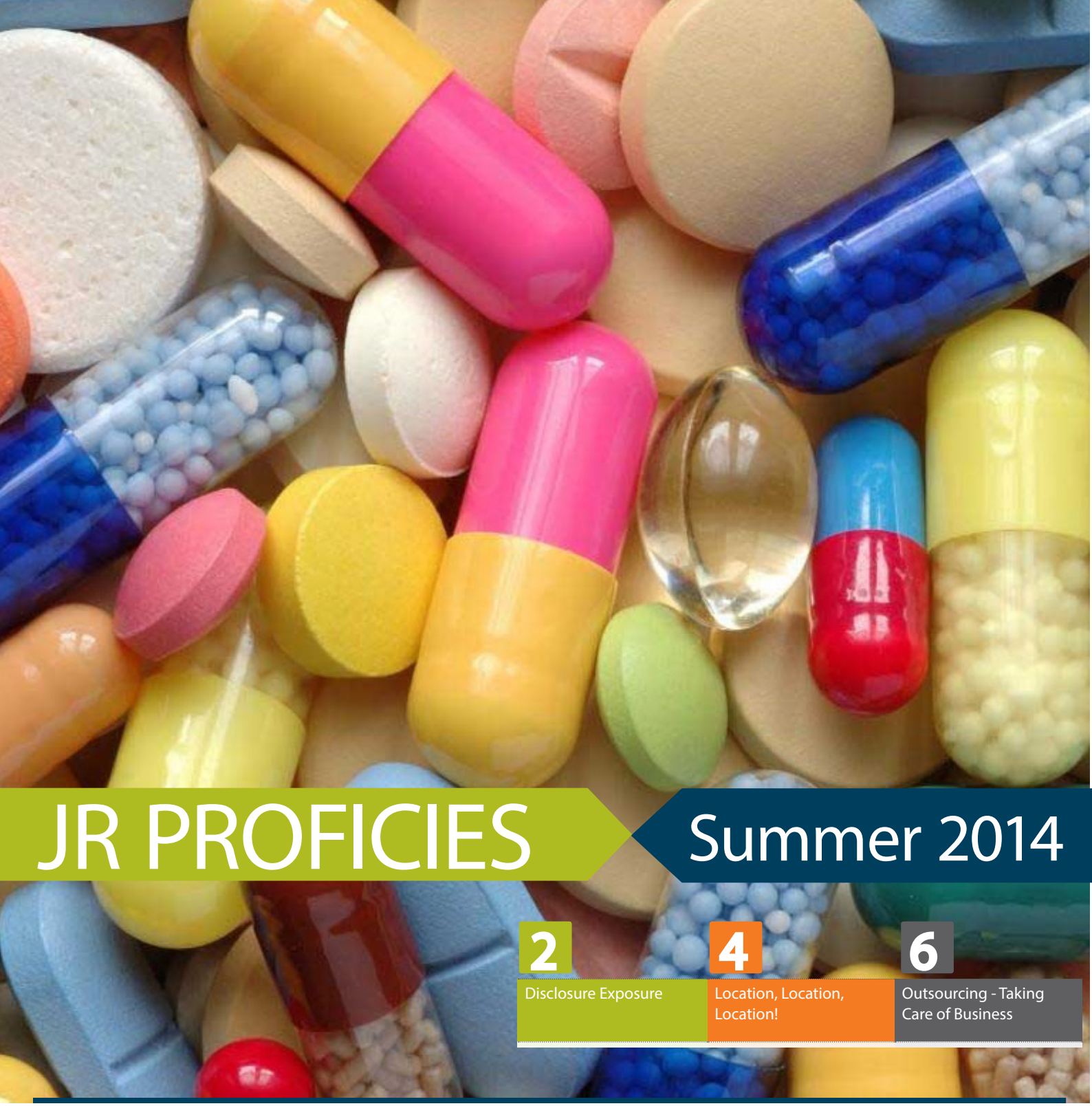

JR PROFICIES

Summer 2014

a word from the Editor

Mark Nicholson

Welcome to JR.pharmacy's Summer 2014-15 newsletter.

Recently we requested clients provide us with various dispensary reports so we could analyse the impact of the October 1 medicine price cuts. In a sign of the level of concern that exists within the industry the response was significant.

In this edition Norman reports on his analysis of the data and discusses the positive steps Pharmacy owners need to be taking to ensure businesses remain successful well into the future.

Also in the wake of the draft report from the competition policy review the Health Minister is seemingly broadening the application of his discretion to grant new Pharmacy licences outside the relevant rules. Inside this edition, I discuss the importance of securing the right long term location in order to best manage the increasing level of uncertainty and risk that emerges following each new decision by the Minister.

Positively it appears growth is returning across the Australian retail sector and Pharmacies can look forward to an improved Christmas trading period .

From everyone at JR Pharmacy we wish you a happy and safe Christmas holiday period. As always please call us for further explanation of any of ours newsletter contents.

JR pharmacy
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A publication examining issues for our clients

Disclosure Exposure

Norman Thurecht

The PBS Medicines Price Disclosure mechanism first introduced in 2007, has been modified and accelerated on a number of occasions in the Government's continuous pursuit of savings to the PBS spend. The most recent of the modifications was in August 2013 immediately before the last Federal election when Kevin Rudd (the then Prime Minister) announced a simplification of the system, which in effect further accelerated the reduction process.

The effect of these changes was to bring forward the price reduction periods so that we now only have two cuts per annum (April & October), previously three, and shorten the disclosure period to effectively 12 months (whereas previously it worked out to be about 18 months before any price reductions might/could occur).

The result is that the reductions now occur faster and act to shorten the lifecycle of the reduction period which ends once the molecules have reached a point where manufacturers cannot offer trade terms exceeding approximately 10%. I suspect - based on current substitution policies driving up the national substitution average to over 80% - the end low point on many molecules in price disclosure will be reached sometime during the 2017/18 financial year.

An owner's ability to adapt their business model to compensate for the lowering of dispensary profitability is unfortunately inextricably linked to this shortened timeframe.

The first SPD Impact

With the passing of 1 October 2014, we have now witnessed the largest price reductions in dollar terms since the introduction of PBS Reforms. As these price reductions roll through, we are noticing significant differences in the effect on different pharmacies.

The different impacts are occurring as a result of two main aspects:

1. The molecule mix;
2. Medicine substitution levels.

The molecule mix cannot be controlled by a pharmacy but the substitution level can. There is however a sinister twist that flows from the substitution benefits - i.e. it is a short term solution with long term impacts. The more pharmacies substitute, the faster prices will fall and the shorter the price disclosure impact period becomes. Interestingly the end outcome may be that pharmacies could end up making more from some originator products than the generic alternatives. This is already occurring on some acute medications.

So, what are we seeing as the overall impact in the numbers?

Table 1 below outlines the average loss of GP$ per script across the period September 2014 to October 2014 compared to October 2013.

Effect on Community Pharmacy

In summary, the average GP$ per script decreased $1.07 (or 7.56%) for the 12 months from October 2013 to September 2014. An additional $0.83 (or 6.41%) has now come out of GP$ since 1 October 2014. So over the rolling period, on average pharmacy GP$/Script is off $1.90 (or 13.48%).

To give you a feel of the spread of loss in the data we collected, the lowest recorded loss of GP$/Script was $0.24 while the greatest loss was $4.30. It is evident that the pharmacy that lost the least, had the opportunity to increase their substitution rate between October 2013 and October 2014 while the pharmacy that lost the most over the same period was already maximising substitution at October 2013. This highlights that while increasing substitution levels is an operational necessity that should be maximised they will not save a pharmacy from declines in the medium term.

More importantly however is the fact that the pharmacy that has now lost $4.30 has a GP$/Script of $11.81 which remains higher than the pharmacy which lost the least at $10.18. So despite losing a large amount already, the higher substituting pharmacy is still generating more profit per script than the Pharmacy with the smaller decline.

Table 1

	Oct-13	Sep-14	$ change	% change	Oct-14	$ change	% change
Sales/Rx	$ 35.89	$ 34.44	-$1.45	-4.04%	$ 33.65	-$2.24	-6.25%
Govt Cont/Rx	$ 24.45	$ 22.80	-$1.66	-6.78%	$ 22.53	-$1.92	-7.86%
Patient Cont/Rx	$ 11.44	$ 11.64	$ 0.21	1.82%	$ 11.12	-$0.32	-2.80%
GP/Rx	$ 14.13	$ 13.06	-$1.07	-7.56%	$ 12.23	-$1.91	-13.48%
GP%	39.38%	37.93%			36.34%		
Net COGS	$ 21.76	$ 21.38	-$0.38	-1.76%	$ 21.42	-$0.34	-1.55%

** % change taken from October 2013 as the base.

One other interesting point is that despite dispensary sales declining by 4% from October 2013 to September 2014, script volume increased 0.54%. Similarly comparing October 2014 to October 2013 dispensary sales declined 7.69% while script volume pleasingly increased 2.53%. Hence script growth is helping offset the price reductions.

Savings to the Government

The Government savings are also evident through the reduction in reimbursement (Govt Cont/RX) down $1.92 or 7.86% from October 2013 to October 2014.

However while the Government and taxpayers have benefited significantly from the reforms, it was recently reported in Pharma In Focus that oncology drugs have grown from 26% PBS in 2013 to be 30% at August 2014.

Given the PBS overall has not reduced (only the growth rate significantly reduced due to price disclosure) the Government is unlikely to shift its focus on containing the PBS. The challenge for community Pharmacy is for its component to be viewed in isolation.

What about the Manufacturers?

To understand their plight we need to go back to 2011/12 and understand what occurred at the peak of the GP$/Script. Back then, according to our client base averages , the average cost to pharmacy (net into store) per molecule was $26.08 with the annual movement outlined in table 2 below.

Table 2

	Jun-11	Jun-12	Jun-13	Jun-14	Oct-14
Net COGS	$26.08	$25.11	$23.64	$22.84	$21.42
Change		-$0.97	-$1.47	-$0.80	-$1.42

At October 2013 it had reduced to $21 (refer table 1) and has been relatively flat since . Overall, the reduction in the net cost per Script has been $4.66 to date. In other words, the manufacturers and wholesalers saw the bulk of the reductions approximately 12 to 18 months before community pharmacy experienced any significant decline.

The fact that the average cost to pharmacy has not fluctuated significantly over the past 12 months suggests the following:

- The net into store floor has been reached on many molecules where there are competitive trade terms;
- The price reductions over the period 1 April 2012 to 1 October 2014 in Atorvastatin and Rousvastatin extracted approximately 50% of the cost for the Government;
- Any increase from period to period will now be subject to the value of new molecules to the PBS increasing this cost, new off patent opportunities with higher trading terms decreasing this cost, and/or new manufacturers coming to market with substitutable molecules and winning pharmacy's business through higher trade terms.

Based on the data we see and the results of pharmacies actively making changes to their business model, we believe the following points should be understood/adopted by all pharmacies:

1. Further discounts from manufacturers will be increasingly difficult to negotiate given the need for manufacturers to maintain a level of profitability in their business and the current net into store pricing on many molecules currently at a plateau point;
2. Script volume growth will not completely offset the reductions in dispensary profitability, but it will counteract some of the effect;
3. Substitution is not a long term solution but needs to be optimised across all relevant molecules;
4. Pharmacies will have to selectively determine whether it is more profitable to now dispense some originators as there may be more GP$ per script in doing so;
5. Given the average sale value per script is now $33.13 (i.e. below the general co-payment but more cuts to come), commercial decisions around molecule pricing need to be undertaken because blanket discounting of these molecules will be financially dangerous for community pharmacy;
6. Relying on an increased dispense fee or changing the mechanics of the dispense fee in the next Guild Government agreement will not be a complete solution given the number of scripts falling below the co-payment (and continuing the decline) over the ensuing years;
7. Government or self funded service based income is essential but will not make up the difference between the GP$/Script today and in the future. Service activities in a pharmacy are not a bolt on but an integral part of any retail model that assist a retailer manage above average margins; (JR averages show that those with higher PPI/services income also have above average retail sale per customer)
8. Understanding who the pharmacy customer is and what they buy is important because the reducing dispensary profit will reduce cashflow and expose the pharmacy to the hurtful cost of slow moving retail stock that will ultimately suffocate cashflow. Buying decisions based only on supplier trade terms will exacerbate this issue because the focus should be on selling more of what the customer wants/needs. Undertaking a retail category review to understand where the opportunities lie is imperative;
9. Managing costs is equally important but minimising them can be destructive to the business. For example, understanding how to optimise wages relative to outcomes will improve future profitability .
10. Understand that change is inevitable. The rate of change is however hastening and will remain a continual process. Maintaining profitability is paramount. This could mean less customer visits but more profit per customer. Understanding how many customers came to the pharmacy in a day rather than the number of scripts filled in a day is a significant but necessary mindset shift.

No longer can a pharmacy rely solely on the dispensary as the profit generator. The dispensary will however remain the traffic generator (and quite a good one at that). How the pharmacy manages costs while exceeding customer's expectations and improving their health outcomes will determine its long term success.

Location, Location, Location!

Mark Nicholson

As a backdrop to the next Guild Government Agreement Professor Ian Harper recently released a draft report into Competition Policy review as commissioned by the Prime Minister in December 2013. Unsurprisingly, the draft recommendations include the removal of pharmacy ownership and location rules on the basis that the rules are anti-competitive and among other things act to exclude supermarkets from operating Pharmacies.

Terry Barnes authored the 1999 Wilkinson Report on pharmacy regulation and is also an often published critic of the rules. He and the Professor share a similar economic theorist view that a consumer would be better off in a deregulated market. Barnes recently added another perspective to his campaign commentary by postulating that women and young Pharmacists would have more opportunities to enter ownership in a deregulated market.

While this is true it conveniently ignores the fact that this "free" environment would allow the bigger players (eg Chemist Warehouse and Supermarkets) to dominate. As such while it may be easier to enter the market many start-ups would simply go broke in the process and destabilise many others.

As an adviser who assists aspiring and current Pharmacy owners to navigate the complexity of the location rules to achieve their business motivations I also concur that the rules are anti-competitive. I consider this position however to be relatively uncontroversial and more a statement of fact. The important issue to actually contemplate is whether the Pharmacy market is uncompetitive because of them.

Hence the questions that I believe need to be considered before championing a deregulation of the Pharmacy market are in the table opposite.

In considering the market competitiveness of the Industry one only has to evidence the rise and effect of Chemist Warehouse which is now positioned within the top 15 retailers in the country. Their dominance of the vitamins, nutrition and fragrance categories is not just affecting Pharmacies but also impacting supermarkets and department stores.

More importantly though, when considering pricing and margins on medicines, the Government's own price disclosure policy has and will continue to be an incredibly

1	Is the Pharmacy market currently uncompetitive?
2	Are there adverse health outcomes occurring that would be solved in a deregulated environment or could they be increased?
3	Would lowering the barriers to entry for Pharmacy owners improve access to medicines and services, and affordability for consumers?
4	Are consumers dissatisfied with the existing level of Pharmacy accessibility, services and cost?

effective tool in minimising PBS spend on behalf of taxpayers.

Ironically, while this mechanism is the Government's creation, Pharmacy owners have been broadly criticised realising the early incentive profits from promoting the use of generic medicines on behalf of the Government. Critically, it is this rapid conversion of patients to generics that has (and will continue to) so effectively reduced PBS spend (which is largely being redirected to new hospital dispensed medications) while now also significantly reducing Community Pharmacy profits and affecting many businesses ongoing viability.

On the face of it Health Minister Peter Dutton appears to understand the value of the current Industry to both Government and consumers as he has positively committed to maintaining both the ownership and location rules within the next agreement. The Minister however has made it clear through various recent Ministerial Discretion decisions granting new PBS licences to Pharmacies that the location rules do not automatically confer the long held security/certainty that owners and financiers have come to rely upon.

It is imperative therefore that owners' ensure that their location remains relevant and convenient to customers over the long term. While relocations to be closer to surgeries or supermarkets etc may reduce profits in the short term it is more important that customer's interests are catered for in the long term and potential competitors are not provided the opportunity to do that in your stead.

Given the improving economy, development activity is once again on the rise across Australia and these types of threats/opportunities are increasing. As always, JR Pharmacy remains well positioned to assist with the strategy development, forecasting and risk analysis required to ensure owners are in the best location to support health consumers both now and in the future.

Background Note:

Over the last 20 to 30 years the Government and the Guild have come together every 5 years (and often in between) to try and manage a Goldilocks (ie just right!) environment that balances the best interests of the Government (the payer), the distributors (Pharmacies and wholesalers), and the manufacturers (who are also the medicine developers) with the best interests of consumers (financially and medically).

The ownership (State legislation) and location rules (Federal legislation) operate in tandem to achieve this outcome. Historically the location rules were created to work with an orderly consolidation of the market by ensuring that owners, financiers and all other participants operated in a stable market and could invest / improve / expand the industry's capability to deliver quality healthcare. Ie there was recognition then and up until recently that a level of scale and stability is required in order to deliver efficient, broad ranging and valued primary care health services in a Pharmacy setting.

Like all sets of rules that balance competing interests there can be less than ideal outcomes at the periphery. For these situations the Howard Government (under the then Health Minister Abbott) created a Ministerial discretion capability for the Health Minister to resolve situations where consumers may as a result be denied the benefit of a Pharmacy in a key location.

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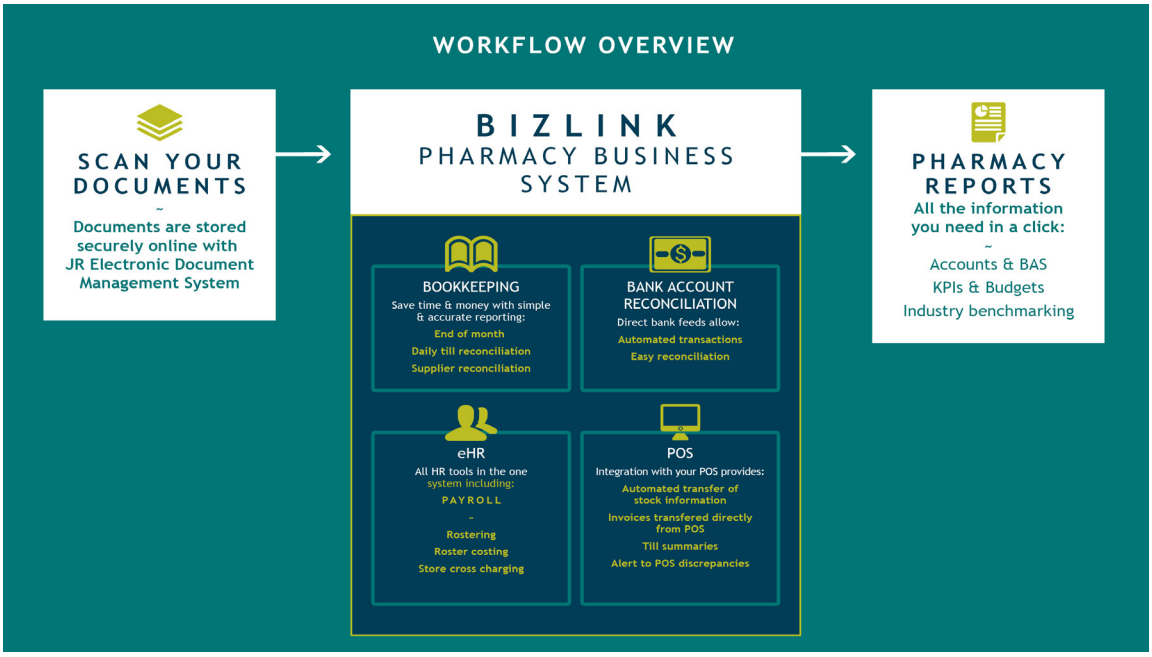

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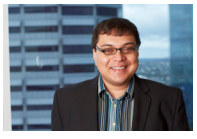

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