I would like to start off by stating that what follows is my perspective, formed to a large extent by the people I interact with. It is not a scientific study or a policy/position paper with ‘statistical significance’ on the points made.

In 1996 the National Drug Policy and in 1997 the Medicines Amendment Act were published and provision were made for the formation of the Pricing Committee to establish a totally transparent non-discriminatory pricing structure and appropriate SEP, fixed professional fee and dispensing fee.

The first draft for dispensing fees made provision for 24%/R24 (2003) and 26%/R26 (2004) and led to extended legal action, affidavits and meetings, culminating in the Constitutional Court and a meeting with the then Minister of Health (2009). During this time the Pharmacy Stakeholders Forum (PSF) was also established.

In 2010, the four tier structure for the dispensing fee (with average income of R38 per item) came into operation – a zero based model was used, and included basic dispensary costs (23 cost lines and 2300 items dispensed per month) and a return on investment (ROI) on dispensary costs. The first “annual” adjustment was in September 2013 and the next in 2015 (increasing the average income per item to between R48 and R50) and 2016 (±R53). The June 2015 publication of fees for comment also included replacement of the paragraph “This fee which is exclusive of VAT represents a maximum dispensing fee…” with a definition of dispensing fee “… that may be charged to dispense medicine.”

The bottom line is that the fee was developed and calculated on the lowest possible cost level with the only profit being the limited ROI and only two “annual” adjustments made in the first 5 years. Furthermore, it was indicated as a maximum and not a fixed fee as initially intended.

Indications are that following the implementation of the Single Exit Price (SEP) and dispensing fee, medicine prices decreased by approximately 19%, thus in general making it more accessible to all South Africans and assisting the Department of Health in delivering a better pharmaceutical service. Despite this positive impact, it has however also had consequences in different sectors of pharmaceutical care and on the profession as highlighted below.

In the academic sector the uncertainty about the viability of community pharmacy was seen in the more than 20% drop in graduations from 2008 to 2010 compared to that in 2007, following lower student intake from 2005. Another interesting trend from 2004 to 2009 was that on average 10 – 20% of graduates did not register for internship the following year. What happened to those graduates?

Fortunately student numbers have steadily increased since then as is evident in the increased graduations from 2011, reaching and exceeding 2007 numbers by 2013. Various factors contributed to this increase in numbers, with the implementation of the Occupation Specific Dispensation (OSD) in 2009 probably playing a key role in providing alternative career opportunities.

With the implementation of the dispensing fee in 2010 and especially with medical schemes reimbursing at lower than suggested fees, the viability of smaller pharmacies declined steadily. This led to a significant number of pharmacies closing and though this is not reflected in the number of pharmacy licences issued per year, it is especially evident in small towns and rural areas where pharmaceutical services are no longer available because pharmacies that served those communities were not sustainable under the new pricing structure, particularly as applied by medical schemes.

The decline in community pharmacy and advent of OSD did however contribute positively to staffing and delivery of pharmaceutical services in the public sector. In the private hospital sector, the ROI for pharmacies decreased as significantly as in the community pharmacy sector, but as the total medicines related cost constitutes less than 10% of the total hospital bill, the impact was probably less significant.

The effect of pricing regulation is also apparent in pharmacist salaries in the community pharmacy sector, which have now fallen to well below that of their counterparts in the public sector. Even locum pharmacists can attest to that with very little if any increase in locum rates over the last 5 years, some even indicating a decrease in the locum fees offered by certain pharmacy groups.

In the pharmaceutical industry the effect of the regulated SEP was also felt, although this was probably initially offset by elimination of incentive schemes. Most economists would however tell you that the surest way to create a shortage of something is to regulate prices by
putting a ceiling to it. This was then also observed for medicines in South Africa and could in this case probably be attributed to suppliers being “forced” to find cheaper active pharmaceutical ingredients (APIs) to meet demands of lower SEPs while maintaining profits for shareholders. Medicines accessibility could in future be compromised further as local manufacturers focus on manufacturing for export only in order to remain financially sustainable.

It is thus a thin line we tread and though it is a noble concept to make medicine more affordable and thus accessible, it needs to be managed well, transparently and fairly to ensure sustainability of pharmaceutical services in South Africa. That is why, in the Constitutional Court judgements, words such as “fair”, “just”, “proper” and “well suited” were used to describe what the dispensing fee should be. In the judgements, the following phrases stand out: “… appropriate not only to the public, but also to pharmacies”; “… should be sufficient to enable a well-run pharmacy to make a reasonable profit”; “… that the price to be fixed would enable properly run pharmacies in appropriate geographical areas to operate with reasonable margin of profit.” The dispensing fee should thus compensate pharmacists for provision of the service, for the costs associated with trading in medicine and also allow for a reasonable profit and ROI.

As mentioned previously, we make a living by what we get and we make a life by what we give; there is however nothing wrong with making a living while making a life or making a difference.