## *From the Editor • Van die Redakteur*

# Generic Substitution

Generic substitution seems to be a minor issue measured in terms of the R5-6m in cost saving it is estimated to effect. There are, however, major implications that should be kept in mind.

The Academy is primarily interested in promoting better standards of Family Practice/Primary Care in South Africa. At the heart of this is an endeavour to improve the quality of the doctor-patient relationship. Generic substitution and the right of the pharmacist not to supply items on a prescription will have massive implications for the doctor-patient relationship when another party becomes involved, adding a large potential for creating distrust towards the doctor and his prescription.

The legal implications for the pharmacist of substitution and/or omission of drugs must also be considered. Who is going to carry the final responsibility?

A further major implication is the effect this will have on the Industry. It is said that they will adapt and stay in the country. We should, however, bear in mind that some companies have all but closed operations in Australia and Canada following generic substitution.

We are promised a saving of R5-6 million. This saving may also mean a similar, or larger, loss to Continuing Medical Education and Research in South Africa. Can we afford this? Can we afford the impact on the economy, loss of job opportunities when companies close operations? A small intervention in the Free Enterprise system to effect a small saving may, in fact, end up with a large loss in relationship and economic terms.

Are we not diverting attention away from the real issues in medical care in South Africa by what is possibly a storm in a teacup?

Perhaps there are other ways to reduce costs and effect a more equitable health care system without making so many people nervous about the future. Giving doctors feedback about their prescribing profiles will reduce costs. It also seems important to bear in mind that the estimated saving on drug costs could be dwarfed by the savings that could be achieved by fully developing an integrated national primary health care system, which includes appropriate training for the job. This would obviate much of the care now having to take place in secondary and tertiary institutions. South Africa daily moves people from potentially low-cost care systems to high-cost systems. This will continue as long as people are encouraged to look down on the generalist and to bypass him. Savings could also be achieved by reducing over-prescribing and over-investigation of people's complaints in specialist institutions and by generalists trained in these institutions to think and behave like specialists in the primary health care sector.

It is easy to make restrictive laws. However, it seems better to put all our energy into the admirable policy embodied in the National Health Facilities Plan and to attempt to make it work. This would entail refraining from developing large institutions to the detriment, and almost total exclusion, of development of facilities and training for primary health care at an internationally acceptable level.

If we save any money, however, it should go to the further development of the health system to make it accessible to the whole community, and more comprehensive.

If the figure of 4% of the Gross National Product being spent at present on health care is correct, then we are probably spending too little on health care in South Africa.