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The Competition Commission
The dti Campus
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77 Meintjies Street
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Pretoria

Per email: health@compcom.co.za

Dear Honourable Justice Ngcobo *(presiding chairman of the Private Healthcare Inquiry)*

SUBMISSION OF THE ICPA - MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

The ICPA, Independent Community Pharmacy Association, is a registered non-profit company collectively acting in the interests of independent community pharmacy owners as its members. This submission is in response to the Draft Statement of Issues, Market Inquiry into the Private Healthcare Sector, published by the Competition Commission on 30 May 2014. According to the said document, the Panel appointed by the Competition Commission is, in particular, required to conduct an analysis of the interrelationships of various markets in the private healthcare sector, including examining the contractual relationships and interactions between and within the health service providers, the contribution of these dynamics to total private expenditure on healthcare, the nature of competition within and between these markets, and ways in which competition can be promoted. The Panel further construes the phrase "prevent, distort or restrict competition" broadly to cover any effect adverse to potentially better competitive outcomes, whether present now or likely to occur in future.

The intention in which this submission has been compiled is to afford the Panel a general understanding of how the pharmacy sector is currently operating, taking into consideration that a market inquiry is a formal inquiry in respect of the general state of competition in a market for particular goods or services. ICPA hereby attempts to identify practices which distorts, restricts and prevents competition in the pharmacy sector which is inextricable to increases in private healthcare costs and expenditure in South Africa. ICPA further hopes that the Panel will investigate our submissions and, where appropriate, implement suitable remedies.

Designated Service Providers and Penalty Co-Payments

General regulations[1] to the Medical Schemes Act[2] were promulgated in 1999 which introduced various risk management mechanisms available to medical aid schemes. We specifically wish to refer to Regulation 7 and Regulation 8(2)(b). Regulation 7[3] defines and allows for the appointment of designated service providers ("DSPs"), or pharmacies for the purpose of this submission, by medical aid schemes in respect of the provision of prescribed minimum benefit conditions ("PMBs"). Regulation 8(2)(b)[4] additionally allows for the imposition of so-called "co-payments" should a non-DSP be utilised by a beneficiary of the medical scheme. The use of DSP arrangements or networks within South Africa has become common place especially since medical schemes have a statutory obligation[5] to pay in full for the closed list of prescribed minimum benefits or PMBs[6]. Schemes therefore utilise this

[1] GNR.1262 of 20 October 1999
[2] Act no 131 of 1998
[3] Regulation 7: *"designated service provider means a healthcare 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 conditions"*
[4] Regulation 8(2)(b): *"Prescribed Minimum Benefits — Subject to section 29 (1) (p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider".*
[5] Regulation 8(1): "*Prescribed Minimum Benefits.— Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions".*
[6] A list of PMB Conditions can be found in *Annexure A, Explanatory Note to the Regulations of the Medical Schemes Act no 131 of 1998 (GNR.1262 of 20 October 1999).*

opportunity to implement various "cost-saving" initiatives, including the appointment of DSPs and charging of co-payments should a beneficiary wish to use a non-DSP to obtain his or her medicines. However, the said regulations are being interpreted and applied by schemes to their own advantage, forsaking not only independent community pharmacies but also the general public paying monthly contributions to medical schemes. The rationale behind enshrining DSP networks and co-payments in the form of regulations, is to ensure the sustainability of medical aid schemes. Through these mechanisms schemes are able to budget more accurately which indirectly decreases beneficiaries' monthly contributions. This argument seems reasonable, provided however that the said mechanisms are restricted to their intended purpose. Unfortunately, the way in which medical schemes have structured the DSP and co-payment mechanisms to suit their own needs, have led to consequences which could not have been envisaged by the legislator.

Regulation 7 does not specify the manner in which DSPs must be "selected by the medical scheme concerned". Schemes therefore unilaterally and without restriction determine the criteria to apply when selecting their DSPs or pharmacies of choice. Some schemes select DSPs, or even a sole DSP, without considering any applications or tenders to join their DSP network from any other service provider. This practice has created monopolies amongst schemes and their selected service providers or pharmacies since beneficiaries of schemes are being channelled to the selected DSPs to service all their healthcare needs. Beneficiaries are forced by their scheme to only use the selected DSPs or risk paying exorbitant co-payments. The influx of scheme beneficiaries to the selected DSPs, which are mostly courier/corporate pharmacies, provide them with the opportunity to lower their dispensing fee rates to a rate that will not be viable to any independent community pharmacy. It must however be noted that the dispensing fee rates that some schemes are willing to offer pharmacies, are wholly inappropriate and will force independent community pharmacies to dispense medicines at a loss while corporate pharmacies can easily absorb such a loss. Further, no due consideration is given to the out-of-pocket cost to the patient to access the chosen Designated Service Provider by the schemes, especially where the provider is outside the area of the patient's home.

The criteria and selection process implemented by schemes in choosing their DSPs must further be regulated in order to obviate the situation where schemes apply their own arbitrary criteria, designed to exclude independent community pharmacies. It seems logical to afford any service provider, including independent community pharmacies, the opportunity to apply or tender to join a scheme's DSP network should the pharmacy be willing and able to service the scheme's beneficiaries at the same dispensing fee rate as their selected DSPs. In addition to appointing DSPs for the provision of PMB conditions to their beneficiaries, certain schemes are also appointing DSPs for the provision of acute medication. The latter practice is unlawful. Regulation 7 allows medical aid schemes to appoint DSPs to provide to its members services in respect of one or more prescribed minimum benefit (PMB) conditions, but not for acute medication. Effectively, independent community pharmacies sustains damage as a result of such a contravention of the law.

Regulation 8(2)(b) similarly does not restrict or regulate a medical aid scheme's discretion when calculating the allowed co-payment that is payable by a beneficiary should he or she utilise the services of a non-DSP. The regulation merely states that the rules of the scheme may provide for the payment of a co-payment, "the quantum of which is specified in the rules of the medical scheme". Schemes therefore unilaterally and without restriction determine how co-payments will be calculated which has resulted in certain schemes charging so-called punitive "penalty" co-payments, calculated as a percentage of the total amount claimed by the service provider/pharmacy from the scheme. In order to clarify and illustrate the consequences of this absolute discretion afforded to schemes to calculate penalty co-payments, we refer to the following examples:-

Glossary:

PMB	= Prescribed Minimum Benefit Conditions
DFR	= Dispensing Fee Rate of the service provider (the rate the scheme is willing to pay in the example is 26% of the price of the medicine capped at R26)
SEP	= Single Exit Price (cost price of medicine)
DF	= Dispensing Fee total the service provider charges
Penalty Co-payment	= The "penalty" co-payment is calculated as a percentage of the total script amount which consists of the SEP of the medicines plus the dispensing fee rate the service provider/pharmacy charges.

NF = Non-Formulary: Should the beneficiary of the scheme choose a drug that is not on the scheme's formulary list, another co-payment calculated as the difference between the price the scheme is willing to pay for a formulary drug and that of the chosen drug is charged

Total co-payment = This amount is the total charged to a beneficiary as a co-payment which monies need to be collected by the service provider

Table 1:

	PMB	DFR charged by pharmacy	SEP	Total DF	Total Script Amount	Payment by scheme	40% Penalty co-pay	NF co-pay	Non-DSP rate co-pay	Total Co-Pay
DSP	Formulary drug	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	0.00	R 0.00
	Non-formulary drug	26%/R26	220.00	26.00	R 246.00	R 226.00	0.00	20.00	0.00	R 20.00
Non-DSP	Formulary drug	26%/R26	200.00	26.00	R 226.00	R 135.60 (less than SEP)	90.40	0.00	0.00	R 90.40
	Non-formulary drug	26%/R26	220.00	26.00	R 246.00	R 127.60 (less than SEP)	98.40	20.00	0.00	R118.40
Non-DSP with higher DFR*	Formulary drug	36%/R59.4	200.00	59.40	R 259.40	R 122.24 (less than SEP)	103.76	0.00	33.4	R137.16
	Non-formulary drug	36%/R59.4	220.00	59.40	R 279.40	R 114.24 (less than SEP)	111.76	20.00	33.4	R165.16

** Should the beneficiary of the scheme choose to obtain his or her medicines from a non-DSP and that non-DSP's dispensing fee rate is higher than the DFR of the scheme (as agreed and contracted with their DSPs), the beneficiary will have to pay another co-payment calculated as the difference between the non-DSPs dispensing fee rate and that of the scheme's DSP*

Based on the abovementioned illustration, it is evident that schemes abuse the co-payment mechanism by charging an additional punitive "penalty" co-payment when a beneficiary uses a non-DSP to obtain medicines. This "penalty" co-payment is calculated as a percentage of the total script amount which consists of the SEP of the medicines plus the dispensing fee rate the service provider/pharmacy charges. We submit that the "penalty" co-payment designed by schemes is unreasonable, not in the best interest of beneficiaries/the public and has no justifiable basis for its implementation.

The calculation of co-payments in terms of Regulation 8(2)(b) should be based on the following:-

a) the difference between the dispensing fee rate of the scheme as agreed with the DSP and the dispensing fee rate of the non-DSP (i.e. different dispensing fee rates charged by pharmacies); and/or
b) the difference between a formulary and a non-formulary drug should the beneficiary not choose a drug on the formulary list of the scheme.

The reason why schemes force their beneficiaries to pay these penalty co-payments is not clear nor is it justifiable. By allowing schemes to charge penalty co-payments, schemes are allowed to penalise beneficiaries for fictional "damages" that were not suffered. CMS (Council for Medical Schemes) also published a Managed Health Care Policy, dated August 2003, which provide guidelines with regard to the quantum of co-payments that should be imposed by schemes:-

> *As a guideline, given the intention of the legislation, <u>it would seem reasonable for the quantum of the co-payment to relate to the difference between the actual cost incurred and the cost that would have been incurred had the designated service provider been used</u> (or in the case of drugs, the difference between the cost of the drug and the reference price of the formulary drug).*

ICPA agrees with the abovementioned policy of CMS. The imposition of an additional punitive penalty co-payment, calculated as a percentage on the overall cost incurred by the scheme

(dispensing fee rate of the service provider and the SEP of the medicine), is therefore unfounded. This business practice further negatively influences consumer choice by effectively removing the consumer's so-called "choice". The abovementioned explanation of how schemes manipulate the statutory regulations is one example of how co-payments influence consumer choice and is in response to the Panel's request in Clause 26 of the Draft Statement of Issues[7]. We wish to further qualify Clause 26 in that it is not only the consumer's choice with regards to which scheme he/she will choose that is effected by a scheme's co-payment terms and conditions, but also which pharmacy he/she will subsequently use in order to obtain medicines.

Table 2 below sets out the preferred position where no penalty co-payment applies. The differences between Table 1 and Table 2 demonstrate that only schemes benefit, to the detriment of beneficiaries (the general public), from penalty co-payments. If a beneficiary chooses to use a non-DSP, the scheme's liability in respect of the total amount owing to the service providers decreases substantially:

[7] Draft Statement of Issues, Market Inquiry into the Private Healthcare Sector, dated **30 May 2014:** Clause 26:*"The requirement to make out-of-pocket payments may arise when patients are required to make co-payments, when a patient's scheme savings or benefits are exhausted, or when a patient has no scheme or insurance cover at all. The requirement to make co-payments, or the extent and level of co-payments, will influence consumer choice. Specifically, consumers may select schemes based on their terms and conditions regarding out-of-pocket payments. The Panel wishes to understand the circumstances under which a system of out-of-pocket payments has arisen in South Africa, what this means for the welfare of consumers, and the effect, if any, of out-of-pocket payments on competition".*

Table 2

	PMB	DFR charged by pharmacy	SEP	Total DF	Total Script Amount	Payment by scheme	**NO Penalty co-pay**	NF co-pay	Non-DSP rate co-pay	Total Co-Pay
DSP	Formulary drug	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	0.00	R 0.00
	Non-formulary drug	26%/R26	220.00	26.00	R 246.00	R 226.00	0.00	20.00	0.00	R 20.00
Non-DSP	Formulary drug	26%/R26	200.00	26.00	R 226.00	R 226.00	0.00	0.00	0.00	R 0.00
	Non-formulary drug	26%/R26	220.00	26.00	R 246.00	R 226.00	0.00	20.00	0.00	R 20.00
Non-DSP with higher DFR*	Formulary drug	36%/R59.4	200.00	59.40	R 259.40	R 226.00	0.00	0.00	33.4	R 33.40
	Non-formulary drug	36%/R59.4	220.00	59.40	R 279.40	R 226.00	0.00	20.00	33.4	R 53.40

It is apparent from Table 2 that a beneficiary's out-of-pocket expense decreases drastically should a penalty co-payment not be charged. Should a beneficiary then choose to use a non-DSP and be charged a co-payment, it is entirely his or her choice. There is no detrimental effect on the scheme whether the beneficiary chooses a DSP or a non-DSP since the SEP of medicines are fixed and schemes only pay pre-determined dispensing fee rates according to the agreement between the DSP and the scheme. The total payment by schemes to service providers also remains the same whether they have DSP status or not. The only apparent

reason why this would not sit well with schemes is that they will no longer enjoy the benefit of passing on to their beneficiaries a portion of the script amount payable to a service provider. This practice clearly has a negative effect on the public, especially since their rights of access to healthcare services and medicines are diminished by being forced to pay exorbitant co-payments. Furthermore, should a scheme not charge a penalty co-payment, the scheme would not pay less than the SEP for medicines. It is not legal or viable for service providers to dispense medicines below cost-price. The SEP for medicine is fixed according to the Medicines and Related Substances Act[8] and its regulations. The SEP is the only price at which manufacturers may sell medicines and scheduled substances to any persons or service providers[9]. Based on **Table 1** above, when imposing penalty co-payments, schemes are not even paying the cost price (SEP) for medicines, which is an unlawful practice. This places community pharmacists in an uncomfortable situation where they do not want to collect the penalty co-payment from their patients for fear of losing them, but they cannot afford to dispense medicines below cost-price. The purpose behind joining a medical aid scheme is to afford beneficiaries with, inter alia, the means to obtain medicine from pharmacies without being "out-of-pocket". The pharmacy then sells its "goods", which it bought from the manufacturer at the legislated cost price (SEP), to the scheme's beneficiary and adds its dispensing fee. The scheme must then reimburse the pharmacy. It could not have been the legislature's intention, by allowing schemes to calculate the quantum of co-payments, to cause pharmacies to sell their "goods" below the price at which they bought it, which will inevitably result in the pharmacy being forced to close its business.

The manner in which medical aid schemes are charging penalty co-payments together with closing their DSP networks, has resulted in undesirable business practices. Monopolies have sprouted amongst schemes since a credible threat of exclusion from a scheme's DSP network provides the scheme with bargaining power allowing it to negotiate unrealistically low dispensing fee rates with service providers/pharmacies. This anomaly has led to many independent community pharmacies being forced to close their doors and further closures are occurring at an alarming rate. It is also the vulnerable (often rural) pharmacies that are forced to close their doors.

[8] Act No. 101 of 1965
[9] Section 22G(3)(a)

Table 3 below contains a list of medical aid schemes that:-

a) have closed DSP networks which independent community pharmacies may not join;

b) are charging punitive penalty co-payments;

c) and are appointing DSPs or preferred providers for the provision of acute medication.

Table 3

SCHEME	OPTION	DSP Status	Provider	Penalty co-pay for use of Non-DSP	DSP for Acute Medication
DISCOVERY HEALTH	Delta Keycare	Closed	MedXpress	20%	
DISCOVERY HEALTH	ARVs for all schemes administered by DH including Altron, AngloVaal, IBM, LA Health, Lonmin, Naspers, Quantum, Remedi, Retail, TFG, Tsogo Sun, Univ KZN.	Closed	Optipharm	20%	
BANKMED	ARVs	Closed	Optipharm	20%	
FEDHEALTH	Blue Door	Closed	Medirite	40%	
	Maxima Basis	Closed	Medirite	40%	
	Maxima Core	Closed	Medirite	40%	
	Maxima Std	Closed	Medirite	40%	

	Ultima 200	Closed	Medirite	40%	
	Maxima Saver	Closed	Medirite	40%	
	Maxima EntrySaver	Closed	Medirite	40%	
	Maxima Entry Zone	Closed	Medirite	40%	
BONITAS	BonClassic	Closed	Pharmacy Direct	40%	
	Standard	Closed	Pharmacy Direct	40%	
	Primary	Closed	Pharmacy Direct	40%	
	Bonsave	Closed	Pharmacy Direct	40%	
	BonEssential	Closed	Pharmacy Direct	40%	
	Boncap	Closed	Pharmacy Direct	40%	
MASSMART	Chronic	Closed	Pharmacy Direct	25%	
SPECTRAMED	Chronic	Closed	Optipharm	40%	
MOMENTUM HEALTH	Various options	Closed	Medipost	5 - 50%	
NETCARE	Acute & Chronic	Closed	Pharmacross, Netcare	100%	YES
DE BEERS	Acute & Chronic	Closed	Direct Medicines	30%	YES

POLMED	Chronic	Closed	Clicks, Medipost, Phy Direct	30%	
MBMED	Chronic	Closed	CMD	30%	
SELFMED	Chronic	Closed	Clicks, DisChem, Pick n Pay	40%	
MEDSHIELD	ARVs & Oncology	Closed	Optipharm	40%	
MOTO HEALTH	Chronic	Closed	Clicks	?	
MEDIHELP	ARVs	Closed	Optipharm	100%	
GEMS	Acute, chronic, PBMs, Over the Counter (OTC)	Open*		30%	YES

** Open - all service providers can apply to join the DSP network, penalty co-payment still charged to non-DSPs that were not selected*

ICPA submits that DSP networks should be open for application by all service providers and must be further qualified in that the criteria for selection should not be arbitrary with the intention of excluding independent community pharmacies. Schemes must engage in a clearly defined fair and reasonable process of evaluating a range of potential pharmacies to select a pharmacy best suited to the needs of that medical scheme, taking into consideration, amongst others things: cost-effectiveness, quality of care and member access to health services cost. Appointing DSPs for the provision of acute medication must also be prohibited since the regulations to the Medical Schemes Act only makes provision for the appointment of DSPs in respect of PMB conditions. Punitive penalty co-payments, calculated as a percentage of the total script amount, which consists of the SEP of the medicines plus the

dispensing fee rate the pharmacy charges, must additionally be prohibited. The quantum of co-payments must be limited to: the difference between the dispensing fee rate of the scheme and that of the non-DSP; and/or the difference between a formulary and a non-formulary drug should the scheme's beneficiary choose a drug not on the scheme's approved formulary.

Dispensing Fees and Single Exit Price of Medicines

Medicines are not normal commodities of trade hence government introduced a single exit price ("SEP") on medicines[10]. Effectively this means that the price paid by the consumer is the exact price set by the manufacturer and distributed via the chain of distributor and wholesaler to the retailer. The retailer (pharmacist or dispenser) adds a "dispensing fee" which is the fee covering the pharmacist's professional fee as well as the overheads of the business. The tier-structured dispensing fee maximums are currently embodied in Regulation 10 of the *Regulations relating to a transparent pricing system for medicines and scheduled substances*[11]. The Medicines and Related Substances Act[12] allows the Minister of Health to appoint a Pricing Committee which must recommend to the Minister, inter alia, the regulations relating to an appropriate dispensing fee to be charged by a pharmacist. The Pricing Committee initially in 2006 introduced the following dispensing fee: 26% on the SEP of medicines, capped at R26 excluding VAT ("26%/R26"). This fee was grossly inadequate and fell well below the margins needed to sustain a business. The fee was subsequently deemed "inappropriate" by the Constitutional Court on 30 September 2005[13]. The Pricing Committee was ordered to republish the regulations in order for the dispensing fee to be "more appropriate". After exhaustive negotiations and submissions from stakeholders in the pharmaceutical and medical scheme industries, the new tier structured dispensing fee ("4-tier-fee") was introduced[14].

[10] Regulation 6 of the *Regulations relating to a transparent pricing system for medicines and scheduled substances* (GNR.1102 of 11 November 2005) of Act No 101 of 1965: *"A manufacturer, importer, distributor or wholesaler may not charge any fee or amount other than the single exit price in respect of the sale of a medicine or Scheduled substance to a person other than the State"*.
[11] GNR 1102 of 11 November 2005 (Regulation of the Medicines and Related Substances Act, 101 of 1965)
[12] Section 22G(b) of Act 101 of 1965
[13] *Minister of Health and Another v New Clicks SA (Pty) Ltd and Others 2005 (CC)*
[14] Regulation 10 of Act 101 of 1965

The 4-tier-dispensing fee is a maximum tariff, unlike SEP which is fixed, and has no minimum. Medical schemes exploited this loophole in the regulation using their superior market power to force pharmacies to accept a dispensing fee well below the legislated maximum, or face losing their customers to a DSP. A large number of medical schemes still offer a dispensing fee at 26%/R26 and certain schemes even offer rates lower[15] than the rate which was declared an "inappropriate" fee by the Constitutional Court back in 2005. The Constitutional Court's judgment has therefore become redundant. All arguments presented during the trial and subsequent lengthy negotiations with the Pricing Committee in order to establish an "appropriate" dispensing fee for pharmacists, is irrelevant. Medical schemes unilaterally decide on the dispensing fee it is willing to pay pharmacies and pharmacies must slavishly abide thereby in fear of schemes not selecting them as their designated service providers to which schemes send their beneficiaries to obtain medicines.

Changes in the regulatory scheme[16] have made it possible for large corporate entities to obtain pharmacy licences and simply employ the necessary staff to deal with the dispensing of medicines. These retail chains, of which Clicks and Dischem are the largest, are not dependent for their survival on the income of the dispensary and can cross-subsidise this business unit with the profits made in their front end stores. Whereas these retail chains derives approximately 70 – 90% of their income from their front end trade and the balance from the dispensary, converse proportions apply in the case of most independent pharmacies. Certain corporate pharmacies utilize so-called subsidization models in which they operate their dispensary at a loss until market share has been attained[17]. This is an

[15] For example: Discovery KeyCare option at 16% capped at R16 (excl VAT) and MassMart (all options) 20% capped at R20.

[16] Regulation 6 of the *Regulations relating to the Ownership and Licencing of Pharmacies* (GNR.553 of 25 April 2003) under the Pharmacy Act, No 53 of 1974.

[17] Clicks Report dated February 2011, page 14: *Pharmacy currently unprofitable – pending maturity will drive operating margins:*

> *"Clicks states that its pharmacies are, on aggregate, EBIT positive at store level (100 of the 251 pharmacies are EBIT loss-making, as a result of being two years old or less and thus still ramping up dispensary sales). However, our allocation of Clicks overheads between front shop and pharmacy suggests that, when taking all corporate overheads into account, Clicks pharmacies are likely EBIT loss making.*
> *We estimate that on aggregate, Clicks 6.9% FY10 EBIT margin comprises a 6% EBIT loss on dispensary, and a 10.7% front shop EBIT margin. Our cost-allocation estimates are predicated on dispensary occupying only c. 6% of Clicks floor-space, but accounting for 31% of the Clicks wage bill (high Pharmacist and Pharmacist assistant costs), and also absorbing 22% of 'other costs' in line with dispensary revenue share.*

example of predatory pricing which is prohibited by the Competitions Act[18]. Pharmacists are therefore not given the opportunity to compete fairly in their profession as corporate chain pharmacies and/or courier pharmacies abuse the professional dispensing fee as "loss leaders". The dispensing fee rates which certain medical schemes are willing to pay are wholly inappropriate and are forcing pharmacies to dispense either at a loss or at very low margins, effectively excluding reimbursement for their advice and service as a trained professional. It is important to further mention, that the dispensing fee has only been adjusted three times since 2006 without due inflation increases.

To add insult to injury, certain medical aid schemes offer dispensing fee rates that are VAT inclusive even though the dispensing fee regulations clearly state that the dispensing fee should be calculated exclusive of VAT[19]. For example:

> *"The Participating Pharmacy shall charge a maximum dispensing fee of 27.50% of the Single Exit Price of the medicine (inclusive of VAT) with a maximum of R27.50 (twenty six rand, inclusive of VAT) per line item. This fee dispensation may be reconsidered having regard to such legislative changes on the dispensing fee for pharmacies, in the sole discretion of the Scheme as and when it becomes necessary."*[20]

Furthermore, with the implementation of a single exit price for medicines (SEP), government envisaged a total transparent pricing structure of medicines. The effect however has been completely the opposite. Currently, pharmacists are dispensing the same medication to different patients on different medical schemes at different rates. The patient is not involved

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Assuming Clicks is able to lift its avg. pharmacy turnover from R8.3m currently to R10.8m (the average turnover for a mature pharmacy, see Fig 36), Clicks should be able to increase the average dispensary EBIT margin from -6% to close to breakeven. This would have the impact of lifting Clicks overall EBIT margin by 0.3%".

[18] Section 8 of Act No 89 OF 1998: Abuse of dominance prohibited — It is prohibited for a dominant firm to sell goods or services below their marginal or average variable cost (exclusionary act), unless the firm concerned can show technological, efficiency or other pro-competitive, gains which outweigh the anti-competitive effect of its act.

[19] Regulation 2 of the *Regulations relating to a transparent pricing system for medicines and scheduled substances* (GNR 1102 of 11 November 2005) of Act No 101 of 1965: Definitions - *"dispensing fee means the maximum fee, exclusive of VAT, that may be charged to dispense a medicine"*.

[20] Clause 8.3 of the *GEMS (Government Employees Medical Scheme) Medicine Provider Network Agreement* (Agreement signed between the scheme and the pharmacy)

at all in the negotiation of that fee and yet his acute or savings portion of his benefit is directly impacted by that agreed rate. When he chooses a scheme he is not privy to these agreed rates and they may vary from provider to provider. Currently, a patient may obtain his medicines from one pharmacy for R120 (SEP of R100 plus R20 dispensing fee) and for R140 (SEP of R100 plus R40 dispensing fee) by another pharmacy. The current model and regulations attempt to bring transparency to the sale of medicines, but this has not been achieved since only a portion of the cost of medicine has been fixed.

It is worth noting that competition amongst independent community pharmacies and corporate or courier pharmacies are further distorted, prevented or restricted by the inter-relationship amongst schemes and corporate/courier pharmacies. A vicious cycle exists where corporate and/or courier pharmacies lower their dispensing fee rates to rates which are not viable for any independent community pharmacy and in turn, schemes appoint corporate and courier pharmacies as their DSPs. Beneficiaries are then forced by their scheme to only use the corporate or courier pharmacy or risk paying exorbitant penalty co-payments. The influx of scheme beneficiaries to the selected DSPs again provide them with the opportunity to lower their dispensing fee rates even more.

The pharmacist's professional fee has become a mere commodity of trade used by the large retail chains in most cases as loss leaders to attract customers. Profitability is measured on a basket of products not related to the profession of pharmacy. Quality pharmaceutical care has been sacrificed in favour of quantity and medical scheme beneficiaries are used as bargaining tools to achieve the lowest dispensing rates with little or no regard for patient choice or the sustainability of pharmaceutical service.

Ownership of Pharmaceutical Manufacturing Companies

In terms of Section 22A of the Pharmacy Act[21], read with Regulation 6 [22], the Minister has prohibited manufacturers of medicines to have a direct or indirect beneficial interest in a retail pharmacy. The Director-General of the Department of Health has however issued Unicorn Pharmaceuticals (Pty) Ltd[23] with a manufacturing licence[24] even though Unicorn Pharmaceuticals is one of the subsidiaries of Clicks Group Limited[25], the holding company of Clicks Retailers (Pty) Ltd[26] which has registered pharmacy licences. There are four directors that are directors of all three of these companies[27]. As such Clicks Retailers (Pty) Ltd is conducting its retail pharmacy business in contravention of the Pharmacy Act and its Regulations. It is anti-competitive behaviour should one trader not be able to compete with another trader because the latter is trading unlawfully. Such practices prevent or restrict fair competition amongst competitors. It is evident from the Integrated Annual Report of Clicks that the company intends to expand their private label scheduled generic medicines range and to increase their front shop private label and exclusive brand sales in 2014[28]. The vertical integration of pharmacy chains owning manufacturing companies, in addition to the unlawfulness thereof, further violates Section 5(1)[29] of the Competition Act[30] which proscribes vertical agreements that have the effect of lessening competition and that do not generate countervailing pro-competitive gains. The fact that Clicks owns a manufacturer, distributor[31], wholesaler[32] and retailer means that they have access to profit at four different

[21] Act No 53 of 1974

[22] Regulation 6 of the *Regulations relating to the Ownership and Licencing of Pharmacies* (GNR.553 of 25 April 2003) under the Pharmacy Act, No 53 of 1974.

[23] Registration number 2000/017879/07

[24] Attached hereto as *ANNEXURE A* is the Unicorn Pharmaceuticals Manufacturing Licence. To further support our submission that Clicks Retailers are manufacturing their own private label medicines under the auspices of Unicorn Pharmaceuticals, please refer to *ANNEXURE B* and *ANNEXURE C* attached hereto.

[25] Registration number 1996/000645/06

[26] Registration number 2000/013054/07

[27] Attached hereto as *ANNEXURE D* are the CIPC Reports of Clicks Group Limited, Clicks Retailers and Unicorn Pharmaceuticals.

[28] Clicks Integrated Annual Report 2013, Review of performance in 2013 and plans for 2014, Page 6 (see *ANNEXURE E* attached hereto)

[29] "*Restrictive vertical practices prohibited — An agreement between parties in a vertical relationship is prohibited if it has the effect of substantially preventing or lessening competition in a market, unless a party to the agreement can prove that any technological, efficiency or other pro-competitive, gain resulting from that agreement outweighs that effect".*

[30] Act no 89 of 1998

[31] United Pharmaceutical Distributors (UPD)

[32] UPD Wholesale

levels, i.e. the manufacturers' mark-up, distribution fees, logistics fees and dispensing fees. This effectively means that the pharmacy retail arm of Clicks is able to subsidise the dispensing fee at other levels and can easily lower its dispensing fee rates, making Clicks pharmacy a desirable DSP option for medical aid schemes.

Reimbursement Models

In Clause 31 of the Draft Statement of Issues, the Panel requests the following:

> *"There are various mechanisms available to administrators and other intermediaries aimed at managing costs. These include managed care, alternative reimbursement mechanisms, and generic substitution. The Panel wishes to understand the extent to which these are used, the effectiveness thereof, and the alignment of these interventions with good healthcare outcomes".*

In response thereto, the practice amongst medical schemes to include so-called reimbursement models in their service level agreements with pharmacies should be noted. In particular, Discovery Health Medical Scheme implements an incentive scheme in which pharmacies are afforded a higher dispensing fee rate should they dispense medicines listed on Discovery's medicine formulary (i.e. formulary adherence) and should they dispense generic substitutes of medicines (i.e. generic substitution). This practice does not affect healthcare outcomes of patients since the sole purpose thereof is to reduce the cost of healthcare by substituting one medicine with another which has been shown to be bioequivalent to a reference, usually the originator drug, and which is less expensive. It is mandatory for a pharmacist when dispensing a script, to offer the patient a less expensive generic, if available, and the choice lies with the patient whether or not to accept the cheaper equivalent. If the patient refuses the cheaper equivalent then usually he would have to pay the difference in cost between the generic and the more expensive drug. In certain cases, when a generic has caused side effects that the originator drug did not cause, then the prescriber can motivate the scheme, on behalf of the patient, for payment of the non-generic medicine. This practice is very effective in reducing healthcare costs and does not affect the

consumer's right to choice. However, a practice that does distort and restrict competition, not necessarily amongst pharmacies, is when a medical scheme institutes a so-called NAPPI specific or trade name specific formulary. In this case a scheme has a formulary of medicines listed by trade name and any deviation from that brand results in a penalty charged to the patient and dispenser. For the pharmacist, adherence to this type of formulary can become unlawful. When a prescriber (for example: a general practitioner) scripts a drug which is less expensive than the branded formulary drug and, because of the schemes NAPPI specific or trade name specific formulary terms and conditions, the pharmacist is forced to substitute the scripted drug with a more expensive drug listed on the scheme's formulary. Generic substitution is desirable and encouraged, but the Medicines and Related Substances Act[33] expressly prohibits a pharmacist from substituting medicine with an equivalent which is more expensive than the one prescribed[34].

Corporate Ownership of Pharmacy

The introduction of lay ownership of pharmacies in 2003 was a move in which government envisaged to improve access of services in less developed areas. The change in legislation has had an unintended consequence, resulting in the complete opposite. The opening of ownership to lay persons resulted in the unacceptable corporatization of pharmacy with large corporate entities opening more dispensaries in well serviced urban areas which inevitably led to the closure of many independent community pharmacies, particularly in rural or less developed areas. Corporate pharmacy chains are currently devouring the market share of pharmacy with the opening of more and more dispensaries in already well serviced urban areas and shopping centres. Corporate pharmacy chains and courier pharmacies are able to accept ridiculously low dispensing fee rates from medical schemes which, in turn, ensures their appointment as DSPs and effectively excludes the independent pharmacies. Corporate involvement has turned Healthcare into a marketable product with patients being channelled to large single providers and being used as vehicle to generate profits in the lucrative front

[33] Act no 101 of 1965

[34] Section 22F(4)(b) - Generic substitution: *"A pharmacist shall not sell an interchangeable multi-source medicine if the retail price of the interchangeable multi-source medicine is higher than that of the prescribed medicine".*

shop area. The interests of the patient are being subjected to financial demands of market share and shareholder profits. Independent community pharmacies are forced to close businesses as they cannot compete against these market giants. Small patient-centric community pharmacies predominately situated in rural areas are forced to close their doors as their chronic patients disappear. As these pharmacies close, access to emergency and acute medicine disappears leading to an erosion of access to pharmaceutical care. This could not have been the intention of the legislature.

Courier Pharmacies

The professional role of the pharmacist in the healthcare system goes beyond the traditional role of a compounder and/or dispenser of pharmaceutical products and has moved to patient-centred care in which pharmacists are integrally involved in drug therapy management. This approach has been associated with improved health and economic outcomes, a reduction in medicine-related adverse events, improved quality of life, and reduced morbidity and mortality[35]. The South African Pharmacy Council's ("SAPC") Code of Conduct of 2008 require pharmacists to give advice on the correct and safe use of drugs; provide specialised assistance to their patients, such as those who are disabled, geriatric or illiterate[36]. The Code of Conduct was issued in terms of Section 35A(b)(i) of the Pharmacy Act[37], 53 of 1974. Pharmacists are increasingly responsible for patients under their care, managing the patient's drug therapy. The concept of pharmaceutical care stipulates that all practitioners should assume responsibility for the outcomes of drug therapy in their patients. Pharmacists located within communities serve this purpose as they are easily accessible, convenient and trusted by those they serve to provide advice on health and medicines. In the *New Clicks* case, former Constitutional Court Justice Sachs recognised the important and broad roles played by pharmacists:

[35] WHO & International Pharmaceutical Federation Handbook: Developing Pharmacy Practice – A Focus on Patient Care 2006 at page 12 available from www.fip.org.

[36] Board Notice 108 of 2008, Rules, Clause 1.1.3 of the Code of Conduct for Pharmacists and other Persons Registered in terms of the Pharmacy Act no 53 of 1974, as amended.

[37] Act 53 of 1974

"These men and women are by vocation dedicated people who express themselves through their work and are publically identified by the concern they show in their relationships with their customers. With their professional skill and human concern, they calm anxieties and turn their places of work into important ports of call for wide sectors of the community"[38].

In contrast to community pharmacies, postal or courier pharmacies do not provide the essential face-to-face interaction required to complete the third phase of the dispensing process which includes advice and counselling. Instead patients receive medicines by post or via a courier and need to contact the courier pharmacist by telephone or in writing to receive counselling. Those beneficiaries are completely excluded from the limited counselling on the effective use of medication that courier pharmacies do provide.

If a patient experiences difficulty with his or her prescriptions, he or she may not have the option of obtaining the professional advice of a pharmacist. Courier Pharmacies further do not comply with Good Pharmacy Practice Codes issued by SAPC. For example:

- The concern about the confidentiality of beneficiaries' health status is widespread. With the stigma associated with HIV, many patients prefer not to be seen by their neighbours, friends or colleagues to be receiving any chronic medication because they may be perceived to be receiving antiretrovirals, which may result in some form of stigma in the community.
- Chronic, acute and over-the-counter medicines should not be dispensed by different service providers since the quality of patient care is severely compromised as a complete patient profile and interactions between medicines is not available. In most cases, a courier pharmacy will be appointed by a medical scheme as the sole DSP for chronic medication to the patient. Courier pharmacy does not supply acute or emergency medication.

[38] *Minister of Health v New Clicks South Africa 2006 (2) SA 311 (CC)* at paragraph 658.

- The quality of care in these situations is severely compromised as a complete patient profile is not available and interactions between medicines which resulted in hospitalisation of the patient have been reported.
- Medicines delivered to patients via courier pharmacies are usually left at the beneficiary's nearest post office for pick up. Post offices do not comply with the applicable strict standards for the storage of medicines and are not set up to be storage facilities for medication. Temperatures are not controlled in post offices nor can a courier pharmacy guarantee that medicines are stored appropriately whilst they are at the post office. The courier pharmacy also has no way of verifying whether the medicines ever reach the patient.
- When beneficiaries are away from their designated address at the time they need their prescription filled, they are unable to source their prescription from elsewhere and some are forced to default from taking their medication if they are unable to pay out-of-pocket for the medication.

In addition to the patient's rights that are adversely affected by the use of a courier pharmacy to deliver medicine, as explained above, the appointment of courier pharmacies as a scheme's DSP further restricts competition. Courier pharmacies generally do not carry the same expenses that a fully operating pharmacy has and can therefore accept very low dispensing fee rates from medical schemes. Certain medical schemes choose courier pharmacies as their sole DSPs and force patients to obtain their medicines only from the courier pharmacy. Given the comprehensive pharmaceutical services offered by independent community pharmacies, the beneficiaries of courier pharmacies would benefit by having an option to obtain their medicines from an independent community pharmacy and must be given the opportunity and choice to do so.

MedSaver benefit - 25% cash-back on Medicines

The relationship between non-for profit medical schemes and for profit administrators or companies also causes distortions in competition amongst pharmacies. The unlawful collaboration between Clicks Retailers (Pty) Ltd, Discovery Health Medical Scheme and Discovery Vitality through the Medsaver 25% cash-back on medicines benefit is worth noting in this regard. Discovery Medical Scheme offers a so-called "Discovery Medsaver Benefit" to members that belong to their Discovery Vitality initiative. The Medsaver Benefit offers these members a 25% cash-back on over the counter (OTC) medicines which includes Schedule 1 and 2 medicines. The Medsaver Benefit was launched and made available to Discovery members since the 2012 benefit year. Incentive schemes on the sale of medicines are strictly prohibited in terms of the Medicines and Related Substances Act[39]. Advertising medicines in such a manner may further be interpreted as having as its aim the promotion of the misuse of medicines since medicines are being portrayed and promoted to the public as normal commodities of trade. Bulk purchases of Schedule 1 and 2 medicines are being promoted which medicines should, in the first place, only be recommended by a pharmacists on a "needs-be-basis" after pharmacist initiated therapy has been conducted.

Discovery Health Medical Scheme is also contravening Section 26(5) of the Medical Schemes Act[40] since it is directly or indirectly providing rebates to members by enticing them to purchase Schedule 1 and 2 medications from Clicks Pharmacies[41]. The 25% discount on Schedule 1 and 2 medicines further contravenes Section 22G(3)(a)[42] which states that the single exit price (SEP) shall be the only price at which manufacturers shall sell medicines and Scheduled substances to any person other than the State. According to Regulation 10(1) of the *Regulations relating to a transparent pricing system for medicines and schedules*

[39] Act No 101 of 1965. Section 18A states that no person shall supply any medicine according to a bonus system, rebate system or any other incentive scheme.
[40] Act no 131 of 1998.
[41] Section 26(5): "*Effect of registration — No payment in whatever form shall be made by a medical scheme directly or indirectly to any person as a dividend, rebate or bonus of any kind whatsoever".*
[42] Act no 131 of 1998.

substances[43] promulgated under the Medicines and Related Substances Act[44], the maximum dispensing fee that may be charged by a pharmacist, must be calculated as follows:

SEP of a medicine or scheduled substance	**Professional Fee (PF) or Dispensing Fee that may be charged**
Less than R81	R6.30 plus 46% of the SEP
Between R81 and R215.99	R16 plus 33% of the SEP
Between R216 and R755.99	R55 plus 15% of the SEP
More than R756	R131 plus 5% of SEP

Allowing a discount on the total selling price of these OTC medicines will inevitably "eat into" the legislated SEP at which these medicines must be sold. The total selling price of medicines includes the SEP and the professional fee or dispensing fee which pharmacists may charge. The agreed professional fee rate between Clicks and Discovery Health Medical Scheme during 2013, for most of the option plans available at DHMS, was 29.64% of the SEP capped at R29.64 (VAT inclusive). When the dispensing fee rate at which Clicks is remunerated is calculated, and the 25% discount is applied, it is evident that this practice is in contravention of the SEP rule. In order to illustrate our argument, we refer to the following example:-

> If the SEP of the medicine is R50, the dispensing fee or professional fee which Clicks may charge is R14.82 (inclusive of VAT) therefore the medicine is sold at a total price of R64.82. Should a 25% discount now be afforded (R16.21), the medicine will be sold at R48.61 which is below the required SEP at which the medicine must be sold according to legislation.

As with the registration of their own pharmaceutical manufacturer, Unicorn, Clicks is again engaging in an unlawful practice in order to gain a competitive advantage.

[43] GNR.1102 of 11 November 2005, Regulation 10 amended by GNR.714 on 26 September 2013.
[44] Act no 101 of 1965.

Collusion with Landlords

It is common for a landlord to prefer a corporate pharmacy chain as a tenant in its shopping centre. A Clicks Pharmacy, for example, receives preferential treatment by landlords not only in that they are offered rental at a rate far less per square metre than an independent community pharmacy, but lease agreements are abundantly one-sided in favour of a Clicks Pharmacy. Even possible future Clicks Pharmacies that might obtain a pharmacy licence to operate in the shopping centre of the landlord enjoys preferential treatment. One such a lease agreement contained the following clause:-

> *"The Lessor will have the right to terminate this Agreement on 60 (sixty) days' written notice to the Lessee in the event that the Clicks store situate in the……..Shopping Centre obtains the necessary license to conduct a pharmacy provided that the Lessee may elect to continue to occupy the premises in terms of this agreement save that the purpose as set out in item 17 will be amended with effect from date of the notice aforesaid, as the Lessee will not be entitled to conduct the business of a pharmacy from the premises"*[45].

Landlords are actively ousting independent community pharmacies to accommodate corporate pharmacy tenants.

Medilogistics

In Clause 39 of the Draft Statement of Issues, the Panel states that it seeks to understand how general practitioners (GPs) and specialists make decisions on directing patients through the healthcare pathway. One answer, is that GPs are enticed by courier pharmacies, such as Medilogistics, in collaboration with Medipost, to directly send their scripts to Medipost via fax[46]. Medipost will pay the doctor to provide the patient with the medicines. Medilogistics' Representatives recruit doctors on behalf of Medipost Pharmacy to channel prescriptions to

[45] Clause 4.11 – Lease Agreement between an independent community pharmacy and a landlord of a shopping centre. Attached hereto as *ANNEXURE F.*

[46] Attached hereto as *ANNEXURE G* is the Medilogistics Agreement.

the courier. The contract is between Medilogistics and the doctor. The scripts however, are faxed directly to Medipost who dispense them and then get Medilogistics to deliver the medication to the contracted doctor. He receives a fee for receiving the medication and then another fee when the patient collects the medication. The contract in no ways binds the doctor to the "dispensing process" and in fact encourages the use of a staff member whom they "train". GPs sending prescriptions to Medipost and then receiving the medicines for their own patients via Medilogistics, is an unlawful practice. The doctor must have a dispensing license to supply his patients with medicines. Even if the doctor has a dispensing licence in terms of Section 22C of the Medicines and Related Substances Act[47], he cannot direct the prescription to Medipost/Medilogistics for dispensing as this would be a violation of the conditions of his licence. This practice effectively removes the patient's choice to choose a service provider or pharmacy of choice and the patient is forced to obtain his medicines from the doctor's consultation room.

Payment of "Additional Fees"

The Panel requests the following information in Clause 43 of the Draft Statement of Issues:-

> *"The consumables market includes pharmaceutical products and other medical consumables. Pharmaceuticals form a considerable part of consumables and operate within a highly regulated market through the Single Exit Pricing (SEP) regime, and are affected by efforts to facilitate generic competition. The Pharmacy Council of South Africa oversees ethical conduct by pharmacists. The other noteworthy part of the consumables market includes the market for medical technology and devices. The Panel wishes to understand the impact of consumables on costs and competition in private healthcare".*

[47] Act 101 of 1965.

Although medicines are regulated via the SEP, there are still a number of methods used by pharmaceutical manufacturers to incentivise the use of their products, including the payment of "marketing fees", "data fees", "efficiency fees" and built in "logistics fees". These are all based on a percentage of the value of SEP products ordered. The larger the corporation and the value of the stock ordered, the bigger the disguised rebate. This allows the large corporations to sell medicines at prices just above SEP, sometimes even below SEP which is unlawful. MediRite is an example of a corporate pharmacy that sells medicines below SEP[48].

Most DSP arrangements are based on a particular list of NAPPI coded products that must be dispensed to a patient according to a medical aid scheme's terms and conditions. The DSP in return receives a fee in the form of various incentives, listed above, from the pharmaceutical companies. Many pharmacists, especially those working in corporate chains, are measured on performance based on the volume of items dispensed and the number of products from the listing. In many cases these incentives are used to make up the difference in the lower paid dispensing fee by the medical aid schemes.

[48] Attached hereto as *ANNEXURE H* is a MediRite advertisement.

Conclusion

It is almost impossible today for a pharmacist to become an entrepreneur within the independent community pharmacy sector as the costs of entry are too high and the profits are non-existent. The majority of graduates, predominately black pharmacy graduates, are being forced to work for corporate pharmacy chains. Entrepreneurship within pharmacy is suffocating as no young emerging pharmacist will be able to open a pharmacy. Pharmacists as healthcare entrepreneurs will cease to exist and will become employees of profit driven monopolistic corporate enterprises.

The abovementioned undesirable business practices are further not complementary to South Africa's proposed National Health Insurance (NHI) as it will inevitably affect the pharmaceutical delivery chain which will be of utmost importance for the implementation of NHI. Independent community pharmacy as a sector has an established presence in all provinces, and approximately 50% of ICPA's pharmacies are based in rural areas. Access to healthcare services in rural areas is one of the largest obstacles to equitable national healthcare delivery in South Africa and is one of the eight priorities identified as part of the framework for the human resources for health strategy. Independent community pharmacies offer healthcare professionals located in an extensive national network that covers all provinces and are easily accessible to the public due to their long operating hours, opening times over weekends, being available on call 24 hours a day and provision of services without appointments.

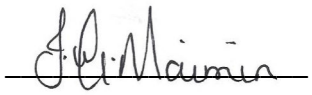
In South Africa's healthcare environment, which is faced with the burden of a dire shortage of healthcare professionals, independent community pharmacies represent a pool of resources available to enhance primary healthcare delivery across all provinces in the country. The increasing closure in independently owned independent community pharmacies further deters potential students of pharmacy from entering the profession for fear of being limited to employment within corporate structured pharmacies. As with other healthcare professionals in the country, international benchmarking shows that South Africa has considerably fewer pharmacists per 10 000 population than some other comparable middle income countries. With just 2.33 pharmacists per 10 000 population, South Africa has fewer

pharmacists per head of population than Brazil, Argentina or Costa Rica[49]. ICPA therefore implores the Panel authorised to conduct the inquiry into the Private Health Care Sector to include our submission in its investigations and to come to the aid of independent community pharmacy.

Should the Panel require any further detailed evidentiary material or arguments in this regard, ICPA will be more than happy to oblige. ICPA offers to work with and support the Panel in the near future should they wish to obtain a further in-depth understanding of our submissions.

Kind Regards

Independent Community Pharmacy Association



Jackie Maimin
CEO of ICPA

[49] Department of Health (2011). Human Resources for Health: HRH Strategy for the Health Sector: 2012/13 – 2016/17.