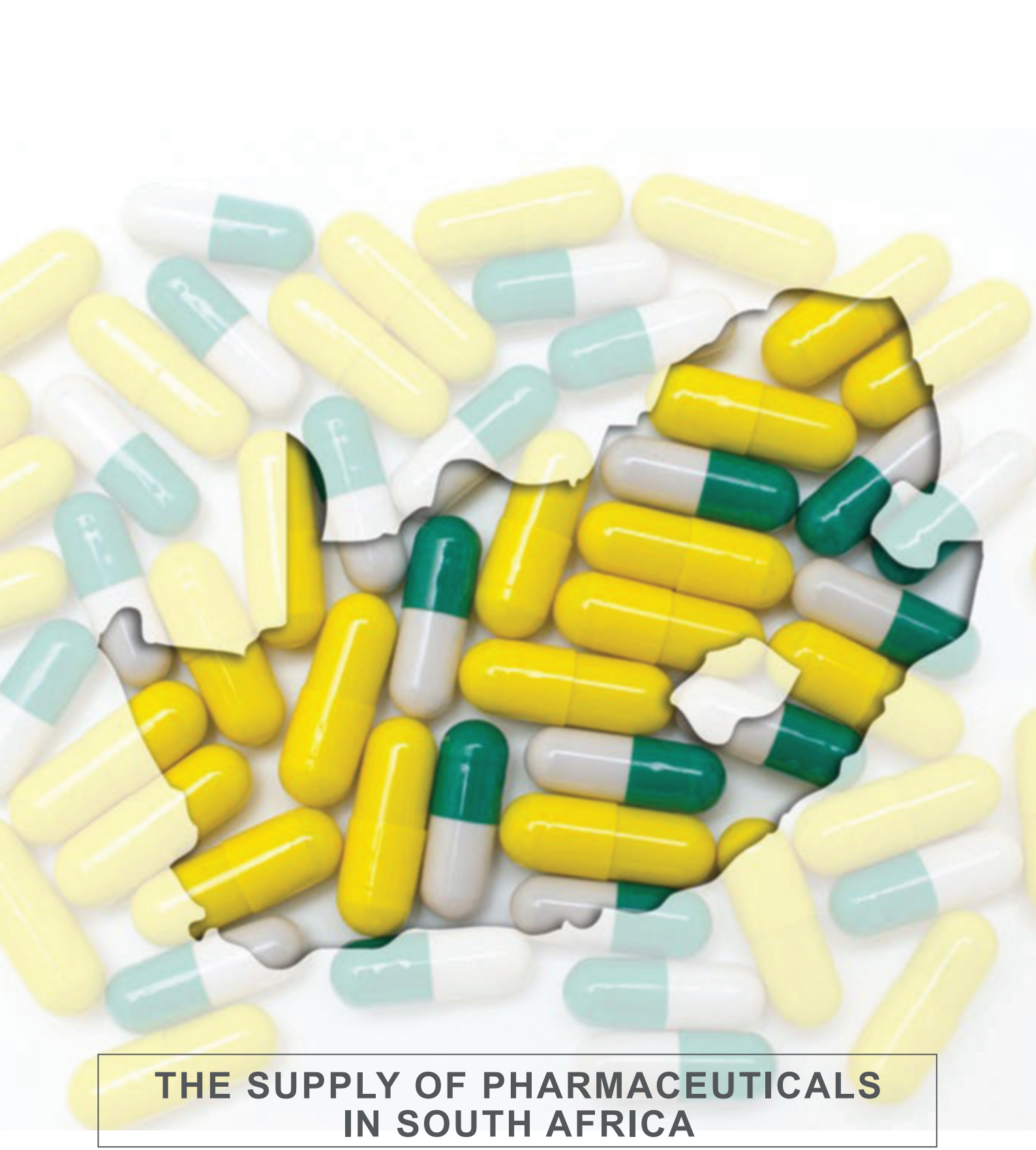

THE SUPPLY OF PHARMACEUTICALS IN SOUTH AFRICA

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INTRODUCTION

This report is a companion to our report Pharmaceuticals in South Africa – an Enquiry, published in 2016. The earlier report focused on the retail of pharmaceutical products. This report starts with their supply by manufacturers and importers. The report is necessarily technical, drawing on the disciplines of economics, law and pharmaceutical chemistry. Every effort has been made to make it comprehensible to readers who are not specialists in one or more of these fields.

This report is structured as follows.

A glossary of acronyms, terminology used in the analysis of pharmaceuticals and economic concepts.

A summary of conclusions, serving as an executive summary, follows.

Section A sets out background information on the size of the pharmaceutical sector, establishes the framework for classifying pharmaceutical products, and presents key information on supply in the private and public sectors.

Section B considers the problem of market definition in the pharmaceutical sector, presents quantitative information about competition in the private sector and discusses the participation of manufacturers in the public sector.

Section C deals with competition, vertical integration and foreclosure. It starts with a discussion of theoretical issues. It goes on to discuss the interaction between regulation and competition in the South African context, attention being paid to the legal environment. Against the background of Sections A and B, it identifies features of the pharmaceutical industry relevant to competition and vertical integration and applies theory to them.

Section D deals with cross-ownership and cross-directorships in the pharmaceutical sector. It indicates why these issues are relevant to competition, sets out the limits of available information and analyses the extent of cross-ownership and cross-directorships.

Section E sets out the legal framework governing the pharmaceutical industry and presents two case studies: one of vertical integration and the other of a horizontal merger. It considers representations made by the Independent Community Pharmacies Association about anti-competitive structures.

The analysis is complex. To facilitate comprehension of the components of the analysis, the structure of each section is presented in summary form at the beginning of each section.

GLOSSARY

Acronyms

ATC	Anatomical Therapeutic Chemical Classification
CEO	Chief Executive Officer
CIPC	Companies and Intellectual Property Commission
ERP	External Reference Pricing
ICPA	Independent Community Pharmacy Association
INN	International Non-Proprietary Name
MARSA	Medical and Related Substances Act
mg	milligram
MPL	Master Procurement List
MPR	Medicine Price Registry
SEP	Single Exit Price
UPD	United Pharmaceutical Distributors

Pharmaceutical terminology

Product	A unique combination of a manufacturer, an active ingredient, a strength and a dosage form. For example, Brunel Laboratoria supplies carbocisteine in 375 mg capsules (and brands it as Lessmusec).
Identical	A unique combination of an active ingredient, a strength and a dosage form. Identicals are sets of products. For instance, carbocisteine in 375 mg capsules are supplied by Brunel Laboratoria, Johnson and Johnson and Pharmacare. In this case, the identical is a three-member set.
Active ingredient	The ingredient which produces the therapeutic effect. Carbocisteine is contained in capsules and syrups of two different strengths.

Economic terminology

Monopoly	A monopoly exists when a specific enterprise is the only supplier of a particular commodity. Monopolies are characterized by a lack of economic competition to produce the good or service, a lack of viable substitute goods, and the possibility of a high monopoly price well above the seller's marginal cost that leads to a high monopoly profit.
Oligopoly	An oligopoly is a market form where a market or industry is dominated by a small number of sellers (oligopolists). Oligopolists behave strategically by watching the price and quantity decisions of their competitors. Strategic behaviour may, or may not, lead to excess profits.
Monopolistic competition	In a monopolistically competitive market there are many producers, and no business has total control over the market price. Producers sell products that are differentiated from one another (e.g. by branding or quality) and hence are not perfect substitutes. Brand loyalty gives sellers pricing power. This situation differs from perfect competition where sellers have no pricing power. It is also different from monopoly (where there is only one seller) and oligopoly (where there are only a few sellers).
Levels of production	Levels of production are distinct stages in adding value to a product. For instance, a pharmaceutical manufacturer creates a product, a wholesaler purchases it and supplies it to retail pharmacies and retail pharmacies dispense it. The final price to the consumer is made up of the value added at each level.
Vertical integration	Vertical integration occurs when more than one level of production occurs within a single business.
Foreclosure	Foreclosure means the removal of the opportunities to trade. Input foreclosure means that downstream retailers are foreclosed from buying from a particular upstream supplier. Customer foreclosure means that an upstream supplier is foreclosed from selling to a particular retailer.
Exclusive dealing	Exclusive dealing occurs when one firm trading with another imposes some restrictions on the other's freedom to choose with whom, in what, or where they deal. An example of exclusive dealing is an arrangement whereby a retailer or wholesaler is tied to purchase from a particular supplier on the understanding that no other distributor will be appointed or receive supplies in a given area.
Refusal to deal	A refusal to deal or a concerted refusal to deal is an agreement between competing companies, or between a company and an individual or business, that stipulates that they refuse to do business with another. There can be a horizontal refusal to deal, which is an agreement between competitors not to compete; and a vertical refusal to deal, which is an attempt to control or leverage the market by only doing business with certain parties. Businesses have the right to use their discretion in choosing whom to do business with. However, if this choice is made through a conspiracy with another competitor, business, or individual, it is anti-competitive.
Horizontal integration	Horizontal integration occurs when two or more businesses operating at the same level of production become one, through mergers or acquisitions. Horizontal integration has the potential to reduce competition, though it does not always do so to a significant extent.
Collusion	Collusion takes place within an industry when rival companies cooperate for their mutual benefit. Collusion most often takes place within an oligopoly, where the decision of a few firms to collude can have a significant impact on the market as a whole. Cartels are a special case of explicit collusion.

SUMMARY OF CONCLUSIONS

The conclusions from this study can be summarised as follows:

1. The output of pharmaceutical industry supplying both the private and public sectors is estimated at R 48.6 billion in 2017. 69% is absorbed by the private sector and 31% by the public sector. Since most South Africans rely on the public sector, the per capita expenditure difference between the private and public sectors is large. This difference is partially offset by the fact that, compared with manufacturers prices in the private sector, the prices at which medicines are supplied to the public sector are much lower.
2. There are 174 manufacturers in South Africa. 95 of them supply exclusively to the private sector, 15 exclusively to the public sector and 64 to both sectors.
3. The variety of products sold in the private sector is much greater than in the public sector. In part, this reflects the differential basis for competition in the two sectors. In the private sector, manufacturers compete by offering their full range to the market. In the public sector, acquisition is by tender, so the competition has taken place before the products are made available to consumers. Even so, the number of active ingredients available in the private sector is two and half times the number available in the public sector.
4. There are 267 ATC 3 categories. At least one medicine is available in 201 of them in the private sector, and 138 of them in the public sector. Public sector availability is slightly under-estimated because of incompleteness in the ATC coding in the MPL.
5. 53% of the identicals supplied to the private sector contain only originator medicines, 33% contain only generic medicines and 14% are a mixture of the originators and generics. Accordingly, there is a consumer choice between originators and generics only in respect of a small minority of medicines. However, the fact that a third of identicals contain only generic medicines is an indication of how competitive generics are in the South African market.
6. Five-eighths of total public sector expenditure is concentrated in ATC 1 Category J (Anti-infectives for systemic use), which includes anti-retroviral medicines for HIV infection, vaccines and medicines to treat tuberculosis. Anti-retrovirals and vaccines alone account for just over half total public expenditure. By contrast, medicines to treat tuberculosis, diabetes and epilepsy account for just over 8% of total public expenditure. The absence of expenditure data in the MPR makes it impossible to compare the concentration of expenditure in the private and public sectors.
7. There is not just one market for pharmaceutical products, but many. There are several criteria for market definition in the pharmaceutical sector and the relevance of each of them will vary from case to case. Accordingly, it is difficult to generalise, but it is clear that monopolies, monopolistic competition and oligopolies are widespread in the private sector. Even within identical classes perfect price competition is uncommon.
8. Five manufacturers have more than 200 products registered on the MPR for sale in the private sector: Pharmacare (607), Adcock Ingram (401), Sandoz (338), Cipla Medpro (223) and Pfizer (219).
9. Six manufacturers supply more than 40 products to the public sector. They are Pharmacare (106), Fresenius Kabi (63), Cipla Medpro (58), Sanofi Aventis (55), Adcock Ingram Critical Care (52) and Gulf Drug Company (42). Seven manufacturers each provide medicines worth more than R500 million to the public sector. They are the Biovac Institute (established in 2003 as a public-private partnership to import, export, package, test and distribute vaccines), Pharmacare, Mylan, Sonke Pharmaecuticals (established in 2006 as a Black Economic Empowerment joint venture between Ranbaxy and Community Investment Holdings), Cipla Medpro, Sanofi Aventis and AbbVie.
10. The current approach to the competitive effects of vertical integration is to enquire whether they lead to input foreclosure or customer foreclosure. Input foreclosure means that downstream retailers are foreclosed from buying from a particular upstream supplier. A situation in which a retail pharmacy is unable to purchase a product from a manufacturer, either directly or through a distributor, or from a wholesaler is a case of input foreclosure. Retail pharmacies will be concerned about input foreclosure. Customer foreclosure means that an upstream supplier is foreclosed from selling to a particular retailer. A situation in which a manufacturer is unable to sell a product to a retailer, either directly or through a distributor, or to a wholesaler is an instance of customer foreclosure. Manufacturers will be concerned about customer foreclosure.
11. The pharmaceutical sector is heavily regulated, in part for reasons common to all countries and in part as result of establishing the Single Exit Price system. However, the SEP system is less rigid than it might first appear. The system depends completely on initial prices proposed by manufacturers. Proposals may be accepted or rejected by the Department of Health, but they cannot be amended by it. The regulation of the income stream for wholesalers and distributors is defined by product. It cannot vary between wholesalers and distributors for a particular product, even though wholesalers assume the risk of ownership whereas distributors do not, and it cannot reflect differences in cost, occasioned for instance by scale of operations or geographical location. Pragmatic adjustments have to be made in order for the system to be workable.
12. Logistics fees as a percentage of the SEPs vary widely: the median is 10% with half of the observations falling between 7.4% and 12.5%. There are differences in the logistics fee as a proportion of the SEP within identical groups where there are two or more manufacturers. The manufacturer's offer of a logistics fee will reflect its view of what is needed to make the product competitive in respect of retail pharmacy purchases. An analysis of the 100 manufacturers supplying at

least ten products to the private sector shows that in fifteen cases the logistics fee as a percentage of SEP does not vary across products offered. The remaining 85 manufacturers vary the logistics fee as a percentage of SEP by product. It is not evident why average logistics fees by manufacturer vary as widely as they do.

13. Competitive conditions exist at the retail level. The two largest corporate pharmacies, Clicks and Dis-Chem, account for roughly 20% each of sales to the private sector, so that neither of them meets the 35% threshold defined in the law concerning abuse of dominance. Retailers can and do compete by setting dispensing fees at different level, subject to regulated maxima. In this, they are influenced by the terms that medical aids offer in return for designation as preferred suppliers.
14. Exclusive dealing by manufacturers of generics is reported not to take place, so that neither input nor customer foreclosure takes place in the absence of vertical integration. There are also no incentives for foreclosure in the cases of two levels of vertical integration between (a) manufacturers and wholesalers/distributors and (b) wholesalers/distributors and retail pharmacies. There is a risk when all three levels are vertically integrated.
15. While price is a major determinant of purchase by retail pharmacies, it is not the only one. The formularies of medical aid schemes often has an influence. Quality of service in respect of products and continuous availability also matter.
16. Cross-ownership and cross-directorships may affect competition through facilitation of exchange of commercially sensitive information, ability to influence the decisions of separate firms and change of incentives facing management. Many firms at all three levels of the pharmaceutical industry (manufacture, distribution and retail) are privately owned and do not publish annual reports. Requesting information on them through the Companies and Intellectual Property Commission is impractical. Moreover, information on the levels of the pharmaceutical industry often cannot be separately identified within listed company reports.
17. From the information available to us, we would assess cross-directorships in the pharmaceutical industry as very limited, indeed possibly non-existent. As far as cross-ownership is concerned, we believe that there are gradations in the likelihood that different forms of cross-ownership will result in anti-competitive conduct. Partial ownership by the Public Investment Corporation is ubiquitous in listed companies throughout the pharmaceutical industry, as it is elsewhere, but it is difficult to imagine the PIC using its cross-investment to promote anti-competitive behaviour in the pharmaceutical industry. Similarly, cross-ownership by unit trusts and similar investment funds, while certainly conditioned by the profitability of the companies in which they invest, is unlikely to result in anti-competitive behaviour. Were cross-ownership and cross-directorships to coincide, there would be a risk of anti-competitive behaviour, but we have not been able to uncover a single case of this in the pharmaceutical industry.
18. Two case studies, both concerning mergers and acquisitions by New Clicks Holdings Limited, are considered from a legal point of view. The first deals with the formation of the Unicorn, UPD and Clicks retail nexus, which involved a merger between Clicks Pharmaceutical Wholesale (Pty) Ltd and New United Pharmaceutical Distributors resulting in UPD becoming a wholly owned subsidiary of New Clicks. Unicorn Pharmaceuticals was not acquired through merger, since it was formed by New Clicks itself. The second case study deals with the merger between Clicks and the retail portion of Netcare's Medicross pharmacies and it examines the reasoning of the Competition Commission and Competition Tribunal in detail.
19. In terms of the second case study and other similar orders handed down by the Tribunal, it has become clear that the consideration employed before approving a merger is based purely on the Competition Act. Neither the Commission nor the Tribunal takes industry-specific law into account when making an order. The effect of a Tribunal order is different to a normal order of court insofar as it serves as a "clearance certificate" of sorts – that there are no restrictive practices at play between the merging parties which would render the merger uncompetitive. The order thus does not prevent alternative legal challenges to ownership, licensing or merger questions.
20. Moreover, the Tribunal can only take decisions based on the current situation. The Tribunal does not project growth when considering the impact on competition. Should an anti-competitive situation arise after the Tribunal has taken a decision, that situation would have to be dealt with in a separate legal process.
21. The information placed before the Commission and subsequently the Tribunal comes primarily from the merging parties themselves. This leaves a gap in terms of pertinent information which the Tribunal should be mindful of when approving a merger. The Commission does afford objecting third parties a chance to make representations during the investigations. The absence of industry regulators enables the Tribunal to act in such a limited capacity. Were such bodies to play a more proactive role alongside the Commission and Tribunal, questions of law which arise from legal instruments other than the Competition Act may play a more prominent, and consequently more instructive, role in the Commission's findings and Tribunal's decisions.
22. To illustrate further the difficulties in application of the law, the report contains an account of a meeting between the Independent Community Pharmacy Association and the Minister of Health in October 2016, in which competition issues in relation to Clicks were discussed.

SECTION A – BACKGROUND INFORMATION

STRUCTURE

SECTION A – BACKGROUND INFORMATION

1. Introduction

An analysis of competition in the supply of pharmaceuticals in South Africa is best situated within a study of pharmaceutical supply conditions in general.

Much useful information about the composition of the pharmaceutical industry can be obtained from two data bases: the Medicine Price Registry (MPR) and the Master Procurement List (MPL). The information in each source is outlined in an Appendix to this section of the report.

2. Aggregate expenditure on pharmaceuticals

The estimates in this section are approximate only, but they are based on broadly coherent information.

Information on expenditure is not available in the MPR. The MPL has information on prices, quantities and duration of contracts and it can be calculated that the annual rate of aggregate procurement ran at R14.9 billion in mid-2017.

Fitch's BMI Research *South Africa Pharmaceuticals and Health Care Report* for 2017 estimates that total expenditure on pharmaceuticals in 2017 will be R48.6 billion. If that estimate is accurate, and all public procurement is accounted for in the MPL, the private sector would account for R33.7 billion, or 69% of the total.

South African Revenue Services Customs and Excise statistics put pharmaceutical imports at R11.8 billion between January and August 2017, implying annual imports of R17.7 billion. Pharmaceutical imports are the sixth largest category of imports, behind crude oil, passenger car components, refined oil, goods vehicle components and cell phones.

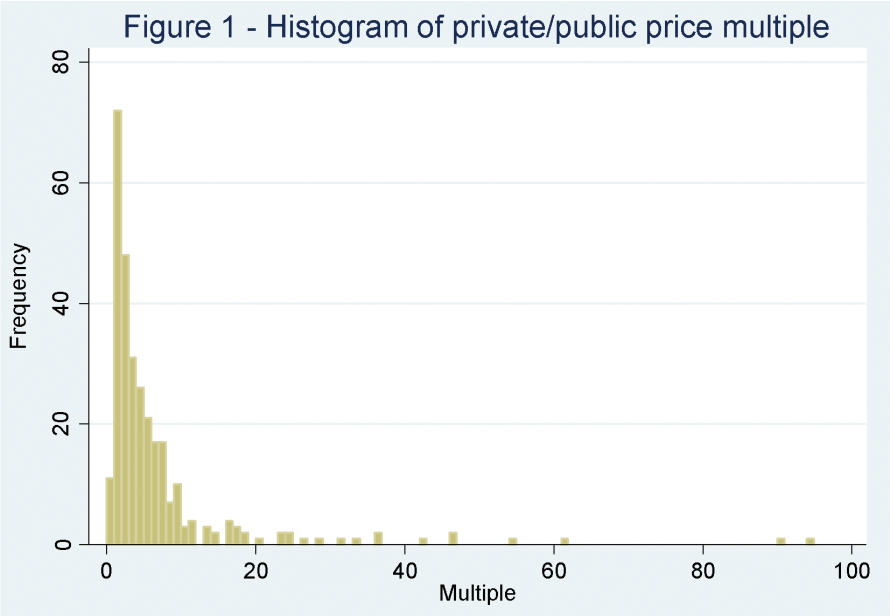
Two further estimates are available.

Dis-Chem reported for the year ending 28 February 2017, that its aggregate turnover was R17.3 billion, the share of dispensary sales in turnover was 36% and the estimated market share was 21.4%. Adding 5% to bring prices to the mid-2017 level, this gives an estimated market size of R30.6 million[1], presumably not counting the medicines supplied to hospital in-patients and by dispensing doctors.

The Council for Medical Schemes 2015/16 Report states that medicines and consumables dispensed by pharmacists and providers other than hospitals accounted for R22.3 billion of benefits paid to medical aid scheme members. Add 12% price inflation into this estimate, and it comes to R25.0 billion in 2017. On top of this, medical aid members will have paid co-payments and people not on medical aids will have made purchases in the private sector.

Aggregate expenditure of R48.6 billion by a population of 56.7 million implies annual average per capita expenditure of R860. If one adds 20% to medical aid pharmaceutical benefits to account for co-payments by medical aid members and in-hospital consumption by medical aid members, the expenditure per capita on 8.8 million beneficiaries would amount to R3 410, while expenditure by and on non-members would average R390.

On the other hand, the prices paid for pharmaceutical products in the public sector are considerably lower, on average, than in the private sector. For 299 identical products in capsule and tablet form, the manufacturer price plus VAT per capsule or tablet in the MPR can be compared with the price paid in the public sector in the MPL. A histogram of the ratio of the private to the public price (the multiple) is presented in Figure 1.



The median multiple Is 3.6, with half the values falling between 1.8 and 6.8.

1 Arithmetic: 1.05*(0.36*17.3/.214) = 30.6

3. Key concepts

The description of pharmaceutical products is complicated and key concepts must be grasped if competitive conditions in the sector are to be understood. This report uses the following framework.

3.1 Originator and generic medicines

An originator medicine means a medicine, registered in South Africa, where such medicine is currently protected by a patent or had been protected by a patent previously. Such medicine may be marketed either by the original patent holder or another entity.

Generics (interchangeable multi-source medicines) are medicines, registered in South Africa, where such a medicine has never been protected by patent legislation. Usually such medicines are being manufactured by companies other than the company that originally held the patent. The company would have not needed to provide a clinical trial showing efficacy upon registration of the medicine, but rather pharmaceutical equivalence.

3.2 Active ingredients

The active ingredient is the chemical substance having the desired therapeutic effect. Some medicines may contain more than one active ingredient. The INN system (International Non-Proprietary Name) is the standard for naming active ingredients.

3.3 Products and identicals

A product is a unique combination of a manufacturer, an active ingredient, a strength and a dosage form. Products may be presented in different pack sizes.

An identical is a combination of an active ingredient, a strength and a dosage form. Strictly speaking, then, an identical is a group of products with one or more members, since different products may have the same active ingredients, strength and dosage forms. An identical is essentially a class of identical products, differentiated only by brand. Where an originator and a generic product exist for an identical, the generic may be substituted for the originator at the option of the consumer.

3.4 Medicine schedules

Medicines are classified by schedule. In deciding the scheduling status of a medicine or substance, the primary emphasis is on evidence of safety in use and the requirements for professional advice and/or supervision of its use. In addition, the requirements for control over access, possession and supply, as stipulated in international agreements, are considered.

The scheduling decision involves the consideration of a number of factors, including:

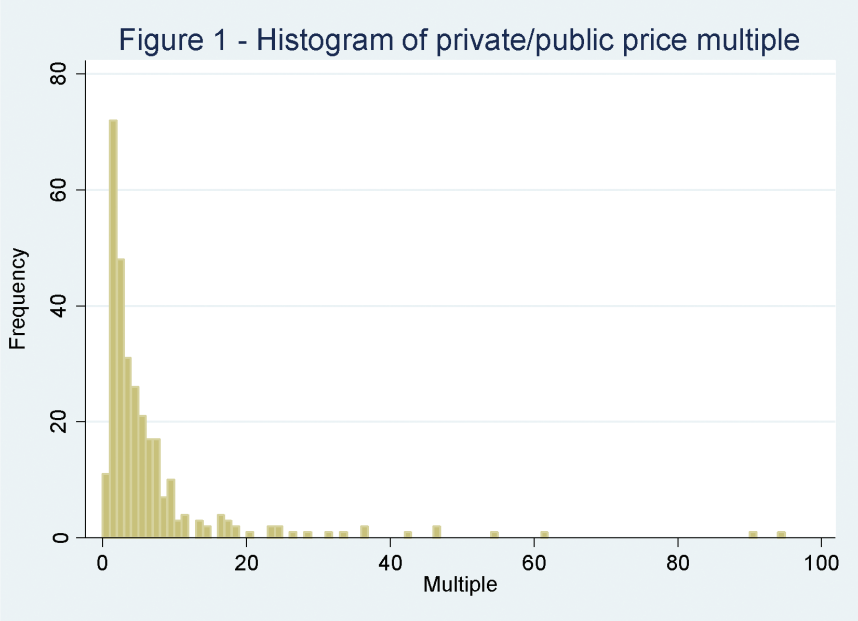
- evidence for the toxicity of the substance and the safety in use;
- the proposed indication for the substance;
- the need for medical diagnosis, monitoring and medical management by a healthcare professional;
- the potential for abuse;
- the need for access to the substance.

A prescription is required for Schedule 3, 4, 5 and 6 medicines.

The higher the schedule number, the greater is (a) the risk from consuming the medicine,(b) the severity of the condition being treated, and (c) the need for medical supervision.

Information on the schedule of each medicine is contained in the MPR.

Schedules are not listed in the MPL, but they may be ascribed on the basis of active ingredient and dosage form when the active ingredients are offered in the private sector.



3.5 The Anatomical Therapeutic Chemical Classification (ATC) system

The ATC system is maintained by the World Health Organisation. In the ATC classification system, medicines are divided into different groups according to the organ or system on which they act and their chemical, pharmacological and therapeutic properties. Medicines are classified into five different levels of increasing specificity.

The first level of the code indicates the anatomical main group and consists of one letter. There are 14 main groups. The second level of the code indicates the therapeutic main group and consists of two digits. The third level of the code indicates the therapeutic/pharmacological subgroup and consists of one letter. The fourth level of the code indicates the chemical/therapeutic/pharmacological subgroup and consists of one letter. The fifth level of the code indicates the chemical substance and consists of two digits. Each level is a subset of the level immediately above it, and the code for a level contains the codes for levels above it. Thus an ATC 3 code consists of a letter followed by two digits and a letter, and an ATC 5 code consists of a letter followed by two digits, a letter, another letter and two digits.

The MPR reports ATC information at level 4. The MPL reports it mostly at level 5.

Often, ATC 3 categories are the starting point for the analysis of competition in pharmaceutical products, though it may be necessary in some cases to consider ATC 4 or even ATC 5 categories. A list of ATC 3 categories is provided in Annexure 2.

4 Supply

4.1 Manufacturers

The MPR and MPL list 174 manufacturers[2]. 95 of them supply exclusively to the private sector, 15 exclusively to the public sector and 64 to both sectors. Of the 159 manufacturers which supply to the private sector:

- 48 supply only originator medicines
- 19 supply mostly originator medicines (more than 80% originators)
- 15 have a mixed output (the supplies of originators and generics are both at least 20%)
- 19 supply mostly generic medicines (more than 80% generics)
- 58 supply only generic medicines.

A list of these manufacturers, indicating some of their characteristics, is contained in Annexure 1.

4.2 Medicines by ATC category

Active ingredients can be classified by ATC category. An active ingredient can fall under more than one ATC category, since it may be used to treat different conditions. The approach taken here is to place each active ingredient in the ATC category most commonly used in the MPR and MPL data bases. The effect of this assumption is to reduce slightly the number of available active ingredients in each ATC category, so that effective coverage is more extensive than indicated in the tables presented here.

2 The Medicines Control Council lists 260 companies licensed by September 2017 for at least one of the following: manufacture, import and export. Some of the manufacturers may only act as third party manufacturers and not be holders of certificates of registration or not actively market their own products.

Some of the coding in the MPR and MPL is missing, incomplete or inaccurate. The information presented here is based on the best reconstruction possible.

4.3 Information about both the private and public sectors

Table 1 sets out the number of products, identicals and active ingredients in the private and public sectors.

Table 1 – Products, identicals and active ingredients, by sector		
	Private	**Public**
Products	6 613	1 173
Identicals	3 921	1 076
Active ingredients	1 228	486

345 active ingredients are common to both the private and public sectors.

The distribution of identicals by schedule is set out in Table 2

Table 2 – Identicals by schedule		
Schedule	**Private**	**Public**
1	272	27
2	492	35
3	836	190
4	1 880	280
5	340	79
6	98	10
Not stated/ascribed	3	455
Total	**3 921**	**1 076**

Table 3 sets out the available active ingredients in the fourteen ATC 1 categories.

Table 3 – Available active ingredients in the private and public sectors by ATC 1 category.			
Code	**Description**	**Private**	**Public**
A	Alimentary tract and metabolism	104	43
B	Blood and blood forming organs	88	30
C	Cardiovascular system	100	29
D	Dermatologicals	59	29
G	Genito-urinary system and sex hormones	64	22
H	Systemic hormonal preparations excluding sex hormones and insulins	26	7
J	Anti-infectives for systemic use	191	79
L	Anti-neoplastic and immunomodulating agents	124	43
M	Muscular-skeletal system	51	8
N	Nervous system	181	55
P	Anti-parasitic products, insecticides and repellents	17	8
R	Respiratory system	86	20
S	Sensory organs	50	25
V	Various	60	17
	Unknown	27	71
	Total	**1228**	**486**

A list of available active ingredients in the private and public sectors by ATC 3 category is presented in Annexure 2. There are 267 ATC 3 categories. At least one medicine is available in 201 of them in the private sector and 138 of them in the public sector. These are under-estimates for the reason that active ingredients may be used in more than one ATC 3 category, and also in the public sector because the MPL does not disaggregate the categories in the S (Sensory organs) group at the ATC 1 level. Had the S level been disaggregated in the MPL, the public sector count would have increased by up to 12.

4.4 Information specifically about the private sector

Originators and generics

Groups of identical medicines can be classified by whether they are made up of originators only, a mixture of originators and generics, or generics only. Table 4 sets out identicals by composition.

Table 4 – Identical medicines, by composition

	Number
Originators only	2 064
Mixed	545
Generics only	1 312
Total	**3 921**

A third of all identicals in the private sector are available only in generic form.

545 (14%) are available as originators or generics. Of the 545, the generics are at least as expensive as the originators (probably when the patent on an originator has expired) in 44 cases. The median savings from generic substitution among the remaining 501 identicals is 53% when the most expensive originator is replaced by the least expensive generic. Savings of at least 31% are available for three quarters of the identicals and at least 77% for a quarter of the identicals. These savings over-estimate what can in practice be achieved, since (a) more than one originator[3] can be included in an identical group, and the most expensive may not have been prescribed and (b) not every retail pharmacy stocks every generic, so the least expensive one may not be available for any given purchase.

Regulation 12(1) of the General Regulations in terms of the Medicines and Related Substances Act provides that:

12. (1) No person shall import any medicine or scheduled substance, including medicines imported in terms of section 15C of the Act, read together with regulation 7, into the Republic except through one of the following ports of entry:

a. Cape Town Airport or harbour;
b. Port Elizabeth Airport or harbour;
c. Durban Airport or harbour; and
d. Johannesburg international airport.

Companies that do not have delivery fleets and facilities use distributors. The typical route of the imports is from the port of entry to a distributor's warehouse. The distributor receives the stock, invoices on behalf of the manufacturer, keeping the distribution fee and refunding the rest to the manufacturer. They then invoice the wholesaler or retailer upon supply.

Bangalee and Suleman have investigated whether the increase in the availability of generic drugs has lowered the price of cardiovascular drugs in South Africa[4]. The study revealed that the majority of generic drugs in the dataset were more than 40% cheaper than the branded versions. They also found that increased generic competition is not a predictor of lower drug prices and that current South African pharmaceutical policies have not yet achieved the lowest prices for drugs when compared internationally.

Information on competition in the private sector will be presented in Section B of the report.

4.5 Information specifically about the public sector

Patterns of expenditure

Table 5 presents the distribution of public sector procurement by ATC 1 category.

3 As defined in the MPR, an originator may be an originally patented medicine for which the patent has expired. Such medicines are often regarded as generics.
4 Varsha Bangalee and Fatima Suleman, Has the increase in the availability of generic drugs lowered the price of cardiovascular drugs in South Africa? Health SA, 21, 2016.

Table 5 – Distribution of public spending by ATC 1 category			
Code	**Description**	**Value R million**	**Per cent**
A	Alimentary tract and metabolism	826,8	5,55
B	Blood and blood forming organs	919,1	6,17
C	Cardiovascular system	607,1	4,07
D	Dermatologicals	288,7	1,94
G	Genito-urinary system and sex hormones	268,7	1,80
H	Systemic hormonal preparations excluding sex hormones and insulins	84,6	0,57
J	Anti-infectives for systemic use	9271,7	62,20
L	Anti-neoplastic and immunomodulating agents	274,1	1,84
M	Muscular-skeletal system	111,9	0,75
N	Nervous system	947,9	6,36
P	Anti-parasitic products, insecticides and repellents	77,8	0,52
R	Respiratory system	298,3	2,00
S	Sensory organs	190,3	1,28
V	Various	92,8	0,62
Z	Unknown	647,6	4,34
	Total	**14907,4**	**100,0**

The most remarkable thing about Table 5 is the predominance of ATC 1 Category J, in which five-eighths of total expenditure is concentrated. Category J includes anti-retroviral medicines for HIV infection, vaccines and medicines to treat tuberculosis.

Nine categories of medicine account for 72.3% of the value of medicines supplied to the public sector. Table 6 sets out the number of different active ingredients, public spending and the percentage of all public spending in each category.

Table 6 – Detailed analysis of top nine category expenditures

	Number of active ingredients	Public expenditure (R million)	Per cent of total procurement
Anti-retrovirals	17	5453	36.6
Vaccines	10	2326	15.6
Anti-bacterials	32	991	6.7
TB drugs	10	441	3.0
Diabetes	5	402	2.7
Epilepsy	9	376	2.5
Anti-hemorrhagics	5	294	2.0
Perfusion solutions	11	257	1.7
Analgesics	4	227	1.5

The heavy impact of the HIV/AIDS epidemic can be seen clearly in Table 5. The cost of anti-retrovirals acting directly on the HIV virus does not include the treatment of opportunistic infections associated with HIV and AIDS.

Anti-bacterials rank below vaccines, followed by TB, diabetes and epilepsy medicines. Health24 reported on 15 June 2015 that approximately one in a hundred South Africans will suffer an epileptic seizure at some time in their lives. Epilepsy can be congenital, but it is often acquired, resulting from infections of the brain, AIDS, diabetes, withdrawal from alcohol, use of some street drugs and exposure to toxins.

Information on competition in the public sector will be presented in Section B of the report.

APPENDIX – DATA SOURCES: THE MEDICINE PRICE REGISTRY AND THE MASTER PROCUREMENT LIST

The private sector

The Medicine Price Registry (MPR) is published by the national Department of Health. The MPR sets out the medicines licensed for sale, and it contains information, *inter alia,* on:

- the identity of the manufacturer (the concept 'manufacturer' refers to importers as well, in line with statutory provision.
- the active ingredient in each medicine, accompanied by its position in the Anatomical Therapeutic Chemical Classification.
- the dosage form that each medicine takes, for instance, whether the medicine is contained in a tablet, capsule, or a solution.
- whether the medicine is an originator drug or a generic. An originator medicine is one that is currently, or has been, protected by patent. A generic medicine is one that has never been protected by patent.

An entry in the MPR does not necessarily mean that the medicine is being sold at any point in time. It merely establishes that it may be sold.

The information used here is taken from the MPR data base of 27 May 2017.

The public sector

The Master Procurement List (MPL) of medicines is published by the national Department of Health. This sets out information on current government procurement contracts, and it contains information, *inter alia*, on:

- the identity of the manufacturer.
- the active ingredient in each medicine, accompanied by its position in the ATC at level 5. The level 5 codes are truncated to level 4, to bring them into line with the MPR classification.
- the strength, unit of measurement and dosage form of the medicine
- the price of a unit of medicine and the quantity to be provided in terms of the contract
- the start and end dates of the contract.

From the price, quantity and contract duration, the annual expenditure on medicines procured by the public sector can be calculated. This information is not available for the private sector. On the other hand, the distinction between originator and generic medicines is not found in the MPL.

The Master Procurement List of 7 July 2017 supplies the information used here.

The data from both sources of information have been cleaned and rendered consistent with thesauruses of manufacturers and active ingredients. Gaps in information remain in respect of ATCs and the originator/generic distinction.

A medicine is said to be supplied to the private sector if it is available in privately owned retail pharmacies or hospitals. Medicines supplied to the public sector are available in dispensing clinics and public hospitals.

SECTION B – COMPETITION IN THE SUPPLY OF PHARMACEUTICALS

STRUCTURE

SECTION B – COMPETITION IN THE SUPPLY OF PHARMACEUTICALS

1 Introduction

This section of the report will deal with the following issues:

1. Central to any assessment of competition is market definition, a complex matter in the field of pharmaceutical products. Approaches to the problem will be discussed.

2. What can be known about competition in the supply of pharmaceutical products to the private and public sectors. There is asymmetry between the two sectors. In the private sector, manufacturers compete by offering products to the market, and the full range of products is contained in the MPR. In the public sector, manufacturers compete for tenders to supply and information about tenders is not in the public domain. The MPL contains information about competition outcomes rather than the extent of competition to supply.

2 Market definition

The core issue in market definition is the identification of products which are close substitutes. In economic terms, this means that cross-price elasticities are high within the set, while these elasticities are low between members of the set and other products.

In practical terms, Morse[5] identifies seven criteria for market definition in respect of pharmaceutical products:

(1) whether drugs treat the same disease, condition or indication;
(2) whether drugs treat a disease by interacting with the body in the same manner (i.e., whether they have the same mechanism of action);
(3) whether drugs have the same specific chemical compounds;
(4) whether drugs have the same dosage form such as injectable, liquid, capsule, tablets, or topical;
(5) whether drugs have the same frequency of dosage, such as once-a-day or extended release;
(6) whether drugs have the same strength of dosage, distinguishing, for example, 30mg and 60mg tablets;and
(7) whether drugs are branded or generic.

In South Africa, Section 22F of the Medical and Related Substances Act 101 of 1965 provides that generic substitution of an interchangeable multi-source medicine must be offered where available. The Act defines "interchangeable multi-source medicine" to mean medicines that contain the same active substances which are identical in strength or concentration, dosage form and route of administration and meet the same or comparable standards, which comply with the requirements for therapeutic equivalence as prescribed.

This definition indicates that Morse's criteria (3), (4) and (6) should be used. Criteria (1) and (2) are implicitly satisfied as well. Criterion (7) will not be used, since one does not want to separate originator products from generic products into separate markets. Criterion (5) is impossible to apply, given the available information. It would, in practice, divide identicals into subgroups since, for instance, a drug in a slow release format is a different product to one that is not a slow release and requires more frequent use.

3 Manufacturer competition in the private sector

3.1 Theory

Three market structures are possible. The set of close substitutions may have a single member, in which case there is a monopoly, in which price can be expected to be above marginal cost. In competition law terms, the excess is regarded as an abuse of dominant position.

The set may have a small number of members, in which case there is an oligopolistic market. Such a market may have one or two firms which meet the conditions for dominance as defined in competition law, or it may not. Oligopolistic markets pose particular problems for analysis, as outcomes depend on strategic behaviour, in particular whether there is price or quantity competition. Under some circumstances, oligopolistic markets may result in no excess of price over marginal cost. In others, an excess may merge. Oligopolistic markets make price collusion easier than in markets with many competing products. The set may have many members, in which case competitive conditions prevail.

Monopolies and oligopolies are common in pharmaceutical markets. Monopolies are usually found where there is no close substitute for a branded originator product, often protected by patent[6]. They may also arise when only a single generic is available. Oligopolies arise either when there is a single originator product and one or more generics on the market, or two or more originator products, possibly accompanied by generic product as well.

Monopolistic competition is also possible. It arises between branded products (generics are branded as well as originator drugs) and actual or perceived differences in quality. In both cases, there is product differentiation which leads to imperfect competition. Since Single Exit Prices (SEPs) are differentiated by both manufacturer and product, it is quite possible that price differentials arise for products containing the same dosage of active ingredient. Monopolistic competition accounts for these differentials.

5 M Howard Morse, Product Market Definition in the Pharmaceutical Industry, Antitrust Law Journal 71, 2003
6 Patents can be regarded as an attempt to bridge the gap between short run marginal cost, which does not take research and development into account and long term marginal cost, which does. Patents, which run for a specified period, are imperfect means to the end, and they may be abused by the practice of ever-greening, i.e slight modifications to a product which entitle it to a further period of patent protection.

3.2 Empirical analysis

As in Section A, the MPR will be used as the source of information. Attention will be paid here to products and identicals as defined in Section A.

Of the 6 613 products, 3 883 (58.7%) were classified as generics and 2 730 (41.3%) were originators.

In order to assess the degree of competition, each identical was considered as a separate market. Table 7 sets out identicals, classified by the number of manufacturers offering them.

Table 7 – Pharmaceutical product markets by number of participants

Number of participants	Number of markets
1	3 038
2	388
3	184
4	83
5	52
6-10	126
11+	50
Total	**3 921**

Table 7 shows how concentrated markets are. 77.5% of pharmaceutical products have no substitutes in terms of Section 22F. 9.9% have only one substitute and 4.7% have only two substitutes and 2.1% have three substitutes. Only 5.8% of markets contain five or more participants. This reflects the finding above that, in terms of number of products, the possibility of generic substitution is quite limited.

Table 8 classifies markets with up to five participants by whether they contain originator products only, generic products only, or a mixture of originator and generic products.

Table 8 – Pharmaceutical markets with up to five participants

Number of participants	Originators only	Generics only	Mixture	Total
1	2018	1020		3038
2	168	179	41	388
3	5	58	121	184
4		26	57	83
5		14	38	52
Total 2-5	**173**	**277**	**257**	**707**

In two thirds of markets where there is only one product available, the medicines are originator drugs. The picture changes as the number of participants increases. Generics only represent 36% of products in identical markets with two to five participants, a mixture of originators and generics represent 40% and originators 24%, originators being concentrated in identicals markets with two participants.

Whereas pharmacists can substitute generics only within identical groups as defined here, medical practitioners have a wider scope of choice in prescribing. Here, Morse's criteria (1) and (2), without the others, are relevant. When looking at market definition from the latter perspective, the World Health Organisation's Anatomic Therapeutic Chemical classification system at level 3 (ATC 3) is often used[7]. Elements of ATC 3 usually contain more than one active ingredient. Thus, for instance insulin and analogues (A10A) used in the treatment of diabetes is a category containing a number of different active ingredients, making at least some of them close substitutes. Where this happens, market definition on the basis of active ingredient defines the market too narrowly.

Accordingly, one may repeat the analysis of Table 6, considering markets to consist of (a) medicines with same active ingredient, strength and dosage form and (b) medicines belonging to the same ATC 3 category. Table 9 sets out the results.

7 Mayer Brown, Product market definition in the pharmaceutical sector: the effect of a recent focus on generics, 25 June 2009.

Table 9 – Number of participants by active ingredients and ATC 3 category		
Number of participants	**By active ingredient**	**By ATC 3 category**
1	449	24
2	240	16
3	102	10
4	80	7
5	49	11
6-10	149	25
11 or more	159	108
Total	**1228**	**201**

There are limits to the usefulness of Table 9. It provides a general overview, but it cannot substitute for a full market definition for any medicine and its close competitors. Active ingredients in different strengths and dosage forms may not be close substitutes for one another. On the other hand, medicines with different active ingredients may be close substitutes. Different medicines within an ATC 3 category may have different mechanism of action, and the diversity of mechanisms can limit substitutability.

Even within identical groups, there is not perfect price competition. Table 10 sets out the average coefficient of variation of prices by the number of participants. In any particular market, the coefficient of variation (the standard deviation of price of each product divided by its average price) would be zero if there were perfect price competition, since all prices would be the same. Values higher than zero indicate monopolistic competition (where branding differentiates products) and/or non-price competition, such as intensity of promotion of particular brands.

Table 10 – Median coefficients of variation in price for identicals, by number of market participants			
Number of participants	**Coefficient of variation**		
	Median	**Minimum**	**Maximum**
2	0.21	0.00	1.41
3	0.39	0.02	1.71
4	0.32	0.03	1.31
5	0.40	0.06	1.86
6 or more	0.42	0.04	2.34

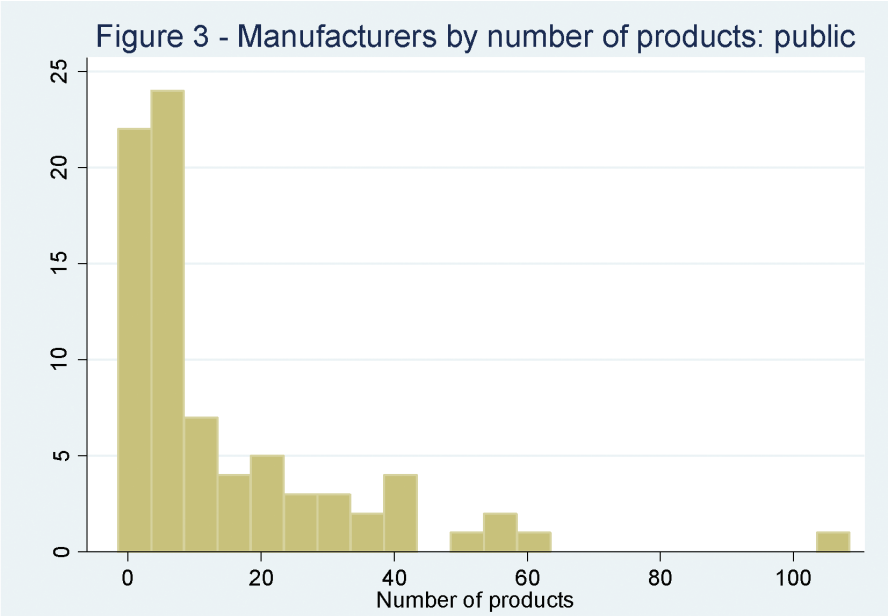
A histogram of the number of manufacturers by the number of products they have registered is presented in Figure 2.

Five manufacturers have more than 200 products registered: Pharmacare (607), Adcock Ingram (401), Sandoz (338), Cipla Medpro (223) and Pfizer (219).

4 Manufacturers in the public sector

It has been noted that competition in the public sector takes place at the tendering stage, and the MPL contains information on successful tenders. Nonetheless, there is interesting information to be derived from the MPL.

Figure 3 is a histogram of suppliers to the public sector.



Six manufacturers supply more than 40 products to the public sector. They are Pharmacare (106), Fresenius Kabi (63), Cipla Medpro (58), Sanofi Aventis (55), Adcock Ingram Critical Care (52) and Gulf Drug Company (42).

Seven manufacturers each provide medicines worth more than R500 million to the public sector. They are the Biovac Institute (established in 2003 as a public-private partnership to import, export, package, test and distribute vaccines), Pharmacare, Mylan, Sonke Pharmaceuticals (established in 2006 as a Black Economic Empowerment joint venture between Ranbaxy and Community Investment Holdings), Cipla Medpro, Sanofi Aventis and AbbVie. The Biovac Institute is in this group because of its supply of vaccines, Pharmacare, Sonke, Cipla Medpro and AbbVie because of their supply of anti-retrovirals, while Sanofi Aventis provides TB, diabetes and epilepsy medicines.

Annexure 3 sets out the value of products sold to the public sector within each category defined in Table 6 above.

5 The private and public sectors compared

Table 11 presents summary statistics which shed light on the contrast between the private and the public sectors.

Table 11 – Private and public sectors compared	
Number of products in the private sector per product in the public sector	5.64
Number of identicals in the private sector per identical in the public sector	3.64
Number of active ingredients in the private sector per active ingredient in the public sector	2.53
Number of ATC 3 classes covered in the private sector per ATC 3 class covered in the public sector	1.46

Table 11 can be interpreted as follows:

That there are many more products in the private sector than in the public sector is partly a consequence of the fact that competition in the private sector is between sales to retail pharmacies and on to consumers, while in the public sector competition between manufactures takes place at the tender level. Medicines appearing on the MPL are selected as an outcome of a prior competitive process.

The difference in the number of identical classes is partly a consequence of the fact that there is a greater variety of strengths and dosage forms in the private sector. This means that strengths and dosage forms can be more closely calibrated to need in the private sector. In the public sector, consumers will characteristically receive medicine in a single strength and dosage form designed to cover most contingencies.

The difference between the numbers of active ingredients is more serious, since active ingredients are likely to be imperfect substitutes for one another. The difference may arise partly because of the more limited range of conditions treated in the public sector.

The difference in the number of ATC 3 classes is the most serious difference. In particular, gaps in public sector coverage by ATC 3 level compared with private include liver therapy, peripheral vasodilators, most beta blockers, anti-thyroid preparations, anti-migraine preparations, drugs used in addictive disorders, anti-vertigo preparations, and most diagnostic radiopharmaceuticals.

The absence of expenditure data in the MPR makes it impossible to compare the concentration of expenditure in the private and public sectors. Expenditure in the private sector will be less concentrated than expenditure in the public sector in the nine categories identified in Table 5. On the basis of the evidence here one can conclude that, the public sector mostly treats HIV/AIDS, vaccinates, provides anti-bacterials for systemic use, treats TB, diabetes and epilepsy, carries out surgery (often for trauma), administers medicine through drips and provides analgesics.

SECTION C – COMPETITION, VERTICAL INTEGRATION AND FORECLOSURE

STRUCTURE

SECTION C – COMPETITION, VERTICAL INTEGRATION AND FORECLOSURE

1 Theory

Vertical integration is the organization of successive production and distribution processes within a single firm. Goods which are inputs to other goods are called intermediate goods and goods supplied to the consumer are called final goods.

Forward vertical integration occurs when a firm expands the scope of its activities to both produce and distribute the final good. A firm integrates backward when it produces an intermediate good that is a component in the assembly of a final product. Vertical integration in either or both directions can be partial or full, depending on whether the firm produces all its requirements for an input, or distributes its final product exclusively through its own distribution channels.

Vertical integration can occur by internal growth or by merger.

Views of the competitive impact of vertical integration have gone through three phases. The first was a tendency to regard both horizontal and vertical integration as anti-competitive and illegal per se[8]. However, an influential article by Spengler[9] in 1950 concluded that:

> Vertical integration, as such, does not necessarily suppress competition. While reduction of competition is sometimes associated with the extension of vertical integration, analysis usually discloses such reduction, if in fact it exists, to be largely the fruit of horizontal integration and/or related arrangements… And if this be the case, it is the horizontal elements that need be singled out for remedial treatment.

This view of vertical integration is known as the 'Chicago school' view and was influential in the second phase. It implies that a 'rule of reason' approach to vertical integration is appropriate rather than per se prohibition.

More recently, the pendulum has swung part of the way back. The emphasis now is on whether vertical integration leads to foreclosure which harms welfare. Foreclosure takes one of two forms:

Input foreclosure means that downstream retailers are foreclosed from buying from a particular upstream supplier. A situation in which a retail pharmacy is unable to purchase a product from a manufacturer, either directly or through a distributor, or from a wholesaler is a case of input foreclosure. Retail pharmacies will be concerned about input foreclosure.

Customer foreclosure means that an upstream supplier is foreclosed from selling to a particular retailer. A situation in which a manufacturer is unable to sell a product to a retailer, either directly or through a distributor, or to a wholesaler is an instance of customer foreclosure. Manufacturers will be concerned about customer foreclosure.

An equally important element of market structure for analysing vertical integration is the power of contracts to align incentives and control the conduct of firms. Foreclosure can be imposed by exclusive contracts and refusals to deal as well as vertical integration.

Bijlsma et al[10] propose a four part rule of reason enquiry for the analysis of foreclosure:

1. Will foreclosure be a chosen strategy in a particular market? Foreclosure is not very likely to be welfare reducing when there is sufficient competition both upstream and downstream. Although an exclusive contract between a supplier and a retailer denies competing retailers access to that particular supplier, or competing suppliers access to that particular retailer, neither upstream nor downstream competition is reduced because there are enough other suppliers and retailers.
2. If foreclosure is theoretically possible, will it be chosen in practice? The likely type of vertical foreclosure differs between markets with and without vertical integration. In addition, markets with competing vertically integrated combinations differ from markets with a single vertically integrated entity.
3. If foreclosure is likely, are there welfare enhancing effects of the vertical restraints or vertical integration that can outweigh the detrimental effects? Not all vertical integration is welfare reducing, as Spengler pointed out. Vertical integration in an imperfectly competitive world enables the higher-stage producer to evade monopolistic surcharges imposed by suppliers in lower stages, thus putting him in a position to ask lower prices than would be asked in the absence of vertical integration and in the presence of existing horizontal integration.
4. If foreclosure is likely and the welfare decreasing effects outweigh the welfare enhancing effects, are there policies whose benefits outweigh their costs?

   In general, there are many possibilities to consider and it will be necessary to narrow them down to live issues in the South Africa pharmaceutical industry.

8 In competition law, when an action is regarded as illegal per se, it is sufficient to show that the action happened. The alternative is to have the action evaluated by the 'rule of reason' which requires that the particular circumstances be evaluated in order to determine whether the action significantly reduces competition or not.

9 Joseph J Spengler, Vertical integration and anti-trust policy, *Journal of Political Economy*, 58(4), 1950.

10 Michiel Bijlsma, Viktoria Kocsis, Victoria Shestalova and Gijsbert Zwart, Vertical foreclosure: a policy framework, CPB Netherlands Bureau for Economic Policy Analysis, CPB Document 157, January 2008

2 Regulation and competition in the pharmaceutical sector

The pharmaceutical sector is heavily regulated. The Medical and Related Substances Act 101 of 1965 (MARSA), and the regulations it authorises, establishes a Medicines Control Council (MCC), sets up a framework for the registration of medicines, their classification into schedules, and regulates the purchase and sale of medicines by manufacturers, distributors, wholesalers, pharmacists and persons licensed to dispense medicines.

For our purposes, two aspects of MARSA are of particular importance. First, Section 22F requires pharmacists to offer a generic medicine (an interchangeable multi-source medicine) in place of an originator medicine where such exists and unless the person prescribing the medicine has specified no substitution on the prescription. This requirement is pro-competitive as it widens the choice available to the consumer.

Secondly, Section 22G, introduced in an amendment to the Act in 2002, establishes the Single Exit Price system. The SEP is the only price at which manufacturers may sell medicines and scheduled substances to any person other than the state. The SEP is initially established when a manufacturer registers a medicine, in the process proposing the SEP. Thereafter, the SEP may escalate up to a limit determined by the Minister from time to time, informed by a formula reflecting cost pressures on manufacturers. A manufacturer may apply for a temporary or a permanent reduction in the SEP and may also apply for a price increase should it be necessary to ensure continued supply. Retailers may charge a dispensing fee over and above the SEP system. Maxima for dispensing fees are set by regulation. Retail pharmacies may charge less and often do to medical scheme aid members in terms of a designated or preferred provider contract. The SEP system conditions the way in which competition in the pharmaceutical industry plays out. There are specific factors within the SEP system which are of particular importance and these will be dealt with below.

The Pharmacy Act 53 of 1974 establishes the South African Pharmacy Council and regulates the ownership of pharmacies. Section 22A provides that the Minister responsible for health may prescribe who may own a pharmacy, the conditions under which such person may own such pharmacy, and the conditions upon which such authority may be withdrawn. The regulations authorised by the Act have two important features, both of which were introduced by Government Notice R553 of 25 April 2003. Prior to that time, only registered pharmacists could own pharmacies, but Regulation 6 provided that any person may own or have a beneficial interest in a community pharmacy in the Republic, subject to the conditions, one of which is that the person may not be the owner or the holder of any direct or indirect beneficial interest in a manufacturing pharmacy.

3 Specific features of the SEP system bearing on competition

Two specific aspects of the SEP system need particular mention. The first is the complete dependence of the system on initial prices proposed by manufacturers. Proposals may be accepted or rejected by the Department of Health, but they cannot be amended by it. Excessive pricing can be investigated, but this capacity has been very little used. Given South Africa's high dependence on imported pharmaceutical products, the Department of Health has more than once initiated consultation on a methodology for international benchmarking for prices of originator medicines, against medicine prices in Australia, Canada, New Zealand and Spain. The purpose of international benchmarking is to contend against price discrimination in respect of products manufactured elsewhere in the world against the South African market. But, to date, no such system has been put into place.

The second issue is the origin of the income stream for wholesalers and distributors. There are two components of the SEP: the manufacturer price and the logistics fee, with value added tax added to both. Notionally, the logistics fee is the source of income for wholesalers and distributors. The pre-2003 position was that the prices paid by wholesalers to manufacturers and the fees paid to distributors was negotiated between the parties involved. But the logistics fee is rigidly defined for each product. It must be so by the logic of the SEP system. It cannot vary between wholesalers and distributors for a particular product, even though wholesalers assume the risk of ownership whereas distributors do not, and it cannot reflect differences in cost, occasioned for instance by scale of operations or geographical location. The result is a major strain in the system which cannot be rationalised, especially given the requirements of the Section 18 of MARSA and the *Rules relating to the Code of Conduct for pharmacists and other persons registered in terms of the Act* in accordance with section 35A (b) (i) of the Pharmacy Act 53 of 1974[11]. These provide that no person may supply any medicine according to a bonus system, rebate system or any other incentive scheme, no person may provide a free supply of medicines to a pharmacist, that no pharmacists may accept a commission or any financial gain or other valuable consideration in return for the purchase, sale or supply of any goods, and that transactions or agreements which are the determining factor in the ordering, stocking or dispensing of medicines or the provision of advice relating to medicines are prohibited. It has been reported to us on several occasions that pragmatic adjustments have to be made in order for the system to be workable. The details of these adjustments are not publically available.

For both these reasons, the functioning of the SEP system is less rigid than might be thought at first glance.

11 South African Pharmacy Council, BN 108 of 24 October 2008, published in Government Gazette 31534

SECTION C – COMPETITION, VERTICAL INTEGRATION AND FORECLOSURE

4 Vertical integration and other relevant issues in South African law

Section 5 of the Competition Act 89 of 1998 governs vertical integration.

Restrictive vertical practices prohibited

(1) An agreement between parties in a vertical relationship is prohibited if it has the effect of substantially preventing or lessening competition in a market, unless a party to the agreement can prove that any technological, efficiency or other pro-competitive, gain resulting from that agreement outweighs that effect.

(2) The practice of minimum resale price maintenance is prohibited.

(3) Despite subsection (2), a supplier or producer may recommend a minimum resale price to the reseller of a good or service provided –

(a) The supplier or producer makes it clear to the reseller that the recommendation is not binding; and (b) if the product has its price stated on it, the words "recommended price" appear next to the stated price.

Section 5(1) authorises a rule of reason approach to restrictive vertical practices, while putting the onus on parties to them to show that the benefits to the consumer outweigh the costs.

Where vertical integration is achieved by merger, section 12A is relevant.

Consideration of Mergers

(1) Whenever required to consider a merger, the Competition Commission or Competition Tribunal must initially determine whether or not the merger is likely to substantially prevent or lessen competition, by assessing the factors set out in subsection (2), and –

(a) if it appears that the merger is likely to substantially prevent or lessen competition, then determine –

(i) whether or not the merger is likely to result in any technological, efficiency or other pro-competitive gain which will be greater than, and offset, the effects of any prevention or lessening of competition, that may result or is likely to result from the merger, and would not likely be obtained if the merger is prevented; and

(ii) whether the merger can or cannot be justified on substantial public interest grounds by assessing the factors set out in subsection (3);

or (b) otherwise, determine whether the merger can or cannot be justified on substantial public interest grounds by assessing the factors set out in subsection (3).

(2) When determining whether or not a merger is likely to substantially prevent or lessen competition, the Competition Commission or Competition Tribunal must assess the strength of competition in the relevant market, and the probability that the firms in the market after the merger will behave competitively or co-operatively, taking into account any factor that is relevant to competition in that market, including –

(a) the actual and potential level of import competition in the market;
(b) the ease of entry into the market, including tariff and regulatory barriers;
(c) the level and trends of concentration, and history of collusion, in the market;
(d) the degree of countervailing power in the market;
(e) the dynamic characteristics of the market, including growth, innovation, and product differentiation;
(f) the nature and extent of vertical integration in the market;
(g) whether the business or part of the business of a party to the merger or proposed merger has failed or is likely to fail; and
(h) whether the merger will result in the removal of an effective competitor.

(3) When determining whether a merger can or cannot be justified on public interest grounds, the Competition Commission or the Competition Tribunal must consider the effect that the merger will have on – (a) a particular industrial sector or region; (b) employment; (c) the ability of small businesses, or firms controlled or owned by historically disadvantaged persons, to become competitive; and (d) the ability of national industries to compete in international markets.

Section 7 of the Competition Act states:

Dominant firms

A firm is dominant in a market if –

(a) it has at least 45% of that market;
(b) it has at least 35%, but less than 45%, of that market, unless it can show that it does not have market power; or
(c) it has less than 35% of that market, but has market power.

Regulation 6 of the Regulations relating to the Ownership and Licencing of Pharmacies (Government Gazette GNR 553 of 25 April 2003), made in terms of sections 22 and 22A of the Pharmacy Act, 53 of 1974, states that:

Ownership of community pharmacies.

Any person may, subject to the provisions of regulation 7, own or have a beneficial interest in a community pharmacy in the Republic, on condition that such a person or in the case of a body corporate, the shareholder, director, trustee, beneficiary or member, as the case may be, of such body corporate –

(a) is not prohibited by any legislation from owning or having any direct or indirect beneficial interest in such a pharmacy;
(b) is not an authorised prescriber;
(c) does not have any direct or indirect beneficial interest in or on behalf of a person contemplated in paragraphs (a) and (b); or
(d) is not the owner or the holder of any direct or indirect beneficial interest in a manufacturing pharmacy.

Regulation 6(d) is a per se prohibition on complete vertical integration between pharmaceutical manufacturers, wholesalers/distributors and retail pharmacies.

Further legal analysis is presented in Section E.

5 Relevant features of South African pharmaceutical markets

5.1 Levels

There are three distinct levels at which value is added to pharmaceuticals products:

1. The manufacturer level, at which the manufacturer's price is added;
2. The wholesaler/distributor level, at which the logistics fee is added; and
3. The retailer level, at which the dispensing fee is added.

5.2 Horizontal competition

Horizontal competition at the manufacturer level

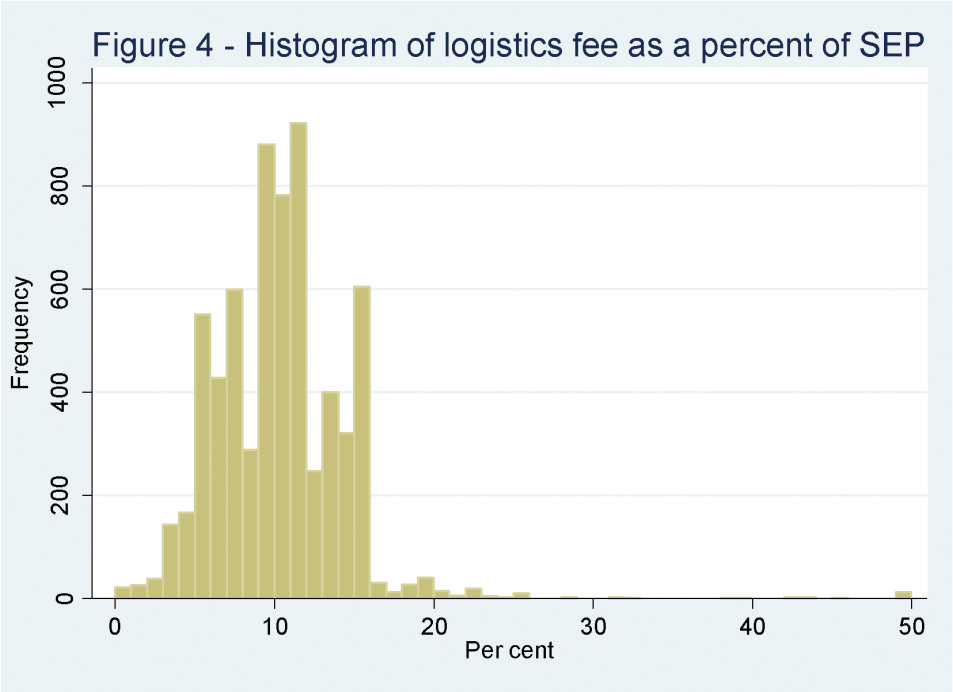
As indicated in Sections A and B, pharmaceutical products do not constitute one market, but many. In some markets, there are monopolies, in others there is monopolistic competition and in the remainder, perfect competition. Perfect competition appears to be relatively rare. Manufacturers set prices in the private sector in their applications for registration of a medicine. Thereafter, they are subject to ceilings in periodic adjustment of prices set by the Department of Health. At any time, they can submit applications for temporary or permanent price reductions. They can apply for price increases if required to keep the medicine available on the South African market. Prices in the public sector are determined by tender. Most manufacturers are importers

Horizontal competition at the wholesaler/distributor level

Fifteen wholesalers account for nearly all pharmaceutical products passing through wholesalers, and there are a larger number of small regional wholesalers[12]. Four distributors account for most pharmaceutical products passing through distributor channels[13]. This configuration makes horizontal collusion unlikely.

Figure 4 presents a histogram of logistics fees as a percentage of the SEP. The median logistics fee is 10.0% of the SEP, with half the observations falling between 7.4% and 12.5%.

12 The Medicines Control Council has licensed 194 wholesalers up to September 2017
13 Personal communication Trevor Phillips, CEO of the National Association of Pharmaceutical Wholesalers



Horizontal competition at the retail level

The Helen Suzman Foundation estimated the numbers of pharmacies open in early 2015 as follows (updated results for 2017 where available):

Table 11 – Pharmacies by ownership, early 2015 and 2017

Ownership	Number	Mid 2017
Clicks	353	400
Dis-Chem	88	108
Medicross Pharmacies	46	87
Pick n Pay	39	
Shoprite/MediRite	152	
Spar	32	50
Independent	2475	
Total	**3185**	

Source: Helen Suzman Foundation, Pharmaceuticals in South Africa – An Enquiry, 2016

Note: In 2016, the Competition Tribunal announced that it had approved – with conditions – the merger between Clicks and Netcare's in-hospital "front shops". Clicks will in due course assume control of all Medicross pharmacies and 45 front shops of the Netcare Hospital division. This means that there will be some double counting of these pharmacies.

In addition, there are a number of courier pharmacies delivering directly to their clients' residential addresses. Details about the largest four are set out in Table 12.

Table 12 – Largest courier pharmacies

Name	Ownership	Nature of business
Clicks Direct Medicines	Clicks	Chronic and highly specialised medicines. More than 50 000 parcels delivered per month
Dis-Chem mail order/delivery service	Dis-Chem	Chronic and repeat medicines delivered from Dis-Chem pharmacies
Southern Rx	Discovery Health	Chronic medicine
Medipost		All medicine, with a special unit for oncology, renal and HIV. More than 795 000 prescriptions per month

As noted in Section A, Dis-Chem reported a 21.4% market share of dispensary sales in 2016/17. Clicks reported a 19.6% share of retail pharmacy sales in 2016.[14]

Neither firm, nor any other, meets criteria (a) or (b) for dominance, so in any matter concerning abuse of dominance, it would have to be established that a corporate retailer has market power.

5.3 Vertical integration

Forward vertical integration

There is some forward integration from manufacturers to wholesalers and distributors. The Specialist Forum of 11 April 2017 reported as follows:

In a significant move to expand their distribution offering, Adcock Ingram Healthcare (Pty) Ltd, has acquired Virtual Logistics (Pty) Ltd, a national and cross border fine distribution company. The acquisition will be effective April 2017. Already a well-established logistics operator, Adcock Ingram is the only local pharmaceutical company offering a full service pharmaceutical distribution solution. As a leading pharmaceutical company, Adcock Ingram does direct distribution nationally to wholesalers, hospitals pharmacies, and home deliveries to patients.

Cipla Medpro, the third largest pharmaceutical manufacturer in South Africa, reported on 25 November 2015 that it had launched a new 16 000 square metre pharmaceutical distribution centre in Cape Town.

On the other hand, many multinationals use distributors like DSV Global Transport and Logistics and the RTT Group (which channels supplies in many markets, not just pharmaceuticals) to store, test and distribute their drugs.

Backward vertical integration

Corporate retail pharmacies are backward integrated with distributors and wholesalers as shown in Table 13.

Table 13 – Corporate retail pharmacies and their distributors or wholesalers

Retailers	Distributors or wholesalers
Clicks	
Medicross	UPD
(None)	
Dis-Chem	CJ Distributors
Pick n Pay	Pick n Pay Pharmaceutical Wholesalers
Shoprite/Medirite	Transpharm
Spar	Spar Distribution Centre

A note on the multiple routes of products from manufacturers to retail pharmacies

14 Clicks, Integrated Annual Report, 2016

SECTION C – COMPETITION, VERTICAL INTEGRATION AND FORECLOSURE

A retail pharmacy can obtain medicine in the following ways:

- Directly from a manufacturer
- From a distributor
- From a wholesaler

Not all these options are available for every medicine. In all cases, the retail pharmacy will pay the SEP. Independent retail pharmacies may prefer to obtain their medicine from wholesalers other than those integrated with corporate retail pharmacies in order to avoid supporting their competitors, and the corporate retailers will obtain their medicines from the distributor or wholesaler with which they are integrated, or from independent wholesalers or distributors or directly from manufacturers.

UPD, CJ Distributors and Transpharm sell to retail pharmacies other than those within the same corporate structure.

Complete vertical integration

The only case of complete vertical integration is between Unicorn, UPD and Clicks.

Table 14 sets out the Unicorn products registered in the MPR.

Table 14 – Unicorn products

Active ingredients	Strength	Unit	Dosage form	Number of manufacturers
carvedilol	5	mg	TAB	1
levetiracetam	250	mg	FCT	1
clopidogrel	75	mg	FCT	1
levetiracetam	750	mg	FCT	1
escitalopram	20	mg	FCT	1
azithyromycin	500	mg	FCT	2
estradiol	0,035	mg	TAB	2
cetirizine	5	mg/5ml	SYR	2
escitalopram	10	mg	FCT	2
cyproterone	2	mg	TAB	6
carvedilol	25	mg	TAB	8
desloratidine	5	mg	TAB	8
lansoprazole	30	mg	CAP	9
lansoprazole	15	mg	CAP	10
risperidone	0,5	mg	TAB	11
bisoprolol	5	mg	TAB	12
bisoprolol	10	mg	TAB	12
risperidone	1	mg	TAB	14
lisinopril	10	mg	TAB	14
lisinopril	20	mg	TAB	16

Key:

CAP	Capsule
FCT	Film coated tablet
SYR	Syrup
TAB	Tablet

Unicorn is sole supplier of five products. Were UPD to supply these products only to Clicks, there would be input foreclosure. Were Clicks to buy only from UPD, there would be customer foreclosure.

5.4 Price discrimination

There can be no discrimination in the price at which products are sold to retailers, since they must take place at the SEP. Wholesalers and distributors are expected to take the logistics fee, negotiated for each product.

There are differences in the logistics fee as a proportion of the SEP within identical groups where there are two or more manufacturers, as Table 15 indicates.

Table 15 – Average coefficient of variation of the logistics fee as a percentage of the SEP within identical groups with two or more manufacturers

Number of manufacturers	Average coefficient of variation
2	0.26
3	0.31
4	0.32
5	0.32
6 and more	0.33

6 Application of theory to South African pharmaceutical market conditions

6.1 Price competition

There are three pricing decisions which are taken within the system of supply. They are:

1. The Single Exit Price, initially proposed by the manufacturer. Once adopted, there are limits to its flexibility, as discussed above. Given that most manufacturers are importers, these prices are often set internationally. The practice of external reference pricing[15], adopted in a number of countries, is designed to lessen price discrimination between countries. And, as has already been shown, there is price discrimination between the public and private sectors.

2. The apportionment of the Single Exit Price between the manufacturer's price and the logistics fee. An analysis of variance of the logistics fee as a percentage of the SEP reveals that the main source of variance is differences in the average logistics fee by manufacturer, with a small additional source of variance contributed by whether a medicine is an originator or generic. The logistics fee as a per cent of SEP for generics is 0.7% higher, on average, than for originators.

   An analysis of the 100 manufacturers supplying at least ten products to the private sector shows that in fifteen cases the logistics fee as a percentage of SEP does not vary across products offered. The remaining 85 manufacturers vary the logistics fee as a percentage of SEP by product.

   Why is there variation in logistics fees as a percentage of SEP across manufacturers and, in most cases, between products for a given manufacturer? A higher logistics fee means that more distributors and wholesalers will deal in a particular product and promote its sales more energetically. Put another way, the manufacturer's offer of a logistics fee will reflect its view of what is needed to make the product competitive in respect of retail pharmacy purchases. But it is not evident why the average logistics fee by manufacturer varies as widely as it does.

3. The dispensing fee. Retail pharmacies compete by setting the dispensing fee at a level below the maximum allowed by regulation. They may also compete by becoming designated or preferred service providers for medical aid scheme members, accepting dispensing fees set by the medical aid schemes. And external effects may account for dispensing fee decisions. A low dispensing fee may attract customers to the dispensary and, by so doing, encourage them to buy non-dispensary items as well.

15 The effectiveness of external reference pricing is open to question. Annexure H of the World Health Organisation's Guideline on Country Pharmaceutical Pricing Policies contains the following conclusion:
"While some countries claim ERP has had positive effects in reducing the prices of medicines there is no evidence from monitoring reports or rigorous analytical studies to support such claims", WHO, 2013

SECTION C – COMPETITION, VERTICAL INTEGRATION AND FORECLOSURE

6.2 Foreclosure

Are there incentives for foreclosure? One may distinguish between four cases:

1. *No vertical integration.* In this case, exclusive dealing would be necessary for foreclosure. The National Association of Pharmaceutical Manufacturers reports no exclusive dealing among its members[16]. They sell their products to all wholesalers willing to buy them. There is no incentive for them to do otherwise. Equally, there is no incentive for a wholesaler to enter into an exclusive contract with any retail pharmacy. Any monopoly or monopolistic rent is captured by the manufacturer, with competition between wholesalers and no input foreclosure against retail pharmacies.

2. *Forward integration between manufacturers and wholesalers/distributors.* Given economies of scale in distribution, this form of vertical integration will be attractive only to large manufacturers, who will undertake it if the costs of distribution are lower than the cost of distribution through other distributors and wholesalers. Because it lowers costs, this form of vertical integration is pro-competitive.

3. *Backward integration between corporate retail pharmacies and wholesalers and distributors.* Here the situation is that corporate retail pharmacies will want to procure as much as they can from the associated wholesalers and distributors, so that corporations will receive the logistics fee as well as dispensing fees. However, the evidence from Dis-Chem is that some procurement will be from other wholesalers and distributors[17]. Available evidence also indicates that integrated wholesalers and distributors will want to sell to other corporate pharmacies and independent pharmacies, though there may be a reluctance on the part of other pharmacies to buy.

   The question then becomes: would integrated wholesalers and distributors have an incentive to practice input foreclosure against non-integrated pharmacies in order to improve the position of pharmacies with which they are integrated. The answer appears to be no, because it is not in the interests of manufacturers that they be in a position to do so. Otherwise there would be customer foreclosure against manufacturers. To prevent such foreclosure, a manufacturer could sell through at least one independent wholesaler. So both on theoretical and empirical grounds, backward integration between corporate retail pharmacies and wholesalers and distributors does not lead to input foreclosure at the retail pharmacy level.

4. *Complete vertical integration.* This can be regarded as case (3) with integration between manufacturer and wholesaler or distributor. Here there is a risk of both customer foreclosure and input foreclosure. Customer foreclosure would be the consequence of the retail pharmacies in the supply chain not purchasing close substitutes for a product produced by the integrated manufacturer. The seriousness of the foreclosure would depend on the share of the market for the product held by integrated retail pharmacies. A monopoly will not practice input foreclosure, preferring instead to as many wholesalers and distributors as possible. Input foreclosure against non-integrated retail pharmacies would exist if integrated manufacturers supply only to the retail pharmacies in their supply chain, a possible strategy to enhance their position.

6.3 The influence of medical aid schemes

Medical aid schemes without ownership of pharmacies

Medical aid schemes can influence the pattern of final demand if

- they have formularies of medicines for which benefits are payable, or
- they designate preferred medicines, for which benefits are fully payable, with co-payments required for other medicines, or
- they use tariffs of reimbursement for expenditure on medicines.

As a general rule, medical aid rules favour generics where they are available, but there are variations on the theme. Discovery, for instance, has a list of non-preferred generics for which a co-payment is required.

When generics are available, medical aid schemes often set a Maximum Medical Aid Price (MMAP) for a product. Generic companies generally try to at least meet this price otherwise patients would have to pay in the difference themselves. As retailers would not want to inconvenience clients they normally only purchase generics that are at or below the MMPA price.

16 Personal communication, Frittelli/Simkins
17 In the UK, Boots does not allow any purchases from wholesalers not owned by them. This may indicate a future development in South Africa

Discovery owns Southern Rx, a courier pharmacy dealing in chronic medicine. At the time of writing, Discovery is finalising registration of Discovery Medical Suppliers as a wholesaler. Once this is completed, Discovery will have the following four entities:

1. Discovery Health Medical Scheme which, like all medical schemes, is not for profit.
2. An administrative division, providing administrative services to Discovery Health Medical Scheme
3. Discovery Medical Suppliers
4. Southern Rx.

Is this structure anti-competitive?

The situation has the following features:

1. There is vertical integration between Discovery Medical Suppliers and Southern Rx. The integration is limited to chronic medicines. As argued above, this situation is not in itself anti-competitive.
2. There is cross-ownership between a medical aid and its administrator and two levels of production of pharmaceuticals. As Section D of this report indicates, this introduces competition issues arising from the risk of exchange of competitively sensitive information, the ability to influence or control the strategic competitive decisions of a (partially) co-owned firm, and the possibility that cross-ownership may change incentive structures of the management of the firms.
3. The board of a holding company of a group of companies should ensure that the group governance framework addresses governance matters as is appropriate for the group[18]. The question as to how such a group governance framework will deal with related companies (as defined in Section 2(1) of the Companies Act, 71 of 2008), where there are potential conflicts of interest as detailed below.
4. There are two potential conflicts of interest of concern. The first is between Discovery Health Medical Schemes and the administrators of the scheme. The medical aid is locked into the administrator. As reported by IOL Personal Finance on 2 July 2016, the issue of the fees charged to the medical scheme by the administrator was a source of controversy at Discovery's Annual General Meeting on 23 June 2017. In 2015, the administrator made a profit of R2.07 billion in administration fees, which is 5.17 percent of the contribution income. In response, management pointed out that the scheme's administration fees, on average per beneficiary per month, are below the open medical scheme average: R118 for DHMS versus R121 for open schemes (albeit excluding self-administered schemes, which typically have lower fees) in an attempt to justify high levels of profitability by emphasising the gains from economies of scale. The second potential conflict is between Discovery Medical Suppliers and Discovery Health Medical Schemes with pressures to align the medical scheme formulary with the trading pattern of the wholesaler.
5. There are two further consequences. Discovery Medical Suppliers and Southern Rx will add to the pressure that courier pharmacies are putting on to consumer pharmacies, which risk losing all chronic medicines from their turnover[19]. Also, Discovery Medical Suppliers will be in a very powerful position to dictate generic prices, given the volume of purchases they will control.

In the light of these features, the emerging situation at Discovery is likely to attract legal scrutiny.

6.4 Two final points

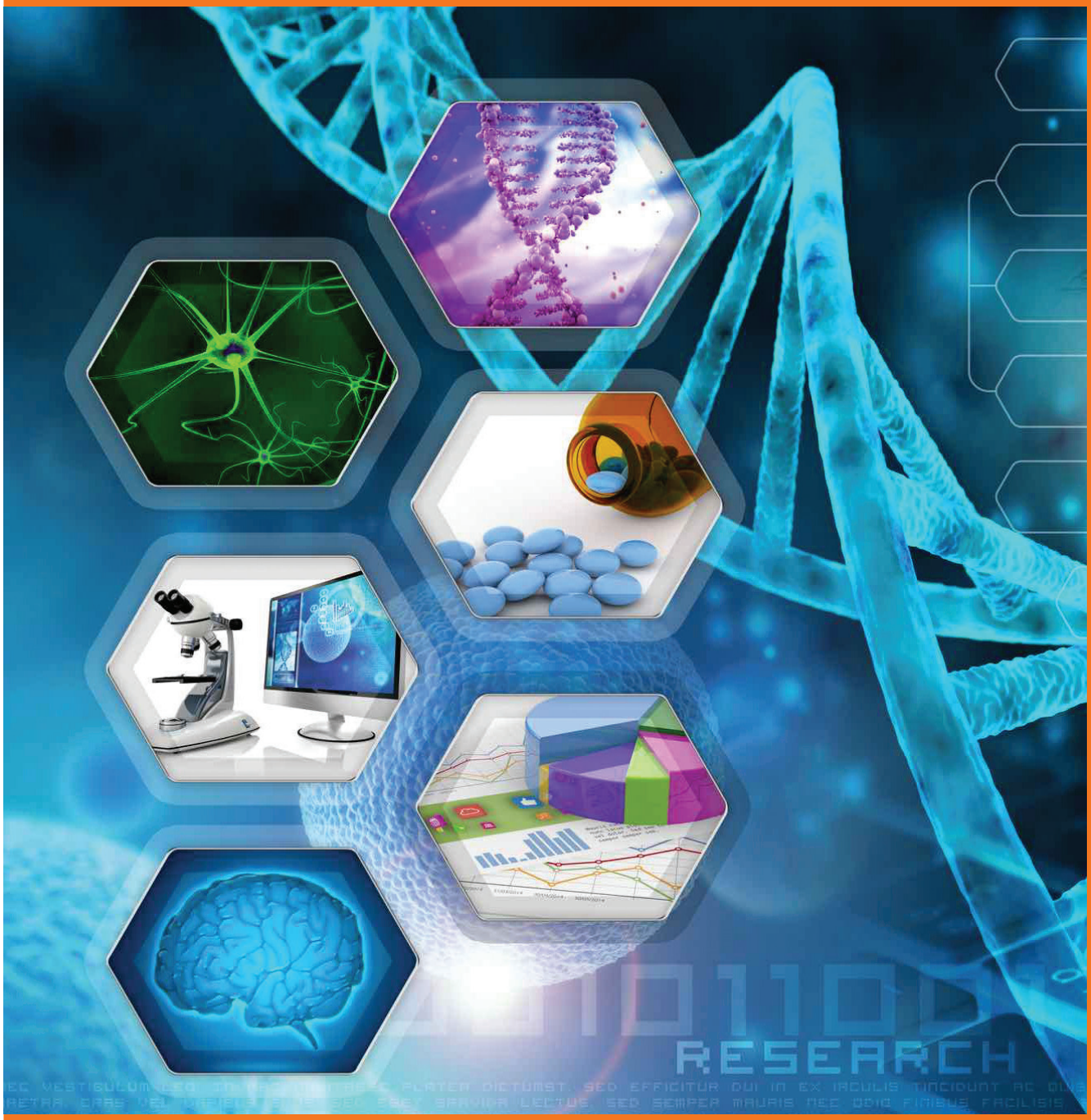
Two final points about competition need to be noted.

1. Price is a major consideration in the selection of products purchased by a retail pharmacy, but it is not the only consideration. The influence of medical aid schemes has been discussed above. Quality of service in respect of products and continuous availability also matter.
2. Medicines have expiry dates. It may be from time to time that manufacturers hold more stock than they can move before the medicines expire. The legally sanctioned route to deal with the situation is for the manufacturer to apply for a temporary price decrease in an attempt to promote throughput to the extent necessary to avoid wastage. The alternative is a temporary increase in payments to wholesalers and distributors, but it runs the risk of falling foul of Section 18A of the Medical and Related Substances Act.

18 King IV Report of Corporate Governance for South Africa, 2016

19 The potential exists for Discovery to require all their members to obtain their chronic medicines through Southern Rx or face a co-payment. This is not the current practice.

SECTION D – CROSS-OWNERSHIP AND CROSS-DIRECTORSHIPS IN THE PRIVATE SECTOR



STRUCTURE

SECTION D – CROSS-OWNERSHIP AND CROSS-DIRECTORSHIPS IN THE PRIVATE SECTOR

1 Introduction

Section 15 of the Competition Commission's Research Note Cross-ownership and cross-directorships in the South African Private Health Sector, published in May 2017, makes the following points:

> Competition problems commonly associated with cross-ownership in general are threefold:
>
> a. Cross-ownership of firms with related commercial interests may increase the risk of exchange of competitively sensitive information. This may facilitate price-collusion or restrain capacity and volumes. Interlocking directorships can play a similar role.
> b. Secondly, cross-ownership structures may increase the ability to influence or control the strategic competitive decisions of a (partially) co-owned firm.
> c. Thirdly, cross-ownership may change incentive structures of the management of the firms.

The existence of cross-ownership and cross-directorships does not in itself establish anti-competitive conduct. But they may be grounds for taking a closer look at conduct.

Moreover, Section 4(2) of the Competition Act reads as follows:

> An agreement to engage in a restrictive horizontal practice referred to in subsection (1)(b)[20] is presumed to exist between two or more firms if –
>
> (a) any one of those firms owns a significant interest in the other, or they have at least one director or substantial shareholder in common; and
> (b) any combination of those firms engages in that restrictive horizontal practice

This section of the report sets out information on cross-ownership and cross-directorships in the private pharmaceutical sector.

2 The limits of available information

In our investigations, we have encountered two major limits on information about cross-directorship and cross-ownership. The first is that private companies are not obliged to report publicly their directors or owners. This limit is particularly important in the wholesale and distributor sector. It matters much less in the case of individually owned retail pharmacies, since they are generally not in a position to behave anti-competitively.

The second limit is that information on the components of the pharmaceutical industry often cannot be separately identified within listed company reports. There are two issues here. The first arises in the case of manufacturers, since global corporations are dominant in the supply of pharmaceuticals to the South African market. The problem here is that South African operations are generally not separated out in the reports of these corporations, but are consolidated into reports of global outcomes. The second arises in the case of vertically integrated components of the pharmaceutical industry within listed South African corporations and the outcomes in respect of the components may not be separated out in company reporting.

Greater disclosure may be required in privileged settings, notably in investigations of the Competition Commission or hearings in the Competition Tribunal and the Competition Appeal Court, or in litigation. Commercially sensitive information is not published in Competition Commission reports or in court judgments.

3 Industrial structure

Manufacturers. The distribution of the 159 manufacturers supplying to the private sector is portrayed in Figure 2 above. Importers are dominant, with international companies providing the largest numbers of products. Notes on six leading manufacturers are attached as Annexure 4.

Wholesalers and distributors. While some companies specialise in wholesaling and others in distribution, many of the larger companies in this part of the supply chain are both wholesalers and distributors. The fifteen largest wholesalers account for over 95% of wholesale turnover.[21] Apart from the operations of companies, manufacturers may employ individuals to facilitate distribution to pharmacies and dispensing doctors. Notes on 21 wholesalers and/or distributors with head offices in South Africa's metropolitan municipalities are attached as Annexure 5.

Retail pharmacies. The structure of this sector is set out in Table 11 above. Notes on the six corporations owning retail pharmacies are contained in Annexure 6 and include lists of directors, organograms and analysis of shareholdings, extracted from the most recent company reports and financial statements.

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20 Subsection (1)(b) defines these practices as:
(i) directly or indirectly fixing a purchase or selling price or any other trading condition;
(ii) dividing markets by allocating customers, suppliers, territories, or specific types of goods or services; or
(iii) collusive tendering.

21 Personal communication between the CEO of the National Association of Pharmaceutical Wholesalers and the HSF, June 2017

SECTION D – CROSS-OWNERSHIP AND CROSS-DIRECTORSHIPS IN THE PRIVATE SECTOR

4 Analysis

From the information available to us, we would assess cross-directorships in the pharmaceutical industry as low, though we warn again that much relevant information is not available to us. There is not a single cross-directorship between the six companies identified in Annexure 6.

As far as cross-ownership is concerned, we believe that there are gradations in the likelihood that different forms of cross-ownership will result in anti-competitive conduct. For instance, investment by the Public Investment Corporation, and behind it the Government Employees Pension Fund which owned 88% of it in 2016, is ubiquitous among listed South African companies and Annexure 6 confirms it for the six listed companies active among retail pharmacies. But it is difficult to imagine the PIC using its cross-investment to promote anti-competitive behaviour in the pharmaceutical industry. Similarly, cross-ownership by unit trusts and similar investment funds, while certainly conditioned by the profitability of the companies in which they invest, is unlikely to involve these entities in anti-competitive behaviour. Cross-ownership by individual companies poses the greatest risk, especially when accompanied by cross-directorship, and the more direct (i.e. less intermediated) the relationship is, the more risky it becomes.

Private companies are widespread, both in the wholesale/distributor and retail pharmacy sectors. This makes it difficult for investigators, such as ourselves, to identify cross-directorships and some forms of cross-ownership within these sections of the pharmaceutical industry. Extensive access to the Companies and Intellectual Property Commission (CIPC) database of registered companies and directors would be required. A sequence of piecemeal applications to the CIPC for particular items of information will not be effective.

SECTION E – LEGAL ASPECTS

STRUCTURE

SECTION E – LEGAL ASPECTS

1 Legislation and regulations

The Pharmacy Act, No. 53 of 1974[22]

Section 22A of the Pharmacy Act provides that the Minister of Health may prescribe who may own a pharmacy and the conditions under which such person may own a pharmacy. The Pharmacy Act empowers the Minister, in consultation with the South African Pharmacy Council, to make regulations in order to achieve the purposes of the Act.

GNR 553 of 25 April 2003: Regulations relating to the Ownership and Licencing of Pharmacies[23]

As empowered by the Pharmacy Act, Section 6 of GNR.553 of 25 April 2003 provides that any person, subject to certain criteria, may own a community pharmacy (where "community pharmacy" essentially means a retail pharmacy), on condition that such person is not, inter alia, "the owner or the holder of any direct or indirect beneficial interest in a manufacturing pharmacy."

A "manufacturing pharmacy" is defined in GNR.553 as "a pharmacy wherein or from which some or all of the services as prescribed in terms of regulation 16 of the Regulations Relating to the Practice of Pharmacy are provided and which shall sell medicine only to the wholesale or retail sector or to the State". The regulation referred to (Regulation 16 of GNR.1158 of 20 November 2000: Regulations relating to the practice of pharmacy) provides that "except as provided in the Medicines Act, only the following services pertaining to the scope of a pharmacist, may be provided in a manufacturing pharmacy –

(1) the manufacturing of any medicine or scheduled substance;
(2) the purchasing, acquiring, keeping, possessing, using, supplying or selling of any medicine or scheduled substance;
(3) the furnishing of information and advice to any person with regard to medicine manufactured by him, her or it;
(4) the application for the registration of a medicine or medical device;
(5) the formulation of medicine for the purposes of registration as a medicine;
(6) the distribution of medicine or scheduled substances;
(7) the repackaging of medicine in accordance with the Medicines Act;
(8) the initiation and conducting of pharmaceutical research and development; and
(9) any other health service as may be approved by council from time to time."

- *The Pharmacy Act*

  Section 22A of the Pharmacy Act, together with Regulation 6 of the Regulations relating to the Ownership and Licensing of Pharmacies prohibit the owner of a retail pharmacy from having a direct or indirect beneficial interest in a manufacturing pharmacy.

- *Compliance*

  Rule 1.2.2.1(a) of the Rules relating to Good Pharmacy Practice state that pharmacy premises situated within another business must be clearly identified and demarcated from the premises of any other business or practice.

The Medical Schemes Act 131 of 1998 and General Regulations

The Medical Schemes Act was enacted, amongst other things, to protect the interests of medical scheme members. It established the Council for Medical Schemes, provides for the appointment of the Registrar of Medical Schemes and, importantly, regulates the registration and control of certain activities of medical schemes. The Council functions as a control and coordinating body for the functioning of medical schemes in line with national health policy. It is the body statutorily mandated to protect the interest of the members of medical schemes, investigate complaints, provide information about private health care and advise the Minister on matters relating to medical schemes.[24]

The Registrar of Medical Schemes, appointed by the Minister, is the executive officer of the Council and manages its affairs.[25] A medical scheme is registered with the Registrar once the Council is satisfied that the scheme will be managed by fit and proper people, is financially sound, complies with the provisions of the Act, does not unfairly discriminate, has sufficient members and the registration is not against public policy.

A medical scheme can be self-administered or administered by a third party or intermediary that has been accredited by the Council.[26] When considering whether or not to grant accreditation to an administrator, the Council must be satisfied that the person: (i) is fit and proper to provide administration services; (ii) has the necessary resources, systems, skills and capacity to render the administration services which it wishes to provide; and (iii) is financially sound.[27] The Council must grant the accreditation for a 24 month period, subject to conditions, if it is satisfied that the applicant has fulfilled these criteria. Once accredited, the terms and conditions regulating the relationship between the medical scheme and the administrator are recorded in a written agreement.

22 Full Act can be accessed here: https://www.mm3admin.co.za/documents/docmanager/0C43CA52-121E-4F58-B8F6-81F656F2FD17/00010723.pdf
23 Regulations can accessed here: https://www.mm3admin.co.za/documents/docmanager/0C43CA52-121E-4F58-B8F6-81F656F2FD17/00010808.pdf
24 Section 7 of the Act.
25 Section 18 of the Act.
26 Section 58(1) of the Act.
27 Regulation 17(2)(f) of the General Regulations.

The Act stipulates that the agreement must, at minimum, provide for the scope and duties of the administrator, the administrator's remuneration, the termination of the agreement, the property of the medical scheme and that the administrator must act on behalf of the scheme in accordance of the Act.[28] While the Requirements for Administration of Medical Schemes published by the Council provides baseline requirements and guidelines for provisions in the agreement, it seems that the parties are free to agree on further terms and conditions to regulate their relationship. Neither the Council nor the Registrar is involved in the agreement process until the agreement is terminated.

Although self-administered medical schemes are not required to be accredited, they are required to maintain the same level of administration as is required of third party administers. The process is included in the Requirements for Medical Scheme Administrators.

The medical scheme's board of trustees plays an oversight role insofar as it must ensure that the administration of the scheme complies with the provisions of the Act and all other laws that are applicable.[29]

The Registrar may, with the agreement of both the Council and the Minister, declare certain business practices undesirable for medical schemes or administrators.[30] To date, no practices relating to the relationship between medical schemes and administrators has been declared undesirable.

General Regulations made in terms of the Medicines and Related Substances Act, 1965 (Act 101 OF 1965), as amended

Section 22 deals with the registration of a medicine.

22(1) Any person residing and doing business in the Republic may make an application for the registration of a medicine.

(3) An application referred to in subregulation (1) shall be made on the appropriate form obtainable from the Registrar and shall be accompanied by:

a. a properly completed screening form obtainable from the Registrar;
b. a proposed label for use on the medicine;
c. where applicable, a copy of the manufacturing licence together with the current Good Manufacturing Practice certificate from the regulatory authority of the medicine's country of origin;
d. in the case of specified Schedule 5, Schedules 6, 7 and 8 substances, a certified copy of a permit to manufacture such substances;
e. data on the safety, efficacy and quality of the medicine, whether positive or negative, as may be determined by the Council;
f. proof of the existence of a manufacturing site, ie a Site Master File;
g. any other information as the Council may determine; and h. an application fee.

Section 15B provides that:

Transfer of certificates of registration

A certificate of registration may with the approval of the council be transferred by the holder thereof to any other person.

The Act entitles wholesalers and even retailers to be the applicant for registration of imported medicines. The reason why this seems not to happen is because the Registrar of the Medicines Control Council is against this practice.

2 Case studies: introduction

Three case studies will be presented. Two relate to Clicks and one to Discovery. The case studies have been selected because they illustrate controversial situations. The issues in the Clicks case are as follows:

- *Vertical Integration*

  Vertical integration applies in the supply chain as distributor, wholesaler, and retailer are subsidiaries of Clicks Group Limited. This affects competition as privately owned pharmacies will struggle to compete within a highly regulated end to end medicine supply chain environment. Clicks and Unicorn can be viewed as a single economic entity.

- *Negotiating power of corporate pharmacies*

  Independent pharmacies are barred from collectively negotiating dispensing fee rates with medical aid schemes as well as forming joint purchasing agreements with manufacturers and wholesalers since this may be seen as price fixing. As the restriction does not apply to corporate pharmacies, Clicks is exempt. This allows Clicks more negotiating power to negotiate dispensing fee rates, as well as purchase unregulated predominantly front shop items in order to sell it at lower prices.

28 Regulation 18(2) of the General Regulations.
29 Section 57(3)(h) of the Act.
30 Section 61(1) of the Act.

- *The Medicines and Related Substances Act*

  Clicks offers rebates classified as incentives on medicines regulated by a single exit price under the Healthycare benefit to Discovery Vitality members. This is unlawful. The contravention gives Clicks a competitive advantage over independent pharmacies.

- *Dominance and Exclusivity in the Market*

  The ICPA has requested that the Competition Commission evaluate Clicks' market share and power in order to determine dominance, and in particular, whether that market dominance is being abused through the exclusive availability of Unicorn products to Clicks pharmacies and (to a lesser degree) Link pharmacies (an affiliate of the Clicks Group Limited). Independent pharmacies cannot procure Unicorn products despite some of these products being on medical aid scheme formularies, a case of input foreclosure. The ICPA has raised the point that this may potentially constitute a breach of section 8(d)(i) of the Competition Act.

  Moreover, if Clicks incentivises its personnel to market Unicorn products to its customers over competing brands – even they are not the most competitive generics – then this may also constitute a breach of section 8(d)(i) of the Competition Act. The ICPA has also requested the Commission to investigate this.

  The issues relating to Discovery have been discussed in sub-section 6.3 of Section C.

  In examining how the relevant legislation takes effect in practice, it is useful to consider how both the Competition Commission and the Competition Tribunal approach mergers between firms in the pharmaceutical sector.

3 Case Study 1: The formation of the Clicks, UPD and Unicorn relationship

This case study illustrates how developments within a firm can affect competition, and how conditions at the time of mergers and acquisitions can change after the transaction.

Clicks

Clicks is a leading pharmacy, health and beauty retailer with over 500 stores countrywide. Clicks has the largest retail pharmacy chain with over 400 in-store dispensaries, with 195 primary care clinics. Clicks is the main operating business of JSE-listed Clicks Group (JSE: CLS).

UPD

On 5 December 2002, the Competition Tribunal issued a merger clearance certificate approving the merger between Clicks Pharmaceutical Wholesale (Pty) Ltd and New United Pharmaceutical Distributors (NUPD) in terms of section 16 (2)(a) of the Competition Act.[31]

The acquiring firm, Clicks Pharmaceutical Wholesale (Pty) Ltd was at the time a wholly owned subsidiary of the Clicks Organisation (Pty) Ltd, which was ultimately controlled by New Clicks Holding Limited ("New Clicks"), a publicly listed investment holding company. One of the brands that New Clicks trades through is Clicks. Clicks was the only brand relevant to this merger.

It is unclear from available resources when NUPD (Pty) Ltd became United Pharmaceutical Distributors (UPD), but UPD is now listed as a brand of the Clicks Group with its activities described as "UPD is the country's only full-line pharmaceutical wholesaler and supplies retail pharmacies, private hospitals, dispensing doctors and retail health stores. The business provides the distribution capability for the group's integrated channel to the healthcare market."

UPD is now a division of the Clicks Group. UPD holds a wholesale pharmacy licence and operates as a pharmaceutical wholesaler and distributor to Clicks retail stores as well as a number of private hospitals and independent pharmacies.

Unicorn

Unicorn Pharmaceuticals (Pty) Ltd (Unicorn) is a generic pharmaceutical products marketer which supplies Clicks retail stores with generic medication which it sources from contracted third-party manufacturers. Unicorn is authorised in terms of the Pharmacy Act to own a manufacturing pharmacy and is licensed to carry on the business of a manufacturing pharmacy only at its plant in Woodstock, Cape Town.

Unicorn Pharmaceutical Proprietary Limited and Clicks Retailers Proprietary Limited

Unicorn Pharmaceutical Proprietary Limited was issued with a manufacturing licence on 30 May 2012.[32] Clicks Group Limited is the 100% indirect owner of both Clicks Retailers Proprietary Limited and Unicorn Pharmaceutical Proprietary Limited (as stated in the Clicks Group Limited annual financial statements of 2016). As a party who owns a retail pharmacy is prohibited from having an interest in a manufacturing pharmacy (as explained above), the issuing of this licence would seem to be a contravention of the Pharmacy Act.

31 See http://www.comptrib.co.za/assets/Uploads/Case-Documents/69LMSEPT02.pdf
32 http://www.compcom.co.za/wp-content/uploads/2016/06/Annexure-C1-Manufacturing-Pharmacy-Licence.pdf

Vertical Effects

The Commission identified two vertical effects:

UPD

The Commission considered both input and customer foreclosure in the markets for the wholesale distribution of pharmaceutical and front-shop products.

The Commission found that UPD did not have the ability to engage in input foreclosure as there are a number of competing wholesalers which carried higher percentages of the total market share. As regards customer foreclosure, the Commission evaluated whether the merged entity would have the ability to foreclose other wholesalers from supplying Medicross pharmacies. It found that a majority of Medicross pharmacies are serviced by Netcare's in-house distribution function.

Additionally, it found that Medicross pharmacies accounted for less than 5 percent in the retail market for pharmaceutical products and no other wholesalers were reliant on Medicross pharmacies as customers.

Unicorn

Unicorn Pharmaceuticals is a wholly owned subsidiary of the Clicks Group. The Commission investigated whether it would result in input or customer foreclosure in the market for the manufacture and supply of pharmaceutical products.

The Commission found that Unicorn holds a negligible market share of less than 1 percent. Furthermore, Unicorn only supplies Clicks, therefore, the Commission could not find risk of input foreclosure.

The proposed transaction would not result in customer foreclosure as the majority of products sold at the target businesses are sourced from an in-house distributor where no other wholesalers are reliant on the target business. The Commission found that this remains true even though the merging parties intend to supply the target businesses with Unicorn products.

The Tribunal concluded its decision by making the finding that the proposed merger is unlikely to substantially prevent or lessen competition in any relevant market. The merger was, accordingly, approved in terms of section 16 (2)(b) of the Competition Act, with conditions.

4 Case Study 2: Merger between Netcare and Clicks

This case study examines the reasoning of the Competition Tribunal in a complex acquisition case.

Netcare

Netcare is listed on the JSE (JSE: NTC) and has a market capitalisation of R37 billion (October 2017).[33] In South Africa, Netcare operates the largest private hospital, primary healthcare, emergency medical services and renal care networks.

Chronological Sequence of Events

Netcare and Clicks entered into an agreement on 8 June 2016 to outsource the 37 retail pharmacies in the Medicross family medical and dental centres ("Medicross") and the hospital retail front shop operations ("front shops") of the Netcare Hospital division to Clicks. Clicks applied on 17 June 2016 to the Competition Commission to approve the merger between itself and Netcare pharmacies.

Clicks is the primary acquiring firm, ultimately owned and controlled by Clicks Group Limited, a public company listed on the JSE. It forms part of the retail offering of the Clicks Group.

On 28 July 2016, Competition Commission sent a letter to competitors regarding the proposed merger. They required competitors to provide reasons in contestation of the merger in order to assess whether a merger is likely to substantially prevent or lessen competition in the relevant markets. Interested competitors were requested to submit responses by 5 August 2016.

The Tribunal's Deliberations

Front-shops

Clicks' acquisition of front-shops is described by the tribunal as only extending to the retail component of in-hospital pharmacies. This is an acquisition of the retail space and business which sells products such as soaps, perfumes, or schedule 0 medications (paracetamol). It is not an acquisition of the pharmacy business or the behind-the-counter business of dispensing schedule 1 and higher medications.

The pharmacy business of Netcare hospitals will continue to remain under Netcare's ownership. There will be no transfer of any pharmacy licence from Netcare to Clicks. The reasons stipulate that branding at Netcare pharmacies will make it apparent to the consumer that the pharmacies are still owned and controlled by Netcare.

33 See https://www.netcare.co.za/netcare-investor-relations

Acquisition of Medicross Pharmacies

The acquisition of Medicross pharmacies will result in Clicks acquiring both the front-shop and retail pharmacy components of the Medicross Pharmacies. As a result, Clicks will also acquire the licences of these pharmacies.

Clicks will also enter into lease agreements with Netcare for the premises of the Medicross pharmacies and front-shop areas within the Netcare in-hospital pharmacies.

Impact on Competition

Front-shop transaction

The Commission focused on the retail of Schedule 0 medications in front-shops. In considering horizontal overlap, it found that the merged entity would also compete with non-specialised retail outlets by retailers such as large supermarkets and small independent stores, and that this constraint would continue post-merger.

There is an overlap in the provision of Schedule 0 medication, as both Netcare pharmacies and Clicks front-shops supply these products. It was established that the overlap will occur only when a doctor's prescription prescribes a Schedule 0 medicine. If the script requires more than 20 of an unscheduled medication, a pharmacist would provide it and charge a dispensing fee. If it were under 20, the unscheduled medication could be taken from the shelf.

The Commission found this overlap to be insignificant.

As regards the sensitivity of dispensing fees in Clicks and Netcare sharing the same premises, the merging parties undertook to keep this competitively sensitive information secret.

The Tribunal found that the front-shop transaction will not result in a substantial lessening or prevention of competition.

Are Medicross Pharmacies Close Competitors?

The Commission found that Clicks and Medicross pharmacies are not close competitors as Clicks has a larger product range and an expansive geographic footprint. Medicross serves a convenience function – usually located in close proximity to doctor's rooms. Medicross is therefore not considered a competitive restraint to retail pharmacies. During the Commission's investigation, this evidence was corroborated by market participants. It was noted that even on a conservative approach, the merged entities would face a number of competing pharmacies within a 5 kilometer radius of every Medicross pharmacy.

The merged entity would be constrained from raising prices of scheduled medications due to the following:

All scheduled pharmaceutical products supplied to the private sector is subject to a Single Exit Pricing (SEP) regulations

Dispensing fees charged by pharmacies are capped according to regulation. Medical Aid Schemes negotiate or have the power to set the dispensing fees which will apply to its scheme members.

Logistics fees are capped according to regulation.

The Tribunal concurred with the Commission that the Medicross transaction would not result in a substantial lessening or prevention of competition.

The Conditions as contained in the Order

Clause 2.2.1 of the Conditions state that the auditors shall not provide the Netcare Group (including its subsidiaries) with disaggregated information relating to the specific dispensing fees charged by Clicks, the specific products stocked or sold by Clicks, or the prices at which specific products are sold – Netcare must procure such undertaking from the auditors.

Clause 2.4 of the Conditions state that Netcare employees at any of its Netcare in-hospital pharmacies shall not provide any competitively sensitive information such as information relating to dispensing fees and prices of non-scheduled medicine to any Clicks employees or representatives at the Netcare in-hospital front shops.

"Future Premises" are defined as being pharmacy areas within future Medicross centres or front shops within future Netcare hospitals which Medicross or Netcare may wish to establish or develop but which are not yet in operation at the Approval Date (date referred to in Competition Tribunal's clearance certificate) but excludes relocations in terms of any existing Medicross pharmacy or Netcare hospital

Clause 3.2 of the Conditions state that nothing in the Purchase, Lease or Sub-Lease agreements shall preclude any other firm (including Medicross and Netcare) from operating a pharmacy or front-shop in Future Premises as the case may be, after three years from the Approval Date.

As concerns employment conditions, the Conditions make specific provision for the retention of existing staff and prohibits retrenchment as a consequence of the merger for a period of five years from the Implementation Date (date on which the merger is implemented by the merging parties).

Clause 4.3 specifically provides that all employees employed in the Medicross pharmacies and Netcare in-hospital front shops as cashiers will transfer to Clicks Retailers in terms of section 197 of the Labour Relations Act, on terms and conditions no less favourable than their current terms and conditions of employment.

Outcome of Tribunal Decision

On 10 November 2016, the Competition Tribunal handed down its Order concerning the merger between Clicks and Netcare pharmacies.[34] On 9 December 2016, it issued its Reasons for the Decision.

The Tribunal approved the transaction involving the outsourcing of the front shop activities which are currently conducted by the Netcare Group in the pharmacies in certain of its Netcare hospitals to the Clicks Group, as well as the sale of a number of pharmacies which it currently operates in the Medicross Centres to the Clicks Group.

Joint Media Statement from Netcare and Clicks

On 11 November 2016, Netcare and Clicks issued a joint media statement regarding the Commission and Tribunal's decision to approve the merger.[35] According to the statement, Clicks will assume control of all Medicross pharmacies on 1 December 2016 and the 45 retail front shops of the Netcare hospital division on 1 February 2016.

The statements make mention that the agreement excludes the dispensing of prescriptions in the Netcare hospital pharmacies, which remain within Netcare's hospital operations.

5 Case study 3: Discovery Health Medical Scheme and the Discovery administrator

Discovery Health

Discovery Health is a medical scheme administrator in South Africa, providing administration and managed care services. It reports 3.3 million beneficiaries. The business has a reported market share of over 40% in the overall medical scheme market in South Africa, and manages 18 restricted medical schemes on behalf of leading corporate clients, as well as Discovery Health Medical Scheme, South Africa's largest open medical scheme.[36]

Discovery Health also administers SAB Medical Aid Scheme, Netcare Medical Scheme, and Glencore Medical Scheme. Their client base includes 18 restricted medical schemes, which is more than any other medical scheme administrator in South Africa, representing approximately 635 000 restricted medical scheme members. [37]

Discovery Health Medical Scheme

The Scheme is a non-profit entity governed by the Medical Schemes Act 131 of 1998, as amended, and is regulated by the Council for Medical Schemes (CMS). An independent board of trustees (the Board) oversees the Scheme's business. The Scheme operates through a formal contractual arrangement with Discovery Health Pty (Ltd), a separate company and an authorised financial services provider, which provides the Scheme's administration and managed care services.[38] It is an open scheme, which means that any member of the public may join subject to the scheme's rules and provisions of the Act.

Is there a real separation between Discovery Health and Discovery Health Medical Scheme?

Although both Discovery Health and Discovery Health Medical Scheme are entities owned by Discovery Ltd, the scheme is not considered to be self-administered. The scheme is administered through a third-party administrator via its contractual relationship with Discovery Health.

In submissions made before the Competition Commission's Health Market Inquiry on 2 March 2016, chaired by Justice Ngcobo, Dr Jonathan Broomberg, CEO of Discovery Health, described the relationship between the two entities as follows[39]:

> "In the context of our relationship with the Discovery Health Medical Scheme we compete if you like alongside the scheme in the market for open scheme members and we are very strongly aligned as I'll share with you in more detail shortly with the objectives of the Discovery Health Medical Scheme which is strong growth and stability so we support the Discovery Health Medical Scheme as a competitor for beneficiaries in the open scheme market."

In submissions made the following day to the panel, on 3 March 2016, Principal Officer of Discovery Health Medical Scheme, Mr Milton Streak, stated the following[40]:

> "I want to emphasize that the medical scheme's oversight structure is the board of trustees. I will deal with that in a lot more detail, but the medical scheme has a non-profit entity, contracts with an administrator and managed care organization, an accredited managed care organization and in this instance, we have contacted the managed care and administration services to Discovery Health (Pty) Limited. I want to make the point that the Discovery Health medical scheme is completely independent from the Discovery Health group and Discovery Health (Pty) Limited."

In response to the panel's probing around the legality of this relationship, the Scheme's justification was that the scheme "belongs to its members"[41], in that contributions are pooled for the benefit of members and the scheme is thus obliged to pay its member's claims. Moreover, the board of trustees is elected by scheme members.

34 See http://www.comptrib.co.za/assets/Uploads/LM055Jul16.pdf
35 See http://www.clicksgroup.co.za/media-centre/press-releases/2016-11-11.html
36 https://www.discovery.co.za/medical-aid/about-discovery-health
37 https://www.discovery.co.za/marketing/integrated-annual-report/?page=46
38 https://www.discovery.co.za/medical-aid/about-discovery-health-medical-scheme
39 http://www.compcom.co.za/wp-content/uploads/2016/03/Health-Market-Inquiry_2-March-2016-Final.pdf at pages 6-7
40 http://www.compcom.co.za/wp-content/uploads/2016/03/Health-Market-Inquiry-3-March-Final-Transcript.pdf at page 60
41 Ibid at pages 60-61

Justice Ngcobo questioned the implementation of this decision-making power by querying whether Metropolitan could administer the scheme – while the answer to this question is yes, the decision to elect Discovery Health was justified by Streak through his presentation on the scheme's business' model which is a "vested outsourcing model"[42]. In essence, the decision by scheme's board to elect Discovery Health as its administrator is based on specific factors that determine the best third party to outsource to.

Streak divulged that during 2011 and 2012, the board of trustees engaged Deloitte Consulting to provide a report on the scheme's operating model and conduct a governance review.

Five key findings in this regard:

1) The scheme is led by a strong and independent board with firm policies of good governance.[43]
2) The integrated model (where the scheme outsources operations to one service provider i.e. Discovery Health) costs less and delivers better performance.[44]
3) A peer-reviewed methodology designed to quantify "value" to members through the administration fees paid to Discovery Health, showed that "for every R1 spent on administration and managed care fees, beneficiaries of the Discovery Health medical scheme receive an additional value of between R1.77 and R2.02."[45]
4) Members are R147 better off each month due the scheme's value proposition when it comes to their contributions.[46]
5) Using the 5 criteria of "financial strength, growth and sustainability, nonhealthcare expenditure, compliance governance and reputation and quality and value for money" the scheme outperformed all its benchmarked open schemes in the Deloitte performance model.[47]

Conclusion

In assessing this purported separation between the two entities, both the scheme and its administrator have evidenced both the legality of the corporate governance structuring and the rationalisation of their business model.

There is no specific prohibition on either the governance structure or the integrated outsourcing model in the Act or its regulations. Moreover, through the submissions presented to the Health Market Inquiry panel, we know that the Competition Commission is alive to the relationship between the scheme and its administrator.

This, of course, does not preclude the possibility of restrictive practices within either entity. The scheme argues that it is incentivised to prioritise its members' interests since it is a non-profit entity. However, both the scheme and its administrator exist under the umbrella body of Discovery Ltd. This close proximity has obvious implications for potential conflicts of interests that adversely affect members' interests, but the ability to assess the extent of this largely depends on what is reported by both the scheme and the administrator. The inextricable interdependency of the scheme and administrator creates tension in that the board may never decide against electing Discovery Health as its administrator, despite it possibly being against the interests of its members. Both must be watched closely by stakeholders.

The issues arising from Discovery's ownership of Discovery Medical Suppliers and Southern Rx are discussed in Paragraph 6.3 of Section C above.

6 The Competition Tribunal

As can be seen from the second case study, and other similar orders handed down by the Tribunal, the analysis before approving a merger is based purely on the Competition Act. Neither the Commission nor the Tribunal takes into the account the Pharmacy Act or its regulations when making an order. It is unclear why this discrepancy between law and practice arises as the law is very clear about the relationship between retail and wholesale pharmacies as concerns ownership.

Moreover, the Tribunal's decisions can be based only on the current situation. The Tribunal does not project growth when considering the impact on competition. Doing so it seems would be akin to a "crystal ball gazing" exercise that the Tribunal is not placed to engage in.

The question of whether the Tribunal has the jurisdiction to consider legislation outside of the Competition Act comes down to its mandate. According to the Tribunal's website, it reads "The Competition Tribunal adjudicates competition matters, in accordance with the act and has jurisdiction throughout South Africa. It is independent and subject to the constitution and the law."[48] Being subject to the law implies that the Tribunal is subject to *any and all* applicable law of South Africa relevant to proceedings before it.

However, section 26 (1) (d) of the Competition Act states that the Tribunal "must exercise its functions in accordance with *this Act*" (emphasis not added)[49]. A strict interpretation of this clause might suggest that the Tribunal is bound to adjudicate only in terms of the Act, and may not consider other legislation in making its orders. However, the Tribunal has often taken into account instruments of labour law legislation such as the Labour Relations Act when employment questions arise in the consideration of a merger approval. These are especially prevalent in the

42 Ibid at pages 68-73
43 Ibid at page 70
44 Ibid at page 70
45 Ibid at pages 71-72
46 Ibid at page 72
47 Ibid at page 72-73
48 See http://www.comptrib.co.za/about/mandate-and-role/
49 26. Establishment and Constitution of Competition Tribunal (1) There is hereby established a body to be known as the Competition Tribunal, which (a) has jurisdiction throughout the Republic; (b) is a juristic person; (c) is a Tribunal of record; and (d) must exercise its functions in accordance with this Act

conditions that sometimes accompany a merger approval order.[50] The Tribunal may also take into account what it deems as public interest considerations.

Section 26 (1) (d), then, would suggest a procedural imperative on the Tribunal by use of the word "functions". The Tribunal prioritises questions of competition, guided by the prescripts of the Act, when considering the approval of a merger. Moreover, the Tribunal relies heavily on the investigation and recommendation by the Competition Commission. So much so that it rarely goes beyond the substantive information provided by the Commission in its deliberations.

The Tribunal abides strictly by its core mandate, which is to ensure that all relevant competition questions in terms of the Act are considered. Unless directly tasked to do so, it does not of its own accord venture into applicable legislation not brought before it. The effect of a Tribunal order is different to a normal order of court insofar as it serves as a "clearance certificate" of sorts – that there are no restrictive practices at play between the merging parties which would render the merger uncompetitive. The order thus does not prevent alternative legal challenges to ownership, licensing or merger questions. It evidences that the Tribunal has satisfied itself as to the questions of competition in terms of the Competition Act and to assure the parties that limited to no liability should arise from a competition law perspective.

The information placed before the Commission and subsequently the Tribunal comes primarily from the merging parties themselves. This leaves a gap in terms of pertinent information which the Tribunal should be mindful of when approving a merger. The Commission does afford objecting third parties a chance to make representations during the investigations. How persuasive these are, especially where they point to prescriptive industry or sector specific legislation, differs case by case.

It is interesting to note that in many of the merger decisions looked at in compiling this report, the absence of industry regulators such as the Pharmaceutical Society of South Africa (PSSA) enables the Tribunal to act in such a limited way. Were such bodies to play a more proactive role alongside the Commission and Tribunal, questions of law which arise from legal instruments other than the Competition Act may play a more prominent, and consequently a more instructive role, in the Commission's findings and Tribunal's decisions.

7 The ICPA's representations

7.1 Introduction

On 4 August 2016, the ICPA wrote to the Competition Commission to express concern over the proposed merger between Clicks Retailers and Netcare pharmacies[51]. The issues raised were as follows:

- The proposed merger means that Clicks pharmacies take over control from Medicross pharmacies. They will need to apply for new community pharmacy licences so that they may conduct business as community pharmacies. The granting of these licences contravenes the Pharmacy Act.
- Pharmacies situated within Netcare hospitals have institutional pharmacy licences while those situated within Medicross have community pharmacy licences.
- Institutional pharmacies cannot provide pharmaceutical services to the general public but only to in-patients of the facility. The proposed Netcare front shop operations taken over by Clicks may only sell unscheduled medicine and other unregulated products located in the front shop.

7.2 Minutes of ICPA Meeting with the Minister of Health

According to the minutes[52], members of the ICPA met with Health Minister, Aaron Motsoaledi, on 14 October 2016, to discuss issues that the ICPA felt were yet to be resolved. Among its concerns, was the relationship between Clicks and Unicorn, and the issue of vertical integration. The ICPA argued that the Click's Group were in contravention of the Pharmacy Act by owning pharmacies and having a beneficial interest in a pharmaceutical manufacturer.

The ICPA alleges that before new Clicks pharmacies open they sign affidavits that state under oath that they have no direct or indirect beneficial interest in a manufacturing company.

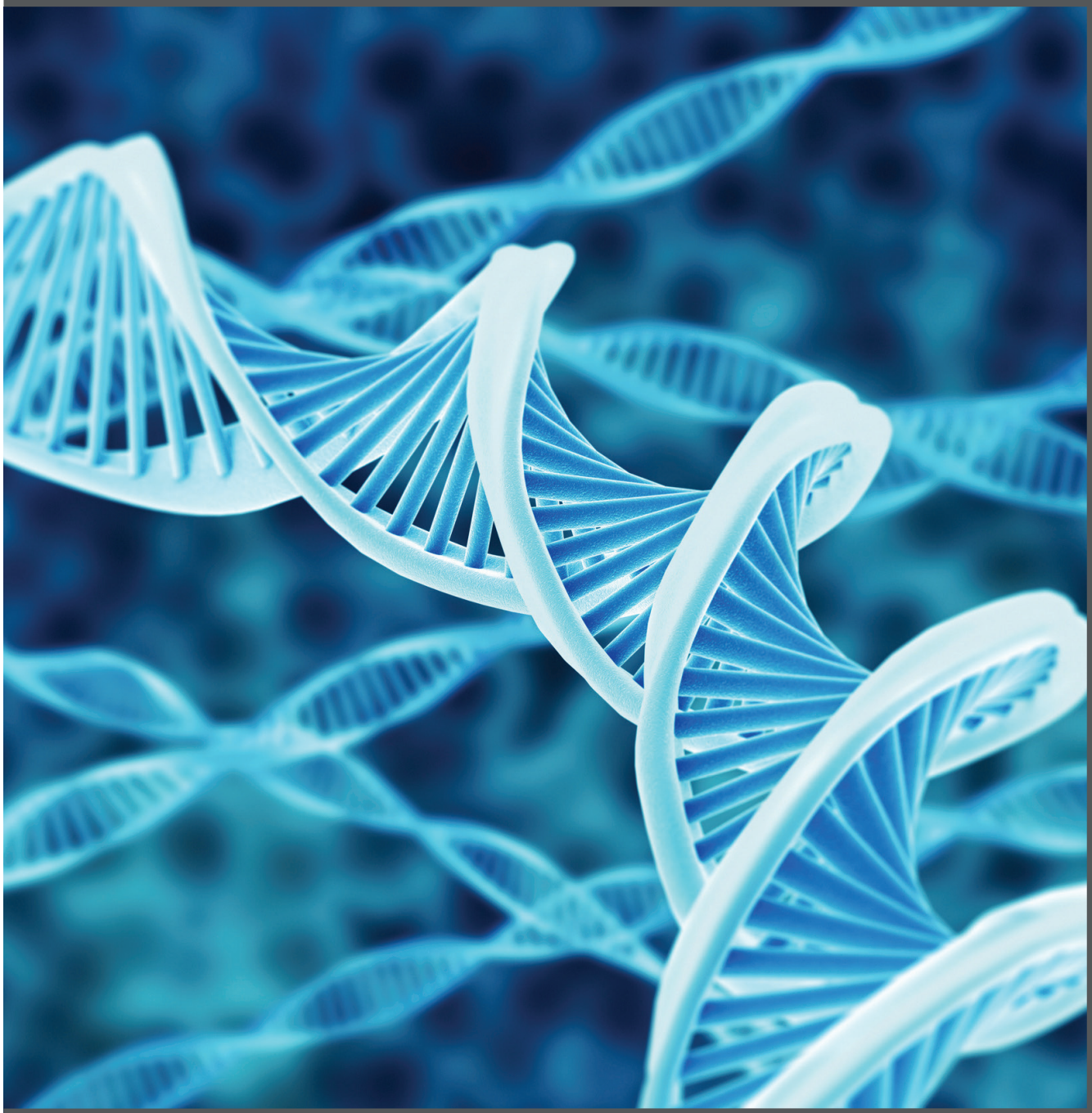
It is further alleged that at the meeting, the Minister enquired as to whether the ICPA had communicated this concern to the Deputy Director General and if so, what actions he had taken. The response from the CEO of the ICPA, Mark Payne, was that the DDG last corresponded two months prior to the meeting wherein he informed the ICPA that the matter had been referred to the State Attorney. Payne relayed that according to the Department of Health, a moratorium has been placed on the issuing of new Clicks pharmacy licences while the case is being investigated.

The ICPA urges that this will require monitoring.

The ICPA concludes by restating its concern over an increase in Clicks market share and market power in a regulatory environment that independent pharmacies struggle to compete. They urge the Competition Commission not to grant approval for the merger.

50 For example, see Annexure A in https://www.comptrib.co.za/assets/Uploads/019893.pdf
51 See https://icpa.co.za/wp-content/themes/ypo-theme/pdfs/Submission-to-Competition-Commission-.pdf
52 See Annexure 5 of this report

ANNEXURES



ANNEXURE 1 – LIST OF MANUFACTURERS

Manufacturer	Generics	Originators	Total private	Output	Total public	Sector
3M SA (Pty) Ltd	0	4	4	Wholly originator	0	Private only
AHN Pharma (Pty) Ltd	0	14	14	Wholly originator	0	Private only
AbbVie (Pty) Ltd	3	24	27	Mainly originator	7	Both
Abbott Laboratories SA (Pty) Ltd	9	53	62	Mainly originator	4	Both
Abex Pharmaceutica (Pty) Ltd	3	0	3	Wholly generic	0	Private only
Accord Healthcare (Pty) Ltd	84	0	84	Wholly generic	29	Both
Actavis Pharma (Pty) Ltd	9	0	9	Wholly generic	0	Private only
Activo Health (Pty) Ltd	13	0	13	Wholly generic	2	Both
Actor Pharma (Pty) Ltd	30	1	31	Mainly generic	3	Both
Adcock Ingram Critical Care (Pty) Ltd	23	442	465	Mainly originator	52	Both
Adcock Ingram Healthcare (Pty) Ltd	2	8	10	Mainly originator	39	Both
Adcock Ingram Ltd	629	81	710	Mainly generic	0	Private only
Africa X-Ray Industrial And Medical (Pty) Ltd	0	0	0	Wholly originator	1	Public only
Akacia Health Care (Pty) Ltd	50	12	62	Mainly generic	16	Both
Alcon Laboratories SA (Pty) Ltd	0	51	51	Wholly originator	21	Both
Alkem Laboratories (Pty) Ltd	7	0	7	Wholly generic	0	Private only
Allergan Pharmaceuticals (Pty) Ltd	0	24	24	Wholly originator	8	Both
Alliance Pharmaceuticals	60	25	85	Mixed	0	Private only
Allied Drug Company	0	12	12	Wholly originator	0	Private only
Amgen SA (Pty) Ltd	0	16	16	Wholly originator	2	Both
Anmaraté (Pty) Ltd	2	0	2	Wholly generic	0	Private only
Arrow Pharma SA (Pty) Ltd	51	0	51	Wholly generic	0	Private only
Astellas Pharma (Pty) Ltd	2	23	25	Mainly originator	3	Both
Astrazeneca Pharmaceuticals (Pty) Ltd	9	100	109	Mainly originator	10	Both
Aurobindo Pharma (Pty) Ltd	89	0	89	Wholly generic	5	Both
Austell Laboratories (Pty) Ltd	84	0	84	Wholly generic	39	Both
Axim Pharmaceuticals (Pty) Ltd	0	31	31	Wholly originator	0	Private only
B.Braun Medical (Pty) Ltd	124	46	170	Mixed	23	Both
Baroque Pharmaceuticals (Pty) Ltd	0	1	1	Wholly originator	0	Private only
Barrs Pharmaceuticals Industries (Pty) Ltd	0	0	0	Wholly originator	32	Public only
Baxter Healthcare SA (Pty) Ltd	0	0	0	Wholly originator	7	Public only
Bayer (Pty) Ltd	1	130	131	Mainly originator	23	Both
Be Tabs Pharmaceuticals (Pty) Ltd	136	0	136	Wholly generic	0	Private only
Bennetts The Chemists (Pty) Ltd	0	3	3	Wholly originator	0	Private only
Biogaran SA (Pty) Ltd	16	0	16	Wholly generic	0	Private only
Biotech Laboratories (Pty) Ltd	82	1	83	Mainly generic	31	Both
Bliss Pharmaceuticals (Pty) Ltd	1	0	1	Wholly generic	1	Both
Bodene (Pty) Ltd	53	6	59	Mainly generic	0	Private only
Boston Scientific (Pty) Ltd	1	0	1	Wholly generic	0	Private only
Brimpharm SA (Pty) Ltd	23	0	23	Wholly generic	0	Private only
Bristol Myers Squibb (Pty) Ltd	0	97	97	Wholly originator	1	Both
Brunel Laboratoria (Pty) Ltd	0	6	6	Wholly originator	0	Private only
Camox Pharmaceuticals (Pty) Ltd	38	0	38	Wholly generic	0	Private only
Caps Pharmaceuticals	27	4	31	Mainly generic	0	Private only
Cipla Life Sciences (Pty) Ltd	16	0	16	Wholly generic	0	Private only
Cipla Medpro (Pty) Ltd	248	10	258	Mainly generic	58	Both
Concord Food & Drug Distributors CC	0	7	7	Wholly originator	0	Private only
Delfran (Pty) Ltd	0	1	1	Wholly originator	0	Private only
Dezzo Trading 392	33	1	34	Mainly generic	38	Both

ANNEXURE 1 – LIST OF MANUFACTURERS

Manufacturer	Generics	Originators	Total private	Output	Total public	Sector
Dr Reddy's Laboratories (Pty) Ltd	55	0	55	Wholly generic	8	Both
Eco Pharmaceuticals (Pty) Ltd	2	0	2	Wholly generic	0	Private only
Eli Lilly SA (Pty) Ltd	0	48	48	Wholly originator	0	Private only
Elttab Pharmaceuticals	1	0	1	Wholly generic	0	Private only
Emcure Pharmaceuticals SA (Pty) Ltd	8	0	8	Wholly generic	1	Both
Equity Pharmaceuticals (Pty) Ltd	4	12	16	Mixed	3	Both
Ferring (Pty) Ltd	3	29	32	Mainly originator	4	Both
Fresenius Kabi Manufacturing SA (Pty) Ltd	61	330	391	Mainly originator	63	Both
Fresenius Medical Care SA (Pty) Ltd	2	17	19	Mainly originator	0	Private only
GE Healthcare (Pty) Ltd	0	4	4	Wholly originator	5	Both
Galderma Laboratories SA (Pty) Ltd	0	12	12	Wholly originator	0	Private only
Genop Healthcare (Pty) Ltd	4	0	4	Wholly generic	0	Private only
Genzyme Biopharmaceuticals SA (Pty) Ltd	0	11	11	Wholly originator	0	Private only
GlaxoSmithKline SA (Pty) Ltd	9	269	278	Mainly originator	0	Private only
Glenmark Pharmaceuticals SA (Pty) Ltd	29	14	43	Mixed	5	Both
Goldex 775 (Pty) Ltd	5	15	20	Mixed	0	Private only
Gulf Drug Company (Pty) Ltd	82	0	82	Wholly generic	42	Both
H. Lundbeck (Pty) Ltd	0	15	15	Wholly originator	0	Private only
Hetero Drugs SA	13	0	13	Wholly generic	0	Private only
Ingelheim Pharmaceuticals (Pty) Ltd	5	125	130	Mainly originator	1	Both
Ingwe Lifescience (Pty) Ltd	3	0	3	Wholly generic	0	Private only
Innovata Pharmaceuticals (Pty) Ltd	35	0	35	Wholly generic	5	Both
Janssen Pharmaceutica (Pty) Ltd	0	142	142	Wholly originator	8	Both
Johnson & Johnson (Pty) Ltd	0	107	107	Wholly originator	0	Private only
Key Oncologics (Pty) Ltd	9	10	19	Mixed	0	Private only
Lasara Traders (Pty) Ltd	17	0	17	Wholly generic	0	Private only
LeBasi Pharmaceuticals CC	31	2	33	Mainly generic	0	Private only
Litha Pharma (Pty) Ltd	45	9	54	Mainly generic	14	Both
Litha Vaccines (Pty) Ltd	0	5	5	Wholly originator	3	Both
Loock Pharmaceuticals (Pty) Ltd	0	1	1	Wholly originator	0	Private only
Lundbeck SA (Pty) Ltd	0	0	0	Wholly originator	6	Public only
MC Pharma (Pty) Ltd	3	11	14	Mixed	0	Private only
MSD (Pty) Ltd	7	141	148	Mainly originator	11	Both
Macleods Pharmaceuticals SA (Pty) Ltd	16	0	16	Wholly generic	1	Both
Mallinckrodt (Pty) Ltd	0	32	32	Wholly originator	0	Private only
Meda Pharma SA (Pty) Ltd	0	20	20	Wholly originator	3	Both
Medchem Pharmaceuticals	0	1	1	Wholly originator	0	Private only
Medi Challenge (Pty) Ltd	0	6	6	Wholly originator	1	Both
Medicine Developers International (Pty) Ltd	66	3	69	Mainly generic	21	Both
Medivision (Pty) Ltd	5	0	5	Wholly generic	4	Both
Medpro Pharmaceutica (Pty) Ltd	21	2	23	Mainly generic	0	Private only
Medwich Pharma (Pty) Ltd	1	0	1	Wholly generic	0	Private only
Mentholatum SA (Pty) Ltd	1	0	1	Wholly generic	0	Private only
Merck (Pty) Ltd	0	85	85	Wholly originator	8	Both
Meyerzall Laboratories (Pty) Ltd	2	0	2	Wholly generic	0	Private only
Micro Healthcare	17	0	17	Wholly generic	0	Private only
Mintedge Trading (Pty) Ltd	0	0	0	Wholly originator	1	Public only
Mirren (Pty) Ltd	23	8	31	Mixed	3	Both
Mundipharma (Pty) Ltd	2	22	24	Mainly originator	0	Private only

Manufacturer	Generics	Originators	Total private	Output	Total public	Sector
Mylan (Pty) Ltd	123	1	124	Mainly generic	37	Both
NTP Radioisotopes (Pty) Ltd	0	80	80	Wholly originator	0	Private only
National Bioproducts Institute (NPC)	17	0	17	Wholly generic	9	Both
Noko Healthcare Cc	0	0	0	Wholly originator	5	Public only
Norgine (Pty) Ltd	0	21	21	Wholly originator	0	Private only
Novagen Pharma (Pty) Ltd	57	0	57	Wholly generic	0	Private only
Novartis SA (Pty) Ltd	15	207	222	Mainly originator	22	Both
Novo Nordisk (Pty) Ltd	0	34	34	Wholly originator	13	Both
Octapharma SA (Pty) Ltd	0	8	8	Wholly originator	0	Private only
Omnimed	0	3	3	Wholly originator	0	Private only
Opus Pharmaceuticals (Pty) Ltd	0	2	2	Wholly originator	0	Private only
Orchid Pharmaceuticals SA (Pty) Ltd	1	0	1	Wholly generic	0	Private only
Orphan SA Pharmaceuticals (Pty) Ltd	0	3	3	Wholly originator	0	Private only
Orthomedics Pharmaceuticals (Pty) Ltd	1	2	3	Mixed	0	Private only
Pfizer Laboratories (Pty) Ltd	0	241	241	Wholly originator	40	Both
Pharma Dynamics (Pty) Ltd	133	0	133	Wholly generic	3	Both
Pharma Q (Pty) Ltd	63	0	63	Wholly generic	17	Both
Pharmacare Ltd	824	91	915	Mainly generic	106	Both
Pharmaceutical Contractors (Pty) Ltd	4	0	4	Wholly generic	4	Both
Pharmaceutical Enterprises (Pty) Ltd	0	29	29	Wholly originator	0	Private only
Pharmachem Laboratories (Pty) Ltd	0	0	0	Wholly originator	13	Public only
Pharmachemie (Pty) Ltd	38	0	38	Wholly generic	0	Private only
Pharmacia SA (Pty) Ltd	16	0	16	Wholly generic	0	Private only
Pharmaco Distribution (Pty) Ltd	2	25	27	Mainly originator	8	Both
Pharmacorp CC	1	0	1	Wholly generic	0	Private only
Pharmadyne Healthcare (Pty) Ltd	2	0	2	Wholly generic	0	Private only
Pharmafrica (Pty) Ltd	13	0	13	Wholly generic	0	Private only
Pharmaplan (Pty) Ltd	76	22	98	Mixed	0	Private only
Pharmascript Pharmaceuticals Ltd	29	0	29	Wholly generic	0	Private only
Portfolio Pharmaceuticals (Pty) Ltd	0	0	0	Wholly originator	8	Public only
Procter & Gamble SA (Pty) Ltd	5	0	5	Wholly generic	0	Private only
Qualipharm CC	0	0	0	Wholly originator	5	Public only
Ranbaxy SA (Pty) Ltd	168	6	174	Mainly generic	26	Both
Reckitt Benckiser Healthcare SA (Pty) Ltd	0	6	6	Wholly originator	0	Private only
Reckitt Benckiser Pharmaceuticals (Pty) Ltd	1	20	21	Mainly originator	0	Private only
Resmed Healthcare CC	0	0	0	Wholly originator	17	Public only
Roche Products (Pty) Ltd	0	133	133	Wholly originator	25	Both
SCP Pharmaceuticals (Pty) Ltd	2	0	2	Wholly generic	0	Private only
Safeline Pharmaceuticals (Pty) Ltd	14	2	16	Mainly generic	5	Both
San Vaccine Producers (Pty) Ltd	0	3	3	Wholly originator	0	Private only
Sandoz SA (Pty) Ltd	379	0	379	Wholly generic	26	Both
Sanichem (Pty) Ltd	0	0	0	Wholly originator	7	Public only
Sanofi Aventis SA (Pty) Ltd	65	195	260	Mixed	55	Both
Schering-Plough (Pty) Ltd- (Site1)	0	23	23	Wholly originator	0	Private only
Sekpharma (Pty) Ltd	0	22	22	Wholly originator	0	Private only
Servier Laboratories SA (Pty) Ltd	2	25	27	Mainly originator	0	Private only
Smith & Nephew Pharmaceuticals (Pty) Ltd	1	2	3	Mixed	4	Both
Soflens (Pty) Ltd	0	20	20	Wholly originator	0	Private only
Sonke Pharmaceuticals (Pty) Ltd	4	0	4	Wholly generic	4	Both

ANNEXURE 1 – LIST OF MANUFACTURERS

Manufacturer	Generics	Originators	Total private	Output	Total public	Sector
Specpharm (Pty) Ltd	67	0	67	Wholly generic	0	Private only
Strides S.A. Pharmaceuticals (Pty) Ltd	1	0	1	Wholly generic	0	Private only
Sun Pharmaceuticals SA (Pty) Ltd	9	0	9	Wholly generic	0	Private only
Takeda (Pty) Ltd	4	32	36	Mainly originator	0	Private only
Technikon Laboratories (Pty) Ltd	0	6	6	Wholly originator	0	Private only
Tema Medical (Pty) Ltd	2	6	8	Mixed	0	Private only
Teva Pharmaceuticals (Pty) Ltd	39	2	41	Mainly generic	12	Both
The Biovac Institute	0	3	3	Wholly originator	10	Both
The Dental Warehouse (Pty) Ltd	5	0	5	Wholly generic	0	Private only
Thebe Medicare (Pty) Ltd	57	0	57	Wholly generic	0	Private only
Trinity Pharma (Pty) Ltd	26	12	38	Mixed	0	Private only
Triton Enterprises CC	0	0	0	Wholly originator	3	Public only
Unichem SA (Pty) Ltd	25	0	25	Wholly generic	0	Private only
Unicorn Pharmaceuticals (Pty) Ltd	20	0	20	Wholly generic	0	Private only
Unitrade 1032 CC	0	0	0	Wholly originator	1	Public only
Watson Pharma No1 (Pty) Ltd	8	1	9	Mainly generic	0	Private only
Western Province Blood Transfusion Service	13	0	13	Wholly generic	0	Private only
Winthrop Pharmaceuticals (Pty) Ltd	45	34	79	Mixed	0	Private only
Wyeth Consumer Healthcare	0	6	6	Wholly originator	0	Private only
Xixia Pharmaceuticals (Pty) Ltd	99	1	100	Mainly generic	0	Private only
Zentiva SA (Pty) Ltd	0	0	0	Wholly originator	1	Public only
Zinplex Marketing Cc	0	0	0	Wholly originator	3	Public only
Zydus Healthcare SA (Pty) Ltd	92	0	92	Wholly generic	2	Both
iNova Pharmaceuticals (Pty) Ltd	0	40	40	Wholly originator	8	Both
iPharma (Pty) Ltd	2	0	2	Wholly generic	0	Private only
iThemba Labs	0	18	18	Wholly originator	0	Private only
Total	**5 115**	**4 137**	**9 252**		**1 175**	

ANNEXURE 2 – ACTIVE INGREDIENTS BY ATC 3 CATEGORY

Code	Description	Private	Public
A	Alimentary tract and metabolism	1	0
A01A	Stomatological preparations	1	3
A02A	Antacids	4	1
A02B	Drugs for peptic ulcer and gastro-oesophageal reflux disease	10	3
A02X	Other drugs for acid related disorders	0	0
A03A	Drugs for functional gastro-intestinal disorders	5	1
A03B	Belladonna and derivatives, plain	3	2
A03C	Anti-spasmodics in combination with pyscholeptics	1	0
A03D	Anti-spasmodics in combination with analgesics	0	0
A03E	Anti-spasmodics and anti-cholinergics in combination with other drugs	1	0
A03F	Propulsives	5	2
A04A	Anti-emetics and anti-nauseants	8	1
A05A	Bile therapy	0	0
A05B	Liver therapy, lipotropics	1	0
A05C	Drugs for bile therapy and lipotropics in combination	0	0
A06A	Drugs for constipation	6	4
A07A	Intestinal anti-infectives	1	1
A07B	Intestinal adsorbents	3	0
A07C	Electrolytes with carbohydrates	0	0
A07D	Anti-propulsives	2	1
A07E	Intestinal anti-inflammatory agents	2	1
A07F	Antidiarrheal microorganisms	0	0
A07X	Other anti-diarrheals	0	0
A08A	Anti-obesity preparations, excluding diet products	6	0
A09A	Digestives, including enzymes	5	2
A10A	Insulins and analogues	6	1
A10B	Blood glucose lowering drugs, excluding insulins	16	4
A10X	Other drugs used in diabetes	0	0
A11A	Multivitamins, combinations	0	0
A11B	Multivitamins, plain	1	0
A11C	Vitamins A and D, including combinations of the two	3	4
A11D	Vitamin B1, plain and in combinations with vitamin B6 and B12	2	1
A11E	Vitamin B-complex, including combinations	1	1
A11G	Ascorbic acid (Vitamin C), including combinations	0	1
A11H	Other plain vitamin preparations	1	2
A11J	Other vitamin products, combinations	0	0
A12A	Calcium	3	4
A12B	Potassium	1	3
A12C	Other mineral supplements	0	1
A13A	Tonics	0	0
A14A	Anabolic steroids	2	0
A14B	Other anabolic agents	0	0
A16A	Other alimentary tract and metabolism products	4	0
B01A	Anti-thrombotic agents	24	5
B02A	Anti-fibrinolytics	2	1
B02B	Vitamin K and other hemostatics	12	4
B03A	Iron preparations	11	4
B03B	Vitamin B12 and folic acid	2	2
B03X	Other anti-anemic preparations	3	1
B05A	Blood and related products	7	1
B05B	I V solutions	7	5
B05C	Irrigating solutions	3	4
B05D	Peritoneal dialytics	0	0
B05X	I V solution additives	12	1
B05Z	Hemodialytis and hemofiltrates	0	0

ANNEXURE 2 – ACTIVE INGREDIENTS BY ATC 3 CATEGORY

Code	Description	Private	Public
B06A	Other hematological agents	1	0
C01A	Cardiac glycosides	1	1
C01B	Anti-arrythmics, class I and III	5	2
C01C	Cardiac stimulants, excluding cardiac glycosides	6	4
C01D	Vasodilators used in cardiac diseases	2	1
C01E	Other cardiac preparations	3	1
C02A	Anti-adrenergic agents, centrally acting	3	1
C02B	Anti-adrenergic agents, ganglion-blocking	0	0
C02C	Anti-adrenergic agents, peripherally acting	2	1
C02D	Arteriolar smooth muscle, agents acting on	3	1
C02K	Oher anti-hypertensives	1	0
C02L	Anti-hypertensives and diuretics in combination	0	0
C02N	Combinations of hypertensives in ATC 2 category C02	0	0
C03	Diuretics	1	0
C03A	Low-ceiling diuretics, thiazides	2	1
C03B	Low-ceiling diuretics, excluding thiazides	1	0
C03C	High-ceiling diuretics	4	1
C03D	Potassium-sparing agents	2	1
C03E	Diuretics and potassium-sparing agents in combination	1	0
C03X	Other diuretics	0	0
C04A	Peripheral vasodilators	3	0
C05A	Agents for treatment of hemorrhoids and anal fissures for topical use	4	0
C05B	Anti-varicose therapy	2	0
C05C	Capillary stablizing agents	1	0
C07A	Beta blocking agents	12	3
C07B	Beta blocking agents and thiazides	0	0
C07C	Beta blocking agents and other diuretics	0	0
C07D	Beta blocking agents, thiazides and other diuretics	0	0
C07E	Beta blocking agents and vasodilators	0	0
C07F	Beta blocking agents and other anti-hypertensives	0	0
C08C	Selective calcium channel blockers with mainly vascular effects	4	1
C08D	Selective calcium channel blockers with direct cardiac effects	2	1
C08E	Non-selective calcium channel blockers	0	0
C08G	Calcium channel blockers and diuretics	0	0
C09A	ACE inhibitors, plain	11	2
C09B	ACE inhibitors, combinations	3	0
C09C	Angiotensin II antagonists, plain	6	0
C09D	Angiotensin II antagonists, combinations	1	0
C09X	Other agents acting on the renin-angiotensin system	0	0
C10A	Lipid modifying agents, plain	12	4
C10B	Lipid modifying agents, combinations	0	0
D01A	Anti-fungals for topical use	8	2
D01B	Anti-fungals for systemic use	2	1
D02A	Emollients and protectives	1	6
D02B	Protectives against UV radiation	0	1
D03A	Cicatrizants	0	2
D03B	Enzymes	1	0
D04A	Anti-pruritics, inclduing antihistamines, anaesthetics etc	1	1
D05A	Anti-psoriatics for topical use	3	1
D05B	Anti-psoriatics for systemic use	1	1
D06A	Antibiotics for topical use	6	0
D06B	Chemotherapeutics for topical use	5	2
D06C	Antibiotics and chemotherapeutics, combinations	0	0
D07A	Corticosteroids, plain	11	5
D07B	Corticosteroids, combinations with antiseptics	4	0

Code	Description	Private	Public
D07C	Corticosteroids, combinations with antibiotics	1	0
D07X	Corticosteroids, other combinations	0	0
D08A	Antiseptics and disinfectants	9	6
D09A	Medicated dressings	0	0
D10A	Anti-acne preparations for topical use	4	1
D10B	Anti-acne preparations for systemic use	1	1
D11A	Other dermatological preparations	2	0
G01A	Anti-infectives and antiseptics, excluding combinations with corticosteroids	1	0
G01B	Anti-infectives and antiseptics in combination with corticostreroids	0	0
G02A	Uterotonics	3	2
G02B	Contraceptives for topical use	1	2
G02C	Other gynecologicals	4	1
G03A	Hormonal contraceptives for systemic use	8	5
G03B	Androgens	6	2
G03C	Estrogens	7	2
G03D	Progestogens	3	1
G03E	Androgens and female sex hormones in combination	0	0
G03F	Progesterones and estrogens in combination	1	0
G03G	Gonadotropins and other ovulation stimulants	6	1
G03H	Anti-androgens	2	2
G03X	Other sex hormones and modulators of the genital system	2	1
G04	Urologicals	1	0
G04B	Urologicals	13	2
G04C	Drugs used in benign prostatic hypertrophy	6	1
H01A	Anterior pituitary lobe hormones and analogues	4	1
H01B	Posterior pituitary lobe hormones	5	1
H01C	Hypothalamic hormones	3	1
H02A	Corticosteroids for systemic use, plain	6	3
H02B	Corticosteroids for systemic use, combination	0	0
H02C	Anti-adrenal preparations	0	0
H03A	Thyroid preparations	3	1
H03B	Anti-thyroid preparations	1	0
H03C	Iodine therapy	0	0
H04A	Glycogenolytic hormones	1	0
H05A	Parathyroid hormones and analogues	1	0
H05B	Anti-parathyroid agents	2	0
J	Anti-infectives for systemic use	1	1
J01A	Tetracyclines	6	1
J01B	Amphenicols	0	0
J01C	Beta-lactam anti-bacterials, penicillins	16	7
J01D	Oher beta-lactam ant-ibacterials	28	9
J01E	Sulfonamides and trimethoprim	4	1
J01F	Macrolides, lincosamides and streptogramins	8	3
J01G	Aminogylcoside anitbacterials	5	3
J01M	Quinolone anti-bacterials	11	4
J01R	Combinations of anti-bacterials	0	0
J01X	Other anti-bacterials	8	3
J02A	Anti-mycotics for system use	9	2
J04A	Drugs for treatment of tuberculosis	9	10
J04B	Drugs for treatment of lepra	1	1
J05		1	0
J05A	Direct acting anti-virals	27	19
J06A	Immune sera	2	0
J06B	Immunoglobulins	11	3

ANNEXURE 2 – ACTIVE INGREDIENTS BY ATC 3 CATEGORY

Code	Description	Private	Public
J07A	Bacterial vaccines	19	3
J07B	Viral vaccines	22	7
J07C	Bacterial and viral vaccines, combined	4	2
J07X	Other vaccines	0	0
L01	Anti-neoplastic agents	0	1
L01A	Alkylating agents	9	4
L01B	Anti-metabolites	14	8
L01C	Plant alkaloids and other natural products	11	6
L01D	Cytotoxic antibiotics and related substances	9	5
L01X	Other anti-neoplastic agents	29	6
L02A	Hormones and related agents	5	1
L02B	Hormone antagonists and related agents	11	3
L03A	Immunostimulants	12	3
L04A	Immunosuppressants	24	6
M01A	Anti-inflammatory and anti-rheumatic products, non-steroids	17	3
M01B	Anti-inflammatory/anti-rheumatic agents in combination	0	0
M01C	Specific anti-rheumatic agents	1	0
M02A	Topical products for joint and muscular pain	4	0
M03A	Muscle relaxants, peripherally acting agents	10	1
M03B	Muscle relaxants, centrally acting agents	4	1
M03C	Muscle relaxants, directly acting agents	1	0
M04A	Anti-gout preparations	2	1
M05B	Drugs affecting bone structure and mineralization	11	2
M09A	Other drugs for disorders of the musculo-skeletal system	1	0
N01	Anesthetics	1	1
N01A	Anesthetics, general	14	10
N01B	Anesthetics, local	8	4
N02A	Opioids	17	3
N02B	Other analgesics and anti-pyretics	9	1
N02C	Anti-migraine preparations	7	0
N03A	Anti-epileptics	16	9
N04A	Anti-cholinergic agents	3	1
N04B	Dopaminergic agents	8	2
N05A	Anti-psychotics	23	10
N05B	Anxiolytics	14	5
N05C	Hypnotics and sedatives	11	1
N06A	Anti-depressants	25	5
N06B	Psychostimulants, agents used for ADHF and nootropics	5	1
N06C	Psycholeptics and psychoanaleptics in combination	0	0
N06D	Anti-dementia drugs	4	0
N07A	Parasympathomimetics	3	2
N07B	Drugs used in addictive disorders	8	0
N07C	Anti-vertigo preparations	3	0
N07X	Other nervous system drugs	1	0
P01A	Agents against amoebiasis and other protozoal diseases	1	1
P01B	Anti-malarials	9	3
P01C	Agents against leishmaniasis and trypanosomiasis	1	0
P02B	Anti-trematodals	1	1
P02C	Anti-nematodal agents	2	1
P02D	Anti-cestodals	0	0
P03A	Ectoparasiticides including scabicides	2	1
P03B	Insecticides and repellents	0	0

Code	Description	Private	Public
R01A	Decongestants and other nasal preparations for topical use	12	2
R01B	Nasal decongestants for systemic use	4	0
R02A	Throat preparations	5	0
R03		1	0
R03A	Adrenergics, inhalantns	7	4
R03B	Other drugs for obstructive airway diseases, inhalants	6	4
R03C	Adrenergics for systemic use	1	0
R03D	Other systemic drugs for obstructive airway diseases	8	3
R05C	Expectorants, excluding combinations with cough suppressants	9	1
R05D	Cough suppressants exlcuding combinations with expectorants	6	2
R05F	Cough suppressants and expectorants, combinations	3	0
R05X	Other cold preparations	0	0
R06A	Anti-hystamines for systemic use	23	4
R07A	Other respiratory system products	4	1
S		10	26
S01	Ophthalmologicals	1	0
S01A	Anti-infectives	4	0
S01B	Anti-inflammatory agents	3	0
S01C	Anti-inflammatory agents and anti-infectives in combination	1	0
S01E	Anti-glaucoma preparations and miotics	11	0
S01F	Mydriatics and cyclopegics	2	0
S01G	Decogestants and antiallergics	7	0
S01H	Local anaesthetics	3	0
S01J	Diagnostic agents	1	0
S01K	Surgical aids	3	0
S01L	Ocular vascular disorder agents	2	0
S01X	Other ophthalmologicals	0	0
S02A	Anti-infectives	1	0
S02B	Corticosteroids	0	0
S02C	Corticosteroids and anti-infectives in combination	0	0
S02D	Other otologicals	1	0
S03A	Anti-infectives	0	0
S03B	Corticosteroids	0	0
S03C	Corticosteroids and anti-infectives in combination	0	0
S03D	Other ophthalmological and otological preparations	0	0
V01A	Allergens	1	0
V03A	All other therapeutic products	19	10
V04B	Urine tests	0	0
V04C	Other diagnostic agents	2	0
V06A	Diet formulations for the treatment of obesity	0	0
V06B	Protein supplements	0	0
V06C	Infant formulas	0	0
V06D	Other nutrients	0	0
V07A	All other non-therapeutic products	0	2
V08	Contrast media	0	1
V08A	X-ray contrast media, iodinated	11	1
V08B	X-ray contrast media, non-iodinated	1	1
V08C	Magnetic resonance imaging contrast media	6	1
V08D	Ultrasound contrast media	0	0
V09	Diagnostic radiopharmaceuticals	1	0
V09A	Central nervous system	0	0
V09B	Skeleton	2	0
V09C	Renal system	4	0
V09D	Hepatic and reticulo endothelial system	2	0
V09E	Respiratory system	1	0

ANNEXURE 2 – ACTIVE INGREDIENTS BY ATC 3 CATEGORY

Code	Description	Private	Public
V09F	Thyroid	3	0
V09G	Cardiovascular system	0	0
V09H	Inflammations and infection detection	1	0
V09I	Tumour detection	1	0
V09X	Other diagnostic radiopharmaceuticals	0	0
V10A	Anti-inflammaory agents	0	0
V10B	Pain palliation (bone seeking agents)	0	0
V10X	Other therapeutic radiopharmaceuticals	4	0
	Unknown	**30**	**74**
	Total	**1228**	**486**

ANNEXURE 3 – NOTES ON LEADING MANUFACTURERS

Fresenius Kabi Manufacturing SA (Pty) Ltd

Fresenius Kabi is a global health care company that specializes in lifesaving medicines and technologies for infusion, transfusion and clinical nutrition.

Fresenius Kabi Manufacturing South Africa has its origins in Labethica – a pharmaceutical manufacturing chemist concern, based in Bethlehem in the Free State Province that produced a wide product range but with relatively low volume output. As well as moving to Port Elizabeth, this company went through a series of acquisitions viz. South African Druggists and MacMed Holdings until it was finally acquired by Fresenius Kabi in 2000 under the new name of Bodene (Pty) Ltd.

Fresenius Kabi Manufacturing South Africa, as it is known today, came into being late in 2010, when Fresenius Kabi AG approved the application for the change of name. The main reasons for the name change: to intrinsically link the local manufacturing arm of the business to its marketing company.

The corporate headquarters of Fresenius Kabi are located in Bad Homburg, Germany. The local market units operate as independent companies coordinated by regional headquarters of the Region Asia, located in Hong Kong, the regional headquarters the Region Europe, Latin America, Middle East, Africa Australia and New Zealand, located in Paris, and by the regional headquarters of the Region North America that is located in Lake Zurich, Illinois, in the greater Chicago area.

Sandoz SA (Pty) Ltd

Sandoz, the generics division of Novartis, participates in the global generics industry. Its products – which are focused in Retail Generics, Biopharmaceuticals & Oncology Injectables, and Anti-Infectives.

B Braun Medical (Pty) Ltd

There is no information on the company's South African operations and the below was taken from the group's global website.

B. Braun is one of the world's leading providers and manufacturers of healthcare solutions today. Every service that B. Braun provides incorporates the entirety of our knowledge and skills, the company's deep understanding of users' needs, and extensive expertise since 1839. With its constantly growing portfolio of effective medical care solutions, B. Braun makes a substantial contribution towards protecting and improving people's health. In total, the B. Braun product range comprises 5,000 different products, 95 percent of which are manufactured by the company. By offering supplementary services and consulting, B. Braun is a system supplier that develops the best solution for patients in close partnership with our customers, making a significant contribution to medical advancements.

Cipla Life Sciences (Pty) Ltd

Cipla is a global pharmaceutical company. Cipla's manufacturing division CMM offers turnkey manufacturing, packaging and testing solution for all solid dosage formulations. Cipla Medpro, 100%-owned by Cipla India, is one of the country's leading pharmaceutical companies. The company is one of the largest pharmaceutical companies in South Africa by volume and third largest by value. Cipla's distribution division CGD has 72 centres in South Africa.

GlaxoSmithKline South Africa (Pty) Ltd

The pharmaceuticals business discovers, develops and produces medicines to treat a range of acute and chronic diseases. GSK has a broad portfolio of innovative and established medicines to treat respiratory illnesses and HIV. Research focuses across respiratory, HIV and infectious diseases, immuno-inflammation, oncology and rare diseases.

The vaccines business has the broadest portfolio of any company, with vaccines for people of all ages – from babies and adolescents to adults and older people. GSK delivers over two million vaccine doses per day to people living in over 160 countries.

The consumer healthcare business develops and markets products in Wellness, Oral health, Nutrition and Skin health categories. GSK's seven leading global brands are Otrivin, Panadol, Parodontax, Poligrip, Sensodyne, Theraflu and Voltaren.

Pfizer Laboratories (Pty) Ltd

Pfizer South Africa's biopharmaceutical division is part of Pfizer Inc., the world's largest research-based pharmaceutical company.

Pfizer's vast product range covers a variety of sectors, including oncology, vaccines, cardiovascular, biological medicine, neuroscience, urology, anti-inflammatory, anti-coagulation, anti-infectives, pain medication and ophthalmology. Stakeholders include healthcare professionals, patient groups, pharmacy groups, hospital groups, media and government.

Pfizer consumer healthcare is one of South Africa's leading providers of consumer healthcare products and a top provider in a number of important OTC categories.

ANNEXURE 4 – NOTES ON 21 WHOLESALERS AND/OR RETAILERS

Name	Wholesaler	Distributor	Location
United Pharmaceutical Distributors	x	x	
Alpha Pharm Distributors (KEMCO)	x	x	Bloemfontein
Pharmed Pharmaceuticals	x	x	Johannesburg/Durban
Dis-Chem Distribution (Pty) Ltd	x	x	
C J Pharmaceutical Enterprises	x	x	
Kawari Wholesalers	x		Pretoria
Transpharm	x	x	
City Medical Wholesalers	x	x	Pretoria/Durban
Qestmed	x	x	Johannesburg
Curasana Wholesalers	x	x	Pretoria
Helderberg Medical	x	x	Cape Town
Topmed Health Care Distributors	x	x	Pretoria
Kharwastan Pharmaceutical & Allied Wholesalers	x	x	Durban
Arrie Nel Groep Groothandelaar	x	x	Pretoria
Pharmasave Wholesalers	x	x	Johannesburg
Norpharm CC	x	x	Cape Town
A G Morris International Pty Ltd	x	x	Cape Town
Ring Pharmaceutical Distributors	x	x	Pretoria
Nazmed Pharmaceuticals	x	x	Johannesburg
Paramount Pharmaceutical Distributors	x	x	Johannesburg
Rand Pharmaceutical Distributors (Pty) Ltd	x	x	Johannesburg

Name	Comments
United Pharmaceutical Distributors	Wholly owned subsidiary of the Clicks Group
Alpha Pharm Distributors (KEMCO)	51% owned by Shogun Holdings und Finanz (Swiss).
Pharmed Pharmaceuticals	Has a website, no financials available
Dis-Chem Distribution (Pty) Ltd	Wholly owned subsidiary of Dis-Chem
C J Pharmaceutical Enterprises	Wholly owned subsidiary of Dis-Chem
Kawari Wholesalers	Has a website, no financials available
Transpharm	Wholly owned by Shoprite
City Medical Wholesalers	Has a website, no financials available
Qestmed	Has a website, no financials available
Curasana Wholesalers	Listed on Afrocentric's website as a "Healthcare Asset" of the company
Helderberg Medical	No website
Topmed Health Care Distributors	Has a website, no financials available
Kharwastan Pharmaceutical & Allied Wholesalers	No website
Arrie Nel Groep Groothandelaar	Has a website, no financials available
Pharmasave Wholesalers	No website
Norpharm CC	No website
A G Morris International Pty Ltd	Has a website, no financials available
Ring Pharmaceutical Distributors	Has a website, no financials available
Nazmed Pharmaceuticals	No website
Paramount Pharmaceutical Distributors	No website
Rand Pharmaceutical Distributors (Pty) Ltd	No website

CLICKS

Director analysis

Director	Other health interests
David Nurek	
Fatima Abrahams	
John Bester	Director of Ascendis Health and Trustee of the Children's Hospital Trust
Bertina Engelbrecht	
Michael Fleming	
Fatima Jakoet	
David Kneale	
Nkaki Matlala	Director of the Hospital Association of South Africa and Chairman of Phodiso Holdings
Martin Rosen	

Organogram

Directly held	% Owned
New Clicks South Africa Pty Ltd	100.0%
Clicks Group Employee Share Ownership Trust	100.0%
Clicks Centurion Pty Ltd	100.0%
Indirectly held	
Safeway (Swaziland) Pty Ltd	100.0%
The Clicks Organisation (Botswana) Pty Ltd	100.0%
Clicks Group (Namibia) Pty Ltd	100.0%
Clicks Group (Lesotho) Pty Ltd	100.0%
Unicorn Pharmaceutical Pty Ltd	100.0%
Clicks Retailers Pty Ltd	100.0%
Clicks Investments Pty Ltd	100.0%
BTB Medi Pty Ltd	100.0%
Kala Hari Medical Distributors Pty Ltd	100.0%
The Link Investment Trust	56.0%
Clicks Mobile Pty Ltd	50.1%
Associate	
Sorbet Brands Pty Ltd	25.0%

Shareholder analysis

Major beneficial shareholders holding 3% or more	%
Government Employees Pension Fund	15.6
GIC Private Limited	4.4
Fidelity International Growth Fund	3.2
Mawer International Equity Pooled Fund	3

ANNEXURE 5 – ANALYSIS OF CORPORATIONS OWNING RETAIL PHARMACIES

Major fund managers managing 3% or more	%
Public Investment Corporation (SA)	14.5
Baillie Gilford & Co (UK)	5.3
Fidelity Management & Research (US)	5
Mawer Investment Management (CA)	4.7
GIC (Singapore)	4.3
Wasatch Advisors (US)	3.7
Aberdeen Asset Management (UK)	3.6
Fund manager no longer managing over 3%:	
Coronation Fund Managers (SA)	1.2
MFS Investment Management (US)	2.4

Dis-Chem PHARMACIES

Director analysis

Director	Other health interests
Laurence Nestadt	
Ivan Saltzman	
Rui Morais	
Lynette Saltzman	
Saul Saltzman	
Mark Bowman	
Anuschka Coovadia	Head of Healthcare for Africa at KPMG International, a Director on a healthcare investment development fund, Ayurveda Investments, and a member of a Global Task Team on Universal Health Coverage
Joe Mthimunye	
Mohamed Gani	

Organogram

Pharmaceutical retailers	% Owned
Dis-Chem Riverside Lifestyle Mall Proprietary Limited	83.3%
Dis-Chem Hemmingways Proprietary Limited	51.0%
Dis-Chem Cape Road Proprietary Limited	83.3%
Dis-Chem Garden Route Mall Proprietary Limited	51.0%
Dis-Chem Mooi River Mall Proprietary Limited	56.7%
Dis-Chem Ballito Junction Proprietary Limited	70.0%
Dis-Chem Krugersdorp Proprietary Limited	51.0%
Dis-Chem Brooklyn Mall Proprietary Limited	51.0%
Dis-Chem Woodlands Boulevard Proprietary Limited	86.7%
Dis-Chem Savannah Mall Proprietary Limited	100.0%
Dis-Chem Three Rivers Proprietary Limited	75.0%
Dis-Chem Bay side Proprietary Limited	100.0%
Dis-Chem The Galleria Amanzimtoti Proprietary Limited	80.0%
Dis-Chem Glen Fair Proprietary Limited	51.0%
Dis-Chem Jefferey's Bay Proprietary Limited	51.0%
Dis-Chem Flamewood Value Centre Proprietary Limited	66.7%
Dis-Chem Nicolway Proprietary Limited	51.0%
Dis-Chem Glenacres Proprietary Limited	50.0%
Dis-Chem Festival Mall Proprietary Limited	100.0%
Dis-Chem Secunda Proprietary Limited	51.0%
Dis-Chem Park Station Proprietary Limited	89.6%
Dis-Chem Worcestor Proprietary Limited	95.0%
Dis-Chem North Cape Mall Proprietary Limited	100.0%
Dis-Chem Highveld Mall Proprietary Limited	100.0%
The Local Choice Proprietary Limited	50.1%
Pharma-Logistical Solutions Proprietary Limited	100.0%
Dis-Chem Distribution Proprietary Limited	100.0%
Oncology Proprietary Limited	100.0%
Wholesaler of pharmaceutical products	
CJ Pharmaceutical Enterprises Limited	100.0%
Marketing activities	
CJ Pharmaceutical Marketing Proprietary Limited	100.0%
Associates	
Evening Star Trading Pty Ltd	51.3%
Limpopo Pharmaceutical Wholesaler and Distributor Pty Ltd	30.1%
Pharmacy Development Academy Pty Ltd	70.0%

Shareholder analysis

Dis-Chem's prelisting shareholders comprised:

- the Saltzman Family holding 66.9% through Ivlyn Proprietary Limited
- other key management holding 23.4% and
- the remaining 9.7% held by a financial investor.

ANNEXURE 5 – ANALYSIS OF CORPORATIONS OWNING RETAIL PHARMACIES

Pick n Pay

Director analysis

Director	Other health interests	
Gareth Ackerman	Director – Tsebo Pty Ltd	Cleaning, catering & facilities management services to hospitals & pharma companies
Alex Mathole		
Audrey Mothupi		
David Friedland		
David Robins		
Jeff van Rooyen		
Hugh Herman		
Lorato Phalatse	Chairman – The Bidvest Group	Bidvest owns 38.4% of Adcock Ingram
Richard Brasher		
Richard van Rensburg		
Bakar Jakoet		
Suzanne Ackerman-Berman		
Jonathan Ackerman		

Organogram

Pick n Pay Supermarkets	100%
Pick n Pay Hypermarkets	100%
Pick n Pay Local	100%
Pick n Pay Express	100%
Pick n Pay Online	100%
Pick n Pay Clothing	100%
Pick n Pay Liquor	100%
Pick n Pay Pharmacy	100%
Boxer Superstores	100%
Boxer Build	100%
Boxer Punch	100%
Boxer Liquors	100%
TM Supermarkets	49%

Shareholder analysis

Non-public shareholders	%
Directors and public officer	2.52
Ackerman Investment Holdings (Pty) Ltd	48.50
Pick n Pay Employee Share Purchase Trust	1.74
The Blue Ribbon Meat Corporation (Pty) Ltd	0.37

Beneficial shareholders holding 1% or more	%
Ackerman Investment Holdings (Pty) Ltd	48.50
Government of Norway	2.28
Public Investment Corportation Ltd	2.03
Pick n Pay Employee Share Purchase Trust	1.74
Allan Gray Equity Fund	1.54
Allan Gray Balanced Fund	1.20
Old Mutual Symmetry Satellie Equity Fund No 1	1.06
Mistral's Trust	1.05

Director analysis

Director	Other health interests	
Graham O'Connor		
Mark Godfrey		
Desmond Borrageiro		
Brett Botten		
Trevor Currie		
Rovert de Vos		
Wayne Hook		
Conrad Isaac		
Kevin O'Brien		
Robert Philipson		
Mike Prentice		
Mario Santana		
Enno Stelma		
Thulusile Tabudi		
Roelf Venter		
Raymond Whitmore		
Alison Zweers		
Mandy Hogan		
Michael Hankinson		
Mziwakhe Madi	Chairman of Allcare Medical Aid Administrators (Pty) Ltd and Respiratory Care Africa (Pty) Ltd	
Marang Mashologu		
Harish Mehta	Chairman of Averda SA (Pty) Ltd	Healthcare Waste Management
Phumla Mnanga		
Christopher Wells		

ANNEXURE 5 – ANALYSIS OF CORPORATIONS OWNING RETAIL PHARMACIES

Organogram

Spar	100%
KwikSpar	100%
SuperSpar	100%
Tops at Spar	100%
Spar Express	100%
Build It	100%
TrenDIY by Build It	100%
Pharmacy at Spar	100%
SaveMor	100%

Shareholder analysis

Non-public shareholders	%
Directors and associates	0.01
Employee Share Trust	0.05

Beneficial owners holding more than 5%	%
Government Employees Pension Fund	15.84
Oppenheimer Funds	8.6

Director analysis

Director	Other health interests	
Richard Friedland		
Keith Gibson		
Jill Watts		
Meyer Kahn		
Thevendrie Brewer		
Mark Bower		
Bukelwa Bulo	Director – Capital Appreciation Ltd	Develops and implements value-added solutions for health sector clients. Susidiaries incl. several insurance and health sector companies.
Azar Jammine		
Martin Kuscus		
Kgomotso Moroka SC		
Norman Weltman		

Organogram

SA Operations	
Hospital division	55 owned and managed hospitals
Netcare offers private hospital and trauma services through owned facilities and Public Private Partnerships (PPPs)	9 262 registered beds 1 543 intensive care and high care beds 48 retail pharmacies 1 hospital and 4 clinics operated by Netcare in Lesotho, forming part of the Lesotho PPP
Emergency services	6 million lives under management
Netcare 911 operates the largest private emergency medical service in the country.	294 emergency response vehicles and motorcycle
Primary Care	66 Medicross medical and dental centres
The Primary Care division offers medical and dental services through Medicross family medical and dental centres and Prime Cure clinics, as well as a managed care service.	20 Prime Cure clinics 6 Netcare travel clinics
National Renal Care (NRC)	58 NRC units
NRC, a 50% joint venture between Netcare and Adcock Ingrams Critical Care is the largest private dialysis provider in SA.	558 dialysis stations in use 10 Healthy Start programmes

Shareholder Analysis

Beneficial shareholder holding 5% or more	%
Public Investment Corporation Ltd	18.70
Allan Gray Various Funds	5.56

Investment Manager top 10	%
Public Investment Corporation Ltd	14.92
Allan Gray (Pty) Ltd	9.37
Old Mutual plc	7.90
Prudential Portfolio Managers	5.33
Liberty Holdings Ltd (STANLIB)	4.32
The Vanguard Group, Inc.	3.52
Sanlam Ltd	3.43
Coronation Fund Managers Ltd	3.27
Abax Investments (Pty) Ltd	3.18
Visio Capital Management (Pty) Ltd	3.10

Beneficial Owner Top 10	%
Public Investment Corporation Ltd	18.70
Old Mutual Life Assurance Company SA	3.27
Liberty Life Association of Africa Ltd	2.76
Investment Solutions Ltd	2.43
Allan Gray Balanced Fund	2.25
Government of Norway	2.05
GIC Private Ltd	2.04
Vanguard Emerging Markets Stock Index Fund	1.74
Allan Gray Equity Fund	1.50
Sanlam Life Insurance Ltd	1.48

SHOPRITE

Director Analysis

Director	Other health interests
JW Basson	
CG Goosen	
M Bosman	
B Harisunker	
EL Nel	
BR Weyers	
JAL Basson	
PC Engelbrecht	
CH Wiese	
JF Basson	
JJ Fouche	
EC Kieswetter	
JA Louw	
ATM Mokgokong	Director – Adcock Ingram and Medscheme Ltd
JA Rock	
JD Wiese	

Organogram

Shoprite International Ltd	100%
Shoprite Checkers (Pty) Ltd	100%
MediRite (Pty) Ltd	100%
Computicket (Pty) Ltd	100%
Shoprite Investments Ltd	100%
Shoprite Insurance Company Ltd	100%

Shareholder Analysis

Beneficial shareholders holding 1% or more	%
Wiese, CH	15.93
Government Employees Pension Fund	11.05
Shoprite Checkers (Pty) Ltd	6.19
Capital Group	4.38
Lazard	3.42
T. Rowe Price	2.53
Vanguard	2.28
Namibian Government Institutions Pension Fund	2.17
BlackRock	1.72
JPMorgan	1.71
Government of Singapore Investment Corporation	1.69
Basson, JW	1.59
Fidelity	1.28
Le Roux, JF	1.23
Bank of New York Unrestricted Depositary Receipts	1.19
Sanlam	1.14

Director analysis

Director	Other health interests	
Lorato Phalatse	Director – Pick n Pay	
Lindsay Peter Ralphs		
Hans Peter Meijer		
Brian Joffe	Vice-chairman – Adcock Ingram	
Douglas Denoon Balharrie Band		
Sibongile Masinga	Director – Regent Insurance and Regent Life Assurance	
Nigel George Payne		
Tania Slabbert	Director – WDB Investment Holdings	Equity investments in South Africa including health.
Anthony William Dawe		
Nompumelelo Themekile Madisa		
Gillian Claire McMahon		
Eric Kevin Diack		
Alexander Komape Maditsi		

Organogram

Bidvest Industrial	100%
Bidvest Namibia	100%
Bidvest Properties	100%
Adcock Ingram	38.40%
Comair	27.20%
Cullinan Holdings	19.50%
Ontime Automotive UK	100%
Mumbai Airport	6.75%
The Mansfield Group	80%

Shareholder analysis

Beneficial shareholders holding 3% or more	%
Government Employees Pension Fund	15.16
GIC Asset Management Private Limited	4.23

Fund managers holding 3% or more	%
Public Investment Corporation	13.47
J.P. Morgan Asset Management	6.70
Genesis Investment Management LLP	4.46
GIC Asset Management Pty Ltd	4.07
BlackRock Inc	3.63
Lazard Asset Management LLC Group	3.18
Sanlam Investment Management	3.14
The Vanguard Group Inc	3.11

ANNEXURE 6 – ANALYSIS OF OTHER COMPANIES

adcock ingram

Director analysis

Director	Other health interests	
Clifford D Raphiri		
Brian Joffe	Director – Bidvest	
Andrew G Hall		
Dorette Neethling		
Basadi Letsoalo		
Lulama Boyce		
Matthias Haus		
Jenitha John		
Tlalane Lesoli		
Mpho Makwana		
Dr Claudia Manning		
Dr Anna Mokgokong	Executive Chair – Community Investment Holdings	Investments that span the manufacturing and distribution of medical & pharmaceutical supplies, the servicing of Healthcare equipment and the provision of comprehensive Healthcare services through Public-Private Partnerships.
Lindsay Ralphs		
Michael Sacks	Director – Afrocentric Group	
Roger I Stewart	Director – Business Sculptors (Pty) Limited	Provided services to health sector companies and hospitals

Shareholder analysis

Investment manager	%
BB Investment Company (Pty) Ltd	37.5
Public Investment Corporation	22.0
Ad-Izinyosi Proprietary Ltd	14.7

aspen HOLDINGS

Director analysis

Stephen Saad	
Gus Attridge	Director – Shimoda Biotech (Pty) Ltd
Kuseni Dlamini	
Chris Mortimer	
Babalwa Ngonyama	Director – The Hollard Insurance Company Ltd
David Redfern	
Roy Andersen	
John Buchanan	
Maureen Manyama	
Sindi Zilwa	Director – Discovery Ltd
Riaan Verster	

Organogram

Fine Chemicals Corporation	100%
Pharmacare	100%

ICPA
INDEPENDENT COMMUNITY PHARMACY ASSOCIATION
ICPA (NPC), Unit 3, Mews 2, Rosmead Centre, 67 Rosmead Avenue, Kenilworth, Cape Town, 7708
Tel: +27 21 671 4473 | Fax: +27 86 5152 000 | Website: www.icpa.co.za.
CIPC Reg. No: 2012/021809/08 | NPO Reg. No: 141-903 | VAT Reg. No: 4420262976

MINUTES OF MEETING BETWEEN ICPA AND THE MINISTER OF HEALTH

TIME:	4 October 2016, 16:00	
PLACE:	Office of the Department of Health situated on the corner of Thabo Sehume and Struben Street, Pretoria.	
ATTENDEES:	Dr. Aaron Motsoaledi	(Minister of Health)
	Mogologolo Phasha	(ICPA Chairman)
	Rakesh Daya	(ICPA Director)
	Maropeng Modiba	(ICPA Director)
	Simonè Eksteen	(ICPA Director)
	Mark Payne	(ICPA Chief Executive Officer)
APOLOGIES:	Wim Grobbelaar	(ICPA Vice Chairman)
	Mehboob Ali Cassim	(ICPA Treasurer)
	Sham Moodley	(ICPA Director)

The ICPA Chairman presented the Minister with a printed PowerPoint presentation compiled by CEO and a dossier containing all the evidential material in support of the submission. He also thanked the Minister for setting time aside to meet with a delegation from ICPA who were then introduced.

The ICPA Chairman provided background to the incorporation of ICPA, being an amalgamation between USAP and SAPPA in 2011. ICPA represents a membership base of privately owned pharmacies in SA (not the corporates) and collectively are the largest community pharmacy network in South Africa. ICPA's head office is based in Cape Town.

1. Clicks Unicorn Integration

Background to the issue of the Clicks Group's contravention of the Pharmacy Act by owning pharmacies and having a beneficial interest in a pharmaceutical manufacturer.

Before new Clicks pharmacies open they sign affidavits that state under oath that they have no direct or indirect beneficial interest in a manufacturing company.
Explained about holding companies etc.

The Minister asked whether ICPA communicated to the Deputy Director General about this and if he did anything about it.
The CEO replied that last correspondence received from the DDG was over two months ago when he replied that the matter is now with the State Attorney. According to the DoH a moratorium has been placed on the issuing of new Clicks pharmacy licences while the case is being investigated.

2. Council for Medical Schemes Appeal Board Hearing regarding closed Designated Service Providers (DSP) and Penalty Co-Payments

In July 2016 Judge Ngoepe, who chaired the appeal board hearing, ordered CMS to investigate the mechanism of closed DSP's and penalty co-payment within 30 days and to consider making it an undesirable business practice. To date, despite CMS undertaking in writing that they are in the process of complying with the order, nothing effectively transpired in proposed legislation being published for commentary.

The Minister mentioned that nobody can be in contempt of the Judge's ruling and requests that ICPA write to him directly about the issue.

3. Discovery Health/Vitality/Dis-Chem/Flu Vaccine/Uber

ICPA provided background to the issue that Discovery Health Vitality members pay R100 towards an Uber nurse's taxi fare to receive a free flu injection and Vitality Points.
This amounts to a contravention of Section 18A of the Medicines Act prohibiting the supply of medicine according to a bonus system, rebate system or any other incentive scheme.

ICPA lodged an official complaint with Medicine Control Council but they referred it to the DoH. Surely this sits in the ambit of the MCC?
The Minister does not agree that the Registrar of Medicines cannot do anything about this matter and suggests that there is possibly a miscommunication.
He used the example of how swiftly the MCC acted on the stem cell issue at Pelanomi hospital in Bloemfontein which was aired on Carte Blanche this past Sunday.

4. Licensing Criteria applicable to Community Pharmacy

ICPA raised the issue that there is no legislated criteria or guidelines to address consistency in application for pharmacy licences and transparency in the process. It was mentioned that 2 years of attempting to get legislation drafted has failed and the end is reportedly not in sight.
The Minister reported that he has raised the issue in a number of Cabinet Meetings and National Treasury.

ICPA is of the opinion that the same licensing criteria used for independent pharmacies are not applied when corporate chains apply for licences.

ICPA feel that the challenge also lies with the Department of Health issuing such licences and not notifying existing pharmacies about the intention to open a new pharmacy, so that they can object if need be. Often they only hear about a new pharmacy when it opens its doors. Members cannot afford to appeal once the new pharmacy is open, due to the cost implication where legal representation is required.

ICPA also addressed the importance of the government's undertaking of investing in small to medium size enterprises and the Minister echoed these sentiment as a driver of the economy.

5. Contracted Medical Scheme Dispensing Fee

ICPA informed the Minister that the contracted Medical Scheme dispensing fee re-imbursement rate is set at a fraction of the legislated rate.

ICPA requests that the dispensing fee be fixed to level the playing field.
Corporate Pharmacy has a different business model and rely on their front shop to drive profitability. Corporate dispensaries are loss leaders and are carried to increase footfall. With most independent pharmacies, the dispensing activity is still the main source of income.

The Minister asked how ICPA is going to continue with this dispensation in terms of NHI since South Africa cannot afford an expensive health care system?
With regards to the Centralised Chronic Medicine, Dispensing and Distribution Program (CCMDD) and Pick up Points (PuP's) – what would be an equitable dispensation?

6. National Healthcare Insurance

The Minister mentioned that we are compromised regarding our chronic medication spend. Patients are now being treated with anti-retrovirals regardless of their CD4 count. We are aiming for 90/90/90 – to get 90% of HIV-infected people on treatment etc.
There is an explosion of non-communicable diseases. Government is trying to keep the controlled chronic patients away and out of hospitals.

The ICPA said that they as an organisation proposed 5 models for NHI submitted to Workstream 3. R8.70 odd per parcel will not cut it for all independent pharmacies, but between 1000 independent pharmacies across South Africa, we could find common ground.
The pharmacist is professionally liable when he/she hands over a parcel of scheduled medicine and will probably have to answer patient questions about the medication.
Furthermore, ICPA believes in terms of upholding standard of patient care and safety, that it is not in the publics best interest to collect medicines from non-health persons or facilities

The meeting was adjourned at 17:00.

CHAIRMAN: _____

DATE: 12 October 2016

NOTES

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