Dispensing fee: doctors next...

The Department of Health's Dr Anban Pillay, director of Pharmaceutical Economic Evaluations, acknowledged on the day after the pharmacists recommended dispensing fee announcement in early March that the dispensing doctors had submitted their recommendations a week earlier.

Responding to a dispensing doctor caller in the After Eight Debate on SAFM Radio's *AM Live,* Pillay said that the department was evaluating the submission "and if there is any merit in their concerns, we will deal with that". This was confirmed by National Convention on Dispensing (NCD) chairman, Dr Norman Mabasa, who said that a meeting with the department had already been arranged for late March. Here the doctors would be motivating for higher – i.e. higher than R16/16% -dispensing fees as achieved by the pharmacists in the recent draft regulations.

Adding to this Mabasa made the point that doctors pay the same price for medicines as pharmacists when buying from wholesalers and didn't see why doctors should make a loss on medicines dispensing.

He agreed that pharmacists should receiver a higher fee for their professional services but at the same felt that the dispensing doctors should receive the same considerations as the pharmacists, i.e. a tier structured dispensing fee arrangement but with lower profit margins.

Minister spells out pharmacy dispensing fees

The recommended pharmacy dispensing fee, as announced by Health Minister Dr Manto Tshabalala-Msimang on March 7, is as follows:

- Where the single exit price of a medicine is less than R75, the dispensing fee is a total of R7,00 plus 28% of the single exit price of the medicine.
- Where the single exit price of a medicine is R75 or more but less than R150, the dispensing fee is a total of R23 plus 7% of the single exit price of the medicine.
- Where the single exit price of a medicine is R150 or more but less than R250, the dispensing fee is a total of R26 plus 5% of the single exit price of the medicine.
- Where the single exit price of a medicine is R250 or more, the dispensing fee is a total of R31 plus 3% of the single exit price of the medicine.

Recommended fees to be tested

The pharmacists have generally accepted the tiered dispensing fee structure recommended by the government appointed Pricing Committee and are expected to be testing the viability of the revised fees in 2000 pharmacies.

The new draft dispensing regulations for pharmacists will be put to the test soon with the activation of computer software in 2000 pharmacies in the country to evaluate the impact the proposed fees will have on the sector.

One group not too happy about the revised fees are the United South African Pharmacists (USAP). Speaking on an SAFM radio debate shortly after their announcement, USAP chairman Julian Solomon said that while the effort to remedy the situation was admirable, "they have got the numbers all wrong again!"

As an alternative to the R7 + 28% for medicine less than R75, Solomon said: "From our own survey an acceptable fixed fee would be about R5,50 and 50% of value."

Where it came to medicines over R250 Solomon suggested a fixed fee of R40 with a 15% mark-up as opposed to the R31 and 3% recommended by the pricing committee.

GEMS gathering momentum

The Government Employees Medical Scheme (GEMS), which opened its doors on January 1 2006, had attracted more than 4000 principal members by mid-March. Adding that this was happening at a rate of about 60 a day, GEMS Principal Officer Dr Eugene Watson said that he was encouraged by the fact that one of the objectives behind the GEMS initiative, i.e. offering affordable cover for people who could not afford medical cover previously, was now being met.

He added that GEMS, which in effect was "correcting inequitable benefits of the past", was being actively promoted around the country by contracted teams of consultants to attract the potential 400 000 members.

This would translate into 1 500 000 "belly buttons" who could benefit from the options on offer.

Watson added that whether or not joining GEMS would become compulsory for government employees had not been considered as yet.

Avian 'flu: what risk SA...?

The availability of antiviral drugs could curtail or even abort a threatening pandemic of the avian 'flu, noted South Africa's virologist, Prof Barry Schoub, explained in a recent issue of the National Institute of Communicable Diseases bulletin.
"There is deep concern that the H5N1 virus, which shares much of the molecular structure of the H1N1 virus responsible for the 1918/19 pandemic, may produce a similar devastating global disease," Schoub wrote.

He made the point that South Africa is on the route of at least two flyways of migratory birds which could theoretically introduce H5N1 infection into this country from Europe.

"However," he added, "the risk of migratory birds introducing H5N1into humans in South Africa is relatively small.

"A far more likely route of importation of infection is via infected humans once human-to-human transmission has been established, probably in South-East Asia."

"Most scientists," Schoub continued,"feel that human adaptation of H5N1 is inevitable. How it will express itself clinically and epidemiologically is difficult to predict. It may be as devastating as 1918/19 or the virus may lose virulence once it has become human adapted. The 1918/19 H1N1 virus rapidly became less virulent for humans after the pandemic and is today one of the lesser virulent subtypes of circulating human influenza virus. In addition, surveillance methodologies have vastly improved since 1918/19 and the availability of antiviral drugs could curtail or even abort a threatening pandemic."

GEMS poser for interns

Interns at the various State hospitals, according to a recent SA Medical Association new brief, have become unsure as to whether they should be joining GEMS and for those who don't, will the government still subsidise them?

This confusion, according to SAMA's Industrial Relations unit, appears to have arisen after some provincial offices apparently acted without a directive from the Department of Public Service and Administration (DPSA) by deciding unilaterally not to subsidise interns who do not wish to belong to GEMS.

After noting that DPSA officials denied issuing any directive to provinces with regards to GEMS, Thembi Gumbi, of SAMA's IR unit, made the point in her association's news brief that GEMS is optional. Doctors who belong to another medical scheme, she added, must make sure that they are receiving the "well-deserved" subsidy.

HPCSA on annual registration fees mission

The Health Professions Council of South Africa (HPCSA) has once again made its annual call with accompanying threats to healthcare practitioners regarding payment of their annual HPCSA registration: pay up or else face erasure!

In a media notice to this effect it is stated categorically that Council is compelled every year to take the drastic measure of removing defaulting practitioners from its register. "Though the decision seems harsh, Council still maintains that what practitioners are expected to pay annually is quite reasonable as compared to the spin offs over the 12 month period," the statement adds.

"All practitioners pay less than R 1 000. The highest paying practitioners are those in the optometry, medical and dental fields who pay R 810, R 570 and R 765 respectively per year. The lowest paying practitioners are anaesthetic assistants, orthoptists and assistant clinical technologists who pay R 125, R155, R165 respectively per year."

It is noted, however, that some practitioners have difficulties in raising the required amounts: "Some practitioners are unemployed, others are taking time off to further their studies, whilst others could be on maternity leave. Council is sympathetic to such causes and makes provision accordingly when notified."

Council concludes with the warning working practitioners who fail to pay the annual fees after deadline will be struck off the roll and will have to pay penalties to be restored to the register. Once removed from the register, practitioners will also be unable to claim from medical aid schemes during the time that they are not registered.

Zokufa's successor at MCC appointed

The acting head of pharmaceutical planning in the Department of Health, Mandisa Hela, has been appointed registrar of the Medicines Control Council (MCC) to replace Dr Humphrey Zokufa who left in November.

Dr Zokufa, who succeeded Precious Matsoso officially at the beginning of 2005, is now CEO at the Board of Health Care Funders (BHF).

Hela, in turn, takes over from the department's director general, Thami Mseleku, who was doing a holding job after Zokufa's departure.

Tamiflu availability assured

Roche announced at the beginning of March that its oral anti-viral agent, Tamiflu (oseltamivir) has been registered with the Medicines Control Council (MCC) for the treatment of influenza in adults and children and for the prevention of influenza in adults and adolescents.

Already indicated for treatment and prevention in both adults and children in the European Union and the United States, Tamiflu has been shown to be an effective influenza drug that works by blocking an enzyme on the surface of the virus which prevents it from replicating and infecting other cells in the body.

NHRPL structured to facilitate billing processes

The standardized structure of the National Health Reference Pricing List (NHRPL) facilitates billing processes in the industry by allowing funder and health care provider systems to 'talk' to each other, while at the same time independently setting benefits and prices matching their own affordability constraints and cost structures.

Stressing this point in a notice prompted by a need to clarify certain issues surrounding the NHRPL, the Council for Medical Schemes senior specialist reponsible for the NHRPL, Stephen Harrison, said that the list that the NHRPL should therefore be seen by providers for what it is – a standardised costing model which can be adapted to the specifics of individual practices to ensure greater rationality in pricing.

Harrison explained that even if the costing methodology underpinning the reference prices in the NHRPL, and the manner of collection of data, were flawless, they would still give rise to a set of average cost values: "In other words, the distribution of actual costs experienced by providers is such that for a portion of providers facing higher than average costs - or who work at lower than average productivity or efficiency levels - they may need to charge above NHRPL to achieve their target income and profit.

"However, equally there will be a substantial portion of providers who would need to charge less than NHRPL to recover their actual costs and achieve their target income and profit levels. These," Harrison added, "are providers who are more productive than the average practitioner or who experience lower costs than the average.

"Even those practitioners who experience higher than average costs could potentially undercut competitors by charging less than the NHRPL by increasing their productivity levels above the norm provided for in the NHRPL."