As we begin the new year, I am encouraged by the opportunities that are unfolding for our profession, while at the same time I’m acutely aware of the challenges that together we must overcome before the full extent of the new opportunities can be realised.

In the interest of servicing our patients and the people of our country with a quality pharmaceutical service, we must urgently focus our attention on the immediate removal of obstacles, while we continue to prepare for the broader scope of practice envisaged by the Pharmacy Council.

I believe that as medicine specialists in the healthcare team, we alone carry the burden of responsibility for identifying and rooting out the hidden agendas, the politics and misguided policies that prevent everyone from receiving the benefit of the quality pharmaceutical service for which we are trained and qualified to deliver.

As we navigate our path towards delivering an improved and more comprehensive quality pharmaceutical service in our country, it is inevitable that we will encounter some stormy weather through which we will have to pass in order to reach calm seas again. I want to address some of these challenges.

Medical schemes and designated service providers

It is my considered opinion that medical scheme contracts and designated service providers challenge the quality of service that we deliver daily in the lives of the people who we serve at community pharmacy level.

While these practices might appear to be financially beneficial to those who endorse or engage in them, at individual patient level, they deliver a clearly less than optimal health service. The complexity of modern medicines, combined with the well documented risks of concomitant complementary medicine usage, screams for the logical response. This is that relative safety can only be achieved when one medicine specialist, who is working with other health team members, has total oversight of a particular patient’s medicine and health profile.

The logical place for this to happen would be in the community, where the patient has unhindered access to a pharmacist who is known to him or her, and preferably, where a solid and personal relationship has been developed over a period of time.

Community pharmacists are receiving increasing requests to offer advice on medicine that they have not dispensed themselves. This is an unacceptable situation. It places the pharmacist, who has earned the trust of the patient over a long period, in an invidious position, while the patient is precluded from selecting their trusted pharmacist without incurring a penalty which is determined and imposed by the medical aid.

In my opinion, the challenge lies in persuading the funders and the Council for Medical Schemes to recognise the value of strengthening the patient’s relationship with their chosen pharmacist, and to have all medicines managed from this point of service.

In this way, there will be a complete record of the patient’s medicine use which will allow the pharmacist to utilise his knowledge and skill to provide pharmaceutical care and add value to the health of the patient on an individual basis, and by extension, to the health of the nation and all its people.

The challenge is to procure a situation in which the medical scheme rules are changed in order for the patient to have the freedom to choose his or her service provider, as is his or her constitutional right. Seen together with the Pharmacy Council plans and programme developments for pharmacy, this will create a real opportunity for pharmacists to add value to the patient’s health. Obviously, it will also result in the healthcare cost savings that will logically flow from improved health outcomes.

Dispensing fee

Another urgent challenge that needs to be overcome is the fair remuneration of pharmacists for the value that they add to the healthcare system. Urgent corrective action needs to be taken, so as not to capsize the healthcare boat in South Africa.

In determining the dispensing fee, the pricing committee is also required, as a component of the deliberations, to consider access to community pharmacies. The question must be asked, does the Department of Health consider the footprint of retail pharmacies to be of any value?

In deciding upon an appropriate dispensing fee, it is inappropriate to simply drive down the cost of medicine to the lowest possible level, without ensuring that pharmacy remains viable. The single exit price (SEP) should be separated from the professional fee of a pharmacist because the responsibility to dispense a medicine remains the same, irrespective of the SEP of that drug.

The system for settling on a fee is discriminatory towards community pharmacy, besides being an exercise in futility, since in any event most payers reimburse pharmacies below the gazetted fee.
Dispensing is only a small component of the cost of the medicine. The data collection tool that is required by the pricing committee is impossible to complete. Pharmacists do not have the resources to complete these forms. Even auditors were unable to do so in the required format. The result is that the dispensing fee has not been adjusted since 2009.

The fee needs urgent review in a way that will ensure that the process is more simple and sustainable in the future.

**Licensing of pharmacies**

The Director General of Health is required to consider access to pharmacies when issuing licenses. The current footprint of pharmacies should be considered before the issuing of new licenses. It appears that in some cases, this is being overlooked.

The recording of pharmacies in the SAPC register is not accurate and contains numerous misleading numbers with regard to determination of the footprint in South Africa. Pharmacies have closed and others have never opened, and yet they still remain on the register. This prevents the presentation of accurate information that is required for decision-making. The Department of Health has caused confusion by removing the final authority with which to manage this important duty from the statutory body.

**National Health Insurance**

Many pharmacists feel that the Department of Health has not clearly stated its vision of the role to be played by community pharmacy in the delivery of pharmaceutical services, particularly with respect to the proposed introduction of National Health Insurance (NHI). It is felt that the Department of Health does not envisage any long-term role for community pharmacy. If this is the reality, we would appreciate being told so that we can prepare ourselves for alternative business models, or to salvage as much of our investment as possible before everything is lost.

While the relationship remains cordial, there are no demonstrable acts and signs that encourage pharmacists to believe that they can partner with the Department of Health as an active participant in charting the future together. A published, implementable common plan and a joint vision are needed, so that everyone will have a clear vision and direction of where we are going.

Considering that the NHI is on our doorstep, numerous uncertainties and unclear issues exist. The big question is: how will the pharmacist fit into a model that at this stage only mentions and makes provision for doctors and nurses? As I understand it, the model should be primary healthcare-driven to be cost-effective and supply health care to the broader nation, not only in the big centres or rural areas, but to all 49 million South Africans.

**The professional future of pharmacy**

The SAPC is moving towards an increased scope of practice, higher standards of compliance and continuing professional development in pharmacy. This results in increased involvement and commitment, as well as added exposure to risk. On the other hand, the state is simultaneously permitting the playing field to be eroded to the point that it is difficult for community pharmacy to survive. There is little or no evidence that the state is taking any action to ensure the future viability of retail pharmacy.

**The way forward**

I see the way forward as follows. Leaders in pharmacy must continue to meet with the officials of government, the Department of Health and other role players on a national and regional level, to agree to certain parameters and objectives to develop a joint vision for health care and pharmacy in South Africa.

A universal healthcare system is built on a primary healthcare basis, with a secondary and tertiary referral network. A public-private partnership is of utmost importance in order to provide an implementable, affordable and efficient service with real commitment from all stakeholders.

In the Western Cape, an opportunity was created to engage with the provincial government and Minister Theuns Botha to discuss and improve health care in the province. We need to explore and achieve this level of co-operation in the remainder of the country, in order to better service our people.

During November, there was a free diabetes screening campaign, organised by the Independent Community Pharmacy Association and endorsed by the Department of Health. This proved to be an example of the value that community pharmacy is capable of contributing to the delivery of health care. This campaign demonstrated the willingness of community pharmacists to provide an effective service to make a difference in their communities. Four to six million people in South Africa have diabetes, and 80% do not know that they have the condition. Early detection and appropriate ongoing care and management have saved healthcare costs and lives, as well as contributing to a healthier South Africa.

It cannot be done without you, the pharmacist.