigation. It would seem potentially easier to facilitate change through a more limited number of networks than through 5,000 individual pharmacies. The newer networks appear to be more often formed by voluntary amalgamation rather than acquisition; to be more limited in the number of constituent pharmacies (i.e. partnerships) than the traditional banner groups; to exert greater influence over a wider range of activities of the constituent pharmacies; and to provide a variety of specialised management services such as accounting and HR to relieve the pharmacists of these duties. It is possible that they are also more interested in adding value through service provision than in competing on price. These are somewhat speculative remarks arising out of comments in interviews but if they are shown to be true, the new pharmacy networks may provide an important part of the launch pad for accelerated delivery of new services.

"I don't think any of us want to own huge numbers of pharmacies individually. We can see value in having a (group of pharmacies); the group will be stronger"

and more vibrant through having like-minded people but with other views, you know, bringing new blood into the organisation. So when I say 'like-minded', we don't want to be surrounded by a group of sycophants by any means...so the basic philosophy is to bring in other, usually younger, pharmacists to build the ideas base and equity base in the group."

1.4.3 Encourage Improved Efficiencies in Service Delivery

We have noted that the pharmacy network has a potential to provide an administrative base for improved health service delivery.

"My view is that we've got the best PBS system in the world. We've got 5,000 distribution platforms or locations for government to get access and to use to deal with the health state of Australia...Australians are unhealthy in so many different areas and we've got this magnificent platform there that if the two came together where we started to manage proactively at various levels of those (disease) states then the net effect for the government would be a massive saving over time...It could be the hub by which all activities take place."

But if this is to take place, the administrative potential of the network will need to be improved. Part of this process is to pick the critically important areas of service delivery.

"The government have said for a long time now that we have to keep people out of hospital, out of nursing homes. How do we service these people? ...Pharmacies are there. The pharmacy is available as a platform to help manage the position that we are in now and we are going to be in for the next 20 to 40 years."

"One of the other big areas (for service provision) is the continuity of care from the hospital to the community and that has been going on for years and nobody can seem to get a handle on that. Again that is a huge opportunity for pharmacy..."

Choosing the areas of delivery must be followed through with determining the most appropriate channels for delivery and ensuring that the network can deliver in efficient ways.

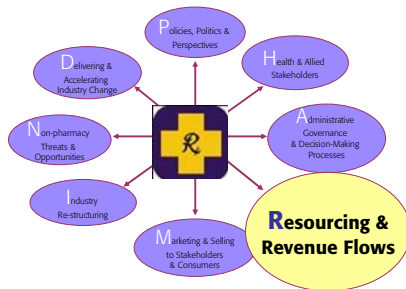
In the final analysis, even the existence of the most effective administrative structures depends on the response of individual people at the grassroots of service delivery in local communities.

"Canberra makes decisions and discussions happen with the Division of General Practice, but at the end of it, it's still the one-on-one interaction between the two people and that can vary a lot."

Recommendation: To build industry-wide support for further service provision, the Guild should move to develop formal and informal collaborative governance structures with other health service providers. (Recommendation 7)

Recommendation: The Guild and the PSA should work with each other and with the Divisions of General Practice, to assist in supporting the further development of these structures at a local level (Recommendation 9)

1.5 Resourcing and Revenue Flow



The move to greater service provision represents a potential transformation of Pharmacy and the change requires adequate revenue and resources to cover the transition costs and to determine the longer term sustainability of the new model. Two strong themes recur across interviews, focus groups and case studies. One theme is the awareness on the part of pharmacists of the need to move to greater service provision and a widespread motivation to change. The second theme is the inadequate financial rewards in many cases for doing so. We are not implying that the answer to bringing about widespread adoption of the new service model is simply to provide financial rewards. Previous research has shown, however, that while providing an adequate financial reward structure is necessary, it is not sufficient to bring about the change (Roberts et al. 2003). Other factors, such as collaborative relationships and teamwork, are also important and therefore financial rewards should not be seen in isolation. Rather, they should be viewed as one part of an integrated solution.

1.5.1 Creating an adequate revenue flow to finance service provision

"Much as I hate to incentivise things, we all know that incentives drive the change process. We had incentives for the QCPP program...we had good incentives to fund people through the process and we haven't had that with HMR. It costs about \$1,000 - \$2,000 to get accredited and you're getting \$140 per review..."

As discussed above, with the possible exception of some support from third party providers, the two primary sources of potential funding for service provision are the Government and the market. We have indicated that, in its own interests and the interests of the general public, the Guild should pursue continuing government subsidy for the provision of essential pharmaceutical products and related services. However the increasing costs of providing essential services will place strong limits on the extent that pharmacies can provide a wider range of discretionary services if they continue to depend on government funding for these. We therefore advocate a significant change in the prevailing reluctance on the part of pharmacists to charge for most services or, if they charge, to charge less than the real cost of service provision. Continuing to provide

subsidised services is vital to for preserving the trust the public express in pharmacists and for reasons of access and equity. However we believe that the future of pharmacy depends on introducing 'fee-for-service' for non subsidised, non-essential services, particularly for those that require substantial investment in expert knowledge and skill and a significant time commitment on the part of pharmacists and specialised staff to provide.

How can such a 'two tier' system be justified? We have found cases of pharmacies already charging fees for services and finding it difficult to meet the demand for the services. (For example see case study 20). One way to justify the charge has been to differentiate the service from other 'free' services by programming specific consultation or testing times so that customers book in for the consultation and/or test. This emphasises the special nature of the transaction and the time involved. Another complementary way to justify charging is to acquire and display specific practitioner certification (as in HMRs) which emphasise the distinctive skills of the practitioner and also highlight the availability of a service beyond that normally provided by pharmacies. Jointly these approaches signal accurately to the public that non-subsidised services involve investment by the pharmacist in substantial time and additional professional expertise beyond that provided by regular professional qualifications.

"I think pharmacy is one of those anomalies where you have got some highly trained professionals who have skills they can provide through counselling and, you know, knowledge that they can provide, that's the only profession I can think of that doesn't actually charge for their knowledge and skills... You know you go to a doctor and you are charged for the consultation. Pharmacists who would do almost as much training as doctors and, when it comes to pharmacology and pharmacotherapeutics, their level of knowledge is much higher."

The current reward structure of pharmacy was designed to remunerate pharmacists mainly for the supply of product to consumers, not services. Consumers are demanding services but the reward system does not remunerate pharmacists for moving to or maintaining service provision. Even under the Third Agreement, in which the services themselves are remunerated, there is only limited financial support to assist in the establishment of or maintenance of the service.

1.5.2 Ensure the supply of qualified personnel to support extended service provision

"We know what the government priorities are at the moment and we're looking at future predictions about which are the diseases that are going to be, need to be managed most... let's have a scenario where the Guild says 'Just great! A wonderful opportunity for pharmacists! We'll go and negotiate.' And the government says: 'Really great! We think that'll save money or it's a wonderful community service or whatever and we're going to pay for it.'... Would the system be able to cope?"

Because service provision demands additional knowledge and expertise and is more labour intensive, extending service provision can easily outrun the human resources available to provide the services. There are already acute shortages of pharmacists and other pharmacy staff and these shortages are expected to escalate in the future (Health Care Intelligence Pty Ltd 2003). There needs to be a substantial upgrading of the existing workforce and provision of more appropriately trained future entrants if the quality of

service delivery is to be assured. In response, several new schools of pharmacy have been established to increase the number of pharmacy graduates in the coming years.

Recommendation: By making use of the Characterising Opportunities Filter, the Guild should determine the likely range of services to be provided by pharmacy and estimate the extent of their adoption in the next decade. (Recommendation 15)

Recommendation: The Guild needs to expand the QCPP quality assurance process to cover the full range of services to be adopted by pharmacies, in line with the approach taken for HMR. (Recommendation 40)

Recommendation: The Guild needs to encourage practitioners with expertise in these areas, who are members of the Guild and/or the PSA, to act as mentors to newly graduated practitioners to accelerate the further development of their professional competence. (Recommendation 69)

Recommendation: The Guild to work with PSA on specifying the competencies needed by practitioners in order to deliver related services to a defined standard of excellence. (Recommendation 54)

Recommendation: The Guild needs to encourage and incentivise these institutions to create the appropriate educational courses or training modules to develop the competencies in potential practitioners. (Recommendation 48)

Recommendation: The Guild needs to select the institutions best fitted to develop these competencies (Recommendation 55)

1.5.3 Work with suppliers to develop the infrastructure to facilitate service delivery

"Pharmacy at the moment isn't set up for providing these sorts of services."

This was a theme in interviews and focus groups with pharmacists. There were three main infrastructure issues raised: (1) the need for an up-to-date, interconnected communication system linking pharmacies nationally (2) the need for up-to-date software in pharmacies linking them to the system and designed to facilitate efficient and reliable product and service provision to customers as well as other business functions such as accounting and human resource management and (3) the need for appropriate physical modifications to the layout of pharmacies to facilitate effective service provision.

Work is already proceeding on the first issue through the development and trialling of *MediConnect*. This is an electronic network designed to connect prescribers and community pharmacists in Australia with the aim of improving medication management and therefore health outcomes for the community. Trials of the new system are in progress in Ballarat and Launceston and the new system is expected to be evaluated this year (PharmIntercom 2003).

Clearly the ability of pharmacy to provide a credible National Health Service delivery system depends partly on the construction of such an 'IT superhighway'. The advantages range from customer benefits (e.g. the ability to quickly review the range of a patient's medications for potential interaction effects) to business benefits (e.g. business to business sales) and professional benefits (e.g. the delivery of self-guided training modules to personnel in remote pharmacies). In the knowledge-based society, organisations and industries which do not use advanced IT technology will be marginalised.

But the benefits of an IT superhighway will only be realised if all pharmacies are effectively linked into it and have compatible up-to-date software systems that facilitate effective and efficient use of the network. Currently access to such systems varies greatly between pharmacies. In the words of some of the research participants:

"The pharmacy has four computers with broadband Internet access on one machine. The owner mostly uses the Internet for online banking rather than for professional pharmacy activities. He prefers to attend local PSA continuing education programs and watches CPE videos to keep up-to-date professionally. The pharmacy has direct telephone lines to the medical practice and other health care services within the centre."

"We don't, or didn't until recently, have the most efficient IT systems by which to handle it (acting as NDSS subagents) so there were no economies there; until fairly recently a lot of it was manual. It's just cost all round."

"While we've been using computers for dispensing, we are really not up with a lot of the IT stuff available...we've still got a long way to go down there."

The move to the provision of services which require counselling by the pharmacist requires the provision of appropriate facilities, such as a counselling room, which safeguard the privacy of customers. Already some pharmacies have installed these facilities.

“The project you are doing is exactly what pharmacy needs to do which is look at services that they should be providing or can be providing that aren't being provided anywhere else...and building an area in the pharmacy which is a consultation area having booths or something like that where patients feel like they are in a private sector and no one is going to overhear what they are talking about – because that is one of the biggest problems with counselling pharmacy at the moment. I mean what guy wants to walk into a pharmacy, stand beside a counter where everyone else is being served and talk about erectile dysfunction or something like that?”

The installation of facilities of this kind can only be justified on a cost/benefit basis which again accentuates the need to ensure that the service is adequately remunerated. The provision of facilities of this kind also signals a serious intent on the part of the pharmacy owner to provide a quality service.

IT, and associated media which are increasingly integrated with IT, have the potential to overcome some of the barriers to the adoption of service delivery in rural and remote communities. IT can do this by providing on-line capability training to pharmacists in these areas and in providing an alternative delivery system to customers for some services which local pharmacists in these areas are unable to provide.

Recommendation: The Guild needs to provide a cost benefit analysis of the investment pharmacies need to make for implementing and delivering services. (Recommendation 35)

Recommendation: The Guild needs to examine the potential of IT infrastructure to overcome some of the deficits in service adoption and provision in pharmacies situated in rural and remote communities. (Recommendation 38)

Recommendation: The Guild needs to work closely with suppliers to develop a shared IT network with the capability of delivering more resources for service provision (product information and service support provision) to leverage pharmacy's strengths. (Recommendation 39)

1.5.4 Coordinate with other stakeholders

We have dealt with this point in more detail in 2 above 'Health and Allied Stakeholders' but here we wish to underline that stakeholder support is an important resource to be progressively built at all levels over time. Change to the profession can be held up or blocked by the opposition or indifference of stakeholder groups. Creating a coalition of stakeholder support at national, state, regional and local levels can accelerate the introduction of change.

“We should align ourselves with groups like pensioners and retirees. If the government thinks economic frugality with this group, they're kidding themselves.”

1.5.5 Build change management capabilities

The meta-resource, on which the effectiveness of all other resources depends, is change management. We have pointed out the fallacy of believing that policy change necessarily results in behaviour change at the pharmacy level. Implementation requires understanding of the ways in which change can be successfully introduced and managed through to achieving a sustainable and ongoing operation.

(On the HMR facilitator scheme) "I think what we've done is skewed, you know, the bell curve of implementation. We skewed it to the right because we didn't have the change processes, the resources to try to get it passed – you know we had the innovators – they were the guys that were all doing it and we had the early majority and those people. But it's not until you get, you know, that critical mass, that full group which is probably 20 -30%. I mean we're still down at 10% or less... You need to get that critical mass of 20 -30% before it becomes self sustaining and you move up."

The issue of lower than expected adoption of service provision for some government funded services was referred to repeatedly. There is a perceived need for putting infrastructure in place to facilitate adoption to reach critical mass but also a perception that there is a need for a greater understanding of how to make that infrastructure effective.

(On HMRs) "There wasn't really an implementation plan put in place right from the start, or even developed before the funding was available. The funding started on 1st October, 2001, and at that stage there was very little, to my knowledge, infrastructure in place to actually help pharmacists implement it, to support them doing it, and so forth. Now we already had an accreditation system going – which was for the nursing home reviews – so that system was in place and it just rolled over. But as far as the practice implementation into your pharmacies, we left people alone (to do it themselves). And I think, in hindsight, that has slowed the change process...and probably put up a lot of barriers that shouldn't have been there...We certainly underestimated the changes that needed to happen for our profession to embrace HMRs and deliver them in a sufficient quality and quantity..."

We will take up this in more detail in section 1.8 below: 'Delivering and Accelerating Industry Change'.

Recommendation: The Guild should sponsor a Change Management Qualification tailored specifically to the needs of pharmacy. This qualification should be available in various modes of delivery including online. (Recommendation 49)

Recommendation: The Guild needs to negotiate with universities and other providers of professional training to include change management training in undergraduate and postgraduate pharmacy courses. (Recommendation 47)

1.6 Marketing and Selling to Stakeholders and Consumers



Facilitating change at the level of the individual pharmacy means help from the Guild in preparing the ground for marketing and selling the benefits of both maintaining and developing the industry to a variety of stakeholders. In this segment we identify some core arguments which can be used to help sell the importance of the industry *as a national asset*, including it being developed into offering a broader range of services to the range of stakeholders identified in section 1.3 of this chapter. The selection and emphasis of the argument will vary depending on the stakeholder group being addressed. Each of these strategic marketing arguments are inter-related and can be used to demonstrate a “bottom-line” effect that the pharmacy industry can have to delivering health care to Australians.

1.6.1 Strategic marketing arguments:

Below are some of the strategic marketing arguments, that can be used in negotiations with governments and industry stakeholders, as suggested by some of our research participants.

1.6.1.1 The “national pharmacy network” argument

This is a very clear argument about the “reach” of the industry throughout the Australian community:

“We’re the most accessible of health professionals. There’s a pharmacy in just about every town in Australia”

This is particularly important in terms of meeting rural consumers’ health care needs. For example:

“...if you are in a country town and you have a prescription that is not very common you need to have a relationship with the pharmacist so the pharmacy will have that on hand for you.”

1.6.1.2 The “front-line health care providers” argument

This elevates the status of the pharmacist, realigning their role as being one of crucial importance to the delivery of health care throughout the Australian community:

“Your pharmacist is the front line, really important role, but I think there’s a strong selling job that hasn’t happened that raises that profile. You know there’s a little thing like that nursing campaign years ago; ‘Nurses Save Lives’ or something like that, a pretty strong media push, about the value of them, and I suspect the value of a pharmacist could do with a bit of sell job.”

1.6.1.3 The “ease pressure on the health care system” argument

With an ageing population and a likely increase in chronic health care conditions governments need to find ways of providing “sustainable access” to health care, including lowering pressure on hospital admissions (assisting in avoiding “bed block”) and assisting with the problems of inadequate GP and other health care provider coverage, especially in rural areas. This would mean the Guild working to:

1.6.1.3.1 Develop broader recognition of pharmacy as a “first port of call” for minor health problems:

“...I mean historically ...pharmacists were the first port of call for people who couldn't afford doctors. And that by all accounts provided quite a reasonable service. And I see them as doing a little bit more of that again... there are so many things that you don't need to go and see a doctor for. Thinks like the common cold. If you are not getting antibiotics then there is no point in going and seeing the doctor. And things like warts and haemorrhoids and so on. There is no point in going and seeing your doctor.”

1.6.1.3.2 Help provide pharmacists with the ability to conduct screening and ongoing monitoring:

“...and the shortage of GPs and other nurses and so forth, so we should be, I guess, trying to take advantage of that in some ways, and say we can deliver a lot of these things - screenings and testing - routine testing like INRs for people on Warfarin, cholesterol testing, HBA1C which is a blood test for people with diabetes and those sort of things. And they’re just and people at the moment - you have to go see your doctor, get a referral - a pathology referral - go to the pathologist and then go back ... and see the doctor again.”

These arguments also need grounding in establishing with the medical profession that pharmacists are not trying to intrude into their professional domain in a way which undermines the primary role of the medical practitioner in health care:

“And pharmacists are very quick to recommend a doctor, very quick. I don’t think there’s a mother on earth that hasn’t taken a baby to a chemist before going to a doctor when she’s not sure if they have to go to a doctor. There wouldn’t be a mother on earth that hasn’t just checked the chemist first save me sitting in a waiting room. So, they’re quasi doctors of advice anyway but all my experience with them, if anything is just a little bit like that and they say “Look, I would take that child to a doctor”. They are very, very cautious. They don’t pretend to be doctors but they play a vital role and it could be good to see the government supporting their role.”

“It’s partly making sure that the medical practitioners understand the role. It’s not as though we’re trying to usurp the role of the GPs or take the responsibilities, but there’s a need for them to understand it’s just another service as part of the whole continuing health care unit. So the public is also important, but it can either be made or broken by the attitude of the clinical professionals”

“Some doctors get fearful as to what chemists are doing and not doing. But, I think even they would buy in because what we’re talking about is broad-brush stuff. We’re not talking about turning chemists into doctors. For this to be successful, for the government to save money, to be serious about it, I would like to see government doing generic advertising on television: pushing people towards their pharmacist...a generic ad [such as]: “It might be an idea to go and have a talk to your pharmacist, blah, blah”. That would do more for the industry and that would just widen the gap between deregulation. I reckon it would, you know, because most people have got a friendly pharmacist. ...”

1.6.1.4 The “dependability and high trust” argument

This positions pharmacy as a “high trust” industry which means that consumers and the general public hold it in high regard. This “reputational capital” is an asset which can be used by the Guild in association with other arguments outlined in this segment. As one pharmacist said:

“Our message to the public is that we’ve been around for 30 years, we’ve looked after you for 30 years, we’re still going to be here, and we’re not a fly by night operation that is purely based on price”.

1.6.1.5 The “quality care” argument

This presents a “value-for-money” argument which states that savings can be made by, for example, a reduction in medication errors. As one case study owner argued, a good case could be made in terms of reduction in medication errors for the government to remunerate pharmacy for a national unit dose packing service and this was something that should be considered by the Pharmacy Guild.. We note that a project is currently underway in this area (Lentil, Stokes et al. 2004). As another said, the ability of pharmacists to assist in drug adherence issues also serves to provide an important quality care consideration

The “quality care” argument will be strengthened where there is an obligatory accreditation system which applies to all pharmacies. As one stakeholder said, from a consumer

perspective the pharmacy profession would be taken more seriously where accreditation applied to a range of practices, including obtaining a PBS approval number. As another stakeholder pointed out:

"So yes I have the credentialing tools now for disease state management and diabetes, asthma, Warfarin and osteoporosis, pharmacotherapy, so that...we have links with overseas organisations that provide us with assistance in this area and access, some materials but access more to their thought processes and things like that. So, yeah this is happening in America now in the ...National Institute of Standards in Pharmaceutical Credentialing. Certified disease managers in diabetes, asthma, anti-coagulation and dislipidaemia"

1.6.1.6 The "public health care campaigns" argument

Through the geographic spread of the industry and the high trust role they enjoy in the community they are well placed to provide a role as a cost-effective, high-impact deliverer of public health care policies, especially health promotion policies, such as anti-smoking campaigns:

"Yes it was quite successful. ...The staff wore a badge saying "I want to quit smoking, ask me how" and that was huge. They were also trained in the area and so on.staff mentioned that if they wore the badge outside in their local shopping centre, people would say, "yeah tell me how", "oh I still have my badge on" and that was quite a good drawcard and that was quite successful. One thing that pharmacies could do to encourage more open discussion about smoking cessation ...it is not threatening, it is non invasive, the customer can self select..."

1.6.1.7 The "flexibility" or "specialised and mass service provider" argument

As we have shown earlier in our discussion of the Pharmacy Viability Matrix (section 4 chapter 2), there are four core business models in the industry which vary by how specialised they are (products/services) and how localised they see their community base. Common to all strategies are some functions which define the "core" of pharmacy operations, such as dispensing medications. This means it can be argued that the industry has the capability to deal with community needs as well as providing services and products for specialised needs. The industry has sufficient capacity and flexibility to deal with both nation-wide and community-specific health care issues because of the different business strategies spread throughout the industry.

"So that model of providing higher level specific advice in a range of either general areas or targeted disease groups is certainly, I think, a way to go"

"I guess one of the issues is - are these services for all pharmacists? Should the expectation be that every pharmacist can deliver these services? I think that's an unrealistic expectation because we all go into pharmacy to become pharmacists but what we do when we leave uni - you know, there's a broad range of different areas of pharmacy you can get into and that range is expanding all the time. When I finished, you went into community pharmacy or hospital pharmacies. A

few went interstate and into academia, but the scope of what a pharmacist is these days is huge and does the profession accept that we can have specialist pharmacists? And I don't think we've accepted that yet."

1.6.1.8 The "consumer focus" argument

This sets out the way pharmacists meet specific needs that consumers have which are not provided by other health care providers:

"A lot of consumers see pharmacists as a way of getting health information; they don't have to make an appointment. They can walk in off the street."

1.6.1.9 The "giving people choice" argument

This sets out the way consumers can be given a choice about cheaper generic drugs, and the ability of pharmacists to therefore lower the costs for consumers:

"I think [generic brands] can make quite a difference in the cost. It can lower things quite a lot. So asking people ... giving people that choice is important."

1.6.1.10 The "community education" argument

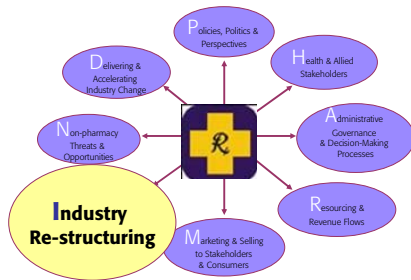
This argument parallels the "public health care campaigns" argument above, identifying that an important role played by pharmacists is concerned with increasing consumer awareness and knowledge. For example, as one stakeholder outlined, consumers are often unaware of the way "natural" medicines also contain ingredients which can interact with other medicines and don't think to tell their doctor or their pharmacist about being on such medications. Raising awareness of issues such as this "could really be a potential role of a pharmacy"

"Well there's all sorts of things that they could do to improve the sorts of information that people are getting, but probably particularly around complementary health - if they have the information available."

1.6.1.11 The "value-added" argument

This is needed to educate consumers about the value that can be added by pharmacists by providing additional services that are not subsidised by government or other third party payers. This will assist in gaining wider acceptance of a "user-pays" mentality for such services. As one pharmacist said, "you actually need a much more simple, but clear, argument, that informs people so that they understand, but, we don't do that."

1.7 Industry Re-structuring



Industries, and the organisations which comprise them, are constantly undergoing change in the form of restructuring. Preparing the ground to assist pharmacies to shift to one of the three emerging business models we have identified in the Pharmacy Viability Matrix (if they wish to do so) requires the Guild's attention to a range of concurrent structural changes occurring within the industry. In some cases the Guild will need to assist these changes, in other cases reorient them, or even try to slow them down, depending upon the nature of the change and how well aligned it is to the conditions associated with the various business models. In what follows we identify eight structural changes occurring, or likely to occur, within the pharmacy industry.

1.7.1 Greater use of support staff

Streamlined use of dispensary technicians and pharmacy support staff to free up time for consumer service, given the pharmacist shortage:

"...rather than delegating the pharmacist-in-charge work which is an extremely expensive thing to do on a dollar rate per hour, what we're going to start seeing is more and more people actually getting support staff in from a clerical management point of view taking on those responsibilities to allow people to get out the front."

As a stakeholder said, in interview:

"I get on my hobby horse about the cost of health to this nation. We send people to universities for six years to be GPs and look after coughs, colds and sore holes and this economy cannot support this cost base. We have higher ...education but we lack technical assistance. Pharmacists should have a pharmacist on site but the dispensary should be run by a technician. You don't need five years training to run a dispensary. You must have a pharmacist with knowledge, skills and training and support but we put a cost burden into our infrastructure whether it's at the GP level or at the pharmacy level and we don't think more laterally about ourselves, primary health systems. ...there should be more preventative medicinetaking place and primary health advice being given by the pharmacist and let technicians run the dispensary and allow us to free up our health model."

Recognising the importance of this issue, the government, through the Third Agreement Research and Development Grants program, has invested in a project to investigate the role of dispensary technicians and pharmacy assistants in community pharmacy (Healthcare Management Advisors 2003).

1.7.2 New contractual arrangements

New contractual arrangements e.g. pharmacists and aged care facilities/private hospitals:

"I know there's increasing contractual arrangements for the provision of pharmacy services with nursing homes and private hospitals type fields being done in this area and I think that's probably something where services are tendered for, rather than being left as more of an ad hoc arrangement. I think that's probably going to increase and continue. As I said...structural changes are coming."

As another stakeholder said:

"...the supply model is designed for the person who walks in off the street and picks up a packet of medicine. It's not what people need. People walking off the street need that but the people in private hospitals, nursing homes and in care in the home don't, it is not what they need. Therefore we are going to have to work out ways and means of supplying medications in appropriate quantities and forms to those institutions and home care settings."

1.7.3 Development of family friendly workplaces

As argued by one stakeholder "There is a feminisation of the pharmacy workforce as the majority of the pharmacists now are female and they need flexibility." This stakeholder argued that if women are not supported in terms of part-time work availability and flexibility in terms of a range of family-workplace issues the industry will face retention problems, which it can ill-afford at a time when there is a need for trained pharmacists

1.7.4 Greater local co-ordination in service provision

Focus on regional coordination of service offerings among pharmacists. In order to ensure that regions have a comprehensive range of services that are available to them, but that individual pharmacists are able to pursue their Pharmacy Viability Matrix business model of their choice, the Guild will need to pay attention to managing this tension, between business model choice and effective pharmacy service coverage across different geographical regions.

In part this will require the Guild to work with a range of networks and banner groups to coordinate service offerings across their members, where it is clear that not everyone wants to implement a particular service. Subject to clarification of any legal ramifications one option would be to form network regional coordination councils to provide regional coordination of service offerings across such stakeholders. In doing so, the Guild could make use of its existing network of facilitators in Divisions of General Practice.

1.7.5 Responding to pressure for equity of access to services, particularly in rural and remote areas

In addition to using the pharmacy locations to maximum capacity, some pharmacists pointed to the need for more flexible delivery options other than “a destination pharmacy”, especially for coastal town locations where there are ageing populations. As one said “...if you are not in a shopping centre it is almost impossible to put a pharmacy in somewhere. So I think we need to look to changing some of these restrictions...”. As another said, “It’s an equity of access issue.”

1.7.6 Creating operating efficiencies by doing things differently

This means encouraging pharmacists to look outside of the industry to adopt competitive operational practices. One stakeholder argued:

“...why do you receive two deliveries a day? Why aren’t I delivering to you at night? This industry had three wholesalers with 15 warehouses and billions of dollars tied up in capital infrastructure – that’s unsustainable in a competitive environment So how else do we do it? We’ve got to think of different ways of achieving that service differentiation relative to a supermarket but don’t use the current models and paradigms to deliver it. I’ll deliver at night, I’ll stack your shelves or I’ll run a motorbike fleet, we’ll deliver it to home as opposed to that person coming back to the pharmacy. They can do that for \$20 but it’s going to cost \$40 to deliver it by truck. So as an industry we’re under pressure with the Guild agreement on the doorstep to find cost savings for the government because our health system is unsustainable yet we want to cosset the way we do things and say this is our competitive advantage and protect the industry. That is the dumbest thing you can do. You will force failure to the industry.”

Another stakeholder argued that the industry was in danger from “fence-sitters”, that is, those “people who aren’t willing to change from what they are doing at the moment”; elsewhere this person said “I can see those sitting on the fence are going to get squeezed and probably maybe even do damage to the industry.”. This suggests that the Guild needs a change management education campaign to encourage pharmacists to question what they do, the way they do it and adopt best operational practices both from within and outside the industry. On a similar point a wholesaler representative referred to creating “centres of excellence” as models and a source of information about industry best practices. Extending this concept, we suggest that a Guild-sponsored industry “Centre of Excellence in Community Pharmacy Change Management” would serve as a central focus to demonstrate industry efficiency, relevance and maintaining up-to-date operational practices. It would also serve as a one-stop-shop for pharmacists who may be interested in pursuing a particular practice but lack awareness of how to go about obtaining relevant information, knowledge or access to appropriate consultants.

1.7.7 Addressing problems of ownership and numbers of pharmacies

The perception of some interviewees is that the days of the independent pharmacy are numbered. One stakeholder stated:

"I think the days of the stand alone corner independent just working on their own will be gone on the next two to three years. I think they have got to buddy up with someone or some entity that can allow them to either improve their business models for themselves, if they don't want to do it, like add in systems and procedures that will help their business or they need to look at one of these banners."

This argument reflects the position outlined above about the need for greater operational efficiencies in the industry. Another factor underpinning shifting ownership relates to the cost of ownership and the difficulty of new pharmacists buying into multi-million dollar partnerships:

"There's not too many young 30 year old pharmacists who can put their mitts on 2 million dollars and go out there and buy themselves a pharmacy."

Another view we encountered was that, rural access issues notwithstanding, there are too many individual pharmacy operations which means that needed operational efficiencies cannot be delivered given the small scale of many individual operations. As one stakeholder said "We have too many". However, this did not mean that ownership should fall outside of the hands of pharmacists:

"...I think I'd be reluctant to suggest that we could have non-pharmacists owning pharmacies. That's not to say that pharmacists aren't interested in profits either, but ... If there's a non-pharmacist there, there's some potential for profit to be put ahead of professionalism, and you would hope that the vast majority of pharmacists would put professionalism ahead of profit. Again if there was a chance, if you came in and told me you wanted some pseudoephedrine and I could see you didn't have a cold, I would be hopeful I wouldn't sell it to you just because you'll go next door and buy it. So because of that reason, that's one reason anyway to maintain ownership in pharmacy owners."

"I mean the other option is that the wholesale banners may improve, they may respond to pressure and competition and improve themselves and API and Priceline getting into bed is an example that may really strengthen up the retail banner. But 50% of people in banners, there is still another 50% who don't like to be in a banner or can't be in a banner."

1.7.8 Relationship of wholesalers and banner groups to pharmacy

While many pharmacists were very positive about the benefits they obtained from belonging to particular banner groups, another view we came across is evidenced in the following quote:

"I think a lot of people are looking for an alternative – to wholesaler owned banners. I think people are sick of the vertical integration that the wholesaler also is just your banner So you are really not independent. You are really answerable to one wholesaler."

This stakeholder suggested that some pharmacy owners "don't want to be told what to do by the brands, they've got enough volume to sell their own infrastructure and they are looking for compliance within their operations." He pointed out that they are forming new buying and banner groups. For him, this re-structuring carries with it another problem – that of industry fragmentation:

"...I mean the proliferation could weaken the industry ...If it's born out of frustration to current banners and it's not done properly then you could end up with a more fragmented industry which ... I don't think would help us at all. If it's done properly and it's set up and they have an offer ... and a positioning in a market place...that meets the needs of customers, pharmacists and the industry then I think they could probablygrow and outgrow the existing banners."

The Guild needs a strategic position about the role of networks, including wholesaler-based banner groups within the industry and needs to adopt appropriate connections with them. This would form part of a more strategic approach to the dissemination of services, in which the banner groups could also provide support and assistance for the implementation process in individual pharmacies. Attempts were made to involve the network groups in the implementation of QCPP, but the same cannot be said about cognitive service-related programs such as HMR and MIC. Specific guides need to be provided to the networks on how they can integrate these professional services.

Recommendation: The Guild should establish a Centre of Excellence in Community Pharmacy Change Management to assist in accelerating the implementation of services. (Recommendation 58)

1.8 Non-Pharmacy Threats and Opportunities



One way of identifying the threats and opportunities facing the pharmacy industry is by using McGahan's (2004) recent classification of types of industry change. This classification can be used in conjunction with a SWOT analysis. McGahan argues that there are four types of change:

- radical
- intermediating
- creative
- progressive

The type of change facing your industry depends upon whether core activities or core assets are threatened. In the case of the pharmacy industry in Australia it can be seen that:

Pharmacy activities might include the following:

- Dispensing
- Product sales
- Provision of drug information, e.g. CMI
- Provision of Pharmacy and Pharmacist Only Medicines
- Clinical interventions, e.g. identification and resolution of a drug-drug interaction
- Medication management services, e.g. medication review
- Preventive care services for patients with chronic conditions, e.g. disease state management
- Participating in therapeutic decisions, e.g. prescribing support
- Advice on minor ailments

(Emerson, Whitehead et al. 1998)

Pharmacy assets might be as follows:

- Location
- Reputational capital
- Approval to dispense PBS prescriptions
- Regulation of pharmacy numbers and ownership structure
- Goodwill

Two key lessons emerge from this classification. First, it provides an understanding of why the threat of supermarkets moving into the pharmacy industry is taken as a real threat. This is because it threatens both pharmacy activities and pharmacy assets. It also has the

potential to threaten public safety, if profits are the primary drivers of decisions, as opposed to the quality use of medicines.

It threatens *core activities* as there is a fear that it will take over dispensing and product sales, but neglect the other pharmacy activities of advice, education and the offering of other services. This is a threat to the general community – that they will not be able to access these other pharmacy activities from a supermarket

It threatens *core assets* as it threatens the ownership structure of pharmacies, their high trust and community reputation and their exclusive right to dispense drugs.

The supermarket threat therefore serves as a threat in the form of being a *radical change*.

Second, it can be seen that the business models outlined in this report, and the opportunities they provide for enhancing the pharmacy industry, provide the industry with *progressive change* options, that is, they enhance both core activities (e.g. offering new services etc) and core assets (e.g. through acquiring new knowledge around services and enhancing pharmacy reputation in these new areas by building upon their pre-existing reputational capital).

1.8.1 Grouping of pharmacy services and their coordination in geographic areas – a new opportunity, and a potential ACCC threat

This was mentioned to us in both focus groups and interviews – that attempts to coordinate services may run into trade practices issues around free competition. From a pharmacy perspective bundling and coordination represents a *progressive change* in that it enhances rather than threatens core assets and activities. However, from an ACCC perspective it could be seen as creating monopoly situations giving advantage to particular groups of pharmacies and/or reducing competition. The solution here is to argue for how this situation enhances health care service delivery and coordination as a public good and is therefore in the public interest, that is, point out that it represents a *progressive change*, not just to the industry but to society as a whole. Of course, this assumes that there is industry monitoring of these services and that they are delivered professionally and at high added-value quality. Failure to do this would damage a core asset, reputational capital.

1.8.2 The relationship with GPs

As one stakeholder said this relationship, between GPs and the pharmacy industry “is at a low point at the moment”. However, this stakeholder also pointed to there being divisions in this relationship and that it was polarised. For example, in relation to HMRS:

“So, from a general practice point of view....those who aren't doing them... it tends to be polarised. ... So there are some GPs who are absolutely evangelists....and there are others who are just philosophically opposed.”

The above model helps to provide some insight into this polarisation. The model would suggest that GPs who are opposed to pharmacy offering such services feel that their core asset (medical knowledge) is under threat from pharmacists as well as their core activities (that they no longer have exclusive control over such areas). For them, it is likely to

represent a radical change and therefore to be avoided. However, for other more sympathetic GPs they are likely to see it as a way of enhancing their practices by adding new activities to their practice and in this way representing for them a progressive change.

However, other suggestions in this report, such that the Guild assist pharmacists to be allowed to conduct routine monitoring and other medically related services may be seen by some parts of the medical profession as either an *intermediating change* (in that they may see it represents a threat to their core medical activities) or worse, a *radical change* where both medical assets and activities are seen to be threatened. This suggests that the Guild needs to emphasise in any such negotiations the **low level scale of change** that offering services by pharmacists may have on medical assets or activities and on the reciprocal benefits that could occur.

In Case Study One the partner expressed the view that doctors have the potential to be competitors in some areas such as complementary medicines. This would represent an *intermediating change* where GPs have the potential to threaten a core activity of pharmacy (complementary medicines) but not the core asset (pharmacists' knowledge of these medicines). This provides further understanding of the fragility of the pharmacy/GP relationship, a situation which characterized intermediating change.

Using this model will be useful for the Guild in helping to clarify the type of changes that they are seeking to provide throughout the industry.

1.9 Delivering and Accelerating Change



"Accelerating change requires skill, determination, and considerable imagination. It requires challenging our accepted paradigms of how change is introduced and managed, and then searching for ways to do things differently or better"

(Jick 1995)

Todd Jick wrote the above statement in relation to fast tracking change in organisations where major change is often discussed in relation to five to seven year time frames. He suggested change can be accelerated through focusing on:

- Getting commitment to the change and understanding of why it is important
- Increasing the propensity for action and experimentation
- Keeping up the momentum

(Jick 1995)

These same lessons can be applied by the Guild to accelerating pharmacy industry change through:

- Identifying educational and marketing strategies to intensify pharmacists concern about why change is needed in the industry, and the potential dangers of “fence-sitters”. In particular, disseminating the viable pharmacy business strategy models outlined in this report and the opportunities they provide for further development at the level of the individual pharmacy will assist in creating identifiable sets of options, coupled with an understanding of their financial implications to assist in motivating pharmacy owners down the change path
- Developing programs and industry recognised test site pharmacies to enable action and experimentation with new ways of doing things
- Using multiple forms of communication to pharmacy owners at regular intervals to keep up the momentum for change such as regularly celebrating innovation successes and change at national conventions and meetings will assist in keeping industry change at the forefront of the agenda.

1.9.1 Developing a vision for the Industry

Assisting in this can include the following:

Developing the IT infrastructure into pharmacies for communication and on-line education. Use of IT for accelerating change may be limited, initially because of current low connectivity across the industry. This is set out by the following two stakeholder comments:

“...we have quickly learnt that the IT systems, hardware, skills and so forth are simply not out there in pharmacy land to do this easily. The reality is that despite even our best efforts, if we were to either establish our own system or to use somebody else’s system, we are only going to hit the tip of the iceberg in terms of being able to deliver electronic connectivity.”

“So while we’ve embraced computer technology in the dispensary ...we are a lot slower in embracing some of the other technology, it’s strange.”

Nevertheless, there is potential for on-line educational schemes to train pharmacists for change, as outlined in the following interchange:

Respondent: *...we should be making them ...[use IT]... more I mean there’s a pack where they’ve introduced an electronic on-line education system log on and have a play so I can tell the rest of the State what I think of it, you know.*

Interviewer: *Is that for educational services?*

Respondent: *Yes, and so I mean even...with our staff training it’s all... paper based and so while we’ve been using computers for dispensing we are not really up with a lot of the IT stuff that is available. So that’s sort of a change ...using some computer tools but we have still got a long way to go down there.”*

Providing sample management models of how to implement change, through the "Centre of Excellence". The "Centre of Excellence in Community Pharmacy Change Management" suggested earlier provides a vehicle for this. This is important, as demonstrated by its apparent absence in the introduction of HMRs:

"...had we given them sample models of how they can actually implement it in their pharmacy - and we haven't and I think that still would be another thing that drives people to do it. I mean you might say, well their business, they should be able to work it out, but you know they're too busy, or they just don't know how to do it, so I think a lot of hand-holding should have happened and can still happen. And that's one of the things that will drive it from the 10 per cent to the 20 to 30 per cent."

Other research has also shown the importance of having role models and external support when implementing a new service (Roberts et al, 2003), and there is currently a focus on the role of mentors for services such as medication reviews (Australian Association of Consultant Pharmacy and The Australian College of Pharmacy Practice 2003).

To accelerate adoption rates in rural areas, provide information in pharmacy schools around opportunities for working in rural areas.

"certainly I suppose if you looked at the recruitment and rejections of our pharmacies in rural areas a few would probably say that it was a problem, but basically by starting to work at student levels [with] certain courses. Including Aboriginal health curricula and then also supporting placement of students in rural areas. We have a number that come through and also work for the Aboriginal health services as well."

Teaching management and change management as a part of pharmacy education courses. As we have seen at numerous points in this report the relative lack of attention to these key issues is evident and needs to be rectified. This gap was also identified in Roberts et al. (2004) report.

Creating consumer awareness campaigns of the services available in pharmacies. By doing this it will create momentum in the industry to offer such services from the added pressure from consumers. We saw earlier on in the report that consumer pressure was cited as a motivator to introduce a service into pharmacies. In relation to the relatively slow adoption rate of HMRs, for example, one stakeholder pointed out that:

"...I think the uptake is ... below what they predicted at this stage. The awareness of them is only starting to come into play. There wasn't a consumer awareness campaign really started until ...earlier this year and then there was not a great deal of dollars spent on it. So the message has still to get out in lots of areas ..."

Coordination through networks and establishing "collaborative advantage". Active steps need to be taken at a pan-network level to leverage this capacity within the industry. The Guild could use its annual Summit (held prior to the Australian Pharmacy Professional (APP) conference), to identify how "collaborative advantage" can be established where the industry *enhances its capacity for change* through encouragement of the various networks and banner groups. Such encouragement and capacity building entails pointing out how competition and cooperation *can occur simultaneously* within the industry. The concept of

“collaborative advantage” and how it can be made to work is something which can be further developed in consultation with management experts in this area.

Recommendation: The Guild should utilise the PharmInd Wheel as a matter of priority noting that effective change management for industry consists of a structured approach to addressing stakeholder issues and delivery of a systematic change program for pharmacies (Recommendation 2)

Recommendation: The Guild should mount a communication program to increase the awareness of its members of the need for change and the priorities and plans for industry change. This communication program should use the channels identified in this Report as those most influential for pharmacists. (Recommendation 61)

Recommendation: The Guild should assist in setting national educational standards for management education relating to service provision, as part of a pharmacists’ training. (Recommendation 53)

Recommendations:

In actioning an overall change program for the industry, the Guild needs to:

- identify the most change oriented pharmacies
- work with these pharmacies to plan the introduction of selected high priority services
- develop with these lead pharmacies the overall design of appropriate educational programs
- select suppliers to complete program designs and deliver programs on trial basis to lead pharmacies
- offer programs on a broader basis through the industry, incorporating volunteers from the lead pharmacies to present on these programs
- evaluate the trials and revise educational programs
- document the benefits including profit and financial benefits (see section 4 – current and future services in conjunction with Roberts et al 2004)
- promulgate these through the channels identified in this study as those most used by pharmacists. (Recommendation 70)

Recommendation: In order to effectively deliver and accelerate change, the Guild should ensure that it systematically address and considers adopting the recommendations in various sections of this report. (Recommendation 1)

Section 5: Chapter 2

2 Pharmacy Change Readiness Wheel

2.1 Introduction

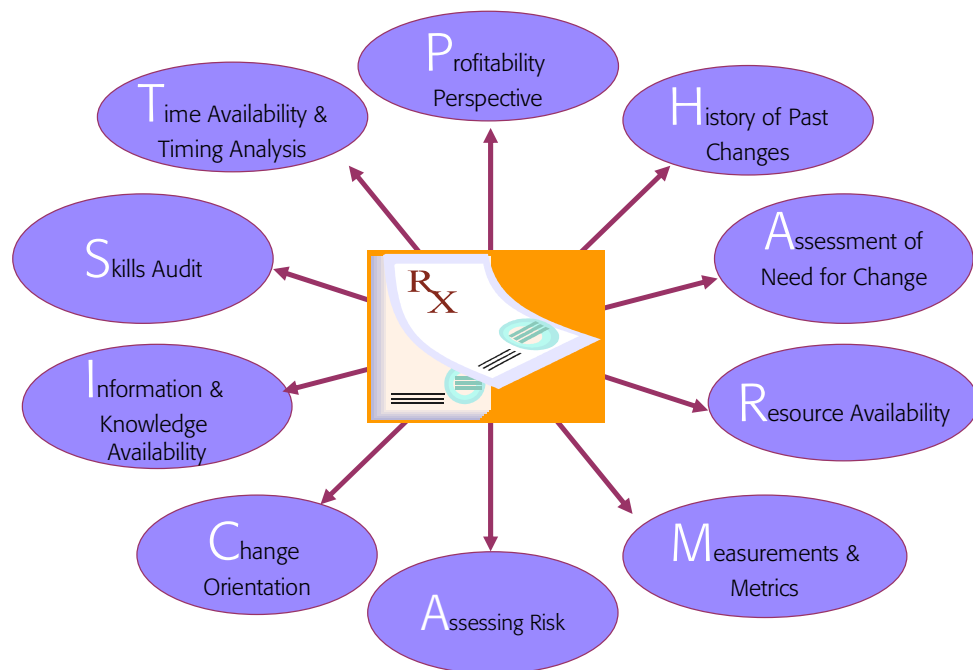
Too often managers commence a change without having adequately assessed the readiness of themselves and their organisation to engage in it. The result is that change outcomes may fail to live up to initial expectations or, worse, create a new set of problems such as staff turnover, dashed expectations or below-par financial results. This is not to say that a rational assessment of change prior to commencing it will always result in change success: as Bolman & Deal (2003) point out there is “an ironclad law: change rationally conceived usually fails”. This occurs where managers are mistaken in their assessment of the need for change or slavishly followed their pre-determined path in implementing the change without adjusting their change actions as new, unanticipated consequences emerge down the track.

Accepting these caveats about rationally conceived change the wise pharmacist will nevertheless assess the readiness of themselves and their pharmacy, not just to engage in change, but to engage in specific types of change. In this chapter we outline the **Pharmacy Change Readiness Wheel**. The wheel was developed following extensive consultation with pharmacists and other stakeholders through focus groups, interviews, case studies and the mail survey. It brings together our knowledge of change management with the realities of practice, and builds on the work done by Roberts et al. (2003). You will see that there are a number of quotes under each of the headings, these have been directly taken from participants in this research. Where appropriate we have also added quantitative material. By using this technique we hope you are exposed to comments by other pharmacists. This wheel identifies ten issues that you as a pharmacist need to pay attention to in determining whether you are ready for change. It is important that you pay attention to each of these issues. Assessing yourself and your pharmacy in relation to them will help you to determine whether the change capability of your pharmacy is adequate to the task at hand.

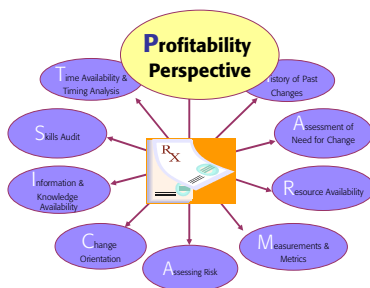
We have written this and the next chapter using “you” to facilitate the use of this chapter as practical change tools for pharmacists.

At the end of the chapter you will have the opportunity to complete the Pharmacy Change Readiness Assessment. This will assist you to determine if your pharmacy is ready to introduce a change program to extend your service offerings.

Figure 5.2: Pharmacy Change Readiness Wheel



2.2 Profitability Perspective



Your awareness of the relationship of the change or service you are considering introducing, and its effect on the bottom-line of your pharmacy, is another important part of assessing the readiness of you and your pharmacy for change. Table 5.2 summarises, from our mail survey, pharmacists' perceptions of satisfaction with some of the services they offer, the bottom-line impact, along with the difficulty of implementing the service and their perceptions of the take-up rate of the service by customers.

Table 5.2: Service Adoption Analysis

	% Offering Service	Satisfaction with Service ⁵	Perceived Profitability ⁶	Take-up by Customers ⁷
CMI	98.4	4.1	1.8	3.5
Unit dose dispensing	82.4	3.9	2.4	3.0
HMR	76.4	3.5	2.2	2.3
Smoking cessation	67.3	3.5	2.6	2.9
Herbal medicines/nutritional supplement counselling	56.5	3.4	3.1	3.3
Asthma Management	49.5	3.2	2.0	2.3
Weight Management	47.4	3.3	2.7	2.7
Harm reduction	42.6	3.9	3.2	3.2
Diabetes Management	35.7	3.5	1.9	3.4
Screening	26.2	3.5	2.1	2.8
RMMR	22.6	3.6	2.2	3.1
Naturopathy	16.1	3.8	3.3	3.6
Specialised Compounding	9.8	3.9	3.0	2.9
Aboriginal Health Services	4.4	3.5	2.3	2.6

It should be noted that what constitutes these service offerings was not specifically defined, but left open to the interpretation of the study respondents. This is discussed further under study limitations in section 3: 2.2.8.

Our analyses from the focus groups suggest that there are three key pharmacy perspectives in relation to profitability of new services:

- profitability needs to be there at the start – or shortly thereafter
- profitability will come later – for a variety of reasons
- profitability will not come later – we will subsidise

It is likely that your “profitability perspective” will fall into one of these categories – or, it may change over time, from one category to another depending on a number of factors such as the current profitability of your overall pharmacy, or the stage you are personally at in your pharmacy career or your perception of potential market shifts in the future. In what follows we explore in more detail these three pharmacy profitability perspectives.

2.2.1 Profitability Perspective 1: Profitability needs to be there at the start – or shortly thereafter

Ensuring that the service is profitable in its own right is one perspective on whether to introduce or retain a particular service. As one pharmacist noted:

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

⁶ on a scale of 1 to 5, where 1=low profitability and 5=high profitability

⁷ on a scale of 1 to 5, where 1=low take-up and 5=high take-up rate

"I think there's an issue about a viability of the business model for some of these activities that needs to be clearly understood. I mean some of the things just don't really stack up. They've got a bit of "feel good" in them but they just don't stack up."

If you are like some pharmacists, especially those belonging to particular pharmacy banner groups, you may be required to go through a formal business plan to establish the viability of the service before you offer it.

"...So we have our own written protocols for undertaking activities like that. But if somebody wanted to - as one of our pharmacies did - explore what they can do in terms of providing a wound care service for patients because they believe there is a need for it in their community, that is up to them to do a business case, to say, "Well, am I am prepared to allocate an area of my pharmacy? Will I refit a small room? Will I have one [staff member] trained? Will I assign so much of my own time to that and what do I think (a) the benefit to the community and (b) the benefit to the pharmacy and is it the right thing to do?" They can come up with that. The only limitation we would place upon them is "If you wish to spend money to support this initiative you have, then it needs to be justified in terms of the expenditure process." So our job is to force them to think about from a business perspective"

Such a formal process is not always typical of how pharmacists go about evaluating whether to introduce a service. For others this evaluation is made on the basis of a "guesstimate", doing "your own homework" or making a "ballpark" call. Sometimes this process is carried out down the track, once there is a better understanding of what is involved. As one pharmacist said in relation to a particular service, "we started it and learned about the financial situation later on". Another explained how he did this in terms of his decision to withdraw from unit dose dispensing packs:

"...we do a lot of dose administration aid packaging and I've done a cost analysis on each and every establishment that I service and I actually got rid of some of them because they're not making me any profit at the end of the day because the distribution costs, the implementation cost were too high and I actually sat down and worked a spreadsheet of what it's costing me and the person in the hostel, so I rang them and said you're costing me \$8,000 per year, I don't want you anymore. They said why, we're giving the scripts and the numbers but it doesn't add up at the end of the day. It's not cost effective for me to send my courier or driver there ten times a day or whatever."

One view put to us is that the need for services to be profitable is stronger these days than in past times:

"I think ... the profession in general has had a bad habit of sticking their hand in the air and saying "Yeah, we can do that" without thinking about the remuneration ... And 20 years ago when pharmacies were cash cows and you could run them badly and still make a fortune, you could afford to do all those ancillary things and not charge for them. But nowadays, it is getting fairly cutthroat and, as I said, margins are shrinking, competition's increasing. It is getting more and more difficult to maintain your profitability and so forth, and to take on all these sorts of additional services means... it is making it very difficult."

2.2.2 Profitability perspective 2: Profitability will come later – for a variety of reasons.

You may subscribe to an alternative perspective on profitability in relation to assessing whether to introduce a change or service. In this perspective, profitability is important, but not necessarily to be expected immediately, or even directly. This can be related to one of three rationales.

2.2.2.1 Eventual recognition (and payment) by government

In this rationale, you may commence offering a service even though it is unlikely, in and of itself, to provide a profit at that point in time. The expectation is that the service meets a need in the community. Through meeting this need governments will come to realise its importance and put in place policies, such as through the negotiated Community Pharmacy Agreements that will lead to future funding for such activities, thereby eventually making them cost effective. A number of pharmacists mentioned this rationale to us, although they did not necessarily have confidence that payment would always be eventually forthcoming:

“...Especially in this context of the Fourth Agreement. There’s lots of things in pharmacy ... we’ve said “Well we’ll do this and eventually the government will pay us” which they generally don’t. ... There are lots of things that we’ve taken on that have been in anticipation of government or community recognition of the value of the service and the chance to get something in it.”

As another pharmacist in a focus group said, more bluntly, “...we do these things in the hope that eventually there’ll be a commercial return, i.e. payment for cholesterol testing or whatever it might be”.

2.2.2.2 Diversification away from government funding

In this rationale, your purpose in introducing a service is to establish a funding base that relies less upon obtaining government funding and more on obtaining alternative sources of revenue, including obtaining consumer acceptance of the expectation of paying for various services offered by community pharmacy. As one pharmacist outlined in relation to offering weight loss services:

“The reason that I got into weight loss in the first place was basically to implement a fee for service for pharmacy. There is no reason for pharmacy not to be in the link where we chargewe should be in the health care loop with Weight Loss Management. We should also be in the health care loop with Diabetic Management. We should be in there with Asthma. We should be getting a fee for our service, and that is where pharmacy has got to go.”

Others mentioned offering naturopathy and complementary medicines advice as other services attracting a fee as this is a “much more profitable way to way to go because the people are coming to you”. In addition “people will pay for it because really they’re paying

for your service” and “they’re used to paying for it”. Other ‘fee for service’ programs included bone density testing, wound care and hair lice programs (paid for by local councils), and charging aged care facilities for unit dose dispensing packages.

However, two cautionary notes need to be added here in relation to this rationale:

- One view is that pharmacists “undervalue ourselves”. What is meant by this is that they are not used to charging a fee for service and tend not to charge themselves out at a rate which is profitable. A counterintuitive suggestion is that psychologically people value services better when they have to pay for them at a price which they think is both fair but also represents the fact that they are getting “professional” advice.
- A second view is that “we’re our own worst enemy” by constantly undercutting each other in terms of what fee is charged for services, thereby pricing many pharmacists out of particular services and markets. One pharmacist referred to how “...you’re being beaten down on price all the time by people who come along trying to take your work saying, “We’ll do it for nothing”. (Pharmacist, focus group)

2.2.2.3 Profit indirectly, through increased product sales

In this rationale you do not expect the service per se to be profitable but you do expect offering the service to increase your customer base and to lead to increased product sales, either directly related to the service or through obligation and loyalty to the pharmacy. This service – product relationship recognises, as one pharmacist put it “80 percent of pharmacy business is prescriptions” and, as another put it, “Most of those things are done with the desire to improve your script quantity”. This rationale was nicely portrayed by another pharmacist who said, in response to a question about how services become profitable:

“Getting prescriptions that relate to the service or the disease state. For example, diabetes, you’re hoping to get the insulin scripts. Asthma, you’re looking at possibly providing the services and getting, you know, customer loyalty to sell them their nebulisers, do their medications for them and be the place that they constantly come back to.”

Of course, not everything that you do will result in the sale of a product: “...we traditionally have done a lot of things for nothing. To make a living we rely on a profit at the end of the day on everything we sell, but quite often what we do doesn’t result in the sale of an item.” (Pharmacist, focus group). This results from the fact that some services are likely to lead to more direct product sales than others:

“... For argument’s sake with asthma patients, I think trying to assist them in the way they need to be assisted and relying on additional sales is wrong. Because most of them don’t need a whole range of extra product. Most of them you actually find that they would be better off with less product more wisely used. Diabetic patients are a different kettle of fish. The diabetic ends up with so many additional, sort of, so many additional health problems whether it be poor circulation in the feet, or you know blood pressure or cardiac disease and other things, that maybe they can be, you know, you can sort of off-set some of your costs against the enormous amount of product that they buy...”

A good summary of this rationale, of offering a service on the basis of profitability following at a later date, is present in the following statement:

"...profitability, doesn't always come first of all. In fact, frequently it doesn't. ... Profitability often comes later because it (providing the service) adds to your business."

2.2.3 Profitability perspective 3: profitability will not come later – we subsidise

In this perspective you offer services for reasons other than profitability – at least up to a certain point. As one pharmacist, who offered services, outlined:

"I don't think there is any service that I've implemented where you could honestly say that the remuneration is worth it. I would like to say I didn't implement anything, but I have. But I don't think they are (worth it). It almost costs me money to keep them."

Why do you do this? You see this as part of what you do as a community pharmacist, without necessarily obtaining direct financial profit (see Change Orientation segment of Change Readiness Wheel). Roberts et al. (2003) identified that the motivation for implementing a new service will not necessarily always relate to immediate financial gain. A desire for professional satisfaction or an altruistic focus may be greater motivations for you. One pharmacist said that they're "keen not to be perceived as a pharmacy that's money hungry". Others referred to the "warm fuzzy feelings" rationale, for example, in relation to methadone:

"But the fuzzy warm feeling that I feel as the pharmacist is that I've got one potential broken family together and at the same time this person becomes a normal person in the community, working again. That's the fuzzy warm feeling that you can't put a price on."

However, this "warm fuzzy feeling" rationale has limits. As another put it:

"Anything we say here, there's got to be a commercial interest in whatever we do. Whatever warm fuzzies, you've got to say well, hang on this is ultimately a business".

2.2.4 Bringing the "profitability perspectives" together

Identifying your "profitability perspective" early on in your decision to take on a new service or change is important to managing your expectations about the outcomes that you desire. Your "profitability perspective" may vary, depending upon the service, how complex it is to implement and how much in the way of resources is needed to set it up and keep it going. Each "profitability perspective" is valid: a key challenge for you is to reflect on what yours is and make sure that you are comfortable in holding this as you launch yourself into a particular pharmacy change.

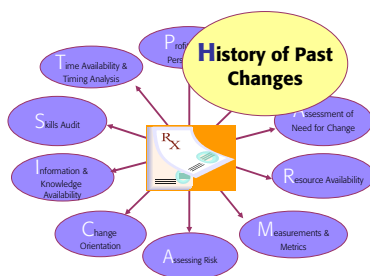


Questions to ask at the end of this stage:

2.2a. I have clearly identified my profitability perspective for the introduction of this service ☐ Yes ☐ No

2.2b. I have made a detailed cost/benefit analysis and identified an acceptable level of profitability for a clearly specified period ☐ Yes ☐ No

2.3 History of Past Changes



Like most other pharmacists you are likely to have had some past experience of pharmacy change, either directly through your own experience or indirectly through observing the changes of other pharmacists or through stories that you have been told about pharmacy change. The past influences the future and pharmacy change is no different in this respect.

2.3.1 Positive experiences of past changes

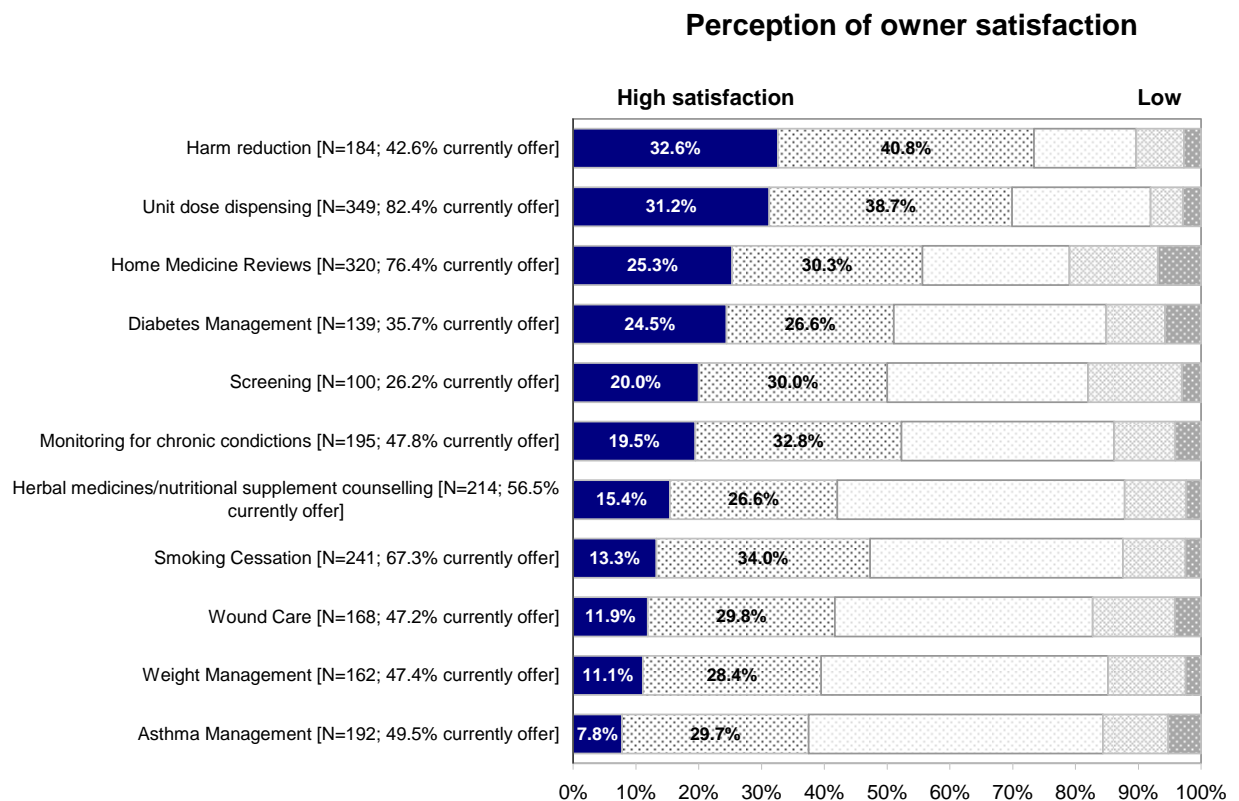
You may have had positive change experiences and feel that you have “made a difference”. For example, some pharmacists referred to the positive aspects of residential medication management reviews (RMMRs) in these terms:

“...I get satisfaction out of the nursing home review because I’ve got quite a large nursing home I look after and so the satisfaction I get through working it. We have a meeting once a month, and we have a round table discussion so I’m getting feedback. And the feedback I get too is that some patients’ medication has been changed.”

“I’m sort of lucky too that I’ve achieved a lot of extra education through this particular nursing home that I try to use in the pharmacy myself and I’m getting feedback with customers coming in and I’m not getting a lot of money out of it but you tend to get a name for yourself. That you specialise in dementia or anti-psychotic medications.”

In terms of positive experiences, the figure below illustrates, from our mail survey, the top 11 services in order of the level of perceived satisfaction with the service. Only respondents that were offering the service indicated their level of satisfaction.

Figure 5.3: Top 11 services ranked by pharmacist satisfaction in terms of the service they offer



NB: What constitutes these service offerings and what was meant by satisfaction was not specifically defined, but left open to the interpretation of the study respondents. This is discussed further under limitations in section 3: 2.2.8.

You may wish to take your colleagues' level of satisfaction into account when considering offering a new service yourself.

2.3.2 Negative experiences of past changes

Of course not all pharmacists experience change in such a positive way. For example, some said that they had had the opposite experience with RMMRs to that described above, one saying that "I basically have no impact on the medication the patient's receiving at all". Others who had started down a change path by introducing a service also pulled back for various reasons. For example:

- one had pulled out of methadone supply because of a string of robberies
- another pulled out of offering a chiropractic service because it was not well accepted by patients and they had trouble obtaining good practitioners

In other situations the change did not fail, so much as not fulfil initial expectations.

In terms of negative experiences, the table below illustrates, from our focus group participants, the top 8 services which, for various reasons, they had implemented but then later discontinued.

Table 5.3: Services discontinued by focus group pharmacists

	N =	Implemented & discontinued
Naturopathy (Total = 100)	9	9%
Community clinic and nurses (Total = 99)	7	7%
Harm reduction and methadone (Total = 100)	6	6%
Iridology (Total = 102)	6	6%
Aromatherapy (Total = 99)	5	5%
Screening eg. Blood glucose, cholesterol, bone mineral density testing (Total = 96)	4	4%
Body piercing (Total = 101)	4	4%
Reflexology (Total = 101)	3	3%
Massage (Total = 101)	2	2%
Monitoring for chronic conditions: eg. blood glucose levels, blood pressure monitoring, peak flow monitoring, cholesterol (Total = 101)	2	2%
Homeopathy (Total = 102)	2	2%
Home Medicine Reviews (Total = 103)	2	2%

2.3.3 Effect of past changes

Where your past change experiences have been positive you are more likely to be in favour of future changes. Apart from the positive experience of the change you will also have acquired some change management skills along the way which are likely to assist you in the future. This assumes that you still have the energy to introduce other changes! As outlined in the table below, our focus group participants indicated that they might consider implementing the following services in the future.

Table 5.4: Services pharmacists are planning to adopt – from mail survey

Service	No. planning to adopt	% of total survey respondents (n=403)
Consumer Medicine Information (CMI)	3	0.5%
Home Medicine Reviews (HMR)	43	7.7%
Residential Medication Management Reviews (RMMR)	29	5.3%
Aboriginal Health Services (AHS)	4	0.7%
Asthma Management	76	13.9%
Diabetes Management	60	11.0%
Harm reduction - methadone/buprenorphine	9	1.6%
Dose Administration Aids (DAA)	12	2.1%
Specialised Compounding	9	1.9%
Naturopathy	35	6.4%
Smoking Cessation	31	5.6%
Weight Management	55	10.0%
Herbal medicines/nutritional supplement counselling	25	4.6%
Screening	42	7.6%

* NB: What constitutes these service offerings was not pre-determined, but left open to the interpretation of the study respondents. This is discussed further under limitations in section 3: 2.2.8.

For some pharmacists, past changes which were negative will serve as evidence that it is not worth the effort. In this situation you are likely to avoid change in the future or minimise the extent of your pharmacy's involvement. As one pharmacist said in focus group in explaining why he now avoids change, "You've tried and tried and it doesn't work, you get so many knock-backs..."

However, even where you may have had a past change experience that was negative, or delivered less than you anticipated, you may nevertheless still be open to introducing change in the future. This can occur:

- if it was your perception that the main problem was not the change itself, per se, but the way it was implemented and consequently that
- you now think that you know how you would implement change differently in the future
- if it was your perception that the main problem was more to do with that specific change than with change generally and consequently that
- you perceive other changes as more relevant to your pharmacy or more likely to succeed or be aligned with the other parts of your pharmacy operations
- if it was your perception that the problem was in the timing of when the change was introduced (see the Time and timing analysis section of this Change Readiness Wheel for more on this), not the change itself and consequently that
- you think that the timing is now better for introducing particular services

Knowing your own perceptions about how past changes impact upon your own and your staff's perceptions of change is an important part of being ready to implement change successfully into the future. In this regard you may want to write down what assumptions

you currently hold about change, based on your past experience, and consider how they currently influence you – and how valid they are in terms of impacting upon your decisions to introduce change.



Questions to ask at the end of this stage:

2.3a. I have reviewed my pharmacy's record of introducing services and am clear about how these changes have impacted the pharmacy staff's attitudes to the introduction of future changes

☐ Yes ☐ No

2.3b. I have taken appropriate action to reinforce past learning and to deal with any residual negative attitudes to change on the part of individual staff members

☐ Yes ☐ No

2.4 Assessment of the Need for Change



The readiness of your pharmacy to engage in change involves assessing whether there is a perceived need for the particular change you are contemplating. This involves awareness of four key issues: pressures to introduce a change, assessment of new market opportunities, fit with business model, and personal rewards that may result from introducing a change. The findings from our research in this area, outlined below, concur with those of Roberts et al. (2003), who found that pressures to implement change could be internally or externally driven.

2.4.1 Pressure to introduce the change (reactive)

For some changes you may perceive that you have little choice but to introduce them in a *reactive* way. This situation may occur due to a number of pressures. Three key ones which you may face are from your consumers and pharmacy community; from the pharmacy profession; and from other industry stakeholders.

2.4.1.1 Pressure from consumers and pharmacy community – the effect of “loyalty” and “customers for life”

If you perceive the need to retain particular customers and consumers for long periods of time you may feel the pressure to respond to them when they make specific requests for

services. This explains why some pharmacies took on services related to methadone, unit dose dispensing and HMR programs:

"Some of our regular customers actually asked whether we do the HMR or not. In this case we have to..."

"What started me off with the methadone program was that I was involved with a customer whose son was a drug addict. And this fellow was a customer of ours for many, many years and picking up his methadone from another pharmacy that was too far away from home and he came one day and said this is my situation can you help? And that's how we started, it was a customer whose son needed it."

"We have implemented dose administration aid packing and we are under pressure. We don't do HMRs but we are under pressure. We get pressure from the doctors and pressure from the public to implement those services. As we get older, more people want those HMRsthe customer - the public - Joe Public. They want those services and so there is pressure there to implement these sorts of services."

If you do not provide a service you need to consider the implications on the continuing loyalty of your customers.

Responding to such pressures may not be always commercially viable in terms of the specific service:

"There are a lot of add-in things in this industry... And it is pretty hard to put a price on how you make your money out of that. If you were doing it commercially you probably wouldn't do it, but you, sort of ... I think the fact that we really do care as a profession"

However, in this case it is the longer-term benefit of having loyalty and "customers for life" that motivates you to assess the need for the service. The customers themselves may appreciate that you are not making a profit from offering the service, but "reward" your pharmacy by remaining a long-term customer:

"they bring the loyalty of the customer to the shop and a lot of them probably know that it is a voluntary service, pharmacists don't make any money. They pay back with their support"

"they were good customers anyway so they're won for life"

For such reasons, as another pharmacist pointed out, keeping a sense of community is itself "a commercial decision as opposed to a community decision".

2.4.1.2 Pressure from the pharmacy profession

You may feel the need to provide a service as a way of responding to pressures more widely from the pharmacy profession. In a context in which the industry is under pressure

from outside retailers to move into the pharmacy territory, the provision of community services is one way of demonstrating the importance of having a protected industry even where the particular service is not well remunerated.

"But there are pressures on us in a professional sense and a community sense. Probably from other directions as well, that are encouraging us, not encouraging us maybe, but influencing us to do a new service and because the pressure's there."

Part of this pressure emerges from making sure that services, particularly those for which doctors provide referrals in the local community, such as HMRs, are available to consumers.

"If you're going to go out and do HMRs, anddoctors start referring and suddenly the three guys don't want to do HMRs, it's not good for the profession either. So whatever we promote we've got to make sure the profession can cover it, so to speak, in these services, and not have gaps where people are treating other things and they don't want to do that."

Of course, not all pharmacists will experience such pressures. As one pharmacist who had been practicing for seventeen years said in interview;

"If something works for me then all well and good, but as for a direction for the profession, I'll leave that to other people. And I'll go with the flow. If something works for me, I'll run with it, but as for having the enthusiasm to get carried away about certain issues, I'm afraid that's well and truly gone"

2.4.1.3 Pressure from industry stakeholders

You may feel that you are under pressure to introduce a change because of the pressure from industry stakeholders. This can occur in situations where change is mandated contractually, such as with large shopping centre pharmacies which may be required to conduct store refits at specified time intervals. It can also occur less formally such as through pressure by "doctors, carers, nurses, relatives. They ring up and say you do it because if you don't you've lost that patient". You may also come under new pressures in the future, as one pharmacist pointed out:

"Well the driving force will ultimately be that some of these future cognitive services you won't be able to access if you're not quality care accredited – where the big crunch will come. And there's, I think, the Guild are arguing a bit internally at the moment as to whether, you know, there's a chance you may lose your PBS number if you don't... you [may] have to be quality care accredited to be entitled to dispense."

You might also feel it through the banner group to which you belong, although whether this is experienced as pressure or encouragement may be open to question or may depend on the group to which you belong, as evidenced in the following statement:

"Well [Banner Group X] does motivate you but not as pushy in that sense as [Banner Group Y]"

2.4.2 Assessment of new market opportunities (proactive). “Pushing the envelope”

Whereas the previous point addressed reactive changes, this issue addresses situations where you adopt proactive behaviour due to your perception of new opportunities. Many such future opportunities were outlined in section 2. For some pharmacists this involves “pushing the envelope”:

“you’re actually providing a service that’s outside of the pharmacy. It’s where pharmacy should be - pushing the envelope of pharmacy.”

As outlined in our discussion of the PVM there are different business strategies are open to you. You may introduce a new service, previously not offered elsewhere (e.g. assessments using spirometry for patients with asthma), supplement services offered by other providers (e.g. distribute a Bowel Cancer screening kit) or substitute services, previously offered by non-pharmacists (INR testing for patients on warfarin). By way of example of the latter, a number of pharmacists referred to the changing market with people in search of alternatives to traditional pharmaceuticals. Through the high trust and credibility of community pharmacy – as one put it “pharmacy’s up the top of the tree in as far as public esteem” – they are well positioned to take on such service/product offerings. Complementary and alternative medicine is:

“actually becoming mainstream. The market is going away from the health food stores, from a lot of alternate practitioners and are going towards pharmacies and we have more credibility.”

Identifying such opportunities for change requires market assessment. You may utilise a number of strategies for doing this that pharmacists identified in focus group interviews;

- Market research
- Demographics
- Bureau of Statistics
- Staff and customer surveys
- Use of banner group information

You might also utilise your own databases to identify potential local demand, such as in the following example:

“Well, for example, if it was say wanting to offer diabetes services you’d search your database and see how many insulin scripts, how many diabetic scripts, how many whatever in that class of drugs in the scripts that you might have dispensed.”

2.4.3 Fit with Business Model

The change is one that you may wish to make because of its fit with your current business model or, as one pharmacist said, with your “vision”. This is different from the **Profitability Perspective**. A service may be potentially profitable and viable but not a good fit with your

current business operations, or with the business model that you are trying to develop for your pharmacy. In this case you either need to readjust your business model (see PVM in section 4 chapter 2 for options available to you) or leave the service for others to provide. As one pharmacist said:

"Another big factor in implementing other things is just how much can you do ... you can't do it all.... there comes a point where you have to draw a line basically"

You may also decide to introduce a change as a way of *differentiating* your pharmacy from others in your area. In this regard, consider the following comment:

"I think that obviously there are a lot of pharmacies in the area and we're competing with each other and also we're competing... [with] ... much bigger players now and we're looking for a point of difference. And obviously those specialties and services give us a point of difference from sometimes our direct competition. But certainly on a service level we provide a big competition to other more convenient places to shop."

At the same time, another important "fit" decision you will need to make is assessing the impact of introducing the change on your current pharmacy operations. This most clearly emerged in relation to the decisions many pharmacists have made about introducing methadone dispensing. A number of pharmacists mentioned that their decision not to introduce methadone dispensing was based on a feeling that it would be detrimental to their existing business. This could be because of the effect on either staff or other customers:

"with methadone, our decision not to supply, probably one of the motivators not to was that a lot of our staff would feel uncomfortable, especially our younger female pharmacists who felt they could not provide the service."

"Maybe I don't like the effect it might have on my existing clientele who would definitely look upon it as a minus point and not wanting to come in when we're dispensing methadone...I feel it would be detrimental to my business to do it."

2.4.4 Personal rewards

An important motivator, separate from financial incentives to introduce a change or service, may be related to the personal rewards that you may experience which result from it. These rewards may relate to your passion, satisfaction, and personal learning.

2.4.4.1 Passion

Passion as a motivator was an important incentive cited by different pharmacists for re-orienting their pharmacies towards nutrition, compounding and complementary and alternative medicines:

"I've got a passion, always had a passion for nutrition and that sort of thing. I've got involved in it."

"Well, I've got to the stage, and I've been in pharmacy longer than most here, I've got a basic range of products that I make up myself, that's why I'm in compounding... But I'm interested, I've got this range I've developed and sort of, I've got to talk to them on how to use it and they've got to come back to me if they want more"

"Yeah, I'm a bit interested in the complementary and alternative medicines."

2.4.4.2 Satisfaction

Personal satisfaction in "making a difference" is another reason behind why you may introduce a service. As some pharmacists explained, "Pharmacy can be very monotonous, if you're not involved. We get to that stage now". As this pharmacist further explained, involving yourself in new services is satisfying: "strangely enough you get rewarded. We're not talking dollar rewards, you're just rewarded that you feel you're doing something worthwhile at the end of the day". Others pointed out that many services:

"would be financially not rewarding for us. But personally as a professional person it is rewarding because you are actually providing the service to your own community. Because say... asthma management.. I will probably get nothing out of that."

Another personal satisfaction is the potential of new service to enhance personal community relationships:

"So it enhances your relationship quite a lot with your local doctors and it also enhances your relationships with your patients and their families because if you do a home medicine review there's always some other family member there too."

2.4.4.3 Learning

Allied with getting satisfaction through making a change is the personal development side of you being up to date and learning new aspects of your profession. For example, one pharmacist said that while HMRs were not "brilliant" from "a raw business point of view" they did force one "to get right up to date so that was a positive thing...professional satisfaction". Others referred to the way learning occurred through "broadening your knowledge base" such as through HMRs.

These personal rewards, however, may be not the primary motivators for introducing a change. For example, some pharmacists pointed out that such personal benefits were "secondary offshoots" but not explanations for "why you do it". Even where a service may start out "essentially as a gift" to the local community the gift could not continue indefinitely unless "it's a sustainable practice". These views were also reflected in the earlier study by Roberts et al. (2003).



Questions to ask at the end of this stage:

2.4a. I have reviewed the need for change (pressures for change from stakeholders and new market opportunities) and have made a thorough market assessment

☐ Yes ☐ No

2.4b. Using the Pharmacy Viability Matrix I have identified the business model my pharmacy is pursuing and determined that there is a clear fit between the new service and the pharmacy's future vision or I have readjusted my business strategy to one of the other three quadrants in the PVM

☐ Yes ☐ No

2.5 Resource Availability



Making sure that you have the necessary resources available, and at the times when they will be required, is a necessary part of being ready for change. The resources that you need will depend upon the particular change that wish to conduct. Elsewhere in the change readiness wheel we consider resources such as time, information & knowledge. In this section we consider four other resources that pharmacists cite as ones that are common to many pharmacy change programs and therefore ones that you are likely to be faced with in preparing for change: space, staff, “reputational” capital and “working” capital. For your guidance see the worked business case example in diabetes business case (see chapter 4: 4.6 in this section).

2.5.1 Space

Space is a scarce pharmacy resource. Whether it is a special area needed to set up compounding, a private area to provide disease state monitoring or screening services, for counselling on sensitive medications such as emergency hormonal contraception pill, health and lifestyle advice, for other practitioners such as dieticians or nurses, or a range of other services, storage facilities for bulk methadone or simply shelf space for vitamins or health-related products – all of these changes require either additional space or a reconfiguration or existing space. Lack of space was cited as a reason why some pharmacists had not implemented new services. One pharmacist outlined the dilemma in this way:

"The cost you're paying per square foot, particularly in the set-up. You have to get a return on every square metre of the business. And one of the pharmacies in town, we give to a nursing health clinic. Very big space for kids – actually free of charge to the government. And you put a dollar figure on that – that has to be subsidised by the rest of the business. So I think it's the cost per square metre, that's one thing. And then that cost is in lost revenue. So it becomes a cost benefit analysis."

In conducting a cost-benefit analysis of your use of your current and projected use of space you might consider a range of complementary strategies such as:

- expanding your shop floor
- contracting out the service so that it is done off-site
- reconfiguring how you do things inside the pharmacy, or
- ceasing some types of product lines to make way for new ones

Of course, some pharmacy leases make it difficult to implement certain types of services, especially by pharmacists working in large shopping centres:

"The banking, newsagency and post office are all sort of services I would like to consider, but I cannot even consider them because I wouldn't be allowed to under the terms of my lease."

2.5.2 Staff

Your ability to engage in a change such as providing a new service will almost always mean the reallocation of staff time for the new endeavour. This is cited by pharmacists as one of the biggest challenges they face due to the often limited availability of suitably qualified and motivated staff and the time and expense which this may involve in searching for and recruiting staff. Attracting staff to rural and remote areas provides additional challenges. One pharmacist we talked to said that he had not had a holiday in three and a half years, whilst another said:

"Why [are] old fellas like me still working? We're still working because there are not pharmacists around. There's a dramatic shortage."

Even within large cities you may find that it is easier to attract pharmacists to some areas rather than others. As one said in relation to Sydney, they have trouble attracting pharmacists:

"Especially in the western suburbs. I find it's easier in Burwood, Strathfield, Bondi, eastern suburbs."

The statutory requirements that you work under as a pharmacist mean that simply reallocating pharmacists away from dispensing to other areas as a way of dealing with this shortage may be problematic:

"Yeah, you need someone to be supervising in the dispensary ... technically you can't dispense whilst you are not under supervision of the pharmacist....So unless

that pharmacist is supervising the dispensing they may need someone else to supervise."

Accepting that staffing is a difficult issue to address, there are four strategies that you, like other pharmacists, may use to find new staff:

- *Word of mouth:* as one said in relation to how they find locums
"It's word of mouth"
- *Employment agencies:* This is an option, although one that has to be paid for:
"There is an agency but you pay an arm and a leg for it!"
- *Networks:* In some banner groups there is assistance in finding pharmacists to fill vacancies. As one person we spoke to said:
"...but half my time is about "Where can I find a pharmacist? I need to bring in another pharmacist." I don't think any time in the last four years I've had less than three vacancies in the group. And my target is to get down to one or less vacancy. And at the moment I've probably got four in the group, across the many locations."
- *Off-shore recruiting* This was mentioned as occurring, especially to attract pharmacists to country areas:
"some of the pharmacists here in [regional Victoria] are going to England to recruit pharmacists so you know, it's a huge exercise."

However, you can consider examining pharmacists are being utilised and reallocating work to non-pharmacist staff members to overcome these issues.

2.5.3 "Reputational capital" - external alliances and relationships

Especially for certain types of services you will need to have well-developed alliances, networks and relationships with a range of community groups and stakeholders in order to best deliver the service. These relationships, in and of themselves, are a resource, and fall under the heading of your "reputational capital". This is the degree to which you are well-known, networked and trusted among those with whom you seek to interact. As outlined in the figure below, services will vary according to how much coordination of external stakeholders is required – something which will be easier if you have good, pre-existing reputational capital with groups such as your local GP, community nurses, local hospitals and the like.

As one pharmacist said in relation to the importance of alliances as part of being ready to engage in organisational change:

"...there's... much more greater need for alliances with other health people than we've had before. ... So say you want to do sports medicine you'd really have to get proper alliances with the local physio, the doctors who are into sports medicine, that sort of stuff. In diabetes you'd have to make sure the local specialist knows you're the local diabetes centre etc, etc. Whereas most of the things you do you, we're quite separate and we can survive being separate. But I don't think that's successful. Looking at these services, particularly the disease state management, if you weren't allied with these other groups, you'd be working alone and probably not effectively. ...It's a team, yeah. I don't think you can be on your own island there"

2.5.4 "Working capital"

In many ways this is the most obvious resource that you will need in order to be ready for change (so we saved it for last!). The amount of cash will vary depending on the scale and extent of the change. If it involves a major reconfiguration of your pharmacy such as a full fit-out this will probably cost you in the order of \$1500 per square metre (Stakeholder). Factored into this may need to be working capital to support some downtime – although, somewhat counter-intuitively, this may not necessarily be a major problem. For your guidance see the worked business case example in diabetes business case (see chapter 4:4.6 in this section). As one fit-out specialist said, they tend to work around the pharmacy's operations, not requiring them to close:

"...it is very rare that the pharmacy will have a downturn in trade in the fit out period. People are sticky beaks and they want to come and have a look and see what is going on when they see construction going on in their pharmacy..."

Working capital will need to be set aside to pay for the set-up costs for various services. So, for example, in relation to compounding:

"Out on the field we will tell them, like it's going to cost you to join up \$15,000. You are looking at another \$20,000 in equipment. You are going to probably have to spend \$20,000 - \$30,000 doing up your lab. Some people spend up to \$100,000 to begin with..."

To summarise, space, staff, reputational capital and working capital are all key elements that you are likely to have to address in preparing for change.



Questions to ask at the end of this stage:

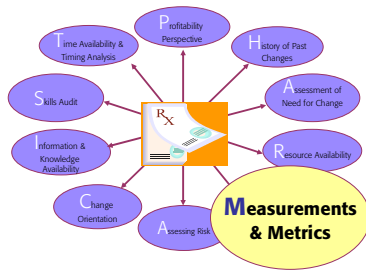
2.5a. I have reviewed the major resources needed to deliver the new service (e.g. space, staff) and taken appropriate action to ensure that they are available

☐ Yes ☐ No

2.5b. I have reviewed the reputational capital (external alliances and relationships) and working capital needed to deliver the service and taken appropriate action to ensure that they are in place

☐ Yes ☐ No

2.6 Measurements and Metrics



Change involves movement from one point to another. In order to identify how well you're going you'll need to be ready for your change by identifying what you will measure to show that movement has occurred. This side of change readiness means know what the baseline measurements are like now, prior to starting the change, so that you can assess shifts from this baseline over time. Staff will also be interested in measurements, particularly where you use them to assess staff performance or pay bonuses! In this situation the oft-heard adage "What gets measured gets done!" may well apply.

This assessment requires you to pay careful attention to what you will measure – and that the measures are unambiguously associated with the change that you wish to assess.

2.6.1 Choosing measures

You are probably already used to the idea of needing measurements to assess your business. You may already be involved in regular measurements, such as product sales in your pharmacy. As one interviewee outlined:

"We do monthly measurements. The actual main pharmaceuticals and our own management company do for the brands."

However, in measuring change, you will need to recognise that change impacts upon pharmacy operations in a myriad of ways, not all of which are easily measurable. As one pharmacist said:

"Some of the other costs that you can't really measure is we might have already a delivery car. But part of that delivery system is that you have to drive via there and the extra petrol you really can't measure. And the extra phone calls, interruptions, the repacking, all the things you can't really measure"

So, how do you do it? You will need to think carefully about the types of measures that you will use to assess a pharmacy change. A *Balanced Score-card Perspective* suggests that you should measure how the change impacts upon different aspects of your pharmacy's operations:

Financial	-	was revenue expanded? Did cost structures improve?
Customer	-	how has the change added value to your customers?
Internal processes	-	is your pharmacy offering the service efficiently?
Learning perspective	-	as your pharmacy and staff grown, that is developed new capabilities and skills that will be able to be utilised in the future?

The specific measure that you use to evaluate the success of your change should meet the following requirements:

Relevant	-	meets the Viability Matrix business strategy that you are aiming to achieve
Useful	-	provides insight into the pharmacy's operations
Easily understood	-	what it means is clear
Availability	-	making sure that you can easily access the data you need for the measurement

Paying attention to these issues will make sure that the process of measuring the progress of your change program does not take more time than actually conducting the change itself!

2.6.2 Using the measures to evaluate change success

When will you use the measures – and at what point will you take action as a result of your evaluation of the measures? You will need to set targets and assess what actions you will take if these are not achieved. For example, as one pharmacist outlined:

"You have to try and project it and say if you don't reach certain targets when you put it in, well, it's axed. ... So say in six months you know it's shown a particular growth or in 12 months hasn't reached a target, then one, you either try and promote it more...[or] You reconsider your position."

Another pharmacist referred to how, after eight months, they decided to opt out of a particular change program:

"...early last year we were approached by Diabetes Australia to put in a national diabetic prescription service agency, which we had some reservations about in the beginning because of the cost involved, the set-up cost and the ongoing prescriptions eight months down the track we actually discontinued the service becauseit was costing us money so in the end we decided to discontinue it."

Other referred to how they focused on achieving "process" measures, such as with the time spend on conducting HMRs:

“That’s right, two hours, that’s it. If you start spending more than two hours you would start to think; ‘is this worth it or not?’ from a monetary point of view. And you’ve got to set yourself those targets because we’re actually going to a person’s home and leaving the pharmacy. I give myself half an hour - I was in and out in half an hour. At the worst of the lot I might get to an hour, but then that’s all part of using two hours as the maximum doctor contact, patient contact, writing it up, back to the GP and all that sort of stuff.”

At the same time you will need to ensure that you have given the change program enough time to get under way that measurable results are likely to be evident. This means making sure that you understand the difference between *leading measures*, that is, those which will show quick results associated with the change, and *lagging measures*, those which will be slower to show up, such as overall pharmacy performance or pharmacy image.



Questions to ask at the end of this stage:

2.6a. I have reviewed the business measures I will use to assess change in the pharmacy and have ensured that these measures are in place and operational

☐ Yes ☐ No

2.6b. I have determined the timing and targets needed to determine if my change program is achieving its goals

☐ Yes ☐ No

2.7 Assessing Risk



Given that change always involves some uncertainty in terms of how it will proceed and what will be the final outcome, you need to be aware of the potential risks which may arise for you and your pharmacy. The fact that risks exist does not mean that change should be avoided; rather, awareness of potential risks means that they are unlikely to surprise you should they arise. In addition, you should already have in place potential options and strategies for how to deal with them if they do arise.

At a time when there are a variety of other businesses interested in moving into the traditional territory of pharmacists it also needs to be remembered that there are risks in not changing. Changing to better realise the capacities of the pharmacy industry to deliver services is one way of demonstrating the continuing need for the industry as a national resource able to deliver valued services in a coordinated way to the Australian community.

Staying the same, not changing, and not realising such capacities in itself places the industry at risk – and, in the longer run, the value of your pharmacy operation.

In this section we will be mainly concentrating on awareness of the risks of change – and ways of assessing this for your pharmacy. In particular, we explore four key risks mentioned by pharmacists in conducting change. These are risks associated with: reputation, coordination, new liabilities and inadequate return.

2.7.1 Reputation

In the Resource Availability segment of the Change Readiness Wheel you will recall that having reputational capital appropriate to the service you intended to implement was an important component of preparing for change. While change will often enhance your reputational capital, the reverse could also apply, that is, your reputational capital may be damaged or diminished. In practice, we came across few instances of this occurring in our consumer forums. However, given the importance of the image of “trust” which is often associated in the local community with the local pharmacist then this reputation is something that you need to protect. It could be damaged in a number of situations such as:

- where constituents feel that your pharmacy no longer serves them well
- where the advice that you offer is contradicted by other experts, or is wrong
- where the products that they seek you no longer stock due to your assessment that they do not add sufficient value to your pharmacy
- where the values held by consumers are not matched by the pharmacy or that they perceive that there is a lack of social responsibility in the actions of the pharmacist

Reputational capital can be affected by another’s reputation and that may affect the trust the local community may have in your advice. For example, some pharmacists have elected not to offer methadone services on the grounds that it would affect their reputation with other customers – although others have found ways of doing this without it impacting upon their existing customer base.

2.7.2 Coordination

As we also saw in the Resource Availability segment of the Change Readiness Wheel, depending on the service that you intend offering you may need to coordinate with a range of stakeholders to ensure that it is successful. One risk is always that an external stakeholder will not be as cooperative as you wish or not deliver their part of the service in a timely and reliable way, or at a quality that you expect.

However, coordination risks also alert you to the need to coordinate your internal pharmacy systems in such a way that you can deliver what is expected of your pharmacy if you offer a service. Failure to deliver to customer expectation is a risk in that it can lead to a loss of revenue, where they go elsewhere for the service, and possibly loss of customer loyalty where their expectations remain unfulfilled. In this respect, one pharmacist referred to a lack of coordination involving his banner group which marketed a program:

"...that went out in a brochure, and people came off the street at all sorts of times and said, you know, 'Will you take my blood pressure?' We just weren't equipped to do it at that point in time. So I actually didn't do any for that month, and I went back to them and said 'If we're going to do this it needs to be done well, we need to notify GPs in the area, I believe you probably need to have a designated time of one afternoon a week when you're going to do it, you either get a health nurse in to do it.' And so I think it becomes quite complex...."

As another said,

"Why go and spend a hundred grand on a marketing programme to attract extra customers in the store when you can't even service your existing customers?"

2.7.3 New liabilities

New activities create not just new opportunities but also new liabilities for pharmacists of which they need to be aware. While most liabilities may remain unrealised, where they are realised as one pharmacist said bluntly "you can get sued". By way of example of some of the risks and liabilities, this pharmacist said:

"Well, if you do a blood test thing and you've got like needles and things and if a customer pricks their finger, you have to send out signed consent forms. I mean even to do piercings you have to sign a consent form. You have to get permission from the local council. They do checks"

Having in place quality controls and systems is one way of minimising such risks. However, these controls and systems require a commitment of time and resources which you may find difficult to put aside. As this pharmacist outlined further:

"If you're a small pharmacy, it's not possible to do everything, you just don't have the time"

This difficulty, of putting aside time and resources to minimise risk, was referred to by another pharmacist. This was in relation to compounding and the need to retain a sample of the product:

"Unless you do that, there's no point in doing it because you have to be able to protect yourself legally. The only way to do this is to have a sample of that particular sample you have made ... and then you have to have an independent test by an independent laboratory. You can't do that in a normal situation."

In discussion with other pharmacists about non-health services that they decided not to implement, such as Automatic Teller Machines and banking at pharmacies, they referred to security liabilities and risks such as "Handling money. We have enough pressure!".

2.7.4 Inadequate returns

As we saw in the Profitability Perspective section of the Change Readiness Wheel, you may decide to enter into a new service or change with different expectations of the

financial return that you expect from it. Where it is a large change and investment then it is likely that your expectations for a financial return will be much higher. In particular, where your pharmacy is smaller, you may lack what is referred to as “slack resources”, that is, the ability to absorb in one section of your operations financial problems which emanate from another part. This can occur when you have planned for financial returns on your investment which are delayed or not forthcoming to the extent that you have anticipated. At the end of the day “You have to get a return on every square metre of the business”.



Questions to ask at the end of this stage:

2.7a. I have assessed potential risks in the following areas:

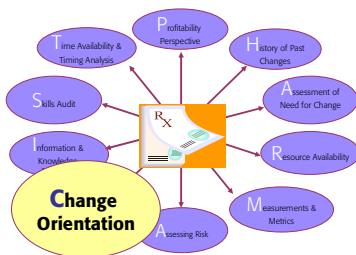
- reputation
- coordination
- new liabilities
- returns

☐ Yes ☐ No

2.7b. Where necessary, I have taken appropriate risk reduction strategies

☐ Yes ☐ No

2.8 Change Orientation



Your orientation to change – whether you seek it out and embrace it, or avoid it – will have a large impact on your willingness to both engage in change and sustain your commitment to change once it is underway. It is instructive to remember that often what we say and what we do are not always aligned. We may say that we are open to change, but deep down will do our best to avoid really taking it on in a meaningful way. This is what Kegan and Lahey (2001) refer to as our “big assumption”, that is, the inner assumption we hold that often undermines what we openly say we are committed to doing.

For example, on the one hand you may say to your staff that you want to take on a range of services or new products because you need to present a more professionalised image for your pharmacy, either to customers or the wider pharmacy industry; but on the other hand, deep down you think that the main thing you should really do is continue to do

things pretty much as you have always done and “not upset the apple cart” in case the change fails and things become worse in the future. In this case the underlying assumption stops you from really engaging in undertaking change in a way which will lead to success.

By the same token, you may know in yourself that you’d rather not change (“what I want”), but recognise that you will need to change (“what I know I need to do”) in order to “stay the same” given the pressures on the pharmacy industry. At a time when the pharmacy industry is under threat from outside industries, such as supermarkets, this issue of “what I want” compared to what I recognise “I need to do” is nicely captured in the following quotation from a pharmacist:

“I mean there are going to be guys out there that just want to do what the old guys are doing as well. I think everyone has probably recognised now that pharmacy does need to change.”

However, whether this recognition is acted upon throughout the industry is another matter. One stakeholder pointed to different orientations to change within the pharmacy industry: some are ignoring it, some are confused by it and others are taking active steps to embrace it:

“We recognise the need for the change but we haven’t sought at this stage to provide service or advice or assistance in that component of that. We talk about this homogenous pharmacy industry. I think it’s so far from homogenous. There’s 5,000 individual CEOs out there and, forget the percentages but there’s about 1/3 of them that ...quite frankly [have] got their head in the sand and they’re just hoping like hell that they’ll retire before the change hits them. There’s another percentage that I’d describe as rabbits in the middle of the road with a stop light on them, that are trying to work out which way to go and they know it’s going to change and they’re not sure which way they’ll turn and then there’s another percentage that are professional entrepreneurs, they play golf twice a week, they have managers running their front of shop, they have managers running their dispensary and their focus is on innovation, differentiation, and are comfortable with change. They will pilot or prototype new models”

This type of pharmacy characterisation: “head in the sand”, the startled “rabbit” or the “professional entrepreneur” forces you to think about what change orientation category you fall into and whether you think it is viable and relevant to your pharmacy’s current and likely future circumstances. Part of this research looked at what pharmacists’ attitudes to change were, it may be helpful for you to look at the detailed mail survey results (see appendix 3 Part C: Attitude to Change).

Our interviews with pharmacists point to two key things which impact upon your pharmacy change orientation: your generation and your professional identity.

2.8.1 Your generation

The impact of age and generational effects on your orientation to change came up many times in our research. It is also hinted at in the long quotation above in reference to those with their “head in the sand”. This relates not just to what services might be offered, but changes in terms of what stock should be maintained. For example:

"We still have a generation of pharmacists who believe the only way you can identify yourself in the market-place is to be seen as having better value than the supermarket ... I think it's a generational thing. As we get older and move on and other guys come through we'll find that'll fade away, because there'll be a higher professional regard to what we stock and don't stock. You can see that certain pharmacies do that already. It's going to take time. Those guys insist on having it. They insist on having these market leaders and insist on having loss leaders and all that other sort of stuff that goes along with it, without really looking at "How does that benefit the overall business?" You know, "What's the business plan behind that?"

Generation also impacts upon change because of its relationship to *pharmacy ownership*. You may be a younger pharmacist who can see the need for change in the industry, but lack control and influence over the pharmacy to achieve it because of your lack of ownership:

"The other issue I think you have got with change in the pharmacy industry is most, or a lot of pharmacies...are...owned by, you know, people in their late fifties early sixties who don't want to change and who are happy and are going to retire very shortly...The young pharmacists coming through do want a change and they recognise that things need to happen but because of the way the licences are set up they can't own a pharmacies so they can't change the way things are. So I think that's a big issue for pharmacy as well, just the ownership of pharmacy prohibits, you know, efficient change."

This situation creates what was referred to as "rear-vision mirror" pharmacists:

"Right now we've got a large group of pharmacists who've built up a large amount of equity and are steering their business in the rear vision mirror, hoping that the wall in front of them, they get out of the car before they get there."

However, we suggest that care needs to be taken in not over-generalising the impact of any one factor such as "generation" on your orientation to change. This was recognised in focus groups where pharmacists acknowledged the "entrepreneurial spirit" of "older pharmacists who want to get out there ...[as drivers] ...of change and do it". Nevertheless, as this pharmacist continued, in relation to younger pharmacists:

"we see them at trade shows, you know, and conferences all the time, you see a completely different attitude to pharmacy and you see an awareness that they think something needs to change and pharmacy needs to do something to develop itself"

As one of our case study pharmacist argued to us, traditional pharmacists are less likely to implement innovative solutions to overcome barriers and constraints to change – our research results confirm this.

2.8.2 Your professional identity: health care provider vs retailer and business manager

2.8.2.1 The identity dilemma

What is meant by professional identity is your perspective on the pharmacy industry, and your role in it as a pharmacist. This builds on the work done by Roberts et al. (2003). A key issue we came across here was the dilemma that many pharmacists struggle with in terms of which is their professional identity, often presented in terms of whether they are health care providers and/or business retailers:

"...some pharmacies are no longer small businesses and you know, they're small to medium size, and some of them in fact are quite large businesses, you know, many, many, many millions of dollars in turnover so it becomes very challenging and you tend to get stuck and you know, well I'm in the situation, am I a pharmacist or am I a business manager?"

2.8.2.2 Pharmacist as health care provider

The pharmacist as health care provider was referred to as a "caring" professional:

"we still care, very much care, or we have still got our self respect. I know if I was in one of those horrible professions like banking or some of those crooks I don't think I would have self respect. I think that is really important"

There are three "health caring" roles that are found in the pharmacy industry.

2.8.2.2.1 Pharmacist as educator

In this role the professional pharmacist sees their role as one of educator, assisting their local community by providing them with needed information in relation to health care and drugs:

"But the community education, I find, does certainly bring the people in to the pharmacy. It is very rewarding when you go to a little pensioner group..."

The fact that in a pharmacy "daily you can re-educate several people" and from this that "You can get good outcomes" is part of this education role. As another summed up this perspective:

"really, pharmacy should be educating patients about healthy cooking, healthy grocery shopping, to nutritional, vitamin supplements, maybe involved with the gyms and weight management."

2.8.2.2.2 Pharmacist as problem-solver

In this role pharmacists as health care professionals are not educators so much as “problem-solvers” in relation to their health care:

“we actually take a problem solving approach where anybody coming into the pharmacy has a problem they want help with, the problem is health related. What we do and what we offer is related to showing people can help solve the problem. If I can get everyone in my neighbourhood to come in when they have a problem, I’m successful as a local pharmacy. And that’s what we’re doing now.”

2.8.2.2.3 Pharmacist as loyal supporter

In this role pharmacists see that their local community is dependent upon them in a range of ways and their role is to support this community to fulfil their various health care needs. As one pharmacist summed up this role:

“we have very little concept of how much an integral part of each and every family that we deal with we are. We are part of their social network and framework. We’re always there and we’re taken the place of the priest and the confessional in a lot of ways. We’re someone they can talk to, we’re someone who can give them generally rational and good advice. And they welcome it.”

As another pharmacist put it, although there is much discussion about the loyalty of the customer to the pharmacy, the reverse also applies: “I think there is a lot of loyalty from a pharmacist towards the patient as well”.

Whilst you may have different understandings of the role of the pharmacist as “health care provider” – whether as *educator*, *problem-solver*, or *loyal supporter* – the overarching perspective is that:

“We are health care professionals. We [need] to promote ourselves that way. That’s the only way we can survive.”

2.8.2.3 Pharmacist as health care retailer & business manager

You may view your professional identity more from the point of view of being a retailer and business manager working in the health care industry. In fact you may see this as the only viable financial position for pharmacy (See Profitability Analysis section of this Change Readiness Wheel). This goes beyond simply being, as one pharmacist said, “glorified floggers of product” but to being “value-added” retailers as a way of competing against the “drain into the supermarkets [of pharmacy products such as ibuprofen]”.

A number of people referred to the need for pharmacists to become more focused on the retail and business management elements of pharmacy. For example, one pharmacist in focus group referred to the underdeveloped nature of “the way we look at our business and do our own evaluation on performance”. Another stakeholder referred to how:

"I struggle consistently with that issue in that pharmacists are not retailers and I think that is very apparent in pharmacy. Certainly the banner groups try and create that sense of retail and professionalism in retailing. But I don't think pharmacists truly understand the value of good retailing. We work with a lot of retailers and the amount of time and energy they put into presentation of their stores is tenfold more than a pharmacy will ever put in."

To summarise, what is important for you to understand is not that this professional identity dilemma exists within the industry, between being a health care provider and a health care retailer and business manager, but rather how you deal with it on a day-to-day basis as a pharmacist. How do you go about "solving" this underlying dilemma? In particular, how does this dilemma impact on your orientation to change? Does it lead you to avoid change? Or only consider change in particular directions (new services rather than new product lines, or vice versa?) or only see some changes as relevant or worthwhile pursuing compared to others? Part of your readiness for change concerns your understanding of these issues and how they impact upon your decisions about whether to change and what to change. It also entails being aware, as noted at the start of this section, of how your personal underlying – and perhaps unstated – assumptions about change need to be confronted early on, particularly where they may work against you successfully conducting a pharmacy change.



Questions to ask at the end of this stage:

2.8a. I have a clear sense of my professional identity as a pharmacist

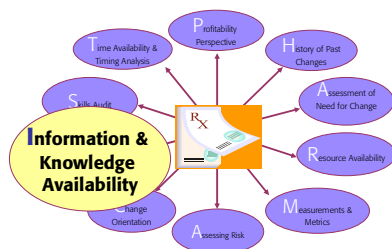
- retailer and business manager
- health care provider (educator, problem solver, provider of community support)

☐ Yes ☐ No

2.8b. I have determined how my sense of identity can be strengthened by introducing the proposed changes

☐ Yes ☐ No

2.9 Information and Knowledge Availability



Being knowledgeable about the change you seek to make, how to go about it and the implications that it may entail for you and your pharmacy, is another part of assessing your readiness to engage in change. One reason why you may not have implemented change in your pharmacy, including offering new services, is a lack of knowledge related to it and a

lack of understanding of how to go about acquiring relevant information. As one pharmacist said about why they had not implemented a range of services:

"There are some things where I just wouldn't know where to go to get the knowledge. ... I don't know enough to get the knowledge about weight management, I don't know enough to get knowledge about sleep apnoea testing, I don't know enough to get knowledge about hypnosis, nutritional support..."

2.9.1 Workable knowledge

Our interviews with pharmacists suggest that "practical" or workable knowledge is most valued. This type of knowledge is referred to in the field of management as "actionable" knowledge. Pharmacists are dismissive of knowledge that is too technical and not practical enough:

"Sometimes it's not relevant to our environment. They establish these things and while they might seem great ideas in their ivory towers, when at the coal face it doesn't work and it doesn't fit into our [context]"

You, like other pharmacists, may be interested in two types of workable or actionable knowledge:

- *knowledge about what changes to implement.* Given the range of choices available to you about possible changes and services that you could implement knowledge and information to help you to identify the ones best suited to your practice is important. In part, this decision-making process is related to your business strategy and where you see your pharmacy placed on the Pharmacy Viability Matrix. If you wish to implement a change you may be in the same position as some pharmacists in terms of not knowing :

"whether it's a completely new idea and you have to start from scratch approaching the Department of Health, or whether they've already been approached, and there's something out there similar..."

Other pharmacists referred to this type of knowledge as helping them to "see outside of our own four walls":

"It'd be nice if there was some research, not necessarily from a strictly academic point of view but just basically some numbers saying there's this many people doing it, there's this many people doing it [for] this amount of money, which might be part of the reason why you're doing it, but, you know, that sort of research report not just in one trade magazine but widely – or even as a special paper on its own – to give people an idea of what people are doing out there. So we can see outside our own four walls what people are actually achieving."

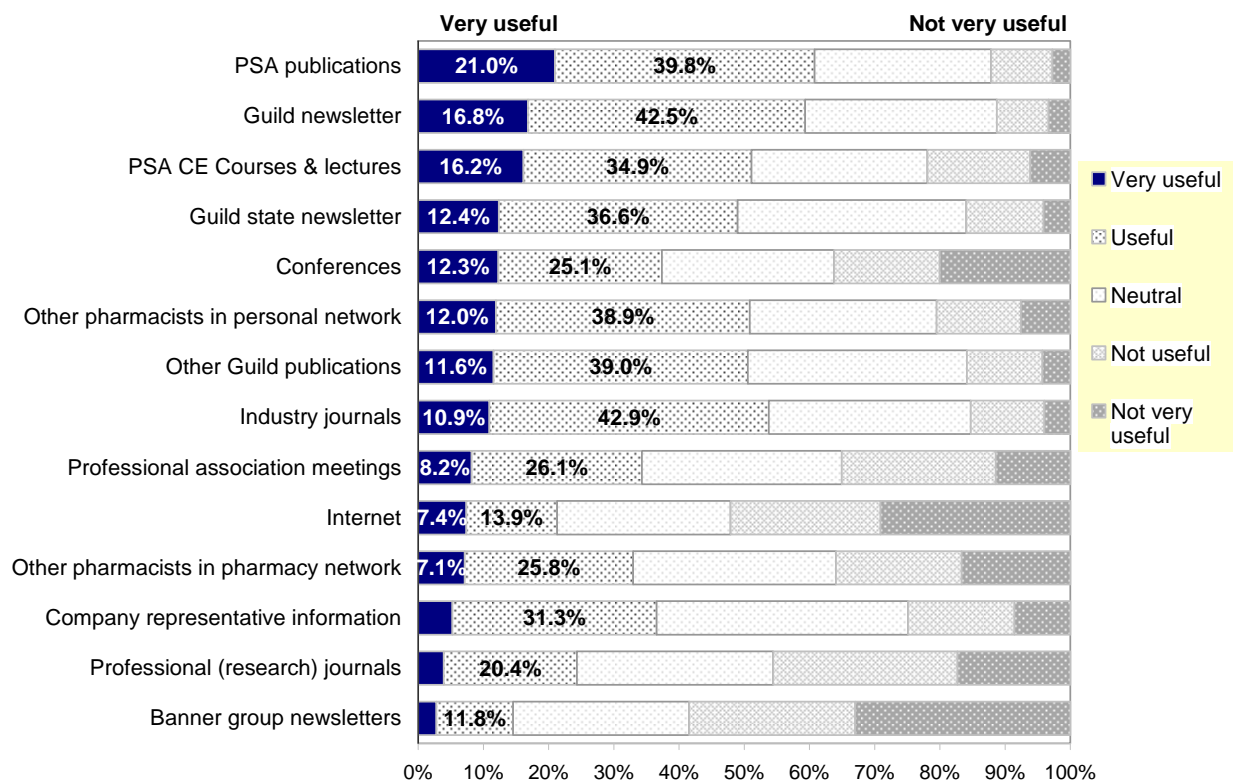
- *knowledge about how to implement change.* As is outlined in more detail in the Change Implementation Wheel, knowledge about how to implement change in general and specific types of change in particular is an important success factor in

pharmacy change. As one pharmacist suggested, case studies of successful implementation of particular types of changes:

"would help, I'm sure. you think, "Oh, okay, this is how they've done it". But I suppose why does someone necessarily want to share their [knowledge]? That's why it's a hard learning curve for each person. Each person has to do it for themselves."

To determine some of the sources for this workable knowledge in terms of implementing services the mail survey asked pharmacists to rank various sources of information relevant to new pharmacy services. The results are shown in figure 5.4.

Figure 5.4: Usefulness of various sources of information as ranked by the survey



PSA publications, the Guild newsletter and PSA CE Courses and lectures were ranked as the three highest sources of information, with approximately 20% for each indicating these were very useful. Some of the conferences specifically mentioned as very useful were: APP, PAC, AIPM and API. Examples of industry journals specified as most useful were: Pharmacy News, Retail Pharmacy, AJP, Australian Prescriber, Complementary Medicine, Pharmacy Trade, Gold Cross information, and Australian Doctor. All of these sources were prompted in the survey and do not include some of the more unusual sources of information from outside of the industry that are available such as business journals or books.

2.9.2 Strategies for obtaining workable knowledge

The question of how you can go about acquiring “workable knowledge” depends on your access to a range of information sources, some of which may be of more use to you than others. You will have your own favourite sources, as we have identified in the mail survey. In this section we identify five key workable strategies that pharmacists mentioned that they used to obtain workable knowledge about change. Roberts et al (2003) also found that being able to access the support and/or assistance of mentors, business advisers, and staff from professional associations, acted as a facilitator of change.

2.9.2.1 Mentors, community leaders and success stories

Each of these is a way of obtaining information about change. One pharmacist referred to how “people are looking for examples and models of ...success. ... that will inspire people to do it.” (Pharmacist, focus group). Still another referred to how, in relation to setting up a change which involved increasing system compatibility among local pharmacists to enable pharmacy information and technology transfer, they:

“...had pharmacists who were acknowledged I suppose as leaders in their community and we’ve used them quite extensively to help and support the implementation”

Change information is also obtained from mentors. For example, in relation to the above change program, mentors would:

“go into the pharmacies, check to see it was all going OK, work with all the staff about how the equipment works, and had they got consent and all of those sorts of things, so it’s very, very practical and operational support which I think has worked extraordinarily well, in supporting pharmacists to go on.”

In addition, a number of people referred to Guild-sponsored mentoring networks and resources kits in relation to programs such as HMRs as being an important way of providing information to pharmacists about change.

2.9.2.2 Alliances, networks and pharmacy industry organisations

Your access to these provides one important source of knowledge. One stakeholder referred to the importance of the Guild-funded Pharmacy Alliance project in coordinating local health care providers. This initiative assisted introducing other pharmacy changes such as MediConnect and generally assisting in knowledge implementation, knowledge sharing and problem solving. For example, in relation to the latter, a problem occurred concerning the location of keyboards in the pharmacy:

"The people that designed the process had thought it was a great idea but had absolutely no idea how far a pharmacist generally is from their consumers...And obviously in pharmacy, bringing someone into the dispensing area was not practical, having cords running everywhere for the keyboards, you know, there was a whole range of these sorts of issues. So we brought the pharmacists in to three or four of them and said, "Look, this is what we've got to do, how do you see yourself being able to do that?" and got their advice..."

Others referred to the importance of their banner groups in providing information, particularly through pamphlets and follow up calls:

"They'll always send you something out. They'll actually give you a call and make sure you got the pamphlet..."

2.9.2.3 On-line information sources.

Chat-rooms and other Internet-based forums represent another important way of sharing information about change and change implementation for pharmacists. This is seen as the case for industry-wide change programs such as the Guild-sponsored ones around HMRs. Others referred to how they use AustPharmList, through which they obtain information and change implementation support on-line:

"And then you find through there that some people that really have expertise [and] knowledge and then you can email them direct as well. I have done that a few times."

2.9.2.4 Journals and magazines.

Trade magazines such as InPharmation are useful sources of information. In addition, one of our case study respondents mentioned how they:

"are spending alot of time keeping in touch with pharmacists in the US with regard to Professional Compounding Chemists Association, the sorts of things that are happening over there. There are journals and things. There's a national pharmaceutical journal which gives you break downs on a month by month of the sorts of things that compounders are doing. Private research, things that we've got, the pet projects."

2.9.2.5 Seminars.

Another forum you might use to obtain information is through seminars such as ones run through various community programs and hospitals as a way of "educating the pharmacist to build up their confidence". Some pharmacist referred to how it was often difficult for them to attend these because of when they were offered; however, others in rural and remote regions spoke highly of the Guild assistance in attending such sessions:

“Yeah, the rural and remote, you know there is funding there to fly you to Adelaide which we’ve actually used. You know, in terms of transport and even to things like the convention in Melbourne or any of those sorts of things. We’ve used it on a number of occasions which is fantastic.”

In summary, there are a range of information sources from which you can obtain “workable knowledge”. We have outlined five of these but there may well be others that you utilise. Your ability to identify which of these are available to you, and which will provide the “workable knowledge” appropriate to your pharmacy change, becomes an important consideration in assessing your readiness for change.

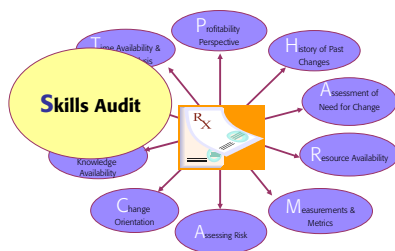


Questions to ask at the end of this stage:

2.9a. I have determined the ‘workable knowledge’ needed to introduce and implement the proposed changes ☐ Yes ☐ No

2.9b. I have strategies in place to obtain the knowledge needed ☐ Yes ☐ No

2.10 Skills Audit



In our survey of pharmacists, 85% indicated that the availability of training for a new service was either important or very important in their decision to introduce a new service. This is an important finding because it indicates pharmacists’ perception that they need new skills in order to introduce new services into their pharmacies. Our interviews and focus groups suggest that as a pharmacist you are likely to appreciate the need for skill acquisition for your pharmacy in three areas:

- New product/service knowledge skills
- People skills
- Business management skills

The readiness of your pharmacy to engage in change will depend upon the extent to which these skills are present in your pharmacy, or able to be accessed relatively easily and in a timely way.

2.10.1 Skill areas

2.10.1.1 New product/service knowledge skills

You may be like many pharmacists who see that a key obstacle which needs to be overcome when introducing a new service is “Your own inadequacy” and the professional desire not to “do a mediocre job”. In contemplating change you will often want “...to know if there [is]...training available for that service or that product category...”. This is because:

“A lot of the services require quite special information, knowledge, skill and facilities”

For example, as one stakeholder said in relation to HMRs:

“Are people confident in that they can provide this service? I mean in HMR... there’s a lot of pharmacists that don’t believe they have the competence or the confidence to provide the service so it’s overcoming that as well. Am I a pharmacist able to deliver the services to the standard that I’m expected to?”

This situation:

“means you have to upskill, you have to always, when you’re introducing a new service, you have to upskill... your whole pharmacy.

“Upskilling” has to cover not just yourself but your whole pharmacy, including pharmacy assistants. This is nicely outlined in the following quote, discussing introducing smoking cessation and weight loss programs:

“...when you are getting into smoking cessation, or weight loss program, you really do need switched-on girls that do know their products. You can’t do it all yourself. That is one thing that you have to realise, is that people are the key. Good people ...the best people you can have around you to make your business sink or swim. So, having them trained properly and efficiently ... We had a staff meeting the other day and the girls even said “Give us some more training. We need more training”.

Skills can also become out-of-date:

“...medicines have changed a lot...there are so many new products and just keeping up on top of the knowledge base that you need .. the skills that I learned in 1969, 1970 and 1971 are pretty old hat now. Even right down to burns management and that.”

If your pharmacy is staffed by older pharmacists their motivation to upskill in relation to introducing a new service may not be as high as others:

"Yes. That [is a] big hurdle. I note that for us guys with the old apple just about to fall off the tree, there is the opportunity to say .. too hard, don't want to go there, that barrier is there."

2.10.1.2 People skills

Some services, where they involve other health care providers, will require particularly well-developed people skills in coordination and negotiation. More generally, the need for well-developed people skills in your staff is common both to the everyday operation of your pharmacy and to the introduction of most new products and services. One pharmacist referred to the importance of such skills being present in all staff and cited their dispensary manager as a case in point:

"I have a dispensary manager here, who's not a pharmacist. She gets paid a very handsome salary. She's a grade 3 dispensary tech and she's not only a great rep, but she's very very skilled in life skills basically. One of those life skills is strength of character and honesty and integrity. Another life skill is just her human resource [and] communication skills"

Another pharmacist pointed to how, where these skills are present in large pharmacies, they may substitute for the type of service levels that people more traditionally associate with a small, community pharmacy where there is traditionally closer one-on-one contact with customers and pharmacists:

"...I've got a very strong view that that feeling of recognition and acceptance and help that people get has nothing to do with (a) being the one person there all the time or (b) the size of the pharmacy or even what pharmacies offer. What it has got to do with is the interaction capabilities of people, customer interactions and if that's managed in a considerate and perceptive way, then people get that recognition they're looking for, and I think that could be taught in pharmacy. I think in most pharmacies it's overlooked as a real needed skill. We go into it in great detail."

A number of pharmacists commented that although communications was taught in pharmacy courses there was not a strong enough focus on "a practical level" (Pharmacist, focus group) with another expressing surprise that "pharmacists are not given training on interpersonal skills" (Pharmacist, focus group). As one educational stakeholder acknowledged, in response to a question about what sort of skills graduates need now compared to twenty years ago:

"Well part of the skills that they need to develop is the ability to talk to people and ask questions, that's the first thing."

2.10.1.3 Business management skills

Whilst, as one pharmacist said "There are some red hot managers out there", another commented, bluntly, "We're notoriously bad business people... that's half the struggle." A strongly held view that we came across was that pharmacists have little in the way of formal training in business management skills. As one stakeholder said "business training

for pharmacists...seems to be almost entirely absent". Another stakeholder pointed out that "The majority of them are trained to be pharmacists. They are not trained to be businessmen, or women, although a lot of them learn it along the way." The result, as argued by another stakeholder, is that "pharmacists are not good retailers. They are not trained in retail. They are poor retailers".

In part, this lack of training in business management has been less problematic where the industry has been:

"in a reasonably controlled situation, in other words 85% maybe 90% in terms of real dollars are protected dollars. They're not competitive dollars, they'd be competitive with another pharmacy maybe [but]... the handling of that from a business point of view is relatively simply even with no training."

However, as the industry changes and enters a more highly competitive business environment so will there be increasing pressure to ensure that good business management skills and efficient organisational processes are in place. This may well be something that you need to pay careful attention to in implementing new services, especially where they are not reliant on government funding and may operate in more of an open market. As one pharmacist said in relation to introducing new services:

"I don't think a lot of the pharmacists when they start really focus at putting good administration and management into their operations"



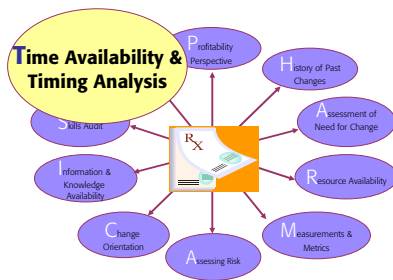
Questions to ask at the end of this stage:

2.10a. I have identified the people skills needed to make the change and have practical plans in place to ensure that these skills will be available as required ☐ Yes ☐ No

2.10b. I have identified the business management skills needed to support the changes and have plans in place to augment my skills or the skills of others where necessary

☐ Yes ☐ No

2.11 Time Availability and Timing Analysis



Assessing your pharmacy's readiness for change means paying attention to issues of time and timing. Your ability to implement a new service or change will depend upon the time that you make available to do this. Often the time commitment that is needed is underestimated. Time commitment issues relate to time to *evaluate* the change, time to *prepare* for the change and time to *implement* the change. Pharmacist mail survey respondents indicated that setting aside time for new initiatives was a difficult task, with just under half agreeing or strongly agreeing that they set aside time to support new initiatives in the pharmacy.

Two other issues are also relevant: the effect on quality of life, and the timing of the change – whether it should be introduced *now*, given all the other things that you are currently doing. You will need to evaluate each of these areas to determine the readiness of you and your pharmacy – as well as consider what strategies you should employ to free up some time for change. Each of these issues is addressed in what follows.

2.11.1 Time to evaluate the need for the change

You may avoid considering a specific change on the grounds that you're "time poor" (Pharmacist, focus group) and lack the time to evaluate whether it is something that you should pursue. As one pharmacist put it "when you're running a busy pharmacy where everything else is happening, it's very hard". As another said "How could you find time to evaluate a new service and see where you fit in? Really!" By way of example yet another pharmacist declared:

"We have been looking at that – on a less formal basis – with a...medical centre. We do have a lot of ties with the medicos through a good working relationship. But we haven't got enough time to sit down and formally discuss [the possible change]"

2.11.2 Time to prepare for it

Assuming that you have had time to evaluate a possible new change and wish to proceed, another element of your change readiness will depend upon having adequate time allocated to prepare for the change. For example, as we saw in the Skills Audit section of the Change Readiness Wheel, a specific change will often require acquisition of new knowledge or accreditation processes to be introduced into the pharmacy before the

service can be offered. You need to be able to put aside time for training, both for yourself and your staff. This can involve significant time commitment, as evidenced in the following quote:

"I looked at it in 1998 and I got my accreditation in 2001 and it took me three years to get my case studies. It's a lot easier now because in those days, you had to attend weekend courses and get case studies on your own."

By way of another example, if you wish to move into compounding, many months or possibly years are likely to be needed when taking into account planning, training in compounding and marketing to customers, all to be done while running the business:

"for someone...from when they first identify that they want to get into compounding to when they are set-up properly and really starting. This isn't something that, you know, you can just wack up a compounding pharmacy in three seconds, you have got to set-up, you have to do a lot of paper work documentation of what you are doing, reporting of batch numbers etc, etc"

2.11.3 Time to implement it

Once you are ready you will need to allocate time to actually offer the new service. This is time that is taken away from other activities if you are doing it "in-house" as opposed to contracting it out to other pharmacists, etc. To go back to the example of compounding:

"there needs clean down plus the preparation time, then there is the counselling of the patients, you know, a script could take, from the time you get the script through to the time you actually dispense it, plus the counselling it could be three or four hour process in some instances. I mean it is going to be much shorter if you have your repeat."

Similarly, with HMR, the scheduling of when they can be done is a timing issue which needs to be addressed:

"I am going to reiterate the time and I find it really difficult if you are managing the pharmacy, you are doing the business side of it. I mean, I am not accredited to HMR I just do the initial interview and then contract the service out to a pharmacist but to go after hours, which is what I have to do, to do an interview. I mean, you are doing that at 5.30 - 6 o'clock at night or in the morning it's not even viable for the consumer, I think. I just have not found it very easy with Home Medicine Reviews."

Even where reviews or counselling might be done within the pharmacy this can be unsatisfactory where other issues serve as interruptions:

"But, you know, if they come into to the pharmacy, you are not giving them your full attention because...I'm dispensing, I've got to check scripts in between. I'm theoretically...supervising S3s obviously, but transactions as well. I use it in situations, especially when the consumer doesn't want me to be in their home. They come in. And it has worked out well but I probably wouldn't do it normally."

As another pointed out:

"Unless you've got another pharmacist there, you can't take off and go and do your interviews. I do mine after hours."

However, even after hours will not always be available to you where you are already on after hours call-outs such as to a private hospital or a nursing home.

2.11.4 Time versus quality of life

Where after-hours training or implementation of services is necessary this is likely to raise quality of life issues for you to balance – both for yourself and your staff. For example, it was pointed out to us that there are a number of single-parent pharmacists who have specific time issues. One person in this category told us:

"There are a lot of pharmacists out there who are single parents. When do you find the time to do this: to work, look after your family and do continuing education? Are you supposed to work a 60-hour week? This is a real quality of life issue."

Others pointed out to us that quite a number of pharmacists work part-time for life-style reasons and were often not willing, at least on a voluntary, self-funded basis to go through the process of training or accreditation

2.11.5 Timing of the proposed change

Even though a change may be potentially attractive you may choose not to pursue it, or at least delay pursuing it, because of the lack of favourable conditions conducive to change that are currently present within your pharmacy. Aside from a lack of resources, this may relate to your plate being "too full" at present or alternatively that you are "change weary".

2.11.6 Plate too full

You may feel that there are too many other things going on in your pharmacy at present to introduce a new change. As one pharmacist said:

"Well, frankly, I feel like I've got enough now on my plate without doing new stuff."

Another, who pointed out he was so busy, being constantly interrupted and not being able to "ever get a clear run at anything" said that when asked to consider a new service he felt "God, I just couldn't be stuffed". This situation is compounded where you want to be able to do things to a professional standard but know that you will lack the necessary time to achieve this:

"Am I as a pharmacist able to deliver the services to the standard that I'm expected to, to do? Time ... [of] course comes into it."

2.11.7 Change weary

Another timing issue relates to whether you feel that you and your pharmacy have already experienced too much change lately – that you are “change weary”.

“but this is an issue that when you sit back and look at it over the last couple of years we’ve asked pharmacists to become involved, you know “Get your act together on schedule 2, schedule 3” go and ask all these questions. You’ve gotta join the QCP program and get that up and running and become accredited to that. You should be doing HMR’s blah blah blah and you’d be looking to adopt, to take on, to quote “Too much change upon that is another issue”. That’s certainly, certainly the thing.”

2.11.8 Strategies for freeing up time

The discussion to this point nicely illustrates how you will need strategies in place to free up time in order to implement a new change or service. As one pharmacist said you need to “budget your time”. Different options are available to you. Some pharmacists cited belonging to a management group as bringing several advantages in this regard including a close network of professional peers (that they can call on for time-saving advice), and a central administration (to conduct a range of business and marketing activities) thereby reducing the workload in these areas on individual pharmacy owners. Lack of staff is clearly an issue that may face you and having flexible working arrangements in order to take advantage of staff who may wish for only part-time work or contracting out parts of a service are other potential strategies to consider. Finally, paying attention to the most efficient way of implementing a service is another strategy for reducing how much time is needed. For example, in relation to HMRs some pharmacists are working on business models to make more efficient the amount of time devoted to this activity:

“We’re at the moment trying to sort of work on some ... business models for HMRit isn’t worthwhile for \$140 if you’re spending five and six hours on it. You know, unless you’ve got ...your techniques refined so you’re spending x number of times on it and x number of minutes on the interview and x number of minutes on the write up and that it ain’t cost effective...Again that comes with practice and the better, the more you do the better you do, the more ...you can use ...software programs that help you [with] ... a lot of the writing up etc ...that will cut the time down. A lot of people struggle to do it within, you know, several hours, four or five hours and others can knock them over in two hours or so and that’s roughly it.”

**Questions to ask at the end of this stage:**

2.11a. I have allocated sufficient time of my own for preparing for and making the change

☐ Yes ☐ No

2.11b. I have designed efficient change strategies which will reduce to a minimum the time needed by my staff and myself to introduce, implement and manage ongoing change.

☐ Yes ☐ No

We now suggest that you complete the Pharmacy Change Readiness Assessment instruments on the following page by entering your answers to the questions at the end of each segment of the Change Readiness Wheel.

2.12 Pharmacy Change Readiness Assessment⁸

Directions: Answer each of the following questions relating to the segments of the *Pharmacy Change Readiness Wheel*. If you are in doubt about what the questions mean, refer back to the appropriate segment of the previous text discussing Change Readiness. When you have answered the questions below, calculate your total score out of 20.

Ranges:	
16 – 20	You're ready – go for it!
11 – 15	You're close – increase your success by addressing all negative scores
6 – 10	You need to work on a range of organisational areas before commencing the change
Less than 6	Stop! Address fundamental business issues before attempting to introduce change

2.12.1 Questions

Profitability Perspective

2.2a. I have clearly identified my profitability perspective for the introduction of this service

☐ Yes ☐ No

2.2b. I have made a detailed cost/benefit analysis and identified an acceptable level of profitability for a clearly specified period

☐ Yes ☐ No

History of past changes

2.3b. I have reviewed my pharmacy's record of introducing services and am clear about how these changes have impacted the pharmacy staff's attitudes to the introduction of future changes

☐ Yes ☐ No

2.3b. I have taken appropriate action to reinforce past learning and to deal with any residual negative attitudes to change on the part of individual staff members

☐ Yes ☐ No

Assessment of the need for change

2.4a. I have reviewed the need for change (pressures for change from stakeholders and new market opportunities) and have made a thorough market assessment

☐ Yes ☐ No

2.4b. Using the Pharmacy Viability Matrix I have identified the business model my pharmacy is pursuing and determined that there is a clear fit between the new service and the pharmacy's future vision or I have readjusted my business strategy to one of the other three quadrants in the PVM

☐ Yes ☐ No

Resource availability

2.5a. I have reviewed the major resources needed to deliver the new service (e.g. space, staff) and taken appropriate action to ensure that they are available

☐ Yes ☐ No

⁸ This scale builds on Stewart, TA (1996) "Rate Your Readiness for Change" Fortune 23 April: 8-10

2.5b. I have reviewed the reputational capital (external alliances and relationships) and working capital needed to deliver the service and taken appropriate action to ensure that they are in place ☐ Yes ☐ No

Measurement and metrics

2.6a. I have reviewed the business measures I will use to assess change in the pharmacy and have ensured that these measures are in place and operational ☐ Yes ☐ No

2.6b. I have determined the timing and targets needed to determine if my change program is achieving its goals ☐ Yes ☐ No

Assessing risk

2.7a. I have assessed potential risks in the following areas:

- reputation
- coordination
- new liabilities
- returns

☐ Yes ☐ No

2.7b. Where necessary, I have taken appropriate risk reduction strategies

☐ Yes ☐ No

Change orientation

2.8a. I have a clear sense of my professional identity as a pharmacist

- retailer and business manager
- health care provider (educator, problem solver, provider of community support)

☐ Yes ☐ No

2.8b. I have determined how my sense of identity can be strengthened by introducing the proposed changes ☐ Yes ☐ No

Information and knowledge availability

2.9a. I have determined the 'workable knowledge' needed to introduce and implement the proposed changes ☐ Yes ☐ No

2.9b. I have strategies in place to obtain the knowledge needed

☐ Yes ☐ No

Skills audit

2.10a. I have identified the people skills needed to make the change and have practical plans in place to ensure that these skills will be available as required ☐ Yes ☐ No

2.10b. I have identified the business management skills needed to support the changes and have plans in place to augment my skills or the skills of others where necessary

☐ Yes ☐ No

Time availability and timing

2.11a. I have allocated sufficient time of my own for preparing for and making the change ☐ Yes ☐ No

2.11b. I have designed efficient change strategies which will reduce to a minimum the time needed by my staff and myself to introduce, implement and manage ongoing change. ☐ Yes ☐ No

2.13 Conclusion

This all may seem a little daunting – but then change can often feel that way! The scoring system above is obviously flexible and based upon interpretation – but it will give you a realistic idea about your pharmacy change readiness. Like a ship’s navigator setting out to sea, you will not always be able to anticipate the weather, tides, currents and other unexpected events that you will experience along the way. However, having a realistic view of the capabilities that you have on board at the start of your change journey will provide you with the confidence that you will be able to meet these challenges as they arise. In addition, having a good understanding about how to plot your change course and chart its likely direction – the task of implementing change – is just as crucial, and it is to these skills that we turn in the next chapter

Section 5: Chapter 3

3 Pharmacy Change Implementation Wheel

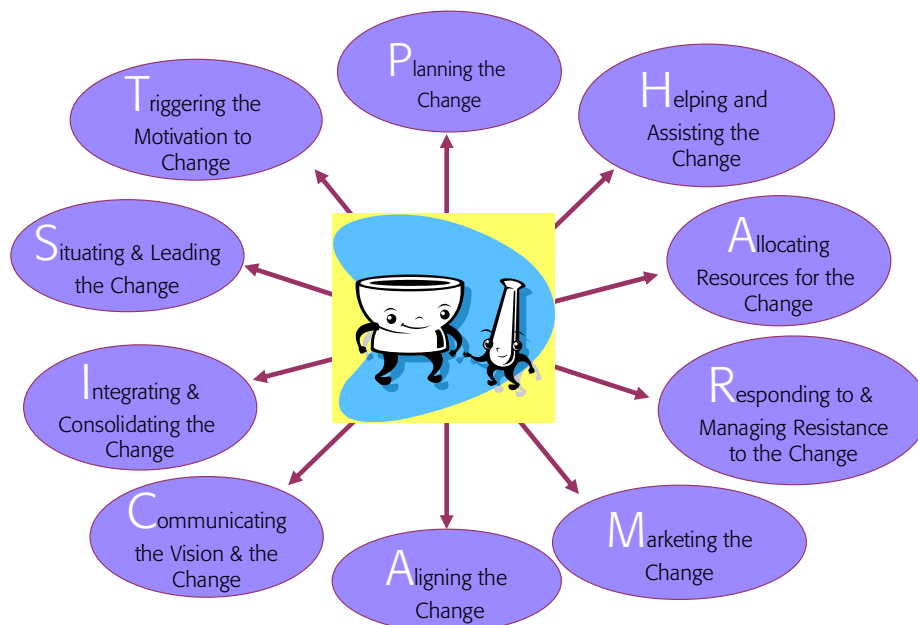
3.1 Introduction

When you have satisfied the criteria of change readiness for your pharmacy, the time has come to begin the actual implementation of change. The implementation of change towards greater service provision requires working on the issues defined by the ten segments of the Pharmacy Change Implementation Wheel (see figure 5.5).

The wheel was developed following extensive consultation with pharmacists and other stakeholders through focus groups, interviews, case studies and the mail survey. It brings together our knowledge of change management with the realities of practice, and builds on the work done by Roberts et al. (2003). You will see that there are a number of quotes under each of the headings; these have been directly taken from participants in this research. Where appropriate we have also added quantitative material.

We have written this chapter using “you” to facilitate pharmacists using it as a practical change tools.

Figure 5.5: Change Implementation Wheel

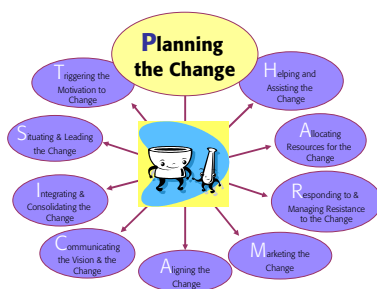


These actions are derived from a thorough review of the organisational change literature and application of these to the particular circumstances of increased service provision in pharmacy (for further reading see 3.12 in this chapter).

The implementation of change is the central issue for management today. It is not enough for governments to develop social policies in areas like the provision of health services or for owners and managers of businesses such as pharmacies to develop business strategies. No matter how appropriate the government policies or how sound the business strategies, they are mere words on paper until translated into the concrete day-to-day actions of people. In the case of pharmacies, strategy is implemented when it is understood by all pharmacy personnel who translate it into meaningful action in relation to customers and other key stakeholders. The challenge for you is not primarily to strategise but to succeed in embodying strategy in your own behaviour and the behaviour of all who work with you in the pharmacy.

The Pharmacy Change Implementation Wheel is designed to help you ensure that this process occurs and occurs as effectively as possible. We suggest that, when initiating change, you review each segment of the wheel and, in particular, answer specific questions in relation to the change program you are undertaking. These questions are found at the end of each of the ten segments in this chapter. We suggest that you pay particular attention to issues which relate to lower scoring items on the Pharmacist Change Readiness Wheel as these are areas that could pose particular problems as you go forward. As the change program proceeds, revisit each issue on a regular basis to ensure that you are paying adequate attention to it. The ten segments are not meant to be sequential steps — we are not suggesting that you start with “Planning the Change” and pay attention to “Triggering the Motivation” only when you have worked on each of the others. You will need to be involved in most of these kinds of actions throughout your change program. Nevertheless, the attention you pay to some will peak at different stages of your change program. For example, you are likely to spend more time on planning early in the change program and more time on integrating and consolidating later.

3.2 Planning the Change



3.2.1 The importance of planning

Planning is a vital element of change — without planning, the change process can be chaotic, aimless and reactive. In planning change, you are creating a roadmap for the future of your pharmacy by envisioning how your business strategy will be implemented

over a specific period of time. Your plan is a practical timetable and set of priorities for strategic change that will introduce and/or increase service provision by your pharmacy or network of pharmacies.

Planning to introduce new services can be scary:

Interviewer: *"What have you learned that were absolute nuggets of wisdom about implementing a new service in a pharmacy?"*

Respondent: *"Find a new job!"*

As a manager you have two different and sometimes conflicting tasks. On the one hand, you have to manage ongoing operations so that the pharmacy continues to operate efficiently and be financially viable on a day-to-day basis. On the other, you have to introduce change that modifies, even disrupts, the ongoing operations so that the pharmacy will be viable in the changed environment of the future. Effective planning of change modifies the disruptive impact of change on ongoing operations so that the change is phased in systematically.

If you fail to plan to introduce changes in an environment that is being transformed, then change is generally forced upon your pharmacy by events outside your control. It is better to be proactively introducing change so that you are in charge of it than to have change imposed upon you from outside the organisation.

If planning is to be effective there are two factors to be taken into account that could sabotage your planning. One is the expectation that you will gain immediate rewards from the time spent planning:

"You have to do the proper research and plan. I wouldn't expect immediate returns the same way you do with goods. There is a lag time for returns..."

The other is that planning, and ongoing planning in particular, can be squeezed out by the demands of managing operations so that the urgent drives out the important.

"Pharmacists are bad at prioritising. Things are urgent all the time and that's really difficult, I think...in that environment because you've got urgent things all the time. The tap's leaking; Mary can't come in to work today; you've got 15 scripts to do; and a rep's sitting there. Well, you've somehow got to prioritise all those...so we're not good at prioritising, we're not good at long-term thinking..."

If you are to make planning work, you must accept that the payoff will not be short term and you must make time available on a regular basis for ongoing planning.

"What we do is we talk about it at the planning meeting in the morning – if there's something we want to bring in, then we set up a project meeting, which is, perhaps, you know, early; so instead of coming in at 8.15 we come in at 7.30 and set up the project head and the project head will work out the commitment – well the aims of the project – the commitment, the cost, the timing and the content..."

3.2.2 What does change planning consist of?

An effective change plan has the following characteristics:

- a clear relationship to the business strategy being pursued by your pharmacy, expressed in defined goals which the change process is designed to achieve, including improved health care outcomes
- a specific horizon in which the plan will be implemented
- a clearly defined scope (i.e. size and range of activities); if the scope is significant, the total project may be broken down into specific subprojects with their own plans
- sub plans for each of the other nine elements of the Pharmacist Change Implementation Wheel (for example, communicating the vision for change)
- a process for progressively monitoring achievement of outcomes and modifying plans accordingly
- a realistic estimate of the set-up, maintenance and transition costs of instituting the new service and estimate of the expected return on investment.
- We will discuss each of these characteristics below.
-

3.2.3 What change planning does not consist of

Change planning is not the creation of an ironclad, inflexible program. It is not possible to foresee and predict the future in detail. Change planning must be an open-ended process, which allows you to respond to unforeseen events that emerge as the plan is expressed in action. Planning is an ongoing process of which the production of the initial plan is only part. A plan is important because it allows you to know at any one time what direction you are taking – however, this does not mean that you may not choose to depart from your original plan if the circumstances suggest that you can achieve your goals more effectively in some other way. The planning process needs to be ongoing, purposive and opportunistic, responding to events and at times allowing for new activities to be initiated that were not envisaged in the original plan. Planning must be done up front but it cannot be completed up front – you need to return to planning intermittently throughout the implementation process.

“But you know in dealing with medication review, which is a bigger issue because it requires considerably more time, there’s obviously a planning process with that and how we’re going to find the time to do this, how we’re going to find the pharmacist’s time and how to go about doing that? And then when are they going to do it and how? What software are they going to use? And then how busy is it going to be, how many are you going to get? So it’s, it’s not an easy thing. You often just have to start doing it and then see where it leads you and you can plan to a certain point but you don’t really know what you’re planning for either.”

3.2.4 Relate the plan to the business strategy

The plan represents a practical roadmap for implementing an important part of your business strategy.

"There's a step before that [planning], there needs to be some sort of strategy in place, regardless of who the owners are. Whether you have got a formal business plan or just a broad discussion and understanding of where your business is going and what you want to do, but there is some sort of strategy that you have got, that you put this new service against and make a commitment to implement it."

So the plan to introduce a new service needs to relate to the strategy and be designed to implement part of the strategy. The results from the mail survey indicate that pharmacists strongly consider their strategy when planning enhanced services, 71.1% agreed/strongly agreed that they only introduced enhanced services that fit the pharmacy's business strategy.

"The partners continue to consolidate the strategy of focusing on services for the aged and have introduced newer services such as residential medication management reviews (RMMRs) and diabetes screening over the last two years".

In this case there is a clearly defined overall strategy and specific plans for sub elements such as the introduction of diabetes screening. Each of these aspects of the plan needs specific measurable goals.

"I've got long-term goals that go for seven years and they're in my head. I'm not writing them on paper, but I write goals for three to six months at a time. That's as long ahead as I do them because things change too much."

Meeting these goals ensures the viability of the ongoing change program.

"The pharmacy has chosen a core customer group – the elderly and infirm – and has developed a number of products and services to deliver to this target group. The services include dose administration aid services, palliative care, oxygen supply, home health care equipment and medication reviews. Long-term contracts with nursing homes exist for the supply of many of these services ensuring that the business has a constant cash flow which accounts for approximately 50% of the total turnover."

Note that the goals should include clearly specified improved health care outcomes for customers as well as outcomes that strengthen the business. When considering your business strategy ensure that you refer to the Pharmacy Viability Matrix for guidance (see section 4 chapter 2)

3.2.5 Choose the planning horizon

Choose a specific horizon for your plan (say a one- to three-year period) and, within that, identify phases or stages of the implementation process.

"For the past two years, the owner has focused on establishing and building the compounding business."

3.2.6 Define the scope of the change

When the planning horizon has been established, then you can determine the scope of the change. What is the focus and what will it affect? Can the change be introduced incrementally and be limited to a specific area of the pharmacy's activities or will it be transformational and involve changes throughout all or most aspects of the pharmacy? Incremental change is emergent, continuing and ongoing and for the most part impacts on the organisation's day-to-day operations. It includes changes to the way people work such as job redesign or teamwork, changes to the organisational processes such as quality assurance and changes to reward systems, information systems and technologies. Incremental change does not include radical changes in organisational strategy, structure or organisational capability. Transformational change by contrast does involve radical changes in strategy, structure and capability.

In terms of the Pharmacy Viability Matrix (discussed in section 4 chapter 2), incremental change involves maintaining the basic choice of, for example, Expanded Pharmacy but modifying some aspect of that strategy such as the product/service mix or the method of delivery. Transformational change means moving from one strategy type to another – say moving from being an Expanded Pharmacy to being a Multi Specialty pharmacy which will involve a fundamental reorientation of many aspects of the business (for further discussion of the differences between incremental and transformational change see Nadler and Tushman 1999; Stace and Dunphy 2001; Dunphy, Griffiths et al. 2003). When the scope of change is large and risks may be consequently greater, so in this case consider running a trial rather than implementing the full change immediately.

"When we begin something new, we actually have a ballpark estimate of exactly how much in the way of resources we will have to put in, in the way of materials, technical time and added qualifications that are needed. So we do a ballpark estimate and we say: 'OK, we can afford to run this for six months and see how we go, and at a six-month review we can either hold it or we can't.'"

3.2.7 Create plans for the other elements of the Wheel

In planning the change, you need to include plans for the other nine elements of the change wheel; that is, your plan will provide, for example, for "allocating resources for the change" and "communicating the vision for change". We will deal with each of these elements in subsequent sections of this chapter.

3.2.8 Progressively monitor outcomes

"The planning process is not an easy thing. You often just have to start doing it and then see where it leads you and you can plan to a certain point but you don't really know what you're planning for either."

The planning process often seems messier and less precise than many management textbooks indicate. However, that is not a sufficient reason to abandon planning – put a plan in place even if it is rough; commit to it but monitor whether it is in fact achieving the outcomes you have specified and moving the pharmacy in the direction of your chosen strategy. And keep planning, redirecting activities where needed as the feedback comes in. Planning is a process rather like launching a heat-seeking missile. In its trajectory the

missile is off target most of the time but its feedback system continually pulls it back on to the desired trajectory until it reaches its target.

3.2.9 Do the financials

Pharmacists in the focus groups identified one of the major barriers to change as inadequate research on the set-up, maintenance and transition costs of introducing new services and a realistic estimate of the return on the investment involved. This led in some cases to services being implemented without a full understanding of the repercussions for the pharmacy and sometimes a subsequent withdrawal of the service. For guidance refer to 4.6 in this section.

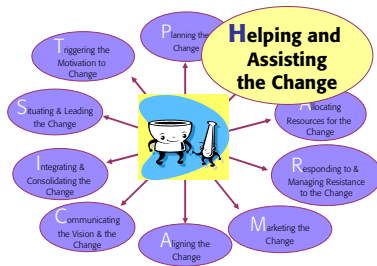


Questions to ask at the end of the initial planning process

Do I have a plan that:

- clearly relates to the overall business strategy of my pharmacy and network?
- has defined goals?
- has a clear horizon for implementation?
- has a defined scope in terms of which aspects of my practice it will affect and how?
- contains sub plans for the other nine elements of the Pharmacy Change Implementation Wheel?
- has a process for monitoring and measuring progress against the planned outcomes?
- has provided for returning on an ongoing basis to the planning process so that adjustment can be made on the basis of feedback and strategic details can be worked out?
- contains realistic estimates of the set-up, transition and maintenance costs of the new service and expected return on investment?

3.3 Helping and Assisting the Change



When you have a plan in place, you need to go on and begin to think about how to build an effective support base that will create the “best chance for change”. The conduct of change is a challenging adventure in any situation so the more you can do to create an infrastructure of support for your change program, the more successful your leadership of change is likely to be. So here are some simple principles which will assist you:

3.3.1 Start where there are existing resources

In moving into service provision, you can support your change program by choosing services where there is existing experience with offering the service and where that experience has been codified and is backed up by professional support services and materials.

“The Guild and PSA ...have education modules where you can avail yourself of training and resources — these have been good. But the one that really stands out is the one that we have been doing which is CMI. The reason we’re doing it is because it’s easy.”

“I looked at Health Information Pharmacy. They have patient-focused services and they provide all the templates.”

You can also monitor new experiments in service provision too and learn from them.

“The fact that we had the Pharmacy Alliance in Ballarat was something that worked in our favour. It is actually a Guild-funded project and there are a couple of reports about it but the concept was like Divisions of General Practice where GPs have been brought together to act in a more coordinated manner in some areas. Pharmacy Alliance was the same sort of thing for pharmacies. In local areas, there’s really not a place where pharmacies come together because they’re independent businessmen to do their own thing. Pharmacy Alliance is a place where they look at their broader community role. It’s something we’ve used extensively to help and support the implementation of MediConnect.”

3.3.2 Consider your level of experience in implementing change

Pharmacist participants in focus groups indicated the relative difficulty of implementing different services. Table 5.5 shows these services in order of difficulty (from 1=very easy to 5=very difficult) the services are:

Table 5.5: Services rated by difficulty to implement and impact on profitability from focus groups

Service	Implementation Difficulty ⁹	Impact on Profitability ¹⁰
Consumer Medicine Information (CMI)	1.5	2.0
Screening/monitoring	1.9	2.1
Smoking cessation*	2.1	3.0
Asthma management*	2.4	2.7
Methadone	2.4	2.4
Dose Administration Aids	2.6	2.3
Diabetes management*	2.6	2.5
Weight management*	2.8	2.9
Residential Medication Management Review (RMMR)	3.0	2.5
Home Medicines Review (HMR)	3.0	1.7
Naturopathy	3.3	3.8
Compounding	3.6	4.2

*It should be noted that what constitutes these service offerings was not pre-determined, but left open to the interpretation of the study respondents. This is discussed further under study limitations in section 3: 2.8.2.

If you are beginning to implement change towards more service provision, you may want to choose to introduce first a service that is relatively easy to implement even though the payoff in profitability terms is relatively low, so that you and your staff have a successful experience of implementing change. When you have built up your readiness-to-change score by creating a history of successful change implementation, then you may wish to introduce services that are more difficult to implement but that have a higher payoff.

3.3.3 Use the resources of your banner group or network

There is considerable variation in the support for service provision amongst the various banner groups and other networks of pharmacies. However, in many cases there are extensive resources that can help your change program. You may identify through your banner group or network some leading pharmacies and you may use these as role models. These resources and support were identified as a facilitator of change in an earlier study (Roberts et al. 2003).

⁹ on a scale of 1 to 5, where 1=very difficult and 5=very easy

¹⁰ on a scale of 1 to 5, where 1=low profitability and 5=high profitability

"The owner believes that an owner-operated banner group is a more effective structure than a non-owner operated group because the pharmacy owners have a real incentive to comply with the group's programs and operations. With the financial reporting and other support functions supplied by head office, the owner has more time to focus on running the business and looking for new business opportunities."

"XX [banner group] have people specifically to look after the ethical area and if we have any questions we can go straight to them and they usually have templates or what have you. There's a person on the other end of the line that you can talk to and they don't just beat around the bush...for example, they have templates that are already set up with consent forms. So you don't have to worry about the legal wording or anything like that. It's all done for you...so banner groups can be very helpful."

"Belonging to a banner group actually helped in some of these things. We're not a big banner group but our head office has arranged naturopaths and iridologists and say there are twelve pharmacies in our banner group in [capital city]; well the person gets a job a day or a fortnight in each if they're a full-time employee. We really don't have to do anything – they do the whole lot for us."

So if your pharmacy is part of a network, ensure that you are fully aware of the services available to you for your change program and that you use them to support your ongoing program of change.

If you are not in a banner group, you can identify a pharmacist who has instituted services of the kind you plan to implement and learn from their experience.

Interviewer: *"If you were going back to two years ago when you were contemplating implementing these services, is there something you wish now you had then?"*

Respondent 1: *"Somewhere to ring where they had already implemented that particular strategy that you knew was doing it well, that had been through the same teething problems and from whom you could learn."*

Respondent 2: *"A mentor?"*

Respondent 3: *"Sort of, but not necessarily. Just someone you can ring up and say, 'Look, I'm going to be doing this, what did you find?' Someone with the experience you can learn from."*

3.3.4 Ensure you have quality staff

Service provision is often labour intensive and demands staff with up-to-date information and relevant high-level skills. So seek out and hire capable, highly motivated staff with existing knowledge or skills if possible and with the capability of learning and developing. Service provision is highly people-dependent.

"For me one of the most important helping factors is the staff – if they're not behind it, it doesn't happen...You can't do everything in the pharmacy yourself."

So you have to rely on the people. So if you can't rely on them to do their job well or follow up, it means it all falls back to you."

Pharmacists in focus groups strongly emphasised that having adequately trained staff and the right personnel are major enablers of the change implementation process, a factor that has also been highlighted in other research (Roberts et al. 2004).

Once you have the appropriate staff, you need to assist your change program by developing them.

3.3.5 Create a learning organisation and reward innovation

Change programs demand continual initiative and innovation from people at all levels. You can help your change program by making your pharmacy a learning organisation where innovation and change management become everyone's responsibility rather than an optional extra.

"The pharmacy managers are responsible for introducing new products and services in the pharmacy. This is viewed as an important part of their professional role particularly as it relates to the down-scheduling of prescription products."

The new behaviours need to be supported by your reward structure so that innovation and successful change implementation are rewarded and seen to be rewarded. The concept of working together as a team to implement change, and communicating the goals for that change to everyone involved, were identified as facilitators in an earlier study (Roberts et al. 2004).

3.3.6 Care for yourself

You will find that managing change is an exciting but challenging and often stressful task. You need to ensure that you help yourself to be an effective change agent by finding ways to keep yourself up-to-date, building a strong support network among your peers, and ensuring that you have a satisfying life outside the pharmacy.

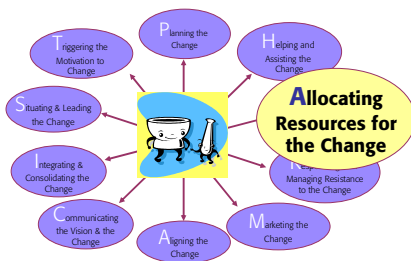


Questions to ask yourself in reviewing this segment:

- If I am moving into the early stages of service provision, have I helped the change process by starting where there are existing resources?
- Are the services I am introducing at a level of implementation difficulty commensurate with the experience and expertise that I and my pharmacy staff have in introducing change?
- If my pharmacy is part of a banner group or network, have I reviewed the full range of resources available to me on the basis of my membership?

- Have I identified other pharmacists who have instituted these or similar changes and reviewed their experiences with them? Can I use their experience and expertise on an ongoing basis?
- Have I ensured that I have staff of the quality needed to implement this change program and put in place the training and developmental activities needed to ensure quality delivery?
- Will my current reward structures reward innovation and learning or do I need to revise them to ensure they do?
- Have I put in a plan to support my own continued learning and psychological support so that I can continue to provide the energy and impetus that the change program deserves?

3.4 Allocating the Resources for Change



If you are to manage change effectively, you will need to find new resources to support the change process or move resources from existing activities (or both). As a pharmacist you have only four kinds of resources available to you:

- capital/finance
- organisational design — including the physical design of the pharmacy, i.e. pharmacy layout
- technology, equipment and systems
- workforce — numbers and skill mix

In discussing the resourcing of new service provision, pharmacists mentioned all of these elements.

3.4.1 Capital/Finance

One of the problems you face is how to finance new service provision, especially to finance change that is related to services not remunerated by government.

“Unfortunately when pharmacists come to charge for the things that they do — blood pressure monitoring and things like that — we don’t charge. Someone asks for blood pressure measuring: I sit them down, I fill out forms, I give them some guidance, ask them some questions. I have a very nominal charge. They’ll often say: ‘The other guy doesn’t charge me.’ So the enemy is within, within ourselves sometimes. We’ve got to be willing to charge what our time is worth.”

You may feel reluctant to charge for services out of fear that you will lose customers. It may seem counterintuitive but that is not the reality experienced by some pharmacists who have taken that risk.

“When we first started our natural therapies and our weight monitoring clinics, we had a really nominal fee and people abused it because they didn’t keep appointments or things like that. So we moved it up a niche and we charged them really top dollar consultation fees for some of the work we were doing. They still paid it and they kept appointments...”

One of the key decisions you need to make when you are considering how to finance new service provision is whether you will finance it by charging a fee for service or fund it from some other source. Many managers see the need for financing ongoing operations but have unrealistic expectations about what is needed to fund change. Charging an appropriate fee for service is one way to ensure that the change is adequately funded. However, in the process you may need to change your own expectations and those of the customers about the value of your professional time and of the quality of the services you are providing. There are important value issues here in terms of equity.

“The owner believes any fee needs to be linked to a value-added service, such as regular educational material about healthy living. This could be sponsored by relevant manufacturers and possibly the Guild.”

You need to look carefully at what services you will continue to provide without charge, and why, and which services you will charge for. Not charging for unsubsidised services which involve commitment of substantial time and high levels of professional expertise will limit the extent of service provision you can undertake. Ultimately someone has to pay for the services you provide if you are to stay in business.

3.4.2 Organisational Design

Organisational design refers to the way you configure the organisation in terms of the roles you create to get the work done, the authorities and responsibilities you give people, what you do yourself and what you delegate to others, and whether your pharmacy is networked to other pharmacies. The concrete representation of your decisions is the visible architecture of the pharmacy — the way it is laid out, the distribution of activities into spaces, the visual displays. When you introduce new services to the pharmacy, you need to consider how to alter the existing design of the organisation. Work systematically from redefining roles and responsibilities to redesigning layout, with each change designed to ensure the effective provision of these services.

“The staff at the pharmacy work as a team so that the best service possible is provided to the customers. The front of the pharmacy is structured to enable pharmacists to focus on prescription delivery, by delegating associated services to other specialists in the store. For example, a naturopath is responsible for providing natural therapies and the pharmacists pass on these enquiries to the qualified staff member on duty at the time. The support that the pharmacy team provides to each other is of utmost importance. The pharmacist in charge stated that ‘without mutual support the pharmacy will fall down.’”

“As the pharmacy is an extended-hours pharmacy, they employ four locum pharmacists to assist by working in the evenings and on weekends. This team is supported by a full-time pre-registration pharmacist, two full-time and some part-time pharmacy assistants, a full-time naturopath, beautician and a part-time lactation consultant.”

Buildings and layout: If you are introducing services which will be provided in the pharmacy itself, then you may have to reconfigure your pharmacy or acquire additional premises. Service provision often involves counselling and this demands a degree of privacy not available in many pharmacies. Some pharmacists reported making modifications to their pharmacy layout to accommodate this.

Choice of a new service strategy may involve a thorough review and reconstitution of the pharmacy's buildings and layout. The following case involved pharmacists moving into compounding who bought a pharmacy with a view to establishing a compounding pharmacy.

“The pharmacy was a retail pharmacy that had been adapted for compounding use. To that end a laboratory was an annexe to the dispensary so that the air was all open. The airborne powder presents all sorts of health issues. In actual fact the design was worse than that in that the staff area was behind the laboratory so the staff had to traipse through the lab and out the back to get to it. So [pharmacist partner] looked at it and he thought, ‘Well, there’s real promise in the field’. He could see a future in compounding with the various avenues you can go down, but the premises were no good... He then set up a specialised compounding facility – a tailor-made facility designed exactly for this purpose. So our laboratory is closed off from the rest of the pharmacy.”

3.4.3 Technology, equipment and systems

Society as a whole and pharmacy in particular are being transformed by new technologies, particularly by Information Technology (IT). Re-equipping your pharmacy with the latest wave of technology may put you on the leading edge but may also make you part of the bleeding edge if the expensive technology does not work. However, to lag significantly in technology can put you out of business. Every modern business needs a sound, workable technological base that is periodically updated in terms of hardware and software. As discussed earlier in this report, being part of an integrated IT health information system may be a critical competitive advantage for pharmacy as a whole and pharmacy needs to keep up with an increasingly sophisticated coterie of IT savvy customers.

New service provision can require sophisticated backup but this can often be done with standard, well-tested current communication technology.

“This pharmacy is technologically up-to-date with broadband access available on all computers. It is quite common for customers in this pharmacy to present with information they have downloaded from the Internet and in this way pharmacists are able to respond to these information requests quickly. The pharmacy is also equipped with a standard Point of Sale reporting system.”

“The pharmacy has broadband capability on all computers which enables the staff to respond quickly to information requests from customers. There is also a large volume of email between the pharmacists and the private hospital staff.”

The owner is currently considering installing a direct telephone line between the private hospital and the pharmacy as an additional service and to lower costs for the hospital."

"Yes, we invested heavily in technology: we put in a point of sale system in 1997, with the aim that that would be a multi-store platform for us to operate dispensary, retail and accounting and never achieved it. Not through want of trying and investing the time and energy to the system because there just wasn't enough to it, so we sort of brought a point of sale system to the eastern states....We are [now] rolling out a whole new platform under a system called YY which is a new retail point-of-sale system and which incorporates a dispensary system."

3.4.4 Equipment

IT is an important area for change but service delivery affects the need for other equipment as well.

Examples from our case studies include counselling desk; area to store and/or display patient information materials such as Pharmacy Self Care Fact Cards; monitoring equipment such as glucometers, blood pressure monitors etc.

However, equipment is not necessarily confined to the pharmacy building itself — you need to consider the complete supply and distribution system for your pharmacy or pharmacy network. One network of five pharmacies assembled a fleet of five vans for the delivery of medications, home health care equipment, oxygen and unit dose dispensing packs to facilitate delivery across the pharmacies' catchment area.

In some cases an emphasis on providing health services will have significant implications for allocation of space in the pharmacy.

"If this pharmacy decides to increase its focus on cognitive pharmacy services, it will need to address floor space allocation as the pharmacy is now predominantly geared towards women's beauty products and associated services."

3.4.5 Systems

Improving systems and specialisation can create more time for those who are best equipped to provide the new services by relieving them of administrative responsibilities.

"This pharmacy group promotes and encourages innovation within its pharmacies by encouraging them to reach out to customers in novel ways to help with their health care needs. The provision of core business activities in head office allows the pharmacists in this group more time with customers at the ground level. This adds value to the individual pharmacy's product/service provision by allowing pharmacy staff to focus on local needs and organising initiatives such as health screening days."

Increasing the size and structural complexity of pharmacies, in particular moving into a sizeable network, demands new coordinating systems.

"The management group is in the process of evaluating a new reporting system which will integrate reporting for the point-of-sale and dispensary systems. This system will be deployed across all the group's pharmacies to provide enhanced reporting functionality and better efficiencies for the group. The pharmacy group also makes extensive use of telephone conferencing for meetings."

Being part of a network can provide substantial advantages in building effective systems. It is possible to "cherry-pick" innovative solutions from different pharmacies in the network.

"These systems were developed from the floor. I had developed them from six pharmacies and we would take the best in the pharmacies. The best staff member, the best outstanding cosmetician or the best technician and we had them write the system so we actually had six systems that we put together into one. We believe this is the best practice."

Remember that it is important to continually innovate and transfer best practice from within your own pharmacy network but it is also important to benchmark yourself against best practice in other pharmacies outside the network and sometimes against best practice in other industries where this is relevant (as it is, for example, with IT).

3.4.6 Workforce

As cognitive services are generally labour intensive and demand relatively high skill levels, workforce numbers and capabilities are central to resourcing new services.

Shortage of key personnel can limit the rate of adoption of new services or lead to a drop off in service provision after a successful introduction.

"This pharmacy also undertakes a small number of Home Medicine Reviews (HMRs). However, growth in this area is slow for two reasons. Firstly, the area does not have a Medication Management Review (MMR) facilitator so there is minimal promotion to the local GPs. Secondly, the pharmacy has ongoing problems sourcing outgoing skilled pharmacists in this area. There is one accredited pharmacist to do the 800 nursing home reviews but she is not prepared to take on HMRs. (She does not work in the pharmacy). The two partners have minimal time to conduct HMRs. GPs in the area have generally been positive about HMRs and the pharmacists credit this to their dedication in communicating the new program to GPs at the time of introduction. This is no longer the focus of the pharmacy."

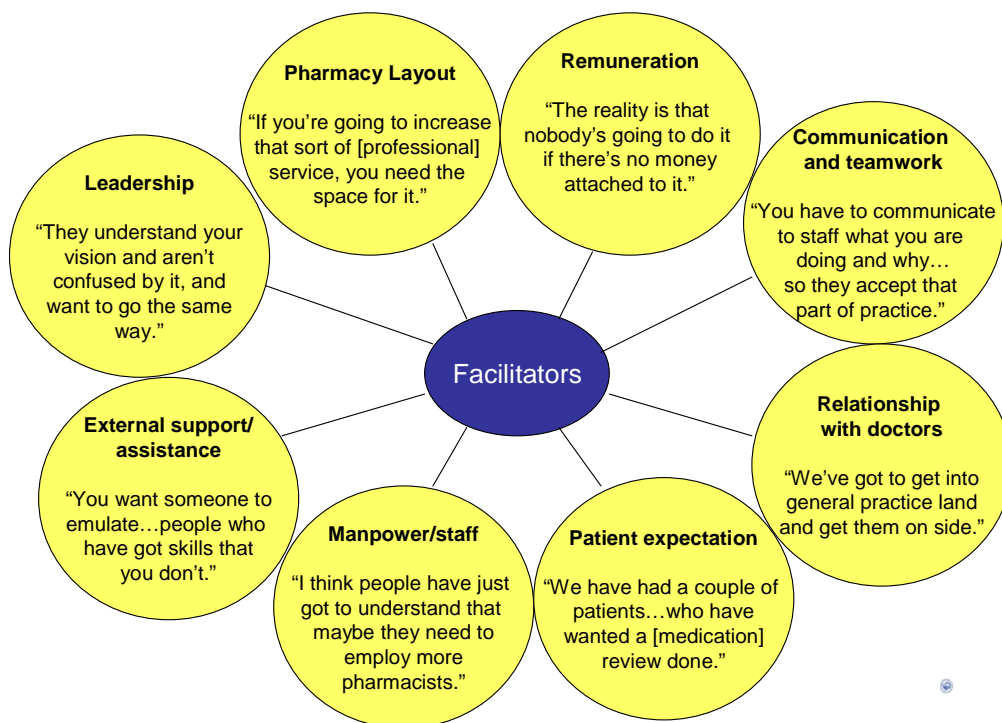
Therefore you need to carefully consider your human resource strategies for they will be critical to success. How many people do you need? What capabilities and skills will they need to provide the services? How will you deploy them?

"We also have a person who is called our Group Operating Manager and she is a person who doesn't work in the stores but has a human resource background and her role is to manage all the recruitment processes, the performance issues, any staffing – you know, staff feedback goes back to her – if there're issues she is sort of the third person, she sits in on all the reviews, she manages all the online appraisal processes, she does all the advertising for recruitment."

Because cognitive services demand higher level skills and different skills, there is usually a need to rethink recruitment processes and to place a stronger emphasis on training and professional development. There were repeated references to the use of training courses offered by the Pharmaceutical Society of Australia, the Australian College of Pharmacy Practice, the Guild and other private providers and to the importance of education programs offered by university-based pharmacy schools and management schools.

In her study of the factors that are facilitators of change, Roberts et al. (2003) identified eight major facilitators that are relevant to our discussion here. The eight facilitators are shown in figure 5.6. They can be regarded as critical resources that you can draw on to ensure that your change program doesn't burn out like a damp squib. You may want to think about the extent to which you have the necessary resources in each of these areas and whether you need to build in some actions to strengthen any of these resource areas early in your change program.

Figure 5.6: Facilitators of Change



(Roberts et al. 2003)

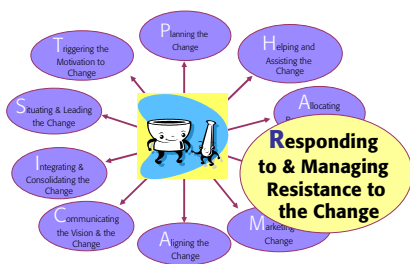
Managers frequently underestimate the resources needed to ensure that change programs fulfil the objectives they are designed to achieve. Consequently many change programs fail or don't achieve optimum results. Think of a change program as similar to any other business project such as opening a new store or launching a new product range. A change program requires at least equivalent resourcing.



Questions to ask yourself in reviewing this segment:

- Do I have the capital and finance needed to support the planned changes?
- Have I thought through the design of the service operation in terms of the roles and responsibilities involved?
- Is the new organisational design or revised organisational design for my pharmacy reflected in a logical redesign of the buildings and layout?
- Do I have the IT hardware, systems and other technology needed to support the change ready in place, or planned to be in place?
- Do I understand the human resource requirements needed for the change program and the service provision to be successful, and have I instituted the resource strategies that will ensure the change program is effectively implemented and maintained?

3.5 Responding to and Managing Resistance to Change



In the literature on organisational change, there is probably more written on how to manage resistance to change than on any other topic. In this study too pharmacists frequently spoke about resistance to change and the reasons for it. The sources of resistance they identified can be divided into resistance from **external stakeholders**, mainly other health care professionals and pharmaceutical companies, and **internal stakeholders** such as owners, other pharmacists and pharmacy staff. We will discuss what they said about these sources of resistance to change and then deal with the insights gained into how you can manage resistance from these sources.

3.5.1 Resistance from external stakeholders

By far the most frequently raised source of resistance to change in the external environment of pharmacies was other health professionals. The extension of service provision in primary health care involves potential conflict over:

- which particular health care professionals will “own” or control the provision of new services or the extension of existing services
- who will be included in service provision and who excluded from it

- of those included, what their respective roles will be
- if there are rewards for service provision, how these will be shared amongst different providers.

Each health profession has its own representative body or bodies which exist largely to preserve and extend the political interests, privileges and payments of members and to shape the future of the profession. They also have their own vision of what health care should consist of – usually a compromise between contributing to the health of the community and preserving their own professional interests. The history of their successes and failures in managing their mutual professional relationships is often written in legal definitions of what they are allowed to control and their representative organisations are zealous in protecting past gains and anticipating future possibilities.

“The GPs certainly see there’s a boundary. One of the issues is that the GPs always feel that pharmacists are overstepping their boundaries. Like with BP [blood pressure] monitoring.”

“One of the barriers to driving this area further has been the hostile reaction from local Diabetes Educators and the owner expressed the view that they felt the pharmacists were not “qualified” in this area and “treading on their turf”.

In these discussions and interviews, pharmacists frequently used terms like “turf”, “territory” and “boundary” and referred to the importance of “qualifications” as legitimising those who provided services. You need to be aware that your attempts to improve health care services may be interpreted as competition and that your qualifications to provide services may be questioned.

GPs were most often referred to as a source of external resistance. GPs and pharmacists exist in a symbiotic and competitive relationship; they depend on each other yet in some ways they compete for the patient’s “share of wallet”. Particularly with minor ailments, people constantly make choices between consulting a pharmacist and a doctor so that effective and personable pharmacists can solve problems that would otherwise lead to an appointment with a doctor. On the other hand, pharmacists are a significant source of referral to doctors.

Attempts to redefine the pharmacist’s role by extending service provision have important implications for the somewhat uneasy balance achieved between the professions. This is illustrated from the following extract from a focus group interview with pharmacists:

Interviewer: “OK, can we talk about the negatives. What hasn’t worked with the services that you have experienced so far?”

Respondent 1: “HMR!” (laughter) “It hasn’t worked with [all] GPs...there are some of the sorts of things we said a bit earlier about territory, boundaries and the typical sort of GP ‘you can’t tell me anything whatever’. You’ve got to get past first base with them.”

Interviewer: “So despite all the effort, with some GPs you don’t get anywhere?”

Respondent 1: “There’s resistance or feelings of threat.”

Respondent 2: “There’s resistance out there, there is, yeah.”

Respondent 3: “You have to handle it as well as you can really.”

However, not all resistance from doctors was seen to be due to boundary issues. In relation to CMI, one pharmacist remarked:

"Some of the doctors resisted. They didn't want the patient to have such information because, according to them, it confuses them. And I tell them [the doctors], 'They [the patients] are sick, not stupid, just sick'. I've had a few calls [from doctors] saying: 'Please don't give them CMLs because they come and question it [the prescribed medicine]'."

There was discussion of the Pharmacy Guild's attempts to extend the range of services into areas such as immunisation and chronic disease management by commissioning research projects, and the reactions of GPs and their representative bodies to this:

"But it just sends General Practice into...I mean, the reactions! I was really surprised. After three years working with Home Medicine Review and believing it was generally a reasonable view about what pharmacy could offer as part of the primary health care team, it just brought out all this anger and vitriol against pharmacy, you know 'taking over our territory' and that kind of stuff."

The interpretations of your actions by other health professionals will be influenced by what they hear from their own professional associations and by what your professional associations are doing and saying about service provision. You need to be informed about the relative positions of the relevant professional bodies so that you are seen to be informed and to have considered the main options.

Apart from other health professionals such as nurses and diabetes educators, there was some reference to resistance (or at least lack of interest) on the part of pharmaceutical companies in pharmacies extending health services.

"The pharmaceutical companies are pushing for product. This is an alternative model – it is an alternative therapy of things rather than services."

This is a perceptive comment that signals that service provision by pharmacies represents a significant departure from a single-minded commitment to selling product. It is not, however, antithetical to product sales for, in most cases, service provision also involves supply of relevant medical products.

The only consumer resistance mentioned in relation to expanded services was in the case of the provision of methadone where some customers, similarly to staff (see below), reacted negatively to the perceived dangers or discomforts of having methadone patients in the pharmacy.

Our consumer forums indicated strong support for the extension of health service provision through pharmacies. This suggests that demonstrated consumer support for a service is one way to reduce resistance to change from health professionals – most health professionals do have a genuine commitment to improving primary health care and are responsive to consumer pressure.

There was appreciation of the potential in this area for improving primary health care if the health professionals could work out a more collaborative relationship:

"From my perspective, through the HMR lens, we see fantastic outcomes for consumers, reasonable return of finances to the players involved, you know, you see good stuff. So therefore my line is that the professions are stronger together than they are apart. And if they could forge an understanding about what the future might look like and develop a relationship where there was a level of ability

to negotiate those territorial issues on the way to sharing the territory then that is a win-win. It could be a win-win. And that's what is needed for the two professions to collaborate more closely."

At the level of the individual pharmacy, pharmacists reported that resistance to increased service provision could be handled in many cases by:

- building effective personal relationships with GPs and other health professionals through activities such as golf or dining out together
- "targeting" first those GPs who are more open to collaboration
- actively communicating vital information about the service and its potential contribution to patient health
- supporting the creation of local primary health care teams involving GPs, pharmacists and other health professionals
- demonstrating that there is a community demand or potential demand for the service
- ensuring that the service works to the mutual advantage of all parties and that these advantages are perceived, that is, building an exchange relationship through, for example, mutual referrals and negotiating through areas of disagreement.

Research by Roberts et al (2004) found that establishing a good relationship with local doctors was a key factor in facilitating change. Accounts by pharmacists who were successful in gaining the support of other health professionals ran like this:

"So because the whole service was in its infancy, I had to do a lot of work with the Division of General Practice. I actually hosted a breakfast out at one of the local nursing homes and we got 25 doctors along for this breakfast the nursing home put on. We gave them bacon and eggs and did a PowerPoint presentation, which was quite innovative back in 1997, and I discussed all about the research behind what led to the creation of the funding as well as a lot of practicalities on how the service was going to be rolled out in X [name of town] and we got the characteristic 'invasion of turf'. We got a fairly hostile response from the doctors. I was fairly firm with them and said, 'Look, this service is a fait accompli. It's going to occur with or without you, but you know, our preference is that it works with you.' So they invited me along to a Division of General Practice meeting and we eventually started a committee at the local hospital where we met once a month. At six months I drafted a protocol for the local Division and, by the time the protocol was drafted, you know it was begrudgingly accepted by the local Division. The service had pretty much taken off..."

In discussing the future of pharmacy in focus groups, pharmacists predicted that there will be a greater use of collaborative alliances with other health care professionals. You need to keep in mind that moving from managing resistance to building supportive relationships with external stakeholders will take substantial time, energy and work on your part and that you are building an exchange relationship. You need to understand the interests and motivations of key stakeholders and ensure that their interests are respected and that their important motivations are sufficiently satisfied for them to cooperate with you. If there is to be more unified primary health care at the community level, it will be built by patience and persistence at the grassroots level by pharmacists like yourself.

3.5.2 Resistance from internal stakeholders

Pharmacists also spoke of experiencing resistance to change from owners and other pharmacists working for the pharmacy (including themselves in some cases) or from staff. The causes of resistance they put down to:

- age
- conservative personality traits
- lack of time
- lack of and/or unavailability and/or cost of education and training
- particular characteristics of a proposed service.

Take this sample of discussion from a focus group of pharmacists:

Respondent 1: "For me, [take] disease state management — my problem would be, is, education for your pharmacists because you get somebody who's just coming in for two hours a few times a week and they're not going to be able to give that service that you're advertising. I find that hard if you've got pharmacists coming up to retirement; you know you can say 'We'll pay for your course' but, frankly, 'I don't want to go on your course' is the response."

Respondent 2: "So it's a cost and time in educating them."

Respondent 3: "And it's resistance; they just don't want to do it."

Respondent 1: "Because they're coming up to retirement..."

Respondent 4: "Or other things..."

Respondent 5: "It would be a time factor. Take the HMR: I haven't done the course. And as soon as I saw the recent brochure saying you can do it on line, I thought, 'Fantastic!' but then I'm thinking: 'Well, I'm time poor. I don't actually have time to do it.' So I employ two pharmacists who are qualified until I become qualified but until I become qualified and I know all the ins and outs of it, I'm not going to implement it in my pharmacy until I have control over it. I can't analyse it and feed it well enough to know. So educating myself first, having the time... And if there were national subsidies like there is for vocational training, I have to find funding to employ someone to cover myself while I'm being trained, while I train myself."

Not only pharmacists but also the staff can be resistant to change, for similar reasons:

Respondent 1: "Some staff have been resistant to change, too. I mean we have two older people that have been there for years and years..."

Respondent 2: "Does it tend to be an age group?"

Respondent 3: "Yes it is. I think so."

Respondent 1: "I don't think it is just an age thing — I think it is the personality."

All: "Yes, I agree with that."

Respondent 1: "...It's just scary for some people."

The particular characteristics of some services also created resistance to supporting their introduction or continuation. Methadone received particular attention:

Respondent 1: "I think staff have a resistance to any service you give where the patient coming in might tend to be abusive to them. I think if it's a service where

that does not happen, I don't think there's much resistance, provided they've been given adequate training. If there's resistance because of lack of knowledge, that's the proprietor's problem."

Respondent 2: *"We want a calm, family-friendly environment. And having fights over payments..."*

In dealing with internal resistance to change, don't assume that age will necessarily be a problem but be aware that it may. Particularly for those pharmacists and staff close to retirement, there may be little perceived advantage in spending time in learning skills that will not be used for long, or in you investing in training those who won't be around to use them. It makes more sense to train those who are keen to learn and use the new skills and who will have time to extend the skills through longer term practice and experience.

Similarly, those with conservative attitudes to change are often better deployed on ongoing operational tasks, freeing up those who enjoy trying new things and innovating to spearhead the move into new services. You need the balance and can create a pharmacy culture where both are rewarded for their respective contributions. Your hiring policies need to ensure that you have a balance of maintainers and innovators, and your human resource practices need to be seen to reward both. You need to identify where education and training resources can be sourced (see Allocating Resources for Change) and budget in the costs of accessing these. And you need to help some people overcome their fear of change through involving them in the change process so they feel that they have real control over how the change takes place. People are generally unafraid of changes they make themselves – it is change they have thrust upon them that they most fear and resist.

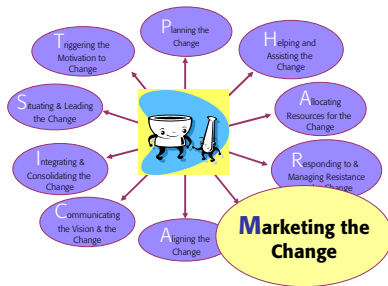
Remember also that your modelling of change through your own behaviour, your confidence in initiating and managing the systematic introduction of change and your personal support for those who actively commit to change, will be powerful factors in overcoming resistance. (See Situating and Leading the Change).



Questions to ask yourself in reviewing this segment:

- Have I reviewed the relevant external stakeholders who can influence the success of this change program and new service provision and realistically assessed their likely support for or resistance to the proposed change?
- Do I have a plan for strengthening the support from those who are positive and dealing with the resistance to change of those who are not?
- Have I reviewed the relevant internal stakeholders who can influence the success of this change program and new service provision and realistically assessed their likely support for or resistance to the proposed change?
- Do I have a plan for strengthening the support from those who are positive and dealing with the resistance to change of those who are not?
- Am I fully committed to the change program myself, modelling the new behaviours needed and seen to be rewarding others who commit to the change program?

3.6 Marketing the Change



Pharmacists are usually not trained in marketing and can be uncomfortable about it. They often feel that their expertise should be enough to attract others to seek their services. But is this reasonable?

3.6.1 Why is marketing important?

Marketing is important because, unless people know you are offering services, they will not know you are changing your business proposition or that they may come to you on a new basis. Historically pharmacy has built a traditional image that is more about supplying medicines than it is about providing sustained and varied services. Therefore you will need to work to change people's conceptions of what a pharmacy is and does and marketing is part of doing that. Take this exchange in a focus group:

Respondent 1: "You have to get on to it. With HMR it depends on how you market it; we don't do any of that well enough. As a profession we don't market ourselves as health professionals in pharmacy either."

Respondent 2: "But again if you're a sole practitioner, it's really hard to do all those things."

Respondent 3: "Marketing is hard full stop."

Remember that you have a double marketing issue here — you are marketing services to your customers and you are marketing your change program to those inside and outside the pharmacy who will have to undertake the changes.

3.6.2 Identify and study your market segment for the new service

"One piece of feedback — find out about your customers."

Marketing begins with listening to your customers and picking up their concerns.

"We're just getting feedback from our customers. We interact with our customers reasonably well and eventually something they've told you often enough — you start to think about it while you're at work or after work and you start getting a few ideas."

Over time, particularly in stable communities, listening can become a way of life and you can ensure that you are critically placed in the informal communication networks in your community. Understanding the needs and expectations of your customers, and targeting your services towards these, has been shown to be a key factor in ensuring the success of your change program (Roberts, Benrimoj et al. 2004).

"Importantly the owner has developed an in-depth understanding of his customer base over the 30 years he has operated his business in this area. He is strongly embedded in his local community and has developed strategic relationships with other local community organisations, for example, the local football club, who can act as referral points for his pharmacy. This depth of understanding of the local community 'psychographics' is highly advantageous when considering new products and services and what will and won't work in the area."

Listening needs to extend to more systematic scanning of the community to identify key market segments represented in the area you serve.

"Have a look at your demographics. Have a look at the people around you. Have a look at the services that are provided. You might find that there are some opportunities."

This results in identification of distinctive groups or organisations with common needs and characteristics who will want to use your service (Ashkenas et al. 2002 Part 3).

"The primary focus of the products and services within the pharmacy is on women as the principal customers. Management estimate that approximately 85% of the pharmacy group's customers are women."

Sometimes the primary focus widens as new opportunities arise for extending into related services. Marketing is more than advertising – it involves developing relationships so that the full scope of service opportunities emerges. This is relationship marketing.

"An initial tender was submitted by the pharmacy for the private hospital's outpatient pharmacy service. In the process of researching this tender, the pharmacy owner saw an opportunity to service all of the private hospital's pharmacy requirements, including inpatient and chemotherapy service. This pharmacy was successful in winning all the business and now serves as an external supply chain for the private hospital."

This is a clear example of how services can be strengthened and then made integral to the day-to-day lives and work of individuals and organisations, so that you have achieved a symbiotic, mutually supportive relationship with key customer groups.

When you are marketing the change program (that will introduce the new service offering) to your staff and others who will determine whether the changes will be effectively implemented, their understanding and enthusiasm will be significantly increased if they see that you clearly understood the target market to be addressed, that there is a clear demand for the services and that the services can be made an integral part of the pharmacy's operations.

3.6.3 If necessary, get specialist advice and back up

Marketing can be complex and difficult as we have indicated above. If you are unsure of how to market services to a specific segment of the market, you may need specialist advice. This is one of the advantages of being part of a network of pharmacies where this kind of advice may be part of the package you signed up for.

“This strategic approach highlights the importance of having highly qualified people in charge of functional areas such as marketing and financial analysis. Having such a core resource pool means that local pharmacists have access to skills they have not the time to acquire themselves and also ensures that the quality and consistency are maintained across all stores in the group.”

Other sources of expertise are commercial marketing groups or others who have faced similar marketing situations in other industries.

“Sales and marketing skills acquired from working in industry can be effectively transferred to the business of running a pharmacy and provide the basis for a sustainable competitive advantage.”

Marketing is a specialised professional area like pharmacy so don't assume that it is simply common sense. If you need professional help, seek it out.

3.6.4 Clarify your message

The test of whether you have your message clearly articulated for the group that you are targeting is whether they respond and seek out your services. It is sometimes useful to test market your services and make a “dry run” on your change program by conducting a pilot study. This gives you the opportunity to clarify your marketing message – the value proposition you are putting to your marketing segment – and to test out your change program and refine it.

“The pharmacies in the group are used as trial locations for ‘test’ implementation of products and services. This allows the group to more accurately gauge the responsiveness of customers to the new product and/or service as a basis for extending the innovation to other pharmacies in the group. For example, the pharmacy group introduced an iridology service. This was well accepted by customers at the pilot store. The service was subsequently launched in a number of other pharmacies in the group, based on customer demand. Customers were willing to pay for this service within the pharmacy and other paid services are being trialled in this network.”

3.6.5 Select marketing channels your target market pay attention to

“Most of our print media doesn't work and we discovered that last year.”

Pharmacists mentioned a large range of ways they reached out to their customers to inform them of new or existing services. These included speaking directly to customers, having pamphlets or brochures available in the pharmacy for customers to pick up,

handing customers pamphlets or brochures, letterboxing with pamphlets or newsletters, use of media such as local newspapers and radio stations, mailing, phoning and visiting other health personnel and operations such as aged care facilities, using the Internet and setting up a web page, arranging joint promotions with other community bodies, speaking at community organisations, and arranging community events. What they did not mention was how they matched the marketing method to the particular market they were targeting. It often seemed that the method used was whatever had been used before and was therefore familiar.

Interviewer: *"How do people find out you're suddenly doing this?"*

Respondent: *"I do a session on commercial radio every week, that we pay for. I just go and talk about relevant issues that may not necessarily even relate to our business in particular but you know to pharmacy in the broader sense, whether it be MMR or even the Bowel Scan Program or just, you know, community health issues. Sometimes we use it for promoting a particular product or it might be a weight loss product....I have talked about MMR and explained what it is and then patients hopefully can go and talk to their doctors about it. You know that probably hasn't driven a whole lot of interest in it. It has to be GP driven I think."*

This appears to be a case where the pharmacist concerned knows that the key target group in this case is the local GPs but goes on using a familiar marketing method to a secondary and diffuse audience that may or may not be listening. Compare this:

"Our other partner, he's fantastic at marketing [compounding services]. He writes to the doctors and tells them what we do and he sends them information and anyone, any doctor, who rings up and has an inquiry about this particular medication, he'll send them out a pack, describing all the different aspects, how it's made, how it's used, the background to what he's done. He's done a lot of training, all the reading. I mean he's got a really good relationship now with the doctors. They ring him up and he is held in very high regard through the GPs and specialists, because of this knowledge base and the way he stays in touch. And he did this with veterinary products. When he was getting a veterinary product out, he sent a pack out to every vet in (capital city)."

By contrast the other partner in the quotation above, understands clearly what his primary target market is (GPs and Veterinarians) and is choosing appropriate ways to reach them – ways that are much more personalised and which strongly relate to their needs and interests. As a result, over time, they initiate inquiries to him so that marketing becomes progressively easier, even more finely targeted and effective.

Similarly:

Interviewer: *"And with GPs, do you do anything in particular to let them know about new services or would it be the same strategies [you use elsewhere]?"*

Respondent: *"I usually ring, if it's something I want to get across. I ring the practice manager and he sometimes says, 'I'm busy. Fax through the details and I'll see that everyone gets it at lunchtime.'"*

Clearly GPs are a vital but difficult group to target:

"With services like HMR and RMMR...we were both trying to get RMMRs up and going and that involved one-on-one doctor visits and lots of hard slogging. And HMRs particularly, I spent heaps of time going around and actually showing them

how to bring the forms up on their desktop and how you print it out and what you do, because there was no pharmacist facilitator here at that stage and they would lose the little bit of paper they had anyway. So we spent a lot of time one-on-one doctor visiting and also going back over that...meetings and things like that."

It is clearly easier to drop a pamphlet in the mail but it generally doesn't work with this target audience.

3.6.6 Use multiple mutually reinforcing relevant channels where appropriate

"These services are promoted by regular advertisements in the local community newspaper and brochures in the pharmacy. A recent baby exposition which was promoted this way was very successful. Pharmaceutical representatives were invited to come in to the pharmacy one morning to discuss issues with customers. This resulted in a huge response with these customers signed up to the pharmacy's baby club loyalty scheme. The event was seen as profitable in terms of product sales at minimal cost to the pharmacy. Similar events are planned for other services..."

Remember that you don't have to do it alone — coordinated action with others who are part of the total primary health care network can make the change easier to introduce and be more effective in reaching your target group.

"As the pharmacy has a large sports nutrition product range, they run joint promotions with a local gym for this range of products. The pharmacists hope to develop this relationship further when implementing new pharmacy services that would benefit gym members."

3.6.7 Develop your campaign and plan for ongoing reinforcement

Marketing is not a once-off promotion effort. It is a normal part of your ongoing planning and implementation activity. If you have your marketing strategy right, the more you involve others in the process and make marketing activities a normal part of the weekly routine, the more effective the implementation of change will be.

"Marketing is also undertaken in a systematic way with a monthly schedule of promotional activity. The owner prepares the monthly program of promotional activities and then delegates the operational aspects to the senior pharmacy staff."

Part of ensuring the continued maintenance and growth of your service is to lock it into place with contractual arrangements.

"There are several contracts in place to supply these services. These include a contract with the Department of Veterans Affairs to supply home health-care equipment to veterans in the area, contracts with the nursing homes for the supply of dose administration aid packs and medication reviews. The pharmacy

makes up approximately 800 packs per week. Medication reviews are done annually for these same 800 patients."

3.6.8 **Make sure that you can deliver on your value proposition**

It is one thing to reach your market and to experience take-up of the service. That is a test of whether your marketing strategy is working and your staff are implementing the vision for change effectively. But then you have to be able to deliver quality services on a sustained and sustainable basis. To achieve this, your staff need to have the opportunity to develop the skills needed to deliver quality services, to be informed about the progress of the change program and to be motivated to turn the change program into part of the ongoing operation of the pharmacy. If the change is to be consolidated, new recruits into your staff will need to be inducted, motivated and trained too.

"To encourage mutual support within the pharmacy and so that all staff members know about the changes that are taking place, regular meetings are held to train staff in new areas. Staff are also encouraged to attend continuing education courses."

To summarise: You have two marketing tasks that must be undertaken simultaneously. The first is to identify the market you will be targeting with the services you are introducing and to develop an effective strategy for capturing the attention and commitment of that potential customer group. The second is to market the change program itself to those who work with and for you so that they are committed to put the marketing strategy in place and to ensure that it becomes an integral and continuing part of your ongoing operations. An important outcome of succeeding in these two tasks is that you, your colleagues and your staff will have acquired experience and skill in undertaking change and this skill can be captured and transferred to new change programs. The most important "meta" skill for business in the future is to develop within the organisation the capability and will to mobilise for continuing innovation and change. Pharmacies deserve not only experienced and competent managers but also experienced and competent change leaders. If you aren't one now, you are on your way to become one of these.



Questions to ask yourself in reviewing this segment

- Have I clearly identified the market segment to be targeted by this new service?
- Have I used all the sources available to me to identify the market segment's characteristics and their likely use of this service or suite of services?
- Do I need specialist advice on how best to reach this target market?
- Do I have a clear message to convey to them the value of the service/product mix I am offering?
- Am I sure that I have chosen the marketing channels that potential consumers in this target market pay attention to and are influenced by?
- Do I need to use mutually reinforcing channels to ensure the program has maximum impact?

- Have I planned beyond the initial launch to ensure ongoing reinforcement of the message?
- Am I really sure that, when potential consumers come, my pharmacy can deliver on the value proposition?

3.7 Aligning the Change



3.7.1 What is alignment?

Leading change strategist Lynda Gratton points out that, "As visions and values and the meanings associated with these visions evolve, so too do the processes and practices which create and support these visions. These realignments may involve one or more elements of the organisational system and processes or...a more fundamental questioning of the basic premise of the organisation" (Gratton 2000). "Aligning the change" raises the issue of whether change can be simply *incremental*, working from the existing base of assumptions people in the pharmacy or network share, or *transformational*, which will involve making some fundamental changes in how people think about the organisation and its purpose.

Some pharmacists clearly perceived the need for alignment as change moves forward:

"The corporate vision for change and the implementation of change in the individual pharmacies in the network need to be carefully managed as there can be a disjunction between the two."

3.7.2 Identify and eliminate organisational disjunctions

This kind of disjunction can occur as you change one part of the organisation, such as the vision for the network as in the quote above, and start implementing the necessary change program to bring that vision into reality. Particularly in a relatively complex organisation such as a network, it is possible for people to understand the vision differently so that the resulting change programs in each pharmacy start to move the network in divergent directions.

Change practitioner Bob Doppelt writes of the importance of senior managers developing a clear and unambiguous vision of "what they want to achieve and effective principles to guide decision making. They are utterly committed to attaining their goals." (Doppelt 2003). He gives numerous examples of firms with leaders who reduce alignment

problems by the clarity and consistency of their own words and actions. “Because of the explicit choices they make, those leading the way believe that an unshakable commitment, unambiguous clarity and the continued production of results will spin the ‘wheel of change’ toward sustainability faster and faster. The faster they go, the more people will jump on board and help push the wheel forward” (Doppelt 2003).

This clarity of vision can be seen in an example from a pharmacy moving into compounding and aligning the layout of the pharmacy to express the change in the vision of how this pharmacy differs from others:

“The compounding story in a nutshell is a story of life extension, okay, and the model is based on functional integrated medicine. What it means is this: You’ve got an obvious retail component which draws people in and you have to have someone in a retail presence. But that’s like what we call the dinosaur part of the pharmacy model. So you give people a bit of retail, okay, what they want to see. Then you go into admin, which controls the prescription activity and make sure that the information is given out to people. That’s what you call the nerve centre. Then you go to the lab, the formal lab where you’ve got technicians, pharmacists, working to produce a compound product. Now the next section we’ve got three consulting rooms, because you get people who come in the belief that there’s more to life than conventional main road pharmacy.”

This is a particularly interesting example because the new layout not only expresses the vision but it shows a sensitivity to the fact that the consumer may not yet share the vision and so needs to first encounter a comforting familiarity as he/she enters the premises but then is inexorably moved on through a realisation that this really is a different kind of pharmacy. The layout of course also signals to staff that this is a transformational view of the nature of pharmacy because it is not a minor modification to the layout of a traditional pharmacy – it is a whole new concept.

In the example above, the staff in the different sections of the pharmacy have quite differentiated functions. It would be possible for dislocations, even conflicts, to occur between the teams in each area. Alignment requires that these teams with very different operational tasks have a view of the whole system and can clearly understand how their contribution fits in to the overriding vision for the pharmacy as a whole. Your task as a manager of change is to ensure that you have a clear vision of the change you wish to bring about, that you articulate that vision in ways that communicate to the minds and emotions of those who work with you and that your behaviour is also aligned with the vision. There is a wise saying: “What you are doing shouts so loud I can’t hear what you are saying.” The first kind of alignment you need to cultivate is alignment between your vision and your own words and actions.

3.7.3 Work toward increasing consistency in all aspects of the life of the pharmacy

You need to ensure that consistency is reflected in the organisational structure you create, which acts like the skeletal structure of the organisation. In another case study of a pharmacy with a Multi-Specialty strategy this organisation was again reflected in the layout. The business operations were divided into three distinct areas:

- the front-of-shop component
- the middle-shop component which includes over-the-counter scheduled and unscheduled medicines, wound care and other professionally driven areas
- the dispensary.

The changing strategy (from Traditional Pharmacy to Multi Specialty) influenced the structure and flow of resources emphasising the service component in the “middle shop”:

“..that service component and the advice from a pharmacist I still view as being one of our core competencies, not something that we do on the side, and it’s something that we’ve always aspired to do well and be the best at in our area..”

This also makes it easier to decide what product areas and services to discontinue. In this case the pharmacy discontinued offering services provided by a beauty and hairdressing specialist, a naturopath and a baby clinic nurse. These services were seen as incompatible with the image the pharmacy was trying to create and the quality of the service flow was intermittently interrupted as specialists left to start their own businesses elsewhere, taking clients with them. Alignment means ensuring that all functions work together to express the core vision of the pharmacy — it affects what services you decide to include and what you exclude. Choices about what *not* to do are often at least as important as choices about what to do.

In the case of another Multi Specialty pharmacy, alignment meant initiating an environmental search to identify new service areas that “fitted” their niche marketing strategy and could be added to grow the business. They commissioned a market research survey. One finding of the research was that teenagers viewed the pharmacy as having an older, more “up-market” image that was “less in touch” with their specific needs. As a result, the pharmacy has decided to develop a dedicated teenage area with products and services designed to appeal to this market segment. Part of the strength of a Multi Specialty approach is that the pharmacy can keep identifying new market niches and adding on new services for these specific groups.

3.7.4 Ensure you have created cultural alignment

We have said that organisational structure is like the skeletal structure of the body. There is also a need to align the culture of the organisation which is like the reflexive part of the brain — the deep consciousness that means we don’t have to think about everything we do but act out of habit. Organisational culture determines what people do when you, as manager, are not looking over their shoulder. You need to ensure that your vision and strategy are so internalised by those who work in your organisation that their actions are consistent with the vision and strategy, even though they are not consciously thinking about them most of the time. The analogy is driving a car — we perform most functions automatically until something occurs that means we have to insert a change in the habitual program we are operating on. This is easier to achieve if you hire people whose values are consistent with the values embodied in your vision and strategy. If you are trying to drive a culture of organisational learning and skills acquisition, as you need to do, for example, in a Multi Specialty strategy, you need to hire staff who are strongly committed to personal growth and professional skill development, rather than those who simply want to get by repeating routine tasks which make few demands for learning on their part.

Alignment can mean a fundamental redesign of your organisational structure and culture or it can be simply like a tune-up for your car. Where it is between these extremes is

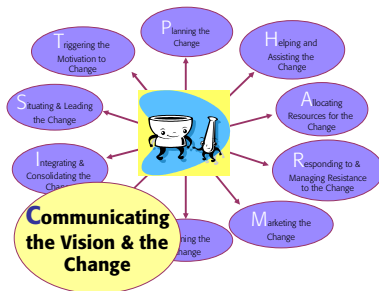
determined by whether your change program has introduced a revolutionary new vision for the organisations with a new strategy to match (transformational change), or whether your vision and strategy have basically been put in place and all you need are relatively minor adjustments to ensure that everyone is working together, making consistent choices on a day-to-day basis (incremental change). Without alignment, however, the change process can lose momentum and fail (for further reading on the importance of cultural alignment see The Price Waterhouse Change Implementation Team 1996)



Questions to ask yourself in reviewing this segment

- Have you identified and eliminated any organisational disjunctions?
- Have you established consistency in all aspects of the life of the pharmacy?
- Have you created cultural alignment within the pharmacy – is everyone committed to your change program and service delivery platform?

3.8 Communicating the Vision and the Change



In undertaking a change program for your pharmacy, you will have a vision of the kind of pharmacy of the future you want to create and the services that your pharmacy will offer. Your vision encapsulates the key elements of where your business strategy will take you so that you can communicate what it is you want to bring about in a compelling way. The results from the mail survey were encouraging in that they indicated that approximately three-quarters of respondents agreed/strongly agreed that they were clear about where they wanted to take the pharmacy. 63.6% of respondents agreed/strongly agreed that they had a clear vision for their pharmacy.

3.8.1 What is a vision?

Harvard Business School change guru John Kotter writes, "Vision refers to a picture of the future with some implicit or explicit commentary on why people should strive to create that future" (Kotter 1996). A vision is a short summary of where you want to take your pharmacy in the future, expressed in a way designed to engage people's attention and begin the process of winning their commitment. Your vision should clearly indicate the direction you plan to take and summarise the outcomes you believe will eventuate.

Like colds, visions can be caught! You may be one of those people who generate your vision entirely on your own, but many people are initially inspired by the visionary ideas of others and go on to develop those ideas in their own work.

"I actually think that the way [X] talks about the provision of service and cognitive services in the last few years has helped me more than anything to have an idea of where I want to go in the profession. So although you know HMRs aren't well remunerated, I actually think that the vision has given me more idea of where I'm going."

Effective visions are simple, like this:

"The pharmacy owner is committed to creating a total 'Wellness and Weight Loss Centre' within the pharmacy."

There it is — short, concise and intriguing. If a pharmacist told me that, I would almost rush to ask, "Oh! And what does he/she mean by a Wellness and Weight Loss Centre?", and "How's she/he going to do it?". I would get an answer like this to my second question:

"The shop refit is due to open by the end of the year. Other plans include a newsletter to members. This could be tied to a membership fee which is currently being considered for the compliance program".

Attached to the vision is a concrete and achievable action plan with an in-built timetable. Maybe all the details and timing aren't worked out yet but I get the impression that the vision is already being translated into a program for change.

In this case, the owner's vision for the pharmacy itself is only part of a much broader, compelling vision for pharmacy as a whole.

"In broader terms, the owner believes his concept of community pharmacy as a wellness and weight loss destination has the potential to revitalise pharmacy. He sees a niche market for pharmacy in helping educate people about health and nutrition. Ideally he would like weight loss programs in community pharmacies funded by a fee for service under Medicare. He argues that if the concept was successfully implemented in community pharmacies then it would result in dramatic reductions in PBS expenditure on a range of expensive medications in areas such as blood pressure, diabetes and cholesterol. This could serve as a powerful case to government."

3.8.2 Develop a vision for your pharmacy

How do you go about developing a vision for your pharmacy? A vision needs to be something you are passionate about. Visions can seldom be realised by the visionary alone — they develop wings when they arise out of the collective experience of those who have to work together to realise them. So dream your own dreams of the future but listen also to the dreams of others in your profession and of the health professionals around you and of members of your local community. What is the greatest imaginable contribution you could make to primary health care in your community? What would you really like to be remembered for when you leave? Who do you most want to work with amongst your peers — so what motivates them? And what would help those who work for you feel great

when they are asked by one of their children at the end of the day: “Mummy/Daddy what do you do when you go to work?” Try asking them.

“I’m very interested in community health and hope I can leave my mark having been in pharmacy by helping everybody manage their weight better, with exercise and stress management and wellness. That is the whole reason I love pharmacy because I really want to make a difference to people’s health.”

Be aware of your own aspirations and listen to the aspirations of others around you – express your vision simply and discuss and workshop it with others; then follow the energy, the sense of developing excitement about what you could, collectively, accomplish together if you dared.

But you are managing a business too – so you do have to work out practical strategies, find resources and make a profit. The vision must be practical and achievable – and believable.

3.8.3 Communicate the vision to your staff

If you have workshoped the vision with your staff they will already be aware of it in general terms. But creating the vision is one thing and communicating it effectively so that it is known, understood and guides the behaviour of staff is quite another. You will need to repeat it many times and through several channels if it is to survive in the torrent of everyday communication. It is not only the vision that has to be communicated but also the evolving change program that will carry the vision through to its realisation. That involves communicating regularly to ensure that everyone involved knows from day to day what their role is in bringing about the changes and what others are doing to make change happen.

“We have a management meeting probably every week, multiple times during the week if big things come up during the course of it, but Monday mornings and certainly reviews with our staff when we take on new staff. So management are working towards monthly meetings with our pharmacists so that we can keep everyone in the chain as regards all the developments that happen. They happen very quickly in a place like this and then between the proprietor and the manager there are meetings on a weekly basis just to micro-manage the issues we’re working through.”

Particularly in larger pharmacies and pharmacy networks, effective communication often demands a more organised approach.

“In order to manage significant transitions effectively, communication within the pharmacy may need to be further formalised when implementing change.”

The importance of communicating the vision and goals for change to everyone in the organisation have also been highlighted in other research (Roberts et al. 2003; Roberts et al. 2004).

3.8.4 Communicate the vision to your customers

If the change program is going to be effective, the vision must also be apparent to your customers. Ask yourself, “What are we really trying to say to our customers? What is the ‘value proposition’ we are putting to them?” After all, they have no obligation to enter your shop, to buy your products or use your services.

“Our message to the public is that we’ve been around for 30 years; we’ve looked after you for 30 years; we’re still going to be here; we’re not a fly-by-night operation that is purely based on price.”

That message should be apparent not only in what you say to your customers but in the layout of your pharmacy, in the store displays, in the information provided, the advertising you use and in the way staff members deal with the customer. What you do shouts much louder than what you say.

This also links in with how you structure your marketing strategy to consumers. Revisit the Marketing section of the Wheel to consider how best to communicate your vision to the public.

3.8.5 Communicate the vision to other stakeholders

The top item on the list of critical stakeholders is of course the local GPs. Given the historical tensions between pharmacists and GPs, your communications to them need to be very carefully considered and preferably take place in the context of positive personal and professional relationships. And the information needs to be accurate and targeted specifically to their interests.

“I think the communication strategies around those issues [of service provision] have not been really well done, in my view, because I think once GPs understand what is involved and why things are being done and discussed and specifically what is planned, they are normally quite happy with it. They won’t feel in any way threatened at all. It is only people who hear third hand about issues and who sometimes are not given an explanation of what is happening who jump up and down and probably they are the ones who don’t have good relationships with their local pharmacies... I think that the GP/pharmacist relationship needs a lot more work.”

Communicate! Communicate! Communicate! But realise that sometimes the most effective ways of communicating involve shutting your mouth, achieving results and letting others take up the case.

“Initially the owner received some hostility to the program from the GPs and other professionals in the area. However, as customers were successful in the weight loss program and were referred back to their doctor for medication changes, GPs have become more supportive. The pharmacy now receives further referral from GPs.”

One of the problems for an integrated primary health care system is to find ways to connect people to those health professionals and carers who can help them with specific health issues. An effective system for “matching” people with sources of information and

help starts with communication within the local health system itself and pharmacists can play an important role in this.

"We did a great one with Mental Health Awareness Week a couple of years ago. I was organising it and we just sat the mental health nurse from the local mental health ward up at a table with all the posters on the backboard and she was quite private. Anyway no one talked to her all week; she sat there, waiting, chatting away to all the locals; [only] two people talked to her.. and the brochures were disappearing when she'd go to lunch. Anyway she rang me three weeks later. She said, '[Name], I got fourteen phone calls from people who said, 'Look I saw you at that pharmacy and didn't want to talk to you but I didn't know what was available' and it was either for themselves or someone in their family'. And then I think we worked out that within three months she had 22 referrals from that week sitting there and talking to nobody. She was really excited because she said no one walks into Community Health and asks for the mental health nurse."

This brings us to our next point about communication of your change program.

3.8.6 Share in the wider vision of an integrated primary health care system

Actions speak louder than words. Maintaining your organisation's reputation as a committed contributor to community health service provision means collaborating with others to construct tight links in the network of care available in your community.

"The pharmacy owner has a good relationship with a nearby pharmacy offering a sleep apnoea service. He refers potential sleep apnoea customers to them and, in turn, he receives referrals for the weight loss program from that pharmacy."

It also means playing an effective and visible role in raising the awareness of significant health issues.

"A cancer support group, had one major fundraiser earlier in the year and we rounded up a number of our staff who actually helped on stalls and put up tents and the usual. Obviously groups, charity groups, need able bodies to do that and it's a two-way street here; it's not just helping the community but it is also involving our staff to [help the staff] realise that there are other people out there and I also think that there is a number of our staff that would want to get involved in community organisations and don't know how to do it. We are launching next week another sponsorship with Life Education [area] Incorporated – there is a number of these around the country, but this one, our local one is looking after education of drug and alcohol programs, self awareness, into all the schools. But it is ironic that a lot of our staff members are very well aware of that because they have kids that have come home with all these programs so that links into what we are trying to do; it is a community health message situation."

Communicating involves listening to the voice of the community and responding in a timely and focussed way to meet community needs.

"If you're working in a pharmacy five days a week, you've got to learn. You hear from your customers, you hear from the doctors, you hear from your nurses. You

hear a lot of what people want and don't want. And if you think there's a need for a particular service within your catchment area that your pharmacy is situated in, and nobody else is doing it, then go ahead and do it."

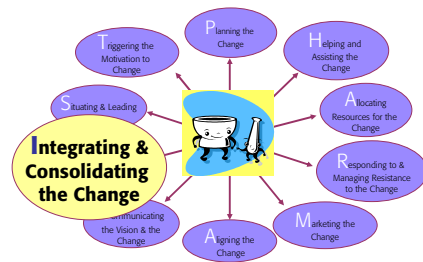
A phrase on the lips of many executives today is "earning the licence to operate". Ultimately what you have going for you in running an effective pharmacy and continuing in business, and what Pharmacy as a whole has going for it, is the community's belief that what you are doing is worthwhile. This is expressed in their patronage of your services and in their support for continuing funding of pharmaceutical products and services by the government. Community support gives every organisation the right to operate — community support can remove that. You can lose your licence to operate when your customers vote with their feet to go somewhere else for their pharmaceutical supplies and health services or when the government decides to remove funding from particular products and services. Your ability to communicate the importance of the services you offer, by what you say and do, will either keep your pharmacy thriving or see it wither away.



Questions to ask yourself in reviewing this segment:

- Do you have a vision which is simply and clearly expressed, will engage people's attention and help win their commitment?
- Have you involved your staff in the development and review of this vision?
- Have you communicated this vision to your staff and put in place an ongoing communication system to involve them translating the vision into action?
- Does each member of your staff who needs to be actively involved know their role in implementing the changes associated with the vision?
- Have you communicated the vision to your customers and other stakeholders so that they understand what outcomes the change program is seeking to bring about and how it might affect them?
- Have you integrated your vision into a wider vision of an integrated primary health care system?
- Have you listened carefully to and responded to your stakeholders' concerns so that you can be sure they will support your continuing "licence to operate" in this area?

3.9 Integrating and Consolidating the Change



One of the challenges you will face in leading change is ensuring that the various activities which you initiate don't peter out but are strengthened and consolidated through being integrated into other related activities. This holds both externally and internally. If your change program remains isolated from other community health care provision, you will need to continue to fuel it largely with your own energy and resources. Similarly, if the service delivery program is isolated from other activities within the pharmacy, it may lose energy no matter how boldly you initiated it.

3.9.1 Integrate your change program externally

Ideally pharmacy is part of the coordinated delivery of primary health care in community settings. We have predicted an increasing government and consumer interest in integrated health service provision models. Your change program can be strengthened by increasing its coordination with and integration into the broader local health care service provider network in the community served by your pharmacy. Pharmacists spoke of linking up with the activities of community health workers, community health nurses, psychiatrists, GP practice nurses, naturopaths, staff of baby health clinics, dieticians and a wide range of carers from associations specialising in care of those with specific chronic diseases such as diabetes, Alzheimer's Disease, eating disorders and cancer. By collaborating with them, the change program is amplified and strengthened.

"Quite frankly, community health people are very under-utilised. By default, through schools or whatever, I got to know a few community health workers. And that's part of our success with the methadone program. But I think we all don't know or use them enough. Community health has got diabetes [management]...recently I think some of them are actually implementing asthma support groups. They have dieticians. They have drug and alcohol services. We hardly use them and we hardly know about them...They [pharmacists] need to visit a community health centre, find out what a baby health clinic in the Community Centre is, what a diabetes educator does."

"There's a broad range of consumer carers that have involvement there so, you know, we've got a pretty strong league across the board, and we have worked with the PSA specifically on Partnerships with Health Promotion and that the role of that organisation is currently to work on issues of joint concern."

“Community health nurses are good because they try to do linking [to us] for chronic disease states and things like that and they come and let us know what courses are on and when you can go to the council for this or that. They’re so good, they come out and just this week we had a professional promotion going, they had their stand in the pharmacy and we’ve got all their brochures and they’ve got our brochures. They’re good... They just come in to us and they stay with us in the morning and have morning tea in the shop and then we go up there....”

With planning, from such ad hoc coalitions of health care professionals, activities and events can be organised to raise community awareness about positive health care issues and to marshal a variety of coordinated activities and programs beyond the resources of a single pharmacy to organise.

3.9.2 Integrate and coordinate within the network and pharmacy

As about 50% of pharmacies are involved in networks, we will consider internal integration within networks and then within the individual pharmacy.

Integration within the network: If your pharmacy is part of a network, you can strengthen your change program by integrating it into network activities.

“Importantly the Group structure provides a close network of pharmacy peers who meet once a month to discuss issues, share ideas, propose new developments, etc. These pharmacists range in age and experience which means there is a lot of potential for knowledge sharing across the group. The group also shares resources. For example, there are ten accredited pharmacists in the group. If the pharmacy receives a request for medication reviews and they do not have an accredited pharmacist at that pharmacy then they can call on an accredited pharmacist within the group to supply the service. Referrals are made to pharmacies with particular areas of specialisation. For example, the owner’s pharmacy specialises in home health care equipment so it receives referrals from other pharmacies within the group for these services.”

Integrating activities across a network allows for higher levels of innovation and flexible deployment of a wider range of resources. This in turn builds the momentum of the change project as well as providing more stimulation and ongoing professional development.

Integration within the pharmacy: Where the introduction of services into the pharmacy is still limited, it is particularly important to ensure that the activity is strongly linked to existing activities on an ongoing basis.

“There is a very close working relationship between the pharmacists and the pharmacy’s naturopath. The pharmacists are very active in referring potential patients to the naturopath who, in turn, is very aware of the possibility of interactions with traditional medications and refers patients back to the pharmacist as necessary. The naturopath is regarded as the in-house ‘expert’ on a large range of complementary products available in the pharmacy. This knowledge is passed on to customers and also to the pharmacists and the front-

of-shop staff. The full-time staff are also educated about the sports nutrition products which are another growth area for the pharmacy."

In this case, the introduction of alternative medicines could have created a rift in the pharmacy – a "them versus us" situation disruptive to the overall service provision. Instead the innovative activity has been given a large degree of autonomy, but integrated into the traditional pharmacy services so that there is a mutually supportive relationship. The result has significant benefits in improving quality of patient care and in business terms by cross-selling.

Involving all or most of the key players in the pharmacy in the provision of a new service increases support for it and ensures that its implications for resourcing and the organisation generally are taken into account.

"Servicing the private hospital is a shared responsibility between all the pharmacists on staff including the owner. This provides them with enhanced professional development opportunities and brings variety into their working day."

This kind of internal integration creates a more stimulating professional environment and energises those who are involved, thus ensuring their ongoing support for the change.

3.9.3 Develop a "clear line of sight"

If you work at integrating and consolidating service provision into the activities within your pharmacy and network and within the primary health care delivery systems operating in your community, you can develop a "clear line of sight" which makes it easier for you to manage their operation. By a clear line of sight we mean that there is an internal consistency and clear logic for their operation within the business strategy you have chosen (see Pharmacy Viability Matrix in section 4 chapter 2). This makes it easier for you and others to understand the reason for having these services, to see how the services relate to their own work and encourages them to support the initiative on an ongoing basis. In this way other internal and external operations sustain, reinforce and continually re-energise your initiative and you can go on to innovate in other areas.

3.9.4 Build a service culture

Culture represents the embedded values, norms, symbols and routine behaviours that determine employee behaviour when you aren't looking over their shoulders. Ideally your organisational culture is strategy in action, so embedded in people's thinking and behaviour that they are mostly unaware of it. Culture derives from the experiences people share while at work and particularly from the drama of organisational life – the successes and failures, the celebrations and traumas. A culture finely tuned to the work that needs to be done drives organisational performance and creates a shared frame of reference for interpreting the meaning of what is happening.

When the other resources are allocated to support service provision, they take on meaning within the context of a service culture. You need to devote time to organising events that bring those involved in service delivery together, are memorable, involving, enjoyable and which underline the importance of being customer focused and delivering high quality health care services.

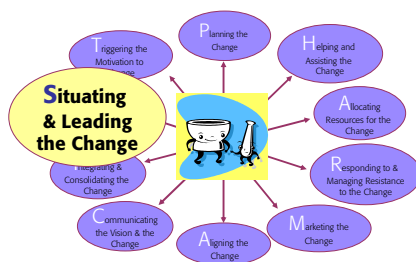
"We can't compete with the major banner groups who've got huge volumes of purchasing power. The thing that makes us different, and that we really want to hang on to and won't let go of, is service. Everybody's got the same products on the shelf and, you know, [Banner Group 1] and [Banner Group 2] have all got the same products. So what is it that we deliver? We want to be the best at looking after customer's needs. So part of what the retail manager's brief is in terms of training is to work slowly and incrementally – because it can't happen very fast – but to keep working with our team to improve what we deliver in terms of service. Can we do it better? The answer is always 'yes'. And then we go away and figure out how we are going to do it for the customer; not 'No, we don't have that'. We don't believe in the single syllable response 'No'. So we are trying to build a service culture."



Questions to ask yourself in reviewing this segment:

- Have I reviewed other health service offerings in my community and endeavoured to coordinate and integrate my proposed/current service provision with them?
- Where possible, have I created collaborative relationships with other providers?
- Are my staff and I working actively with other groups to increase community awareness of health issues?
- Within the pharmacy, have I ensured that new services are fully integrated into the overall pharmacy operations?
- Have I developed a "clear line of sight" so that all staff can see the way in which their work impacts on the desired outcomes for service provision?
- Are we building a service culture throughout the pharmacy and the pharmacy network?

3.10 Situating and Leading the Change



As leader of the change process, you have an important role in situating the change internally in the pharmacy with your staff and externally with your key stakeholders. Realise that change leadership has different characteristics from the ongoing operational management of the pharmacy. Management expert John Kotter distinguishes what managers do from what leaders do. Managers, in his view, spend their time on planning and budgeting, organising and staffing, and controlling and problem solving. Leaders, by contrast, establish direction through developing a vision and strategies for reaching that vision, aligning people behind the vision and strategies, and motivating and inspiring them

(Kotter 1990; Kotter 1996). Of course, as a pharmacist you will probably find it necessary both to manage and lead but it is important to realise that they are very different activities.

3.10.1 Situate and lead the change internally

You must lead change.

"Achieving this level of success in the weight loss program area requires a significant long-term commitment, both professionally and financially, by the pharmacist owner or owners."

Commitment from the top is necessary but not sufficient for a change program to be successful; in addition those in the pharmacy must each understand their own role in bringing about the change and identify with the change. If this is to be achieved, their own enthusiasms and dislikes must be taken into account in distributing the responsibility.

"I make sure that I choose the right staff for the right job. I've just been to an AIPM conference which was fantastic and I came back and did a strategic planning evening with my key seniors. And part of it was just asking them some things, personal goals of their own, things that they'd like to do. And from that I've actually made sure that I've got the right staff looking after the right sections of the shop. What do you really hate doing? So there's someone who really hates dealing with the baby section, so I'm not going to give them the baby section to develop. It's a big mistake."

Internally leadership is about positioning the change so that it is aligned with the interests and enthusiasm of those who need to drive it. You must ensure that there is commitment to change at every level – no weak links in the chain so that the inspiration goes right to the front line where it is evident to customers.

"We took what [banner group name] gave us and we filled it up with all this cool professional stuff underneath – like having morning tea for diabetics and getting the staff to cook diabetic food and putting a cook book together and giving it to customers when they come in. In Insomnia Awareness Month the staff wear pyjamas every Thursday and wear a badge saying, you know: 'Not sleeping? Ask me.' You know, how we can help and we do training in advance so they [the staff] can help."

But what if no one in the pharmacy is really interested in supporting the offering of a new service? There may be no one on the staff with the enthusiasm to manage a new service delivery project. Rather than give the project to someone who will not fully commit to it (or give up on the idea altogether), it may be better to go outside and find a committed person elsewhere:

"We hadn't had a lot of success with the diabetes project with Sydney University because neither of the two pharmacists working in the pharmacy were particularly passionate about diabetes. But I had another friend who's actually a diabetic pharmacist, who's got the time and she's done the diabetic specialist management model as well and no matter which pharmacy she works in she'll have a little following of diabetic people. I think passion is absolutely essential for somebody implementing something because if you don't have some degree of interest in it, it's very hard to keep the motivation up."

There may be other reasons for going outside — beside finding someone with enthusiasm, there may also be a need for specialist knowledge that no one in the pharmacy can bring to bear on the change project. You could try to develop that specialist knowledge in-house but that will take time and you may not at first have enough business in the area to warrant such an investment in training an insider.

“As this side of the business has expanded, the owner has spent more of his time developing this project. He had a ‘real passion’ in the area of nutrition but he also looked outside the pharmacy for a specialist trained in this area.”

However, the staff of a pharmacy is not simply a collection of individuals. Part of situating and leading the change, particularly in larger pharmacies, is building teams in which staff collaborate to move the change ahead. Creating “self-leading” or “semi-autonomous” teams means that you as the pharmacy owner don’t need to manage every staff member’s contribution to the change program on an individual basis — you can simply manage the teams.

3.10.2 Teamwork begins at the top

“You’ve got the older partners and then you’ve got the younger partners coming in so you’ve got this broad spectrum of knowledge you can draw on... We’re a team. If I don’t have something, I’ll ring another pharmacist and refer them on.”

Teamwork needs to be built into the culture of the organisation as a whole.

“Teamwork across the group and the idea of ‘strength in numbers’ is a central component of the Group’s corporate philosophy. Being part of a larger structure is also a motivating factor for the owner who enjoys having a network of pharmacist peers with whom she can share knowledge and discuss pharmacy issues. Being a team player also extends to the pharmacy staff who are encouraged to be part of the group’s community sponsorship strategy and to be active in the local community. Continuing pharmacy education is funded by the head office and senior staff are rewarded by being given the opportunity to attend the Group’s annual conference.”

This strong team basis can be further supported by carefully designed human resource policies and practices.

“At this pharmacy, the owner uses a participative management style and encourages staff to ask questions and seek further information. Exit interviews and staff appraisals are a standard part of the operating procedures of the pharmacy.”

In the case of one group of pharmacies that worked on developing a strong human resource program, they were able to spin off this aspect of the pharmacy’s practice into a profitable business in itself.

"I set up a joint venture with a mate who helped me with the Human Resources Program and [we] set up a human resource company for pharmacy which I've recently consolidated under [name of company]...It evolves out of the infrastructure for the Group but then develops into commercial infrastructure where it does actually self-service into other stores."

This is an interesting case of capitalising on an initial outlay in the building of in-house capability so that what could have been a business expense becomes financially self-supporting and an independent source of profit.

You don't have to do it all yourself — learn to delegate. Delegation of administrative tasks and "sticking and stapling" in the dispensary frees the pharmacist to focus on professional and business activities. This has been shown to be a facilitating factor when implementing a new service (Roberts, Benrimoj et al. 2003).

3.10.3 Situate and lead the change externally

Externally your role in leading change is to situate your pharmacy with the activities of key stakeholders and build a support base with them so the internal momentum is amplified. Your unfolding change implementation program deserves to meet with external support rather than with indifference or opposition.

Increasing dependence on one stakeholder — the government — was seen as a risky strategy into the future by some pharmacists. There is a need, perceived by some, to situate pharmacies so that their financial support is more widely spread. For example:

"It is clear that the owner is 'feeling his way' with some of the newer programs being offered in the pharmacy. The pharmacy's strategy de-emphasises the dependence on PBS funding as it is believed by management that the pharmacy industry will need to be less reliant on PBS funding in the future. The owner believes prevention and the nutritional influences in disease states will increasingly be seen as more important than treatment. With compounding and front-of-shop business accounting for 50% of total business, the owner sees a viable future for the pharmacy focusing purely on compounding and preventive and complementary medicine."

Externally then you proceed to identify the key stakeholders whose support you need. For example, one pharmacy saw the local hospital as an important stakeholder and actively worked to gain their continuing support.

"The hospital pharmacy service has been in operation for one year and the pharmacists have developed excellent working relationships with the clinicians over this time. According to the owner, the clinicians compare the pharmacy service across the public and private hospital systems and many believe the outsourced pharmacy service model is more efficient and provides a better service to them. It's efficient, it's cost effective and for them [the clinicians] it involves a higher service component than they have seen previously in the public hospital."

Examples of strengthening other stakeholder relationships:

"The pharmacy also has good established relationships with the town's Drug and Alcohol Centre, an important relationship for the pharmacy's methadone and buprenorphine patients. Other important professional relationships are with the local incontinence team and other health care providers."

"You have got to build a relationship first [with the doctors in order to gain their cooperation for collaborative reviews]. At [country town], there were doctors there that were, you know, 50 years older than me at the time, and you know they hated me ringing them, but the fact that I played golf with them or I saw them or we had these dinners every couple of months and then you talked to them about what some of the challenges were and they then realised that you were only doing your job."

The support received by increased service provision will only be as strong as the potential demand for the services and the network of stakeholder relationships you build in the community your pharmacy serves. Support must be built by communication, personal and professional relationships and collaborative exchange. Even apparent competitors can be involved in a collaborative exchange to their mutual benefit:

"The town's health food store is directly opposite the pharmacy and there is a also a good relationship established there. The pharmacy owner acknowledges that the health food store has some specialised products and knowledge that the pharmacy does not currently have. Referrals from one business to the other are relatively common."

All this is designed, however, to build competitive advantage in key business areas.

"Community pharmacy is very well positioned to monitor customers' weight loss progress together with their use of medicines and refer to GPs if needed. In the owner's opinion, this provides community pharmacy with a competitive advantage over other weight loss centres."

If, despite repeated attempts, you can't do better than your competitors, consider leaving the field to them.

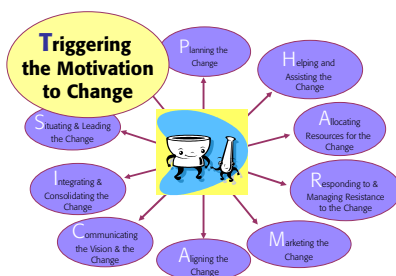
Situating and leading involves achieving a balance in the time you spend on internal and external activities. Your aim should be to create momentum for change within your pharmacy or network of pharmacies which is increasingly reinforced by the enthusiasm of staff committed to the move to service provision. This then allows you to spend more time externally situating and leading the change in a network of supportive stakeholder relationships so that you are able to build your pharmacy's contribution to primary health care and focus its competitive positioning in the market.



Questions to ask yourself in reviewing this segment:

- Have I thought through what I need to do differently to lead change as well as to manage ongoing operations within my pharmacy and/or network?
- Do I have the personal capabilities and skills to be a leader of change? If not, where can I find the developmental opportunities I need?
- Are the partners working as a team in supporting and leading the change?
- Does the change program I/we have devised capture the imagination and interests of staff in my pharmacy?
- Do I have enough staff who are committed to the change and have the knowledge and skills to make it happen? If not, do I need to go outside for these resources?
- Am I providing leadership in managing the change with external stakeholders, progressively winning their support?
- Am I ensuring that my pharmacy is providing the highest quality service provision in this area?

3.11 Triggering the Motivation to Change



3.11.1 Why change?

In the end, change is a very human process and depends on everyone involved in making the change, including yourself, being motivated to change. Our focus groups, interviews and case studies addressed the question of what motivates pharmacy owners, other pharmacists and pharmacy staff to participate actively in change, particularly in change to increase service provision. There is no single trigger, for human motivation varies greatly from one individual to another; however, we can make some useful generalisations about the major triggers that motivate commitment to change in pharmacies.

The obvious (and simplistic) answer to the question of what triggers motivation to change was given by some as “financial rewards”, although those giving this answer were in a minority. The long history of research into human motivation shows that financial rewards are important motivational factors but not the most important factor in most circumstances (Wood et al. 1998). This is certainly true of pharmacy owners and personnel. Nevertheless, pharmacies are businesses that are run for profit and therefore financial

rewards for service provision may seem at first to be not only important but also **the** answer in motivating personnel, particularly pharmacy owners. So let's look first at the role of financial incentives in motivating change.

Certainly the absence of adequate financial rewards for service provision was a **demotivating** factor for many pharmacists. Given a busy schedule and the substantial and well understood incentives for alternative (traditional) activities such as filling scripts, many pharmacists viewed increased service provision as an unattractive option. This was particularly the case where government subsidies provided comparably less reward for an equivalent time commitment. In this case, a sticking point in service provision was seen to be the public's expectation of obtaining free services from pharmacies — an expectation often supported by the norms of pharmacists themselves. Many pharmacists were reluctant to consider charging customers for enhanced services unless the government was prepared to subsidise them, as in the case of HMRs. Even where government subsidy was involved, comparisons were made of potential financial rewards that could be earned by devoting time and resources to alternate activities.

But overall there was strong motivation to provide extended services if incentives were available and other key resources for service provision were accessible. There were two prime reasons for this: the opportunities for professional development provided by service provision and the satisfaction of contributing to enhanced patient wellbeing. We deal with these motivational factors in turn.

3.11.2 Professional Development Opportunities

Pharmacists view themselves as highly trained professionals yet much of their work can be repetitive, boring and unchallenging. They spoke of "the regimentation of the dispensing process", "the sausage factory in the dispensary", where they spent hours churning out medications to fill scripts, and of the unchallenging work of front-of-shop sales.

"But who around here, around this table, likes selling detergent? You do it because you have to. If the remuneration was there for professional services then, hell, I wouldn't be selling washing up liquid"

Service provision is attractive to many pharmacists because it provides "professional variation" — i.e. new and challenging professional work, professional development and stimulation, and opportunities to broaden knowledge and professional capabilities.

Expansion into further service provision also triggers motivation because it is seen to strengthen the pharmacist's role as a primary health care provider. Clearly many in pharmacy see it as a "helping profession" and specifically refer to money as a secondary motivator.

"Sometimes you have just spotted a community need...you see some people in the community just need help. As a pharmacist, you can't always think of the dollar."

"When you think about some of the services — half of those would not be financially rewarding for us. But personally as a professional person it is rewarding because you are actually providing a service to your own community. Asthma management, for example...I will probably get nothing out of that."

A trigger such as professional development was enhanced by pharmacists working actively and collaboratively with other health care professionals who represent “the front line of primary health care” and “a virtuous circle of patient care”.

“The Home Medication Reviews circle was created by providing a financial incentive and meant that the GP had someone – a pharmacist – sitting in front of them going, ‘This is a great service. All the evidence shows benefit to your patients, benefit to you, medico-legal benefit, financial benefit...the whole stuff’. So I think Home Medication Reviews work. So therefore, you know, the GP and the pharmacist stepped into the circle and it proved to be a nice circle. So really, in a sense, the system drew the circle and invited the players to step inside and have a go at coexisting there. And some liked it and some didn’t.”

It is important that your change program offers you opportunities for professional development otherwise your motivation may falter.

3.11.3 Keeping up and gaining competitive advantage

Pharmacy owners are running a business and are often aware of emerging trends in the business environment of pharmacy. Some referred to their awareness of present and future threats such as competition from supermarkets. These threats produced an awareness that, as one pharmacist expressed it, “If we don’t change, we die”. So perceived threats to business viability were also a trigger for change. For some pharmacists, the innovators, this was enough in itself to trigger their motivation to innovate and to search around for positive examples of successful pharmacy change. Others were slower to become aware of what other leading pharmacies were doing but professional communications from the PSA, the Guild and other sources nudged their increasing awareness. Positive models of change in other pharmacies were a help in motivating them “to keep up” and to find out more, sometimes by a systematic search process, about how more innovative pharmacies were engaging in changing the model of pharmacy. These positive models then became the basis for innovation and were used to inspire pharmacists and their staff to emulate perceived success and to strive for increased excellence.

Some pharmacists felt that their staff were more motivated when change was introduced and that change stimulated interest, enthusiasm and commitment particularly where the staff members themselves were given an active part in designing and implementing the changes. Interest and special events around the introduction of service provision and its promotion and then the celebration of success were seen as contributing to ongoing motivation to introduce further change, maintaining the momentum. The availability and accessibility of courses and training manuals also increased the likelihood of change being adopted as they represented tools to facilitate the transition.

Most employees enjoy being part of a leading-edge team where they too can help keep their existing skills updated and also extend their repertoire of work skills. If you create an exciting change-oriented culture where there are opportunities for learning and growth, you will attract more competent and motivated employees. Becoming an ‘employer of choice’ reduces recruitment problems and allows you to employ more highly motivated and more capable employees who will enhance the success of new change initiatives.

3.11.4 Demotivators

The burden of repetitive tasks could be a motivator of change but it can also be a barrier to change by not allowing you enough time to research change options, plan for change and implement it effectively. Similarly, the shortage of qualified staff and difficulty of accessing training resources often means that there is no spare capacity to implement changes or provide more labour intensive services. Frequently pharmacists we interviewed wished to introduce change but felt powerless to do so because they were barely coping with the existing traditional functions of managing a pharmacy. If you are in this situation, work at freeing up enough time to engage in the more important and exciting tasks of initiating strategic change and introducing more cognitive services and watch how your motivation and the motivation of your staff increases.

3.11.5 Summary

The triggers motivating change in pharmacies can be summarised as follows:

- Services are more likely to be introduced if
- the financial rewards are commensurate with those rewards available from existing alternative activities such as dispensing or selling retail products
- the service work offers opportunities for professional development such as the extension of professional knowledge, acquisition of new professional skills and greater work variety
- the service work is seen to meet a recognised community need so that service provision strengthens the role of pharmacy as the front line of primary health care
- the service brings the pharmacist into a positive, collaborative relationship with other health care professionals in improving primary health care
- the services provide a competitive advantage *vis-à-vis* other pharmacies by strategically repositioning the pharmacy so that it occupies a stronger market position
- the ongoing change contributes to raising the motivation, commitment and capabilities of pharmacy staff.



Questions to be asked in reviewing this segment:

- Have I figured out what motivates me and ensured that the change program I have designed will keep me motivated? In particular, will I be adequately motivated by: (a) the expected financial rewards (b) the professional development opportunities (c) the expected competitive advantage of offering the new service(s) (d) the contribution to meeting community needs?
- Have I ensured that the new tasks, jobs and work design will be motivating for the pharmacy staff involved?
- Have I provided opportunities for staff to be involved in planning and implementing the change?
- Have I ensured that staff have the necessary training, development and resources to deliver the change?

3.12 Further Reading

For further reading see the following texts:

- Burke, W.W. 2002, *Organization Change: Theory and Practice*, Sage Publications, Thousand Oaks, California.
- Burnes, B. 2004, *Managing Change*, 4th edn, Prentice Hall, Essex UK.
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Section 5: Chapter 4

4 Practical Applications

4.1 A Pharmacy Change Management Program – Delivering Asthma Management Services

In what follows we demonstrate the integration of the different parts of this report by showing how to design a change program to enable accelerated and effective implementation of a new service offering. We use Disease State Management with services for Asthma as an indicative example. Similar concepts, principles and procedures can be used by policy makers and pharmacists for implementing a range of other services. There are five phases involved in designing a major change program:

- | | |
|----------|-------------------------------------------------------------------------------------------------------------------------|
| Phase 1: | Identifying pharmacy opportunities for the future: <i>Future Opportunity Matrix</i> |
| Phase 2: | Preparing for industry-level change: <i>PharmInd Change Wheel</i> |
| Phase 3: | Identifying the fit between opportunities and individual pharmacy business strategies: <i>Pharmacy Viability Matrix</i> |
| Phase 4: | Identifying individual pharmacy readiness for the change: <i>Change Readiness Wheel</i> |
| Phase 5: | Implementing the change within the pharmacy: <i>Change Implementation Wheel</i> |
| Phase 6: | Business case for a Diabetes DSM service |

Each phase is important for achieving sustained pharmacy change in new service provision. Whilst it may be helpful to work through each phase in a linear way, in practice it is likely that each phase will need to be revisited at various points in the change process as new issues and opportunities emerge or are realised. On completion of our outline of these five phases we have provided some examples of change tools which, through a Guild-sponsored Centre of Excellence in Community Pharmacy Change Management, could be developed and offered to pharmacists to assist them through a pharmacy change process.

4.1.1 Phase 1: Identifying pharmacy-level, future opportunities for the delivery of asthma services

In the same way that the Characterising Opportunities Filter can be used by policy makers to identify opportunities for the industry as a whole, it can also be used by individual pharmacists to characterise the type of services that will be offered and ways in which they will be provided. This is an example of how an individual pharmacy could use the Filter. The reader is referred to section 2 of this report which outlines the probable future delivery of health care and the opportunities for Pharmacy. The following filter summarises the key decision issues involved in offering pharmacy services for asthma.

Figure 5.7: Characterising Opportunities Filter

1 In spectrum of health care	2 In spectrum of client/professional engagement	3 In spectrum of pharmacy activity	4 By source of remuneration	5 By community pharmacy's professional role	6 In relation to the business setting	7 In relation to resources required
Prevention Early detection Diagnosis and assessment Treatment Rehabilitation Palliation	Self-management ↑ ↓ Professional care delivery	Product ↑ Combined ↓ Service-orientated	Payment by client ↑ Other payers e.g. insurance ↓ Payment by government	<ul style="list-style-type: none"> Novel service being provided by community pharmacy Supplementation by community pharmacy of service provided by others Substitution by community pharmacy of service of service previously provided by others Used to be a pharmacy role and now trying to regain it again Loss of role 	Options include: <ol style="list-style-type: none"> Shop Other professional premises Mixed (1) & (2) pharmacy only With other professionals (1) – (3) Patient's home Nursing home Facilitators E-pharmacy Others 	Skills: <ol style="list-style-type: none"> Basic education Continuing education Training Incentives Infrastructure

4.1.1.1 Column 1 Spectrum of health care

Of the categories in column 1, asthma services are positioned towards early detection, prevention of symptoms, and optimising treatment. Note that the services do not include diagnosis of asthma, rather, an assessment of risk and referral for diagnosis by a doctor.

4.1.1.2 Column 2 Spectrum of Client/Professional engagement

Each of the areas identified in column 1 (above) has elements ranging from self-management to professional care for service delivery. In the self-management area, the pharmacy's services will be directed to enhancing the patient's ability to optimise their drug therapy and manage their lifestyle to avoid triggers for their asthma. At the other end of the spectrum the pharmacy will be monitoring the optimal treatment prescribed by the doctor and this would lead to collaboration between the doctor and the pharmacist to ensure that the treatment is targeted to the patient's needs, that the patient is complying with the treatment program and that the treatment is having the desired effect.

4.1.1.3 Column 3 Spectrum of pharmacy activity

For asthma, this would be across the spectrum of retailing products to professional service. For example, on the product side, the pharmacy may specialise in retailing products like nebulisers, spacers etc to consumers. On the professional service side it would be involved in educating consumers about how to use these devices appropriately, and may specialise in the screening component of disease state management, for example.

4.1.1.4 Column 4 Source of remuneration

Payment for this service could come entirely from government if this were negotiated by the Guild. If these services were not fully subsidised by government support could be forthcoming from other payers and/or consumers themselves.

4.1.1.5 Column 5 Professional role of community pharmacy

Since elements of this new service have not been previously provided, it could be classified as a *novel* service. However, there will be elements of the service which will *supplement* the service provided by others, e.g. by the GP, or *substitute* for services provided by others, e.g. asthma educators. Since this involves both supplementation and substitution, care will need to be taken to ensure smooth implementation of the service by involving current providers/stakeholders at appropriate points of service delivery (e.g. doctors, specialists, asthma educators) in the development and delivery of the service.

4.1.1.6 Column 6 Business setting

The business setting may change over time. However, it is envisaged that the current retail premises would be the main location for service provision since currently asthma patients already frequent these premises for the dispensing of prescriptions and the purchasing of other health care goods. This does not preclude the service being provided:

- in other professional premises, e.g. doctors' surgeries, or
- in collaboration with other health care professionals, e.g. the employment of an asthma educator in a pharmacy, or
- in the patient's home for specific groups of patients, e.g. the elderly,
- through the internet, or

- through phone, videoconference, or web-cam to patients at a distance or to patients who may prefer these modes of communication.

4.1.1.7 Column 7 Resources required

A whole range of resources will be required for the implementation of asthma services. Resources include a variety of skills which will need to be provided through a number of modes of education and training, such as face-to-face, distance, weekend modules etc. This training should be directed to all staff including pharmacists and pharmacy assistants who are involved in the delivery of the service. Financial and non-financial incentives will need to be negotiated as part of the service delivery framework. Changes in infrastructure will also be needed. For example, changes in the service setting, i.e. remodelling the pharmacy to create private areas where patients can be assessed and counselled, and IT programs both to provide the service at a distance and to document service provision are examples of some of these changes. If adopted, a *Centre of Excellence In Community Pharmacy Change Management* could be a key resource for pharmacists as a "one-stop" shop for advice and assistance for those seeking to introduce changes, such as the delivery of asthma services, into their pharmacy. For more guidance in this section see section 4: 3.5, 4.6 & 5.4 and section 5: 4.6).

4.2 Phase 2: Preparing for Industry Level Change: PharmInd Change Wheel

This phase is directed at assessing and preparing the overall strategic framework in which asthma services should be delivered. To date the Government funding model has received the most detailed attention by the Guild where it has considered the strategic resources needed to deliver services that have already been offered. In considering the implementation of asthma services, it would be worthwhile for the Guild to attempt extending the strategic resource base to other potential payers, such as health insurers and individual consumers.

At present there is a policy vacuum in the area of business positioning for both the community pharmacy network and for individual pharmacies. There is an opportunity to change this by using the Pharmacy Viability Matrix to assess the capacity of the industry to deliver services now and in the future. This can be achieved through research to determine the spread of business models across the sector. The research reported here has already undertaken some preliminary work in this area (see data results of the mail questionnaire). The assessment entails mapping the capacity or potential of the current business strategies to deliver an Australia-wide cognitive pharmaceutical service, such as asthma.

In what follows we utilise the *PharmInd Change Wheel* as a conceptual and practical tool to enable industry-wide assessment of service capacity and a framework for making policy decisions and taking actions to influence individual pharmacy owners and their networks. Following this, we outline how individual pharmacies will need to use the *Change Readiness Wheel* (to decide whether they are ready to make the change to offering asthma services) and the *Change Implementation Wheel* (to ensure that they have the necessary skills, knowledge and resources to successfully implement and deliver asthma services).

To reduce reading time, we present the main elements in the adoption of asthma services in dot point form rather than in full text.

4.2.1 PharmInd Wheel: Policies, Policies and Perspectives



Currently there appears to be no overall national strategic policy framework for asthma: the Guild should develop a position paper about role of Pharmacy in delivery of care for asthma.

We recommend that the Guild:

- Distribute this paper to other stakeholders — ministers, health bureaucracy, universities, etc., for fuller feedback and then formalise and periodically update it.
- Introduce standards of practice around implementation of delivery of care for asthma — service standards, advice standards, protocols, quality assurance, and accreditation systems at all levels of the service provision for asthma sufferers.
- Ensure clear cost/benefit analysis for delivery of asthma services at the levels of government, pharmacy industry, community and individual consumer (as per current tender for Asthma Disease State Management).

4.2.2 PharmInd Wheel: Health and Allied Stakeholders



Here the Guild needs to:

- Obtain support from respiratory physician specialists, National Asthma Council and the Thoracic Society.
- Conduct a stakeholder analysis and identify key opinion leaders in each stakeholder group (see stakeholder wheel) and seek to influence positively their support for pharmacy asthma service delivery.
- Obtain support from Divisions of General Practice to encourage them to influence local GPs to support the role of pharmacy in delivering asthma service in collaboration with local GPs.
- Ensure all the relevant stakeholders in the pharmacy industry support pharmacy-level delivery of asthma services.
- Ensure that there are adequate resources to support the implementation of the service at an individual pharmacy level.
- Lobby with stakeholders, including governments, to ensure national priority support for delivery of asthma services.

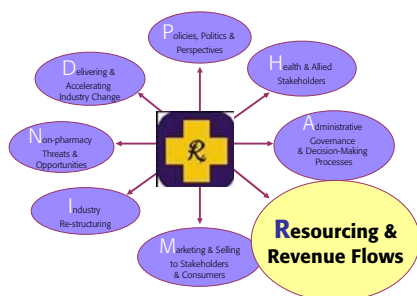
4.2.3 Administrative Governance and Decision-Making Processes



In this area the Guild could consider:

- Developing an appropriate governance structure at an industry level for delivery of asthma services. What is meant by “governance” is clarifying the lines of responsibility indicating who is making decisions around each activity involved in delivering asthma services. For example, if someone is not delivering asthma services to an appropriate standard, what mechanisms will be put in place to address this adequately?
- Creating a Cognitive Pharmaceutical Services Division. All services negotiated would come under this Division, including the delivery of asthma services. This Division to provide oversight for the totality of each service including resourcing, documentation and oversight for quality delivery of the service (e.g. asthma services).
- Establishing a Cognitive Pharmaceutical Services Board that would provide oversight to this division and have wide representation of key stakeholders to provide appropriate industry buy-in to service delivery models.
- Establishing in each service delivery area (e.g. asthma) a CEO/General Manager responsible for the service and reporting to the Board.

4.2.4 PharmInd Wheel: Resourcing and Revenue Flows



The Guild needs to:

- Ensure that an adequate reward structure exists for delivery of asthma services.
- Identify the appropriate resourcing role of government, third party insurers and consumers for delivery of asthma services.
- Identify allied products associated with delivery of asthma services for which consumers would pay, either at a full or a subsidised (co-payment or non-government third party) level.

- Ensure adequate availability of service delivery channels for consumers willing to pay privately for the service.
- Ensure an adequate supply of appropriately trained personnel. Conduct industry skills audit for this purpose. Work with educational providers as appropriate to overcome any deficits.
- Obtain assist from pharmaceutical manufacturers of asthma products and services

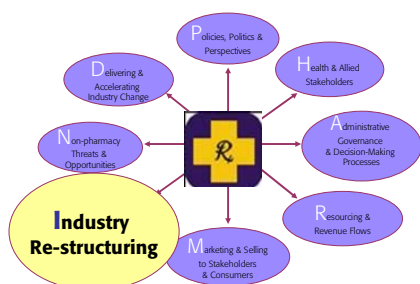
4.2.5 PharmInd Wheel: Marketing and Selling to Stakeholders and Consumers



In this area the Guild needs to:

- Construct a values–proposition matrix which identifies all key stakeholders and types of arguments to be utilised.
- Select high value-proposition arguments to use with appropriate asthma delivery stakeholders, e.g. quality arguments, cost arguments, early identification and screening arguments, etc.
- Ensure that such arguments are tailored appropriately to stakeholders other than government.

4.2.6 PharmInd Wheel: Industry Re-structuring



The Guild needs to:

- Identify expected adoption rate of service among pharmacies. This entails recognition that not all pharmacies will adopt all services.
- Identify ways of ensuring adequate regional coordination of the asthma service to ensure widespread coverage and equity of access throughout the Australian community.
- Identify for individual pharmacies the type of internal employment changes that might be associated with delivery of asthma services, e.g. appointment of a dedicated senior pharmacy assistant, etc.

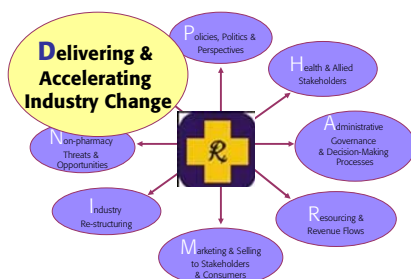
- Identify what new contractual arrangements can or might be utilised, e.g. subsidisation for rural and remote areas or to ensure adequate regional coverage where necessary. This relies upon minimum coverage agreements with government and appropriate funding.
- Map supply chain management issues for delivery of asthma services, e.g. role of manufacturers, banner groups/wholesalers, other local groups/stakeholders, third-party payers and individual pharmacies. Reach agreement with government and stakeholders on appropriateness of roles and related issues.
- Identify lead pharmacies in asthma management as example sites

4.2.7 **PharmInd Wheel: Non-Pharmacy Threats and Opportunities**



- Asthma service delivery is defined as a “progressive change” in that it does not threaten either existing core assets or core activities of pharmacies but rather adds to both (e.g. through accreditation to offer the service etc.).
- The Guild could use this assessment to market to the pharmacy industry how delivery of asthma services enhances activities and the profile of the industry to the wider community, e.g. represents an opportunity to obtain repeat customers and scripts and new customers.
- The Guild needs to define the areas where the service is novel, supplementary or a substitution map out the non-pharmacy threats and opportunities

4.2.8 **PharmInd Wheel: Delivering and Accelerating Industry Change**



The Guild needs to:

- Develop profitability modules to give them tools to guide the pharmacists in the adoption of service
- Ensure importance of asthma service delivery is widely understood by pharmacists.

- Work with state branches to identify ways of recognising excellence in service delivery at level of individual pharmacies: “Outstanding Asthma Service Delivery” Awards, etc.
- Map out other techniques to be implemented over time (12 – 18 month plans) for continuing to capture pharmacists’ attention and interest in the continuing importance of delivering asthma services. This is important to ensure that the momentum of the change program is maintained throughout the industry. Regular media campaigns sponsored by the Guild about the delivery of asthma services will also assist in this.
- Market to pharmacists and owners the importance of delivery of asthma services prior to Guild–Government negotiations. This is designed to shorten the implementation time-lines. Training programs and pilot projects will be needed. Time lags between pilot projects and conclusion of negotiations need to be recognised as a prelude to full-scale implementation. Special Guild funding needs be utilised in this transition period to ensure continuity of build-up and adoption rate in offering the service. Enlist product manufacturers and other motivated parties in providing early resources to get service established.

4.3 Phase 3: Identifying the Fit Between Opportunities and Individual Pharmacy Business Strategies: The Pharmacy Viability Matrix

Figure 5.8: 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	

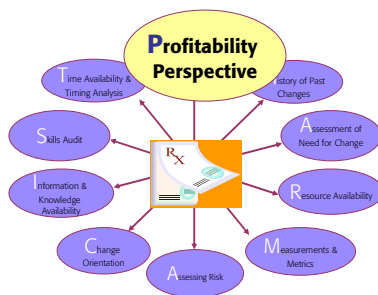
We have now identified the opportunity characteristics of the asthma service. Next we move on to adopt the point of view of the pharmacist, pharmacy manager or owner in determining whether this opportunity should be pursued, given the business strategy of the particular pharmacy or pharmacy network. The Pharmacy Viability Matrix provides a strategic overview and assists in developing and selecting from four different business strategies that can be pursued.

- The first task is to make an assessment of your current business strategy in terms of which of the four quadrants best describes your pharmacy's strategy. You may not have formalised such a strategy but nevertheless it is likely that you will be pursuing one or other of these strategies or, in some cases, a combination of them.
- The second task is to confirm that this business strategy is one that you wish to retain for the foreseeable future and that it is sustainable.
- The third task is to determine the fit of asthma services with your business strategy. This involves assessing the fit in terms of the range of products and services you currently provide, including your pharmacy's core product and services offering, and the breadth of the market (local or extended community) that you serve.

4.4 Phase 4: Identifying Individual Pharmacy Readiness for the Change: Change Readiness Wheel

Assuming that the Guild has helped to prepare the general context for introducing the offering of asthma services as part of the pharmacy industry in Australia, then individual pharmacies will need to determine their readiness to offer these services within their particular pharmacy setting. Going through the *Change Readiness Wheel* will enable this assessment.

4.4.1 Change Readiness Wheel: Profitability Perspective



- Individual pharmacy owners or network partners will need to identify their profitability perspective in relation to asthma services:

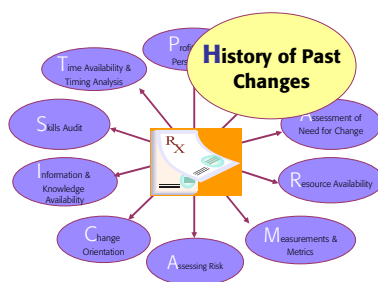
Do they expect it to be profitable at the start, or shortly thereafter?

Do they expect profitability to come later, for example through government funding or increased willingness of the public to pay for such services privately?

Do they expect the services to be cross-subsidised through other parts of the pharmacy business, such as through selling related asthma products, etc.?

- Part of this profitability perspective will be determined by the assessment of the pharmacist of their positioning in their local and extended market.

4.4.2 Change Readiness Wheel: History of Past Changes



- Has the pharmacy undertaken a screening system before, or provided services for DSM groups or information to other categories of disease state customers? What results were achieved or problems encountered in doing this?
- What have been the experiences of pharmacists in how customers use programs such as the Asthma Card?

4.4.3 Change Readiness Wheel: Assessment of Need for Change



Individual pharmacists may choose to offer this service for reactive or proactive reasons, such as the following:

Reactive

- GPs referring
- Competition from other pharmacies
- Influence attempts from the profession – Guild, Society, Universities, Pharmacy Board
- Asthma Foundation influence
- Media campaigns about asthma
- Staff interests or concerns
- Consumer pressure
- Asthma Friendly Schools program – they may approach your pharmacy for resources, or to provide an information session

Proactive

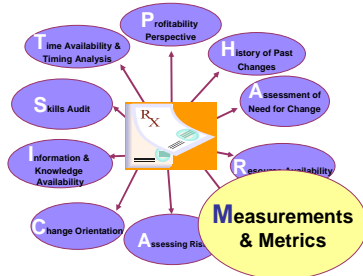
- New business opportunities
- New products:
 - Spacers
 - Nebulisers
 - Generics
 - Allergy products, e.g. dust-mite protective covers for beds
 - Monitoring products, e.g. peak flow meters
- New services:
 - Looking for other disease conditions that have similar service provision characteristics e.g. Chronic Obstructive Pulmonary Disease (COPD)
 - Professional motivation, due to a desire for one or more of the following:
 - to help the public
 - to gain professional satisfaction
 - to gain a competitive edge over other pharmacies

4.4.4 Change Readiness Wheel: Resource Availability



- Training and accreditation system – not set up for asthma yet (only one for HMRs).
- Space in pharmacy – Do you have the space to put in new products? Which products will you get rid of to make room? What is the right way to display advertising and products related to this service?
- Staff – Do they have the ability and willingness to do this?
- Reputational capital – Are you well known and trusted in your community?
- Costs – Do you have the financial resources to cover the costs of promotional materials, information evenings (renting spaces), refitting the pharmacy, etc.?

4.4.5 Change Readiness Wheel: Measurements and Metrics



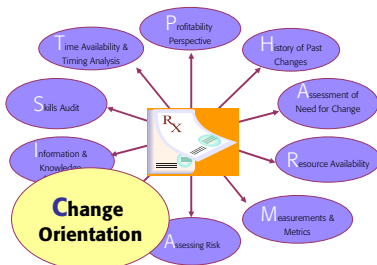
- What measures will you use to evaluate the change? (see 4.6 of this chapter for worked example)
- Number of patients with asthma, counting script numbers and OTC sales
- Number of new prescriptions
- Number of repeat prescriptions
- Increasing staff capability (new knowledge/skills)
- Time spent on the service
- Charging – Are customers price sensitive to the products or charging for screening? Will your charges cover such items as accreditation costs, new supplier costs?
- Cost of space modifications
- Cost of delivering the service.

4.4.6 Change Readiness Wheel: Assessing Risk



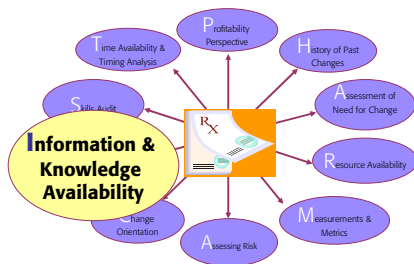
- Reputation — Don't know enough about asthma and may run the risk of giving inappropriate advice to customers or not meeting customer expectations?
- Coordination — Is there likely to be a problem in over-promising and under-delivering?
- Liabilities — Trouble with local GPs which may affect script numbers; insurance premiums.
- Returns — Are your expectations likely to be met in six month's time, e.g. for financial returns, given initial financial investment needed to offer the service and advertising and delivery costs? Are your professional expectations likely to be met? Will customers have valued this service and want to maintain it?

4.4.7 Change Readiness Wheel: Change Orientation



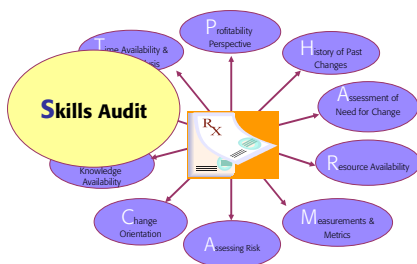
- Seek it out and embrace the change or avoid it.
- Asthma accords with the pharmacists' identities of health care provider, educator and problem solver. It matches their values in relation to professional satisfaction, altruism, and a desire to achieve a competitive edge over other pharmacies.

4.4.8 Change Readiness Wheel: Information and Knowledge Availability



- What working knowledge do you already have available within the pharmacy?
- Are there ready sources of information that you or staff can access?
- From the manufacturers
- From training and education providers
- From other sources you already use.

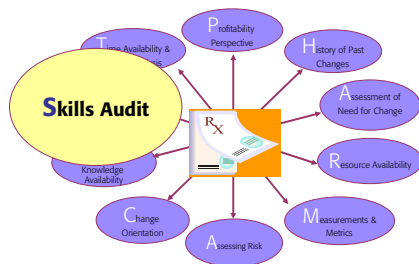
4.4.9 Change Readiness Wheel: Skills Audit



- New product/service knowledge — You need knowledge in these areas:
- Devices and equipment
- The disease
- The products
- Lifestyle issues for patients
- Service delivery
- Business management skills:
- Are the current skills available to your pharmacy adequate for managing asthma as a new service area?
- Costing of service (as opposed to costing of products)
- Marketing the service
- Four Ps of marketing: Price, Promotion, Place and Promotion
- Strategic fit with rest of business
- Preparing a business plan for the asthma service

- People skills
- Co-ordinating with other health care professionals
- Do you have good relationships with other health care professionals already?

4.4.10 **Change Readiness Wheel: Time Availability and Timing Analysis**



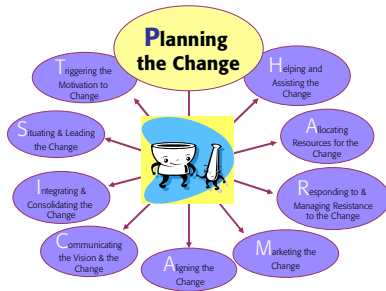
- Evaluate the change and the need for change.
- Time/brain space to consider the new service.
- Time to prepare for the service.
- Time to implement the service — Are you willing to put aside the necessary time for this?
- Strategies to free up time at the moment — What will you or others stop doing to make time available? Do you need to add new staff?
- Are you and/or your staff change weary? Do you need time to “light the fire” again?

4.4.11 **Change Readiness Wheel: Overall evaluation of your pharmacy’s readiness for change**

At this stage you should complete the Pharmacy Change Readiness Assessment Instrument in relationship to the provision of the Asthma service and calculate whether your pharmacy can proceed with the change or needs to increase its readiness for change. In what follows, we assume that your change readiness score is high enough to proceed (i.e. above 10/20).

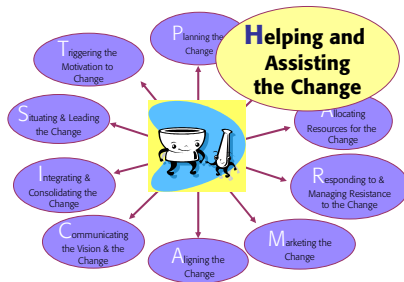
4.5 Phase 5: Implementing the Change within the Pharmacy: Change Implementation Wheel

4.5.1 Change Implementation Wheel: Planning the Change



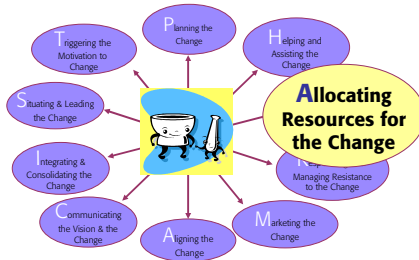
- Relate the plan to the pharmacy's overall business strategy.
- Identify the time horizon for implementing the asthma service and incorporate it into the business plan — 1–3 years etc.
- Asthma — Do you have the time to implement and will it provide adequate financial returns? What season is the most appropriate to introduce the service e.g. asthma in winter and spring for allergies? — is timing critical to implementation? Are there many young children in peak ages for asthma in your catchment area?
- Focus and scope of change — this is critical as the success of change will be dependent on your confidence in the knowledge and skills of your staff; for focus look at external stakeholders and how easy it is to get GPs on side, what range of products you will need to stock to start the service.
- Do financials, e.g. mark up on products; cost to employ a pharmacist to provide the service if specialist needed; cost of obtaining knowledge related to asthma including cost of courses.
- Check cash flow and impact on future sales and the value of the pharmacy.

4.5.2 Change Implementation Wheel: Helping and Assisting the Change



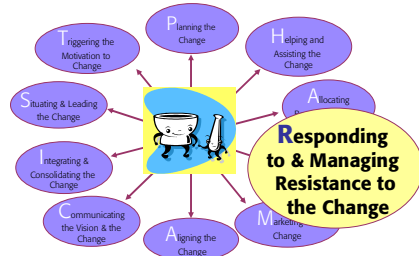
- Build out from existing resources, e.g. begin with staff who are already interested in asthma – maybe you have asthma sufferers on your staff or staff who have asthmatic children – build up from there; build on the already existing product range if possible; build up from existing to new customers.
- What is your pharmacy's current level of experience in implementing change, e.g. CMI or HMRs?
- Do you have a packaging system you could learn from and adopt? (dosettes); experience with other diagnostic tools, e.g. blood screening system, pregnancy testing, etc. (knowing how to give people their results).
- Use resources from banner group, e.g. marketing, better deals, templates to contact doctors etc., list of staff who have expertise in area, role models.
- Ensure you have quality staff – invest in training. Either train your staff or bring in people who already have the skills.
- Create a learning organisation and reward innovation – e.g., does your network have someone to assist with implementation of innovative programs for its members?
- Ensure you align banner group vision and vision of pharmacy owner with respect to the asthma service.

4.5.3 Change Implementation Wheel: Allocating Resources for the Change



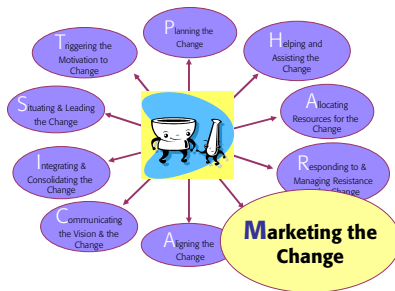
- Are you reluctant to allocate internal resources and generally look for others to do this? Or are you willing to commit your own resources to implement the asthma service?
- Organisation design and technology — do you have the necessary structure and computer systems needed in place?
- Allocate space and specific tasks to individuals.

4.5.4 Change Implementation Wheel: Responding to and Managing Resistance to the Change



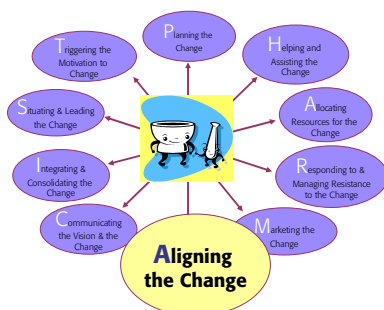
- How will you manage any potential resistance from GPs or asthma specialists? How can you give them a place in the process?
- Internally, are pharmacy assistants unwilling to change?
- Are employee pharmacists unwilling to introduce the service or not committed to maintain an asthma service over time?
- Is the owner willing to introduce asthma services as well as the manager wanting to?
- Do other staff feel their power and influence are being eroded as new staff are brought in or others upskilled?
- Ensure balance is maintained between ongoing and new activities. Ensure ongoing tasks are not perceived to be less important or downgraded because of the asthma management program.
- Pay attention to managing both stability and change simultaneously.

4.5.5 Change Implementation Wheel: Marketing the Change



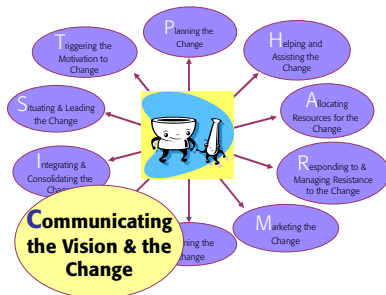
- Identify market segment for asthma – make sure everyone understands what you are trying to achieve, including other pharmacists who have already adopted the service, asthma clinics, etc.
- Focus on prescriptions and products, and competitors and representatives to find out market distribution; ask professional organisations for support and patient support groups about materials they have; involve other health care professionals with an interest in the area, e.g. nurses.
- Clarify your message about the asthma service – ensure that you maintain the reality and image of being a highly professional pharmacy offering a high quality service.
- Target marketing channels can include emergency clinics frequented by people with asthma, respiratory specialists, day care centres, local schools, GP surgery notice boards, patient support groups, ABS health statistics for distribution of asthma-prone populations; ask product manufacturers, advertise in professional journals.
- Develop a marketing campaign and plan for ongoing reinforcing – do not conduct just a one-off implementation; plan to regularly contact target marketing channels(e.g. every three months); redo window displays; send new information to customers with repeat prescriptions; create an Asthma Club; talk to schools on a regular basis.

4.5.6 Change Implementation Wheel: Aligning the Change



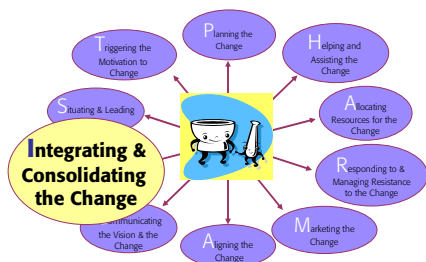
- Eliminate organisational disjunctions, e.g. align the image you are trying to create with the pharmacy appearance: if externally you promote a “health care” image, this may conflict with the “product discounting” presentation customers see as they walk in. Ensure consistency between your actual service offering and advertising.
- Align staff with type of service, e.g. ensure staff know about asthma, etc.

4.5.7 Change Implementation Wheel: Communicating the Vision and the Change



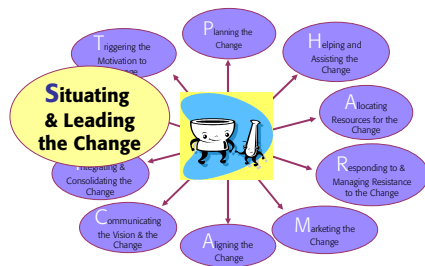
- Create a vision for asthma patients – e.g. optimise the patient’s drug management; achieve a better night’s sleep for parents; gain consistency in asthma treatment outcomes; prevent hospitalisation; ensure children are well enough for school attendance.
- Vision for staff – make sure staff know the benefits for the consumer which the asthma service is meant to achieve; know their role in achieving the vision and are committed to it.
- Other stakeholders – enrol them as partners – enlist them in image of coordinated community health care; identify potential asthma patients for referral to GPs; also identify others who are not receiving optimal treatment or not using treatment optimally; ensure education of children and parents in the need for prevention treatments.

4.5.8 Change Implementation Wheel: Integrating and Consolidating the Change



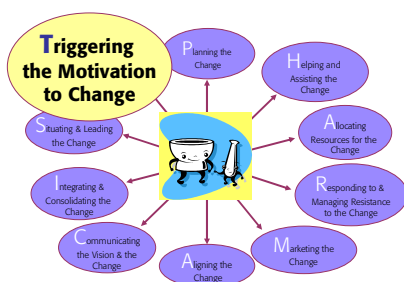
- Relate to other respiratory diseases: e.g. nursing home – chronic pulmonary disease.
- Coordinate asthma service with over-the-counter sales, e.g. cold and flu products which may trigger asthma in susceptible individuals.

4.5.9 Change Implementation Wheel: Situating and Leading the Change



- Decide whether you yourself or someone else will lead the change. If the latter, identify a staff member in the pharmacy responsible for leading the change.
- Ensure there is commitment to change at the top by owners and/or partners and ensure the change is driven by a team approach.
- Identify specific roles for others within the team to deliver the service – and identify who will not be involved as well as who will be involved. Reach agreement on how those in these roles will work together.
- Situate the service in your current workload and those of others involved to make service delivery sustainable.
- Identify whether parts of the service (compared with all of it) can be delivered by yourself or by others.
- Identify any shortcomings in your personal leadership style and ensure that these will not inhibit successful implementation of this particular service.

4.5.10 Change Implementation Wheel: Triggering the Motivation to Change



- Identify the incentives needed to get individual staff on board – use incentives that relate to the needs of individual staff.
- Address the “What’s in it for me?” question for your staff.
- Provide people with new titles to demonstrate importance of the change and recognition of new roles in relation to asthma service, e.g. Pharmacy Assistant/“Ask me about Asthma” badging etc.

- Ensure motivation at all relevant levels of the hierarchy
- Owner
- Pharmacy manager
- Pharmacist in charge
- Dispensing technician &/or
- Senior Pharmacy Assistant — Shop Manager
- Pharmacy Assistant
- Other part-time staff

We have now taken the reader through an introduction to how the change models we have developed can be applied to the introduction of a new service, in this case, asthma services. The change models represent major stages in the effective planning and delivery of a new service or service set. The same process can be applied to any other service or set of related services. In the following phase we use a worked example of the business case for another service, Diabetes Disease State Management, to provide a more detailed model of how a business case can be developed for the introduction of a new service.

4.6 Phase 6: Business Case for a Diabetes DSM Service

4.6.1 Introduction

In preparing this financial model we have chosen as an example to focus on diabetes Disease State Management (DSM). The model can then be utilised for other DSM in-pharmacy services such as Asthma. To our knowledge, this is the first time that this sort of detailed financial modelling has been carried out for a cognitive pharmaceutical service, therefore there are a large number of assumptions based estimates of how the service would be implemented. These have been explained throughout the document.

4.6.2 Objective

This section is specifically limited to analysing the cost structures at a micro level, of diabetes DSM delivered from the pharmacy premises by the proprietor pharmacist and/or an employed pharmacist plus a level 3 pharmacy assistant. Therefore the discussion excludes the utilisation of specialist contractor pharmacists to deliver the service and any reference to products sales and prescription dispensing. There may be other models of delivering DSM, however, there is limited information on such models.

4.6.3 Definition of Cost

For the purposes of the analysis the following costs have been included:

- Establishment and capital costs
- Initial education and training
- Computer system
- Fixtures, furniture and fittings
- Direct overheads
- Staff salaries, wages and oncosts
- Floor space rental plus outgoings
- Communication with patients in the general market
- Indirect overheads
- Includes a contribution to overall indirect pharmacy overheads.

Refer to **appendix 10 Part A** for a summary.

In addition to the costs of establishing and delivering the service we also considered the notion of economic or opportunity cost of delivering the diabetes DSM services, i.e., assuming DSM services will become a greater feature of community pharmacy then it is reasonable to expect that not only costs must be recovered but also there must be an adequate net profit earned which is at least consistent with current community pharmacy activities (volume dispensing and retail sales including OTC Schedules). In our view the only effective way that can be achieved is through calculating an hourly rate revenue charge for delivering the DSM service that includes the recovery of 4 components; i.e. direct labour overhead, indirect labour overhead, plus indirect pharmacy overheads and a profit component.

4.6.4 Cost Analysis

The costs in the model have been calculated based on a pharmacy servicing 100 patients per annum.

4.6.4.1 Professional and Support Staff

- Pharmacist

The Diabetes DSM service will be provided by a specialist trained employee pharmacist or in some cases, the pharmacy proprietor. It has been assumed several tasks will be delegated to a Level 3 Pharmacy Assistant trained appropriately.

In relation to the pharmacist we have assumed a standard work week of 47.5 hours at an hourly rate average of \$37, which are both based on current community pharmacy averages in our experience. However, this \$37 may be an underestimate since one would expect that a higher salary for a DSM-accredited pharmacist. Furthermore, we assumed four weeks annual leave and 4 days per annum average sick days. Long service leave will be accumulated at .867 weeks per annum or 8.67 weeks after 10 years services. A relieving pharmacist will be employed at a slightly higher casual rate during these absences. Superannuation has been calculated at 9%. There are approximately 11 public holidays per annum and we assumed for this exercise that the pharmacy would be closed. These assumptions result in total fulltime pharmacist cost per annum of \$113,554 in return for 2,371 total work hours available. Therefore the hourly cost of the pharmacist is \$47.89.
- Level 3 Pharmacy Assistant

The Pharmacy Guild advised us that a Level 3 Pharmacy Assistant is paid \$30,000 per annum in return for a standard 38 hour week. In addition we included four weeks annual leave, leave loading of 17.5% and sick leave of 4 days on average per annum. We used 11 days for public holidays and again assumed that the pharmacy would be closed.

Long service leave was calculated on the same basis as Pharmacists' ie, .867 weeks per annum.

That resulted in a total salary plus on costs of \$37,396 per annum in return for total work hours of 1,892 after including casuals working the holidays and sick days.

Accordingly the hourly cost is \$19.76.

4.6.4.2 Floor Space

It has been assumed that the consulting room or a booth including surrounding area for privacy would total approximately 4m². Obviously circumstances will vary between pharmacies.

It is also important to recognise that the counselling area or room will be applied to other uses such as dietary advice, naturopathy, baby care, pharmacist advice and other ancillary

services. Accordingly we estimated that pharmacies involved in delivering diabetes DSM will utilise the area for 50% of the total time it will be used.

Rent cost per square metre plus outgoings was obtained from the Johnston Rorke 2002/03 client base average for all pharmacies. That figure is \$512 per square metre.

4.6.4.3 Communication (Advertising and Promotion)

Communication to patients, potential patients, the market place at large and doctors in particular is critical to the success of being able to deliver an effective DSM program. Without it patient numbers will be minimal, an opportunity to convey a health care image will be sub-optimised, patients won't receive a complete service/information and the opportunity for improving pharmacist/doctor relationship will suffer.

Communication will be important on several fronts including screenings (obtaining and assessing the patients), running education evenings (reinforcing the service to existing patients and gathering new ones), communications and visits with doctors (obtaining patients through cross-referral, improving the relationship, developing the diabetes HMR relationship and an opportunity to cement the pharmacy's strong position in the health care community) and a regular newsletter devoted entirely to diabetes matters (mail out using patient database, hand-out in store and distribute to doctors etc) prepared in-house using Microsoft Publisher.

We assumed that the screenings, education evenings and newsletter will be conducted on a quarterly basis with much of the preparation being carried out by the level 3 pharmacy assistant. The pharmacist must of course contribute to writing the quarterly newsletter and preparing letters to doctors in the vicinity. In addition the pharmacist would be expected to attend and conduct the doctor visits. The level 3 pharmacy assistant duties would include carrying out the screenings, advertise and prepare for the education evenings, assemble and send the doctor letters and compile the quarterly newsletter.

4.6.4.4 Computer Maintenance

Hardware maintenance is included in the purchase price of most laptop computers and the cost of annual support for the DSM database support will be negligible.

4.6.4.5 Printing, Postage and Stationery

We allowed a general amount of \$500 per annum, which varies according to patient load, as a general allowance to cover the usage of such items in the overall DSM service that cannot be allocated specifically to a task.

4.6.4.6 Indirect Overhead

It should be reasonably expected that income earned from delivering diabetes DSM must include a contribution to the indirect overheads of the pharmacy that are incurred to support the total pharmacy facility.

The amount was calculated at 12% of the total direct overheads and was based on the JR Pharmacy Services 2002/03 client base averages for all stores.

4.6.4.7 Establishment and Capital Costs

We estimated that the capital costs will total \$12,866 dollars to establish the service.

These costs involve the following:

- **Education and training**
The pharmacist must attend a suitable accredited five day course to learn how to deliver diabetes DSM within the pharmacy. We calculated the cost using the pharmacist's hourly rate cost calculated per appendix 10 part B. In addition we have added the cost of attending the course of \$1,500 based on \$300 per day. In addition there will be initial in-store training lasting approximately 1 day that will be organised by a Pharmacy Guild facilitator at no cost. However, we have applied the hourly rate cost (refer appendix 10 part B) for the pharmacist's time. The level 3 pharmacy assistant would need to undertake a 3 hour in-pharmacy awareness course conducted by the Guild Facilitator at no charge. The purpose is to train the Pharmacy assistant in how to run the screening programs, assist the patient with completing the assessment questionnaire and how to go about some of the communication (advertising and promotion) tasks. There will be ongoing training required, and in the pharmacist's case this will probably involve attending a one-day annual refresher course. The pharmacy assistant will continue to learn through in-pharmacy training. Cost of the initial pharmacist education and training should be amortised over a 5 year period assuming the pharmacist is the proprietor or otherwise remains employed by the pharmacy. At the end of that 5 year period, undertaking another major course should be considered to upgrade skills and knowledge.
- **Information technology**
We assumed that the pharmacy should acquire for exclusive use in disease state management a fairly good laptop computer. In this case, we assumed that diabetes DSM will be the only one delivered, hence the total cost is allocated to the program. Cost of the system has been amortised over 3 years being the approximate effective life of computer hardware. Database DSM Management software costing approximately \$220 used to maintain the patient treatment records will be written-off over 2 years.
- **Fixtures, Furniture and Fittings**
For the purpose of this model it has been assumed that a counselling room will need to be built, costing approximately \$5,000. It will be amortised over 6 years. Because the room will in all likelihood be applied to other uses, only 50% of the cost was allocated to the diabetes DSM program. The room will need to be fitted out and furnished and again it has been assumed the cost will be allocated 50% to diabetes DSM. In addition, signage will be required in and around the counselling room plus at the pharmacy frontage. The cost has been amortised over 6 years.

For full details of the costings and assumptions please refer to appendix 10 part C.

In summary the total capital cost of establishing the services will be approximately \$12,866 and the ongoing cost incurred in operating a diabetes DSM program for 100 patients per annum will be approximately \$24,684. That equates to \$257 per patient per annum to run the service and recover cost only.

The concept of what is the opportunity cost of delivering this service is therefore now considered. In our view that cost is the income that would have been earned had the pharmacist and the level 3 pharmacy assistant been deployed carrying out traditional pharmacy activities, ie: volume dispensing and selling OTC Schedules and other non-prescription products.

Refer to appendix 10 part B for details of the calculations and assumptions.

4.6.5 The Diabetes DSM Business Case

From a financial standpoint and to encourage adoption of in-pharmacy disease state management on a uniform basis it is most important that a net profit (EBIT) after the recovery of all direct and indirect overheads be earned. In our view that profit should be at least the same as that currently generated from carrying out traditional community pharmacy activities. If it isn't the up-take by community pharmacies will be no faster than has been the case with MMR and HMR fee for service programs. It seems that in both these cases the fee approximates the hourly rate of a pharmacist plus some allowance for salary on-costs without any provision for pharmacy direct and indirect overheads and certainly no provision for a net profit return.

Two approaches were considered in calculating a profit return. The first involved equating the return on the diabetes DSM per hour of service delivered with the net profit (EBIT) earned per hour for all hours worked by all employees in a community pharmacy. According to Johnston Rorke 2002/03 client base averages that number is \$12.26.

The second approach considered was setting an hourly charge rate calculated by multiplying the base salary per hour paid excluding all oncosts and multiplying that figure by a factor of 3. The multiple of 3 is commonly used by a myriad of professionals in calculating hourly charge rates when performing productive and recoverable client/patient services.

Hourly rates calculated were \$47.56 for the pharmacy assistant level 3 and \$115.63 in the case of the pharmacist. These rates were then applied to the hours spent delivering the service to 100 patients per annum.

The details of all these calculations and assumptions can be found in appendix 10 part E.

Appendix 10 part E shows that the total income earned from the DSM service would be \$29,616, which equates to \$513 per annum per patient where an HMR is required, and where it isn't the charge would be \$224.

Applying these income calculations and combining them with the overheads incurred results in a profit of \$3,908 or \$14.43 per hour. Refer to appendix 10 part F for details.

As already mentioned these figures have been arrived at assuming 100 patients per annum were treated and the pharmacist hourly rate is \$37. However it is more than reasonable to argue that given the additional investment enhancing the pharmacist skill,

the nature of the service being delivered and the savings in downstream health costs, a hourly rate of say \$50 per hour may be justified. In that case the profit would increase to \$8,098 or \$29.90 net profit per hour worked. Refer to table 5.6 for a summary.

Another iteration of the model where 200 patients per annum are involved in the DSM program and the pharmacist is paid \$50 per hour reveals a net profit of \$28,768 (subject to some fine tuning of indirect overheads) or \$53.11 per hour. Refer to table 5.6 for a summary. In this situation the patients would be charged the same as the aforementioned iteration because the hourly labour rate cost is the same.

Table 5.6: Diabetes DSM Business Case

Based on providing diabetes DSM services to n patients per annum:	100	200
Pharmacist hourly salary rate excluding on-costs: \$50		
INCOME		
	\$	\$
Screenings	6,398	12,795
Diabetes HMR	11,720	23,439
Review & advice	5,860	11,720
Management & Education	15,626	31,253
Total Income	39,604	79,207
EXPENDITURE		
Staff costs – Services (incl on-costs)		
- Pharmacist	15,910	31,821
- Pharmacy assistant	494	988
Advertising & Promotion	6,469	6,469
Education	1,941	1,941
Rent	1,024	1,024
Depreciation – Fixtures, Fittings, Furniture, Computers	1,902	1,902
Other	3,766	6,294
Total Expenditure	31,506	50,439
Net Profit EBIT	8,098	8,768
Net profit return per hour	29.90	53.11
Annual average revenue per patient	395	396
Annual average cost per patient	315	252

Section 5: Chapter 5

5 Closing the Gap: Conclusion

This section has presented three Change Wheels. The first, the PharmInd Wheel, presents an agenda for change to be undertaken by the Guild in the context of the industry as a whole. The key points arising from this are presented in the Recommendations appended to the Executive Summary at the beginning of this Report. The second wheel, the Change Readiness Wheel, is designed as a practical tool to be used by the pharmacy owner or manager to diagnose their pharmacy's readiness for change. In some cases, this will result in the owner/manager being alerted to areas of the pharmacy's current operations that will need further attention before a significant change program is undertaken. In other cases it will result in the pharmacist being given an 'amber light' ('proceed with caution') or a green light ('go for it') in initiating a change program. The third wheel, the Change Implementation Wheel, is a practical tool designed to assist the owner/manager design a change program for new service implementation in their pharmacy.



Section 6 – Conclusion

1 Conclusion

There are a number of key messages for the Guild and the Pharmacy Profession that emerge from the body of the Report. They are:

- There needs to be an Australia-wide change program for the pharmacy industry initiated by the Guild. This would be the first time internationally that such a program had been undertaken and it represents a significant leadership opportunity for the Pharmacy Guild of Australia. We have outlined the major components of this change program.
- A systematic procedure is needed to assess new opportunities for service provision (We have provided this in COF).
- There needs to be recognition that there can be a number of fundamentally different but viable business models for pharmacy. We have developed the PVM to progress the specification of these strategic models
- There needs to be a shift in thinking within the industry from the notion that 'all services must be offered by all pharmacies' to the strategic offering of "core" and "specialised" health services.
- The definition of what services will constitute core and specialised health services needs to be negotiated with governments and stakeholders
- We have argued for further work to determine potential synergies between services which could form the basis for grouping of services for their more efficient delivery
- There should be alternative sources of funding for the provision of services through community pharmacies. This is a controversial recommendation because it advocates legitimisation of fee-for-service charges relating to added-value services that are not supported by governments or other payers.
- We have advocated building internal industry infrastructure and capabilities before negotiating a service rather than later and we see a role for a Centre of Excellence in Community Pharmacy Change Management in contributing to this process.

We have made specific recommendations for Guild initiatives that may help move the industry context in a way that facilitates the introduction and expansion of change programs in pharmacies which will widen the scope of professional service offerings and promote health. These measures are designed to make multi level changes that can energise the potentially powerful health service delivery system comprising Australia's 5,000 community pharmacies, making them an even more vital element in the creation of more integrated health service delivery in local communities.

In the Executive Summary, we have grouped these recommendations into key themes as listed below:

- Macro Policy Issues
- Systematic Methods of Identifying and Reviewing Opportunities
- Macro Implementation Issues
- Stakeholder Management
- Building Human Capability for Increased Service Provision

- Accelerating Implementation:
 - Raising Awareness
 - Funding
 - Mobilising the Change

In order to effectively deliver and accelerate change, the Guild should ensure that it systematically addresses and considers adopting the recommendations in various sections of this report. In actioning an overall change program for the industry, the Guild needs to:

- identify the most change oriented pharmacies
- work with these pharmacies to plan the introduction of selected high priority services
- develop with these lead pharmacies the overall design of appropriate educational programs
- select suppliers to complete program designs and deliver programs on trial basis to lead pharmacies
- offer programs on a broader basis through the industry, incorporating volunteers from the lead pharmacies to present on these programs. (Section 5: 1.9.1)
- evaluate the trials and revise educational programs
- document the benefits including profit and financial benefits (see section 4 – current and future services in conjunction with Roberts et al 2004)
- promulgate these through the channels identified in this study as those most used by pharmacists. (Section 5: 1.9.1)

In our view, the adoption of the recommendations in this Report will represent an important initiative of significant national and international importance in the improved provision of primary health care services at the community level and strengthen community pharmacy's role in this provision.



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