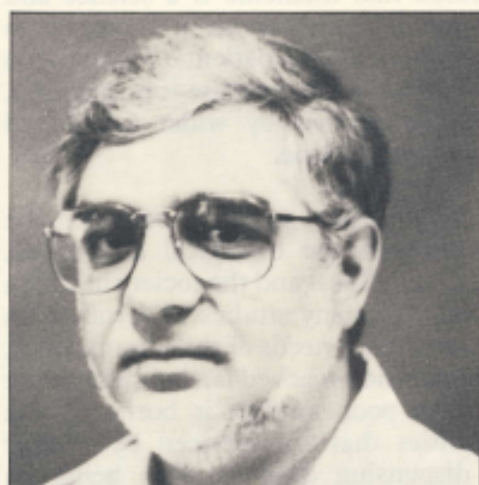


# Update on Dispensing

## Part III: Dispensing and Patient Care

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### Curriculum vitae

Dr Cassimjee has been in active family practice for the last 18 years. He has been part time Senior Lecturer in Family Medicine at the University of Natal since 1988. Presently he is working toward an Honours degree in medical science in Pharmacology at the University of Durban, Westville. As an executive member of the Natal Inland Branch of the Academy of Family Practice/Primary Care he is convenor of the committee for continuing medical education. His personal interests are in the economics of general practice and the legal issues relating to dispensing by doctors in South Africa.

**H**ealth is a universally accepted human right (the first article in the Charter of the World Health Organisation) and therefore the means for achieving it should be guaranteed by every civilized state to all citizens.

Health, accordingly, is fundamental to life and cannot be treated as a commodity; it should be free of market forces so that need, rather than the ability to pay, determines access to health care.

The deteriorating socio-economic conditions of the majority of people characterized by high rates

### Summary

*The dilemmas and implications of dispensing in the South African situation is evaluated. The vital role the dispensing doctor is playing, is highlighted against the backdrop of certain aspects like maldistribution of health services, cost of medicines, doctor-pharmacist ratios, medical aid societies, sick benefit societies, urban-rural proportions and doctor-patient relationship.*

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**KEYWORDS:** Pharmacists; Physicians, family; Dispensing fees; Physician-patient Relations; Patient Compliance

of unemployment, and a soaring cost of living, makes it imperative that at a minimum, health services are available to all. *The infant mortality rates, the average monthly earnings and the household incomes* of the different race groups clearly demonstrate the dilemma.

The tables listed below (Race Relation Survey 1984) clearly demonstrate the pathetic state of the majority of the people:

**Table 1 — Official Infant Mortality Rates (per 1 000)**

According to Racial Groups in South Africa			
	1981	1982	1985
African	80	80	80
Coloured	59,2	59,2	90,7
Indian	18,8	20,7	16,1
White	13,3	13,4	9,3

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Table 2 — Average monthly earnings of workers in all sectors of the economy (excluding agriculture and domestic service)

According to Racial Groups in South Africa				
	African	Asian	Coloured	White
1979	R156	R278	R210	R 665
1981	R228	R412	R309	R 936
1983	R310	R584	R417	R1 210
1985	R423	R765	R552	R1 531
1986	R500	R912	R634	R1 732

Table 3 — Household incomes for the different race groups

According to Race Groups in South Africa				
	African	Asian	Coloured	White
1980	R136	R 505	R344	R 912
1982	R204	R 819	R548	R1 380
1984	R273	R1 072	R624	R1 834

The ideal differs greatly from the reality and the position is further complicated by the dual system of health care delivery in South Africa:-

1. Fee for service for the "haves"
2. Government sponsored systems for the "have-nots"

However, the "have-nots" who make up the bulk of the population, comprising mainly of Africans, are also compelled to seek fee for service health care. This quite often results from disorganization, inadequate facilities and unsatisfactory treatment meted out to them at Government institutions. The imbalance in the health budget clearly reflects this. The budget gave 20% of allocated money to 80% of the population who were black, while the white population, which consists of 20% of the population received 80% of available resources.

Historically, the legislations dealing with health care in South Africa has ignored the needs of the majority of the population comprising Africans, Indians and Coloureds. The legislators, the main body of our profession and the medical education system, also appear to have a tunnel-vision-approach in making assumptions about medicine and health.

As these assumptions appear to me, they are quite problematic in that:-

1. It is assumed that the determinants of health and illness are predominantly biological so that patterns of morbidity and mortality have little to do with the social and economic environment in which they occur.
2. It is assumed that medicine is a science and that it is possible to separate a doctor from his subject matter (the patient). Hence it is assumed that medicine, because it is scientific, should not be tainted by wider social and economic considerations.

There is a very serious need to consider the relationship between the biological and social, between health and illness and the society in which it occurs. From the many studies undertaken on the social and economic needs of the communities, the obvious conclusion reached is, that the burden of ill health and poor services is borne by the very communities that are serviced by a large number of dispensing doctors. This being an important determinant, leaves little or no alternative for the vast majority of general practitioners but to dispense medicines.

In order to appreciate the perspectives and the convictions of dispensing doctors, it is important to take a close look at the dispensing doctor and his problems and the categories of patients he services.

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*Need, not the ability to pay, should determine access to health care*

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### The Dispensing Doctor and his Patient

South Africa has a unique situation whereby a first world and a third world live side by side with one another, in terms of their own 'group areas'.

Dispensing medical practitioners in urban areas not only service urban patients of all races, but are also consulted on a fee-for-service basis by a large number of patients from the peri-urban and rural areas, who make tremendous sacrifices in terms of time and cost and distance to seek medical assistance. Health, being a priority issue to them, takes precedence over any inferior service, no matter how accessible it may be.

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These are the communities who, despite having to suffer unemployment and economic deprivation, value the continuing care and the continuity of care, so essentially vital and fundamental to primary health care. After a consultation most of the patients require medication. The prescribing of medication in most instances symbolizes that a firm diagnosis has been made by the doctor. The medication can be given by a doctor in the form of a script and it is then the patient's responsibility to get the medicine.

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### *The burden of ill-health and poor services is borne by communities served by dispensing doctors*

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However, since time immemorial, medical practice has been historically and traditionally marked by a few basic identifying facts: the inherent right of the general practitioner to physically examine his patient and to dispense medicine to him and the choice accorded to his patient to receive such medication from him, or by means of a prescription, from a chemist. In fact, it is part of the whole therapeutic process towards care and well-being of the patient.

In the South African context dispensing doctors cater for patients falling into three categories. They are:-

1. the patient belonging to one of the many registered and non-registered medical aid societies;
2. the private or fee paying patient, and
3. the sick benefit fund patient.

#### **1. Medical Aid Patients**

Here the patient is a member of one of about 250 Medical Aids. About 225 are registered in terms of Medical Schemes Act and 25 are not registered. Approximately 80% of the white population is covered by medical aid schemes. Only 4% of blacks belong to Medical Aid schemes. (Hansard 28 March 1984; 9 col. 3932). Many Medical Aids have limitations or built-in disincentives.

Medical schemes in this country provide for the needs of a select sector of our society. In the first instance, they are all linked to employment one

way or another. In other words, the economic system has an interest in maintaining the health of its workers and their immediate families (particularly the higher paid employees).

Secondly, if one examines the racial and economic distribution of the membership of these schemes, one sees that it is the group which enjoys political rights that is being catered for.

On the other hand, if one examines the majority of the population who are in the greatest 'need' as measured by statistics of mortality and morbidity (Botha in Dorington 1985), one notices that the bulk of them are neither economically active nor have any political rights. Hence, there seems little chance in the future of their health care needs being provided for by this system.

Table 4 below indicates the number of people covered by various medical schemes (Report by the Registrar of Medical schemes for the year ended 31/12/1983).

Tables 5 and 6 analyse the membership of Industrial Council Medical Schemes (Dous Dekker in Dorington 1985) and compare Exempted Schemes in 1982 with the number of workers covered by Industrial Council (Budlender in Dorington 1985).

These tables show that little has changed over the last 11 years.

Tables 4-6 indicate that 78% of the Whites are covered by registered medical aid schemes whereas only 42% of the other race groups are covered by medical aid schemes. By 1985 in white designated South Africa, 72% of whites belongs to these schemes and 8% of blacks.

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### *Medical schemes cover the rich, urban, employed South African*

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Further, when one examines the contribution rates of medical aid schemes, one notices that, although the monthly contributors are graded by income, the lower income members pay proportionately more. In addition, if one takes into account the tax abatement that can be claimed, the high income earner ends up paying less for health care than the low income earner. The figures indicate that only 36% of all workers who could be covered, are covered, (compared

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Table 4 — Medical Scheme Membership Statistics : 1982

According to Racial Groups in South Africa					
<i>Medical Aid Schemes</i>	<i>Whites</i>	<i>Coloureds</i>	<i>Indians</i>	<i>Africans</i>	<i>Total</i>
Members	1 034 405	90 669	35 415	50 893	1 211 38
Dependants	1 690 558	186 825	93 662	131 608	2 101 653
Total	2 724 963	277 494	129 077	182 501	3 313 035
<i>Medical Benefit Schemes</i>					
Members	122 257	30 833	3 819	64 689	221 598
Dependants	230 160	42 944	4 647	69 649	347 400
Total	352 417	73 777	8 466	134 338	568 998
<i>Exempted Schemes</i>					
Members	150 557	160 256	54 811	95 795	461 419
Dependants	245 805	161 306	37 040	72 264	505 415
Total	396 362	321 562	91 851	168 059	966 834
<i>Grand Total Covered by Various Schemes</i>	3 473 742	672 833	229 394	484 898	4 860 867
<i>Population ('000) (est)</i>	4 688	2 729	854	21 890	30 161
<i>% of Population Covered by Schemes</i>	75%	25%	27%	2%	16%

Table 5 — Membership of Industrial Council Medical Schemes (ICS) (1971)

According to Racial Groups in South Africa					
	<i>Whites</i>	<i>Coloureds</i>	<i>Indians</i>	<i>Africans</i>	<i>Total</i>
No of workers covered by all ICS (1971)	218 686	192 915	61 386	537 475	1 010 562
No of workers covered by medical aid schemes	145 865	40 593	7 017	549	194 024
No of workers covered by medical benefit schemes	10 629	76 316	31 127	40 468	158 540
% of all workers covered by schemes	72%	61%	62%	8%	35%

Table 6 — Approximate Membership of Industrial Council Schemes (ICS) (1982)

According to Racial Groups in South Africa					
	<i>Whites</i>	<i>Coloured</i>	<i>Indians</i>	<i>Africans</i>	<i>Total</i>
No of workers covered by all ICS (1982)	207 357	281 561	65 959	715 345	1 267 222
No of workers covered by exempted schemes	146 028	159 480	54 782	95 573	455 863
% of all workers covered by schemes	70%	57%	83%	13%	36%

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with 35% in 1971). Although the percentage of Africans covered has improved, only 13% of eligible workers are covered.

From the above comparisons it can be clearly seen that medical schemes cover the rich, urban, employed (usually the white people) and fail to cover the poor, rural or unemployed (usually the black people). It is tragic that both the State and the Medical Schemes, base health care needs on two assumptions:

1. That Health Care Services can be treated as commodities, to be bought and sold in the free market.
2. That through this operation of medical schemes in the free market, health care needs will be most efficiently met.

The Minister of Health and Welfare, on introducing the second reading of the recent Medical Schemes Amendment Bill, stated that in his opinion "the market mechanism will compel the respective parties to act in a realistic way" and that "we all have to guard against being compelled to move away from the free market system."

### **2. The Private or Free-Paying Patient**

These are patients who have no form of medical insurance. They include the whole spectrum of the population from the senior executive, self employed on one end, to the skilled and unskilled employee, the unemployed and the pensioner at the other end.

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*Sadly, health care services are treated as commodities to be bought and sold*

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Because of the socio-economic circumstances, the vast majority of fee paying patients are low income patients, not belonging to either a benefit or a medical aid society, and include the unemployed, the pensioners as well as the self-employed and the skilled and unskilled employee. They are only able to afford primary health care provided by the dispensing doctor, because of the all inclusive lower charges of the dispensing doctor.

Here the doctor charges a fee between R18,00 and R20,00 for consultation plus medication. The

medical aid scale of benefit is presently R17,60 for consultation only.

The recommended tariff of Medical Association of South Africa for a consultation alone is between R33,00 to R39,60.

The doctor cannot divorce himself from the social reality of the communities he services, and for the same reason a doctor chooses to serve on panels of benefit societies, he has to accept the reality and reduce his fee which is an all inclusive one. This reduced fee basically also subsidises the cost of medicine dispensed to private patients.

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*--- it would be catastrophic to thousands, if doctors should stop dispensing*

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### **3. Sick Benefit Funds**

They are registered in terms of the Industrial Conciliation Act. Medical Benefit Funds have a contract with a panel of doctors. These doctors get paid by the Scheme for looking after members when sick. Benefit Funds are the only schemes, which workers with low wages can afford.

Benefit Funds are exempted from certain provisions of the Medical Schemes Act, enabling them to fix a fee with their panel doctors. This fee is far lower than the suggested consultation fee accepted by the Medical Aid Societies. The position of the Medical Association of South Africa has been that these fees have been unrealistically low. Notwithstanding this, many doctors in our communities have chosen to serve on these panels in order to make health care available to low-income communities. These doctors, serving on panels are *contractually bound* to dispense medicines to 'panel patients'.

In Cape Town two of the larger benefit funds are:

1. Cape Town Municipal Worker Medical Benefit Fund.
2. Cape Clothing Sick Fund.

Together these funds make health care available to about a quarter million people in the Peninsula.

These funds basically offer a consultation and

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medication service by the doctor appointed on the "panel". A lesser fee is fixed for the doctor — anything between R3,00 and R5,00 per consultation. Medicines are charged for to the Sick Fund at a much lower price than Mims. Some Sick Funds have a ceiling of R5,00 for the total medicines supplied.

In Pietermaritzburg, the National Union of Leather Workers is the single largest Sick Benefit Fund, catering for 5008 workers. At the first consultation the member pays R1,00 and the Sick Benefit Fund pays R16,60 for a consultation plus medicines supplied. For repeat consultation the Sick Benefit Fund pays R8,30 inclusive of medicines supplied.

Benefit Funds are unable to function without the low tariffs charged by panel doctors. Since Benefit Fund patients constitute a large section of dispensing practice, it is clear that it would be catastrophic to thousands of people in South Africa if doctors stopped dispensing.

Unfortunately dispensing has been seen in the context of the Medical Aid situation, and the other two aspects, ie the Benefit Fund and the low income private patient, are completely ignored in the debate that rages. Even when medicines are dispensed to Medical Aids, the doctor charges a Mims price which is fully acceptable to the Medical Aid Society and Medical Association of South Africa. John Ernstzen of RAMS has clearly stated that the cost of medicines to medical aid is less when supplied by dispensing doctors.

The dispensing doctor does not charge:

1. Dispensing fee
2. A 'broken batch' or 'open stock' fee
3. 'Added water' fee
4. 'Cost of Container' fee
5. 'Photocopy of Script' fee
6. 'After Hours' fee
7. GST.



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The above exclusions are surely important considerations in keeping the cost of medicines down in South Africa. In fact, many Medical Aids prefer that the doctor dispenses, as they save on these charges.

### Other Advantages of Dispensing to Patients

1. More complete service allowing for a much better and more cordial *Doctor/Patient Relationship* — an important factor in the quality of health care provided and received.

2. *Patient Compliance* — therapy is undoubtedly better when the medicines are given by the doctor personally. The doctor has a better chance to motivate the need for, and the specific indication of individual medicines.

3. *Cost awareness of medication*

The dispensing doctor is cost conscious as he has to buy quality medicines at keen prices. A survey by Consolidated Employers Medical

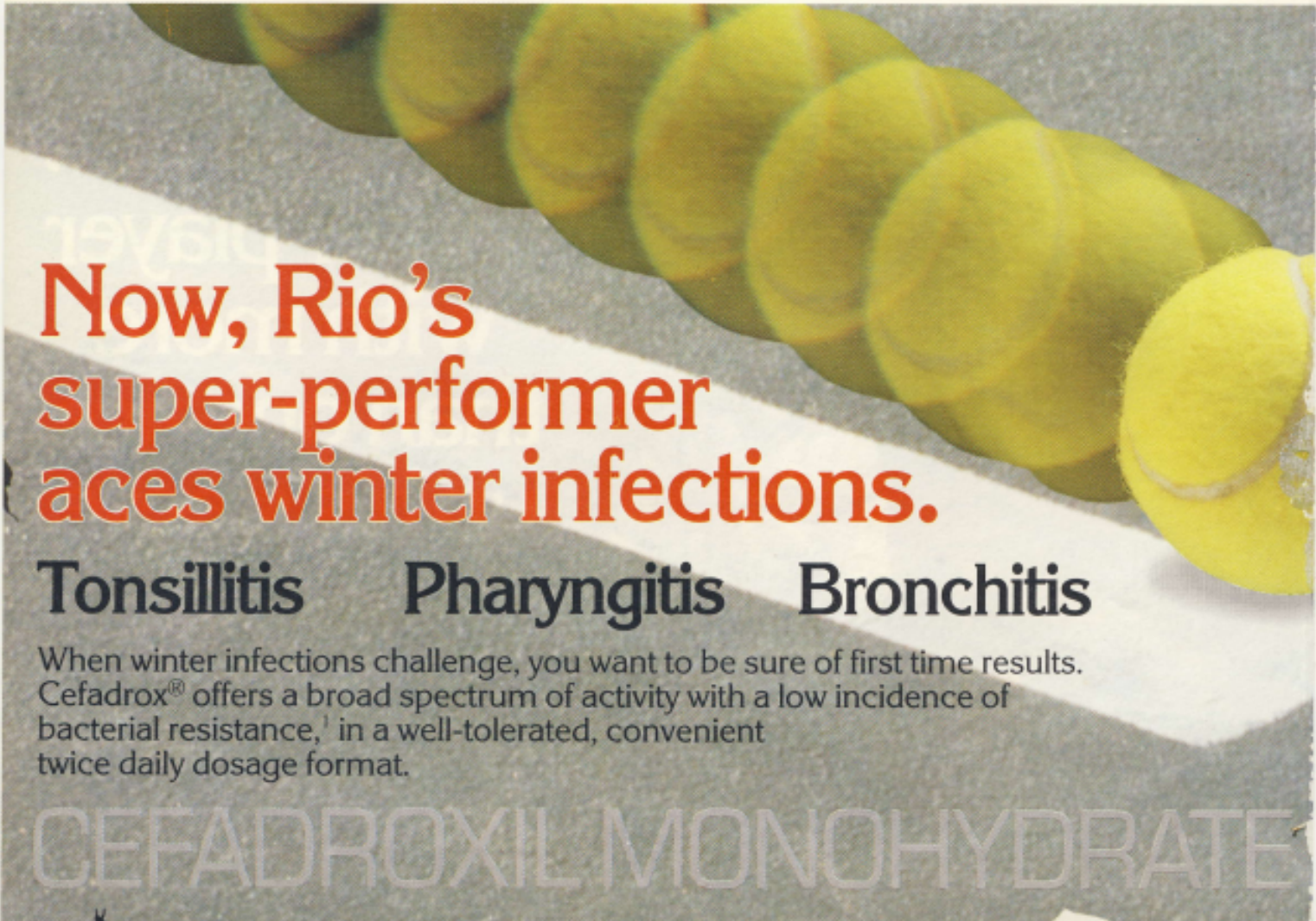
Aid Society in 1982 showed an appreciably lower average cost per script when dispensing doctors were compared to non-dispensing doctors. A Cape Medical Plan survey also showed that dispensing doctors give less medicines per average script. For the patient it is decidedly cheaper.

4. *Drug Side-Effects* — can also be better anticipated and more pertinently assessed when drugs have been given by the doctor himself. The dispensing doctor will also tend to have an increased awareness of *drug interactions* when he physically handles them together.

5. *No additional Fees* — are incurred when drugs are prescribed by a dispensing doctor.

6. Medicine is available to patients *at all* hours, at a moment's notice.

7. Patients know what they are *getting in value* for the amount they pay.



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8. *Patient Convenience* — in that it is a *one stop* visit and hence they save time.
9. Patients do not have to pay *immediately*. This is of particular importance to the medical aid patient.

### The Dilemmas and Implications of Dispensing

These are largely:

- (a) Legal
- (b) Ethical
- (c) Economic
- (d) Time Factor.

The legal and ethical constraints have already been alluded to in Part 2.

#### **Economic**

##### (a) *Capital Outlay*

Doctors acquire medicines on cheque with

order on 30 day payment basis. Some drug firms slap on monthly interest if the account is not paid by the 25th. It is a known fact, that Medical Schemes Act allows medical aids to take anything from 90 to 120 days to pay accounts. In terms of the long recovery period, this represents a financial loss to the dispensing doctor. Some medical aids send the medicine cheque to the patient. This cheque very seldom reaches the doctor.

##### (b) *Storage*

Storage space presents a significant cost factor to the average dispensing practice.

##### (c) *Administration*

Drug accounts often call for extra staff and time. Medical Aids that are administered by Davidson and Ewing and the Medscheme Group require that their patient signs the script as soon as it is dispensed. The account plus copies of the script must be sent to the



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patient for re-signing and submission to the Medical Aid. This performance has to be repeated each month. This cumbersome procedure is an additional burden and an administrative nightmare.

(d) *Packaging*

Costs have been rising steadily over the years.

(e) *Direct Losses*

Expiry of drugs and breakages also constitute a loss of return on monies expended.

(f) *Bad Debts*

Dispensing doctors incur these and they are continuously growing in these times of rising unemployment.

(g) *Medicine Levies*

Charged per script by numerous medical aids are invariably written off by many dispensing doctors. This can be anything from R2,00 to R5,00 or up to 20% of the total script.

(h) *Medicine Limits* — Imposed by Medical Aids

These can be unrealistically low eg R200,00 medication for one year for a family of four. The dispensing doctor often provides the medicine gratis to the member and his family, if his medicine benefits are exhausted, and carries the patient until he is once again in benefits.

### Time

The dispensing doctor has to perforce spend more time with the patient to complete the medical encounter viz he has to set aside extra time per patient to instruct him/her on how medicines are to be taken and the specific indications for medicines supplied — time for which he does not charge. The dispensing doctor has to spend extra time in purchasing drugs, administering accounts, doing stock control and supervising storage. Dispensing certainly entails extra work and sacrifice on the part of the doctor.

If one looks at the total dispensing situation (including the low income private and Sick Fund patients) and not just the 'cream' of medical aids, then it becomes obvious that the dispensing doctor is not making the "handsome" profit which the media and pharmacist would have the public believe.

Is the main feud between the pharmacist and the

dispensing doctor, entirely based on the profit motive?

It would appear that forty to fifty years ago, the number and distribution of retail pharmacy outlets and their distribution was very limited. In addition, Pharmaceutical formulations for the treatment of ailments and diseases, required the skilful blending of numerous ingredients. As time went on, the number of Pharmacy Schools in South Africa increased. During the same period rapid development within the Pharmaceutical Manufacturing Industry has resulted in most of today's modern medicine being available in treatment packs manufactured under strict control of the modern Pharmaceutical Manufacturing Industry which has virtually made blending of medicine obsolete.

We have a situation in South Africa today where there are more Pharmacy Schools than Medical Schools. Broken down to provincial level the doctor to pharmacy ratios are as follows:

Transvaal — 2:1

Natal — 2,9:1

Eastern Cape — 2,3:1

Western Cape — 2,5:1

OFS — 2,2:1

On the East Rand the ratio of one pharmacy to every doctor is quite common. The ideal ratio which is the norm in most western countries, is one pharmacist to ten doctors.

In the republic of South Africa there are altogether 2 500 retail pharmacies, 4 500 general practitioners and 1 800 specialists in private practice.

The annual turnover of the drug manufacturers in South Africa is R350,000,000; of the wholesalers, R427,000,000; and of the retail pharmacies R630,000,000.

Every year 75,000,000 prescriptions are dispensed, which bring in revenue of R100,000,000 in dispensing charges alone. Copies for medical aid purposes (15c) bring in R6,500,000. A 10% surcharge is made for breaking a bulk pack, and this brings in R11,000,000. The mark-up from manufacturer to wholesaler is 15%. Dispensing medicines account for 40% of the average pharmacy's turn-over. In some areas, pharmacies outnumber doctors — in Alberton there are 35 doctors and 40 pharmacies. Fifty five percent (55%) of pharmacies are controlled by two companies. [S Afr Med J 1985; 68: 4,7.]

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There appears to be a mark-up of almost R575,000,000 between the time the ethical product leaves the manufacturer and the price is finally paid by the consumer.

Because of the automatic 50% mark-up on drugs, the pharmacist has been able to increase his profit above the rate of inflation and greatly increases his share of the total annual medical bill.

Further, many pharmacists belong to a wholesale group, from which they buy at wholesale prices to sell at full retail prices, plus R1,30 dispensing fee per item, to gain at the end of each financial year, a not inconsiderable bonus!

The issue involves not only what is best and most convenient for the patients, an issue pharmacists and legislators seem to overlook, but also the vital cost effectiveness factor. It is tragic that both the legislators as well as the statutory bodies tend to adopt a consumer-commodity approach to the dispensing issue.

The main concern of dispensing doctors is with patients and with medical services in general. The pharmacists and legislators have nowhere addressed themselves to the central problem namely "what is in the patient's interest?"

Pharmacists and legislators tend to perceive dispensing in purely physical terms of marketing and selling of medicines in rands and cents; in much the same way that occurs over the counter when buying a camera or an ornament.

To the dispensing doctor, after information is gained from a consultation, the providing of medicines to the patient becomes a total or partial symbol of his healing. The doctor and patient are intensely involved. The patient understands more, and is more involved with his own treatment — he becomes motivated.

Since prescribing is an inherent part of the doctor/patient relationship which is also a learning situation, then the actual dispensing of the medicine and the meaning it assumes in the relationship serves as a repeating and a reinforcing power in the learning process. Not only does the patient's insight of himself and his disease improve, but also his insight regarding the doctor's relationship to him.

Communication and dispensing between the doctor and his patient is between person and

person, which mutually involves understanding, empathy, appreciation, patience and respect. It cannot be conveyed by a prescription; it is not marketable and cannot acquire a price tag.

Dispensing improves the doctor's ability in assessing the global need of the patient in the framework of the disease entity, and the economic determinant active within his environment.

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**Part IV will deal with Responses of Relevant Organisations to the Dispensing Issue.**