

The Pharmaceutical Society of South Africa Die Aptekersvereniging van Suid-Afrika

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Attention: Mr Clint Oellermann

The Inquiry Director
Market Inquiry into the Private Healthcare Sector
The Competition Commission
Private Bag x23
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Per email: submissions@healthinquiry.net

Dear Sir

PSSA SUBMISSION: MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

The Pharmaceutical Society of South Africa (PSSA) thanks you for the opportunity of presenting our observations of the effect of certain practices and legislation on the private healthcare sector.

The PSSA is a voluntary professional association representing more than 7000 pharmacists. This includes both pharmacists who are employers and those who are employees. Pharmacists practice in both the public and private sectors. Within the private healthcare sector, our members practice in a variety of settings, including community (retail) pharmacy, private hospitals and the distribution and manufacturing industry. We support all our members and their right to work in the pharmacy of their choice, and we base our observations on both research and members' experiences.

We are aware that role players in the private hospital, distribution and manufacturing arenas will be making submissions, so we will focus on those factors that manifest in community pharmacy.

Background

It must be noted that there is a broad spectrum of community pharmacies, ranging from those with a single owner to those that belong to listed companies. This creates a complex community pharmacy market, where various factors, including legislation and market power, influence each pharmacy to a greater or lesser extent.

There is no other healthcare professional as severely affected by changes in legislation as the pharmacist. Pharmacy is the only profession in South Africa where lay ownership is allowed, and is the only profession for which the professional fee (dispensing fee) is regulated at a capped maximum. The impact of these factors has resulted in closure of many independent pharmacies, with the result that some small towns no longer have a pharmacy.

The intent of legislative changes has been compromised by the unintentional consequences of the changes. The right given to citizens by Chapter 2 of the South African Constitution to freedom to practise one's trade, occupation or profession have been affected and eroded, as has the Competition Act's objective "to promote a greater spread of ownership (in this case ownership of pharmacies) of historically disadvantaged persons".

FEATURE #1 – MARKET POWER AND DISTORTIONS IN HEALTHCARE FUNDING

It sometimes appears to the observer that the medical scheme industry holds both the consumer and the healthcare provider to ransom.

- **Designated Service Providers (DSPs)**

Regulation 8 of the regulations to the Medical Schemes Act 131 of 1998 provides for the appointment of DSPs. The regulations define DSP as a health care provider or group of providers selected by the medical scheme concerned as the *preferred provider* or providers to provide to its members diagnosis, treatment and care in respect of one or more *prescribed minimum benefit* (PBM) conditions. Medical schemes are required to pay for the diagnosis, treatment and care costs of these conditions in full, without co-payment by the consumer.

1. *Effect on consumers*

In the environment where consumers are dependent on medical schemes, the purpose of the Competition Act, 89 of 1998 ("the Competition Act") "to provide consumers with competitive prices and product choices" is actively negated by the consumer having no option of selecting a healthcare service provider of their own choice. In healthcare, a relationship of trust is usually built up between a patient and the healthcare professional, and unfortunately this is not taken into account when members are obliged to get services from a DSP.

This is particularly a problem in pharmaceutical services where a number of DSPs are courier pharmacies and there is no possibility of face-to-face interaction between pharmacist and patient.

Supply of medicines for chronic conditions by DSPs, which are often postal or courier suppliers and large retail chains, has resulted in a situation in which a patient uses different suppliers for acute medicines and chronic medicines. The quality of care in these situations is severely compromised as a complete patient profile is not available. While medicines may save lives, their use is not without danger, particularly when more than one medicine is used. The activity of a medicine may be changed when taken with other medicines, medical conditions or food. These medicine interactions increase the risk of adverse effects. In South Africa, interactions have been recorded where the effects led to hospitalisation of the patient.

Another unintended consequence occurs when monthly supplies are prepared, and claimed for, in advance. If a patient ceases to take a particular medicine, it sometimes happens that the supplier cannot be notified in advance, and the patient receives unnecessary medicines. This is both dangerous and adds to the cost. The PSSA is in possession of a letter written by a medical scheme member whose DSP had been changed. (Annexure A) The member noted that the previous DSP continued to send her medicines by courier for a period of 4 or 5 months following the change in DSP. This is wasteful in the extreme.

The consumer is furthermore penalised when rules prescribed by medical schemes in this regard are not adhered to. If a medical scheme member chooses to obtain medication from a service provider other than a DSP, a co-payment may be imposed on the member. (This does not apply in the case of an emergency.)

The PSSA is aware of complaints that have been lodged with the Competition Commission. See Annexure B for an example. A consumer complained that his medical scheme had entered into a DSP arrangement with a courier pharmacy, which disadvantaged him and his pharmacy. Unfortunately, in this case the analyst took the situation at face value and issued a Notice of Non-referral without verifying the conclusions he drew from the information supplied by medical schemes. The analyst uses an interesting argument that the co-payment is necessary because a medical scheme must “ensure that its members make use of the services of the DSP as it will also need to be guaranteed business”. While we understand that contractual arrangements must benefit both signatories, the result is that the consumer is denied freedom of choice and other pharmacies are denied the right to compete. (See also paragraph 2 below, effect on community pharmacies.) The response from the Commission also shows lack of understanding of the regulated pricing structure of medicines, which will be discussed below. It will be shown that the only cost that may be reduced by a DSP arrangement is the dispensing fee portion of the cost, which is minimal in comparison to the regulated price of the medicine and can therefore not result in vast savings when it is discounted by a DSP.

2. Effect on community pharmacies

The purpose of the Competition Act “to ensure that small and medium-sized enterprises have an equitable opportunity to participate in the economy” does not feature in the pharmacy environment. Evidence for this can be found in the exclusionary tenders drafted by prominent medical schemes.

Although some medical schemes state that a DSP contract is available to all pharmacies who meet their requirements and who are prepared to charge the dispensing fee that the medical scheme is prepared to pay, medical schemes tend to favour pharmacies that belong to large groups because of ease of contracting with one entity, preferably with a national footprint, rather than a number of smaller individual pharmacies confined to one location. There are obviously exceptions, particularly in small towns, but in general many small pharmacies have been excluded from the system.

The provisions of the Competition Act, which prohibit individual suppliers from agreeing to a fee or service conditions, contributes to the inability of small private community pharmacy practices to join forces and offer a cost-effective DSP package.

A challenge to the viability of community pharmacies is that medical schemes not only apply the DSP provision for PMB conditions as specified in regulation 8, but they apply the provision to *all* medicines supplied.

Pharmacists are also challenged by third parties who develop complex delivery and dispensing systems which are offered to medical schemes as a DSP. For the community pharmacist, this poses a threat because if they do not participate in the system, their loyal customers will be obliged to leave them and go to another DSP. The financial remuneration model is complex and requires the pharmacist, in addition to submission of DSP prescriptions, to also channel a specified number of non-DSP prescriptions through the system. If the specified ratio is not achieved, either by submission of too many DSP prescriptions or too many non-DSP prescriptions, the pharmacist is penalised. Dispensing in these cases occurs at different facilities and the medicines dispensed must contractually be provided by the third party, despite the fact that theoretically the pharmacist should be able to purchase these medicines themselves at a price which by law should be exactly the same for both parties. This system precludes a non-DSP pharmacy from supplying a similar or lower priced competitor product.

- **Prescription administration fee (PAF)**

Effect on consumers and/or community pharmacies

Prescription clearing houses charge a prescription administration fee (PAF). This health care cost is currently absorbed by the pharmacy or charged as an out of pocket expense to the consumer.

- **Services for which pharmacists may levy a fee**

Effect on consumers

Pharmacy provides other healthcare services associated with medicines, but not with dispensing per se. The South African Pharmacy Council has published a list of these services for which a pharmacist may levy a fee. (Annexure C) These charges relate to services which could have a significant impact on patient care when delivered as planned, particularly in screening for and monitoring of non-communicable diseases such as diabetes. Unfortunately, many medical schemes do not reimburse pharmacies for these services. This results in an out-of-pocket payment by the consumer.

- **Reimbursement models**

Effect on community pharmacies

Quality care in the private sector is inextricably linked with the incentives (perverse or otherwise) that are created by reimbursement models. Pharmaceuticals are entwined in that system and cannot be selectively excluded.

In 2013, a particular medical scheme proposed a new dispensing fee model, offering pharmacists a substantially higher dispensing fee when a branded medicine, as specified in the schemes formulary, is supplied rather than when another similar priced or even lower price product is supplied. The scheme therefore apparently now has contractual financial agreements with manufacturers in deciding what should be dispensed. This system is contrary to the intention of the Single Exit Price mechanism established in terms of the Medicines Act, and also the requirements of the Competition Act 89 of 1998. Sections 4 and 5 of the Competition Act deal with restrictive practices, while section 8(d)(1) deals with abuse of dominance, by requiring that a supplier should not deal with a competitor. In this case, the pharmacist is restricted to supplying only the products specified by the medical scheme, even if rival equivalent products are available at a more competitive price. This is also contrary to the requirements of the Medicines Act, which states that dispensers must dispense a cheaper generic medicine, i.e. not a branded medicine, unless specifically forbidden by the patient to do so.

In another model, performance-based reimbursement schemes reward pharmacists for supplying low-cost generic medicines. This is seen as an incentive to pharmacists to lower the cost to the patient.

FEATURE #2 – MARKET POWER AND DISTORTIONS IN RELATION TO HEALTHCARE PRACTITIONERS AND FACILITIES

- **Perverse incentives**

Effect on community pharmacies

Section 18A of the Medicines and Related Substances Act, 101 of 1965 (“the Medicines Act”) states: “No person shall supply any medicine according to a bonus system, rebate system or any other incentive scheme.”

Despite this, perverse incentives still apply in ways which distort the private healthcare market. Please see Annexure D, a newsletter that was sent to PSSA members, and Annexure E, an article which appeared in *Noseweek* in January 2014.

In an effort to curb this, the Minister of Health has published draft regulations relating to bonusing and sampling. (See Annexure F) It will be difficult however to reverse the impact that has already occurred.

Some of the fees mentioned are paid to pharmacies, such as data fees. The PSSA has been told that the estimated annual value of data fees is in the region of R 800 million, with the large suppliers receiving the lion’s share. The result is that the large pharmacies and chains have been in a position to give bigger discounts with which the smaller pharmacies cannot compete. Unfortunately, as explained in Feature #5, the inadequate income obtained from the dispensing fee has been supplemented by these data fees to ensure continued viability.

- **Vertical integration**

Effect on community pharmacies

Market distortion exists through vertical integration of pharmacy chains owning wholesalers and in one instance, this includes ownership of a manufacturing company, despite this being prohibited in law.

FEATURE #3 – BARRIERS TO ENTRY AND EXPANSION

- **Hostile business environment**

Effect on consumers and/or community pharmacies

It can be argued that the purpose of the Act “to promote employment and to advance the social and economic welfare of South Africans”, has been frustrated because in effect the reverse has now been achieved in pharmacy as closure of small pharmacies due to failure to thrive in a hostile business environment has resulted in unemployment for many staff members.

Closure of these pharmacies has decreased access options for consumers, particularly those in already under-served areas.

- **Lack of incentives for entrepreneurship**

Effect on community pharmacies

The objective “to promote a greater spread of ownership (in this case of pharmacy ownership) of historically disadvantaged persons” in the current market environment has to a large extent been invalidated by a continued growth in a greater shareholding by companies rather than pharmacists, the majority of whom are now employees rather than entrepreneurs practising their profession in their own business.

- **Effect of anchor tenants**

Effect on community pharmacies

Prior to 2003, only a pharmacist could own a community pharmacy. In 2003, the Pharmacy Act, 53 of 1974, was changed to permit lay and corporate ownership. The entry into the market of retail chains has had far reaching effects. One detrimental effect for small community pharmacies has been that shopping centre give preference to anchor tenants which will act as drawcards for the centre. This includes preferential rental rates. In some cases, licences have been issued by the Department of Health for a retail chain to establish a pharmacy in a shopping centre which already had a community pharmacy tenant. Smaller pharmacies have not always been able to survive and many were unable to relocate.

FEATURE #4 – IMPERFECT INFORMATION

Effect on consumers

Community pharmacists find that many consumers are profoundly ignorant about their medical schemes. There is an enormous range of fees paid to pharmacists as every medical scheme and scheme product has different fee options, making it difficult for patients to understand the fee being charged.

The complex pricing system used for medicines in terms of the regulations to the Medicines Act also confuses consumers. Please refer to Feature #5 below.

FEATURE #5 – REGULATORY FRAMEWORK

- **Single Exit Price and dispensing fee regulation**

Effect on consumers and/or community pharmacies

Medicines remain an important component of costs in all private healthcare settings, and these costs cannot be separated neatly and completely from all other costs. The Council for Medical Schemes (CMS) report reflects the total medicine expenditure, but excludes medicines supplied in hospitals from this number. If medicines supplied in hospitals are added then the medicine component is R18.6 billion, or almost 20% of all healthcare expenditure paid through medical schemes.

The medicine expenditure is a composite of the manufactures price inclusive of the logistics fee (referred to as the Single Exit Price (SEP)) and the relatively small portion pharmacists and other

persons licensed to dispense receive. Whilst the SEP is a guaranteed capped fixed fee which may not be discounted, the dispensing fee component is listed in the legislation as a maximum fee.

We therefore have a “consumable” of which one portion is a guaranteed fixed fee, adjusted annually with the maximum annual increase published by the Department of Health and another portion which is capped at a maximum. In practice however the actual fee level is determined by market forces driven by competition between large corporate and courier suppliers who generally supply medicines with the dispensing fee below their marginal or average variable cost.

It is important to note that the Regulations relating to a transparent pricing system for medicines and related substances, published in terms of the Medicines Act for the first time in April 2004, have at times been controversial and have had varying success. The dispensing fee initially published was challenged by the PSSA and others in court. Eventually, in September 2005 the Constitutional Court ruled that the dispensing fee as published was inappropriate.

Despite this, and despite the fact that since then the dispensing fee has been adjusted a number of times, many medical schemes cap reimbursement of the dispensing fee at the level of the fee found to be inappropriate. The result is that the consumer is expected to pay a co-payment as the scheme does not cover the full amount claimed by the service provider. This amount is substantial and for the consumer it is an out of pocket expense which is not reflected in the CMS report.

The low dispensing fee has affected all community pharmacies, whether small and independently owned or part of a retail chain. See Annexure G. The continued pressure to further lower the fee paid to pharmacists, even though it is sometimes reimbursed below a level which the Constitutional Court found to be inappropriate, in the bigger picture of health expenditure cannot be justified.

It should be noted that the dispensing fee has not been charged by pharmacies located in and owned by private hospitals, and medicines in such settings are sold at the SEP, without any direct recovery of the costs associated with their procurement, distribution, storage and dispensing. Such costs are, nonetheless, recovered as part of the ward and/or theatre charges levied on all in-patient stays. There is therefore a direct link between the cost of private hospital care and the system of charging for medicines. No consideration of the cost structure of private hospitals can therefore ignore the contribution of medicines pricing, and the impact on the business model of the SEP and dispensing fee structure.

Although some interventions have been made to address the price of medicines in the form of the SEP, others have yet to be concluded and may still have an impact. These include capping of the logistics fee component of the SEP, international benchmarking and pharmacoeconomic evaluations of data presented by holders of market authorisation.

Conclusion

The issues raised above illustrate that in a highly regulated sector have an effect on service delivery, freedom of choice of the consumer and viability of small businesses, especially if the focus is only on cost.

Yours faithfully



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