Making the most of an accredited South African Pharmaceutical Journal

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For many years, whenever the possibility of achieving recognition for the South African Pharmaceutical Journal (SAPJ) as an accredited, peer-reviewed academic publication was raised, South African pharmacy academics were implored to "sacrifice" their own or their students' work by publishing it in the journal. The assumption was that, through demonstrating the existence of an appropriate peer review process and the publication of academic articles, the relevant authorities could be persuaded to recognise the publication as worthy of accreditation. Those publications submitted prior to accreditation would not be recognised as peer-reviewed and would not attract the subsidy provided to universities by the education authorities. They would, however, be considered "published", so could not be submitted elsewhere. Academics' reluctance to contribute to this process was thus understandable.

In September 2025, the editor of the SAPJ announced that the journal had been included in the Department of Higher Education and Training's accredited Scopus list.[1] She pointed out that the journal now carries "a disproportionate responsibility and opportunity — it is the primary accredited, local journal fully dedicated to pharmacy in South Africa, and one of only a handful across the continent that blends discipline specificity, accreditation, and continental identity". She expounded on the responsibility to ensure that the journal maintains the required quality standards, proposing in addition that there should be a focus on "contested questions — around policy, equity, cost, accessibility".

While not detracting from the journal's remit to cover issues of relevance at the African and global levels, it is worth highlighting some of the burning questions that need urgent attention in the South African pharmaceutical arena. Manuscripts that address these questions, not only exploring the problems in depth, but offering potential solutions, are urgently needed. Locally relevant and rigorous scholarship will make the most of an accredited SAPJ.

There are design elements of the South African health system that seem so "hard baked" as to be immovable. They are "designed" in the sense that they represent political choices and compromises at particular points in colonial and post-colonial periods of history and are now entrenched. An early choice made at the time of Union was to separate preventive and curative functions. Preventive health, which was defined rather idiosyncratically to include such services as family planning and psychiatry, was to be the responsibility of the central government, while the four new provinces were entrusted with delivering curative health services. The separation had first been introduced in the Cape Colony in 1897. David Harrison has covered the ways in which public health advocates argued for a co-ordinated approach to the delivery of health services but failed to make any progress.[2] At various points, Commissions of Inquiry tried to find a way forward. The 1925 Committee of Inquiry into Public Hospitals and Kindred Institutions was followed by the National Health Services (Gluckman) Commission, which sat from 1942 to 1944. Despite these forays into what would now be considered universal health coverage (UHC) ideas, the separation between preventive and curative health was retained in the 1977 Health Act. That decision had implications for the supply of medicines, in that hospitals operated by the Department of National Health and Population Development, as well as family planning clinics and the homeland health services, relied on the Defence Force medicine depots until the late 1980s.

While less easily traced in historical documents, the separation between the public and private health sectors in South Africa is also well entrenched. The Gluckman Commission envisaged a unitary health system, but implementation failed even before the 1948 election.[3] While by no means aiming to abolish the private health sector, the 2023 National Health Insurance Act has the potential to overturn more than a century of sustained divisions in the South African health system. In particular, the NHI Act will radically affect the powers and roles of the provinces in ways which are still somewhat unclear. There is even less certainty regarding the ways in which medicines will be selected, priced, procured or reimbursed by the National Health Insurance (NHI) Fund. There are principles outlined (such as the use of health technology assessment), some structures

defined (and even some in nascent form), but many unanswered questions. The SAPJ presents a wonderful opportunity to publish analyses of the options, assessments of the policy choices, and descriptions of early implementation and its impact.

UHC, whether in the form outlined in the contested NHI Act or some variant that emerges following legal challenges to the legislation, will depend on the availability of sufficient financing, health infrastructure and human resources. South Africa's pharmaceutical infrastructure is currently divided sharply between public and private sectors, notwithstanding the few public-private partnerships and under-utilised "pick-up-points" for repeat medication. South Africa is in the anomalous situation of having insufficient pharmaceutical human resources, inequitably distributed, but simultaneously at risk of producing more pharmacy graduates than the existing health system can absorb. NHI holds out the promise of being able to bring the entirety of South Africa's pharmaceutical human resources to bear in meeting the health needs of the country. However, much rests on how medicines supply will be reimbursed and how clinical services are valued. The SAPJ would welcome analyses of the current situation, efforts to address the divisions and shortcomings of the past, and evidence of the added value of expanded pharmacy services. The South African Pharmacy Council's efforts to reform the role of pharmacy support personnel and develop sustainable specialist registers are also deserving of close scholarly attention.

The impact of centuries of colonial rule, *apartheid* health policies and continued dysfunction in South Africa's health system are evident in the burden of disease faced by communities.[4] Equitable access to affordable, quality-assured essential medicines is critical to any efforts to deliver UHC and ameliorate South Africa's burden of disease. Like many African health systems, the South African public sector has been focused predominantly on the delivery of episodic, acute care for communicable diseases. The private sector is also not able to ensure effective, people-centred, differentiated delivery systems geared to long-term management of non-communicable diseases. Distance dispensing options, whether in the public or private sectors, are poorly designed to support adherence and persistence, with responsive monitoring of health outcomes. Health information systems are also poorly developed or fragmented. While electronic health records hold out the possibility of improved access to data, transforming those data into actionable health management information and ensuring its effective use remain challenges across the entire South African health system. By focusing particularly on the role of essential medicines and their impact, South African academics and health practitioners can contribute to bridging this gap.

The COVID-19 pandemic has raised global interest in the challenges of ensuring health technology supply security, including for essential medicines and vaccines. Geographically diversified production of both active pharmaceutical ingredients and finished pharmaceutical products is now being actively pursued by national, regional and continental bodies. The entire pharmaceutical ecosystem requires attention, from industrial policies to regulatory capacity, from tax incentives to pricing practices, from pooled procurement to reliance. Although South Africa has not yet, inexplicably, ratified the treaty establishing the African Medicines Agency, it is already heavily engaged in continental efforts to build reliance, work-sharing and eventually mutual recognition options. At the same time, the South African Health Products Regulatory Authority (SAHPRA) is pursuing Maturity Level 3 status with the World Health Organization for medicines regulation, having already achieved that status for vaccine regulation. Continued reform of South Africa's medicines regulatory system will require the passage of a new SAHPRA Act, finally consigning the 1965 Medicines and Related Substances Act to the history books. While the development of the new law has already commenced, that effort is occurring without an underpinning national medicines policy. The 1996 National Drug Policy no longer provides a meaningful set of policy directives, nor does it cover what would be needed in a unified health system aimed at UHC. The SAPJ provides a suitable "home" for publishing relevant policy analyses, learning from past experience and outlining the options for the future, while tracking the implementation and impact of emergent policies. A fit-for-purpose National Medicines Policy will depend on the evidence generated by those scholarly endeavours.

South Africa's experiences during the COVID-19 pandemic have also spurred the development of the Department of Science, Technology and Innovation (DSTI) - National Research Foundation (NRF) Institute for the Preparedness and Prevention of Pandemics (IP3).[5] This effort brings together 10 South African universities. Every element of the pharmaceutical value chain, from research and development to manufacturing, distribution and effective use will require attention. Among the expected outcomes are "rapid development pipelines for vaccines, diagnostics and therapeutics generated locally rather than relying on global supply chains", "expanded clinical trial and laboratory capacity across the country and, eventually, the region", and "stronger, more resilient health systems able to respond quickly to threats while maintaining essential services".

Each of those outcomes echoes elements already explored in this editorial. Each represents a research imperative that the pharmacy profession cannot afford to ignore. Each represents an opportunity to build the reputation of the SAPJ as a preferred journal to publish high-quality and locally relevant manuscripts.

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