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**The Dispensing Fee for
Medications: The Negative Effects
of Pricing Uncertainty on Pharmacy
Practise in South Africa**

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The Dispensing Fee for Medications: The Negative Effects of Pricing Uncertainty on Pharmacy Practise in South Africa

Abstract

This paper explores the contested issue of the dispensing fee for medications in South Africa. Focusing on the dispute between organised pharmacy and the Health Department, it follows the history of the negotiations, traces possible implications, outlines key perceived problems with the policy, and explores possibilities for its resolution. The paper draws on published data and documents from government and pharmacy representatives and supplements this with interviews with pharmacy owners and managers.

Relevant Organisations

Pricing Committee (PC): Appointed by the Health Minister to make recommendations leading to regulations on a transparent pricing system for all medicines – including the formulation of a single exit price and a dispensing fee - for anyone licensed to dispense

Pharmaceutical Society of South Africa (PSSA): Organisation of individual pharmacists dealing with industry-wide legal representation, professional development, and public affairs

United South African Pharmacies (USAP): Organisation of smaller infrastructure, helping independent community-practice pharmacies mainly in negotiations with medical schemes, defers legal issues to the PSSA.

Pharmacy Stakeholders Forum (PSF): Formed jointly by the PSSA and USAP to negotiate a dispensing fee with the Health Department

South African Pharmacy Council: Formed under the 1974 Pharmacy Act to advise Health Minister on matters relating to pharmacy; registers pharmacies for practise in South Africa and records closures

Introduction

The pricing of medicines in South Africa has historically been unregulated and non-transparent. Pharmacies are free to levy a range of fees in dispensing to the general public despite an ongoing effort by the government to standardise fees in order to contain health care costs and protect consumers. Dispensing fee legislation, proposed in 1997 and finally applied in 2003, was meant to level the cost of any given medication at any given pharmacy by uniform standards of transparency. The architects of the 1997 Medicines Amendment Act sought to eliminate extraneous mark-ups (administration fees, shelving fees, etc) used at individual pharmacies by requiring each medicine to be sold by the pharmacy at its single exit price (SEP) with the addition of a uniform dispensing fee for profit.

Debate rose immediately and continues over how this fee should be set. Concerned parties include representatives of civil society looking out for affordability, medical schemes whose policies change in accordance with drug pricing, pharmacy owners and employees with their various consortia, the consumers themselves, and a mediating Health Department billed with balancing these interests.

But six years of planning and another six of attempted practise have seen communication breakdown between government and stakeholders, inadequate and un-enforced policy announcements, and unresolved negotiations causing disruption in the market between consumer and pharmacist. No appropriate fee can be determined without weighing all interests involved, but the scope of this paper will centre on the history, outlook and impact of pricing negotiations between organised pharmacy and government representatives.

History of the negotiations

In 1997, the Health Department issued the Medicines Amendment Act to add pricing regulations to the 1965 Medicines and Related Substances Control Act. The new bill established a single exit price for all medications – a fixed selling price down the chain from manufacturer to distributor to consumer – and called for the establishment of a Pricing Committee (PC) to determine the dispensing fee that was to replace cost mark-ups in pharmacies.¹ By 2003, the Pricing

¹ Medicines Amendment Act, 1997. Section 22G

Committee had proposed its first draft: an allowable fee of 24% of the SEP with a cap of R24.

The fee was adjusted to 26% / R26 after submissions by the Pharmaceutical Society of South Africa (PSSA), but even so, the announcement of the fee in April 2004 was met with immediate objection. Pharmacy representatives warned of inadequate returns and questioned the decision-making methods and transparency of the PC. The PSSA proposed a tiered system based on a SEP with an average fee of R37, but this was ignored.²

Starting in the second half of 2004, the PSSA led a successful legal challenge to the new regulations. The 26% / R26 plan was suspended in a 20 December ruling by the Supreme Court of Appeal and discarded by the Constitutional Court on 30 September 2005. The Constitutional Court ordered that the Medicines Amendment Act be kept but renegotiated by the Health Department and organised pharmacy within 60 days.³ In order to renegotiate the fee and collaborate more closely with the Health Department, the PSSA and USAP joined with several smaller community pharmacy groups to form the Pharmacy Stakeholders Forum (PSF), which came to represent about 80% of pharmacy business in South Africa.⁴

The period between April (when the fee was announced) and December 2004 (when the regulations were suspended) would be the closest the dispensing fee came to legal enforcement. According to Ivan Kotzé, legal director for the PSSA, the Health Department threatened to charge any pharmacy levying fees above 26% / R26 for these months, but the PSSA's legal team promised to defend any pharmacy so charged and none, in the end, ever was.

Negotiations following the Constitutional Court ruling continued to break down. Talks between the PSF and Health Department amounted to a series of policy announcements open for comment, with none ever agreed upon or implemented. The next push at legislation began in March 2006, when the PSF and PC settled on the same set of pharmacy financial data and – supposedly- a common means of analyzing it. Their findings for the cost of dispensing were discrepant, though: the PC arrived at R19.46 and the PSF at R30 for the cost incurred per

² 2007 PSSA Conference Document (p.1)

³ “Court orders review of medicine-dispensing fees.” *Mail and Guardian*, 30 September 2005. <<http://www.mg.co.za/article/2005-09-30-court-orders-review-of-medicinedispensing-fees>>.

⁴ 2007 PSSA Conference Document (p. 2)

item dispensed at a community pharmacy (i.e. one without a wholesaler's license).⁵

Following these findings, a PC report to the Health Minister led to new fee announcement on 31 October 2006. Though based on a more comprehensive cost assessment, the average R21.46 per item proposed was considered to be well below the break-even point for community pharmacy and unmindful of those in rural and underserved areas.⁶ From the side of organised pharmacy, this lower-cap announcement was inconsistent with the Constitutional Court ruling, the process of its determining being neither collaborative nor transparent. The PC used a new financial model not approved by the PSF, according to Kotzé, and took its data on the cost of dispensing from a different year than data on the actual number of products dispensed.

Just days after the R21.46 fee was announced in a December 2006 Gazette, the PSF met with the Director General and Deputy-Director of Health as well as the PC Secretariat in hopes of deferring it. The PSF submitted a report to the Health Minister emphasising the differences between its findings and those of the PC. When the Minister decided against deferment on 15 December, the PSF filed an application and was awarded urgent interim relief by the High Court, allowing pharmacies to charge an individualised dispensing fee in accordance with specific costs and income needs.⁷

In the end, negotiations had failed and reverting to the courts would prove no more productive. The PSF filed a Rule 35 notice in the High Court on 21 December 2006, ordering the Health Department to supply a full record of its decision making process (including pharmacy financial survey data, government documents and phone records) so that the process leading to its R21.46 announcement could be seen plainly and scrutinised by the Court and the PSF. By June 2007, after continuous debate over pharmacy confidentiality and the documents that should or should not be included, the record filed by the Health Department was still considered incomplete by the PSF.⁸ At this point, the PSF shifted focus to out-of-court correspondence with PC and Health Department representatives in hopes of settling the issue directly.

Since 2007, announcements by the Health Department have been shaped and discarded by these meetings with organised pharmacy. The latest came in a June

⁵ 2007 PSSA Conference Document (p. 3)

⁶ 2007 PSSA Conference Document (p. 3)

⁷ 2008 PSSA Conference Document (p. 8)

⁸ 2008 PSSA Conference Document (p. 3-7)

2009 Gazette, proposing a tiered structure with a maximum 36% on SEP. The period for public commentary was extended to 31 July, but as of late August, the time of writing, it appears no further action has been taken.⁹

In setting their various fees, individual choice affects business viability in a number of ways from pharmacy to pharmacy. Some stick to the 26% / R26 policy while others have set higher fees, a distinction that often separates large wholesale chains that can afford the low fee, like Clicks,¹⁰ from smaller retail (i.e. “community”) pharmacy that cannot. Though no pharmacy has been forced to set a fee against its choosing, there is general agreement among pharmacists and their representatives that the industry is hurting and that government’s mismanagement of pricing regulations is largely to blame. The following are commonly perceived problems amongst South African pharmacy owners that have been attributed to dispensing fee legislation. The extent to which this is true, however, is still an open question.

Problems facing organised pharmacy

Failure of community pharmacy

The survival of community pharmacy is the broadest and most cited concern over dispensing fee legislation. These are small chains or independent retailers with no wholesaler’s license and a narrower product base than supermarket dispensaries or large corporate chains like Clicks.

Of the 2,467 pharmacies whose cost and pricing data was supposedly used to inform the 2006 fee proposals, an estimated 1,500 are community pharmacies that “serve where they’re needed,” says Gus Ferguson, Director of USAP. The PSSA notes that independent pharmacy takes a larger share in rural and disadvantaged communities, as corporate chains do not venture into these areas.¹¹

⁹ Government Gazette (No. 32330) Notice on the Medicines and Related Substances Act, 1965. 19 June 2009; and Amendment for extended commentary. 20 July 2009.

¹⁰ Negotiations over drug pricing have helped cause an estimated 5-6% drop in gross profit since 2003, but Clicks continues to sell medication at its SEP plus a dispensing fee or 26% with an R26 cap for prescriptions over R100. No administration fees are charged. *Interview with Kobie Visagie, Manager of Clicks on Glengarriff, Sea Point (April 2009).*

¹¹ 2007 PSSA Conference Document (p. 4)

The lack of a wholesaler's license prevents community pharmacies from buying directly from the medicine's manufacturer or primary importer to South Africa. Whereas Clicks has direct access and the power to negotiate bonuses with distributors, community pharmacies deal through intermediaries. With their broader product base, corporate chains are also better insulated against revenue loss from fees on medication sales. Kobie Visagie, manager at a Clicks store, notes little change in the type of products stocked and sold over the last five years while the manager of an independent pharmacy in Muizenberg- name withheld for the sake of anonymity- relates the loss of an unprofitable toiletries and infant department. Although the dispensing fee does not affect these items directly, he attributes the loss to a general difficulty attracting customers with his higher medication prices. Independents without an adaptive strategy are forced to narrow their product stock while levelling higher fees, which inevitably puts pressure on profit margins and has reportedly led to the closure of many small pharmacies.

Of prime concern in the closure of community pharmacies is whether they need replacing. Visagie says that Clicks participates in mergers when independents close, but admits that new pharmacies are often not set up where the old were buried. Given constraints on the consumer in terms of time and travel costs, and the share independent pharmacies have in rural and underserved areas, their closure may result in problems for access. In response to the closures, says Gus Ferguson of USAP, the Health Department has licensed a number of public pharmacies, but these also tend not to take up the reins in places where community pharmacy is lost.

Data on pharmacy openings and closures from the South African Pharmacy Council dates to 2005, but illustrates a trend that may continue currently. Table 1 compares the presence community pharmacy to wholesaler pharmacy. Aside from its larger presence across the country, there are more community pharmacies per wholesale pharmacy in rural provinces like the Northern Cape and Mpumalanga than there are in more urban provinces like Gauteng and the Western Cape.

Table 1. Number of registered pharmacies by province

Province	Community Pharmacy	Wholesale Pharmacy	Ratio, Community per Wholesale Pharmacy
GT	890	218	4.082568807
KZN	461	42	10.97619048
WC	424	61	6.950819672
EC	190	20	9.5
MP	142	3	47.33333333
NW	134	5	26.8
FS	128	13	9.846153846
LM	100	7	14.28571429
NC	53	2	26.5

Source: South African Pharmacy Council (2005)

If community pharmacy has a greater presence in rural areas, and if ownership is generally changing from community to wholesale, which Hall states it is,¹² there is little indication that wholesalers are opening in the same areas. Table 2 shows rural provinces like KwaZulu Natal and the Eastern Cape with no net gain in wholesalers to make up for the loss in community pharmacies, Limpopo being the notable exception. With its largest gains in Gauteng and the Western Cape, wholesale pharmacy continues to show preference for the more urban provinces.

Table 2 adds dispensaries in government hospitals and clinics because these are likely to serve poor populations with fewer alternatives in seeking medication. Community pharmacy shows the biggest net loss and public institutional clinics the biggest net gain, but Elsje Hall points out the fact that a number of public pharmacies were opened on or near military bases.¹³ Names on the register are not all clear, but it appears that at least 8 and at most 14 of the openings have a military affiliation. Civilians would presumably have limited or no access to such pharmacies.

The South African Pharmacy Council tracks other categories of pharmacy, but these are the most relevant the potential problem of access and ongoing debate between organised pharmacy and government. The data is somewhat is outdated; a more recent count would help support the popular idea within organised pharmacy that failed negotiations continue to weigh on community retailers.

¹² Hall, p. 416: “at least 27 per cent of pharmacies that opened their doors from January 2004 were owned by big business, for example Shoprite Checkers and New Clicks.”

¹³ Hall, Elsje. Human Resources Development and Review 2008, Ch. 19: Pharmacists. HSRC Press 2008 (p. 416).

Table 2. Number of registered openings and closures in 2004

	Community Closed	Public Institutional Closed	Wholesale Closed	Community Open	Pub. Inst. Open	Wholesale Open	NET
GT	32	1	9	16	6	13	-7
KZN	8	1	1	4	3	1	-2
WC	8	1		12	11	2	16
EC	3		1	1	4	1	2
MP	1		1	1	1	1	1
NW	5	4	1	5			-5
FS	3		1			1	-3
LM	3			8	2	1	8
NC				1	1		2
TOTAL	63	7	4	48	28	20	12

Source: South African Pharmacy Council (2005)

Inconsistent pricing under uncertainty

In the thick of legal disputes and ongoing negotiations, the Medicines Amendment Act has clearly failed to do what it originally sought: to ensure that consumers pay the same price for the same medicine at any pharmacy. Corporate chains are able to follow the 26% / R26 cap from 2004 while others, mostly community retailers, make additional mark-ups to stay in business. Kobie Visagie, Clicks manager, relates that the chain has always adhered to the 26% / R26 plan without charging extra administration fees. Vaughan Clark, owner of two independents in Hout Bay, uses a flat 38% mark-up.¹⁴ “Business,” he says, “wouldn’t be able to survive on anything less.”

The independent manager in Muizenberg uses a tiered structure with rates higher than those proposed by government thus far. He cites the Medicines Amendment Act as the beginning of a “disruptive effect.” Though no pharmacy has ever been forced to change its pricing plan, announcements by the government about levelling prices and by the Health Minister that consumers should “shop around for their medications”¹⁵ put pressure on small pharmacies to fall in line with the corporate chains. “Either you stick to the 26/26 cap and

¹⁴ The 38% mark-up on prescriptions holds profits at 8.5-9%, which Clark considers necessary to both Wheeler’s and Sentinel pharmacies of Hout Bay in business. *Interview with Vaughan Clarke, owner of Wheeler’s and Sentinel Pharmacies, Hout Bay (May 2009).*

¹⁵ *Announcement of the New Dispensing Fee for Medicine* from the Health Minister. 31 October 2006.

<<http://www.doh.gov.za/docs/sp/2006/sp1031.html>>

risk going out of business, or you charge your own fee and risk going out of business,” he says.

Consumer choice and adaptation by the supplier are part of any competitive market, but six years of publicising regulations without implementing or resolving them have left government with one foot in and one foot out of the regulatory arena. A market that once self-regulated has long been warned of change, but left wondering how and whether it will happen.

The effect of pricing uncertainty on consumer choice depends on the ability of consumers to “shop around” given possible constraints on travel or restriction to a given pharmacy (and thus a given fee) by a hard-to-find medication.

Their medical schemes, meanwhile, are accused by the PSSA of setting unreasonably low reimbursement rates and justifying them under conditions of uncertainty in the market. Certain schemes have allegedly refused to increase reimbursements since 2005, sticking to the R26 cap and pressuring pharmacies to either adjust their dispensing fees or pass the excess on to the consumer.¹⁶ In the latter case, small pharmacies risk losing customers to corporate chains that implement the R26 cap as a matter of course.

Human resources

The PSSA is particularly concerned with the Health Department’s apparent lack of concern for human resources in evaluating the cost of running a pharmacy. Underestimating the cost of pharmacists and their assistants was its biggest oversight in determining the R19.46 per item cost in 2006, according to the PSSA.¹⁷ Salaries for dispensary staff have to do with wider trends in pharmacy training and staffing.

The general impression among pharmacists and their representatives is that there is an efflux of South African trained pharmacists from South Africa and that fewer students are choosing to enter the profession. A pharmacist two years out of school and now employed at Lakeside Pharmacy in Muizenberg says that job openings in her field have grown since 2003 due to drops in pharmacy school enrolment and a noticeable loss of South African trained pharmacists to more lucrative positions abroad. Vaughan Clark lost four pharmacists to America and one to Europe over the last three years.

¹⁶ 2007 PSSA Conference Document (p. 2)

¹⁷ 2007 PSSA Conference Document (p.3)

Recruitment statistics from countries like the UK, US and Australia are difficult to come by, but various sources suggest “an outflow of skills.”¹⁸ And with the additional stress put on community pharmacy, those staying in South Africa have reason to be wary of where they enter practise.

Enrolment and graduation numbers from pharmacy schools may also indicate a waning of confidence in pharmacy as a profession. Graduation rates for the B.Pharm- the first and most common degree for entrance into pharmacy practise- at Nelson Mandela Metropolitan University (NNMU) in Port Elizabeth shows a clear decline from 21.4% of 2002 enrolees graduating to 14% in 2003, the year Health Department first took action on medication pricing. Enrolment also declined from 330 in 2004 to 227 in 2009.¹⁹ Similar data from Rhodes University shows no clear decline in the proportion of entrants graduating over the same period, but retention over four years hovers around 60%.²⁰ This brief analysis doesn't account for the seven other pharmacy schools in South Africa (though not all train pharmacists for practise) or for students taking more than four years of study.

Organised pharmacy tends to attribute the loss of skill and interest in the field to the struggle over medication pricing. A possible explanation may be the strain placed on the community pharmacy sector by competition from the large corporate chains. As ownership changes hands from community to corporate, the large chains gain an increasing share in job offerings and come to dictate industry-wide terms in hiring. Clark loses pharmacists due to an inability to compete with starting salaries offered elsewhere. Pharmacy closure has also concentrated consumers in fewer dispensaries. An independent manager in central Cape Town has lost employees and seen profits fall despite heavier consumer traffic. “Morale is low,” she relates.²¹ And the problem is not contained to small pharmacies: on first visit to the Glengarriff Clicks, an irate customer left the long queue and interrupted our interview, complaining at

¹⁸ The Organisation for Economic Cooperation and Development found 23 400 South African trained health workers (including pharmacists) practicing in western countries in 2001, which was about 10 per cent of all registered health professionals in South Africa (OECD 2004). Statistics South Africa reports an increase in emigration by pharmacists from 1992 to 2003. For others, see Hall p. 413.

¹⁹ NMMU Pharm School Data (attached)

²⁰ Rhodes U Summary of Pharmacy Stats (attached)

²¹ This independent retailer is represented by USAP. She started with the pharmacy 30 years ago and says 2006 was the biggest hit to the business: staff were lost to other employers, more customers were buying, and profits were hurting. “It truly is a battle,” she says, “Morale is low.” *Interview Cape Town CBD (May 2009)*.

volume that “one chemist cannot possibly serve all these people.” (Ms. Visagie was not working behind the counter prior to the interview, but began shortly thereafter).

Problems in government regulation

Because it was never effectively enforced, the dispensing fee per se cannot be blamed for problems seen in South African pharmacy. More persuasive is the idea that the long process of resolution drags on the system, and that government mismanagement holds some of the blame. Negotiations fuel an uncertain market, debate expends time and resources, and organised pharmacy struggles to show commitment to a solution while still keeping to its own fees to safeguard business. Communication breakdown and policy disagreement could be minimised if a few problems internal to the Health Department could be addressed. The solution, it seems, will have to have as much to do with clear decision-making and enforcement as with the dispensing fee figure itself.

The PC and methodology

“The Pricing Committee remains problem number one,” said USAP Director Gus Ferguson during a phone interview in April 2009. The committee suffers structural problems, according to the PSSA, and chief among them is the fact that key members are employed by the medical aid industry.²² Medical insurers stand to benefit from a low-capped dispensing fee and, as previously discussed, seem to be profiting to the detriment of the consumer in these times of uncertainty.

Organised pharmacy cites the PC’s lack of a chartered accountant as evidence that the committee is not equipped to account accurately for the cost of running a pharmacy. Returning to the 2006 cost per item analyses, the industry’s R30 figure was validated by Price Waterhouse Cooper, whereas the PC’s R19.46 had no outside validation. Delays in policy implementation have been attributed to “incorrect accounting interpretations.”²³

Also at issue is the PC’s exclusion of pharmacy costs outside the dispensary.²⁴ Though the fees proposed apply only to the dispensary, their financial

²² 2007 PSSA Conference Document (p.3)

²³ 2007 PSSA Conference Document (p.3)

²⁴ see *Announcement of the New Dispensing Fee for Medicine* from the Health Minister. 31 October 2006. <<http://www.doh.gov.za/docs/sp/2006/sp1031.html>>

implications reach to wider concerns like property, utilities, staffing and product stocking. Dispensing fee policy and resultant financial constraints have in some cases forced pharmacies- community retailers especially- to make changes in staffing and in stocking of non-medication products like vitamins and toiletries.

Problems internal to the PC and inconsistencies with the PSF led to discrepancies in cost projections, and hence to the repeated objection to proposed legislation the part of organised pharmacy. After the Health Department's announcement of an R21.46 fee, the PSF determined that of a sample of 2,467 community pharmacies, 1,557 would likely fail and another 368 would be put at significant risk.²⁵

Non-transparency in government

Vaughan Clark characterises the relationship between the organised pharmacy and the Health Department under Health Minister Manto Tshabalala-Msimang as one of “mistrust and disillusionment,” where meetings with representatives from the Department and the PC would lead immediately to incongruous policy announcements. Though established to collect information from all stakeholders and advise the Health Minister, the PC was thought to be misrepresenting organised pharmacy's interests in communication with higher decision makers in the Health Department.

The PSF hopes to see greater accountability and accessibility of these decision makers in government. Recent efforts to settle a fee out of court, and indeed much of the preceding legal history, involved meetings with representatives whose communication up the chain appeared warped to those on the ground. The 2006 PC report leading to the announcement of a R21.46 fee – “totally inaccurate” according to the PSSA – seemed to suggest to the Health Minister that the majority of stakeholders were in agreement when in fact this wasn't the case.²⁶

The Health Department has also been tardy in its release of information concerning pharmacy closure. USAP projected closures of some 2-300 pharmacies leading the Health Department's 2004 release of the data, which, despite a flurry of new state licensures for railway dispensaries and state pharmacies, was around a “shockingly high” 500 according to Gus Ferguson.

²⁵ 2007 PSSA Conference Document (p. 4)

²⁶ 2007 PSSA Conference Document (p. 3)

As mentioned previously, closure data from the South African Pharmacy Council reveals important gaps. Closures date to either 2004 or 2007 with no indication of turnover in between, and 2004 is the latest and only available report on the type and number of pharmacies operating in the country.²⁷ The Council was established to register all pharmacists and pharmacies in the Republic. Composed of pharmacists itself, it seems in prime position to “advise the Minister or any other person on any matter relating to pharmacy,”²⁸ as prescribed in the 1974 Pharmacy Act. In practise, though, pharmacists seem to regard the Council as less of an advisor and more of a tool of the Health Department. It “registers who the Health Department tells [it] to,” says Emily Kalonga, Officer of the Registration and Records department. Given some initiative of its own, and with its relationship to the Health Department recalibrated, the Pharmacy Council could be instrumental in channelling information on the state of pharmacy business to government and to the public.

Issues of accessibility and transparency in decision-making are particularly disconcerting given the weight of responsibility vested in small groups to resolve these multilateral and complex negotiations. The 2008 Medicines Amendment Bill, for example, aimed to regulate costs in the private sector delivery of health services through the office of a Facilitator, one person appointed by the Health Minister to weigh the interests of many stakeholders (pharmacy, medical aid, civil society).²⁹ The Treatment Action Campaign in a 2008 release labels this office “entirely political” and “fundamentally mistaken,” calling for the increased independence of the Facilitator via parliamentary appointment.³⁰

Barbara Hogan’s appointment as Health Minister in 2008 was viewed as a positive step to some. She expressed interest in working toward an expedient and fair solution,³¹ and Clark and Ferguson both confirm that she met personally with representatives of the PSF. Though too soon to comment on the intentions of the new Health Department under Aaron Motsoaledi, they hope for the good

²⁷ Website for the South African Pharmacy Council. Closures at http://www.pharmcouncil.co.za/pharmacies_closed.asp National Count at <http://www.pharmcouncil.co.za/content.asp?ContentId=60>

²⁸ 1974 Pharmacy Act, Section 3

²⁹ Government Gazette No. 611. 2 June 2008 (p. 3)

³⁰ *Joint Submission on the Draft National Health Amendment Bill*. The Treatment Action Campaign and the AIDS Law Project. 16 May 2008 (p. 4-5) www.tac.org.za/community/files/SubmissionOnNationalHealthAmendmentBill20080516.pdf

³¹ “Dispensing Fee- PSF and Minister of Health agree to further discussions: PSSA perspectives.” *SA Pharmaceutical Journal*. 2009. 76:1 www.sabinet.co.za

faith effort to carry over and take as a positive indicator the fact that the PSSA expects a more reasonable announcement as early as June 2009.

Way Forward

Given the lack of resolution and prolonged uncertainty in negotiations over the dispensing fee, the process itself must be examined and altered if any reasonable resolution is to be reached. No appropriate fee can be settled without the inclusion of all interests- civil society, pharmacy, government and medical schemes. The following suggestions focus on ways in which talks between pharmacy representatives and policy makers could proceed.

As indicated by the High Court's action in 2004, legal decisions will only result in the validation or disposal of a given dispensing fee and will not lead to settling the fee itself. The court will defer the proposal of an appropriate fee back to the PC and other stakeholders, and negotiations will begin again. Court action was deemed necessary to discard the 26% / R26 fee and to suspend the R21.46, but recent hearings over the Health Department's decision making process seem to have consumed time and resources while getting nowhere. The PSSA took account of this in initiating its out of court meetings and the Health Department's practise of making announcements for public comment without enforcing- though driving uncertainty in pricing- is at least beneficial in keeping the struggle out of court.

Key policy makers in the Health Department must also engage more actively in the negotiation process. Barbara Hogan showed unprecedented initiative in this regard, but no one person can or should be charged with balancing all interests involved. Reaching a fair fee depends on the interpretation of common information by all vested parties, and breakdowns in negotiation were often the result of inconsistencies in the information itself. Publicising the information used to formulate decisions, or at least sharing it openly between the Health Department and organised pharmacy, would remedy situations like this. Confidentiality of financial data- the very source of argument over the Rule 35 notice- should be respected, but updating and disseminating information on pharmacy closures would help to clarify and guide negotiations. Common knowledge of where and what pharmacies are closing (and how, when financial data is offered) would help all parties agree on the state of pharmacy in South Africa as well as a course of action. As mentioned before, the South African Pharmacy Council could be instrumental in gathering and distributing reliable information.

Where financial data is made available to both the Health Department and the PSF, the accounting process for costs of running a pharmacy should be reviewed and agreed on by both sides. The PSSA calls for an independent accounting firm to determine the “true cost of dispensing”³² and though took a step in this direction by employing Price Waterhouse and Cooper in 2006 to assess its methods, cooperation between government and organised pharmacy in using such external assessors, has yet to materialise.

Adaptation by community pharmacy

Whether or not the dispensing fee is to blame, community pharmacy is under increasing pressure to compete with corporate chains. Among community pharmacists interviewed around Cape Town, the common tactic is to offer the customer an experience they wouldn't find at a Clicks or Checkers. This means seeking products the consumer couldn't find at a corporate retailer and personalizing the shopping experience. Either way, pharmacy managers hope to give consumers a reason to look beyond their higher fees.

An independent manager in Muizenberg pushes his staff to advise customers on the ideal medicine for their concern or on which medicines and vitamins shouldn't be mixed. He promotes his pharmacy in the area, canvassing at a local nursing home, and says that he seeks better products to stock his shelves—vitamins that need be taken less frequently, medicines confirmed by studies—than the corporate chains.

In expanding its product base, an independent in city centre an unusual move in advertising. Rather than populating separate shelves, supplements and alternatives to prescription medication are displayed along the dispensary counter. Even without a standard dispensing fee, it's possible that a high fee is more tolerable when it comes attached to a hard-to-find supplement rather than a prescription whose price could easily be compared elsewhere. A tub of “Immune Booster” caught my eye, with a label depicting a large red ribbon and, “Wandisa amashosa wehlise i-HIV,” which translates roughly to “together we fight HIV.” Though the packaging makes no overt claims at treating HIV infection, its hard-to-miss display begs the possibility that profit incentives might drive pharmacies to market illegitimate treatments.

³² 2007 PSSA Conference Document p. 5

Vaughan Clarke, owner of two community pharmacies in Hout Bay, gives perhaps the most complete picture of adaptation in an uncertain market. He writes personalization into the staffing schedule, keeping dispensary shifts consistent so that routine customers see familiar faces, and in expanding services has gone so far as to open a basic clinic offering free consultation in the basement and to offer a medication delivery service that fills quickly and ships in temperature-controlled boxes. He keeps one pharmacy open for extended hours and seven days a week, and “works with the community to know that community pharmacy works.”

He’s found means of survival, but admits to worsening conditions. A trained pharmacist, he now spends only 2-3 hours per day behind the dispensary counter and another 6-7 on overall business concerns. Due mainly to the high starting salaries commanded by pharmacists in a market that demands them, he’s lost four to the US and one to Europe over the last three years. To cope with the human resources problem, he’s reduced dispensary staffing to a system whereby one pharmacy school intern or internal trainee assists two licensed pharmacists behind the counter. This way, a student intern is trained in community pharmacy, a community member (non-pharmacy school graduate) is given the opportunity to further their career, and the cost of maintaining a dispensary is brought down.

Clark accuses the public sector of “imposing a model into businesses that have run successfully for years.” He sees the need for cost control, but maintains that his higher mark-up is necessary and points to medical aids in adding that his is not the only business profiting in conditions of uncertainty. “A good business will survive no matter the conditions.”

None of these solutions alleviate the whole problem. They simply enable community pharmacy to handle the yet unclear market effects of these negotiations. As these problems are defined with time, mediation between all concerned parties will hopefully lead to fair and lasting policy that resolves them, with or without the implementation of a uniform dispensing fee.

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