Improving accessibility to medicine: the “missing link”

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Recent initiatives by the National Department of Health to provide an alternative chronic medicine access programme to public sector patients strengthened the belief that the preferred direction by government for improving accessibility to medicine for public sector patients was through centralised dispensing.

The initiatives referred to were the invitation to bid, firstly for the dispensation of prescriptions for patients receiving antiretroviral treatment and certain chronic conditions, and secondly, for the distribution of already dispensed patient medicine parcels to pickup points, but restricted to facilities in the National Health Insurance (NHI) pilot districts (Tender HSP01-2013). These initiatives were followed-up by an invitation to members of civil society to attend a meeting on 14 April 2014, to inform civil society stakeholders of the benefits and operational aspects relating to the “Central Chronic Medicine Dispensing and Distribution Programme (CCMDD); request support from (members of) civil society for social mobilisation of healthcare professionals, patients and communities; and the recruitment of eligible patients for programme participation”.

The above initiatives should be read together with the statements by representatives of the National Department of Health at the National Pharmacy Conference held at Sun City in June 2013. These statements referred to the way forward as ensuring accessibility to medicine by the majority of the people of South Africa against the background of NHI. In terms of these statements, the role of community pharmacies in supporting accessibility to medicine by people who do not belong to a medical scheme, or who mostly make use of public sector facilities, or exercising patient preference.

What could be discussed in greater detail is that if such statements are valid and reasonable, and take into consideration the perceived direction that the National Department of Health is following to improve accessibility through its CCMDD programme, contemplation must be given to what could be the “missing link” with respect to the increased utilisation of community pharmacies in order to improve accessibility to medicine (pharmaceutical care) by public sector patients, in particular. There could be many “missing links”, but one which is analysed further in this article is the issue of the availability of pharmaceutical services in the geographical areas where the majority of patients are situated, and who either do not belong to a medical scheme and/or are currently utilising public sector facilities, or exercising patient preference.

In the introduction to Tender HSP01-2013 referred to previously, the National Department of Health made the following (well known) statements:

- “The changing epidemiological profile of South Africa has led to an over extension of public sector facilities. This has placed enormous strain on available resources, and has contributed to medicine shortages and declining quality care”
- “The patient experience is one of long waiting times … to collect medicines that were not available during a routine visit. This poses potential adherence barriers which may lead to poor outcomes, and places strain on the patient in terms of transport costs and loss of income”.

In addressing the above shortcomings (lack of service delivery), it seems that the preferred option is to appoint service providers to “centrally dispense medicine and distribute them to designated pickup points”. However, these pharmacies, and with reference to Tender HSP01-2013, as awarded, must be “suitably licensed to provide a chronic medicines dispensing service” and have at least five years’ experience in the central dispensation and distribution of medicines, or deal with the dispensation and distribution in a final dispensed format of high volumes of prescriptions from a single site. These and other requirements practically exclude any independent pharmacy from partaking in the CCMDD programme of the National Department of Health as far as dispensation and distribution to designated pickup points is concerned. This is further illustrated by the following pricing (professional fee), as accepted by the National Department of Health for Tender HSP01-2013, to provide alternative chronic medication access programme services for public sector patients, starting on 1 February 2014, for
up to three years (pricing based on, among other factors, average items per script, economies of scale, the available infrastructure and the demands of distribution to the relevant NHI pilot districts, excluding stock (Table I)).

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<tr>
<th>Province</th>
<th>Price per script (VAT inclusive)</th>
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<tbody>
<tr>
<td>Limpopo</td>
<td>R16.23</td>
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<tr>
<td>North West</td>
<td>R16.23</td>
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<tr>
<td>Gauteng</td>
<td>R19.95</td>
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<tr>
<td>Eastern Cape</td>
<td>R21.09</td>
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<tr>
<td>KwaZulu-Natal</td>
<td>R22.12</td>
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<tr>
<td>Western Cape</td>
<td>Not included in the tender</td>
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Source: www.health.gov.za/tenders

The only remaining opportunity for community pharmacies in general (excluding the selected few currently involved in high-volume dispensing) to partake in the CCMDD programme of the National Department of Health is to offer prescription pickup or collection points for designated patients to collect their already dispensed medicine parcels.

In terms of Tender HSP01-2013, as awarded, pickup points would be prequalified, based on the following criteria:

• “Fees are within an agreed tariff structure
• Geographical accessibility of the pickup points
• Operates at least six days a week
• Ability to verify patient identity before collection, or the identity of the person delegated to collect the medication
• The availability of appropriately skilled persons to issue packages, and maintain the necessary patient records of patients who have collected their medication”.

The functions at the pickup point would include, among others:

• Receiving patient packs with medicine in a dispensed format, ready to be handed over to patients and to take them into inventory
• Storing patient packs in a location that is secure and temperature controlled, and which complies with the relevant legislation
• Maintaining an accurate register of patient visits
• On collection of the patient pack, opening the patient pack and reviewing it against a copy of the included prescription, and preferably providing relevant medication counselling.

A professional fee of R7.98 (VAT inclusive) was accepted by the National Department of Health for Tender HSP01-2013 to provide the above services (pickup points) as part of an alternative chronic medication access programme service for public sector patients. It is questionable whether or not the relevant group of pharmacies is geographically distributed well enough, if at all, within the relevant NHI pilot districts, in order to comply with public sector patient preference for the collection of their patient packs.

Other facilities (or the “missing link”)

It should be clear by now that the “missing link” previously referred to is the geographical footprint of community pharmacies for the purposes of partaking in any CCMDD programme of the National Department of Health or the provinces, and how to resolve or improve such a footprint.

The question still remains (even if community pharmacies, and independent community pharmacies, in particular, are willing and able to partake in any CCMDD programme that would improve accessibility to medicine), as to how would it be economically viable to offer any services to the National Department of Health or any of the provinces who wish to implement such a programme.

The solution may be found in the so-called “missing link” referred to previously, subject to such conditions, as may be determined by the South African Pharmacy Council (SAPC).

The definition of “pharmacy”, as prescribed in the Pharmacy Act 54/1974, refers to “any place wherein or from which any service specially pertaining to the scope of practice of a pharmacist is provided”. It would be safe to say that the intention of the legislature at the time was that the provision of services “specially pertaining to the scope of practice of a pharmacist” should not necessarily be confined to the four walls of what is traditionally known as a “pharmacy”. Such services could also be provided from an existing pharmacy, and also presumably from “another facility”.

It is also interesting to note that the legislature in 2000 (and because reference is made to regulations, it would be the Minister of Health) most probably already contained the vision or intention of providing for “other facilities” whereby pharmacists could provide their services, other than in a traditional pharmacy, and thereby offering opportunities to community pharmacies, in particular, to expand their service delivery beyond the four walls of their pharmacies.

In this regard, Regulation 12 of the Regulations relating to the practice of pharmacy (“the Practice Regulations”) provides that a pharmacist’s assistant (post-basic, i.e. pharmacy technician) may perform most of the acts, or provide most of the services, as prescribed, in his or her scope of practice under the indirect supervision of a pharmacist under certain circumstances, four of which are:

• The services are provided or acts are performed at a primary healthcare clinic which has been defined as a place “that is owned or controlled by an organ of state”; or
• Any other facility, as approved by the SAPC. “Other facility” has not been defined. Therefore, it falls within or subject to the discretion of the SAPC. This is also enabling as the SAPC could support the expansion of service delivery by community pharmacies via “other facilities” as it may deem fit, and

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Protocols and standard operating procedures are available “describing clearly the responsibility of the pharmacist’s assistant (post-basic, i.e. pharmacy technician) and pharmacist under whose indirect personal supervision the pharmacist’s assistant (post-basic, i.e. pharmacy technician) performs the acts or provides the services”, and

- Only repackaged medicines or patient-ready packs are provided.

Patient-ready packs have not, as far as can be determined (not to be confused with the repacking or pre-packaging of medicines as defined by the Medicines Act), been properly defined therein, and could thus also be interpreted as meaning “pre-dispensed patient medicine parcels” or any other definition that the SAPC deems to be necessary for the purposes of the expansion of services by community pharmacies under the indirect supervision of a pharmacist.

Furthermore, the SAPC has already provided for an “application for the recording of a primary healthcare clinic or facility approved by SAPC, it’s supervising pharmacist and pharmacist’s assistant (post-basic) in terms of the Pharmacy Act 54 of 1974, as amended”, including a recording fee. Whether or not the SAPC has recognised the opportunities for the expansion of community pharmacy services through “other facilities”, or if it merely prefers to apply a narrow vision and interpret “other facilities” to mean those in the public sector only, is not known.

It might also mean that no community pharmacy has “tested the waters” to date, and applied for the recording of an “other facility” to expand services, or improve its geographical footprint, to areas or patients who have been deprived of pharmaceutical services and the treatment of self-limited medical conditions to date.

Would it be economically viable to establish such an “other facility” to be able to partake in the CCMDD of the National Department of Health?

The response to such a question would most probably be determined by, among others:

- The number of patient-ready packs that the “other facility” would receive per day to issue to patients
- What additional (remunerated) services could be provided from such “other facility”, and in particular, in cooperation with a registered nurse.

If the intention is to offer a service as a pickup point only, it would most probably not be economically viable. However, “other facilities” provide an opportunity for accessibility to medicine to be improved, particularly if also utilised for adding screening or wellness services, for example. (Refer to the agreement between the Department of Health and community pharmacies in the Western Cape, whereby certain medication for preventative care are provided free of charge).

The wider scope of practice foreseen for pharmacy technicians would assist further in supporting the establishment of “other facilities” to improve community pharmacy’s geographical footprint.

**Conclusion**

The geographical footprint of community pharmacies (the “missing link”) in areas where patients utilise mostly public sector facilities, is unsatisfactory in addressing the “long waiting queues at facility level and improving (public sector) patient care”. The policy which facilitates expansion of the ownership of pharmacies in order to improve accessibility to medicine (pharmaceutical services) in previously underserviced areas has also failed miserably, and has most probably only supported the cannibalisation of existing community pharmacies.

One opportunity (and it must be emphasised that this is one of many available opportunities), that could be exploited in order to explore “other facilities” as the missing link, or to improve geographical footprint, would be to assist government to achieve its objective by “providing an alternative chronic medicine access programme for public sector patients”.

Furthermore, the time to implement “other facilities” as an opportunity to improve accessibility to medicine is right now. The Practice Regulations must be amended to allow for, among others, a new scope of practice for the new cadres of pharmacy support personnel, e.g. pharmacy technical assistants and pharmacy technicians. The amendment of either Regulation 12 of the Practice Regulations, or the inclusion of a similar regulation as part of the new scope of practice of pharmacy technicians, would enable community pharmacists to legally expand their services, e.g. improve their geographical footprint in a cost-effective manner, without having to sell, purchase or relocate any existing pharmacy. However, such a bold step would require some visionary action, firstly by the SAPC, by enabling community pharmacy to improve accessibility to medicine, and secondly, by community pharmacists, through realising that they can provide an affordable pharmaceutical service outside the four walls of their pharmacies.