Slide 1
Thank you for the opportunity to share with you the complexities of the community pharmacy environment. I'm Lorraine Osman from the Pharmaceutical Society, and my colleague Joe Ravele is a community pharmacist who serves as treasurer of our community pharmacist sector.

Slide 2
Pharmacy operates under a formidable regulatory framework, and a large factor in community pharmacy is the implementation of healthcare funding rules. I must make it clear that these factors apply to both independent community pharmacies and corporate or chain pharmacies.
We'll talk about communication problems, in particular how difficult it is for consumers to understand funding rules, and we'll end with a discussion on the barriers to entry into community pharmacy and to expand existing pharmacies.
All of this will be presented within the context of competition, and the influences that affect competition in community pharmacy.

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We are fortunate that we live in a country that recognises the importance of accessible healthcare for all consumers. We know that our country has a heavy burden of disease and if we're to deal with it as a country, we must all work together. Policy and legislation has been put in place to help the country to achieve the goal of good quality healthcare that is accessible to everyone who needs it.

Unfortunately, at the moment it is a burden to both consumers and healthcare professionals, and the beautifully balanced scale in the diagram is perhaps a pipe dream at the moment.

So we are going to speak about the impact on both consumers and pharmacists of the factors that challenge our daily practice.

It's important to realise that the Pharmaceutical Society represents pharmacists, not pharmacies, and we have members in all sectors. So in the community pharmacy environment we have both independent community pharmacists and those who work for corporate owners. We will focus on the challenges that face pharmacists in both areas of practice.

At the same time, we are also consumers.

Slide 4
The bottom line is that everyone, including government, private healthcare and consumers, is battling under our current financial environment so it is critical that we find solutions that will benefit all of us.

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The Pharmacy Act and the Medicines and Related Substances Act underpin the practice of all sectors of pharmacy. The Medical Schemes Act is obviously important in the private sector, but there are many other laws that affect pharmacists as well. The important thing to remember about the regulatory framework is why it is there. It isn't there to punish consumers or healthcare professionals. We must remember that

law is the way in which everyone living in a community is protected so we have laws that will ensure our safety and our rights as citizens. The laws that affect healthcare are no different.

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Pharmacy is complicated by the fact that we can't just open a pharmacy where we would like to. We must first comply with the guidelines issued by the Department of Health. It's actually similar to the certificate of need that the National Health Act will require for all healthcare practices, in that the professional must show that there is a need for that service. The intention is to make sure that communities that need healthcare receive it, but in a way it can be considered to be anticompetitive.

The Pharmacy Act defines the services that a pharmacist may offer, and some time ago embarked on a comprehensive time and motion study to see just how long it takes to offer services. This applied not just to dispensing medicines, but also to other services such as counselling patients, doing medicine use evaluations and a range of public health services, like family planning, immunisation and tests to screen for disease risk factors.

The fees published by Pharmacy Council for these services are maximum fees, and not reference fees. The implication is that a maximum fee should be discounted. This certainly impacts on viability.

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An important aspect of pharmacy regulation is the Good Pharmacy Practice Rules. The professional standards that it sets are there in order to ensure that consumers receive high quality professional service, and pharmacists are obliged to comply with them. They include standards for pharmacy premises, facilities and equipment, the services we offer and even the way we use pharmacists and pharmacy support personnel in the pharmacy.
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Slide 8
The Good Pharmacy Practice rules can be expensive and difficult to implement. This diagram comes from the rules, and shows us the kind of plan we must submit to the Pharmacy Council when we open a pharmacy. The amount of space needed for individual dispensers or to provide privacy for patients, even the materials used for the floor and the work spaces, and the way in which medicines must be stored are regulated.

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This is another example of the way a rule can influence practice. We know it's important that medicines must be transported and stored in the best possible way, especially for those medicines that can be destroyed by high temperatures. Some of the rules are that we must use a World Health Organisation approved thermometer to monitor the temperature of the fridge in which we store vaccines, insulin and other medicines. Ideally, we should not use a domestic fridge for this purpose either because you cannot guarantee that the temperature is effectively controlled in all areas of the fridge. Obviously this adds to our burden of costs.

The Rules require us to have an emergency power system, which can pose a challenge, particularly if the pharmacy is situated in a shopping mall that doesn't allow individual stores to have their own generators.

The rules explain the way that our fridges must be packed in order to ensure that each different type of medicine is in the right place. For example, certain vaccines, such as the polio vaccine, cannot be allowed to freeze or they must be discarded. Clearly this adds to the expenses of the pharmacy and increase the financial risk for pharmacists.

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The bottom line is that Good Pharmacy Practice rules are there to protect the consumer and to ensure that all medicines and services comply to best practice, but it comes at a price. Over and above normal business costs, pharmacies have specific costs related to professional activities and this can be a challenge to viability of the pharmacy.

One example here is the reference material required by pharmacies. Some prescribed books are published in the United Kingdom, so the price to our pharmacists is influenced by the weak rand, resulting in prices ranging from R 7 500.00 to over R 12 000 per book.

Regular inspections by the Pharmacy Council identify problems, and if a pharmacist does not comply with the rules, the pharmacist and the pharmacy may not be permitted to continue functioning. So we take them seriously

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Community pharmacy is unlike other private sector healthcare practices, in that competition is limited by publication of the dispensing fee in terms of the Medicines Act. It is a maximum fee, and the published fee is seldom paid by funders.

Unlike other suppliers in the economy, no bonusing or incentive schemes are permitted in the supply chain from the manufacturer through to the end seller to the consumer, which obviously affects competition. There are however currently loopholes in this legislation, which often results in a competitive advantage to those pharmacies that are not compliant with the spirit of the legislation. We are assured that the Pricing Committee is closing these loopholes.

It is critical to keep accurate and up to date records, but this can be very onerous.

Slide12
The PSSA has always supported the need for transparency in pricing, but there are challenges in the dispensing fee. We want to show how complex the determination of the fee is, but discussions on the merits of the fee belong with the Pricing Committee and the National Department of Health

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In the past, it was common practice in community pharmacy to follow other retail trends. They added a mark up to the price of medicines, and then discounted the price to different purchasers. Manufacturers and wholesalers offered discounts and

bonuses to pharmacies, which added considerably to their income. The bottom line was that as a consumer, you had no idea how the price was calculated. Small pharmacies were disadvantaged because bigger pharmacies could buy in bulk and get the discounts and bonuses offered. Because of this, the legislators introduced regulations to ensure transparency and consistency in pricing.

Slide14
Explain that the published fee was capped at R 26.

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There are two components to the price that a consumer pays for medicine. The Single Exit Price is determined by the Pricing Committee in collaboration with the manufacturer. This means that the price paid for a single tablet, for example, is the same whether you buy 10 or 1000.

The other component is the dispensing fee, that is added to the SEP. It must be remembered that there is no mark up allowed to community pharmacists, so their sole income for dispensing is the dispensing fee that the consumer or the funder pays, and this must cover all business costs, including salaries.

The original fixed fee was changed to a four tiered system, and we'll show you how this works. It basically means that there is a complex system where the dispensing fee is calculated differently, depending on the SEP of the medicine. This was important because if the fee was the same across all prices of medicine, the consumer would end up paying a high price for low priced medicines, and clearly this would not be in the interests of allowing consumers access to affordable medicine.

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This is the current structure of the dispensing fee. There are four price bands that medicines fall into. As you can see, the percentage decreases as the SEP increases. 46% may sound a lot, but it really applies only to the inexpensive medicines and we'll show you how that works. The fixed rand amount increases in order to cover the cost to the pharmacist of keeping the medicine. So in effect the higher priced medicines are intended to cross subsidise the lower priced medicines. I say "are intended to" because it must be noted that the dispensing fee is a maximum fee so the funder may not agree to pay it, depending on the medical schemes' rules.

We must also note that there are currently thousands of items on the SEP list, which is freely available to consumers on the Department of Health's website. Of these, about 3000 have an SEP of less than R 90, and a further 3000 falls between R 90.00 and R 240.05. So there is a considerable number of lower priced medicines that are available.

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As an example, let's take a commonly prescribed antibiotic, which costs R4.28 per tablet. The course of medicine would be 15 tablets, i.e. one three times a day, so it's easy to work out the Single Exit Price at R 64.60. The dispensing fee is a little more complicated. The percentage portion works out at R 29.53 and the fixed fee is R

7.65. So the patient plays R 101.38, excluding VAT, and the most that the pharmacist is paid is R 37.18. Most medicines currently fall into this price range of less than R 90 ex manufacturer, so the income out of which the pharmacist must pay all expenses is often not enough to cover them.

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An example of a medicine that falls into a higher SEP range is a cholesterol lowering medicine which has a better side effect profile than the cheaper medicines in the same therapeutic class. The price to the patient is the SEP of R 421.14 plus the dispensing fee of R 127.25, i.e. R 548.39 excluding VAT. So the maximum income that the pharmacist may get is R 127.25.

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We fully understand that the introduction of DSPs is to manage unregulated costs. As consumers, we tend to forget that medical schemes do not have unlimited pots of money, and they must manage that money so that essential medical needs are paid for, such as prescribed minimum benefit to which every medical scheme member is entitled.

We are however concerned because the cost of medicine is not an unregulated cost. As we have shown you, the price of medicine is already regulated by law, with very little room to negotiate. The PSSA therefore believes that it should not be necessary, and may even be unwise, to appoint DSPs for a well regulated healthcare service.

We are also concerned because there is a penalty in the form of a co-payment for medical scheme members who want to exercise their right to their choice of provider to obtain services from a non-DSP member.

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Our real concern in terms of the risk to consumers is that the best possible pharmacy care is not always possible when a DSP is appointed. There is a very real risk to the patient if you fill your prescriptions for acute and chronic prescriptions at different pharmacies – the pharmacist who dispenses the acute medicines must be made fully aware of any chronic medicine that is taken, but we are currently prevented in the private healthcare sector from having access to that information electronically. This is possibly something that will be addressed in the future, but at present it cannot happen unless the pharmacy belongs to a chain of pharmacies that is also a DSP.

Not all DSPs give patients the safety net of face to face consultation. If the DSP is a courier pharmacy, the patient may have access to telephonic advice, but it is always better for the patient to be able to speak directly to the pharmacist, especially when there is the potential for interactions between the medicines being taken.

One of the complaints that we have received is about medicines that are sent automatically to the patient, there are times when the patient no longer uses particular medicines, so they are forced to stockpile medicines that arrive when requests to the DSP to stop the supply have not been successful. The result is that hundreds of rand are wasted and the consumer needs to dispose of unwanted or expired medicines.

From a community pharmacy point of view, small pharmacies are not able to participate as DSPs, even if they are prepared to accept the DSP conditions. It may well be that it is more convenient for a medical scheme to negotiate with a chain that has a national footprint, but that excludes small pharmacies. This means that a significant portion of their income, which is for chronic medicine, is taken away from them, which threatens their viability.

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It must be noted that there are schemes, such as the example given here, that have opted to use a flat fee, rather than the legislated tiered fee.

These examples are what would happen to those two prescriptions that we referred to earlier, where number 1 is the antibiotic and number 2 is the cholesterol lowering medicine, if the pharmacist was reimbursed by a particular medical scheme, which we would prefer not to name here. Please note that it is very similar to the original dispensing fee that the Constitutional Court ruled to be inappropriate. It does not conform to the current dispensing fee model, and it caps the pharmacist's income at R 31, no matter what it costs. So a recent prescription that the PSSA received for a medication that is critical for a patient suffering from haemophilia would bring in R 31, even though the SEP of the amount of medicine that the doctor prescribed was R 31 968.86. R 31 will never come close to covering the pharmacist's costs of acquiring, storing, insuring and dispensing that medicine.

Again, we remind you that there is no mark-up on medicines. The pharmacist's sole income from its sale is in the dispensing fee. And the funding mechanism is insufficient for both independent community pharmacies and corporate pharmacies to conform to either scheme requirements or patient care.

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The Pharmacy Administration Fee is not included in the costs considered when the dispensing fee was determined, so it remains an expense for the member of the medical scheme.

The other services that we mentioned that a pharmacist may provide, such as immunisation and screening tests, are very seldom paid for by medical schemes, so the patient needs to pay them. We understand that the public sector provides free immunisation, for example, but it often costs the consumer in terms of time taken away from work and transport to a public sector facility. In the long run, we believe that it would really be an advantage to the consumer who is cash strapped and has limited free time if the state were to purchase these services from the community pharmacists.

There is another category of pharmacists who are working in community of pharmacists, these are the Primary Care Drug Therapy pharmacists. They have undergone additional training in primary health care, and have been given permits to offer primary health care services to patients. This includes screening tests and initiation and continuation of medicinal treatment when necessary. It has been difficult for these pharmacists to be reimbursed by medical schemes, but we are hoping that this will be suitable resolved soon.

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From a consumer point of view, the PSSA sees this as one of the major reasons for consumer dissatisfaction with service offered by healthcare professionals in the private sector. It is not only our pricing system that is complex and difficult for consumers to understand. Medical scheme's rules, however logically devised, are frequently not understood by their members.

The limitation on benefits by medical schemes, for example, is not adequately explained to members of the public. What are the Prescribed Minimum Benefits, for example? And if the medical scheme pays for those conditions, what about my chronic condition, which isn't listed there?
Consumers don't always understand that prescribers in the private sector don't have the same constraints as in the public sector, but their medical scheme imposes additional constraints in order to make their money go further. So it becomes a huge source of frustration when the scheme caps what it will pay for a particular condition or medicine.

Clearly it is the responsibility of the medical scheme to make sure that members understand the rules. Healthcare practitioners have other priorities and it is both difficult to defend the medical scheme and unprofessional to criticise them at a time when the patient is vulnerable because they need immediate access to the medicine.

For community pharmacists, one of the gaps in information and understanding at the moment is that there is little information available about their role in National Health Insurance. Obviously the ideal situation would be for the NHI to pay pharmacists a realistic tariff to pharmacists that would assure their viability so that they can continue and expand the services they offer to the public. So far the focus appears to be on procurement of medicines and the logistics of distribution, but we hope that the private sector pharmacist's role in service delivery to the patient will become clearer.

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This is a difficult environment in which to work, and it can be very daunting for a young pharmacist who would like to take responsibility of his or her own community pharmacy. The start up costs can be much more than the costs originally considered by the Pricing Committee when they used a zero based model to determine the dispensing fee. This model assumes that you are opening a modest pharmacy with adequate but rudimentary fixtures, fittings, equipment and medicine stock.

The hostile business environment with all its challenges and restrictions is not conducive to a pharmacist who wishes to supply only professional services, which is why so many pharmacies rely on the retail sale of other goods and commodities to supplement their professional income from the dispensing fee. The pharmacist who does not which to be sidetracked by this other retail aspect is likely to find the income to be inadequate to support the services he or she want to supply.

Vertical integration further complicates the situation. Although there may be an element of convenience for the owner, ownership of wholesalers by larger pharmacies and pharmacy chains certainly introduces an additional income stream for owners of these pharmacies because logistics fees are payable by the manufacturers to the wholesaler. Small pharmacies are left out in the cold.

The Helen Suzman Foundation recently completed a study into the impact of legislation allowing for the open ownership of pharmacies in South Africa. We will make their report available to the Health Market Inquiry as soon as we receive copies. The report makes the point that horizontal collusion between shopping mall owners and anchor tenants extends to pharmacies as well. The HSF report refers to cases where corporate pharmacies are large lessees of space in malls, and they have been able to insist that the leases of smaller pharmacies already operating in the malls were terminated. This eviction of the existing pharmacy makes a mockery of competitive principles.

It must also be point out that there may be differential conditions even for anchor tenants. A corporate pharmacy chain may not necessarily be afforded the benefits offered to large retailers, such as furniture and clothing stores, that will attract customers to the mall. A small pharmacy, even if it belongs to a corporate owner, will also not receive the benefit of being an anchor tenant. So even for them, it may be difficult.

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Why would I as a possible entrepreneur want to invest in a community pharmacy?

Would it not be easier for me to invest my money elsewhere? In an environment that is enabled by legislation and that provides an acceptable return on my investment? And why should I do this if my passion is for healthcare in general, and pharmacy in particular? Surely a win-win solution can be found, where the patient receives appropriate care, at a price that he or she, or the funder, can afford, and where I can make a satisfactory living? There must be opportunities that we can identify that will make this possible.

I also need reassurance as a pharmacist that there will be a place for me as an independent healthcare professional when we embark on universal coverage for all citizens.

As a consumer, I want to be able to choose my healthcare provider, including my pharmacist, and I want convenient access to high quality service. I know that I can get pharmacy services with little or no cost in the public sector, but I have to balance this against substantial travel costs, long queues and waiting times, and frequent stock outs of medicine. Will convenient access to pharmacy services still be available if community pharmacies are not able to afford to offer me the service I deserve? There are already areas in the country where there are no community pharmacies, and we need to be able to prevent the further erosion of service. There are already rural areas that are no longer serviced by community pharmacies.

There must be a way to solve this predicament, and we look forward to finding the solutions.