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CIPC Reg. No: 2012/021809/08 | **NPO Reg. No:** 141-903 | **VAT Reg. No:** 4420262976

25 May 2026

Att: Mr. Bukhosibakhe Majenge

Chief Legal Counsel

Competition Commission of South Africa

Email: Ms. Itumeleng Letebele - ItumelengLe@compcom.co.za

REPORT DETAILING THE INDEPENDENT COMMUNITY PHARMACY ASSOCIATION'S EXEMPTION APPLICATION IN TERMS OF SECTION 10 OF THE COMPETITION ACT 89 OF 1998

Dear Sir,

The Independent Community Pharmacy Association ("ICPA") applies to the Competition Commission of South Africa ("the Commission") for an exemption in terms of section 10(1) of the Competition Act 89 of 1998 ("the Act") in respect of a category of agreements that would otherwise contravene section 4(1)(b) of the Act.

The Requested Exemption seeks to enable ICPA, on behalf of its members who are independent community pharmacies ("ICPs"), to engage in limited and structured collective negotiations with:

- suppliers of non-SEP medicines; and
- medical schemes and administrators in respect of reimbursement rates and network participation, as well as
- relevant statutory bodies in matters relating to pharmacy practice and the sustainability of the sector.

The purpose of these arrangements is to address structural imbalances in the retail pharmacy market, characterised by increasing concentration among large corporate pharmacy groups and the comparatively weak bargaining position of independently owned pharmacies.

Board of Directors: **Mehboob Cassim, (Chairman), Kgabo Komape (Deputy Chair), Shushu R.C. Mhangwane (Treasurer), Sham Moodley, Paul John Kleinsmidt, Khahliso David Tladi.**

Alternate Directors: **Vuyiswa M Ngacakani, Balindile Mlindazwe.**

The Commission has itself recognised these dynamics, noting the growing market share of corporate pharmacy groups and the barriers faced by independent pharmacies in accessing retail space, securing favourable trading terms, and participating effectively in the private healthcare economy. This application directly responds to those identified concerns and seeks to promote a more inclusive, competitive, and sustainable pharmacy sector.

The ICPA submits that the Requested Exemption satisfies the requirements of section 10(3) of the Act in that:

- it promotes the effective participation and expansion of small and medium-sized enterprises ("SMMEs"), many of which are owned or controlled by historically disadvantaged persons ("HDPs"), in the retail pharmacy market; and
- it contributes to improved competitiveness and efficiency within the sector, with positive downstream effects for patient access, affordability, and continuity of care.

Importantly, the proposed arrangements are limited in scope and necessary to achieve these objectives. Individual ICPs lack the scale and bargaining power to negotiate effectively with large suppliers and funders. Collective engagement is therefore not merely beneficial, but essential to enable meaningful participation in the market.

The Requested Exemption does not seek to fix retail prices or restrict patient choice. Rather, it aims to establish a pro-competitive countervailing mechanism that enables independent pharmacies to compete more effectively with vertically integrated and corporatised pharmacy groups that already benefit from collective negotiation structures.

The ICPA further proposes appropriate safeguards and reporting mechanisms to ensure that the exemption is implemented in a manner consistent with the objectives of the Act and subject to ongoing regulatory oversight.

In light of the above, the ICPA respectfully submits that the Requested Exemption is justified, proportionate, and aligned with both the statutory objectives of the Competition Act and the broader public interest in ensuring equitable access to healthcare services in South Africa.

REPORT DETAILING THE INDEPENDENT COMMUNITY PHARMACY ASSOCIATION'S EXEMPTION APPLICATION IN TERMS OF SECTION 10 OF THE COMPETITION ACT 89 OF 1998

1. DEFINITIONS

The following terms used in this report have the meanings ascribed below:

1.1. "**Applicant**" means the ICPA;

1.2. "**Commission**" means the Competition Commission of South Africa;

1.3. "**Community Pharmacy**" bears the meaning provided in section 1 of the Pharmacy Practice Regulation;

1.4. "**Competition Act**" means the Competition Act 89 of 1998;

1.5. "**Consultant Pharmacy**" bears the meaning provided in section 1 of the Pharmacy Practice Regulation;

1.6. "**co-payment**" means the difference or shortfall that patients have to pay out of their own pockets for medicines or services, the full cost of which the scheme will not pay;

1.7. "**corporate pharmacy**" means Clicks, Dis-Chem and Medirite, which stores operate as pharmacies;

1.8. "**dispensing**" bears the meaning provided in section 1 of the Pharmacy Practice Regulations, being the interpretation and evaluation of a prescription, the selection, manipulation or compounding of the medicine, the labelling and supply of the medicine in an appropriate container according to the Medicines Act and the provision of information and instructions by a pharmacist to ensure the safe and effective use of medicine by the patient and "**dispense**" has a corresponding meaning;

1.9. "**DSP**" means a designated service provider, and is defined as a health care provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions;

1.10. "**formulary**" means a defined list of medicines used to treat various diseases;

1.11. "**ICP**" means an Independent Community Pharmacy;

1.12. "**ICPA**" means the Independent Community Pharmacy Association;

1.13. "**Institutional Pharmacy**" bears the meaning provided in section 1 of the Pharmacy Practice Regulations;

1.14. "**IP Network**" means the network of ICPs that ICPA intends to establish under the Requested Exemption.

1.15. "**manufacture**" bears the meaning provided in section 1 of the Pharmacy Practice Regulations, being all operations including purchasing of raw material, processing, production, packaging, releasing, storage, quality assurance, importation, exportation of medicine and scheduled substances and related control and "**manufacturing**" has a corresponding meaning;

1.16. "**manufacturer**" means a "manufacturing pharmacy" as defined in section 1 of the Pharmacy Practice Regulations;

1.17. "**Medical Schemes Act**" means the Medical Schemes Act no. 131 of 1998;

1.18. "**Medicines Act**" means the Medicines and Related Substances Control Act 101 of 1965;

1.19. "**medicine**" bears the meaning provided in section 1 of the Medicines Act;

1.20. "**Non-SEP medicines**" means unscheduled and Schedule 0 medicines (in terms of the Medicines Act);

1.21. "**open shop**" means any business (or part thereof) that does not have a pharmacy licence and includes supermarkets (excluding any pharmacy that may operate within the supermarket), shops in the forecourts of service stations and health shops;

1.22. "**Pharmacy Act**" means the Pharmacy Act 53 of 1974;

1.23. "**Pharmacy Practice Regulations**" mean GNR 1158 of November 2000 to the Pharmacy Act;

1.24. "**Pharmacy services**" means pharmacy activities including the supply and distribution of medicines and other health care products, the provision of appropriate advice to patients to ensure the correct use of medicines, monitoring the effects of the use of medicines and screening for diseases within the relevant scope of practice and in compliance with Good Pharmacy Practice.

1.25. "**PMB**" means a prescribed minimum benefit, and is defined as the benefits contemplated in section 19(1)(o) of the Medical Schemes Act, and consist of the provision of the diagnosis, treatment and care costs of

(a) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and (b) any emergency medical condition.

1.26. "**PP**" means a preferred provider, being a pharmacy / network of pharmacies that has been identified by a medical scheme as the preferred providers to treat and care for its members in respect of one or more specific benefits;

1.27. "**SEP Regulations**" means GNR 1102 of 11 Nov 2005: Regulations relating to a transparent pricing system for medicines;

1.28. "**SMME**" bears the meaning attributed to it in the National Small Enterprise Act 102 of 1996;

1.29. "**SEP medicines**" means Schedule 1-6 medicines (in terms of the Medicines Act);

1.30. "**supplier**" means any supplier of medicine, including the manufacturer, wholesaler and distributor and excludes the community pharmacy;

1.31. "**Tribunal**" means the Competition Tribunal of South Africa;

1.32. "**VAT**" means Value Added Tax; and

1.33. "**wholesaler**" means a "wholesale pharmacy" as defined in section 1 of the Pharmacy Practice Regulation.

2. Introduction

2.1. The ICPA represents over 1200 independent community pharmacies operating across South Africa. These pharmacies face increasing competitive pressure due to market concentration among corporate pharmacy groups and structural barriers to participation in private healthcare networks.

2.2. As will be further discussed and elaborated upon below, the market for the import, manufacture, distribution and retail of medicines in South Africa is highly regulated.

2.3. For purposes of this application, the retailing of medicines can be categorised into non-SEP and SEP medicines.

2.4. Non-SEP medicines can be sold in both pharmacies and "open shops". These medicines are not currently subject to price regulation and pharmacies can therefore both negotiate the price at which they purchase non-SEP medicines from their suppliers and can sell non-SEP medicines at a price above cost.

2.5. SEP medicines can only be sold in pharmacies and must be regulated by pharmacists. SEP medicines may not be sold to consumers at a price above the SEP (as a pharmacist must, by law, purchase its medicine at SEP from its suppliers and may not negotiate the price of SEP medicines. Pharmacists are therefore unable to realise a margin on the medicine itself however the customer pays a dispensing fee (which is also subject to regulation and capped at a maximum) for dispensing services provided by the pharmacist on the SEP medicine.

2.6. The sustainability of a pharmacy is therefore dependent on:

2.6.1. the profit margin on the sale of non-SEP medicines;
2.6.2. the dispensing fee charged on SEP medicines (which dispensing fee is subject to a regulated cap); and
2.6.3. the professional fee charged for the provision of pharmacy services.

2.7. At the retail level at which ICPs operate, regulatory constraints significantly limit opportunities for profit realisation. This position is further exacerbated by the pricing and reimbursement practices of medical schemes, coupled with the limited bargaining power of ICPs as individual small businesses in their dealings with both medical schemes and pharmaceutical distributors. Collectively, these factors have rendered the retail of medicines increasingly unsustainable for many ICPs.

2.8. Corporate pharmacy groups benefit from economies of scale, vertical integration, and centralised negotiation structures, enabling them to secure more favourable procurement terms and reimbursement arrangements. In contrast, ICPs must negotiate individually with suppliers and medical schemes, resulting in less

favourable pricing, limited access to distribution-related income streams, and reduced participation in DSP and preferred provider networks.

2.9. ICPs, as small, independently operated businesses, have significantly constrained bargaining power in their dealings with both suppliers and medical schemes.

2.10. As a result, ICPs are unable to secure competitive procurement prices, access favourable reimbursement arrangements, or meaningfully participate in DSP and preferred provider networks.

2.11. These constraints directly undermine all three key drivers of pharmacy sustainability identified in paragraph 2.6 and significantly impair the ability of ICPs to compete effectively with corporate pharmacy groups.

2.12. Having regard to the above, the ICPA intends to set up the IP Network, comprising a number of willing ICPs who will, under the umbrella of the IP Network, allow the ICPA to negotiate and enter into the following categories of agreements:

2.12.1. agreements with medicine suppliers to obtain favourable prices or terms and conditions on the purchase of non-SEP medicines for the member ICPs (the IP Network will essentially operate as a joint buying group); and

2.12.2. agreements with medical aid schemes / administrators to appoint the IP Network / the member ICPs as DSPs / PPs and for favourable dispensing and professional fee rates for the member ICPs.

2.13. The agreements referred to in paragraph 2.12. are likely to contravene section 4(1)(b)(i) of the Competition Act and ICPA therefore requests that these agreements are exempt from the application of Chapter 2 of the Competition Act (the "Requested Exemption").

2.14. The Applicant respectfully submits that the agreements referred to in paragraph 2.12. are required to enable the ICPs, which are small businesses in the industry for the retailing of medicines, to become competitive. Such an objective is recognised by section 10(3)(b)(ii) of the Competition Act as a basis for granting an exemption.

2.15. The Requested Exemption further serves as a necessary countervailing mechanism to address structural concentration in the pharmacy retail market and to promote inclusive participation, consistent with the Competition Commission’s identified advocacy priorities.

2.16. Accordingly, the parties respectfully request that the Commission unconditionally grants the Requested Exemption.

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3. The market for the retail of pharmaceuticals in South Africa

South African healthcare system

3.1. The healthcare system in South Africa is essentially two tiered, consisting of the public healthcare sector (that portion of healthcare services that is funded by public funds and operated by the state) and the private healthcare sector (that portion of healthcare services that is funded by private patients themselves, either through medical schemes, insurance or out-of-pocket payments).[1]

3.2. Over 84% of the population is dependent on the public healthcare sector, while only approximately 9,17 million[2], approximately 16% of the population can afford private healthcare.[3] Despite this, the public healthcare sector's spending accounts for only approximately 50% of total healthcare spending in South Africa.[4][5] In the pharmaceutical sector specifically, public healthcare spending accounts for less than 20%.[6][7] The public healthcare system is therefore under immense pressure and the private healthcare sector has the role of reducing this significant burden.

3.3. This exemption application focuses solely on the private healthcare sector, in particular the market for the retail of medicines in South Africa.

3.4. *Brief overview of the pharmaceutical product supply chain in South Africa*
The diagram below provides a brief overview of the medicine supply chain in SA.

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[1] Notice 1166 of 2013, *"Terms of Reference for Market Inquiry into the Private Healthcare Sector"* Government Gazette No. 37062, Vol 581, 29 November 2013, at 75-76.
[2] CMS Industry Report 2024 https://www.medicalschemes.co.za/publications/#2009-2010-wpfd-annual-reports
[3] Notice 1166 of 2013, *"Terms of Reference for Market Inquiry into the Private Healthcare Sector"* Government Gazette No. 37062, Vol 581, 29 November 2013, at 75-76.
[4] Oxfam SA 2020 Healthcare Policy Brief www.oxfam.org.za/wp-content/uploads/2020/06/Oxfam_Healthcare-Policy-Brief_FINAL_20200630-2.pdf
[5] Mkhize NI. Critical assessment of health financing indicators and expenditure in South Africa. Health SA. 2026 Jan 27;31:3142. doi: 10.4102/hsag.v31i0.3142. PMID: 41647058; PMCID: PMC12869480.
[6] Minnie, T Impact Rx *"A review of the South African Pharmaceutical landscape"* (prepared for UTI South Africa), November 2015 at Slide 4.
[7] IQVIA South Africa Monthly Market Feedback Report January 2024

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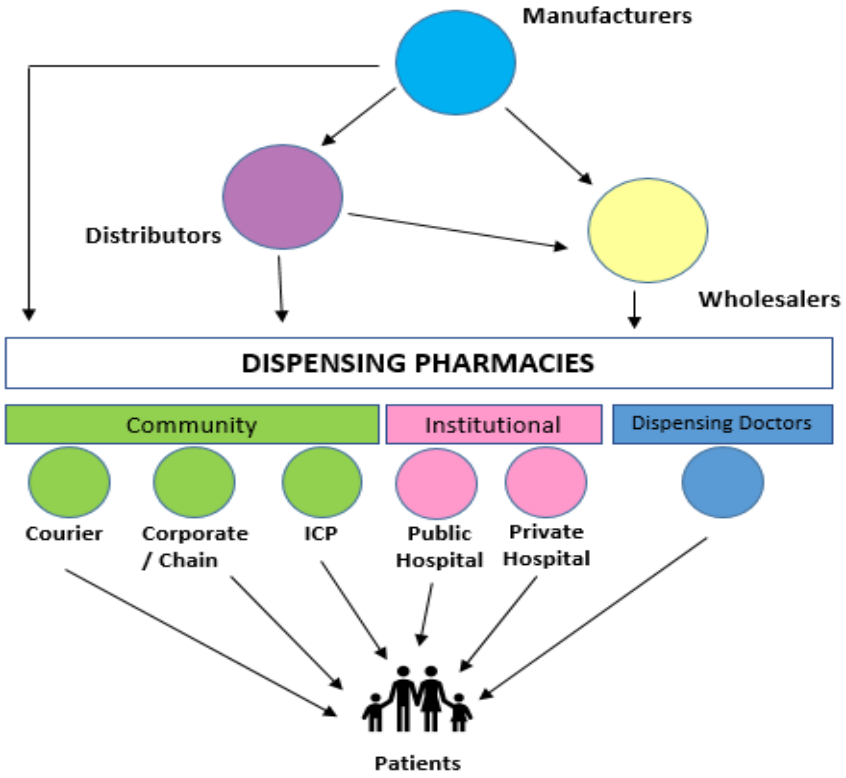

3.5. South Africa's medicines supply chain is fragmented and complex.

3.5.1. Medicines are either manufactured in South Africa or imported. These manufacturers (including importers) provide medicines to distributors, wholesalers or directly to dispensing pharmacies.

3.5.2. Distributors provide medicines to wholesalers or to dispensing pharmacies.

3.5.3. Wholesalers provide medicines to dispensing pharmacies.

3.5.4. Community and institutional pharmacies provide medicines directly to patients.

3.6. The price of SEP medicines is regulated ex-manufacturer at all points of the supply chain and is essentially sold at the same price at each level. This is discussed in further detail in paragraphs 3.16 to 3.18 below.

3.7. This application involves only the private healthcare market for the retail of medicines and therefore does not focus on pharmacies that provide medicine funded by the public healthcare system. The application focuses specifically on community pharmacies which is the category within which ICPs fall.

Community pharmacies

3.8. Community pharmacies include courier pharmacies, corporate pharmacies and ICPs.

3.8.1. Courier pharmacies enable consumers to order chronic medication online / telephonically which is then delivered to a specified delivery point for the

customer to collect / directly to the customer.

3.8.2. Corporate pharmacies include Clicks, Dis-Chem and Medirite who operate their entire stores as pharmacies which may also supply non-medicine items.

3.8.3. ICPs are often owner-run and are mainly small businesses. In contrast to corporate pharmacies, an ICP's business is traditionally limited to the sale of medicines and related products and the provision of pharmacy services in the community they serve.

Regulation of the market for the sale of medicines

3.9. The market for the sale of medicines is highly regulated. The main legislative instrument is the Medicines and Related Substances Control Act, under which several regulations have been promulgated.

3.10. Of relevance to the present application are sections 18A and 22G of the Medicines Act.

3.11. Section 18A states that no person shall supply any medicine according to a bonus system, rebate system or any other incentive scheme. The provisions do appear broad, however there are currently draft regulations that aim to clarify the meaning and application of the section.[8]

3.12. Section 22G essentially provides for the introduction of a transparent pricing system for all medicines.

3.13. The Medicines Act further divides medicines into schedules, to which various restrictions apply, *inter alia*:

3.13.1. Any Schedule 0 substance may be sold in an open shop.;

3.13.2. Schedule 1 and 2 medicines may be sold over-the-counter at pharmacies only, by pharmacists and Pharmacist's Assistants under the supervision of a pharmacist, and do not require a doctor's prescription;

3.13.3. Schedule 3 – 6 medicines sold in a pharmacy, may only be dispensed by a pharmacist, pharmacist intern or a pharmacist's assistant acting under the supervision of a pharmacist and require a prescription from an authorised prescriber.

3.14. Medicines that do not fall into any of the categories as outlined in the schedules are termed "unscheduled" medicines.

3.15. The transparent pricing system contemplated in section 22G was introduced by the SEP Regulations.

3.16. The SEP Regulations introduced a Single Exit Price (SEP) to which the sale of all

[8] GNR 642 of 22 August 2014, Government Gazette No. 37936 at 3.

scheduled medicines in South Africa are subject (but see paragraph 3.19 below). The SEP comprises the price for a medication set by the manufacturer or importer of a medicine, a logistics fee and VAT.

3.17. The SEP Regulations state that the relevant medicines must be sold at the SEP at every stage of the supply chain (however, wholesalers and distributors are entitled to receive / retain the logistics portion of the SEP). No buyer may receive a discount on the SEP. Importantly; pharmacies must purchase the medicine from the supplier at the SEP and may not sell the medicine at a price below the SEP to the consumer. The SEP must be clearly and legibly reflected on the packaging for medication.

3.18. In this regard, the Regulations further provide for a dispensing fee that pharmacists may charge when dispensing medicines. Such dispensing fee is subject to a regulated cap. The cost of medicines for consumers can therefore not exceed the SEP plus the maximum prescribed dispensing fee.

Non-SEP medicines

3.19. In terms of GN 49140 of 18 August 2023 , Schedule 0 medicines are exempt from the application of sections 18A and 22G(3) of the Medicines Act for a period of three years from the date of publication thereof.[9] As a result, Schedule 0 medicines, in addition to unscheduled medicines, are currently not subject to the transparent pricing system and there is no SEP for such medicines

3.20. Non-SEP medicines may be sold in pharmacies or "open shops". They do not have to be dispensed and do not require a prescription.

3.21. As non-SEP medicines are not subject to section 18A of the Medicines Act and the transparent pricing system, pharmacies are able to negotiate their price and the terms of purchase with manufacturers and other suppliers and are able to base the price at which non-SEP medicines are sold to consumers on the price at which such medicines are obtained from suppliers and on competitive considerations.

SEP medicines

3.22. Scheduled medicines may only be purchased and sold by pharmacies at the SEP. Pharmacists may charge a dispensing fee on the dispensing of SEP medicines in addition to the SEP, however as referred to in paragraph 3.18 above, such dispensing fee is capped by regulation.

3.23. Where the cost of a certain SEP medicine is recognised as one that will be covered by a medical aid scheme, this is subject to certain conditions especially in regard to Prescribed Minimum Benefits (PMBs)

Regulation 8(1) of the MSA makes it mandatory for medical schemes to pay in full for the provision of treatment in respect of the list of PMBs. It is immediately

[9] We note that such an exemption has been granted several times before and has been renewed prior to it lapsing. Currently it applies until 17 August 2026..

followed by regulation 8(2) which provides for the appointment of DSPs, and the levying of co-payments when a beneficiary uses a non-DSP. Regulation 8(2) reads:

(2) Subject to section 29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that-

- *the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and*
- *a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.*

Regulation 8(2)(b) does not expressly set the manner in which a medical scheme is required to calculate the co-payment or deductible. The obvious purpose of the provision is that, if a medical scheme appoints one or more DSP, it need only pay the price for treatment for PMBs it has agreed with its DSPs. If a member uses another service provider that charges more than the DSP, the difference is charged as a co-payment to the member. The medical scheme never pays more than the DSP rate. Unfortunately, medical schemes have decided to use the co-payment rule as a tool to channel patients to chosen providers and they achieve this by applying exorbitant co-payments, anywhere from 20% to 100% of the SEP and dispensing fee. This reduces access as the financial burden prevents scheme beneficiaries using pharmacies of choice.

3.24. Medical schemes are generally disinclined to appoint ICPs as DSPs or PPs due to the administrative burden of individual contracts. (meaning that medical scheme subscribers will be required to make co-payments at these ICPs which may effectively exclude them as customers) or to negotiate individual terms with ICPs and therefore impose unsustainable dispensing and professional fee rates at which they will reimburse ICPs. This exclusion from DSP arrangements means scheme beneficiaries must pay a penalty co-payment if they access services from their local ICP.

3.25. If a medical scheme does invite an ICP to join a DSP or PP network they do not negotiate individual terms with ICPs and therefore impose unsustainable dispensing and professional fee rates at which they will reimburse ICPs.

3.26. As the ICP cannot sell the SEP medicine above the SEP, the dispensing fee is crucial to the viability of its business. The ICP is therefore unable to contribute to the sustainability of its business through the sale of SEP medicines to medical scheme subscribers, who form a significantly large portion of the private healthcare market.

3.27. ICPs are effectively faced with the choice of accepting unsustainable reimbursement rates or being excluded from scheme networks.

3.28. Pharmacies that form part of DSP / PP Network negotiate the dispensing fee rate at which the medical scheme will reimburse it. This may not exceed the regulated cap for the relevant dispensing fee but usually falls well below it. Again, single ICPs do not have the ability to negotiate with schemes and must accept the DF offered or face exclusion.

Professional pharmacy services

3.29. Pharmacists also provide professional pharmacy services including, *inter alia*, administering blood pressure, cholesterol and blood glucose tests amongst others.

3.30. In providing these services, the rate thereof must be negotiated with the relevant medical scheme.

Practical Impact on Independent Community Pharmacies

3.31. ICPs are facing a number of financial challenges that are directly linked to their weakened bargaining power as small individual businesses.

3.32. The sustainability of ICPs is dependent on:

3.32.1. the margin on the sale of non-SEP medicines;

3.32.2. the dispensing fee charged on SEP medicines (which dispensing fee is subject to a regulated cap); and

3.32.3. the professional fee charged for the provision of pharmacy services.

3.33. To remain financially viable, a pharmacy must therefore, *inter alia*:

3.33.1. be able to negotiate an appropriate price for the purchase of non-SEP medicines from suppliers such that it can sell these medicines to customers at a competitive yet sustainable price;

3.33.2. be able to effectively negotiate with medical aid schemes / administrators to become a DSP or PP and for the payment of appropriate dispensing fees on SEP medicines and professional fees.

3.34. With regard to non-SEP medicines:

3.34.1. ICPs are generally small, owner-run businesses who negotiate individually with suppliers and therefore have very weak bargaining power compared to the economies of scale available to large corporate pharmacy groups. They also, do not enjoy logistics fees through vertical integration.

3.34.2. ICPs compete with, *inter alia*, large corporate pharmacies (which may

comprise in excess of 800 pharmacies with annual revenue in billions of rands), in the retail of non-SEP medicines. Such competitors are large companies / groups that purchase in large quantities, have strong bargaining power and are able to negotiate low / favourable prices for the purchase of unscheduled medicines.

3.34.3. These corporate pharmacies are able to then impose a profitable mark-up on the non-SEP medicines and sell at a price with which ICPs cannot compete – often below prices ICPs can even purchase at. ICPs are essentially price-takers and are forced to sell non-SEP medicines at a price that is not, relative to the price at which such medicines are purchased, sustainable and thus cannot remain competitive.

3.34.4. It is therefore imperative that ICPs are able to negotiate best prices at which to purchase non-SEP medicines so that they are able to sell these on to customers at prices that are both sustainable and competitive. The bargaining power conditional exemption would provide ICPs with would increase competition, lower medicine prices and ultimately benefit the patient.

3.35. With regard to SEP medicines:

3.35.1. In the private healthcare system, a significant portion of the sales of medicines are to medical scheme beneficiaries for chronic and PMB conditions (repeat business) – it is therefore crucial to the business of a pharmacy that it is recognised as a DSP / PP. Where a pharmacy is not part of a DSP / PP network (and a medical scheme has appointed such a closed network) a patient must pay an out-of-pocket penalty co-payment for medicines that would otherwise be covered in full by the medical scheme. This co-payment is a percentage of the SEP and the DF. Consumers who already pay high medical scheme membership fees are loathe to pay out-of-pocket expenses on items that can be covered by the medical scheme at another pharmacy. When a pharmacy is not recognised as a DSP or PP it is essentially then excluded from fairly competing for the business of medical scheme members, who purchase a large portion of SEP medicines.

3.35.2. ICPs find it extremely difficult to become part of DSP / PP networks as it is cumbersome for medical schemes to negotiate such status with each ICP individually. In contrast, where a corporate pharmacy wishes to become part of such a network, this involves a single negotiation with a single point of entry that will result in several pharmacies being so recognised.

3.35.3. Where a pharmacy is recognised as a DSP / PP this is not sufficient to ensure a viable business. Where a pharmacy is a DSP and/or PP the dispensing fee that is charged on relevant medicines purchased under a medical scheme is negotiated with that scheme and the pharmacy may not charge a higher fee to members of that scheme. The pharmacy must be able to negotiate a sufficient dispensing fee to remain viable.

3.35.4. In this regard, we note that the methodology for calculating the dispensing fees

on SEP medicines was based on what was necessary for the sale of such medicines to be viable for pharmacies. Where the dispensing fee is below the regulated cap this is then likely to be unviable. It is impractical for medical schemes to negotiate price and other terms with each of the over 1200 ICPA members and this, together with the weak bargaining power of ICPs, prevents them from negotiating appropriate dispensing fees with medical schemes. Accordingly, ICPs are often forced to accept reimbursement at a rate well below the regulated cap. Medical Schemes will further not grant / will remove DSP and PP status from Independent Pharmacies if they are not prepared to agree to these lower dispensing fees.

3.35.5. ICPs are therefore either forced to accept low and unsustainable dispensing fees or to operate outside of the DSP or PP network and essentially not compete for the business of medical scheme members . Neither option is viable for ICPs. Were ICPs able to increase their bargaining power through collective negotiation as an IP Network, such challenges could be overcome and contribute to ensuring the continued viability of ICPs. The medical schemes would have the ease of negotiating with a single entity to secure access points across the country for their beneficiaries.

3.36. Similarly, ICPs cannot negotiate appropriate professional fees, and while it is imperative that they be recognised as venues at which the full cost of such services will be covered for medical scheme members, it is equally important that Independent Pharmacies are able to negotiate sufficient professional fees, which the ICPA submits can only be done by collective negotiations.

Social importance of pharmacists and ICPs

3.37. Pharmacists serve the very important healthcare role of enabling and regulating access to medications.

3.38. In a country where the healthcare system is struggling to manage the increasing burden of disease due to the lack of resources, pharmacies can relieve some of the burden on the private and public healthcare systems and provide a route through which patients can receive care and treatment for certain conditions.

3.39. As an accessible member of the healthcare team, the pharmacist plays an important role in the maintenance of the health of the community. The promotion of health through the implementation of disease prevention programmes in the community at large, screening programmes to identify community health deficiencies and responding to epidemiological trends in the community are important roles of the pharmacist in their role as healthcare provider. This was evident during the Covid 19 Pandemic, when pharmacies were the first responders in testing and vaccinating the country's population.

3.40. Pharmacy has an essential social function and the viability of the profession and business is a matter of public interest.

3.41. ICPs, particularly in rural areas, provide the only or at least first port of call for

affordable trusted medical advice and treatment. While the corporate and chain pharmacies are largely located in busy shopping and commercial centres / malls, ICPs are often located in rural and suburban areas. The cost of access to the local ICPs is often significantly less than the cost of access to the commercial centres. ICPs that are able to operate sustainably can therefore provide customers with more affordable access to medicines. The erosion of ICPs due to weak bargaining power will deprive patients of such care and access.

3.42. These structural constraints demonstrate that ICPs are unable to compete effectively on an individual basis. This fact establishes the necessity of the Requested Exemption as a proportionate mechanism to enable meaningful participation in the market.

4. Application of Section 10(3) of The Competition Act

The ICPA respectfully submits that the Requested Exemption satisfies the requirements of section 10(3) of the Competition Act.

In accordance with Competition Tribunal guidance, the assessment requires consideration of:

(i) whether the agreement contributes to a recognised objective; and

(ii) whether the restriction on competition is required to achieve that objective.

4.1. Contribution to Statutory Objectives

4.1.1. Promotion of SMME participation (section 10(3)(b)(ii))

ICPs are predominantly small, owner-managed businesses operating in a highly regulated and increasingly concentrated market.
Corporate pharmacy groups benefit from:

- centralised procurement;
- vertical integration (distributor, wholesaler, retailer supply chain with multiple profit points)
- established supplier relationships; and
- collective negotiation power.

The Requested Exemption will enable ICPs to:

- improve procurement terms;
- secure sustainable reimbursement rates;
- remain competitive in a highly competitive market;
- reduce costs of essential medicines; and
- participate meaningfully in DSP and preferred provider networks.

4.1.2. Competitiveness and efficiency gains (section 10(3)(b)(v))

The exemption enhances competitiveness by:

- reducing fragmentation in negotiations;

- improving operational sustainability; and
- enabling ICPs to compete more effectively.

This supports:

- improved patient access;
- continuity of care; and
- reduced pressure on public healthcare services.

4.2. Necessity of the Restriction

The Requested Exemption is necessary.
ICPs acting individually:

- lack bargaining power;
- face higher procurement costs;
- struggle to access DSP networks.

Collective negotiation is therefore essential—not optional—to enable meaningful participation in the market.
The restriction is limited and proportionate to achieving these objectives.

5. Scope and limits of the requested exemption

5.1. The ICPA emphasises that the Requested Exemption is narrowly defined.

The exemption will **not** permit:

- fixing of retail prices;
- restriction of patient choice;
- standardisation of service delivery.

The exemption is limited to:

- procurement negotiations (non-SEP medicines);
- reimbursement and network negotiations.

ICPs remain independent in:

- pricing decisions;
- service offerings;
- clinical and operational matters.

5.2. Safeguards

The ICPA proposes:

- voluntary participation;
- eligibility limited to independent pharmacies;

- no unnecessary exchange of competitively sensitive information;
- annual reporting to the Commission;
- a defined exemption period (e.g. 5 years).

6. **Parties to the Proposed Agreements**

6.1. The IP Network intends to negotiate, on behalf of its members, with:

6.1.1. manufacturers / other suppliers of medicines;

6.1.2. medical schemes / administrators; and

6.1.3. relevant statutory bodies or any other relevant organisation where required

6.2. The intention is for members of the ICPA to have the option of joining the IP Network (i.e. it will be an "opt-in" network within the ICPA) on the following conditions:

6.2.1. any member that joins the IP Network will become party to any agreements it has with the relevant manufacturers / other suppliers or medical schemes / administrators at the time of joining; and

6.2.2. any member that leaves the IP Network will cease to be a party to such agreements.

6.3. The members of the IP Network will continue to compete amongst themselves, *inter alia*, with:

6.3.1. the prices to consumers of unscheduled medicines; and

6.3.2. the dispensing fees charged to medical scheme subscribers (IP Network members will be allowed, if they wish, to charge below the rate agreed with the medical schemes but not above it); and

6.3.3. the dispensing fees charged to non-medical scheme subscribers.

7. **Overview of the Proposed Agreements**

The Proposed Categories of Agreements involve:

7.1. the centralised / collective procurement and collective bargaining with medicine suppliers to obtain favourable prices or terms and conditions on the purchase of non-SEP medicines for the member ICPs (the IP Network will essentially operate as a joint buying group with the ability to leverage economies of scale similar to the corporate pharmacy groups); and

7.2. the centralised negotiation of agreements with medical aid schemes / administrators to appoint the IP Network / the member ICPs as DSPs / PPs, and for favourable dispensing and professional fee rates for the member ICPs by the IP Network on behalf of its members.

8. **Proposed Categories of Agreements likely to contravene Chapter 2 of the Competition Act**

8.1. ICPA's members and potential members of the IP Network (Independent Pharmacies) are in a horizontal relationship.[10] Section 4 of the Competition Act reads as follows:

(1) An agreement between, or concerted practice by, firms, or a decision by, firms, or a decision by an association of firms, is prohibited if it is between parties in a horizontal relationship and if –

(a) …

(b) it involves any of the following restrictive horizontal practices:

(i) directly or indirectly fixing a purchase or selling price or any other trading condition;

(ii) …

(iii) …

8.2. The restrictive practices contained in section 4(1)(b) are "per se" contraventions – i.e. they constitute contraventions of the Competition Act regardless of the effect of the practices. Therefore, it is only necessary to prove the existence of the relevant agreement / practice to establish a contravention of the Competition Act.

8.3. We believe that any decision taken by the IP Network (on behalf of its members) will constitute conduct by an association of firms and falls to be assessed under section 4 of the Competition Act.

8.4. Assessment of the proposed joint procurement (including joint negotiations for the prices) of unscheduled medicines from manufacturers / other suppliers (through the IP Network):

8.4.1. The Tribunal has ruled that joint procurement constitutes price-fixing in contravention of section 4(1)(b)(i) of the Competition Act. [11]

8.4.2. Essentially, where parties to a joint procurement agreement are competitors, they behave as a buyers' cartel.

8.4.3. The proposed agreements to jointly procure (and negotiate the prices) of unscheduled medicines from manufacturers / other suppliers will by itself,

[10] In *Competition Commission and two others v United South African Pharmacies and other* 04/CRJan02 at page 8 the Tribunal explained that "what the Act requires by the notion that parties are in a horizontal relationship is an allegation that they are in the same line of business". Neither the language of the Act nor the logic of how the section works requires that the allegations that the respondents' operation in the same geographical market in order to be considered competitors. Take, for instance, the prohibition of dividing markets by allocating territories, set out in section 4(1)(b).

[11] See*, inter alia, The Competition Commission and Columbus Stainless Proprietary Limited,* Case No. 020297

if implemented, amount to price fixing and constitute a contravention of section 4(1)(b)(i) of the Competition Act.

8.5. Assessment of the proposed joint negotiations with medical schemes of dispensing and professional fee rates (through the IP Network):

8.5.1. The Commission and Tribunal have consistently considered joint negotiations to constitute price-fixing in contravention of section 4(1)(b)(i) of the Competition Act.[12]

8.5.2. The proposed agreements to jointly negotiate the dispensing fees on scheduled medicines and relevant professional fees with medical schemes will by itself, if implemented, amount to price fixing and constitute a contravention of section 4(1)(b)(i) of the Competition Act.

9. **Proposed Agreements will promote the ability of small businesses to become competitive**

9.1. The weak bargaining power of ICPs has prevented them from effectively competing with the larger chain pharmacies and from being able to operate viable businesses.

9.2. Importantly, the ICPA's members are SMMEs, many of which are owned / controlled by historically disadvantaged persons.

9.3. Under current circumstances, the businesses of ICPs are largely unsustainable. The closure of any ICP represents a loss to the community in terms of its role in the community and the services it is able to provide and the resultant loss of jobs.

9.4. By negotiating as a network , the effective bargaining power of ICPs will increase, resulting in ICPs being able to remain sustainable through the sales of non-SEP and SEP-medicines and pharmacy services by:

9.4.1. being able to sell non-SEP medicines at sustainable and competitive prices; and

9.4.2. being able to sustainably operate as an Independent Pharmacy Network (i.e. the pharmacies will be able to negotiate recognition as part of a DSP / PP Network and each pharmacy will be able to receive a reasonable dispensing and professional fee from medical schemes on the sale of dispensed medication to medical scheme members).

9.5. The ICPA submits that the Required Exemption is therefore imperative to promote the ability of these small businesses to become competitive.

9.6. The Requested Exemption is vital in ensuring the continued viability of ICPs, the absence of which will likely lead to small businesses exiting the market. In this situation they will cease to compete with the courier and larger corporate

[12] Consent orders: Competition Commissioner v South African Medical Association and Members of First Respondent CT Case No. 23/CR/Apr04 *and* Competition Commissioner v The Hospital Association of South Africa and Ordinary Members of First Respondent CT Case No. 24/CR/Apr04.

pharmacies.

10. **Request for an exemption from the provisions of Chapter 2 of the Competition Act**

10.1. Section 10 of the Competition Act provides that a firm may apply to the Commission to have, *inter alia*, an agreement / category of agreements or practices exempt from the application of Chapter 2 of the Competition Act. It further states that the Commission must grant a conditional or unconditional exemption for a specified term where the agreement / category of agreements meets the requirements of subsection 3, which reads as follows:

(a) any restriction imposed on the firms concerned by the agreement or practice concerned, or category of either agreements or practices concerned, is required to attain an objective mentioned in paragraph (b); and

(b) the agreement concerned, or category of agreements or practices concerned, contributes to any of the following objectives:

(i) maintenance or promotion of exports;

(ii) promotion of the effective entry into, participation in or expansion within a market by small and medium businesses, Competition Commission South Africa 41 or firms controlled or owned by historically disadvantaged person

(iii) change in productive capacity necessary to stop decline in an industry;

(iv) the economic development, growth, transformation or stability of any industry designated by the Minister, after consulting the Minister responsible for that industry; or

(v) competitiveness and efficiency gains that promote employment or industrial expansion.

10.2. Accordingly, the parties hereby request that the following categories of agreements be exempt from the provisions of Chapter 2 of the Competition Act:

10.2.1. the collective procurement, including joint negotiations, with manufacturers and other suppliers in order to obtain favourable prices or terms and conditions on the purchase of unscheduled medicines (the IP Network will essentially operate as a joint buying group);

10.2.2. the joint negotiation of dispensing fee rates with medical aid schemes and/or medical scheme administrators and facilitating agreements to this effect; and

10.2.3. negotiations and agreements with relevant statutory bodies or any other relevant organisation to further the needs of the IP Network in order to afford them the opportunity of equal competitive power with large corporate and chain pharmacies.

10.3. The ICPA requests that such exemption be granted for a period of 5 (five) years.

10.4. The ICPA respectfully submits that, having regard to –

10.4.1. the high level of regulation in the pharmaceutical industry in general and in the market for the retail of medicines in particular;

10.4.2. the limited avenues and scope for profit realisation in the market for the retail of medicines;

10.4.3. the current weak bargaining power of ICPs as compared to manufacturers / other suppliers, medical schemes and large chain pharmacies and supermarkets; and

10.4.4. the resulting unsustainability of ICPs in the long-term,

the Requested Exemptions are required to promote the ability of small businesses (Independent Pharmacies) to become competitive. Without the Requested Exemptions being granted, these small / medium businesses and/or firms owned / controlled by historically disadvantaged persons cannot effectively participate and definitely not expand in the market. Furthermore, this report and application is aligned with the objectives set out in Section 10(3)(b).

10.5. Accordingly, the ICPA requests that the Commission grants the Requested Exemption unconditionally and for a period of 5 years.

11. **Precedent in Granting Similar Exemption in the Healthcare Industry**

11.1. In 2018 the Commission granted the National Hospital Network ("**NHN**") a five-year exemption from certain provisions of Chapter 2 of the Competition Act allowing collective bargaining, global fee negotiations and centralised procurement.

11.2. The NHN is, similarly to ICPA / the IP Network, a group of independent private hospitals struggling, as small businesses and/or firms controlled by or owned by historically disadvantaged persons to become competitive in a healthcare industry characterised by high levels of concentration and high barriers to entry.[13]

11.3. The Commission found that the pro-competitive gains that would arise from the exemption would enable the NHN members to compete effectively in the market.

11.4. We believe that the exemption granted to the NHN is, as regards the market for the provision of hospital services to patients, identical to the exemption requested herein, having regard to the nature and position of the parties to whom the

[13] Competition Commission Media Statement, *"National Hospital Network Granted Conditional Exemption"* 8 November 2018.

exemption is to apply to, the activities sought to be exempt, and the legal and competitive basis for the exemption.

12. **Public interest considerations**

Independent community pharmacies are essential to healthcare access in South Africa. They:

- provide frontline healthcare services;
- support early intervention;
- reduce burden on public facilities;
- serve as a counterbalance to the market power that the 3 (three) corporate pharmacy groups wield.

Without intervention:

- pharmacy closures in poorly resourced areas may increase;
- access may decline;
- inequality in healthcare provision may worsen;
- an oligopoly may form.

The Requested Exemption supports:

- equitable access to care;
- sustainability of SMMEs;
- improved competition;
- national health policy objectives.

13. Conclusion

The ICPA respectfully submits that the Requested Exemption satisfies the requirements of section 10(3) of the Competition Act and should accordingly be granted by the Commission.

The evidence set out in this application demonstrates that independent community pharmacies operate within a highly regulated and increasingly concentrated market in which they face significant structural disadvantages relative to large corporate pharmacy groups. These disadvantages materially impair the ability of ICPs to compete effectively, negotiate sustainable procurement and reimbursement arrangements, and continue providing accessible healthcare services within the communities they serve.

The Requested Exemption is limited in scope, proportionate, and necessary to address these structural imbalances. It does not seek to fix retail prices, restrict patient choice, or undermine competition. On the contrary, the exemption seeks to enhance competition by enabling ICPs to participate more effectively in the market and by providing a countervailing mechanism against increasing concentration within the retail pharmacy sector.

The Requested Exemption will:

- promote the participation and sustainability of SMMEs and firms owned or controlled by historically disadvantaged persons (HDPs);
- improve competitiveness and efficiency within the sector;
- support equitable patient access to healthcare services;
- reduce pressure on the public healthcare system; and
- contribute to the long-term sustainability and diversity of the pharmacy profession in South Africa.

The ICPA further submits that the safeguards proposed in this application ensure that the exemption will operate in a transparent, accountable, and proportionate manner consistent with the objectives of the Competition Act.

In light of the above, the ICPA respectfully requests that the Competition Commission grant the Requested Exemption for a period of five (5) years, either conditionally or unconditionally, on such terms as the Commission may deem appropriate.

Yours sincerely

Jackie Maimin
Chief Executive Officer
Independent Community Pharmacy Association NPC (ICPA)