The Future of Community Pharmacy in England

The debate on building a sustainable industry is not a new one: The economics of community pharmacy are under pressure and the business model, particularly for independent pharmacists, is at a tipping point.
The Future of Community Pharmacy in England is our latest publication in our Tipping Point series which examines the different trends shaping the delivery of healthcare in the 21st century.

Pharmacy is one of the foundational pillars of modern medicine and many of today’s leading pharmaceutical companies can trace their origins back to a pharmacy entrepreneur. Community pharmacy is now at a crossroads. In the UK, as in many other developed markets, revenues are capped, competition is more intense and there is an increasing expectation on pharmacies to play a stronger role in managing chronic conditions. Independent pharmacies have long been the backbone of community services but, like post offices before them, they risk becoming obsolete as more nimble or better resourced players shape the market and capture its value.

This report looks at the forces shaping community pharmacy and models the impact these forces could have on the financial viability of pharmacy contractors. It also reviews the options for securing the future of the sector and confirms that doing nothing will not be an option.

We would like to thank Dr. Philip Brown and SG Court Pharmacy Group for their contributions to the funding of this research programme, Professor David Taylor of the UCL School of Pharmacy, and all those who participated in our interviews. We also thank Jonathan Plimley and Paula Bellostas Muguerza from A.T. Kearney’s Health Practice for their efforts in conducting the research and writing the report.

Jonathan Anscombe
partner

Michael Thomas
partner
Executive Summary

The debate on the sustainability of community pharmacy is not a new one. While everyone recognises the vital role that pharmacies play in the delivery of front-line care, the reality is that the economics of community pharmacy are under pressure and the model, particularly for independent pharmacists, is at a tipping point.

Five forces will profoundly shape the future of community pharmacy:

**Squeeze on healthcare budgets.** Despite rising demand and volumes, all indications are that the pharmacy settlement will remain flat in real terms. This reflects the pressures on public funding, which stem from the current financial crisis and longer-term pressures on National Health Service (NHS) expenditure as a result of an ageing population. The proposed shift from simply dispensing drugs to providing front-line services is unlikely to bring with it net new money and will be financed by a restructuring of the existing settlement.

**Intensifying competition.** The industry continues to consolidate slowly. With the demise of the high-street and the rise of out-of-town shopping, supermarkets are becoming an increasingly competitive force in the pharmacy landscape. In the race for the new 100-hour licences, multiple pharmacies have largely won out.

**Transformation of the supply chain.** The nature of innovation is changing and with it pharmacy models. Community dispensing is already dominated by commodity generics. This will become even more prevalent as the higher-value biologic therapies that currently dominate industry pipelines move into hospitals and homes. As manufacturers struggle to make a profit in primary care products, alternative distribution arrangements are being implemented that threaten the wholesalers in the short term and will inevitably impact pharmacies' buying profits in the future.

**Emergence of new alternative channels.** Internet and mail-order pharmacies are gaining strength and research suggests that the Internet has no age limits. If there is one constraint, it is on the side of commissioners who have been slow to see its potential as a way of fulfilling repeat scripts. In Germany, supported by regulatory change and sickness fund policies, mail-order pharmacy has grown rapidly. In the most conservative scenario these new channels should account for at least 20 per cent of all volumes. With the rise of the connected consumer, bricks-and-mortar pharmacies will not be the only way to deliver service.

**Demand for convenience and expertise.** Today’s health consumer wants it all. Whether it is prescription services, personal care products, or clinical services, the priority is on expertise, convenience, and accessibility.

Where does this leave community pharmacy? We have worked with industry experts to build a scenario model to simulate the impact these five forces could have on community pharmacies’ profits. Our findings suggest that the combined impact of these forces could result in a 38 per cent decline in the average profitability of a pharmacy.

All pharmacy contractors will have to change to meet the challenge. Independent pharmacies, in particular, will be severely challenged with a very real prospect that up to 2,000 outlets could be closed.

To survive, contractors, regardless of size, should consider two strategies:

**Improve efficiency of supply.** To meet rising dispensing volumes within a fixed budget, pharmacies need to improve their efficiency in filling prescriptions by at least 20 per cent. This
The Future of Community Pharmacy in England

The Future of Community Pharmacy in England can only happen with greater scale economies of operations and investment in dispensing automation. Multiples will need to centralise dispensing within their own networks. Independents will need to rely on wholesalers to deliver central dispensing services, as is the case in the Netherlands, or develop cooperative or in joint-partnership models.

Become the first port of call in the healthcare system. As dispensing becomes a commodity, pharmacies need to develop a sustainable revenue stream based on monetising their role in the front line of healthcare. This may come both from nationally and locally commissioned services.

There is no doubt that multiples will be in a better position to achieve both scale economies in dispensing and provide an improved approach to delivering nationally commissioned services. On the other hand, independent pharmacies and smaller regional chains have the unique opportunity of differentiating their positions by tailoring their offering to local priorities.

Our findings suggest that pharmacies that deliver dispensing efficiencies and strengthen the role of services in their business mix, can sustain current profit margins over the medium term. But doing so will require up-front investment and will not be without risk.

---

The impact of five forces for change could result in **900 closures representing up to 7.5 per cent of all pharmacies in England.**

Importantly, pharmacists cannot do it alone. Government and regulators must provide an enabling environment and the profession needs to demonstrate leadership in building the capabilities required in the new model. As seen in Scotland with the development of a new, service-oriented pharmacy model, the Department of Health (DH) and the NHS have key roles to play in setting the agenda for change and aligning stakeholders across the spectrum of commissioners, clinicians, pharmacy contractors, and patients.

Pharmacy at a Crossroads: Five Forces for Change

For some time the pharmacy market has been heading towards a tipping point as trading conditions have become increasingly challenging. More recently, two other factors have contributed to the challenges: government spending, which is under scrutiny as the country faces unprecedented levels of sovereign debt and the possible emergence of yet another recession, and increased demand for healthcare services, which is being fuelled by the burden of an ageing population and the rise of chronic conditions. Adding to these challenges is intense competition within the industry and pressure from both suppliers and customers in the value chain.

With these five forces for change putting pressure on community pharmacy, it comes as no surprise that the pharmacy industry as we know it has become unsustainable. Pharmacy is heading for a much-needed period of restructuring as it attempts to respond to these five major forces (see figure 1 on page 5). The following outlines these five forces and their implications in more detail.
Community pharmacy in the United Kingdom is reaching a tipping point under five forces for change

1. Squeeze on healthcare budgets
   - Reduced funds
   - Growing demand

2. Intensifying competition
   - Supermarkets
   - Multiples
   - Independents

3. Transformation of the supply chain
   - Manufacturers
   - Wholesalers

4. Emergence of new alternative channels
   - Online pharmacy
   - Remote dispensing

5. Demand for convenience and expertise
   - Patients

Source: A.T. Kearney analysis

UK healthcare spending is under extreme pressure

Growth rate (%)

Sources: HM Treasury, Public Expenditure Statistical Analyses - central government expenditure on services by sub-function (2001-2011), A.T. Kearney forecast
1. Squeeze on healthcare budgets

The government is under extreme pressure to curb healthcare spending and to reduce sovereign debt levels while managing another period of negative GDP growth. Although healthcare spending will not suffer as much as other items on the national budget, its rate of growth is expected to continue to slow down in coming years (see figure 2 on page 5).

With a projected annual population growth of 0.8 per cent, the year-on-year increases in expenditure in the range of 1 to 3 per cent in healthcare spend shown in figure 2 may seem generous.¹ The demographics and epidemiology of the UK tell a different story. With a rapidly ageing population and a dramatic rise in chronic conditions, the NHS needs to find efficiencies in the range of 20 per cent of its £100 billion budget to meet rising demand within its current settlement.

Today, about 10 million people or one in six people in the UK are age 65 or older. By 2050, that number will be about 19 million or one in four people as the population reaches 77 million. On top of the proliferation of age-related ailments that come with a maturing population, the UK will also have to deal with an increasing number of patients suffering from lifestyle-related conditions such as cardiovascular and respiratory diseases (see figure 3).

¹ Economist Intelligence Unit, UK Population Report (December 2011); Office for National Statistics, mid-1971 to mid-2010 population estimates; United Kingdom estimates of resident population for constituent countries and regions (2011).
contact count. Unfortunately, the new responsibilities may not come with more money. A portion of funding originally dedicated to the remuneration of the traditional medicines supply function is being shifted to pay for new health services. Although this shift is a justified attempt from the DH to address budgetary challenges while improving the management of chronic disease in a community setting, the implications for pharmacy are significant.

This change in funding is coming at a time when pharmacies are already suffering constraints on their main source of income (that is, generics buying profits) through reductions in Category M funding. These constraints will likely worsen as extra profits are expected to come into pharmacies, which the DH will be quick to claw back because of a growing number of drugs moving from branded to generic status. In addition, the era of generic blockbusters in primary care will begin to tail off from 2013 onwards.

A growth in item dispensing has already been straining pharmacy margins, as year-on-year increases of total contract funding have not kept pace with additional volumes supplied by pharmacies (see figure 4). Forecasts estimate a 4.7 per cent average annual growth in dispensing volumes over the next three years.

Not surprisingly, concerns among all players in this market are increasing as the impact of cuts in reimbursement prices is felt in contractors’ returns and cash flow positions. This is set to continue as the DH is counting on a further 25 per cent efficiency improvement in pharmacy productivity. While this is generally in line with expectations for the NHS, little thought has been put into how these efficiencies will be delivered, the reforms required to enable this step change in productivity, or the potential impact on different pharmacy contractors. Pharmacy is being forced to do more with less, which may turn out to be too much to ask.

**Figure 4**

*Pharmacy funding in England is failing to keep pace with dispensing volumes*

---

Source: PSNC indicative income tables (2005-2006 to 2011-2012); A.T. Kearney analysis
2. Intensifying competition

Even without the external environment pressures, pharmacy is a ferociously competitive marketplace. The 2005 changes to the control of entry regulation, including the promotion of 100-hour licences aimed at improving access for patients, further exacerbated the issue. More than 1,200 new licences have been issued since then which is more than 10 times the number issued in the five years preceding the regulatory change (see figure 5).

There were clear winners and losers from the 2005 exemptions. Most of the 100-hour and out-of-town licence applications came from the retail-driven large multiples protecting their business on the high-street and retail parks, or from the supermarkets making an aggressive entry into the market.

3. Transformation of the supply chain

The nature of pharmaceutical innovation is changing. In value terms, primary care medicines sales are flat after decades of growth because the current generation of blockbusters is now mostly available as generics with little to replace them. Innovation is coming almost exclusively from biotech drugs delivered in hospital, out-patient settings, or in the home.

---

Note: Percentages add up to 99 due to rounding.

---

Even for pharmaceutical companies, every point of margin is important as they struggle for returns in community care. Within this context, manufacturers are adopting alternative distribution arrangements such as reduced wholesale and direct to pharmacy (DTP) to protect their margins, potentially to the detriment of pharmacy buying profit.

This new fee-for-service type of distribution arrangement is significantly less lucrative to wholesalers than the traditional wholesale model and can add complexity to pharmacy operations. Pharmacies have so far been protected from the impact of these new arrangements. For now, manufacturers have to demonstrate that pharmacy profitability is not affected. But as the threat of disintermediation of the traditional wholesaler model gathers pace, it seems likely that existing discounting conventions will change.

4. Emergence of new alternative channels

2005 marked the arrival of Internet pharmacy. Changes to the control of entry legislation combined with technological advances and a growing demand for convenience means that physical pharmacies are no longer the only show in town. Liberalisation of the online and mail-order pharmacy market has varied across Europe with Germany, the Netherlands, Sweden, and the UK leading the way for new licences.

**Future profitability is predicated on pharmacies’ ability to deliver operating efficiencies and to become the front-line point of care.**

Germany is full-steam ahead in the development of online and mail-order pharmacy with 1,500 licensed contractors in operation. Although slower on the uptake, the UK is experiencing increasing growth in the number of Internet licences, indicating that this channel may well become a genuine alternative to traditional bricks-and-mortar pharmacies.

Online pharmacy is still in its infancy; based on our analysis, some of the large multiples are reporting sales only 1 per cent of total revenue through online channels. However, we expect this channel to grow in popularity. The UK is, after all, the largest online retail market in Europe, so chances are that, regulation permitting, traditional high-street pharmacies will start experiencing the same shift in buying behaviours that the retail high street has been experiencing in recent years.

The rise of the Internet channel is not the only challenger to pharmacy as we know it. Remote dispensing is also being explored in the UK as a viable alternative to meeting customers’ increasing demands for convenience. Following success stories in Canada and the United States, remote dispensing machine trials have started in the UK with the aim of reducing dispensary queues and improving access in remote locations. Results from these trials highlight these as a viable alternative to the physical channel and a way to reduce dispensing costs. Remote dispensing will never completely replace real pharmacies, but it will contribute to shaping the future of community pharmacy.
5. Demand for convenience and expertise

To add to environmental and supply chain pressures, patients are also expecting more from their pharmacies, with convenience and quality of service their main demands (see figure 6).

How is pharmacy performing against these expectations? A review of the recently conducted pharmacy needs assessments from a representative selection of PCTs reveals that there is room for improvement both in convenience and quality of service. In 44 per cent of PCTs, a significant number of patients stated that opening hours did not reflect their lifestyle needs and in 50 per cent of PCTs, many patients said prescription waiting times were too long. All PCTs reported a high number of patients demanding better information about the range of services offered and in 79 per cent of PCTs, patients thought the privacy offered during formal or informal consultations was inadequate.

Making these improvements will obviously require investment. Longer opening hours and shorter waiting times will require more staff. Raising awareness of services offered will require advertising and staff training. Improving privacy will require investment in building more or better consultation facilities. Importantly, these additional costs will have to be incurred against a backdrop of decreasing revenues.

Pharmacy is not only expected to deliver more with less, but also better.

---

Figure 6

Today’s UK patients expect more from pharmacies

<table>
<thead>
<tr>
<th></th>
<th>Prescription medicine</th>
<th>Over-the-counter medicine</th>
<th>Clinical services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximity</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Opening hours</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Waiting times</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Convenience</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Range</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Price</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Advice and expertise</td>
<td>Medium</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Quality of service</td>
<td>Low</td>
<td>Medium</td>
<td>Low</td>
</tr>
</tbody>
</table>

Sources: Office of Fair Trading, evaluating the impact of the 2003 OFT study on the control of entry regulations in the retail pharmacies market, dimensions of consumer choice for pharmacy goods and services (March 2010)

* Analysis of a representative sample of PNA survey results
The Impact on Profits, Revenues, and Costs

Pharmacy has traditionally been a profitable business that has attracted entrepreneurial individuals who are drawn to the profession by the prospect of an interesting career with a steady income and an appreciating asset. It has also caught the eye of large multiples and supermarkets that have entered into pharmacy to enhance their offer to customers and generate attractive levels of return. Pharmacy has been the place to be, and to a certain extent, it still is.

The five forces for change will alter these financial prospects.

To calculate the financial impact on community pharmacy, A.T. Kearney developed a model of the pharmacy market that analyses the impact of the five forces for change on pharmacy revenues and costs. The model takes into account differences in the financial makeup of five types of players: independents, small multiples, non-retail-driven large multiples, retail-driven large multiples, and supermarkets. The model is based on financial data gathered from different contractors and simulates the impact of these forces on each player, providing insight into what the community pharmacy sector might look like in the future.

We created a baseline scenario built around a pharmacy handling 6,000 prescriptions per month which, on average, could generate approximately £340,000 gross profit per year with an average EBIT margin of 9 per cent. Figure 7 shows the gross profit, costs, and EBIT margins that could be expected for each type of pharmacy contractor under this scenario.

Returns of this order of magnitude should be acceptable for most players in the industry. This level of profitability allows independents to pay off their loans and make a small profit, while investing in an asset which may be worth five times net profit in exit—based on current valuations. Large multiples and supermarkets are achieving more than double the average of the 4 to 5 per cent net retail profit margins in their pharmacy operations.

Figure 7
Pharmacy today—a snapshot of expected returns

£ (thousand)

<table>
<thead>
<tr>
<th>Type</th>
<th>Gross profit</th>
<th>Cost</th>
<th>EBIT margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independents</td>
<td>325</td>
<td>258</td>
<td>7.4%</td>
</tr>
<tr>
<td>Small multiples</td>
<td>331</td>
<td>256</td>
<td>8.2%</td>
</tr>
<tr>
<td>Non-retail-driven large multiples</td>
<td>346</td>
<td>248</td>
<td>10.3%</td>
</tr>
<tr>
<td>Retail-driven large multiples</td>
<td>353</td>
<td>248</td>
<td>10.8%</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>341</td>
<td>259</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

Note: EBIT is earnings before interest and taxes.
Source: A.T. Kearney analysis

Contractor Interviews; Department of Health; PwC Cost of Service Inquiry for Community Pharmacy (July 2011) adjusted for independents to take into account owner’s equivalent salary.
While revenues are fairly stable for different pharmacy types, buying profit and cost performance in our model vary significantly among the different players, equivalent to an additional 3.4 percentage points of EBIT margin. Cost base is where scale becomes an advantage for the large multiples and, to a lesser extent, the supermarkets. This will become increasingly important as we look at the financial impact of the five forces for change.

All five forces will have an impact on the financial performance of pharmacy by reducing its ability to grow buying profits, increasing its cost base, or reducing its revenue line (see figure 8).

**Figure 8**
The five forces for change will push average UK pharmacy profits down

<table>
<thead>
<tr>
<th></th>
<th>2012</th>
<th>2016: No change</th>
<th>Budget squeeze</th>
<th>Competition and supply chain pressures</th>
<th>Alternative channels and consumer demand</th>
<th>2016: all five forces for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Earnings (£ thousand)</td>
<td>87</td>
<td>94</td>
<td>20</td>
<td>8</td>
<td>8</td>
<td>58</td>
</tr>
</tbody>
</table>

Source: A.T. Kearney analysis

- **Healthcare budgets.** The squeeze on healthcare budgets will cause the biggest drop in profitability, with its combination of item growth and funding cuts. Reductions in Category M funding were already set at 20 per cent for 2011-2012 and further aggressive reductions are likely to occur in the next two years as growing numbers of drugs move from branded to generic status. These reductions will then continue at a lower rate as the DH attempts to further curb the cost of medicines. At best, buying profits will remain flat in absolute terms. While these funding cuts take place, volume demand is forecast to grow by 4 per cent per year. As a result of these measures, earnings across the industry will drop by an average of 35 per cent by 2016 from today’s levels, according to our analysis.

However, if the funding of the New Medicines Service (NMS) is anything to go by, these reductions in Category M funding will not be completely lost to pharmacy and are likely to be partly reinvested in service provision. This would soften the profit loss resulting from the funding cuts described earlier, but we still believe players will suffer an average reduction in earnings of 23 per cent by 2016.

- **Intense competition and supply chain transformation.** Together these two forces will have a negative impact on buying profit. As rivalry between players intensifies, pricing strategies will become more aggressive, reducing buying profits on non-reimbursed products. Also, as manufacturers continue to move towards more direct models of distribution to protect their

---

5 Pharmaceutical Services Negotiating Committee (PSNC) and industry interviews
margins, pharmacy will begin to see an impact on buying profits. We estimate the combination of these two forces will generate an average drop in profitability of 9 per cent by 2016.

**Alternative channels and convenience.** The emergence of new alternative channels and the demand for both convenience and expertise will affect pharmacy’s revenue line and cost base. New entrants will erode the overall market share of the physical channel, whereas increasing patient demands will make operating costs rise. Our analysis shows the combination of these two forces will also cause a profit drop of 9 per cent by 2016.

The combined impact of the five forces for change will be very visible on the financial statements of pharmacy players in years to come. And, with an average profit reduction of 38 per cent, it is clear that the industry will not remain in its current shape for much longer.

**Everyone's a Loser: Independents Hit Hardest**

Not all players will be able to endure the profit losses. Although large multiples and supermarkets will suffer, their ability to benefit from scale economies and find revenue sources other than NHS reimbursement should guarantee their survival. Independents will suffer most. Without changes, EBIT will drop by 44 per cent by 2016 and will result in a significant number of closures (see figure 9).

Our analysis suggests that the impact of the five forces could result in 900 closures representing up to 7.5 per cent of all pharmacies in England. These figures may seem alarming but they are low when compared with our projected closures of 40 per cent in Greece and 10 per cent in Sweden, Spain, and Portugal.

---

**Figure 9**

Failure to employ strategies to address five forces will harm profitability by 2016

<table>
<thead>
<tr>
<th></th>
<th>£ (thousand)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Industries</strong></td>
<td>2016 if no forces for change</td>
</tr>
<tr>
<td>Independents</td>
<td>69</td>
</tr>
<tr>
<td>Small multiples</td>
<td>78</td>
</tr>
<tr>
<td>Non-retail-driven</td>
<td>109</td>
</tr>
<tr>
<td>Retail-driven</td>
<td>118</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>89</td>
</tr>
</tbody>
</table>

Source: A.T. Kearney analysis

---

6 Stakeholders’ opinions vary about the implications of the five forces and the potential closures. Some believe all efforts should be made to protect pharmacy as we know it. Others believe the industry is truly anachronistic and that the external factors should run their course to bring pharmacy in line with other industries and to adapt to an evolving healthcare environment. Opinions aside, simple economics dictates that the combination of nearly flat growth in funding and an increasing number of pharmacies will be sufficient to force players out of the market.
Will these closures matter? They will to affected contractors, which, judging from the results of our analysis, are most likely to be the independents. Not only will the livelihoods of these contractors be affected, so will the neighbourhoods they operate in. The clinical knowledge accumulated over the years by these very experienced independent pharmacists will also be lost at a time when pharmacy needs to step up its contribution to the healthcare system.

Will patients notice the difference? We don’t think so. Before the control of entry regulation changes in 2005 the number of pharmacies per million people had remained stable for many years at around 196, growing to 210 in 2010-2011 after the four exemptions were introduced.

The sharp increase in the number of pharmacies was hardly noticed by the overall patient population as throughout England the mean distance to a pharmacy from either home or general practice (GP) surgery only dropped by 40 metres. Our predicted 900 closures would bring the ratio back to the 2005 levels of 196 pharmacies, which should be sufficient to cater to the population’s needs and the DH’s aspirations for pharmacy.

Independent pharmacies can build on their trusting relationships with customers to become the front-line point of care.

Nevertheless, the journey for remaining players will not be an easy one. Those left in the new market will need to evolve rapidly both to find a new sustainable economic model and to remain relevant to the emerging needs of the healthcare system. Those that are not prepared or fail to change will inevitably withdraw from the market. In any case, the industry will never be the same.

Strategies for Survival: Efficiency and Front-Line Care

What must players do to manage the impact of these changes? Profitability is predicated on pharmacies’ ability to improve their operating efficiencies and on the DH significantly increasing investments in pharmacy services to support the right environment for future pharmacy models.

We contend that pharmacies can secure their future survival by implementing two strategies: (1) develop a more efficient supply function to reduce the overall cost of medicines distribution, and (2) become a front-line point of care in the healthcare system to optimise the use of medicines, manage long-term conditions, and promote self-care and healthy lifestyles.

Develop a more efficient supply function

Funding pressures are forcing community pharmacies to operate more efficiently. The continued increase in item volumes, combined with the continuing move toward repeat prescriptions, will make the pharmacy industry largely a scale business, lending itself to

---

7 Office of Fair Trading (OFT), Evaluating the Impact of the 2003 OFT Study on the Control of Entry Regulations in the Retail Pharmacies Market (March 2010)
industrialised processes and streamlined supply chains. Minor tweaks in the dispensing process will not be enough to secure survival.

The transformation has already started with some chains investing in automation and others, chiefly the large multiples, exploring centralised dispensing of repeat prescriptions.

This concept, although still nascent in the UK, is already working in the United States and the Netherlands where many wholesalers and pharmacy chains have invested in central-fill infrastructures and are reaping the benefits in reduced labour costs, improved patient care as pharmacists have more time to spend in quality interactions with patients, and supply chain efficiencies from optimised deliveries (see sidebar: Central Dispensing in the Netherlands).

And while the United Kingdom is well positioned to adopt central dispensing to achieve the required efficiencies in the supply function, there is no one-size-fits-all solution, with players responding in different ways (see figure 10).

### Central Dispensing in the Netherlands

In the Netherlands, about 500 pharmacies have been using centralised dispensing since 2006 when wholesalers began offering this service. Seven central-filling pharmacies currently work together under the name of Central Filling Platform of Companies, offering next day picking, packing, and labelling services for approximately 6,000 product lines. This offering is suitable for about half of the prescriptions in the Netherlands, where 80 per cent of all scripts are repeats.

Central dispensing has reduced processing times by 20 to 30 per cent, thus delivering significant cost savings and creating headroom to deal with the increasing volume arising from the Dutch ageing population.

Central dispensing also provides pharmacies the opportunity to operate with lower stock levels, thereby reducing their working capital commitments. Finally, central dispensing enables pharmacies to start moving from a model built entirely around supply to one more focused on patient care.

#### Success factors
- Registration of patients with a single pharmacy
- Changes in regulation to allow scripts to be filled and dispensed by different entities
- Training of the pharmacy team to help them understand why the process changes are necessary since not all team members will easily let go of familiar dispensing tasks
- Robust pharmacy systems that can handle the transfer of information between local pharmacies and central dispensing units, which, in most cases, have had to be funded by pharmacy owners

---

**Figure 10**

How will pharmacy players respond to the efficiency challenge?

<table>
<thead>
<tr>
<th>Likely to improve efficiency</th>
<th>Independents</th>
<th>Small multiples</th>
<th>Non-retail-driven large multiples</th>
<th>Retail-driven large multiples</th>
<th>Supermarkets</th>
</tr>
</thead>
<tbody>
<tr>
<td>How they will improve efficiency</td>
<td>Outsource to wholesalers (if offered)</td>
<td>Hub and spoke, dispensing robots</td>
<td>Central dispensing via owned wholesaler</td>
<td>Central dispensing via owned wholesaler</td>
<td>Central dispensing via owned distribution networks or outsource to wholesalers (if offered)</td>
</tr>
</tbody>
</table>

Source: A.T. Kearney analysis
Let’s look at how improved efficiency might affect different industry players:

- **Large multiples.** The need for supply chain efficiency has already driven vertical integration and three of the six largest pharmacy entities are now part of groups that also own a wholesale arm. For these integrated operators, setting up the necessary infrastructure to industrialise the dispensing of repeat prescriptions should be a relatively easy step. They will be able to co-locate the central dispensing units within their wholesale networks in a way that will not be possible for an independent pharmacy. In addition to the cost savings, the creation of dispensing “headroom,” and the potential for improved patient care, centralised dispensing may also provide an opportunity for the multiples to reduce working capital tied up in stock.

- **Remaining players.** Achieving the same level of efficiency as the large integrated multiples will be far more difficult for the rest of the players in the market. Small multiples and supermarkets will be able to achieve efficiencies, albeit smaller, within their own networks. The former will consolidate volumes from several stores and create hub-and-spoke operations, where one pharmacy, potentially fitted with dispensing robots, will centrally fill repeat prescriptions on behalf of the rest. The latter will set up central dispensing operations within one or more sites in their distribution networks to assemble repeat prescriptions on behalf of all their stores.

The independents could struggle to find an alternative option unless wholesalers step in as dispensing service providers. In the Netherlands, for example, wholesalers have chosen to provide these services and have forward-integrated into the value chain, providing pre-prepared repeat prescriptions to all players in the market. However, in the United Kingdom, because all major wholesalers are part of integrated groups, it remains to be seen whether wholesalers will pass on the competitive advantages enjoyed by their retail cousins to the rest of the sector. To remain competitive, independent pharmacies may have to explore cooperative structures if wholesalers do not emerge as dispensing service suppliers.

**Taking Efficiency a Step Further, or a Step Too Far?**

Could the DH and the NHS take the efficiency model even further? In an extreme case, the entire supply function could be decoupled from pharmacy and the National Commissioning Board could subcontract it to a small number of players, obtaining absolute transparency of the total cost of supply. Most prescriptions could be filled centrally and sent directly to patients, along the lines of mail-order pharmacy in the United States. Patient registration would allow for much more effective medicine use reviews in a way that retail pharmacies with travelling scripts find hard to do reliably. Retail pharmacies would remain to dispense prescriptions for acute and supervised conditions, initiate chronic care regimes, and offer an expanded programme of advisory services.

Although possible, this scenario may be one step too far. The cash flow and working capital implications of taking over the procurement of pharmaceutical products may be prohibitive for the NHS at the current time. More importantly, divorcing the delivery of medicines from the patient interaction could have unintended consequences.

Only if the two go hand in hand can pharmacists fulfil their role in medicine optimisation and take advantage of face time with patients to perform on-the-spot interventions that promote healthy lifestyles and self care. The vital importance of pharmacist-patient interaction has been brought to our attention on numerous occasions during our research. As one interviewee explains, “Only by looking into the eyes of a patient and checking if they’re yellow can I determine if his treatment with statins is causing jaundice.” Pharmacy is much more than just supplying medicines.
Realising the benefits of centralised dispensing will require not only transforming the profession, but also making significant capital investments, changes to regulations, and developing IT systems to support the new operating model. Those making these investments will need sufficient incentives to do so. Any savings generated for the healthcare system should not be entirely clawed back. Indeed, the DH should take a system view and share the benefits among the players in the value chain to ensure sustainability (see sidebar: Taking Efficiency a Step Further, or a Step Too Far? on page 16).

- **Opportunity for demand management.** Although increasing efficiency through different forms of centralisation will address the symptom of growing demand, there are other, more fundamental changes that would tackle the root cause, such as slowing the growth in repeat prescription volumes with a more flexible approach to treatment course length. For example, moving 50 per cent of repeat prescriptions from 28 days to three months for the four main chronic diseases (hypertension, diabetes, hyperlipidaemia, and respiratory problems) would reduce the number of items dispensed in England in 2012 by over 40 million—equivalent to 4 per cent of all prescriptions in England. This would reduce system costs, make home delivery more economically attractive, and be far more convenient for some patients. However, under the current reimbursement system, it would reduce pharmacy income—presenting yet another argument for improving the alignment of incentives in the system.

**Become the front-line point of care**

The broader role of pharmacists, beyond performing a simple supply function, is an integral part of their history. Pharmacy has all the right ingredients to become a valuable provider of healthcare services, including clinical skills, trusting patient relationships, unmatchable access, and cost effectiveness (see figure 11).

---

**Figure 11**

**Pharmacy is poised to become a valuable provider of healthcare services in the United Kingdom**

<table>
<thead>
<tr>
<th>Clinical skills</th>
<th>+ Provides medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>+ Promotes healthy living</td>
</tr>
<tr>
<td></td>
<td>+ Offers diagnosis and treatment of minor ailments and injuries</td>
</tr>
</tbody>
</table>

| Trusting patient relationships | + Many adults (44 per cent) are likely to seek advice from a pharmacist when they get sick |
|--------------------------------| + Pharmacy is considered a step up from self-care and a step away from visiting the GP |
|                                | + Patients (57 per cent) want more primary care services, health screenings, and advice from their local community pharmacy |

| Unmatchable access | + Approximately 1.8 million people visit a pharmacy daily |
|--------------------| + A majority of adults (84 per cent) visit a pharmacy at least once a year |
|                    | + Many adults (68 per cent) say they prefer pharmacies to GP surgeries because of more convenient hours |

| Cost effectiveness | + Pharmacy has the lowest cost per intervention |
|--------------------| + GP: £80 |
|                    | + Nurse: £40 |
|                    | + Pharmacist: £25 |

Sources: Industry interviews; A.T. Kearney analysis
Pharmacists’ role in medicines management has already been formalised in the commissioning of advanced services—including providing medicine-use reviews and the NMS. Broader healthcare services are also being explored with locally commissioned public health services (smoking cessation, weight loss, alcohol issues, and sexual health), minor ailments schemes, and patient group directives. The latest policy development is the healthy living pharmacy (HLP) concept, which, after great success in the Portsmouth PCT has been rolled out nationally to 30 PCT pathfinder sites.

According to impact studies of several HLP pathfinders, patient outcomes have improved. Furthermore, HLPs demonstrate a halo effect of improved trading results and increased staff motivation. This has prompted many independents and small chains to turn their businesses into HLPs, including stores outside the scheme’s pathfinder areas. These services will complement those delivered by more commercially minded pharmacists that have already expanded into private services such as travel vaccinations, mole clinics, and health checks.

We expect differences in how the large multiples and independents approach the front-line care challenge, with larger retailers using their scale and operations to deliver more standardised models of care, and the independents striving to localise their services.

The following takes a closer look at the players:

- **Large multiples (retail and non-retail).** Larger players are in the best position to meet the challenge of becoming the front-line points of care for patients who need healthcare advice. They have the necessary scale, the resources to invest in infrastructure, and the capabilities to implement high-quality, nationally specified private services with consistent delivery.

  Both commissioners and service partners will be attracted by the coverage and reach that large multiples can offer in partnering to deliver sponsored services. Commissioning capabilities will become an important competency, and a potential differential advantage against independents, as clinical commissioning groups (CCGs) become increasingly important in the commissioning of care. An account team of 10 commissioning managers could provide a major chain with the ability to serve CCGs nationally, an unaffordable luxury for smaller chains and independents.

  Although unrivalled accessibility, longer hours, and convenient locations give multiples plenty of opportunities to engage with patients, they will need to work hard to transform patients’ perceptions if they are to be considered trusted clinical advisors as much as independent pharmacists tend to be.

- **Independents and small chains.** With half the population regularly visiting independent pharmacies, pharmacists can build on the trusting relationships with their customers to deliver more clinically led pharmacy services. The future will see a broad catalogue of services with an emphasis on nationally commissioned interventions and locally commissioned services, developed through close working relationships with CCGs and targeted at the priorities of the local community. This will require closer integration and in some instances co-location with health centres or GP practices, moving pharmaceutical care away from high street.

  Pharmacists will need to gradually transform their premises into healthy living centres as has happened with the HLP concept, repurposing retail space into consultation rooms or healthy lifestyle information areas. This new look will be necessary to shift patients’ perception of pharmacists from dispensers to providers of healthcare services and trusted clinical advice.
This transformation will take time and investment. Independents will have to find innovative models of cooperation to enable the evolution into the more clinical model. These new models will take many forms, and some are already emerging with clusters of independent pharmacies coming together under limited liability partnerships to tender for certain services.

Independent pharmacies as we know them today will largely cease to exist. Those that embrace the change will tailor their front-line clinical delivery to local markets. Although all players will offer nationally commissioned healthcare services, local pharmacies can differentiate their offerings by developing leading capabilities on specific conditions and commissioning pathways considered high priority in their community.

Many independents will also need to consolidate to survive. For those with unsuitable premises, contractors may need to relocate and possibly share the up-front investment to create a new pharmacy practice aligned to local needs.

- **Supermarkets.** Supermarkets will introduce a limited range of services, focusing on those that can capitalise on their greatest selling point: convenience. These players will offer nationally commissioned and private services, but pharmacy will very much remain secondary to their retail activity. It is therefore unlikely that they will develop a highly clinical component to their pharmacy offering.

Given pharmacy’s potential as a healthcare provider and its desire to fulfil that role, why has it taken so long to engage the industry in the provision of healthcare services? And why is it happening slowly and in a rather piecemeal fashion? We believe it is due

### Pharmacy in Scotland: A Success Story

**The Scottish pharmacy model is based on a comprehensive set of nationally specified services supported by a pharmacy contract that acknowledges the shift in role for pharmacy. The new contract boasts a remuneration system that offers incentives to encourage continuous improvement and quality healthcare services, and breaks the link between payment for service provision and volume of items dispensed.**

The new contract has three main elements: medicines supply remunerated on a volume basis, locally negotiated additional services, and centrally negotiated core pharmaceutical care services that are compensated based on patient registrations with capitation (namely chronic medication service, minor ailments service, emergency supply service, and public health service.)

**Benefits**
The new contract has had a positive effect both on patient care and on the integration of the community pharmacy into the Scottish healthcare system. There are also two clear examples where patient outcomes have improved: Smoking cessation (the total number of smoking cessation items dispensed across Scotland rose from 162,000 in 2007 and 2008 to more than 330,000 in 2010 and 2011) and emergency contraception (since its introduction in 2008, this service has dispensed more than 81,000 items in 2010 and 2011).

**Success factors**
- National specification and commissioning of new services, which means both pharmacists and patients know what to expect from these interventions, regardless of location
- Alignment of industry stakeholders around a common vision, and as one united front advocating for pharmacy
- Significant investment to underwrite the transition; for example, the Scottish government invested more than £11 million in information and communication technology development alone
- Bite-sized change management interventions to implement new ways of working—to help pharmacists buy into the new processes and to ensure high quality and consistent services from the start
- Creation of a mutual NHS with solid foundations of cooperation and collaboration
to a lack of consistency in the specification and commissioning of services and poor integration with other players in the healthcare system. Community pharmacy in England can learn from other players in the system:

- **A lesson in specification.** Scotland is a great example of where national specification and commissioning of services has resulted in an enhanced role for pharmacy and positive health outcomes for the population. Since devolution in 1998, the Scottish Executive committed to improving patient care by making better use of pharmacists while reducing the strain on GP and hospital services through the introduction of four core pharmacy healthcare services. These services were specified, commissioned, and negotiated at a national level but with great emphasis on adapting local delivery to the needs of the community which has been a critical factor to their success (see sidebar: Pharmacy in Scotland: A Success Story on page 19).

- **A lesson in integration.** Hospital pharmacies provide an example of where the future for community pharmacy may lie, with pharmacists fully integrated in front-line delivery of care working as peers with other clinicians to reduce errors and improve patient outcomes. While there are important differences between hospital and community pharmacies, the principle of integration in care delivery is essential to articulating a way forward for pharmacies in the community.

**What Will the Market Look Like?**

If pharmacy embraces the two proposed strategies for survival, our model suggests that community pharmacy will remain viable and profitability will be largely sustained. This will not come without a cost. Although we estimate that, by implementing these two strategies, average EBIT in 2016 can be managed to a decline of 7 per cent versus the 38 per cent reduction under a do-nothing-scenario, the next few years will be financially challenging for all players (see figure 12).

**Figure 12**

**Profitability will return to current levels after a few financially challenging years**

<table>
<thead>
<tr>
<th>£ (thousand)</th>
<th>2012</th>
<th>2016: without forces for change</th>
<th>2016: with five forces</th>
<th>With increased efficiency</th>
<th>With stronger clinical offering</th>
<th>2016: both strategies implemented</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>87</td>
<td>94</td>
<td>58</td>
<td>14</td>
<td>15</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: A.T. Kearney analysis

Recovery in profitability is predicated on pharmacies being able to deliver operating efficiencies and on the DH significantly increasing investment in pharmacy services to enable the right environment for the development of future pharmacy models. This won’t happen immediately.
so we expect that profitability will drop significantly in the first few years as funding fails to keep up with the increasing costs of dispensing and service ramps up more slowly.

This will pose a challenge to the survival of some independents and small chains that have significantly shallower pockets than the large multiples and supermarkets. The most negative predictions suggest that up to 2,000 independents could go out of business in the next three years, twice as many as our prediction, reducing the total number of contractors to approximately 8,500. The next few years will be tough while the industry undergoes a process of right-sizing.

Large multiples will continue to dominate the market. Non-retail driven chains will thrive in the new environment, able to achieve efficiency quickly by utilising the assets of their wholesale networks while capturing a significant share of the services market thanks to patients associating their brands with clinical excellence. Retail-driven multiples will achieve efficiency in the same way and although service revenue may take longer to acquire, the large contribution of health and beauty retailing will absorb the initial profit losses. In the case of supermarkets, it is unlikely that margins will return to today’s levels. However, we do not envisage that grocery retailers will exit their pharmacy investments as its substantial halo effect will allow them, in the extreme, to operate their dispensaries as loss leaders (see figure 13).

Figure 13
Large multiples will continue to dominate the UK pharmacy market

£ (thousand)

<table>
<thead>
<tr>
<th></th>
<th>2016 with no forces for change</th>
<th>2016 with five forces</th>
<th>2016 addressing five forces (using two strategies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independents</td>
<td>69</td>
<td>39</td>
<td>63</td>
</tr>
<tr>
<td>Small multiples</td>
<td>78</td>
<td>46</td>
<td>76</td>
</tr>
<tr>
<td>Non-retail-driven large multiples</td>
<td>109</td>
<td>71</td>
<td>104</td>
</tr>
<tr>
<td>Retail-driven large multiples</td>
<td>118</td>
<td>76</td>
<td>108</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>89</td>
<td>50</td>
<td>79</td>
</tr>
</tbody>
</table>

Source: A.T. Kearney analysis

Seven Ways to a Sustainable Future

There is a sustainable commercial future for community pharmacy, but it will require a concerted effort from all stakeholders—the DH, NHS commissioners, the Royal Colleges, and pharmacists— to make the transition work. We believe seven enablers can ensure the industry is rebuilt on a solid foundation and the profession is fit for its new purpose (see figure 14 on page 22).

1. Healthcare system integration

The DH will have to put into practice a policy of using the best professional for each intervention to ensure proper allocation of resources across the healthcare system. Although most recognise
that pharmacy will have a key role to play in the new environment, it is currently far from integrated in the healthcare system. Integration will require three elements:

- **Process changes.** These will be required to make pharmacy part of the patient pathway by formalising patient referrals to nominated pharmacies (after discharge from hospital, for example) for follow-up, assisting with registration with a chosen pharmacy for advice about new medicines, and offering community-based monitoring and management. Co-location with other healthcare professionals where appropriate could help ensure pharmacy contributes as part of a multidisciplinary team approach to improve patient outcomes.

- **Behaviour change.** Change management will be crucial to inform both patients and other healthcare professionals about the benefits of making pharmacies a truly integral part of the patient pathway. For GPs, the DH will have to highlight that pharmacies can be the vehicle to allow them to provide better care for patients and even free up their time to focus on more complex cases without threatening their ability to earn QOF points. For patients, the benefits of easy access will be clear, but the challenge will be to rebuild the image of pharmacists as healthcare professionals.

- **Investment in systems and infrastructure upgrades.** Investment will be necessary to increase integration between pharmacies and the NHS. In their new role, pharmacists will need access to summary or even full patient records, and PharmaBase will need to be upgraded so that patient interventions can be managed and recorded. Implementing the new model will also be significantly easier if electronic prescriptions are fully rolled out and operational across all GP practices.

2. **Funding and specification**

Funding and specification will require a major overhaul to reflect pharmacy’s new role:

- **Funding and reimbursement.** A new contract will need to reflect the state of flux pharmacy is in by including a mechanism to reward the industry for the role it plays today while enabling a transition into the role that will be expected of it tomorrow. Recognising the dual function pharmacies will fulfil should be the starting point for any change to the current contract.
On the supply side of the contract, increased transparency will be welcome by all players as convoluted reimbursement mechanisms that undergo constant changes and revisions make it impossible to forecast earnings. However, more significantly, to make the new model for pharmacy a success, it will be critical to move away from reimbursement linked to dispensing volume towards new models based on patient registrations that operate on a capitated basis. This approach will not only ensure consistency and higher-quality service, but will also reflect the diverging roles players will choose in the new environment by breaking away from the current one-size-fits-all approach. In the extreme, the DH could move toward having salaried pharmacists—removing the contractor condition—and formally integrating the profession into the healthcare system, potentially incentivising their performance through the QOF or an equivalent outcome-based framework.

- **Specification and commissioning.** Local commissioning of services is fragmented and uncoordinated, which has led to significant regional differences in the types of services offered, their definition, and the fees they command. National specification is the key to unlocking real value for the system from important services that are relevant to all patient populations. With national specification should come national training and accreditation, which will bring about both quality and consistency in service delivery and give pharmacists flexibility to practice across different localities. Nationwide programmes, such as vaccinations in schools, demonstrate that services that are nationally conceived, designed, and commissioned, even if delivered outside the traditional clinical settings, can bring great value to the overall healthcare system.

3. Market management

The 2005 control of entry regulations distorted the industry’s natural growth rate. Regulators need to find a suitable mechanism to strike a balance between market liberalisation and developing an infrastructure that is both economically viable and fit for purpose. Pharmaceutical needs assessments and the end of the 100-hour licence exemption are steps in the right direction, but regulators will need to watch the market closely in coming years as the impact of the five forces for change results in pharmacy closures. Although a reduction in the number of pharmacies is a necessary evil to right-size the market, mismatches are likely to arise between where the closures take place and where excess pharmacy capacity is located.

4. Representation

There are around 200 bodies representing the pharmacy industry today so it is easy to imagine why, from the outside, it looks as if views are fragmented and leadership is lacking when compared, for example, with the GP community. However, from the inside, there is such diversity of players in the industry that no single body will be able to effectively represent and lobby on behalf of all contractors.

Therefore, it will be important to develop one single voice for all players operating in this market, and for the pharmacy profession as a whole by strengthening the Royal Pharmaceutical Society (RPS). In its infancy as a stand-alone representing body, the RPS has an opportunity to take the driver’s seat for the industry, consolidating the views of all players, leading on political advocacy, and raising the profile of pharmacy among the patient population and the wider healthcare professional community. This will make it much easier to encourage the acceptance of pharmacy’s new role, both from within and outside the industry.
5. Regulation

The Medicines Act 1968, which governs the control of medicines, is undergoing a much-needed review, especially around the definition of “responsible pharmacist.” This definition will need to be amended to acknowledge the profession’s new role, including a change to pharmacists’ legal responsibilities for checking medicines. Pharmacists must be freed up to move out of the dispensary to engage with patients—a role that could be taken even further by broadening pharmacists’ clinical authority to include diagnostic and prescribing activities.

There is a risk, however, that evolving toward a more clinical definition of the responsible pharmacist could be viewed by other healthcare professionals and the general public as a step too far. Ongoing assessment and revalidation, which the government plans to introduce more broadly, will help maintain public confidence in the profession, prevent competence from diminishing over time, and create equality among healthcare professionals.

Although pharmacy will have a key role to play in the new environment, it is currently far from integrated in the healthcare system.

6. Education

Schools of Pharmacy will have to ensure the development of professional pharmacists who are capable of taking on a more active role in the delivery of care. This will require greater emphasis during initial qualification and pre-registration on developing the necessary skills for engaging in successful patient interactions (clinical pharmacology, for example). The more forward-thinking schools are already making this a core part of their programmes, but there needs to be consensus among all schools, which will be even more challenging in the context of the devolved nations.

The need for formalised development will not stop after registration. To achieve the ambitions for the profession, pharmacists need to be able to refresh their skills, develop new ones and progress towards a specialisation in a consistent and formalised way. Again, the RPS is well positioned to provide a framework that allows the profession to grow and plans are underway to reform pharmacists’ professional development. However, the industry and the profession will have to find ways for training time to be protected as it is for other clinicians, rather than relying on pharmacists’ willingness and ability to attend and, in the case of independents, to fund relevant training outside their normal working hours.

7. Mindset

Along with the DH, GPs and patients will have to be convinced that repositioning pharmacy as a key player in the healthcare system is the way forward. Pharmacists will have to be convinced as well. The profession is battling significant change, uncertainty, and instability, which are causing a degree of anxiety among many practitioners. The NHS, legal framework, value chain, and demands the healthcare system places on them are all changing.
Many pharmacists are embracing the change and seeing it as a great opportunity to use their skills, grow their businesses, and become more meaningful contributors to the nation’s health. The profession should now build on the momentum created by these early adopters. Doubters will be more easily convinced if initiatives such as HLP result in good patient outcomes and willingness from the government to invest in pharmacy. In any case, all players will have to invest in change programmes to win hearts and minds and make the transition a reality, which will undoubtedly be an easier task for large multiples. Once again, leadership from the RPS to engage the entire pharmacist population will be crucial to making the transition to the new role of pharmacy an easier pill to swallow.

Industry at a Crossroads

The pharmacy industry is rapidly approaching a crossroads that offers an opportunity for true transformation. Pharmacy can become a more efficient supplier of medicines and a more integrated provider of care and clinical advice, which can help the healthcare system tackle the burden of an ageing population and rising levels of chronic conditions.

Smaller independent pharmacies may be at an immediate disadvantage in achieving a step change in dispensing productivity, but their knowledge and connections with local health economies and GP practices could allow them to build a highly localised approach to service delivery. We see independent pharmacies increasingly coming together to form local partnerships. Larger multiples need to move rapidly to implement centralised dispensing models and standard services to position themselves favourably with commissioners.

Change will not be easy and will require significant investment and commitment from within and outside the industry. Change may also result in the forced or voluntary exit of some contractors. However, we believe this transformation journey will be one worth starting as this may well be the last chance pharmacy gets to reinvent itself as a credible contributor to the improvement of the health of the nation, and to ensure its financial survival.

Authors

Jonathan Anscombe, partner, London
jonathan.anscombe@atkearney.com

Jonathan Plimley, consultant, London
jonathan.plimley@atkearney.com

Michael Thomas, partner, London
michael.thomas@atkearney.com

The authors thank Paula Bellostas Muguerza, Tamara Gilberto, Bhavini Singh, and Lorna North for their help in researching and publishing this report.
Appendix

Acknowledgements

We would like to thank Dr. Philip Brown of SG Court for co-sponsoring this report. Our special thanks also go to David Taylor, professor of pharmaceutical and public health policy at the UCL School of Pharmacy, for his guidance and support during the research phase of this paper. We also wish to thank all the interviewees whose insights and experience were invaluable in painting a picture of what the future might bring to the pharmacy industry:

- SG Court team: Sanjay Magecha, Kevin Cottrell, Richard Cox, and Raj Chopra
- Gerald Alexander, Middlesex Pharmaceutical Group
- John d’Arcy, managing director, Numark Pharmacy Group
- Martin Astbury, president, Royal Pharmaceutical Society
- Nick Barber, professor of pharmacy practice, UCL School of Pharmacy
- James Davies, Ph.D candidate, UCL School of Pharmacy
- Howard Duff, director for England, Royal Pharmaceutical Society
- Catherine Duggan, director of professional development and support, Royal Pharmaceutical Society
- Sanjay Ganvir, director, Green Light Pharmacy
- Christine Glover, fellow, Royal Pharmaceutical Society of Great Britain
- Mike Holden, chief executive, National Pharmacy Association
- Michael Levitan, Middlesex Pharmaceutical Group
- Jonathan Mason, national clinical director for pharmacy, Department of Health
- Alex McKinnon, director for Scotland, Royal Pharmaceutical Society
- Sandra Melville, chairman, Scottish Pharmacy Board at the Royal Pharmaceutical Society
- Bob Nicholls CBE, chair of the General Pharmaceutical Council
- Amanda Rae, regional pharmacy manager in Scotland, Alliance Boots
- Priya Sejpal, head of standards and fitness to practice policy, General Pharmaceutical Council
- Sue Sharpe, chief executive, Pharmaceutical Services Negotiating Committee
- Anthony Smith, professor and former dean, UCL School of Pharmacy
- Ash Soni, member of NHS Future Forum and owner of an independent pharmacy
- Baljinder Srann, Canadian pharmacist
- Faisal Tuddy, commercial manager for pharmacy, ASDA
Glossary of Terms

For the purpose of this report, the pharmacy market is divided into six types of players:

**Independents**: one branch

**Small multiples**: more than one branch but less than 20 and not one of the six large entities: Boots, Lloyds, Rowlands, Co-operative, Day Lewis, and Superdrug

**Non-retail-driven large multiples**: branches from the six largest entities that focus on NHS services

**Retail-driven large multiples**: branches from the six largest entities that focus on retail services

**Supermarkets**: in-store pharmacies from Sainsbury’s, Morrisons, Asda, and Tesco

The sixth player, hospital pharmacy, is considered to be out of scope.
A.T. Kearney is a global team of forward-thinking, collaborative partners that delivers immediate, meaningful results and long-term transformative advantage to clients. Since 1926, we have been trusted advisors on CEO-agenda issues to the world’s leading organizations across all major industries and sectors. A.T. Kearney’s offices are located in major business centers in 39 countries.

<table>
<thead>
<tr>
<th>Americas</th>
<th>Atlanta</th>
<th>Detroit</th>
<th>San Francisco</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Calgary</td>
<td>Houston</td>
<td>São Paulo</td>
</tr>
<tr>
<td></td>
<td>Chicago</td>
<td>Mexico City</td>
<td>Toronto</td>
</tr>
<tr>
<td></td>
<td>Dallas</td>
<td>New York</td>
<td>Washington, D.C.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Europe</th>
<th>Amsterdam</th>
<th>Istanbul</th>
<th>Oslo</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Berlin</td>
<td>Kiev</td>
<td>Paris</td>
</tr>
<tr>
<td></td>
<td>Brussels</td>
<td>Lisbon</td>
<td>Prague</td>
</tr>
<tr>
<td></td>
<td>Bucharest</td>
<td>Ljubljana</td>
<td>Rome</td>
</tr>
<tr>
<td></td>
<td>Budapest</td>
<td>London</td>
<td>Stockholm</td>
</tr>
<tr>
<td></td>
<td>Copenhagen</td>
<td>Madrid</td>
<td>Stuttgart</td>
</tr>
<tr>
<td></td>
<td>Düsseldorf</td>
<td>Milan</td>
<td>Vienna</td>
</tr>
<tr>
<td></td>
<td>Frankfurt</td>
<td>Moscow</td>
<td>Warsaw</td>
</tr>
<tr>
<td></td>
<td>Helsinki</td>
<td>Munich</td>
<td>Zurich</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asia Pacific</th>
<th>Bangkok</th>
<th>Melbourne</th>
<th>Singapore</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beijing</td>
<td>Mumbai</td>
<td>Sydney</td>
</tr>
<tr>
<td></td>
<td>Hong Kong</td>
<td>New Delhi</td>
<td>Tokyo</td>
</tr>
<tr>
<td></td>
<td>Jakarta</td>
<td>Seoul</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Kuala Lumpur</td>
<td>Shanghai</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Middle East and Africa</th>
<th>Abu Dhabi</th>
<th>Johannesburg</th>
<th>Riyadh</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dubai</td>
<td>Manama</td>
<td></td>
</tr>
</tbody>
</table>

For more information, permission to reprint or translate this work, and all other correspondence, please email: insight@atkearney.com.

A.T. Kearney Korea LLC is a separate and independent legal entity operating under the A.T. Kearney name in Korea.

© 2012, A.T. Kearney, Inc. All rights reserved.

The signature of our namesake and founder, Andrew Thomas Kearney, on the cover of this document represents our pledge to live the values he instilled in our firm and uphold his commitment to ensuring “essential rightness” in all that we do.