The position of the dispensing doctor in relation to the retail pharmacist

- Dr R J Kobrin

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Curriculum vitae

Raymond J Kobrin completed a BSc at the University of Pretoria in 1968, and attained MB ChB in 1973. His internship was done at H F Verwoerd Hospital, and he entered private practice in Benoni in 1975, where he still practises. He has been a member of the Medical Association (Eastern Tvl branch) for 2 years, is a member of the Dispensing Doctors Group, and since October 1985 secretary of the Eastern Transvaal sub-group at the National General Practitioners Group.
Raymond has a great interest in the application of computers in general practice. He is married with 3 children.

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Summary

The cost effectivity of the dispensing doctor in relation to an over-regulated and oversupplied number of retail pharmaceutical outlets in South Africa is presented. Suggestions for ensuring the future harmonious and rightful role of dispensing doctors and pharmacists in the health team are made.

KEYWORDS: Costs benefit analysis; Prescriptions, drug; Family Practice; Community pharmacy services; Fees and Charges

The dispensing doctor has in recent times been subjected to a misinformation campaign unparalleled within our profession, only rivalled in intensity by the current political campaign against our country. I shall attempt to provide a more factual and balanced view on the role and the need for the dispensing medical practitioner in South Africa. Before doing so, I would like to quote from a research paper presented by Professor George Silva of the Institute of Social and Policy Studies at Yale State University:[1]

> "It is comforting to believe that doctors, by their professional oath, are a worldwide fraternity of individuals with similar value systems that, given the same information, will make much the same diagnosis and when the sick seek care, doctors will always respond. But how much truth is there in this notion of the bond that transcends nations, class, and race?"

For many, many years in our country, and specifically in the rural areas the dispensing doctor has been part of the local communities with very little, if any, opposition from other members of the health care team. The dispensing doctor provides a twenty-four hour service to the public at large. There is no such luxury as fixed working hours and as the doctor is intimately involved with his patients, he is fully aware of both the social and financial status and means of these people. More

often than not, under-privileged patients will be provided with drugs by the dispensing doctor at or even well below the cost that a drug was purchased at. To cite one of many documented examples, a single practice in the Cape performs up to 11 000 consultations in one year for needy patients, charging the patients an all-up fee of R3,00, including medicine.

The dispensing doctor provides a 24 hour service

By and large, South Africa has a population which, in numerical terms, has by far the largest percentage in the third world environment. These people, even if employed, due to the lack of skills, earn relatively low wages which therefore limits their buying power as far as all commodities are concerned, including medicines. As stated earlier, the dispensing practitioner has traditionally provided a service to this sector of our community at ridiculously low rates, which in fact has saved the State coffers over the years millions of rands as these people would otherwise have been forced to move to government and provincial hospitals for treatment, or mobile clinics would have had to be provided to care for this sector of our population.

Even in the first world sector of our population, people are hard-pressed to make ends meet. Surely, if a dispensing practitioner can provide a cost effective service to his patients, he should be allowed to do so?

As a medical practitioner, I have never yet forced my patients to purchase their medicines from me. It is their choice whether they prefer me to supply, or a retail pharmacist. Yet, not surprisingly, when questioning patients, the majority are in favour of receiving their medicines from the general practitioner for the following reasons:

1. It is definitely cheaper
2. "I know that I get what I pay for"
3. Any misunderstanding regarding the administration of the medicine is minimised
4. It is very convenient and saves time, in that only one visit is required
5. I do not have to pay immediately
6. Medicine is available at all hours, at a moment's notice.

Why then the sudden vociferous outcry against the dispensing practitioner? All, I am sure, are familiar with the "total onslaught" to discredit our profession, which has over the past two years captured the lay-press headlines. This well-orchestrated public relations campaign, I feel, has done tremendous harm to the professions within the health care team. Surely, the forum to discuss grievances and make suggestions should be our professional bodies? Why then this unethical approach by organised pharmacy to discredit the dispensing medical practitioner?

I think we have to move back in history a bit. Casting one's mind back forty to fifty years, the number and distribution of the retail pharmacy outlets were 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. This has virtually made blending of medicines obsolete.

Today, in South Africa, we have a situation where there are more pharmacy schools than medical schools. The net result of this is that the average ratio of pharmacies (not pharmacists) to general practitioners and specialists in South Africa, is 2,4 pharmacies to 1 general practitioner/specialist. One has to remember that more often than not, you will have more than one pharmacist in a pharmacy. Broken down to provincial level, the doctor to pharmacy ratios are as follows:[2]

Transvaal	:	2:1
Natal	:	2,9:1
Eastern Cape	:	2,3:1
Western Cape	:	2,5:1
OFS	:	2,2:1

When compiling this statistical information, I found it interesting to note that on the East Rand, where the dispensing feud between the doctors and the pharmacists was possibly the most intense, ratios of one pharmacy to every doctor was quite common.

The ideal ratio, which is the norm in most other Western countries, is one pharmacist to ten doctors.

It has been stated before by senior and responsible members of our profession in government service that the prescribing doctor is unaware of drug costs. This I, as a medical practitioner, wish to refute explicitly. One cannot hang a profession on one or two exceptions. A medical practitioner has as much ability to select a cheaper drug for his patient than has a pharmacist and will do so if the financial need of the patient dictates it.

Based on November[3], 1985 syndicated audit data, the pharmaceutical manufacturing industry for the period December 1984 to November 1985 had a gross income on ethical products sold in the trade sector to the value of R382 000 000. The wholesalers, after adding their standard mark-up, sold these ethical drugs to the retail chemist at R463 000 000. The retailer in turn, after having added his fifty percent mark-up, dispensing fees, broken bulk fees, photocopy charges for prescriptions and adding GST, finally sold the ethical drugs which the manufacturer put onto the market at R382 000 000 to the general public for R957 000 000. A mark-up of R575 000 000 between the time the ethical products leave the manufacturer and the price finally paid by the consumer.

Many patients are supplied well below cost

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 increase his share of the total annual medical bill while the responsible general practitioner has seen his share decrease by 45% over ten years. The recent weakening in our rand has obviously had a negative effect on the importing costs of raw materials for pharmaceutical products. The pharmacist (with his fixed percentage mark-up, even though he has not at all been subjected to these cost increases) reaps the benefit by virtue of this mark-up.

Let us look at the cost structure of the medical aid societies which is made up as follows:

± 11% General practitioners
± 20% Specialists
± 30% Hospital costs
± 35% Medicines
± 4% Administration

As the general practitioner is the beginning point for all medical services, he has a responsibility towards his patients. Most families pay upwards of R200,00 per month towards medical aid. Imagine the cost saving if 35% on medicine costs could be decreased by 20%, i.e. from 35% to 28%.

One cannot help but wonder, why in fact, the then Pharmacy Board in South Africa managed to change Ethical Rule 1, allowing substitution of doctors' prescriptions by pharmacists when at best, if every single product that could be substituted was substituted, the total savings in the private market would have been between R20 000 000 and R30 000 000, when in fact, major savings in drug costs can be brought about by reducing the mark-ups that exist between the manufacturer and the final consumer, i.e. the patient. As a professional person, I believe the reversal of Ethical Rule 1 to its original form was the correct action because no amount of wishful thinking or administrative fiat can change the

Patients are in favour of receiving medicines from general practitioners

present state of affairs in which differences in drug bio-availability from different products are common indeed, and therapeutic inequivalence because of such differences is a potentially serious threat to the patients' welfare which we as medical practitioners should safeguard.

As a general practitioner, I can only speculate what influence the various interest groups had on the Pharmacy Board's decision to alter Ethical Rule 1. Another question, I ask myself, is whether the direct and indirect control that the pharmaceutical wholesaler has over the pharmaceutical retailer is healthy?

Looking at this staggering markup of R575 000 000 between the manufacturer and the final consumer and accepting that prescibing will be done by those able to do the necessary job, the best, fastest and the cheapest, and accepting that there is really no conflict of interest for the prescriber and the dispenser to one and the same individual, it is not difficult to see that patient care would be more cost effective and better integrated through the physician. Large cost savings could be effected in the private sector pharmaceutical market in South Africa by reducing what is by world standards the rather large mark-ups afforded in the retail chain – savings considerably higher than the theoretical savings that could occur in a substitution environment.

If the full mark-up of 50% is maintained but all extra costs are removed, like dispensing fees, etc., there would be a saving of ± R150 million per annum. Going a step further, if all prescription medicines are sold, at a mark-up of 12,5% at wholesale level and 30% at dispensing doctor/pharmacy level and all extra costs are removed including GST, we could save the South African consumer, our patients, a substantial R300 million per annum.

The argument is often used that the medical practitoner:

1. does not have the necessary knowledge to dispense drugs, and

2. if a doctor dispenses, he/she will only dispense products available in the dispensary, thereby denying the patient the wide choice of drugs available from a retail chemist.

This allegation is not true for the following reasons:

1. The medical practitioner, who is qualified to diagnose and prescribe accordingly, has both the technical and practical knowledge as to the choice of medicine as well as assessing the effectiveness of such medication. Medical practitioners' knowledge of prescription drugs, both old and new, is enhanced by –
   (a) articles in medical journals
   (b) continuing medical education meetings where both local and international experts lecture,
   and
   (c) visits from representatives from pharmaceutical drug houses who receive many hours of intensive training.
2. Most doctors acquire expert knowledge on probably 20 to 30 drugs such as antibiotics, anti-hypotensives, diuretics, beta-blockers, other cardiac drugs and even cough mixtures and anti-diarrhoeal drugs. In the course of normal practice, doctors do not vary very much from this armamentarium unless the particular choice which they use daily and know as regard to response, side effects and reliability lets them down.

A uniform, fixed mark-up of 50% is not compatible with free enterprise

Whether the doctor dispenses or prescribes, he/she will, in most cases, remain within this specific list of drugs. In a given area one might find a number of doctors with a different armamentarium, so what the patient receives self-dispensed or prescribed, depends on the individual doctor. The retail pharmacist in the area where these doctors operate will only stock the drugs prescribed by the various doctors and not all drugs available on the South African market. The patients' choice of drug does not depend on what is available on the retailer's shelf but what is prescribed by the doctor. It must also be remembered that no chemist keeps large stocks – he has deliveries in urban areas of up to five times a day from the wholesaler.

Providing the dispensing doctor stocks all the drugs he/she normally prescribes, which is invariably the case, or as for the retail pharmacist, he can in fact order daily from the wholesaler, the patient will not be limited or forced to utilise a "special deal" which the doctor might have on a weekly special from a manufacturer. No doctor would use drugs unless be believed in their effectiveness. He would lose patients if they did not get better, and as stated earlier, no dispensing doctor will force a patient to buy drugs from him, and not from the retail pharmacist.

Subjected to unparalleled misinformation campaign

What then of the pharmacist? I believe the retail pharmacist has a rightful place within the health care profession, but should be free to compete in a 'free market', be able to discount and, advertise the prices to the public. The time has arrived for organised pharmacy to realise that it cannot wish to remain a healthy profession by protecting its weakest links. The role of the retail pharmacist has changed dramatically. Instead of forcing more and more restrictions as to what may or may not be sold by a retail pharmacy, the Pharmacy Board should allow its members to continue as traders and not try and limit them in their trading activities. Also, if a pharmacist wishes to get involved as a partner within a medical practice and be responsible for the dispensary, this should not be prevented by law.

In conclusion I would like to stress that the dispensing doctor in South Africa forms a vital part of the health care profession and should be encouraged to develop his/her practice and not be restricted in his/her activities because members of other health care professions have become increasingly subject to adverse economic pressures attributable to manpower surpluses. As a dispensing doctor, I provide two types of services:

1. Examination and treatment for indigent patients at a fixed consultation cost, which includes medicines. In this way I provide a service that would otherwise put a far greater burden on the State.
2. I am willing to dispense medicines for private/medical aid patients at a great cost saving to the patients and their medical aids.

I believe that doctors should have every right to provide and dispense medicines for their patients provided:

(a) they do not:
   - provide medicines if they would not be prepared to take it themselves or give it to their families,

- change their prescribing habits to provide medicines they have in stock,
- make a profit beyond thei reasonable handling charge.

(b) the medicine they obtain is at cost, similar to that available to all final sellers.

(c) this service is provided primarily as a cost saving for their patients, and not a profit centre for the practice.

I strongly believe that the time has arrived in South Africa for the South African Medical and Dental Council together with the Medical Association of South Africa to enter into serious discussions with the manufacturers of ethical drugs, RAMS (the controlling body of the Medical Aid Societies) and organised pharmacy so as to effect real cost savings in the supply of ethical drugs to our South African population at large. If we, as a country, wish to remain in the forefront of medical

The dispensing doctor should be encouraged

advancement, it is vital for us to ensure that the research-based pharmaceutical companies in South Africa remain viable and interested in staying in our country. It must be remembered that these research-based manufacturers have been accountable for at least ninety-five percent of all drug discoveries in the world.

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